



Center for  
Health System  
Development



*American  
University-  
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## **Policy Research Paper № 49**

# **Tracking Global HIV/AIDS Initiatives and their Impact on the Health System: the Experience of the Kyrgyz Republic**

### **Interim Report**

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## Abbreviations

AIDS	- Acquired immune deficiency syndrome
ARV	- Antiretroviral therapy
CMCC	- Country Multi-Sectoral Coordination Committee on HIV/AIDS, TB and Malaria under the Government of the Kyrgyz Republic
CSW	- Commercial sex worker
ES	- Epidemiological Surveillance
FGP	- Family Group Practice
FMC	- Family Medicine Center
GFATM	- Global Fund to Fight HIV/AIDS, TB and Malaria
GUIN	- Punishment execution department
HIV	- Human immune deficiency virus
IDU	- Intravenous drug user
KR	- Kyrgyz Republic
MOH	- Ministry of Health
MOI	- Ministry of Interior
MOJ	- Ministry of Justice
M&E	- Monitoring and evaluation
MSM	- Men having sex with men
NEP	- Needle exchange point
NGO	- Nongovernmental organization
OMCC	- Province (oblast) Multi-Sectoral Coordination Committee
PLWHA	- People living with HIV/AIDS
SMT	- Substitutive Methadone therapy
STI	- Sexually transmitted infections
VCT	- Voluntary consulting and testing
WHO	- World Health Organizations

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## EXECUTIVE SUMMARY

- The **Center for Health System Development** of the **Kyrgyz Republic** is conducting a three-year project: 'Tracking global HIV/AIDS initiatives and their impact on health systems'. Partners are the London School of Hygiene and Tropical Medicine and the Royal College of Surgeons in Ireland. The project is financed by the Open Society Institute in New York. The study is part of the *Global HIV/AIDS Initiatives Network*: <http://www.ghinet.org/>
- A context report was prepared based on document review and interviews with national stakeholders in 2006 that is available at: <http://www.ghinet.org/downloads/kyrgyz.pdf> or <http://chsd.med.kg>
- The current research focuses on the effects of the **Global Fund to Fight AIDS, Tuberculosis and Malaria** (Global Fund) HIV/AIDS grant and the **World Bank Central Asia AIDS Project** (CAAP) in Kyrgyzstan in three case study regions: **Bishkek/Chui, Osh/Jalalabad and Issyk-Kul**.
- Study participants include national and regional stakeholders, HIV/AIDS service providers and clients. Methods include semi-structured interviews, structured interviews and a facility survey intended to measure scale up and capacity among HIV/AIDS service providers.

Key findings from the 2007 phase of the study include:

### Overview

- The Global Fund grant in Kyrgyzstan has financed substantial scale up of HIV/AIDS services including prevention, testing, treatment, care and support, although the focus of activity is Bishkek where organisations have most capacity, despite the epidemic being concentrated in Osh.
- The majority of service providers indicated there were sufficient staff to cover present activities, that personnel in their organisation were motivated delivering HIV/AIDS services, and that their workloads were more manageable than previously.
- Oblast Multisectoral Coordination Committees were viewed by some interviews as imposed from above and as having a weak role in regional coordination, although they vary: interviewees evaluated Osh OMCC as having a relatively substantial role in determining regional HIV/AIDS policy, while coordination in Issyk-Kul was seen as underdeveloped by comparison.
- Clients indicated that the stigmatisation of HIV/AIDS by their communities was the most important barrier to using HIV/AIDS services: this risked them becoming known as HIV positive, or a drug user or sex worker, which are also stigmatised activities. An related problem is the criminalisation of injecting drug use which prevents clients using services since police frequently intercept drug users or sex workers.

### Scale up of HIV/AIDS programmes

- Global Fund grant disbursements to sub-recipients increased steadily between 2004 and 2006, as has expenditure on commodities including medicines, infrastructure and equipment, staff training and other costs. NGOs are becoming increasingly reliant on the Global Fund grant, which provides an high proportion of their overall funding.
- Some interviewees believe the distribution of the Global Fund grant was based on organisational capacity rather than the HIV/AIDS epidemic itself. Indeed, the majority of

services funded by the Global Fund are based in Bishkek where they have more capacity, despite the vast majority of PLWHA living in Osh in southern Kyrgyzstan.

- The survey suggests an increase in client numbers receiving a range of interventions including information/education, VCT, harm reduction (needle/syringe exchange and substitution therapy) and ARV therapy. Coverage of vulnerable groups including PLWHA, young people, IDUs, SWs, MSM and prisoners has increased since the inception of the Global Fund. New groups are now receiving interventions including young people from rural areas and street children.
- Interviewees suggested factors inhibiting scale up include: the law on drug possession undermining the effective delivery of needle/syringe exchange programmes; stigma and discrimination; and interruptions in organisation funding due to sub-recipients not submitting quarterly reports on time.

### **Regional HIV/AIDS coordination committees**

- The Country Multisectoral Coordination Committee (CMCC) for HIV/AIDS was evaluated by interviewees as having an increasingly significant role in HIV/AIDS-related decision making and engaging a wide constituency of stakeholders.
- Oblast Multisectoral Coordination Committees (OMCCs) are predominantly formed of representatives of government institutions including AIDS centres and other healthcare providers and law enforcement agencies; few NGOs are represented on the committees. Meetings are infrequent, and recent political upheaval led to the discontinuation of some OMCCs.
- OMCCs were viewed by some interviews as imposed from above, and as having a weak role in regional coordination, although this varies: interviewees evaluated Osh OMCC as having a substantial role in determining regional HIV/AIDS policy, while coordination in Issyk-Kul was seen as underdeveloped by comparison.
- Barriers to effective coordination include: ongoing changes in committee membership; lack of clear working procedures and lines of accountability; lack of clarity among members about how coordination works; limited civil society representation; lack of funding for coordination structures.

### **Coordination between HIV/AIDS services**

- Most respondents indicated their HIV/AIDS organisation coordinated their activities with other government and NGO HIV/AIDS service organisations, including client referrals. Some organisations sign MoUs formalising these arrangements. Contradicting this view the vast majority of clients indicated that they had *not* been referred between services; information about services through personal contacts was seen more important.
- Other forms of coordination between some HIV/AIDS organisations include: coordinated strategic planning; information sharing; integrated resources; common protocols; common M&E system.

### **Human resources**

- Allocation of the Global Fund grant to sub-recipients led to an increase in personnel working on HIV/AIDS: increases in NGO workers have been substantial; among government service providers numbers remained stable. The greatest growth is among NGO volunteer workers and social workers. Peer-to-peer outreach workers have become an important category of worker: they bring knowledge of vulnerable groups and an ability to built rapport.

- Unequal distribution of personnel by regions remains. Increases in numbers of personnel have been greatest in Bishkek/Chui. Increases in Osh have been substantial although the overall number of HIV/AIDS workers lags behind Bishkek/Chui.
- The majority of service providers indicated there were sufficient staff to cover present activities, that personnel in their organisation were motivated delivering HIV/AIDS services, and that their workloads were more manageable than twelve months previously.
- The majority of service providers received financial incentives for delivering HIV/AIDS services (funded by the state) although interruptions in funding led to some workers being unpaid for several months.
- The majority of survey respondents indicated they had received training. Global Fund-supported workshops and training were seen by interviewees as having positive impacts on staff skills and their attitudes to clients. However, rapid staff turnaround undermines some of this capacity building.

### **Quality and access to HIV/AIDS services**

- The majority of stakeholders and service providers indicated that the Global Fund grant contributed to improved quality of HIV/AIDS services; moreover, the majority of clients said they were satisfied with the quality of services they received. Increased staff numbers with better training and improved provision of key commodities had led to better service quality.
- Interviewees suggested there is scope for improved quality in a number of areas including: effective and anonymous/confidential VCT services; appropriate information materials for population groups in rural areas and in the south; and staff training for substitution therapy.
- Clients tended to have several problems accessing HIV/AIDS services despite the fact they were using them. They indicated that the stigmatisation of HIV/AIDS by their communities was the most important barrier to using HIV/AIDS services since this risked them becoming known as HIV positive, or a drug user or sex worker, which are also stigmatised activities.
- An important related problem is the criminalisation of injecting drug use which prevents clients using services since police frequently intercept drug users or sex workers.
- Other key access barriers from clients' perspectives include shortages of medicines and other commodities, poverty, and limited knowledge of different HIV/AIDS services and eligibility to use them.



# CHAPTER 1. Introduction

## 1.1 Study tracking global HIV/AIDS initiatives and their impact on health systems

In July 2006 the Center for Health System Development started implementing the Kyrgyz part of a three-year international research project 'Tracking global HIV/AIDS initiatives and their impact on health systems'. The partners in this project are the London School of Hygiene and Tropical Medicine and the Royal of College of Surgeons in Ireland. The project is financed by the Open Society Institute (OSI) in New York. The study forms a part of the *Global HIV/AIDS Initiatives Network* (GHIN): <http://www.ghinet.org/>

There are several stages to the study:

**Stage 1 August - November 2006:** *Preparatory stage* – contacting key stakeholders; policy and programmatic document review; interviewing national stakeholders; preparation of a situation report <http://www.ghinet.org/downloads/kyrgyz.pdf> or [www//chsd.med.kg](http://www.chsd.med.kg)

**Stage 2 December 2006 - December 2007:** *Regional case studies baseline* - collection of data in three case study sites: Bishkek/Chui, Osh/Jalalabad and Issyk-Kul through policy and programmatic document review; analysis of secondary data; semi-structured interviews with local stakeholders; semi-structured interviews with providers of government medical and nongovernmental social services for HIV/AIDS; semi-structured interviews with clients of HIV service organisations; a facility survey of organisations funded by the Global Fund to Fight AIDS, TB and Malaria (GFATM) grant; analysis and interpretation of data; preparation of the report and dissemination of results.

**Stage 3 December 2007 - January 2008:** *National data collection* – policy and programmatic document review; interviewing national stakeholders.

**Stage 4 February - July 2008:** *Regional case studies follow up* – focused collection of data in Bishkek/Chui, Osh/Jalalabad and Issyk-Kul through a policy and programmatic document review; analysis of secondary data; semi-structured interviews with local stakeholders; semi-structured interviews with providers of medical and social services; semi-structured interviews with clients of HIV-service organisations; a facility survey of organisations funded by the GFATM and CAAP grants; analysis and interpretation of data.

**Stage 5 August-December 2008:** *Advocacy and dissemination* - analysis and interpretation of data collected during previous stages of the study; preparation, publication and distribution of a final study report; preparation of briefing sheets and policy briefs; holding national events including a press conference; preparation of papers for scientific journals; participating in global advocacy and dissemination events and outputs as part of the *Global HIV/AIDS Initiatives Network*.

This report presents results of Stage 2 of the study.

## 1.2. Overview of Global HIV/AIDS Initiatives in Kyrgyzstan

- Kyrgyzstan has financial resources to control HIV/AIDS coming from two sources: the state budget and international donor organizations and programs. During the period from 2004 to 2006 the total amount of funds allocated specifically for HIV/AIDS related services/activities from all sources was US \$7.2 million.
- Main funding programs of global HIV/AIDS initiatives have provided major grants in Kyrgyzstan: the Global Fund to Fight HIV/AIDS, TB and Malaria (GFATM) and the Central Asian AIDS Project (CAAP), a four-country regional project of the World Bank. There are also many other international programs on HIV/AIDS funded by UN and bilateral donor organizations.
- Kyrgyzstan received a Second Round Grant for HIV/AIDS from the GFATM named the “Development of preventive programs on HIV/AIDS, TB and malaria aimed at reduction of social and economic consequences of their spread”. The grant was approved in August of 2003 and commenced in March of 2004. The total approved amount was more than US \$17 millions and main grant recipient was the Kyrgyz Republican AIDS Center under the Ministry of Health. During the period 2004 to 2007 the GFATM contribution to the implementation of HIV/AIDS control activities was US \$9,125,351. Currently Kyrgyzstan has received an approval for its application for a US\$28.2M Seventh Round GFATM HIV/AIDS grant that is scheduled to for the period January 2009-December 2013.
- The Second Round GFATM grant funds were used for development of strategies for HIV/AIDS services/activities implemented mainly by nongovernmental organizations (NGOs). Emphasis was placed on preventive interventions among high-risk groups such as intravenous drug users (IDUs), commercial sex workers (CSWs), young people and prisoners. Considerable resources were used for distribution of condoms and needles/syringes as well as training of health workers. In total 102 organizations (including 80 nongovernmental, 18 governmental/public and 4 private organizations) in all provinces of Kyrgyzstan received funds in the period of March 2004 – April 2007.
- CAAP consists of two main programs: a minor grant program and a major grant program. In 2007 nine NGOs initiated their activity oriented at HIV/AIDS prevention, ensuring support to people living with HIV/AIDS and training of health workers. Draft proposals on a second grant round were going through a selection process at the time of writing this report.

## 1.3. Epidemiological situation on HIV/AIDS in the Kyrgyz Republic

General data on the number of reported HIV/AIDS cases in the Kyrgyz Republic are shown in Table 1.

**Table 1.1. HIV/AIDS situation in the Kyrgyz Republic (data for 01.10.2007)**

Years	Number of detected cases	Citizens of the Kyrgyz Republic (males/females)		Foreign and CIS citizens
		HIV infected	Including AIDS	
1987-2000	53	14 (11/3)	1 (0/1)	39 (36/3)
2001	149	134 (123/11)	1 (1/0)	15 (12/3)
2002	160	146 (134/12)	9 (8/1)	14(13/1)
2003	132	125 (107/18)	10(10/0)	7 (7/0)

2004	161	153(119/34)	14 (12/2)	8 (6/2)
2005	171	165 (114/51)	20(17/3)	6(6/0)
2006	244	233(170/63)	27(22/5)	11(9/2)
2007 (9 months)	277	263 (189/74)	24 (24/0)	14(10/4)
<b>Total</b>	<b>1347</b>	<b>1233 (967/266)</b>	<b>106 (94/12)</b>	<b>114 (99/15)</b>

Source of information: Republican AIDS Center

Of total number of registered cases 156 people died including 81 people who died from AIDS-related illnesses. The prevailing form of transmission is parenteral: 73,7% from injection drug use and 2% from medical manipulations (Figure 1.1).

**Figure 1.1 Ways of HIV infection transmission in the Kyrgyz Republic**

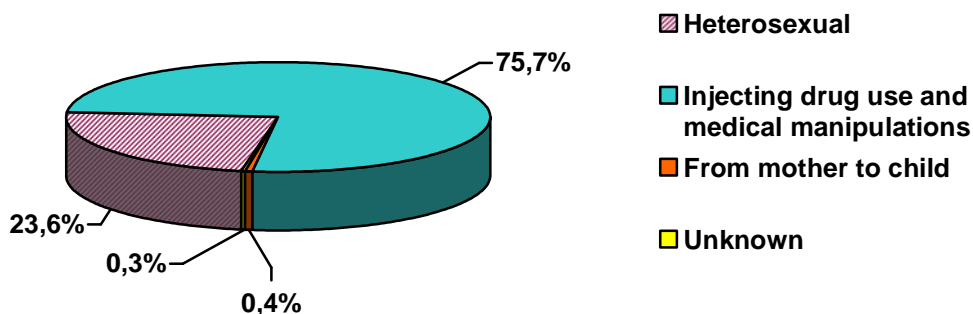
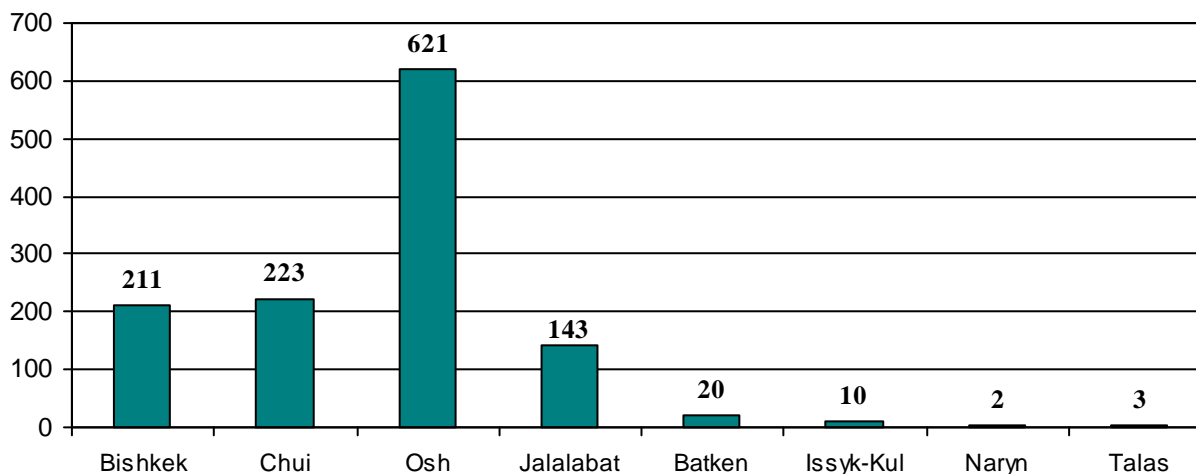


Figure 1.2 shows the distribution of HIV/AIDS cases by regions: the majority of people living with HIV/AIDS live in the southern region of Osh which is a transit-route for international drug traffic that has experienced sharp increases in intravenous drug use.

**Figure 1.2. Number of HIV/AIDS cases by KR regions, data for 01.10.2007**



## **CHAPTER 2. Aims and objectives of the study**

### **2.1 Study aims**

The aim of Stage Two of the study 'Tracking global HIV/AIDS initiatives and their impact on health systems' was to assess the effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) HIV/AIDS grant in Kyrgyzstan in three case study regions: Bishkek/Chui, Osh/Jalalabad and Issyk-Kul including the effects on scale-up of HIV/AIDS services, health systems capacity (quality of care, human resources and sub-national coordination) and equitable access to HIV/AIDS services.

The broad goal of the study 'Tracking global HIV/AIDS initiatives and their impact on health systems' is to provide reliable research findings on the effects of global HIV/AIDS initiatives to inform decisions made by government policymakers and practitioners, international agencies and nongovernmental organisations in Kyrgyzstan.

The study assesses the effects of the Global Fund to Fight HIV/AIDS, TB and Malaria (GFATM) and the Central Asian AIDS Project (CAAP), the regional project of the World Bank. However, this report focuses on GFATM-funded projects taking into account the fact that CAAP started to work in the country only in 2007.

### **2.2 Study objectives**

The study has the following objectives:

#### **Scale up of HIV/AIDS programmes**

- To assess levels of scale-up of HIV/AIDS programmes in the three study regions;
- To explore key factors enabling and inhibiting scale up;

#### **Coordination of HIV/AIDS programmes**

- To describe the functions and composition of sub-national HIV/AIDS coordination councils;
- To assess the effectiveness of sub-national HIV/AIDS coordination councils and identify factors enabling and inhibiting sub-national coordination;
- To examine levels and forms of coordination between HIV/AIDS services;

#### **Human resources for HIV/AIDS programmes**

- To explore perceptions of the adequacy of staffing levels among GFATM government and nongovernmental sub-recipients;
- To assess the effects of the GFATM on staffing levels, staff workloads, training and motivation;

#### **Quality of care of HIV/AIDS services**

- To examine perceptions of the quality of care of GFATM-financed HIV/AIDS services;
- To identify aspects of services that clients considered important in terms of quality;
- To assess whether and how HIV/AIDS service organisations evaluated client satisfaction;

#### **Access to HIV/AIDS services**

- To assess level of accessibility of governmental and nongovernmental GFATM-financed services;

- To identify key household/community and institutional/programmatic barriers to accessibility from clients' perspectives.

## CHAPTER 3. Study methodology

### 3.1 Study methods

The study combined qualitative and quantitative methods of data collection. The following four instruments were used for this study:

- 1. Semi-structured interviews with local government and nongovernmental stakeholders and managers of GFATM and CAAP-funded organizations/services;
- 2. Semi-structured interviews with HIV/AIDS service providers (frontline staff);
- 3. Facility survey to collect data on organizations' activities including client numbers, staff levels and budgets;
- 4. Semi-structured interviews with users of GFATM and CAAP-funded services (clients).

### 3.2. Description of the sample

- The study sampled 33 GFATM and 4 CAAP-funded organizations in Bishkek/Chui, Osh city and province and Jalalabat cities (both with high level of HIV/AIDS prevalence) as well as Issyk-Kul province (low level of HIV/AIDS cases). Table 3.1 summarizes the organizations sampled.

**Table 3.1 Number of organizations**

	Public/governmental organizations	NGOs	Total
<b>Bishkek city</b>	6	9	15
<b>Chui province</b>	2	-	2
<b>Osh province</b>	6	3/1*	10
<b>Jalalabat city</b>	-	1	1
<b>Issyk-Kul province</b>	5	3/1**	10
<b>Total</b>	<b>19</b>	<b>18</b>	<b>37***</b>

**Note:**

\* Meder and EMB Private FGP

\*\* Dastan TV Private TV and Radio Company

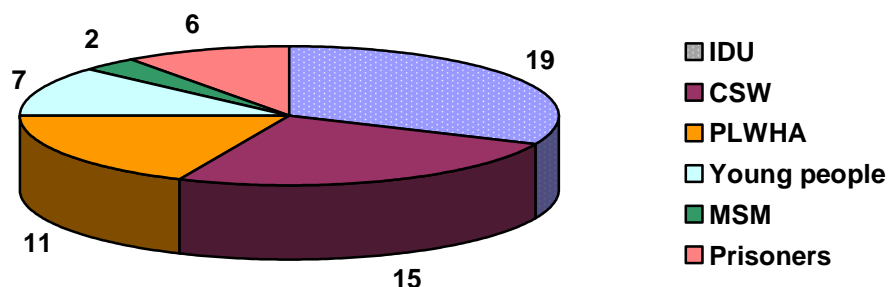
\*\*\*Complete list of organizations with their activities are provided in Annex.

- The total number of conducted interviews was 130 broken down as follows:
  - 38 stakeholders and managers of organizations;
  - 32 service providers (frontline staff);
  - 60 clients who were representatives of vulnerable population groups (IDUs, CSWs, PLWHA, prisoners, MSM and young people);
- In addition three focus-group discussions were conducted with CSWs and young people in Osh and Bishkek (a total of 18 people).

Of the 32 surveyed frontline staff 10 were male and 22 were female. From them 24 people had a higher education, 3 people had incomplete higher education and 5 people specialized secondary education.

- Figure 3.1 show the breakdown of the 60 clients from vulnerable population groups participating in the study.

**Figure 3.1. Survey respondents from different vulnerable population groups (N=60)**



- Of the sample 31 people were male and 29 people were female. The age of the respondents ranged from 14 to 56 with the majority consisting of the age group 20 – 39 years (42 people). The ethnicities of respondents were as follows: Kyrgyz (18 people), Uzbek (8 people), Russian (19 people) and other ethnicities (15 people). Education levels of clients participating in the study were as follows: higher education (11 people), incomplete higher education (2 people), general/specialized secondary (38 people), incomplete secondary (9 people).

### 3.3. Constraints of the study

This study has a number of methodological constraints:

- **Several sources of financing in the organizations included in the sample.** For the purpose of this study it was required to explore activity of the organizations which have comparatively sustainable experience of working in the area HIV/AIDS. In this connection it was decided to include in the sample mainly those NGOs that began their activity before the GFATM grant was received: most were funded by donors such as UNAIDS, the Soros Foundation – Kyrgyzstan, USAID and others prior to the GFATM. However, at the time of implementing the study some NGOs were still getting funding for their activities from several sources. As a result, it was not always possible to make an unambiguous distinction between GFATM impacts and the impacts of other donors.
- **Small sample size of service users.** Semi-structured interviews were conducted with 60 service users. The relatively small sample size and prevailing number of IDUs in the group means it is difficult to make generalizations across the whole of Kyrgyzstan from this sample.
- **Access to the groups of service users was organized through the staff members of AIDS service organizations.** Service users were recruited to the study through staff members of the organizations because of difficulties making contact with vulnerable groups not accessing services. This fact could affect the results of the survey in terms of building up a picture of access to HIV/AIDS services since it is assumed problems of access are more acute among people not using services than those that do.

## CHAPTER 4. SUB-NATIONAL HIV/AIDS SERVICE SCALE UP

### 4.1 Dimensions to scale up

In recent years Kyrgyzstan achieved positive outcomes in the promotion of work to fight HIV/AIDS. A significant share of activities planned under the Second State Program on Prevention of HIV/AIDS and STIs for 2001 – 2005 has been implemented<sup>1</sup>. Ongoing work on almost all strategies and components of the newly developed Third State Program on HIV/AIDS Epidemic Prevention for 2006 – 2010 is continuing with support of donor organizations.

At present, the GFATM grant is making a significant contribution to financing current and planned activities to fight HIV/AIDS in the Kyrgyz Republic. Since 2004, the following elements of the HIV/AIDS program supported by the GFATM have experienced scale up<sup>2</sup>:

- Financing levels;
- Number of organizations and coverage of new catchment areas;
- Coverage of target groups;
- Range and scope of delivered services;
- Distribution of medical supplies and commodities including needles/syringes and condoms.

This chapter reviews key indicators of HIV/AIDS service scale up at the national and sub-national level.

### 4.2 Scale up in financing levels

Data provided by the GFTAM Principal Recipient the Kyrgyz Republican AIDS Center show increasing grant disbursements over the period 2004 – 2006. By the end of 2006 the amount of disbursed funds from the Second Round Grant was US \$9,125,351. Table 4.1. shows the distribution of financial resources by different types of expenditures. A major share of funds was allocated to sub-recipients as grants (42.1%) and for procurement of goods and supplies (32.4%). Overall, currently the GFATM provides financial support to 13 (25.5%) public/governmental health organizations and 38 (74.5%) nongovernmental organizations (NGOs)<sup>3</sup>.

**Table 4.1 Distribution of GFATM Second Round Grant funds 2004 – 2006**

Expenditure	2004	2005	2006	Total	
	US \$	US \$	US \$	US \$	%
Grant sub-recipients	491,908	1,158,094	2,191,634	3,841,636	42,1
Goods and supplies	90,902	874,922	1,986,781	2,952,605	32,4
Infrastructure/equipment	170,884	217,440	659,128	1,047,452	11,5

<sup>1</sup> Assessment report on execution of Second State Program on Prevention of AIDS and STIs (2001-2005)

<sup>2</sup> The term “scale-up” implies to increase gradually, enhance or expand the whole set of activities related to HIV/AIDS programs.

<sup>3</sup> Data from GFATM Principal Implementing Unit in Kyrgyzstan (1.10.2007)

Publications	41,405	139,151	205,903	386,459	4,2
Training of staff	71,729	147,211	131,507	350,447	3,8
Medicines	87,433	84,421	146,417	318,271	3,5
Monitoring & evaluation	394	18,921	45,366	64,681	0,7
Administrative costs	15,518	51,943	96,339	163,800	1,8
<b>Total</b>	<b>970,173</b>	<b>2,692,103</b>	<b>5,463,075</b>	<b>9,125,351</b>	<b>100,0</b>

Source: Republican AIDS Center (2007)

In the context of the second stage of this study quantitative data including financial data were collected from 8 governmental and 16 nongovernmental organizations in Bishkek/Chui, Osh/Jalalabat and Issuk-Kul. Information on annual budgets of these organizations was collected for the years 2004, 2005 and 2006 broken down by source of financing (state budget, local budget, GFATM grant, CAAP grant, other donors and user fees).

In 2004 only 3 out of 8 surveyed governmental organizations received funding from the GFATM (Figure 4.1). Since then the share of GFATM funding as a proportion of annual budgets increased across these organizations. Much funding relates to the supply of laboratory-diagnostic equipment and corresponding test systems (immune-enzyme analysis, immunoblotting test, polymerase chain reaction, CD4-lymphocytes), increased volumes of medicines for treating STIs and HIV/AIDS associated conditions and when ARV therapy became available in the country. By 2006 the GFATM contribution to the annual budgets of government organizations increased (Figure 4.1). These funds were mainly allocated for procurement of test systems, medicines and medications for Substitutive Methadone therapy (SMT) as well as supply of disposable needles/syringes.

**Figure 4.1 Financing levels from GFATM in governmental organizations, 2004-2006 (n=8)**

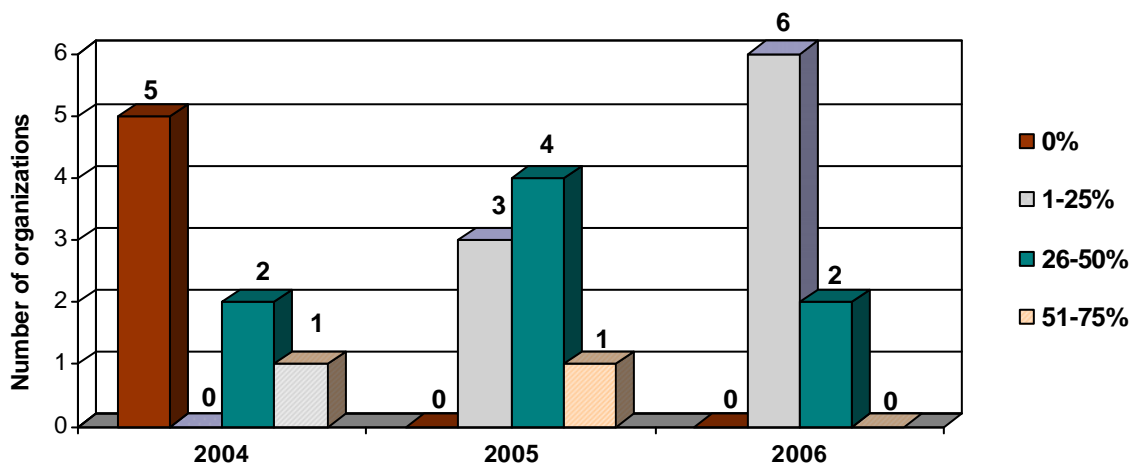
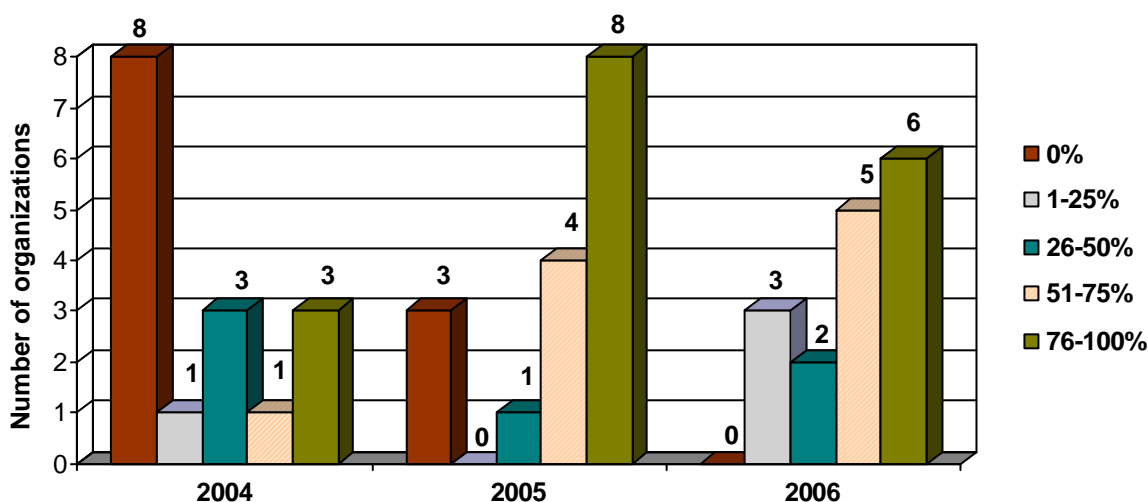


Figure 4.2 shows that the GFATM is also becoming an important funder of NGO HIV/AIDS organizations in the three case study locations. Some NGOs included in the group of



organizations with GFATM financing level of 76-100% were established after 2004. They implement mainly information/educational activities on the issues of HIV/AIDS prevention. Other NGOs started their activity before 2004 and already had certain experience in HIV/AIDS related work by 2004, and tend to have a wider range of delivered services including harm reduction programs, STI diagnostic and treatment, consultancy services and support and care. These more established organizations tend to also receive funding from other donors such as Soros Foundation in Kyrgyzstan, USAID, UNAIDS, CARHAP and AIDS Foundation East-West.

**Figure 4.2 Financing levels from GFATM among nongovernmental organizations, 2004-2006 (n=16)**



#### 4.3 Scale up of the number of organizations and catchment areas

There were a limited number of HIV/AIDS service organizations prior to the Round Two GFATM grant. They were predominantly located in Bishkek and Osh cities, and implemented pilot projects and tried to establish effective forms of service delivery for vulnerable population groups.

NGOs tend to serve limited catchment areas and the overall volume of delivered services was relatively low in terms of client numbers. This leaves some parts of the country with limited coverage of HIV/AIDS services. As a policy document suggested:

*Involvement of regional NGOs in preventive programs is determined by their capability rather than actual needs of the region. In particular, activity of local NGOs in Naryn and Jalalabat provinces is obviously insufficient. No NGO developing preventive programs is functioning in Chui, Issyk-Kul, Talas and Batken provinces which are potentially problematic areas regarding epidemic evolution due to geographic location<sup>4</sup>.*

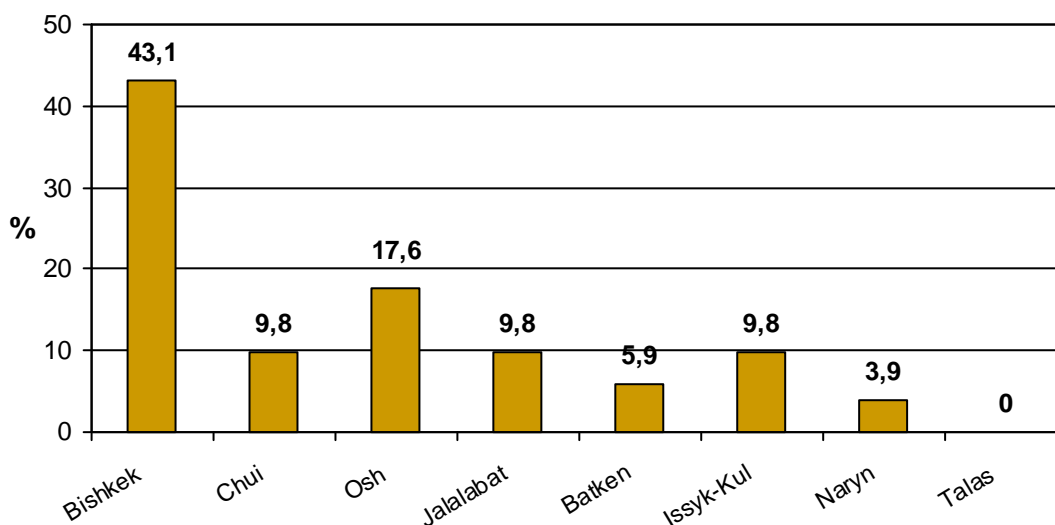
The situation in the country changed drastically since the receipt of the GFATM grant. In the period from 2004 to September 2007 the GFATM grant had been allocated to 167 sub-grants

<sup>4</sup> AIDS in Kyrgyzstan: 5 years of confrontation.//L. Bashmakova, A. Kashkaryov, G. Kurmanova, B. Shapiro, 2003

that had supported work of 102 organizations (including 80 nongovernmental, 18 governmental/public and 4 private organizations) implementing different HIV/AIDS activities<sup>5</sup>. In October 2007 there were 51 organizations supported by GFATM grants<sup>6</sup>. Figure 4.3 shows their distribution by regions. The majority are based in Bishkek, followed by Osh: it was these two regions that received the greatest concentration of HIV programs prior to the receipt of the GFATM.

It is worth mentioning that while there are no GFATM sub-recipients based in Talas province, although three HIV/AIDS service organizations based in Bishkek city are working in this province and implementing HIV/AIDS activities through regional affiliates. Moreover, the availability of GFATM grant support facilitated not only the growth in total number of organizations delivering HIV/AIDS services but also the enhancement of geographic coverage. At present, activities to fight HIV/AIDS are carried out in all regions of the Kyrgyz Republic, whereas prior to 2004 HIV/AIDS programs mostly existed in Bishkek and Osh cities.

**Figure 4.3 Percentage of HIV/AIDS organizations working with GFATM support in each region: October 2007 (N=51)**



According to interviewees the GFATM has critical in scaling up HIV/AIDS services across the country, and consolidated the work of previous donor programmes. The following illustrate this perspective:

*...the Soros Foundation Kyrgyzstan and UNDP created, in a sense, a model while Global Fund enhanced catchment, namely coverage with all spheres and agencies... Now we succeeded to meet the needs of our consumers...*

*...the Global Fund ... supports, scales-up and ensures sustainability of existing services...*

*... Talking about regional level, there were five to six AIDS service organisations in the South of the country prior to Global Fund's appearance. With appearance of Global Fund the number of NGOs increased and similar services emerged in other cities along with financing of new projects: educational, police, penitentiary institutions...*

<sup>5</sup> Data from GFATM PIU

<sup>6</sup> Data from GFATM PIU

More governmental and especially nongovernmental organisations are getting involved in the implementation of HIV/AIDS activities. Respondents assess this fact positively:

*... Number of non-governmental organizations and their staff has increased and, respectively, they cover more population. More people begin to understand this situation...*

Despite the fact that NGOs started to work in towns and rural areas across the country it is nevertheless necessary to draw attention to a certain imbalance in the geographical distribution of organizations. Shortages of HIV/AIDS service organizations is observed in cities of Osh and Jalalabat and Osh provinces relative to increasing levels of need in these high prevalence regions and problems with human resources (this is illustrated by comparing Figures 1.2 and 4.3). The Issyk-Kul province is also seen by interviewees as having a deficit of HIV services since high levels of seasonal tourism are believed to fuel a small but growing epidemic that without effective preventative programmes could become explosive.

Stakeholders believe the misbalance of HIV/AIDS service activity between Bishkek (which receives the bulk of funding) and other parts of the country that are under-served is due to a number of factors:

- Although the majority of interviewed respondents believe that in general all organizations have equal chances to receive GFATM grants (as one interviewee said: '*... chances are equal for everyone, everything depends on quality of application and incidence rate...*') it is important to note that potential grant recipients have different capacities. In particular, organizations in Bishkek city have better developed capacity and more experience in the preparation of grant proposals putting them at an advantage. A number of stakeholders suggested this was also due to limited initiative among some organizations outside the capital.
- In the opinion of respondents it is necessary to conduct a more systematic analysis of the HIV/AIDS epidemic context in different parts of the country as the basis of allocating grants which has been lacking to date. It was believed that some grant applicants had been creative in their claims about levels of need and are skilled at writing proposals for activities to address those needs. One stakeholder said: '*... In no circumstances the funds should be allocated to areas where the problem and figures are spun out of thin air. Hearing some astronomic figures makes you think that it cannot be so..., however it ends up with the fact that the grant goes to those who wrote beautiful project [applications]...*'.
- Respondents noted that application form for receiving GFATM grant is comparatively simple but the procedure of grant applications selection itself requires improvement since: 1) insufficient information is provided about specific selection criteria, hence the basis for some decisions are not obvious; 2) the time frames for the submission of applications and provision of information about selection results are not always set and followed accurately; 3) in cases when an application is rejected insufficient information is given on causes of rejection. Respondents consider this information important since they could learn from this in order to prepare subsequent grant proposals.

#### **4.4 Scale up in the coverage of target groups and different service types**

HIV/AIDS service organizations currently functioning under GFATM grants cover different target groups (Table 4.2). Most of these organizations work with the young people and IDUs. Coverage of other groups such as CSWs, MSM, PLWHA and prisoners has also increased considerably. HIV/AIDS preventive programs supported by the grant also cover new target

groups, namely rural youth and street children who had not received HIV/AIDS prevention services prior to the receipt of the GFATM grant.

**Table 4.2 Numbers of organizations receiving GFATM grants targeting different groups: October 2007**

Target groups	Number of organizations, absolute figures	Number of organizations, %
Young people	28	54,9
IDU	8	15,6
PLWHA	2	3,9
Military personnel	2	3,9
Prisoners	2	3,9
CSW, IDU	2	3,9
CSW, IDU, MSM	2	3,9
STI patients	1	2,0
IDU, PLWHA, CSW, MSM	1	2,0
STI, CSW, IDU	1	2,0
IDU, STI	1	2,0
Youth, CSW	1	2,0
<b>Total</b>	<b>51</b>	<b>100</b>

Source: GFATM PIU

Based on data elicited from the facility survey element of the study Table 4.3 summarizes the total number of clients by target group in the 24 surveyed organizations.

**Table 4.3 Number of clients of surveyed organizations: 2004-2006**

Previous target groups	2004	2005	2006
Youth	2,527	7,159	21,941
IDU*	2,982	4,969	8,225
CSW	2,491	2,549	2,620
MSM**	6,500	7,200	7,500
PLWHA***	****	****	324
Prisoners	No data	3,325	6,500

N=24

\* Data on NEP and MST;

\*\* Data include MSM and lesbians;

\*\*\* Patients receiving services regularly;

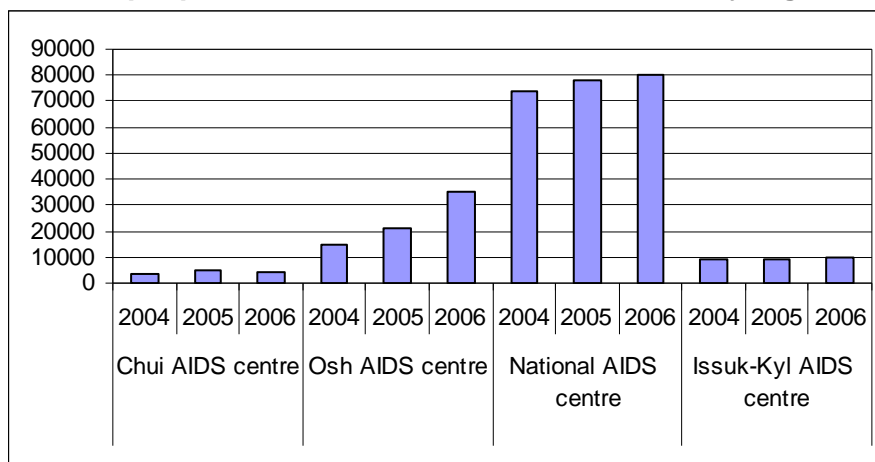
\*\*\*\* Incomplete data.

### Scaling-up of previously delivered services

A number of HIV/AIDS service existed in Kyrgyzstan prior to the receipt of the GFTAM grant. The grant enabled these services to be scaled up substantially. The following figures illustrate

numbers of clients receiving different services delivered by the 24 organizations participating in the facility survey. The data suggest that since the inception of the GFATM grant in Kyrgyzstan an increasing number of people are being testing for HIV/AIDS in each study region (Figure 4.4). Table 4.4 shows the scale up in the numbers of young people and CSWs obtaining user-friendly services, IDUs obtaining needle exchange services and substitution therapy.

**Figure 4.4 Number of people tested for HIV/AIDS in the case study regions: 2004-6**



Source: facility survey

**Table 4.4 Scale up in key services in the case study regions: 2004-6**

Type of service	2004	2005	2006
Young people and CSWs who received user-friendly services*	1,415	2,168	3,618
IDUs who received needle exchange services*	2,786	4,862	7,993
IDUs receiving substitution Methadone therapy**	196	107	232

Source: \*facility survey; \*\* Republican AIDS Center

One of major forms of HIV/AIDS activity in the Kyrgyz Republic is providing information on HIV/AIDS prevention among general population and targeting key vulnerable groups. For example, a study<sup>9</sup> suggests that level of awareness about HIV/AIDS reached 91.1% among young people, and their level of knowledge about the three main ways of transmission is 84.8%. An interviewee suggested:

*... The Global Fund increased the range of information forms many times. Even we receive plenty of information now. Prior to Global Fund we allocated small amounts of money for information materials, we ordered them ourselves, prepared and edited them while Global Fund does it all itself...*

<sup>9</sup> Sociological survey "Awareness of young generation of the Kyrgyz Republic about HIV/AIDS", GFATM, Republican AIDS Center, "M-Vector", 2006, N= 3003

## Introduction of new types of HIV/AIDS services

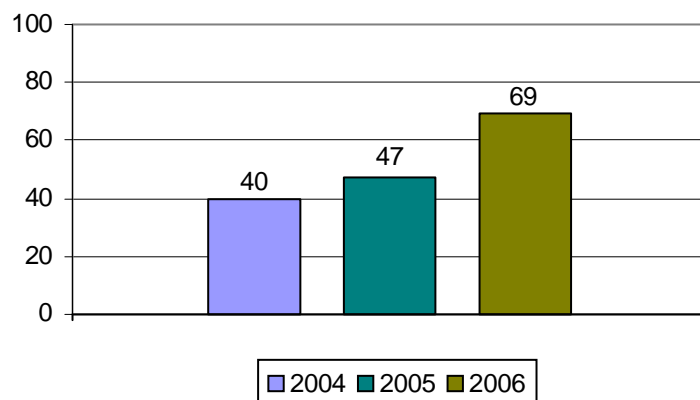
New services on HIV/AIDS are delivered since the introduction of the GFATM grant:

- Anti-retroviral therapy (ARVT) (since 2005);
- New types of laboratory-diagnostic tests (PCR, CD4);
- Blood quarantining (since 2007).

Delivery of therapy with ARV medicines was initiated only in 2005 despite the existing need. This became possible thanks to financial support from the GFATM. ARV medicines are centrally procured by the Principal Recipient the Republican AIDS Center and then based on needs they are delivered to 1) AIDS centers of Bishkek city, Chui and Osh provinces; 2) individual health organizations (Republican clinical infectious diseases hospital, Republican narcology center as well as several FMCs/FGPs); 3) GUIN (Punishment execution department). To date, clinical protocols on treatment of PLWHA are developed with WHO support and introduced into practice, all required 1<sup>st</sup> and 2<sup>nd</sup> line medicines including medicines for ARV therapy in pregnant women and children are available and accessible. Managers of the organizations which provide ARV therapy indicated good provision and flexibility of supply of ARV medicines.

In 2005 and 2006 the number of persons receiving ARV therapy was 40 and 47 patients accordingly. By September 1, 2007, the number of patients receiving ARV therapy was 69 (Figure 4.5). Their distribution by regions is shown in Table 4.5.

**Figure 4.5 Number of PLWHA receiving ARV therapy: national level**



Source: Republican AIDS Center

**Table 4.5 Distribution of patients receiving ARV therapy by regions: September 1<sup>st</sup> 2007**

Region	Number of people	%
Bishkek city	4	5,8
Chui province	1	1,4
Osh city	31	44,9

Osh province	19	27,5
Jalalabat province	7	10,1
Batken province	1	1,4
Penitentiary system institutions (Bishkek city, Chui and Issyk-Kul provinces)	6	8,7
<b>Total</b>	<b>69</b>	<b>100</b>

Source: Republican AIDS Center

New types of laboratory tests are introduced such as PCR and CD4 counts where none existed prior to the introduction of the GFATM grant. In 2005 there were 82 PCR tests; in 2006 there were 140 PCR tests and 70 CD4 count tests conducted. Moreover, the Republican Blood Transfusion center installed and launched equipment for blood quarantining which should ensure reliability of tests for HIV-infection and safety of donor blood.

#### 4.5 Factors influencing scale up of services at the sub-national level

Interviews with study participants revealed range of issues which if effectively addressed could contribute to further expansion of client coverage including:

**Monitoring systems used by HIV/AIDS organizations including record keeping of client numbers require significant refinement.** Different organizations do not have a common approach to record keeping of clients. In some cases organizations delivering services to the same target groups use different systems and formats for keep records. Double counting is also common: the same consumer receives services from different organizations (in the same area or when moving from one region to another) is counted more than once as receiving support, thereby spuriously inflating coverage figures in a region. It is not clear how client numbers are recorded receiving information or educational services provided by several HIV/AIDS service organizations jointly.

**There is a shortage of analytical information.** Many HIV/AIDS service organizations are interested in learning from the experiences of their colleagues and receiving information about their catchment areas in order to improve the services they provide:

*...That is where we need consultant assistance. For example, I sit here and work with my groups and another NGO works with its women and the consultant should collect overall information and see everything, but this doesn't exist. But at the same time I can say that Global Fund does a lot...*

Some respondents reported not having accurate information about the number of individuals who could benefit from services in their catchment area, which made it difficult to carry out their work. For example an interviewee said: '*... we have total figures for the country but in our city I don't know how many people we cover; such studies are not carried out...*'; another interviewee explained: '*... probably, wrong evaluation data. Extensive work is carried out, a wide range of services is offered and continuous awareness raising about ... services is taking place but involvement of new clients proceeds very slow*'.

**Further expansion of coverage of target groups requires delivery of additional services.** For example, during the period of 2004 – 2007 sub-recipients of GFATM consisted of 18 organizations delivering various services to IDUs. Most of them were implementing harm reduction programs. By 2007 it became possible to expand coverage of IDUs with needle exchange programs from 5 to 20% of the estimated number of IDUs<sup>7</sup>. Increase in total number of IDUs involved in the needle exchange program countrywide was achieved due to increased number of organizations, increased coverage of IDUs in each organization as well as work of needle exchange points (NEP) in 11 penitentiary institutions. However, according to service providers further coverage requires (1) delivery of additional range of services; and (2) scaling-up of HIV/AIDS activities to new areas previously underserved including rural areas.

**Strong support from governmental organizations could enable expanded coverage and increased effectiveness of ongoing HIV/AIDS activities.** Firstly, according to respondent opinions it would be advantageous to involve Family Group Practice (FGP) doctors (primary care) to a greater extent in delivering HIV/AIDS services. For example one interviewee suggested: '*... Global Fund should support FGPs and train them on HIV/AIDS because they represent service closest to population. They can enter any family and talk... Make this their responsibility...*'. Second, government premises made available to NGOs was identified as a recurring problem. An interviewee said: '*... although we have good relations with local authorities and get support from them we still have problems with premises...*'; other interviewees also described this problem, for example: '*... since you can do this work and execute it ... state authorities should provide buildings...*'; '*... probably we demand too little, we should apply more in order to receive what we need...*'.

**Planning of HIV/AIDS activities should reflect changing conditions.** Opinions were expressed by stakeholders that conditions in which HIV/AIDS activities are implemented are changing over time, for example patterns of risk taking behaviour; this fact needs to be factored into decision making. For example:

*... drug users, commercial sex workers and police all together adjust to what they want. Maybe the problem is in economic situation. For example, sex workers were out in the streets when all these projects came to existence. Now they realize that, as it turns out, there are organizations which protect them and where they can come and receive services. Today all of them rent private apartments and see clients there according to schedule, i.e., they adjusted in such a way that no one can see them, neither doctors nor police. They ran away from use and became difficult to reach...*

*... the situation has changed now, in 1996... research findings suggest that 67% of those who sought care started to consume drugs at age of 16-17 out of curiosity. Now, those who seek care report starting drug consumption at mature age; among them are people involved in trade. In my opinion, nowadays schools are doing good in prevention, curiosity is [reduced]....*

*... maybe the socio-demographic profile of drug users is changing – now more often they are mature age people with definite social status and welfare for who needle exchange services are not attractive...*

**Factors hindering the scale up of needle exchange and substitution therapy services in Kyrgyzstan.** A number of key factors were identified by interviewees as having inhibited the scale up of needle exchange programs:

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<sup>7</sup> Data of Kyrgyz Republican AIDS Center



- The existing regulatory-legal framework for implementation of needle exchange program;
- Remaining stigma with regard to needle exchange program leading to service providers discriminating against potential clients in some regions;
- Interruptions in financing occurring between tranches/projects.

Starting from 2002 after development of proper regulatory-legal framework Kyrgyzstan initiated the introduction of substitution Methadone therapy with financial support from Soros Foundation Kyrgyzstan and UNDP. The noticeable reduction in total number of patients in 2005 (Table 4.4.) resulted from interruptions in Methadone supply into the country. At present, Methadone is procured in required volumes entirely from GFATM funds. There is a trend to growing number of recipients of this service. GFATM plans significant program enhancement starting from 2007.

#### 4.6 Summary

- Global Fund grant disbursements to sub-recipients increased steadily between 2004 and 2006, as has expenditure on commodities including medicines, infrastructure and equipment, staff training and other costs. NGOs are becoming increasingly reliant on the Global Fund grant, which provides an high proportion of their overall funding.
- Some interviewees believe the distribution of the Global Fund grant was based on organisational capacity rather than the HIV/AIDS epidemic itself. Indeed, the majority of services funded by the Global Fund are based in Bishkek where they have more capacity, despite the vast majority of PLWHA living in Osh in southern Kyrgyzstan.
- The survey suggests an increase in client numbers receiving a range of interventions including information/education, VCT, harm reduction (needle/syringe exchange and substitution therapy) and ARV therapy. Coverage of vulnerable groups including PLWHA, young people, IDUs, SWs, MSM and prisoners has increased since the inception of the Global Fund. New groups are now receiving interventions including young people from rural areas and street children.
- Interviewees suggested factors inhibiting scale up include: the law on drug possession undermining the effective delivery of needle/syringe exchange programmes; stigma and discrimination; and interruptions in organisation funding due to sub-recipients not submitting quarterly reports on time.

## CHAPTER 5. Regional coordination of HIV/AIDS activity

### 5.1. Composition and functions of national and regional HIV/AIDS coordination structures

This chapter discusses structures responsible for coordination of HIV/AIDS epidemic prevention activities in the Kyrgyz Republic. Overall coordination and management of the implementation of state and donor HIV/AIDS programs as well as the implementation of the national strategic plan on epidemic prevention are on the responsibility of the Country Multi-Sectoral Coordination Committee (CMCC)<sup>8</sup>. There are Oblast Multi-Sectoral Coordination Committees (OMCC) in each region of Kyrgyzstan. OMCC serve as structural subdivisions of the CMCC and are responsible for general coordination of HIV/AIDS control activities at the regional (oblast) level. Bishkek and Osh cities also have a Municipal Multi-sectoral Coordination Committees. However, this study identifies other agencies performing coordination functions, and suggests the extent of coordination of HIV/AIDS activities in different regions of the Kyrgyz Republic varies considerably. This chapter also describes the effects of the GFATM on the development of coordination mechanisms and identifies key factors contributing to and hindering effective coordination of HIV/AIDS epidemic prevention activities at country and regional level.

The first national coordination mechanism on HIV/AIDS issues in Kyrgyzstan, the National Multi-Sectoral Coordination Committee (NMCC) on HIV/AIDS and STIs, was created in 1997. Since then it reformed many times<sup>9</sup>. A governmental Decree dated June 2, 2005 endorsed the creation of the Country Multi-Sectoral Coordination Committee (CMCC) to Fight HIV/AIDS, TB and Malaria<sup>10</sup>. Figure 5.1 represents the current CMCC structure.

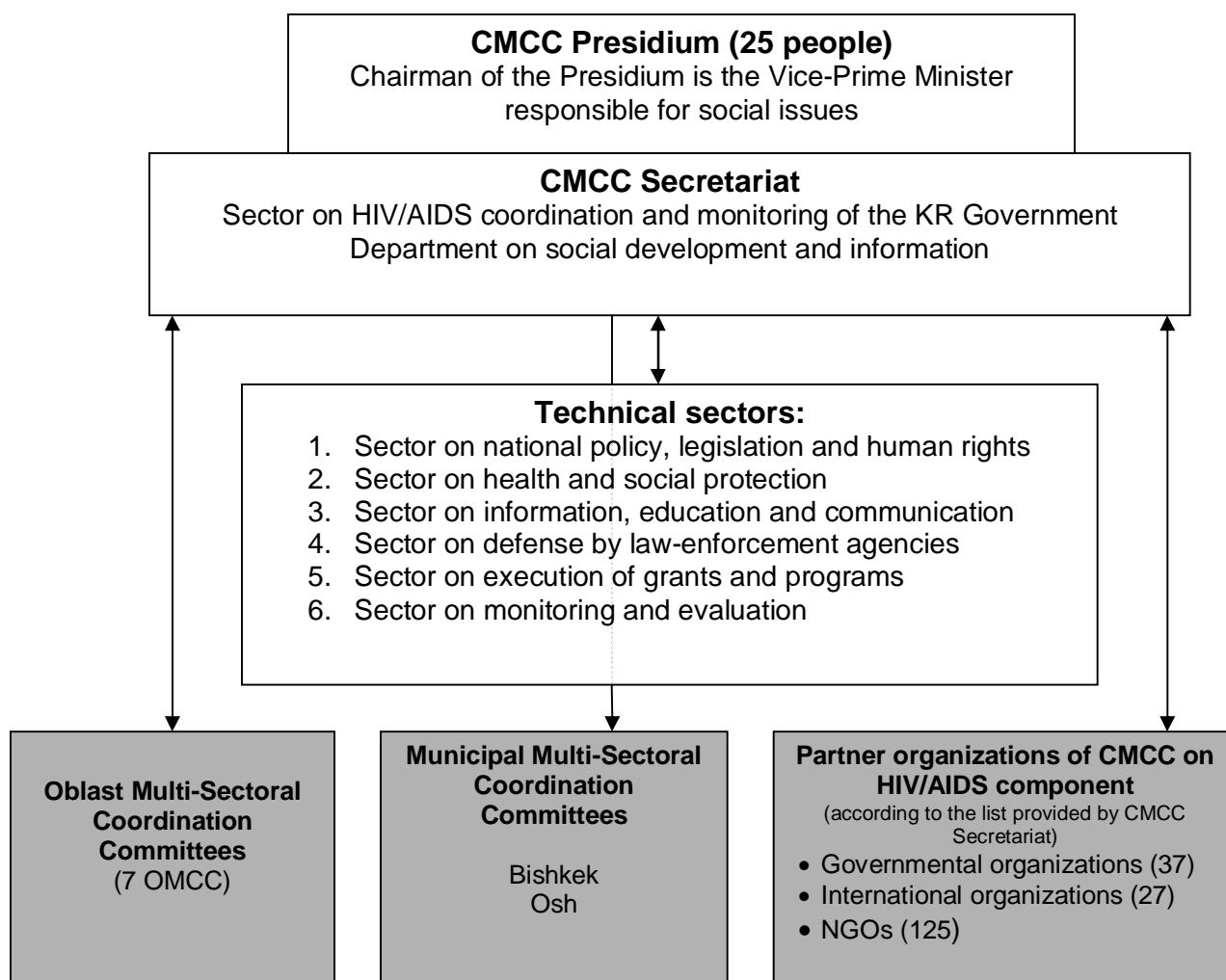
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<sup>8</sup> Governmental Decree "On Country Multi-Sectoral Coordination Committee on HIV/AIDS, TB and Malaria" dated June 2, 2005.

<sup>9</sup> NMCC was created in the KR in 1997. In 1998 NMCC functions were transferred to Coordination commission on health reform and medical education under the Government of the Kyrgyz Republic. In 2001, the Republican Multi-Sectoral Coordination Committee was created. In 2002, Country Coordination Committee was created which functioned in parallel to RMCC. In 2005, RMCC and CCC were merged into Country Multi-Sectoral Coordination Committee (CMCC).

<sup>10</sup> Find the description of CMCC in the study Context Report on <http://chsd.med.kg>

**Figure 5.1. CMCC structure<sup>11</sup>**



OMCCs were created to promote coordination of HIV/AIDS epidemic control activities at the regional (oblast) level. Nominally, regional coordination mechanisms were created in 2001 as structural subdivisions of the then Republican Multi-Sectoral Coordination Committee in all regions of the Kyrgyz Republic. However the extent of their actual impact varied substantially: regions with more effective coordination tended to be those that had established HIV programs such as Bishkek and Osh<sup>12</sup>. Interviewees reported that OMCCs include predominantly representatives of governmental organizations, for the most part health facilities. NGOs were not represented in OMCCs in the majority of regions, and that OMCC meetings were not systematic, nor were tangible decisions made. Osh Oblast Multi-Sectoral Coordination Committee used to be relatively active but stopped functioning after the political upheaval in March of 2005 and political instability following it.

During 2006, the CMCC Secretariat made significant efforts to reactivate the work of the OMCCs. Meetings were held with representatives of local administrations and other

<sup>11</sup> The figure is based on information provided by the CMCC Secretariat in June 2007.

<sup>12</sup> Based on Rapid Assessment Report in the Kyrgyz Republic, CARHAP 2005.

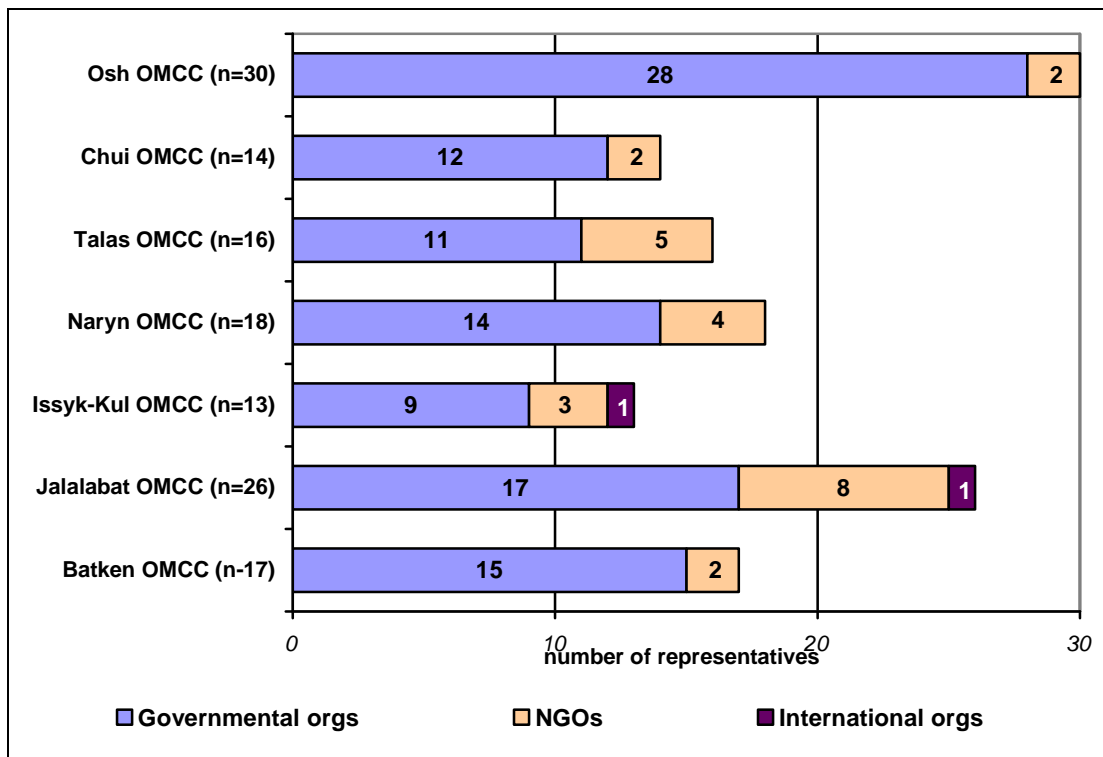
stakeholders to explain goals, objectives and functions of OMCCs as well as the multi-sectoral nature of cooperation. Common regulations for OMCCs were developed and used as the basis for each region to prepare their own regulations. By the Autumn of 2006 OMCCs in their current form were established.

The purpose behind creating the OMCCs was to promote coordination of activity of regional, district and city state administration, local government authorities, representatives of international donor organizations, nongovernmental and religious organizations regarding the implementation of programs and activities for HIV/AIDS control.

Each OMCC is led by the regional vice-governor who has deputies elected by OMCC members. According to OMCC Regulations the “OMCC consists of sectors formed on principles of involvement of all stakeholders including PLWHA and representatives of hard-to-reach and vulnerable groups”. However, it is worth mentioning that none of the OMCCs has representatives of vulnerable groups as their members.

As of June 2007 the composition of all OMCCs was primarily representatives of governmental organizations including directors of oblast Family Medicine Centers and oblast merged territorial hospitals, directors of AIDS centers and centers of State Sanitary Epidemiological Surveillance, directors of oblast TB Control centers, representatives of law-enforcement agencies and Kazy of oblast Kazyiats. In some OMCCs civil society is represented by mass media, educational institutions and nongovernmental organizations. Analysis of OMCC composition in different regions shows that in Osh region there are only two NGOs.. OMCC composition in different regions of Kyrgyzstan is shown in Figure 5.2.

Figure 5.2 OMCC member composition, 2006



Source: [http://www.aids.gov.kg/rus/doc/Partners\\_Database.xls](http://www.aids.gov.kg/rus/doc/Partners_Database.xls)

According to OMCC Regulations discussed at the CMCC Presidium meeting (Minutes of the CMCC Presidium meeting dated October 4, 2006) major objectives of OMCC include:

- Ensuring political support as well as developing and implementing preventive and anti-epidemic activities in the context of priority interventions at local level;
- Coordinating interaction of all OMCC members in the framework of epidemic control at local level;
- Ensuring financing of local programs from centralized funds and from local resources;
- Ensuring control over implementation process of regional, district and city agency-level programs on epidemic prevention;
- Ensuring flexibility of response to situation evolution at local level.

## 5.2. Other coordination structures at the regional level

Despite the existence of OMCCs in each region interviewees said that it needs to be recognized that OMCCs were created artificially from “above” and became active quite recently. Therefore, they have a limited role in coordination performance to date. Respondents of the survey mentioned other structures which in reality perform coordination of HIV/AIDS epidemic prevention activities at local level:

- Oblast AIDS centers;
- Oblast and district coordination councils on health;
- Projects of international and donor organizations;
- Partner associations.

In practice oblast AIDS centers tend to have the most important coordination role at the region level since the Republican AIDS Center is the primary recipient of the GFATM grant, and a significant proportion of resources for service delivery (including medicine, syringes, needles, condoms and information materials) are distributed through its regional branches to all organizations involved in HIV related work (except NGO). Another reason is the fact that oblast coordination committees have been continuously undergoing changes including staff turnaround and for some their activities have been interrupted then resumed, whereas oblast AIDS centers have been static, that is they have not interrupted their work since they were created, for the most part, have had the same people leading them.

Regional and district coordination councils for health are another structure to which coordination function of HIV/AIDS activity is often attributed. Often, HIV/AIDS OMCCs and regional coordination councils for health consist of the same individuals<sup>13</sup>, including managers of regional level health facilities. Both structures are led by the regional vice-governor responsible for social and cultural issues. Any member of an HIV/AIDS OMCC can become a deputy chairman (elective position) whereas in health council functions of deputy chairman are performed by the director of Family Medicine Center. Nevertheless, while coordination councils for health cover issues of HIV/AIDS they tend only to hold one meeting a year primarily covering issues of intra-hospital prevention of HIV.

Survey respondents indicated that coordination is also performed international and donor organizations that coordinate their own projects, and fund activities that reflect their own priorities, not necessarily those determined by OMCCs.

To certain extent coordination of HIV/AIDS activities of NGOs in Bishkek and some regions are performed by NGO Partner Associations – that is associations consisting of a number of NGOs that agree to cooperate. There were five of them at the time of the survey. For example the AntiAIDS Association with support from the GFATM grant and the International HIV/AIDS Alliance delivers training activities for partner NGOs, organizes public hearings in all regions of the country, has a website which is used for information dissemination among partners and is developing an information resource center for partners.

### **5.3. HIV/AIDS coordination in the case study regions**

Survey respondents indicated that despite the existence of a single structure responsible for the coordination of HIV/AIDS activities in all regions of the Kyrgyz Republic in reality this function is performed by different organizations in different regions.

#### **Bishkek city and Chui region**

A Municipal Multi-Sectoral Coordination Committee was created under the Bishkek city administration, although the majority of study respondents appeared to be unaware of it. The CMCC is based in Bishkek, as are the majority of HIV-related programs and organizations: such a network was seen by survey respondents as fostering opportunities for informal information exchange, although limited formal coordination beyond that at municipal level.

Some coordination functions for health facilities that provide HIV/AIDS services are performed by the city Coordination Council on Health. In particular, Bishkek City AIDS Center receives

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<sup>13</sup> The exception are AIDS service NGOs who are members of OMCC but not members of Oblast coordination councils on health.

funding from city budget approved by the Council on Health. Staff members of the Center reported that they have the opportunity to coordinate their activities as well as identify new needs and suggest new activities at Council meetings.

An OMCC exists at Chui oblast level. Member organizations of the OMCC are located in Tokmak, the Chui oblast center and also Bishkek city. Transportation costs for OMCC members are not covered which makes it difficult to conduct OMCC meetings with the full composition of members. Based on the fact that composition of OMCC on HIV/AIDS and Coordination Council on Health includes virtually the same people it was unofficially decided to merge these two structures. Hence the Council on Health hears the reports of the HIV/AIDS program implementation once a year.

Work with vulnerable population groups in Chui region is carried by local as well as Bishkek-based NGOs. NGOs tend only to provide information about their activities to the local administration of those villages where they work. They are not accountable and do not report to the OMCC and/or Oblast AIDS Center. As a result, coordinating bodies have only fragmented information about what kind of work and activities are carried out in Chui region. Hence, at the time of the survey coordination of programs and activities for HIV/AIDS is limited in the region.

### **Osh region**

The study shows that the Osh OMCC has limited role as a coordination structure. More significant and leading role is belonging to Osh oblast AIDS center which has a relatively strong coordination role compared to other regions. Virtually all respondents from different organizations participating in the study agreed that the oblast AIDS center “determines policy with regard to HIV/AIDS in the region” and “coordinates all activities”.

Respondents indicated that coordination activity particularly includes the following:

- Monthly meetings held by the AIDS Center which covered 73 civil servants and over 10 representatives of NGOs<sup>14</sup> (for comparison: OMCC includes only 2 NGOs) in the period of 2006 – 2007;
- Joint actions and probations implemented on regular basis according to initiative of oblast AIDS center physicians;
- Development of action plans for each agency under the AIDS Center control and organization of work by the AIDS Center on implementation of these plans;

### **Issyk-Kul region**

Despite the existence of a regional HIV/AIDS program and an agreed ‘matrix’ of activities for its realization survey respondents indicated that Issyk-Kul region’s HIV/AIDS programs lack coordination.

In practice, organizations delivering HIV services act independently and at times are unaware of the existence and work of other organizations working in this area. In particular representatives of governmental organizations including health facilities remain uninformed about NGO activity. Unlike Osh the role of the Oblast AIDS Center in coordination of activities is limited. Indeed, health facilities delivering HIV/AIDS services have formalized with the AIDS center meaning they are expected to submit reports on their activities. However, in practice such cooperation is not practiced.

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<sup>14</sup> Data obtained from Osh Oblast AIDS Center.

At the time of the survey attempts were being made to develop an oblast coordination mechanism. Various organizations met together for the first time and jointly developed a matrix of activities for implementation of national and regional programs.

### **District coordination mechanisms**

Work in districts is based on district HIV/AIDS epidemic prevention programs developed on the basis of Order of the Ministry of Health and approved by the Decree of district (rayon) state administration. An annual action plan is developed for implementation of district programs. District programs on HIV/AIDS prevention consist of 3 main components: (1) an information, education and communication component; (2) an organizational component; and (3) a curative-preventive component. Representatives of district coordination committees report that inter-sectoral approach is used for development of district program and action plan.

Coordination of HIV/AIDS activities and programs implementation process should be performed by district coordination committees on health (each led by the district FMC). Taking account the epidemic situation in some district coordination committees for HIV/AIDS were created in some districts (led by district governors 'Akims'). As a rule, composition of committees is predominantly represented by directors of local health facilities. Recently, interaction with local rural organizations such as village councils, village health committees and others was observed.

The relationships between district coordination committees and OMCCs varies in different regions. In Osh region, district coordination committees submit progress reports on the implementation of district HIV/AIDS programs during the meetings of the OMCC and Oblast Council of Health. All activities implemented by coordinating bodies are recorded in minutes. In Issyk-Kul region, according to a member of one of the city coordination committees, information about HIV/AIDS related activities in the city "was never requested by the OMCC".

### **5.4. Impacts of global HIV/AIDS initiatives on regional coordination**

Key impacts on coordination at regional levels were identified in the process of this study:

- **Coordinated HIV activities within civil society.** One of the strategies of the GFATM-funded project implemented in the Kyrgyz Republic is "Strengthening political and legal support of HIV/AIDS prevention programs"<sup>15</sup>. Projects supported in the context of this strategy are aimed at capacity building of 'Partnership Networks' (associations of a number of NGOs intended to promote information sharing); strengthening institutional communications within the nongovernmental sector and inter-sectoral interaction; mobilization of NGO community for constructive involvement in national programs on epidemic prevention and development of dialogue with governmental structures; and provision of technical support for AIDS service organizations which contributes to their capacities.
- Clarity of roles and responsibilities of different organizations in implementing HIV/AIDS programs. Respondents expressed the opinion that coordination and inter-sectoral cooperation have improved since the GFATM started to provide funding for HIV/AIDS. The

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<sup>15</sup> Progress report on the first phase implementation of the Project of Global Fund to Fight AIDS, TB and Malaria in the Kyrgyz Republic (AIDS Component)



GFATM provided money for implementation of all components of the second National Program on HIV/AIDS and STI Prevention (2001-2005) including for governmental organizations. From this point of time, public agency-level and health facilities became active in HIV/AIDS related activities. The work of the unit on execution of grants and CMCC programs as well as the work of CMCC Presidium was focused on coordination of GFATM project. One meeting was conducted to discuss issues related to financing of organizations under the CAAP. So, some mechanisms of coordination have been launched at country level.

## **5.5. Effectiveness of national and regional coordinating structures**

The majority of respondents reported a growing trend towards improved coordination, and an inter-sectoral approach to the implementation of HIV/AIDS programs and activities at national and regional levels.

The existing CMCC structure and composition are recognized as appropriate since this ensures wide involvement of representatives from different sectors in executing CMCC activity. Membership of the CMCC is active in terms of a high level of participation in meetings.. The growing role of the CMCC in decision making regarding the implementation of the national HIV/AIDS strategy including GFATM and CAAP-funded programs was recognized by respondents. A set of strategic and legal documents were developed including:

- the Third State Program on prevention of HIV/AIDS epidemic and its socio-economic consequences for 2006 – 2010;
- a multi-sectoral integrated matrix of activities for the implementation of the State Program for 2007 – 2008;
- regulations “On state of monitoring and evaluation of HIV/AIDS situation in the Kyrgyz Republic”;
- a National Plan on monitoring and evaluation of HIV/AIDS situation in the Kyrgyz Republic.

Good progress was made in involving stakeholders across the health, justice and education sectors in the process of development of the Third State Program on prevention of HIV/AIDS epidemic and its socio-economic consequences for 2006 – 2010. By and large, the CMCC experience in the Kyrgyz Republic is considered by international donors as the most successful within the Central-Asian region<sup>16</sup>.

Respondents also suggested there had been progress made in terms of coordination at the regional level. The OMCCs were created and regulations on OMCCs were developed along with development of regional programs on HIV/AIDS epidemic prevention for 2006 – 2010. Meetings to discuss implementation plans of regional HIV/AIDS programs were conducted as part of OMCC activity. Interaction between governmental and non-governmental organizations, including information sharing and integration of resources and programs appears to be taking place. Nevertheless, respondents suggested that both the CMCC and OMCCs are problematic. Problems include: lack of clear procedures of work and subordination structure; lack of funding for coordinating structures; lack of initiative from the civil sector to cooperate and isolation of this sector; and poor material and technical basis for performance of coordinating function. One

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<sup>16</sup> Introduction of GFATM portfolio by V. Cherniavsky at CMCC Presidium meeting / Minutes of CMCC Presidium meeting dated as of October 12, 2006

respondent suggested that “...it is easier and more effective to organize coordination work in one locality (small village) than at the level of district or region”.

**Example: Kara-Suu district in Osh oblast**

Kara-Suu district is a suburb of Osh city. It is of interest for HIV/AIDS service organizations because more than half of all HIV cases in Osh region are registered here and also this is the place with high prevalence of intravenous drug use and sex work. Three coordination structures exist: a district coordination council on health, a district coordination committee on HIV/AIDS and a city health council, all of which are located in Kara-Suu town, the center for Kara-Suu district. One member of all of these coordination committees reported that members of coordination committees are not well informed about HIV/AIDS-related activities, especially about NGOs working with IDUs and CSWs locally.

## 5.6. Factors promoting or hindering effective coordination

Factors contributing to effective coordination of implementation of HIV/AIDS programs and activities include the following:

- Third State Program on prevention of HIV/AIDS epidemic and its socioeconomic consequences for 2006 – 2010 is based on a multi-sectoral approach in that it was agreed on and drafted by multi-sectoral committees including health, justice and education, and linked with other national and state programs on health sector development. According to stakeholders this program clearly defines the roles of all sectors including civil society organizations.
- High level of commitment from political leaders is observed in the Kyrgyz Republic. The secretariat of the CMCC has moved from the Ministry of Health to Prime-Minister's Office, and regionally OMCCs fall within state administrations. Interviewees suggested these arrangements helped to ensure buy in at the highest political level.
- The establishment of OMCCs has promoted better coordination. Interviewees suggested that there are some examples of where governmental and nongovernmental organizations have started to cooperate more fully than they did previously; however, as a whole this is not the case. In some regions the creation of OMCC helped, as one interviewee put it, “...all AIDS service organizations to sit down together to bargaining table for the first time”.

The study also revealed some issues in common across the case study regions which suggest further work is required to ensure more effective coordination:

- According to respondents' accounts, one of the most significant factors hindering the effectiveness of OMCC is the financing of regional programs. OMCCs expected to receive funds for the realization of programs right after the development of the matrix of activities under the Third State Program. The Chairman of one OMCC said the following during the interview: “We cannot start implementation of planned activities because we haven't received the money for that”.
- Replacement of OMCC leaders caused by political change in the country. As a result, Secretariats or other OMCC members have to brief new leaders which in turn delays

progress. The work of OMCCs in many respects depends on the commitment of key individuals leaving these structures vulnerable in the event of change of membership.

- There are multiple coordination structures at the level of oblast state administration: in addition to HIV/AIDS OMCCs there are oblast Coordination Councils on Health, projects of international and donor organizations and Partnership Associations. OMCC members representing health facilities believe that HIV/AIDS OMCCs and oblast Coordination Councils for Health in particular duplicate each other. One respondent suggested: *“I am a member of either 5 or 6 different commissions, head-quarters and committees at the same time. But none of them is addressing directly the issue in which I am interested. Each commission consists of about 6 people who are mainly the regional level officials. There are no representatives from districts”*. Some respondents suggested that work of these committees is only about organizing meetings rather than meaningful coordination leading to effective interventions.
- OMCC work remains within the frameworks and guidelines imposed by the CMCC Secretariat. At present, OMCC members do not possess sufficient capacity to work independently on locally identified objectives.
- Some respondents who were listed as OMCC members representing governmental institutions were not able to describe the coordinating mechanism in their region and moreover were not aware they were a member of an oblast coordination committee.
- Interaction of governmental and nongovernmental organizations remains at low level in those regions where HIV/AIDS activities have a limited history. Representatives of civil sector reproach governmental structures with being “closed” whereas they in turn mention “lack of initiative towards cooperation” from NGOs.

## 5.7 Summary

- The Country Multisectoral Coordination Committee (CMCC) for HIV/AIDS was evaluated by interviewees as having an increasingly significant role in HIV/AIDS-related decision making and engaging a wide constituency of stakeholders.
- Oblast Multisectoral Coordination Committees (OMCCs) are predominantly formed of representatives of government institutions including AIDS centres and other healthcare providers and law enforcement agencies; few NGOs are represented on the committees. Meetings are infrequent, and recent political upheaval led to the discontinuation of some OMCCs.
- OMCCs were viewed by some interviews as imposed from above, and as having a weak role in regional coordination, although this varies: interviewees evaluated Osh OMCC as having a substantial role in determining regional HIV/AIDS policy, while coordination in Issyk-Kul was seen as underdeveloped by comparison.
- Barriers to effective coordination include: ongoing changes in committee membership; lack of clear working procedures and lines of accountability; lack of clarity among members about how coordination works; limited civil society representation; lack of funding for coordination structures.

## CHAPTER 6 Coordination and cooperation between organizations delivering HIV/AIDS services

### 6.1 Levels of coordination and cooperation between HIV/AIDS services

This chapter provides examples of coordination and cooperation between HIV/AIDS service organizations, and assesses the impacts of the GFATM on the development of coordination and cooperation between HIV/AIDS service organizations. The chapter focuses mainly on the practice of referral of service users to other organizations as a key form of cooperation.

Results of interviews with service providers show that half of the respondents assess the level of cooperation between HIV/AIDS service organizations as “moderate” (Figure 6.1).

**Figure 6.1 Level of cooperation between HIV/AIDS service organizations: frontline providers’ perspectives**

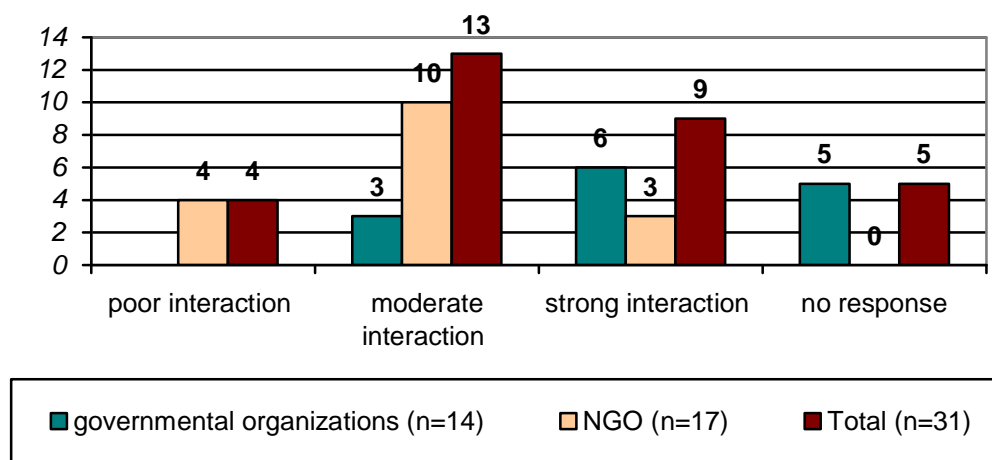


Table 6.1 suggests that HIV/AIDS services sampled coordinate their activities to a high degree with FMCs, (other) NGOs and AIDS centers. HIV/AIDS services also coordinate their activities with narcology dispensaries since half of the organizations included in the study sample provide various services for IDUs.

**Table 6.1. Coordination between surveyed organizations and other organizations: frontline providers’ perspectives**

	Governmental organizations (n=14)	NGO (n=17)	Total # of responses (n=31)
FMC	9	15	24
NGO	6	12	18
AIDS Center	4	14	18
Narcology dispensary	6	10	16
Dermatology-venereal dispensary	7	8	15

Public hospital	7	6	13
Public laboratory	5	8	13
TB Control Center	6	5	11
Maternity hospital	5	5	10
FGP	3	6	9
Private laboratory	1	3	4
Privately practicing physician	0	4	4
Private polyclinic	1	1	2
Private hospital	1	1	2
Other	0	6	6

## 6.2. Service user referral between HIV/AIDS organizations

A key form of interaction between organizations is the referral of clients to receive additional HIV services.

The majority of frontline providers indicated they referred clients to other organizations. Referral of clients is not practiced in five organizations; this primarily relates to the mandate and mission of these organizations<sup>17</sup>. Most often the clients are referred to AIDS, TB and Dermato-venerology centers. Interviewees indicated this was primarily for diagnosis. The data suggest that referrals to NGOs are less common than to these organizations (Table 6.2).

**Table 6.2. Organizations clients are referred to: frontline providers' perspectives**

	Governmental organizations (n=13)	NGO (n=17)	Total # of responses (n=30)
AIDS Center	5	12	17
TB Control Center	10	7	17
Dermatology-venereal dispensary	10	6	16
Narcology dispensary	7	7	14
Maternity hospital	7	7	14
NGO	6	7	13
Public laboratory	7	5	12
Public hospital	6	5	11
FMC	5	3	8
FGP	4	4	8
Private laboratory	3	2	5
Other	1	3	4
Private hospital	1	2	3
Privately practicing physician	1	2	3
Private polyclinic	1	1	2

There are 2 distinct forms of referral:

- Mandatory referral of clients for testing and diagnosis;
- Referral for services based on clients' needs.

<sup>17</sup> Including NGOs conducting informational work with youth and penitentiary institutions

## **Mandatory referral of service users**

Mandatory referral implies referral of clients (or blood samples) to laboratories of AIDS Centers for HIV testing. Mandatory referral is practiced primarily in governmental health facilities, for example:

- Narcology dispensaries often refer their clients for HIV testing in AIDS Centers, fluorography and a number of other general tests as a condition of them receiving substitutive methadone therapy.
- Usually blood sampling and pre-test consultation take place in the health facilities such as FMCs and FGPs. In the case of positive test results, the staff of AIDS Centers provide a post-test consultation service.
- There are certain groups that are required by the “Law on HIV/AIDS in the Kyrgyz Republic” to receive mandatory testing for HIV. They include donors of blood and other biological fluids, foreigners and persons with certain professions. However, it was observed during the study that some public outpatient health facilities (FMCs and FGPs) refer all pregnant women for mandatory HIV testing. Such practice was observed in Issyk-Kul region and mentioned by interviewees in Bishkek city.

## **Referral to services based on clients’ needs**

Referrals related to service delivery based on clients’ include:

- Needs related to receiving health services;
- Needs related to voluntary consulting and testing;
- Needs for services related to social inclusion, support and rehabilitation.

Clients are primarily referred to public health facilities rather than to private clinics and laboratories since the majority of surveyed organizations target vulnerable groups who frequently experience financial difficulties).

Another type of referral commonly practiced by organization involved in the study is referrals for voluntary counseling and testing for HIV. The vast majority of NGO staff reported that they referred clients for HIV testing. As a rule, consultation and motivation for testing are initiated by social workers of NGOs. After the client agrees to take the test s/he is either referred to the AIDS Center as an anonymous client (i.e., the client gets a free test) or a sample of his blood is taken by the NGO and sent to the laboratory for testing. The problem with this approach is that not all the clients return for results after an anonymous test.

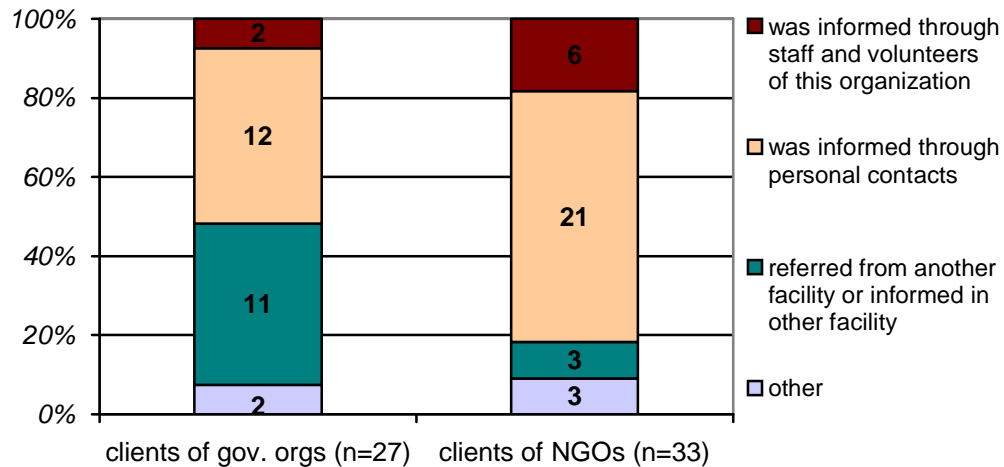
Services related to social inclusion, rehabilitation, information sharing and support are mostly provided by nongovernmental organizations. Governmental organizations delivering such services include Bishkek City AIDS Center, oblast AIDS centers and local government authorities at district level.

At the same time, less than 10% of clients of nongovernmental organizations said that they were referred to these organizations by other (governmental) organizations, whereas in public facilities over one forth of the clients reported referral (Figure 6.2). These data suggest that at present the most widespread means by which clients are informed about services is through personal contacts rather than referral between services<sup>18</sup>.

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<sup>18</sup> Interviews with service users suggest that personal contacts include friends, parents, relatives, cohabitants and other community members.

**Figure 6.2. “How did you learn about this organization?”: clients’ perspectives**



### 6.3 Examples of client referrals between GFATM-funded services

There are some examples of GFATM-funded services that appear to practice high levels of referrals from and to other services. A good example is coordination between two NGOs, “Nauchmedlite” and “Adilet” in Bishkek which receive GFATM funding for delivery of specialized (health and/or social) services. “Nauchmedlite” NGO provides support in terms of consultative, diagnostic and curative activities aimed at reduction of STI and HIV/AIDS prevalence among CSW, MSM and IDUs, and delivers venereal and gynecological services for a number of NGOs and provides services of pre-test consultation and HIV testing. Services of this clinic are used by clients of various nongovernmental organizations as well as some governmental organizations that refer them to this organization. The legal ‘clinic’ “Adilet” receives grant financing from different donor organizations including the GFATM. It provides assistance in terms of helping clients recover lost documents (common among ex-prisoners and people who are arrested), and provides lawyer/advocate and other legal services to the clients of other AIDS service organizations.

Interaction between AIDS service organizations delivering various services has been based on memorandums of understanding, many of which within the last two years. One respondent mentioned that partner organizations can provide HIV services to not only their main target group but to the clients of other organizations as well:

*“Friendship agreements are funded by the Global Fund. The Global Fund [Principle Implementing Unit] gave us all the addresses (of friendly organizations). There are such organizations in Issyk-Kul region, one in Jalalabat, one in Osh and two organizations in Bishkek. We refer our clients there using cards. We have official cards and give them to everyone who comes to us. The card is given only for the first visit and for following visits we assigned a number to a client. The client may go there using this number or may not come at all. We don’t even know who goes to these organizations, we keep in touch over the phone and asked these organizations about how many people came there and what diseases they had. And that is how we obtain this information”. (Interview excerpt, NGO, Bishkek city)*

To maintain such an approach and avoid duplication in the registration of clients a voucher system is used: a client of an organization which has agreement with other partner organizations receives a voucher (referral) for service obtainment. Afterwards the vouchers are taken into account and organizations share information about the number of clients and types of delivered services. At present, the voucher system is used only by a small number of nongovernmental organizations which have signed partnership agreements.

A number of NGOs as well as governmental organizations working with vulnerable groups deliver social support services known as “Social bureaus” that provide “social escort” services, which implies providing support for client to enable them to access health and social services. Funding to support client escort was first provided by the GFATM in 2006. According to the opinion of staff of the organizations with such practice, these projects are quite timely and impact on the efficiency of NGO work. Often the barriers to clients receiving a service include lack of money for transportation and reluctance/fear to approach organizations or lack of time. ‘Escort’ of clients helps clients approach a service and make sure that s/he receives it. One interviewee explained:

*“Effectiveness of overall work with vulnerable groups depends on comprehensive approach. System of referral plays its part in this comprehensive approach. We have to be sure that the person will not get lost. We should know where the person goes, where he received care and follow the client through the database. Global Fund provided support to the project on social support. Health facilities used not to accept drug users without this project but now with escort they accept and help them... This project also covers the cost of services. Now these services are delivered for free and even if there is a need to pay we can cover it through social bureau”.* (Interview excerpt, NGO, Bishkek city)

#### **6.4 Problems arising from limited client referral**

Systems of client referral is almost not functioning in the regions where HIV services are just developing and the number of service providers is relatively low. The study reveals a range of problems related to client referrals as follows:

- The most important issue is the ability to deliver specifically those services to clients which they most need. Therefore, lack of referral system may have negative impact on the appropriateness of services clients receive.
- Duplication of work of the organizations performing identical activities in the same location and for the same target group is observed.
- There is limited or no information sharing among service provider organizations about the number of clients they serve. Moreover, service providers mentioned cases when clients came to different NGOs for the same kind or similar services. As a result, distortion of figures about the actual number of people that received one or more services in a locality is inevitable.
- In small regions and rural areas the number of physicians capable of providing HIV services is extremely limited. It was observed that the same specialists work on several projects in nongovernmental organizations at the same time or combine jobs in governmental and nongovernmental organizations. This creates problems of client confidentiality between services.

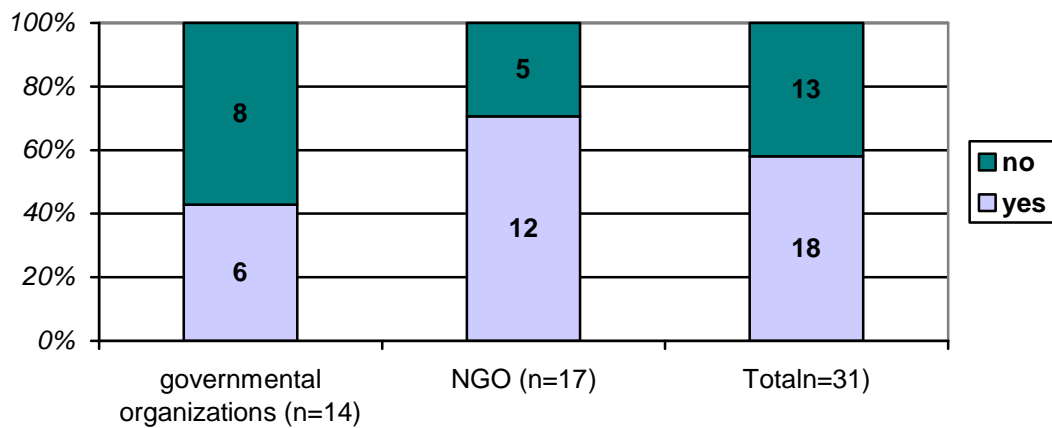


## 6.5. Other forms of cooperation between organizations

### Programmatic planning

Findings of the frontline staff survey suggest that 18/31 organizations practice programmatic planning in cooperation with other providers of HIV services (Pic.6.3.). Data suggest that NGOs jointly plan their activities more often than government providers.

**Figure 6.3. Organizations that are involved in strategic planning with other HIV organizations: frontline providers' perspectives**

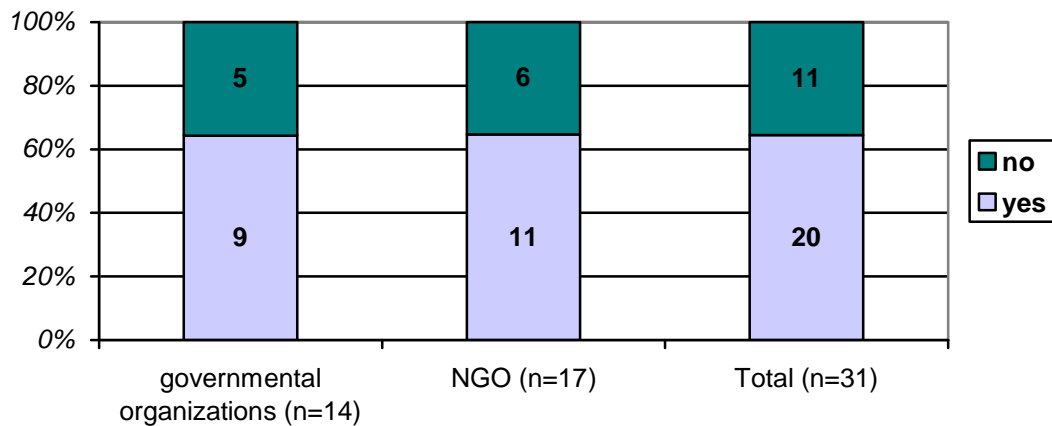


Strategic planning primarily implies development of territorial and agency-level HIV/AIDS programs and preparation of matrix of activities for implementation of these programs. However, comments of some respondents and some observations allow to draw a conclusion that the nature of this process is rather formal. The most active AIDS service organizations introduced their comments to program documents but none of them tracked down whether these comments were taken into account.

### Information sharing

Staff members of 20 organizations reported practice of information sharing with other providers of HIV services (Figure 6.4). Patterns are similar for governmental and nongovernmental organizations.

**Figure 6.4 Organization that share information with other HIV service organizations: frontline providers' perspectives**



A significant number of workshops, conferences and trainings conducted in the Kyrgyz Republic contribute to the process information sharing among organizations. Most of these activities were conducted under the financial support from GFATM. As rule, such activities involve governmental organizations representing various fields (education, health, the military) as well as HIV NGOs. Interviewees agree that such experience sharing contributes to closer “acquaintance” of sectors with each other, reduces bias among governmental organizations towards NGOs and prepares the ground for further cooperation. As an interviewee said:

*“Previously it seemed to us that NGOs took too much of responsibility on themselves. Even physicians didn’t assume such responsibility while they (NGOs) wanted to work in the areas such as preparation for ARV therapy and management of ARV therapy. But nowadays we participate in joint workshops a lot and see that NGOs have great capacity. They indeed know a lot and can do a lot and it seems to me that they even know more than physicians... They are the people who can provide at least some assistance to vulnerable groups at the moment while we train our physicians. They can also provide basic psychological assistance better than physicians”.* (Interview excerpt, health worker)

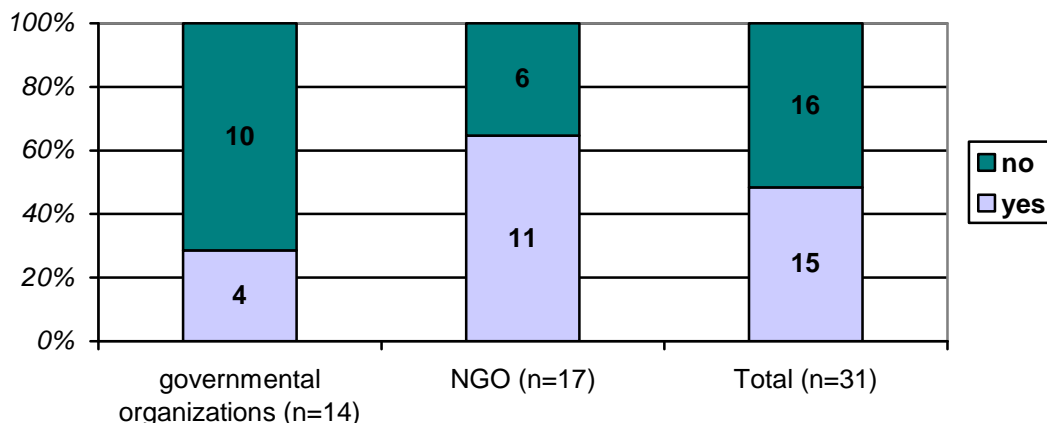
NGOs working with vulnerable groups also conduct public hearings with involvement of representatives from different sectors to lobby their activity. It was also reported by organizations functioning in cities of Karakol in Issyk Kul, Jalalabat and Osh that NGOs conduct round table meetings upon completion of GFATM grants to inform partner organizations about their activity.

A negative form of cooperation between agencies imposed from above was the practice of physicians from narcology and AIDS centers and FMCs assisting police conduct spot-checks aimed at identifying and apprehending sex workers and/or drug users. Indeed, up until very recently there was a regulation according to which narcology centers were obliged to submit data about patients to law enforcement agencies.

## Integration of resources

Results of interviews with staff members show that half of the organizations practice some form of integration of resources for implementing HIV services (Figure 6.5). Data suggest this is more common among NGOs than government service providers.

**Figure 6.5. Organizations that integrate financial resources with other HIV service organizations: frontline providers' perspectives**



Nevertheless, managers of surveyed organizations placed high emphasis on this form of cooperation. It was reported that the most widespread form of interaction between different organizations involved in activity on HIV epidemic prevention is conduction of joint events (for example, Day to Fight AIDS, the Day of Remembrance of People Died from AIDS, etc.). The views of survey respondents suggested the GFATM grant was important in supporting such activities, and that representatives of governmental organizations started to treat the problem with more understanding and show more interest in the issues. An interviewee suggested:

*“With the Global Fund we started to conduct large-scale actions [events] more often. Previously each organization used to carry out their actions separately whereas now we tend to integrate our resources and opportunities. Maybe this happens because we take money from the same pocket and thus can save some and because work proved to be more effective when several organizations are involved in such activities. This action has one goal and we merge our efforts it becomes more effective and significant. Interaction has improved because we started to invite each other more for different events and carry out assessment for staff of different organizations”.*

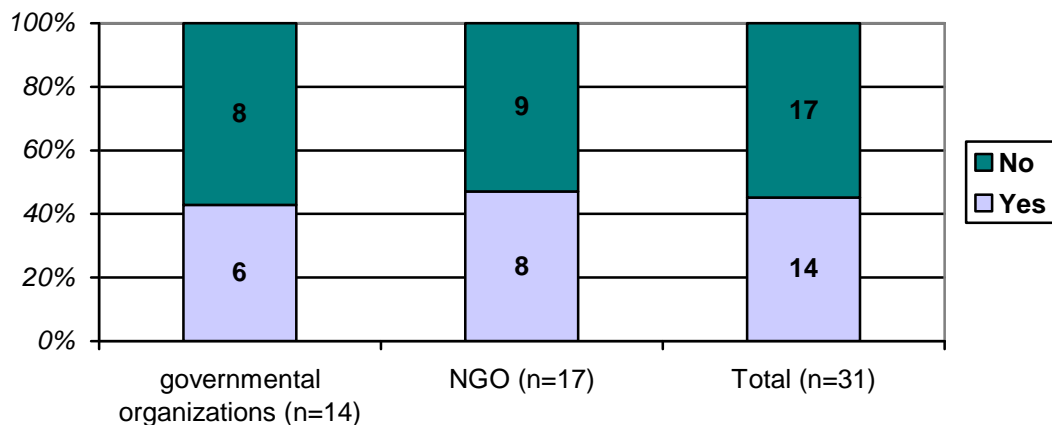
(Interview excerpt, NGO, Osh city)

Joint training activities conducted by nongovernmental organizations to their staff are a relatively new form of cooperation. The best example is the AntiAIDS Association which conducted training workshops for staff of Association member organizations on the most relevant topics in the framework of a project “Ensuring constructive involvement of civil society in national response to HIV epidemic in Kyrgyzstan”. There is also practice of smaller scale activities where several organizations use joint approaches to deliver training for newly recruited staff, namely social workers and volunteers.

## Common guidelines for treatment, examination and support

Almost all organizations delivering health services report the application of common clinical guidelines (Figure 6.6). The most widespread example is the guideline on pre-test consultation management developed with GFATM financial support. Organizations which provide antiretroviral therapy and substitutive Methadone therapy also follow clinical guidelines that were developed under GFATM financial support.

**Figure 6.6 Organizations that use common guidelines on treatment/examination/support: frontline providers' perspectives**



## Common monitoring and evaluation system

The technical body on Monitoring and Evaluation is currently developing plans for a “State system of monitoring and evaluation of HIV/AIDS situation in the Kyrgyz Republic” and National Plan on monitoring and evaluation of HIV/AIDS situation in the Kyrgyz Republic. However, at the time of this study these plans were submitted to the Government of the Kyrgyz Republic for approval. Hence, no common system of monitoring and evaluation of HIV/AIDS programs and activities is in place yet.

### 6.6. Factors promoting and hindering effective cooperation between HIV/AIDS service organizations

On the whole, the most developed cooperation between organizations delivering HIV services exists in regions where HIV programs were launched before the GFATM Round Two grant was initiated in 2004 (that is, Bishkek city and Osh region). In regions where HIV related activity had not been executed at all or executed on fragmented basis before 2004 cooperation between organizations continues to be limited. A major factor contributing to effective cooperation between organizations was the rise in awareness level and development of commitment in management and staff of governmental organizations though informational-educational activities helped to involve more organizations and provide services to vulnerable groups in governmental organizations. This also facilitates increased trust and understanding among HIV service providers. An interviewee suggested:

*“Interaction is already felt since some joint activities are conducted more frequently and support and understanding are shown by governmental bodies during implementation of certain activities... Now they (representatives of governmental bodies) often participate in these activities and this is gratifying if we take into account how busy they are. On the other hand they started to invite us (NGOs) to some of their HIV related activities implemented in the context of national programs and most importantly listen to the opinion of NGOs”*  
(Interview excerpt, NGO, Osh city).

Nevertheless, there is still some factors hindering effective cooperation between HIV service providers, especially in regions with lower levels of HIV services development (Jalalabat and Issyk-Kul regions) as follows:

1. Many government service providers said they viewed NGO staff as having limited training and professionalism, and this limited their willingness to coordinate with NGOs.
2. The allocation of the GFATM Round Two grant whereby the bulk of funding for the implementation of services was received by NGO service providers, caused a degree of resentment among some government services. Moreover, representatives of governmental organizations accused NGOs in lack of willingness to cooperate with them, whereas NGOs pointed to the “closed nature” of governmental bodies.
3. Competition among service providers for limited donor funding undermined efforts to promote coordination among service providers. This resulted in a lack of willingness to refer clients, share resources and information and develop joint activities.

## **6.7 Summary**

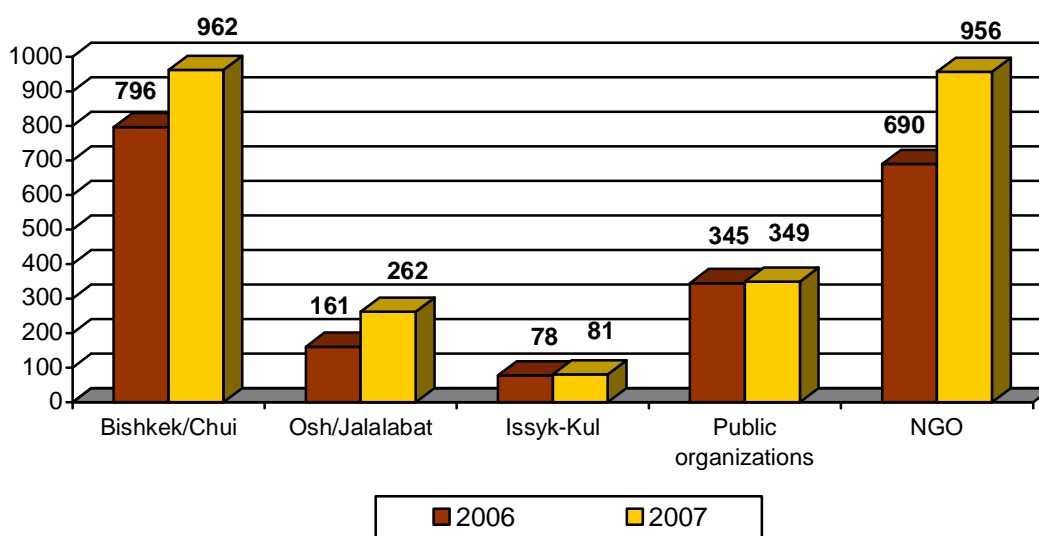
- Most respondents indicated their HIV/AIDS organisation coordinated their activities with other government and NGO HIV/AIDS service organisations, including client referrals. Some organisations sign MoUs formalising these arrangements. Contradicting this view the vast majority of clients indicated that they had *not* been referred between services; information about services through personal contacts was seen more important.
- Other forms of coordination between some HIV/AIDS organisations include: coordinated strategic planning; information sharing; integrated resources; common protocols; common M&E system.

## CHAPTER 7. Human resources delivering HIV/AIDS services

### 7.1. Availability of personnel and their workload

Figure 7.1 shows the total number of personnel in surveyed organizations. The data suggest that the numbers of personnel have increased most in Bishkek and Chui, and that while NGO personnel have increased substantially, numbers among government services remained stable. Comparative data for 2006 and 2007 show that the number of personnel working in the area of HIV/AIDS service delivery increased in all regions. The largest increase is observed in Bishkek city and Chui province (by 20,9%) primarily within the nongovernmental sector (by 38,6%).

**Figure 7.1. Number of personnel in the 24 organizations delivering HIV/AIDS services**



Detailed analysis of the data provided the following findings (Table 7.1). Besides doctors and nurses traditionally involved in delivery of health services including HIV/AIDS, new categories of personnel have appeared such as social workers and outreach workers delivering services according to the “peer to peer” principle, as well as volunteers. As a rule, the majority of outreach workers and volunteers are representatives of vulnerable population groups themselves or co-dependant persons. In the opinion of many managers interviewed, recruiting such workers is one of factors contributing to increased effectiveness of HIV/AIDS control programs since they have good knowledge of the experiences and perspectives vulnerable groups, have access to these groups and can communicate effectively with them. For example an interviewee suggested:

*“... At first we employed pedagogues with higher education and tutors, such intellectual people. They are very good people and we worked well together. But they were saying in tears that they cannot work with our clients, that the organization is good with good money, but, sorry, they still cannot work. And then we realized that we should follow the principle “peer to peer”...”*

Moreover, this arrangement has direct benefits to the workers themselves. For example:

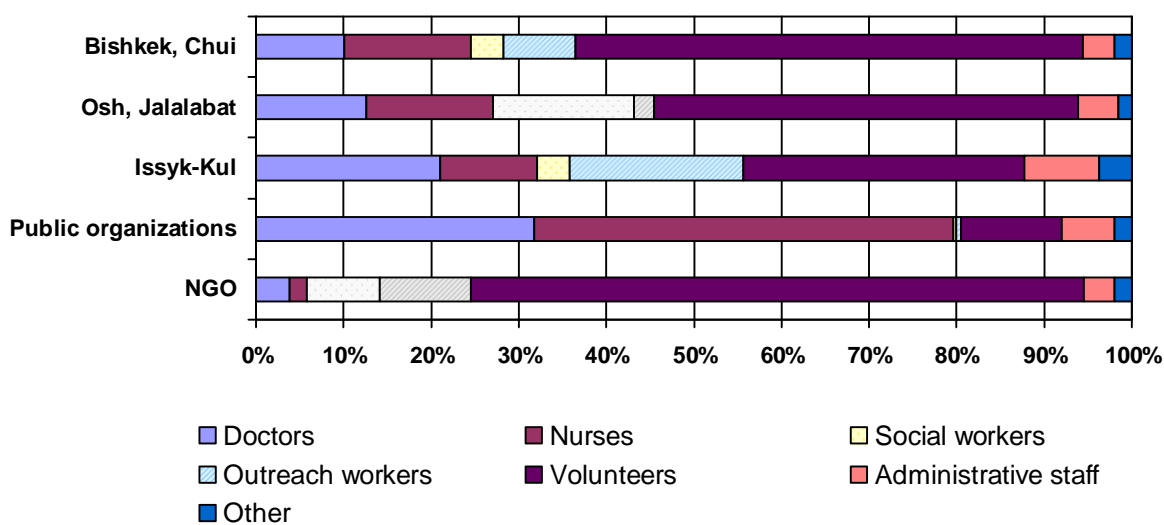
“... Social tension is relieved. People from vulnerable groups are directly involved in work, they work in our organization, their work is paid, i.e., this is substantial support for them...”

**Table 7.1. Personnel categories in 24 surveyed organizations**

Personnel category	Province						Organization type			
	Bishkek, Chui		Osh, Jalalabat		Issyk-Kul		Government		NGOs	
	2006	2007	2006	2007	2006	2007	2006	2007	2006	2007
Doctors	85	97	27	33	19	17	101	111	30	36
Nurses/paramedics	159	139	33	38	7	9	184	167	15	19
Social workers	25	36	19	42	1	3	2	1	43	80
Outreach workers/“peer to peer”	72	79	18	6	16	16	19	2	87	99
Volunteers	417	557	53	127	26	26	17	40	479	670
Administrative staff	26	35	11	12	5	7	19	21	23	33
Other	12	19	0	4	4	3	3	7	13	19
<b>Total</b>	<b>796</b>	<b>962</b>	<b>161</b>	<b>262</b>	<b>78</b>	<b>81</b>	<b>345</b>	<b>349</b>	<b>690</b>	<b>956</b>

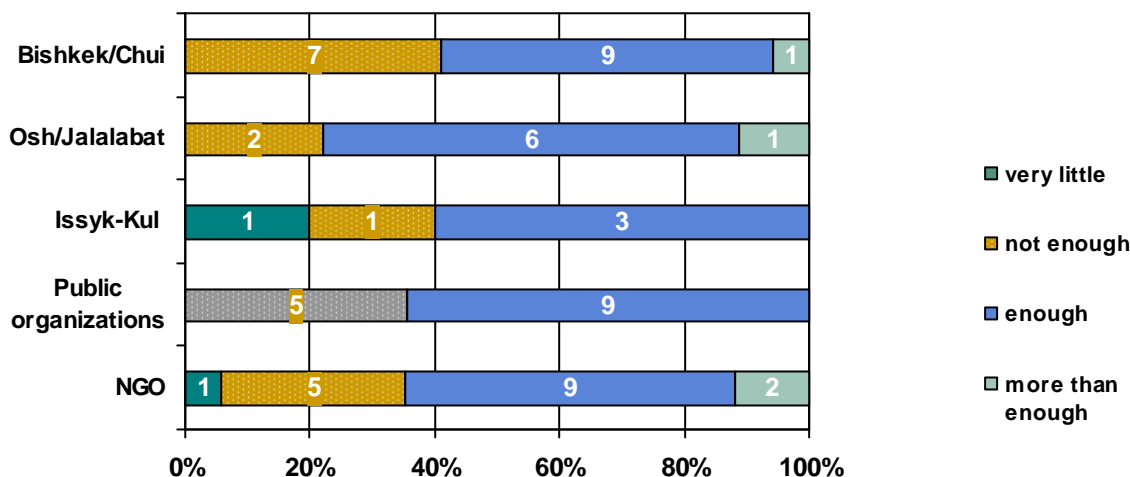
As seen from Figure 7.2, governmental organizations are mainly employ doctors and nurses while NGOs mainly recruit social workers, outreach workers and volunteers. Such distribution of personnel reflects roles and functions carried out by organizations involved in HIV/AIDS programs. The difference in the proportion of volunteers in Bishkek/Chui reflects the substantial growth in NGO activity in that region since the inception of the GFATM HIV/AIDS grant.

**Figure 7.2. Categories of personnel in 24 surveyed organizations**



During interviews service providers were asked whether there are enough personnel within their organization to deliver current service adequately (Figure 7.3). Most respondents in all three regions reported having enough personnel in their organizations. At the same time, in Bishkek/Chui about 40% of respondents, and in Osh/ Jalalabat about 20% of respondents indicated there was a shortage of personnel.

**Figure 7.3. Is there enough personnel in your organization? Frontline providers' perspectives (N=31)**



## 7.2. Training of personnel

About two thirds of sub-national stakeholders interviewed believe that the GFATM grant had a positive effect on development of human resources both in terms of numbers and professional competence (Table 7.2).

**Table 7.2. GFATM impact on development of human resources (N= 38)**

Factors	Positive impact*
Number of workers	54%
Personnel skills	58%
Technical execution of services	65%
Personnel attitude towards clients	57%

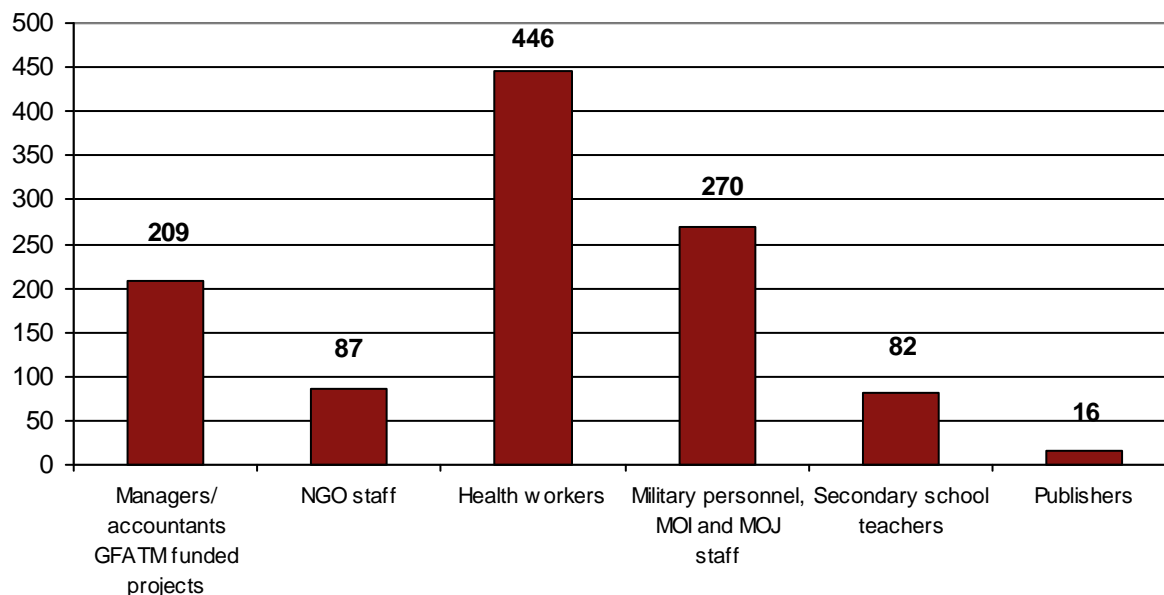
**Note:** \*Positive impact was assessed as 'moderate', 'strong' or 'very strong'.

During the first phase of the GFATM funded HIV/AIDS program 3% of the total volume of funds was allocated for training of staff<sup>19</sup>. In this period a total of 1,110 individuals received training (Figure 7.4.). Training covered specialists from different sectors including health, education, MOI (Ministry of Interior, responsible for policing) MOI (Ministry of Justice, responsible for prisons) and representatives of mass media.

<sup>19</sup> PIU Report on the First Phase of the Second Round Grant, 2006)



**Figure 7.4. Number of specialists trained in the context of Project first phase (March, 2004 – March, 2006)**



Source: PIU Report on the First Phase of the Second Round Grant, 2006

Table 7.3 contains a breakdown of conducted training topics for government staff (data are not available for training received by NGO staff), indicating different types of training. However, interviewees suggested that it may be necessary to further increase coverage of training workshops and possibly revise topics of conducted workshops. Taking into account the following factors: (1) the small number of patients currently receiving ARV therapy (69 people as of October 2007); (2) decision making about prescription of ARV therapy, selection of treatment schemes and follow-up are done at the level of Republican AIDS Center, or in Osh, at the Osh province AIDS center; (3) preference of patients to receive treatment somewhere away from place of living revising the balance between these topics may be appropriate. For example, focus more on VCT issues. Moreover, interviews revealed that despite conducted trainings on project management issues, administrative staff in some organizations still need additional training on reporting, especially financial reporting. During interviews it was also suggested many times that health workers in governmental health organizations have poor skills in working with vulnerable population groups, and that discrimination of these groups is quite common. Developing training programs in this area may therefore be beneficial.

Moreover, it is important to take into account a quite high level of staff turnover both in governmental and nongovernmental organizations. For example, an interviewee explained this was a problem: "... training is required, some topics need to be repeated since new people are joining..."

**Table 7.3. Topics of workshops (March, 2004 – March, 2006)**

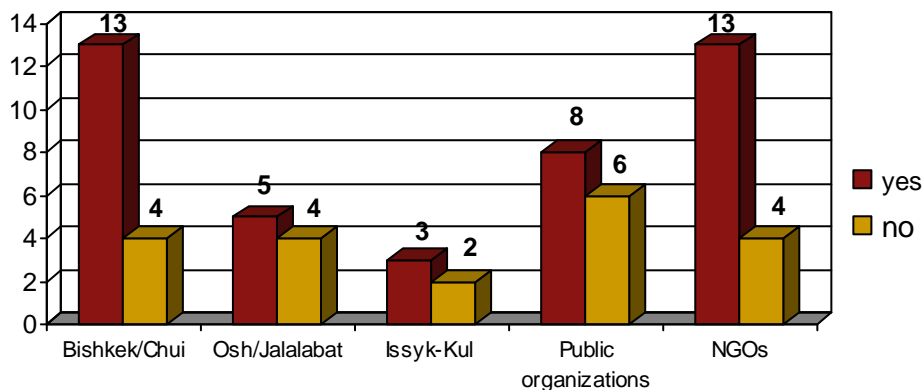
No	Topics of workshops	Specialists	Number of people
1	"Voluntary donors – safe blood"	Doctors	22
2	"Transfusion aspects of HIV infection"	Doctors	59
3	"Problems of donor blood safety and HIV/AIDS"	Health workers	25

	diagnostics”		
4	“AIDS and modern esthetic dentistry”	Dentists	27
5	“Modern aspects of prevention of HIV vertical transmission”	Managers of obstetric service	66
6	“National workshop on development of HIV/AIDS prevention plan and introduction of treatment guidelines”	Representatives of health facilities	60
7	“Anti-retroviral treatment of HIV-infected and AIDS patients”	Doctors	104
8	“Consulting as integral part of testing for HIV”	FGPs	83

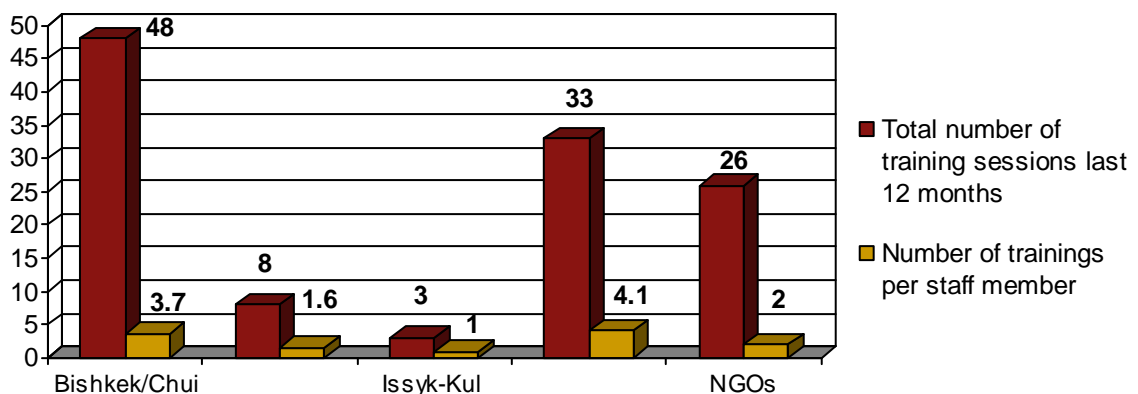
Source: PIU Report on the First Phase of the Second Round Grant, 2006

All frontline service providers were asked whether during the last 12 months they were involved in training on HIV issues (Figure 7.5). Of the three regions, a higher proportion of staff working in Bishkek/Chui (predominantly from nongovernmental organizations) appeared to receive training than those from the other study regions. Moreover, staff of governmental and nongovernmental organizations of Bishkek/Chui also appear to receive a higher number of training session than elsewhere (Figure 7.6).

**Figure 7.5. “During recent 12 months, were you involved in training on HIV issues?” (results of interviews with frontline staff N=31)**



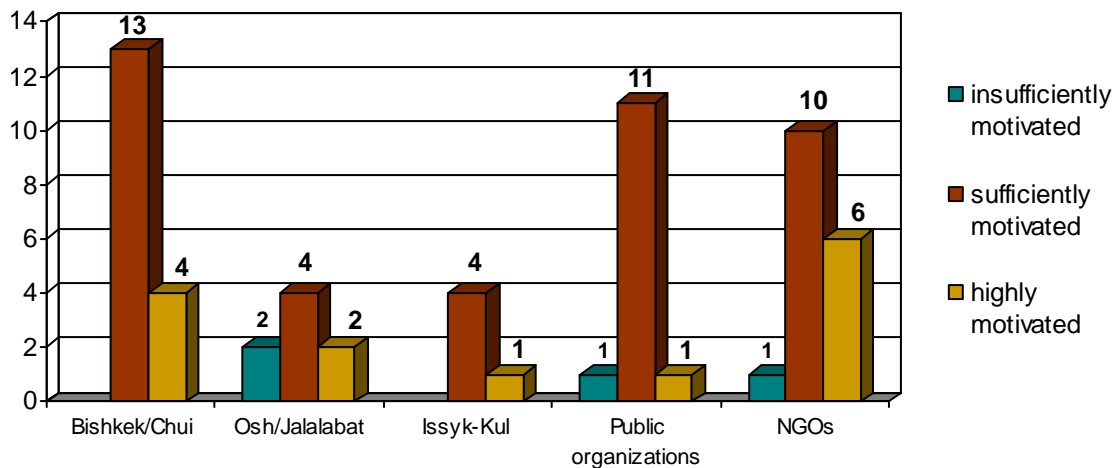
**Figure 7.6. Number of training sessions per staff member**



### 7.3. Motivation, workloads and incentives

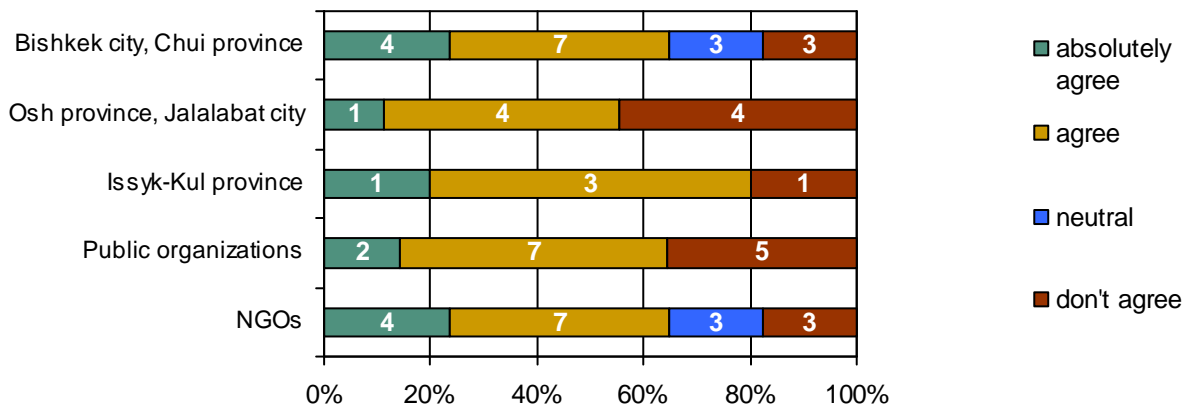
Frontline providers were asked how motivated they believed the personnel in their organization were in terms of delivering HIV/AIDS services (Figure 7.7). The data suggest that the majority of personnel in surveyed organizations are sufficiently motivated to deliver HIV/AIDS services. Higher level of motivation was indicated in governmental and nongovernmental organizations of Bishkek/Chui. A higher proportion of personnel from nongovernmental organizations assessed motivation as high than among government services.

**Figure 7.7. “How motivated is the personnel in your organization to delivery HIV/AIDS services?”: frontline providers’ perspectives (N=31)**



Frontline personnel were also asked whether their workloads had become more or less feasible in the last twelve months (Figure 7.8). The data suggest that workloads have become less feasible among a greater proportion of personnel of government institutions, and particularly in Osh region. Such patterns are explained by the limited increase in numbers of personnel delivering HIV/AIDS services within government organizations, and the relatively modest scale up of HIV services in Osh/Jalalabat relative to levels of need.

**Figure 7.8. “During recent 12 months, my workload in this institution became more feasible” : frontline providers’ perspectives (N=31)**



Analysis of information obtained from interviews in all three regions suggests that increased workload is associated with (1) scale-up of activities; (2) shortage of personnel; and (3) in some cases – shortcomings in project management. Below are the interview excerpts from different regions that illustrate these points:

*“... workload increased. The number of those who want to obtain these services is growing since we are able to deliver these services. Everything is interrelated, we have to do lot of writing, more reporting work...” (NGO interviewee)*

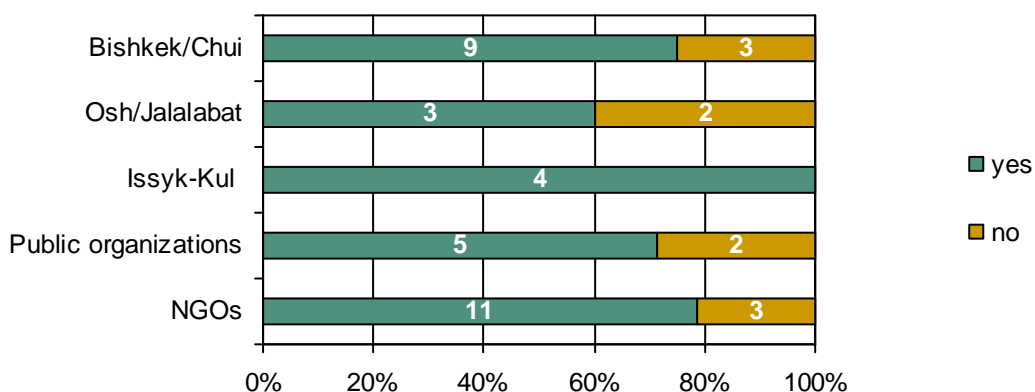
*“... great workload, the project doesn’t specify the workload of people per one specialist... the result is that one has 27, another – 45 [clients] ... workload should be taken into account...” (government interviewee)*

*“... people [have to] work even on Sundays. Incentive double pay should be paid for work on the week-ends but this doesn’t exist...” (government interviewee)*

*“... I had a vocation of only 15 days in two years...” (government interviewee)*

Analysis of incentives among surveyed organizations suggested the following. One third of respondents found it difficult to answer the question “Have you received any incentives (besides salary) for delivery of HIV/AIDS services?” (Figure 7.9). The data suggest that a substantial proportion of staff receive incentives. However, interviews at national level confirmed that it is the state budget that funds these incentives among some government workers delivering HIV/AIDS services rather than GFATM funding.

**Figure 7.9. “Have you received any financial incentives for delivery of HIV/AIDS services?”: perspectives of frontline staff (N=21)**



The following opinions of interviewees suggest that low salaries and limited financial incentives, especially among government employees, and perceptions that it is risky delivering services to people with HIV/AIDS, undermine motivation and create high staff turnaround:

*“... when the salary level is the same, people quit. Good guys used to work, they obtained good deal of knowledge. But they left because salary was small...”*

*“... not easy community, these are very difficult people and it is difficult to work with them... workers run risks and therefore this needs to be paid accordingly...”*

*“... for example, young specialist comes and his salary level is same as that of others. The person may have experience and be qualified but for some reason they don't raise the salary...”*

*“... there is not so to say differentiated pay. One NGO may be vigorous, strong, work for many years and have large real coverage while another one just appeared yesterday. This NGO may yet have no group and don't know what to do, but salary is the same for all...”*

Moreover, it is important to consider the data that suggest that 15 organizations out of 24 surveyed organizations reported interruptions in financing that had implications for their ability to pay staff:

*“... we haven't received salary for almost 4.5 months this year...”*

*“... there were interruptions. Since 2004 it happened two times. Our employees reacted sensitively to it. During that time we, of course, lost patients...”*

*“... When financing stops we withhold evening visits. That's first. Second, implementation of planned workshops is laid off...”*

*“... interruption intervals are very big, as consequence we lose clients, we have to pay rent from own funds otherwise we can lose the address and no contact information will be available. Besides, people will not work for free...”*

*“... organization should have audit but the audit process for some reasons has been delayed for more than six months. People waited but then changed job...”*

Existing interruptions in financing (between tranches) are often related to the issue of timely submission of quarterly reports by GFATM sub-recipients to the PIU.. Additional training of administrative staff of the organizations on the issues of management and reporting could address these problems.

Hence, GFATM work had a positive effect on strengthening of capacity of human resources involved in HIV/AIDS services:

## **7.4 Summary**

- Allocation of the Global Fund grant to sub-recipients led to an increase in personnel working on HIV/AIDS: increases in NGO workers have been substantial; among government service providers numbers remained stable. The greatest growth is among NGO volunteer workers and social workers. Peer-to-peer outreach workers have become an important category of worker: they bring knowledge of vulnerable groups and an ability to built rapport.
- Unequal distribution of personnel by regions remains. Increases in numbers of personnel have been greatest in Bishkek/Chui. Increases in Osh have been substantial although the overall number of HIV/AIDS workers lags behind Bishkek/Chui.
- The majority of service providers indicated there were sufficient staff to cover present activities, that personnel in their organisation were motivated delivering HIV/AIDS services, and that their workloads were more manageable than twelve months previously.

- The majority of service providers received financial incentives for delivering HIV/AIDS services (funded by the state) although interruptions in funding led to some workers being unpaid for several months.
- The majority of survey respondents indicated they had received training. Global Fund-supported workshops and training were seen by interviewees as having positive impacts on staff skills and their attitudes to clients. However, rapid staff turnaround undermines some of this capacity building.

## CHAPTER 8. Quality and access to HIV/AIDS services

### 8.1 Stakeholders and frontline providers' perceptions of the quality of HIV/AIDS services

The majority of stakeholders and service providers unambiguously indicated that GFATM activity in the country contributed to the improved quality of delivered HIV/AIDS services. The most frequently mentioned aspects of improved quality were as follows:

- Increased total number of personnel working in the area of HIV/AIDS and professional training of staff;
- Improved provision of HIV/AIDS diagnostics equipment, including at the primary care level (supply of laboratory-diagnostic equipment and test-kits);
- Improved provision with medical supplies and medicines including drugs for STI treatment and ARV therapy;
- Expanded harm reduction programs, improved delivery of NEPs and continued development of outreach work;
- Expanded provision with syringes, condoms and information materials regarding various aspects of HIV/AIDS prevention;
- Near to 100% testing of donor blood for HIV and the introduction of a 'quarantine' system of donors' blood to protect recipients.

Nevertheless interviewees pointed to a number of ways various types of HIV/AIDS services could be improved that are summarized in the following sections.

#### Information materials and educational programs activity

***Interviewees suggested that there is an emerging need to change approaches to the implementation of information and educational activities.*** During the initial stage of the GFATM-supported program involved a large number of information dissemination activities (including information through the mass media, public lectures, contests, concerts, discos, the provision of posters and leaflets and lessons in some schools). These activities aimed to raise population awareness on HIV/AIDS-related issues. However, interviewees were critical of the effectiveness of these activities since they were seen as not engaging the communities they were targeted at, and not being effective in terms of influencing their patterns of behavior. During later phases of the program more emphasis has been placed on encouraging people to change their behavior rather than supplying information per se. Interviewees suggested:

*"... scaled actions require significant money input while their effect is considerably lower since during these action we do not build effective behavior, we simply provide information and ... it is really difficult to trace the awareness level of the attendants..." (Osh city, NGO)*

*"... we used to organize contests and discos for young people and tell them about AIDS, but they smoke and drink alcohol right after they leave these places... no effect of whatsoever... It is better to work with small group of 15-20 people and achieve behavioral change..." (Bishkek city, NGO)*

*"... I conduct trainings with young people, they know everything but nevertheless make risky choices – sex without condoms, consumption of drugs..." (Bishkek city, NGO)*

*“Level of problem perception by population is different... when I simply talk with a person who completed 10 grades of school I see that he/she doesn’t have any idea about AIDS. And this is despite the fact that he/she watched something about it on TV thousand times and read some kind of brochures... Mentality should be taken into account, we have different interpretative discipline... People here think that AIDS does not apply to them. People do not want to have AIDS and simply do not want to know what AIDS is...” (Osh city, NGO)*

**Presentation of informational materials is not always culturally sensitive.** Many informational materials do not take cultural norms and practices into account. This provokes some resistance and ultimately undermines the effectiveness of programs. Interviewees suggest this is particularly problematic in rural areas and in the south of the country where communities are more conservative, and hence less responsive to modern lifestyles depicted in many information materials. Interviewees suggested:

*“When we conduct workshops for school students in Uzbek schools their parents are very resistant. They believe that talking about condom is a sin, that this prompts children to begin sexual life before marriage. They want us to talk about fidelity, about sex abstinence before marriage but not about condoms” (Osh city, NGO)*

*“... some informational video clips are not acceptable for our population, they show naked bodies and they are very unconcealed. If I should watch TV with my kids and they start showing this, I would switch to different channel...” (Osh city, NGO)*

**Content of informational materials is not always inaccessible and appropriate.** Respondents also indicated that information materials for vulnerable groups are often written in sophisticated language with use of medical terminology and provided recommendations are sometimes difficult to follow. Moreover, a number of donor programs fund separate information materials including leaflets that may confuse clients about the different choices they have. An interviewee suggested some of the information contained in leaflets may be inappropriate or even dangerous to the intended target group:

*“... sometimes quality of informational materials is very low. Sometimes they contain harmful things. For example, one of the recommendations there says “if your friend has overdose... give him artificial respiration” and a picture shows how one person presses the chest of another. But the drug user on dope cannot control his power and can break the thorax. This should be done by a specialist... There is very little control in this regard...” (Bishkek city, NGO)*

**Large volumes of condoms are supplied without appropriate quality control and guidance on their use.** Respondents including clients reported that while GFATM procured condoms (especially early consignments) were of poor quality, in succeeding years quality of condoms has improved and condoms were now supplied in large consignments. It was also reported that condoms are not always stored in proper conditions before they are delivered to the organizations and thus their quality also worsens. Moreover, information accompanying condoms that encourages their correct use tends to be more limited.

## **Voluntary counseling and testing**

**Pre-test counseling is provided in limited scope.** Respondents representing managers and service providers indicated that VCT services tend to be poorly provided, with particular problems relating to a lack of confidentiality and anonymity. This fact is associated with several



factors: 1) limited staff training; 2) high turnover of staff including trained staff members; 3) low motivation for delivery of counseling services.

Respondents emphasized the problems of pre-test counseling not being carried out: if pre-test counseling was not provided then, as an interviewee suggested "... a person often doesn't know why he had blood sampling..." and as a result tends not to be interested in test results and does not return to receive test results. In case of a person who tests positive it becomes necessary to explain anew why and when these tests were made, hence "... post-test counseling looks more like crisis counseling since the person is simply shocked". This hampers timely implementation of treatment.

**In the majority of cases proper conditions for VCT are not available.** Specialists face the problem of shortage of proper conditions for high quality provision of this service including the lack of suitable premises. As an interviewee said:

*"... there is no universal coverage with pre-test counseling in the country. All efforts that were previously focused on pre-test counseling did not bring to noticeable result. In practice we face the problem of not having sufficient number of premises and rooms..."*

**There is shortage of information about anonymous free testing for HIV/AIDS.** Interviews with clients revealed that many of them are not aware that it is possible to have an anonymous free test for HIV/AIDS. For example, participants from a focus-group discussion with CSWs suggested that in practice they had to provide a passport and pay fee-for-service in order to have a test.

### **Needle exchange programs**

**There is a need to improve services for IDUs.** Respondents expressed the opinion that there is a need to revise and expand existing services for IDUs in order to further improve quality and effectiveness. In particular needle exchange programs delivered in isolation had limited effect. An interviewee explained:

*"... When a drug user receives these syringes it is easier for him to sell them and buy a dose... Well, certain share of syringes possible reaches the drug users but significantly less than distributed..." (Interview excerpt)*

Other respondents indicated that "... it is necessary to think of a system for a drug user to use syringes rather than selling them..." or "... exchanging for bread or tea...", and that poverty resulted in IDUs selling GFATM needles/syringes as an income source to meet daily needs. In this respect developing a package of interventions was recognized by respondents would improve the effectiveness of needle exchange. One interviewee said:

*"... we need rehabilitation centers, social escort, half-way homes, doss-houses.... It is more important than simple distribution of needles. People will receive more information in such places. Work in these places should be based on "peer-to-peer" approach as well as involvement of professionals, for example narcologists. This should be a well developed scheme..."*

**Interruptions in needle/syringe supply.** Respondents indicated that interruptions in needle/syringe supply had a negative impact on the quality of delivered services, although interruptions in supply are partially compensated by the fact that some organizations receive assistance not only from FGATM but other sources as well. .

*“...when needles were not available they again used one needle for three people. They were able to afford one dose but no money remained for the needle...” (Interview excerpt)*

### **Substitutive Methadone therapy (SMT)**

***Need for ongoing training on SMT issues.*** It was reported by interview respondents that staff received training at the very beginning of the introduction of SMT. However, taking into account very high turnover of staff, especially nurses, it is necessary to provide training on more regular basis since in practice staff members receive training informally from each other.

***Barriers in access to SMT.*** A course of SMT is free to clients. However, hospitalization is required for a client to be accepted onto a SMT scheme. Users of services rarely have health insurance and therefore have to pay fees for admission to hospital. Moreover, prior to SMT prescription it is mandatory to receive detoxification therapy and for that patients have to buy medicines themselves. The total expenditure including laboratory tests is 1500 to 3000 soms (about US \$40-80), which constitutes a serious barrier in access to SMT for many people.

***Absence of support for patient rehabilitation programs.*** Service providers suggested that the effectiveness of SMT program would be significantly higher if patients received a rehabilitation course after hospital treatment. However, at present time the organizations cannot afford such programs and donor organizations, in particular GFATM, do not support rehabilitation programs.

## **8.2. Satisfaction of service users**

### **Perception of service quality by service users**

The opinions of 60 representatives of vulnerable population groups about satisfaction with services were elicited as follows:

***85% of interviewed respondents were satisfied with the quality of received HIV/AIDS services.*** No particular differences in responses across the three case study areas were apparent. However, more positive answers were reported by service users receiving services from NGOs compared to public organizations and satisfaction level was higher in IDU and PLWHA groups.

***45% of respondents reported improved quality of services over time.*** The largest proportion of positive answers was received in Osh/Jalalabat (18/22 interviewees). In Bishkek/Chui 11/32 respondents felt there had been no improvement.

***97% of respondents indicated they were satisfied with staff attitudes towards them, especially among users of NGOs.***

***The majority of clients indicated the services they received had had positive effects on their quality of life as follows:*** health (70%), psychological state (82%), their ability to interact socially (62%), family life (63%), work (47%).

***62% of respondents reported that staff members of AIDS service organizations asked them whether they were satisfied with the services they received.*** The proportion was

higher in Osh/Jalalabat city than other regions and also higher among NGOs than in public organizations.

**55% of respondents mentioned that they would like to receive additional services.**

Although respondents were in general satisfied with quality of received services nevertheless 33 respondents mentioned that they would want to receive additional services from their organizations. These additional services included:

- medical assistance for a range of conditions including hepatitis and psychologist services;
- STI treatment through outreach workers;
- improved quality of condoms, increased supply of the right type of needles/syringes;
- need for additional consultative services including lawyers and social workers who could offer support in terms of legal protection, employment, restoration of missing documents, addressing housing problems, benefits for children and admission of children to school;
- more training for physicians and police officers "... to eliminate discrimination".

### **8.3 Stakeholders/managers and frontline providers' perceptions of accessibility to HIV/AIDS services**

The majority of interviewed sub-national stakeholders and managers of HIV/AIDS service organizations assessed GFATM-funded HIV/AIDS services as easy to access (22/24 interviewees), and all interviewed frontline providers indicated they felt their organization was easy to access (N=31). However, both stakeholders managers and frontline providers acknowledged that accessibility of HIV/AIDS services is different for some target groups. It was suggested that services are easier to access for IDUs, CSWs and PLWHA compared to accessibility for other representatives of vulnerable groups such as prisoners, youth and MSM.

Sub-national stakeholders and managers indicated that the GFATM had had a positive effect in terms of improved accessibility to HIV/AIDS services. The most important changes that had resulted in improved accessibility included increased supplies of equipment and medicines, improved technical delivery of services, clients have better information and staff have better skills. Interviews with frontline providers suggest a number of specific barriers remain. The most important barriers are: clients' limited knowledge of risk factors relating to HIV/symptoms, stigma, clients' limited knowledge of services and their eligibility to use them, and the costs of using services such as transport and time off work.

According to interviewees one of the factors limiting the utilization of services is the level of understanding of HIV/AIDS and readiness of communities to use services. As one interviewee suggested:

*"...It is impossible to provide services in a place where no one has worked with people before. Before talking about services the community needs a period from four months up to a year to understand the problem and be ready to use these services."*

Work undertaken with GFATM support was reported by interviewees as contributing to the improvement of stigma and discrimination. Nevertheless, according to the opinion of managers it is necessary to continue working on this problem, especially in public organizations. Interviewees suggested:

*“... if a person comes to narcological dispensary he is registered there and then it is a stamp for the rest of life. The city is small and despite the fact that this information is confidential it is enough to see a person on the territory of narcological dispensary to make a conclusion that this person has a problem or suffers from alcohol/drug abuse or has some abnormalities. It doesn't matter there why you came.”*

*“... they are afraid that the police officers may detain them. A person thinks that if he is registered then he might be detected...”*

*“... they are afraid that attitude towards them will change. They are afraid that this won't be kept secret, won't be anonymous and will disseminate further...”*

Interviewees described the GFATM as having a significant effect on service accessibility through training of staff of HIV/AIDS services. However, at present high rate of staff turnover remains to be a problem which is linked to the general trend of health workers migrating internationally. Interviewees stressed the need to provide incentives to encourage staff to remain in the country. As one interviewee explained:

*“... staff turnover takes place and many people after working for 5-6 months realize that the work is difficult and has no incentives. We sign contracts with them and they barely endure till the end of their contract. We ask them, hold them. We provide training to them as a way of motivation but some people leave anyway.”*

#### **8.4 Clients' perspectives on access to HIV/AIDS services**

The survey assessed clients' views on the relative importance of different barriers to accessing HIV/AIDS services. Table 9.1 summarises clients' perceptions of the most important barriers.

**Table 8.1. Most important barriers to receiving HIV/AIDS services: clients' perspectives (N=60)**

<b>Barriers to access</b>	<b>Percent (number)</b>
Stigmatization of HIV, drug use and sex work	42% (25)
Costs of accessing services (transport, time off work)	33% (20)
Shortages of medicines	32% (19)
Limited knowledge about available services	30% (18)
Limited knowledge of eligibility	30% (18)
Limited knowledge of HIV risk factors/symptoms	25% (15)
Problems articulating needs to service providers	18% (11)
Shortage of required equipment	18% (11)
Lack of information about needs of clients	17% (10)
Inconvenient opening times	17% (10)

Clients indicated that the stigmatisation of HIV/AIDS by their communities undermined their abilities to use HIV/AIDS services since this risked them becoming known as HIV positive, or a drug user or sex worker, which are also stigmatised activities. A related problem is the criminalisation of injecting drug use and sex work and policing of these activities: police frequently intercept drug users or sex workers, including these who try to use HIV/AIDS-related services. Illustrating this problem clients explained:

*“... of course we would go there with pleasure if the unit was ... not in a densely populated place. If we know that the person coming here has the same problem...”*

*“... fear that parents, relatives, wife may know about this...”*

The data suggest limited knowledge of HIV/AIDS among clients - in terms of knowledge of risk factors/symptoms, the existence of services and eligibility to use services - is a relatively important factor influencing utilisation of HIV/AIDS services. The Kyrgyz GFATM grant supports HIV/AIDS awareness programmes through the mass media, leaflets/booklets and other materials distributed by GFATM sub-recipients, posters displayed in public spaces and lessons at primary and secondary schools about sexual health and HIV/AIDS. Nevertheless some Kyrgyz stakeholders suggested that information is not always accessible in terms of the language used, neither is it culturally sensitive for more conservative communities outside the capital city, especially in rural areas.

Clients saw shortages of medicines and equipment (e.g. needle/syringes and laboratory equipment) as important barriers to receiving HIV/AIDS services, as were the indirect costs of service use, including travel costs and disruption to economic activities. Other key barriers include clients' difficulties articulating their needs to service providers, and the inconvenient opening times of some services.

## **8.5 Summary**

- The majority of stakeholders and service providers indicated that the Global Fund grant contributed to improved quality of HIV/AIDS services; moreover, the majority of clients said they were satisfied with the quality of services they received. Increased staff numbers with better training and improved provision of key commodities had led to better service quality.
- Interviewees suggested there is scope for improved quality in a number of areas including: effective and anonymous/confidential VCT services; appropriate information materials for population groups in rural areas and in the south; and staff training for substitution therapy.
- Clients tended to have several problems accessing HIV/AIDS services despite the fact they were using them. They indicated that the stigmatisation of HIV/AIDS by their communities was the most important barrier to using HIV/AIDS services since this risked them becoming known as HIV positive, or a drug user or sex worker, which are also stigmatised activities.
- An important related problem is the criminalisation of injecting drug use which prevents clients using services since police frequently intercept drug users or sex workers.
- Other key access barriers from clients' perspectives include shortages of medicines and other commodities, poverty, and limited knowledge of different HIV/AIDS services and eligibility to use them.

## 9. Annex: List of organizations involved in the study

### A. Public/governmental organizations

No	Organization name	Activities
<b>Bishkek city and Chui province</b>		
1	Republican AIDS Center	Information-educational and methodic activity, consultancy, diagnostic and treatment of HIV/AIDS (including prescription of ARV therapy), distribution of medical supplies and means of individual protection (syringes, condoms, etc.)
2	Bishkek AIDS prevention and control center	Dissemination of information about HIV/AIDS prevention, distribution of condoms, needle exchange, diagnostic and treatment of STIs and HIV/AIDS, consultancy, social support and escort
3	Chui province AIDS prevention and control center	Dissemination of information about HIV/AIDS prevention, distribution of condoms, needle exchange, testing, consultancy and treatment of STIs and HIV/AIDS
4	Department for punishment execution (GUIN) of the Ministry of Justice KR	Dissemination of information about HIV/AIDS prevention, distribution of condoms, harm reduction programs (organization of NEPs, preparation for substitutive Methadone therapy), rehabilitation programs
5	Republican Narcology Center	Services delivered by user-friendly clinic, substitutive Methadone therapy program
6	Republican clinical infectious diseases hospital	Treatment of HIV/AIDS, viral hepatitis, other opportunistic infections
7	Chui PMCC	Development and implementation of province program to fight HIV/AIDS
<b>Osh city and Osh province, Jalalabat city</b>		
8	Osh province AIDS prevention and control center	Information-educational activity, consultancy, testing and treatment of HIV/AIDS (including prescription of ARV therapy), needle exchange, distribution of condoms
9	Osh province Sanitary-epidemiological surveillance center	Dissemination of information about HIV/AIDS prevention, trainings for health workers
10	Osh city Sanitary-epidemiological surveillance center	Dissemination of information about HIV/AIDS prevention
11	Osh province narcology dispensary	Dissemination of information about HIV/AIDS prevention, detox-therapy, substitutive Methadone therapy, rehabilitation
12	Osh province TB dispensary	Treatment of TB in HIV/AIDS patients
13	Osh province, Karasuu district FMC	Dissemination of information about HIV/AIDS prevention, needle exchange, consultancy, testing and treatment of HIV/AIDS
<b>Issyk-Kul province</b>		
14	Issyk-Kul province AIDS prevention and control center	Information-educational activity, dissemination of information about HIV/AIDS prevention, consultancy, HIV/AIDS testing
15	Issyk-Kul province Sanitary-epidemiological	Dissemination of information about HIV/AIDS prevention

	surveillance center	
16	Issyk-Kul province narcology dispensary	Dissemination of information about HIV/AIDS prevention
17	Issyk-Kul TB dispensary	Treatment of TB in HIV/AIDS patients
18	Issyk-Kul province FMC	Dissemination of information about HIV/AIDS prevention
19	Issyk-Kul PMCC	Development and implementation of province program to fight HIV/AIDS, dissemination of information about HIV/AIDS prevention

## B. Non-governmental organizations

No	Organization name	Activities
<b>Bishkek city and Chui province</b>		
1	Tais Plus	CSW – dissemination of information on HIV/AIDS prevention, distribution of condoms, harm reduction programs, work with user-friendly clinics, social escort
2	Nauchmedlait	CSW, MSM – delivery of user-friendly service (diagnostic and treatment of STIs, consultancy and testing for HIV/AIDS)
3	Oasis	MSM – dissemination of information on HIV/AIDS prevention, distribution of means of individual protection, harm reduction programs, social escort
4	Socium	IDU – dissemination of information, distribution of condoms, needle exchange
5	Ranar	IDU, released prisoners, MSM – harm reduction program, community center, care and support program
6	Issyk-Kul, Public Foundation of Anti-AIDS Project	Awareness raising of the youth
7	Koz Karash	PLWHA – programs of treatment, care and support
8	Health for all, Public Foundation*	Dissemination of information about HIV/AIDS prevention among migrants from Uzbekistan and Tajikistan to reduce vulnerability towards HIV/AIDS
9	Family medicine specialists, Community Alliance**	Training of health workers, training of trainers for FGP training, development of training plans and guidelines
<b>Osh and Jalalabat cities</b>		
10	Parents against drugs	IDU – dissemination of information materials and condoms, needle exchange
11	Healthy generation (Jalalabat)	IDU – dissemination of information materials and condoms, needle exchange, user-friendly service
12	Girlfriend	CSW – dissemination of information materials and condoms, user-friendly service (diagnostic and treatment of STIs), training, social escort
13	Master of joy	Awareness raising of the unorganized youth (street children)
14	TV and Radio Company Dastan TV***	Awareness raising of Uzbek and Kyrgyz population of Fergana valley on HIV/AIDS related issues
<b>Issyk-Kul province</b>		
15	Aphiyat (Karakol)	CSW – dissemination of information about HIV/AIDS prevention, distribution of condoms, user-friendly service, training
16	Meder and Emb**** (Karakol)	CSW – awareness raising of the youth, diagnostic and treatment of STIs
17	Sakbol	CSW – dissemination of information about HIV/AIDS prevention,

	(Balykchy)	distribution of condoms, diagnostic and treatment of STIs, training
18	Ulukman Daryger (Karakol)	Awareness raising of the youth, diagnostic and treatment of STIs

**Note:**

- \*This organization gets support from GFATM and received small grant from CAAP but at the time of study implementation it had not started the activities;
- \*\*CA under the Kyrgyz State Institute of post-graduate training and continuous education received small grant from CAAP but had not started the activities;
- \*\*\*Private organization received small grant from CAAP but had not started the activities;
- \*\*\*\*Private FGP