Mapping of Key HIV/AIDS Services, Assessment of their Quality, and Analysis of Gaps and Needs of Most-at-Risk Populations in Selected Sites of Kazakhstan

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March 3, 2011

This document is made possible by the generous support of the US President’s Emergency Plan for AIDS Relief (PEPFAR) and the US Agency for International Development (USAID) under contract No. GHH-I-00-0700068-00. The contents are the responsibility of the AIDSTAR-Two Project and do not necessarily reflect the views of USAID or the US Government.
Acknowledgements

The AIDSTAR-Two Project, led by Management Sciences for Health (MSH) in partnership with the International HIV/AIDS Alliance, would like to express its gratitude to the Ministry of Health of the Republic of Kazakhstan and all other governmental, non-governmental and international organizations for their continuous support while implementing this assessment to identify gaps in HIV/AIDS service delivery for most at risk populations (MARPs).

The authors would also like to acknowledge the useful contribution and assistance provided by the Regional and the Kazakhstan Office of the USAID Dialogue Project on HIV and Tb and the NGOs from the survey sites funded by the Dialogue Project, especially the NGO “Kuat” (Ust-Kamenogorsk), the NGO “Umit” (Karaganda), the NGO “Credo” (Temirtau) and the Association “Zholdas” (Shymkent) for the logistical and organizational support during implementation of this assessment.

Lastly, this assessment could not have been completed without the guidance and participation of USAID/Central Asia Regional Bureau and USAID/Kazakhstan.

Recommended Citation:
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<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<tr>
<td>ARVT</td>
<td>Antiretroviral therapy</td>
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<td>CAAP</td>
<td>Central Asia AIDS Control Project</td>
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<td>CAR</td>
<td>Central Asia Region</td>
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<td>CARHAP</td>
<td>Central Asia Regional HIV/AIDS Programme</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
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<td>CSW</td>
<td>Commercial sex workers</td>
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<tr>
<td>DOTS</td>
<td>Directly Observed Treatment Short course</td>
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<td>FC</td>
<td>Friendly Cabinet</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>HIP</td>
<td>Health Improvement Project</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>IDU</td>
<td>Injection Drug Users</td>
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<tr>
<td>IEC</td>
<td>Information, education and communication</td>
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<tr>
<td>MARP</td>
<td>Most at Risk Populations</td>
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<tr>
<td>MAT</td>
<td>Medication assisted therapy</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<td>MSM</td>
<td>Men who have sex with men</td>
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<tr>
<td>NGO</td>
<td>Non-governmental Organization</td>
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<tr>
<td>OST</td>
<td>Opioid Substitution Therapy</td>
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<tr>
<td>PEP</td>
<td>Post exposure prophylaxis</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PHC</td>
<td>Primary health care</td>
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<tr>
<td>PICT</td>
<td>Provider initiated counseling and testing</td>
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<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
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<tr>
<td>PSI</td>
<td>Population Services International</td>
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<tr>
<td>RHC</td>
<td>Rural Health Complexes</td>
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<tr>
<td>SES</td>
<td>Sanitary and Epidemiology Station</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<tr>
<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>USG</td>
<td>United States Government</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
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Executive Summary

The HIV epidemic in Central Asia requires a solid understanding of the epidemiological data and the services currently available for the general population and those most at risk, as well as the gaps in program delivery. USAID has commissioned this assessment in order to develop a deeper understanding of the current status of HIV/AIDS services for most at risk populations, particularly for injection drug users, commercial sex workers, men who have sex with men, former prisoners, and people living with HIV (PLHIV). This assessment describes the access and the quality of the services being provided to these groups, and identifies the service delivery gaps and capacity building needs of both nongovernmental and governmental agencies. The assessment was conducted using qualitative research methodologies, namely semi-structured interviews and focus group discussions, in several sites located in Almaty, Shymkent, Ust-Kamenogorsk, Karaganda, and Temirtau in Kazakhstan.

The assessment’s key findings illustrate that HIV services in Kazakhstan are mostly delivered through a network of specialized vertical programs (AIDS Centers) with the spectrum of services still falling behind the internationally recommended combination of interventions. Drawing of blood for HIV testing is the only HIV-related service effectively implemented by most governmental medical facilities. The rich potential of non-governmental and community-based organizations to help provide services is significantly under recognized. This has created an environment with a severe lack of social and other support services, which has resulted in a limited responsiveness of existing services to vital needs of clients and prospective clients, and reduced access to HIV prevention and care for most-at-risk groups. Other key obstacles to providing increased services include a low level of motivation among medical personnel and high levels of discrimination against PLHIV and MARPs in general.

Collaboration between NGOs and governmental medical facilities is most effective when medical facilities’ staff receive financial incentives from NGOs, such as topping up salaries. A common understanding already exists among medical personnel of the need for and the added value of such collaboration, especially when dealing with psychosocial problems of MARPs and ensuring treatment adherence. When clinical facility personnel must take on additional functions that would normally be performed by community-based organizations, it results in a lack of rapport with their clients; building trust with clients constitutes one of the key success factors of community-based programming, without it, achievements in outreach and service accessibility are modest, and the services are not well-used by clients. This can be seen when looking at the work of Trust Points located within governmental health care facilities, which is not effective and services only a small number of IDUs. More people at risk would use services of Friendly Cabinets located at the local AIDS Centers or polyclinics if these sites offered a wider range of testing and treatment of STI services, had more convenient hours, and were not affected by extended periods of funding interruptions.

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1 A Trust Point, sometimes referred to as needle exchange point, is a place for MARPs to come and receive free-of-charge clean needles and syringes, condoms, and IEC materials. Some Trust Points also provide social support counseling and referral to medical services. The Trust Points originally emphasized the trust-based relationship between service providers and clients, which was their distinctive feature. The governmental ‘Trust Points’ borrowed the rhetoric but failed to introduce required changes in staff attitudes and accessibility parameters.

2 A Friendly Cabinet is a room in a medical facility specifically designed and focused on providing free-of-charge STI testing and treatment services, HIV testing services, as well as basic information support and condoms to MARPs. It is usually located at the AIDS Centers. Similarly to the Trust Points, the original meaning of the term has been diluted in the atmosphere of a post-soviet clinical facility which can be described as anything but friendly.
In order to achieve the required level of access to HIV prevention and care, better respond to essential needs of those at risk, and satisfy growing demand, programs need to move away from the provision of basic HIV prevention services reduced to a combination of testing, basic counseling and medical care, and move towards targeted and integrated programs that are tailored to the key segments of each of MARP group. Concerted efforts of the governmental facilities, community-based and community-focused non-governmental organizations are one of the pre-requisites for the successful development of HIV prevention and care work in Kazakhstan. Other key recommendations of the assessment include:

- Improved program monitoring to reduce the monitoring workload of service delivery practitioners and at the same time ensure more focused and reliable intervention measurements;
- Wider application of a case management approach in HIV prevention in addition to care;
- Better integration of HIV and migration programs strengthening continuity of service access; and
- Strengthened medication-assisted therapy programming with better investment of funding, technical support, and policy development efforts.
Introduction

The growing HIV epidemic in Central Asia requires a solid understanding of the epidemiological data and a review of the services currently available and the gaps in program delivery. The USAID Central Asia Regional Bureau (CAR) is tasked with scaling up its response to the epidemic and to this end has been implementing the USAID Dialogue on HIV and Tb Project (also known as the Dialogue Project). In the near future, it will also start implementation of the Quality Health Care Project, which will focus on facility-based HIV and other public health services, linking them to outreach programs such as the Dialogue Project. In order to inform both of these projects, USAID/CAR is interested in developing a deeper understanding of the current status of HIV/AIDS services for most at risk populations (MARPs), particularly for injection drug users (IDU), commercial sex workers (CSW), men who have sex with men (MSM), former prisoners, and people living with HIV (PLHIV), as well as the access they have to and the quality of these services. In addition, USAID is interested in defining service delivery gaps and the capacity building measures required to bridge them. This assessment report aims to provide this information and recommendations that can be implemented in the near future.

Background and objectives

Epidemiological Situation

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

According to official statistics, as of January 1, 2010, the HIV prevalence rate was 73.1 per 100,000 people in the Republic of Kazakhstan, with 15,318 HIV-positive people cumulatively registered in Kazakhstan by October 1, 2010. The majority of people (95%) living with HIV (PLHIV) are 15-49 years old, with almost 80% of them falling in the age range of 15-29. Although the epidemic is still dominated by injection drug use (55%), recent data indicate a steady increase of HIV transmission through unprotected sexual contact, from 5% in 2001 to 35.5% in 2009. This trend has recently been observed across several countries of Central Asia and Eastern Europe and has been shown to be predominantly associated with sexual transmission from IDUs to their sexual partners.

According to the latest sentinel surveillance results, HIV prevalence in 2009 was 2.9% among IDUs, 1.3% among female sex workers, 0.3% among MSM, and 2.6% among prisoners. High prevalence rates of viral hepatitis C among injection drug users (60.3% in 2009) and prisoners (43.3%) indicates that unsafe injection practices are pervasive among key populations at higher risk. The prevalence of syphilis in 2009 was 18% among sex workers, 5% among MSM, 11% among IDUs and 11% among prisoners, which illustrates high rates of unsafe sexual practices.

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3 According to the Agency of Statistics of the Republic of Kazakhstan the population of Kazakhstan as of January 1, 2010 was 16,198,314 people.
6 See e.g.
HIV/AIDS-Related Services
According to the latest UNGASS Country Progress Report, the total budget for the National HIV Program in 2009 was approximately USD 22.8 million, out of which approximately USD 16.3 million (72%) came from the national and local budgets, with the rest coming from external donors, primarily the Global Fund to Fight AIDS, TB, and Malaria (GFATM).

As of July 1, 2010, 168 Trust Points, primarily targeting injection drug users, were established in the country, as were 30 Friendly Cabinets located within AIDS Centers that provided STI testing and treatment services to MARPs. In 2008, two pilot sites of medication assisted therapy (MAT) were opened, one in Temirtau and another in Pavlodar, to provide methadone and related services to up to 50 IDUs. To facilitate the delivery of voluntary counseling and testing services (VCT), 362 counseling rooms and 299 rooms for anonymous HIV testing were opened.

Kazakhstan began offering anti-retroviral therapy (ARVT) in 2005. As of July 1 2010, 1,171 PLHIV were receiving ART in all oblasts of the country. Since 2009, most anti-retrovirals are procured using the country’s own resources with the GFATM steadily decreasing its support.

USAID initiated the Dialogue Project in September 2009 to provide technical assistance, training and direct outreach services to increase access to quality HIV prevention and tuberculosis (TB) prevention and treatment interventions among most at-risk populations (MARPs). The Dialogue Project works in Almaty city and Karaganda, East Kazakhstan and South Kazakhstan oblasts in Kazakhstan; Bishkek city and Chui oblasts, Osh and Djalalabad cities in Kyrgyzstan; Dushanbe, Vahdat, Kurgan tube, Kulyab and Khujand in Tajikistan; and if the Government of Uzbekistan approves the project’s work plan, it will operate in the cities of Tashkent, Samarkand, and Termez.

The Quality Health Care Project was launched in October 2010, providing technical support, training, equipment and commodities to assist the Central Asian Republics in improving the quality, scope, and coordination of health services, including HIV. By incorporating modern quality improvement techniques and evidence-based international standards into ongoing health system reforms, this program will help Central Asian countries to improve their management, financing, and implementation of medical services for tuberculosis, HIV/AIDS, maternal and child health, and primary health care. USAID envisions that the project will work in the same geographical areas as the Dialogue Project.

Objectives
The main objectives of this assessment were to:

1. Identify HIV services currently being provided to the five MARP target groups (MSM, CSW, IDU, former prisoners, and PLHIV) in selected sites in Kazakhstan to assess their:
   - Service provision and geographic coverage
   - Fees
   - Referral processes
   - Best/promising practices
   - Perceived challenges and barriers
   - Informed consent procedures
2. Identify perceived quality of services and service gaps among MARP target groups that are users and non-users of HIV services in the sites.
3. Develop recommendations for improving access to and the quality of services provided by the facilities.

**Methodology**

The assessment was based on qualitative research methodologies. Semi-structured interviews and focus group discussions were conducted among different groups of respondents in five sites in Kazakhstan (see List of respondents in Appendix 1).

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

1. Local AIDS Centers (5 centers)
2. Local TB Dispensaries (4 dispensaries)
3. Local STI Dispensaries (4 dispensaries)
4. Local Narcology Dispensaries (5 dispensaries)
5. MAT Point in Temirtau
6. Trust Points (6 sites)
7. Friendly Cabinets (4 sites)
8. A private pharmacy that participates in ARV distribution
9. Local polyclinics (4 polyclinics)
10. Infectious disease hospitals (3 hospitals)

In addition, semi-structured interviews using a separate tailored tool were conducted with key staff from these seven Dialogue Project-funded NGOs: Umit, Omir LAD, Adali, Credo, Association Zholdas, Sau-Urpak, and Kuat (see Interviewer Guide: Dialogue-funded NGO Staff in Appendix 3). The objective of the interviews with the NGOs was to assess the range and coverage of the services provided by them in relation to the size of the key MARP groups they serve.

In addition to these two sets of semi-structured interviews, a series of focus group discussions and individual in-depth interviews were conducted with IDU, PLHIV, commercial sex workers, MSM and former prisoners. These were held to identify the perceived quality of services provided by governmental facilities, NGOs and the private sector, as well as service gaps, unmet needs, and challenges these MARP groups have encountered when accessing needed services.

**Limitations**

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

- This assessment was conducted using qualitative methodology, which limits the possibility of statistical analysis of obtained data.
- The assessment focused only on five geographical locations, most of which are bigger cities, and as such its results do not necessarily represent the country’s overall situation.
• Collection of statistical information about the number of MARPs served by a medical facility (other than Friendly Clinics or Trust Points) during implementation was not possible due to the fact that medical facilities do not keep attendance records by specific groups of people, but rather by gender, age and the reason for referral (disease).
• Representatives of MARPs who participated in the focus groups or individual interviews were recruited through NGO representatives (outreach workers) and, thus only included clients of HIV-related services. In addition, the number of focus group/interview participants was too small to be representative of the population.
• It is possible that participants could have expressed views that are consistent with social standards and thus tried to present themselves in a positive manner. This social desirability bias may have led respondents to self-censor their actual views, especially when asked questions in a group setting. To partially control this bias, in-depth interviews with individual clients from each of the MRP groups were conducted, in addition to the focus group discussions.
• Some of the respondents from the governmental medical facilities were also employed in different projects managed by NGOs. Therefore, some of the services they provided were actually delivered within the NGO’s scope of work and would not be normally provided by the staff of the governmental medical facility. In such situations, respondents were asked to specify in which capacity they were providing services to MARPs.

Detailed Findings

Findings from the Mapping Assessment with Government Facilities

Services offered by governmental facilities
The key responsibility of overall supervision of all medical activities at the local level lies with the Oblast Health Department. In addition to a number of specialized vertical programs (e.g. TB, HIV, narcoology and STI), a network of general health care systems that includes inpatient care and numerous outpatient polyclinics/Family Medicine Clinics (SVA) and Rural Health Complexes (RHC) provide different medical services to the population according to a government-approved guaranteed benefit package.

Local polyclinics organize outpatient primary health care (PHC) and family medicine services for adults and children enrolled with them. They provide some HIV-related services, including blood collection for HIV tests, sputum smear microscopy, X-ray examination, continuation-phase of TB treatment, and some STI screening tests, including the Wasserman test for syphilis. They also carry out limited activities on HIV prevention such as health promotion and counseling services. Some polyclinics run Trust Points for injection drug users (supported by the GFATM-funded Project). In Temirtau, one polyclinic also provides outpatient services, including ARVT monitoring for PLHIV.

Oblast and city AIDS Centers are the key implementers of the National HIV Program on a local level. Every suspected case or confirmed case of HIV is referred to the city/oblast AIDS Center, for proper confirmation and further management. AIDS Centers organize a range of preventive and diagnostic services (clinical, biochemical, serological and immunological tests), out-patient treatment and care for PLHIV, ARVT, as well as treatment of opportunistic infections. With the support of the GFATM-funded Project, AIDS Centers also run Trust Points and Friendly Cabinets to provide specific services to MARPs. Within their prevention terms of reference, AIDS Centers are expected to implement outreach programs for their target populations (IDUs, sex workers and MSM).
Services provided by the Oblast and City TB Dispensaries include prevention, diagnostics and treatment of TB. Local TB Dispensaries also draw blood for HIV testing from all hospitalized patients. Treatment of TB during the continuation phase of Directly Observed Treatment Short course for TB (DOTS) is integrated into a number of PHC polyclinics.

Services of local Dermatovenerereal Dispensaries (here referred as STI dispensaries) include early detection and all relevant preventive, diagnostic and treatment services for STIs (both outpatient and inpatient). They also draw blood for HIV testing and require mandatory fluorography for patients referring to in-patient care.

Local Narcology Dispensaries are another specialized vertical service, responsible for early detection and enrollment of drug-users and alcoholic patients, and the organization of counseling, diagnostic, treatment and rehabilitation services through either outpatient or inpatient services. Among HIV and TB related services, narcological dispensaries draw blood for HIV testing, collect sputum or sometimes perform sputum smear microscopy and perform Wasserman tests for syphilis. Also, consultation and counseling on HIV/AIDS, TB and STIs are reportedly provided.

There are also separate Infectious Hospitals that provide inpatient care to adult and children for specific infectious diseases. Recently, all infectious disease hospitals have allocated several beds in their hepatitis departments for PLHIV.

Funding for all governmental health facilities mentioned above comes from the local health budget which is administrated by the Oblast or City Health Department. Funding for local polyclinics comes from the local health budget according to per capita rates based on the specific PHC services they are mandated to provide to the enrolled population. Funding for specialized dispensaries is based on the specific requirements for the corresponding medical facilities/services determined by the relevant state/oblast directives. Some facilities are able to charge fees for their services and accumulate additional income.

Hours of operation for all out-patient services at the governmental facilities are standard working hours (either from 8:00 a.m. to 5:00 p.m., or 9:00 a.m. to 6:00 p.m., depending on the work schedule); these same hours of service are in place at Trust Points and Friendly Cabinets. During non-operating hours, clients can only access services in emergency situations using an ambulance.

All facilities have some sort of system in place to assess the quality of services provided. For most organizations, this system includes both the periodic review and analysis of data that comes from official statistics, as well as passive collection of feedback from clients, which is done by placing a suggestion box for clients somewhere in the facility or putting up a note with the telephone numbers clients can call with complaints. This mechanism is not very effective, as only very few clients leave suggestions (mostly negative feedback) and those suggestions are reviewed on ad hoc basis and do not necessarily lead to action. A few facilities, such as the Karaganda Oblast TB dispensary, conduct periodic client satisfaction surveys.
**Key Challenges**
The main challenges in implementation of quality HIV prevention, treatment, care, and support services from the perspective of the health facilities include:

- Low motivation of service providers due to low salary levels and very high workloads (especially paperwork);
- A lack of systematic training to sensitize personnel to the issues and challenges faced by MARPs and to eliminate the widespread stigmatization of these populations;
- A lack of supportive supervision: Numerous inspections lead only to punishment and are rarely conducted in the form of supervisory visits. Inspection terms of reference do not contribute to establishing levels of service quality and recommendations for improvements;
- Lack of collaboration with community-based entities and absence of personnel prepared to provide psychosocial support and address some of the non-medical needs of MARPs and other socially vulnerable groups of people as well as to ensure individual attention to clients;
- Lack of rapport with MARPs which could be compensated by closer collaboration with and support from non-governmental service providers;
- A regulatory environment and current changes related to the introduction of a single health care system that challenges provision of anonymous services or services to people who do not have documents and/or fails to ensure confidentiality of those with HIV and other STIs;
- Inadequate level of awareness among medical professionals about HIV/AIDS;
- Inadequate distribution of equipment and supplies between key centers located in big cities; small cities are badly supplied/undersupplied.
- The inability to provide an optimal level of care to patients due to the absence of required medicines caused by planning, procurement and supply management deficiencies.

Increased salaries or additional payments are still the most welcome incentive for health service providers working at governmental facilities. Improved working conditions (e.g., renovated buildings, modern equipment, expanded opportunities for diagnosis and treatment of patients) and an opportunity to receive additional training and high quality professional literature are additional motivations valued by the staff.

Most governmental medical organizations recognize that closer cooperation with NGOs is needed, especially when working with MARPs on HIV prevention ARVT adherence. Almost all respondents have noted that currently this cooperation is not sufficient and they would like to see NGOs providing more support to them. NGOs are also perceived to have better access to donor funds and to be more capable of providing MARPs with social services that are in high demand.

Almost none of the facilities assessed have had a chance to participate in the system of vouchers started by the Dialogue Project. Since there are no services that are available only to clients referred by the Dialogue Project, service providers think that vouchers are only useful for internal project monitoring purposes and thus do not feel responsible for filling them in or making sure they are not lost.

**HIV Prevention and Awareness Activities**
Among governmental medical facilities, local AIDS Centers are generally in charge of HIV prevention and awareness raising among the general population and MARPs.
The **HIV awareness activities** conducted by epidemiologists of the AIDS Centers usually take the form of short educational lectures to organized groups (such as those found in educational facilities or workplace environments), as well as specific outreach worker activities among MARPs. Each AIDS Center employs 10-20 outreach workers, and each of them is assigned to a specific group. Outreach workers are recruited from either the medical personnel (usually nurses) or representatives of MARPs and their family members. Approximately half of the outreach workers are paid by the GFATM-funded Project, while the other half is covered through the local department of social protection under the support of the employment program. Outreach workers conduct basic HIV awareness education, distribute information, education and communication (IEC) materials and condoms/syringes to MARPs. IEC materials, most often developed within the GFTAM-funded Project or other projects, are also distributed to clients of the Trust Points and Friendly Cabinets.

**Needle and syringe exchange** is available through Trust Points located at local AIDS Centers and polyclinics. Working hours of Trust Points located at governmental facilities vary significantly. Some are opened from 9 a.m. until 6 p.m., some from 10:30 a.m. to 4:15 p.m. and closed on Saturdays and Sundays. But despite fixed operating hours, Trust Points are not always open; for example, three of nine Trust Points visited during the assessment were closed during their operating hours. Almost all Trust Points located within the governmental medical facilities are staffed by a nurse and a social worker. Only a few have 1-2 outreach workers (mostly those located at the AIDS Centers). Most of the time, nurses of the Trust Point receive only 25% of their salary for the job they do at the Trust Points and most of their duties are performed elsewhere in the facility; this is one reason why Trust Points are often closed during operating hours. The number of people that use services of Trust Points at governmental medical facilities is very low (from 6-50 IDUs per month). All needles and syringes are procured through local health budgets or the GFATM-funded Project and are provided to clients free of charge. Though the quality of needles and condoms being distributed has improved, many clients still complain about needles being too thick, syringes being the wrong size and condoms being of cheap quality. All AIDS Centers have Mobile Trust Points that are considered by all respondents to be the most effective, especially when distributing condoms to sex workers.

**HIV Voluntary Counseling and Testing (VCT)**
According to the Health Code of the Republic of Kazakhstan any person can undergo VCT free of charge in any governmental medical facility. VCT can be done anonymously or using passport details; in all the cases testing should be confidential. To facilitate anonymous testing in accordance with the **MOH prikaz (order) #227**, special anonymous counseling rooms were opened in many governmental medical facilities. In 2008 the Ministry of Health signed a revised **prikaz #150** that approves clinical guidelines for VCT. Provider-initiated testing is performed in accordance with the **prikaz #575**. Personal documentation is required for provider-initiated testing. Written consent of a person tested is required for any type of HIV testing.

Counseling and testing is done free of charge. Sometimes in the case of hospitalized patients admitted on a pay-basis, patients are charged a very small fee (approximately USD 0.2) for drawing of blood, but the testing itself is always done free of charge.

Over the last several years, HIV testing among MARPs has increased significantly, from 32,703 tests in 2003 to 134,891 tests in 2009. However, most HIV testing is still provider-initiated. Table 1 on the following page shows that only about 1% of all people tested in 2009 were IDUs, which is the most

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8 This number includes only tests with codes 102 (IDUs), 103 (MSM), 105 (sex workers) and 112 (prisoners).
epidemiologically significant population group in Kazakhstan. At the same time the percentage of positive HIV results among IDUs is significantly higher when compared to the other groups.

Table 1: Number of people tested for HIV in 2009, by the testing code (reason for testing). Selected codes only

<table>
<thead>
<tr>
<th>Code</th>
<th>Groups of people tested</th>
<th>Number of people tested</th>
<th>% from the total number of people tested</th>
<th>% of people with confirmed HIV+ status out of the total number of people tested</th>
</tr>
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<tbody>
<tr>
<td>109</td>
<td>Pregnant women</td>
<td>850,142</td>
<td>41%</td>
<td>0.01%</td>
</tr>
<tr>
<td>108</td>
<td>Donors</td>
<td>289,945</td>
<td>14%</td>
<td>0.02%</td>
</tr>
<tr>
<td>113</td>
<td>Patients tested because of clinical symptoms (adults)</td>
<td>198,549</td>
<td>10%</td>
<td>0.16%</td>
</tr>
<tr>
<td>112</td>
<td>Prisoners</td>
<td>101,498</td>
<td>5%</td>
<td>0.49%</td>
</tr>
<tr>
<td>117</td>
<td>Patients tested because of clinical symptoms (children)</td>
<td>68,160</td>
<td>3%</td>
<td>0.01%</td>
</tr>
<tr>
<td>200</td>
<td>Foreign citizens arriving for more than 3 months</td>
<td>70,494</td>
<td>3%</td>
<td>0.2%</td>
</tr>
<tr>
<td>104</td>
<td>Patients with STIs</td>
<td>59,575</td>
<td>3%</td>
<td>0.11%</td>
</tr>
<tr>
<td>113.5</td>
<td>Patients with pulmonary TB</td>
<td>51,006</td>
<td>2.5%</td>
<td>0.28%</td>
</tr>
<tr>
<td>120</td>
<td>Medical professionals</td>
<td>36,346</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>102</td>
<td>Injection drug users</td>
<td>25,402</td>
<td>1%</td>
<td>1.18%</td>
</tr>
<tr>
<td>114</td>
<td>Anonymous testing</td>
<td>18,809</td>
<td>0.9%</td>
<td>0.29%</td>
</tr>
<tr>
<td>105</td>
<td>Sex workers</td>
<td>7,583</td>
<td>0.4%</td>
<td>0.2%</td>
</tr>
<tr>
<td>103</td>
<td>Men who have sex with men</td>
<td>408</td>
<td>0.02%</td>
<td>0.74%</td>
</tr>
<tr>
<td>TOTAL number of people tested</td>
<td>2,065,210</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL number of tests performed</td>
<td>2,297,588</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All facilities assessed – AIDS Centers, TB Dispensaries, STI Dispensaries, Narcology Dispensaries, and Polyclinics – provide HIV counseling and drawing of blood for testing. Rapid HIV test kits are available at the maternity delivery sites, in case a woman is admitted for delivery with an unknown HIV status, as well as at STI dispensaries for STI clients that are being treated anonymously (in Almaty, for example). Besides those specific instances, all other actual testing is always done at the AIDS Centers (ELISA at the local AIDS centers and Western-blot at the National AIDS center).

Currently pregnant women constitute the group that is tested the most (for example, out of 350,000 tests performed at the South-Kazakhstan AIDS Center, 150,000 were done for pregnant women). Every facility has a trained person who is specifically assigned to provide VCT. In case of a negative result, post-test counseling is done at the facility where the blood was drawn. Post-test counseling in the case of a positive HIV result is conducted by staff of the local AIDS Center.

The quality of HIV testing is monitored through laboratory verification methods. In addition, all positive ELISA tests are verified through a Western-blot test at the reference laboratory of the National AIDS Center in Almaty. There is no system to monitor the quality of counseling provided at any of the governmental medical facilities. Based on the interviews with providers, very little pre-test counseling is done in case of provider-initiated testing. Whenever delivered, the pre-test is conducted as a set of

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questions rather than discussion encouraging clients to decide and learn. Almost no post-test counseling is provided to those who tested negative, which means that the important prevention potential of HIV testing is underutilized.

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

In the case of a negative result, a person can receive test results the same day or the next day at the latest. A little more time is needed if the person resides outside of cities that have AIDS Centers. Confirmation of a positive result takes 1-3 weeks. In the case of anonymous VCT, a person is only required to provide his/her confidential code to receive test results. Personal identification documents are only requested when a person wants to receive a certificate confirming his or her HIV status. When an HIV positive test result is confirmed by the National AIDS Center, test results are sent back to the local AIDS Centers. Upon the receipt of positive results, epidemiologists of the local AIDS Centers initiate epidemiological investigations during which newly-diagnosed PLHIV are asked to refer their partners (sexual and injection) for HIV testing. During the epidemiological investigation, PLHIV are also being provided with counseling that includes information about possible legal consequences of further spreading HIV. AIDS Center staff can also provide partner notification support upon request.

**Treatment Services to PLHIV**

Antiretroviral therapy (ARVT) was launched in Kazakhstan in 2005; 1,171 PLHIV were receiving ARVT as of July 1, 2010. The majority of PLHIV on ARVT were in Karaganda oblast (293), South-Kazakhstan oblast (242) and Almaty city (142). Apart from one pilot program located in Temirtau (Karaganda oblast), under which ARVs are officially provided at the polyclinic-level and random cases of ARVT provision at the PHC level in Almaty and Almaty oblast, ARVT in the country is centralized and is mostly provided through a network of local AIDS Centers. Based on the official ARVT report of the AIDS Center, by the end of June 2010, 84% of those on ARVT were receiving it at the AIDS Center; 14% of PLHIV on ARVT were prisoners receiving their drugs at the specialized medical facilities of the penitentiary systems; and less than 3% were getting ARVs at the PHC level.\(^\text{10}\) Of those PLHIV on ARVT who were getting their ARVs at the polyclinic (30 people), 50% were children in the oblast of South Kazakhstan, who were receiving all their HIV-related services at the Mother and Child Center.

The updated National HIV Treatment Protocol currently being considered by the Ministry of Health recommends starting ARVT at a CD4 count level of 350 cells. Current protocol allows early start of ARVT, but generally recommends starting treatment at CD4 count of 250 cells. The perceived ability of a person to adhere to treatment is also considered for ARVT initiation aside from the CD4 count. As such, active drug users are often not started on treatment despite their CD4 cell counts. The majority of doctors responsible for ARVT at all levels have received special training by the National AIDS Center or through different projects. Updated clinical protocols and prikazes are sent by the National AIDS Center to all local AIDS Centers.

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ARVs are provided free of charge for patients. Before 2009, almost all the ARVs, except pediatric ARVs and ARVs for PMTCT, were provided by the GFATM-funded Project. Since 2009, the portion of ARVs procured using national resources has been steadily increasing; it is expected that by 2011, the national health budget (including local health budgets) will fully cover the funding for all ARVs.

PLHIV receive ARVs for a period of 1-3 weeks, depending on their adherence. During the last 12 months there were no stock-outs of drugs. Monitoring of ARVT is done based on the clinical symptoms and CD4 counts (once in 6 months).

The centralized ARV distribution system was questioned by many assessment respondents, who noted that it prevents easy access of ARVs by PLHIV who reside in rural areas; and that it adds an enormous amount of work to the few HIV Centers’ clinicians. This was especially noted in Southern-Kazakhstan and Karaganda.

Temirtau is a pilot site where the USAID-funded CAPACITY Project has helped to establish an off-site clinic for ARVs. At the time of the assessment 216 PLHIV were on ART in Temirtau. Treatment and care services for PLHIV were provided at the city AIDS Center and the satellite clinic located at the city polyclinic #2. This satellite polyclinic is staffed with a nurse and an infectologist (physician) seconded by the AIDS Center to the polyclinic for three hours per day.

Although the Temirtau AIDS Center continues to store and distribute ARVs procured using the GFATM funds, the local health department announced a tender and selected one commercial pharmacy that is currently responsible for procurement, storage and distribution of ARVs purchased through the local health budget in 2008. This was done because (1) the Temirtau AIDS Center lacks the pharmacy capacity to store large quantities of ARVs; and (2) to further decentralize procurement and supply management of ARVs. In order to receive ARVs at the commercial pharmacy, PLHIV need to obtain a prescription from the AIDS Center and go to the pharmacy to receive their drugs. This system is inconvenient for both patients and the doctors. For patients, it is inconvenient because they often receive part of their prescription from the GFATM-funded stock and the other part from the stock funded by the local budget, meaning they must go to two sites to receive all their drugs. For doctors, the system is inconvenient too, because they recognize that two separate visits to obtain drugs poses an additional challenge to adherence; and as physicians, they are unable to control whether or not a patient receives all of his/her drugs or not. Although strictly prohibited, physicians often write prescriptions and receive drugs from the commercial pharmacy themselves and then give the drugs to PLHIV together with the GFATM-funded drugs at the AIDS Center. None of the sites have experienced stock-out of ARV during the last 12 months.

Clinical monitoring of patients on ARVT including doing a CD4 cell count and a viral load. All AIDS Centers assessed had the necessary equipment to perform those tests on site and did not experience any stock-outs of supplies over the last 12 months.

Outpatient treatment of opportunistic infections excluding TB (please see TB section below) is provided by staff at the AIDS Centers. A good portion of the drugs to treat these infections (antifungals, broad spectrum antibiotics, anti-virals) are provided by the GFATM-grant. Over the past 12 months, AIDS Centers have experienced stock-outs of some OI drugs. PLHIV have to buy any other drugs that are not provided by the GFATM at the local commercial pharmacies. Generally, proper diagnosis, especially its laboratory confirmation, remains challenging due to the low qualification of specialists and little experience managing opportunistic infections.
For inpatient treatment services for opportunistic infections, a certain number of hospital beds are allocated for PLHIV in infectious disease hospitals. All inpatient services are provided for free, though the range of services is limited due to the low laboratory and treatment capacity of infectious disease hospitals. When in the hospital, PLHIV are normally put in separate isolated rooms. An AIDS Center staff is called to consult the patient, but hospital physicians in several sites complained that specialists of the AIDS Centers are reluctant to come to the hospital. Also infectious disease hospitals are not able to provide all the pharmaceuticals and laboratory tests needed to properly manage PLHIV and thus, they provide suboptimal level of medical care for these patients.

**Hepatitis C testing and treatment**
In accordance with the established HIV management protocol, PLHIV are tested for Hepatitis B and C free of charge at the AIDS Centers. Hepatitis C treatment remains extremely expensive and is currently not provided to PLHIV by any of the projects. Moreover, there are not many specialists in the country, especially at the oblast level, that have experience treating Hepatitis C, so Hepatitis C treatment can be considered as not accessible for PLHIV.

**Prevention of Mother to Child Transmission (PMTCT)**
On December 29, 2008, Kazakhstan approved updated PMTCT clinical standards (under the order of the Ministry of Health #699) and has been successful in their implementation. All PMTCT services are provided free-of-charge at PHC-level, AIDS centers (for HIV-positive women) and maternity sites.

Universal HIV testing is performed at the PHC level twice during pregnancy (at the time of antenatal registration – around 12 weeks of pregnancy – or prior to abortion, and again at 28-30 weeks of pregnancy). Maternity hospitals also conduct intrapartum testing for women with undocumented HIV status. All maternity facilities have rapid tests available on-site. Counseling and antenatal management of all HIV-positive pregnant women is performed by the AIDS centers.

Although national clinical guidelines recommend using the three component scheme of lamivudine and zidovudine (Combivir) and lopinavir/ritonavir (Aluvia) for antenatal ARV prophylaxis in women that do not receive ARVs for their own health, different schemes are used to prevent vertical transmission. This includes the recommended three-component schemes, two-component schemes with Combivir only and rarely used single drug prevention with retrovir (Zidovudine). In the case of late HIV testing and a need for emergency intrapartum prophylaxis, zidovudine is given to a mother every three hours prior to the start of delivery, and lamivudine during the delivery. Babies born to HIV-positive women are given zidovudine. Babies also receive four months of prophylaxis against *Pneumocystis carinii pneumonia* (PCP) using cotrimoxazole. All ARVs for PMTCT are procured using the country’s own resources. There were no stock-outs of drugs during the last 12 months. All infants born to HIV-infected mothers are diagnosed using PCR technique and receive an HIV test within the first year of their life.

Infant feeding counseling is done by staff at maternity sites and AIDS Centers. Provision of free-of-charge baby formula is included in the PMTCT plan and local health departments include procurement of formula into their budgets. There were no stock-outs of baby formula during the last 12 months.

Family planning counseling for PLHIV is commonly done by a gynecologist at the AIDS Center.
Community and home-base care and support for PLHIV

AIDS Centers are the only governmental facility that provides support to PLHIV. The range of services includes adherence counseling and support, individual psychological counseling, provision of legal counseling on-site, as well as referral for legal counseling, support in obtaining permanent disability status or getting personal identification documents, food packages and provision of other humanitarian aid. AIDS Centers try to attract the family member of PLHIV to work as outreach workers and help with adherence. AIDS Centers also refer clients to different NGOs where they can receive more support within different projects. In some areas there are social adaptation centers (for example in Maikuduk, Karaganda oblast) funded by the local budget that provide temporary residence, food and other support services to socially vulnerable groups of people; however people with TB or HIV cannot be accepted to those centers.

Unfortunately, home-based care is not implemented either by any of the governmental medical facilities on-site nor through referrals. Occasionally patients and their family members are referred to different religious organizations or Red Crescent branches to seek home-based care services, but those referrals are not systematic.

TB Diagnosis and Treatment

In Kazakhstan primary health care providers (polyclinics) are responsible for the identification of TB suspects among the general population (done by sputum microscopy, fluorography or chest x-rays, skin tests for people younger 18) and referring TB positive cases to specialized services (city or oblast-level TB Dispensaries or the National TB Center in Almaty).

Sputum smear microscopy is considered a key activity for passive TB screening among the general population and is done free of charge at the PHC level for patients with pulmonary symptoms. Each polyclinic has a laboratory specialist specifically assigned and trained to do sputum microscopy. Active TB screening by fluorography is mainly done for organized groups of people and those at high risk, such as students, women in early postpartum period, prisoners, etc. Fluorography is also done free-of-charge, however anecdotal evidence exists that in the case of self-referral patients have to pay a small fee (approx 200 tenge or USD 1.3). Chest x-rays are also used for TB screening and are usually done for a fee.

TB diagnosis and treatment is done at specialized TB dispensaries. All TB diagnosis and treatment services are free of charge if patients are referred by the PHC. Self-referred patients have to cover the costs of basic medical examination (about 500 tenge, USD 7); other costs directly related to TB treatment, including drugs, are covered by the facility. All drugs necessary for DOTS therapy are procured using the country’s own resources, DOTS+ (second line TB drugs) are procured from the local health budgets, as well as the Global Fund grants. Oblast TB Dispensaries are generally satisfied with the range of laboratory equipment they have. In addition to x-ray examinations, basic smear microscopy, and general medical examinations, TB Dispensaries also perform culture and drug susceptibility testing (DST) on site. There were no stock-outs of TB drugs and necessary laboratory supplies during the last 12 months.

The intensive phase of treatment for the smear-positive TB patients is provided on an in-patient basis free of charge. Smear-negative TB patients, especially PLHIV, can opt to be treated at the PHC level on an out-patient basis. The continuation phase of DOTS and DOTS+ is also provided at the PHC level. Adherence to the continuation phase of treatment, including those with MDR TB remains a challenge. This is due to the fact that none of the TB dispensaries have a full-time psychologist that could provide
adherence counseling support to patients and there are almost no NGOs that help to ensure further adherence when patients are being released from TB dispensaries for the continuation phase at the PHC level. In some oblasts, for example in Eastern Kazakhstan, the city administration provides monthly payments (around USD 50-60) for those TB patients that have good adherence. The Global Fund supported project also provides food packages for a limited number of MDR TB patients through the Red Crescent Society.

Part-time medical consultants (for example, a gynecologist, narcologist, or STI specialist) are available at the oblast TB dispensaries for patients that require additional examinations outside of TB treatment. However, since TB dispensaries (as well as other specialized facilities) are not allowed to procure drugs that are not included in the approved standards for treatment of their respective diseases (in this case TB), effective treatment of other conditions cannot be offered, and patients are either asked to procure the needed medicines themselves or delay treatment until they are released from the facility.

Management of patients with dual TB and HIV infection is done in collaboration with staff of the AIDS Center (either the city or oblast AIDS Center) based on the clinical protocol approved by the MOH. Oblast TB dispensaries do not have cotrimoxazole on site, but in the case of dual TB/HIV infection, AIDS Centers transfer the necessary amount of the drug. ARVs are also supplied by the AIDS Centers. Patients with dual infections often receive additional food packages and the necessary supply of drugs from NGOs. Sometimes this causes conflicts with other TB patients who are not dual diagnosed, as they do not receive this type of support.

Oblast TB dispensaries often receive the Global Fund-funded condoms and distribute them to patients through nurses. There are no Trust Points or regular needle exchange services at the TB service sites.

**Substance Use Services**

In general, drug treatment facilities in urban Kazakhstan include mental health care hospitals (psychiatry hospitals) and specialized Narcological Dispensaries that provide both outpatient (at the polyclinic) and inpatient services, including compulsory treatment. In rural areas, rayon polyclinics also have narcologists that provide drug related counseling, basic treatment, referral services, as well as drawing of blood for HIV and HCV testing. The range of services provided by Narcological Dispensaries includes screening, assessment, treatment planning, detoxification, counseling, HIV prevention, testing and counseling and HCV testing. Narcology Dispensaries serve as a point of reference for other governmental facilities and often NGOs in case drug treatment is needed. In Almaty, narcologists from the city Narcological Dispensaries are also involved in provision of periodic (once a month) counseling at Trust Points located in polyclinics and at the AIDS Center.

For self-identified drug users who have formally registered with the narcological registry, all treatment services offered at the narcology dispensary are free-of-charge, including withdrawal treatment and rehabilitation of up to 60 days. Narcological dispensaries approved for provision of fee-based services also provide anonymous treatment services (with the exception of the Oblast Narcological Dispensary in Ust-Kamenogorsk, which is not allowed to provide paid services due to the bad conditions of the buildings and absence of a separate entrance for the pay-department). One day of withdrawal treatment (detoxification) costs around 5,000 tenge or approximately USD 35. This fee includes accommodation and treatment only; all medical examinations except for the HIV test and x-ray have to be paid separately. While the quality of detoxification services is considered satisfactory by all the physicians surveyed, the quality of rehabilitation remains a challenge, as patients enrolled in
rehabilitation are not provided with sufficient psychosocial support, are not occupied with anything while in the clinic and have nothing to do during the day.

There are only a couple of rehabilitation centers that receive funding from the national budget, (the best one is located in Pavlodar) and that provide a relatively good range of services, including skills-building opportunities, labor-treatment activities and occupational therapy.

Medication Assisted Therapy (MAT) or opioid substitution therapy (OST) with methadone is currently only provided by a GFATM-funded Project on a pilot basis in two sites (Pavlodar and Temirtau). Starting in 2011 there is a plan to expand the number of sites to four; however expansion plans are being challenged by very strong resistance and opposition at the local level.

Temirtau city narcology dispensary is responsible for the OST program in Temirtau. The usual working hours for the outpatient department of the Narcological Dispensary are from 8 a.m. until 6 p.m., closed on Sunday. However for OST, patients are required to pick-up their medication (methadone) every day between 10 a.m. and 11 a.m. In case a patient has a good reason and is not able to come during these hours, he or she can pick up methadone anytime within the normal working hours of the clinic from an OST nurse. In very rare cases, another nurse on duty is asked to distribute methadone after hours. The OST team includes a narcologist (substance abuse specialist), a psychologist, a social worker and a nurse. Psychological counseling is done when the person is enrolled into the OST, and then repeated if urine test for drugs is positive. The absence of systematic psychotherapy available to IDUs can limit the broader health impact of OST services.

The lack of psychosocial support is also most likely to limit the outcomes of OST itself. The current status of MAT services is not sustainable and the national plan for further expansion is not sufficiently ambitious to overcome resistance to this treatment and to protect the pilots from efforts to discredit them.

STI Services
Oblast or city dermotovenerology dispensaries (local STI dispensary) are mandated to provide outpatient and inpatient STI services for all the patients, including MARPs. At the rayon level STI Dispensaries were recently reorganized to become wards of the central rayon hospitals. These facilities also serve as a point of reference in case of STIs for other medical governmental facilities. Inpatient services are free-of-charge, but require personal documentations and referral by the PHC (prikaz 695). For outpatient services, counseling is free for patients with documentation but requires an HIV test, a syphilis test and a smear. All drugs for outpatient treatment have to be procured by the patients themselves, regardless of their HIV or social status. The average cost of drugs normally used for STI treatment is below (range depends on brand of drug and on pharmacy).11

- Benzathine benzylpenicillin (2.4 million IU) in 5-ml vial – USD 3-4;
- Ceftriaxone 1 g (as sodium salt) in vial – USD 1-3;
- Azithromycin 250 mg – USD 4.5-6;
- Ciprofloxacin 500 mg (as hydrochloride) – USD 2-5;
- Doxycycline 100 mg (hydrochloride) – USD 0.5-2;
- Fluconazole (in capsule: 50 mg) – USD 3.5-15;
- Acyclovir 200 mg (in tablets) – USD 1-3;

11 Data from the Pharmacy hotline in Almaty (+130) and a central pharmacy in Karaganda (+7 7212 515718).

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- Metronidazole (suppository: 500 mg, 10 pack) – USD 2-4;
- Clotrimazole 100 mg (in vaginal tablets, 6 per pack) – USD 1.5-3

With the introduction of a Single Healthcare System in Kazakhstan in 2010, information about all patients with STIs is transferred by oblast STI Dispensaries to the oblast health information centers where it is entered into a central database. Assessment respondents noted that this innovation jeopardizes the possibility of anonymous services and poses an additional challenge to patient confidentiality. Information about positive cases of some specific STIs (e.g. syphilis, gonorrhea and trichomoniasis) is sent to the local sanitary-epidemiological station (SES) in the form of an urgent notification. Each patient diagnosed with an STI at the STI Dispensary signs a form confirming that he is informed about legal consequences of spreading STIs. Partner notification is mandatory in the case of syphilis, and each STI Dispensary has a team responsible for finding and referring to treatment all patients diagnosed with syphilis and their sexual partners.

Physicians at STI Dispensaries are also called upon to provide counseling in other medical facilities in cases where these facilities have STIs among enrolled patients. In such cases, STI dispensaries sometimes provide drugs to the other facilities to treat those patients, but most of the time they only leave prescriptions and patients are expected to cover the costs of drugs themselves or delay treatment until they are released from a hospital and enrolled in the STI dispensary. Doctors of STI Dispensaries are also mandated to provide periodic counseling services at different Trust Points. Since this work is in addition to the usual workload (i.e. after regular hours) and is usually unpaid, STI specialists are not motivated to go to Trust Points.

Following the prikaz # 295 in 2004, Friendly Cabinets (FC) for provision of friendly STI services to MARPs were opened in the country. Most of the clinics are located at the AIDS Centers, some at the STI dispensaries and very few at the PHC level. All FC have different hours of operation, with some open five days a week and some closed on Saturdays and Sundays; the majority are opened from 8:30 a.m. to 5:00 p.m. These clinics mostly serve sex workers and drug users referred by different projects, and services provided at these sites are free of charge. The scope of services currently available at most of the Friendly Clinics includes HIV counseling and testing, general counseling, a medical examination, smear and a syphilis test. Friendly Cabinets located at the AIDS Centers are also able to do blood tests for STI using ELISA. At the time of the assessment none of the Friendly Clinics had drugs available for patients, and thus, no treatment was performed at the site. Previously most of the Friendly Clinics implemented a syndromic approach to treatment of STIs using drugs provided by the GFATM.

**Findings from Semi-structured Interviews with Staff from NGOs funded by the Dialogue Project**

This assessment was conducted with seven NGOs that implement several projects and serve different groups of MARPs; this approach helps them to ensure sustainability of their work and organizations, as well as provide an array of services to their clients. All NGOs assessed, with the exception of Omir Lad (which is working only with IDUs) and ADALI (which works only with MSM) provide services to a variety of target groups.

These services include counseling services, such as psychological counseling, legal and social support, as well as help with obtaining documents, finding jobs, etc., and referral to other medical services. All
organizations conduct individual and group educational sessions, distribute IEC materials, some distribute condoms and syringes. All the NGOs also provide space for target groups to gather together. All of the services provided by NGOs are free of charge. All NGO activities are funded through grants.

The NGOs have a system to measure the quality of services they provide. The quality of services was informally discussed during focus groups discussions or unofficial conversations with clients. NGOs also conduct annual to semi-annual surveys among their clients to assess their satisfaction with services and determine their needs. They also have routine monitoring systems to track the number of clients reached by each of the outreach workers, as well as the number/type of services and supplies provided. Outreach coordinators conduct periodic field visits to monitor the work of outreach workers.

With the aim of ensuring effective referral systems within different projects, all NGOs have signed formal memorandums of understanding (MOUs) with various governmental medical facilities. These MOUs are mostly needed for NGOs to show to their donors as proof of support and collaboration with governmental institutions. The MOUs also function as a means to keep governmental facilities informed about activities and projects implemented by NGOs. The real collaboration and support from governmental medical facilities in ensuring client-friendly and accessible services to MARPs is provided mostly when staff of government medical facilities are employed by NGOs for projects or there are good personal relations between NGO leaders and someone at the facility.

The NGOs highlighted a number of commonly expressed needs and challenges faced by target populations:

**IDUs & former prisoners:**
- Lack of money to access medical services (transportation costs, service fees, cost of medicines)
- Absence of work, absence of income
- No place to live
- Problems with law-enforcement structures
- Health problems, especially post-injection complications, hepatitis B and C

**PLHIV:**
- High level of HIV related stigma in society, and high level of self-stigmatization among PLHIV and their family members
- Fear of stigma and discrimination, and lack of confidentiality in medical facilities
- Opportunistic infections and their treatment (expensive drugs)
- Need to go to different medical facilities to receive all the medical support needed
- Difficulties accessing free-of-charge medical services for people that do not have a permanent place of residence and are not registered with any of the polyclinics
- Access to social support, including medical insurance and disability pension
- Food packages and other humanitarian aid

**Commercial sex workers:**
- Problems with law-enforcement structures. Women are regularly arrested by the police without any charges and let go after paying bribes
- Supply of high quality condoms and lubricants. Some clients reject using Global Fund condoms because they think they are low quality
- Access to free-of-charge STI screening and treatment services
• Educational information, supplies and events for children of sex workers that are often left without much attention

MSM:
• Psychological support and peer-to-peer support
• Social networking, finding partners and friends
• Stigma and discrimination

Inability to provide comprehensive services to MARPs was named as a key challenge for effective HIV work by most NGOs. In the opinion of most NGOs, an ideal HIV service delivery system for MARPs would be based on a client-centered approach with individual tailored packages that draw upon a wide range of social, legal, psychological and social services. The ideal project would also include a temporary housing solution (drop-in center, community center), a place where clients could spend time, socialize and learn new income generating skills. In order to provide services in a drop in center, NGOs would prefer to have an opportunity to buy/build premises using grant funds, rather than renting different locations and spending the same and even more funds without ever being able to get a permanent place. The NGO Credo received a grant from the Japanese Embassy and built its own social counseling center in Temirtau which provides services to socially vulnerable groups of people and children, including street children.

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

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

Regarding the need to strengthen management systems, NGOs need support in strategic planning and management, human resources management, including staff development and remuneration approaches, and overall programmatic and operational management. Some NGOs mentioned the need for leadership development trainings that would enable them to create new NGOs or allow them to develop new directions of work.

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

Focus group discussions with PLHIV
Three focus group discussions were conducted (one in Ust-Kamenogorsk, one in Shymkent and one in Karaganda); all were conducted on NGO premises. A total of 12 PLHIV participated, including 5 men and 7 women. Each focus group lasted for about 80 minutes.

All focus group participants had received HIV-related services at the governmental facilities more than once over the past 12 months. These services included ARVT and psychosocial support services, treatment of opportunistic infections, TB diagnosing and treatment. The vast majority of respondents received those services at the local AIDS Centers or with the referrals from the AIDS Centers. All services provided at the AIDS Center are free-of-charge. Services provided at other governmental medical facilities with the referral of the AIDS Centers are also often provided free of charge, though some facilities demand payments if a person is not registered with the facility. In the case of self-referrals, polyclinics provide free of charge services only when a person has a registered place of residence and is registered with a polyclinic, otherwise all medical services are provided for a fee.

Fear of having their HIV status revealed and discriminating attitudes of medical specialists remain a key challenge for PLHIV to use medical services outside of the AIDS Centers. For example, in Shymkent, participants talked about several cases where PLHIV were refused medical assistance (by a gynecologist and a surgeon) when they told the practitioners about their HIV status. In the case of inpatient services, confidentiality of PLHIV is protected by a code that is put on a medical history form instead of the HIV status, but since all the staff working at the medical facilities know this code, information about an HIV-infected person can spread by personnel, resulting in discrimination by the medical staff. Because of this, most of the focus group participants said that they would prefer to receive all the medical services at the AIDS Center.

Self-stigmatization among PLHIV is also high and many do not want to seek any medical assistance, even at the AIDS Centers, because they are afraid that their status may be revealed to their family or friends. Also, since many PLHIV are still actively using drugs, they do not really care about their health and do not want to participate in the AIDS Center of NGO activities.

All focus group participants were also NGO clients: some of them participated in peer-to-peer support groups, some came to the NGO to receive social, legal or psychological services and some came for referrals to medical services. Those who use NGO services find them very helpful and useful, especially in terms of providing information and social support. Referrals from NGOs to the governmental medical facilities work the best when one of the NGO’s employees is also working at the medical facilities. For example, in Ust-Kamenogorsk, PLHIV using services of NGO Kuat are happy to have an opportunity to be easily hospitalized at the local infectious disease hospitals for a regular check-up because of the relationships between NGO and hospital staff. Focus group participants expressed the belief that NGOs have no real power to change anything on a structural level, aside from paying fees to service providers or hiring staff to ensure friendly and quality services. It would be good if NGOs working with PLHIV could expand the menu of their services to include on-site medical counseling, humanitarian aid provision, help with finding a job, and temporary housing opportunities. PLHIV would like to see more legal support services provided by the NGOs, not just counseling, but services of legal advocates during civil and housing disputes.
Aside from making direct complaints – which most PLHIV prefer not to do for fear that their HIV status be disclosed – there is no way PLHIV can give their opinions about services to providers. PLHIV do discuss quality of doctors and services with NGOs or during peer-support group discussions as a way to express their satisfaction or dissatisfaction.

When asked about the design and implementation of a service delivery system most responsive to the needs of their community, PLHIV said that they want to be treated in all medical facilities as they are being treated by the AIDS Center. More work is needed to decrease stigma and discrimination of PLHIV among general population and medical professionals. Also, they would like to see the AIDS Center or Friendly Clinic at the AIDS Center expanding its menu of services to include most PHC services.

**Focus group discussions with sex workers**

*Two focus group discussions (5-6 participants each), one in the Almaty and one in Karaganda. Discussions lasted from 40 minutes to an hour.*

Only a few respondents used services of the governmental medical providers over the last 12 months. Services used included an abortion done at one of the local maternity sites and several visits to the Friendly Cabinet at the AIDS Center for HIV testing and STI screening (all clients were referred by the outreach worker). Some focus group participants in Almaty participated in the sentinel surveillance survey when AIDS Center staff came to the sauna to draw blood for testing.

Among the reasons participants cited for not using governmental services included: not wanting to wait in lines at the polyclinic; not wanting to do a lot of tests nor collect all the documents necessary for hospitalization (in case of abortions); perceptions about low quality of services at the governmental facilities; and inconvenient locations or working hours. Most of the women said that they use private clinics or pay doctors they know to provide services at a time and manner convenient to them. They all had positive opinions about the Friendly Cabinet at the polyclinic (the case in Almaty) or at the AIDS Center (in case of Karaganda), but since the range of services provided by the friendly clinic is really limited, they currently go there only as a “favor” to the outreach workers to get tested for HIV.

All sex workers were previously contacted by NGO outreach workers, mostly for the provision of condoms and lubricants. The quality of condoms (GFATM condoms) is relatively good, though some clients reject using these condoms because they are not of the best quality.

When asked about design and implementation of a service delivery system most responsive to the needs of their community, sex workers said that they would like to see an expanded menu of services available at the Friendly Cabinet (full range of STI testing, a full-time gynecologist) and a mobile clinic that could come to the sauna in the evening before working hours and provide a wide range of medical services at the site (STI screening, gynecological assistance and HIV testing) as well as regular provision of quality condoms.
**Focus group discussion with men who have sex with men**

A focus group discussion with MSM (11 participants) was held at the ADALI office in Almaty. In addition, a small group discussion (2 people) was conducted in Ust-Kamenogorsk. Discussions lasted for approximately 80 minutes.

Only a few focus group participants have contacted governmental medical services over the last 12 months. Most of them usually contact private clinics or pay for the medical services. Two men from the Almaty group reported using services of the Friendly Clinic at the AIDS Center and one had very good feedback about the quality of services received, while the second one had the opposite opinion and said that he felt discriminated against and had to wait in the corridor for a long time before seeing a doctor. All of the focus group participants said that they wished the Friendly Cabinet offered hours of operation on Saturdays, since most of them are working full-time, and going for an HIV test during regular working hours is complicated.

Although more MSM-friendly services and a wider range of services would be desirable, overall access to medical services is not a key need for the group. They are generally comfortable with using a network of private doctors or clinics in case they need medical assistance. Social networking, an opportunity to organize social and edutainment events for the group, crisis centers and temporary housing solutions, as well as access to health-related information and provision of good quality specialized condoms and lubricants are among the most desired program components for the group. NGOs are very important as they give an opportunity for people to meet, to receive new information and needed psychological support. The quality of IEC materials on HIV-related topics currently provided through an NGO need to be more adapted to the interests and preferences of the group.

**Focus group discussion with former prisoners**

One focus group discussion with former prisoners (8 participants) was organized with support from the NGO Credo in Abai, Karaganda oblast. Three more former prisoners have shared their ideas and views during a focus group discussion organized by the NGO Kuat with a mix of MARPs representatives in Ust-Kamenogorsk. Discussions lasted from 40 minutes to an hour.

Most of the focus group participants had been released from the prison less than 12 months prior to the discussion. Absence of documents, legal residence and money are the key challenges that prevent those newly released prisoners from entering medical services at the PHC level. Most of them seek health services only in cases of emergency (through the ambulance). Since former prisoners do not have a regular source of income, they are not able to buy even simple medicines (for example, one of the respondents had an infected wound on his hand, but was not even able to buy a bottle of disinfectant and antibacterial ointment from a pharmacy at a cost of USD 3-4).

An ideal service delivery system for newly released former prisoners would includes a more comprehensive set of services such as help with temporary housing, provision of clothes, basic personal items and medicines, legal and psychological support and some income generation support (furniture shops, farming, etc.). Focus group participants all liked the project “A Halfway House” that is being implemented by NGO Credo in collaboration with one of the religious groups in Karaganda oblast and thought this is the model that should be expanded.
Focus group discussion with IDUs

Focus group discussions or individual (with 2-3 people at a time) interviews were conducted in each of the sites. The total number of IDUs that participated in the survey was 18. Most of the focus group discussions were organized at the offices of AIDS-servicing NGOs, while the one in Almaty was conducted at a place where people meet to use drugs.

Money and the absence of documents is a general obstacle for IDUs when trying to access any type of medical services. Since many focus group participants, as well as other IDUs they know, do not have a permanent place of residence and are not enrolled into a polyclinic, they are not able to access medical services at the governmental organizations. Therefore self-treatment or no treatment is the usual health-seeking behavior even in serious conditions. Overdose treatment and surgical assistance are the two most common conditions under which IDUs seek medical assistance. In case of an overdose, the normal practice is to call the ambulance only when home remedies and “peer-to-peer” support (cold shower, salty injections, etc.) do not help. Calling the ambulance is usually done without mentioning the exact condition of a patient, otherwise there is a fear that the ambulance will not come or will come late. The person overdosed is taken out of the place where people use drugs to the street or to the common stairways and left for the ambulance to pick up. In the case of post-injection complications with veins IDUs also try self-treatment, but in case it does not work they usually go to the polyclinic or to the general hospital. The main complaint about using polyclinic or hospital services is that before being provided with medical assistance IDUs are asked to pass fluorography and syphilis tests, among other requirements, which take time and sometimes money if a person is not enrolled with the polyclinic. Those IDUs that are not registered with narcology are less likely to seek any medical assistance for fear of being registered as a drug addict.

Visits to governmental or NGO-based Trust Points are not common because (1) IDUs are afraid to be caught by police when picking up clean needles and syringes or (2) these locations or times are not convenient for them. Therefore it is very common for one person from a group to go to the Trust Point or meet the outreach worker and take supplies for the whole group. Mobile Trust Points are a preferred way of getting clean injecting equipment. The quality of needles and syringes was suitable for all the respondents, though some of them wished for thinner needles.

An ideal service delivery system for IDUs would be a service delivery site where doctors ask fewer questions and provide services without asking for documents.
Conclusions and Recommendations

1. **Unmet need for psychosocial and other support services:** Access to health care is difficult for MARPs due to stigma, cost, bureaucracy, etc. This lack of social support significantly limits the effectiveness of clinical services, particularly for ARVT, TB treatment and MAT (OST) among MARP groups. Based on assessment findings, there is also an unmet need for psychosocial and other support services to be provided alongside medical services.

   **Recommendation:** Practical collaboration between health care specialists in governmental facilities, community groups and non-governmental service providers should be promoted, particularly for specific services such as psychosocial support. Further analysis of successful cross-sectoral service delivery mechanisms would facilitate the planning and rollout of meaningful collaboration. It is important to also explore the use of structured monitoring and referral systems as well as the strategic development and utilization of human resources qualified to effectively reach and provide services that respond to the interests and needs of MARPs.

2. **Insufficient testing and counseling services for MARPs:** The amount of HIV testing is significantly lower among MARPs, although these groups have the highest prevalence of HIV. Most counseling and testing services for MARPs are provider-initiated, and a system to monitor the quality of patient counseling is not in place. Providers significantly miss opportunities to ensure adequate access to risk reduction information and materials for those individuals at high risk of infection.

   **Recommendation:** Wider utilization of HIV rapid testing technology and mobile testing units among governmental and non-governmental facilities is a promising strategy to increase access to and availability of VCT services particularly in areas where there is a high concentration of MARPs. Implementing a systematic record keeping system to track HIV tests performed on individuals at high risk, while protecting their confidentiality, is critical to ensure that they receive their test results and get counseling services based on their individual risk factors. Equally important, all facilities that provide VCT services should adopt and enforce policies requiring their staff to provide post-test risk reduction counseling to all patients that get tested for HIV, regardless of their test results, to increase their adoption of prevention methods. Pre-test counseling should not be performed as a simple question and answer session, but instead should be conducted in a form of health education encouraging behavior change.

3. **Limited spectrum and intensity of services:** The spectrum and intensity of current services are not sufficient to have a significant impact on HIV incidence and prevalence. NGOs and their clients need more comprehensive and client-centered HIV programs that are not limited to basic HIV services. Provision of legal, social and psychological support, as well as temporary housing solutions, are the greatest needs among almost all MARP groups.

   **Recommendation:** A combination approach to HIV prevention and care service delivery needs to be applied to improve the current situation of MARPs. In addition, donors should consider the wide range of needs that MARP groups have when planning for grant programs and other interventions designed to reduce HIV transmission and improve quality of life of-at-risk groups.
4. **Need to improve and scale up key services for IDUs:** Based on epidemiological data, IDUs are a driving force of the HIV epidemic in Central Asia. The provision of clean needles and syringes through Trust Points located at the governmental medical facilities is not effective due to various factors, including inconvenient service hours and locations, absence of full-time employees and outreach workers to deliver this service. Also, it is particularly important to further improve and scale up the delivery of services such as the Medication Assisted Therapy (MAT) for this group.

**Recommendation:** Expanding access to clean needles and syringes through Mobile Trust Points could be an effective way of ensuring that IDUs have these materials available when they need them the most. Further expansion of MAT should be based on a more detailed study of its current status, particularly looking into the adequacy of the doses, the support provided to patients, and the human rights dimensions of this type of service. Based on current evidence, the social and psychological support services for patients on MAT could be strengthened with the participation of community-based organizations. Special attention should also be paid to policy programming aimed at challenging existing opposition to this type of therapy.

5. **Need for improved integration of HIV/AIDS, STI, TB and narcology with other public health services:** HIV/AIDS services are generally implemented by the network of AIDS Centers with little integration into PHC or other specialized services, such as STI, narcology and TB. However, MARP groups have a wide range of needs that could be addressed in a comprehensive manner.

**Recommendation:** HIV-related services can be incrementally integrated into general health care to improve the effectiveness of these programs and allow MARPs to have better access to other needed medical services. One way to do this is by having the AIDS Centers expand their menu of services through the network of Friendly Cabinets (FCs). In addition, FCs should implement a mechanism to actively collect, analyze and respond to feedback from clients, to assist in planning and programming their services. It is also crucial that FCs have sufficient and uninterrupted funding, as the periodic absence of services and drugs discourages MARPs from using their services.

6. **Limited services to ensure patient adherence to ARVT:** Based on assessment findings, adherence to ARVT is low, and as the number of HIV patients grows, it will become increasingly challenging for the limited staff in the AIDS Centers to effectively follow-up on patients using a mostly paper-based monitoring system.

**Recommendation:** Piloting and rapid scale-up of an electronic surveillance system is crucial. This would allow specialists to have instant access to structured and systematized patient data. Some ARVT functions, especially those related to ARVT adherence monitoring (follow-up and tracking), could be transferred to PHC or designated to specially assigned and trained social workers that could be, for example, seconded by NGOs to the governmental medical facilities. Better monitoring of adherence is also needed. AIDS Centers in collaboration with NGOs should make sure that there is a sufficient number of PLHIV on ARVT that are able and willing to provide peer-to-peer support and demonstrate the effectiveness of ARVT, especially to those PLHIV who are starting treatment or have low adherence rates.

7. **Need to improve coordination and collaboration across NGOs:** A number of NGOs are currently engaged in the provision of HIV prevention, treatment, and support services; however, there is a lack of coordination and collaboration between NGOs. In addition, effective collaboration between NGOs and governmental medical facilities is only seen when medical facilities’ staff receive financial
incentives from NGOs, topping up their salaries.

**Recommendation:** Long-term strategies are needed to ensure effective collaboration between NGOs and governmental medical facilities, given the need to leverage the limited resources available and the added value of cross-collaboration. Each AIDS Center should take the lead in creating a multidisciplinary team with the responsibility to develop and implement a coordinated system that optimizes adherence in patients by providing comprehensive support services. Donors should shift towards supporting PLHIV care and support projects that officially involve both governmental and non-governmental organizations.

8. **Need for additional stigma reduction interventions for health care providers:** In general, staff at the governmental medical facilities demonstrate limited ability to respond to the psychosocial problems of MARPs, especially IDUs, as well as difficulty supporting PLHIV to adhere to treatment (TB, ARV, MAT, and other STI treatments). Factors such as excessive workloads, stigma and limited understanding of the vulnerabilities experienced by these groups may influence their behaviors toward MARP groups.

**Recommendation:** An increase in tailored activities among medical workers at all levels is crucial, to addressing stigma and discrimination toward PLHIV who are also MARPs; this need is especially critical for health workers who provide surgical and gynecological services. Governmental facilities and community-based organizations, working in partnership, could employ full-time social workers or psychologists to help physicians deal with psychosocial issues faced by MARPs.

9. **Need for good planning and use of available resources:** Quality control of HIV prevention services is not always a top priority to implementers who are concerned about reaching target numbers and expanding services. However, it is important to ensure the quality of service and prevention commodities for MARPs to prevent misuse, de-motivation and a reduced demand for prevention methods that could be vital to them. It is also critical to establish realistic standards and targets for outreach workers (e.g., number of clients to be reached by one outreach worker per month) to prevent false reporting and ineffective outreach.

**Recommendation:** Integrating quality standard measures and controls for key services and commodities should be considered for all programs and in all institutions, governmental and non-governmental. Moreover, realistic targets and workloads should be established and constantly monitored to prevent burnout, reduced service quality and inaccurate reporting. A user-friendly and simple client management database should be developed and introduced to provide quality information on the number of MARPs covered with certain prevention activities and avoid double counting of clients by different programs working in the same area.
### Appendix 1: List of Key Respondents

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization and Title</th>
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<tbody>
<tr>
<td>Akhmetova, Kulzhahan</td>
<td>City AIDS Center, Almaty Head of Treatment and Follow up Care Department</td>
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<tr>
<td>Almenov, Sergazy</td>
<td>Oblast Narcology Dispensary, Shymkent Chief Doctor</td>
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<tr>
<td>Amanzholov, Nurali</td>
<td>Kazakh Union of PLHIV President</td>
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<tr>
<td>Antipin, Vadim</td>
<td>NGO Kuat, Ust-Kamenogorsk Outreach Worker</td>
</tr>
<tr>
<td>Aralbaeva, Nataliya</td>
<td>City Perinatal Centre, Ust-Kamenogorsk</td>
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<tr>
<td>Badygulova Roza</td>
<td>Social bureau “Kredo,” Abai, Karaganda Oblast Social Worker</td>
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<tr>
<td>Balgimbekova, Dinara</td>
<td>Oblast AIDS Center, Karaganda Psychologist of the Friendly Clinic</td>
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<tr>
<td>Baltynova, Rauza</td>
<td>City Infectious Diseases Hospital., Karaganda Chief Doctor</td>
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<td>Batalova, Saltanat</td>
<td>Oblast Narcology Dispensary, Ust-Kamenogorsk Chief Doctor a.i.</td>
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<tr>
<td>Belguzhanova, Aiman</td>
<td>NGO Umit, Karaganda Project Coordinator</td>
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<tr>
<td>Dementeva, Ludmila</td>
<td>Oblast AIDS Center, Ust-Kamenogorsk Nurse of the Friendly Clinic</td>
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<tr>
<td>Deryabina, Lidiya</td>
<td>City Infectious Diseases Hospital, Almaty Head of the department/Postgraduate Medical Institute, Department of Infectious Diseases, Assistant Professor</td>
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<tr>
<td>Devyatko, Vladimir</td>
<td>City Polyclinic #2, Temirtau Chief Doctor</td>
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<tr>
<td>Dus, Nataliya</td>
<td>City Hospital #1, Ust-Kamenogorsk Head of Isolation Ward</td>
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<tr>
<td>Eralieva, Gulzhan</td>
<td>City Dermatovenerological Dispensary, Almaty Physician responsible for HIV</td>
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<td>Golovina, Lidiya</td>
<td>City Narcological Centre of Medical &amp; Social Correction, Almaty Head of the org-metod. Department</td>
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<td>Gribok, Ludmila</td>
<td>Polyclinic #8, Ust-Kamenogorsk Nurse of the Trust Point</td>
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<td>Gryaznova, Elena</td>
<td>Trust Point on the Independence Avenue Nurse</td>
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<td>Isabekova, Aida</td>
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<td>Oblast TB Dispensary, Karaganda Deputy Chief Doctor</td>
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<td>Kalibaeva, Marzhan</td>
<td>City Infectious Diseases Hospital, Almaty Infection Control Nurse</td>
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<td>Oblast Narcology Dispensary, Ust-Kamenogorsk</td>
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<td>City Infectious Diseases Hospital, Almaty</td>
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<td>NGO OmirLAD, Almaty</td>
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<td>Loginova, Elena</td>
<td>Trust Point at the RailRoad Hospital</td>
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<td>Loskutova, Elena</td>
<td>Pharmacy #28, Temirtau</td>
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<td>Mashirov Kozhakhmet</td>
<td>Oblast AIDS Center, Shymkent</td>
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<td>Meirkhanov, Talgabek</td>
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<td>Nurmagambetova, Gulmira</td>
<td>Oblast Dermatovenerological Dispensary, Shymkent</td>
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<td>Omarbekova, Elmira</td>
<td>Director, Oblast AIDS Center, Ust-Kamenogorsk, STI Specialists of the Friendly Clinic</td>
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<tr>
<td>Oralbaeva, Natalya</td>
<td>Director, Oblast AIDS Center, Ust-Kamenogorsk, Physician, responsible for PMTCT</td>
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<td>Orymbeva, Almargul</td>
<td>Chief Doctor, City Narcology Dispensary, Temirtau</td>
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<td>Otzhanova, Indira</td>
<td>NGO Kuat Shymkent, Director</td>
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<td>Pak, Irina</td>
<td>Director, Maternity Hospital, Karaganda</td>
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<td>Pashilova, Svetlana</td>
<td>Head of the Treatment Department, Polyclinic #8, Ust-Kamenogorsk</td>
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<td>Pavlik, Elena</td>
<td>TB Doctor, City TB dispensary, Temirtau</td>
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<td>Rakhimbekova, Dina</td>
<td>Clinical Epidemiologist, City Infectious Diseases Hospital, Karaganda</td>
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<td>Sadvakasov, Kanat</td>
<td>Chief Doctor, Oblast Dermatovenerological Dispensary, Karaganda</td>
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<td>Sadykova, Asiya</td>
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<td>Sagimbekova, Leila</td>
<td>OB/GYN responsible for MARPs, Maternity Hospital, Karaganda</td>
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<td>Said, Nurlan</td>
<td>Director, NGO Kuat, Ust-Kamenogorsk</td>
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<td>Seitmagambetova, Aidana</td>
<td>Head of the Outpatient Department, Oblast Narcology Dispensary, Karaganda</td>
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<td>Expert Physician, Oblast Narcology Dispensary, Karaganda</td>
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<td>Oblast TB Dispensary, Karaganda Head of the MDR-TB Department</td>
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<td>Tuluppave, Maira</td>
<td>City AIDS Center, Temirtau Head of the Treatment Department</td>
</tr>
<tr>
<td>Turganbaeva, Saule</td>
<td>Karaganda Oblast Health Department Chief Physician</td>
</tr>
<tr>
<td>Turgunbaev, Bolatbek</td>
<td>Association “Zholdas”, Shymkent Director</td>
</tr>
<tr>
<td>Turzhanova, Ardak</td>
<td>City AIDS Center, Almaty Dermatovenerologist (STI Specialist) of the Friendly Cabinet</td>
</tr>
<tr>
<td>Vetrova, Tatyana</td>
<td>City AIDS Center, Almaty Gynecologist of the Friendly Cabinet</td>
</tr>
<tr>
<td>Vinogradov, Vitalyi</td>
<td>NGO Adali, Almaty Outreach Coordinator</td>
</tr>
<tr>
<td>Volodko, Galina</td>
<td>Oblast Narcology Dispensary, Karaganda Head of org-metod. Department</td>
</tr>
<tr>
<td>Yakovlev, Sergei</td>
<td>City TB Dispensary, Temirtau Head of the Treatment Department</td>
</tr>
<tr>
<td>Zhdanova, Irina</td>
<td>NGO “My home”, affiliate organization of NGO Kredo, Counseling Center, Temirtau Director</td>
</tr>
<tr>
<td>Zhegolko, Marina</td>
<td>Oblast AIDS Center Epidemiologist and also Outreach Coordinator at the NGO Kuat, Ust-Kamenogorsk</td>
</tr>
<tr>
<td>Zhegolko, Victor</td>
<td>Doctor of the Infections Department of the hospital#1 and also Outreach Worker at the NGO Kuat, Ust-Kamenogorsk</td>
</tr>
<tr>
<td>Zholdybaeva, Ainur</td>
<td>City AIDS Center, Almaty Epidemiologist</td>
</tr>
<tr>
<td>Zhumanbalinova, Ryzbike</td>
<td>Oblast Dermatovenerological Dispensary, Ust-Kamenogorsk Chief Doctor</td>
</tr>
<tr>
<td>Zhumaniyazova, Makhabbat</td>
<td>Friendly Cabinet and Trust Point of Almaty City Polyclinic #8 Gynecologist, Doctor of Friendly Cabinet</td>
</tr>
<tr>
<td>Anonymous</td>
<td>Oblast TB Dispensary, Ust-Kamenogorsk Chief Doctor</td>
</tr>
<tr>
<td>Anonymous</td>
<td>Oblast TB Dispensary, Shymkent Physician responsible for HIV</td>
</tr>
</tbody>
</table>
Appendix 2: Interviewer’s Guide: Government Facility Staff

Questionnaire for HIV Mapping Activity
Government Facility Level Interviews
Central Asia

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

The entire interview will be administered to both groups. Each section of the interview tool covers a specific technical service that may or may not be offered by the facility. If a specific service is not offered, say HIV treatment, then the interviewer will skip to the questions in that section that ask about referrals.

- AIDSTAR-One and AIDSTAR-Two will work with PSI to set appointments at each of the centers.

- Priority centers for interviews are: (1) Oblast AIDS Center; (2) TB Centers; (3) Venerology Centers; (4) Narcology. If HIV services are provided in PHC settings or private pharmacy, they may be included. To be discussed and determined with PSI and the Mission.

Introductory remarks by Interviewer:
AIDSTAR I or II has been commissioned to conduct a rapid mapping of the service delivery responses to HIV epidemics in (name country) in order to guide future programs that USAID is planning to support.

The objectives of this mapping are:
- Identify the spectrum and scale of services provided in selected oblasts of Kazakhstan, Tajikistan and Kyrgyzstan to 5 population groups most at risk of HIV infection. We will be looking at the coverage of services, their affordability, level of integration of different services and functionality of referral systems, effective practice of service delivery, as well as any challenges and other obstacles that prevent vulnerable people from accessing services;
- Define whether these services are sufficiently responsive to the essential needs of the target populations and are in line with international recommendations relevant to Central Asia. Identify any significant quality issues and gaps in the required continuum of services;
- Develop recommendations for improving accessibility and quality of services available to most at risk populations in selected sites.

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

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

Please feel free to ask any questions before we start.
We can now proceed with the questions.

Name of Interviewer: ______________________  Date of Interview: __________

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Contact information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. Facility/program operating hours/days (24 hour clock):

12. Is there a means by which clients can contact a provider during non operating hours? Please describe:

13. In your opinion, what does the ideal HIV service delivery system look like? What prevention, treatment, care and support services should be provided?

14. Can you describe 1-2 best and promising practices of HIV prevention, treatment, care and support work that you implement that you would like to share with others doing similar work?

15. What are the 3 most significant challenges (other than funding) for which you need assistance to implement quality HIV prevention, treatment, care and support services?

General HIV Program

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

<table>
<thead>
<tr>
<th>Worker category</th>
<th>Employees</th>
<th>Volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselors</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Peer Educators
Outreach workers
Social Workers
Laboratory technicians
Trained Pharmacist
Admin/Finance
Other (specify)

2. Do you partner with any NGOs who place staff within your facility to provide services (such as NGO peer educators)?
   a. Yes. If yes identify the NGOs
   b. No

3. Has any staff received training between October 2009 - September 2010 in the any of the following cross cutting issues?

<table>
<thead>
<tr>
<th>Training topics</th>
<th>Yes/No</th>
<th>Cadre of staff trained (List all)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling, including disclosure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma and discrimination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidentiality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality improvement/ quality assurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supportive supervision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV counseling and testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STI treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Clinical Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Treatment (ART)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB screening and care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB/HIV coordinated care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical assisted therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overdose management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Services</th>
<th>On-site</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education/Awareness Training or counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention: sexual (including condom distribution)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Prevention: IDU (including needle/syringe exchange)
Counseling and Testing
Laboratory testing
Prevention with Positives
STI
PEP
PMTCT
Needle exchange
Medical assisted therapy
Home-based care
HIV care, non-ART
HIV care, ART
General medicine/clinical care
Obstetrics and gynecology
TB
Hepatitis C
Other (specify)
Other (specify)

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

- Clinic (outpatient)
- Hospital
- Non-clinical facility/NGO
- Mobile
- Community
- Workplace
- Other (specify)

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

<table>
<thead>
<tr>
<th>Target Groups</th>
<th>Rank Order</th>
<th>Number Served (Oct. 2009 – Sept. 2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Former prisoners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PLHIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family of PLHIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB/HIV patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migrant workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Truckers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community at large/general population</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7. Do you face challenges working with these populations? (please describe)

8. What practical strategies and interventions (if any) are you using to reduce stigma?

9. What support could be provided to assist you in better serving these populations?

10. What is the geographic coverage of your program?
   a. Oblast(s) (specify)
   b. Rayon(s) (specify)
   c. Village(s)/town(s) (specify)

11. Do you have a system in place for ensuring client confidentiality? Please describe.

A. HIV Prevention and Awareness Raising

1. Do you provide any HIV prevention activities?
   a. Yes
   b. No (if No skip to Section B)

2. Are there any systems in place to assess the quality of services?
   a. Yes (check all that apply)
      i. Routine review of data
      ii. Client satisfaction surveys
      iii. Other (specify)
   b. No

3. Which of the following areas are included in your HIV and AIDS awareness/community mobilization programs? Check all that apply.

<table>
<thead>
<tr>
<th>Area</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>General HIV Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual prevention education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VCT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma/discrimination reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom promotion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom negotiation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical assisted therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe injection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overdose management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug demand reduction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. What type of material do you use to communicate HIV and AIDS messages? Check all that apply

| Printed documents, pamphlets, posters, billboards |  |
| Audio-visual, video, |  |
| Media, TV spots, radio spots |  |
| Other (specify) |  |

5. Do you develop your own education materials?
   a. Yes
   b. No

6. Do you use education materials developed by others?
   a. Yes (If developed by others, by which organization)?
   b. No

7. Do you provide condoms? Check all that apply

| Male condoms |  |
| Female condoms |  |
| Lubricant |  |

8. Do clients have to pay for condoms or lubricant?
   a. Yes (specify amount)
   b. No

9. Do you provide any of the following supplies and/or drugs to IDUs? Check the appropriate column?

| Bleach and cleaning materials | Yes | No |
| Clean needles and syringes |  |
| Medical assisted therapy? |  |
| Other (specify) |  |

10. Do clients have to pay for bleach, cleaning materials, or syringes?
    a. Yes (specify amount)
    b. No

11. Do you train any peer educators?
    a. Yes
    b. No (if no skip to Section B)
12. If the organization trains peer educators, how many were trained between October 2009 and September 2010?

<table>
<thead>
<tr>
<th></th>
<th>Number trained</th>
<th>Number still active</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Former prisoners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PLHIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family of PLHIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB/HIV patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migrant worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Truckers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community at large/general population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. Briefly describe how peer educators are supervised.

B. HIV Counseling and Testing

1. Do you provide HIV counseling and drawing blood for testing?
   a. Yes
   b. No (skip to Question 20 in this section)

2. Do you charge any fee for HIV counseling and testing?
   a. Yes (specify amount)
   b. No

3. Briefly describe how counseling staff are trained and supervised.

4. Are there any systems in place to assess the quality of services?
   a. Yes (check all that apply)
      i. Routine review of data
      ii. Client satisfaction surveys
      iii. Other
   b. No

5. Which of any of the following are available and used routinely to guide HIV counseling and testing (check all that apply)? Get copies of all that are available.

<table>
<thead>
<tr>
<th></th>
<th>Treatment protocols</th>
<th>Treatment guidelines</th>
<th>Government prikazs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used routinely</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. How are staff informed of and trained in changes in any of treatment protocols, guidelines or prikazs?

7. How many clients were tested in August 2010: Provide information for all that apply.

<table>
<thead>
<tr>
<th>Clients</th>
<th>Counseled</th>
<th>Blood Drawn</th>
<th># who received results</th>
<th># positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDU</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Former prisoners</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PLHIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family of PLHIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB/HIV patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migrant worker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Truckers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community at large/general population</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of returned clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

10. What is the average amount of time spent with a client (where possible verify with patient logs)?
    a. 15 minutes or less
    b. 15 to 30 minutes
    c. 30-45 minutes
    d. 45 minutes to 1 hour
    e. More than an hour

11. Between April 2010 and August 2010, how many Dialogue Project vouchers did you accept?

12. Do you have recommendations on how the voucher system could be improved?
13. In which settings are your HIV testing services provided (please check all that apply)

<table>
<thead>
<tr>
<th>Setting</th>
<th>Elisa/Western Blot</th>
<th>Rapid test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-clinical facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workplace</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. How do clients receive information about receiving results, including when to return for results, why it is important and where to go?
   a. Printed materials
   b. Counseling
   c. Printed materials and counseling
   d. Other (specify)

15. On average, how long does a client have to wait to receive results?

16. What information do clients need to provide in order to obtain test results?
   a. Name or other personally identifying information
   b. Unique identifier code

17. Does this program provide partner notification support for those who test positive for HIV?
   a. Yes
   b. No

18. What test kits are used for HIV testing?

19. During the past six months, have there been any stock outs of test kits? (Specify which test kits have experienced stock out)

GO TO NEXT C

20. If you don’t provide C&T, do you refer?
   a. Yes
   b. No (Skip to Section C)

21. Where do you refer clients for C&T?

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

C. Sexually Transmitted Infections

1. Do you provide screening and treatment for STIs?
   a. Yes
   b. No (skip to Question 20 in this section)

2. Does the program charge any fee for STI services?
   a. Yes (specify amount)
   b. No

3. Briefly describe how staff are trained and supervised.

4. Are there any systems in place to assess the quality of services?
   a. Yes (check all that apply)
      i. Routine review of data
      ii. Client satisfaction surveys
      iii. Other
   b. No

5. Which of any of the following are available and used routinely to guide STI screening and treatment (check all that apply)? Get copies of all that are available.

<table>
<thead>
<tr>
<th></th>
<th>Treatment protocols</th>
<th>Treatment guidelines</th>
<th>Government prikazs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used routinely</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Clients</th>
<th>Treated for STI</th>
<th>Provided or referred for C&amp;T</th>
<th>Tested for HIV</th>
<th>Tested positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8. For each of the periods in the table below, what is the number of clients who returned to receive test results?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of returned clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

10. What is the average amount of time spent with a client (where possible verify with patient logs)
   a. 15 minutes or less
   b. 15 to 30 minutes
   c. 30-45 minutes
   d. 45 minutes to 1 hour
   e. More than an hour

11. Between April 2010 and August 2010, how many Dialogue Project vouchers did you accept?

12. Do you have recommendations on how the voucher system could be improved?

13. Does this program provide counseling about STI prevention and treatment?
   a. Yes
   b. No

14. How do clients receive information about receiving results, including when to return for results, why it is important and where to go?
   a. Printed materials
   b. Counseling
   c. Printed materials and counseling
   d. Other (specify)

15. On average, how long does a client have to wait to receive results?

16. What information do clients need to provide in order to obtain test results?
   a. Name or other personally identifying information
   b. Unique identifier code

17. Does this program provide partner notification support for people treated for an STI?
   a. Yes
   b. No

18. What laboratory supplies and treatment drugs are supplied for the STI program?

19. During the past six months, have there been any stock outs of laboratory supplies or drugs? (specify which products have experienced stock out)

GO TO SECTION D
20. If you don’t provide STI services, do you refer?
   a. Yes
   b. No (Skip to Section D)

21. Where do you refer clients for STI services?

22. How is the referral made? Check all that apply
   a. Information given
   b. Appointment booked
   c. Health navigator/peer support
   d. Other (specify)

23. Is there a system in place to determine if a referral was used?
   a. Yes (describe)
   b. No

D. PMTCT (this section may be optional)

1. Do you provide PMTCT at site?
   a. Yes
   b. No (skip to Question 16 in this Section)

2. Do you charge any fee for PMTCT services?
   a. Yes (specify amount)
   b. No

3. Briefly describe how staff are trained and supervised.

4. Are there any systems in place to assess the quality of services?
   a. Yes (check all that apply)
      i. Routine review of service delivery data
      ii. Client satisfaction survey
      iii. Other (specify)
   b. No

5. Which of any of the following are available and used routinely to guide PMTCT services (check all that apply)? Get copies of all that are available.

<table>
<thead>
<tr>
<th>Available</th>
<th>Treatment protocols</th>
<th>Treatment guidelines</th>
<th>Government prikazs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Used routinely</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal HIV testing and counseling</td>
</tr>
<tr>
<td>Provision of ART to mother</td>
</tr>
<tr>
<td>Provision of ART to baby</td>
</tr>
<tr>
<td>Safer delivery practices or caesarean section</td>
</tr>
<tr>
<td>Infant feeding counseling</td>
</tr>
<tr>
<td>Infant feeding supplies</td>
</tr>
<tr>
<td>Family planning counseling</td>
</tr>
<tr>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of returned clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

10. What is the average amount of time spent with a client (where possible verify with patient logs)
   a. 15 minutes or less
   b. 15 to 30 minutes
   c. 30-45 minutes
   d. 45 minutes to 1 hour
   e. More than an hour

11. Between April 2010 and August 2010, how many Dialogue Project vouchers did you accept?

12. Do you have recommendations on how the voucher system could be improved?

13. How many women were enrolled in PMTCT October 2009 – September 2010?

14. What ARVs are supplied for PMTCT?

15. During the past six months, have there been any stock outs of ARVs? (specify which ARVs have experienced stock out)

GO TO SECTION E

16. If you don’t provide PMTCT, do you refer for PMTCT services?
   a. Yes
   b. No (Skip to Section E)

17. Where do you refer HIV+ pregnant women for PMTCT?
18. How is the referral made? Check all that apply
   a. Information given
   b. Appointment booked
   c. Health navigator/peer support
   d. Other (specify)

19. Is there a system in place to determine if a referral was used?
   a. Yes (describe)
   b. No

E. TB

1. Do you conduct TB screening at this site?
   a. Yes
   b. No (skip to question 21 in this Section)

2. Do you charge any fees for TB services?
   a. Yes (specify amount)
   b. No

3. Briefly describe how staff are trained and supervised.

4. Are there any systems in place to assess the quality of services?
   a. Yes (check all that apply)
      i. Routine review of service delivery data
      ii. Client satisfaction survey
      iii. Other (specify)
   b. No

5. Do you provide treatment for TB on site?
   a. Yes
   b. No (Skip to Question 7 in this section)

6. Which of any of the following are available and used routinely to TB treatment (check all that apply) Get copies of all that are available.

<table>
<thead>
<tr>
<th>Available protocols</th>
<th>Treatment guidelines</th>
<th>Government prikazs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used routinely</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

8. How are patients screened for TB? Check all that apply
   a. Skin test
b. Chest x-ray  
c. Sputum sample  
d. Other

9. How many clients were treated for TB for the first time in August 2010?

<table>
<thead>
<tr>
<th></th>
<th>New TB cases</th>
<th>TB clients screened for or referred C&amp;T</th>
<th>TB clients tested for HIV</th>
<th>TB clients tested HIV positive</th>
<th># of clients who received their HIV results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

|----------------------------|-------------------|-------------------|------------------|-----------------|

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

12. What is the average amount of time spent with a client (where possible verify with patient logs)
   a. 15 minutes or less  
b. 15 to 30 minutes  
c. 30-45 minutes  
d. 45 minutes to 1 hour  
e. More than an hour

13. What drugs are supplied for treatment and prevention of TB?

14. During the past six months, have there been any stock outs of TB drugs? (specify which drugs have experienced stock out)

15. Between April 2010 and August 2010, how many Dialogue Project vouchers did you accept?

16. Do you have recommendations on how the voucher system could be improved?

17. Does this program provide counseling about TB prevention and treatment?
   a. Yes  
b. No
18. How do clients receive information about receiving results, including when to return for results, why it is important and where to go?
   a. Printed materials
   b. Counseling
   c. Printed materials and counseling
   d. Other (specify)

19. On average, how long does a client have to wait to receive results?

20. What information do clients need to provide in order to obtain test results?
   a. Name or other personally identifying information
   b. Unique identifier code

GO TO SECTION F

21. If you don’t provide TB services, do you refer clients?
   a. Yes
   b. No

22. Where do you refer clients for TB services?

23. How is the referral made? (Check all that apply)
   a. Information given
   b. Appointment booked
   c. Health navigator/peer support
   d. Other (specify)

24. Is there a system in place to determine if a referral was used?
   a. Yes (describe)
   b. No

F. Substance Use Services

1. Do you provide services to address substance use, particularly injection drug use?
   a. Yes
   b. No (skip to Question 16 in this section)

2. What services do you provide? (Check all that apply)
   a. Harm reduction/prevention
   b. Needle and syringe exchange (NSE)
   c. Wound management
   d. Medical assisted therapy (including counseling support)
   e. Other (specify)

3. Do you charge fees for any of these services
   a. Yes (specify amount and for which service)
   b. No
4. Briefly describe how staff are trained and supervised.

5. Are there any systems in place to assess the quality of services?
   a. Yes (check all that apply)
      i. Routine review of data
      ii. Client satisfaction surveys
      iii. Other
   b. No

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

<table>
<thead>
<tr>
<th></th>
<th>Treatment protocols</th>
<th>Treatment guidelines</th>
<th>Government prikazs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used routinely</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

8. How many clients were provided services in August 2010: Provide information for all that apply.

<table>
<thead>
<tr>
<th></th>
<th>Harm reduction/ prevention</th>
<th>NSE</th>
<th>Wound management</th>
<th>MAT</th>
<th>Other (specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of returned clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

11. What is the average amount of time spent with a client (where possible verify with patient logs)
   a. 15 minutes or less
   b. 15 to 30 minutes
   c. 30-45 minutes
d. 45 minutes to 1 hour  
e. More than an hour

12. Between April 2010 and August 2010, how many clients have been referred to you by the Health Outreach Program?

13. Do you have any recommendation on how the voucher system can be improved?

14. What drugs and supplies are distributed as part of this program?

15. During the past six months, have there been any stock outs of these supplies? (specify which supplies have experienced stock out)

GO TO SECTION G

16. If you don’t provide services for substance use, do you refer?  
   a. Yes  
   b. No (Skip to Section G)

17. Where do you refer clients for substance use services, including MAT?

18. How is the referral made? (Check all that apply)  
   a. Information given  
   b. Appointment booked  
   c. Health navigator/peer support  
   d. Other (specify)

19. Is there a system in place to determine if a referral was used?  
   a. Yes (describe)  
   b. No

G. HIV Care and Treatment

1. Do you provide clinical treatment for HIV on site?  
   a. Yes  
   b. No (skip to question 22 in this Section)

2. Does the program charge any fee for HIV clinical care services?  
   a. Yes (specify amount and for what services)  
   b. No

3. Briefly describe how staff are trained and supervised.

4. Are there any systems in place to assess the quality of services?  
   a. Yes (check all that apply)  
      a. Routine review of service delivery data  
      b. Client satisfaction survey
c. Other (specify)

b. No

5. Which of any of the following are available and used routinely to guide HIV treatment (check all that apply) Get copies of all that are available.

<table>
<thead>
<tr>
<th>Gender</th>
<th>New HIV case</th>
<th>HIV care, no ART</th>
<th>HIV care and ART</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

7. How many clients were treated for HIV for the first time in August 2010?

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

|---------------------------|-------------------|-------------------|-------------------|-----------------|

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

10. What is the average amount of time spent with a client (where possible verify with patient logs)
    a. 15 minutes or less
    b. 15 to 30 minutes
    c. 30-45 minutes
    d. 45 minutes to 1 hour
    e. More than an hour

11. Do you provide adherence counseling and support, including side effect management?
    a. Yes
    b. No

12. Between April 2010 and August 2010, how many Dialogue Project vouchers did you accept?

13. Do you have recommendations on how the voucher system could be improved?
14. Does the facility include routine laboratory tests (CD4 and viral load)? Check all that apply
   a. CD4
   b. Viral load
   c. Other (specify)

15. Are pharmacy services for distribution of opportunistic illness drugs and ARV available on site?
   a. Yes
   b. No (Skip to Question 12)

16. What ARVs and drugs to manage OIs are supplied for treatment of HIV?

17. During the past six months, have there been any stock outs of these drugs? (specify which drugs have experienced stock out)

18. Does the clinic provide other health services? Check all that apply
   a. PHC
   b. Obstetrics and gynecology
   c. Other (specify)
   d. Other (specify)

GO TO SECTION H

19. If you don’t provide HIV treatment services, do you refer clients for treatment?
   a. Yes
   b. No (Skip to Section H)

20. For each of the periods in the table below, how many clients were referred for HIV treatment services?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

21. How is the referral made? (Check all that apply)
   a. Information given
   b. How is the referral made? (Check all that apply)
   c. Health navigator/peer support
   d. Other (specify)

22. Is there a system in place to determine if a referral was used?
   a. Yes (describe)
   b. No

H. Community and Home-based Care
1. Do you provide community and home-based care for PLHIV?
   b. Yes
   c. No (skip to question 16 in this section)

2. Does the program charge any fee for community or home-based services?
   a. Yes (specify amount)
   b. No

3. Briefly describe how staff are trained and supervised.

4. Are there any systems in place to assess the quality of services?
   a. Yes (check all that apply)
      i. Routine review of service delivery data
      ii. Client satisfaction survey
      iii. Other (specify)
   b. No

5. Which of any of the following are available and used routinely to guide HIV treatment (check all that apply) Get copies of all that are available.

<table>
<thead>
<tr>
<th>Treatment protocols</th>
<th>Treatment guidelines</th>
<th>Government prikazs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used routinely</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

7. How is the referral made? (Check all that apply) Which of the following activities are provided as part of community or home based care. Check all that apply.

| Physical care of PLHIV                          |                      |
| Client counseling                               |                      |
| Family counseling                               |                      |
| Support for the care givers                    |                      |
| Social and legal services                      |                      |
| Other (specify)                                 |                      |

8. How does the community and home based care program recruit clients? Check all that apply.

| Self-referrals                                      |                      |
| Family                                              |                      |
| Community and religious leaders                     |                      |
9. For each of the periods in the table below, what is the number of clients who returned for services?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of returned clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

11. What is the average amount of time spent with a client (where possible verify with patient logs)
   a. 15 minutes or less
   b. 15 to 30 minutes
   c. 30-45 minute
   d. 45 minutes to 1 hour
   e. More than an hour

12. Between April 2010 and August 2010, how many Dialogue Project vouchers did you accept?

13. Do you have recommendations on how the voucher system could be improved?

14. What supplies are provided as part of home and community based care?

15. During the past six months, have there been any stock outs of these supplies? (specify which supplies have experienced stock out)

GO TO SECTION I

16. If you don’t provide community or home-based care services, do you refer clients for these services?
   a. Yes
   b. No (Go to Section I)

17. How is the referral made?
   a. Information given
   b. Appointment booked
   c. Health navigator/peer support
   d. Other (specify)

18. Is there a system in place to determine if a referral was used?
   a. Yes (describe)
   b. No
I. Support for PLHIV

1. Do you provide support to PLHIV?
   a. Yes
   b. No (Skip to question 12 in this section)

2. Does the program charge any fee for PLHIV support services?
   a. Yes (specify amount)
   b. No

3. Briefly describe how staff are trained and supervised.

4. Are there any systems in place to assess the quality of services?
   a. Yes (check all that apply)
      i. Routine review of service delivery data
      ii. Client satisfaction survey
      iii. Other (specify)
   b. No

5. Which of the following activities are provided as part of PLHIV support? Check all that apply.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income generation/skills training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home based care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family planning counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug demand reduction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to other medical services (reproductive health, management of complications due to drug use; PMTCT; ART adherence support and counseling; etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Gender</th>
<th>Less than 1</th>
<th>1-5</th>
<th>5-15</th>
<th>15-25</th>
<th>25-35</th>
<th>35-45</th>
<th>45+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

9. What is the average amount of time spent with a client (where possible verify with patient logs)
   a. 15 minutes or less
   b. 15 to 30 minutes
   c. 30-45 minutes
   d. 45 minutes to 1 hour
   e. More than an hour

10. Between April 2010 and August 2010, how many Dialogue Project vouchers did you accept?

11. Do you have recommendations on how the voucher system could be improved?

GO TO SECTION J

12. If you don’t provide PLHIV support services, do they refer clients for these services?
    a. Yes
    b. No (Go to section J)

13. How is the referral made? (Check all that apply)
    a. Information given
    b. Appointment booked
    c. Health navigator/peer support
    d. Other (specify)

14. Is there a system in place to determine if a referral was used?
    a. Yes (describe)
    b. No

J. Family Support

1. Do you provide support to family of PLHIV?
   a. Yes
   b. No (Got to question 8 in this section)

2. Does the program charge any fee for family support services?
   a. Yes (specify amount)
   b. No

3. Briefly describe how staff are trained and supervised.

4. Are there any systems in place to assess the quality of services?
   a. Yes (Check all that apply)
      i. Routine review of service delivery data
      ii. Client satisfaction survey
iii. Other (specify)

b. No

5. Which of the following activities are provided family support? Check all that apply.

<table>
<thead>
<tr>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual counseling</td>
</tr>
<tr>
<td>Income generation/skills training</td>
</tr>
<tr>
<td>Home based care</td>
</tr>
<tr>
<td>Legal services</td>
</tr>
<tr>
<td>Nutritional support</td>
</tr>
<tr>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

6. Between April 2010 and August 2010, how many Dialogue Project vouchers did you accept?

7. Do you have recommendations on how the voucher system could be improved?

GO TO SECTION K

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

9. How is the referral made? Check all that apply
   a. Information given
   b. Appointment booked
   c. Health navigator/peer support
   d. Other (specify)

10. Is there a system in place to determine if a referral was used?
    a. Yes (describe)
    b. No

K. Closing Questions

1. Are there services which your clients need which you feel this site could add? Please specify.

2. What are your top 3 priority areas/needs that would improve your motivation and job satisfaction? Rank the order the responses with 1 being the most beneficial and 5 being the least.
   a. Training
   b. Routine supportive supervision
   c. Materials and supplies
   d. Appropriately trained
   e. Client education materials and support
f. Greater NGO involvement,
g. Incentives (identify other than money)
Appendix 3: Interviewer Guide: Dialogue Project-funded NGO Staff

Semi-Structured Interview Guide
Interviews with Dialogue Project Grantees (Non-governmental organizations providing services to most at risk populations in selected sites)

Central Asia

General Notes:

NGO are key service providers for various MARP groups in the three countries. The purpose of this short structured NGO interview is to obtain information and especially their perspectives on service gaps, coverage, quality and best practices.

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

Introductory remarks by Interviewer:

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

- Identify the spectrum and scale of services provided in selected oblasts of Kazakhstan, Tajikistan and Kyrgyzstan to 5 population groups most at risk of HIV infection. We will be looking at the coverage of services, their affordability, level of integration of different services and functionality of referral systems, effective practice of service delivery, as well as any challenges and other obstacles that prevent vulnerable people from accessing services;
- Define whether these services are sufficiently responsive to the essential needs of the target populations and are in line with international recommendations relevant to Central Asia. Identify any significant quality issues and gaps in the required continuum of services;
- Develop recommendations for improving accessibility and quality of services available to most at risk populations in selected sites.

The mapping will be conducted by a group of experienced consultants supported by international experts in concentrated HIV epidemics.
You are invited to participate in the interviews as a non-governmental service provider. Your knowledge of the needs of at risk populations as well as of the services available in your area is very important for this assessment. The interview will take about an hour. We will not use your personal data in the assessment report or in any other way.

Please feel free to ask any questions before we start.

We can now proceed with the questions.

Name of Interviewer: ______________________  Date of Interview: ____________

NGO Organization/Facility Details
1. Name of Organization:
2. Country and city:
3. Address:
4. Telephone number:
5. Fax. Number:
6. Email address:
7. Director:
8. Staff participating in the interview (with positions)

<table>
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<tr>
<th>Name</th>
<th>Position</th>
<th>Contact information</th>
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1. What HIV/STI services do you currently offer?
2. What oblasts do you work in?
3. Within each oblasts and/or rayons do you reach?
4. What are the target populations you serve?
   Probe for: MSM, CSW, IDU, former prisoners, migrants, PLWH
5. How many people [specify MARP group] did you serve in August 2010?

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<tr>
<th>MARP Group</th>
<th>Number of Population Served</th>
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6. How many were served from October 2009 through September 2010?

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<tr>
<th>MARP Group</th>
<th>Number of Population Served</th>
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7. What are the most sought after services by each of the MARP groups you serve?

8. What is your estimate of unmet demand for services? How many people are there in the MARP group(s) you serve that don’t access your services?

9. How is your program staffed? Describe the roles of paid staff as well as volunteers/peers.

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<tr>
<th>Role</th>
<th>Paid Staff</th>
<th>Volunteers</th>
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10. Do you charge fees for any of your services? Which ones? If you do, how much is charged? Do you have a program to subsidize the costs for those that cannot pay?

11. What are the 3 most significant challenges (other than funding) for which you need assistance to implement quality HIV prevention, treatment, care and support services?

12. Can you describe 1-2 best and promising practices of HIV prevention, treatment, care and support work that you implement that you would like to share with others doing similar work?

13. What are you aiming to achieve by working with these populations? What is the mission and goals of your organization?

14. What are the most commonly expressed needs and challenges/difficulties faced by your target population? Please prioritize needs by assigning numbers with the 1st being the most essential 5 being the least essential.

15. What systems do you have in place to measure the quality of the services you provide? How often do you assess the quality of your services?

16. If you could design and implement the ideal HIV service delivery system for the MARPs you service, what would it look like?
17. Please comment on the level of integration of the services you provide with other government and NGO services in your area? Is the integration effective? What makes it effective? If it isn’t effective, what are the reasons for this?

18. What are your 3-5 most significant and important organization and management systems strengthening needs?
Appendix 4: Moderator Guide: Focus Group Discussions with Clients of HIV Services and Vulnerable People Not Accessing Services

General Comments:
- There will be at least five FGs per country; one per MARP (MSM, IDU, SW, prisoner, PLWH).
- FG will be done at the oblast level, depending on the MARP population to be served by the Dialogue Project.
- Both users and non-users of services should be included. Wherever possible separate discussions will be organized with these two segments of the participants.
- AIDSTAR-One and AIDSTAR-Two will work with PSI and NGOs to set up FGs.

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

Focus Groups Discussions with Clients of HIV Services and Vulnerable People Not accessing services

| Target population: | 1. Men who have sex with men (MSM)  
| | 2. Injection drug users (IDU)  
| | 3. Commercial sex workers (CSW)  
| | 4. Former prisoners  
| | 5. People living with HIV (PLWH) |

| # of FDG sessions to conduct: | There will be at least five focus groups per country. One per MARP sub-group - MSM, IDU, SW, former prisoner, and PLWH. They will be done at the oblast level, depending on the MARP population to be served by the Dialogue Project NGOs. |

| # of participants per FGD session: | 5-10 individuals. Both users and non-users of HIV services should be included. |

| Approximate duration per FGD: | 50-60 minutes |

| Informed consent: | The moderator must get signed copies of the informed consent forms from each participant. For participants that don’t know how to read or write, the moderator should |
read the consent form, ask if they would like to be part of the focus group discussion and ask them to mark an X in the space provided for their signature in the consent form.

All participants should be provided an opportunity to ask any questions about the consent form prior to beginning the group discussion.

| Introduction: | Hello. My name is ________________ and I have been asked by the AIDSTAR-Two/AIDSTAR-One Project to conduct a series of focus groups discussions to assess the HIV services available to you. The information you share with me will be used to guide future prevention, care and treatment programs that are being planned in this country.

It is important for me to hear your opinion about the services you currently receive and/or need and your impressions about the quality of these services. Feel free to make positive or negative comments about any of the things we’ll be discussing today. This is a free flowing discussion and there is no right or wrong answers. I will not be offended in any way by anything you say so please feel free to speak your mind. |
| General Notes: | Name of Facilitator: |
| Date of FGD: | |
| FG Facility Information: | Name of Facility: |
| Name of person assisting with recruitment/logistics: | Address: |
| Country: | Oblast: |
| Telephone: | Email: |
| Demographics of the group: | MARP Group: |
| Number participating: | • Women: |
| • Men: | Duration of FG: |
A. **HIV-related services accessible to MARPs**

1. What HIV-related services do you have access to?
   *Probes: If not mentioned, ask for services such as voluntary counseling and testing (VCT), needle exchange, medical assisted therapy, anti-retroviral treatment, STI screening and treatment, psycho-social support, peer educations, prevention of mother to child transmission (PMTCT), etc.*

B. **Perception on government facility services**

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

2. Could you please tell me what HIV-related services did you received in the past between September 2009 and August 2010 months and where?
   *Probe for names of government facilities.*

3. Were you charged any fees these services? Which ones and how much?

4. What did you like about these services? What didn’t you like?

5. If you are not pleased with a service at the [name of government facility], is there a way for you to give your opinions to providers?
   *Probe: If there is a way, have you ever done it? What resulted from that?*

6. How was your confidentiality protected?

7. Did you receive referrals for any services you wanted or needed but weren’t provided by the government program? Where were you referred?

8. If you have the opportunity to improve the services provided by [name of government facility], what would you change?

C. **Perception on NGO services**

Now, I would like us to focus on the services you have received at non-governmental organizations (NGOs) sites.

9. Could you please tell me what services you received in the between September 2009 and August 2010 and where?
   *Probe for names of NGOs.*

10. Were you charged any fees these services? Which ones and how much?

11. What did you like about these services? What didn’t you like?
12. If you are not pleased with a service at the [name of government facility], is there a way for you to give your opinions to providers?
   Probe: If there is a way, have you ever done it? What resulted from that?

13. How was your confidentiality protected?

14. Did you receive referrals for any services you wanted or needed but weren’t provided by the NGO program? Where were you referred? Did you use the service?

15. If you have the opportunity to improve the services provided by [name of NGO], what would you change?

16. Of the services you have received in the past, which ones do you think should be expanded or replicated in other regions/oblasts/cities?

D. Perceived barriers and challenges to access HIV-related services

17. What other HIV-related services that you need are not available to you?
   Probe: Why do you think they are not available?

18. What challenges or difficulties do you face in accessing HIV-related services?

19. For people who haven’t used a government service between September 2009 and August 2010, what kept you from using the services?

20. For people who haven’t used an NGO service between September 2009 and August 2010, what kept you from using the services?

E. Involvement of MARPs in the design and/or delivery of HIV-related services

21. Describe how have you been involved in the design and/or delivery of HIV-related services in the past?

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