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

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Center for Health System Development

GLOBAL HIV/AIDS INITIATIVES NETWORK

Researching the national and sub-national effects of global HIV/AIDS initiatives at the country level

The Global HIV/AIDS Initiatives Network (GHIN) is a network of researchers established in 2006 that aims to track the effects of the major global HIV/AIDS initiatives:

- The World Bank's Global HIV/AIDS Programme including the Multi-country AIDS Programme (MAP)
- The Global Fund to Fight AIDS, TB and Malaria (GFATM)
- The United States President's Emergency Plan for AIDS Relief (PEPFAR).

The Members of the Network are researching the country effects and inter-relationships of these initiatives at national and sub-national levels. This network builds on two earlier studies: the Tracking Study, led by the London School of Hygiene and Tropical Medicine (2003-2004) and the System-Wide Effects of the Fund (SWEF) Research Network (since 2003) coordinated by the Partners for Health Reformplus project.

GHIN countries undertaking 2-4 year studies include: Angola, Benin, China, Ethiopia, Georgia, Kyrgyzstan, Malawi, Mozambique, Peru, South Africa, Tanzania, Uganda, Ukraine, Vietnam and Zambia. The Network is facilitating comparative work across these countries and will synthesise research findings.

For further information on the Network, please visit our website:
www.ghinet.org

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Additional copies of this report can be found at:
www.ghinet.org

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Abbreviations

AIDS	Acquired immune deficiency syndrome
AFEW	Aids Fund East-West
ARV	Antiretroviral therapy
CARHAP	Central-Asian Regional HIV&AIDS Program
CDC	Center for Disease Control
CMCC	Country Multi-Sectoral Coordination Committee
DfID	Department for International Development
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
IFA	Immune Ferment Analysis
KR	Kyrgyz Republic
MOF	Ministry of Finance
MHIF	Mandatory Health Insurance Fund
MOH	Ministry of Health
MOI	Ministry of Interior
MOJ	Ministry of Justice
M&E	Monitoring and evaluation
MSM	Men who have sex with men
NEP	Needle exchange point
NGO	Nongovernmental organization
OMCC	Province (oblast) Multi-Sectoral Coordination Committee
PLWHA	People living with HIV/AIDS
PSFHA	People suffering from the effects of HIV/AIDS
PIU	Project Implementation Unit
SEP	Syringe Exchange Point
SMT	Substitutive Methadone therapy
STI	Sexually transmitted infections
SW	Sex worker
UNFPA	United Nations Fund on Population
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WB	World Bank
WHO	World Health Organization

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Executive Summary

In July 2006 the Centre for Health System Development in Kyrgyzstan (Kyrgyz Republic) started implementing 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), New York. The study forms a part of the *Global HIV/AIDS Initiatives Network* (GHIN): **http://www.ghinet.org/**

This report presents results from a desk-based review and fieldwork conducted between April 2008 and January 2009 in three regions of Kyrgyzstan - Bishkek/Chui, Osh/Jalalabad and Issyk-Kul. The aim of the report is to assess the effects of two global health initiatives (GHIs) for HIV/AIDS the Global Fund to Fight AIDS, TB, and Malaria (GFATM) and the World Bank's Central Asian AIDS Project (CAAP) at national and sub-national levels, including the effects on HIV/AIDS service scale-up coordination, human resources, and access to HIV/AIDS services.

Key findings of the study include:

Scale-up of HIV/AIDS services

- Significant increases in GFATM and CAAP financing has promoted substantial scale-up of HIV/AIDS services in terms of the numbers of service providers, types of services and the numbers of clients receiving services.
- Geographical coverage of HIV/AIDS services has expanded through increased numbers of state-owned and nongovernmental organizations (NGOs) delivering services to new target groups, including migrants, rural communities and people living with HIV/AIDS (PLWHA).
- However, coverage in the capital Bishkek remains higher than in the southern regions of Kyrgyzstan in particular Osh where the greatest number of people in risk groups and PLWHA live.
- Challenges to further scale-up remain, with the main factors being breaks in financing of GFATM sub-recipients, declining commitment to HIV/AIDS-related activities from political leaders, and the existence of multiple monitoring and evaluation (M&E) systems.

Coordination bodies for HIV/AIDS programs

- In an effort to streamline HIV/AIDS coordination structures in the Kyrgyz Republic, in August 2007 the Country Multi-sectoral Coordination Committee (CMCC) was replaced by the Multi-Sectoral Country Coordination Committee on Socially Significant and Especially Dangerous Diseases (MCCC).
- Whereas the CMCC was widely perceived to function effectively, the MCCC was widely criticized. Specifically, its broadened remit to 'socially significant especially dangerous diseases' undermined its focus on HIV/AIDS to the detriment of HIV/AODS programs. It also had a weak organizational capacity that limited its ability to coordinate programs effectively and to monitor HIV/AIDS interventions.
- Following reform of the CMCC in 2007, national level support for oblast (regional) coordination structures - the Oblast Multi-sectoral Committees on Control of Social and Especially Dangerous Diseases (OMSC) – has also reduced substantially.

- In addition to MCCC and OMSC structures there are a number of parallel efforts to coordinate HIV/AIDS programs including: periodic coordination meetings of donors and international organizations; national-level NGO and inter-sectoral Steering Groups; and the Osh city NGO Working Group.

Cooperation between HIV/AIDS service providers

- There has been marked increased in efforts by the focal GHIs and their implementers to coordinate their activities.
- Almost every organization that provides a HIV-related service in Kyrgyzstan now cooperates with other organizations through client referrals.
- A challenge to effective cooperation is breaks in financing from GHIs, in particular the GFATM when a project comes to an end or a sub-recipient fails to submit monitoring data on time. Discontinuity in funding, enhances competition, reduces the number of providers, and creates difficulties in referring clients between organizations.
- Although the need to introduce a common M&E system for HIV/AIDS programs is widely acknowledged, it is only very recently that comprehensive measures to launch such as system have been made, and parallel data recording systems remain in use based on donors' requirements.

Human resources delivering HIV/AIDS services

- Despite a declining number of health personnel in Kyrgyzstan, much of which is due to international out-migration, the number of personnel involved in HIV/AIDS programs has increased since the introduction of the GFATM which as funded a large number of new posts in NGOs which primarily provide HIV/AIDS prevention services.
- The availability of human resources for HIV/AIDS programs is worst in oblasts with the highest incidence of HIV infection such as Osh oblast. Moreover, personnel are mostly concentrated in oblast centers whereas shortages of workers at rayon (local) level remain.
- The focal GHIs are making important contributions to development of human resources capacity of HIV/AIDS service organizations, or example through funding training sessions relating to HIV/AIDS and organizational development.
- However, training activities are not monitored in terms of whether they are received by the most appropriate workers, whether courses correspond to existing needs or lead to improved knowledge and practice among service providers.
- Poor salary incentives, unfair bonus systems in governmental organizations, breaks in payments to NGO personnel, and weak legal protection among medical personnel are key factors undermining the delivery of HIV/AIDS services.

Access to HIV/AIDS services

- GHI funding for ARVs and STI treatment have resulted in better accessibility, affordability, and quality of HIV/AIDS services both for the general population and key vulnerable groups.
- Broad involvement of NGOs, public, and private organizations has increased delivery of HIV/AIDS-related services in all regions of the country, although Southern regions and rural areas are still not receiving the level of service they require.
- Better access is beginning to translate into positive trends in terms of increased knowledge of safe behaviors among key population groups, and better awareness of their rights.
- Key barriers to using HIV/AIDS services include: breaks in financing among NGO service providers; poor quality commodities including condoms and syringes; poor coordination

of services between government and NGO providers; financial barriers experienced by clients.

- Household and community-related factors undermining accessibility include: low levels of awareness of the range of services available among clients and poor knowledge of their legal rights; stigma and discrimination by members of families/communities; discriminatory practices among law-enforcement authorities and in some cases by health professionals.

Chapter 1. Introduction

1.1 Tracking study of global HIV/AIDS initiatives and their impact on health systems in Kyrgyzstan

In July 2006 the Centre 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**

Stage 2 December 2006 - December 2007: *Regional baseline case studies* - 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 January 2008 – March 2008: *National data collection* – policy and programmatic document review, and interviewing national stakeholders.

Stage 4 April 2008 – January 2009: *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 February 2009 – June 2009: *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 a national event (May 2009); 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 4 of the study. A Context Report and Interim Report from previous stages of this study can be found at:

http://www.ghinet.org/countrystudies_europe_kyrgyzstan.asp

1.2 Overview of Global HIV/AIDS initiatives in Kyrgyzstan

Kyrgyzstan has financial resources for HIV/AIDS programs from two sources: the state budget and international donor organizations and programs. Global HIV/AIDS initiatives have provided major grants in Kyrgyzstan: the GFATM and the Central Asian AIDS Project (CAAP) which is a four-country regional project of the World Bank. There are also a number of other international programs on HIV/AIDS funded by UN and bilateral donor organizations including CARHAP/DfID, "Capacity" Project/USAID, CDC, AFEW and others (see Context Report).

1.2.1 Key activities of the GFATM HIV/AIDS program in Kyrgyzstan

- Kyrgyzstan received a Round 2 GFATM Grant for "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 the Principal Recipient was the Kyrgyz Republican AIDS Center under the Ministry of Health. The implementation of the activities within this Grant was completed in December 2008.

- 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), sex workers (SW), men having sex with men (MSM), people living with HIV/AIDS (PLWHA), young people and prisoners. Considerable resources were used for distribution of condoms and needles/syringes as well as training of health workers.

- In 2007, Kyrgyzstan received a GFATM Round 7 grant of more than US$28 million for the program "Expansion of universal access to prevention, diagnostics, treatment, care and support for key population groups on HIV/AIDS in the Kyrgyz Republic". The Principal Recipient is the Kyrgyz Republican AIDS Center, and implementation of the grant is from January 2009 to December 2013.

- The activities envisaged in the Seventh Round Application are aimed at meeting the following challenges: (i) ensuring universal access to basic HIV/AIDS services for vulnerable populations and PLWHA in all regions of the Kyrgyzstan; (ii) extension and improving the efficiency of preventive programs for IDU, prisoners, SW, MSM, with a particular focus on work with mobile population groups; (iii) ensuring continuity/institutionalization of preventive programs for youth, including street children, orphans and disorganized youth; (iv) improving multi-sectoral coordination for HIV/AIDS control through strengthening national capacity (governmental and nongovernmental organizations), increasing political commitment, partnership and institutionalization of activities being undertaken.

- In the Seventh Round application, a significant amount of financing (US$8 millions.) is envisaged for strengthening health system capacity. It is planned to use this money to purchase equipment for laboratories of the dermato-venereal service (Bishkek and Osh) and blood quarantinization (Osh and Jalalabad), to ensure safety of medical waste (Osh and Jalalabad); offices for Voluntary Counselling and Testing (VCT) in all Family Medicine Centers and specialized organizations; personnel training and drugs provision are also planned.

1.2.2 Key activities of the CAAP Program in Kyrgyzstan

- In 2005, implementation of the Central Asian AIDS Project (CAAP), funded on a grant basis by World Bank and Department for International Development (DfID), UK, started. The total amount of the grant is US$27 millions for the period 2005-2010 (approximately £1M from DfID). The Project is implemented in four Central Asian countries: Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan. The main objectives of the Project are: (i) contribute to counteracting the HIV/AIDS spread in Central Asia; (ii) establish a Regional AIDS Fund as a sustainable mechanism of funding activities to fight HIV within the period and on completion of the Project; and (iii) strengthening cooperation between governmental, nongovernmental and private sector organizations at the regional and national levels.

- CAAP in Kyrgyzstan has two main activities: work to improve regional policy and coordination of HIV/AIDS programs through broad involvement of decision-makers, religious leaders and mass media representatives; and implement small and large grant projects and programs for HIV/AIDS prevention among vulnerable population groups (IDU, CSWs, MSM, prisoners and others.).

- Since CAAP started its activities, it has conducted three grant rounds. In 2008, implementation of the first round sub-projects was completed. Funded by small grant programs, 9 organizations (8 NGOs and 1 private organization) worked on HIV/AIDS prevention, provided support to people with HIV/AIDS, and trained health professionals (total amount of the allocated funds was over US$ 60 thousands). In the second grant round, the Regional AIDS Fund allocated funds to 6 organizations for small grants implementation (US$ 138,310). Since 2009, based on the small grants program, 8 organizations have received approval (the total budget was US$ 200,174).

Chapter 2. Epidemiology of HIV/AIDS in Kyrgyzstan

2.1 National statistics

General data on the number of reported HIV/AIDS cases in the Kyrgyz Republic are shown in Table 2.1.

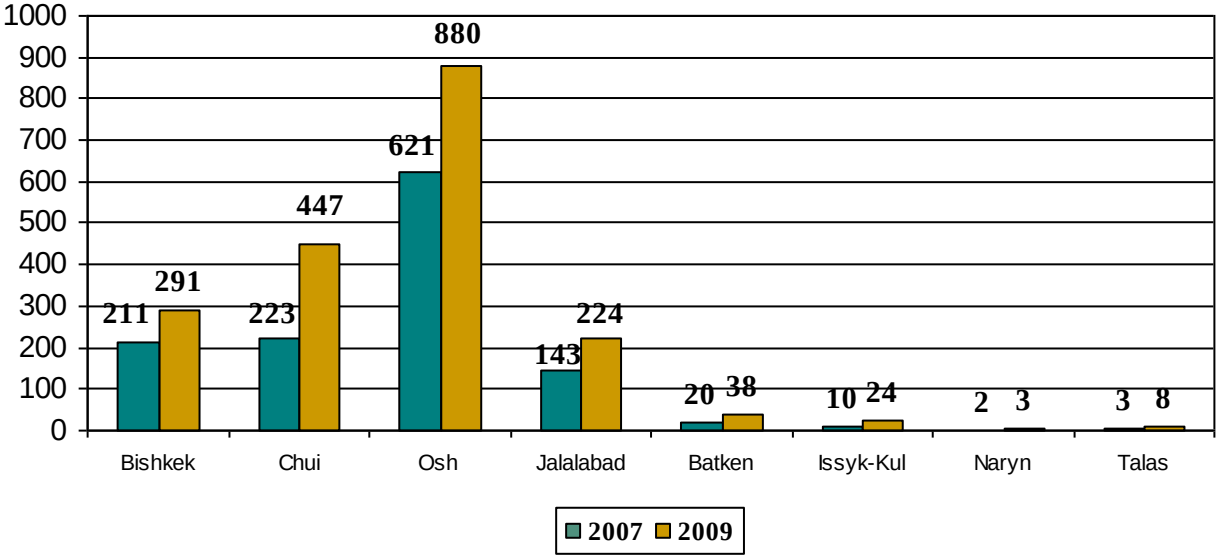
Table 2.1 HIV-infection situation in the Kyrgyz Republic

Years	Number of detected cases	Citizens of the Kyrgyz Republic (male/female)		Foreign and CIS citizens	Drug addicts (including KR citizens)	Prisoners
		HIV-infected	including AIDS			
1987-2000	53	14 (11/3)	1 (0/1)	39 (36/3)	31(1)	0
2001	149	134 (123/11)	1 (1/0)	15 (12/3)	142(126)	70
2002	160	146 (134/12)	9 (8/1)	14(13/1)	126 (114)	75
2003	132	125 (107/18)	10(10/0)	7 (7/0)	113 (106)	39
2004	161	153(119/34)	14 (12/2)	8 (6/2)	126(119)	50
2005	171	165 (114/51)	20(17/3)	6(6/0)	108 (102)	39
2006	244	233(170/63)	27(22/5)	11(9/2)	168 (161)	46
2007	409	388(280/108)	26(26/0)	21(17/4)	251(237)	87
2008	552	532(354/178)	37(27/10)	20(17/3)	293(277)	127
2009 (1 month)	26	26(20/6)	7(6/1)		18(18)	1
TOTAL	**2057**	**1916(1432/484)**	**152(129/23)**	**141(123/18)**	**1381(1275)**	**534**

Source: Republican AIDS Center (data for 1.02.2009)

The table suggests that while in the pre-2000 period the majority of people with HIV were non-Kyrgyz citizens from 2001 onwards the vast majority of people with HIV are Kyrgyz citizens. Out of 2,057 official HIV-infection cases, 152 people also had AIDS. From 1987-2009, 152 HIV-infected people died, 98 of whom died from AIDS-related illnesses people (the remaining 52 died from a range of causes including over doses and road accidents). The principal means of HIV transmission is injecting drug use (74%), compared with 22% through sexual intercourse, and 1% through vertical transmission from mother to child. Intra-hospital infection owing to an outbreak of HIV-infection in Osh oblast in 2007 has increased to 3% (Republican AIDS Center data). The majority of HIV-infection cases are registered in age group of 20-35 years (over 60%). The distribution of HIV-positive cases by regions is shown in Figure 2.1.

Figure 2.1 Number of HIV-infection cases by regions of the Kyrgyz Republic



Source: Republican AIDS Center

While HIV cases are registered in all regions of the country, the situation in Osh oblast is most acute, with the number of HIV cases almost 50% of the total number registered in the republic.

2.2 Prevalence of HIV infection among children and pregnant women

Before June 2007, 18 HIV positive children (aged 0 – 14 years) were registered in the country, 5 of them through vertical transmission. After June 2007, following intra-hospital outbreaks of HIV-infection in children's hospitals of Osh oblast, an epidemiological investigation was conducted. In total, 10,800 children, 198 parents, 34 donors and about 8000 health professionals were tested. Of the total number tested, 72 children, 16 mothers and 1 health professional were found to be HIV positive.

71 pregnancies have been registered in the republic among HIV-positive women, out of them 58 ended with deliveries and 11 were terminated.

Chapter 3. Aims, objectives and methodology of the study

3.1 Study aims

The aim of Stage Four of the study was to assess the effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) HIV/AIDS grant in and the Central Asian AIDS Project (CAAP), the regional project of the World Bank 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 is to provide reliable research findings on the effects of these global HIV/AIDS initiatives to inform decisions made by government policymakers and practitioners, international agencies and nongovernmental organisations (NGOs) in Kyrgyzstan.

3.2 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 national and sub-national HIV/AIDS coordination councils;
- To assess the effectiveness of national and sub-national HIV/AIDS coordination councils and identify factors enabling and inhibiting 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 and CAAP government and nongovernmental grant recipients;
- To assess the effects of these initiatives 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 and CAAP-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 and CAAP-financed services;
- To identify key household/community and institutional/programmatic barriers to accessibility from clients' perspectives.

3.3 Study methodology

The 2008 (Stage Four) research combined both quantitative and qualitative methods of data collection. The following tools were used:

- Semi-structured interviews with national stakeholders and representatives of international donor organizations and donors;
- Semi-structured interviews with local stakeholders, managers of governmental and nongovernmental organizations, implementing GFATM and CAAP grants;
- Semi-structured interviews with HIV/AIDS service providers (frontline staff);
- A facility survey involving data collection from HIV service providers including data on number of service users, personnel and budgets;
- Data on financing HIV/AIDS programs were collected through (i) a survey of international organizations to identify sizes of funding; (ii) a survey of sampled NGOs in order to identify structure of the HIV/AIDS services delivered; (iii) analysis of the MoH reports on public expenditure in the field of HIV/AIDS;
- Semi-structured in-depth interviews with users of services delivered with the support of GFATM and CAAP.

15 governmental, 13 nongovernmental and 2 private organizations from three regions (Bishkek/Chui oblast, Osh/Jalalabat and Issyk-Kul oblast) participated in the 2008 research. Distribution of organizations by regions is shown in Table 3.1 and Appendix 1.

Table 3.1 Number of organizations

	Governmental organizations	NGOs/private sector	Total
Bishkek	5	7	12
Chui oblast	2	-	2
Osh	4	3/1*	8
Jalalabad	-	1	1
Issyk-Kul oblast	4	2/1**	7
Total	**15**	**15**	**30**

Note: *Private TV radio company "Dastan TV"
** Private FGP "Meder and EMB"

The numbers of interviews conducted and organizations where quantitative data collected are shown in Table 3.2.

Table 3.2 Number of interviews

	Survey tools	Number of interviews
1	Semi-structured interviews with national stakeholders	17
2	Semi-structured interviews with stakeholders at sub-national level (government organizations)	15
3	Semi-structured interviews with stakeholders at sub-national level (NGOs)	16
4	Facility survey	19
5	Semi-structured interviews with service providers (government organizations)	8
6	Semi-structured interviews with service providers (NGOs)	18
7	Semi-structured interviews with service users*	24

Note: *The number of surveyed service users included representatives of IDU (12 people, out of them 5 people received substitutive methadone therapy), SW (4 people), youth (5 people), PLWHA (2 people) and migrants (1 person).

Chapter 4. Analysis of HIV/AIDS program financing

4.1 Healthcare sector financing in Kyrgyzstan

At the present time, in the healthcare system of the Kyrgyz Republic there are three main sources of funding: state, private and external financing. State sources include the national government budget consisting of general taxation, contributions from the Mandatory Health Insurance Fund (MHIF), and allocations from the Labor Fund. Private means include out of pocket payments of households. External funding includes funding from international organizations and bilateral donors allocated to the healthcare sector of the Kyrgyz Republic.

Within the period 2002 - 2007 total health expenditures increased from 1, 5 billion soms up to 3 billion soms (approximately $67 million). In 2007 about 520 million soms were additionally allocated to the total health expenditures in terms of parallel financing from donor organizations (Kyrgyz Health Expenditure Survey, 2008). Consequently, the health expenditure as a percentage of GDP increased from 5,1% to 6,4% (Table 4.1).

Table 4.1 Total health expenditures in Kyrgyzstan

	2002	2003	2004	2005	2006	2007
Total expenditure in healthcare (million. soms)						
Budget	1 478,1	1 528,2	1 809,0	2 147,6	2 421,0	2 966,9
MHIF	142,1	197,4	338,2	254,5	466,9	704,5
Private	2 254,2	2 628,2	3 090,6	3 490,7	3 921,9	4 291,6
External financing					252,6	1049,5
Total	**3 874,4**	**4 353,8**	**5 237,8**	**5 892,8**	**7 062,4**	**9 012,5**
As share of total health expenditures						
Budget	38,2%	35,1%	34,5%	36,4%	34,3%	32,9%
MHIF	3,7%	4,5%	6,5%	4,3%	6,6%	7,8%
Private	58,2%	60,4%	59,0%	59,2%	55,5%	47,6%
External financing					3,6%	11,7%
Total	**100,00%**	**100,00%**	**100,00%**	**100,00%**	**100,00%**	**100,00%**
As share of GDP						
Budget	2,0%	1,8%	1,9%	2,1%	2,1%	2,1%
MHIF	0,2%	0,2%	0,4%	0,3%	0,4%	0,5%
Private	3,0%	3,1%	3,3%	3,5%	3,5%	3,1%
External financing					0,2%	0,8%
Total	**5,1%**	**5,2%**	**5,6%**	**5,9%**	**6,2%**	**6,4%**

Source: 1) MOF – Execution of state budget for 2002, 2003, 2004, 2005, 2006, 2007
2) MHIF – National Health Account for 2004, 2006, 2007

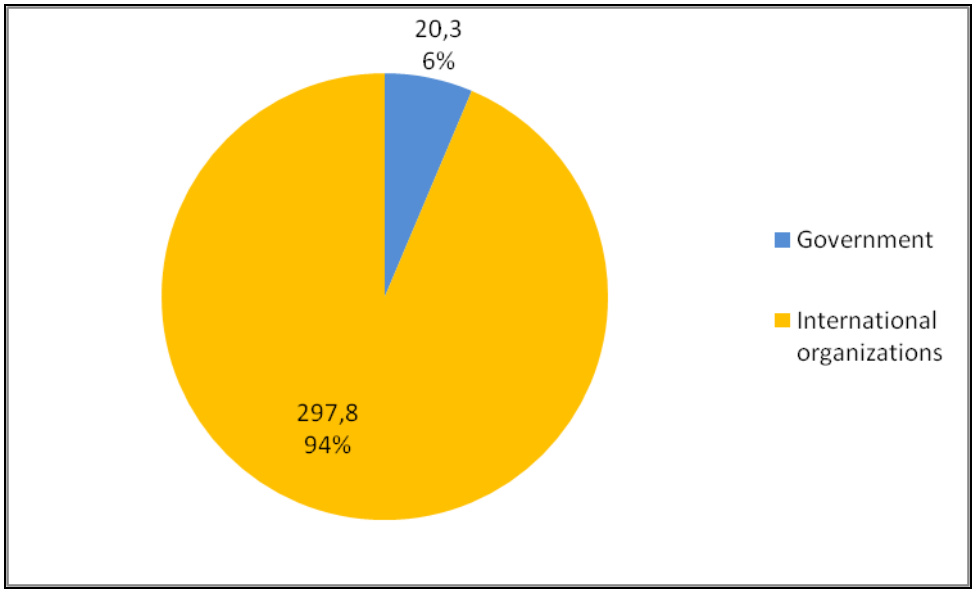
In 2007 state funding (including MHIF funds) represented 2,6% of GDP; in 2000 it was 2,1%. In this period private means grew from 2,3% to 3,1% and external funding increased to 0,8% of GDP. Private payments, despite the steady increase 2002 – 2006 decreased as a percentage of GDP in 2007 in comparison with the previous year (3,1% of GDP in comparison 3,5% of GDP). Per capita, total health expenditures increased from 780 soms in 2002 up to 1760 soms in 2007.

These trends are confirmed when analyzing the share of the health expenditure in the total state budget. The share of health expenditures in total budget expenditures increased from 9.3% in 2002 to 11.1% in 2007.

4.2 Expenditure on HIV/AIDS programs by sources of financing

In the Kyrgyz Republic, HIV/AIDS-related services are funded from two sources: the state budget and from international organizations and bilateral donors. In 2007, the total budget for HIV/AIDS-related services amounted to 318 million soms which represented 3,5% of total state expenditures for the health sector. A major portion of this amount was received in terms of external aid (Figure 4.1), which constitutes 297,8 million soms or more than 28% of all funds provided by international organizations are for HIV/AIDS programs in Kyrgyzstan. The volume of funding from the state budget amounted to over 20 million soms or about 0,7% of state health expenditures.

Figure 4.1 Total expenditures on HIV/AIDS-related services by sources of funding 2007 (million soms)



Source: National Health Account for 2007, International Donor Organizations survey (data is provided by WHO, DfID, CAAP/WB, CDC, GFATM, UNFPA, UNICEF, USAID)

The key donor funding activities to fight HIV/AIDS is GFATM through its Round 2 grant "Development of preventive programs on HIV/AIDS, tuberculosis and malaria". The Fund allocated 147 million soms in 2007, which constitutes about 50% of all funds for HIV/AIDS. Indeed, the bulk of HIV/AIDS funding is provided primarily by international organizations and donors (Fig 4.1).

By contrast, private funding accounted for almost half of total health expenditure (47.6%) in 2007. Although there is no data on out-of-pocket-payments it is likely this constitutes a large portion of this total private sector expenditure. This does suggest a degree of fragility in the structure of expenditures on activities relating to HIV/AIDS in Kyrgyzstan as it is heavily dependent on external financing. If international organizations and bilateral donors decided to reduce or cut their financing of HIV/AIDS-related programs, the state would struggle to make up the financial deficits and maintain current levels of financing.

4.3 State financing for HIV/AIDS programs

HIV/AIDS-related programs funded by the state are conducted by the Ministry of Health and mostly targeted at maintaining the infrastructure of state health organizations involved in HIV/AIDS-related services such as the Republican AIDS Center and its oblast branches.

Table 4.2 Distribution of state expenditures on HIV/AIDS programs, 2007

Expenditure items	Thousand som.	% as share of state expenditures on HIV/AIDS
Current expenditures	**20 110,5**	**99,3%**
Expenditures connected with staff	12 129,8	59,9%
Salary payment	*9 792,6*	*48,3%*
Allocations to the Social Fund	*1 997,2*	*9,9%*
Travel expenditures	*340,1*	*1,7%*
Purchase of goods and services	7 980,7	39,4%
Purchase of items and materials for every day business transactions	4 675,7	23,1%
Expenditures for food	*42,5*	*0,2%*
Expenditures for purchasing medicaments and dressings	*4 633,1*	*22,9%*
Services	*3 305,0*	*16,3%*
Municipal services	218,2	1,1%
Renting costs	*6,0*	*0,03%*
Transportation costs	*755,7*	*3,7%*
Purchase of other services	2325,1	11,5%
Total capital investments	**144,9**	**0,7%**
TOTAL	**20 255,4**	**100%**

Source: MOH, Republican AIDS Center

The bulk of expenditures come under what is known as “Current expenditures” which constitute more than 99% of all expenditures of organizations that are involved in HIV/AIDS programs. These expenditures include “Expenditures connected with staff” and “Purchase of goods and services” which made up 60% and 39% respectively. The highest percentage of expenditures falls on fixed costs such as salary payments (48%), and purchasing medical commodities (23%) (Table 4.2).

Total capital investments are 145 thousand soms or 0,7% of all expenditures on HIV/AIDS programs.

4.4 Funding of HIV/AIDS-related activities by international organizations

Most financing for HIV/AIDS programs in Kyrgyzstan comes from international organizations and bilateral agencies (94% of financing). Almost half of the amount is provided by GFATM (Table 4.3).

Table 4.3 Distribution of external financing of HIV/AIDS programs in Kyrgyzstan, 2007

Funding organizations	mill. soms	in %
Global Fund	147,6	49,6%
Other donors	150,2	50,4%
Total	**297,8**	**100%**

Source: International Donor Organizations survey (data is provided by WHO, DfID, CAAP/WB, CDC, GFATM, UNFPA, UNICEF, USAID)

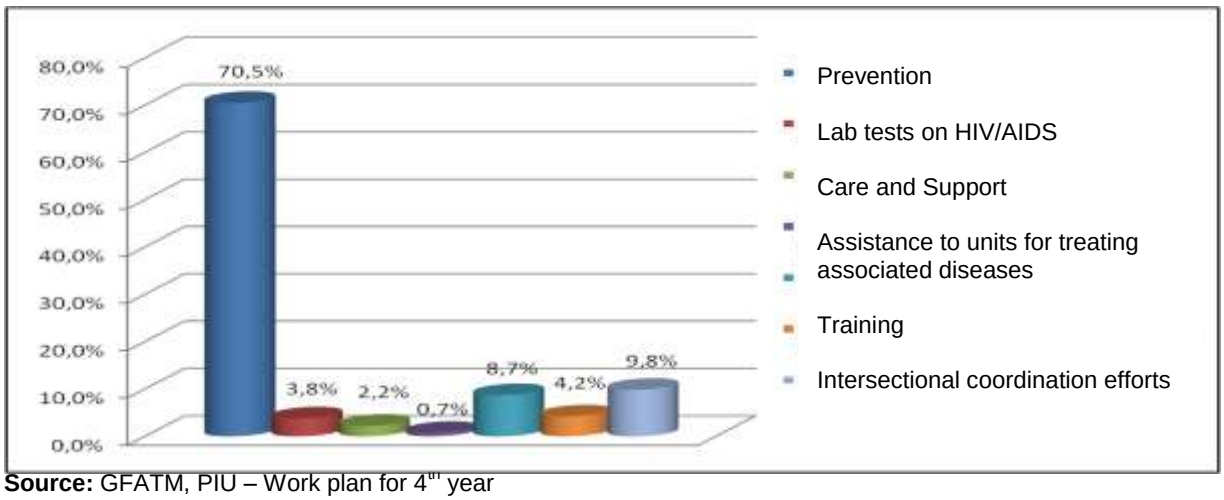
Five components of the GFATM Round 2 grant HIV/AIDS program are as follows:

- Strengthening political and legal support for HIV/AIDS prevention programs based on a multi-sectoral approach;
- Reducing vulnerability of young people;
- Containing HIV infection among vulnerable populations;
- Ensuring safety of donor blood;
- Providing medical and social support to people living and affected by with HIV/AIDS.

The majority of funds in 2007 were used to support two strategies: “Containing HIV infection among vulnerable populations” and “Reducing vulnerability of young people”, 60,1% and 23,3% of total Global Fund expenditures respectively. Considerable attention has been placed on interventions for IDUs, prisoners, sex-workers and young people. Indeed the focus has been on preventive interventions among high-risk groups such as the distribution of condoms and syringes/needles and health worker training. Around 70% of funds were used for prevention. Around 9% of funds were used for training and 10% for other activities (summarized in Figure 4.2).

In 2007 sub-recipients received grant support. The majority of them were NGOs, who received around 49 million soms or one third of the total budget. However, the largest expenditures were made for purchasing goods/items/medical drugs to the value of 70,7 million soms or almost 48% of all expenditures. The remaining funds were used for the development of political and social support in Kyrgyzstan, monitoring and evaluation of current activities within HIV/AIDS sector, for development, and organization of labs, training of specialists, control and coordination of sub-recipients’ activities and their support (Table 4.4).

Figure 4.2 Global Fund HIV/AIDS disbursements in Kyrgyzstan, 2007



Source: GFATM, PIU – Work plan for 4th year

Table 4.4 Distribution of the Global Fund HIV/AIDS grant in Kyrgyzstan, 2007

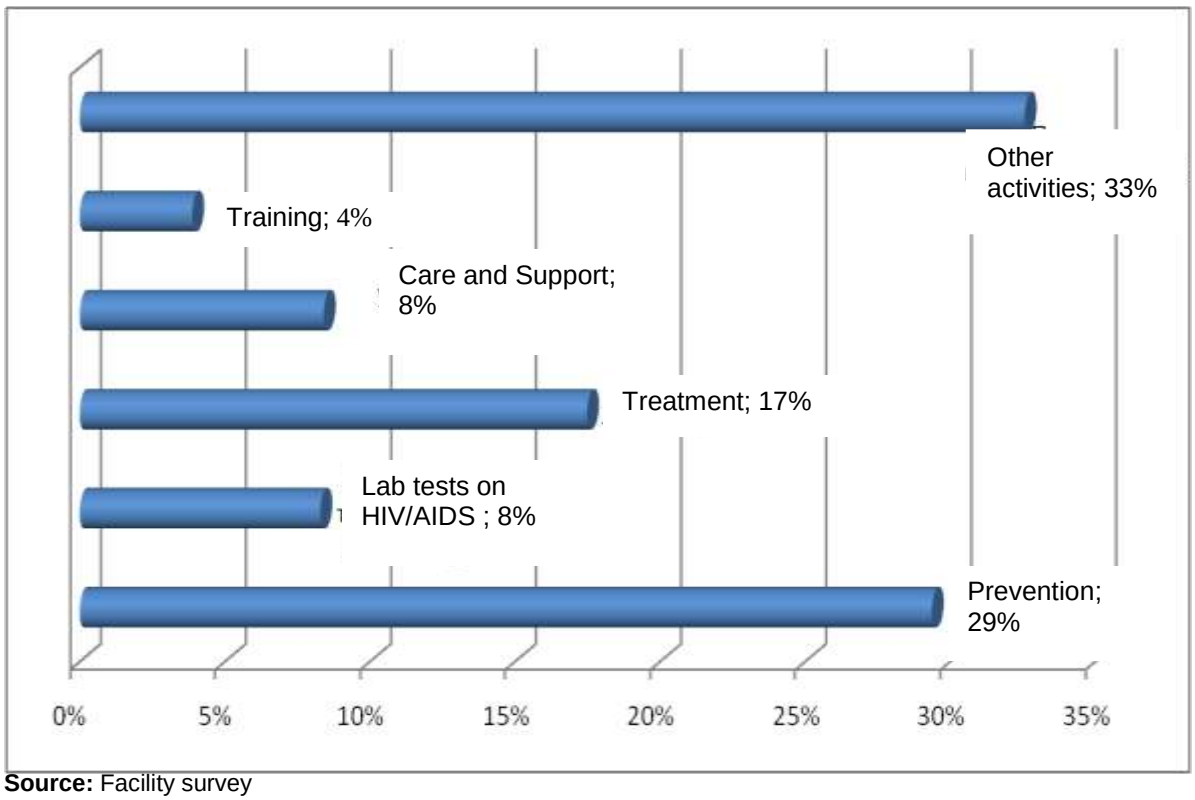
Expenditure items	Thousand soms	%
Expenditures of sub-recipients, consultants and others	48,946,3	33,2%
Infrastructure/equipment	6,063,0	4,1%
Training of staff /planning	9,194,5	6,2%
Goods/items/drugs	70,691,9	47,9%
Monitoring and evaluation	4,803,7	3,3%
Administrative expenditures	2,424,5	1,6%
Publications	5,487,8	3,7%
Total	**147,611,7**	**100%**

Source: GFATM, PIU - Work plan for 4th year

Other donor organizations also support NGOs working in the field of HIV/AIDS. However, data collected from the facility survey (a sample of 19 NGOs) show that around two thirds of financial grants received by the sample of NGOs were received from GFATM.

Most of NGOs working in HIV/AIDS fields focused on preventive activities (29% of funds are allocated to prevention). This category includes preparation and distribution of information materials for different audiences (including vulnerable groups), outreach activities, condom distribution, syringe exchange and others. The category Treatment (17%) includes the distribution of medical drugs (but not ARV-therapy). The highest proportion is in the category "Other activities" (33%), which include expenditures for office maintenance (Figure 4.3).

Figure 4.3 Services of NGOs supported by international organizations (proportion of funding), 2007



Source: Facility survey

4.5 Conclusion

- The analysis shows that financing of HIV/AIDS-related activities from two sources: state budget – 20,3 million soms (6% of total HIV/AIDS expenditures) and external assistance – 298 million soms (94% of total HIV/AIDS expenditures), that is a total of 318 million soms or 3,5% of total health sector funding (2007). In 2007, 0,7% of funds from total public health sector financing and over 28% of all funds provided by international organizations for health care of Kyrgyzstan were spent on HIV/AIDS activities. These figures indicate a high degree of instability of financing HIV/AIDS programs since if there is a drastic decline in financing by international organizations, it will be difficult for the government to cover the potential funding gap.
- About half of all international organizations' funds are from the GFATM – 147,6 million soms. Of this, around 70% of expenditures are used to finance activities for HIV/AIDS prevention, while about 9% are spent on training.
- One third of GFATM resources were spent on financing of NGOs implementing HIV/AIDS programs. 29% of these funds were spent on prevention and 17% on treatment.

4.6 Recommendations

Recommendation #1. The key recommendation to the government is to explore ways of increasing the amount of public spending on HIV/AIDS services. The present ratio of governmental to external financing has the potential to create a very unstable system: if international organizations and bilateral donors decided to reduce their external assistance, the state would need to find ways to substitute these funds in order to maintain services.

Chapter 5. HIV/AIDS service scale up at national and sub national levels

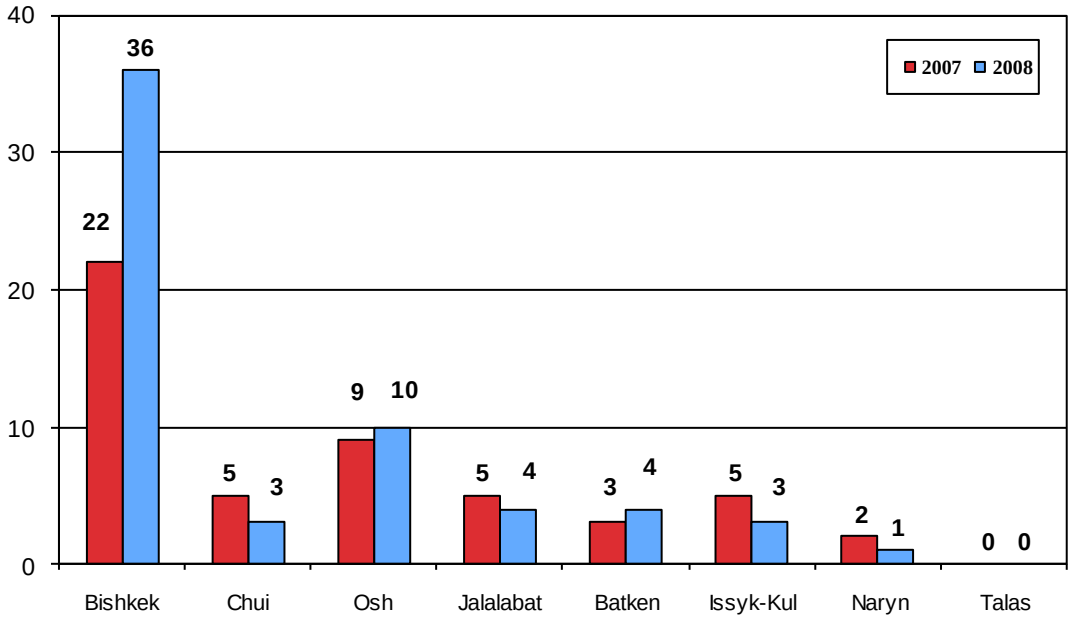
This chapter examines changes in scale up of HIV/AIDS service delivery between October 2007 and December 2008.

5.1 Organisations implementing GFATM and CAAP grants

GFATM

By the end of 2008 the total number of sub-recipients that received grants from the GFATM Round 2, HIV/AIDS grant was 61 organizations. Among them 68.8% were NGOs, 19.7% were state-owned organizations and 11.5% were mass media governmental and nongovernmental organizations. Information below shows the distribution of grants by regions of the Kyrgyz Republic (Figure 5.1).

Figure 5.1 Number of HIV/AIDS organizations implementing GFATM grants by regions, data for the end of 2007 and for 2008 (absolute figures)



Source: GFATM PIU

The data shows that although the number of GFATM grant recipients increased (in 2007 there were 51, in 2008 there were 61), the distribution of these grants by regions was uneven: most sub-recipients are located in Bishkek city.

Target groups of GFATM grants sub-recipients are shown in Table 5.1. As before, the majority of organizations are focused on preventive activities for young people (50.8%). In 2008 there was a rapid growth of organizations working with PLWHA (from 2 to 8 organizations), an increase partly explained by an HIV infection outbreak among children in Osh oblast.

Table 5.1 Target groups of GFATM grants sub-recipients

№	Target groups	Number of organizations, 2007		Number of organizations,, 2008	
		Absolute figures	%	Absolute figures	%
1	Young people	28	54,9	31	50,8
2	IDU	8	15,6	8	13,1
3	PLWHA	2	3,9	8	13,1
4	Military personnel	2	3,9	-	-
5	Prisoners	2	3,9	2	3,3
6	CSW, IDU	2	3,9	4	6,6
7	CSW, IDU, MSM	2	3,9	2	3,3
8	IDU, PLWHA, CHW, MSM	1	2,0	-	-
9	STI, CSW, IDU	1	2,0	-	-
10	IDU, STI	2	4,0	-	-
11	Youth, CSW	1	2,0	-	-
12	CSW	-	-	3	5,0
13	MSM	-	-	1	1,6
14	Epidemiological Surveillance	-	-	1	1,6
15	Blood	-	-	1	1,6
	Total	**51**	**100**	**61**	**100**

Source: GFATM, PIU

CAAP

During its activities CAAP has conducted three grant rounds. The legal status of most of the organizations receiving CAPP grants are public organizations implementing their activities in Bishkek, Osh cities and in Osh and Batken oblasts. The distribution of sub-recipients by regions and target groups are shown below (Tables 5.2 and 5.3).

Table 5.2 Distribution of CAPP grants sub-recipients by regions

Region	Round 1	Round 2	Round 3
Bishkek city	1	3	4
Chui	3	-	-
Osh	2	3	3
Jalalabat	1	-	-
Batken	2	-	1
Issyk-Kul	-	-	-
Naryn	-	-	-
Talas	-	-	-
Total	**9**	**6**	**8**

Source: http://www.caap.info

Table 5.3 Target groups of CAAP grants sub-recipients

№	Target groups	Round 1	Round 2	Round 3
1	Youth	4	-	1
2	General population	2	-	1
3	Medical workers	1	2	1
4	Migrants	2	-	-
5	IDU	-	1	1
6	IDU, CSW, MSM, prisoners	-	1	1
7	Social support to PLWHA	-	2	1
8	Fight against stigma and discrimination / promotion of tolerant attitude towards PLWHA	-	-	1
9	Mobilization and capacity building of NGOs	-	-	1
	Total	**9**	**6**	**8**

Source: http://www.caap.info

5.2 Information on number of clients and visits in selected organizations

In the research carried out in 2008, collection of quantitative data in selected organizations was conducted separately for clients and number of client visits as two indicators of scale-up. The total number of clients by years is shown in Table 5.4.

Table 5.4 Total number of clients by years

	2004	2005	2006	2007
Number of clients who received services	8 460	13 089	15 859	18 538

Source: Facility survey. However figures are based on the 11 out of 19 organizations which could provide data for 2004-2007

In 2007 the majority of clients who received services in selected organizations were men (72.5% of clients). Information about the number of client visits is available only in state-owned facilities. Data on four organizations show annual growth of total number of client visits (Table 5.5). The average number of visits for one client varies from 1.4 to 4.6 times.

Table 5.5 The total number of client visits to select facilities by years

State-owned organizations	2004	2005	2006	2007
Republican association AIDS	74046	80329	80562	79515
Chui AIDS center	3881	4828	6635	9904
Issyk-Kul AIDS center	10987	12167	11912	17812
Republican Narcology Center	3530	3922	3918	4179
Total	**92444**	**101246**	**103027**	**111410**

Source: Facility survey from 4 facilities

5.3 Scale up in different types of HIV/AIDS services

5.3.1 Delivery of user-friendly dermatology-venereal services

In 1998, a program aiming at the reduction of HIV/AIDS amongst CSW was launched in Bishkek city. Within this program, the first 'user-friendly' dermatology-venereal clinic was launched. Before implementing GFATM grants, the number of organizations providing user-friendly dermatology-venereal services was only five. Starting from 2004, with GFATM support, there was a significant scale up in this regard: increased geographical coverage, an increase of service providers, additional target groups and a growth in the number of clients. In 2007, there were seven organizations providing dermatology-venereal services on a user-friendly basis[1] for target populations. In 2008 the number of this type of service grew to nine organizations.

As part of the GFATM project, such organizations are financed to provide free services for diagnostics and treatment of STIs among sex-workers, their clients, rural populations, youth and military personnel[2]. Geographical coverage of these services has increased over time: in 2007 several NGOs in Osh, Jalalabat and Issyk-Kul oblasts launched branches in neighboring villages/districts or started practicing outreach works that provide more accessibility of services to populations. For example:

> *This is our fourth project (financed by GFATM); we have adjusted it slightly and are expanding it in Ton, Issyk-Kul and Kochkor rayons* (*interview fragment, NGO*)

Growth rates of clients in various organizations have varied. Thus, organizations providing services to non-key populations declare client increases. But coverage of sex-workers in 2007 was a little lower than in 2006 (Table 5.6). Among the selected sample of organizations that provided free diagnostics and treatment of STI for CSW and prisoners, one organization has stopped its activities and another's client coverage has decreased by 800 people (this happened between mid-2007 and mid-2008). Data on similar services for young people and the rural population suggest there has been a substantial scale up in client numbers among those groups.

Table 5.6 Numbers of clients using organizations providing user-friendly dermatology-venereal services, 2004-2007

Target group	2004	2005	2006	2007
Youth (n=1)	No data available	No data is available	541**	754**
Rural population (n=1)	No data available	488**	685**	1053**
SW (n=4)	2491*	2549*	2626*	2610**

Note: * Facility survey, 2007.
** Facility survey, 2008.

[1] Basic principles of user-friendly clinics are kindly attitude to clients, anonymity and confidentiality, accessibility, acceptability of health service delivery conditions, combination of health care with primary prevention of STI and HIV.

[2] It is impossible to indicate the exact number of GFATM financed organizations providing user-friendly dermatology-venereal services for two reasons: (1) in 2008 GFATM PIU did not provide detailed information about financed projects, (2) the type of published information in the public domain only contains information only about the number of projects working with specific target groups but does not contain information about types of services.

The main reason for the decrease that has occurred from 2006 to 2007 is breaks in financing by GFATM[3]. Most of the organizations providing services on diagnostics and treatment of STI for CSW could only function with the help of GFATM funding. In the absence of financing, these organizations stopped their activities and only recruited personnel and clients to continue service provision once GFATM funding had resumed[4]. Organizations who received not only GFATM grants but also funding from other sources (CAAP, CARHAP, paid services) were more sustainable. These organizations have managed to retain some of their clients by offering them other services and changing their field of works.

> *If there is a support this cabinet (user-friendly services) will be open and if not, then any private clinic will search for efficient conditions… But in any case we will keep at least 50% of our clients (clients of user-friendly services) … We will figure out something so that our clients stay with us … (Interview fragment, private organizations)*

5.3.2 Syringe exchange programs

After starting to implement GFATM grants in Kyrgyzstan the syringe exchange program has expanded significantly in terms of geographical coverage, number of organizations providing syringe exchange services and increased numbers of clients.

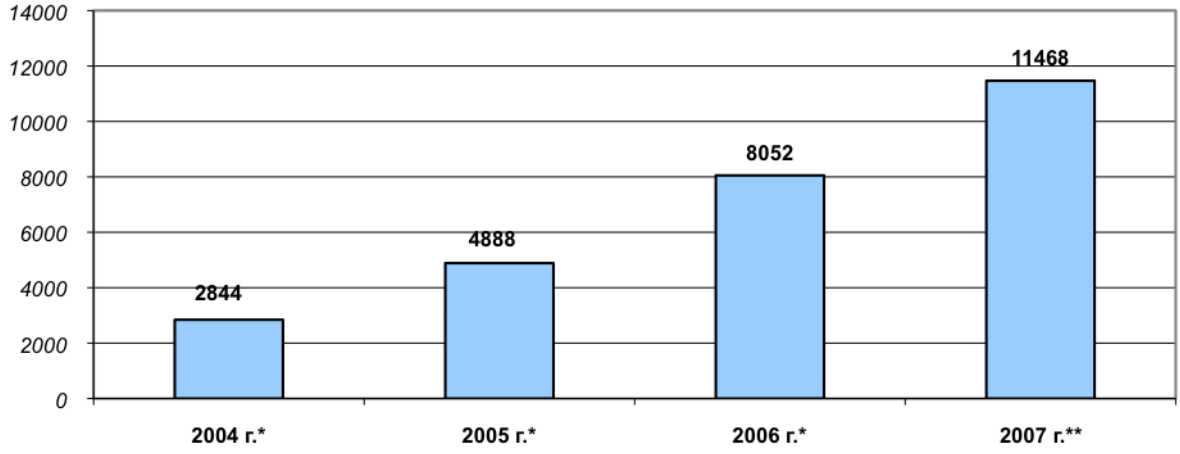
Before 2004 the exchange of syringe program was conducted by a limited number of organizations in only three cities (Bishkek, Osh and Jalalabad). In the middle of 2008, the program was being conducted in more than ten large and small cities, and outreach works were carried out in neighboring villages. In general, the syringe exchange program is conducted in all oblasts that have a high concentration of drug-addicted people (i.e. Bishkek city, Chui, Osh, Jalalabat and Batken oblasts).

The number of organizations providing such services has also substantially increased. According to the data from the GFATM PIU in Kyrgyzstan, in 2007 there were eight organizations working with IDUs, while seven organizations covered IDUs and other groups (MSM, CSW). In 2008 the total number of GFATM sub-recipients working with IDUs remained the same as at 2007 (8 organizations)[5]. The role of state-owned organizations providing such services has also increased. In 2008, there were four syringe exchange points working under the FGP in Bishkek. Four more stations are planned to be launched within the FGP and two stations in infection hospitals of Bishkek city. Moreover, GFATM PIU provides syringes and other instruments to CARHAP sub-recipients who conduct activities in rural areas and small cities.

The number of people who receive services has grown steadily. Between 2005 and 2006 the number of service receivers grew more than by 3,000, and there was a similar growth between 2006 and 2007 (Figure 5.2).

[3] There are 2 reasons: (1) some organizations did not submit their monitoring reports on time, (2) according to the GFATM PIU procedures, all organizations after completing one grant should apply a new grant proposal for further funding. All proposals are reviewed at a Grant Committee meeting (see Chapter 6). This procedure takes some time and leads to interruptions in an organization's activities.
[4] For example, NGO "Podruga" (Osh) , "Afiyat" (Karakol)
[5] Data provided by the GFATM PIU. The official data in 2008 from the GFATM PIU was not available.

Figure 5.2 Trends in client numbers among organizations providing services to IDUs



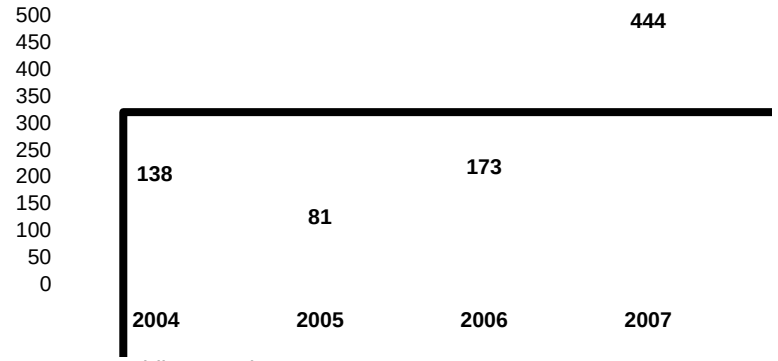
Source: * Facility survey, 2007.
** Facility survey, 2008.

It is worth noting that in 2008, needle exchange services in jails also increased. Mid-2008, there were 13 syringe exchange points in Kyrgyz jails, covering almost all jails of the republic and reaching up to 4,763 people. Moreover, in order to guarantee syringe exchange services for new prisoners and released ones, WHO and GFATM supported the introduction of the syringe exchange program in pre-trial detention facilities and open type jails in 2007.

5.3.3 Substitutive methadone therapy (SMT)

The substitutive methadone therapy (SMT) program has been carried out in Kyrgyzstan since 2002 by government narcology centers. The program was initiated with financial support from the Soros Foundation and UNDP. In 2005 the program started to be financed through a GFATM grant. From the beginning of the program until 2007, SMT was carried out in two facilities: Republican (Bishkek) and Osh government-run narcology centers. In 2007 SMT services were extended in terms of geographical coverage, financing, and number of clients. Participation of state-owned facilities in the program also grew. In the middle of 2007 seven SMT stations were launched: three new stations in Bishkek city, three in small cities of Chui oblast (close to Bishkek city), and one new station in Osh city. With geographical coverage increasing, the number of service receivers grew significantly, to 444 persons by the end of 2007(Figure .5.3).

Figure 5.3 Number of clients receiving SMT in Kyrgyzstan



Source: Republic Narcology Center

The Kyrgyz government attaches great importance to the SMT program, recognizing the necessity of integrating SMT in jails. In 2007, with the support of WHO and GFATM, a pilot SMT program started in one jail located in Bishkek city and in two investigatory facilities in Bishkek and Osh cities. SMT in jails is based on continuity principles, and the program is intended primarily for those who are already receiving methadone.

According to data received from Republican Narcology Center and Osh Oblast Narcology Center, there are key changes to the SMT program which include:

- **Improvement of physical accessibility of services to potential clients**. The research conducted in 2007 showed that one of the limiting factors of SMT was the absence of methadone distribution stations in areas with high concentrations of IDUs. New stations in Bishkek city, Osh city and Chui oblast has solved this problem;
- **Increased personnel working with methadone receivers**. A result of the involvement of more specialists in the program, including social workers has improved the quality of the service. SMT has gradually transformed from a simple procedure of methadone distribution, to a complex approach which makes this service more attractive to clients;
- **Constant funding and uninterrupted delivery of methadone,** due to GFATM activities in Kyrgyzstan.

At the same time it is necessary to recognize that many methadone receivers do not adhere to the program; in 2007 302 new clients received SMT and 158 left the program[6]. This situation is explained by several factors such as:

- **Labor migration** among service receivers. In southern oblasts of Kyrgyzstan, many men go to Kazakhstan or Russia in the spring for work.
- **Criminalisation:** Many clients are incarcerated for committing crimes.

Towards the end of 2008 there was a heated discussion around SMT in Kyrgyzstan, which significantly influenced future scale up. The expediency, efficiency and ethical components of the program were debated in the mass media and among politicians. Civil society groups representing IDUs could not give strong enough and persuasive arguments for keeping SMT[7], and as a result, the program expansion was stopped. In order to collect evidence about the effectiveness of SMT a study was initiated by the WHO. However, its results have not been yet distributed and the program expansion remains under question.

5.3.4 Antiretroviral therapy

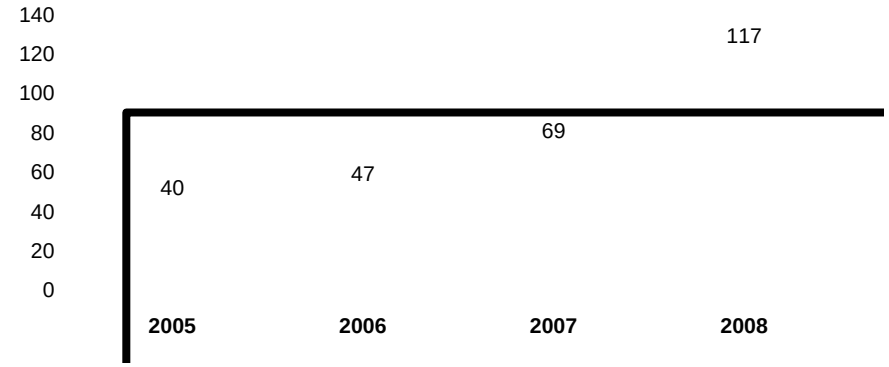
Provision of Antiretroviral Therapy (ART) began in 2005 with GFATM support. Procurement of Antiretroviral medicines (ARVs) in the country is conducted in a centralized way through tender bids. Usually a tender committee consists of representatives from the Kyrgyz MoH, international organizations and PLWHA groups. Before 2008, the procurement of medicines was conducted only once a year. The situation has changed since an intra-hospital HIV infection outbreak, and demand for ARVs has grown. According to one of the respondents, there are difficulties in planning and forecasting the demand level for ARVs. Consequently, training seminars were organized for workers in AIDS centers.

In 2008, it was decided that ARVs would be procured twice a year. According to data from the Republican AIDS Association, by 1st of September 2008 there were a range of 13 ARVs for adults, and 3 types of syrups for children. In Kyrgyzstan, several ART schemes are conducted, and the treatment price for one patient ranges from US$ 1,500 to 3000 per year.

[6] Данные, полученные в РЦН и Ошском ЦН
[7] Publications expressing views of different groups were located in the website: www.volvox.in.kg/pro

The GFATM is the sole funder of ART in Kyrgyzstan; the number of patients receiving ART is growing annually in Kyrgyzstan (Figure 5.4).

Figure 5.4 Number of people receiving ART in Kyrgyzstan



Source: Republican AIDS Center

Data collated in September 2008 shows that of 187 people introduced to ART, 117 persons were under treatment (of which 84 were adults and 33 children), sixty three patients refused to take ART and 35 of the 63 had died (Source: Republican AIDS Center).

There are two national consultants (in Bishkek and Osh cities), who see patients and if necessary make treatment corrections. ART is conducted according to clinical protocols on HIV/AIDS treatment, which were reviewed in 2008 with technical assistance from WHO. There are 800 medical workers trained to put people on ARVs who work according to newly introduced clinical protocols “Treatment HIV infection with antiretroviral medicines”.

Another problem relating to the delivery of ART is linked to the low level of adherence of patients to treatment. Several factors are associated with this: (1) the majority of adult patients are IDUs who according to interviewees are sometimes undisciplined and break treatment schedules; (2) despite much effort, level of knowledge about HIV/AIDS and its treatment is very low, and most patients do not understand and do not consider the significance of regular medication; (3) insufficient qualification of medical personnel (“…*medical workers do not know how to deal with HIV patients, how to talk with them* …’) despite international consultants under technical support of UNICEF, running seminars about adherence in Osh.

Regular supervision of patients receiving ART is assigned to primary healthcare (PHC) physicians. However, lack of specialists (especially in regions), and overload of FGP physicians create difficulties in providing the service.

There are unsolved problems on providing services to patients with both HIV and tuberculosis, including weak continuity in providing services between different services, and insufficient knowledge among providers about features of tuberculosis with HIV infection.

In 2007, obligatory testing was introduced for all pregnant women and children under five registered and getting treatment in hospitals (with the agreement of patients)[8]. Individual training on artificial feeding for HIV-positive parents is conducted (in oblast centers of AIDS, FGP and CFM). In Bishkek city, paid for through the GFATM grant, artificial food was procured for new-born children in order to avoid breast feeding.

[8] Decree of the MOH KR №400 13.11.2007. “On analytical research about HIV infection outbreak among children in Osh oblast”

5.3.5 Response to the HIV infection outbreak in Osh oblast

The outbreak of HIV-infection in Osh oblast occurred because of insufficient attention to safety measures during medical procedures in health organizations (specifically, multi-use of single use instruments). The situation was worsened by a constant deficit of medical instruments, disinfectants, and the means to ensure personal safety of medical workers.

For prevention of further HIV infection proliferation, short-term, intermediate term and long-term actions were developed. These actions were included in the joint plan of the Kyrgyz MOH and international organizations. The roles and responsibilities of every actor were defined in the joint plan, including donor organizations (GFATM PIU, CDC, UNICEF, UNAIDS, USAID, WHO, KFW and others). Donor organizations, particularly the GFATM PIU, responded very efficiently to help localize the outbreak. GFATM, for example, provided US$961,384 for commodities and laboratory services including:

- Express test systems;
- Children's single use needles, including needles for catheterization of subclavian veins (3,000 items) in all children's clinics of the republic;
- Single use medical items (sterile syringes, needles, scarificators, gloves, spirit napkins, plastic containers for utilization of medical waste, disinfectant solution) for health organizations in Osh, Jalalabat and Batken oblasts);
- Equipment for cytoflow meter, intended for investigating immune status (CD4 and CD8) of patients with HIV/AIDS for treatment correction with ARV medicines in AIDS prevention and treatment center of Osh oblast;
- Equipment for conducting polymerase chain reaction for defining virus load of HIV infected patients in AIDS prevention and treatment center of Osh oblast;
- Refrigerating machinery for blood quarantine in the blood center of Osh city;
- ARV medicines for full coverage of HIV-infected children.

Within the framework of the Joint Action Plan, and with support from other donor organizations, the following actions were conducted: epidemiological investigation: provision of social assistance to families with HIV infected children; treatment protocols on HIV/AIDS treatment were reconsidered including ARV therapy; training seminars on care; support and treatment of HIV infected children, and training for mass media representatives as well.

Overall, the outbreak of HIV infection revealed the weaknesses of previous approaches to fight HIV/AIDS, but important lessons emerge from interviews conducted with respondents at the national level as part of this study:

In connection with public health systems:

- Presence of real problems with safety of medical procedures;
- State budget is insufficient to provide the equipment necessary to ensure staff safety (e.g. provision of sufficient gloves, single-use catheters and other medical items);
- Insufficient qualification of medical workers resulting in low quality of medical services;
- Prevention activities in hospitals and heath facilities are limited; there are no clearly defined procedures for control of infections and existing MoH orders are often not followed;
- Medical establishment is not ready to deal with HIV infection epidemic (for example some physicians still refuse to observe and treat people with HIV positive status)
- A positive factor is that, following the outbreak, means for capacity building of the public health system and for safety of medical services was considered in the application for Round 7 GFATM grants.

In connection with society in general:

- Population was not ready to accept HIV infected persons;
- Mass media was not ready to inform the population about HIV, and that a more appropriate way of informing the population could help to reduce stigma.

5.3.7 Legal services

Compared with 2007, more attention was given to legal services in 2008. Such services were largely supported by large and small grants from CAAP. For example, lawyers from the public foundation "Adilet" worked very actively to develop training seminars on "Improvement of legal knowledge of workers from organizations that work in HIV/AIDS prevention and drug addiction". They have conducted these seminars for thirty people including NGO representatives and state organizations in Osh and Jalalabat. The following issues were considered and discussed during the seminars: human rights and health; national public health systems; access to medical-sanitary aid and drug provision to vulnerable groups; social-legal protection; criminal and administrative regulation of HIV/AIDS and drug addiction issues; and methods of documenting citizens of Kyrgyzstan[9].

Lawyers from "Adilet" have also conducted guest consultations for social workers and participants of methadone programs on legal issues. During the consultations discussion topics included: key legal issues concerning administrative and criminal regulation and issues about civil-legal disputes.

All of these issues discussed at seminars took into consideration harm reduction services expansion and HIV infection outbreak in the country. During the research it became obvious that the demand for legal services is high but not yet fully met by services available in 2008.

5.3.8 Voluntary counseling and testing

The GFTAM grant has enabled increased attention to be paid to voluntary counseling and testing (VCT). With GFATM grants, seminars on counseling and testing for HIV have been conducted for medical workers and representatives of NGOs, and the purchase of HIV diagnostic test-systems is now fully financed the grant. Most training was provided by specialists from the Republican AIDS Center.

A number of measures have been adopted to improve the effectiveness of VCT services at all levels of the public health system. A clinical protocol on VCT and the manual on psychosocial consultation were developed and approved. Introduction of clinical protocols and education through training on psychosocial consultation are being conducted partly funded by the GFATM. Physicians from FGPs and FMCs, narcologists, dermato-venereologists, social workers and volunteers from NGOs have received these trainings.

In addition, the legal base for creating voluntary counseling and testing for HIV has been prepared. The Kyrgyz MOH issued Decree 445 "Introduction of voluntary counseling and testing for HIV/AIDS in medical organizations of the republic" on the 11th December 207, where VCT standards were approved and qualifications of VCT specialist were defined. With the support of the donor KfW, the opening of VCT rooms in 54 pilot treatment facilities of the republic is planned for the future.

[9] http://www.adilet.kg/carhap/news.html

However according to interviewees VCT quality problems still remain unsolved. Pre-test counseling is still provided in limited scope and does not lead to testing for HIV. The reasons for this are (1) insufficient staff experience for VCT; (2) high workload of medical workers and low motivation; (3) problems related to a lack of confidentiality and anonymity.

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

Enabling factors

1. **GFATM financing of HIV/AIDS-related activities.** Financing from the GFATM is the main factor that had led to the substantial expansion of all types of HIV/AIDS services and coverage of new target groups and locations. This has led to a growth in activity among civil society and state-owned organizations.

2. **Improved coordination and cooperation among financing organizations**
   - A strategic plan for distribution of finances from different donor organizations was developed within the Third State Program on HIV/AIDS Prevention for 2006-2010. This was intended to avoid financing duplication, and better target distribution of means. "…*There is such a matrix a strategic plan for introducing the national program which has information about… financial gaps, financing plans…"*[10]*.* (Interview fragment, Bishkek.)
   - GFATM support to projects that are also financed by other donor organizations (for instance, CAAP and CARHAP), in terms of provision of essential harm reduction program instruments. Projects under CAAP financial support could continue provision of syringe exchange services for IDUs and services for SWs in Osh city and Osh oblast. Similarly, CARHAP financial assistance enabled syringe exchange services to be maintained in Bishkek, Jalalabat and Kyzyl-Kiya cities. Co financing allows service providers to provide complex interventions, which enhances their relevance and utility among clients and promotes clients' long-term use of HIV/AIDS services.

3. **Creation of a favorable environment for service provision.** Within the framework of the "Tumar" project (CAAP), several activities were carried out to create a favorable environment for services, for example opening an accessible service centre[11]. This has stimulated scale up of services for IDUs in Kara-Suu city (Osh oblast)[12].

4. **Efforts to institutionalize activities.** State institutions have been gradually identified, to take responsibility for large scale components of HIV/AIDS services and thus promote their scale up and sustainability. For example, the Ministry of Education receives funds through the GFATM grant to introduce courses on healthy life-styles in educational institutions. Introduction of the syringe exchange program at the FGP and FMC levels.

Factors hindering scale up of services

1. **Breaks in project financing.** In 2008 a significant number of NGOs that were previously active, did not receive further funding through the GFATM grant due to changes in project extension conditions. With project breaks for 3 - 4 months, established activities suffered significantly in terms of fewer clients and displacement of

[10] See also Context Report p.23-25, May, 2007
[11] More detailed in the chapter "Cooperation"
[12] Only 2 outreach workers for IDUs worked in Kara-Suu city. They only provided syringe exchange service and information.

trained outreach workers who had to search for other jobs. Approximately one year is required in order to establish an effective project in a new location, develop a network of outreach workers, train them and gain service users' confidence. Interviewees indicated that as a consequence of funding breaks a significant amount of work by NGOs had to be repeated. Moreover, as organization's capacity declined, client confidence diminished.

Breaks lead to coverage decline, it is especially hard when outreach workers how had a large coverage are lost. New outreach worker needs to be educated again, he should know how to exchange syringes, and he must gain client's confidence…coverage is reached during a year… (interview fragment, NGO)

No one is interested in starting all the work again from the beginning… (Interview fragment, NGO)

2. **Low-level commitment from politicians.** The context of political instability and frequent replacements of high-level officials requires constant effort to build high level political commitment to HIV/AIDS related activities. However, the CMCC secretariat[13], whose job it is to encourage political commitment, had weak capacity and this led to misunderstanding of roles and significance of activities conducted in the country. One consequence is that political support for continuing to deliver SMT programs in Kyrgyzstan is now under question.

3. **Absence of a single M&E system.** Currently, implementation of the Third State Program on HIV/AIDS is carried out by a number of organizations with the support of many donor organizations, including the GFATM and through the CAAP program. Data from field work conducted in 2008 showed that there is no single approach adopted across donors for program implementers to register clients[14] and record activities and impacts. Hence each sub-recipient must use a number of different reporting systems in parallel which both places a burden on them and also leads to some double-counting of clients. Moreover, quality indicators such as satisfaction level of clients and changes in behavior are not tracked.

4. **Lack of access to key population.** Until recently in some oblasts there were no services for drug addicted people and MSM, and places where high numbers of SWs received no coverage. Often this was justified by denying that any of the above mentioned groups were present in these areas. However experts have met with these groups, and suggested that there was a lack of trust between communities and potential service providers.

[13] See. More detailed in chapter "Coordination"

[14] Thus, during the field-work (April-October, 2008) it was discovered that some organizations consider coverage as number of clients who at least took services once in a certain period of time and some consider clients who relatively more often has contacted with representatives of an organization; another group of organizations consider coverage as coverage of 60% key concentration of community meaning that they cover 60% of target groups.

5.5 Conclusion

- In 2008, GFATM Round 2 activities were completed. Financial support was used to procure commodities including medicines, equipment, and to train staff and to fund the activities of government, NGO and private sector sub-recipients.
- GFATM activity resulted in a significant scale up of HIV/AIDS related activities. The geographical coverage has been expanded; a number of state-owned and nongovernmental organizations involved in delivering services has expanded; the volume of services to key population groups has been increased; a number of information and educational activities were carried out; new target groups were covered (migrants, the rural population, PLWHA); new services were introduced (for example, ARVs therapy, blood quarantine and new laboratory tests).
- The Round 2 GFATM grant is targeted at large-scale service provision. The Central Asian Aids Project (CAAP) is focused on services with lower coverage, but aimed at changing client's behavior and improving their lives. It was a timely complement to GFATM activities because it provided services for key population during GFATM financing breaks.
- Financing of HIV/AIDS programs from the GFATM, CAAP and other donors has promoted the substantial scale-up of services. Efforts among funders and their implementers to coordinate activities has also been important factor facilitating scale up.
- Factors hindering further scale up still remain. The main factors are breaks in financing of GFATM sub-recipients, which weakened the capacity of organizations and confidence of clients. In recent years, the commitment of political leaders to HIV/AIDS related activities has declined. Multiple M&E systems continue to be imposed by donors that place a burden on sub-recipients and sometimes leads to double counting of clients.

5.6 Recommendations

Recommendation #1. In order to promote scale up of HIV/AIDS-related activities in the under-served regions of Kyrgyzstan more attention should be given to capacity building for project management in organizations working in these regions enabling them to compete for grant money.

Recommendation #2. Taking into consideration the problems created by financing breaks experienced by GFATM sub-recipients (and to a lesser extent CAAP sub-recipients) it is necessary to reconsider how to improve disbursement mechanisms to projects.

Recommendation #3. Unify current approaches to M&E from HIV/AIDS related activities to ensure uniformity across government and donor funded programs.

Chapter 6. Coordination of HIV/AIDS programs

Coordination of HIV/AIDS activities in the Kyrgyz Republic is strongly promoted by the government. Currently, the *National Program for Prevention of HIV/AIDS Epidemic and Its Social Consequences - III for 2006-2010* is in the process of implementation. Implementation of this Program is based on a sector-wide approach, with defined roles for the different agencies, including both public and nongovernmental organizations.

The task of general coordination and management of HIV/AIDS public and donor programs was delegated to the Country Multi-sectoral Coordination Committee (CMCC), established in 2005. Establishing a country coordination mechanism is also a condition of receiving the GFATM Grant.

Significant changes took place in the period 2007-2008 in coordination structures at the national and oblast levels, notably:

1) CMCC to Fight AIDS, Tuberculosis and Malaria was reformed into the Country Multi-sectoral Coordination Committee on Socially Significant and Especially Dangerous Diseases (MCCC).
2) Oblast multi-sectoral committees stopped functioning.
3) New structures have emerged that are aimed at coordination in certain sectors (NGO Steering Group, Inter-sectoral Steering Group on Health Protection and Social Care in the Penal Enforcement System) or certain geographical areas (Working Group in Osh city).

This section describes coordination structures – their goals, functions, composition and dynamics for the last year – drawing on survey participants' inputs, and analysis of coordination efficiency of HIV/AIDS activities and its determinants that have been carried out in the Republic based on the accounts of the survey participants in 2007 and 2008 and also drawing on the results of an earlier study "Analysis of CCM working experience in KR"[15].

6.1 HIV/AIDS coordination structures at the national level

Development of coordination mechanisms

The process of development of the multi-sectoral coordinated approach to HIV/AIDS programs in the Kyrgyz Republic started in 1996. The development of the coordination of HIV/AIDS programs has 4 main stages (Figure 6.1)[16]. According to accounts from survey participants involved with HIV/AIDS policy implementation, reforming of the country coordination mechanism, its operation, and functions have always been carried out with regard to international requirements and lessons learned. The Country Multi-sectoral Coordination Committee on HIV/AIDS, Tuberculosis and Malaria[17], established in 2005 was

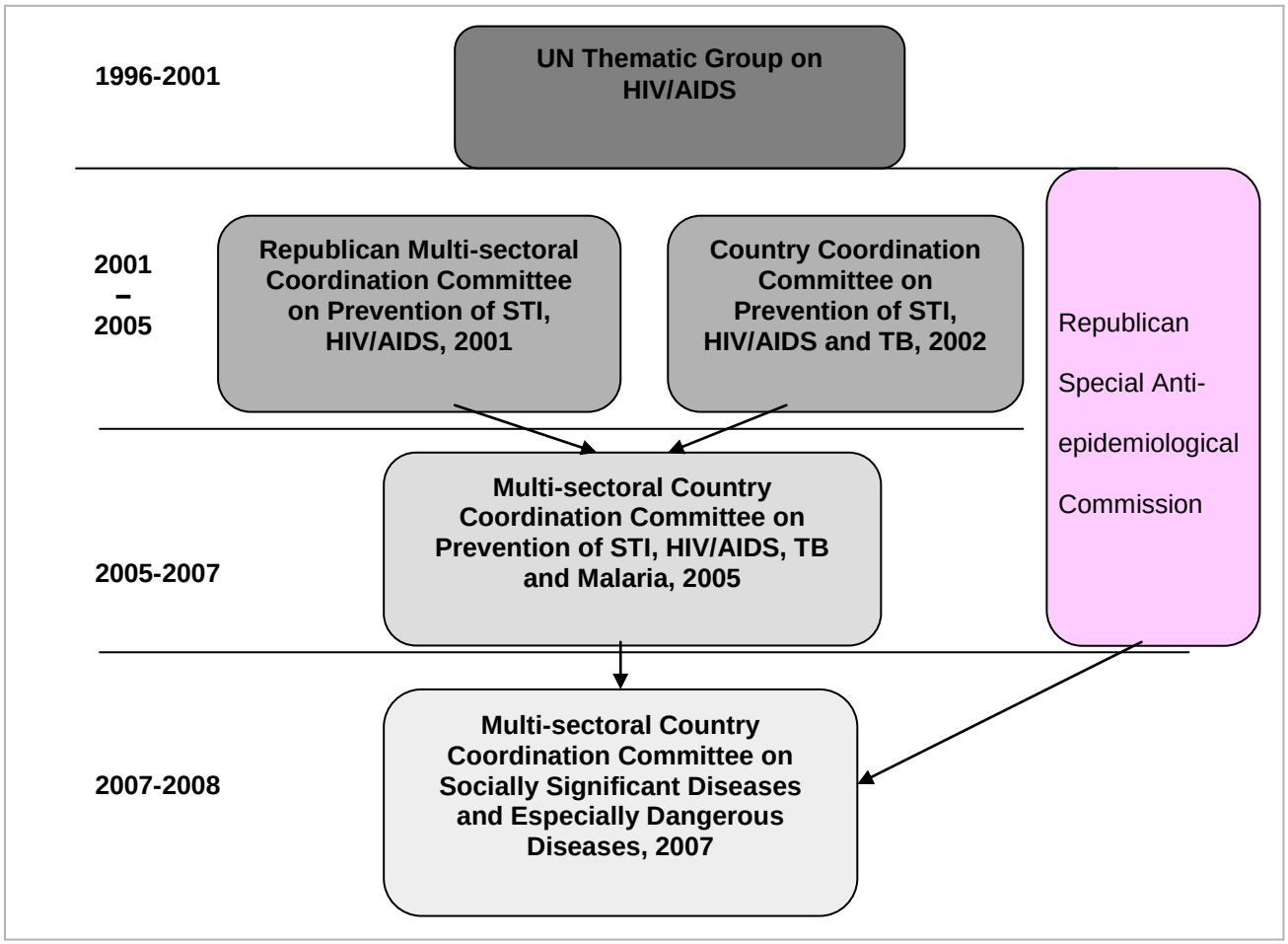
[15] Soros-Foundation Kyrgyzstan, NGO «Isildoo Plus», CA «Expert», 2007.
[16] http://chsd.studionew.com/images//context_report_1_rus.pdf Research Paper *Global Initiatives in HIV/AIDS and Their Impact on Health System of the Kyrgyz Republic*. Situational Analysis Report
[17] http://chsd.studionew.com/images//prp49hivaids_r.pdf Research Paper *Global Initiatives in HIV/AIDS and Their Impact on Health System of the Kyrgyz Republic*. Interim Report»

recognized by the same survey participants as the most successful form of coordination in terms of the team member composition, structure and real performance.

However, in 2007 the Ministry of Health of the Kyrgyz Republic reformed the existing CMCC and merged it with the Republican Special Anti-epidemiological Commission (RSAC). The official reason from the Government to explain this move was, as indicated in official documents: 'their membership and functions are similar in many instances'[18]. Nevertheless according to interviewees, the decision to reform the CMCC has created several difficulties in coordinating and implementing HIV/AIDS activities. According to respondents, this decision 'was taken by a few people' and 'it was based on personal interests', and it was mainly determined by financial considerations and 'big money of the Global Fund'. Despite this disquiet the Multi-sectoral Country Coordination Committee on Socially Significant and Especially Dangerous Communicable Diseases was formed on August 24, 2007 by a Resolution of the Kyrgyz Republic Government.

The key differences between the two bodies include: (1) focus of CMCC activities on more than 40 human and animal diseases, including HIV/AIDS, tuberculosis, malaria, brucellosis, anthrax, avian flu; (2) transfer of the CMCC Secretariat functions to appropriate departments of the Ministry of Health and the Ministry of Agriculture, Water Resources, and Processing Industry; (3) liquidation of two technical units (National Policy, Legislation and Human Rights Unit, and Grants and Programs Implementation Unit), and also creation of a new technical unit on animal health.

Figure 6.1 Key HIV/AIDS coordination mechanisms 1996 - 2008



[18] Report on Mid-term Review of the National Health Reform Program of the Kyrgyz Republic *Manas Taalimi,* MOH KR, 2008, (p. 108)

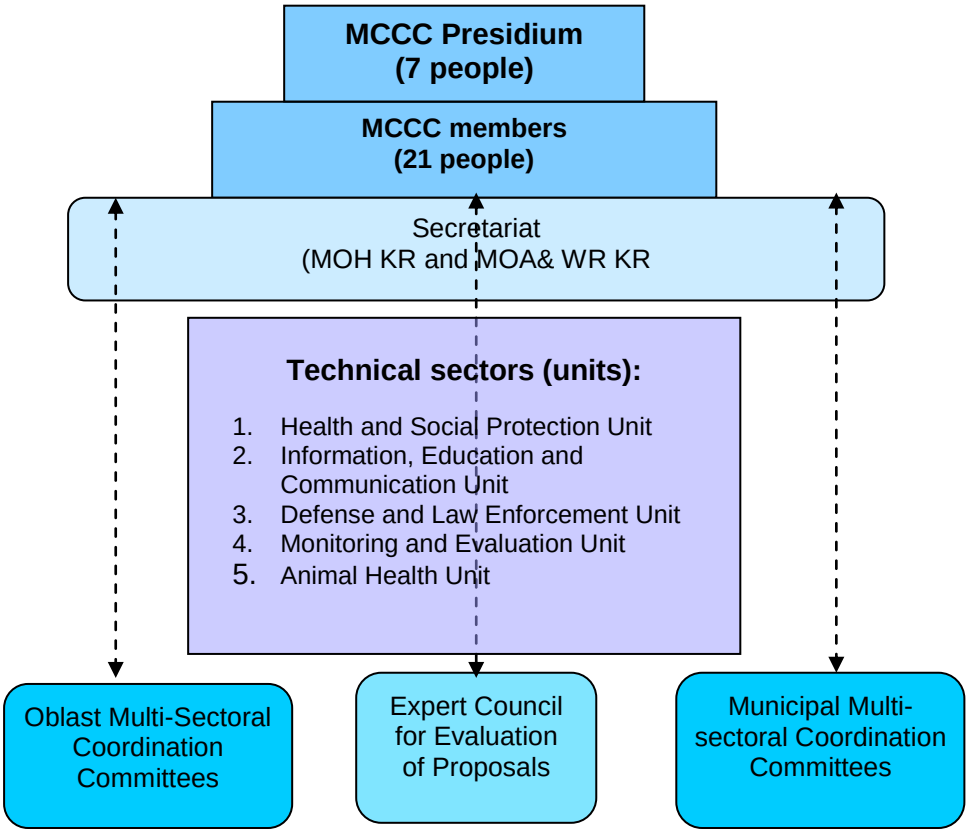
Goal, Structure and Functions of the current MCCC

At the time of the 2008 phase of the survey, the Multi-Sectoral Country Coordination Committee on Socially Significant and Especially Dangerous Diseases (MCCC) had begun operating in the Kyrgyz Republic. The main goal of the MCCC is coordination of activities of different organizations involved in the fight against communicable diseases including HIV/AIDS; timely organization of emergency interventions against socially significant and especially dangerous human and animal diseases; and localization and elimination of epidemic, mass poisoning of the population. The MCCC has the following specific functions:

- **Coordination of activities** aimed to fight against socially significant and especially dangerous diseases, including prioritization of interventions;
- **Informing** the Government of the Kyrgyz Republic about large scale outbreaks of communicable diseases, emergencies, resulting from deterioration of epidemiological and epizootic environment, and response measures.
- **Development of partnership** between different stakeholders, ministries and agencies, as well as international and regional cooperation to fight against socially significant and especially dangerous human and animal diseases;
- **Reviewing proposals and draft strategic plans** to fight against socially significant and especially dangerous human and animal diseases;
- **Oversight of program implementation** and assessment of effectiveness of activities aimed to fight against socially significant and especially dangerous human and animal diseases.

The CMCC's organizational structure includes a Presidium, secretariat, 5 technical units, 7 oblast and 2 municipal coordination committees, as well as a Technical Council for the evaluation of proposals and awarding grants (Figure.6.2.)

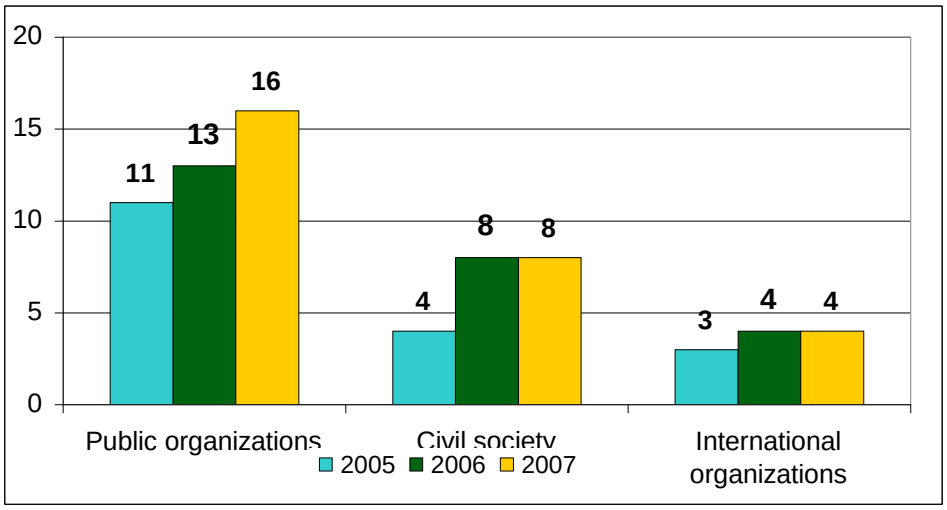
Figure 6.2 Organizational Structure of MCCC on Socially Significant and Especially Dangerous Diseases (2007)



The Presidium includes 7 people, including Vice-Prime Minister, and representatives of the Ministry of Health and the Ministry of Agriculture, Water Resources, and Processing Industry, nongovernmental sector, and international organizations. A working body (the Secretariat of the Committee) is represented by appropriate departments of the Ministry of Health and the Ministry of Agriculture, Water Resources, and the Processing Industry.

The MCCC included 28 people in 2007; in previous years the CMCC included fewer people. The number of civil society representatives doubled in 2006, but this did not change significantly the proportion of civil society organizations on the committee since the number of public organizations also increased substantially (Figure 6.3).

Figure 6.3 Number of Organizations on the CMCC and MCCC Representing Different Sectors: 2005 - 2007



The transition from the CMCC to the MCCC

When discussing HIV/AIDS coordination respondents clearly defined two periods: before August 2007, and afterwards.

It was suggested by many interviewees that the CMCC was an effective structure owing much to the commitment of the government and cooperation of all stakeholders (ministries, agencies, civil society and etc, who are involved in National program implementation). Between 2005 and 2007 all decisions taken at meetings of the Presidium, and technical units were considered by interviewees to be legitimate, effective, and in line with the HIV/AIDS situation in the country. Effectively coordinating the development of a number of important national documents was reported as one of the most significant CMCC achievements during 2006-2007[19]:

> *I used to participate in work of the information unit (Information, Education and Communication Unit) and social protection unit (Health and Social Protection Unit). We worked really hard there; this was a platform, where we could share our opinions, and where we could develop certain documents… And these decisions, and developed papers had really a permanent nature (*a representative of MOE).

[19] (1) Country proposal for the 7th Round of the Global Fund, which was approved; (2) Third Government Program on HIV/AIDS and Its Social and Economic Consequences for 2006 – 2010, (3) Matrix of Multi-sectoral Integrated Actions for 2007 -2008 for implementation of the Government Program, (4) Regulation On the Monitoring and Evaluation System of HIV/AIDS Situation in the Kyrgyz Republic.

In contrast to the effectiveness of the CMCC pre-2007, respondents gave negative accounts about the effectiveness of MCCC established in 2007. After a year interviewees suggested the MCCC performs only two of its functions: prioritization in HIV/AIDS interventions, and evaluation of proposals and projects. Indeed, between August 2007 and August 2008, on three meetings of the MCCC took place. At these meetings the Progress Report on the National HIV/AIDS Prevention Program was presented, and in the application for the 8th Round of the Global Fund and reallocation of funds of the current Global Fund grant were discussed. Interviewees suggested that the most important recognized achievements of the Coordination Committee include:

- Approval of a joint plan of action of the Kyrgyz Government and donor organizations in relation to the HIV/AIDS outbreak in Osh oblast. This led to an effective response to the outbreak, and, according to respondents, prevented the further spread of HIV in Osh oblast hospitals.
- Development and submission of a proposal for the 8th Round of the Global Fund TB component. The decision was made not to submit an HIV/AIDS proposal for 8th Round Global Fund funding in spite of the pressure from some stakeholders to do so.

Interviewees suggested that the main weaknesses in terms of the performance of the new MCCC were:
(1) lack of coordination between different actors within the first six months of the MCCC being established;
(2) lack of monitoring of current HIV/AIDS interventions;
(3) lack of continuity between the previous and existing structures. In particular:

a. It took more than 6 months to launch the new MCCC and its Secretariat and for it to become operational. During this time, international organizations tried to solve emerging issues themselves, and coordination of NGO activities was carried out to a certain extent by international organizations or through different NGO associations. Government organizations, including ministries and different agencies, benefitted least from these delays. Interviewees from government organizations suggest that as a consequence many employees of these organizations do not have a clear idea about HIV/AIDS-related activities that have taken place in the country.

b. Since the reform of the coordination structure, there have been significant problems in getting information about HIV/AIDS, activities being implemented, and on partners involved in the implementation of these activities. Previously this information was collected by CCM Secretariat and was accessible for all stakeholders. After reforming the MCCC the process of information collection was stopped, and most of organizations did not know where and how they could get necessary information.

c. At the point of dissolution, the pre-2007 CMCC's Secretariat was working towards the approval of key documents, including '*On the Government Monitoring and Evaluation System of HIV/AIDS Situation in the Kyrgyz Republic'*, and the '*National M&E Plan for HIV/AIDS Situation in the Kyrgyz Republic'*. After the CMCC was dissolved, this work was stopped and the documents were not approved as of August 2008.

Evaluating the performance of the MCCC

Interviewees reported a number of specific criticisms of the ways the MCCC was operating including:

(1) **Limited multi-sectorality:** Analysis of interviews of the first and second stages of the survey shows that management of MCCC's operation plays a decisive part in the

effectiveness of its performance. Many respondents noted that because the MOH was the Secretariat of the CMCC, it was able to re-frame HIV/AIDS as a health problem rather than a social problem. It also meant that the MCCC was less multi-sectoral than it had been in the past.

> *We tried really hard for a long time to make HIV/AIDS problem to be recognized as a social problem in our country. However, if the Secretariat is now by the Ministry of Health, it means that HIV/AIDS became the health problem again*. *CMCC's Secretariat has lost its multi-sectoral nature (A representative of a public organization)*

> *The time of people, who are members of CMCC is very 'expensive'. And when I see that agenda includes discussion of issues related to animal health, and only one of the three issues is related to HIV and my work, I ask myself, do I really need to go to this meeting?* (representative of an international organization).

(2) **Dependence on donors.** Many organizations (NGOs and governmental organizations), who are members of the MCCC, at the same time are sub-recipients of the GFATM and CAAP grants. For this reason they feel dependent on these grants to some degree. Interviewees suggested that on the one hand, many members of the MCCC cannot freely criticize donor organizations; on the other hand, they are more oriented at unconditional execution of donors' will.

> *It might be the case that the problem is in the fact that only representatives of donor organizations express some criticism. NGOs are funded by the Global Fund, so they depend on it. They (NGOs) are not ready to criticize*. *And we (international organizations) have to act as a watch dog (*representative of an international organization*)*

(3) **Transparency in coordination of HIV/AIDS activities.** Respondents suggested that financing of HIV/AIDS activities funded by GFATM and CAAP grants is insufficiently transparent. For example, stakeholders may receive only very general information from donors regarding funding flows. At the same time, policy makers in HIV/AIDS issues believe that such information is not sufficient for effective planning and coordination of activities.

> *At CMCC meetings we cannot possibly get detailed information concerning the facts on what and how much funds have been spent. We asked for this information so many times already, but all our attempts failed. We just receive general reports back…* (a representative of an international organization*)*

(4) **Human resources.** According to interviewees experienced and knowledgeable representatives of organizations who are MCCC members, are an important part of what makes the MCCC effective. Moreover, experience of the operation of the coordination mechanism shows that its performance depends in many aspects on understanding of HIV/AIDS goals, the mission and policy by leaders and staff of MCCC members.

Table 6.1 summarizes interviewees' accounts of the strengths and weaknesses of the CMCC (2005-2007) compared to the MCCC (2007-date).

Table 6.1 Comparison of CMCC and MCCC structures: key findings

	CMCC	MCCC
Composition	CMCC Presidium (2005-2007) included representatives of all relevant sectors including representatives of all key Ministries and agencies, bilateral and multilateral partners, as well as NGOs and communities affected by the epidemic. The proportion of nongovernmental actors in the CMCC Presidium was 48%.	The composition has not changed in terms of the proportion of members from different sectors. However it was reported by many interviewees that representatives of the NGO sector are just token figures, which in reality represent rather their personal interests or interests of their organizations than the interests of NGOs collectively. In general, the composition of MCCC was characterized by some interviewees as 'less oriented to HIV/AIDS problems'.
Position of the Secretariat	The HIV/AIDS Coordination and Monitoring Unit of the Social Development and Information Department of the Government Office performed the functions of the CMCC Secretariat (2005-2007). Without being a stakeholder, and at the same time being positioned at a high political level, the Secretariat had the ability to coordinate activities of different ministries and agencies, thereby promoting a high level of multi-sectorality.	The Secretariat of the MCCC has lost its multi-sectoral nature. Transfer of the Secretariat functions to the Ministry of Health has significantly weakened its position. Now the secretariat does not have an opportunity to expect information from other ministries, and more often they have to act as "a petitioner". Moreover, the Secretariat does not have its previous political power. According to its Regulations, the Secretariat is an operating body of MCCC by the Government Office. But in reality, in order to reach the Government Office, the head of the unit (sector) has to go through several 'stages': documents from the Secretariat go to the MOH, from MOH to personnel of the Social Development Department, then to the Government Office and only after that do they reach their destinations. As a result decision making tends to be a highly protracted process.
Capacity of the Secretariat	The capacity of the Secretariat had been established and was seen by interviewees as sufficient for effective performance. Moreover, the Secretariat had all the resources it required to do its work. For example, informing MCCC members and partners was carried out with the use of strong information resources, including websites, electronic mailing lists, newsletters and publications in the mass media.	Limited capacity of the Secretariat. The majority of staff from the previous Secretariat, which had developed very good skills and knowledge, have been replaced. New staff have received minimal training; as one respondent noted: '*there are no opportunities to be trained now, we need to work'*. Moreover, the Secretariat is under-resourced: it does not have its own premises, equipment, and access to the internet, office supplies and indeed salaries. These issues have been discussed by the Government but they remain unresolved.
Functioning of the body	Involvement in CMCC work was not tokenistic: interviewees noted a real interest from most actors in taking part in the meetings of the Presidium, and very high attendance rate, as well as a high degree of key decision-maker involvement.	Token interest in participating in MCCC meetings. The MCCC is responsible for a wide range of human and animal infectious diseases. This means that meetings are frequently of minimal interest to members concerned primarily with HIV/AIDS.

6.2 Oblast HIV/AIDS coordination structures

Format of oblast multi-sectoral coordination structures

The history of oblast HIV/AIDS coordination committee development started in 2001, when they formed structural units of the national-level Republic Multicultural Coordination Committee. However, virtually no HIV/AIDS coordination activities have been carried out at the oblast level. By autumn 2006, some activities had been carried out by the Osh oblast multi-sectoral committee with funding from USAID's Capacity Program, and they were seen by members as quite successful[20]: The oblast HIV/AIDS committees started to hold meetings on a more regular basis; they developed oblast HIV/AIDS programs and implementation plans; and started interacting with the national CMCC. However, changes in coordination at the national level were seen by interviewees as impacting negatively on the operation of oblast-level committees. Data from the second phase of the study shows that oblast committees in 2008 were facing the same problems as the MCCC, or had stopped operating completely[21].

In spring 2008, as a consequence of reforming of MCCC at the national level, some of previous oblast coordination structures were also reformed. In Osh and Issyk-Kul oblasts of the Kyrgyz Republic Oblast Multi-sectoral Committees on Control of Social and Especially Dangerous Diseases (OMSC) were established by decree of the oblast public administrations. The focus of these new coordination structures is prevention of communicable diseases and mass food poisoning. According to OMSC Regulations, their main objectives include organization of urgent measures to fight against socially significant and especially dangerous human and animal diseases and elimination of mass epidemics and poisoning among the population; and coordinating and optimizing the operations of local organizations (governmental, international, educational, religious organization, civil sector and mass media). The composition of these new oblast coordination committees has not changed significantly: they are still composed mostly of physicians – in – chief of different health care facilities, representatives of law enforcement bodies, and certain NGOs. Vice-governors of the oblasts lead the work of the coordination committees, while Social Departments of oblast administrations perform the functions of the Secretariat. In Chui oblast, HIV/AIDS coordination is s performed by a Health Coordinator (the Director of a Family Medicine Center). The Council is also involved in coordination as its members include all chief physicians of oblast health care facilities, and representatives of the oblast public administration. Meetings of the Council take place once a quarter, and HIV/AIDS related issues are discussed once a year, or when needed in case of emergency.

In other oblasts, OMSCs have practically stopped functioning, although there is no official notice that they have gone into abeyance.

Assessment of effectiveness of oblast coordinating structures

Interviewees suggested that the reform of the national coordination structure had negative impacts on the operation of oblast structures: there were no meetings of OMSC members on regular basis during the period from August, 2007 until March, 2008 neither at the national or oblast levels Moreover, respondents suggested that in some cases decision-makers at

[20] More detailed description is in Research Paper G *Global Initiatives in HIV/AIDS and Their Impact on Health System of the Kyrgyz Republic*. *Interim Report*. Available on http://chsd.studionew.com/images//prp49hivaids_r.pdf

[21] The geographical restrictions limited the description of coordination structures to three oblasts out of seven. However, results of the first stage of the study showed that these three oblasts were the most active and successful. Evidence suggested that in other oblasts of the Republic, there was virtually no activity of coordination committees.

oblast or city levels were not aware of which key organizations implemented HIV/AIDS activities in their oblast.

Doubts were also repeatedly expressed by interviewees regarding the fact that the existing format of oblast multi-sectoral coordination committees is viable. While discussing the performance of oblast coordination structures, the respondents outlined the following factors influencing their effectiveness:

- **Leadership/support of the MCCC Secretariat.** It was reported that intensive activities by MCCC to activate OMSC work, conducted in 2006-2007, produced some good results. At the same time termination of this activity resulted in instantaneous cessation of OMCC operations.
- **Frequent replacement of OMSC leaders**. It was noted that new OMSC leaders in oblasts are not well-versed in the issues related to HIV/AIDS, which limits the operation of the committees down to perfunctory planned meetings, where people listen to statistical data and reports of oblast AIDS centers. Illustrating this point interviewees said:

  Another replacement of OMSC leaders has taken place. And during the meeting, we were hearing a conventional report of the AIDS Center. It was clear that the Chairman does not know the situation well. After all, if he gets this information in advance, and comes to this meeting being well-prepared, we could dedicate this meeting to solving of specific problems (NGO representative, Osh city)

  *People approach these meetings (OMSC) in a tokenistic way. For example, despite the changed epidemiological situation…. a presentation of representatives from the Oblast AIDS Center was done according to a standard format: he reported the epidemiological situation, but didn't answer specific questions regarding their activities (financing) (*a representative of a governmental organization, Osh).

- **Oblast coordination committees include people that are not committed to HIV/AIDS work.** Often, the OMSC is staffed by appointees who often have limited personal interest in or commitment to OMSC activities. Participation in the meetings is viewed by some members as a 'waste of time', and in this regard senior managers of organizations send their subordinates to take part at the meetings. However, delegated people usually do not have the authority of their organizations to participate in the actual decision-making. Moreover, in two oblasts (Chui and Issuk-Kul oblasts) covered by the survey, the OMSCs included non-core NGOs, or NGOs that do not work in this geographical location (organizations based in the capital). At the same time, none of the NGOs in these oblasts that were very active in HIV/AIDS field were included in the new OMSC. An interviewee said:

  Frankly speaking, directors do not attend OMCC meetings. For example, it is little fun for me; I have a lot of other very important work to do. I usually send my subordinate there, and then she gives me general outline. And believe me, everybody does the same (a head of oblast governmental organization).

- **Token and conventional approaches to management of coordination structures**. When creating oblast coordination structures, failures of the previous years have not been learned from taken into account in improving the ways these structures operate. Hence, organizational structures, functions, composition and operation methods have

not been revised, and each time are replicated virtually without any changes[22]. For example:

> *On the one hand, there are some active HIV/AIDS and TB interventions. People conduct field panel meetings (collegiums), OMCC meetings in oblast administration, different audits, etc. But there are no good results. Maybe this is because the mechanisms are not properly developed? There is no transparency at all…Until there is a good transparency, for example of on OMCC spending, we won't be able to set this business up and running* (a representative of a governmental organization, Osh city)

- **Lack of technical equipment and materials** has resulted in dysfunctional OMSCs**.** The MCCC Secretariat does not have computers, and therefore access to the internet; and they cannot pay their transportation costs.

6.3 Additional coordination structures

In the process of interviewing representatives of different organizations, some other mechanisms and structures have been noted which have a remit for coordinating HIV/AIDS activities. This section outlines some examples identified:

Coordination between donors and international organizations

Meetings of donors and international organizations (UNAIDS, DfID WB, USAID, GF PIU) are aimed at discussions about ongoing activities, results, planning next steps, and development of plans and concepts. Such meetings took place infrequently before 2007, but after the reform of the national-level body they became more frequent and more coordination-focused. A formal framework structures some of the meetings, though not all; and some of the meetings are non-recurrent. Interviewees indicated that examples of what could be achieved through coordination meetings were:

- A Grant Committee was established in the end of 2007 with the purpose of reviewing grant proposals from potential sub-recipients for receiving funds from GFATM, CAAP, CARHAP. Local representatives of International organizations, some NGO Associations and National AIDS Center took part in the process of reviewing proposals. Since the Grant Committee was established, financing organizations have been able to avoid duplication when they approve proposals and grantees in different organizations. This has made it possible to diversify types of services, expand geographical and quantitative coverage, and ensure continuity and cooperation between different organizations;
- International organizations and donors that conduct and finance training activities, now share programs, training modules, and lists of participants. This avoids overlap and enhances effectiveness of capacity building activities for people involved in HIV epidemic prevention;
- A new database has recently been developed, which encompasses information on all consultants of international organizations working in the Kyrgyz Republic. The availability of the common database constitutes an efficient resource by involving local specialists; it increases the effectiveness of interventions by involving well-recognized experts; and it also contributes to the country's capacity building;
- In recent years, international organizations have tended to combine their resources for development of key documents. For example, since 2006, a number of key country

[22] An example to this is the fact that the version of Provisions, dated February 5, 2002 still regulates the work of the City Multi-sectoral Committee on Prevention of HIV/AIDS, Sexually and Injection Transmitted Infections.

papers[23] and regulatory legal acts[24] have been developed under such joint financing and technical support. Different assessments and research papers[25], and standards for service delivery have also been developed and conducted[26];

- Besides that, international organizations make joint efforts in promoting some services, and certain aspects of service delivery, for example the introduction of substitution therapy in prisons. CARHAP and UNODC provided technical assistance to promote this program, and GFATM provided funding to implement it.

NGO Steering Group

In 2008 a Steering Group (SG) of AIDS services NGOs was established at the national level that includes NGOs from all oblasts. The idea of creating such a steering group was articulated at a Forum of AIDS-services NGOs in January 2008. The forum also approved the steering group's foundations, principally its regulatory framework and membership. The main purpose of the SG is to ensure overall coordination of activities of NGO AIDS services and representation of the interests of this sector of civil society.

The SG functions include coordination aimed at capacity building and provision of technical assistance to NGOs, and also coordination with other entities (with public and international organizations, the MCCC, etc.). The SG includes 17 members, including 8 people that represent each oblast of the Kyrgyz Republic and Osh city. The NGO Relations Officer of the MCCC Secretariat/ 'Capacity' Project was appointed as Executive Secretary of the SG. Moreover, SG members represent different minority groups: work with sex workers, IDUs, youth groups, PLWHA, and others. The SG has conducted two planned meetings, including one where they discussed the possibility of submitting a country proposal from civil society to the Global Fund for a grant.

Establishment of the SG has not received wide publicity yet, and SG activity relates mainly to organizational issues such as development of the work plan, and reports on activities carried out by SG members. Nevertheless, there are a number of positive developments of the SG:

- Involvement of representatives from every oblast into the Steering Group is agreed as very important. The lack of representation, which used to exist before, had generated strong criticism. Now, as one respondent commented, '… [it is] a platform is established, where NGOs from different regions may speak, and their voice will be heard';
- Surveyed participants stressed that the SG has strong capacity, and it has a real opportunity to impact on priority areas of HIV/AIDS policy, Decisions made by the SG will be articulated at MCCC meetings, and representatives of the NGO sector will be lobbying by SG members.
- Creation of the SG is recognized as a significant achievement, and is evidence of a new stage of NGO development – moving from competition and fragmentation to consolidation and cooperation. The SG has consolidated and regulated these changes;
- Readiness to support the work of the SG was expressed by several organizations including UNDP and UNAIDS. Currently, development of the SG website, supported by the Capacity Project, is underway. In September 2009 there will be a public

[23] Country proposals for the 7th and 8th Rounds of the Global Fund, Report on UNGASS Indicators for 2007
[24] 3rd Government Program on *Prevention of HIV/AIDS and its Social and Economic Consequences for 2006 – 2010*; Government Program '*Preparing Prisoners for Release and Their Social Adaptation for 2008 – 2010'*.
[25] Assessment of the Kyrgyz Republic legislation and departmental bylaws related to ensuring accessibility of HIV prevention and treatment for injection drug users and prisoners.
[26] Quality standards for harm reduction services, clinical protocols on substitution therapy, clinical protocols on VCT, etc.

presentation by the SG which will also receive support from these international organizations.

Inter-sectoral Steering Group on Health Protection and Social Care in the Penal Enforcement System

The Inter-sectoral Steering Group on Health Protection and Social Care in the Penal Enforcement System (PES) was established in April 2007 through the initiative of the Ministry of Justice. In addition to the Ministry of Justice, it includes the Ministry of Health and the Ministry of Labor and Social Protection. A Chairperson of this group is a Vice Minister of Justice, and co-chairpersons are representatives of the MOH and the Ministry of Labor and Social Protection.

This group was established in order to coordinate donors' investments in health protection (including HIV and TB) and social care in the penal enforcement system. At the last meeting of the group a report of a working group that reviewed professional standards for PES personnel with regard to HIV/AIDS preventive programs was presented, as well as a survey report relating to assessment of prisoners' access to HIV/AIDS related services.

It appears that the operation of the group is deemed very important by the Ministry of Justice since it enables them to be more effective in the implementation of grants and government HIV/AIDS programs.

Working Group

It was mentioned in the first stage of the study that the OMSC was tokenistic, and that organizations implementing oblast HIV/AIDS prevention programs require better coordination of their activities. Consequently, some oblasts set up alternative mechanisms that focused on better coordination of HIV/AIDS activities. The Working Group on Prevention of HIV/AIDS epidemic in Osh city is a good example. During field-work in April 2008, development of the Working Group was discussed by partner organizations. The draft Regulations of the Working Group state that it shall be established 'by the initiative of NGO 'Podruga' with the financial support of JSI (John Snow Inc.)'. The purpose of establishing the Working Group is to coordinate planning, and the introduction of monitoring of HIV/AIDS programs in Osh. According to this draft – the working group should include representatives of AIDS-service NGOs, key oblast and city-level mass media, as well as representatives of public health and educational organizations and law enforcement bodies of the city.

6.4 Conclusion

- In August 2007, the CMCC on HIV/AIDS, Tuberculosis and Malaria was merged with the Republican Special Anti-epidemiological Commission on Socially Significant and Especially Dangerous Diseases by the Government of the Kyrgyz Republic (MCCC). Activities of the existing MCCC are focused on more than 40 different animal and human diseases.
- Most interviewees regarded the changes to the national coordination body as negative developments, and its performance was assessed as being not sufficiently effective. After reforming the body, the country faced significant coordination problems.
- A serious obstacle for effective coordination is the organizational structure of the new MCCC, specifically: the position and capacity of the Secretariat; loss of an inter-sectoral nature in approaches to addressing HIV/AIDS related problems; and unpreparedness of certain significant actors for open cooperation

- The work of the oblast coordination structures (OMSCs) depends on the leadership and support of the MCCC Secretariat. In 2008, OMSC had virtually terminated their operations Partly due to lack on ongoing support from the national level following reforms to the national body
- Bedsides Country and Oblast Coordination Committees, Kyrgyzstan has some other structures involved in coordinating HIV/AIDS activities: periodic coordination meetings of donors and international organizations; the national-level NGO Steering Group; the Inter-sectoral Steering Group on Health Protection and Social Care in the Penal Enforcement System; the Osh city NGO Working Group.

6.5 Recommendations

Based on these findings it is possible to make the following recommendations as regards further development of country coordination mechanisms for HIV/AIDS:

Recommendation #1. The work of the MCCC could be enhanced by:
(1) the Secretariat should have 'super-departmental' status and be at the Office of Government; (2) the MCCC should have a narrower focus to ensure buy-in from members;

Recommendation #2. In order to intensify activity in oblast coordination structures it is necessary to:
(1) provide OMSC Secretariats with appropriate material and technical resources;
(2) ensure regular technical assistance to OMSC on coordination of HIV/AIDS activity; and
(3) ensure regular specified communication between OMSC Secretariats and the MCCC Secretariat.

Chapter 7. Cooperation between organizations providing HIV/AIDS services

The Kyrgyz Republic has adopted a multi-sectoral approach since it began its national HIV/AIDS policy implementation in 1997, and has been a fundamental principle of the *Third Government Program of HIV/AIDS Prevention and Its Social and Economic Consequences in the Kyrgyz Republic for 2006-2010*.

Early implementation of HIV/AIDS national programs was limited to principles expressed in national documents, and was initiated primarily by donor organizations. Since 2006, cooperation between different organizations has been initiated by organizations implementing HIV/AIDS projects; the range of referrals to other organizations has increased; and organizations cooperate more on strategic issues. Data from the survey conducted for this report supports the claim that cooperation between service providers is increasing.

Interviewees with frontline service providers provides an understanding of the interaction between AIDS service NGOs, with a specific focus on (1) cooperation in HIV/AIDS related services delivery; (2) cooperation in capacity building of organizations (3) cooperation in development of a favorable environment and advocacy of HIV/AIDS related activities; and (4) developing one monitoring and evaluation (M&E) system.

7.1 Cooperation at HIV/AIDS service delivery level

According to respondents' accounts about HIV/AIDS services delivery, use of a comprehensive client-focused approach is crucial for effective service provision. In addition to their ill-health, clients that go to organizations providing HIV/AIDS services, often have to deal with a whole range of different social and legal problems, which cannot be resolved just one organization[27]. Referral of a client to another organization is one of the common forms of cooperation between different organizations, and respondents of all surveyed organizations reported that they referred their clients to additional service providers (Figure 7.1).

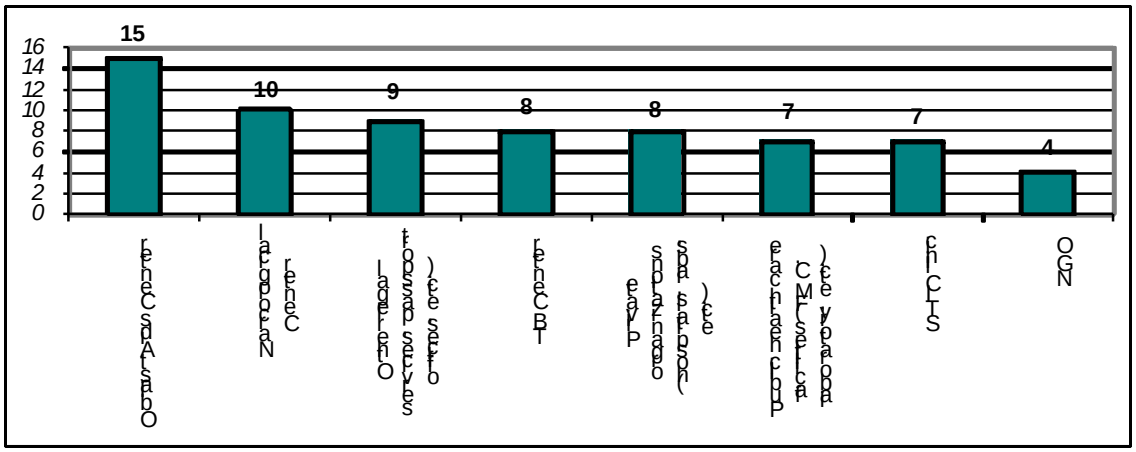
Interviewees reported that with all organizations that provide HIV/AIDS-related services it is necessary for them to cooperate with their city or oblast AIDS center to some degree. Moreover, client referral is common; clients are referred most often to get medical services in narcotics treatment centers (10 out of 15 organizations), tuberculosis centers (8 organizations), clinics for dermato-venerology diseases (7 organizations) and other public health care facilities (7 organizations) such as laboratories, Family Medicine Centers (FMC), maternal hospitals and hospitals.

Since 2007, a number of changes have taken place. Firstly, due to lack of financing for delivery of client friendly STI services, cooperation between NGOs providing services for sex workers and private clinics has been strengthened. NGO personnel explain this as relating to clients' behavior change, believing as one interviewee said that '…*sex workers became more responsible and more willing to pay for their own health*'. Secondly, the survey suggests that the number of client referrals to other organizations providing non-health

[27] For example, SWs who are clients of the NGO "Tais Plus" receive different services including information, counseling, condom distribution either through outreach workers or services of the drop-in center. However the clients often need additional services such as medical care or legal support.

services significantly increased between 2007 and 2008. These referrals are more often related to legal assistance and rehabilitation of documents, with fewer related to employment and allowances.

Figure 7.1 'To which organizations do you refer your clients?' (number of organizations, n[28]=15)



Cooperation between different organizations in the Kyrgyz Republic has three forms:

Formal partnership agreements are partnerships between different organizations that are mainly initiated by donors. Cooperation between GUIN (Department of Penal Enforcement) and NGOs is a good example of this form of cooperation that, according to interviewees, has been effective (see below). Development of an appropriate legal framework, the commitment of leaders, and support of donor organizations, has led to a range of projects aimed at HIV prevention and support and treatment of PLWHA being implemented in the Kyrgyz republic's penal enforcement system. Substitution therapy, ART, and needle exchange programs for IDUs have been carried out in prisons (these projects are financed by the GFATM) and '*Atlantis'* rehabilitation centers are operating there (financed first by Soros-Kyrgyzstan Foundation, then by BOMCA/CADAP). NGOs have also provided assistance both to prisoners and to GUIN staff. For example, a remand prison has a social bureau that is focused on counseling prisoners and preparing them for release (the project is financed by CARHAP). The NGOs *Koz-Karash* and *Ravnovesiye*, which work with PLWHA, attend prisons several times a year in order to carry out some information and education activities and do counseling to encourage adherence to ART and to provide material assistance to prisoners (the projects are financed by CAAP).

Another example of what was seen by interviewees as successful cooperation is a 'consortium' of the Bishkek City Administration, Bishkek Territorial Department of MHIF, FGP and an NGO that manages a needle exchange network in Bishkek FGPs. This project is financed by the Global Fund.

However, more often than not, agreements within such partnerships do not result in increased commitment in practice from implementing organizations, and does not work well. Indeed, those organizations implementing HIV/AIDS related activities now face greater challenges in building cooperation on a formal basis such as limited capacity and skills to build relationships for official cooperation. An interviewee suggested:

[28] Only those people who are responsible for referrals of clients to other organizations are included. Lawyers, psychologists, and information officers are excluded.

We have an agreement with policlinic concerning referrals of our clients. But if we do not accompany them, doctors in policlinic may not be willing to see our clients. We have to take the Memorandum each time with us, show it and ask 'Why don't you receive their visits, if we have this agreement? (NGO, Bishkek)

Private partnership agreements are partnerships between organizations, mainly between NGOs, which are part of partnership networks and associations. How the partners cooperate is chosen by the organizations themselves.

Informal cooperation between government organizations and NGOs is cooperation between organizations that is built on personal relationships and contacts. In these cases there are no formal frameworks at all; participation is fully voluntary, and partners interact when deemed necessary. Such cooperation was regarded by interviewees as common and effective. Informal cooperation in service delivery for vulnerable groups is built not only with AIDS service organizations, but with private individuals as well. For example organizations involved in needle exchange activities are starting to cooperate closely with drug dealers or 'aunties' (pimps) and they arrange educational activities on HIV/AIDS issues for them. This allows them to do outreach work (needle exchange, counseling and providing information materials) directly in drug dens and saunas.

Among CAAP funded projects, which are executed by NGOs, there is budget provision for clients' travel costs to a facility providing HIV/AIDS services, which eliminates one of the most significant barriers relating to use of multiple services – travel costs[29]. This support has increased the chances for referrals of clients to different organizations, as well as the delivery of a comprehensive set of health, social and legal services working cooperatively.

Respondents outlined in their interviews a number of barriers to effective cooperation of HIV/AIDS-related services delivery:

(1) *Lack of continuity (providing services without interruption) between public organizations, including health organizations*. This problem was addressed quite often in different contexts. In particular, despite the fact that HIV/AIDS and TB-related activities are financed by the Global Fund (Kyrgyzstan received TB Round Two and Six grants) there is no comprehensive approach to the problem of HIV and TB co-infection. For example, it was reported by an interviewee that due to the absence of test systems in a TB hospital in the south of the country, patients had not been tested for HIV for more than six months. Also, TB service personnel do not have a clear understanding of how many patients have HIV and TB, they are not trained in administering ART in these cases and do not know what happens to HIV-positive patients after they are discharged from TB hospitals. Staff at TB centers in Osh and Bishkek are not very aware of organizations providing services for IDU and PLWHA, and do not refer their clients to appropriate organizations.

Another problem is limited continuity between AIDS services and FMCs. Although information on HIV positive patients is communicated to FMC staff, they do not have appropriate skills and resources to work with this category of patients. Illustrating this point an interviewee said:

The AIDS Center informs us about detected HIV positive people in our catchment area. One of them is in remand prison now, and two other people are active drug users. When a doctor goes to visit them, they are hiding and don't want to talk to him/her. They don't want to disclose their HIV status. We cannot make them to have

[29] Results from the first stage of this survey showed that 33% of respondents viewed expenses for services as a barrier to access. For more details see Interim Report (2007) p 72.

tests done and control their health somehow. We cannot reach them; we do not have anything to entice them.

(2) *Lack of GFATM funding in the first semester of 2008*. During this period, a significant number of NGOs did not receive GFATM financing due to the change of terms for project extensions. Therefore, the possibility of referring clients to partner organizations had significantly decreased. This may explain why clients in Bishkek had virtually no access to STI services at that time.

(3) *Strengthening competition between organizations and the fight for resources*. In order to get financing, some organizations have started undertaking functions that used to be carried out by other organizations. This has led to significant difficulties in referring clients to other organization and services delivery, and has resulted in a situation where a number of clients have refused to use services at all, including ART.

(4) *GFATM projects have no budget for staff to accompany clients to service facilities*. Usually, staff accompany clients when they are referred to other organizations. However, the Kyrgyz GFATM HIV/AIDS grant does not include a budget for this in its projects. Often social workers have to take a client to another organization at their own expense, and stay with a client the whole time while he/she is receiving the service. However, formally this is not a part of social workers' functions, and therefore they do not receive payment for it.

Interviewees explained:

> *We don't use forms of referrals, since we always accompany out clients. You know, don't you, if you tell an active drug user 'Go there and have your tests done', or 'Go to this doctor', he will never do this. That's why we lead him by the hand and fetch him there. We have to pay our own money for transportation, and we don't get this money back.* (NGO representative, Osh city)

> *It is very bad that Global Fund does not pay for transportation expenses. We don't have any friendly clinic for sex workers in our town. In order to have the girls screened, I have to take a taxi, put 3 or 4 girls there and take them to Osh at my own expense. And what else can I do?* (NGO, Kara-Suu, Osh oblast).

(5) *Scarce number of organizations or unpreparedness of state organizations to work in the HIV/IADS field.* In Jalalabad and Issyk-Kul oblasts, for example, there are few organizations providing services for clients, and staff in state organizations are poorly trained. This creates serious challenges in providing a comprehensive set of services for clients.

An interviewee said:

> *We have very high HIV detection rate in IDU. But we cannot refer them anywhere, since there is no organization in Jalalabat, which would work with PLWHA. And people have such a mentality, which require working with a client a lot and explaining everything before referring him/her to the AIDS center to FMC for a visit; and we do not know all twists and turns of work with PLWHA. We cannot provide them any HIV related services. It turns out that they (PLWHA) are 'abandoned'* (NGO, Jalalabat city)

7.2 Cooperation in capacity building of NGO HIV/AIDS services

Expansion of HIV/AIDS related activities in the Kyrgyz Republic places new demands on organizations involved in this process. It is currently required not just to reach a certain degree of coverage and implement an appropriate list of activities, but they also have to perform ongoing organizational development, professional development of their personnel, and improve the quality of their services. Research data suggest that there has been some enhancement of cooperation between different organizations in their capacity building activities. There are several dimensions to cooperation in this area, and each is outlined below.

Integration of organizations into associations

The Kyrgyz Republic currently has four AIDS services Associations. Joining an association provides access to information resources, and gives an opportunity to take part in joint projects, involve local and international consultants, conduct joint research, participate in development of regulatory legal documents, and represent one's own interests at different events. Associations also provide active support to their members in terms of their organizational development, fundraising and project implementation.

Box 7.1 "Anti-SPID" Association

One of the best examples of an NGO association is the "Anti-SPID" Association. Under the project 'Ensuring Constructive Involvement of the Civil Society into the National Response to HIV/AIDS Epidemic in the Kyrgyz Republic' (funded by GFATM), the Association has carried out four training events for personnel of member organizations on topics related to organizational development. The Association has a permanent website www.volvox.in.pro.kg which publicizes information relating to its work. Association members have an opportunity to participate in discussion of CMCC Regulations (2005). The publication 'Experience of Nongovernmental Organizations, Involved into HIV/AIDS-related Activities in the Kyrgyz Republic' was developed jointly by members.

The Association implements sub-grant programs. For example, since 1st December 2007, the International HIV/AIDS Alliance in partnership with Anti-SPID Association has implemented a project 'Strengthening of Partnership and Involvement of People Living with HIV and Affected by the Epidemic in the Central Asia as a Key to Universal Access', supported by the CAAP initiative. Three NGOs received sub-grants to implement this project at the local level. Earlier, four NGOs from different regions of the country received sub-grants under the project 'Ensuring Constructive Involvement of the Civil Society into the National Response to HIV/AIDS Epidemic in the Kyrgyz Republic', funded by the GFATM.

Joint training for human resources

Despite the fact that international organizations finance several different training activities and seminars, these organizations still have quite a high demand for training, particularly training of mid-level personnel (social workers and volunteers) – a group that has a particularly high attrition rate. Since 2007, NGOs have organized joint training for their staff without looking for additional funding sources from donor organizations. Staff Trainers have themselves been trained at larger training events, and organizations also now have an opportunity to send their personnel for training at stronger NGOs. For example, the legal service *Adilet* provides two weeks of on-site training for lawyers from other NGOs (funded by CARHAP). Some international organizations provide opportunities to attract local consultants to solve some specific problems of certain organizations.

Combining resources to carry out joint campaigns

Since the beginning of the GFATM grant implementation, the number of large-scale health promotion/information campaigns for population or target groups has increased. Usually, both public and nongovernmental organizations are involved in implementation of these campaigns, and cooperation is very efficient. As it was noted by one respondent:

> *Each of us [organizations] has certain resources and certain opportunities. Public organizations can provide premises, universities and schools can mobilize people, and we [NGOs] deal with the actual program*.

Regional training of trainers (TOT) courses

Development of regional training courses on the basis of existing institutes in four Central Asian Countries is planned in the framework of the CAAP initiative. Respondents reported that preparation for these courses has provided a good platform for cooperation between AIDS service NGOs for the entire region: they cooperated in development of training modules and curricula.

Nevertheless several factors affected cooperation between organizations in the field of capacity building. Firstly, many training activities were conducted in the first years of the GFATM grant implementation, which allowed for the establishment of a pool of local consultants. Secondly, GFATM and CAAP supported and financed initiatives for inter-sectoral cooperation (for example the NGO "Anti-SPID" ran a project on capacity strengthening for NGOs that was funded by the GFATM. Also, expansion of financing has resulted in more frequent implementation of mass health promotion/information campaigns, which helps cooperation.

7.3 Cooperation in development of a favourable environment for advocacy of HIV/AIDS activities

Creating a favorable environment[30] for advocacy of HIV/AIDS activities in the Kyrgyz Republic has always been a high priority for the Kyrgyz government and donors, but at the beginning such activities were initiated and implemented by donor organizations. However, interviewees reported that this situation did not contribute to improvement of cooperation between different organizations, or understanding the roles of each sector in HIV/AIDS related activities.

Many different activities are currently being implemented in the country in order to create a favorable environment for the involvement of different sectors. NGOs implementing the Global Fund and/or CAAP projects, organize these activities. For example in 2008, under the project *TUMAR* (CAAP), NGOs conducted seminars aimed at development of tolerance to vulnerable groups, and communication of principles of HIV/AIDS prevention programs for personnel of law enforcement bodies, representatives of local councils and religious leaders. NGOs also organized public hearings in 2007-2008, inviting representatives of different sectors (health professionals, personnel of law enforcement bodies, local administrations) to participate. It was also reported that after completion of GFATM grant projects implementation, NGOs organized round table meetings to inform partner organizations of their activities.

[30] Activities for creating the favorable environment are included: 1) forming of understanding of key principles of harm reduction programs and adherence among health workers and law-enforcement staff; 2) providing access to key populations through establishing relationships and promoting understanding of key principles of harm reduction programs and adherence among relatives and other representatives of communities.

According to the survey, NGO action significantly contributes to improvement of cooperation. Representatives of public services now have a better understanding of activities carried out by NGOs and are more open to cooperation with this sector. An interviewee said:

> *Before launching the project, we had meetings with law enforcement bodies, and with imams. And now, their level of understanding is much better… For example, imams help us, they speak openly in mosques about prostitutions, condoms and on what we have been doing (needle exchange)* (NGO, Kara-Suu, Osh oblast).

Nevertheless, there are still a range of challenges to overcome. One is the lack of an appropriate legal framework. Survey participants noted that a memorandum of cooperation between public organizations does not have any legitimacy if it does not include decrees or resolutions for implementing the above-mentioned activities. Reaching agreements with law enforcement bodies represent the greatest challenges. As an interviewee explained:

> *One can make a lot of effort to train personnel of law enforcement bodies and inform them about NGO activities, and purposes of our work. But every service operates on the basis of decrees of their own ministry. If a ministry enacts a certain decree, everything will work well. If, some other decree is enacted… then no memorandum will be helpful.* (NGO representative, Osh city).

Another problem is that NGOs are sometimes perceived as 'grant money eaters' and are not always acknowledged as equal partners. This situation is more relevant to those regions where HIV/AIDS activities have only been implemented for a short time. For example:

> *In order to improve cooperation, NGO status has to be raised up to the level of an equal partner. Unfortunately, some leaders of the government organizations still believe that NGOs are just wasting money.* (NGO representative, Osh).

7.4 Developing one monitoring and evaluation system

A common system of monitoring and evaluation (M&E) is required to be able to monitor the large number of organizations providing HIV-related services as well as the high number of financing organizations. There is provision for such a system in the implementation framework of the Third Government Program on HIV/AIDS. Interviewees suggested, however, that AIDS service NGOs are not cooperating in this regard. Survey respondents noted that NGO service providers use different performance indicators and different approaches to data collection. Despite the fact that virtually all NGOs have been using a system of universal identification codes for registration of their clients, there is no database shared between different organizations since each donor imposes their own M&E system which sub-recipients have to adopt. Moreover, these data have not been requested by most of financing organizations.

Box 7.2 Difficulties working towards a single M&E system

So, while discussing different approaches that are used in internal M&E system, it became clear that different organizations of the same profile use different coverage calculation methodology. Some organizations use the term 'coverage' for a total number of clients (a number of unique identification codes), which had received any services at least once in the process of the project. Other organizations imply their permanent clients, when they talk about coverage. The third category of organizations means an estimated number of representatives from vulnerable groups.

CAAP has undertaken certain steps in order to improve cooperation by developing an on-line database 'CARISA', and also by adapting its MIS (Management Information System)[31] database - financed by CARHAP. However, according to interviewees these reforms have not improved the situation, because these are one-off attempts to solve what is a complex problem.

Interviewees suggested that barriers to introduction of common monitoring and evaluation system include the following factors:

(1) Different financing organizations use different approaches to M&E system. In this regard, AIDS service NGOs often use several databases and reporting forms, and they have to maintain several reporting systems.

(2) Delay by more than a year for approval of the *Provisions on the Government System of Monitoring and Evaluation*, and delays in the implementation of the *Government Program of HIV/AIDS Prevention and Its Social and Economic Consequences in the Kyrgyz Republic,* and the *National Plan of Monitoring and Evaluation of* the *Government Program of HIV/AIDS Prevention and Its Social and Economic Consequences in the Kyrgyz Republic for 2006-2010*. The purpose of the National M&E system is to ensure systematic collection, storage, analysis and dissemination of accurate information regarding implementation of HIV/AIDS Program. This delay was caused by the political situation in the country, replacement of decision-makers, and reforms of CMCC that reduced its capacity to lobby enactments of the provisions.

(3) Poor capacity of AIDS-services organizations in relation to data collection and analysis. The majority of organizations acknowledge that they collect only those data which have been requested by donors. Data have been collected by outreach workers that represent vulnerable groups or who are co-addicted and do not have appropriate skills to operate databases. Data quality has not been double-checked. Only some organizations collect data related to the quality of services delivery and needs of clients. The reason for this is lack of skills in using data collection methods.

7.5 Conclusion

- Improvement of coordination and cooperation between AIDS-services NGOs in the Kyrgyz Republic is ongoing. The number of organizations embracing different forms of cooperation is increasing, as is the number of interactions between organizations.
- The most common form of cooperation is through client referrals between organizations – an activity that is adopted to some extent by almost every organization providing HIV-related services. Clients are often referred to health care facilities to get specialized services.
- The nature of referrals of clients to other organizations suggests that clients are adopting more responsible behaviors than previously.
- The private sector has been more actively involved in HIV/AIDS service delivery to vulnerable groups, and clients express their readiness to pay for the services.
- Cooperation with non-health organizations has been strengthened (mainly because of reform of legal processes and also an increase in employment), and this has promoted clients' integration into society.

[31] Database provides for collection of the following information: unique identification code of a client, his/her demographic details, delivered services, referrals to other organizations and results of referrals, information on behavior changes (use of disposal syringe, and condoms)

- Recent breaks in financing have enhanced competition and reduced the number of providers, and have generated great difficulties in referring clients between organizations.
- Organizations are very actively cooperating in their capacity building exercises. This is expressed through joining associations, in implementation of joint training activities for personnel, and combining resources in conducting large-scale education campaigns.
- More and more activities organized by NGOs involving representatives of public organizations and civil society have been taking place recently to create a favorable environment for collaboration. This is a significant change, and it greatly improves understanding of HIV/AIDS related activities conducted at the local level and contributes to more constructive cooperation.
- Certain prerequisites for the introduction of a common M&E system are already developed in the Kyrgyz Republic: all organizations use a common client identification code and a National M&E Plan has been developed. However, until very recently no comprehensive measures to launch a common M&E system were made and parallel data recording systems remain in use based on donors' requirements.
- In general, organizations are cooperating more formally in the implementation of joint projects relating to counseling and training. However, cooperation based on personal relationships and agreements is still common.

7.6 Recommendation

Recommendation #1. Continue to further strengthen cooperation between governmental, nongovernmental, and private-sector organizations with the aim of ensuring efficiency and continuity in HIV/AIDS service delivery.

Chapter 8. Human resources delivering HIV/AIDS services

Data from the first phase of the research showed that the GFATM had a positive impact on capacity building for human resources (HR) involved HIV/AIDS activities[32]. Appropriation of grant funds contributed significantly to increasing the total number of personnel working in the field of HIV/AIDS, particularly in the nongovernmental (NGO) sector. New categories of staff such as "social workers" and "outreach workers" emerged and started to deliver services. Both the GFATM and CAAP grants have also been used to provide training for HIV/AIDS workers. The data suggest that training provided with GFATM funds improved knowledge and professional skills of staff in various AIDS-service organizations.

This Chapter presents an analysis of data collected since 2007, identifying new trends and factors that are facilitating/hindering further development of HR for effective delivery of HIV/AIDS services.

8.1 The human resources context in the Kyrgyz health system

Human resources (HR) for health in the Kyrgyz Republic have exhibited the following characteristics since 2003-2004:

- **Decrease in the total supply of health personnel that reinforces a geographic imbalance.** In 2003-2004, staff supply was characterized by a decrease in the total number of doctors and nurses in the country. This process was associated with external economic factors: some doctors left the health care sector in search of higher earnings, whilst others practised private medicine and continued a second job in public health organizations. At the same time, growing internal migration was also observed as health specialists started to migrate to Bishkek capital and adjacent Chui oblast, and occasionally other oblast centers. This reinforced an imbalance in regional distribution of HR[33]

  Prior to 2003, the supply of doctors and nurses in the KR as well as other CIS countries was high, and so the subsequent decrease in total numbers of personnel did not cause serious concern. Additionally, within the framework of the current health system reforms (where one of the goals was improved efficiency of health organizations' performance) some small planned reductions/redistributions of working (predominately, middle-level and junior) health personnel were undertaken[34]. Based on 2006 data, in all oblasts except Bishkek and Osh, the supply of doctors was below the average (19.9 per 10,000 population) – 12.7 to 16.9 per 10,000 population, and in some rural areas as low as 6.8 – 9.1 per 10,000 population.[35]

- **Substantial growth of external migration of health professionals.** Since 2004, annual HR outflow from the healthcare system has exceeded inflow. The situation escalated dramatically because of the rapid growth of external labor migration of health

[32] See Interim Report, April 2008. http://chsd.studionew.com/index.php?option=com_content&task=view&id=73&Itemid=96&lang=english
[33] Joint annual review of the Manas Taalimi Health Sector Reform Program, Human Resources Component, September 20-29, 2006.
[34] Policy Research Paper #30. Evaluating Manas Health Sector Reforms (1996-2005): Focus on Restructuring. http://chsd.studionew.com/index.php?option=com_content&task=view&id=73&Itemid=96&lang=english
[35] Data of the Republican Health Information Center, MoH of the KR.

professionals (doctors: 2004 – 3%, 2005 – 8%; nurses: 2004 – 2,9%, 2005 – 5,6%)[36]. In 2007, 1,086 doctors left the healthcare system, including 225 doctors who left the republic[37]. In part, this process started to happen because of changes in the HR policy of neighboring countries such as Russia and Kazakhstan. These countries have increased their salaries, especially for doctors and nurses; and they have a more beneficial social package and working conditions. Furthermore, migration of doctors is highest in southern regions of Kyrgyzstan (Osh, Jalalabat and Batken oblasts), and in the north of the country (Issyk-Kul oblast). A survey of 243 doctors[38] countrywide demonstrated dissatisfaction in respect to such factors of labor activity as salary size (82,7% of respondents) and incentive systems (63,8%). Of particular concern was the high level of readiness by health workers to migrate outside the republic. For example, 62,1% of young doctors and 44,6% of middle-age doctors planned to leave the country in the 12 months period following the survey.

- **Lack of doctors at PHC level.** Kyrgyzstan has been implementing systematic health care reform that focuses on family medicine development, and integration of separate services that used to be delivered by vertical, specialized services at PHC level (including HIV/AIDS services). These reforms have increased the demand for HR. In 2009, there is a HR shortage in PHC, particularly in the regions, and the continuing migration of health personnel is increasing the workload of PHC doctors. For example, the percentage of PHC doctors caring for 2,000+ people increased from 58% in 2004 to 81% in 2007[39] (in some cases the workload per doctor is as high as 5-7,000 people). Inevitably, this has a negative impact on accessibility and quality of healthcare.

- **Inadequate salary scales for health personnel.** Salaries in the health sector are some of the lowest compared to other economy sectors in the country. Although health reforms have increased salaries several times, the overall level remains very low. For example, the average monthly salary of a doctor is 3,040 som (US$77) – below the minimum consumption level of 3,364.66 som (US$85) per capita per month[40]. To meet the needs of their families, health professionals usually have to take on a second job, often in a non-medical profession. In rural areas, the majority of doctors try to maintain a plot of land that in itself demands considerable costs.

  One of the additional income sources for health personnel are informal payments made by patients. In Kyrgyzstan, as well as in many other countries with transition economies, the level of informal payments in the health sector is quite high. Research has shown that health-financing reforms have in recent years reduced informal payments, particularly for drugs and medical supplies[41]. However, the volume of payments to health personnel increased by 18%, particularly in oblast centers and Bishkek city. This fact highlights the need to make further political reform at the national level.

[36] Express analysis of medical personnel migration for the period 2004-2006. Prepared by HR Department of the MoH, September, 2006.
[37] Data of the MOH, KR
[38] Kojokeev K., Murzalieva G., Manjieva E. Policy Research Paper #51 «Exploring reasons for doctors outflow from the Kyrgyz health care system», 2008, http://chsd.med.kg
[39] Report on Mid-Term Review of the Kyrgyz National "Manas Taalimi" Health Care Reform Program, May 7, 2008.
[40] Data from National Statistics Committee for the 1st quarter of 2008.
[41] Jakab and Kutzin. Policy Research Paper «Trends in informal payments for 2001 – 2006 years», 2008, http://chsd.med.kg

8.2 Scale up of HR personnel in HIV/AIDS service organizations

Data on HR personnel during the period 2004-08 shows significant growth in total numbers of personnel owing to both staff increases in each organization and the opening of new AIDS service NGOs (Table 8.1). Meanwhile, in public organizations the biggest increase occurred between 2005 and 2006, whilst among NGOs the biggest increase was between 2006 and 2007. The main cause of the increase in numbers is the increasing number of NGOs. For example, in 2007 eight NGOs were supported by GFATM, and the number of personnel increased to 54,2% compared to the previous year (the total number of personnel in eight NGOs in 2006 was 83 persons, and in 2007 it was 128 persons). Some respondents indicated that without support from the GFATM such a significant increase of number of staff in NGOs providing HIV/AIDS-related services would not be possible. For example:

> *Even though we have capacity and possibilities it is unlikely that our doctors would deal with education, conduction of informational campaigns, trainings in HIV/AIDS, if there is no support ensured by Global Fund… (interview fragment, NGO)*

Table 8.1 Number of personnel in selected organizations by years

	2005	**2006**		**2007**		
	Pers.	Pers.	%**	Pers.	%**	%***
Total (n-14*)	**384**	**439**	**14,3**	**521**	**18,7**	**35,7**
NGO (n-8)	68	83	22,1	128	54,2	88,2
Gov.org-s (n-6)	316	356	12,7	393	10,4	24,4

Note: * - number of organizations that provided data for 2005-2007
** - % increase compared to previous year
*** - % increase compared to 2005

Source: facility survey in 14 facilities

The increase in numbers of personnel is not replicated in other sectors. For example, according to interviewees there is a critical shortage of doctors in Blood Transfusion Center, where key work is done by specialists with secondary medical education. Laboratory services in AIDS centers are facing a similar shortage of staff.

There is also a regional imbalance in numbers of personnel delivering HIV/AIDS services (Table 8.2)[42]. There is a significant shortage of staff in Osh and Jalalabat oblasts in relation to the worsening situation with comparatively high HIV infection rates (see Figure 2.1).

Table 8.2 Number of personnel in selected organizations by regions

	2006	**2007**
Bishkek/Chui		
NGOs (n-3)	109	147
Gov.organizations (n-4)	281	309
Total	**390**	**456**
Osh/Jalalabat		
NGOs (n-3)	47	55
Gov.organizations (n-2)	102	115
Total	**149**	**170**
Issyk-Kul		
NGOs (n-3)	25	61
Gov.organizations (n-1)	17	20
Total	**42**	**81**

Source: facility survey in 16 facilities

[42] Also see section 8.5 below

Comparison with data from 2007 shows some interesting patterns in personnel working for public sector organizations and NGOs (Table 8.3).

Table 8.3 Personnel structure in public organizations and NGOs 2007

Personnel category	NGOs (n-11)		Public orgs (n-8)		Total	
		%		%		%
Managers	26	8,1	19	4,0	45	5,6
Doctors/nurses	40	12,5	292	61,0	332	41,6
Social/ Outreach workers	87	27,2	63	13,2	150	18,8
Volunteers	123	38,4	2	0,4	125	15,6
Administrative personnel	20	6,3	55	11,5	75	9,4
Other	24	7,5	48	10,0	72	9,0
Total	**320**	**100**	**479**	**100**	**799**	**100**

Source: Facility survey conducted in 19 facilities in 2008

For example, the number of social/outreach workers in public sector organizations grew from 0,9% to 13,2% (based on data by early 2007 – 3 people out of 349[43], based on data for late 2007 – 63 people out of 479). The category 'Other' for NGOs increased from 2% to 7,5% (early 2007 – 19 people out of 956, end of 2007 – 24 people out of 320). This increase can be explained in part by the increased involvement of lawyers and psychologists into HIV/AIDS-related work. In 2007, use of legal advice in all regions increased, and most NGOs attempted to provide this service. The above changes reflect growing demands in this type of services among clients.

A review of these categories of personnel in 2008, found that there were no clear criteria to distinguish 'social' and 'outreach' workers because they: (a) generally deliver similar functions (provide information, protection, escort and visit clients, etc.); and (b) engage in activities more commonly associated with a different category of personnel. For example, there are examples of staff members functioning as a social/outreach worker but listed (on the payroll) as a psychologist in the organization.

According to interviewees with frontline service providers the majority of personnel have not received appropriate professional training, i.e. training as a social worker or a psychologist. Indeed, staff came from diverse backgrounds (business owners, vendors, biologists, economists, locksmiths, long-term unemployed and representatives of vulnerable groups among others), and had become service providers for a wide range of different reasons. For example one interviewee said: '…*it turned out by chance: I have background in economics, my brother-medical man left abroad and I was offered to replace him*…'. Even though they cope with their general duties, without regular intensive training they are not able to improve the quality services, build HR capacity in HIV/AIDS issues and, consequently, to further build the sustainable development of organizations.

[43] See also Table 7.1 in the Interim Report «Global Initiatives on HIV/AIDS and their impact on health care system of the KR», April 2008, http://chsd.med.kg

8.3 Activities and workloads

Survey data showed that the majority of providers of services were involved in activities to improve awareness of HIV-prevention, VCT, training for staff, and care and support to clients (Table 8.4).

Table 8.4 'Which services do you deliver in this organization'? (n – 26)

№	Services	Number of people who answered «Yes»
1	Prevention of HIV-infection	15
2	Testing/VCT	13
3	Consultations, training for other organizations and training mini-sessions	10
4	Care/support	8
5	Arrangement of the personnel's work	4
6	Diagnostics and treatment of STDs, opportunistic infections	3
7	Social care	3
8	ART	2
9	Methadone substitution therapy	1

Source: Frontline providers' survey

14 people out of 26 indicated that their workload had increased between 2007 and 2008 (Table. 8.5). According to respondents in Issyk-Kul and Osh/Jalalabat oblasts this is generally associated with increased number of clients. For example:

> *We believed their work is not so hard, one can work, however, at that time they had few clients. Presently, it becomes harder, more people seeking care, more tests, formerly we did have that much (interview fragment, government organization)*

Additional causes of increased workload included additional time needed to participate in training (service providers in Osh/Jalalabat), and increased administrative activities (Osh/Jalalabat and Bishkek/Chui).

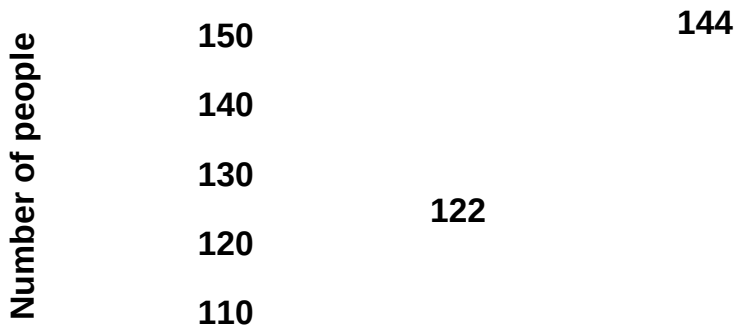
Table 8.5 'How has your workload changed over the last 12 months?' (n – 26)

	Gov. Organ-s	NGO	Bishkek/ Chui	Osh/ Jalalabat	Issyk-Kul	Total
Increased	6	8	3	8	3	**14**
Unchanged	2	10	6	5	1	**12**
Total	**8**	**18**	**9**	**13**	**4**	**26**

8.4 Participation in training

Based on data from questionnaires on organizational performance since 2004, the number of people who have completed their training in HIV/AIDS issues has been continuously growing (Figure. 8.1).

Figure 8.1 Number of staff members who completed training in HIV/AIDS issues (n – 16)



Source: Facility survey

Thus, in 2007 144 people were trained from 16 organizations and participated in 179 different workshops/training sessions. The GFATM and CAAP were mentioned most frequently as a funding source for these training sessions, while other international donor organizations such as WHO, CARHAP, CDC, UNICEF, SOROS-Kyrgyzstan Foundation, USAID, AFEW, and DFID, were also mentioned although less frequently.

Of the 26 staff surveyed from selected organizations, 22 replied affirmatively to the question 'Did you participate in training sessions on HIV/AIDS during last 12 months?'. In total, there were 43 attendances at training sessions, covering a range of topics (Table 8.6).

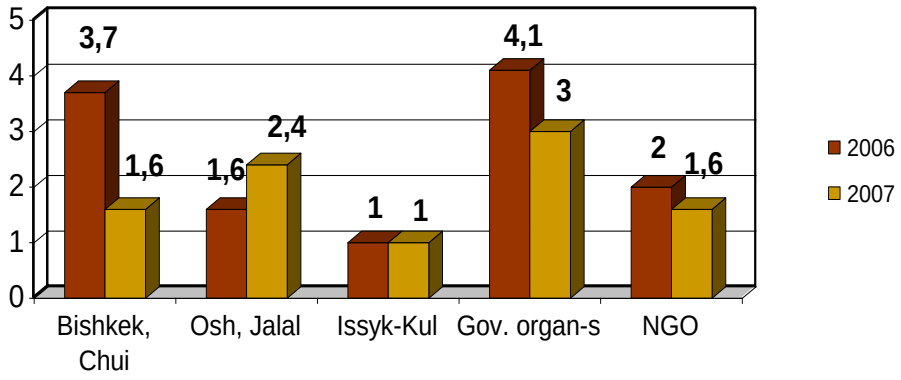
Table 8.6 Topics of training sessions and number of staff receiving each (n – 22)

Topic of the training session	Govt orgs	NGOs	Bishkek/ Chui	Osh/ Jalalabat	Issyk-Kul
Testing/VCT	2	3	1	4	0
Treatment of HIV-infection	2	1	1	2	0
Other health care	0	2	1	1	0
Prevention of HIV infection	2	7	4	4	1
Care/support	1	3	2	2	0
Adherence to ART	2	0	1	1	0
Methadone substitution therapy	1	0	0	1	0
Social support	1	0	1	0	0
Other related to HIV/AIDS: motivational counseling, legal rights of CSW, training of outreach workers, TOT	2	5	3	4	0
Other not related to HIV/AIDS: accounting, projects development and other	2	7	2	7	0
Total	**15**	**28**	**16**	**26**	**1**

Nevertheless the survey results demonstrate a decline in overall intensity of training of personnel both in governmental and nongovernmental organizations as compared to 2006 data (Figure 8.2). However, it is clear that between 2006 and 2007 considerable attention was given to improving the qualifications of staff in one part of the country – Osh and

Jalalabat. The number of training sessions provided for each specialist increased in those oblasts from 1,6[44] to 2,4 – an increase associated with a HIV-infection outbreak in this region at that time.

Figure 8.2 Number of training activities per specialist in 2006 and 2007



Source: Facility survey

During interviews with managers of organizations and service providers, the issue of building HR capacity in the field of HIV/AIDS was an important concern. Interviewees asserted that compared to other Central Asian countries, The Kyrgyz Republic has a relatively strong workforce, particularly in the NGO sector. Respondents gave examples of staff members of particular NGOs providing services in neighboring countries as international consultants. The role of the GFATM and CAAP grants in this process is significant. In the frame of these programs specialists have opportunities to participate in different international events (trainings, conferences) and receive new knowledge. CAAP is funding the creation of Regional Training Centers in four Central Asian countries - Kyrgyzstan, Kazakhstan, Uzbekistan and Tajikistan. Each Center has own specialization. For example, in Kyrgyzstan it will be the Center on Harm Reduction Programmes that will provide training for staff of all four countries.

At the same time respondents emphasized a range of factors hindering improvement of training activities.

- **GHIs provide training at irregular intervals.** Despite the fact that GFATM and CAAP, as well as a number of donors and international organizations, pay considerable attention to training, nevertheless training sessions tend not to be provided on a regular basis. Because of the rapid turnover in staff, staff find it necessary to train new-comers themselves. Thus, 10 out of 26 respondents mentioned that they provided consulting and training sessions for staff members of their own and other organizations (Table 8.4). One respondent noted that the quality of the training has declined as a result:

  Of course, everyone tries to learn in the workplace, however, these are different things when a trainer trains and when someone listened to and told to another one. These are different things. A trainer should be able to explain and establish good understanding (fragment of the interview, NGO)

[44] See Fig. 7.6. in the Interim Report "Global HIV/AIDS initiatives and their impact on health care system of the KR", April 2008, http://chsd.med.kg

- **High percentage of social and outreach workers need training.** As noted above, there is considerable overlap between these two groups, and there are few qualified staff. Respondents cited examples of particular workers who had little understanding of the ideas and ultimate ends of those activities in which they took part. One of the managers of an organization shared his experience:

  For 16 days I have been on my business-trip and saw many projects and almost half of all outreach workers need training. When they plan training probably they [organizers of the training activity] have no information or resources. I believe they do not plan the way to cover everybody. Why do they all the time provide training activities in Bishkek, and we come from Osh? Well, manager goes every time…they arrange separate training for outreach workers and train them. (interview fragment, NGO)

- **Training opportunities are unevenly distributed.** This feature is equally typical both for NGOs and government organizations, and there are various factors that explain this pattern. Respondents explained that, typically, a manager takes part in training sessions, meetings, and roundtable discussions. In one of the surveyed organizations a frontline provider mentioned that when a manager is not able to participate in these activities usually they stand in. But that person cannot specify topics for the training sessions or conferences, and often it is felt the person is present for sake of appearances. Furthermore, managers sometimes did not make rational decisions about who received training, or the training topics:

  [The program] needs to train in the way that there is a feedback. It needs to send those people for training who will continue work in this direction, it is necessary to monitor this training [to ensure] it is not for no reason. (interview fragment, government organization).

  These examples suggest that training activities may be having limited impacts on capacity development. If the focus is limited to building the capacity of managers, then this will cause problems for the sustainability of the organization. If a manager makes a decision to leave, that organization will either just stop functioning, or some services will no longer be covered.

- **Low HR capacity in governmental organizations compared to NGOs.** Low HR capacity in terms of levels of training relating to HIV and staff numbers providing HIV-related services continues to characterize governmental organizations in the Kyrgyz Republic. Respondents noted:

  It is necessary to upgrade staff members in governmental organizations. They are better in NGOs… Governmental organizations should be stronger, however, it comes out conversely, all information and works are provided in NGOs… (interview fragment, NGO)

  In the AIDS Center capacity of personnel is weak … if they decide to leave in a couple of months, it would be again necessary to train staff members. 2-3 people [benefit] and the others sit for no reason in particular… (interview fragment, governmental organization)

- **Shortage of doctors with knowledge and experience in HIV/AIDS prevention and treatment.** However**,** an outbreak of HIV infection in hospitals in the south of the country is a factor that has contributed to growing recognition of this problem among health professionals. For example:

Medical community was interested very much in training activities on HIV prevention… (interview fragment, governmental organization)

In addition, there is a significant shortage of 1) doctors with available experience and skills in providing prevention and care/ART to HIV-positive patients, particularly children, as one respondent noted '…*old doctors leave, new ones are not able to understand specificity, young doctors don't want to come*'; 2) lack of professional psychologists/psychotherapists capable of delivering qualified psychological support to PLWHA and PSFHA[45].

- **Absence of a system for monitoring the training process.** Most of the above mentioned problems are exacerbated by the absence of an efficient system to monitor the training process in HIV/AIDS issues such as who receives training, the quality and appropriateness of training and changes of skills/practice of trained specialists. With this information, it would be possible to introduce timely improvements in the efficiency of training activities.

  Nevertheless, the experiences of the Family Medicine Center specialists who worked on the CAAP Grant implementation deserve mention. In the process of training activities, initial and final knowledge levels of the participants were assessed. After training was completed, a twofold monitoring of trainees' performance was provided according to specifically developed indicators.

8.5 Motivation, financial incentives and satisfaction

A number of key motivating factors to work in AIDS service organizations were reported by respondents. Empathy/commitment and financial/salary factors were the most common factors (11 and 9 people out of 23 respondents respectively). 5 people from representatives of governmental medical organizations and 6 people from NGOs noted that during the last 12 months they received financial bonuses and premiums from their employer. In organizations, there is a tendency to introduce different incentives for personnel. Thus, 5 people from Osh and Issyk-Kul oblasts mentioned that their organization helped to pay for accommodation, 8 people mentioned that their organization allocated funds for transport costs, and 9 people mentioned that their organization paid their health insurance.

Compared with respondents' comments during the baseline survey for this report, in 2008 far fewer respondents cited the opportunity to participate in training activities as a motivating factor: just 4 people out 22 replied positively to the question "Did you get funds to cover daily costs while attended training sessions?"

Despite weak training opportunities, 2008 data showed a high level of job satisfaction, with 19 people out of 26 respondents replying positively to the statement "I am satisfied with my job" (Table 8.7).

[45] This fact is also mentioned in Final Report of Ketlin Ferrer MD, Susan Ghilespy MD PhD, Stefaniya Michale, MSW. International Pediatric Institute of Beilor with Mission in Kyrgyzstan, 10/6/2008.

Table 8.7 How far do you agree or do not agree with the following statements? (n – 26)

		Govt orgs	NGOs	Total
I am satisfied with my job	Agree	4	15	**19**
	Neither statement is true	3	2	**5**
	Do not agree	1	1	**2**
I am more satisfied with my job now rather than 12 months ago	Agree	5	10	**15**
	Neither statement is true	1	6	**7**
	Do not agree	2	2	**4**
It is difficult for me to work with clients of services related with HIV/AIDS	Agree	3	4	**7**
	Do not agree	5	11	**16**
	No reply	-	3	**3**
I prefer to work in other unit/organization	Agree	2	3	**5**
	Do not agree	6	14	**20**
	No reply	-	1	**1**

Source: Provider survey

15 people mentioned that they were more satisfied with their job now than 12 months previously; 7 people continued experiencing difficulties at work with clients; and 5 people preferred to change workplace. Around half of the respondents believed that in their organization there were enough staff members and other resources for adequate performance of their job, and almost 1/3 stated that they needed further training.

As with the baseline (2007) survey, many opinions were expressed with respect to financial incentives, particularly about low salary levels.

- **Lack of common approach to pay for employees in governmental organizations delivering HIV/AIDS services.** Although staff members of the Republican AIDS Center and its Regional Centers benefitted from a 60% increase in their wages because the deal with HIV-positive people (from the state budget – GFATM and CAAP grants do not cover these costs), most respondents were not satisfied with their wages:

  Everyone believes 60% is much, in reality the estimation is made on the basis of minimum salary and it is entirely scanty. Basic rate is added 1,400 som ($35 US) with supplementary rates and increases it comes up to 2,400 som (about $61 US), and for all that one should stay at work from 08.00 up to 17.00, there is no interest to work. (interview fragment, government organization)

  Moreover, not all specialists – laboratory technicians, family doctors, surgeons, gynecologists and, epidemiologists – involved in HIV/AIDS services delivery received salary increases. This raises the problem of perceived lack of fairness. For example:

  …why does a driver in AIDS Center receive 60% of increase, and we, those who directly contacts with patients - don't ? (Interview fragment, government organization)

  The TB Service does not face the same problems, however. In Osh oblast, for example, TB dispensary specialists delivering services to HIV positive patients have received pay increases. The National TB Center in Bishkek, however, has been raising this issue for several years without a satisfactory resolution.

- **Limited level of financing engenders limited engagement from government organizations in fighting HIV/AIDS.** Although there are many governmental organizations directly or indirectly involved in the fight against HIV/AIDS, respondents from governmental organizations saw their role as being quite passive. For example:

  Let AIDS Center and NGOs deal with these issues, they get money for that. (interview fragment, governmental organization)

  NGOs receive all funds; we have nothing, so they should be responsible (interview fragment, NGOs)

  When he/she needs to report to a governor, he/she says "you know, I have nothing, NGO has", that is why I don't know how to improve this. (interview fragment, NGO)

- **Low salaries in governmental organizations and breaks in financing NGOs represent negative incentives for personnel.** Unsatisfactory salary and low staff motivation impacts negatively on the quality of service delivery. In particular, vigilance decreases with respect to observing safe medical procedures and practices to prevent epidemic outbreaks in hospitals. As the experience in Osh oblast (where health staff used disposable medical supplies) showed, violation of safe medical procedures can cause hospital-acquired infection. Two points can be made here: On the one hand, a limited health budget does not allow organizations to provide sufficient medical supplies to the fullest extent (medical instruments, disposable gloves etc), and so part of the burden is borne by patients; on the other hand, even though patients bring their own syringes and other supplies, there are reported cases of health personnel attempting to save and use syringes they collect from patients as an income source.

  Breaks in funding projects is a serious problem for NGO staff salaries:

  The recent break has been lasting for two months and two weeks. And everyone of us would like to continue without a break, even though the Global Fund provides its items, we have syringes, we have everything except for salary. All this time people work for free. They could compensate at least post factum, but they don't. At least they could reconsider this. (interview fragment, NGO)

  According to one outreach worker, the problem is that during financing breaks syringes are considered as payment to worker (who commonly sell these to IDUs, market traders, drugstores and clinics) and such breaks are more typical for the GFATM than other funding sources (indeed, according to the 2007 survey 15/24 organizations experienced funding breaks; see also Annex 2). An interviewee explained:

  Intervals between tranches in the Global Fund depend upon workers themselves. As for the projects… here one cannot start in advance, when you finish the project, submit the report and afterwards you may fill in an application and apply. Here you think how to compensate salary. (interview fragment, NGO)

  One solution has been for organizations to work with several donors, but this creates additional administrative work (see previous chapter on multiple M&E systems).

- **Low government and NGO salaries lead to loss of HR.** One of the respondents described in detail the problem they came across in their NGO:

  We have an instability problem, salary is not stable as well as the [overall] economical situation. Let's assume that we trained someone, he/she gets a salary of

approximately 2,000 som ($50,6 US). Suddenly, he/she is offered 2,500 ($63,1 US) for guarding potatoes or weeding, he leaves this job and goes there. Thus, three people left during recent six months. When you make a contribution, it is too bad when they leave. You train them and they work at the bazaar afterwards. Well, one person says «I will work at the bazaar, there I will earn about 200 soms, so for 10 days I will earn as much as I earn here for one month. (interview fragment, NGO)

Some NGOs solve the problem by reducing the number of staff members, predominantly outreach workers, and using the money saved to supplement salaries of the remaining staff.

- **Need for legal protection.** The 2008 survey also revealed that a new factor had emerged that was impacting on the satisfaction of health personnel, namely the need for legal protection. A clearer recognition of need in legal protection arose after outbreaks of HIV-infection in health organizations. Most doctors feel they are working in a risky situation since they lack supplies and have old laboratory including old sterilization equipment. However there are no clear rules, procedures and practices about how who is deemed responsible for cases when HIV was transmitted in clinical settings; hence doctors often feel vulnerable. For example doctors interviewed said:

  We are lacking disposable medical goods. We ask parents to bring gloves, it occurs that a nurse cannot find vein of an ill patient. So, we have to call another more experienced nurse and again gloves are needed. Parents do not know this and start complaining that we require much. It comes out that we are guilty. (interview fragment, government organization)

  People work with precaution, there is pressure on the part of law-enforcement agencies. (interview fragment, government organization)

  Now, our doctors have a fear…. health personnel try to discharge them [HIV-positive people] in the soonest possible time, treat them quickly and discharge. (interview fragment, NGO doctor)

  Doctors do not want to work. Workload is much, conditions are difficult, no any protection. Those who doubted earlier, try to retire and leave. (interview fragment, government organization)

  The above mentioned comments show a wide range of unsolved issues: from difficulties in ensuring proper work conditions for doctors on the part of the government, to limited rights of HIV-positive patients, together with weak development of mechanisms to regulate doctor-patient relationships. In addition, a sense of the lack of legal protection visibly decreased motivation of doctors to work with HIV-positive patients.

8.6 Conclusion

Data from 2007 and 2008 surveys on HR issues in organizations providing AIDS services suggested the following:

- HIV/AIDS services are developed against the background of deteriorating provision of health personnel in Kyrgyzstan. Despite this deficit in HR the, number of HR personnel involved in HIV/AIDS programs has increased – primarily because of the increase in NGOs largely funded by the GFATM and CAAP grants;

- There is still a problem of inadequate provision of HR in Osh and Jalalabat oblasts, where the highest incidence of HIV-infection occurs in these regions. HR are mostly concentrated in oblast centers and their performance at rayon level remains limited;
- In the process of NGO formation and development, new personnel categories emerged such as social and outreach workers. The majority of social workers do not have professional training and thus need training on a regular basis. There is also a deficit of psychologists/psychotherapists as well as lawyers working in the field of HIV/AIDS;
- GFATM and CAAP programs made an important contribution to development of HR capacity of AIDS-service organizations (equipment support, training in HIV/AIDS and organizational development). According to respondents, in the NGO sector the professional level of particular specialists is significant and they started to provide consulting services in the Central Asian region;
- With support of the GFATM and CAAP, training in different HIV/AIDS aspects is provided annually. However, there is often illogical selection of participants for training activities; there is no information on how the obtained knowledge is used in daily practice; and training activities are provided without considering existing needs and not on a regular basis. Development of an M&E system focusing on the effectiveness of training could also contribute to efficiency of the training process;
- As before, salary issues have also arisen for the personnel delivering HIV/AIDS services. Low salaries and an unfair bonus system in governmental organizations, and also breaks in payments to NGO personnel, also contribute to decreasing motivation, poor quality of services, negative incentives of personnel and consequently poor retention;
- Personnel of governmental health organizations lack legal protection. According to respondents, doctors perform in the context of risk in respect to HIV/AIDS and that clear legal guidelines are lacking.

8.7 Recommendations

Recommendation #1 Revise the system of financial incentives for HR in governmental organizations and NGOs working in the field of HIV/AIDS (overall salary level and the bonus system). The importance of this issue is highlighted due to its negative impacts on motivation and retention of personnel;

Recommendation #2 Develop and implement an M&E system for training process in order to promote improved effectiveness and appropriateness of training programs;

Chapter 9. Access to and quality of HIV/AIDS services

There are some discrepancies as to what are considered the main barriers to access among interviewees from public health organizations, NGOs and service users. Whilst health professionals tend to focus on factors affecting affordability and availability of services (provision of drugs, medical supplies, information materials, numbers of staff, their professionalism and motivation), those working for NGOs pay more attention to issues including acceptability of services to users (empathy of staff, developing trusting relationships, providing anonymity and confidentiality). Given the diverse nature of service users, the relative importance of these factors varies considerably.

9.1 Stakeholders, managers and providers' accounts of access to HIV/AIDS services

Tables 9.1 and 9.2 show the results of the survey on what service providers perceived to be the most important barriers to accessibility to HIV/AIDS services. The most significant barriers restricting the use of services are:

- Clients' limited knowledge about risk factors/symptoms of HIV, and lack of awareness about the available services and their entitlement to use these;
- High costs of transport and receiving services, especially when services are a long distance for clients;
- Stigma and discrimination towards PLWHA, and criminalization of drug users and sex workers;
- Shortage of resources such as drugs and medical supplies, and lack of training for personnel.

Table 9.1 Influence of different factors on users' access to HIV/AIDS services (n-26)

Factors	No or little influence	Moderate influence	Strong influence
Stigma/discrimination/criminalization			
Stigma as regards HIV-infected/drug users/sex workers	12	7	6
Criminalization of key groups of clients and attitude of police	18	5	2
Relationship between clients and personnel/staff members	18	5	3
Economic and geographic barriers			
Place of service is far for some clients	13	8	3
Transport availability	10	6	4
High cost of service for a client	20	3	0
Travel costs and other costs to get service	11	6	8
Resources and human resources			
Shortage of drugs and medical supplies (for example, ARV drugs, syringes, condoms)	14	2	4
Shortage of personnel/staff	18	6	0
Absence of personnel/staff at working place	18	4	2
Some staff members are short of skills to deliver service	16	5	3
Quality and organization			
Inconvenient opening time for clients in the organization	20	4	1
Complicated procedures to get service	21	1	3
Barriers related with knowledge			
Clients have limited knowledge about available services	9	13	4
Clients have limited knowledge about their entitlement to use services	11	11	4
Clients have limited knowledge about risk factors/symptoms recognition	9	10	7
Clients have difficulties with articulation of their needs to personnel	14	7	3

Source: *Data of survey of providers in selected organizations
**The table does not include data in column «No reply»

Table 9.2 How much do you agree or disagree with the following statements? (n-26)

	Agree	Neither agree nor disagree	Disagree
There are enough staff members in the organization to properly deliver services	14	8	4
Shortage of resources in the organization impacts quality of services	10	9	7
I received enough training to properly perform my work	14	5	7
I have equipment, supplies and materials for adequate performance of my work	14	5	7

Source: Data of survey of providers in selected organizations

9.1.1 Barriers related to knowledge of clients

Stakeholder and service providers suggested that the level of knowledge about HIV/AIDS among the general population, particularly in rural areas, remains low. In spite of intensive information/educational activities during recent years, many people still do not know the ways in which HIV is transmitted:

> *They fear and believe that if a child is sick, it means one cannot stay beside this child. They say that it is too dangerous. So, this is their perception…. Many people still do not know about [HIV] transmission routes (Interview fragment, NGO, Osh.)*

> *Among the rural population, in particular, where children got infected, there is panic (Interview fragment, NGO, Osh.)*

According to respondents, lack of knowledge about HIV has hindered efforts to work with the families of children who were infected during an outbreak of HIV in the South of the country. Many mothers of these children are young and found it difficult to understand explanations and advice given by medical professionals. One reason for this is that doctors and trainers usually speak in Russian whereas they speak Kyrgyz or Uzbek. Furthermore, many families reside in rural areas where households with HIV-infected people are stigmatized, and this limits the number of people with whom they can discuss problems.

This issue highlights the need to use appropriate specialists to work with families of PLWHA. Currently, several NGOs, including those that are supported by GFATM, run self-help groups for mothers and infected children, where along with other issues they also provide assistance with ARV. However, currently these self-help groups are located in urban areas, and are not accessible to people living in remote areas.

There are several reasons why information and education activities have not been successful in raising awareness about HIV/AIDS:

- **Awareness raising activities do not reach the target audience.** For example, for one project which aimed to improve HIV/AIDS awareness amongst people aged 18-40 years old, according to staff members at the facility, many of the participants were older (pensionable and pre-pensionable age). One reason for this is that many of the target audience were at work during the time that the session was planned. An interviewee explained: '…*my son has no time; he is at work. That is why I've come'*.

- **Language barriers.** Many HIV/AIDS awareness raising activities take place in rural areas where most of the population does not speak Russian. They find it difficult to understand the education materials such as booklets which are produced in Russian.

  Furthermore, there is a shortage of trainers with knowledge of the Kyrgyz, Uzbek and Tajik languages. As a consequence, staff members face considerable challenges during training activities and have to resort to communicating through other means:

  > *It happens you should explain sometimes using any ways- examples, hands, jests (interview fragment, NGO).*

  Language barriers reduce the efficiency and quality of training. To solve this problem and ensure the sustainability of activities for raising awareness, staff members try to train leaders of communities who then conduct such sessions independently and in an accessible form.

Despite the challenges, data from the 2008 survey demonstrates that key population groups have changed their risk behavior as a result of information and education activities. Below are examples from interviews with managers and specialists:

- **Sex workers** appeared to be more willing to pay for health services and to seek the services of private providers. For example: '*At first we followed girls, told them this and this. Now, they come, do prevention, every month they do tests. They know already what to do in such cases' (Interview fragment, NGO).*

  Managers and staff working at NGOs that provide services to SWs have made considerable effort to raise awareness and carry out preventive activities. For example, in Osh, many SWs are migrants from Uzbekistan who do not have documents or official registration and have limited opportunities to walk or travel in the city. Outreach workers visit them, conduct training sessions in Uzbek, and provide condoms and medicines.

- **Injecting drug users.** Similar changes in behavior have been observed by specialists working with IDUs. Below is a description of behavior of people giving blood for regular surveillance:

  > *People came back to learn about their status. We told them that if they continue examination and suddenly positive test result is confirmed, they could receive further care. For example, antiretroviral therapy, regular examinations. People agreed, although, previously we did not have that. Most people did tests anonymously and left, not even learning the results. They told when they were giving blood «you could not even say about the result, anyway it is all over for us». …And here perceptions were entirely different, they waited for their results during these 4-5 months. We had a bit delay because of laboratory. We believe our clients, drug users are a closed group, in general like that…. However, some part, I don't say the most part, but it will be correctly to say for 1-2 years it has been a progress. To work in the group of drug users generally requires long time, these years are needed to make maximum number of people understand this. (interview fragment, NGO)*

- **Knowledge of legal rights.** HIV/AIDS service organizations have paid a lot of attention to increasing awareness among PLWHA of their legal rights. Availability of legal services was indicated by most of the organizations in all three regions. In one NGO, a lawyer developed a memo for SWs which stated the basic rights of citizens and provided advice about what they should do if they are arrested by police as well as contact information for the lawyer himself. Staff members described the experience of one SW who, during her next meeting with police, was able to prove the illegality of her detention. As a result, she was released without paying any money (usually a minimum payment is 200 som (5$)). Despite the fact that such examples are few to date, they undoubtedly demonstrate positive changes.

9.1.2 Service delivery barriers

The most frequently mentioned barriers to access of HIV/AIDS services are transport costs and costs related to the receipt of service themselves. During this phase of the research, there has been a tendency towards forming new priorities in delivery of HIV/AIDS services. As a result of the rapid increase the in number of PLWHA, the types of services required have changed. In Osh, Jalalabat and Chui oblasts, the focus has shifted from preventive activities to comprehensive examination and treatment of PLWHA, including antiretroviral therapy, delivery of support and care. In regions with support of GFATM and CAAP, new projects have started which work with PLWHA. Given the rise in numbers of PLWHA and of services available, it is important that services are well organized, ensuring access to patients, continuity of health services and social support.

- **Addressing needs of PLWHA with complex problems.** Respondents mentioned that if additional needs of service users arise, it is quite difficult for one organization to provide additional interventions. Thus, it is necessary to organize the delivery of an integrated package of services for PLWHA who also have tuberculosis, hepatitis, or other opportunistic infections.

- **Organization of care to new and hard to reach PLWHA groups.** Some groups of PLWHA are particularly difficult to reach, such as children and HIV-positive women from rich families (whose husbands are HIV-negative), where the infection occurred as a consequence of medical treatment or infection sources being unknown. For example:

  They do not let in, they are not examined, want to forget that they have HIV. They say that when they recollect they have HIV-infection, they start feeling discomfort, worries and desire to forget about this infection. That is why they do not come to the AIDS Center… We have several people who do not want to get any care they ask us to forget about them and not to come. They even agree to reject all our care.

  They need care at home, some outpatient care and some support to the groups should be started.

- **Assistance to PLWHA to get social benefits.** According to existing legislation, benefits payment (about 25$ a month) and subsidies for public utilities (electricity and heating) are envisaged for patients with HIV/AIDS. However, based on 2008 data[46], only 5 HIV-positive people received such social benefits in Kyrgyzstan. This low level of receipt is related to several factors: (1) low awareness of existing laws and patients' lack of knowledge of their rights; (2) lack/loss of documents (passport, registration etc.); (3) complicated procedure for getting benefits, where patients are made to repeatedly pass through examinations by the medical-social expert commission at the Ministry of Social Protection and Labor (4) Many PLWHA do not want to seek benefits due to high levels of stigma in society. An interviewee said:

  For example, according to law there are different benefits children are entitled to. However, their parents fear the attitude of people, they are afraid that everyone in the city will learn because they have to go to different instances, prepare documents, and open up themselves. Getting benefits is offensive or shameful for them, that is why they refuse. Sometimes they say:"you do all documents, we will not be able to collect them. It is true….some legal assistance, some support should be. An individual who could deal with this may be a social worker. However, we don't have such structures to do this job…. It turns out that only oblast AIDS center deal with HIV-infected people (interview fragment, NGO)

On the whole, according to respondents activities of the GFATM and CAAP have positive impacts on access to HIV/AIDS services, specifically the following were seen as enhancing access:

- Introduction of ARV drugs to PLWHA and introduction of co-payment if hospitalization is needed;
- Increased network of organizations delivering HIV/AIDS services including in rural areas (detailed in Chapter Five).
- Treatment of STIs and raising awareness. Support of the GFATM allows delivering STI services and treatment for free.

[46] Source: Ministry of Labor and Social Protection

9.1.3 Stigma, discrimination and criminalization

Recent experiences highlight the need to revise approaches to information/educational activity with an aim to change public opinions towards HIV/AIDS. The intra-hospital outbreak of HIV infection in southern Kyrgyzstan has demonstrated that there are high levels of stigma and discrimination towards HIV in society (see details in section 9.2.). Below are reflections of respondents about sources of stigma and possible ways of overcoming this:

> *Over 70% of all teams taking part in the competition told that "AIDS – is plague of the 20the century", "AIDS- is so frightful, it is more frightful than plague, cholera or anthrax" etc. It was beautiful, in verses, everything is colorful, fancy. However, again these are consequences of what we did, not we but early preventive programs, which thickened clouds above all this and now it is very difficult to overcome (Interview fragment, Bishkek)*

> *Policy of prevention with fear was not right, we are sure… We cultivated stigma ourselves, inspired fear, and now we have to say «oh no, HIV/AIDS and TB are the same… One ought to smooth and continuously use all resources starting with mass media, so that people know about ways of transmission. (Interview fragment, NGO, Osh)*

> *So what, if it is HIV? There are people who take pills for years, and we see them, they live normally with HIV. One must explain this…Diabetes mellitus, every day injection of insulin, and here just take a pill and live OK. It is probably needed to prepare TV, papers, journalists in this regard, so that they could change attitude of people, at least provide right understanding (Interview fragment, NGO)*

9.1.4 Shortage of resources and lack of training

- **Breaks in funding GFATM Projects.** Many respondents indicated breaks between projects as a problem and that in 2008 the problem appears to have become more frequent. Most of the organizations that deliver syringe exchange services did not stop work even when financing breaks occurred, and relied on volunteers to provide services. However, long breaks in 2007-2008 forced several organizations to suspend activities entirely, forcing users to rely on alternative (CARHAP) projects to receive syringes.

- **Breaks in paying salaries.** This has resulted in many staff working for AIDS services seeking employment elsewhere. For example:

  > *They leave for another place of work or go to Russia. When a break is too long, they just don't come back. But, to recruit new people is the same as to start again (interview fragment, NGO).*

  > *We have the firmest, the most faithful people, it means that despite of the fact we are without financing for three months, you may see that the work is going on. Although I stay without salary, managers – without salary, outreach worker – without salary, however, the work is going on. If we stop work now, we would lose all our clients we collected for three years (interview fragment, NGO)*

- **Shortage of some specialists.** Surveys of HIV/AIDS organizations' managers and staff reveal shortages of specialists including psychologists, psychotherapists, legal experts, narcologists, gynecologists, dentists, lab technicians (particularly those trained in carrying out CD counts) and specialists in VCT.

- **Insufficient preparedness of Family Group Practice (FGP) doctors to work with PLWHA.** It is expected that, following diagnosis at an AIDS centre, PLWHA will receive follow-up services at the primary health care level. However, according to respondents, PLWHA often do not want to use public health organizations and FGP doctors as they are not adequately trained to deal with the issues. An interviewees said: '… *they [FGP staff] do not possess skills of communication with this group, they don't know about the peer-to-peer principle*'.

- **Lack of training in infectious disease control in health organizations.** The outbreak of HIV-infection in Osh oblast revealed deficiencies in existing practices within medical institutions. The situation was aggravated by a deficit of medical instruments, lack of supplies for individual protection for health personnel, and disinfectants. Furthermore, some health personnel did not pay proper attention to the safety of medical procedures. In order to prevent further spread of HIV countrywide, it is necessary prioritize the following: training of health workers in infectious disease control, better safety of blood and provision of medical supplies including disposable gloves.

9.1.5 Additional factors impacting on access to HIV/AIDS services

Other key factors enabling or hindering access include:

Factors that facilitate access:

- **Availability of alternative services.** According to views of some respondents, it is important that at one facility there are several health workers that can deliver the same service. This would allow patients to have a choice. An interviewee said:

  > *For example, he thinks 'why should I go again to this doctor, maybe there is another one'. And if he goes to another doctor, he will find the third one as well. It is psychology of consumers. i.e. available alternative services also improve access… (interview fragment, NGO).*

- **Work with co-dependent individuals (those living with IDUs) helps to improve communication with IDUs themselves.** The experience of attracting co-dependent individuals for outreach work showed positive results. However, there are examples when in different territories due to differences in local mentality this approach works differently. For example an interviewee said that in one of the rayons: '… *there is a perception that if anyone distributes syringes he is a person of [lower status]' (interview fragment, NGO).*

- **Improvements in the quality of services delivered.** In order to improve the quality of HIV/AIDS services, professional training of staff members is required. An interviewee suggested: '*Today, quality depends upon what level is possessed by managers of projects. If a manager is a professional then his staff efficiently and qualitatively deliver these services' (interview fragment, NGO).* In 2008, the CAAP project made a significant contribution towards staff training: a working group was established which developed 18 different modules on harm reduction which were then used to train trainers and staff members working in this field.

- **Increasing role of religious leaders.** During interviews, many respondents highlighted the role of clergy in promoting preventive HIV/AIDS programs among population. This support is very important, especially in rural areas and for the South of the country where religious traditions are strong.

Barriers to access

- **Examination by Office of Public Prosecutor and law enforcement agency.** Whilst the supply of syringes by GFATM is ensured through governmental organizations, representatives of the Office of Public Prosecutor carry out regular examinations: they ask for reports on syringe distribution and information about clients. This has created mistrust from IDUs, led to outreach workers leaving work and a loss of services.

- **Inadequate attention towards improving the quality of services.** Respondents have often pointed to the low quality of some supplies imported by the GFATM implementer including condoms. Also, some of the supplied products, such as syringes, often do not meet needs and demands of clients (for example 2 ml syringes are preferred, whereas 10 ml syringes are generally supplied, especially in prisons). Furthermore, managers of organizations have complained several times about the poor conditions of storage facilities used by the GFATM implementer;

- **Inadequate attention is paid to complex service delivery.** Many of the interviewees believe that a focus on increasing coverage is not always the correct approach and foremost attention should be given to service quality. For example: '*Why should we chase quantity, may be few people receive services, but they would be complete' (interview fragment, NGO).*

9.2 Perception of HIV/AIDS service quality and accessibility by service users

In 2008, in-depth interviews were conducted with 24 representatives of key risk groups (IDUs, SWs, PLWHA, youth and migrants), where they described their experiences of using HIV/AIDS services in three regions of the country. The perceptions of these respondents are summarized below.

9.2.1. Syringe Exchange Program (SEP)

Drug using practices. According to one respondent, the usual process of purchasing drugs and syringes can undermine the effectiveness of SEP services. For example:

> *There is a superstition – first you find drug and then you think about syringe.*
>
> *It happens that you share dose with strangers you've met today and afterwards you may never see them again. But today sharing the drug joins us and you would not say "I need another syringe", you would just inject with one syringe and scatter*
>
> *When you need injecting drugs you don't think about separate syringe*

Attitudes of IDUs to using SEP services. The SEP services that have been developed are not always acceptable for all drug users. For example, SEPs are not secure ('…*it is risky to walk in the city with syringes*…'), and users risk being detained by law-enforcement officers when they access these services. It has also been mentioned that many IDUs reject services from outreach workers to better hide their drug dependence ('*If an outreach worker visits homes, a drug user hides his dependence from relatives and neighbors, he just refuses services of outreach workers').* Services of outreach workers are more often used by long term drug users who do not try to hide their dependence. Such users' needs must be taken into consideration: '… [they need special] *syringes as their veins are not visible already, and they inject in groin, and micro and insulin syringes are distributed'.* Thus, for SEP to be more effective, more attention must be paid to individual needs.

Standards of outreach workers. In many SEPs the standard number of people that outreach workers are supposed to work with is between 50-100 people. However, in the opinion of one respondent, it is very difficult to find so many users in one territory: '… *there are no so many users in one district, maximum 20 or 30'*. This is partly because drug users are very mobile group and usually they do not lead a settled lifestyle ('… *owing to pursuit by law-enforcement bodies, drug users can change place of residence for a long period of time. A consequence of this is that distribution of so many syringes is not needed. Out of 10 syringes 2-3 would probably reach drug users, the rest are lost on the way'*.

SEP in Family Medicine Centers (FMCs). The MoH's plan to open SEPs in FMCs has received mixed responses. In Bishkek people have been positive about their location. However, in smaller towns, where people know each other, there is more resistance to having SEPs in FMCs since this is likely to make confidentiality difficult.

Additional needs of IDUs. The need to broaden services for IDU has already been highlighted. The services in greatest demand are detox-therapy, rehabilitation and treatment of coexistent diseases. Health service providers have also highlighted the need to develop new services for IDUs, in particular rehabilitation services.

> *To change behavior of drug users, first of all it should be their need and desire…. Probably, some programs are necessary, which are related with purely psychological and moral factors, rehabilitation centers. But, only there, in narcology hospital, where they receive treatment. And namely such rehabilitation, where drug user will say himself "yes, I want, i.e. yes, I will do".*
>
> *Our purpose was to gather groups of drug users so that in the future they could do work, the active ones so they do the job. However, there were 2-3 people during these years, they initiated something independently, but could not manage. Self-help group should be created, based on the wish of these groups. And when we dictate and say "you get together, do it" it is again our wish.*

Stigma. Interviews show that stigma towards IDUs by society in general, but also people working in health organizations, remains a substantial problem. Moreover, "self-stigma" also exists whereby IDUs believe that they deserve to be treated badly by others. In these situations, more knowledge about their rights may help to overcome stigma.

Qualities appreciated by IDUs in services. According to IDUs, important factors affecting the acceptability of services include:

- **First impression.** The acceptability of services can depend upon the personal characteristics of staff and their initial attitude towards patients ('… *first impression is very important for drug users; there should be such qualities as patience, tolerance').*
- **Confidentiality.** Many IDUs try to keep their drug dependence a secret. If they believe that an HIV/AIDS organization would not keep this confidential, then it is unlikely they will choose to use the service again ('*I don't want to see this outreach worker again, and will never go there again. Why did she tell my mom that I take syringes').*
- **Security.** It is important for IDUs to know that when using an AIDS center, he/she is free from being harassed or arrested by law-enforcement bodies ('… a whistler is settled in the drop-in center, he whistles to police men…and nobody will visit this center').

9.2.2. Substitutive Methadone Therapy program (SMT)

Lack of information about SMT. During interviews with participants of the SMT program, it became clear that there is a lack of information for participants, their friends and family. For example, interviewees mentioned that not all of them know that *'it is synthetic narcotic chemical… many of them believe it is medicine'*. Among the potential recipients of SMT and their relatives, it is believed that methadone causes more dependence than heroine and has more serious side effects on the functioning of vital organs. For example: '…*methadone has many, five times more side effects*'. Furthermore they also believe that it is more likely to lead to death. These preconceptions prevent many people from accessing the SMT program. For people that do use the program, questions remain about the duration, outcomes and forecasts of SMT, and many rely on information from personal contacts to answer these questions.

Procedure for receiving SMT. According to respondents, the procedure for joining the SMT program is not complicated: a dose of methadone can be delivered through outpatient facilities (in 2007 hospitalization was necessary and this led to significant financial costs to clients). On week days, the facilities are open from 8.00 am until 1.00 pm and there have been some suggestions to begin delivery of methadone from 6.00am, thus enabling people to reach work on time ('… *there is always queue in the morning, especially at 7-8 hours'*). However, the cost of traveling to a clinic is still a factor which can prevent some people from using services.

Effectiveness of SMT. All surveyed participants of the program felt that SMT had a positive influence on their general state and social functioning. For example: '*…sleep becomes normal, possible to work'; '…feeling of cheerfulness'; '…I don't feel sick'; '…no thirst for alcohol'; '…desire to use heroine disappears'; '…stops psychological dependence'; '…no danger to choose dose wrongly, as for heroine sooner or later it results in overdose and death…'; '…no need to look for narcotic money'; '…saves from fatality, and prison…'; '…now I live with my family'; '…some space has appeared for other things'.*

Unrealistic expectations among SMT clients. During interviews, participants expressed some disappointment as to the length of time that it takes to complete the SMT program. This was due to the fact that many participants did not have permanent employment and planned to travel to Russia or Kazakhstan to work. The 6-7 months it takes to complete the SMT program disrupted their plans. Being forced to discontinue SMT caused anxiety for some people, they said that: '… *there is methadone in Russia, but it is not liquid, it is powdery and should be diluted. Pushers sell it as a narcotic'*.

Police activities. There is evidence that police often detain people using the SMT program, although the frequency of this has reduced. Participants of the SMT program are supposed to carry a certificate stating that the methadone they have has been supplied legally, however, often people do not have this document. Interviewees said: '*We are sick and tired of police…they pick people up to detention centers without a hearing, they beat, accuse… murder…'; '…they "plant" heroin, accuse you of a crime; I was arrested last year…'; '…they start beating at once and force you into the car…'; '…there is an example when heroin was planted to one of the guys, and he was on methadone, finally he was imprisoned'.*

When participants of the program are arrested their SMT course discontinues. For example: '*…one feels sick for 1-2 weeks from heroin and from methadone – this is very long…'; '…methadone results in different sweats…'.*

Extension of the SMT program. Since 2008, coverage of the SMT Program has been significantly extended with new facilities opened, increased numbers of staff and more training. Staff members from these organizations indicated the importance of the SMT program, enabling them to deliver integrated HIV/AIDS services. For example:

For users it is necessary to develop methadone program to promote better anti-retro viral therapy, not only for HIV, but also treatment of tuberculosis, hepatitis. About 70-80% users have tuberculosis now. If he is on methadone, there is more understanding, he starts receiving different treatment. This would also help to improve accessibility (interview fragment, governmental organization).

9.2.3. Services for PLWHA

A review of the experiences of PLWHA, based on data received during interviews with service users and staff members, shows barriers to access for a range of services:

Low awareness about how HIV is transmitted. Common to all respondents is a lack of awareness about how HIV can be passed on to others. Further, following a positive diagnosis, some patients did not know where to go to seek care. The story below illustrates this point:

Story 1

A middle-aged man said that during many years he used to be a drug user. Six months ago he was diagnosed as HIV-positive. After this diagnosis connection with doctors of oblast AIDS center was interrupted. He did not receive comprehensive information about transmission routes and what he should undertake hereafter. He said that while he lives with his family, he tries to avoid contact with his children and wife and has individual dishes. He was not sure his actions were correct and did not know what he should do with his disease. He had no money to go to the oblast AIDS center. Moreover, he feared to show up in crowded places, since he scared to meet with police officers, who knew him very well as a drug addict.

Stigma and discrimination by family members. After being diagnosed with HIV, many patients faced stigma and discrimination from close relatives. Shortage of prompt and complete information about HIV infection, treatment methods and prognosis, and a lack of professional psychological help created additional psychological and emotional trauma. Examples of this are illustrated in the stories that follow:

Story 2

A young woman, 25 years old, mother of two children of 4 year and 7 month old. In 2003 she got married and did not know that her husband had used drugs in the past and was HIV positive. In early 2007, she became pregnant for the second time. She passed through all necessary examinations including testing for HIV, and all tests were normal. In September 2007, right after childbirth she was informed that she had positive tests for HIV infection. In compliance with recommendations given by doctors since first days the child had been artificially fed. Soon, the husband was put into prison for drugs and theft. Her mother, having learnt about HIV positive status of the daughter refused to help her. The young woman had to leave home and rent a room. Since she had two little children it was difficult for her to find suitable work. Over 7 months she received 2 packages of powdered baby milk and one of diapers. Last month the baby was sick with a high temperature and convulsions. A doctor prescribed expensive drug for 600 soms ($15). There was no money; she took the drug in the pharmacy as a debt, having pledged her passport.

Story 3

An elderly woman said that '… doctors infected her grandson with HIV infection'. Initially, she tried to isolate them, provided her daughter-in-law and grandson with individual room and dishes. Her husband stopped coming home because of them. The woman said that she would not like her son to live with the daughter-in-law and was afraid that other family members would be infected. After some time, she threw the daughter-in-law and grandson out of her house.

Story 4[47]

A baby was diagnosed; the father-in-law summoned his son from Russia where he stayed earning money and who could, in the father's opinion, communicate dangerous virus to the grandson. However, he proved to be healthy, and, having learnt about what had happened, he gave up the family and accused his wife of an extra-marital affair, since he believed this was the only way of transmission.

These stories illustrate that the lack of information about HIV causes fear and misunderstanding. According to one interviewed doctor, there is need to conduct regular education programs about HIV that are facilitated by health professionals so that the information is reliable and trusted by the population.

Lack of social assistance. Many HIV positive patients are poor: they have no dwelling, support from relatives or permanent employment, and their income usually does not meet basic needs. Also, many PLWHA do not have proper documentation. In this context, it is particularly important that these people are able to receive social benefits. As previously mentioned, the State procedure for giving benefits makes it virtually impossible for PLWHA to access these. Many patients are isolated as a result of their problem as the following story illustrates:

Story 5[48]

A mother of an HIV-infected child said that on her initiative her two elder children and husband staying in Russia also were tested for HIV/AIDS. They proved to be healthy. However, her husband who formerly sent money for treatment of the child from Russia has now refused to help. «Where you got the virus you should treat it!' reacted her husband. He has left for Russia permanently and does not let her know about his whereabouts. According to her '… all these families are needy and left by their fathers…'.

ARV therapy. Following the outbreak of HIV in southern Kyrgyzstan there has been a rise in the number of children that need ARV therapy. However, health professionals have encountered resistance from some family members to the therapy because they consider the treatment to be a new drug trial. As a result there have been some cases where parents of HIV infected children prevented their children from receiving treatment. In addition to fears about the efficacy of ARV, there are other reasons why some people will not accept treatment. For example:

These drugs cause strong side effects, such as worse memory, severe pains, depression etc. Available severe negative effects mean that these drugs are merely not suitable for you, and you should choose other, alternative ARV drugs. However, it

[47] Abdymomun Mamaraimov, "Kyrgyzstan: Desire to treat children turned out to be HIV infection and loss of family", 07.04.2008, http://www.ferghana.ru/article.php?id=5659

[48] Abdymomun Mamaraimov, "Kyrgyzstan: Desire to treat children turned out to be HIV infection and loss of family", 07.04.2008, http://www.ferghana.ru/article.php?id=5659

is almost impossible, since very limited list of drugs are supplied to Kyrgyzstan. Besides, there are breaks in supplies making meaningless all treatment.

Ensuring adequate provision of ARV for prisoners is a particular problem. This is illustrated by the experiences of one ex-prisoner receiving ARV described by another client:

He did not even understand for which purpose he was given tablets. He said that twice breaks occurred in drugs administration. After discharge from the prison there was again break in treatment. He learnt afterwards that ARV therapy should not be discontinued at all and said he would not take them at all; "what's the use".

According to respondents, one reason why patients do not continue to use ARV therapy is the lack of visible and positive effects of the drugs. Patients feel the side effects but they do not see any overall health benefits. One reason for this is that health professionals have used incorrect approaches to administer therapy – for instance without considering whether patients are suffering from opportunistic infections. Over the last two years intensive work has been carried out to revise clinical protocols (with technical support of WHO) and to train personnel (with financial support from the GFATM and UNICEF). ARV is now administered only after treatment of active phase of any concomitant opportunistic infections such as tuberculosis

Follow-up of HIV-positive patients. Whilst the diagnosis of HIV-infection is confirmed in AIDS centers, follow-up services are provided by FGP doctors. Their responsibilities include: follow-up on the general condition of a patient; control of laboratory indicators; (including levels of CD4-cells once every three months); distribution of ARV and control their acceptability. However, in practice this process does not work efficiently for several reasons:

- In all regions of the country, especially in the south, there is a lack of health workers at primary health care centers (see Chapter Eight on human resources). Doctors have a high workload and follow-up of HIV-positive patients is perceived as an undesirable additional task;
- According to family doctors, they do not possess any levers for effective delivery of care to HIV-positive patients. For example:

  They do not come for consultation themselves, we go home, but they don't open the doors or many times promise to come and be examined, but don't come. Either they have no money to reach AIDS center, or they have no money for tests. We cannot help them and provide them with any benefits or material assistance; there is no any sense in us for them. We may call for examination only.

- The process of fulfilling the requirements to prescribe ARV therapy, such as taking tests, can be time consuming, and often patients are unwilling to go through these tests. Further, in order to prescribe ARV therapy it is necessary to inform a spouse, who have in the past, rejected treatment.
- There are also hindrances on the part of patients themselves; many of them prefer to receive care in AIDS centers rather than at local clinics, as this way it is easier to hide their status.

With increased number of HIV/AIDS patients it has become clear that previous approaches used to provide services have not worked. According to respondents there is a need to change the organization of caring for HIV/AIDS patients. This requires considering which system of service delivery would be optimal, revising terms of reference, identifying rights and responsibility of specialists at each level of health care delivery, and then identifying training needs and costs.

9.2.4. Services for prisoners

The Ministry of Justice, including GUIN, takes an active part in providing HIV/AIDS services for prisoners. To date almost the full range of HIV services have been implemented on a pilot basis in the penitentiary system. GFATM grants have supported the implementation of SEP, VCT services, ARV therapy, social assistance, information/educational activities, and scale-up of the SMT program. However, interviews with ex-prisoners highlight some key barriers to accessing HIV/AIDS services.

Disruption in the supply of syringes. According to some interviewees, there are occasionally periodic breaks in work of SEPs due to a lack of syringes. This was caused by breaks in funding between projects. In such periods, NGOs have continued to provide syringes to prisons using their own channels, which often violate rules in doing so. Prisoners have also tried to stock up on syringes, which are then exchanged for food products, soap and other goods when the supply of syringes runs out.

Poor service continuity between penitentiary and civil sectors. This problem was mentioned in several interviews:

> *A prisoner who, for example, started receiving ARV therapy or SEP service should be linked with civil health care, so that after discharge from imprisonment he could continue receiving treatment or exchanging syringes, as well as keep on safe behavior…. In reality, it is very problematic, primarily because there no any normative documents regulating all of these.*
>
> *They discharge from imprisonment and again have nowhere to go, and absolutely no money, for example, to go from Bishkek to Osh. So, he has got this blacklisting, got off and that's it, do what you want. It is natural that he comes back to criminal world as a recidivist. This round could be somehow discontinued. There should be definite support in this regard.*

9.2.5. Drop-in centers

The interview findings suggest that services of drop-in centers are in demand from all key risk groups. Currently, this need has not been met and as a result, centers designed for SW are also being used by male IDUs, pregnant women and ex-prisoners. It is important that separate shelters are created for IDUs with tuberculosis to reduce its spread.

Along with providing information about HIV prevention, drop-in centers try to assist users with document restoration in cases where an individual looses their documents, getting consultation on medical problems from a healthcare provider.

9.2.6. STI prevention services

Since in 2008, many organizations have not received funding from the GFATM or experienced long periods without funding. Thus, services aimed at preventing STIs have been considerably reduced. A key problem mentioned during interviews was the low quality of condoms bought with the GFATM grant.

One of the reasons for the declining efficiency of preventive activities is the underestimation of risk factors experienced by SW. For example a SW said: '*…if a client offers to pay extra, it is possible not to use condom*'.

9.2.7. Voluntary counseling and testing

Lack of information about free, anonymous HIV/AIDS testing. It is somewhat surprising that in the course of information/educational activities, interviews suggest that there has been little focus on the fact that it is possible to be tested for HIV/AIDS anonymously and free of charge, and that clients are sometimes unaware of this. Limited knowledge about anonymous and free testing among the population was also mentioned in the previous phase of this research.

9.2.8. Access to general medical services

Many PLWHA have a number of concomitant health problems. Whilst in recent years access to HIV/AIDS services has improved considerably, following support from international donor organizations (GFATM and CAAP), access to general medical services remains problematic. Based on data received during interviews, several barriers have been identified.

- **Confidentiality.** Potential service users avoid seeking care from general medical services because they are usually required to show documents, and there is no guarantee of confidentiality. One interviewee said: '*I am scared to go to a hospital, probably, someone would recognize me, here nobody knows me, I come here*';
- **Financial barriers.** For many representatives of vulnerable population groups general medical services are not affordable. When seeking medical care, financial resources are required ('…*one must pay for reference, tests, drugs, services of specialists*'; '*I had difficulties when I was 17 years old, I went to get treatment but it was too expensive*'). Many people do not have health insurance which is normally used to cover such costs.
- **Shortage of client-friendly services among general healthcare providers.** An outreach worker suggested that '… *all of them are sick and when they seek care themselves, they could be rejected. And you don't know where to refer and how to help…there are no client-friendly doctors*'.
- **Continuity.** In practice NGOs work with clients but do not always refer them to government run medical services if needed. Whilst communication between NGOs and the public sector improves annually, interviewees believed that it was still not enough to ensure acceptable level of accessibility.
- **Stigma and discrimination in governmental health organizations.** The attitude of health personnel to representatives of vulnerable groups is not always friendly. There are examples when PLWHA are refused hospitalization or, having learnt that they are IDU or HIV positive, health workers tried to discharge patients quickly without providing all the services needed.

9.3 Conclusion

- On the whole, in the period of GFATM (since 2004) and CAAP (since 2006), there have been considerable improvements in terms of access to and affordability of HIV/AIDS services, both for the general population and key groups (IDUs, SWs, MSM, PLWHA, youth, migrants and prisoners);
- Broad involvement of NGOs as well as public and private organizations has made it possible to deliver HIV/AIDS services in all regions of the country. The widest range of services is delivered in Bishkek and Osh, Chui and Osh oblasts (regions with the highest prevalence of HIV infection). However, the needs of people living in the southern regions (Osh, Jalalabat, Batken oblasts) and in rural areas (rayon level) are still not entirely met;
- Representatives of vulnerable population groups have free access to basic services (prevention and treatment of STI, SEP, testing for HIV, information/educational materials). Other types of care such as support to PLWG are also increasing;
- The research findings suggest there are positive changes in the risk behavior among key population groups, better awareness of their rights and of the services available to them.;

- However, barriers to accessing HIV/AIDS services remain. At institutional/program level these include financing of organizations, ineffective activities about raising awareness (quality of training activities, language of informational materials, correctness and timeliness of the information provided), and poor quality of supplies to prevent the spread of HIV (condoms, syringes). Further, communication and referrals between NGOs and governmental health organizations is still weak.
- At community/individual level the most substantial barriers are: clients' lack of awareness of HIV/AIDS services and their legal rights; stigma and discrimination by members of families and wider communities, law-enforcement authorities and in some cases, by health professionals. Financial barriers to accessing services also remain, including general medical services, and social care for PLWHA is inaccessible.

9.4 Recommendations

Recommendation #1. Intensify and improve the effectiveness of activities that aim to increase knowledge about the ways HIV can be transmitted and reduce stigma and discrimination in society.

Recommendation #2. Increase the types of services available with a focus on the development of rehabilitation programs, psychological-social counseling, legal services, and activities to ensure continuity between sectors.

Recommendation #3. Revise the mechanism for allocating benefits and social benefits to PLWHA so that the procedures are simplified and PLWHA confidentiality is ensured.

Annexes

Annex 1: List of organizations involved in the study

Governmental organizations

№	Organization name	Activities
Bishkek city and Chui oblast		
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 Oblast 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	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 oblast, Jail FMC	SEP, SMT
Osh and Jalalabat		
8	Osh oblast 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 oblast Sanitary-Epidemiological Surveillance Center	Oblast centers of State Sanitary-Epidemiological Surveillance were abolished according to Decree of the Kyrgyz MoH #124 «On improving organizational structure and standards of financing sanitary-epidemiological surveillance organizations for 2008 year» dated 27.03.2008.
10	Osh oblast Narcology Dispensary	Dissemination of information about HIV/AIDS prevention, detox-therapy, substitutive Methadone therapy, rehabilitation
11	Osh oblast TB Dispensary	Treatment of TB in HIV/AIDS patients
Issyk-Kul oblast		
12	Issyk-Kul Oblast AIDS Prevention and Control Center	Information/educational activity, dissemination of information about HIV/AIDS prevention, consultancy, HIV/AIDS testing
13	Issyk-Kul oblast Narcology Dispensary	Dissemination of information about HIV/AIDS prevention
14	Issyk-Kul TB Dispensary	Treatment of TB patients
15	Issyk-Kul oblast FMC	Dissemination of information about HIV/AIDS prevention

Nongovernmental organizations

№	Organization name	Activities
Bishkek and Chui oblast		
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	Socium	IDU – dissemination of information, distribution of condoms, syringe exchange
4	Ranar	IDU, released prisoners, MSM – harm reduction program, community center, care and support program
5	Koz Karash	PLWHA – programs of treatment, care and support
6	Health for all, Public Foundation	Dissemination of information about HIV/AIDS prevention among migrants from Uzbekistan and Tajikistan to reduce vulnerability towards HIV/AIDS
7	Family Medicine Specialists, Community Alliance *****	Training of health workers, training of trainers for FGP training, development of training plans and guidelines
Osh and Jalalabat cities		
8	Parents Against Drugs	IDU – dissemination of information materials and condoms, needle exchange
9	Healthy Generation (Jalalabat)	IDU – dissemination of information materials and condoms, needle exchange, user-friendly service
10	Girlfriend	CSW – dissemination of information materials and condoms, user-friendly service (diagnostic and treatment of STIs), training, social escort
11	Master of Joy	Awareness raising of the unorganized youth (street children)
12	TV and Radio Company Dastan TV******	Awareness raising of Uzbek and Kyrgyz population of Fergana valley on HIV/AIDS related issues
Issyk-Kul oblast		
13	Meder and Emb******* (Karakol)	CSW – awareness raising of the youth, diagnostics and treatment of STIs
14	Sakbol (Balykchy)	CSW – dissemination of information about HIV/AIDS prevention, distribution of condoms, diagnostic and treatment of STIs, training
15	Ulukman Daryger (Karakol)	Awareness raising of youth, diagnostics and treatment of STIs

Note: *NGO under the Kyrgyz State Institute of postgraduate training and continuous education, recipient of the small CAAP grant;
******Private organization which received small CAAP grant;
*******Private FGP

Annex 2: Sources of financing, 2007-2008

Non-governmental organizations

№	Organization name	Financing sources	
		2007	2008
Bishkek and Chui oblast			
1	Tais Plus	GFATM	GFATM
2	Nauchmedlait	GFATM	GFATM
3	Oasis	GFATM	The activity is ceased
4	Socium	GFATM	GFATM (as part of Consortium)
5	Ranar	GFATM	CAAP (rehabilitation)
6	Issyk-Kul, Public Foundation of Anti-AIDS Project	GFATM	The activity is ceased
7	Koz Karash	GFATM	CAAP (end of the project)
8	Health for All, Public Foundation	GFATM + CAAP (launch of the project)	CAAP (extension of the project)
9	Family Medicine Specialists, Community Alliance	CAAP (launch of the project)	CAAP (end of the project)
Osh and Jalalabat			
10	Parents Against Drugs	GFATM	GFATM + CAAP (regional project «Tumar» with involvement of 7 organizations)
11	Healthy Generation (Jalalabat)	GFATM	GFATM
12	Girlfriend	GFATM	GFATM + CAAP (regional project «Tumar» with involvement of 7 organizations)
13	Master of Joy	GFATM	No financing, break in the activity
14	TV and Radio Company Dastan TV ***	CAAP	CAAP (project is completed)
Issyk-Kul oblast			
15	Aphiyat (Karakol)	GFATM	The activity is ceased
16	Meder and Emb**** (Karakol)	GFATM	Break between two GFATM projects
17	Sakbol (Balykchy)	GFATM	Break between two GFATM projects
18	Ulukman Daryger (Karakol)	GFATM	Break between two GFATM projects