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DESK REVIEW OF HIV-RELATED POLICY RECOMMENDATIONS FOR KAZAKHSTAN, KYRGYZ REPUBLIC, AND TAJIKISTAN



2007–2012

This publication was prepared by Oleg Semerik, Kip Beardsley, Anita Datar, and Margaret Dadian of the Health Policy Project.

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Desk Review of HIV-related Policy Recommendations for Kazakhstan, Kyrgyz Republic, and Tajikistan (2007–2012)

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ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARVs	antiretrovirals
CAAP	Central Asia AIDS Control Project
CAR	Central Asia Region
CARHAP	Central Asia Regional HIV/AIDS Programme
CBO	community-based organization
CMCC	Country Multisectoral Coordinating Committee
DIC	drop-in center
DOT	directly observed therapy
EHCMS	Electronic HIV Case Management System
EHRN	Eurasia Harm Reduction Network
FC	friendly cabinet
FHC	family health center
FMC	family medicine center
FP	family planning
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAART	highly active antiretroviral therapy
HBV	hepatitis B virus
HCT	HIV counseling and testing
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HPP	Health Policy Project
ICAP	International Center for AIDS Care and Treatment
IEC	information, education, and communication
MARPs	most-at-risk populations
MAT	medication-assisted therapy
M&E	monitoring and evaluation
MOH	Ministry of Health
MSM	men who have sex with men
NGO	nongovernmental organization
NSEP	needle-syringe exchange program
NSP	needle syringe program
OI	opportunistic infection
OST	opioid substitution therapy
PEPFAR	President's Emergency Plan for AIDS Relief
PFIP	Partnership Framework Implementation Plan
PHC	primary health centers
PITC	provider-initiated testing and counseling
PLHIV	people (or person) living with HIV
PMTCT	prevention-of-mother-to-child transmission
SPM	procurement and supply management
PWID	people who inject drugs
QALY	quality-adjusted life year
RAC	Republican AIDS Center
RH	reproductive health
SOP	standard operating procedure
STI	sexually transmitted infection

TB	tuberculosis
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session (on HIV/AIDS)
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization

INTRODUCTION

Funded by the U.S. Agency for International Development (USAID) and the President’s Emergency Plan for AIDS Relief (PEPFAR), the overall goal of the Health Policy Project (HPP) is to strengthen policy, advocacy, governance, and finance for strategic, equitable, and sustainable health programming in developing countries. HPP specifically focuses on key health issues, such as family planning/reproductive health (FP/RH), HIV, and maternal health, while also promoting program integration and health systems strengthening.

HPP received funding to work in three countries in the Central Asia Region (CAR)—Kazakhstan, Kyrgyz Republic, and Tajikistan—to support and strengthen collaboration and coordination between nongovernmental organizations (NGOs) and governments working together to identify linkages and referral protocols for HIV-related health and social services.

As a critical step in identifying high-priority policy areas within each country, as well as regionally, the HPP team conducted a desk review of nearly 30 assessment reports,¹ many of which were identified by USAID and other implementing partners as key sources for policy information. Organized by country, and wherever relevant, the desk review attempted to answer the following questions:

1. What assessments were conducted, and by whom?
2. What were the findings for the country/ the region?
3. What are the continuing policy gaps and associated recommendations?

This analysis is intended to provide a detailed review of recently published assessment reports (2007–2012)² conducted in Kazakhstan, Kyrgyz Republic, and Tajikistan to serve as a resource for USAID (CAR) and other groups interested in identifying priority policy areas.

Recommendations from the desk review, combined with findings from a 2013 HPP-led participatory assessment conducted in Kazakhstan, Kyrgyz Republic, and Tajikistan, were also collated and synthesized to inform the development of an options paper, which outlined the most strategic use of available HPP funds.

¹ While the original bibliography listed approximately 40 documents, once HPP initiated the desk review, it became clear that some on the list were summary documents and that the information they contained was redundant.

² One report dated as early as 2003 is included in this review.

POLICY RECOMMENDATIONS

While conducting a detailed analysis across policy documents falls outside of the scope of this desk review, several broad themes worth noting emerged, both within and across the three countries. The policy issues identified in the review were relatively consistent across the region, with minor country-specific differences. These cross-cutting issues identified in the literature and corresponding recommendations are presented below, in alignment with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the PEPFAR Partnership Framework Implementation Plan (PFIP) funding categories to inform the direction for continued PEPFAR-supported policy work in the region. A table cross-walking each assessment report by GFATM and PFIP categories may be found in the Annex.

Stigma and Discrimination

Issue: Drug user registries appear to be a primary barrier to services for all countries, although some sites have found ways to work around registration requirements. These sites could serve as examples to roll out to other parts of the region.

Policy recommendation across countries: Abolish central registries of people who use drugs and ensure information maintained by providers is kept under strict confidentiality.

Issue: Discrimination against people living with HIV (PLHIV) and people who inject drugs (PWID) is prevalent across all three countries.

Policy recommendations across countries: There is an identified need to repeal discriminatory provisions against prisoners with HIV or drug dependence (e.g., transfer to better conditions, eliminate segregation). There is a related need to repeal discriminatory provisions against persons solely on the basis of drug dependency in employment or educational settings and on issues of housing, parental rights, and more.

Country-specific policy recommendations: In Kazakhstan, while discrimination against people based on HIV status is prohibited in general terms, it is important to identify and revise legislative restrictions on the rights of PLHIV that are scattered throughout the legal framework. In Kyrgyz Republic, review and revise the list of occupations where discrimination based on HIV status is allowed.

Issue: The desk review highlights the need to establish and strengthen basic patient rights (e.g., treatment provided within good clinical practice, without discrimination, and with the meaningful participation of the patient in setting treatment goals).

Country-specific policy recommendations: In Kazakhstan and Tajikistan, repeal administrative liability for refusing examination and treatment except for truly exceptional circumstances of imminent harm to oneself or others. Strengthen confidentiality of health information for all citizens, including prisoners. Establish and guarantee strict observance of confidentiality for patients receiving narcological assistance, including prohibition of use of health information for legal proceedings.

Issue: Address criminalization of transmission of HIV.

Policy recommendations across countries: Repeal criminal liability for transmission and exposure to HIV. Use other elements of the respective criminal codes to address intentional transmission (e.g., infliction of bodily harm).

Issue: Compulsory drug dependence treatment.

Policy recommendations across countries: Amend legislation to limit compulsory drug treatment to clearly defined circumstances to prevent serious risk of harm to oneself or to others (e.g., drug testing before employment or enrollment in educational institution).

Country-specific policy recommendations: In Kazakhstan and Tajikistan, amend the criminal codes to allow drug dependence treatment as an *alternative* to imprisonment rather than an additional sentence.

Issue: Compulsory HIV testing and treatment/informed consent.

Policy recommendations across countries: Repeal compulsory HIV testing in employment and educational settings.

Country-specific policy recommendations: In Kazakhstan, there is no requirement for informed consent for HIV testing in current legislation. Amend the law to require informed consent. Likewise, repeal compulsory HIV testing (prisoners, individuals believed to be infected with HIV, foreigners, military personnel, etc.). In Kyrgyz Republic, repeal provisions allowing mandatory testing as a residence/entry requirement for foreigners or stateless persons. Amend the law to limit compulsory treatment of HIV in prisons. In Tajikistan, establish a policy that ensures informed consent to HIV testing. Establish a policy that ensures protections against involuntary testing and treatment.

Multisectoral Linkages

Issue: Coordination needed between the health and law enforcement sectors.

Establish coordination between the health and law enforcement strategies to emphasize prevention of harms associated with unsafe drug use while removing the emphasis on punitive measures against persons who use drugs.

Issue: Harm reduction services in prisons.

Country-specific policy recommendations: In Kazakhstan and Tajikistan, ensure delivery of harm reduction services in prisons, including condoms, needle-syringe exchange programs (NSEPs), disinfectants, information and education, medication-assisted therapy (MAT), and medical and social rehabilitation programs. In Kyrgyz Republic, while the national AIDS program authorizes broad harm reduction services in prisons, additional regulations and guidelines are needed, including establishing guidelines that ensure access to voluntary HIV testing and treatment in prisons.

Issue: Integration of health services (e.g., HIV/tuberculosis (TB)/drug dependence/hepatitis).

Country-specific policy recommendations: In Kyrgyz Republic, the Ministry of Health (MOH) order on hepatitis prevention needs specific provisions on prevention of hepatitis among PWID.

Strategic Information

Issue: Strengthen data for decision making.

Country-specific policy recommendations: In Kyrgyz Republic, develop and monitor indicators on drug use in prisons.

Access to Drugs

Issue: Address restrictions on access of PWID to antiretroviral therapy (ART).

Policy recommendations across countries: Address operational restrictions on access of PWID to ART (not identified by current policy analysis, but a common problem with disease progression and transmission impact), which often include “stability” and detoxification requirements, restrictions on past or current drug use, or hepatitis or TB co-infection.

Key Populations (Most-at-Risk-Populations [MARPs])

Issue: Address the high risk of HIV and TB transmission and low access to prevention/care resources in prison environments, and reduce the barrier of potential criminal sanctions when accessing HIV prevention and harm reduction services.

Policy recommendations across countries: Decriminalize personal drug consumption, reduce penalties for possession of small quantities of drugs without intention to sell, and revise definitions of the quantity of drug that results in criminal charges; decriminalize possession of residual amounts of drugs, including in used syringes.

Country-specific recommendations: In Kazakhstan and Kyrgyz Republic, repeal intoxication as an aggravating factor for criminal liability. In Kyrgyz Republic, establish alternatives to imprisonment and extra-judicial punishment for drug offences for possession of small quantities of drugs for personal use.

Issue: Establish clear legislative authority, operational guidelines, and financing for delivery of harm reduction services.

Policy recommendations across countries: Issue legal protections against criminal or administrative liability for harm reduction programs.

Country-specific recommendations: In Kazakhstan, develop a formal harm reduction strategy that includes specific roles and responsibilities of government ministries and NGOs. Involve NGOs and PWID in law reviews to ensure coordination and clarity across multiple legislative and regulatory acts. Establish guidelines that expand anonymous drug treatment and rehabilitation services. In Kyrgyz Republic, issue a new law on drug dependence and treatment that includes the basic rights of patients, definitions and requirements for informed consent, and the right to withdraw from treatment. Formalize the roles and responsibilities of government ministries and NGOs for implementation of AIDS programs.

Issue: Strengthen the government’s ability to fund NGOs.

Country-specific recommendations: In Kazakhstan, strengthen the legal and operational framework for implementation of social order contracting to prepare for the Government of Kazakhstan (GOK) assuming more responsibility for funding prevention activities as eligibility for GFATM resources comes to an end. In Kyrgyz Republic, increase national budget resources and mechanisms to fund NGOs.

Issue: Strengthen and standardize outreach efforts.

Policy recommendations across countries: Develop clear operational regulations including the support for peer outreach workers (e.g., people who have a history with drug use).

Issue: Needle and syringe programs (including disposal of used syringes).

Country-specific recommendations: In Kazakhstan, the AIDS program includes NSEP outside of prisons but needs clear operational regulations. There is a specific need to change hours of operation to make NSEPs more accessible and delineate services and information provided by NSEPs. There is a related need to repeal the prohibition of needle and syringe possession in prison and authorize implementation of NSEPs in prisons. In Tajikistan, establish a clear legislative framework for NSEP, including delineation of services and information provided by NSEPs and guarantees of access.

Issue: Medication-assisted therapy (MAT)

Policy recommendations across countries: Decriminalize methadone registration status.

Country-specific recommendations: In Kazakhstan/Tajikistan, establish a clear legislative basis to support scale-up and protect the rights of program participants. In Kyrgyz Republic, operational guidelines need to be brought into alignment with international standards, including authorization of implementation in prisons and additional funding needed for scale-up.

Issue: Overdose prevention and management.

Policy recommendations across countries: Authorize and train NGOs, outreach workers, and peers to distribute and administer medications such as naloxone in cases of overdose.

KAZAKHSTAN: ASSESSMENTS, FINDINGS, RECOMMENDATIONS

The following section provides a review of existing assessment reports, findings, and gaps and/or recommendations for Kazakhstan.

Assessment of Medication Assisted Therapy in Kazakhstan

Boltaev, A., A. Deryabina, and A. Howard. 2012. Almaty: ICAP.

Findings

Feasibility and efficacy of medication-assisted therapy (MAT): Results from the MAT pilot project funded by the Global Fund in Kazakhstan have clearly demonstrated the feasibility and efficacy of methadone to treat opioid dependence in the local context. With MAT, the frequency of heroin use was reduced from more than once a week across all three sites to once a week or less (Pavlodar) or total abstinence (Temirtau and Ust-Kamenogorsk). Statistically significant reductions in risky drug injection behavior as well as criminal behavior were observed at all three sites. The proportion of patients remaining free from opioids for 12 months after MAT enrollment ranged from 41 percent to 92 percent. The retention rates achieved in Kazakhstan's pilot MAT project (46 to 61 percent for 12 months) are consistent with those observed in other countries.

Favorable legislation: Kazakhstan's laws are favorable for introducing MAT as a standard of care for treatment of opioid dependence. Methadone and buprenorphine are scheduled as narcotic substances allowed for medical use under strict control, and MAT is included in the national healthcare development program, Salamatty Kazakhstan, endorsed by the President. Enrollment in MAT is associated with significant reductions in patients' spending on nonprescribed psychoactive substances. In the absence of MAT, these drug-related expenses may be as high as 229,403 KZT (US\$1,492) per month per patient, causing additional social harms from drug-related crime.

A low-cost solution: In 2010, a daily dose of methadone medication per patient in Kazakhstan was procured at a low cost of US\$1.85; in 2011, this cost was reduced to under US\$1.00 (150 *tenge*). If methadone were produced locally, so that Kazakhstan no longer depended upon external suppliers, the procurement cost would be even lower. According to the World Health Organization (WHO), for instance, 100 mg of methadone produced in Thailand is US\$0.01 and US\$0.05 in New Zealand.

One-stop shopping for MAT and other harm reduction services: The MAT site in Pavlodar effectively integrated MAT and other narcological services with harm reduction programs, including distribution of injection equipment and condoms, in the same building. The Pavlodar Narcology Center also supports the work of a MAT patient's self-help group; the office of the NGO is located next to the MAT dispensing room. In addition, the Pavlodar site has an HIV specialist from the oblast AIDS center working part time at the MAT site to provide integrated HIV care for MAT patients.

Impact evaluation needed: Current monitoring and evaluation of MAT in Kazakhstan is mainly focused on collecting data on program implementation (number of patients enrolled, material expenditures, etc.) and does not adequately evaluate the quality of services, patients' satisfaction, and MAT's impact on patients' drug use and on criminal and sexual behavior. There are inconsistencies in data collection and documentation approaches at the sites, which require both optimization and standardization.

Scale-up of technical assistance: Technical assistance to support MAT implementers needs to be scaled up. Most of the technical assistance is provided by international agencies. MAT training for

medical workers is not offered routinely, and the involvement of the national system of cadre preparation, including pre- and postgraduate medical education, is rather weak.

Knowledge management: There is little information available on MAT, which has resulted in biased attitudes about MAT among various stakeholders, including the general public, medical professionals, and PWID. The arguments of MAT opponents are influenced by incorrect clinical and pharmacological information about opioid agonist therapy. There is no systematic exchange of experiences and best practices among MAT sites.

Procurement: An effective mechanism for procurement of methadone is lacking, resulting in stockouts, as well as unnecessarily high medication costs, an inability to procure methadone by individual clinics, and a consequent failure to implement clause No.108 of the state program, Salamatty Kazakhstan.

Consistency and quality: The current infrastructure of the facilities providing MAT impedes the provision of high-quality services. The opening hours at MAT sites don't always fit the employment- and family-related needs of patients, who are obliged to visit narcological clinics daily. Infrastructure, staff skills, and the comprehensiveness of services provided to PWID differ among MAT sites.

Treatment interruption: MAT is often interrupted when patients undergo inpatient treatment at other medical facilities or move away from their home cities. The unregistered status of methadone in Kazakhstan does not allow for prescription of take-home doses of this medication. The absence of MAT for PWID in the penitentiary system not only contributes to the interruption of MAT for incarcerated patients, but also seriously limits the healthcare system's ability to control HIV and other blood-borne diseases among these populations.

Recommendations

Scale up MAT: Support staged expansion of MAT, starting in localities with a high prevalence of intravenous opioid use and HIV among PWID, with continuation to other places in the country where there might be a need for such therapy.

Train and authorize practitioners to provide MAT: Train and authorize narcologists at dispensary outpatient departments to prescribe MAT to opioid-dependent patients in their catchment area. Doing so helps scale up the availability of MAT and also reduces the workload of narcologists currently working in the pilot MAT project, who are the only ones authorized to prescribe methadone to eligible patients.

Formalize MAT curricula: Incorporate MAT into graduate and postgraduate medical curricula.

Select, train, and engage specialists in addiction psychiatry from medical institutions to work as technical advisors to support current and new MAT sites, ensuring the provision of high-quality services in line with national and international standards.

Create clinical guidelines and standards: Adopt full clinical guidelines and standards to provide opioid substitution medications based on lessons learned and WHO recommendations. These would cover providing or continuing MAT for patients undergoing planned or urgent medical care at inpatient hospitals, revising admission and discharge criteria, and expanding the opening hours of MAT sites to meet patients' needs.

Strengthen infrastructure: Continue to improve the infrastructure of narcological facilities, ensuring that patients have access to a full range of services that are confidential. MAT sites should be equipped with automated dispensing machines to improve methadone-dispensing practices and contribute to the prevention of methadone diversion.

Build a procurement and distribution system: Establish a state-controlled mechanism for procuring and distributing medications for MAT.

Expand MAT monitoring and evaluation (M&E): Improve and expand MAT M&E procedures, ensuring the collection and analysis of data related not only to program implementation but also to the impact on changes in patient behavior and health. At the same time, it is important to ensure standardization and simplification of data collection and reporting forms from various sites, increase data quality, and reduce paperwork through the introduction of health management information systems (HMIS).

Implement advocacy and communication strategies: Develop comprehensive advocacy and communication strategies for MAT-related issues in order to deliver easy-to-comprehend, evidence-based information and reduce the negative impacts of false information. Nongovernmental and community-based organizations should be engaged in such activities as intensively as possible, especially to implement interventions to promote MAT among PWID and their families.

Base practices on the evidence: Continue adherence to evidence-based medicine in the decision making process as it relates to the development of HIV and drug dependence treatment services. Strengthen the emphasis on the results of state-of-the-art research, such as Cochrane reviews, that repeatedly confirm the safety and effectiveness of MAT compared to other methods of treatment.

Report on the Baseline Assessment of HIV Care and Treatment Services in Kazakhstan

ICAP. 2012. Almaty: ICAP.

Findings

A high level of political commitment: Kazakhstan has worked to ensure access for PLHIV to care and treatment services. Currently, the national health budget funds procurement of antiretrovirals (ARVs), demonstrating the Ministry of Health's commitment to providing comprehensive medical services to all PLHIV who need them.

An effective vertical structure: Kazakhstan has a well-established vertical system of HIV care and treatment services separate from other healthcare activities. While this creates challenges for the HIV program, most stakeholders and HIV specialists consider this discrete system to be appropriate for the current level of the epidemic.

Health Management Information Systems: Kazakhstan is the first country in Central Asia to officially approve and support national scale-up of the Electronic HIV Case Management System (EHCMS), which can significantly improve the quality of data related to treatment and care. The current paper-based reporting system is often ineffective in generating the data analysis needed by the clinical managers of AIDS centers to make improvements.

Quality improvements for basic infrastructure: The infrastructure of the AIDS centers is generally adequate, although some improvements (e.g., increasing the number of counseling and examination rooms) would help to improve the quality and confidentiality of services.

Better-trained human resources needed: While staffing is sufficient at some AIDS centers, an increase in the numbers of qualified HIV specialists and nurses—as well as improved training—should be considered at facilities with high numbers of enrolled PLHIV. This is due in part to high staff turnover

and lack of supervisory visits and on-site support from training partners, especially for nurses. The lack of ongoing mentorship by trainers reduces the likelihood that the knowledge and skills will be effectively applied in real clinical settings.

Adherence and clinical management: Assessment results show a relatively high level of initial enrollment of PLHIV into care and treatment services. However, insufficient patient adherence to care and treatment visits demonstrates the need to build capacity to provide comprehensive clinical management of PLHIV, especially for diagnosis, prophylaxis, and treatment of co-infection and bacterial infection. The use of a facility-based, patient-centered, multidisciplinary approach to counseling, as well as community- and home-based care services (e.g., visiting nurse programs) should be developed and increased. While the MOH and RAC as well as AIDS center staff at the oblast level are highly motivated to improve care and treatment services, targeted technical assistance will be important.

Recommendations

Revise clinical guidelines and protocols: Existing national protocols on clinical management of HIV infections need to be revised to match the revised WHO protocols on ART and management of dual tuberculosis/HIV and HIV/hepatitis C/hepatitis B infections. Copies of the revised protocols should be printed and disseminated to all the AIDS centers.

Offer training in clinical management: Clinicians and other health personnel working at the AIDS centers should receive formal training on using holistic approaches to clinical management of people living with HIV. Training topics should specifically focus on ART initiation, monitoring of adherence and ART effectiveness, management of side effects, and change of ARV regimen in case of treatment failure; diagnosis, prophylaxis, and treatment of opportunistic infections (OIs); and counseling techniques, including motivational counseling, couple-based counseling, and gender-based counseling. Training should include clinical case studies and discussion, and should be supplemented with mentoring and targeted technical assistance as needed. Follow-ups, including supervisory visits and on-site support, are crucial for the proper application of skills learned from the trainings.

Provide clinical management training for nurses: It is also important to ensure that nurses employed at AIDS centers are properly trained in key principles of HIV clinical management and are actively involved in monitoring and supporting patients' adherence. Postgraduate nursing schools should develop and introduce training curricula on HIV management.

Hire and train visiting nurses: Beyond basic medical treatment, PLHIV have a range of needs that AIDS centers do not have the capacity to address, including home-based care and nutrition education. Visiting nurses can help to improve retention in care and ARV adherence, as well as improve care services provided to PLHIV unable or unwilling to come to the AIDS centers. Visiting nurses should be trained in basic home care for common problems associated with HIV infection, as well as in limited clinical and palliative care. They should also receive training in psychological support and in providing information about HIV, AIDS, and opportunistic infections to PLHIV and their caregivers.

Provide training in counseling for PWID: Because most PLHIV in Kazakhstan are PWID, clinicians need special training on how to conduct counseling for people who use drugs. Involvement of psychotherapists and narcologists is important. Expansion of MAT models and promotion of MAT for those PLHIV and PWID who are on ART can facilitate adherence and make it possible to integrate ART and MAT services, and implement directly observed therapy (DOT) when needed.

Support monitoring for clinical quality assurance: Monitoring visits by representatives of the RAC or qualified staff from different oblasts should be encouraged and supported. Periodic evaluations to identify areas for improvement are necessary to ensure that the care and treatment system's objectives are

achieved efficiently and effectively. Monitoring visits should include medical chart reviews to ensure completeness and accuracy of reported results.

Promote a team approach to patient management: AIDS center teams should include clinicians, nurses, epidemiologists, and psychologists; TB specialists should be available to counsel all enrolled PLHIV at least once a year. This will improve referrals for TB screening, especially for those presenting with symptoms that suggest TB. Wherever possible, AIDS centers need to identify a group of adherent and motivated peer counselors to provide counseling, especially for newly enrolled patients. Peer counselors should be properly trained and supervised.

Improve treatment adherence by using a combination of monitoring and measuring methods: Since using only patient-reported data may exaggerate levels of adherence behavior, a combination of methods to measure adherence is more likely to yield accurate results. Pill counts can be performed by clinicians and nurses during every visit to the AIDS center and during home visits. It is also important to properly report both self-reported adherence data and pill counts. Distribution of pillboxes and reminding devices (text notifications) could also improve adherence. Doctors and nurses should receive clear guidelines and training in how to assess self-reported adherence—including reasons for non-adherence—and how to take action to improve adherence.

Use ARV procurement forecasting tools: ART planning and forecasting can be improved by developing and introducing an ARV forecasting tool and clear instructions on how to use it. To further facilitate the process, annual national ARV planning workshops can be organized so that staff responsible for ARV forecasting can discuss their approaches and receive appropriate feedback. Wherever possible, the ARV forecasting tool should be integrated with the EHCMS to allow for automated calculation of the estimated number of PLHIV in need of treatment.

Implement data quality assurance mechanisms: Quality assurance mechanisms for data collection and analysis are necessary to improve M&E of care and treatment services. Analysis of EHCMS data should be conducted to evaluate the effectiveness of ART programs in the country. Clinicians can receive EHCMS training to monitor their patients.

Standardize laboratory procedures for CD4 counts and HIV viral load testing: Comprehensive standard operating procedures (SOPs) compliant with good laboratory practices should be developed, approved, and disseminated for all AIDS centers. Laboratory staff should be trained in newly developed SOPs. To ensure timely and proper calibration of equipment, one staff person from each laboratory facility needs to be appointed and trained in regular maintenance and internal control procedures. Terms of reference for that staff position should be changed to reflect maintenance, calibration, and internal control activities. Distributors of certain kinds of equipment should be contracted to implement periodic preventive maintenance and calibration.

Improve Health Management Information Systems: Linkages between laboratory and clinical personnel at the AIDS centers can be improved by organizing joint training and regular discussion of patient data management where discrepancies between clinical picture and laboratory results are observed. Because a high number of PLHIV, including those on ART, are in and out of prisons, it is important to maintain close linkages between medical services at penitentiary institutions and AIDS centers and to perform assessments of care and treatment services in the penitentiary system.

Register more ARVs: Expanding the number of ARVs registered in Kazakhstan is crucial to ensure that treatment programs will have a sufficient variety of antiretroviral medications to cater to the needs of patients. It is necessary to develop government policies and processes, including simplified registration procedures and customs regulations, to encourage ARV manufacturers to register their medications and deliver them to Kazakhstan.

Increase fiscal resources: Existing budget allocations for ARVs and for drugs to manage ART side effects and opportunistic infections are not sufficient to cover the growing number of people who need treatment. Efforts should be made to ensure that an increase of allocated budgets covers not only inflation rates but also allows adding new patients to the ART program.

Evaluating the Cost-effectiveness of Needle-syringe Exchange Programs in Kazakhstan, 2000–2010

Wilson, D. P., L. Zhang, C. Kerr, A. Kwon, A. Hoare, et al. 2011. Almaty: UNAIDS, World Bank, and University of New South Wales.

Findings

A high return for funds invested: NSEPs aim to prevent HIV and hepatitis C virus (HCV) infections among PWID. From 2000–2010, NSEP implementation in Kazakhstan cost a total of US\$17 million but yielded substantial epidemiological and economic returns.

Decreased frequency of sharing equipment: There is strong evidence that the scale-up of NSEPs has decreased the frequency of sharing injecting equipment among PWID. From 2000 to 2010, NSEPs in Kazakhstan prevented an estimated 2,205–2,720 new HIV cases, 435–934 HIV-related deaths, and 20,941–24,715 cases of hepatitis C.

Cost-effectiveness: From 2000–2010, NSEPs gained an estimated 78,606–85,670 quality-adjusted life years (QALYs) by averting new HIV and hepatitis C cases (mostly the latter). The average cost per QALY gained was calculated to be only US\$132–147 (for reference, the standard threshold for cost-effectiveness in Kazakhstan is US\$9,136 per QALY gained), and are thus extremely cost-effective.

Better health, greater savings: The infections averted during the period 2000–2010 will lead to further health savings in the future. The benefits of the investment in NSEPs in 2000–2010 include an estimated lifetime gain of 322,905–388,954 QALYs. Overall, the average cost per QALY gained when considering lifetime benefits is estimated to be US\$23–31. Needle-syringe exchange programs also result in savings associated with HIV diagnostics and treatment (HIV testing, screening, laboratory tests, ART). Kazakhstan has already saved an estimated US\$2.31–2.6 million in health costs because of NSEPs. Lifetime savings of US\$3.82–5.04 million are expected (including 3% discounted). Reductions in funding will result in more new infections as well as extra spending for health services in 2011–2020, with a large relative reduction in return from investments. The optimal cost per QALY gained appears to be associated with the current level of investments. But further scale-up of NSEPs would lead to substantial additional gains in health and cost savings, and would be highly cost-effective.

Recommendations

Maintain investments in NSEPs: The investment in NSEPs over the scale-up period yielded important health and economic returns. However, decreased funding for NSEPs after 2013 could compromise the achievements of the national response. It is necessary to maintain service and coverage levels for NSEPs and also consider increasing their coverage to achieve greater health and economic benefits. After Round 7 of the Global Fund is completed by the end of 2013, activities within the Round 10 grant will cover only five oblasts of Kazakhstan. Thus, there is a strong economic and health argument for the government to invest in NSEPs to compensate for funding reductions in the rest of the country to achieve national health program targets for 2011–2015.

Expand NSEP coverage: There is evidence that NSEPs could be further expanded to cover greater numbers of PWID, as saturation has not been reached, and increases in NSEP services would likely be cost-effective. On the other hand, if NSEPs were to be scaled down, the study indicates that HIV and HCV incidence among PWID would resurge. It is important for Kazakhstan to at least sustain its relatively high NSEP coverage to ensure that HIV and HCV epidemics do not resurge.

Invest in program improvement to increase efficiency: A 2011 assessment of the complexity and quality of NSEP services in four cities determined that there are areas for improvement. Given that NSEPs are extremely cost-effective, improving program design will increase efficiency and value.

Improving Efficiency: A Rapid Evaluation of ARV Procurement, Storage Distribution, and Dispensing in Kazakhstan

Quality Health Care Project. 2012.

Currently, procurement, logistics, and supply management (PLSM) of ARVs in Kazakhstan are experiencing organizational challenges, resulting in multiple problems at the local level. If ARV forecasting and stock management software were rolled out with adequate expertise, ample training, and adequate equipment, Kazakhstan's AIDS centers could have a world-class ARV distribution system. This report assesses two oblast AIDS centers.

Findings

Zeroing out ARV inventory: An unwritten rule requires ARV inventory levels to zero out at the end of each year, and ARV budget lines must be completely used up by that time. When this rule is violated, the AIDS center is penalized financially by losing the budget surplus for the next year. One AIDS center successfully argued against this requirement in 2011, but these discussions were cumbersome and required a lot of energy.

Sparse written guidance: Currently, ARV procurement, logistics, and supply management have few guiding documents or proper descriptions of roles and responsibilities. As a result, AIDS center staff outsource procurement and supply management (PSM) steps to SK Pharmaceuticals, and have little negotiation power. This assessment was unable to find any official document related to ARV PSM, forecasting methodology, process flow, and timelines, nor a description of roles and responsibilities for the RAC, MOH, and oblast AIDS centers. Given the general lack of written guidance, it is understandable that unwritten policies have become the norm and have led to considerable confusion for AIDS centers.

Quantification methodology lacking: The AIDS centers need to develop their own methodology for quantification. This methodology can vary quite substantially, depending on staff expertise, the time allocated to computation, and the availability and quality of the data.

A weak approval process: Since there are no established roles and responsibilities, oblast AIDS centers have difficulty in receiving approval from the Oblast MOH Departments of Healthcare. These centers are in a weak position when requesting approval, instead of being able to confidently request their needs to be met using evidence. In addition, this process varies quite substantially from oblast to oblast.

Lack of support for staff: Staff receive insufficient support. This inevitably leads to improvisational solutions that may seem pragmatic but could also be detrimental to good practice. This situation should be partially resolved with the rollout of ARV Forecasting and Stock Management Software.

Working with a single pharmaceutical contractor: Contracting with a single company—SK Pharmaceuticals—to work with multiple oblast AIDS centers with little PSM knowledge is inefficient and places great power in the contractor’s hands. As a result, contract terms are often unfavorable to the centers, which makes it even more difficult for staff to manage ARV stock adequately and provide good healthcare. For example, delivery dates in the contract are labeled by month rather than by day. Oblast AIDS centers have difficulty finding out from SK Pharmaceuticals whether the delivery will happen at the beginning of the month or at the end. They face this uncertainty for up to 30 days and sometimes resort to asking other oblast AIDS centers for temporary stock relief. The product range available from SK Pharmaceuticals is limited, which hinders HIV treatment, and the company is not consistently responsive to complaints, causing logistical challenges.

Inadequate storage standards: The two AIDS centers do not implement best practices for good stock, storage, refrigerator, and freezer management; staff are not even aware of these standards. This leads to poor stock management, limited stock turning (First-Expired-First-Out), difficulties in quantifying needs, and expiration dates going unnoticed. Furthermore, sunlight is not always properly blocked, and storerooms are not always well ventilated, air conditioned, and heated. There is poor control over the conditions of refrigerated and non-refrigerated goods due to an absence of hygrometers (a device that controls humidity levels in the storeroom), temperature monitoring before and after temperature logging (once a day) in the storeroom, and refrigerator and periodic cycle counting. The process of receiving goods is worrisome. An evaluation of staff control of received goods has not been carried out.

Little control over stockouts: According to AIDS center staff and RAC, the primary and the most dramatic challenge for AIDS centers is frequent and rotating stockouts, especially for ARV or OI medications. Overstocking also happens when storage capacity and proper stock management knowledge are poor.

Inefficient budget approval process: Budget approval has now become a convoluted and time-consuming process, leaving staff less time to provide good client care. Negotiations with the MOH Departments of Healthcare are uncertain.

Recommendations

Implement ARV Forecasting and Stock Management Software: This will help improve data quality, standardize quantification, align forecasting processes, and unify timelines.

Provide oblast AIDS centers with organizational tools: This would include an overall organizational chart, pragmatic step-by-step tasks, and detailed roles and responsibilities of RAC, MOH, and oblast AIDS centers for PSM, and for the forecasting process.

Define roles and responsibilities: Ensure that the RAC plays the role of the centralized coordinator for the forecasting process and provides guidance and expertise in PSM. Delegate to the RAC centralized supervision of ARV contracting, logistics, and distribution to oblast AIDS centers.

Develop, distribute, and ensure implementation of national Guidelines for Stock, Storage, Refrigerator, and Freezer Management, with associated tools: These documents will serve as a reference for good practices.

Hire an ARV PSM manager at the RAC: This person would be responsible for contracting with the distributor, managing the supply relationship, centralizing complaints from oblast AIDS centers, facilitating quantification and delivery date computation, conducting training as needed, and generally coordinating and ensuring a streamlined supply chain.

Desk Review of HIV-related Policy Recommendations
for Kazakhstan, Kyrgyz Republic, and Tajikistan (2007–2012)

Sign a contract between the RAC and SK Pharmaceuticals, rebalancing and fine-tuning contract terms in favor of RAC and oblast AIDS centers: This ultimately benefits patients.

Further evaluate oblast AIDS centers: Start with those with the largest quantity of ARV-dispensed volume and with the HIV populations that are most remote and have the lowest budget.

Quantify and specify the needs by site for the following:

- Storeroom renovation, guidance in storeroom selection and relocation, and so on
- Standardized medicine cabinets for consultation rooms
- Standardized professional refrigerators and/or freezers
- Standardized storing equipment (shelves, stock cards)
- Standardized monitoring equipment (hygrometer, temperature data logger, etc.)
- Standardized logging tools (temperature log sheet, stock cards, etc.)
- Standardized security equipment (electronic alarm, fire extinguisher, etc.).

Train oblast AIDS center staff and the RAC PSM manager on the following:

- National Guidelines for Stock, Storage, Refrigerator, and Freezer Management
- Provision and placement of signs such as Dos and Don'ts, fire extinguisher placement
- Relevant tools, such as temperature log sheets and stock cards

Ensure quality of supply chain: Evaluate and ensure that the sole distributor does not compromise the supply chain with poor warehousing and transportation to oblast AIDS centers.

Study and Evaluation of Central Asia Health Facilities' Capacity in Provider-initiated HIV Testing and Counseling

Murzalieva, G. and A. Elizaryeva. 2010. Almaty: AIDS Control Project, Republic of Kazakhstan.

Findings

HIV is not a national priority: After Kazakhstan's National AIDS Programme ended in 2010, the government decided to make HIV a part of the Governmental Programme of Public Health Development 2011–2015. Because the government does not consider AIDS a priority (HIV prevalence in the country is low), there is a strong fear that HIV activities will not be fully reflected in the Public Health Programme and may even be lost among other health priorities.

Harm reduction is not a national priority: The government's commitment to harm reduction programming is low, so harm reduction activities are funded by GFATM.

High staff turnover: Frequent replacement of government officials and loss of experienced government staff to projects weaken the technical capacity of national institutions.

Poor coordination: Coordination among government agencies, NGOs, and international organizations needs improvement.

Many PWID cannot afford to pay for services: In this region, both confidential and anonymous treatment is often fee-for-service only; many of those most in need of treatment are indigent.

A paucity of high-quality facilities: While there are some well-equipped medical facilities (e.g., the Republican Academic and Research Center of Medical and Social Drug-related Problems in Pavlodar), such facilities cannot address the full scope of the need for treatment and rehabilitation across Kazakhstan.

Insufficient regulation of and support for NGOs: Despite their important contributions to HIV prevention efforts, including prevention among the most vulnerable population groups, the activities of NGOs are not regulated, which often makes it difficult for NGOs to work with target groups and interact with the government. Funding and procedures for government contracts for NGO assistance need to be developed in Kazakhstan.

Barriers to STI treatment: In Kazakhstan, vulnerable groups have poor access to treatment for sexually transmitted infections (STIs). Services are mainly connected with attending dermato-venereologic dispensaries, which are fee based. To obtain free care for STIs, one must be registered in an STI treatment facility and provide information on one's contacts under threat of administrative sanctions provided for by the Code of Administrative Offences. Inpatient treatment is required in the case of an STI diagnosis, such as syphilis. Such obstacles often cannot be overcome by vulnerable groups of population and youth, and are not required by international STI treatment protocols supported by WHO. National experts believe that these conditions have led to high STI rates.

HIV prevention for PWID in prisons: Because opioid use is a principal driver in spreading HIV among prisoners, the national expert group has recommended implementation of opioid substitution therapy in prisons, an intervention also recommended by WHO, the United Nations Office on Drugs and Crime (UNODC), and UNAIDS. Similarly, the national expert group has also recommended considering such interventions as sterile syringe programs, which are recommended by WHO and reflect international best practice. The AIDS Programme in Kazakhstan for 2006–2010 recognized the value of needle-syringe programs among PWID outside of prisons. Kazakhstan should respect the principle of providing prisoners with the same HIV prevention and treatment services as are available outside of prisons; implementing needle-syringe programs within prisons is also in compliance with Kazakhstan's obligation to take measures to protect and promote the highest attainable standard of health for all persons (including prisoners), as stipulated in the International Covenant on Economic, Social, and Cultural Rights (Article 12), which it has ratified.

Recommendations

Provide HIV counseling and testing (HCT) training to healthcare providers: Specialists in the many health fields related to HIV—obstetrics, infectious diseases, narcology, and more—need HCT training. It's important to choose the most motivated employees to participate in training, develop a separate module on psychosocial counseling, update the information given in current workshop curricula, and improve current training materials. Paramedical personnel and staff of laboratory services should also receive training.

Explore ways to effectively serve high numbers of clients: Group counseling may be one solution for handling a large flow of clients who need HIV counseling. Another is to more actively involve paramedical personnel, especially in obstetrics, tuberculosis care, and prenatal services. Brochures and other information formats can help disseminate key information to clients.

Improve accessibility of services for marginalized populations: PWID and incarcerated people throughout Central Asia need legislation to ensure their access to HIV prevention, treatment, and care services.

Advocate for the rights of PLHIV: Limiting the rights of PLHIV threatens public health by contributing to stigmatization, which drives vulnerable individuals away from prevention and treatment services, and thus furthers the spread of HIV.

Reduce the harm resulting from criminalization of drug use: Under current legislation, people who cannot overcome dependence on drugs must purchase them illegally and are therefore defined as criminals. They then avoid HIV prevention and other health services because they fear arrest, criminal prosecution, and punishment.

Develop better drug treatment options: The treatment offered in most narcological dispensaries does not accommodate people who use drugs (both HIV negative and positive). The only treatment offered is abstinence oriented, which has very limited effectiveness. As a result, PWID are not motivated to have contact with medical or other authorities and often refuse to participate in prevention activities.

Improve access to ART to improve testing uptake, extend lives: Improving access to antiretroviral treatment is necessary. Access to ARV treatment improves the health and prolongs the lives of people living with HIV; such benefits are a strong motivation for people to seek testing to learn their HIV status. ARV treatment further supports HIV prevention by reducing viral load and therefore lowering the risk of HIV transmission to others (e.g., sexual partners).

Support involvement of civil society and affected groups: The national expert group recommends legal support for the activities of outreach workers and peer educators, including those involved in operating needle-syringe programs. In addition, regulations should be adopted to support the involvement of NGOs, PLHIV, and PWID in planning and implementing national programs and strategies on HIV and drugs.

Strengthen harm reduction strategy and efforts: The national expert group has recommended that a number of steps be taken to strengthen harm reduction efforts:

- Governmental agencies should develop a full harm reduction strategy, including harm reduction measures in penal institutions, to prevent HIV and protect the health of people who use drugs.
- The Ministry of the Interior and the Ministry of Health should develop guidelines on interaction between public bodies (especially law enforcement bodies) and centers that implement harm reduction programs within the framework of the Programme on Combating Drug Dependence and Drug Trafficking.

Reduce penalties for drug use: The government should de-penalize drug possession for personal use with no intent to sell. Current punitive legal codes force drug users underground and away from seeking health services.

Support effective operation of NSEPs: The national expert group recommended changing the hours of operation and other procedures of the existing trust points in AIDS centers and other public health facilities to make them more accessible for PWID. In addition, to support effective HIV prevention among PWID and protect public health, the national expert group has recommended creating a clear legislative framework for needle-syringe programs, including the disposal of used syringes. Such a framework should also support effective program operation by ensuring clear legislative support for outreach workers, including peer workers (i.e., people who use or have used drugs, or other members of the affected population).

Preclude criminal and administrative liability for harm reduction programs: Harm reduction and outreach activities operated by NGOs, including services providing sterile syringes or other equipment to reduce harm associated with drug use (including HIV transmission), should be clearly exempt from

liability. The law should make clear that those operating such services are not targeted under either the “propaganda and advertising” provisions of the Law “On Drugs” (Article 24) and Code of Administrative Offences (Article 321) or the “incitement of drug use” provision of the Criminal Code (Article 261). In addition, articles of the Criminal Code (Article 259) and the Code of Administrative Offences (Article 320) governing possession of drugs should be amended to state clearly that NSEP workers do not face any criminal or administrative liability for possessing residual quantities of drugs in used injection or other equipment. To achieve this, specific legislative provisions such as the following could be inserted in the Criminal Code and Code of Administrative Offences:

- Nothing in this or any other law prevents the supply of syringes and other related material, or the giving of advice, information, or instruction on the safe use of syringes and other related material, by staff of a sterile syringe program or other program aimed at reducing harms associated with the use of prohibited narcotics or psychotropic substances.
- A person who is in possession of any residual amount of a prohibited narcotic or psychotropic substance that is contained in or on a syringe or other equipment used to ingest such a substance does not, by the mere fact of that possession, commit an offence under this or any other law.

Remove intoxication as an aggravating factor for criminal liability: According to the Criminal Code (Article 54), being intoxicated (by drugs or alcohol) while committing a crime is an aggravating circumstance that heightens liability and sentence. However, whether a person is intoxicated does not affect the gravity of the harm of his or her crime. Such a provision effectively discriminates against people accused of crimes based on their health status (i.e., dependence on drugs or alcohol), imposing harsher penalties for a given crime on people with this health condition.

Eliminate or reduce compulsory drug testing: The national expert group recommended prohibiting drug testing except in very limited circumstances, which should be strictly defined in one regulatory act. Currently, compulsory testing for drugs may be imposed in situations of drug use in public places (Code of Administrative Offences, Article 336-2), as well as in the event a person is intoxicated in public places, at work, or in certain other specified circumstances, pursuant to an order of the Ministry of Health. Furthermore, as noted above, the Code of Administrative Offences (Article 326) imposes fines for “avoidance of medical examination and treatment by the persons using drugs and psychotropic substances without physician prescription.” This means Kazakh law gives police considerable powers to impose compulsory testing for drugs on a wide range of people, beyond those situations where such intervention may be justifiable in order to prevent serious risk of harm to oneself or to others. The following should be done to eliminate unjustifiably broad provisions for compulsory drug testing:

- Articles 326 and 336-2 of the Code of Administrative Offences should be repealed.
- The Ministry of Health “Instruction on medical testing to establish drug use and state of intoxication” (Order No. 446) should be revised to narrow the authorization of involuntary drug testing to very limited circumstances.

Repeal administrative liability for avoiding testing and treatment: Articles 326 to 328 of the Code of Administrative Offences, which impose administrative liability in various situations for avoiding examination and treatment, should be amended. Article 326 targets those who are in contact with HIV-positive people; people with HIV, STIs, and tuberculosis (after written warning by public health officials); as well as those who are dependent on drugs or alcohol or about whom there is “sufficient information” that they use drugs without prescription. Article 327 imposes liability for avoiding treatment on those with diseases that pose a “serious hazard” to others (which is defined to include HIV, even though it is not casually communicable), as well as those who have been in contact with such people and have received a written warning issued by healthcare officials. Article 328 also imposes liability on a person with a disease that is a “serious hazard” who does not disclose the source of infection or name past

contacts. These broad provisions are an infringement on personal privacy, security, and liberty. Even where intervention to impose testing or treatment may possibly be justified—in cases where there is risk of harm to the targeted person or others—the goal should be to protect the individual or others from harm, not to impose penalties.

Eliminate HIV- and STI-specific criminal laws: Articles 115 and 116 of the Criminal Code, which provide for punishment for transmission and exposure to STIs and HIV, should be repealed. Intentional transmission of these kinds of infections could be treated as infliction of bodily harm, which is covered by other articles of the Criminal Code.

Pass a new law on drug dependence treatment: There is no law in Kazakhstan on drug dependence treatment, an issue governed by different legislative and regulatory acts. The national expert group has recommended drafting and adopting a comprehensive law on drug treatment and narcological care to address improvement and scale-up of drug dependence treatment options.

Implement opioid substitution treatment: Opioid substitution treatment is recognized in international best practice as key to HIV prevention among people who inject drugs. Methods of drug dependence treatment need to conform to international standards and good practice. The process of developing such a law should include NGOs and people who use and/or have used drugs.

Protect anonymity and confidentiality in drug dependence treatment: The national expert group has recommended the scaling up of anonymous drug treatment and rehabilitation services, and specifies that confidentiality must be strictly observed, with legal liability for failure to do so. The national experts recommend amending legislation to strengthen the confidentiality of health information of narcological patients. Suggested legislative provisions could include the following:

- The confidentiality of all healthcare information shall be respected, including records of the identity, diagnosis, or treatment of any patient which are created or obtained in the course of drug dependence treatment.
- No record referenced in Section (1) may be used to initiate or substantiate any criminal charges against a patient or act as grounds for conducting any investigation of a patient.
- Program staff cannot be compelled under any other law to provide evidence concerning the information that was entrusted to them or became known to them in this capacity.
- All use of personal information of patients and program staff in research and evaluation shall be undertaken in conditions guaranteeing anonymity, and any such information shall also be governed by Section (2) of this article.

Eliminate or limit compulsory drug dependence treatment: Review of the effectiveness of compulsory drug dependence treatment in Kazakhstan is necessary, with the goal of reforming existing legislation that has broad provisions for compulsory treatment. In general, compulsory medical treatment violates human rights and should be applied only in extreme, clearly defined cases in order to prevent a person from causing imminent serious harm to self or to others. Currently, various legal instruments in Kazakhstan affect compulsory drug dependence treatment; several are too broad and require amendment. Under current Kazakh law, compulsory drug dependence treatment may be imposed if there is a general possibility of administrative liability and penalty for a person who avoids treatment if there is “sufficient information” regarding their drug use (Code of Administrative Offences, Article 326). Compulsory drug dependence treatment may also be imposed as part of sentencing for an administrative or criminal offense. Furthermore, a person convicted of committing a criminal offense while intoxicated may be ordered to undergo compulsory treatment in addition to imprisonment (Kazakh law does not currently provide for drug dependence treatment as an alternative to imprisonment). In this respect, Kazakh law

fails to take advantage of flexibility offered under international drug control treaties. The national technical group and technical advisers recommend the following to limit compulsory drug treatment:

- Repeal or at least narrow Article 326 of the Code of Administrative Offences, which imposes liability for avoiding treatment for drug dependence, among other things.
- Repeal Presidential Decree No. 2184 (“On compulsory treatment of alcohol, drug, and toxic substance abuse”).
- Amend the Criminal Code to conform to international drug control treaties by allowing drug dependence treatment to serve as an alternative to imprisonment in some cases of less serious criminal offenses. Such treatment would take place at “voluntary” medical and social rehabilitation departments, under supervision similar to that imposed on persons who are conditionally discharged following a prosecution.

Reform registration of people who use drugs and protect confidentiality: To protect and respect human rights, and to remove barriers to seeking treatment for drug dependence or help with problematic drug use, Kazakhstan should abolish its central registry of drug-dependent people, which can be used to violate human rights. To this end, the Order of the Ministry of Health stipulating registration of drug users should be repealed.

Prevent and treat overdoses: To prevent deaths and other serious harm from overdoses among opioid users, outreach workers—including NGO staff and peer workers—should have the legal right to distribute and administer medications such as naloxone in cases of overdose. Outreach workers should also receive training mandated by the Ministry of Health in the administration of opioid antagonists. To respond to overdose emergencies in prisons, peer educators among the prisoners and prison staff should be trained to administer naloxone.

Promote continuity of care: The national expert group has recommended developing partnerships between the HIV, drug dependence, tuberculosis, and hepatitis C treatment facilities to regulate transfer of patients with HIV and drug-dependent people from closed institutions into other medical facilities.

Ensure informed consent to HIV testing: As mentioned above, a Ministry of Health order specifies HIV testing should be done with informed consent and counseling. However, there is no specific requirement for informed consent in the Law “On Prevention and Treatment of HIV and AIDS.” Therefore, a law should be introduced that stipulates no testing for HIV or other blood-borne infection except with the informed voluntary consent (in writing) of the person being tested.

Compulsory testing and treatment for HIV and STIs: Currently, Kazakh law includes very broad provisions for imposing involuntary testing for and treatment of HIV and STIs. These provisions violate human rights and do not accord with international best practice recommendations.

Ensure access to free and confidential STI treatment: The technical consultants and the expert group recommend ending the practice of registration of persons with STIs and instead introducing free, voluntary, and confidential STI testing and treatment.

Strengthen harm reduction measures: Given the significant role of injecting drug use in the HIV epidemic in Kazakhstan, it is important for the Law “On Prevention and Treatment of HIV and AIDS” to support measures to prevent HIV infection and other drug-related harm, in accordance with international standards and recognized good practice. To this end, the Law “On Prevention and Treatment of HIV and AIDS” should be strengthened by legislatively mandating measures to reduce harms, including HIV infection, among prisoners and people who use drugs. This should include directives to such government

agencies as the Ministry of Health and Ministry of Justice, as well as law enforcement, to cooperate with other government bodies and with NGOs to ensure the effective delivery of harm reduction services.

Protect other patient rights: The Law “On Public Health Care” and the Law “On Health Protection” should be strengthened by adding a provision that explicitly guarantees the right of patients to the following:

- Treatment provided in accordance with good clinical practice;
- Treatment without discrimination;
- Meaningful participation in determining his or her own treatment goals;
- Meaningful participation in all treatment decisions, including when and how treatment is initiated and withdrawn;
- The exercise of his or her rights as a patient; and
- Confidentiality of medical records and clinical test results.

Implement harm reduction programs, including NSEPs, in prisons: Amendments and appendices are necessary to improve the Internal Rules of Prisons and Detention Facilities and the Official Order regulating healthcare for accused and convicted persons. The objective is to introduce NSEPs and distribute condoms and sterilizing agents to protect prisoners’ health, including preventing HIV and other blood-borne diseases. Provisions of the Internal Regulations prohibiting prisoners from possessing needles and syringes should be repealed, as these represent a barrier to implementing NSEPs in prisons. Provisions such as those below could be inserted into the Law “On Prevention and Treatment of HIV and AIDS” and/or the Penal Code, or could be prepared as “Rules for Syringe Exchanges and Other HIV Prevention Measures in Prisons and Detention Facilities.”

Distribute condoms and other safer sex materials in prisons: The Ministry of Health and the Ministry of Justice need to ensure that condoms and other safer sex materials, along with appropriate information on their use and their value for prevention of HIV and other STIs, are available and easily accessible to prisoners in a manner that protects their anonymity. Furthermore:

- The Ministry of Health needs to develop a plan for the disposal of used condoms that protects the anonymity of prisoners and the health of prison officers.
- The distribution and possession of condoms and other safer sex materials in prisons should not constitute a criminal or administrative offense, nor are condoms and other safer sex materials admissible as evidence of sexual relations for the purposes of determining any criminal or administrative offense.

Authorize harm reduction programs: Harm reduction programs should be implemented in all prisons, with the objective of reducing harms associated with unsafe use of drugs, including the risk of transmission of HIV or other blood-borne diseases. Important provisions should include the following:

To prevent the spread of blood-borne diseases and minimize the health risks associated with drug use by prisoners, either the Ministry of Health or a local prison authority may authorize a specified person or organization (including NGOs) to offer harm reduction programs, including measures to supply sterile syringes and other related material to prisoners, as well as condoms and other materials.

Increase the flow of harm reduction information: Staff of harm reduction programs may also provide information on the following topics:

- Drug dependence treatment services and other health services;
- Means of protection against transmissible diseases, including blood-borne diseases such as HIV;
- The risks associated with the use of controlled substances;

- Harm reduction information specific to the drug being used, including safe injecting and inhaling practices;
- How to find legal aid services;
- Employment and vocational training services and centers; and
- Available support services for people with drug dependence and their families.

Allow for distribution and possession of sterile syringes and related material: An authorized person or organization should be legally empowered to distribute sterile syringes and related material via one or more of the following means:

- Prison nurses or physicians based in a medical unit or other areas of the prison
- Prisoners trained as peer outreach workers
- NGOs or health professionals who enter the prison for this purpose
- One-for-one automated sterile syringe-dispensing machines

Ensure prisoner confidentiality: Maintain confidentiality for prisoners seeking sterile syringes and related material by not requiring the prisoner to identify himself or herself to prison authorities.

Ensure safe storage and disposal of syringes for prisoners: The Ministry of Justice, in consultation with the Ministry of Health, should establish rules for the safe storage and disposal of syringes possessed by prisoners.

- The sterile syringe program needs to include measures to encourage safe disposal of syringes and monitor the number of syringes distributed and the number in storage.
- Sterile syringes and related material distributed by harm reduction programs should be used only in accordance with the law and any other applicable regulations or institutional policies established by the relevant authority.

De-criminalize syringe possession in prisons: The distribution and possession of syringes and related material in prison should no longer be a criminal or administrative offense, and such items should not be admissible as evidence of illegal drug use.

Make bleach available as a disinfectant: Prisons should be required to provide bleach and instructions on using bleach as a disinfectant to prisoners. Prison officials and staff should also do the following:

- Encourage participation of prisoners and their assistance in bleach distribution.
- Ensure that bleach is available to prisoners in ways that preserve prisoners' anonymity.
- Ensure that in no instance shall a prisoner be required to approach a staff member in order to obtain bleach.

Create information and education programs for prisons: The MOH should be required to develop and implement information and education programs on HIV and AIDS and other blood-borne diseases, and on drug dependence treatment, in every prison, including materials useful following release, as well as providing information on treatment, care, and support.

- These programs could include peer education and use of non-Ministry of Justice personnel, including delivery of these programs by community-based organizations.
- As much as possible, material should be available in the languages of the relevant populations, written at the literacy level of and sensitive to the social and cultural needs of the relevant populations.

Charge the MOH with responsibility for providing training and education: The MOH should be required to provide regular training and education to staff and prisoners on a regular basis, covering standard precautions to prevent and control blood-borne diseases, and information on post-exposure prophylaxis, if available.

- Training and education provided to prisoners should also cover available services and treatments, as well as peer education and counseling programs that include the meaningful participation of prisoners as counselors.
- Training in universal precautions should be provided for prisoners and staff who may be exposed to blood and body fluids.

Provide opioid substitution treatment (OST) in prisons: Given the high prevalence of drug dependence among prisoners, the significance of risky drug-use practices in contributing to the HIV epidemic, and the importance of providing access to health services that respect human rights and help promote the highest attainable standards of health, the Kazakh government should implement OST in prisons as soon as it is available in the community at large. Regulatory and Penal Code language regarding OST in prisons could be worded as follows:

- The MOH, with the support and cooperation of the Ministry of Justice, shall establish opioid substitution treatment programs in all prisons.
- Prisoners with opioid dependence shall be eligible for opioid substitution treatment in accordance with opioid substitution treatment guidelines applicable in the community.
- Opioid substitution treatment shall be available for free on imprisonment and throughout the duration of imprisonment.
- Opioid substitution treatment shall not be restricted to those on a course of opioid substitution treatment prior to imprisonment; all prisoners shall be entitled, if eligible, to being on opioid substitution treatment while incarcerated.
- Participation in opioid substitution treatment programs shall be offered on a voluntary basis to all prisoners with opioid dependence.
- Opioid substitution treatment programs may include a variety of approaches, including maintenance treatment.
- The program shall ensure that staff members, prison officers, policymakers, and prisoners have factual information regarding opioid substitution treatment.
- The program shall develop a comprehensive discharge planning system for prisoners nearing release, including a system for referral to opioid substitution treatment programs in the general community.

Ensure access to rehabilitation for drug-dependent prisoners: The national expert group has recommended that the government adopt legislative regulations for medical and social rehabilitation programming for drug-dependent prisoners.

Eliminate compulsory HIV testing of prisoners and ensure access to voluntary counseling and testing (VCT) in prisons: Compulsory testing is contrary to human rights and international best practice. Furthermore, to ensure the right of access to equivalent health services, authorities responsible for correctional facilities need to implement universal access to ART and other necessary medications and treatment for HIV-positive prisoners. To this end, a provision using the following language on equal and adequate healthcare for prisoners should be inserted into the Law “On Prevention and Treatment of HIV and AIDS” and/or the Penal Code:

- HIV testing for prisoners is conducted only on a voluntary basis.
- A prisoner who has tested positive for infection with HIV is entitled to adequate healthcare, counseling, and referrals to support services while in prison.
- Health practitioners shall provide prisoners with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

The language should include explicit reference to HIV; ideally, such an amendment would be worded more broadly to extend to those who need healthcare services and medications beyond HIV-specific care. The national expert group has also recommended that the correctional authorities, together with other interested public bodies and NGOs, develop a Program on Social Support to ensure continuity of care for prisoners with HIV upon release from prison.

Protect confidentiality of prisoners' health information: Amendments to the Penal Code should include new provisions about the obligation of prison system personnel to maintain the confidentiality of medical information of prisoners, including their HIV status. A provision on confidentiality such as the following should be inserted into the Penal Code:

- All information on the health status and healthcare of a prisoner is confidential, and all healthcare procedures shall be designed so as to preserve the confidentiality of prisoners.
 - Information shall be recorded in files available only to health practitioners and not to non-healthcare prison staff. No mark, label, stamp or other visible sign shall be placed on a prisoner's files, cells, or papers that could indicate his or her HIV status, other than necessary notations inside the medical file in accordance with standard professional practice for recording clinically relevant information about a patient.

Information may only be disclosed with the prisoner's consent, or where warranted to ensure the safety of other prisoners or staff, in accordance with the same principles as generally applied in the community applying to the disclosure.

Eliminate discrimination against prisoners with HIV or drug dependence: To eliminate discrimination currently embedded in the law, the Penal Code should be amended in a number of ways:

- Repeal the prohibition on transferring prisoners who are ordered to undergo compulsory drug dependence treatment to better conditions (lower-security institutions); and
- Remove HIV-positive status and the fact of not completing a full course of treatment for drug dependence or STIs from Articles 73 (and others as follows) as factors that restrict a prisoner's right to transfer and movement.

Provide early release for prisoners participating in HIV prevention activities: The national expert group has recommended that persons actively participating in HIV prevention efforts or vocational activities and training on HIV prevention be eligible to apply for early parole.

Enforce anti-discrimination laws: Kazakh laws include provisions prohibiting, in general terms, discrimination against people based on HIV-positive status. Yet discrimination is a reality, and Kazakh law itself contains discriminatory provisions in other areas. Legal protections against discrimination are important elements of successfully addressing the marginalization that contributes, in multiple ways, to people’s vulnerability to HIV and to the impact of HIV infection. Legislation can be strengthened in several ways in this regard to comply with human rights principles.

Prohibit HIV testing in employment or educational settings: Current Kazakh law already prohibits refusing to employ someone or dismissing someone from employment based on HIV status. However, it would be useful to recognize explicitly that requiring HIV testing before or during employment or attendance at an educational institution amounts to unjustified discrimination. Thus, a new provision should be introduced into the Labour Code that prohibits employers from conducting HIV testing as a condition for employment. Such a provision could be worded as follows:

- Discriminating against a person, or against a relative or associate of a person, on the basis of real or perceived HIV infection or AIDS diagnosis, is prohibited, including but not limited to such contexts as employment or education. For greater clarity, it is unlawful discrimination to require that a person be tested for HIV as a condition of employment or enrollment in an educational institution, either before or during employment or enrollment.

Prohibit discrimination against drug-dependent persons in employment settings: Kazakh legislation restricts the rights of people who use drugs and who are registered with drug dependence treatment facilities from obtaining a driver’s license or working in high-risk jobs, as well as in pharmacological facilities. As the national experts group has noted, there are contradictions between the cited Ministry of Health policy and the broader government policy on prohibition of employment in certain jobs of people who previously used drugs. The Ministry of Health order provides that such employment restrictions do not depend on the current state of a person’s health, but the government resolution lifts restrictions on many types of activities and on driving for those in remission. It is recommended to review current regulatory acts in order to ensure no unjustified discrimination in employment based on drug use.

Prohibit discrimination against drug-dependent persons in educational settings: Legislators need to address the question of discrimination in employment, but also in educational institutions, based on drug dependence. Requiring drug testing before employment or enrollment in an educational institution is also unjustifiable discrimination based on a health condition. Requiring testing for drug use during employment may only be justifiable in limited circumstances, such as limiting testing to positions that are safety sensitive, and then only in cases where there are reasonable grounds to suspect impairment, or possibly random drug testing of persons returning to work after receiving drug dependence treatment. It is recommended that the law (perhaps the Law “On Drugs”) be amended to include a provision along the lines of the following:

- Absent a reasonable justification, given the circumstances of the case, it is prohibited to discriminate against a person, or a relative or associate of the person, on the grounds that the person uses or has used drugs, or is perceived to use or have used drugs.
- It is unlawful discrimination to require that a person undergo drug testing as a condition of enrollment in an educational institution, either before or during enrollment.
- It is unlawful discrimination to require that a person undergo drug testing as a pre-condition of employment. Making drug testing a condition of continued employment is permitted only in positions where impairment while at work may pose a significant risk of harm to the individual employee or to others, and where there are reasonable grounds to suspect that the individual employee may be impaired by drug use.

Respect and protect family relationships: The Law “On Prevention and Treatment of HIV and AIDS” prohibits restricting the “rights and legitimate interests” of people with HIV based on HIV-positive status, and of family members of the HIV-infected persons. Yet people living with HIV are denied the right to adopt children, a blanket restriction which is not justified. People who use drugs are also denied the right to adopt. In addition, mere drug dependence can be a basis for depriving someone of child custody in cases of concern about child neglect or abuse: the Law “On Marriage and Family” states that parents may be deprived of their parental rights if they “are recognized in due order as person abusing alcohol, drugs, and substances.” If drug use or dependence is per se assumed to be a basis for depriving parents of their children, this would amount to unjustifiable discrimination simply on the basis of a health condition that can be treated. Instead, there must be regard for individual circumstances, not simply assumptions or prejudices about people who use drugs or are drug dependent. The following reforms are recommended:

- Article 67(5) of the Law “On Marriage and Family” should be amended to clarify that, in cases of concern about child abuse or neglect, drug dependence should not be assumed to be per se sufficient grounds to deprive someone of parental rights; rather, a careful analysis of the individual circumstances is required.
- The government resolution that lists HIV and drug dependence as barriers to adopting or receiving custody of a child should be amended to delete these conditions from the list.

Kazakhstan Country Situation

UNAIDS. 2009. Geneva: UNAIDS.

Findings

Subsuming HIV and AIDS into more general public health programming: Since Kazakhstan’s National AIDS Programme is coming to an end in 2010, the government has decided that HIV will become a part of a Governmental Programme of Public Health Development (2011–2015). Because the government does not consider AIDS as a priority, there is much concern that HIV activities will not be properly and fully reflected in programming and may even be lost amongst other health priorities.

High staff turnover: Staff turnover is rather high in Kazakhstan. Frequent replacement of governmental officials, who flow out of experienced governmental staff to projects, weakens the technical capacity of national institutions. The government’s commitment to fund some activities is low, so harm reduction is funded from GFATM.

An Assessment of the HIV/AIDS and Related Health Delivery Systems in Karaganda Oblast in Kazakhstan (Study of Patient-flow, Functionality and Funding Issues)

Routh, S. 2007. Almaty, Kazakhstan: CAPACITY Project.

Findings

Primary healthcare (PHC)/family medicine clinics are often the first providers: Patients dealing with HIV, TB, and STIs often choose to visit primary care clinics first, even though they could go directly to specialized centers that focus on specific infectious diseases. Proximity to home is one reason, as is the traditional practice of territorial distribution of populations among respective area physicians/PHC providers inherited by the Central Asian countries from the former Soviet health system. Unfortunately,

other than referral to the AIDS centers and some nominal consultation and counseling, PHC clinics currently offer no substantial HIV services.

The healthcare system faces a growing client population: ART and management of HIV-related illnesses (except for TB co-infection, which could require inpatient care at different stages) is principally a long-term ambulatory treatment regimen. It is then critical to determine, for areas of high HIV prevalence, whether it is feasible and sustainable for the current oblast/city AIDS centers to absorb an increasing number of HIV-positive and ART cases. It is thus important to decide whether it is better to strengthen the vertical AIDS centers so they can autonomously offer ART, including management of side effects and other general healthcare requirements of AIDS patients, or instead use alternative service provision arrangements by involving the existing general healthcare systems, including the PHC providers.

Co-infection testing is insufficient: Although AIDS, TB, and dermato-venereal programs claim that tests for co-infections are compulsory for all clients who test HIV positive, only four of the eight HIV-positive persons reported undergoing tests for TB and four for STIs. Similarly, of the 21 TB respondents, 12 each got tested for HIV and STIs; of the 12 STI-positive interviewees, five underwent tests for HIV and seven for TB.

Private practitioners and traditional healers are rarely consulted by HIV, TB, and STI clients: A key explanation for this could be the scarcity of alternative sources in Karaganda Oblast in particular and in Central Asian countries in general.

Clients with HIV disclose their serostatus to family and friends: All of the eight HIV-positive respondents said they had shared their serostatus with either spouse or family, or with relatives, friends, colleagues, and neighbors. On the one hand, this finding apparently might seem to contradict the idea that HIV-positive persons fear stigma and discrimination, yet the HIV-positive interviewees identified confidentiality and privacy as overriding concerns. These findings may not hold for other Central Asian countries.

Some HIV-positive clients are dissatisfied with conditions in hospitals and clinics: Three HIV-positive respondents expressed dissatisfaction with conditions in the TB hospital, citing the absence of proper treatment procedures for AIDS-TB co-infected cases and lack of proper skills among the polyclinic doctors in handling HIV and AIDS cases.

Clients trust AIDS centers to maintain confidentiality: With regard to the most preferred health facilities for HIV tests and treatment, the AIDS centers were the overwhelming choice of HIV-positive respondents. The key reason behind this appeared to be their confidentiality concerns. As a matter of fact, the HIV and AIDS respondents did not actually know of any alternative health facility that can address their treatment needs in keeping with their privacy and confidentiality preferences. However, all of them saw it as much more convenient if they could be serviced from a suitable health facility relatively nearer to their homes, along with their confidentiality and privacy concerns duly addressed.

The healthcare system is too complex, with too little transparency: The functionality and funding assessment reveals that the oblast healthcare system has too many specialized vertical systems in place, and the functional roles and relationships of key service providers are not very clearly defined. Very minimal or no HIV services are obtainable within the general healthcare systems, including the primary healthcare polyclinics/family medicine clinics. Although some TB and STI-relevant preventive, early detection, and treatment services (including DOTs for TB) are integrated into the polyclinics/family medicine clinics, and diagnosis and treatment services for STIs are available at the general hospitals, there is apparently a lack of clear-cut policy direction, as well as functional arrangements and resources for the

effective integration of HIV and AIDS, TB, and STI-related services within the existing general healthcare systems.

Interaction between programs is poor: Apart from being distinctly disconnected from primary healthcare and the remaining general healthcare systems, interaction between and across the various specialized vertical programs to effectively address critical issues, such as prevention, early detection, and treatment services for the key populations at higher risk, are seemingly inadequate and ambiguous as well. For instance, the two major HIV and AIDS most-at-risk groups in the existing concentrated phase of the epidemic—PWID and sex workers—are principally serviced by the vertical Narcology and Dermato-Venereal programs, respectively. Therefore, running a vertical HIV and AIDS system in Central Asia is a greater challenge than running other vertical infectious diseases systems. In addition, the absence of an effective and functional referral tracking system makes it harder to understand the actual dynamics between and across the various elements of the complicated health system, including the vertical programs that at times might appear to overlap.

Insufficient outreach: Another significant shortfall, common to all of the specialized vertical programs, is the absence of any active outreach program for the corresponding most-at-risk groups. Some of them run static outreach facilities, but there is no proactive mechanism to reach out to offer needed preventive services. Although some NGOs and community-based organizations (CBOs) offer outreach and prevention initiatives for most-at-risk groups, there are too few of them, and most are funded by donors. Furthermore, the links between the public healthcare systems and the NGO/CBO programs are not adequately formalized and well defined. Therefore, both the short-term functional effectiveness and long-term sustainability of the NGO/CBO programs must be addressed in the Central Asian countries.

Insufficient community-based care and support: The public sector AIDS program arguably has limited prospects in ensuring supplemental care and support services, so NGO/CBO initiatives are probably the only option to fill this void. It is therefore highly important that such private initiatives become established in Central Asian countries, with financial and technical support from the public sector AIDS program. There is indeed no clear long-term strategy for the financial sustainability of these private initiatives. Country public finance systems in Central Asia generally do not have the mechanisms to fund NGOs/CBOs. In order to help ensure government commitment and the financial sustainability of such activities as outreach and prevention among high-risk groups, it is certainly critical to begin building country finance mechanisms to support specific NGO/CBO activities with public money.

Changing roles for greater cost-efficiency: Arguably, existing vertical systems might become much more cost-efficient if, rather than functioning as direct providers of services, with each building and maintaining service delivery systems of its own, they instead act as technical/methodological leaders in developing and implementing cost-effective individual and public health interventions. The focus should be on integration of the corresponding individual services into the PHC and general health delivery systems. However, this fundamental change in the roles and responsibilities of the vertical programs will need to be implemented gradually—perhaps over a decade or so.

Recommendations

Plan for integration but plan realistically: Complete integration of HIV and AIDS services is not possible in the short term due to the current structure of the health delivery system and to preventing an explosion of the concentrated epidemic in the general population. In the long term, integration is necessary to ensure the financial viability and sustainability of the entire health service delivery system—including programs for HIV and AIDS and other specialized vertical programs. A step-by-step implementation strategy is critical to success, and short-term steps should be consistent with the long-term vision and strategy for integration.

Build a long-term strategy for integration: The long-term vision and strategy for integration of HIV and AIDS services and other vertical infectious disease systems could be separating the functions of individual health services and public health services, and integrating them into a seamless individual health (general health) delivery system and broad public health system, while maintaining and enhancing outreach and prevention for high-risk groups and community care, and support for people living with HIV and AIDS, through both public and private mechanisms.

Ensure key services: In a concentrated epidemic phase, it is arguably not critical for all PHC practices to be able to deliver treatment or services such as ARV drugs. However, there are a number of important elements that should be within the service scope of all PHC facilities, such as promoting appropriate and accurate information to decrease stigma, better interpersonal communication and counseling skills, universal precautions, and basic health promotion and prevention activities. In addition, over time, voluntary counseling and testing could also be incorporated into all PHC practices—maybe initially targeted at specific groups, such as pregnant women.

Adding outpatient ARV treatment services: In geographic areas with high HIV prevalence, PHC facilities could incorporate ARV drug distribution, adherence support, and VCT. This strategy should involve defining the regulatory criteria for selection and accreditation, selecting a few PHC facilities, providing training and needed logistics, and conducting quality assurance monitoring and ongoing accreditation of these PHC facilities. Also, an adjustment in the existing per capita payment systems of these PHC facilities will be necessary to compensate for the added services. Rather than having a direct role in service delivery, HIV and AIDS centers should serve as technical and methodological centers to provide training to select PHC facilities in high prevalence areas, ensure proper supply of ARV drugs and other needed medicines and supplies, and operate an accreditation and quality assurance mechanism.

Strengthen prevention outreach among high-risk groups: This is essential to cost-effectively mitigate the spread of a concentrated epidemic to the general population. In both the short term and possibly the long term, neither the general health system nor the vertical systems (HIV and AIDS, narcology, STIs) are particularly effective at outreach and prevention among most-at-risk groups, in part because they tend to prioritize treatment over prevention. Currently, there are few NGOs/CBOs involved in prevention outreach for most-at-risk groups, and most are donor funded, with no clear long-term strategy for financial sustainability. Country public finance systems do not have the mechanisms to support NGO/CBO programs.

Discourage expansion of inpatient capacity: The most important short-term policy decision to enable long-term integration of inpatient services for clients with HIV is to discourage establishment of inpatient capacity (hospital beds) in the vertical HIV and AIDS system. This is important both to the financial sustainability of the entire health system and to encourage the HIV and AIDS centers to focus on prevention rather than treatment. Establishing new hospital beds when the health sector is underfunded and there are already too many beds is not consistent with the current and long-term health system reforms of the Central Asian countries, which aim to increase efficiency, financial sustainability, and optimal coordination and integration of health service delivery.

Integrate HIV and AIDS and TB services: An important activity initiated within CAPACITY Strategy-3 is piloting integration of HIV and AIDS and TB services. Strengthening these two vertical programs separately may hamper long-term integration of these services into the broad health delivery system. Their integration could be a good short-term step, especially if it contributes to the objective of not establishing inpatient capacity in the vertical HIV and AIDS system. AIDS patients without TB but requiring inpatient care for certain illness conditions could be treated in general hospitals, and AIDS patients with TB could be treated in TB hospitals.

Pay attention to the politics: It will be difficult to fully integrate HIV and AIDS and TB without major changes in the existing health system structures and financing mechanisms. In theory, integrating the vertical HIV and AIDS and TB systems is no different than integrating broader health systems. But it is also highly political, involving changes in the legal and regulatory framework, structure, organization, and financing of services. It may be possible to develop both short-term steps to establish better linkages between HIV and AIDS and TB services initially, and then longer-term steps to change the structure and financing to enable a more meaningful integration, but the level of corresponding problems in organizational restructuring, monitoring and supervision, and health financing, can't be underestimated.

Kazakhstan: Health System Review

Kulzhanov, M. and B. Rechel. 2007. *Health Systems in Transition* 9(7).

No recommendations are offered.

Fanning the Flames: How Human Rights Abuses Are Fueling the AIDS Epidemic in Kazakhstan

Struthers, M. and J. Csete. 2003. *Human Rights Watch* (June) 15(4).

The following information comes verbatim from this report.

Recommendations

On HIV and AIDS:

- Implement fully and as soon as possible the decision announced by the government in July 2002 to rescind the policy of mandatory testing of all persons in government detention.
- Review the proposed replacement policy on voluntary testing against the United Nations International Guidelines on HIV/AIDS and Human Rights, with particular attention to safeguarding the provision of voluntary and confidential HIV testing and minimizing the use of mandatory HIV testing by the state.
- Discontinue the registration of HIV-positive persons by government offices and any other practice that violates an individual's right to confidentiality about HIV status.
- Discontinue the practice of isolation of HIV-positive prisoners.
- Discontinue the practice of confiscating official identification papers of detainees, drug users, and persons living with HIV and AIDS.
- Amend Article 14(2) of the Constitution of the Republic of Kazakhstan on non-discrimination or issue a policy or official edict to interpret the article to ensure that no person can be discriminated against based on HIV status or sexual orientation. Similarly, specify that all persons regardless of HIV status should enjoy equality before the law, as noted in Article 14(1).
- Ensure the prompt review of HIV and AIDS legislation and regulations being undertaken by the government and the use of international standards such as the U.N. International Guidelines on HIV/AIDS and Human Rights against which to judge the appropriateness of laws and policies.
- Establish humane treatment services for narcotics addiction in accordance with Kazakhstan's commitment as a state party to the Single Convention on Narcotics Drugs of 1961 and its

additional protocol of 1972, the Convention on Psychotropic Substances of 1971, and the U.N. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.

- At AIDS centers, skin and venereal disease hospitals, and other health facilities, establish health services for persons at risk of and living with HIV and AIDS according to the standards of the U.N. International Guidelines on HIV/AIDS and Human Rights, with particular attention to confidentiality of HIV testing and non-mandatory HIV testing with appropriate counseling.
- Eliminate all practices by government authorities at these centers and facilities that violate the right to confidentiality of HIV testing and to non-mandatory HIV testing.
- Government officials at all levels should use public events and contacts with the media to condemn persecution and police harassment of and human rights abuses against high-risk groups and HIV and AIDS workers and to reiterate the crucial importance of HIV and AIDS prevention services for persons at high risk.

On international human rights conventions:

- Ratify the International Covenant on Civil and Political Rights and its additional protocols.
- Ratify the International Covenant on Social, Economic, and Cultural Rights.

On law enforcement conduct:

- Establish and maintain a program of training for police at all levels on HIV and AIDS, the importance of harm reduction services, and related human rights issues. All new officers should be trained, and there should be refresher training for veteran officers. Police and legal and judicial officers should also be trained on the provisions of the 1997 Kazakh law repealing the prohibition of homosexuality and recent international agreements on the right to nondiscrimination based on sexual orientation.
- Abolish the use of arrest or detention quotas by police at all levels. Accused persons should be detained before trial only in cases where they are likely to flee or represent a threat to the community. Prosecute to the fullest extent of the law those law enforcement agents responsible for arbitrary arrest, extortion, mistreatment, and abuse of office.
- Ensure that detainees have full and unimpeded access to counsel during all phases of investigation and trial, that the practice of mistreatment in pretrial detention be ceased, and that confessions coerced under duress cease to be admitted as evidence in Kazakhstan's courts.
- Ensure that individuals can, without intimidation, put cases of mistreatment to independent authorities for prompt and thorough investigation.
- Ensure that the office of the Ombudsman in Kazakhstan takes it upon itself to investigate violations committed by law enforcement officers.
- Strengthen constitutionally guaranteed legal assistance services and ensure the implementation of these services in a way that does not discriminate against socially marginalized groups such as drug users and sex workers.

To the National AIDS Program:

- Expand and increase the scope of existent harm reduction services, including in prisons, and provide appropriate and adequate training to harm reduction personnel. Ensure access to comprehensive information on HIV and AIDS, and voluntary and confidential HIV testing for all persons in state detention.

- Implement as soon as possible pilot methadone therapy programs scheduled for start-up in the first trimester of 2003.
- Include in AIDS program work plans regular monitoring and follow-up of human rights abuses against individuals in high-risk groups, and define performance indicators showing specific compliance with human rights standards.
- Include persons living with AIDS on government policymaking bodies and coordination committees related to HIV and AIDS policies and programs.
- Take measures to ensure the collection of accurate statistics on HIV and AIDS incidence and prevalence and numbers in high-risk groups.
- Intensify and increase educational and training programs on HIV and AIDS for law enforcement officers and medical professionals.
- Ensure that injection drug users are not discriminated against in access to antiretroviral medicines.
- Intensify information campaigns that explain the basic facts of HIV and AIDS to the general population, including to young people in schools and young men doing their obligatory military service. Such campaigns should stress the importance of not criminalizing or stigmatizing either persons living with HIV and AIDS or vulnerable individuals or groups, and should include information on the legality of same-sex behavior.
- Increase information and outreach campaigns to men who have sex with men and expand cooperation with NGOs representing men who have sex with men.

To UN agencies and other multilateral and bilateral donors:

- Urge that Kazakhstan immediately accede to basic human rights treaties, including the International Covenant on Civil and Political Rights and its additional protocols, and the International Covenant on Social, Economic, and Cultural Rights.
- Target support for HIV and AIDS programs and policies in Kazakhstan to measures that help bring services in line with international standards and that reflect protection from stigma and discrimination for persons affected by HIV and AIDS, and the right to voluntary and confidential testing and comprehensive treatment and care.

To the European Union and Member States:

- Use the periodic reviews of the Partnership and Cooperation Agreement (PCA) to urge the government of Kazakhstan to bring its laws and practices with regard to due process guarantees and freedom of expression into compliance with bilateral agreements and international standards, with particular attention to the violations documented in this report. The parliament should request that the EU Kazakhstan

Cooperation Council issue a public report regarding the state of Kazakhstan's compliance with these international standards and should make clear that continuation of the PCA is contingent on specific and measurable progress in observation of these standards.

To the United States:

- Continue to urge the government of Kazakhstan at the highest levels to bring its laws and practices with regard to due process guarantees and freedom of expression into compliance with bilateral agreements and international standards, with particular attention to the violations documented in this report, and with specific regard to resolutions such as the Joint Resolution

Expressing the Sense of the Congress with Respect to Human Rights in Central Asia, S.J. Res. 3
of January 14, 2003.

To the European Bank for Reconstruction and Development:

- Article 1 of the Agreement Establishing the European Bank on Reconstruction and Development states that its purpose is to promote development in “Central and Eastern Europe countries committed to and applying the principles of multiparty democracy, pluralism, and market economics.” In light of this statutory commitment, the Bank should consider the findings contained in this report in the context of its annual country assessment for Kazakhstan and signal that the nature and level of future assistance will be contingent on substantial progress in implementation of the recommendations listed above.

KYRGYZ REPUBLIC: ASSESSMENTS, FINDINGS, RECOMMENDATIONS

The following section provides a review of existing assessment reports, findings, and gaps and/or recommendations for Kyrgyz Republic.

Comprehensive Analysis of Harm Reduction Services in Kyrgyzstan (draft)

Bivoli, S., M. Smelyanskaya, Y. Aleshkina, and K. Lezhentsev. 2011. Bishkek: UNAIDS, DFID, and Quality Health Care Project.

Findings

Clear progress in HIV service provision: Kyrgyz Republic successfully developed an extensive infrastructure of NGO and government-based institutions and a large, trained, and experienced workforce to address HIV. The country has not only a high number of service providers, but also a wide range of services, especially for drug treatment. With support from various donors, the country has a well-trained pool of providers of new services.

Political leadership and commitment to services in prisons: The development of a wide network of OST and needle-syringe program (NSP) service delivery in the prison sector and the “normalization” of these services and positive attitudes of medical and law enforcement personnel within prisons demonstrate Kyrgyz Republic’s leadership in prison harm reduction services in the region.

The strength of NGO advocacy: Kyrgyz Republic has a well-developed NGO service provision sector with skilled and dedicated staff, as well as a strong network of NGOs with good advocacy and community mobilization skills that participate regularly in national HIV policymaking and decision making.

OST programming: The leadership of several state-based institutions, such as the Republican Narcology Center and Prison Health Administration, has been instrumental to the introduction and scale-up of opioid substitution treatment in their service areas. As a result, the current OST program is truly low threshold, with flexibility to transfer OST, in case of sickness, to other health institutions, and development of procedures to rely on relatives for OST dose administration in exceptional situations.

Continued innovation: Although the environment for implementing harm reduction has not always been positive, and the program has faced multiple challenges, the services have adapted and introduced innovative and informal approaches, including that of continued reaching out to people who inject drugs in dire situations, such as development of secondary syringe exchange practices, delivery of clean syringes at drug-selling points, and delivery of Naloxone despite administrative barriers.

Service delivery models: The team has observed some good practices of development of horizontal models of integration of medical services that make delivery of the comprehensive package of services more effective in reducing the incidence of HIV and other infections among people who use drugs, such as provision of OST to TB patients who are hospitalized, integration of highly active antiretroviral therapy (HAART) and OST in prisons, integrated HAART and TB treatment in prisons, and development of multidisciplinary teams and a good NGO-based case-management model developed for women who use drugs.

The need for evaluation: Despite tremendous effort by so many actors and donors, it is next to impossible to evaluate the effectiveness of harm reduction programs because of the insufficiently developed national monitoring and evaluation system for HIV prevention programs targeting people who inject drugs. The current quantitative information available is of insufficient quality to make any conclusions about overall NSP coverage of people who inject drugs, and it is impossible to merge coverage data from all sectors. Well-defined baselines, targets, and benchmarks for harm reduction programs did not exist in the previous National AIDS Strategy.

Fragmentation: Because HIV prevention among key populations has received increased attention from many donors and implementers, service provision has grown quite complex, and many efforts to map all of the services in the country have failed. Often, in the same region, the main service providers are not aware of the whole range of services available, and each entity has only partial information. The same service providers are often contracted by several funding sources and provide some of the same services, in several formats and with several M&E frameworks that cannot be merged into one system.

Need for national coordination: Poor national coordination of the harm reduction sector also causes fragmentation. There is no single authority responsible for HIV prevention programming among people who use drugs that is enabled to set a program framework, measure progress, and determine the success of the program. The current program delivery is fragmented by service delivery areas and donor priorities. The AIDS center network seems to have no ownership of HIV prevention among PWID.

Increased emphasis on HIV prevention: In Kyrgyz Republic, interventions among PWID have shifted from a strong focus on HIV prevention toward drug recovery and abstinence. This means that a drug treatment continuum of care comprising OST and rehabilitation interventions overshadows NSP as the central intervention (proven globally to have the fastest impact on HIV transmission among PWID) and entry point to a comprehensive package of HIV prevention services. Thus, PWID and OST patients are often discouraged from receiving many of the currently available services and cannot be enrolled as peer workers.

Inconsistent resources: NSP service delivery has experienced several interruptions in funding in the past several years, with delays in salaries for personnel, inadequate procurement of syringes and condoms (poor-quality condoms and needles, inappropriate syringes not meeting client needs), or stockouts.

Comprehensive services: PWID still face significant barriers to access to a comprehensive package of services for the top infectious problems: TB, HIV, hepatitis, skin infections, and reproductive health services for women who use drugs, even in family medicine centers where NSP and OST are physically located. They may lack appropriate documentation and health insurance and are unable to pay out-of-pocket expenses, which has led to the emergence of service delivery models in which NGOs pay for medical services provided informally on a private basis.

Limited testing options: Even though access to HIV testing is available in the AIDS centers, many clients avoid it because of the recently increased practices of identification and contact tracing. As a result, the only opportunity to test for HIV and other infections on an anonymous basis is the yearly integrated biological-behavioral surveillance (IBBS). There is an urgent need for community-based, low-threshold HIV testing.

More difficult outreach due to changing drug markets: Changes in drug markets have led to a more closed drug scene and greater suspicion and fear among people who use drugs, leading to closed groups that avoid contact with harm reduction service providers. The current network of drug dealers is less sensitive about the need for clean syringes, which could lead to more group sharing of needles and syringes. Young drug users depend on older drug users for acquiring drugs, needles, and syringes, and avoid contact with harm reduction providers.

Excessive policing and criminalization: Access to NSP and OST programs continues to be affected by excessive policing and criminalization of drug use and syringe possession, despite adoption of more relaxed laws. Excessive attention of police to clients of these two programs make day-to-day operations difficult, leads to increased levels of unsafe injecting and unsafe syringe disposal, and makes younger drug users avoid contact with harm reduction service providers. Moreover, a high imprisonment rate of people who use drugs leads to a circulation of drug users in and out of prison and, upon release, they forfeit their passports, which further hinders access to medical services.

Community opposition to OST: The future of OST is threatened by the increased resistance of some community groups toward it. Often, myths about what an OST program is and is not are driving the debate. However, some legitimate concerns about the quality of OST delivery have been voiced and need to be appropriately addressed in the next programming cycle.

Recommendations

Refocus on the quality of services: While until recently the focus of harm reduction efforts has been scale-up, development of new services, and outreach to clients, the quality of service delivery must become the priority for the next program cycle. The current policy environment is positive for focusing on quality. Officials from the MOH have mentioned the importance of results-based programming, cost-effectiveness, and quality improvement as future directions for HIV prevention efforts.

Own and fund the services: Kyrgyz Republic will continue to receive significant HIV funding from external donors in the next five years. However, the country needs to gradually take over ownership and funding of these services to help reprioritize HIV prevention efforts toward evidence-based interventions with documented success. In this context, Kyrgyz Republic needs to refocus on NSP as the key strategy for effective HIV prevention, and on the need to develop better horizontal models of service delivery away from vertical systems and duplication of efforts.

Establish one authority responsible for coordination of HIV prevention among key populations: This entity should supervise both governmental and NGO harm reduction services, and apply the same standards of a minimum package of services. This will lead to a standardized approach so that drug users throughout the country receive a similar level and quality of services.

Reinstate NSP as the key intervention for HIV control among PWID: This should be done not only on paper (in the Strategy) but in levels of funding and as a priority for future strengthening.

Develop a unified M&E system: The system should include a set of key coverage and quality indicators with clear baselines and targets, to be implemented by both government and nongovernmental organizations. Establish a single unique electronic reporting system for civilian and prison sectors based on a single unique identification code used by all agencies.

Provide support to the AIDS center structure: The AIDS center structure needs significant institutional support to rebuild its organizational capacity to perform in the areas of HIV clinical management, surveillance, and commodity and supply chain management, as well as to strengthen its M&E system. AIDS center clinical staff should receive clinical training on ART for PWID to ensure a uniform level of skills in working with PWID.

Increase advocacy efforts: A key priority for the future of NSP and OST is increased advocacy with the government to ensure that a human rights-based and public health approach underpins the national HIV response. Law enforcement should be at best supportive of, or at worst neutral, toward NSP and OST.

Address the missing links from the comprehensive package: These include access to hepatitis B (HBV) and HCV testing, and HBV and hepatitis A (HBA) vaccinations. A strategy to make HCV treatment more affordable is also important.

Come to a national consensus on service delivery models for combined services adapted for local conditions: Based on disease burden and current unmet need, several service integration models with different levels of investments are possible:

- NGO-based NSPs and mobile NSPs providing one-stop shop services
- NSP and OST sites at family medicine centers (FMCs) as entry points to the services available in FMCs
- Integration of TB and HIV screening at OST sites
- Integration of supervision of OST and ART administration with TB treatment
- Opening of OST sites in the AIDS centers
- Maintenance of functional multidisciplinary teams
- Creation of city- and oblast-level coordinating committees on HIV and TB prevention

Improve communications between donor agencies: To avoid overlap and parallel programming, consider developing inter-donor technical working groups to meet on a regular basis until overlap in programming is eliminated.

Avoid parallel reporting on the same services: Streamline reporting requirements, including forms, frequency, and timing of reporting, based on user and country needs. Decide which database meets most of the donors' needs so it can be used by all HIV prevention service providers.

Improve NSP program quality: Some of the ways to accomplish this include the following:

- Increasing the quality of NSP service delivery and monitoring, and strengthening outreach work
- Expanding and adapting gender- and youth-specific packages within current NSPs
- Allowing young people who use drugs to work as volunteers at harm reduction sites
- Addressing safer sex negotiation
- Developing a communication strategy and new information, education, and communication (IEC) materials
- Further integrating NSPs into existing drop-in and community centers and medical service delivery
- Carrying out scale-up geographically only after rapid site assessments

Improve OST program quality: Some of the ways to accomplish this include the following:

- Increasing the quality of OST programs (increase average dosing, increase patient long-term retention, address parallel use of substances)
- Improving delivery of integrated and wraparound services to OST patients by expanding access to social services available through NGOs
- Continuing to improve continuity of healthcare for OST patients by opening OST sites in TB hospitals in the South and in prisons
- Coordinating OST for pregnant women more effectively and efficiently

Improve HIV counseling and testing: Arrange for anonymous testing at AIDS centers and expand access to rapid testing at NSP sites and through outreach.

Improve HIV clinical management and access to HAART: Strengthen the organizational capacity of the AIDS centers to ensure that high-quality clinical management is provided to PWID, and build the

skills of NSP and OST service providers to provide good counseling and basic case management for timely HIV testing, diagnosis, and treatment.

Improve TB prevention, diagnosis, and treatment: Clearly establish the roles and responsibilities of services that interact with people in TB control and management. Increase the awareness of both PWID and service providers about TB infection control and TB clinical management.

Improve reproductive health services: Establish better models for access to family planning services, safe abortions, and prenatal care by women who use drugs.

Technical Report: Individual, Social, and Structural Barriers to ARV Adherence in Kyrgyzstan, and a Proposed Plan of Action in the Central Asian Republics

Thumath, M., A. Bolotbaeva, D. Parsons, and D. Burrows. 2011. Bethesda, MD: Quality Health Care Project in the Central Asian Republics, Abt Associates Inc.

Findings

Political leadership: Despite multiple challenges, Kyrgyz Republic's response to HIV and AIDS has a number of strengths. The country is a recognized regional leader in introducing harm reduction and prevention services, particularly in needle and syringe access in closed settings. Similarly, release planning from prisons and cooperation between prisons and NGOs is well organized when patients have appropriate documentation and plans are in place to address the issue of patients without documents. Progress has also been made in integrating vertical systems into primary care at the FMC level. Strong community-based organizations are active in the region, with meaningful involvement in the Country Coordinating Mechanism of the Global Fund.

Innovative service delivery models: Regarding treatment innovations, the country has begun some early piloting of multidisciplinary team models, although these teams are hampered by their inability to prescribe and dispense ARVs. There is also widespread use of routine provider-initiated HIV testing, which can improve access to early diagnosis and linkages to care in detoxification services, prenatal clinics, and prisons. Finally, there is a generally supportive legislative framework for human rights, including antidiscrimination laws for PLHIV and MARPs, although challenges remain in human rights and relationships with police and the justice system.

Most PLHIV do not get regular care: According to a recent unpublished WHO Kyrgyz Republic report, there were 2,977 PLHIV registered and currently alive as of the end of 2010 (WHO, 2011). Of those, only 36 percent (1,074) were seen for care in 2010.

Most PLHIV do not get CD4 cell count monitoring: In 2010, 570 newly diagnosed HIV cases were registered by the health system. However, CD4 cell count monitoring was performed for only 31.6 percent (180) of those patients monitored, 50.5 percent (91) of whom had CD4 counts less than 350. Such a high level of readiness for ART among those monitored may indicate unaddressed barriers within the health system that prevent compliance with national recommendations. In other words, the HIV testing policy and/or practice is not sufficient to attract PLHIV at earlier stages of infection, which is a prerequisite for early enrolment in HIV care and timely initiation of ART.

An unmet need for ART: The high percentage of those undergoing CD4 monitoring and indicated for ART initiation also indicates that, at a population level, the immediate need for ART is significantly

higher than the number of people currently enrolled. This unmet need has serious implications for accurate forecasting of the need for ARV medications in the country.

Barriers to treatment: According to WHO, of the 548 PLHIV ever started on ART, only 65 percent (356) were enrolled at the end of 2010. Reasons for ART dropout for 192 patients were the following: 70 (36%) due to death, 25 (13%) due to intolerance and lack of adherence, while the rest (97 = 50%) were lost to follow-up. Unfortunately, there are extremely limited data on access to ARVs for specific key populations. Key informant interviews and experiences in other countries indicate barriers to ARVs are highest for PWID, sex workers, and women with children living in poverty, but reliable data are urgently needed to appropriately address the situation.

Health professionals vary widely in approaches to ARVs: Wide variation was found in approaches to ARV adherence support, and even in estimating appropriate levels of adherence. Most of the respondents considered themselves as in charge of HIV and AIDS services; half considered themselves as other health providers providing care for HIV patients. One FMC staff member did not consider him/herself involved in the provision of HIV services at all, yet this person is a family doctor in a clinic with a substantial caseload of PLHIV. All 10 respondents stated that their health facilities provide VCT. Only the Narcology Center provides MAT and social support to assist adherence. ART could be prescribed by only four of the 10 respondents, three of whom work at the National AIDS Center.

Other findings on key tests for PLHIV: According to the results of the survey, CD4 count, viral load, and lymphocyte counts are conducted only at the AIDS centers. The National Narcology Center and NGO respondents reported involvement in blood sampling for HIV. Only the National AIDS Center and multi-disciplinary teams (MDTs) reported involvement in ARV treatment (five respondents). In both MDTs interviewed, the physician was from an AIDS center.

Dispensing of ARVs: Respondents stated that ARVs are mainly dispensed on a monthly basis, or every two to three weeks. According to AIDS center staff, ARVs for established patients can be picked up by a patient, a registered support person, family member, or community health worker; however, NGO representatives report that only patients were allowed to collect their ARVs and, in exceptional cases, community health workers could be granted permission to do so.

Data available on clinic visits: The following are the top five data types most frequently available in the records for each clinic visit of ARV patients (in descending order):

- Reported side effects
- Number of ARV pills dispensed (by type)
- Expected days' supply of ARV dispensed (by type)
- Date of next scheduled clinic visit
- Providers' impression of recent patient adherence

The burdens of testing HIV positive: A positive HIV diagnosis can create a huge psychological burden on the individual receiving the diagnosis and his/her support network, including the parents of HIV-positive children. A positive status gives rise to uncertainty in all spheres of life, including the quality of life and life expectancy, the effectiveness of treatment, and the reaction of the community to the changed status of the person. Reactions to a positive diagnosis are hard to predict, and may include shock, denial, fear, reduction of self-esteem, and depression. These emotional states may be recurrent, and adequate psychological support must be available not only during post-test counseling, but throughout the continuum of the patient's lifetime in care, at any time upon request.

Availability of counseling for PLHIV: Officially, each AIDS center has a psychotherapist in its staff list, but often an existing staff member performs counseling in addition to his/her main job. If a patient needs

consultation with a psychotherapist, he/she is referred to an appropriate specialist at a partner NGO or FMC, or may also be seen by a non-psychotherapist physician at the AIDS center, although these physicians themselves express concern over this practice and note that not everyone has the skill to provide proper psychological support to PLHIV. Furthermore, physicians from AIDS centers cannot prescribe antidepressants, which can be prescribed only by psychotherapists.

Peer counselors are seen as valuable: Physicians at AIDS centers, NGO representatives, and the participants of focus groups with different MARPs highlighted the need for peer consultants for PLHIV throughout the continuum of care, from immediately post diagnosis to enrollment and continuance on ART. PLHIV focus group members said that the best psychological support they receive is from peer consultants. During focus group discussions, different risk groups were identified as presenting differing needs for social and psychological support services to assist with ART adherence.

Identified needs of specific key populations: These include the following:

- Special psychological support for pregnant PWID, as pregnancy may cause increased anxiety. Drug users and NGOs working with drug users said that due to experiences of trauma and complex health issues, drug users may experience untreated pain and discomfort. Many people needing ARV treatment may be reluctant to start, due to fear of side effects. It is also important to regulate the dose of methadone for those who start ARV treatment after being enrolled in MAT programs to prevent withdrawal syndrome.
- Reduction of the double stigma for PWID and sex workers living with HIV. Fear of learning about their positive status stops many young PWID and sex workers from testing for HIV. They know they are at risk for HIV infection; however, confidentiality is a major issue, and positive drug users or sex workers fear double stigma.
- Dealing with domestic violence for HIV-positive women: HIV-positive women and/or mothers of HIV-positive children frequently become victims of domestic violence, including psychological abuse. The main aggressors are husbands and mothers-in-law.
- Poverty and family issues for PWID: Most PWID lose their connection to families when they start using drugs, and most active drug users are not employed and do not have stable incomes. Food security was also reported as a significant issue for the families of positive PWID.
- Sexuality support for positive men who have sex with men (MSM): An MSM focus group reported that young MSM especially need psychological support, as they are more vulnerable than other MSM. Food security was also reported as a significant issue for the families of HIV-positive children. Families with HIV-positive children on average have four or five children, and have difficulty providing even one hot meal for the family per day. Children are usually given only tea with bread.

The limitations of decentralization: HIV and AIDS treatment and care services have been theoretically decentralized across the country to nine AIDS centers and 66 FMCs. However, decentralization of service has not been accompanied with defining roles and responsibilities among different levels of the health system to ensure continuity and quality of services. During this assessment, the assessment team did not encounter any FMCs that could actually prescribe or even dispense ARVs; all ARVs had to be picked up at the Regional AIDS Center (up to six hours away for some patients). Only the National AIDS Center in Bishkek and the Osh City AIDS Center can prescribe ART, give out medications to PLHIV, and perform immunological and virological tests (CD4 cell count and viral load), which are essential for a decision on timely ART initiation and monitoring its effectiveness. They are also the only providers that can do laboratory confirmations of HIV.

Service limitations that create barriers: Since other facilities are not permitted to perform laboratory tests and stock ARVs, they have to send out blood samples for HIV initial testing and confirmation, and each time they see an HIV-infected patient, the patient must be referred to the National AIDS Center or the City AIDS Center in Osh for CD4 cell and viral load monitoring, or for obtaining ARV medications. This creates substantial additional barriers for patients in receiving services, as they have to visit both their local FMC and AIDS center. It also makes the role of the infectious disease specialists in the FMC very unclear. Even in the innovative MDT teams set up by NGOs, the staff cannot actually prescribe or dispense ARVs, which essentially prevents them from achieving their primary goals of supporting PLHIV on therapy.

Individual and social gaps include the following:

- Overemphasis on individual vs. structural barriers to adherence;
- Limited use of provider-based adherence strategies (cell phones, MAT/DOTs, timers, outreach);
- Lack of involvement of peers in clinical services;
- Poor integration of case management and social supports/NGOs with AIDS centers; and
- Poor implementation of 2010 WHO guidelines for ARV treatment, resulting in delayed access to care and increased loss to follow-up.

Structural gaps include the following:

- Vertical HIV services with little integration into TB, STI, NSP, or OST systems;
- Major supply chain and procurement issues (infant formula, food packages, HIV tests, CD4 and viral load testing, ARVs, OI drugs, drugs to ease side effects, etc.);
- Quality concerns in all spheres of HIV prevention, treatment, care, and support;
- User pay models make services inaccessible for key populations;
- Major barriers to documentation/identification impacting access;
- Monitoring and evaluation system weak on outcomes and access for key populations;
- Major issues with infection control and universal precautions;
- Poor access to HIV testing for key populations;
- High threshold, high barriers to services;
- Accessibility issues: geography, culture, and gender;
- Weak linkages to care after diagnosis;
- Gender-sensitive services lacking in most spheres, including for women and lesbian-gay-bisexual-transgender (LGBT) communities;
- Lack of child- and youth-friendly services;
- Limited linkages to public health and prevention benefits of treatment;
- Stigma and discrimination of key populations and PLHIV; and
- Human rights abuses of key populations.

Missed opportunities for MAT/DOT programming: The dispensing of weeks of ARVs at a time, while understandable due to the long distances patients travel to pick up medications, represents a missed opportunity for MAT/DOT programming. At the same time, the insistence that patients pick up ARVs is also a high barrier to care, especially for patients who live far away, have children, or are working.

Recommendations

Overcome social and structural barriers to care: Of critical importance is a philosophical underpinning grounded in the scientific evidence that the biggest barriers to care for key populations are in fact social and structural, and often beyond the individual drug user's control. These barriers can be overcome, and many regions around the world, including Ukraine, Russia, Canada, Brazil, and Australia,

have successful ARV treatment programs for MARPs that combine social and medical interventions in a one-stop shop model that integrates other needed services with ARVs. In this era of treatment as prevention, where comprehensive social programs that support ARVs for key populations are associated with decreased community viral load and decreased population levels of HIV, it is time to invest in universal access for all PLHIV.

Empower patients by adopting a chronic disease model: A growing body of literature supports a chronic disease model approach to treating HIV and AIDS, incorporating principles of patient empowerment and patient self-management as core components of HIV care. Patient self-management is defined as the ability of patients, in a complementary partnership with their healthcare providers, to manage the symptoms, treatment, lifestyle behavior changes, and the many physical and psychosocial challenges that are a part of living with chronic diseases.

Implement devices to aid adherence: These could include mobile phone alarms, wall charts, pagers, or timers.

Improve medical and peer counselor training: Use training to enable staff and peer counselors to proactively address side effects and provide supportive therapy, especially during treatment initiation. Develop a peer support curriculum on peer navigation or self-management of HIV.

Offer 24/7 support: Ensure that physicians or nurses are available all day, every day to answer questions about missed dosages or side effects.

Use peer counselors and support groups integrated into the clinic: Use peers on ARV treatment to provide peer counseling on adherence. Formalize support groups for PLHIV and integrate them with clinician and peer education on ARV treatment. Introduce case management into AIDS centers, with clearly defined roles, scope, and responsibilities.

Create IEC materials for key populations: Complete a request for proposals to translate or develop IEC materials on ARV treatment for PWID, sex workers, MSM, women and children, prisoners, and migrants.

Provide adherence support materials in variety of languages and at a low literacy level: Materials for PLHIV could include videos of PLHIV on ARVs, cartoons for children, online modules on why to take ARVs, healthcare diaries, log books to record CD4 cell counts and medications, among others.

Address barriers limiting access to care and encouraging adherence: Provide transportation subsidies to all patients. Improve contact tracing and provide anonymous peer and online options. Ensure that clients can access HIV care and treatment through any service, be it NSP, TB, prison clinics, OST, STI, hospital, maternity services, and so on. Eliminate user fees for PLHIV for vaccines, HCV testing, and labor and delivery services. Ensure access to documentation and residency cards for PLHIV.

Provide incentives for engagement and adherence: These could include vouchers or cash (instead of food packages) for PWID, sex workers, women, and families, and mobile phone cards for MSM.

Create linkages between clinical services: Pilot DOTs for ARVs paired with existing DOT services, such as MAT and TB.

Expand community-based services: Expand the scope of NGOs and MDTs to include low-threshold ARV programs in community settings, not just AIDS centers.

Desk Review of HIV-related Policy Recommendations for Kazakhstan, Kyrgyz Republic, and Tajikistan (2007–2012)

Re-orient VCT services to key populations: Provide low-threshold mobile and NGO-based rapid testing, paired with such attractive services as abscess care, HCV testing, legal services, dental services, support services, vaccines, and so on.

Improve linkages to care after diagnosis and during monitoring by decentralizing CD4 and viral load testing: Immediately open access to CD4 and viral load testing beyond AIDS centers.

Improve clinical strategies: Immediately adopt new WHO guidelines on treatment to limit loss to follow-up. Improve the quality of CD4 and viral load laboratory systems.

Improve the procurement and supply management of lab tests: This should include rapid plasma regain (RPR), HCV, HIV monitoring, and HIV testing, including rapid testing. Procure an efficient system for transporting lab samples from NGOs, FMCs, prisons, OST sites, and TB sites.

Mapping of Key HIV Services, Assessment of Their Quality, and Analysis of Gaps and Needs of Most-at-Risk Populations in Chui Oblast and Bishkek City, Kyrgyzstan

Deryabina, A. 2011. Arlington, VA: AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Findings

Moving HIV into the primary healthcare system: Kyrgyz Republic is successfully moving toward integration of previously vertical HIV services into the PHC system. Family health centers (FHCs) play an important role in ensuring easier access of key populations to various services, including ART, prevention of mother-to-child transmission (PMTCT), MAT, and basic harm reduction services. Implementation of those components largely depends on the external funding provided through GFATM.

Access to ART is poor: This is mostly due to the inability of PLHIV to receive testing for CD4 cell counts.

Difficulties in assessing service quality: Quality assessments provided at government medical institutions are limited to the periodic review and analysis of data that come from official statistics. None of the facilities conducts client satisfaction surveys or involves clients in its programming.

Low motivation of medical personnel: This remains a key obstacle to improving services provided to key populations.

Collaboration between NGOs and government facilities: Collaboration between NGOs and government medical facilities is most effective when medical facility staff receive financial incentives from an NGO. To ensure access to services, many NGOs hire key medical personnel from government facilities to work part time on projects.

Obstacles that make it hard for PWID and others to access services: A system of co-payments required by the government that requires a person to be employed, to have an identification document, to have a place of residence, and to have funds to cover 50 percent of the fees is a key obstacle that prevents PWID, former prisoners, and PLHIV from accessing services.

Stigma and discrimination from society in general and medical personnel in particular are decreasing: Nevertheless, barriers remain for PLHIV seeking to access public healthcare or even participate in NGO activities.

Overall forward movement: Kyrgyz Republic has made significant progress in integrating HIV services into the PHC system, and FHCs play an important role in ensuring easier access of key populations to various medical services, including ART, PMTCT, and OST. The country has also put significant effort into better integrating TB and HIV services. Though there are continuous challenges, mostly related to funding mechanisms and human resource capacities of this integration, positive results are noticeable for providers and patients.

Recommendations

Do a better job of integrating HIV and maternal and child health services: This should become a priority, given the varied expressed needs of the clients.

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

Develop and support multidisciplinary teams to routinely measure and address quality issues, both in government facilities and NGO programs: The system to assess the quality of services provided at government medical institutions is limited to the periodic review and analysis of data that come from official statistics. None of the governmental medical facilities conducts client satisfaction surveys or involves clients in programming. To provide the highest quality of services and continuously monitor quality, quantitative and qualitative approaches to data collection should be supported.

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

Alleviate paperwork tasks: The staff of government medical facilities are overloaded with paper-based reporting and other tasks that make it difficult for them to deal with the many psychosocial problems of MARPs, especially PWID and PLHIV. They often face difficulties in working with these groups and are not able to provide sufficient counseling to ensure adherence to treatment (for HIV, TB, substance use, STIs, and more). It would be beneficial to have social workers or counselors serve as full-time staff of medical facility services to help physicians and serve as a focal point for socially vulnerable groups. Considering the low level of funding of government health facilities, NGOs could use project money to send social workers to government medical facilities. This would improve collaboration between NGOs and the government health sector, improve the quality of services provided, and improve access of key populations to medical services.

Offer financial incentives to medical staff: Collaboration between NGOs and government medical facilities is most effective when the medical staff of facilities receive financial incentives from an NGO. To ensure access to services, many NGOs hire key medical personnel from government facilities to work

part time on projects. This measure works well in the short term, but long-term strategies are needed to ensure effective collaboration of NGOs and government medical facilities, especially considering that, as of now, everyone understands the need and the added value of such collaboration. Joint planning of activities, including implementation of joint quality improvement activities, should be encouraged and supported.

Make HIV programs more comprehensive and client centered: There is demand on NGOs for HIV programs that are not limited to basic harm reduction services. Provision of legal, social, and psychological support, as well as temporary housing solutions, are the top needs of almost all groups of key populations. Technical assistance partners should be encouraged to expand the scope of technical expertise provided to meet these needs. Emphasis should be placed on how to integrate a more complete set of services into existing packages.

Provide only top-quality protection to clients: When planning and budgeting for harm reduction services, implementers need to ensure that the quality of individual protection materials (condoms, lubricant, syringes/needles) provided to key populations is of the highest standard, as the poor quality of some of these materials unavoidably leads to misuse, low motivation to use, and low demand. Also, there is a need to establish rational and realistic standards for outreach work (e.g., the number of clients reached by one outreach worker per month) to prevent false reporting and ineffective outreach. Included in this should be a system for continuous supportive supervision systems that reward excellent performance and address challenges without punishing outreach workers.

Make medical insurance accessible and affordable for PLHIV: Development and implementation of a nonjudgmental system of providing PLHIV with medical insurance regardless of their residence and employment status could improve access to medical services and increase continuity of care. The out-of-pocket cost of services (even if minimal) remains a significant obstacle for those PLHIV who do not have any permanent income.

Offer training and retraining on HIV to staff: With the growing number of PLHIV, FHC personnel, including “narrow” specialists, such as gynecologists, STI specialists, and dentists, need to be trained and retrained on HIV and provided with materials related to specific needs of PLHIV. This HIV training can be incorporated into other types of trainings (e.g., PMTCT courses as part of the safe motherhood training). Once they are trained, supportive supervision and clinical updates are essential.

Tracking Global HIV/AIDS Initiatives and Their Impact on the Health System: The Experience of the Kyrgyz Republic

Murzalieva, G., J. Aleshkina, A. Temirov, A. Samiev, N. Kartanbaeva, et al. 2009. Bishkek: Center for Health System Development and London School of Hygiene and Tropical Medicine.

Findings

High levels of funding from international donors: The fact that 94 percent of HIV funding comes from foreign donors reflects serious instability and unsustainability, since the government would find it difficult to cover potential funding gaps if international organizations decrease their contributions.

One-third of GFATM resources were spent on NGOs working on HIV: Twenty-nine percent of these funds were spent on prevention and 17 percent on treatment.

GFATM activity resulted in sufficient scale-up of HIV- and AIDS-related activities: Geographical coverage has been expanded, a number of state-owned and nongovernmental organizations became involved, the volume of low-liminal services to key population has increased, a number of information and educational activities were carried out, new target groups were covered (migrants, rural population, PLHIV), and new services were introduced (ARV therapy, blood quarantine, new laboratory tests).

The GFATM grant increased the sustainability of some programs: In particular, scale-up of substitutive methadone therapy, growth of clientele, and program expansion to prison settings became possible due to a sustainable source of financing.

A synergistic role between GFATM and the Central Asian AIDS Project: The Central Asian AIDS Project (CAAP) focuses on services with lower coverage but is aimed at building a favorable environment for behavior change. It became a timely complement to GFATM activities because it provided services for key populations during GFATM funding gaps and also complemented the package of services, which attracted more clients.

GFATM activities were more efficient because of the financing scale, coordination and cooperation efforts between financing organizations, creation of a favorable environment, and institutionalization of some activities.

Factors hindering further scale-up remain: The main factors are breaks in funding for sub-recipients, which leads to capacity loss of organizations and clients. Lack of access to population hinders geographic scale-up. In recent years, the commitment of political leaders to HIV- and AIDS-related activities has declined. A single M&E approach is needed to identify the real volume of activities.

The most common form of organizational cooperation is referrals to other organizations: Despite its importance, the referral function has been undermined recently by funding interruptions, which have enhanced competition and reduced the number of providers.

Organizations are very actively cooperating in their capacity-building exercises: Organizations are now joining associations, implementing joint training activities for personnel, and combining resources to conduct large-scale education campaigns.

It is significant that more and more activities organized by NGOs involve representatives of public organizations and civil society: This improves understanding of HIV- and AIDS-related activities conducted at the local level and contributes to a more constructive collaboration.

Prerequisites for introduction of a systematic and uniform M&E are already in place in the Kyrgyz Republic: All organizations use unique identification codes, there are several electronic data recording systems, and a national M&E plan has been developed. However, until very recently, no comprehensive measures to launch a common M&E system had been made.

Organizations are more formally cooperating in the framework of different associations, in implementation of some joint projects, and in counseling and training: It is recognized that interaction between the organizations is more cost-effective and effective. However, cooperation based on personal relationships and agreements is still preferable.

The broad involvement of NGOs as well as public and private organizations helped bring HIV- and AIDS-related services to all regions of the country: The widest range of services is delivered in Bishkek and Osh, Chui, and Osh oblasts (regions with the highest prevalence of HIV infection). However, the needs of the southern regions (Osh, Jalalabat, and Batken oblasts) and in rural areas are not fully being met.

Representatives of vulnerable population groups have free access to basic services (prevention and treatment of STI, NSEP, testing for HIV, informational-educational materials): ARV drugs and methadone are completely provided by GFATM. The number of care and support services for PLHIV is also increasing.

There are still barriers to improving the accessibility and quality of HIV services: At the institutional/program level, these are gaps in funding for organizations. The efficiency of activities for raising awareness (quality of training activities, language of informational materials, correctness and timeliness of the information provided, and more) is low. The quality of protection materials (condoms, syringes, napkins) is poor. Continuity in service delivery between NGOs and governmental agencies, penitentiaries, and the civil sector is inadequate. Financial barriers remain for service access within the general medical network. Social care for HIV-positive persons is nearly inaccessible.

At the community and individual levels, there is still insufficient awareness of the availability of services and of legal rights to counter stigma and discrimination by members of families/communities, law enforcement authorities, and, in some cases, health professionals.

Recommendations

Increase the share of public spending on HIV and AIDS services: The ratio of governmental and external financing shows the instability of the system. If international donors decide to reduce their assistance, the state would have to substitute these funds with its own.

Build capacity in project management: To scale up HIV- and AIDS-related activities in the most disadvantaged regions in the south of the country, give more attention to capacity building for project management to organizations working in this region.

Unify current approaches to M&E of HIV- and AIDS-related activities: The first steps to take are (1) putting the national M&E system approval on the MOH and government levels, and (2) developing approaches for implementing M&E in donor organizations regarding coding issues and client and service registration.

Base coordination of HIV and AIDS activity on observed continuity, based on experience, both positive and negative: (1) the Country Multisectoral Coordinating Committee (CMCC) Secretariat should have super-departmental status and be based at the Office of Government, (2) the focus of the

CMCC should be on similar problems to ensure the involvement of all parties, and (3) it is necessary to undertake focused activity to ensure commitment among decisionmakers at the higher government level.

Continue enhancing a coordination mechanism at the oblast level: To increase the participation of oblast coordination structures, it is necessary to (1) provide CMCC Secretariat with an appropriate material and technical base, (2) ensure regular technical assistance to CMCC on coordination of HIV and AIDS activity, and (3) ensure regular specified communication between the OMCC Secretariats and the CMCC Secretariat.

Continue further strengthening of cooperation between governmental and NGO and private organizations to ensure efficiency and continuity in HIV and AIDS service delivery.

Revise the system of financial incentives for human resources in government agencies and NGOs working in the field of HIV and AIDS (overall salary level and extra fee system): This could have a decisive impact on motivation, fluctuation level, and quality of the delivered services, and could prevent negative incentives for personnel.

Develop and implement an M&E system for training: This would involve the process for selecting training participants, quality assurance of the training materials, the level of using knowledge obtained in practice, and the scheduling of training on a regular basis.

Undertake activities to engage professional social workers, psychologists/psychotherapists, and lawyers to work with HIV and AIDS: This can help meet growing demands for these services among PLHIV as well as the staff of AIDS-related organizations (governmental and NGO).

Final Report and Functional Analysis of the Institutional Structure, Roles and Relationships for HIV/AIDS and Related Service Programs in Kyrgyzstan

Routh, S., A. Kovalenko, N. Kinderbaeva, J. Malabekov, and S. Ashymova. 2008. Bishkek: CAPACITY Project Central Asian Program on AIDS Control in Vulnerable Populations.

Findings

The different elements of the AIDS-related service system are too complicated, with too many specialized vertical systems in place: There are ambiguities and overlaps in their specific functional roles as well as in the relationships across them. Most of the MOH-run specialized programs do not have service outlets of their own below the oblast (province) headquarters, except a few that possess service facilities in select districts and cities. Therefore, they use the general healthcare network (the multi-profile general hospitals and PHC outpatient clinics).

Training arrangements for the specialists dealing with HIV-positive people with co-infections are inadequate: For example, not all TB specialists possess the knowledge and practical skills to treat TB-HIV co-infected patients. There is an urgent need to carry out special training programs on strengthening the technical competence of all corresponding medical providers in treating HIV-positive people for opportunistic co-infections.

Insufficient attention to hepatitis B and C: Although the number of HIV and hepatitis B and C co-infection cases is increasing at an alarming rate, and hepatitis C has become a serious concomitant

infection for PLHIV, there is seemingly some reluctance to recognize this problem and take the required measures.

There is a serious shortage of social support services for vulnerable populations in general and PLHIV in particular: This is a result of the dearth of psychologists and sociologists. As an immediate strategy to filling this void, the MOH might explore the possibility of deploying excess social cadres/workers employed by the Ministry of Labor and Social Development.

Existing clinical contents and practices for treatment and care are not adequately up to date across all of the AIDS-related services (dermatology, infectious diseases, narcology): This includes management of all relevant co-infections and services. They need to be streamlined on the basis of clinical protocols/guidelines, developed upon or adapted to the principles of modern evidence-based medicine (EBM). The EBM Center might play an important role in this regard.

Qualified medical personnel are leaving the system: Attrition of skilled, qualified medical personnel is due to inadequate salaries and the absence of adequate living conditions, such as housing. This is a persistent problem for all of the participating programs/organizations. An attractive compensation package and incentive schemes should be introduced to retain skilled and qualified medical personnel, especially in the high-priority areas.

The role of NGOs and community-based organizations is weak: Active outreach activities among the vulnerable groups in particular and the general population are either weak or practically nonexistent within the government health system. This is true for the AIDS and all other specialized programs. There is a serious need to involve NGO and community-based initiatives to change this. Whatever limited government-NGO/CBO collaborations on outreach services exist currently are mostly funded by external donors and operate at specific sites for particular vulnerable populations. Since such initiatives are not systematically included in the public system, there are valid concerns about their sustainability once the outside funding is ended. Therefore, it is extremely important to extend all required support to the establishment, effective functioning, and financial sustainability of similar health NGOs/CBOs, and to develop formal, functional linkages of the government health facilities/programs with them.

Nosocomial infections pose a threat: Concerns about nosocomial infections persist in the hospitals and medical facilities dealing with serious infectious diseases like AIDS, TB, STIs, and hepatitis: patient to patient, patient to provider, provider to patient, and provider to provider. Already a large number of medical workers are reported to have been infected by hepatitis B and C. Steps should be taken immediately to address these threats of nosocomial infections, such as issuing clear instructions on isolation of infectious patients and implementing protective measures, such as supplying an adequate number of disposable instruments and training medical providers on universal precautions.

The relationship between the AIDS and TB programs needs strengthening: This means implementing such measures as providing regular information on HIV-positive persons to the TB program for the purposes of referral, providing training to coordinators in each TB facility, creating a joint database of AIDS and TB programs, and more. It's worth drawing lessons learned from a pilot program in Cui Oblast conducted from 2005 to 2007, which improved the collaboration between the AIDS and TB services within the penitentiary system.

Programs and organizations involved in the treatment of co-infected cases should exchange all needed information about the patient's health status: Although it is important to maintain confidentiality, medical providers need to stay well-informed if the patient is co-infected with any serious infectious diseases, such as HIV, TB, STIs, or hepatitis. This is extremely important for the following reasons: (1) the personal safety of the medical providers, (2) the proper treatment of the patient, and (3) the safety of other patients being treated in the same medical facility.

Funding is inadequate and irregular: This is an obstacle to normal operations of all programs across the board. Lack of funding at times stalls the introduction of new approaches. For example, methadone substitution therapy could not be initiated for the last two years due to the unavailability of required funds.

Concerns about donor funding disruptions: There are serious concerns about the sustainability of various projects and activities if donor funding is discontinued, such as how to ensure repair and maintenance of buildings, equipment, and transport vehicles; fuel costs; and maintenance of a regular supply of disposable syringes. To address this, it is very important to rationalize/optimize the size of buildings/physical infrastructure of the specialized programs and try to make maximum use of the existing facilities (clinics/hospitals) within the general healthcare system. Any proposal to set up inpatient (hospital) facilities within the AIDS program should be categorically rejected.

Recommendations

Set up working groups immediately: This will help address the concerns described above and strengthen the interrelations and linkages across the AIDS-related service systems—that is, working groups of representatives of the AIDS, TB, dermato-venereology, infectious diseases, narcology, and other relevant departments. The task of these inter-program working groups should be to reach out more effectively to the corresponding preventive and treatment services. Such working groups should also be established at the oblast level, as and where needed.

Establish formal interactive mechanisms between the Ministry of Internal Affairs (MOIA)-run temporary detainee program (IVS) and the AIDS program: In general, the existing interrelationships among the specialized programs (AIDS, TB, dermato-venereology, etc.) and the health programs operated for the penitentiary systems by the MOJ and MOIA are somewhat weak. These linkages urgently require strengthening.

Clarify roles and functions: There exists a certain ambiguity in the specific roles and functions of the various specialized, vertical programs working on AIDS and related services. For example, according to the existing policy documents, Sanitary-epidemiologic Service (SES) is vested with the mandate to organize all preventive and epidemiologic functions on infectious diseases, including AIDS. However, most HIV- and AIDS-related functions, including HIV sentinel surveillance, are in fact being implemented by the AIDS program. Similarly, according to the current official mandates, the two key most-at-risk populations for the AIDS epidemic—sex workers and injecting drug users—theoretically should be served by the dermato-venereology and narcology programs, respectively. It is critical to clarify these ambiguities and eliminate overlaps and gaps resulting from them.

Strengthen and systematize the linkages between STI/HIV and narcology/HIV services: The CAPACITY model on interaction of the TB/HIV services can provide lessons learned. Rather than having an extensive role in direct service delivery, the specialized programs should ultimately assume the role of technical and methodological guidance and capacity building for their specialties, and use to the maximum extent the general healthcare system (the network of existing primary healthcare facilities and multi-profile hospitals) for the direct provision of these services.

Implement integration gradually: It is extremely important that the integration of AIDS and other specialized services in the general healthcare system is implemented in a gradual way, with proper training and logistical arrangements for general health service providers, so that the most-at-risk populations, people living with HIV, and other related groups feel welcome to obtain services there.

Compensate all medical personnel adequately: Medical staff working in the AIDS and TB programs receive an additional payment (danger pay) amounting to 60 percent of their salaries.

Equivalent compensation for similar professional hazards needs to be paid to all medical providers dealing with people infected with HIV and/or TB within the other health programs (general healthcare and other specialized programs).

Improve clinical activities to prevent infectious diseases: The MOIA-run IVS is apparently the biggest and most dangerous breeding place for many infectious diseases because of the relatively high number of PLHIV, plus the great number of people who engage in risky behaviors (unprotected sex and needle-sharing drug use) who are thought to pass through this system. The IVS facilities need up-to-date equipment and skilled personnel, and should be supervised directly by the MOH.

Reassign organization and oversight of medical programs for the penitentiary system/prisons (GUIN and SIZO/MOJ) and temporary detention centers (IVS/MOIA) to the MOH: This will increase the number of people who can take advantage of programming for drugs, social support, and other important services.

Provide suitable incentives for the PHC providers (e.g., danger pay): This provides motivation to staff. Ensure that preventive services are duly accounted for in salary calculations of PHC and other medical personnel.

CARHAP Lessons Learnt on Setting Up Harm Reduction Services in Kyrgyzstan's Prisons

Central Asia Regional HIV/AIDS Programme. [no date]

Findings

Setting up comprehensive harm reduction services in prisons requires considerable levels of advocacy, coordination, and collaboration: The case of Kyrgyz Republic shows that two parallel directions of work are necessary: strengthening service provision and creating an enabling environment among others through changes in the legal frameworks and provisions.

Harm reduction work in prisons can be implemented by building on NGO service providers: It is essential to include and properly link all service providers in prisons in the implementation of pre- as well as post-release services. Allowing social bureaus to take up the role of one-stop shops facilitates effective service integration and ultimately leads to better service uptake among all service providers.

Investment in proper capacity building for prison management and staff of Ministry of Justice on harm reduction increases awareness and participation in program activities: It also helps in more effective program implementation and supports advocacy for required changes in the implementation environment. The Central Asia Regional HIV/AIDS Programme's (CARHAP's) experience shows that the provision of additional capacity building and technical assistance to NGOs involved in program implementation can considerably improve grant performance and service quality. Long-term (one-year) commitment by CARHAP on capacity building in the areas of M&E and organizational development played a crucial role for successful implementation of the project.

The success of pre-release programs is particularly dependent on staff qualification: Experience shows that in prisons with qualified and motivated psychologists and social workers, the quality of client motivation and overall service was generally higher, resulting in better service uptake. Provisions for additional training and other capacity-building measures will be crucial to ensure continued program success.

Strong attention needs to be paid to issues related to staff motivation and burnout: This is an aspect that is frequently overlooked but is crucial for ensuring project success. Burnout results in high levels of staff turnover, which requires additional resources for recruitment and training of new staff. Interactive training and capacity-building activities conducted three times per year helped staff of social bureaus deal more effectively with signs of burnout.

Harm reduction in prisons is critical: Each year between 2007 and 2009, at least three inmates died of AIDS-related illnesses. Test results show that HIV infection is still on the rise in prisons, with the number of new cases rising from 83 in 2007 to 154 in 2009. Although much of the increase can be attributed to the increase in the number of tests taken, as well as improved test quality, these figures prove the need for continued attention to the further development of harm reduction services in prisons.

CARHAP and the Harm Reduction Association made strong efforts toward coordinating and harmonizing funding for post-release services: This resulted in other donors engaging in these areas. Examples include a social dormitory for ex-inmates funded by the AIDS Foundation East-West (AFEW) and an additional half-way house established in Jalal-Abad with funding from GFATM. However, demand by far exceeds the capacity of currently available services. Further advocacy for expansion to meet these needs, as well as more attention and funding from donors, is required to ensure long-term sustainability of harm reduction services for pre- and post-release services.

TAJIKISTAN: REVIEW OF ASSESSMENTS, FINDINGS, RECOMMENDATIONS

The following section provides a review of existing assessment reports, findings, and gaps and/or recommendations for Tajikistan.

Analytical Report—Tajikistan: Opportunities for Harmonization of National Legislation Related to HIV with Best International Standards and Practices

United Nations Development Programme. 2012. New York: UNDP.

Recommendations

Further strengthen the incentives for persons to undergo voluntary testing by ensuring that testing is physically available and accessible.

Optimize the time and procedure for HIV testing by ensuring availability and access to rapid HIV tests: Use other, slower, and more expensive (even if more accurate) HIV tests only when necessary to cross-check HIV status, type of HIV infection, and so on.

Introduce, in a widespread manner, universal approaches to testing: These include approaches such as those recommended by WHO and UNAIDS, such as provider-initiated HIV testing (opt-in, and opt-out), which would further minimize mandatory testing.

Ensure that confidentiality requirements of HIV testing and the results of the testing are strictly obeyed, and no breaches of this requirement occur.

Ensure that every tested person receives adequate information and counseling before and after the testing and gives her/his informed consent to be tested.

Ensure the availability and access to anonymous HIV testing and promote this availability.

Pay special attention to key populations: Using data from the most recent national United Nations General Assembly Special Session (on HIV/AIDS) (UNGASS) report, concentrate on promoting voluntary HIV tests among PWID and their sex partners, sex workers, and men who have sex with men. Promote voluntary, confidential HIV testing and anonymous testing, as allowed by the HIV Law, among seasonal migrant workers, where epidemiological evidence suggests an increase in the incidence of HIV infections.

Limit mandatory HIV testing to the minimum: Explicitly prohibit the expansion of the list developed as per the requirement of the HIV Law in further acts of secondary legislation.

Revise the existing list to exclude certain professionals where no evidence supports the assumption of their being under increased risk of HIV infection, such as dentists and tattoo artists.

Ensure that equipment used is sterile and meets modern medical/professional safety requirements, and that universal precautions are implemented and monitored properly at all medical facilities/settings.

Ensure that blood, blood products, and other biological fluids/tissues used are always tested and are not contaminated with HIV and other diseases.

Refrain from introducing mandatory HIV testing as a precondition for marriage: UNGASS data do not support the assumption that people who are getting married are under increased risk of HIV infection. The introduction of such measures may discourage people to register their relationships, thereby excluding them from access to certain benefits and services available to families under Tajik law, and potentially negatively impact the rights of their children. Instead, promote voluntary confidential testing with informed consent, as available under Tajik law. Ensure that couples understand the availability of voluntary confidential testing with informed consent, including anonymous testing, at any time, not only prior to the marriage. Ensure that individuals and couples are provided with counseling before and after the testing.

Discontinue mandatory testing of pregnant women and support and promote voluntary confidential testing with informed consent instead: According to the UNGASS Progress Report for Tajikistan, there is no evidence that pregnant women are at high risk of HIV infection. At the same time, the Criminal Code of Tajikistan introduces criminal responsibility for putting someone in danger of HIV transmission and for infecting someone with HIV, even without intent (e.g., mother-to-child transmission). This paradox could potentially lead to mothers preferring to give birth outside of medical facilities, unregistered births, and health complications for mothers and children. It is important for pregnant women to be provided with counseling before and after testing. If a pregnant woman is diagnosed with HIV, it is important that the counseling advises her on the opportunities to reduce, with great probability, the chances for mother-to-child transmission of HIV. It is important to remove the provisions criminalizing HIV transmission from the Criminal Code of the Republic of Tajikistan.

Remove provisions that require mandatory testing of foreign nationals and stateless persons: There is no evidence in Tajikistan that foreign nationals and stateless persons are at higher risk of HIV infection. Considering that Tajikistan abrogated deportation requirements in its legislation, testing of foreigners has become redundant, as is the requirement for such persons to provide a certificate indicating that they are HIV negative to reside in Tajikistan. In the Law on the Status of Foreign Nationals of Tajikistan, a provision indicating that an HIV-positive status alone is not grounds to consider the person a threat to public health or grounds for deportation. Also, promote voluntary confidential testing with informed consent among these persons.

Test asylum seekers for HIV as part of a comprehensive health assessment package carried out for all people who seek asylum/refuge in Tajikistan, but do not single them out for HIV testing: The purpose of this assessment should be to identify the health status of asylum seekers and the medical attention/services they may need. It is recommended to introduce guarantees to the Law of Tajikistan on refugees that HIV-positive status alone does not constitute a threat for public health and is not grounds for deportation and/or rejection of the asylum claim.

Remove provisions on forced testing contained in laws and secondary legislation: Forced testing is inconsistent with the principles of the HIV Law of Tajikistan and the Constitution of Tajikistan, as well as with the international best practices. Voluntary testing, under the conditions set forth in the Tajikistan HIV Law, should be promoted instead.

Consider abandoning the provision of non-disclosure of HIV infection as a cause for annulment of a marriage: The rationale for adopting Paragraph 3 of Article 15 of the Family Code that provides for annulment of a marriage if one of the spouses has not disclosed his/her HIV-positive status is unclear, especially since HIV is not an obstacle to getting married. It does not seem possible to establish how this provision could serve a positive social purpose and prevent the spread of HIV.

Increase the age during which children living with HIV are eligible for state support from 16 to 18: This would make the requirements of the HIV Law consistent with the definitions in the Civil Code of the Republic of Tajikistan.

Amend any provisions in laws or secondary legislation that prohibit the sale/distribution of condoms to minors: Carry out educational activities on sexual and reproductive health with teenagers at school or in other suitable environments. Educate children about HIV, how it is transmitted, and how to prevent HIV transmission.

Introduce a definition of key populations most at risk of HIV infection (vulnerable groups) using the evidence provided by the UNGASS Progress Reports and other research documents about the HIV epidemic in Tajikistan: Consider including in this definition injecting drug users, sex workers, men who have sex with men, transgender people, and possibly migrant workers.

Make relevant secondary legislation more precise by specifying that HIV-positive status alone is not a reason for a person to be considered unsuitable to perform military service duties: Develop precise assessment criteria stating when the health of a person living with HIV who is subject to conscription in the army of Tajikistan, or is on active military duty, makes this person unsuitable for military service.

Introduce legal guarantees that PLHIV who serve in the army of Tajikistan be provided with treatment, care, and support.

Consider repealing Article 125 of Tajikistan's Criminal Code as inconsistent with the guarantees provided in the Law on HIV and best international practices: Tajikistan's legislation contains sufficient safeguards that foresee responsibility for intentionally transmitting infectious diseases to others. Singling out HIV, especially without including intent in the criminal provisions, is likely to create much more injustice than justice and is not likely to have any preventive effect against the transmission of HIV.

Report on the Baseline Assessment of HIV Care and Treatment Services in Tajikistan

Support Project. 2012. Dushanbe: ICAP.

Findings

Tajikistan has made real progress in ensuring and expanding access to HIV treatment and care services: Although the ART program is funded by GFATM, the Ministry of Health and the RAC have made tremendous efforts to provide adequate healthcare to all PLHIV in Tajikistan. At the moment, the country has a discrete vertical system of AIDS center-based specialized treatment and care service delivery to PLHIV, which is inadequately integrated in the general population's healthcare network. According to the majority of interviewed specialists, such a system of service provision is appropriate for the existing epidemic level but, in the long term, considering the annual increase of PLHIV, it can result in ineffective service delivery.

The infrastructure of the AIDS centers is generally adequate: Some improvements (e.g., increasing the number of counseling and examination rooms) would help to improve the quality and confidentiality of services.

Many staff have large workloads: While current staffing generally meets the needs, at some AIDS centers serving large PLHIV populations, the staff is overloaded, and there is a need for additional

qualified clinicians, infectious disease specialists, and trained nurses. Nurses are undertrained in working with HIV patients and underworked in ensuring patient adherence to follow-up care and ART. The level of knowledge and skills among the medical staff, particularly nurses, generally requires continuous improvement, which is partially caused by high staff turnover and lack of supervisory visits, mentoring, and support on site. The lack of ongoing mentorship by trainers reduces the likelihood that knowledge and skills will be effectively applied in real clinical settings.

Reporting systems are outdated and inadequate: The current paper-based reporting system is inappropriate for effective data analysis and quality improvement of the received information, and demands much of staff time that could be better spent with patients. GFATM funds key components of the system of specialized healthcare provision to PLHIV. ARV procurement is centralized and performed by the United Nations Development Programme (UNDP), based on the RAC's request. However, there are challenges in planning and needs forecasting for drugs and laboratory test systems, which often result in failures in drugs and test systems supply to AIDS centers.

There are quite high levels of primary enrollment of the officially registered PLHIV in follow-up and of their adherence to ART: Due to low staff capacity, the AIDS centers do not have a comprehensive approach to PLHIV management, and patients show low adherence to regular follow-up and treatment. High levels of PLHIV stigmatization in Tajikistan, particularly at the provincial levels, make follow-up challenging and force certain PLHIV populations to transfer to the RAC in Dushanbe for further follow-up; this reduces the local availability of treatment and care programs, and entails additional financial costs for transportation and accommodation incurred by PLHIV.

Critical HIV services are largely unavailable: Also, some crucial components of clinical PLHIV management are missing, such as viral load testing, as are effective diagnostics, treatment, or prevention for co-infections (HIV/viral hepatitis, HIV/TB) and opportunistic infections (suboptimal rates of cotrimoxazole treatment). Furthermore, there are no home visits/nursing available for PLHIV or palliative care programs; nurse staff capacity is underused.

Care and treatment services require technical assistance: While the MOH and RAC as well as AIDS center staff at the oblast level are actively working to improve care and treatment services, technical assistance from international agencies is needed to strengthen care and treatment services provision.

Recommendations

Revise existing HIV protocols: Existing national protocols on HIV clinical management need to be revised to conform with the revised WHO protocols on ART (2012) and TB/HIV and HIV/HCV/HBV co-infections management. Following MOH approval of the revised protocols, sufficient numbers of printed copies of the revised protocols should be disseminated to all of the AIDS centers.

Continue training for disease specialists working at the AIDS centers: The main emphasis should be on a comprehensive approach to clinical management of PLHIV, and training topics should include ART initiation; monitoring of ART adherence and effectiveness; side effect management; changing ART regimens in case of treatment failure; prevention of opportunistic infections; diagnostics and treatment; and counseling techniques, including motivational counseling, couples-based counseling, and gender-based counseling.

Secure funding to introduce ART training courses: To ensure sustainability of capacity-building interventions for clinical staff regarding HIV issues, funding is needed to introduce an enhanced regular training course on ART for AIDS center staff at the Tajik Institute of Postgraduate Medical Training (TIPMT). It is important that training is not limited to theoretical lectures, but includes specific clinical

case studies and discussions. Training needs to be supplemented with field mentoring to ensure the practical use of skills gained, and targeted technical assistance as needed. Follow-ups, including supervisory visits and on-site support, are crucial for the proper application of skills learned from the training.

Ensure that nurses employed at the AIDS centers are properly trained in key principles of HIV clinical management: Nurses should also be actively involved in monitoring and supporting patients' adherence. Ideally, training curricula on HIV management for nurses should be developed and introduced in the training programs of existing postgraduate nursing schools.

Support regular monitoring visits by representatives of the RAC or qualified staff from oblast-level centers: Such visits should be encouraged. Monitoring visits should include patient medical records review to ensure the completeness and accuracy of reported data. Periodic evaluations (by both external experts and internal AIDS service staff) of the existing system of healthcare provision to PLHIV are also necessary; these contribute to better efficacy and cost-effectiveness.

Involve and train visiting nurses: Beyond the specific medical treatment provided by AIDS centers, PLHIV have a range of health needs that AIDS centers do not have the capacity to address at the moment, including home-based care and nutrition education. To improve retention in care and ART adherence, as well as improve access to healthcare for PLHIV not able or willing to visit AIDS centers, it is recommended that visiting nurses be involved and sufficiently trained. Visiting nurses should be trained in basic home care for PLHIV, as well as basic counseling skills to counsel PLHIV and their caregivers/family on the course of HIV infection, and prevention and treatment of HIV, of opportunistic infections, and co-infections.

Promote a team approach to patient management, with active participation of clinicians, nurses, and epidemiologists at the AIDS center.

Enhance integration of TB and HIV services, and address the issue of free PLHIV testing for TB: This will improve TB screening among PLHIV, particularly those presenting to AIDS centers with symptoms suggestive of TB. Wherever possible, AIDS centers need to identify (either in close collaboration with local PLHIV organizations or independently) a group of adherent and motivated peer counselors, and ensure that peer counseling is available at the AIDS center, especially for newly enrolled patients. Peer counselors should be properly trained and supervised. Personalized interventions (involving caregivers, home visits to adjust treatment schemes to individual lifestyle, and so on) are effective in promoting adherence.

Use a combination of methods to measure adherence: ART adherence monitoring remains a challenge and needs to be addressed, especially because using only patient-reported data may overestimate adherence. Pill counts can be performed by clinicians and nurses at every patient visit to the AIDS center and during home visits. It is also important to properly document both self-reported adherence data and pill counts in the patient medical records. Distribution of pillboxes and reminders (SMS notifications) could also improve adherence and can be piloted. Staff (doctors and nurses) should receive training in assessing self-reported adherence, including reasons for non-adherence, and take action to improve adherence.

Train clinicians in counseling techniques for PWID: Since most PLHIV in Tajikistan are PWID, it's important to provide special counseling training to clinicians, including psychotherapists and narcologists. Expansion of OST models and promotion of OST for those HIV-positive PWID on ART can facilitate adherence and make it possible to integrate ART and OST services, and implement DOT, at least for some PLHIV.

Develop a planning and forecasting tool: ART planning and forecasting can be improved by developing and introducing a planning and forecasting tool with clear instructions on how to use it. To further facilitate the process, it is recommended to arrange annual national ART planning workshops so that staff in charge of ART forecasting can discuss their approaches and receive appropriate feedback. Ideally, the ART forecasting tool should be integrated with EHCMS to allow for automated calculation of the estimated number of PLHIV in need of treatment.

Introduce quality assurance mechanisms to improve M&E of care and treatment services: Quality assurance mechanisms for data collection and analysis should be introduced. Following EHCMS introduction, EHCMS data analysis should be done to evaluate the effectiveness of ART programs in the country. Clinicians can be trained on using EHCMS data to monitor their patients.

Standardize CD4+ count and HIV viral load testing procedures: Comprehensive SOPs compliant with good laboratory practices (GLP) should be developed, approved, and disseminated among all AIDS centers. Laboratory staff should be trained on newly developed SOPs. To ensure timely and proper calibration of equipment, one staff member from each laboratory facility needs to be appointed and trained in regular maintenance and internal control procedures. Terms of reference for that staff position should be changed to reflect maintenance, calibration, and internal control activities. To further monitor the quality of CD4+ and viral load testing, the RAC should ensure that necessary customs clearance procedures are completed for reference laboratories to receive serum controls for these tests as part of the Centers for Disease Control and Prevention's (CDC's) Dried Blood Spot (DBS) HIV Quality Assurance Proficiency Testing Program.

Maintain close linkages between AIDS centers and penitentiaries: Considering that a high number of PLHIV, including those on ART, are often in and out of prisons, it is important to maintain close linkages between medical services at penitentiary institutions and AIDS centers. To better understand the situation and existing gaps, assessment of care and treatment services in the penitentiary system should be performed.

Ensure increased funding to cover critical treatment services: Existing GFATM budget allocations for ARV procurement are only sufficient to cover the period through 2014. They do not cover costs of ART side effects management and opportunistic infections treatment and prevention. Efforts should be made to ensure increased funding to cover ART side effects management, OI treatment, and ART for the increasing number of PLHIV in need of treatment. For the future, it is important to ensure state budget funding.

Mapping of Key HIV Services, Assessment of Their Quality, and Analysis of Gaps and Needs of Most-at-Risk Populations in Selected Sites of Tajikistan

Musaeva, Z., D. Abbasova, and A. Deryabina. 2011. Arlington, VA: AIDS Support and Technical Assistance Resources, AIDSTAR-Two, Task Order 2.

Findings

Key populations have insufficient access to testing and counseling services: The amount of HIV testing is significantly lower among vulnerable groups, even though they have the highest prevalence of HIV. Most counseling and testing services for key populations are provider initiated, and there is no system to monitor the quality of the counseling being provided to patients. Providers miss opportunities to

ensure adequate access to risk reduction information and materials for individuals at high risk of infection.

Insufficient coverage by needle exchange programs: Coverage of PWID by needle exchange programs is insufficient, especially in rural areas. Most Trust Points are located in urban and semi-urban areas, while there is no access to any HIV prevention services in rural areas. It is also important to further improve and scale up the delivery of such services as MAT for this group.

HIV prevention and VCT services in rural areas need scaling up: Tajikistan's population resides predominantly in rural settings. Labor migrants are one of the key at-risk groups for HIV in the country. Many young men from rural areas travel abroad, and some of them return home HIV positive. An increase in HIV incidence among women is due to an increase in HIV infection among the wives of migrant workers, many of whom are not aware of their HIV risk.

Low ART adherence, insufficient ART support: There is a limited scope of services provided to PLHIV. Based on assessment findings, adherence to ART is low; as the number of HIV patients continues to grow, it will become more challenging for the limited staff in the AIDS centers to effectively follow up on patients using a mostly paper-based monitoring system.

Services could be improved, and staff could be better motivated with basic improvements: Low motivation of medical personnel remains the most serious challenge to effective provision of HIV-related services in the public sector. Low salaries, poor working conditions, limited access to information and capacity-building opportunities, and outdated buildings and equipment result in suboptimal levels of services provided by government medical institutions to the population in general and key populations specifically.

Funding is currently not sustainable: The current funding situation, which depends solely on GFATM and other external funding, is not sustainable. Implementation of the most important prevention and treatment components of an HIV national program (ART, opioid substitution therapy, needle exchange, condoms, and TB treatment) fully depends on external funding, mostly provided through GFATM. This poses a serious threat to long-term planning and implementation of those components.

Recommendations

Implement tailored, intensified activities among medical workers at all levels to address stigma and discrimination against PLHIV who belong to vulnerable groups: This is crucial, especially in surgical services and gynecology. Government facilities and community-based organizations working in partnership could also employ full-time social workers or psychologists to help physicians deal with psychosocial issues faced by key populations.

Integrate HIV-related services incrementally into general healthcare to improve program effectiveness and give key populations better access to other 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) for all vulnerable groups. In addition, FCs should implement a mechanism to actively collect, analyze, and respond to feedback from clients to help plan and program their services. It is also crucial that FCs have sufficient and uninterrupted funding, because the periodic absence of services and drugs discourages key populations from using their services.

Adopt a combination approach to HIV prevention and care service delivery to improve the current situation for key populations: In addition, donors should consider the wide range of needs that these groups have when planning for grant programs and other interventions designed to reduce HIV transmission and improve quality of life of at-risk groups.

Expand the use of mobile testing units: Wider utilization of mobile testing units among governmental and NGO facilities is a promising strategy to increase access to and availability of VCT services, particularly in areas where there is a high concentration of key populations. Implementing a systematic and confidential record-keeping system to track HIV tests performed on individuals at high risk is critical to ensure that they receive their test results and get counseling services based on their individual risk factors.

Initiate strategies to ensure that all who are tested get post-test risk reduction counseling, no matter the test result: 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. To facilitate this, additional training in VCT should be required for all staff responsible for VCT, especially outside of the AIDS centers.

Expand access to clean needles and syringes through Mobile Trust Points: This could be an effective way of ensuring that PWID have these materials available when they need them the most. Expansion of needle exchange services should be accompanied by the development of a normative base and an effective implementation mechanism for safe disposal and recycling of used injection equipment.

Strengthen and expand MAT: Further expansion of MAT should be based on a more detailed study of its current status, particularly 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. Substitution therapy programs should, where possible, include psychologists and social workers who can help patients re-socialize, including through employment assistance.

Expand information and education campaigns in the rural areas significantly: To do this, develop simple, easy-to-understand information materials on healthy lifestyles and basic safe sex practices that are socially and culturally acceptable. Such information work can be carried out by NGOs in partnership with rural health facilities.

Pilot and scale up an electronic surveillance system as quickly as possible: This would give specialists instant access to structured and systematized patient data. Some of the ART functions, especially those related to adherence monitoring (follow-up and tracking), could be transferred to the PHC level or delegated to specially assigned and trained social workers who could be, for example, seconded by NGOs to the governmental medical facilities.

Provide food support and psychological support to increase adherence of ART programs to treatment.

Improve compensation and infrastructure: As part of the efforts to address sustainability, issues of compensation should be addressed. Also, a systematic review of infrastructure and strategic support for essential equipment and materials should be considered.

Final Report: Functional Analysis of the Institutional Structure, Roles, and Relationships for HIV/AIDS and Related Service Programs in Tajikistan

Routh, S., A. Kovalenko, and Z. Musaeva. 2009. Dushanbe: CAPACITY Project.

Findings

Linkages between HIV and AIDS services and the TB, narcology, and blood transfusion programs: Some functional linkages exist among these services, but mostly for the oblast headquarters and select cities. It is important to strengthen these linkages further and scale them up to cover the entire country, including rural areas.

Recommendations

Expand such pilots as the CAPACITY Project to promote linkages: With technical assistance from the USAID-funded CAPACITY Project, a pilot model on the wide-ranging linkages of AIDS and TB services was successfully implemented, but this initiative was limited to specific pilot sites. There is an urgent need to roll out this model nationwide. It's also important to expand such initiatives for addressing other relevant co-infections, both within the general healthcare network as well as the penitentiary systems.

Regularize and strengthen horizontal linkages between HIV and TB programs: This would help make the ongoing work on HIV-TB co-infection management more effective, especially in such areas as exchange of information, cross-referral, and joint monitoring of the corresponding screening and treatment processes. It is important to supply the TB services with adequate express testing kits for HIV and to jointly develop and disseminate IEC materials on TB prevention to persons living with HIV, as well as materials on prevention of HIV among TB patients.

Systematize and strengthen the link between the Ministry of Defense and TB services: This will improve the TB screening process among draftees.

Improve linkages between the dermato-venereology and infectious diseases programs: This could address some of the issues about screening and early detection of STIs and hepatitis C.

National Study on the Stigmatization and Forms of Discrimination against People Living with HIV

Strategic Research Center under the President of Tajikistan. 2008. Dushanbe: Government of Tajikistan.

Findings

Low levels of knowledge about HIV transmission routes: Even though many respondents said that they are aware of how HIV is transmitted, only 30 percent of them correctly identified the transmission routes (unprotected sex, blood, and from mother to child).

Awareness and opinion vary on the right of PLHIV to work: Violation of the right of HIV-infected people to work is a major form of discrimination. The majority of those surveyed, 66.4 percent, said that PLHIV are entitled to work, while 27 percent answered negatively, and 6.8 percent had no answer. Respondents who in their official capacities should be aware that PLHIV have the right to work said

PLHIV do not have that right: 42 percent of law enforcement employees, 28.6 percent of teachers, 23.3 percent of judges and lawyers, and 20 percent of Hukumat (local authorities) staff said that PLHIV do not have a right to work. Only 39 percent of those interviewed responded that PLHIV have a right to work as school teachers; 51 percent said they oppose PLHIV working in schools. More than 77 percent believe that PLHIV do not have a right to work within the services sector.

Educational restrictions as a form of discrimination against PLHIV: Not all respondents support the idea of PLHIV being educated together with other children. Of the total interviewees, 42 percent answered that HIV-infected children should not attend classes with healthy children in schools. Respondents frequently opposed HIV-infected children going to regular secondary schools: among law enforcement employees, 57 percent held that position; 45.7 percent among teachers; in the service sector, 60.9 percent; and 50 percent of mass media employees felt that way. Approximately 24 percent of teachers from public education facilities responded negatively when asked whether they would agree to work with HIV-infected children. More than 48 percent of them had participated in training on HIV and AIDS prevention at schools, and 70 percent had attended lectures on how to conduct such classes.

Insufficient supplies of protective equipment for clinical staff: Doctors and paramedical staff as a whole are aware of HIV and AIDS preventive measures in medical facilities. Of the doctors and paramedical staff interviewed, 92 percent said that they know about the possible HIV and AIDS transmission risk when sharing a syringe, and 97.1 percent know about the blood transfusion risk. Despite the high level of knowledge about HIV transmission routes among doctors and paramedical staff, not all medical facilities are fully supplied with the necessary sterile materials and disinfectants. Among medical workers, 75.4 percent of the interviewees responded that they are adequately supplied with necessary materials; 7.9 percent said they are not adequately supplied, and 16.7 percent said they are partially supplied.

Stigma and discrimination in medical facilities: Not all medical workers are ready to provide medical assistance to PLHIV. More than 62 percent of the medical workers interviewed said that they are ready to provide the same medical assistance to PLHIV as they do for other patients. Of medical workers, 73 percent said they would assist in the delivery of an HIV-infected infant, 13 percent would not, and approximately 14 percent did not answer. The majority of medical workers—89.2 percent—said that medical workers should by all means be tested for HIV. More than 87 percent of medical workers said that they are tested for HIV annually, but more than 62 percent said that PLHIV should not work in medical facilities. Knowledge of the law on liability for disclosing HIV status among medical workers is 67.5 percent; 80 percent of doctors knew of the law, but only 40 percent of paramedical staff were aware of the liability for disclosure of HIV status.

Knowledge about HIV contamination risks: Post-contact preventive measures are a way of reducing the HIV contamination risk for medical workers dealing with infectious diseases, including HIV and AIDS. Only 38.8 percent of medical workers knew about post-contact measures, while 35.5 percent said they practice them in their facilities. Nearly all doctors and the majority of paramedical staff (75.5 percent) said that people infected with HIV as a result of the negligence of medical workers are entitled to benefits.

Discrimination against PLHIV in the legal realm: Under the law of Tajikistan, PLHIV are entitled to protect their rights and to receive legal support. The overwhelming majority of judges and lawyers—87 percent—would provide legal support to those who are HIV-infected, but the level of knowledge of judges and lawyers of the law on HIV and AIDS in Tajikistan is not high. Only 50 percent knew that there is such a law in Tajikistan.

How judges and lawyers view liability and other legal issues for PLHIV: A large majority of judges and lawyers—90 percent—shared the opinion that a person who purposely infects others with HIV should

be held criminally liable. Many respondents—60 percent—believed that a person must reveal his HIV status in some cases; 30 percent expressed the opinion that PLHIV may keep their status secret. Among the respondents who are judges and lawyers, 70 percent believed that a person on trial should inform judicial bodies and the prosecutor's office about his or her disease. More than 76 percent of the respondents agreed with compulsory testing of suspects. Lawyers said that stigmatization of and discrimination against PLHIV in Tajikistan is insignificant; 40 percent of judges and lawyers opposed special legislation in this regard.

Isolation of PLHIV in prisons: More than 46 percent of interviewees supported isolating PLHIV in separate prison cells to prevent the contamination of other prisoners; 28.1 percent said they should be held with other PLHIV.

Personal attitudes about PLHIV: About 30 percent of the total respondents expressed their negative attitude toward PLHIV, but 70 percent said that they treat PLHIV normally and with sympathy. More than 50 percent of the total respondents expressed their extremely negative opinions to their HIV-infected colleagues.

Discrimination against HIV-infected children and their families: Of the interviewees, 45 percent said that they do not allow their children contact with healthy children whose parents are HIV infected. HIV-infected children appear to suffer a high rate of discrimination; 70 percent of the total respondents said that they would not allow their children to be in contact with HIV-infected children.

Sympathy toward family members who are PLHIV: Respondents treat PLHIV with much sympathy and compassion when family members or relatives are involved. More than 90 percent of respondents claimed that they would take care of HIV-infected family members.

Isolation of PLHIV from the rest of society: This highly negative form of stigmatization and discrimination can force PLHIV to seek alternative housing residences, as if they were defective and dangerous people. The study showed that one-third of the respondents favored isolation of PLHIV from other members of society. More than 47 percent of the respondents noted various forms of discrimination toward PLHIV in Tajikistan.

Attitudes about PLHIV and religion: Although 44 percent of respondents said that religion treats PLHIV negatively; they expressed a more democratic view regarding the right of the HIV-infected to pray together with other parishioners. Thus, 59.4 percent of the religious leaders interviewed answered that they would permit PLHIV to pray in a mosque or a church.

Attitudes and experiences of religious leaders: The discussions with religious leaders show that parishioners do not often speak about HIV issues in society. Of the religious leaders interviewed, 25 percent said they are asked questions about HIV and AIDS. More than 84.4 percent of religious leaders said that if a person dies from HIV or AIDS, they would arrange his or her funeral. Religious leaders held a similar opinion about burial locations; 84 percent said that the remains of PLHIV should be buried in a general cemetery. Of religious leaders, 65.6 percent thought PLHIV should keep their status secret. A majority—65.6 percent—believed that a religious leader should not be HIV infected because he would not be respected and people would disregard his opinion.

Issues surrounding HIV testing: HIV testing is not currently a top priority in Tajikistan. The study revealed that most of the patients found out about their HIV status either after anonymous testing or after they underwent medical checks for other diseases. The results of the study show that the majority (59.3 percent) of both men and women received their HIV or AIDS diagnosis at AIDS prevention centers. Approximately 14 percent of PLHIV said that they became aware of their status after compulsory testing in prison. About 60 percent of all PLHIV interviewed said that they had received pre- and post-test

consultations. Most—58.7 percent—said that their confidentiality has been maintained. More than 62 percent of PLHIV said that they get examinations, psychosocial consultations, and treatment at AIDS prevention centers.

Disclosure to family members: The study revealed that 51 percent of the total respondents informed their family members about their HIV status (58.1 percent of the women and 45.9 percent of the men). But 46.2 percent of the men and 41.9 percent of the women were afraid to reveal their HIV status to their families. Of the respondents who revealed their HIV status to their family members, 57.4 percent answered that attitudes in their family toward them did not change; 7.5 percent noted a worsening attitude, while 20.8 percent said it became better. The study shows that attitudes about HIV-infected women in families are relatively worse than for men.

Disclosure of serostatus: More than 43 percent of the HIV-infected revealed their status on their own initiative. Women were more willing to reveal their status (55.8 percent) than men (34.4 percent).

PLWH face the problem of revealing their status when seeking medical assistance because they fear they will be provided with needed medical assistance if they reveal their status and they fear that confidentiality will not be maintained. Only 13.5 percent of the PLWH interviewed responded they would reveal their status when visiting medical facilities.

Discrimination against PLHIV at medical facilities and other services: Problems faced by PLWH when in need of medical assistance are one of the many forms of discrimination they face. The main problem is the refusal of treatment in medical facilities (38.1 percent); women face this problem more often than men. Approximately 36 percent of PLHIV mentioned that they feel neglected by medical workers. More than 20 percent of PLHIV responded that they faced disclosure of their HIV status without their permission. A large percentage, 80.8 percent, said they have no problem getting disposable syringes and condoms in their daily life. A slight majority—52 percent—of PLHIV said that they do not always get the necessary support when accessing law enforcement, education, and medical agencies. About half of PLHIV believe that fear of possible risk of contamination is the main cause for the refusal of service.

Ignorance of protective laws: About 75 percent of PLHIV are not aware of the rights and benefits that are included in the law, “On resistance to immunodeficiency virus and immune deficiency syndrome.” Under this law, PLHIV are liable for premeditated contamination of other people with HIV. The study shows that the majority of PLWH (82.7 percent) are aware of their responsibility for premeditated contamination with HIV of other people. The level of knowledge of liability for premeditated contamination among women is 69.8 percent—much lower than among men (91.8 percent).

Living standards for PLHIV: These standards are much lower than the national average. Among interviewees, more than 48 percent do not have any source of income; the average monthly income of 23 percent of PLWH is lower than the national average living standard. Of the total PLHIV interviewed, only half said that they had gotten any kind of assistance during last six months. More women—60.5 percent—received assistance than men (42.6 percent). PLHIV said that they receive assistance mainly from city and district AIDS prevention centers (52.8 percent) and NGOs working with PLHIV. Despite the low level of knowledge regarding special services guaranteed to PLHIV, many (85.6 percent) were aware of the free ARV therapy in Tajikistan.

Access to and uptake of services for PLHIV: Only 46.1 percent of PLHIV who were aware of free ART services in Tajikistan sought them (men, 37.3 percent; women, 57.9 percent). The remaining 53.9 percent believed that there is no need for ARV therapy because it will not help. ART was administered to only 51.2 percent of the interviewed PLHIV who sought it.

Desk Review of HIV-related Policy Recommendations
for Kazakhstan, Kyrgyz Republic, and Tajikistan (2007–2012)

The mass media and coverage of issues relating to PLHIV: Half of mass media employees said they do not cover discrimination-related issues in their publications.

Assistance from Hukumats (local-level authorities): Of PLHIV, 40 percent receive assistance from local Hukumats. However, 50 percent of respondents said that local authorities do not support PLHIV. Based on the data, 75 percent of the respondents believed that local Hukumats closely collaborate with international organizations and NGOs on HIV and AIDS issues.

REGIONAL: REVIEW OF ASSESSMENTS, FINDINGS, RECOMMENDATIONS

The following section provides a review of existing assessment reports, findings, and gaps and/or recommendations for multiple countries within the Central Asian region.

Medication-assisted Treatment in Kazakhstan, Kyrgyzstan, and Tajikistan in Mid-2011

Quality Project. 2012.

Recommendations

Build political support for MAT: Maximize the number of clients receiving MAT while continuing to ascertain the likelihood of continued political support for MAT. Decreased support may affect the ability of MAT pilot clinics to ensure continuity of care. Contingency plans must be developed.

Implement task shifting: Develop the specialist role of narcologists further by reserving their skills for the patients with more complex cases and encouraging general practitioners and other doctors to prescribe MAT for patients with less complex cases.

Eliminate treatment interruption between facilities and countries: Ensure continuity of treatment when patients are admitted to inpatient or correctional settings and when they move to different regions in the same country. Explore the feasibility of establishing a system to enable the transfer of MAT care to neighboring countries.

Identify compelling and credentialed MAT champions: Identify and recruit narcologists who support the MAT approach to become opinion leaders in Kazakhstan. They could write articles about clinical experiences with MAT for scientific and grey literature, and for various popular media. Their positive attitudes should also be harnessed in training and mentoring programs for MAT clinicians.

Create a MAT advocacy platform: Increase support for the MAT approach in local communities. Encourage MAT advocacy activities led by medical and other professional associations. Find ways to more widely disseminate MAT service evaluations and review findings in the scientific literature.

Recruit families and others as advocates: Support the formation of NGOs made up of families and caregivers of PWID to advocate the benefits of MAT to local and national politicians and other community opinion leaders through various media. Support the formation of consumer groups to promote the MAT approach to opioid-dependent PWID, their families, and the broader community.

Deregulate MAT delivery systems: Consider authorizing non-narcologist medical personnel, nurse practitioners, and a greater range of sites to prescribe and/or dispense methadone, including HIV and TB specialists, and general medical practitioners at HIV and TB treatment facilities and primary healthcare settings and pharmacies.

Ensure continuity of treatment: Explore opportunities to initiate or continue MAT in inpatient hospital and correctional settings.

Consider other modes of MAT delivery: These could include custom-made outreach vehicles to achieve geographical coverage in more remote locations, where health personnel are limited in number.

Telemedicine options (for example, using Skype) could enable specialist support from narcologists in more remote regions.

Ensure that existing MAT pilot sites are low threshold: Review client eligibility criteria to ensure that these are not restrictive; for example, remove requirements that clients have more than one previous failure in drug detoxification programs, be opioid dependent for more than two years, or be HIV positive. Training for medical staff potentially involved in client assessment for MAT should include developing the skills needed to do the following:

- Distinguish between diagnostic indicators of opioid dependence (such as previous attempts at detox) and MAT eligibility criteria, which should minimize barriers to entry. It's important to recognize that MAT should be considered a first-line rather than last-resort (harm reduction/HIV prevention strategy only) treatment approach to opioid dependence.
- Distinguish between prioritizing HIV-positive PWID and excluding HIV-negative PWID from MAT, particularly because such a requirement potentially stigmatizes MAT programs and also has client privacy implications. It may even become an incentive for HIV seroconversion among PWID desperate to gain access to MAT.

Introduce new funding models: Consider introducing funding models based on the average daily number of clients attending to increase the incentive to enroll and retain more PWID in MAT. All clinics should admit the maximum number of patients to MAT so that the treatment is seen to have a real force and vibrancy behind it. Any reluctance to offer treatment to new patients because of uncertainty about continued support for MAT modality sends a message that clinic staff are not really behind the treatment and weakens the urgency and impact of MAT. Ceasing support for MAT when there are only 20 patients is a lot easier than if there are 150 patients.

Ensure that MAT is accessible, acceptable, and welcoming to PWID: Decentralize locations of MAT clinics to be near where PWID reside to avoid traveling time, associated cost, and client congregation. Ensure that clinics have a welcoming atmosphere; review the need for high-security arrangements. Review operating hours of MAT clinics; encourage extended hours into the morning and evening to maximize client treatment capacity, enable client employment, and split dosing arrangements.

“De-medicalize” MAT delivery models: Refocus the efforts of specialist narcologists on clients with more complex medical treatment needs and on MAT induction and early stabilization. Less complicated cases, once stabilized, should be referred to the care of other health practitioners. Narcologists should also be resourced to provide continuing training and support in “shared care” arrangements to such practitioners, when appropriate. In addition the following could be implemented:

- Develop the nurse practitioner role, particularly for remote regions with few medical staff.
- Extend the nursing role to include counseling and welfare support capacity.
- Support training and employment of more personnel with psychosocial and welfare assistance skills to assume case management responsibilities in MAT clinics.
- Ensure broader access to training for health professionals by ensuring the distribution of written summaries of training initiatives, or by using technology to video training sessions and upload them to YouTube or a similar platform to benefit clinicians across the region.
- Encourage client participation and feedback in MAT planning and delivery.

Maximize client retention to achieve MAT goals: Support the development of the “case management” approach, particularly for the clients’ early treatment phase and for those with more complex health and psychosocial needs, as well as the following:

- Encourage the co-location and integration of other relevant health and social welfare services with MAT, including ART, TB, HBV, and HCV services; needle and syringe programs; mental health; sexual and reproductive health; child and maternal, antenatal, and dental health; general health; counseling and social welfare services; and drop-in areas.
- Ensure the continuity of MAT by developing systems to enable the temporary transfer of clients' methadone dispensing to hospital and correctional settings.
- Explore the significant challenge to continuity of care posed by high levels of migration to other areas and countries in the region (particularly from Tajikistan to Russia or other places of high HIV prevalence among PWID).
- Conduct “assertive follow-up” surveys of those patients who leave MAT to determine why they discontinued methadone.

Technical Report: Women and Harm Reduction in Central Asia

Shapoval, A. and S. Pinkham. 2011. Bethesda, MD: Quality Health Care Project in Central Asian Republics, Abt Associates Inc.

Findings

This report identified a wide range of harm reduction needs for women in Central Asia:

- Preserving women's reproductive rights
- Protecting women's human rights in general
- Drop-in centers (DICs) for women and children
- Social support
- Support from medical specialists (surgeons, gynecologists)
- Availability of information about friendly clinics (the network of friendly clinics exists in Kazakhstan but women do not know about them)
- Condoms, but needles even more
- Medication-assisted treatment
- Rehabilitation centers
- A legal framework for female PWID social welfare
- Creating a social house of hope for female PWID with children (rehabilitation of children from drug-using families)
- Medical support in prisons (psychologist, gynecologist, TB doctor, narcologist)
- Information on prevention of overdoses and on naloxone

The report found significant challenges to implementation and uptake of harm reduction programming for women in Central Asia:

- The absence of propiska (local registration and documents); women without identification cannot receive services;
- Low awareness of available medical and social services because service providers don't have direct access to women—female PWID are mostly dependent on their male partners;

- The absence of special harm reduction and other service programs tailored for women;
- The absence of state funding for such programs;
- Self-stigmatization and fear of rejection among female PWID;
- Stigmatization by medical professionals and the general public;
- Lack of coordination of efforts among NGOs and state agencies;
- The absence of special rehabilitation centers for women and an insignificant number of rehab facilities in the country in general;
- A lack of employment opportunities and related support for female PWID (most women stay at home)—such support could help resolve the issue of dependency on men;
- No protocols for provision of healthcare for female PWID—doctors have had little or no training in how to manage their cases, especially during pregnancy, and how to treat babies with withdrawal syndrome;
- A lack of training among medical and social workers on how to work with female PWID;
- Gender discrimination inside the PWID community, with women always the “last on the needle”;
- A lack of qualified staff to work with women in prisons;
- No DICs for PWID in general;
- Limited access to MAT and naloxone; and
- No needle and syringe exchange in prisons, although condoms are available.

Recommendations

This report offers recommendations to improve the response to female PWID in Central Asia:

- Provide DICs for PWID with services for women;
- Provide motivational, hygienic food packages; milk formulas (provided by the state only for those who are registered for prenatal care; women who do not register and learn about their HIV status in labor do not receive anything for three to four months);
- Create a 24-hour hotline for PWID and PLHIV (for PLHIV, it is more urgent);
- Provide informational materials from international organizations on childcare and social issues, and referral information on the services to which vulnerable women can apply for additional assistance;
- Develop social bureaus specifically for women with children;
- Train and engage new personnel—especially social workers, psychologists, specialist lawyers, and gynecologists—to work with vulnerable women;
- Organize study tours among NGOs to learn about existing experiences and models in the region and globally;
- Provide NGOs with computers (especially laptops to take on business trips or site visits to prisons) and printers; and
- Set up children’s day care centers.

Technical Report: HIV Counseling and Testing in Kyrgyzstan, Kazakhstan, and Tajikistan

Coughlan, M., A. Manukyan, A. Bolotbaeva, D. Parsons, and D. Burrows. 2011. Bethesda, MD; Quality Health Care Project Central Asia Republics, Abt Associates Inc.

Findings

NGOs' critical role in serving key populations: The quality of VCT services depends on a close working relationship between NGOs working with key populations and medical services, rather than on a whole-system strengthening approach. In many instances, the NGO and the health facility will agree to have the latter provide high-quality services for key populations, in some cases with a referral system that provides a referral voucher as an entrée into the service and as a guarantee of better care. In some situations, however, the voucher alone is not sufficient, and an NGO staff member must accompany the client to ensure high-quality service.

Informal payment for services: Informal payments to healthcare workers are common, including for VCT, which is mandated as a free service in all three countries. Many health workers expect informal payments to supplement their salary. Some groups of clients accept this; others, with little money, such as PWID, see this as a barrier to accessing services.

Training in communication for healthcare providers: Clinic staff identify communication skills training as a pressing need. VCT training has generally been theoretical and based more on the need to collect data and register people who test positive than on developing the counseling skills that should accompany HIV testing. Many health workers said they would welcome training in communication skills, enabling them to address difficult or taboo topics with clients, including taking a full risk assessment.

Few healthcare providers initiate discussions about HIV or VCT or conduct risk assessments: While some health workers interviewed said they had received training in PICT, it is rare for them to initiate a discussion with clients about HIV. There was no evidence of comprehensive risk assessment at any centers visited. Often health workers used a passive approach to get consent for testing by giving a client an information sheet to sign. Discussions took place only if the client asked questions.

Health worker workload: Overwork for health workers is a considerable barrier to improving the quality of counseling for VCT. Many health staff interviewed said they did not have time to provide the appropriate level of counseling needed in VCT. Emphasis is on tracking clients who test HIV positive, but little attention is placed on risk reduction counseling for clients who test HIV negative. NGOs sometimes fill this role.

Confidentiality issues: The importance of confidentiality and non-disclosure of the positive status of clients is not well understood in some settings, even at centers that provide counseling and testing. Surveillance rather than testing is emphasized as a pathway to treatment, care, and support.

Access to rapid HIV tests: Many NGO staff would like rapid HIV tests for the client's first HIV test. They believe this would increase uptake of VCT and reduce the number of people lost to follow-up.

Frequent stockouts of protective equipment: Stockouts of essential protective equipment, such as gloves and goggles, were a regular feature at one site visited and may well be an issue in other settings. Staff were concerned about occupational health and safety and infection control.

Recommendations

Provide training targeted to staff needs in communication and counseling: Develop a short course on basic communication skills and skills specific to VCT and PICT for front-line workers (doctors and nurses) currently involved in HCT, with refresher training offered a year later.

Train staff in addressing stigma and discrimination: This training could be tailored to the needs of the locality; for example, in Tajikistan and the southern part of Kyrgyz Republic, stigma and discrimination against men who have sex with men are particularly severe and need to be specifically addressed.

Provide materials in local languages: Translate material resources—client informational materials, HIV counseling and testing training materials, clinical guidelines and protocols, and medical handbooks—into local languages, and produce low-literacy information resources on HCT.

Improve quality assurance and supervision:

- Develop and roll out a system of mentoring and clinical (supportive) supervision for doctors involved in VCT in one or two health facilities in each of the Quality Project localities, with plans to expand to all health facilities within the localities in Year 2. Mentoring and clinical supervision for nurses in facilities in the localities should be included as part of a larger strategy of task shifting.
- Develop a standardized risk assessment pro forma. Health workers who have undergone training in communication skills should receive additional training on the use of the risk assessment.
- Develop a monitoring and evaluation system focusing on the quality of HCT, based on qualitative indicators and measures.
- Develop a post-training evaluation for implementation after three months with clinicians who have received training in communication skills. Collaborate with representatives of health services and NGOs to define and then implement high-quality services (such as partnership-defined quality).

Review the referral system: Thoroughly review referral systems, including individual NGOs' referral forms, as well as the current practice of escorting clients to clinics. The review should be conducted within each locality in collaboration with NGO staff, and recommendations should be made on ways to improve and streamline the system.

Launch advocacy efforts for rapid HIV tests and other issues: Advocate to regulatory authorities about the need for rapid tests at health facilities and NGO sites, and develop appropriate training on use of the tests. Lobbying for the assessment of NGOs as VCT delivery sites is also needed.

Plan for and implement task shifting: Develop a strategy for task shifting specific to HCT, with recommendations on incentives and salary issues, in consultation with appropriate regulatory and legislative bodies, relevant faculty members, and representatives of the health workforce.

Expand methadone programs to increase VCT uptake: Expand methadone programs and increase their accessibility. Methadone programs have been demonstrated to be successful in engaging clients with other health services, including uptake of VCT.

Work with police to reduce harassment of clients: Consult with police to reduce harassment of clients, especially near health facilities, a strategy that has already proved successful at some sites. This will likely improve acceptance and access to VCT as well as other health services.

Cost Analysis of Kyrgyzstan and Tajikistan HIV/AIDS Harm Reduction Services: A Survey Funded by UK aid under the Central Asia Regional HIV/AIDS Programme

CARHAP. 2012.

Findings

Program events may disrupt implementation and costing: Such events could be related to disruptions of finance, untimely goods delivery, or even political instability that negatively affect service delivery. The “ideal” costing approach therefore allowed the NGO to correct for these disruptions by adding those resources judged necessary by the NGO to optimize the experienced service delivery, whether the required additions were due to quality or quantity. Whereas the factual cost estimate reflects actual cost, including experienced program deficiencies and flaws, the ideal cost estimate therefore represents an adjusted cost estimate, correcting for the experienced biases in the chosen cost base year.

The benefits of unit costing: The unit cost estimates and the related evaluation of services can help program managers optimize the effectiveness in resource allocation at the various stages of project implementation, from initial planning as well as at the during current implementation. Service unit cost can also be an important factor when assessing the rationality in use of certain service components; the service unit cost could be used as well for development of funding applications to international donors, such as GFATM.

The largest portion of the service budget is recurrent costs, constituting between 80 and 90 percent of total cost: Capital cost (which mainly includes cost of premises) therefore constitutes between 10 to 20 percent of total cost.

The largest part of the budget goes to salaries of personnel (24%–67% of the budget), followed by supplies (7%–70%) and buildings (2%–18%): These figures show the large variation between the respective service types, due to differences in the scale of volume among the services. Generally, those services having high client coverage would have a smaller share of salaries and high share of supplies. Fixed costs, such as salaries and rent of premises, will constitute a gradually smaller part of total cost when scale is increased, whereas the variable cost will be more dominant. All in all, the dynamics related to scale-up will result in decreasing unit costs and robust unit cost estimates for NSEPs, at about US\$85 for coverage of 2,000 clients.

The Tajik NSEPs have the largest share of cost for “rent of buildings”: A possible reason for this could be due to the relatively low number of clients covered in Tajikistan, where the average NSEP project only covers 15 percent of an average Kyrgyz Republic NSEP.

Kyrgyz NSEPs (with coverage of 2,000 clients) have the lowest salary cost shares (24%), while the highest cost share is for the Tajikistan social bureau (66.7%).

The Global Fund's New Funding Model: What It Might Mean for You and Your Country

Eurasian Harm Reduction Network. 2013. Vilnius: EHRN.

GFATM has recently adopted a New Funding Model (NFM) with allocation criteria that reclassify most Eastern European and Central Asian (EECA) countries in the lowest priority eligibility category for funding. This brief discusses the potential consequences for the region, particularly for people who depend on critical health services from community-based and civil society organizations. To better understand how the NFM could affect the EECA, the authors examine four countries—Armenia, Georgia, Moldova, and Uzbekistan—that will face significant challenges as a result of Global Fund allocation changes. The EHRN recommends advocacy by communities in affected countries and urges greater transparency from the Global Fund about its funding processes.

Accessibility of HIV Prevention, Treatment and Care Services for People Who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform

United Nations Office on Drugs and Crime. 2010. Ashgabat, Turkmenistan: UNODC.

Findings

Tajikistan's location and instability make it a narcotics corridor: As a result of its geographical position (bordering Afghanistan, China, and the other Central Asian republics of Uzbekistan and Kyrgyz Republic) and its unstable social and economic situation, Tajikistan has become a transit corridor for narcotics destined for other countries, meaning that narcotics are also easily accessible and cheap in Tajikistan itself, thus contributing to the transmission of HIV and other blood-borne diseases. Additional drivers of the HIV epidemic in Tajikistan include high levels of labor migration and low levels of HIV awareness among the population as a whole, with risky activities as a consequence, especially among young people, such as initiating drug use and engaging in unsafe sex.

High levels of blood-borne infection among PWID: One source estimates that some 15,000 people inject drugs in Tajikistan, of which 23.5 percent have HIV and 43.4 percent have HCV. According to more recently published data, there are an estimated 17,000 people in Tajikistan who inject drugs, which represents a prevalence of injecting drug use of 0.45 percent (among adults between the ages of 15 and 64). The number of officially registered drug users rose from 4,200 in 2000 to 8,607 in 2007. HIV prevalence among PWID has been estimated at 14.7 percent. In 2006, HIV prevalence among PWID in the capital city, Dushanbe, was estimated at 23.5 percent.

Recommendations

Ensure attention to and involvement of vulnerable groups: In the interests of being more inclusive, and hence better informed and more effective, national programs and strategies on HIV and AIDS and drugs should explicitly guarantee the following:

- Attention to HIV prevention, care, treatment, and support for vulnerable groups, including people who use drugs and prisoners, among others; and

- The involvement of NGOs, people living with HIV, PWID, and members of other vulnerable groups.

Repeal unnecessary, unenforced prohibitions on drug consumption: As noted above, the Law on narcotics, psychotropic substances, and precursors (Article 15) currently states a prohibition on consumption of such substances without a prescription, but nothing in this or another law imposes a penalty. This provision serves no purpose but to stigmatize people with drug dependence.

Consider reducing penalties on possession of small quantities of drugs without intention to sell: Under the Administrative Code (Article 42), possession of drugs without an intention to sell attracts only administrative liability, punishable by a fine, in the case of very small quantities falling below the “small” quantities that can trigger criminal liability. In this regard, Tajik law sets a positive example by eliminating criminal penalties in some circumstances of possessing minimal quantities of drugs without intention to sell. However, in many cases, Tajik law still imposes quite harsh penalties for possession of drugs, even where there is no intent to sell. Given the nature of drug dependence as a chronic, relapsing condition, criminalizing repeated possession of even small and minor quantities of a prohibited drug, even without intention to sell, criminalizes people with drug dependence. The Government of Tajikistan should consider entirely removing criminal penalties for possession of such small quantities where there is no intention to sell. This could be achieved by enacting a provision in the Criminal Code (and in the Administrative Code as well, should the decision be made to remove administrative penalties for possession of small quantities without intention to sell).

Enact a clear legislative framework for needle and syringe programs: With the objective of supporting effective HIV prevention among PWID and protecting the public health more generally, the national expert group has recommended creating a clear legislative framework for needle and syringe programs, including the disposal of used syringes.

Preclude criminal or administrative liability for harm reduction programs: The harm reduction and outreach activities of NGOs targeting people who use drugs, such as programs providing sterile syringes or other equipment to reduce harms associated with drug use (including HIV transmission), should be clearly exempt from possible liability. In particular, they should be exempt from liability under Article 203 (“involvement in drug use”) or Article 205 (“organizing a site for drug consumption”) of the Criminal Code, or under Article 42.1 of the Code of Administrative Offences on responsibility for “possession” of residual quantities of drugs in used injection or other equipment.

Eliminate unjustifiably broad provisions for compulsory drug testing: Currently, Article 16 of the Law on narcotics, psychotropic substances, and precursors authorizes compulsory drug testing on the basis of sufficient grounds to believe that a person has consumed illegal drugs, even though drug use is not a criminal or administrative offense in itself. In addition, Article 18 of the Law on narcological assistance currently states that: “Where there are grounds to believe that a person suffers from drug dependence, alcoholism, is under the influence of alcohol or narcotics, or has used a narcotic or psychotropic substance without a prescription from a medical doctor, the person may be referred for physical examination.” As outlined above, such provisions infringe on numerous human rights. Among other things, compulsory drug testing violates the privacy and security of the person, without justification in most circumstances, since merely showing past use of drugs does not prove there is a risk of harm to self or others, which should be the only basis for possibly justifying an intrusion by the state into such rights. To eliminate unjustifiably broad provisions for compulsory drug testing, it is recommended that the Parliament of Tajikistan repeal Article 16 of the Law on narcotics, psychotropic substances, and precursors, and Article 18 of the Law on narcological assistance.

Decriminalize sex work: The International Guidelines on HIV/AIDS and Human Rights recommend that with regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalizing and legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work. Repeal of Article 174.1 of the Administrative Code of Tajikistan (sex work) is recommended. Articles 238–239 of the Criminal Code are sufficient for punishing criminal behavior in relation to sex work.

Eliminate HIV- and STI-specific criminal laws: Articles 125 and 126 of the Criminal Code, which specifically provide for punishment for transmission and exposure to “venereal diseases” and HIV, should be repealed. In the case of intentional transmission of venereal or HIV infection, this could be dealt with as infliction of bodily harm, which is covered by other articles of the Criminal Code.

Implement opioid substitution treatment: Methods of drug dependence treatment need to be expanded and brought in line with international standards and good practice. It is recommended that the MOH introduce OST programs immediately. As noted above, opioid substitution treatment is permitted under existing Tajik legislation and is supported in both the national AIDS program and an MOH order. Implementation of OST programs should not be delayed; small-scale pilot projects approved in 2008 should proceed and be scaled up. Additional legislation is not needed to move ahead with this important health service, which is critical to drug dependence treatment and HIV prevention among people who inject drugs.

Reform the system of registration of people who use drugs: To protect and respect human rights, and to remove any reason for people to avoid seeking out treatment for drug dependence or help with problematic drug use, Tajikistan should abolish its central registry of people who use drugs and are dependent on them, which can be used in ways that infringe human rights. To this end, the relevant paragraph of Article 14 of the Law on narcological assistance should be amended to repeal the provision on registration of people who use drugs; the relevant provisions of the Order of the MOH that implement such a registry should also be amended.

Provide for full confidentiality of health information of people who use drugs: Currently the Law on narcological assistance mandates that narcological institutions must “cooperate” with law enforcement bodies (Article 22) and also requires that they disclose, upon receipt of a written request, information about a person’s drug dependence to various bodies, including the public prosecutor and judicial and investigative bodies (Article 21). Information exchange and cooperation between law enforcement bodies and the medical institutions engaged in treatment of drug dependence should be limited by law. Routine disclosure of such personal information, including health information, to law enforcement bodies undermines patients’ trust in medical workers and drives them away from seeking medical services, including treatment for drug dependence. It is recommended that these articles be amended to narrow significantly the scope of “cooperation” by narcological centers with law enforcement authorities and the requirement to disclose confidential health information.

Reform legislation on compulsory drug dependence treatment: According to the national expert group, the Law on compulsory treatment of people with alcoholism and drug dependence, which is not implemented, should be repealed so as to eliminate the possibility of compulsory treatment of drug dependence being applied to any person. As noted above, involuntary medical interventions are almost always a violation of basic human rights recognized in international law. At most, compulsory treatment for persons who are confirmed to be drug dependent (and not simply casual drug users) can be justified only as a last resort, in exceptional circumstances.

Implement programs on overdose prevention and management: To prevent deaths and other serious harms from overdoses among opioid users, outreach workers (including those working for NGOs

and including “peers” who are themselves persons who use or have previously used drugs) should have the legal right to distribute and administer medications such as naloxone in cases of overdose.

Strengthen harm reduction measures: In 2008, amendments to the Law on counteracting HIV/AIDS were enacted, which included an article proclaiming that HIV prevention is a government priority, based on human rights principles and taking into account UN recommendations. This is a welcome development, but to further strengthen prevention, Tajik legislators might consider legislatively mandating measures to reduce harms, including HIV infection, among people who use drugs and prisoners. This should include directives specifically to government bodies and agencies that have particular responsibilities in this area, such as the MOH and Ministry of Justice, as well as clearly directing law enforcement bodies (e.g., the Drug Control Agency) to cooperate with other government bodies and NGOs to ensure the effective delivery and operation of harm reduction services (e.g., sterile syringe programs, OST).

Ensure informed consent to HIV testing: The national expert group has reported that welcome steps are being taken to ensure a clear legal requirement to ensure that people give consent to HIV testing that meets the requirements of informed consent, and that testing be accompanied by pre- and post-test counseling. While the details could be set out in different instruments (e.g., a regulation or order from the MOH), it would also be advisable to include, in the Law on counteracting HIV/AIDS, a provision along the lines of the following: “No test for HIV or other blood-borne infection shall be undertaken except with the informed voluntary consent of the person being tested, which informed consent should be clearly documented in writing.”

Eliminate inconsistency and the infringement of human rights as related to compulsory testing and treatment for HIV and STIs: The current Law on counteracting HIV/AIDS states the general principle that HIV testing should be voluntary, and the Law on public healthcare also recognizes a general right to refuse medical examination and treatment. However, current Tajik law also contemplates numerous unwarranted exceptions to this principle, including other provisions in the Law on public healthcare that allow compulsory testing and treatment, as well as possible administrative or criminal liability for refusing or evading testing and treatment in the case of various diseases, including HIV. This inconsistency, and the infringement of human rights reflected in compulsory medical interventions, should be addressed through legislative reforms to comply with international guidelines.

Provide for protection of other patient rights: While the Law on public healthcare currently recognizes some important rights of patients, it should be strengthened—to the benefit of all patients, and not just those with HIV, STIs, or drug dependence—by explicitly adding provisions guaranteeing the right to treatment based on good clinical practice, without discrimination; to the right to meaningful participation in determining treatment goals and decisions; to confidentiality of medical records and test results; and to be fully informed about medical matters and obligations as a patient, such as fees owed.

Provide access to voluntary drug dependence treatment, including OST, in prisons: Given the high prevalence of drug dependence among those imprisoned, the significance of risky drug use practices in contributing to the HIV epidemic, and the importance of providing access to health services that respect human rights and help promote the highest attainable standard of health for all persons, it is recommended that Tajikistan should implement voluntary drug dependence treatment programs in prisons. As OST is made available outside prisons, it should similarly be made available inside prisons as one important element of programs for addressing drug dependence. To this end, if amendments are introduced to the Law on narcological assistance to create a clear legal framework for substitution therapy that protects and promotes the human rights of patients receiving OST, those amendments should include explicit reference to providing access to OST to drug-dependent persons in prisons.

Introduce HIV prevention and harm reduction programs in prisons and detention facilities: The internal regulations of penitentiary institutions should be revised to strengthen HIV prevention among prisoners, including by ordering measures to ensure access to bleach and sterile syringes, as well as ensuring access to condoms and information related to the risks of HIV transmission through unsafe sex or drug use. The provisions prohibiting prisoners from possessing needles and syringes should be removed because they represent a barrier to implementing needle and syringe programs in prisons.

Eliminate discrimination against prisoners with HIV or drug dependence: To eliminate discrimination currently embedded in the law, the Penal Code should be amended as follows:

- Repeal the prohibition on transferring prisoners who are ordered to undergo compulsory drug dependence treatment to better conditions (lower-security institutions);
- Remove HIV-positive status and the fact of not completing a full course of treatment for drug dependence or STIs from Articles 80 and 100 (and others as follows) as factors that restrict a prisoner's right to transfer and movement; and
- Abolish Article 78, which provides for the segregation of HIV-positive prisoners, as discriminatory.

Eliminate HIV testing in employment or educational settings: Current Tajik law already prohibits refusing to hire someone or dismissing someone from employment based on HIV status. These laws should also clearly state that requiring HIV testing before or during employment or attendance at an educational institution amounts to unjustified discrimination.

Eliminate discrimination against drug-dependent persons in employment or educational settings: Requiring drug testing before employment or enrollment in an educational institution is also unjustified discrimination based on health conditions. Requiring testing for drug use during employment may potentially be justifiable only in quite limited circumstances, such as limiting testing to positions that are safety sensitive, and then only in cases where there are reasonable grounds to suspect impairment, or possibly random drug testing of persons returning to work after receiving drug dependence treatment.

Respect and protect family relationships: The Law on counteracting HIV/AIDS prohibits restricting the "rights and legitimate interests" of people with HIV based on HIV-positive status and "equally, restriction of housing and other rights and legitimate interests of family members of the HIV-infected persons." Yet, as noted above, current law states that mere HIV-positive status can be a basis for denying someone's application to adopt. In light of this:

- Articles 69 and 14(5) of the Family Code should be amended to clarify that, in cases of concern about child abuse or neglect, drug dependence should not be assumed to be per se sufficient grounds to deprive someone of parental rights; instead, this should be determined by a careful analysis of the individual circumstances. In addition, the limitation of the right to marry based on drug dependence should be removed.
- The government resolution that lists HIV and drug dependence as barriers to adopting or receiving custody of a child should be amended to delete these conditions from the list.

Needs Assessment Report for the Central Asian Training and Information Center on Harm Reduction

Schonning, S. and R. Stuikyte. 2009. Central Asia AIDS Control Project (CAAP).

This report describes recommended areas of activity for the Central Asian Training and Information Center on Harm Reduction.

ANNEX

Table: CAR Assessment Reports Aligned with Global Fund and PEPFAR PFI Categories

	General	Stigma and Discrimination	Gender	Human Resources for Health (HRH)	Laboratory	Multisectoral linkages	Strategic Information	Access to Drugs	Key Populations (MARPs)	Children (not OVC)	HCT	Other Prevention	TB/HIV	Clinical Services	Community-based
Kazakhstan															
Boltaev, A., A. Deryabina, and A. Howard. 2012. <i>Assessment of Medication Assisted Therapy in Kazakhstan</i> . Almaty: ICAP.	X	X		X			X	X	X					X	X
ICAP. 2012. <i>Report on the Baseline Assessment of HIV Care and Treatment Services in Kazakhstan</i> . Almaty: ICAP.	X			X			X		X						
Wilson, David P., Lei Zhang, Cliff Kerr, Amy Kwon, Alexander Hoare et al. 2011. <i>Evaluating the Cost-effectiveness of Needle-syringe Exchange Programs in Kazakhstan, 2000–2010</i> . Almaty: UNAIDS, World Bank, and University of New South Wales.	X								X						
Quality Health Care Project. 2012. <i>Improving Efficiency: A Rapid Evaluation of ARV Procurement, Storage Distribution, and Dispensing in Kazakhstan</i> . Quality Health Care Project	X						X								

Murzalieva, Gulgun and Alla Elizaryeva. 2010. <i>Study and Evaluation of Central Asia Health Facilities' Capacity in Provider-initiated HIV Testing and Counseling</i> . Almaty: AIDS Control Project, Republic of Kazakhstan.	X	X		X		X	X	X	X		X	X		X	
UNAIDS. 2009. <i>Kazakhstan Country Situation</i> . Geneva: UNAIDS.															
Routh, Subrata. 2007. <i>An Assessment of the HIV/AIDS and Related Health Delivery Systems in Karaganda Oblast in Kazakhstan (Study of Patient-flow, Functionality and Funding Issues)</i> . Almaty, Kazakhstan: CAPACITY Project.	X	X		X					X				X	X	X
Kulzhanov, Maksut and Bernd Rechel. 2007. <i>Kazakhstan: Health System Review. Health Systems in Transition 9(7)</i> .															
Struthers, Marie and Joanne Csete. 2003. <i>Fanning the Flames: How Human Rights Abuses Are Fueling the AIDS Epidemic in Kazakhstan</i> . <i>Human Rights Watch</i> (June) 15(4).	X	X	X					X	X						
Kyrgyz Republic															
Bivoli, Stela, Marina Smelyanskaya, Yulia Aleshkina, and Konstantin Lezhentsev. 2011. <i>Comprehensive Analysis of Harm Reduction Services in Kyrgyzstan</i> (draft). Bishkek: UNAIDS, DFID, and Quality Health Care Project	X					X	X	X	X		X	X		X	

Desk Review of HIV-related Policy Recommendations
for Kazakhstan, Kyrgyz Republic, and Tajikistan (2007–2012)

Thumath, Meghan, Aisuluu Bolotbaeva, Danielle Parsons, and Dave Burrows. 2011. <i>Technical Report: Individual, Social and Structural Barriers to ARV Adherence in Kyrgyzstan and a Proposed Plan of Action</i> . Quality Health Care Project in the Central Asian Republics. Bethesda, MD: Quality Health Care Project in the Central Asian Republics, Abt Associates Inc.	X	X	X	X			X		X	X			X	X	
Deryabina, Anna. 2011. <i>Mapping of Key HIV Services, Assessment of Their Quality, and Analysis of Gaps and Needs of Most-at-Risk Populations in Chui Oblast and Bishkek City, Kyrgyzstan</i> . Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.	X	X		X					X	X				X	
Murzaliyeva, Gulgun, Julia Aleshkina, Adyl Temirov, Amol Samiev, Nurzada Kartanbaeva et al. 2009. <i>Mapping Context Report: Tracking Global HIV/AIDS Initiatives and their Impact on the Health System: the Experience of the Kyrgyz Republic</i> (draft). Center for Health System Development and American University in Central Asia.	X						X	X							X

Routh, Subrata, Anton Kovalenko, Nurgul Kinderbaeva, Jumabek Malabekov, and Saltanat Ashymova. 2008. <i>Final Report and Functional Analysis of the Institutional Structure, Roles and Relationships for HIV/AIDS and Related Service Programs in Kyrgyzstan</i> . Bishkek: CAPACITY Project Central Asian Program on AIDS Control in Vulnerable Populations.	X			X		X	X						X	X	X
Central Asia Regional HIV/AIDS Programme. [no date]. <i>Lessons learnt on setting up harm reduction services in Kyrgyzstan's prisons</i> . CARHAP	X			X								X			
Tajikistan															
United Nations Development Programme. 2012. <i>Analytical Report—Tajikistan: Opportunities for Harmonization of National Legislation Related to HIV with Best International Standards and Practices</i> . New York: UNDP.	X	X			X				X	X	X				
Support Project. 2012. <i>Report on the Baseline Assessment of HIV Care and Treatment Services in Tajikistan</i> . Dushanbe: ICAP.	X			X	X	X							X	X	
Musaeva, Zarina, Dilorom Abbasova, and Anna Deryabina. 2011. <i>Mapping of Key HIV Services, Assessment of Their Quality, and Analysis of Gaps and Needs of Most-at-Risk Populations in Selected</i>	X	X		X				X	X		X	X		X	X

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Sites of Tajikistan. Arlington, VA: AIDS Support and Technical Assistance Resources, AIDSTAR-Two, Task Order 2.															
Routh, Subrata, Anton Kovalenko, and Zarina Musaeva. 2009. <i>Final Report: Functional Analysis of the Institutional Structure, Roles and Relationships for HIV/AIDS and Related Service Programs in Tajikistan</i> . Dushanbe: CAPACITY Project.	X					X						X	X	X	
Strategic Research Center Under President of Tajikistan. 2008. <i>National Study on the Stigmatization and Forms of Discrimination against People Living with HIV</i> . Dushanbe: Government of Tajikistan.	X	X										X		X	
More than one country															
Quality Health Care Project. 2011. <i>Trip report: Medication-assisted Treatment in Kazakhstan, Kyrgyzstan and Tajikistan in Mid-2011</i> .	X			X				X		X					
Shapoval, Anna, and Sophie Pinkham. 2011. <i>Technical Report: Women and Harm Reduction in Central Asia</i> . 2011. Bethesda, MD: Quality Health Care Project in Central Asian Republics, Abt Associates Inc.	X	X	X						X	X		X			X
Coughlan, Marie, Aram Manukyan, Aisuluu Bolotbaeva, Danielle Parsons, and Dave Burrows. 2011. <i>Technical Report: HIV Counseling and Testing in Kyrgyzstan, Kazakhstan, and</i>	X			X		X						X			

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Murzalieva, Gulgun, Julia Aleshkina, Adyl Temirov, Amol Samiev, Nurzada Kartanbaeva et al. 2009. *Mapping Context Report: Tracking Global HIV/AIDS Initiatives and their Impact on the Health System: the Experience of the Kyrgyz Republic* (draft). Center for Health System Development and American University in Central Asia.

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Musaeva, Zarina, Dilorom Abbasova, and Anna Deryabina. 2011. *Mapping of Key HIV Services, Assessment of Their Quality, and Analysis of Gaps and Needs of Most-at-Risk Populations in Selected Sites of Tajikistan*. Arlington, VA: AIDS Support and Technical Assistance Resources, AIDSTAR-Two, Task Order 2.

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