



Pharmacy Pilot Intervention in Tbilisi, Georgia

Final Report

January 2012

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USAID
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GEORGIA HIV
PREVENTION PROJECT

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
FSW	female sex worker
GHPP	Georgia HIV Prevention Project
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GPC	Georgia Pharmaceutical Communication
HIV	human immunodeficiency virus
IDU	injecting drug user
IEC	information, education, and communication
MARP	most-at-risk population
MIA	Ministry of Internal Affairs
MSM	men who have sex with men
NGO	nongovernmental organization
PATH	Program for Appropriate Technology in Health
RTI	RTI International
SHIP	STI and HIV Prevention Project
STI	sexually transmitted infection
USAID	United States Agency for International Development

Background

RTI International (RTI) and its subcontracting partners, Save the Children and PATH, as well as Georgian partner nongovernmental organizations (NGOs) Tanadgoma and Bemoni Public Union, are implementing the United States Agency for International Development (USAID)-funded Georgia HIV Prevention Project (GHPP). The overall goal of the GHPP is to improve and expand on HIV prevention among most-at-risk populations (MARPs), namely injecting drug users (IDUs), female sex workers (FSWs), men who have sex with men (MSM), and their partners; and at-risk youth.

In recent years, Georgia has seen significant increases in the numbers of new HIV infections. By March 2011, 2,752 HIV/AIDS cases had been registered by the Infectious Diseases, AIDS and Clinical Immunology Research Center in Tbilisi; this included 2,029 men and 723 women. The majority of patients are between the ages of 29 and 40; 1,450 patients have already developed AIDS, of whom 592 have died. The majority of people (57%) are understood to have acquired HIV infection via injection drug use. Most cases of HIV are in the Georgian capital city, Tbilisi. HIV prevalence among IDUs varies in different regions of the country: 2.5% prevalence in Tbilisi and 4.5%, the highest in the country, in Batumi.¹

Hepatitis B and C incidence rates are growing in Georgia, presumably due to some extent to widespread injection drug use in the country. Rates of hepatitis C among IDUs are significantly higher than HIV rates. The statistics, although a few years old, indicate that in 2006 and 2007, the prevalence of hepatitis C in the three largest cities in Georgia—Kutaisi, Tbilisi, and Batumi—ranged from 58.8% to 76.4%. The prevalence of hepatitis B was much lower, however, from 3% to 7%.²

In 2009, the National AIDS Center estimated that there were 4,000 people living with HIV in Georgia. The epidemic in Georgia remains largely concentrated among IDUs, MSM, FSWs, and the sexual partners of these groups. Injection drug use itself accounts for 60% of reported HIV cases, and one-third of heterosexual transmissions involved sex with a partner who injected drugs. As a result, injection drug use is at the root of approximately 70% of HIV infections in Georgia.³

While HIV infections are increasing in Georgia, the epidemic is still at a stage where it can be limited and new infections controlled and reduced. The international experience has shown that low-level epidemics concentrated in MARPs can be stopped with the correct mix of prevention interventions.

In Georgia, as in many other countries, one of the most important groups of health care providers is pharmacy personnel. Even in settings where there is an array of service providers in both the public and private sectors, many people still rely on the pharmacy as the first and sometimes only stop for health care advice, products, and services. People often prefer to self-treat, purchasing antibiotics without prior diagnosis or treatment at hospitals or clinics. Pharmacy personnel are an important source of care and information on HIV/AIDS, sexually transmitted infections (STIs), and hepatitis prevention. This is particularly true for IDUs and

¹ RTI International. *Georgia HIV Prevention Project. Mapping the Future: Options for Drug Policy in Georgia*. Research Triangle Park, NC, USA: RTI; 2011, p. 2.

² Ibid, p. 4.

³ Kingston S, Spellman D, for the Global Health Technical Assistance Project. *HIV Prevention Assessment in Georgia*. Washington, DC, USA: 2009, p. v.

FSWs, as they often fear the repercussions of seeking care in government health facilities. Also, sexually active adolescents prefer to use pharmacies for needs related to sexual activity, due to embarrassment and fear of disapproval. Thus, pharmacists can play a major role in providing information that can help prevent HIV and STI transmission. Through condom promotion and sales, they can help prevent HIV transmission. Pharmacists are also an excellent potential source of referral to HIV voluntary counseling and testing services, professional treatment and care, and peer support.

In 2010-2011, the GHPP piloted an intervention in five pharmacies in Tbilisi in collaboration with the private pharmacy network Aversi and partner organizations Tanadgoma and Bemoni Public Union. PATH led the intervention, expanding on work it conducted under the USAID-funded STI and HIV Prevention (SHIP) Project. The goal of the pharmacy intervention was to increase the accessibility and effective use of HIV, STI, and hepatitis prevention information and services by building on the role pharmacists can play in their delivery to pharmacy clients, including IDUs, who are at high risk of becoming infected. The project team adapted a proven curriculum⁴ for pharmacists on counseling clients on STIs and HIV, harm reduction, and stigma reduction; supplied pharmacies with informational materials for clients on HIV, STIs, and hepatitis; produced counseling algorithms for pharmacists and client referral cards; established a referral system to key partnering facilities; and incorporated a monitoring and evaluation system using referral cards to track referrals. The determination to expand to other project sites in Georgia will be based on evaluation of the effectiveness of the pilot intervention.

This report presents the results of the pilot pharmacy intervention collected through mystery client visits to evaluate the quality of services and focus group discussions with pharmacists.

Pharmacy Intervention Strategy

A strategy for the pharmacy intervention was developed based on the assessment conducted by PATH, Tanadgoma, and Bemoni Public Union under the SHIP Project in February–April 2009 in Tbilisi, Georgia, and the baseline mystery client visits conducted by the GHPP on July 30–August 1, 2010.

HIV and STI Assessment with Pharmacists and MARPs in Tbilisi (SHIP Project)

The goal of this assessment was to assess the role of pharmacists in providing high-quality STI- and HIV-related information and services to individuals who are at high risk of becoming infected, to better understand the needs of IDUs, FSWs, and MSM who visit pharmacies and to gather information on how pharmacists in Tbilisi could more effectively address those needs.

The assessment was conducted using the following methods:

- Six focus group discussions with 26 pharmacists of the Georgia Pharmaceutical Communication (GPC) network.
- A total of 24 in-depth interviews with IDUs (four interviews with males and four interviews with females), FSWs (four interviews with street-based FSWs and four interviews with sauna-based FSWs), and MSM (four interviews with MSM who are involved in commercial sex and four interviews with MSM who are not involved in commercial sex).

⁴ PATH. *Counseling Pharmacy Clients about Sexually Transmitted Infections (STIs), HIV/AIDS and Hepatitis*. Seattle, WA, USA: PATH; 2009.

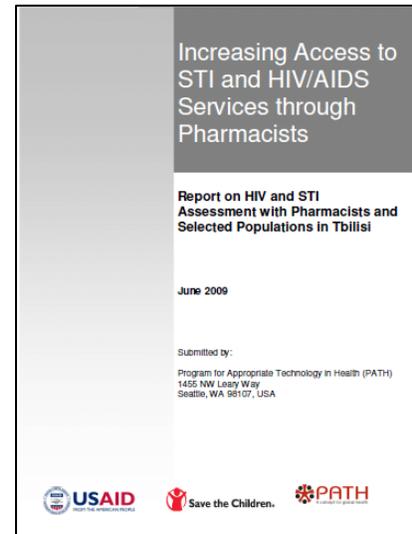
Based on the assessment results, the research team made the following recommendations⁵:

1. It is possible to develop a successful STI/HIV prevention intervention in partnership with a pharmacy network. Pharmacists recognize their important role in STI/HIV prevention and are willing to distribute informational materials, provide basic counseling to selected groups of clients, and refer them for STI and HIV testing.

NOTE: PATH conducted FGDs with the GPC pharmacies and recommended to implement pharmacy intervention with the GPC network.

2. There are a number of barriers to providing counseling to representatives of vulnerable groups in a pharmacy setting:

- Pharmacists can easily recognize IDUs; however, counseling them in a pharmacy is not realistic. Most of them come to the pharmacy to get a syringe for the immediate injection of drugs, so they are not in the mood to talk. Also, they are afraid of police.
- Pharmacists cannot recognize MSM, and it is unlikely that these clients will reveal their status in the pharmacy.
- Pharmacists are afraid of stigmatizing their clients.
- Most of the time, there are other customers in the pharmacy. This makes it difficult to talk to a client privately and to allow for a sufficient amount of time.



3. MARPs visit pharmacies. Many of them expressed the need for STI/HIV/hepatitis information and referrals for services and said they are willing to communicate with pharmacists if privacy and confidentiality are ensured:

- FSWs would like to receive STI/HIV counseling at pharmacies if it is provided to them with the same approach that is taken with other women at risk of STIs; FSWs should not be separated as a special group because of their occupation. Pharmacists can initiate counseling if FSWs ask for medication or approach them with a question.
- IDUs said they would refuse counseling at pharmacies; however, they agreed that pharmacists should provide referrals for hepatitis- and HIV-related services and place informational materials in the package with their purchases.
- Some MSM agreed that pharmacists could offer basic counseling when they come to buy medication for STI symptoms, or, in rare cases, approach pharmacists with questions. Pharmacists should provide referrals for STI/HIV services and distribute informational materials.
- Basic counseling, appropriate referral, and informational materials should be provided to clients who are at risk of STIs/HIV, including clients with symptoms of an STI, clients with questions on pregnancy prevention (before or after sex), and youth (whenever it is possible).

⁵ PATH. *Increasing Access to STI and HIV/AIDS Services through Pharmacists: Report on HIV and STI Assessment with Pharmacists and Selected Populations in Tbilisi, Georgia*. Seattle, WA, USA: PATH; 2009.

The IDUs, FSWs, and MSM who participated in the in-depth interviews preferred GPC pharmacies. Some respondents also mentioned PSP pharmacies. However, when RTI approached the GPC and PSP pharmacy networks in 2010 to assess their interest in collaborating on HIV prevention, the management of both networks refused to participate in the pilot. Only the Aversi pharmacy network agreed to participate in the intervention. The following five Aversi pharmacies were chosen for the intervention based on the selection criteria:

- Pharmacy #22, 55 Tsereteli Street.
- Pharmacy #45, 110 Tsereteli Street.
- Pharmacy #3, 5 Kazbegi Street.

- Pharmacy #23, 2 Pekini Street.
- Pharmacy #110, 23 Pekini Street.⁶



One of the partnering Aversi pharmacies in Tbilisi.

Baseline Mystery Client Visits

PATH conducted mystery client visits to the participating pharmacies to collect information on clients' satisfaction with pharmacists' interpersonal communication and counseling skills regarding STIs, HIV, and hepatitis. Each pharmacy was visited by three types of mystery client (IDU, FSW, and MSM) before and at the end of the intervention.

Through the visits, PATH gathered information on the following key indicators:

1. Percentage of pharmacists offering information about STI/HIV and hepatitis risk.
2. Percentage of pharmacists offering correct referrals.
3. Percentage of pharmacists offering information about STI/HIV and hepatitis risk prevention.
4. Percentage of pharmacists offering services to vulnerable groups in a positive manner.
5. Percentage of pharmacists offering their clients appropriate informational materials.

The baseline mystery client visits to five participating pharmacies were conducted on July 30 and August 1, 2010 (total of 15 visits), and served as a way to obtain baseline information about the services provided by pharmacies to vulnerable populations.

The key questions explored during baseline mystery client visits were:

1. What information about HIV/AIDS, STIs, and hepatitis do pharmacists provide to their clients?
2. Do pharmacists conduct counseling with MARPs in the pharmacy?
3. Where do pharmacists refer MARPs for further assistance?
4. What are pharmacists' attitudes toward MARPs?
5. Are privacy and confidentiality observed while a pharmacist interacts with a MARP representative?

⁶ In March 2011, Aversi management decided to close Pharmacy #110, and the pilot continued in the remaining four pharmacies.

6. Do pharmacists provide their clients at risk for HIV with written information on HIV prevention?

NGOs Tanadgoma and Bemoni Public Union recruited mystery clients among MARPs. Each target group was represented by two people (two IDUs, two FSWs, and two MSM). Prior to the baseline visit, PATH conducted training for mystery clients in skills necessary to conduct mystery client visits, including interpersonal communication, basics of STIs/HIV and hepatitis, taking mental notes on the conversation, observation, and how to complete the recording forms. Two practicing Aversi pharmacists participated in role plays and made recommendations for the mystery client visits.



Mystery client training, July 29, 2011, Tbilisi.

Key results of the baseline mystery clients visits are as follows:

- In the overall majority of cases, pharmacists failed to provide appropriate and accurate information to representatives of MARPs on HIV, STIs, and hepatitis.
- Pharmacists lacked the knowledge needed to provide appropriate counseling on HIV, STIs, and hepatitis.
- Pharmacists did not know where to refer representatives of MARPs for STI/HIV and hepatitis testing and other services; in the majority of cases, they referred the person to a polyclinic to see a doctor and did not provide an address.
- Pharmacists did not pay attention to assessing the risk factors of the target groups for STIs, HIV, and hepatitis.
- Pharmacists demonstrated different attitudes toward the MARPs representatives: they treated IDUs positively in the majority of cases, while their attitudes toward FSWs and MSM were much more stigmatized. Pharmacists treated them aggressively, rudely, and with condemnation in the majority of cases.
- Overall, privacy and confidentiality were not observed while pharmacists interacted with the mystery clients.
- There were no printed informational materials on STIs/HIV and hepatitis prevention in the pharmacies.

Technical Advisory Group

On August 3, 2010, PATH conducted a Technical Advisory Group meeting for representatives of Aversi pharmacy network management and participating pharmacies, RTI, Save the Children, Bemoni Public Union, Tanadgoma, and MARP groups. PATH presented the results of the 2009 HIV and STI assessment with the pharmacists and MARPs, as well as the mystery client visit results. Advisory group members discussed the assessment findings and PATH recommendations for the pharmacy intervention and agreed on the following:

1. Taking into consideration MARP opinions and the challenges mentioned by pharmacists, if possible, basic counseling on STI/HIV prevention can be provided to the following clients:

- IDUs who approach pharmacists with questions and are willing to communicate, and relatives of IDUs (rare occasions).
- Clients with STI symptoms (this category can include all target groups).
- Women and men (rare cases) who ask for help to prevent unwanted pregnancy after unprotected sex (they are potentially at risk of STIs/HIV from unprotected sex); this category can include all target groups.



Technical Advisory Group meeting.

2. Basic and refresher training for pharmacists on counseling clients on STIs, HIV, and hepatitis should be conducted.
3. An effective referral system needs to be developed prior to pharmacist training, as referring clients should be a critical part of the training. Confidentiality and free-of-charge services are key issues for a successful referral system. Using referral cards, pharmacists can refer clients for HIV, hepatitis, and STI tests and other services. Referral cards should be printed only in Georgian. RTI should make sure that all tests are available before the intervention starts. PATH proposed the following referral models:
 - IDUs will be referred by the pharmacists to Bemoni for hepatitis B and C tests (if available) and voluntary counseling and testing for HIV. Since most STI tests are not provided free of charge, IDUs will receive a coupon from an Averssi pharmacy and be referred for STI testing (as needed) at one of the following facilities: “Kabinet zdoorovia,” supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) harm reduction program for free testing, or to an Averssi clinic (and then back to an Averssi pharmacy to have prescriptions filled). Those IDUs who test HIV positive will be referred to the HIV/AIDS center for confirmation of their test result. Referral cards will include hotline information.
 - Clients with STI symptoms will be referred to Tanadgoma for voluntary counseling and testing for HIV and STI counseling. They will receive a coupon from an Averssi pharmacy and be referred for STI testing at one of the following facilities: Global Fund “Kabinet zdoorovia” or an Averssi clinic (or other clinic). Those who test HIV positive will be referred to the HIV/AIDS center for confirmation of their test result.
4. Three counseling algorithms (for IDUs, people with STI symptoms, and clients after unprotected sex) and two referral cards (for IDUs and people with STI symptoms) should be developed and distributed to participating pharmacies prior to the intervention. Referral information should be determined as soon as possible, as referral cards and algorithms need to be approved by Averssi, RTI, and PATH, translated into Georgian, and then printed. This might take considerable time and delay pharmacist training.
5. Pharmacists should distribute printed information on STI/HIV prevention to clients at risk of STIs and HIV by inserting informational materials into the packages with their purchases or during counseling.
6. Information, education, and communication (IEC) materials focusing on STIs, HIV, and hepatitis prevention should be produced or selected from existing IEC materials.

PATH and the Georgia RTI team agreed on the following:

- RTI will follow up with Aversi to decide on the final referral models and pharmacist training schedule.
- RTI will inform PATH regarding availability of the hepatitis tests at Bemoni and possibility of the Global Fund harm reduction program providing free STI testing at the “Kabinet zdorovia” to MARP pharmacy clients referred by Aversi pharmacists.
- When referral models are finalized, PATH will develop three counseling algorithms and two referral cards.
- RTI will review the HIV prevention IEC materials in Russian provided by PATH (nine brochures) and let PATH know if any need to be reprinted for use in Georgia. Also, RTI will check IEC materials developed by Georgian partners that can be distributed through pharmacies.
- PATH will adapt the training program and materials for pharmacists and conduct trainings when all the necessary components mentioned above are ready.

Pharmacy Intervention Implementation

In December 2010, the pilot intervention was launched in five participating Aversi pharmacies.

The objectives of the intervention were as follows:

- Support the training of pharmacists to expand their technical knowledge and enhance their counseling skills.
- Encourage vulnerable groups to seek pharmacy-based services by raising awareness about HIV, hepatitis, and STIs and by providing friendly services that make them feel welcome.
- Establish referral linkages between pharmacies and Tanadgoma and Bemoni Public Union, which provide services, including counseling and testing, for target populations.

The pilot pharmacy intervention consisted of three phases (see Table 1 below):

- Preparation (March–November 2010).
- Implementation in the five partnering pharmacies (December 2010–June 2011).
- Evaluation of intervention outcomes (July–December 2011).

Table 1. Phases of the pilot pharmacy intervention.

Activities	Time period
Preparation	
<ul style="list-style-type: none"> – Establishment of the Technical Advisory Group. – One-day training for mystery clients. – Baseline mystery client visits to five participating pharmacies to collect information on pharmacy client satisfaction with services provided. – Analysis of the baseline mystery client visits. – Technical Advisory Group meeting in Tbilisi with pharmacy pilot 	March–November 2010

Activities	Time period
<ul style="list-style-type: none"> stakeholders, including presentation of mystery client visit results. – Development and printing of referral cards: 1,500 blue referral cards for IDUs and 1,000 yellow referral cards for people with STI symptoms. – Development and printing of three types of counseling algorithms for pharmacies. – Development and printing of an announcement on the pilot pharmacy intervention to be placed at the participating pharmacies. – Selection of existing IEC materials published by Tanadgoma and Bemoni Public Union (about 1,800 brochures, booklets, and leaflets were provided to participating pharmacies). – Development of a monitoring system and forms. – Three two-day trainings for 29 pharmacists representing the five participating pharmacies. – Supply of counseling algorithms, referral cards, project announcements, and IEC materials to the five participating pharmacies. 	
Implementation	
<ul style="list-style-type: none"> – Forty-eight monitoring visits to five participating pharmacies in Tbilisi. – Four monitoring visits to Bemoni and Tanadgoma. – One two-day training for seven pharmacists who did not participate in the PATH training in November 2010 (conducted by Bemoni and Tanadgoma). – On-the-job training of pharmacy staff, conducted by the GHPP monitoring coordinator and Bemoni and Tanadgoma staff. – Supply and distribution of IEC materials and referral cards. – Monitoring of successful referrals from pharmacies to Bemoni and Tanadgoma (including hotline calls). – Review of monitoring reports and monthly conference calls with PATH and the GHPP pharmacy intervention coordinator and monitoring coordinator. 	December 2010–June 2011
Evaluation	
<ul style="list-style-type: none"> – One-day training for mystery clients. – Twelve post-intervention mystery client visits to four participating pharmacies. – Eight in-depth interviews with pharmacy heads and pharmacists from four participating pharmacies. – Analysis of mystery client visits and in-depth interview results. – Development of the final report. – Distribution of project findings. 	July–December 2011

Pharmacist Training

Information gathered from the baseline assessment supported the development of intervention activities, including a pharmacist training course. The course focused on building the capacity of pharmacists to provide information and counseling services related to unprotected intercourse and injection drug use to MARPs and referring them for additional HIV services. Specifically,

PATH adapted the pharmacy training curriculum *Counseling Pharmacy Clients about Sexually Transmitted Infections (STIs), HIV/AIDS and Hepatitis* to the training needs of participating pharmacists in Tbilisi. The two-day training course was oriented around the following key modules:

- Interpersonal communication and counseling.
- HIV/AIDS.
- Hepatitis B and C.
- Sexually transmitted infections.
- Counseling of pharmacy clients at risk for STIs, HIV/AIDS, and hepatitis B and C.
- Counseling on condoms, emergency contraception, and other contraceptive methods.



PATH conducted a series of three two-day trainings for 29 participants from five Aversi pharmacies (November 24–25, 26–27, and 29–30, 2010). The goal was to train all pharmacy staff who would be participating in the pharmacy intervention. Representatives of Bemoni Public Union and Tanadgoma also participated in the trainings so that pharmacists could become acquainted with the organizations and the qualified staff to whom they would refer their clients. The training agenda is provided in Attachment 1.

The pharmacists provided very favorable feedback on the quality of the trainings. They highly rated both the knowledge and the counseling skills they were provided.

Seven pharmacists who could not participate in a November training were trained during a two-day course conducted by Bemoni and Tanadgoma in December 2010.

Additionally, on-the-job training was offered to pharmacy staff by GHPP's monitoring and evaluation specialist, as well as Bemoni and Tanadgoma staff. On average, each on-the-job training session lasted from five to 15 minutes. The trainers answered pharmacists' questions regarding the counseling and referral algorithms and discussed the mistakes revealed during the monitoring visits. Table 2 illustrates the number of pharmacists who were trained throughout the course of the intervention.

Table 2. Number of pharmacists trained in Tbilisi.

Aversi pharmacies	Basic training (PATH, Nov 2010)	Basic training (Bemoni/Tanadgoma, Dec 2010)	On-the-job training (Dec 2010–Jun 2011)	Number of pharmacy staff
#3, #22, #23, #45, #110	29	7	113	35

Referral Cards and IEC Materials

Preparing for the pharmacist training and the intervention, PATH, together with Georgian partners, developed and printed in the Georgian language the following materials:

- Two types of referral cards: 1,500 blue referral cards for IDUs and 1,000 yellow referral cards for people with STI symptoms. (Please see Attachment 2 for referral card information.)
- Three types of counseling algorithms (job aids) for the pharmacists, on counseling of IDUs, counseling of clients with STI symptoms, and counseling of clients after unprotected sex. The algorithms were developed by PATH and pretested during the pharmacist training. Each pharmacist received a set of three algorithms.
- Announcement on the pilot pharmacy intervention to be placed at the participating pharmacies.



Counseling algorithm for clients after unprotected sex.

In addition, all pharmacies received nine types of brochures and leaflets in Georgian on HIV/AIDS, harm reduction, STIs, and hepatitis B and C. Materials were selected among existing IEC materials developed and published by Tanadgoma and Bemoni Public Union. Approximately 1,800 copies of the materials were provided to the pharmacies.

Intervention Monitoring

To assess intervention progress, PATH developed a monitoring plan and forms. PATH and RTI agreed that RTI would take the lead on monitoring the intervention, and PATH would provide technical assistance as follows:

1. The GHPP's monitoring and evaluation specialist, Tamuna Kasrashvili, was appointed the monitoring coordinator. She would visit participating pharmacies, Tanadgoma, Bemoni, and hotline staff at least once a month to check with the chief pharmacist and pharmacists on the intervention progress, project indicators, additional training (refresher) needs; to help with problem solving; and to plan for further follow-up with pharmacy staff.
2. To monitor the intervention, we would track data on the:
 - Training status of the Aversi pharmacists to make sure that all pharmacists who serve customers are trained.
 - Number of client referrals made by the pharmacists.
 - Number of pharmacy clients who visited Bemoni and Tanadgoma for testing.

- Number of referral cards and IEC materials distributed through pharmacies.
 - Pharmacists' opinions on counseling clients.
3. By the tenth of each month, Tamuna would submit the monitoring forms to PATH. PATH would review them and conduct monthly conference calls with RTI to discuss the monitoring results and provide recommendations.
 4. RTI would conduct mid-term mystery client visits three months after the training (March 2011) to obtain constructive feedback from the target groups and take steps as needed.

The GHPP's monitoring coordinator and Tanadgoma and Bemoni staff conducted a total of 52 monitoring visits (see Table 3).

Table 3. Schedule of monitoring visits.

Pharmacy	Dec 2010	Jan 2011	Feb 2011	Mar 2011	April 2011	May 2011	June 2011	Total
#3	12/01, 12/10, 12/29	01/28, 01/31	02/25	03/30	04/29	05/31	06/30	10
#110	12/01, 12/10, 12/16, 12/29	01/31	02/17, 02/25	03/30	<i>The pharmacy was closed.</i>			8
#23	12/01, 12/10, 12/29	01/31	02/22, 02/25	03/30	04/29	05/31	06/30	10
#22	12/01, 12/10, 12/29	01/31	02/22, 02/25	03/30	04/29	05/31	06/30	10
#45	12/01, 12/10, 12/29	01/31	02/25, 02/28	03/30	04/29	05/31	06/30	10
Bemoni	12/29					05/31		2
Tanadgoma	12/17						06/30	2
Total	18	6	9	5	4	5	5	52

Monitoring and supervisory visits began right after the pharmacy training. During the visits, the GHPP's monitoring coordinator (or Tanadgoma and Bemoni staff) evaluated pharmacists' knowledge about HIV, STIs, and hepatitis, as well as their referral habits; assessed the supply of project informational materials in the pharmacy; and provided technical support and advice as needed.



Monitoring Results

Achievements

- In all five pharmacies, condoms were placed in visible areas. (Before the training, pharmacy clients had to ask pharmacists for condoms, as they were not openly displayed.)
- Announcements about the pharmacy intervention, inviting clients to approach pharmacists with questions on HIV, STIs, and hepatitis, were placed in each pharmacy.
- HIV and hepatitis B and C tests were available at Bemoni and Tanadgoma for people referred from the pharmacies.

- In February, two pharmacy clients visited Bemoni and Tanadgoma with referrals from pharmacies.
- All pharmacists received training.
- A memorandum was signed between the GHPP and Aversi management on the pharmacy project intervention.
- During the pharmacy intervention, 965 IEC materials and 163 referral cards were distributed through participating pharmacies (see Table 4).

Table 4. Supply and distribution of IEC materials.

IEC materials	Pharmacies											
	#3		#110		#23		#22		#45		Total	
	S	D	S	D	S	D	S	D	S	D	S	D
Brochure "AIDS"	40	22	40	20	40	23	40	26	40	12	200	103
Leaflet "STIs"	40	10	40	18	40	20	40	31	40	36	200	115
Brochure "Advice for IDUs"	40	32	40	26	40	17	40	21	40	25	200	121
Leaflet "Why to Use Condoms"	40	23	40	25	40	25	40	33	40	12	200	118
Booklet "Hepatitis B"	40	9	40	21	40	15	40	33	40	29	200	107
Booklet "Hepatitis C"	40	13	40	16	40	10	40	32	40	27	200	98
Leaflet "Shared Syringes"	40	4	40	21	40	23	40	18	40	5	200	71
Booklet "Complications of Drug Use"	40	19	40	19	40	22	40	34	40	47	240	141
Booklet "Overdose"	40	6	40	25	40	21	40	31	40	8	200	91
Total	360	138	360	191	360	176	360	259	360	201	1840	965
Referral card for IDUs (blue)	98	10	100	19	99	23	100	37	100	16	497	105
Referral card for people with STI symptoms (yellow)	50	14	50	8	50	9	50	6	50	21	250	58
Total	148	24	150	27	149	32	150	43	150	37	747	163

S: Supplied to pharmacies by the monitoring team. **D:** Distributed by pharmacies.

Concerns

- Some pharmacists did not follow the proposed algorithms:
 - They attempted to provide counseling to IDUs before being asked for counseling. It had been agreed at the trainings that referral cards and IEC materials would be inserted in the packages of purchases made by IDUs.
 - Counseling and referral for HIV testing were provided to people who purchased condoms even though they were already using condoms for prevention.

- IEC materials were distributed to the general population.
- Pharmacists did not always remember which referral card was provided to a client.
- Monitoring revealed some decrease in pharmacists' motivation and readiness to provide counseling and referrals. Pharmacists reported that they worked under great pressure to sell their products to ensure a profit, which required that they serve a large number of clients.
- Pharmacists reported that they had almost no opportunity to counsel on HIV/AIDS, hepatitis, and STIs because there were almost no such clients. Pharmacists seemed to be reluctant to initiate counseling. They were afraid to defend or to stigmatize a client and provoke potential aggression, although they would provide counseling when it was initiated by a client.
- It was determined that it was not enough to conduct only one monitoring visit to each pharmacy per month. For example, monitoring revealed a number of problems in December; however, the gap between monitoring visits was the whole months (Dec 29 and Jan 31). So, for a month nobody visited pharmacies to follow up on those problems. The same situation was observed in March-June.

Recommendations

To address the concerns listed above, PATH provided the following recommendations to the GHPP:

1. PATH would develop a brief memorandum for pharmacists that summarizes all three counseling algorithms and serves as a reminder.
2. The GHPP intervention and monitoring coordinators should meet with Aversi management and chief pharmacists to reiterate the importance of the pilot pharmacy intervention.
3. More than one monitoring visit monthly should be conducted by the GHPP, especially to those pharmacies where problems exist. Problems should be immediately reported to the GHPP pharmacy coordinator to take appropriate action.
4. The GHPP monitoring coordinator should include more detailed information in the narrative report to PATH regarding counseling (whether any counseling happened during the month; which type of client was counseled; how the counseling went; if no counseling was provided during the month and why; etc.), so PATH can better track intervention progress and provide effective recommendations.
5. RTI would conduct interim mystery client visits to determine any problems to be addressed during refresher training. If refresher training was not needed, RTI would notify PATH in writing with evidence that the intervention in all pharmacies was going well.



Challenges

- The number of participating pharmacies was insufficient. Five pharmacies participated during the period December 2010–March 2011, but pharmacy #100 was closed at the end of March, and only four pharmacies continued to participate in the project in April–June 2011. This resulted in a lower probability that MARPs would approach the trained pharmacists with questions regarding HIV/AIDS, STIs, and hepatitis.
- One possible reason that very few target group representatives visited the pilot pharmacies could have been selection of the wrong pharmacy network for participation in the pilot.

- Beginning in February 2011, pharmacists reported a dramatic decrease in the number of IDUs visiting their pharmacies. The Ministry of Internal Affairs (MIA) started a campaign to locate and arrest IDUs caught using injection drugs. Many IDUs were arrested, and many of those who were not stopped using intravenous drugs and started to use oral pills. After February, nobody asked for insulin syringes. In March 2011, the MIA obliged all pharmacies to install an outside surveillance camera at their entrance. This was an additional barrier for IDUs in particular in turning to pharmacies for help.
- Pharmacists reported that some IDUs refused to take the referral cards and IEC materials placed in the package with their purchases, as they did not want the paperwork to cause problems for them with the police. IDUs either removed the materials from their packages immediately, at the counter, or threw them in a trash receptacle as they were leaving the pharmacy. This contributed to a stressful working environment.
- Pharmacists reported that their pharmacies were usually frequented by the same IDUs, to whom they provided referral cards and IEC materials on the IDUs' first visit and not thereafter. Visits by new IDUs were rare. Thus, the number of referral cards and IEC materials distributed was small.

Although 68 referral cards were distributed to the pharmacy clients during the first three months of intervention, only two of the cards were turned in to Tanadgoma and Bemoni Public Union for services: A person who received a yellow referral card from pharmacy #45 visited Tanadgoma in February 2011 and was provided with counseling on HIV and STIs and was tested for HIV. The other person, who received a blue referral card (pharmacy is unknown), called the Bemoni hotline for information, also in February 2011. (See Table 5.) This raised a major concern that influenced the further course of pharmacy intervention.

Table 5. Pharmacy referrals.

	Dec	Jan	Feb	Mar	Apr	May	June	Total
Number of referral cards distributed								
For IDUs (blue)	15	25	8	29	10	11	7	105
For people with STI symptoms (yellow)	8	10	2	23	6	0	9	58
Total	23	35	10	52	16	11	16	163
Number of people who accessed services								
Bemoni								
Tanadgoma			1					1
Hotline, Bemoni			1					1
Hotline, Tanadgoma								

Given these results, in March the GHPP team decided to cancel mid-term mystery client visits and refresher pharmacy training, terminate the intervention, and conduct an end-of-intervention evaluation.

End-of-Intervention Evaluation

The goal of the end-of-intervention evaluation was to assess the extent to which the pharmacy intervention enhanced the capacity of pharmacies to provide high-quality services to vulnerable

groups, with a technical focus on HIV, STI, and hepatitis risk identification, and referral to testing and other professional care.

Key questions of the evaluation were:

1. To what extent do trained pharmacists conduct counseling according to suggested counseling algorithms and provide appropriate referrals as needed/requested?
2. What are the reasons for pharmacists becoming discouraged and potentially resistant to using counseling/referral models?
3. In what ways was PATH's training effective or not in increasing pharmacists' knowledge on interpersonal communication, STIs/HIV, hepatitis, existing services for HIV and hepatitis B and C testing, and attitudes toward target groups?

PATH used the following methods to gather information:

1. Pre- and post-intervention mystery client visits: A total of 27 visits were conducted (15 visits at baseline in July 2010 and 12 visits at the end of the intervention in July 2011).
2. Eight in-depth interviews with pharmacists from participating pharmacies. Results of the interviews are presented beginning on page 28. (See Attachment 3 for the in-depth interview guide.)

Mystery Client Visits

Each pharmacy was visited by three types of mystery client before and at the end of the intervention: IDU, FSW, and MSM. All visits were conducted in pairs of a mystery client and an interviewer. The mystery client went into the pharmacy alone and presented his/her scenario, while the interviewer waited outside the pharmacy. Upon leaving the pharmacy, the interviewer asked the mystery client questions from a questionnaire, and the answers were recorded on a recording sheet. The questionnaire consisted of 23–26 questions (depending on the scenario), aimed to evaluate the pharmacist's awareness of HIV, STIs, and hepatitis, and communication skills. The questionnaire also sought to determine pharmacy staff practices regarding referral of clients for information, products, or services related to HIV, STIs, and hepatitis. Mystery client guidelines were pretested with the target groups and are provided in Attachments 4, 5, and 6.

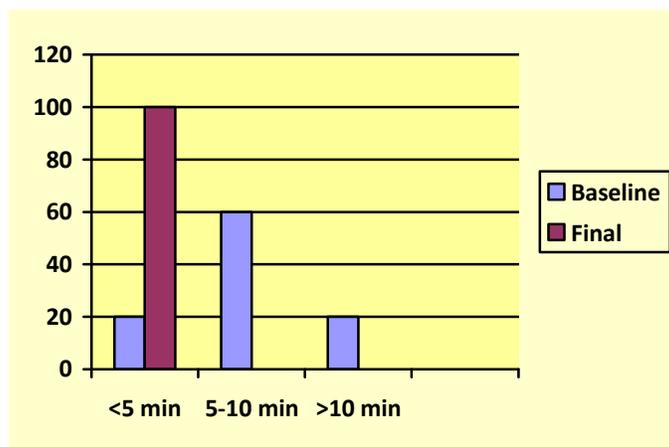
Mystery Client Visit #1 (Injecting Drug User)

Scenario: The mystery client is a young man who has used injection drugs for a long time. Sometimes he shares syringes with other IDUs. He has a girlfriend whom he trusts. Usually they do not use condoms. Lately, he has been visiting a pharmacy to buy oral pills commonly used by drug users (Lyrica[®], khilimon, and baklosan).⁷ He is afraid of becoming infected with hepatitis and wants to ask the pharmacist how it is transmitted and can be prevented.

Duration of visits with pharmacists: At baseline, the majority of mystery clients (60%) spent from five to ten minutes talking with pharmacists, with one mystery client (20%) spending less than five minutes and one mystery client (20%) spending more than ten minutes with the pharmacist. Over the life of the project, the average time spent with pharmacists declined. During the final visits, 100% of pharmacists spoke with the mystery client for less than five minutes. (See Figure 1.)

⁷ After the Ministry of Internal Affairs began arresting IDUs for using intravenous drugs in February 2011, almost no IDUs requested supplies for intravenous drug use, so oral pills were substituted in the end-of-intervention IDU mystery client visits.

Figure 1. Duration of IDU mystery client visits with pharmacists.



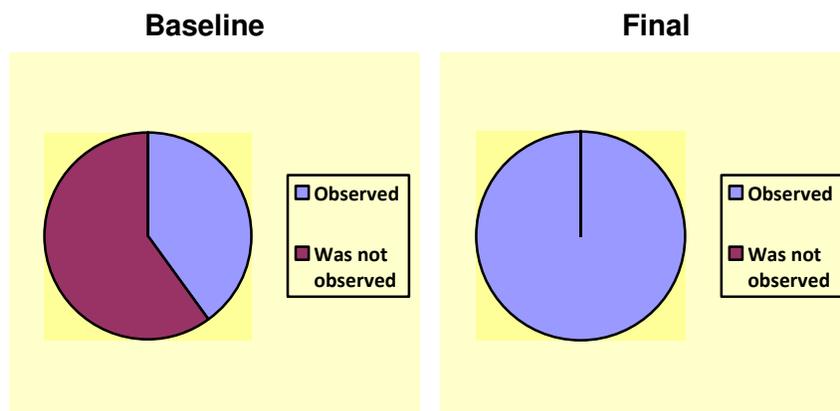
Privacy and confidentiality: At baseline, in three of five cases (60%), other people were present in the pharmacies during the IDU mystery client visits, and the pharmacists let other customers stand next to them and listen to their conversations with the mystery client. In the majority of cases, the IDU mystery client said that pharmacists' colleagues joined the conversation, to help, and the privacy and confidentiality of the counseling session was breached. In one case, three pharmacists were involved in discussing the IDU mystery client's problem.

During the training, the importance of providing privacy and confidentiality during counseling sessions was highlighted. During final visits, in 50% of cases, other people were present in the pharmacies or entered the pharmacies during the conversation. However, in 100% of cases, pharmacists understood the importance of privacy and confidentiality. They lowered their voice and/or asked the mystery client to wait until other visitors had left the pharmacy. (See Figure 2.)

When I came to the pharmacy, there were two pharmacists. One pharmacist served a customer. I approached the other pharmacist, bought drugs, and then said, "I have a problem. May I consult with you?" The pharmacist immediately came out of the counter and asked me to come to the side, so no one could hear us.

The pharmacist spoke to me in a lower voice, so that the other customer could not hear us.

Figure 2. Observation of privacy and confidentiality during IDU mystery client visits.



Counseling on HIV, STIs, and hepatitis: The baseline visits showed that the majority of pharmacists did not ask the IDU mystery client questions to clarify the situation when he presented his story. Only one pharmacist asked whether the client used a new syringe or his own syringe every time he used drugs. The same pharmacist also asked whether he used condoms. Nobody asked the IDU mystery client whether he used the same ware for drug preparation when he used drugs with others.

The project training curriculum emphasized the importance of collecting information regarding clients' HIV, STI, and hepatitis risk factors. However, data from the final visits demonstrated no significant difference from baseline. In most cases, pharmacists did not have additional questions for the IDU mystery client. In one case, the pharmacist asked the mystery client if he used injection drugs and confirmed that hepatitis could be transferred through shared syringes.

The pharmacist asked me, "Do you take drugs by injection?" I replied, "Yes." She said that hepatitis is transmitted through a syringe.

One out of four pharmacists briefly told the IDU mystery client about hepatitis.

She told me that hepatitis could be transferred by injecting drugs.

During conversations with the IDU mystery client, pharmacists did not provide information on HIV and STI risks and prevention. However, all four pharmacists (100%) provided the mystery client with a blue referral card with key information on HIV, STIs, and hepatitis and where to seek testing and treatment. In three of four cases (75%), pharmacists provided printed information on HIV, STI, and hepatitis prevention. So, although pharmacists did not provide this information verbally, they provided the IDU mystery client with written information about risk factors and the importance of HIV, STI, and hepatitis testing and prevention.

Referral: End-of-intervention results showed a dramatic improvement in provision of referrals for testing and provision of correct contact information (see Table 6 on the following page). At baseline, only one pharmacist knew where the IDU mystery client could get tested for hepatitis C ("drug abuse clinic at Mardzhnishvili Street"). At the final visit, as soon as the IDU mystery client said he was afraid of becoming infected with hepatitis because of injecting drugs, all four pharmacists (100%) recommended he be tested for hepatitis B and C, and recommended he seek counseling regarding hepatitis at Bemoni Public Union and provided the contact information. None of the pharmacists, however, recommended to the client that he also get tested for HIV and STIs.

When I told that I was afraid of being infected with hepatitis because I used drugs, the pharmacist said that there is an organization where I can get tested for hepatitis free of charge and confidential.

You must go there to be tested.

Do not lose this referral. The test will be made there and consultation will be provided.

She told me that there is such an organization, named Bemoni, at Kavtaradze Street. She said that it is a clinic where good doctors work.

She gave me a referral card at once and said, "You should go to this organization; there, the hepatitis tests will be done. Be sure to go there. They will tell you everything there."

Although none of the pharmacists recommended an IDU to have an HIV and STI test during conversation, they provided him with a referral card that include information about HIV test and counseling on STIs at Bemoni as well.

Informational materials: End-of-intervention results illustrated a considerable improvement in provision of informational materials to the IDU mystery client. At baseline, no informational materials were provided to the client. Following the intervention, three out of four pharmacists provided the mystery client with the booklets, leaflets, and brochures on HIV/AIDS, hepatitis B and C, and harm reduction for IDUs. (See Table 6.)

Pharmacists' attitudes toward the IDU mystery client: As during the baseline survey, in the majority of cases (three out of four), the pharmacists treated the IDU mystery client positively. They were attentive to the client's problem, listened carefully, and were ready to help (Table 6).

The pharmacist treated me very kindly and tried to help. She has even told that today is the last day when Lyrica® is sold without a prescription and that starting tomorrow, this medication will be sold only in the psychotropic pharmacies and with a doctor's prescription.

The pharmacist gave the information, advice.... She came out of her counter and asked me to come to the side to talk.

The pharmacist listened to me very attentively. She was not distracted during our conversation. She even advised me to go to another pharmacy, giving the address where they sell Lyrica® in a dosage which I needed.

There was a renovation in the pharmacy; the packed boxes were everywhere. The male pharmacist provided me, with readiness, with the information about Bemoni and Tanadgoma and asked to wait while he and the other pharmacist were looking for booklets: "Please wait, and do not go away." At the end of our conversation, he even thanked: "Thank you for visiting Aversi pharmacy." It was very nice.

In one case, the IDU mystery client reported that the pharmacist seemed very tired, which may have been the reason she treated him with indifference; however, she provided a referral card and insisted the mystery client go to Bemoni for further information.

There were no clients at the pharmacy; the pharmacist was talking with her colleague over the counter. She treated me indifferently. I thought that she was just tired. She immediately gave me a referral card; she gave me no specific additional information; she was just repeating that I should go to that organization and they will tell me everything there.

Table 6. Comparison of the baseline and final IDU mystery client visit results.

Service provided by pharmacists	Baseline %	Final %
Respected privacy and confidentiality	40	100
Advised IDU mystery client to get tested for HIV	40	0
Advised IDU mystery client to get tested for STIs	0	0
Advised IDU mystery client to get tested for hepatitis B	20	100
Advised IDU mystery client to get tested for hepatitis C	60	100
Provided written referral to Bemoni Public Union	0	100
Provided IEC materials	0	75
Treated IDU mystery client positively	75	75

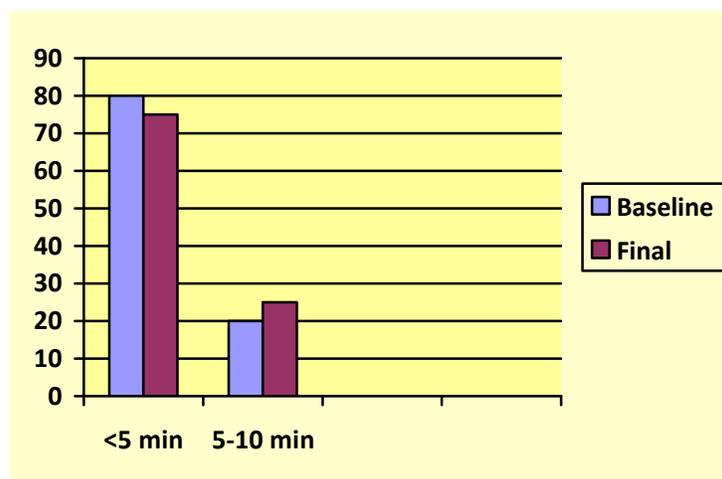
Mystery Client #2 (Female Sex Worker)

Scenario: The mystery client is a woman who had unprotected sex with a man whom she knew just a little. After a few days, she noticed some symptoms on her genitals: painful ulcers, itching, and a burning sensation during urination. She has no money to visit a doctor. She wants to buy medication for self-treatment to eliminate the symptoms. Also, she is worried about unwanted pregnancy and is interested in preventing it.

Duration of visits with pharmacists: At baseline, four out of five pharmacists (80%) spent less than five minutes talking with the FSW mystery client, and one pharmacist talked from five to ten minutes with her. At the end of the intervention, there was no significant difference: three out of four pharmacists talked with the FSW mystery client for less than five minutes. In one case, the mystery client had to return to the pharmacy because she had forgotten to ask the pharmacist about unwanted pregnancy, according to the scenario. Thus, in one case, the mystery client talked to the pharmacist from five to ten minutes. (See Figure 3.)

I came back to a pharmacy for the second time, approached the pharmacist with whom I talked before and said that I was so nervous that I forgotten to ask her a very important question.

Figure 3. Duration of FSW mystery client visits with pharmacists.

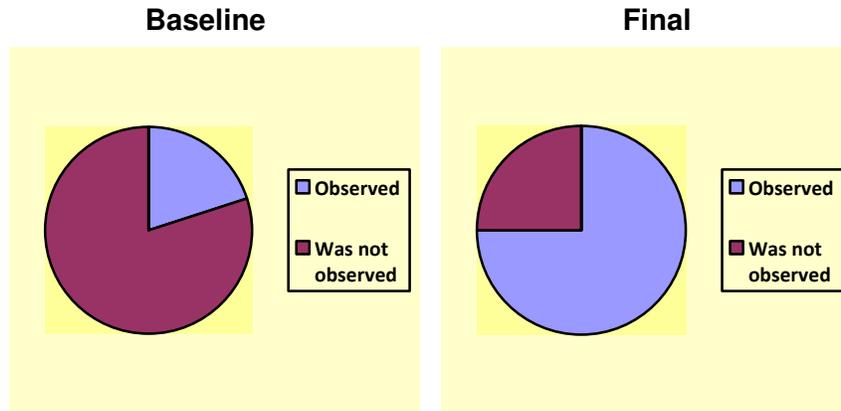


Privacy and confidentiality: At baseline, in 80% of cases, privacy and confidentiality were not observed. Moreover, the pharmacists did not care at all that other customers or colleagues could hear their conversation with the FSW mystery client. In some cases, they loudly and aggressively responded and offended the client. In one case, the mystery client playing the role of an FSW was so offended and upset by the pharmacist's attitude that the research team had to calm her down before she could conduct the next visit.

The training highlighted the importance of preserving privacy and confidentiality. During end-of-intervention mystery client visits, in three out of four cases (75%), privacy and confidentiality with the FSW mystery client were observed. Though other visitors came into the pharmacy, pharmacists dealt much better with disruptions. In two cases, when other visitors entered the pharmacy, the pharmacists stopped the conversation, waited until the other pharmacist was serving the customers, and only after that, continued the conversation. In the fourth case, the head of the pharmacy joined the conversation to help the FSW mystery client. Together with the

pharmacist, she searched for referral cards and brochures; this, however, breached the mystery client's privacy and confidentiality, although it was well intentioned. (See Figure 4.)

Figure 4. Observation of privacy and confidentiality during FSW mystery client visits.



Counseling on HIV and STIs: The training emphasized the importance of collecting information to evaluate a client's risk factors. However, both baseline and end-of-intervention data showed that the majority of pharmacists did not ask the FSW mystery client questions concerning risk factors, as recommended in the counseling algorithm:

- When did you have unprotected sex?
- Do you have a permanent sexual partner?
- Did you use condoms when you had sex with other men after you noticed painful ulcers on your genitals?

None of the pharmacists told the FSW mystery client about STI and HIV risks, nor recommended how to protect herself in the future.

However, there was considerable improvement in pharmacists' knowledge about the necessity of being tested for STIs before treating symptoms. At baseline, all five pharmacists (100%) offered anti-fungal or anti-bacterial medication to self-treat STI symptoms, without recommending to the FSW mystery client that she get tested for STIs before starting the treatment. Following the intervention, this indicator improved dramatically: 75% of pharmacists emphasized the importance of testing for STIs first to receive the proper treatment and did not offer the mystery client any medication for self-treatment (Figure 5).

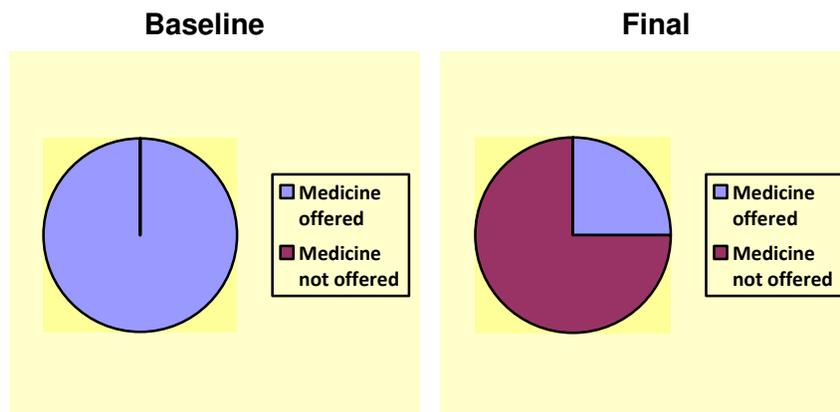
I cannot give you any medicines until you visit a doctor.

We have a lot of different drugs, but it is better to go to a doctor first and to be tested for STIs.

Only one pharmacist recommended that the FSW buy medication, in this case, to treat cystitis:

You must have cystitis. Here is a medicine; the symptoms will go away, and there won't be any complications.

Figure 5. Instances in which medication was offered to the FSW mystery client to treat STI symptoms.



None of the pharmacists advised the FSW mystery client to use a condom to prevent unwanted pregnancy and STIs, including HIV. Instead, they gave her a referral card and advised her to visit Tanadgoma, where she would be provided the information.

We have different medication for preventing pregnancy, but it is better for you to go to this organization, and there, they will tell you everything.

This is for you [referral card]. Please go there. They will tell you about the pregnancy as well.

Not one pharmacist told the mystery client to abstain from sexual contact until her symptoms had been treated.

Referral: From baseline to the end-of-intervention, the percentage of pharmacists who referred the FSW mystery client for STI testing and provided the clinic address rose from 0% to 50%. One pharmacist referred the mystery client to Tanadgoma and provided a referral card.

Please go to this organization; they will tell you everything there, will do tests free.... It is not far from here.

One pharmacy was undergoing renovation at the time of the FSW mystery client visit. The pharmacist told the client she had special referral cards and tried to find them but could not. She wrote the contact information for the testing clinic on a piece of paper and gave it to the client.

Here is the information for you. Just go to this organization. You will receive all the necessary information there, and you could be tested free of charge there as well.

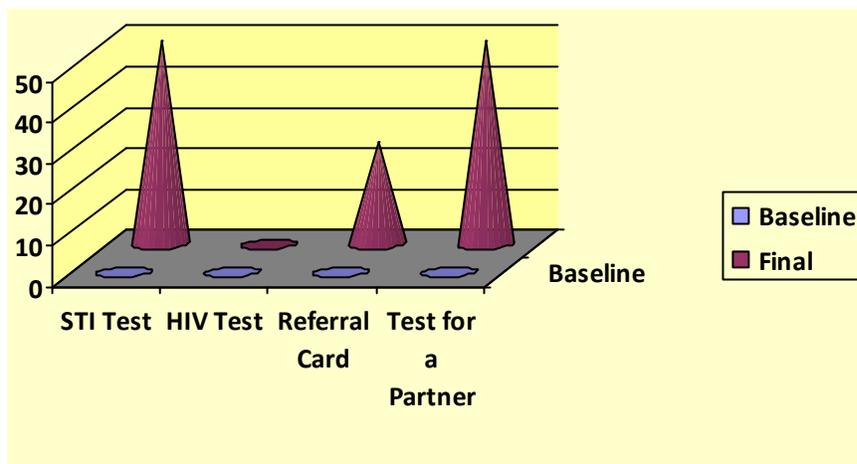
Two out of four pharmacists referred the FSW mystery client to a gynecologist, saying, “You need to go to a doctor,” or “You need to be checked by a gynecologist.”

At baseline, not one pharmacist (0%) highlighted the necessity for a partner to get tested and treated. At the end of the intervention, 50% of pharmacists recommended the partner be tested for STIs as well (Figure 6).

You should get tested. Both you and your partner.

A gynecologist should see you. You and your partner should be tested.

Figure 6. Referrals provided to the FSW mystery client for STI and HIV testing.



Informational materials: No informational materials were provided to the FSW mystery client at either baseline or end-of-intervention. Pharmacists at the pharmacy undergoing renovation attempted to find the IEC materials, which were packed in boxes, but did not find them.

Pharmacists' attitudes toward the FSW mystery client: The baseline visits demonstrated very poor attitudes of pharmacists toward the FSW mystery client. In three out of five cases, pharmacists treated the client with indifference, expressing no sympathy for a woman in such a difficult situation, instead trying to get rid of her as soon as possible. In two cases, the pharmacist treated the FSW mystery client rudely, aggressively, and with condemnation.

Following the intervention, pharmacists' attitudes toward the FSW mystery client improved considerably. Seventy-five percent (75%) of pharmacists were friendly and positive; they listened carefully, and tried to help (Figure 7).

The pharmacist looked at me kindly and carefully listened to me.

The pharmacist, young woman, listened to me very carefully. I got the feeling that she was trying to help me and did not condemn.

The pharmacist said that they had referral cards and brochures and tried to find them. She explained that because of renovation at the pharmacy, the materials were somewhere shifted, and she could not find them. Then the pharmacist wrote on a separate piece of paper the name, address, and phone number of the organization where I can get help and gave it to me.

Even the head of the pharmacy joined the pharmacist in her search for referral cards and brochures. She even called someone to clarify where those materials could be found.

In one case, the pharmacist provided a referral card at once and tried to refer the FSW mystery client to Tanadgoma; the pharmacist did not provide any information herself.

As soon as I told the pharmacist about my problem and STI symptoms, she immediately gave me a referral card. When I tried to ask her any clarifying questions, she answered that in the organization where she referred me, I would be explained in details and that there I could be tested free of charge. I got the feeling that the pharmacist wanted to get rid of me quickly.

Figure 7. Manner in which the FSW mystery client was treated by pharmacists.

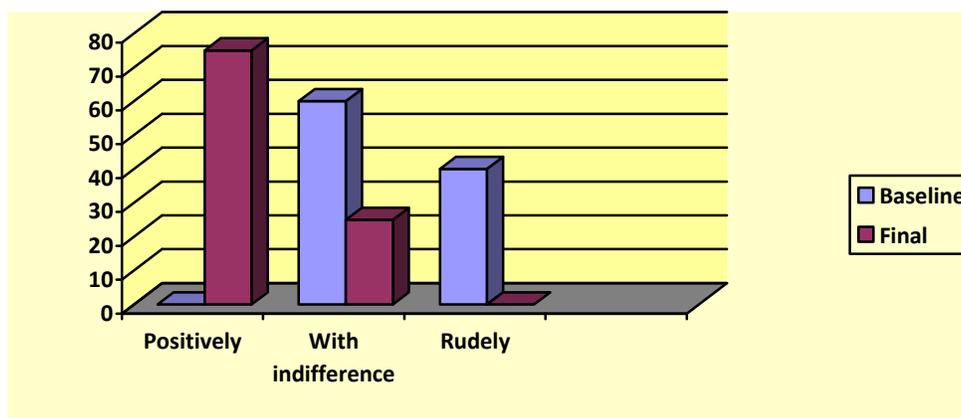


Table 7. Comparison of the baseline and final FSW mystery client visit results.

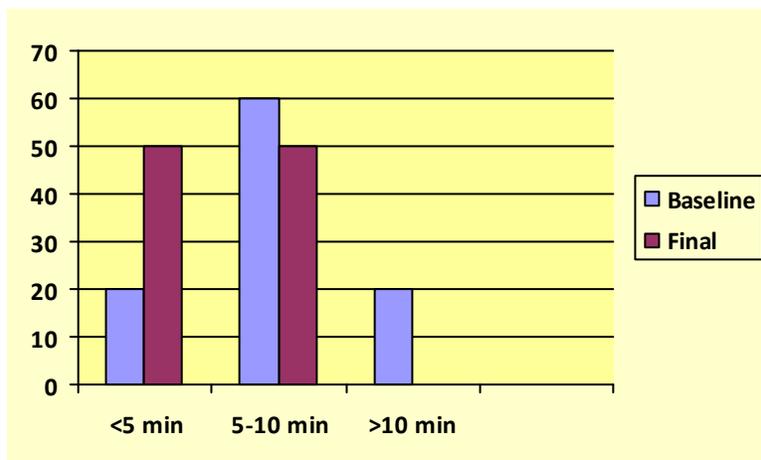
Service provided by pharmacists	Baseline %	Final %
Respected privacy and confidentiality	20	75
Explained the importance of getting tested before taking any treatment	0	75
Advised FSW mystery client to get tested for HIV	0	25
Advised FSW mystery client to get tested for STIs	0	50
Advised that the partner get tested	0	50
Recommended condom use	0	0
Provided written referral to Tanadgoma	0	25
Provided IEC materials	0	0
Treated FSW mystery client positively	0	70

Mystery Client #3 (Men Who Have Sex With Men)

Scenario: The mystery client is a young man having sex with a man. Usually, he uses condoms. However, a week ago, he had unprotected sex with the man, whom he knew just a little, and he is now noticing the following symptoms: some discharge, redness, and painful anal erosion. He is afraid these might be symptoms of HIV. He wants to buy medication to eliminate the symptoms.

Duration of visits with pharmacists: At baseline, the majority (60%) of MSM mystery client visits with pharmacists were from five to ten minutes in duration. At the end of the intervention, 50% of visits lasted less than five minutes, and the other 50% lasted longer than ten minutes. (See Figure 8.)

Figure 8. Duration of MSM mystery client visits with pharmacists.



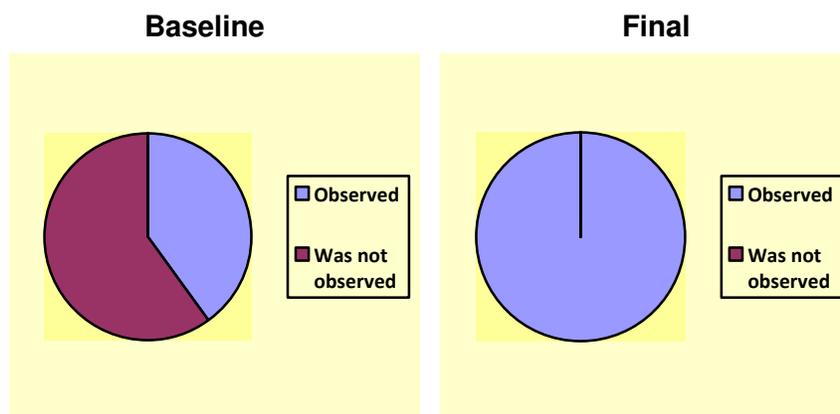
Privacy and confidentiality: At baseline, in 60% of cases, the privacy and confidentiality of the counseling session was not observed. Other people were present in the pharmacies during the MSM mystery client visits and had an opportunity to listen to the conversation between the pharmacist and the client. In one case, a pharmacist started to discuss the client’s problem with her colleagues. At the end of the intervention, pharmacists paid more attention to client privacy and confidentiality (Figure 9). In all cases, pharmacists ensured that no one could hear the conversation. In two cases, when other people entered the pharmacy during the conversation, the pharmacists lowered their voices or stopped the conversation until the visitors had departed.

We talked quietly with the pharmacist. When the other customers entered the pharmacy, they approached the second pharmacist and talked in a distance from us.

When I asked the male pharmacist if I could talk to him confidentially, he immediately came out of the counter and approached me. We stood in the corner of the pharmacy. During our conversation, three customers entered the pharmacy, but they did not hear our conversation, as the pharmacist spoke with me very quietly.

I approached a female pharmacist and asked her in a very low voice, “I want to talk to you but I’m so embarrassed.” The pharmacist asked me to talk a bit louder in order she could hear. But because the pharmacy was empty (there were only two of us), it was a convenient request.

Figure 9. Observation of privacy and confidentiality during MSM mystery client visits.



Counseling on STIs and HIV: With regard to asking questions of the MSM mystery client to clarify risk factors, end-of-intervention and baseline data were relatively similar. The importance of collecting information to evaluate a client's risk factors was emphasized at the training; however, only 50% of pharmacists asked the MSM client whether he had unprotected sex. In 75% of cases, the pharmacist told the client about STI risk. Both at baseline and end-of-intervention, not one pharmacist asked the MSM mystery client the following important questions, recommended in the counseling algorithm:

- When did you have unprotected sex?
- Did you have sex after that?
- Did you use condoms when you had sex after you noticed STI symptoms?

Both at baseline and end-of-intervention, no pharmacist told the mystery client about HIV risks.

I asked about HIV myself. The pharmacist answered: "Everything is written in the brochure, and the organization will tell you everything. Take it and go with God."

I told, "I am afraid that it might be symptoms of AIDS. The pharmacist replied, "Maybe, but you should go to this organization; there you will be tested."

At baseline, 40% of pharmacists offered the MSM mystery client anti-fungal or anti-allergy medication to treat STI symptoms. At the end of the intervention, 75% recommended that the client get tested for STIs and highlighted dangerous consequences of self-treatment.

You correctly think that your symptoms are related with the fact that you had unprotected sex. Judging by what you said, I won't be able to explain you everything you need to know about this problem till the next morning. I can give you brochures to read and advise to go to this organization. They will tell and explain to you everything.

There is nothing embarrassing in what you ask. Please do not start self-treatment.

You should be tested first....

No, I will not give you medicine. Please go to Tanadgoma. You will be explained there everything in details.

All pharmacists recommended the MSM mystery client get tested for STIs, and 75% of pharmacists recommended HIV testing.

If you had unprotected sex, you have to go there and get tested....

At both baseline and the end of the intervention, not one pharmacist recommended that the partner of the MSM mystery client be tested.

Referral: From baseline to the final MSM mystery client visit, the percentage of pharmacists who referred the client to a clinic for STI testing rose from 60% to 100%. End-of-intervention results showed that 100% of pharmacists referred the MSM mystery client to Tanadgoma for STI testing (Figure 10), and provided the correct address and telephone number (versus 0% at baseline).

In addition, there was improvement in referral of the MSM mystery client for HIV testing. At baseline, not one pharmacist recommended the client be tested for HIV. At the end of the intervention, 75% of pharmacists recommended HIV testing.

Additionally, 75% of pharmacists provided the MSM mystery client with a referral card. In one pharmacy (undergoing renovation), the pharmacist could not find a referral card, but wrote down the contact information for Tanadgoma and Bemoni on a piece of paper and gave it to the client.

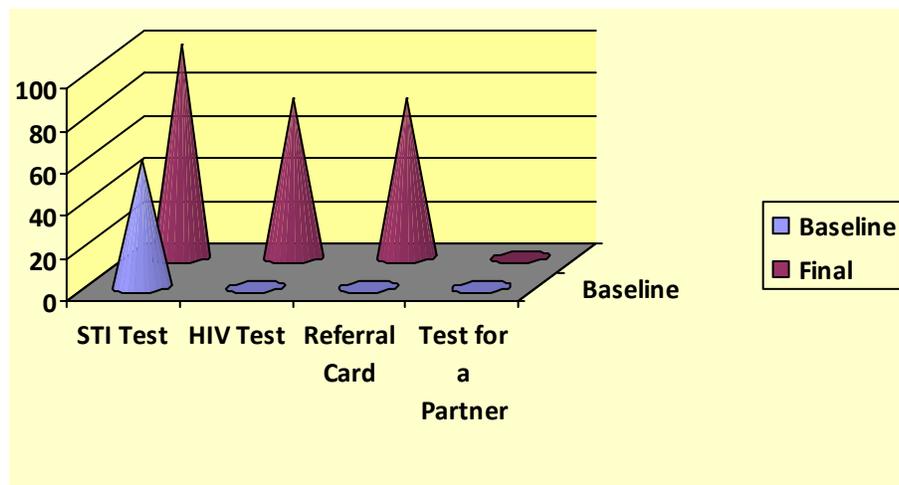
When you give them this referral card with the special number here, they will know that you came from a pharmacy.

Having written down the title, address, and contact phone of the organization on a piece of paper, the pharmacist looked at the clock and confirmed the time and said to go there right now.

There is an address on this card. You can be tested there.

Here is a referral card for you. There is an address of the organization where you can receive counseling and testing. Everything will be free of charge, anonymous, and confidential.

Figure 10. Referrals provided to the MSM mystery client for STI and HIV testing.



Informational materials: At baseline, no informational materials were provided to the MSM mystery client. Following the intervention, 50% of pharmacists provided the client with the booklets, leaflets, and brochures on HIV/AIDS and STIs.

Before you reach this organization, these are brochures where you can read everything about STIs and HIV.

In the pharmacy undergoing renovation, the pharmacist was not able to find the IEC materials.

We are currently doing renovation of our pharmacy. I don't know where the brochures are and can't give them to you now.

Pharmacists' attitudes toward the MSM mystery client: At baseline, 80% of pharmacists treated the MSM mystery client positively. However, there was one case when a pharmacist treated the client aggressively and rudely.

At the end of the intervention, all pharmacists treated the MSM mystery client positively, listened carefully, and tried to help him (Figure 11).

The pharmacist was in a pharmacy alone. However, when I told her that I would like to talk to her on a private matter, she stood up, came out of the counter, and walked me to the pharmacy's corner.

The pharmacist smiled to me and talked to me politely. There was no aggression.

The pharmacist calmly talked to me and said at the end, "Take care of you."

For a client whom I played, it was a good and clear counseling session. He would definitely go to this organization.

The male pharmacist treated me very positively. He even accompanied me to the pharmacy's door.

When I directly told a young female pharmacist that I had discharge and anal erosion, she immediately blushed but continued communicate with me positively and without condemnation.

Figure 11. Manner in which the MSM mystery client was treated by pharmacists.

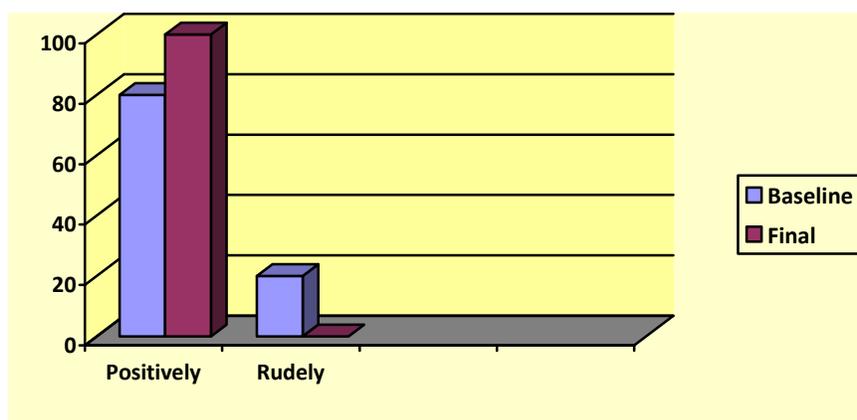


Table 8. Comparison of the baseline and final MSM visit results.

Service provided by pharmacists	Baseline %	Final %
Respected privacy and confidentiality	40	100
Asked whether MSM mystery client used condoms	0	50
Advised MSM mystery client about STI risks	0	75
Explained the importance of getting tested before taking any treatment	0	75
Advised MSM mystery client to get tested for HIV	0	75
Advised MSM mystery client to get tested for STIs	0	100
Explained that testing is free of charge and anonymous	0	50
Provided written referral to Tanadgoma	0	100
Provided IEC materials	0	50
Treated MSM mystery client positively	80	100

In-Depth Interviews with Pharmacists

A total of eight in-depth interviews with pharmacists were conducted by the PATH project officer and PATH consultant in Russian (three interviews with chief pharmacists and five interviews with pharmacists). The majority of the participants demonstrated poor knowledge of Russian; their language skills varied from being able to maintain satisfactory dialogue to being able to formulate their responses only in Georgian. In this case, we used translation provided by GHPP and Tanadgoma representatives.

The interviews explored the following main topics:

- Role of pharmacists in STI/HIV prevention.
- Experience in counseling and referring MARPs for STI/HIV testing.
- Barriers that prevent MARPs from seeking services at pharmacies.
- Barriers that prevent pharmacists from conducting counseling.
- Use and effectiveness of IEC materials and counseling algorithms prepared by the project.
- Relevancy of support from the project, including monitoring visits and on-the-job training.
- Achievements and barriers in implementation of the intervention.
- Recommendations regarding the intervention.

Role of Pharmacists in STI/HIV Prevention

The research team tried to clarify what pharmacists think about their role in preventing STIs and HIV after seven months of the pharmacy intervention. All interviewees felt that their role in STI/HIV prevention is important. They considered that it is their duty and responsibility to provide information, including information on STIs and HIV, to their clients regardless of who they are.



Pharmacists should know about HIV. This is their responsibility.

It is pharmacist's duty to tell everything she knows to the customer, including FSW.

I will do anything to help.

One pharmacist mentioned that a possible role they might play is to talk to young people, especially men, to educate them on how to protect themselves from STIs and HIV.

All pharmacists noted that the knowledge and skills they received during the training were important for them and helped them in their work. Of particular importance: syringe disinfection, the 'window period',⁸ and how HIV is transmitted. Many topics were familiar to the pharmacists,

⁸ The 'window period' is a term used to describe the period of time between HIV infection and the production of antibodies. During this time, an antibody test may give a 'false-negative' result, which means the test will be negative, even though the person is infected with HIV. To avoid false-negative results, repeat testing is recommended three months after potential exposure to HIV infection.

and the trainings helped them to look at those issues from a different angle. Other topics were completely new.

Knowledge that we received at the training was very important for us.

Training was very timely and useful for me. I used the gained knowledge in my work. For example, that HIV test should be repeated because of the window period.

Pharmacists not only used the information in their own pharmacies while serving clients, but also shared it with their friends, families, and others.

I told my brother and gave him booklets so he could distribute them also at the store where he works.

Also, as one of the pharmacy heads indicated, the trainings boosted courage and freedom to overcome shame and fear to discuss sensitive topics with clients.

This training gave us more bravery and freedom to discuss such intimate topics. We are not ashamed anymore to talk about this with our clients. Pharmacists could overcome this barrier. This is probably the most important result of the training.

However, all pharmacists expressed regret that despite the fact that they really wanted to apply the knowledge and skills received during the training, and help people, they were not able to do so, as opportunities for counseling were very limited. Clients either did not visit the pharmacies during the implementation period (in the case of IDUs, who stopped seeking syringes for injection drug use and started using oral pills after the MIA began arresting IDUs caught using intravenous drugs), or when they did, did not initiate conversation or refused to talk with the pharmacists.

Also, some pharmacists mentioned that the project—although important—was not timely because the situation with IDUs had changed. The intervention could have been very successful earlier, prior to the winter of 2011.

I expected that there would be large demand from IDUs, but it did not happen.

They don't come to the pharmacies. Earlier, in the fall, women (FSWs) were coming, and IDUs....

This intervention is good and needed in Georgia. However, the problem is that people don't approach us with such questions. Formerly, this project would be more successful as there were a lot of IDUs. Now there is almost none of them.

Experience in Counseling and Referring MARPs for STI/HIV Testing

Injecting Drug Users

The research team tried to clarify how pharmacists perceive their capacity and ability to initiate and provide counseling on STIs and HIV. Almost all pharmacists pointed out that they did not have an opportunity to conduct a single counseling session for IDUs.

IDUs don't ask.

I only put referrals in the bags. Nobody [IDUs] asked any questions.

One pharmacist noted that there had been clients recently who had asked for information, but that they were not “real” clients, meaning they were the mystery clients; prior to their visits, no clients had sought information.

Two days ago, there was some case. I think it might be your mystery clients, as there were no such visitors in our pharmacy before.

Some pharmacists reported that they had an opportunity to provide counseling to IDUs one or two times in the previous seven months. The visitors had been anxious to obtain information and had asked for it.

Only one or two times, I could talk about HIV with IDUs. They asked about testing and whether it is confidential. It was easier to communicate with them, as they approached me. One IDU even said, "I don't like to take drugs, but what can I do? I got used to that."

I know one IDU. He comes to us. I provide complete counseling to him, and he continue coming to us.

The pharmacists felt that it was impossible to broadly provide counseling for IDUs, as they do not seek it, nor ask questions of the pharmacists to initiate counseling or referral. Almost all pharmacists underlined the change in drug use, from injection drugs to oral pills, and that drug users no longer consider themselves at risk of intravenous transmission of HIV and hepatitis. They receive the same effect with the oral pills, purchased at a lower price.

Half of respondents mentioned that IDUs are usually in a hurry, thus avoid long contact, and they are scared of police harassment. (One benefit of pills in that regard is that they can be swallowed quickly, inside the pharmacy.)

At the same time, due to new regulations, some pills that are popular among IDUs (including Lyrica[®] and khilimon) will no longer be sold without a prescription, so some pharmacists expect that drug users may return to injecting.

The number of injecting drug users decrease significantly; however, there are a lot of those who take pills.

They switched, but it is possible that they will return to syringes, as we will not sell Lyrica[®] and khilimon without prescription now.

...he came again to buy syringes and medicine to prepare drugs at home. So I think that they might start using injecting drugs again.

Pharmacists' opinions regarding the use of surveillance cameras in their pharmacies and the possible effect on IDUs split equally. One group of pharmacists considered cameras to be an additional barrier for IDUs in turning to the pharmacies for help.

For IDUs, it [camera] is a large barrier; they might not come to pharmacy at all or can be very careful.

The other group did not expect the cameras to change the behaviors of IDUs.

Surveillance camera is not a barrier.

It is hard to see who by what. Besides, IDUs might don't even notice that camera.

People with Symptoms of a Sexually Transmitted Infection

When pharmacists were asked whether their clients approached them with questions about STIs and HIV, most respondents stated that there were no such clients; therefore, they did not provide counseling to people with STI symptoms.

There were no cases that a person came without prescription and asked questions.

No, nobody came after unprotected sex, or with questions about STIs.

The pharmacists explained that improved STI medical services and better access to medical care was the reason for this, as clients with STI symptoms visit pharmacies for prescriptions after having been diagnosed by a doctor. As previously noted, people with STI symptoms asked for advice and pharmacists provided antibiotics and anti-fungals with directions for use of the drugs, but over the previous seven months, nobody approached them for counseling.

People don't ask about STIs or ask seldom. They are ashamed. It is easier to go to a doctor. I remember that earlier, people did not have money and it was expensive to go to the doctor. So, then every other person had such questions, and I was tired to respond to them....

There was no case that people asked questions. I inserted referrals in the shopping bags.

Some respondents mentioned that they managed to conduct counseling regarding STIs once or twice.

There was a woman with STI symptoms. I recommended her to use condoms and go to the doctor and gave her yellow referral card.

People Seeking Services After Unprotected Sex

More than half of respondents did not remember a single instance when they were asked for information or could provide counseling in the case of unprotected sex.

I don't remember that I talked to somebody about this, but I provided referral cards in 10-20 cases.

There were such cases. Even if a condom was broken, they would not talk about this. For some reason, it is shameful to them.

That clients did not seek information on STIs did not surprise the pharmacists; they explained the tendency toward shyness on the subject (further explored below), and that clients receive advice from doctors on testing and treatment.

If I start to talk, they get ashamed and leave even without booklets. That is why in such situation, I just insert the booklet. She will read it later.

All respondents confirmed that condoms are available and accessible in their pharmacies. They are purchased more often by men. Pharmacists assumed that women who purchased condoms late in the day were involved in commercial sex, and gave them referral cards and informational materials. Some respondents provided counseling, although in two cases, it was incomplete, as the information on HIV scared the clients.

There were one or two cases when I provided counseling.

When I started to talk about HIV, they left, as they don't think that they can get it.

An indirect indicator related to unprotected sex was the demand for emergency contraception. The majority of respondents mentioned that Postinor® had been requested by clients, although in limited number. Interestingly, in two cases, the medication was purchased by men, and the

pharmacists did not provide counseling, as they did not consider it appropriate for men, but they did provide IEC materials with the purchase.

We do have Postinor[®], but people ask for it not often. I remember a young man asked for emergency contraception after a broken condom. I responded to all his questions and provided with materials, including referral card.

For the last few months, only once I was asked for Postinor[®].

The respondents mentioned that even in cases when Postinor[®] was requested, they did not initiate a conversation, since customers asked only for the medication and not for information. In some cases, pharmacists provided women with a referral card.

If a person asks only for Postinor[®], it is hard to start conversation if he/her doesn't ask any.

I remember a woman who asked about Postinor[®]. She was calm and did not have any questions. I was hard to say that she was nervous and she looked like she knows what she needs. She only asked for pills, so I did not offer her anything other than that.

I provided them with yellow referral card. Some young girls asked for emergency contraception. It means that there was unprotected sex and risk of STI/HIV. If they asked how to take the pills, I explained.

At the same time, based on the explanations of the pharmacists themselves, it became clear that some client visits had been conducive to initiating counseling—or at least some conversation. However, the pharmacists did not take advantage of these situations, either for the reasons mentioned above (fear, shyness, unwillingness to intrude into a person's private life) or simply due to a lack of skills to recognize the relevancy and opportunity to help.

There was one case; a woman asked for an abortion pills. I said that without doctor, cannot give anything. Her term was large. She asked what can be done. She, of course, said that it is not for her. It is for her girlfriend. We advised her to go to the doctor. She said that she cannot go to the doctor and asked for some drug. At this time, another customer came, and that woman left.

There was a girl that had unprotected sex. She asked for emergency contraception, but she did not know time when the pill is effective. So, we recommended her to go to the doctor. There were a few cases when customers asked for pills and then left.

In terms of other risk groups, with a higher risk for STIs as the result of having unprotected sex, several pharmacists mentioned women involved in commercial sex. Two respondents reported that FSWs no longer visit their pharmacies.

I did not see FSWs and MSM in our pharmacy.

In the past, I saw them everywhere, even in front of our pharmacy. And now, there are much less of them on the streets. It is prohibited. Maybe they switched to work in the saunas....

Barriers that Prevent MARPs from Seeking Services at Pharmacies

The pharmacists listed a number of reasons that, in their opinion, prevented the target audiences from seeking help in pharmacies. First, all the pharmacists felt that shyness is an

obstacle. Clients of a pharmacy usually come from the same neighborhood and have attended the same pharmacy for many years and know each other.

Our customers are our neighbors. We know each other, and they are ashamed to ask.

They are ashamed to ask. They are afraid that their neighbors will know about them.

Most respondents also said that clients are uncomfortable talking about private issues such as HIV risk, suspicious symptoms, or unprotected sex; that Georgians are very protective of their privacy.

Nobody asked for counseling. Never. This is probably “complex” of Georgian nation.

Another barrier, according to pharmacists, is fear of a confidentiality breach and prejudice toward vulnerable groups.

Person can think that a pharmacist will not keep his/her secret and share information with others. They are afraid of blame. They don't know who that pharmacist is....

Some respondents also mentioned a lack of understanding by MARPs on the importance of STI and HIV risk.

Maybe it is not important issue for them. If there are some symptoms, they think that they will go away by themselves. They underestimate the complicity of the situation.

Some pharmacists connected reluctance of the target groups to approach them with questions with a preference for consulting doctors. STI testing and treatment are very expensive, but those who can afford it can also afford to visit a doctor, and would prefer to do so, rather than discussing their problem with a pharmacist.

STI diagnostics and treatment is still very expensive. If a person can pay for that, she/he would rather to the doctor than discuss it with a pharmacist.

Also, as some pharmacists reported, vulnerable groups now receive better access to medical care due to changes in the medical insurance system in Georgia to include insurance packages designed for socially unprotected groups.

We have medical insurance company now. Doctor's consultation is practically free of charge. There is different medical insurance—for middle class; however, there are also some packages for socially vulnerable groups. It is not large; however, enough to go to the doctor.

Medical insurance is now obligatory. This is a law. If you work somewhere, your employer is obliged to provide you with insurance.

But other respondents expressed concern on this issue:

I doubt whether our target groups have a chance to get medical insurance. They usually don't work. How they can get medical insurance? Of course, you can get medical insurance individually, but it's expensive. Where will they get money for that?

Some respondents pointed out that MARPs may not be aware that pharmacists are knowledgeable on issues of STIs and HIV.

Maybe they think that pharmacists don't know about STI/HIV....

Barriers that Prevent Pharmacists from Conducting Counseling

Most pharmacists did not feel discouraged from conducting counseling and providing referrals, although they provided other reasons why they had not initiated counseling during the intervention. According to most, it was because their clients had not requested counseling.

It is uncomfortable to do until the first question from the customer. It is difficult for pharmacists to initiate dialogue, as they don't know how the customer will react.... Will he/she like it or will become aggressive? However, if there is a question from a customer, pharmacist can counsel without a problem according to algorithm.

Without customer's desire, it is difficult to provide counseling. It can be insulting to the customer. We can distribute IEC materials and referral cards without a problem.

All pharmacists felt that sensitivity regarding STI/HIV-related issues is a major barrier. The vast majority of participants claimed that they are comfortable discussing such issues, but they are mindful of long lines in the pharmacy, being busy, and having limited time for clients' queries, as well as being afraid of client reaction to their initiation of such a discussion (incomprehension, misunderstanding, aggression, etc.). In addition, again, the vast majority of pharmacists emphasized that Georgians are very mindful of tact and privacy and that initiating a conversation on intimate topics is not the norm. Thus, pharmacists felt comfortable only including referral cards or informational materials with purchases.

Why I don't initiate counseling? It is hard when there is a line in a pharmacy. However, nobody asks for that.

It is Georgian mentality not to initiate conversation, don't trouble people with your advice, especially with such intimate issues.

I am afraid that she will become aggressive and that it is not my business.

Yes, there was a barrier. I am afraid that there might be some aggressiveness or some inadequate reaction from the client.

Use and Effectiveness of Project IEC Materials and Counseling Algorithms

All respondents said they kept the counseling algorithms conveniently located, so if counseling was needed or requested, they were easily accessible.

Algorithms and booklets are in the same place and accessible. Everything is clear. If there are people to counsel, we would use them.

They are placed close to us. If a client asked about something, I then read it one more time.

It is great, if you know ahead of time how to respond to people.

All of the pharmacists gave positive feedback on the content, quality, and structure of the counseling memorandum and algorithms, and did not see the need for revisions.

Nothing should be changed. I like it. Brief. In my opinion, it is very good and professional materials.

They are useful. Problem is not in algorithms, but in the customers. They are not open for such conversation.

In terms of distribution of and customers' reactions to the referral cards, all respondents reported that the referral cards were very useful in informing clients of available services. All pharmacists, even those who were wary and did not initiate or provide counseling, distributed referral cards to the target groups.

The pharmacists determined which referral card to provide based on the request or the type of medication purchased. A limited number of cards was distributed, which corresponded in part to the low number of requests from the target groups. More blue referral cards (for IDUs) were distributed than yellow cards (for people with STI symptoms).

Yellow card was inserted in a package when women bought Pharmatex or some suppositories.

They never had questions. They buy something very fast and run. We inserted materials and a card in the package. Some asked, "What did you put in my package?" We explained, "This is information. Read it." They did not refuse.

Another reason for the low number of cards distributed: Half of pharmacists reported that they do not get new clients; their clients are repeat customers, and they did not provide referral cards on return visits.

The group of IDUs is the same. I don't see unfamiliar faces. There is maximum of 15 IDUs whom we serve here.

The same person is coming all the time. I can give him a card only once.

Respondents complained that it was difficult for them to decide which clients should receive the informational materials and a referral card, as they could only guess which risk group the customer belonged to, and they were afraid of backlash as a result of misidentifying a customer.

There was aggressiveness. Some of IDUs threw out the brochures or read them and left in the pharmacy.

At the same time, some respondents remarked that they did not experience resistance or aggression from clients.

...there was no aggressiveness or negative reaction.

I did not see any aggressiveness and nobody threw materials out.

When asked about the poster informing clients that the pharmacists had received training on STIs and HIV, placed in all participating pharmacies, all pharmacists noted that it did not generate requests from clients, as planned.

People read it while standing in the line, but nobody asked about HIV.

Relevancy of Support from the Project

All respondents indicated that pharmacy monitoring visits were conducted on a regular basis.

There were monitoring visits and pretty often. Eight pharmacists work in our pharmacy. So they came often in order to talk to people working on different shifts.

They often visited us. I am not at work every day. I personally met with them three times.

The visits usually included inventory of IEC materials and referral cards, recording the number of clients for the period, review of counseling algorithms, handling of referral cards, and discussion of any problems.

Counted the number of booklets distributed. Asked about counseling that we conducted.

During those visits, we discussed counseling algorithms and how to behave in different situation.

The main problem raised during the monitoring visits was the absence of clients and, therefore, lack of opportunity to provide counseling or referrals.

The most important problem: decreasing the number of clients.

Pharmacists informed Tamuna that there were not clients, and we could not distribute the referral cards. I also asked her what we should do. We really wanted to help. Don't think that we missed something or did not want to do it. We hoped that there would be more clients interested in our help.

The pharmacists were aware that they could contact project staff if they had problems, but they did not have any, so there was no need for additional support.

We got so much information at the training, so there was no need to ask for additional help.

I did have a chance to ask questions, but did not ask anything, as there was no time and a lot of customers in the pharmacy.

With regard to refresher trainings, half of the pharmacists mentioned that they took part in on-the-job training, conducted in the form of short meetings not usually exceeding 15 to 30 minutes for pharmacists who were free at the moment. Information was presented in the form of a lecture on how to handle the booklets, understanding of algorithms, etc. The other half of the respondents remarked that they did not know of such training or did not comment on the topic.

Those pharmacists who were free participated in on-job training. Usually, it took 15-30 minutes.

Once there was training. They discussed algorithms and how to distribute booklets. Also, they asked questions regarding who was coming to the pharmacy. I did not participate in such training, and nobody discussed algorithm with me.

I don't know. Maybe I was not at work on that day.

Achievements and Barriers in Implementation of the Intervention

The pharmacists reported that the intervention increased their knowledge on HIV, STIs, and hepatitis; provided them with a greater sense of responsibility toward helping vulnerable groups; and influenced their communication with clients in general.

My colleagues changed their attitude to the problem. They became more interested, began to provide more information, and better communicate with clients.

I did not think about this problem before the training, but now I think that this is my responsibility to provide information and help people. It became my duty.

Attitude towards vulnerable groups changed. Training helped us to look at those people differently. I even could not recommend them condoms before because of shame. Not anymore.

Even though the research team did not ask the respondents to comment on their attitudes toward vulnerable groups, most pharmacists mentioned they felt some sympathy toward IDUs. They felt the intervention was particularly important for drug addicts, but not as beneficial for people with STI symptoms, as the information could not be practically applied by such clients.

Pharmacists think that this project is important, especially in providing HIV information to IDUs. Regarding STI symptoms, it is not so useful, as it is difficult to apply in real life.

Pharmacists reported that the main barrier to implementation of the intervention was absence of clients, about which they were disappointed; they had been looking forward to providing information and referrals to clients, but there was no response and their initial enthusiasm decreased.

It appeared that my knowledge is not needed and I cannot share it. Maybe those five-six people with whom I talked took advantage of that information. Maybe without this information, they would vanish. However, I expected different effect. I expected more people to help.

We thought that people would come to us and felt well-prepared to help them and do something good for others.

What can we do if people don't come for our help? I think that everything was done to provide them with help, but they don't come. What can we do? Where can we find them?

Among other reasons noted by pharmacists for not conducting counseling: a decrease in the number of customers in general due to growth in the pharmacy market and the opening of additional pharmacies; a decrease in the number of IDUs due to the changes in MIA legislation; and expansion of insurance coverage, and thus greater access to doctors.

There are a lot pharmacies now. People don't want to stay in lines. We have now 150-200 customers daily, and we used to have 1,000 customers before.

The number of IDUs and FSWs decreased dramatically. Maybe there so many pharmacies on Tsereteli Street, so they just don't come to us.

Situation in Georgia changed now, became better. It is noticeable that drugs are not coming to the country. Police is more strict now and controls the situation better. Profiteers are not at each corner as it used to be before.

Recommendations Regarding the Intervention

When asked for their opinion as to whether the intervention should be continued or stopped, there was no consensus among respondents. Half of pharmacists responded that the intervention should be stopped, as they had done their best but there were no clients and the expenses were not justified.

I think that intervention is not effective. Clients don't come; they are not attracted.

I would suspend intervention in our pharmacy at this stage. We don't know IDUs' reaction to those cameras yet. Even without camera, we did not have a lot of clients.

I don't think the intervention should be continued in its present state.

A third of the pharmacists commented that they would like to keep the IEC materials and referral cards available, since the oral pills preferred by drug users would soon become available only

by prescription, and sold only in special pharmacies, which could bring about an increase in injection drug use that would bring IDUs back to the project pharmacies. These participants said they would not mind distributing informational materials to relevant visitors.

You did everything.... I would leave those booklets and cards in the pharmacies. Maybe you should inform general population about pharmacy intervention, so more people know about it....

Don't take away booklets. Let them be in the pharmacies in case somebody comes.

Some participants emphasized that the main rationale for determining if the intervention should continue should be cost-effectiveness.

If you asked me today whether to continue intervention or not, I would say that there is no much expenses, we should continue. If it is expensive to continue, then we should stop and look for other possibilities.

We like this project; it is useful. However, a lot of money was invested, but people don't come with questions and the number of IDUs decreased.

Pharmacists suggested two recommendations if the project continued: expand to additional pharmacies, with some modifications, and use other channels and strategies. Pharmacists suggested including pharmacies closer to train stations, where large numbers of commuters gather, and pharmacies near sites where target groups are known to gather. They suggested that large, colorful posters should be produced to attract clients' attention, as well as pocket-sized IEC materials for target groups (particularly for IDUs). In addition, a representative from an HIV service NGO could be on duty in a pharmacy, so clients could be directly referred for counseling and expert assistance.

There are pharmacies where there are always a lot of customers. For example, at the railway station. There, many women there, and IDUs. Maybe you should try there.

Place bright posters at the pharmacies to attract attention. I think customers will ask questions then.

IDUs sometimes hid syringes and left packages in the pharmacy. It seems to me that they were afraid to carry booklets. Maybe we should make informational materials of smaller size to fit in the pocket and it should not be clear that they are developed directly for people taking drugs.

If a representative of NGO is present in the pharmacy, pharmacist would refer a client to him. We don't know if the client would go to NGO, but if it is in the pharmacy, it might work....

One pharmacist suggested that a different training model should be employed at the national level for increasing awareness of pharmacy personnel. One or two people from 100 pharmacies could receive a short training, and could then return to their pharmacies and educate their staff, and in three months, invite them for refresher training. The pharmacist did not think this would be very costly.

I would do this intervention in the pharmacies, but in a large pharmacy network. All pharmacy staff should know basics, key information. One-two people in the pharmacy should be experts on those issues. If one person from 100 pharmacies in Georgia is trained, they can train their pharmacy staff. In three months, they can have a refresher training, and then another one if needed. It should not cost a lot of money.

Conclusions

Analysis of the monitoring, baseline, and end-of-intervention evaluation data measured the extent to which the project enhanced the capacity of pharmacies to provide high-quality services to vulnerable groups, with a technical focus on HIV risk identification and referral. The data showed an increase in knowledge among trained pharmacy staff on key HIV, STI, and hepatitis issues and better referral for additional services, as follows:

- The majority of mystery clients received key informational messages on HIV, STIs, and hepatitis.
- One hundred percent of pharmacists recommended that the IDU mystery client get tested for hepatitis B (an 80% increase from baseline) and hepatitis C (a 60% increase from baseline).
- Seventy-five percent of pharmacists emphasized to FSW and MSM mystery clients the necessity of STI testing before starting any treatment (versus 0% at baseline).
- All pharmacists advised the MSM mystery client to get tested for STIs, and 75% also advised HIV testing.
- Fifty percent of pharmacists advised the FSW mystery client to get tested for STIs (versus 0% at baseline).
- One hundred percent of pharmacists provided referral cards to IDU and MSM mystery clients, with key messages and contact information for Bemoni Public Union and Tanadgoma.
- In 100% of cases, pharmacists respected privacy and confidentiality for IDU and MSM mystery clients, and 75% of pharmacists did the same for the FSW mystery client (a 60% increase from baseline).
- The percentage of pharmacists who treated the FSW mystery client positively rose from 0% to 75%.
- The proportion of pharmacists who recommended that FSW partners get tested for STIs rose from 0% to 50%.

However, the end-of-intervention mystery client visits demonstrated the following problems:

- None of the pharmacists advised the IDU mystery client to get tested for HIV and STIs, although the mystery client initiated conversation.
- Only 25% of pharmacists recommended that the FSW mystery client get tested for HIV and referred her to Tanadgoma.
- In all cases, pharmacists did not recommend that mystery clients use condoms for HIV prevention.

At the same time, 50% of pharmacists provided the MSM mystery client with IEC materials on HIV, STI, and hepatitis prevention, and 75% of pharmacists did the same for the IDU mystery client (versus 0% at baseline). In this way, the lack of verbal information provided by the pharmacists was compensated by the availability of printed materials. Also, pharmacists referred mystery clients to local HIV service NGOs, where they could receive more complete information.

The following conclusions can be drawn from the evaluation results:

1. Pharmacists clearly understood their important role in STI, HIV, and hepatitis prevention and considered it their responsibility to provide information to clients. The vast majority of pharmacists interviewed felt that they could be involved in STI, HIV, and hepatitis prevention by referring clients to NGOs that provide services to MARPs, and by distributing IEC materials by inserting them into packages containing purchases.
2. All pharmacists highly rated PATH's training and noted that the knowledge and skills they received during the training were important for them and helped them in their professional activities.
3. The pharmacists' attitudes toward vulnerable groups changed considerably:
 - At baseline, 53% of pharmacists treated mystery clients positively; 27% with indifference; and 20% were rude and aggressive and did not provide the mystery clients with any information, trying to get rid of the clients instead.
 - Post intervention, the majority of mystery clients (83%) stated that pharmacists were friendly and positive; they listened carefully and did their best to help. Only 17% of mystery clients reported that they felt they had been treated with indifference. However, in each case, the pharmacist did provide a referral card at once and tried to refer the client to a recommended NGO.
4. There was a considerable improvement in the pharmacists' understanding of the necessity of ensuring client privacy and confidentiality. Mystery clients reported that pharmacists did their best to ensure that no one could hear their conversation: they lowered their voice or stopped the conversation until other visitors left; they immediately came out of the counter and asked the mystery client to come to the side, so no one could hear them; they asked their colleagues to serve the other pharmacy clients so they could continue their conversation with the mystery client.
5. Although pharmacists' knowledge and attitudes toward the target groups had improved by the end of the intervention, and mystery clients received much better information and more referrals than at baseline, in the majority of cases, mystery clients did not receive counseling, and pharmacists did not follow the algorithms. Despite extensive education efforts, the majority of pharmacists still did not want to initiate conversations with their clients about STIs, HIV, and hepatitis. Pharmacists provided the following reasons:
 - Lack of clients at risk for HIV, STIs, or hepatitis, which they found disappointing; they were ready to provide information and referrals to clients but there were no opportunities, and their initial enthusiasm diminished.
 - An overall decrease in customers due to growth in the pharmacy market, resulting in an increase in neighborhood pharmacies.
 - Reluctance of pharmacy clients to talk about sensitive and private issues.
 - Fear of rudeness and aggressiveness from IDUs.
 - Fear of offending or stigmatizing a client.
 - The cultural norm in Georgia to refrain from discussing private and confidential issues in a pharmacy: fear of shame, embarrassment, disgrace, and damage to reputation.

Pharmacists reported that counseling on HIV, STI, and hepatitis prevention with members of vulnerable groups is possible only when a client initiates a conversation and asks direct questions, provided that the conditions in the pharmacy allow for it (lack of additional customers, or the presence of another pharmacist to help with other customers, etc.).

6. A small number of clients can perhaps be explained by the fact that Aversi was never mentioned by the vulnerable groups as a preferred pharmacy network. According to the baseline assessment results, clients usually attended GPC or PSP pharmacies which were initially suggested by PATH as preferred networks for intervention. In addition, five Aversi pharmacies was too small number to see sufficient quantity of the target group clients. Also, pharmacists emphasized that at the beginning, they distributed information to IDUs; however, they generally serve repeat IDU customers, and pharmacists did not give them information each time they visited.
7. Pharmacists reported a dramatic decrease in the number of IDUs who visited their pharmacies, beginning in February 2011. This was the result of an intensive campaign by the MIA to arrest and incarcerate IDUs, and the Ministry's requirement that outside surveillance cameras be installed at pharmacy entrances. In addition, a ban was placed in effect, disallowing the sale of certain drugs without a prescription, including Lyrica® and khilimon, popular among IDUs.

Recommendations

Training pharmacists and providing ongoing support to pharmacies through monthly monitoring visits is a feasible approach to improving pharmacists' ability to counsel and provide accurate information to high-risk clients. The pilot pharmacy intervention showed that pharmacists' knowledge and counseling skills around HIV, STIs, and hepatitis significantly improved, and all mystery clients received information that was not provided at baseline; however, pharmacists' motivation deteriorated with time, as they did not receive many MARP clients, nor were clients willing to initiate conversations with pharmacists.

The pilot pharmacy project in Tbilisi showed that it is not feasible for pharmacists to spend a lengthy amount of time counseling clients. On average, pharmacists could spend less than five minutes talking to a mystery client. This time frame is enough to provide basic messages to vulnerable clients and to provide them with correct referrals and informational materials about STIs, HIV, and hepatitis.

If the MIA lifts some of its strict regulations regarding IDUs, and the pharmacy intervention is conducted in other pharmacies, the following lessons learned should be considered:

- It would be highly important to partner with the same pharmaceutical network that was initially involved in the baseline research (GPC).
- The number of participating pharmacies should be much more than five, to increase the likelihood that more members of vulnerable groups will be reached.
- It would be very important to gain the support and understanding of the pharmacy administration and chief pharmacists; if they are not supportive of the project from the very beginning, participating pharmacists will perform poorly despite all project team efforts.

- It would be highly important to efficiently plan and conduct monitoring visits to participating pharmacies. They should be conducted more than once a month depending on the number of questions, problems, and challenges that arise during project implementation.
- On-the-job training should be conducted at a highly professional level to address specific information gaps and problems that pharmacists face.
- Mid-term mystery client visits following refresher pharmacy trainings would be very useful for detecting and addressing problems with counseling and referrals in a timely manner.

One of the main reasons the intervention was interrupted was that during the first three months, only two people came for testing with referrals from pharmacists. However, it takes time for a person to accept the possibility of being infected with an STI or HIV and to change his/her behavior, so people may come for services later. In the PATH team's opinion, three months of active intervention during December through February (which included the January holidays) was not enough, and longer-term research is needed to determine if referrals to Tanadgoma and Bemoni Public Union can result in higher utilization of services and an increased number of vulnerable group members getting tested for STIs and HIV.

Counseling Pharmacy Clients about HIV/STIs

*November 24-25, 26-27, and 29-30, 2010
Tbilisi*

Agenda

Goal:

To enhance pharmacists' knowledge and skills of interpersonal communication and counseling of vulnerable populations on STIs, HIV/AIDS, and hepatitis prevention and to promote the establishment of an efficient referral system of pharmacy clients for further needed assistance.

Training Objectives:

- Present and discuss the results of the baseline pharmacy assessment;
- Provide information and practice skills of effective interpersonal communication and counseling;
- At the practical sessions, practice the main steps of effective counseling of pharmacy clients;
- Provide basic information on STIs, HIV/AIDS, and hepatitis necessary for providing counseling to the MARP pharmacy clients;
- At the practical sessions, work out a referral system and practice how to refer a pharmacy client for further assistance;
- Familiarize the training participants with the monitoring and evaluation system of the GHPP pharmacy intervention component.

Training Participants:

Pharmacy heads/deputy heads and pharmacists of five Aversi participating pharmacies; Bemoni and Tanadgoma social workers.

Interactive Training Methodology:

- Mini lectures
- Presentations
- Role plays
- Work in groups
- Discussions
- Individual exercises
- "Brainstorming" sessions
- Dynamic exercises

DAY 1

Activity	Time
<p>Opening</p> <ul style="list-style-type: none"> • Opening remarks and introduction of trainers. • Overview of the pharmacy component of the Georgia HIV Prevention Project. • Participants' introduction. • Review training objectives and agenda. • Presentation of the pharmacy HIV and STI assessment in Tbilisi. 	9:00 – 10:00
<p>Interpersonal Communication and Counseling</p> <ul style="list-style-type: none"> • Stages of behavior change process. • Overview of communication process and the basic elements of effective communication. Definition of counseling. • The effects of personal attitudes and values in communication and counseling. Perception and values. • Effective interpersonal communication and counseling skills. Verbal and non-verbal communication. • Barriers to effective communication and typical mistakes. 	10:00 – 11:00
<p>Coffee break</p>	11:00 – 11:15
<p>HIV/AIDS</p> <ul style="list-style-type: none"> • Overview of HIV/AIDS epidemic in Georgia and in the world. • HIV transmission and development of AIDS. • Overview of HIV diagnostics and treatment. • Prevention of HIV. 	11:15 – 13:15
<p>Lunch</p>	13:15-14:15
<p>Hepatitis B and C</p> <ul style="list-style-type: none"> • Importance of Hepatitis B and C prevention in relation to prevention HIV. • Symptoms. • Ways of transmission. • Hepatitis risk assessment. • Diagnosis and treatment. • Prevention. Hepatitis B vaccination. 	14:15 – 15:15
Activity	Time
<p>Other Sexually Transmitted Infections (STIs)</p> <ul style="list-style-type: none"> • What are STI? • Transmission of STIs. • STI risk assessment. • Consequences of STIs. 	15:15 – 16:15

Coffee break	16:15 – 16:30
Other Sexually Transmitted Infections (STIs) (continued)	16:30 – 17:45
Summary of the Day 1	17:45 – 18:00

DAY 2	
Activity	Time
Recap of DAY 1 and objectives for DAY 2	9:00 – 9:20
Emergency Contraception.	9:20 – 10:00
Types of Condoms and Their Role in STI/HIV Prevention.	10:00 – 11:00
Coffee break	11:00 – 11:15
Main Steps of Effective Counseling <ul style="list-style-type: none"> • Create pleasant and comfortable atmosphere for the patient. Privacy and confidentiality. • Collect information/ask questions. • Listen actively. • Provide information. • Use printed materials. • Get a feedback, check understanding, and encourage patient to ask questions. • Help patient to make a decision. • Make a referral. 	11:15 – 12:30
Counseling Clients at Risk of STI/HIV <ul style="list-style-type: none"> • Key messages and counseling vulnerable group representatives on STI/HIV prevention. Job aids. 	12:30 – 13:00
Lunch	13:00 – 14:00
Counseling Clients at Risk of STI/HIV (continued) <ul style="list-style-type: none"> • Using IEC materials. • Referrals and monitoring system. • Coordination with Bemoni and Tanadgoma. Meeting the representatives of partnering organizations. 	14:00 – 15:30
Practicing Skills on Counseling Clients about STIs/HIV <ul style="list-style-type: none"> • Role plays 	15:30 – 16:00
Coffee break	16:00 – 16:15
Practicing Skills on Counseling Clients about STIs/HIV (continued)	16:15 – 17:30

DAY 2

Activity	Time
• Role plays	
Training evaluation.	17:30 – 17:45
Summary and closing	17:45 – 18:00

Attachment 2

Referral Cards Supplied by PATH and Distributed by the Pharmacies

Referral cards for IDUs

English translation of referral card is provided below.

Face

ინექციური ნარკოტიკების მოხმარებლები იმყოფებიან ადამიანის იმუნოდეფიციტის ვირუსით (აივ), სქესობრივი და სისხლის გზით გადამდები სხვა ინფექციებით (სგგი, ჰეპატიტი B, C) დაინფიცირების მაღალი რისკის ქვეშ, თუ ისინი:

- ინექციური ნარკოტიკების მოხმარებისას იყენებენ საზიარო შპრიცს ან ნემსს;
- ნარკოტიკის ხსნარის მოსამზადებლად იყენებენ საზიარო ჭურჭელს;
- აქვთ დაუცველი (პრეზერვატივის გარეშე) სქესობრივი კავშირი.

დაინფიცირების თავიდან ასაცილებლად (აივ, ჰეპატიტი B, C და სგგი):

- შეწყვიტეთ ნარკოტიკის მოხმარება!
თუ მაინც მოიხმართ ინექციურ ნარკოტიკებს:
- ყოველთვის გამოიყენეთ ერთჯერადი, სტერილური შპრიცი!
- გამოიყენეთ ინდივიდუალური, სტერილური ჭურჭელი ნარკოტიკის ხსნარის მოსამზადებლად!
- გამოიყენეთ პრეზერვატივი ყოველი სქესობრივი კავშირის დროს!

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მხოლოდ ტესტირებით არის შესაძლებელი გამოვლინდეს, არის თუ არა ადამიანი ინფიცირებული აივ-ით და ჰეპატიტით

აივ-ზე და ჰეპატიტზე კონსულტირება და ტესტირება, აგრეთვე კონსულტირება სქესობრივი გზით გადამდებ სხვა ინფექციებზე შესაძლებელია:

- უფასოდ
- ანონიმურად
- კონფიდენციალურად

საზოგადოებრივ გაერთიანებაში "ზემონი", მისამართზე:

ქვეთარამის 16, თბილისი
სამკურნალო კომბინატი, VII სართული
სამუშაო საათები: 10.00 - 18.00 (ორშაბათი – პარასკევი)
ცხელი ხაზის ტელეფონი: 188-788

ჩაიტარეთ ტესტირება აივ-ზე და ჰეპატიტზე, ურჩიეთ იგივე თქვენს პარტნიორს!

 **USAID** | GEORGIA HIV PREVENTION PROJECT 

პროექტს ახორციელებს RTI International, Save the Children, PATH, საზოგადოებრივი გაერთიანება "ზემონი" და საინფორმაციო სამედიცინო-ფსიქოლოგიური ცენტრი "იანადგომს".

Face

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Injection drug users are at risk of HIV and other infections that can be transmitted through sexual contacts (STIs) and through blood (in particular, Hepatitis C and B) if they:

- share syringes and needles for using injecting drugs
- share equipment to prepare drugs
- have unprotected sexual contacts (without condoms)

To avoid infection with HIV and hepatitis B and C, and STIs:

- Stop using drugs!
- Use only your own syringes!
- Always use individual equipment to prepare drugs!
- Use condoms every time you have sex!

	 USAID FROM THE AMERICAN PEOPLE	GEORGIA HIV PREVENTION PROJECT	 სავერსი AVERSI
The project is implemented by RTI International, Save the Children, PATH, Bemoni Public Union and Medical, Information and Psychological Center "Tanadgoma"			

Back

Only HIV and hepatitis B and C testing can determine if a person is infected or not.

You can get tested for HIV and hepatitis B and C as well as counseling on STIs:

- free of charge
- anonymously
- confidentially

at the Bemoni Public Union at the following address:

16, Kavtaradze Street, Tbilisi
treatment department, 7th floor
working hours: 10.00-18.00 (M - F)
Hot Line: 188-788

Get tested for HIV and hepatitis and recommend your partner to be tested as well!

Referral cards for clients with STI symptoms

English translation of referral card is provided below.

Face

ნებისმიერი ადამიანი, რომელსაც აქვს დაუცველი სქესობრივი კონტაქტი, იმყოფება სქესობრივი გზით გადამდები ინფექციებით (სგგი), მათ შორის ადამიანის იმუნოდეფიციტის ვირუსით (აივ) დაინფიცირების საფრთხის ქვეშ.

თუ თქვენ აღმოგჩნდათ შემდეგი სიმპტომები: გამონადენი სასქესო ორგანოდან, გაღიზიანება, ქავილი (შარდვის დროს), წყლულები, გამონაყარი სასქესო ორგანოზე, მაშინ აუცილებელია სგგი-ზე და აივ-ზე გამოკვლევის ჩატარება და მკურნალობა.

მხოლოდ ტესტირებით არის შესაძლებელი გამოვლინდეს, ინფიცირებულია თუ არა ადამიანი სგგი-ით და აივ-ით.

აივ-ზე კონსულტირება და ტესტირება შესაძლებელია:

- უფასოდ
- ანონიმურად
- კონფიდენციალურად

საინფორმაციო სამედიცინო-ფსიქოლოგიურ ცენტრში "თანადგომა" მისამართზე:
ქურდიანის 21, თბილისი
სამუშაო საათები: 10.00 - 18.00 (ორშაბათი – პარასკევი)
ცხელი ხაზი: 25-18-19



პროექტს ახორციელებს RTI International, Save the Children, PATH, საზოგადოებრივი ცენტრის "თანადგომა" და საინფორმაციო სამედიცინო-ფსიქოლოგიური ცენტრი "თანადგომა"

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სქესობრივი გზით გადამდებ ინფექციებზე კონსულტირება შესაძლებელია:

- უფასოდ
- ანონიმურად
- კონფიდენციალურად

საინფორმაციო სამედიცინო-ფსიქოლოგიურ ცენტრში "თანადგომა" მისამართზე:
ქურდიანის 21, თბილისი
სამუშაო საათები: 10.00 - 18.00 (ორშაბათი – პარასკევი)
ცხელი ხაზი: 25-18-19

არასდროს მიმართეთ თვითმკურნალობას! ინფექცია შესაძლოა დარჩეს ორგანიზმში, მაშინაც კი, როდესაც სიმპტომები ქრება.

თუ არ ჩაიტარებთ დროულ მკურნალობას სგგი-ზე, ამას შესაძლოა მოჰყვეს მძიმე გართულებები:

- ქრონიკული ანთება
- უნაყოფობა
- იმპოტენცია
- სიმსივნეები

ჩაიტარეთ გამოკვლევა და ურჩიეთ იგივე თქვენს პარტნიორს!

Face

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Every person with unprotected sexual contacts is at risk of getting infected with sexually transmitted infections (STI), including HIV.

If you have suspicious symptoms, for example, discharge from genitals, itching, pain (including during urination), lesions or blisters on genitals and lower abdominal pain, **you are strongly recommended to get tested for STI and HIV** and receive appropriate treatment.

Only HIV and STI testing can determine if a person is infected or not.

You can get **HIV test**:

- **free of charge**
- **anonymously**
- **confidentially**

at the Medical, Information and Psychological Center "Tanadgoma" at the following address:

21, Kurdiani Street, Tbilisi
working hours: 9.00-18.00 (M - F)
Hot Line: 25-18-19



GEORGIA HIV
PREVENTION PROJECT



The project is implemented by RTI International, Save the Children, PATH, Bemoni Public Union and Medical, Information and Psychological Center “Tanadgoma”

Back

You can get **counseling on STIs**:

- **free of charge**
- **anonymously**
- **confidentially**

at the Medical, Information and Psychological Center “Tanadgoma” at the following address:

21, Kurdiani Street, Tbilisi
working hours: 9.00-18.00 (M - F)
Hot Line: 25-18-19

Do not practice self-treatment! Infection may still remain in your body even if disturbing symptoms have disappeared.

Untreated STIs have rather severe consequences:

- chronic inflammation
- infertility
- impotence
- malignant growth

Get tested yourself and recommend your partner to be tested as well!

Attachment 3

Guide for In-Depth Interviews with Pharmacists

Date (month/day/year): _____ Time interview began: _____
Name of interview: _____ Time interview ended: _____
Name of note taker _____
Pharmacy # _____

INTRODUCTION

Note to facilitator:

An in-depth interview is used as an open-ended, discovery-oriented method that is well suited for describing the pharmacy pilot intervention processes, outcomes and recommendations from the perspective of a participating pharmacist, assessing and analyzing outcomes of the pilot pharmacy-based intervention within the Georgia HIV Prevention Project (GHPP), and developing recommendations on future steps for the pharmacy-based education component in Georgia.

The goal of the interview is to deeply explore the respondent's point of view, feelings and recommendations.

While conducting an in-depth interview, the interviewer should use active listening skills to insure that you completely understand the meaning the respondent intends. The interviewer should not rush the respondent and allow him/her to speak freely while guiding the conversation to cover important issues. The interviewer should be flexible and open to slight deviations from the topic, which may require rearranging/reordering the questions or coming up with new questions. If the respondent deviates too far from the topic, then carefully return him or her to the topic at hand.

Upon the interviewee's oral consent, audiotape the interview for later reference and increased accuracy. Always ask permission of the interviewee before audio recording. The note taker captures both the verbal responses and nonverbal cues.

PREPARATION FOR THE INTERVIEW

Greet the interviewee in a friendly manner to begin establishing positive rapport. Ask the participant to get comfortable and be seated.

Relay the following statement to the interviewee:

Thank you: I want to thank you for taking the time to meet with me/us today. It was so nice to meet you at the pharmacy training in November 2010.

Your name and organization: I just wanted to remind you my name. I am _____ and represent the international nonprofit organization PATH which partners with the international organization RTI and Save the Children and local NGOs Bemoni and Tanadgoma to implement the USAID project on HIV prevention in Georgia. The pilot pharmacy-based intervention is one of the components of this project and is implemented in the partnership with Aversi pharmacy network.

Purpose: As one of the components of our overall pilot evaluation, we are assessing pharmacy pilot effectiveness in order to capture lessons that can be used in future interventions. We invited you to talk about your personal experience participating in the pharmacy pilot, to listen to your point of view, feelings and recommendations on future steps for the pharmacy-based education component in Georgia. Your opinion is very important to us.

Duration: the interview should take around an hour.

How the interview will be conducted: If it is okay with you, I will be tape recording our conversation. The purpose of this is so that I can get all the details but at the same time be able to carry on an attentive conversation with you. My colleague from PATH, _____, will be taking notes of our conversation in written because we don't want to miss any of your comments.

Confidentiality: All your responses will be kept confidential. This means that your interview responses will only be shared with the research team members and we will ensure that any information we include in our report does not identify you as the respondent. Remember, you don't have to talk about anything you don't want to and you may end the interview at any time. However, we will be very much thankful to listen to your point of view and treasure all the information you provide.

Do you have any questions about what I have just explained?

Do you give an informed consent orally to tape record our conversation?

Are you willing to participate in the interview?

Let's start the interview.

CONDUCTING THE INTERVIEW

I'm now going to ask you some questions that I would like you to answer to the best of your ability. If you don't know the answer, please say so.

1. The pilot pharmacy project has been already conducted for seven months (Dec. 2010 – June 2011) and you participated in it serving pharmacy customers every day. What do you think now about pharmacists' role in preventing HIV?
2. You were trained at the pharmacy training "*Counseling Pharmacy Clients about Sexually Transmitted Infections (STIs), HIV/AIDS and Hepatitis*" in November 2010. How the knowledge and skills acquired at that training helped you in your work? Which particular knowledge and skills did you apply?

3. At the training we agreed that pharmacists would conduct counseling according to three counseling algorithms. Tell me please about your experience in conducting counseling of IDUs.

Probe:

- Did IDUs address you with questions within seven month of the pharmacy pilot?
- *If yes*, which particular questions did they ask?
- What did you usually answer?
- Did you refer IDUs for testing?
- Did you provide IEC materials to them?
- What are the reasons for IDUs to come to the pharmacy?
- What did you do in those situations?

4. Tell me please about your experience in conducting counseling people with STI symptoms.

Probe:

- Did people with STI symptoms address you with questions within seven month of the pharmacy pilot?
- *If yes*, which particular questions did they ask?
- What did you usually answer?
- Did you refer them for testing?
- Did you provide IEC materials to them?
- *If no*, why do you think people with STI symptoms feel reluctant to address pharmacists with questions on STIs, including HIV?
- Did you initiate counseling? If not, why?

5. Tell me please about your experience in conducting counseling people after unprotected sex.

Probe:

- Did people who had unprotected sex address you with questions within seven month of the pharmacy pilot?
- Did women/girls ask about emergency contraception?
- *If yes*, which particular questions did they ask?
- What did you usually answer?
- Did you refer them for testing?
- Did you provide IEC materials to them?
- *If no*, why do you think people after unprotected sex do not address pharmacists with questions on STIs, HIV, and prevention of unwanted pregnancy?
- Did you initiate counseling? If not, why?

6. Please share with your point of view what has been preventing the target audiences from going to pharmacies and looking for services there?

7. How you used the counseling algorithms which were suggested at the training?

Probe:

- How useful they were?
- Is there a necessity to change anything in them?
- Was the brief counseling memo useful?

8. How did you distribute referral cards?

Probe:

- Whom did you give them to? In which way?
- What was the reaction of people you gave referrals?

9. We noticed during monitoring visits at some point that pharmacists became discouraged to conduct counseling and provide referrals. In your opinion, why did it happen?

10. On the basis of results of monitoring visits, we got a feeling that people with STI symptoms and after unprotected sex did address pharmacists with questions. However, pharmacists felt uncomfortable to initiate counseling. What are the reasons you think?

11. How were monitoring visits to your pharmacy conducted?

Probe:

- How often they were conducted?
- Which issues did you discuss during monitoring visits?
- Did you have a chance to discuss problems that concerned you?
- How those problems were addressed?

12. Which support did you receive from the representatives of the project during the seven months of the pilot?

Probe:

- How were on-job trainings conducted?
- Did you have a chance to ask questions to clarify?
- Did you receive complete answers to your questions?

13. What were some barriers for implementing the pharmacy intervention that you encountered?

14. How did you overcome those barriers?

15. If you have a chance to develop a project on HIV prevention with the involvement of pharmacists, what would you do differently? Please explain why.

16. What recommendations do you have for future efforts such as these?

17. Is there anything else you would like to add?

CONCLUSION

The interviewer should say the following text to the participant:

“Thank you very much for your time. Your responses have been very valuable for evaluating the effectiveness of the pharmacy-based intervention and for advising improvements for future projects. This information will be used to improve the pharmacy-based interventions according to their realities and preferences in Georgia”

AFTER THE INTERVIEW

Immediately after the discussion:

- Interviewer and note taker debrief together.
- Check the tape to see if the interview was recorded. If it was not, expand your notes immediately
- Revise, edit, and complete notes.

That evening (interviewer and note taker) – DO NOT DELAY THIS STEP:

- Complete and correct the notes in accordance with the recording.
- Summarize important themes or points made in the summary section of the interview.

Attachment 4

Mystery Client Survey Guidelines #1 and Recording Sheet

NOTE: This page should be used to prepare for the pharmacy visit. It should not be used while in the pharmacy. The attached form (page 2) is to be used by the interviewer who will interview the mystery client after he has finished the visit.

You are “mystery” client – young man, injection drug user (IDU), modestly dressed. You usually are afraid to buy syringes because of police. You use used syringes and clean them before use. You are afraid to get infected with hepatitis and want to ask pharmacist whether how it is transmitted and can be prevented.

You have a girlfriend. You trust each other and usually don't use condoms.

You came to pharmacy to buy a set of drugs that are usually used by IDUs. After you entered the pharmacy, do not approach the pharmacist right away. If there are visitors, wait until they leave. If there are no visitors, wait a little. Show that you hesitate to address the pharmacist. Show that you study showcases. Try to show with your behavior and appearance that you hesitate and feel nervous. Address the pharmacist with a low voice:

“I need... Dimedrol and also Kodelak... Do you have Disepam? One package please.

May I ask you? I have a problem... I take drugs. Frankly speaking, I am afraid of being infected with hepatitis... Do you know whether I can be infected by using drugs? How do I know that I am not infected? What should I do to prevent it?”

If pharmacist asks whether you used condom, say: *“We never use condoms”*.

If pharmacist says, *“I know nothing about this”*, ask: *“Where can I get this kind of information?”*

If pharmacist gave you all the information without additional questions from your side, do not ask these questions.

Questionnaire No: _____

Date: _____

Mystery client's name: _____

Interviewer's name: _____

Pharmacy #: _____

City: _____

1. After you told about your problem, did pharmacist ask you anything else?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", what did he ask and what did you answer?

2. Did pharmacist ask you whether you use new or your own syringe every time you take drugs?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", what did you answer?

3. If you answered "No", did pharmacist advise you to use new syringe and not to share your syringe with others?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", what did she say?

4. Did pharmacist ask you whether you use condoms?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", what did you answer?

5. Did pharmacist advise you to use condoms every time you have sex?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", what did she say?

6. Did pharmacist offer you to buy condoms?

Yes ⁽¹⁾ No ⁽⁰⁾

7. Did pharmacist ask you whether you use the same ware for drug preparation when taking drugs with others?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", what did you answer?

8. Did pharmacist tell you about HIV?

Yes ⁽¹⁾ No ⁽⁰⁾

If "yes", what did she say?

9. Did pharmacist tell you about sexually transmitted infections (STIs)?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", what did she say?

10. Did pharmacist tell you about hepatitis?

Yes ⁽¹⁾ No ⁽⁰⁾

If "yes", what did she say?

11. Did pharmacist advise you to have the test for STIs?

Yes ⁽¹⁾ No ⁽⁰⁾

12. Did pharmacist advise you to have test for HIV?

Yes ⁽¹⁾ No ⁽⁰⁾

13. Did pharmacist advise you to have test for hepatitis B?

Yes ⁽¹⁾ No ⁽⁰⁾

14. Did pharmacist advise you to have test for hepatitis C?

Yes ⁽¹⁾ No ⁽⁰⁾

15. Did pharmacist advice your girlfriend to be tested, too?

Yes ⁽¹⁾ No ⁽⁰⁾

16. Did pharmacist refer you to any other institution?

Yes ⁽¹⁾ No ⁽⁰⁾ **Go to question №19**

17. If "Yes" where did pharmacist refer you? (*Please check all that apply.*)

17.1 To another pharmacy

17.2 To the polyclinic

17.3 To STI clinic

17.4 To AIDS Center

17.5 To HIV-service organization

17.6 To drug abuse clinic

17.7 Other

18. Why did pharmacist refer you there? (*Please check all that apply.*)

18.1 Lack of medicine or information.

18.2 For syringe exchange.

18.3 For STI test.

18.4 For HIV test.

18.5 Other _____

19. Did pharmacist recommend you how to protect yourself from HIV, STIs, and hepatitis in the future?

- Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", what did she say?

20. How did pharmacist treat you?

- Positively (friendly, hospitably, attentively, etc.) ⁽¹⁾
 Indifferently ⁽²⁾
 With condemnation, rudely ⁽³⁾

21. Why did you have such opinion?

22. Did other clients visit the pharmacy during your conversation?

- Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes" what was the behavior of the pharmacist?

23. Did pharmacist offer you any informational materials?

- Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", please list them?

24. For how long did you communicate with the pharmacist?

- less than 5 minutes ⁽¹⁾
 5-10 minutes ⁽²⁾
 more than 10 minutes ⁽³⁾

25. Do you have any additional comments or observations?

Yes (1) No (0)

If "Yes" please explain.

Attachment 5

Mystery Client Survey Guidelines #2 and Recording Sheet

NOTE: This page should be used to prepare for the pharmacy visit. It should not be used while in the pharmacy. The attached form (page 2) is to be used by the interviewer who will interview the mystery client after she has finished the visit.

You are a “mystery” client – a young lady who a week ago had unprotected sex with man whom you know just a little. After a few days, you noticed some symptoms on your genitals – painful ulcers and itching and also burning sensation during urination. You are afraid of the infection and want to get rid of these symptoms. Also, you worry about possible unwanted pregnancy. You are interested in PREVENTING pregnancy, not in getting medicine for abortion. You had sex with other men after that.

After you entered the pharmacy, do not approach the pharmacist right away. If there are visitors, wait until they leave. If there are no visitors, wait a little. Show that you hesitate to address the pharmacist. Show that you study showcases. Try to show with your behavior and appearance that you hesitate and feel nervous. Address the pharmacist with a low voice:

“May I ask you? How to say... So, I had sex... And I feel bad. I have itching and some discharge... burning pain during urination... I need your advice. Help me please. Can I ask you one more question? To tell you the truth, I don't need a baby now because of my work. I don't want to get pregnant. Is this possible to something now... after?”

If a pharmacist asks why you didn't come earlier, say: *“I thought it would go away itself”*.

If a pharmacist asks whether you had sex after that with other man, say: *“Yes, with the “friend”*.

If a pharmacist asks whether you used condoms, say: *“Not that time”*.

If a pharmacist offers you to buy a medicine, say that you do not have money for the full course of treatment now. Ask: *“Will this medicine cure me?”*

If a pharmacist did not tell you about emergency contraception, say, *“A have a girlfriend who told me about pills which you can take after sex to prevent unwanted pregnancy. But this medicine is not for abortion. Does this medicine really exist?”*

If a pharmacist says, *“I do not know”*, ask: *“Where can I get this kind of information?”*

If a pharmacist gave you all the information without being asked, there is no need to ask the prompting questions.

Questionnaire №: _____

Date: _____

Mystery shopper's: _____

Interviewer's name: _____

Pharmacy #: _____

City: _____

1. After you told about your problem, did pharmacist ask you whether you have any other complains?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", what did you answer?

2. Did pharmacist ask you if you had sex after that?

Yes ⁽¹⁾ No ⁽⁰⁾ **Go to question №4**

If "Yes", what did you answer?

3. If "Yes", did pharmacist ask you whether you used condom?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", what did you answer?

4. Did pharmacist advise you to use condom every time you have sex?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", what did she say?

5. Did pharmacist offer you to buy condoms?

Yes ⁽¹⁾ No ⁽⁰⁾

6. Did pharmacist offer you any medicine?

Yes ⁽¹⁾ No ⁽⁰⁾ **Go to question №10**

If "Yes", please list them.

#	Name	How many times per day?	Number of days

7. Did pharmacist explain you what is this medicine for?

Yes ₍₁₎ No ₍₀₎

If "Yes", what did she say?

8. Did pharmacist explain how effective this medicine is and whether it would cure you?

Yes ₍₁₎ No ₍₀₎

If "Yes", what did she say?

9. What instructions did you get from the pharmacist?

10. Did pharmacist tell you about sexually transmitted infections (STIs)?

Yes ₍₁₎ No ₍₀₎

If "Yes", what did she say?

11. Did pharmacist tell you about HIV?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", what did she say?

12. Did pharmacist advise you to have test for STIs?

Yes ⁽¹⁾ No ⁽⁰⁾

13. Did pharmacist advise you to have HIV test?

Yes ⁽¹⁾ No ⁽⁰⁾

14. Did pharmacist advise your sexual partner to be tested, too?

Yes ⁽¹⁾ No ⁽⁰⁾

15. Did pharmacist refer you to any other institution?

Yes ⁽¹⁾ No ⁽⁰⁾ **Go to question №17**

16. If "Yes" where did pharmacist refer you? (***Please check all that apply.***)

16.1 To another drugstore

16.2 To the polyclinic

16.3 To STI clinic

16.4 To AIDS center

16.5 To HIV service organization

16.6 To gynecologist

16.7 Other

17. Why did pharmacist refer you there? (***Please check all that apply.***)

17.1 Lack of medicine or information

17.2 For pregnancy test

17.3 For STI test

17.4 For HIV test

17.5 Other

18. Did pharmacist recommend you how to protect yourself from HIV and STIs in the future?

Yes ₍₁₎ No ₍₀₎

If “yes”, what did she say?

19. Did pharmacist recommend you any pills to prevent pregnancy after sex that you had?

Yes ₍₁₎ No ₍₀₎

If “yes”, what did she say?

20. Did pharmacist recommend you any regular contraception method for future use?

Yes ₍₁₎ No ₍₀₎

If “yes”, what did she say?

21. How did the pharmacist treat you?

Positively (friendly, hospitably, attentively, etc.) ₍₁₎

Indifferently ₍₂₎

With condemnation, rudely ₍₃₎

22. Why did you have such opinion?

23. Did other clients visit the pharmacy during your conversation?

Yes ₍₁₎ No ₍₀₎

If “Yes” what was the behavior of the pharmacist?

24. Did pharmacist offer you any informational materials?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", please list them?

25. For how long did you communicate with the pharmacist?

less than 5 minutes ⁽¹⁾
 5-10 minutes ⁽²⁾
 more than 10 minutes ⁽³⁾

26. Do you have any additional comments or remarks?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", please explain.

Attachment 6

Mystery Client Survey Guidelines #3 and Recording Sheet

NOTE: This page should be used to prepare for the pharmacy visit. It should not be used while in the pharmacy. The attached form (page 2) is to be used by the interviewer who will interview the mystery client after she has finished the visit.

You are a “mystery” client – a young man, MSM. Usually you use condoms; however, two weeks ago had sex with man whom you know just a little. Since you were drunk, you are not sure whether you used condom that time. A week ago, you noticed some symptoms on your genitals – some rash and also painful anal erosion. You are afraid that these are HIV symptoms and want to buy some antibiotics to get rid of these symptoms. You had one unprotected sex with other man after that.

After you entered the pharmacy, do not approach the pharmacist right away. If there are visitors, wait until they leave. If there are no visitors, wait a little. Show that you hesitate to address the pharmacist. Show that you study showcases. Try to show with your behavior and appearance that you hesitate and feel nervous. Address the pharmacist with a low voice:

“May I ask you a very private question? I have very delicate problem. I don’t want other people know about this. Please keep it between us.”

I developed some strange rash and something like erosion... There, you where...It appeared a week ago already. I am scared and don’t know what to do. What can it be?

What if this is HIV? Can you recommend me anything? Maybe you have some ointment or antibiotics to prevent HIV?”

If a pharmacist asks why you didn’t come earlier, say: *“I thought it would go away itself”*.

If a pharmacist asks whether you had sex after that, say: *“Yes, one time”*.

If a pharmacist asks whether you used condoms, say: *“No”*.

If a pharmacist offers you to buy a medicine, ask: *“Will this medicine cure me?”*

If a pharmacist says, *“I do not know”*, ask: *“Where can I get this kind of information?”*

If a pharmacist gave you all the information without being asked, there is no need to ask the prompting questions.

Questionnaire №: _____

Date: _____

Mystery shopper's: _____

Interviewer's name: _____

Pharmacy #: _____

City: _____

1. After you told about your problem, did pharmacist ask you whether you have any other complains?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", what did you answer?

2. Did pharmacist ask you if you had sex after that?

Yes ⁽¹⁾ No ⁽⁰⁾ **Go to question №4**

If "Yes", what did you answer?

3. If "Yes", did pharmacist ask you whether you used condom?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", what did you answer?

4. Did pharmacist advise you to use condom every time you have sex?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", what did she say?

5. Did pharmacist offer you to buy condoms?

Yes ⁽¹⁾ No ⁽⁰⁾

6. Did pharmacist offer you any medicine?

Yes ⁽¹⁾ No ⁽⁰⁾ **Go to question №10**

If "Yes", please list them.

#	Name	How many times per day?	Number of days

7. Did pharmacist explain you what is this medicine for?

Yes ₍₁₎ No ₍₀₎

If "Yes", what did she say?

8. Did pharmacist explain how effective this medicine is and whether it would cure you?

Yes ₍₁₎ No ₍₀₎

If "Yes", what did she say?

9. What instructions did you get from the pharmacist?

10. Did pharmacist tell you about sexually transmitted infections (STIs)?

Yes ₍₁₎ No ₍₀₎

If "Yes", what did she say?

11. Did pharmacist tell you about HIV?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", what did she say?

12. Did pharmacist advise you to have test for STIs?

Yes ⁽¹⁾ No ⁽⁰⁾

13. Did pharmacist advise you to have HIV test?

Yes ⁽¹⁾ No ⁽⁰⁾

14. Did pharmacist advise your sexual partner to be tested, too?

Yes ⁽¹⁾ No ⁽⁰⁾

15. Did pharmacist refer you to any other institution?

Yes ⁽¹⁾ No ⁽⁰⁾ **Go to question №18**

16. If "Yes" where did pharmacist refer you? (***Please check all that apply.***)

16.1 To another drugstore

16.2 To the polyclinic

16.3 To STI clinic

16.4 To AIDS center

16.5 To HIV service organization

16.6 Other _____

17. Why did pharmacist refer you there? (***Please check all that apply.***)

17.1 Lack of medicine or information

17.2 For STI test

17.3 For HIV test

17.4 Other _____

18. Did pharmacist recommend you how to protect yourself from HIV and STIs in the future?

Yes ⁽¹⁾ No ⁽⁰⁾

If "yes", what did she say?

19. How did the pharmacist treat you?

Positively (friendly, hospitably, attentively, etc.) ⁽¹⁾

Indifferently ⁽²⁾

With condemnation, rudely ⁽³⁾

20. Why did you have such opinion?

21. Did other clients visit the pharmacy during your conversation?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes" what was the behavior of the pharmacist?

22. Did pharmacist offer you any informational materials?

Yes ⁽¹⁾ No ⁽⁰⁾

If "Yes", please list them?

23. For how long did you communicate with the pharmacist?

less than 5 minutes ⁽¹⁾

5-10 minutes ⁽²⁾

more than 10 minutes ⁽³⁾

24. Do you have any additional comments or remarks?

Yes (1) No (0)

If "Yes", please explain.
