Qualitative research among most at risk populations for TB in Health Outreach Program pilot sites in Tajikistan

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Abbreviations and Definitions

DOT – Direct Observation of Treatment
DOTS – WHO strategy to fight TB
FGD – Focus Group Discussion(s)
GFATM – Global Fund to fight AIDS, Tuberculosis and Malaria
HIV - Human immunodeficiency virus
IDI - In-depth interview
IDU - Injecting drug users
MARP - Most at risk population
MSM - Men who have sex with men
PHC – Primary Health Care
PLHIV - People living with HIV
SW - Sex workers
TB – Tuberculosis
TB case – person with TB disease;
TB infection – presence of *Mycobacterium tuberculosis* bacilli in the body, not necessarily disease

1. Executive Summary

Starting in October 2009, Project HOPE as part of the Health Outreach Program Consortium has started implementation of the "Health Outreach Program" in the areas of Dushanbe, Vahdat, Kurgan-Tube and Kulyab in Tajikistan.

The present study used Focus Group Discussions (FGD) and in-depth interviews to investigate the determinants of barriers and motivators for seeking care and getting treatment for tuberculosis (TB). From January to February 2010, 10 in-depth interviews were conducted with people living with HIV/AIDS (PLHIV) who currently have or recently had TB disease. One of the TB patients interviewed had not been informed about his confirmed HIV status at the time of the interview. Over the same period, 12 FGDs were conducted among representatives from most at risk populations (MARP) for TB, including 40 intravenous drug users (IDU), 40 sex workers (SW), 20 men who have sex with men (MSM), and 21 people living with HIV/AIDS (PLHIV) from all four project pilot sites: Dushanbe, Vahdat, Kurgan-Tube and Kulyab. This research was focused on obtaining information about group's knowledge, attitudes and practices on TB and to determine both barriers and motivators for seeking care and getting TB treatment.

The results of the FGDs consistently showed that affordability of medical services and lack of accurate information about TB and its curability were the highest barriers to use of TB services. Stigma related to TB was rated as a less important factor. However, it indirectly contributed to affordability, as in the case of having TB symptoms many FGD participants would prefer to go to a TB facility rather than a Primary Health Care (PHC) facility, mostly for perceived higher quality of care, but possibly also to avoid stigma. Such health care seeking led to higher transportation costs and consequently to lowered affordability of medical care.

People, who perceive their need for medical services, need to be able to readily access them to receive the whole range of services needed. Access to health care services is determined by their acceptability and affordability. Perceived discrimination by the health system and, most importantly, perceived high costs of TB treatment were the most important reasons for preventing MARPs from seeking care and getting treatment for TB.

The main motivators for seeking care and getting TB treatment were reported to be support from family and friends, as well as financial support.

2. Background

Since 1997, USAID has focused considerable resources on addressing the HIV and TB epidemics in five Central Asian Republics (CAR). All countries in CAR now have national HIV/AIDS and TB control programs supported by the governments and by international

donors such as USAID, the US Centers for Disease Control (CDC), the World Health Organization (WHO), and the Global Fund to Fight AIDS, TB and Malaria (GFATM), among others. These national programs seek to address HIV and TB among the general population and most at risk populations (MARP), including: injecting drug users (IDU), sex workers (SW), migrants, men who have sex with men (MSM), prisoners, and people living with HIV/AIDS (PLHIV).

The new "Health Outreach Program", funded by USAID and implemented by the Health Outreach Program Consortium (PSI, Project HOPE, AFEW, the Kazakh Association of PLHIV) started in 2009. In the region with one of the fastest growing HIV/AIDS epidemics in the world, the Health Outreach Program Consortium targets MARPs most likely to contract or transmit HIV and TB: IDUs, SWs, migrants, MSM, prisoners, and PLHIV. Risk for TB infection is higher among IDUs, prisoners and migrants, but is particularly dangerous for PLHIV. Thus, TB interventions will specifically target these four groups, but will also include general TB/HIV co-infection prevention messages in outreach to MSM and SW.

Formative research was designed to be conducted among MARPs to obtain information about each group's knowledge, attitudes and practices on TB and to determine barriers and determinants for seeking care and getting TB treatment. The result of the formative research will be used for revision of the Tajikistan TB National Communication Strategy, revision and development of an education program for TB outreach among MARPs and development of information, education and communication (IEC) materials.

3. Objectives of this study

The objectives of this study were to:

1. Document current level of knowledge about TB among MARPs in pilot sites
2. Identify factors impeding or contributing to seeking care and getting TB treatment
3. Identify the above-mentioned factors covering different population subgroups, including both genders, as well as rural and urban populations.

4. Methods

A mixed methodology was followed to conduct this study among MARPs communities in the Dushanbe city, Vahdat town, Kyrgan-Tube and Kulyab towns of Khatlon oblast of Tajikistan, which are Health Outreach Program pilot sites. Qualitative FGDs and in-depth interviews were conducted to determine factors impeding or contributing to seeking care and getting TB treatment.

4.1. Research Area and Participants of Focus Group Discussions

The qualitative research discussed in this report was conducted in project pilot sites

(Dushanbe, Vahdat, Kurgan-Tube, and Kulyab) from January to February 2010. A total of 12 FGD were conducted among MARPs and 10 in-depth interviews among PLHIV who are currently being treated or have been treated for TB, to investigate the determinants of adherence to diagnostic procedure and treatment for TB.

Table 1. Summary of FGD participants by risk group category and pilot site location

Pilot site	**SW**	**MSM**	**IDU**	**PLHIV**	**Total # of participants**
Dushanbe	10	20	10	10	50
Vahdat	10		10	11	31
Kurgan-Tube	10		10		20
Kulyab	10		10		20
Total:	40	20	40	21	121

FGD with MARPs (except MSM) were carried out in both urban and rural areas. A total of two FGD with MSM were conducted only in Dushanbe, as this group will be included in target interventions only in Dushanbe. FGDs were stratified by gender and age (young adult vs. medium-aged to elderly). They were conducted in private rooms of drop-in centers, NGO offices and in the AIDS Center.

FGD were conducted in Tajik, with the possibility for participants to also speak in Russian. FGD were transcribed directly from the Tajik (or Russian) audio recordings to English transcription.

Local NGOs were also included in the research process to encourage more accurate responses from MARP group representatives, as they may have greater trust in people who have already worked with them. Two representatives from six local NGOs working with different groups of MARPs in Health Outreach Program pilots were suggested by PSI to participate in the training. The research team for each FGD consisted of the moderator who was fluent in Tajik and Russian and the transcriber.

The whole research team underwent a two sessions training, which was facilitated by the Regional ACSM Specialist of Project HOPE. It covered introductions to the research questions, methodological characteristics of FGD, reasons for the choice of this method for the questions to be investigated, as well as content and use of the discussion guidelines. On the second day of the training, the practical sessions were followed by a demonstration of a FGD which was conducted by Project HOPE Regional ACSM Specialist with the group of youth.

4.2. Research Protocol and Inclusion Criteria for Participants of In-depth Interviews

Current and former TB patients among PLHIV were identified through the local NGO "Guli Surkh" and the TB Center. Interviews were conducted to identify any barriers encountered in obtaining TB diagnosis and treatment. Criteria for inclusion were PLHIV who have or had TB during the previous two years.

Ten one-hour in-depth interviews were conducted among PLHIV TB patients who had previously received or who were currently on TB treatment. Four TB patients from the Republican TB Macheton Hospital (three from Dushanbe and one from Nurek) and 6 from connections of the NGO "Guli Surkh" were interviewed. Five out of 10 PLHIV interviewed were currently on TB treatment.

An in-depth interview protocol adapted from Project HOPE migrant's study was used in the study. Five interviews were conducted by Project HOPE and the other five by trained outreach workers from the NGO Guli Surkh. In-depth interviews with TB patients were conducted in Tajik or Russian, depending on the language of preference of the participants. Informed consent was obtained from all participants at the beginning of each interview. The aims and objectives of the study were clearly explained, and participants were remunerated for their time. Data was transcribed in Tajik or Russian, and subsequently translated into English. The field note-taking by the interviewer with the observations made during the in-depth interview were transcribed and added into the interview guide for each patient separately. The interviews were conducted between February 11-18, 2010.

4.3. Topics of Focus Group Discussions

Discussion guidelines for the FGD are given in the annex of this report. These discussion guidelines were used in the training as well as during the FGD. The topics and general questions covered were:

1. Knowledge about TB
2. Care-seeking behavior
3. Barriers for seeking care and getting TB treatment
4. Motivators for seeking care and getting TB treatment
5. TB stigma and discrimination
6. Needs for additional information on TB

4.4. Analysis of Focus Group Discussions

All FGD were recorded in Tajik and Russian on audio tape and then transcribed directly to English. The transcriptions were coded and entered into Excel and qualitative data was extracted according to the MARP status. For the coding, the transcriptions were read repeatedly and codes were continuously added. Seven main subjects were differentiated, including knowledge of symptoms, perceived causes, curability, affordability and others. The main subject areas were subdivided into a variable number of subcodes. The context in

which statements were made was coded according to whether an idea came up spontaneously out of the discussion or was an answer to a question or a statement by the moderator. However, the context was used to understand which topics were most important to participants. Differences among FGD with different groups were taken into account. These may help in identifying the different levels and needs of groups which need to be taken into account during program implementation. In the data analysis, the terms and concepts from the participants' own phraseology were used.

4.5. Analysis of In-depth interviews

In-depth interviews with PLHIV TB patients were analyzed to identify themes such as lack of money to pay for private consultation, the economic need to keep working, the lack of knowledge that TB could be cured, or fear of community stigma and being socially ostracized. In the data analysis, the terms and concepts from the participants' own phraseology was used to distill themes. Themes regarding reasons for PLHIV delaying seeking TB diagnosis treatment were identified.

5. Key findings

The average level of knowledge regarding TB transmission is relatively low and although many MARPs know that TB can be transmitted through the air when a person coughs or sneezes, serious misperceptions remain such as the common belief that transmission can occur through shared meals, eating utensils and handshakes.

TB is a significant problem among MARPs' communities and access to affordable care is an important issue. When becoming ill and in need to access health services, the majority of MARPs found it difficult due to perceived expensive services.

The sputum microscopy test for TB diagnostics and TB drugs, according to the National TB program, are both supposed to be provided free of charge, however patients have to pay for diagnostic services such as x-rays and other costs such as vitamin supplements and hospital costs, thus creating a significant financial burden for the MARPs and their families.

5.1. Key recommendations

TB Services should be consistently strengthened in order to ensure adequate diagnosis and treatment of tuberculosis for the whole population, including MARPs. Tuberculosis services, including microscopy and radiology and essential and ancillary medicines, should be provided free of charge to help ensure treatment compliance.

More information should be provided to MARPs on TB signs and symptoms, on the means

of TB transmission, and on the process of TB treatment with emphasis on the curability of TB. The messages should be delivered through the most effective channels, like TV, and via health workers and brochures. However, other approaches for the dissemination of information to MARPs through outreach workers should be also considered via local NGOs working with MARPs.

6. Results

6.1. Participants of FGD

Thirty-nine IDUs participated in the FGD, 5 women and 34 men with a mean estimated age of 38 years. Twenty MSM and 40 SW participated in FGD. Their mean age was 40 years. Of 21 PLHIV participants, 4 were women and 17 were men, altogether with a mean age of 36 years.

6.1.1. Knowledge about TB

A summary of responses to FGD questions by MARP group:

i. What do you know about TB?

IDUs:

- Deadly disease
- Serious disease
- Mostly affects lungs
- There is an open form (that means pulmonary TB patients discharging bacteria) which is incurable and a closed form (that means pulmonary TB patient without bacteria discharge) which is curable.
- Lung disease

SWs:

- Infectious disease
- A person can die
- Early stage is curable
- Affects lungs and bones

MSM:

- It is a dangerous disease
- Mostly spread among prisoners
- Related to lungs
- Open form is dangerous

PLHIV:

- Dangerous disease
- Lung disease
- It can't be cured
- Can be cured in earlier stage

As observed, all groups of respondents have various, incomplete and mostly inaccurate information about TB. There were a few people among the SW group thinking that TB is not a serious disease.

ii. What are the most important signs of TB?

IDUs:

- Weakness
- Weight loss
- Cough
- Sweating at night

SWs:

- Weight loss
- Cough; coughing up blood
- Sweating
- Fever

MSM:

- Cough
- Fatigue
- Chest pain
- Weight loss
- Pain in legs

PLHIV:

- Sweating at night
- Fatigue
- Weight loss
- Cough
- Fever
- Blood in sputum

The informants are aware more or less of the most important signs of TB. However, cough was only mentioned after several other symptoms had been named. Symptoms appearing later in the natural history of TB, like weight loss and severe fatigue more readily prompted mentioning of TB.

iii. How TB is transmitted?

IDUs:

- Through air
- Through needle or blood
- Mutual dish
- By shaking hands

SWs:

- Through air
- Through sharing dishes, things and a bed
- Through kissing and sexually
- Mutual dish
- Through needle or blood

MSM:

- Through air
- Sexually
- Through kissing
- Through sharing dishes
- Through water

PLHIV:

- Through air
- By shaking hands
- Through mutual dish
- Sexually
- Through needle or blood

As can be seen in the responses above, knowledge about causes of TB among all groups were incomplete. Particularly, an incorrect belief that TB spreads by using the mutual/shared dish was widespread and strong:

> *"When I was in prison we used to share the dish with my friend who had TB. I got TB too. It is often happens in our country, as according to our culture we use mutual dishes even with the sick person."*
>
> (Male 42 years-old, IDU, Vahdat)

A further critical misperception is doubt about the curability of TB, which was encountered in all FGDs.

iv. Is TB curable?

The main response to this question was that TB treatment takes a very long time and lasts from 6 months to 5 years. Almost half of the participants from all groups held the opinion that TB is not curable. A considerable proportion of the participants believe that TB can't be cured completely, but rather that after a few years it will cause death. This is illustrated by a number of statements like the following:

"My neighbor had TB. After 10 years of treatment he died from TB."
(42 year-old man, IDU, Kulyab)

"After being cured from TB one will die soon anyway."
(36 year-old woman, CSW, Dushanbe)

This lack of belief in the curability of TB exacerbates the frequent occurrence of death among TB patients known to FGD participants.

6.1.2. Health Care Seeking

Even with a lack of confidence in TB curability, the FGD participants showed themselves completely convinced that medical treatment for TB is needed and helpful to the patient. FGD participants spontaneously named health facilities where people could present with symptoms consistent with TB.

i. If somebody has TB symptoms where he/she should go for help/advice?

The general suggestion was to go to the TB center and do fluorography (x-ray screening, the primary method that was used for screening for TB prior to use of the DOTS strategy). The second place identified was a PHC facility. PLHIV mentioned that they would visit a doctor, whom they trust, meaning a specialist from the AIDS center. The choices of visiting TB centers were explained by respondents as a more confidential place where one can receive professional help.

6.1.3. Barriers for seeking care and getting treatment

i. If you had TB what would prevent you from seek care and getting TB treatment?

Almost all participants mentioned that lack of financial means would prevent them from seeking care and getting treatment for TB. The groups of IDUs and PLHIV listed the following barriers:

- drug addiction
- fear of having to disclose their HIV status
- negligence of medical staff

"Drug addiction will prevent me and other drug addicts from starting TB treatment in hospital, because there I wouldn't have access to drugs."
(28 year-old man, PLHIV, Dushanbe)

The groups of people most concerned about accessing services are IDUs and PLHIV. These groups reported feeling badly through experiencing fear and anxiety when seeking care and treatment for TB. This part of the sample group might be considered as the most vulnerable

on this issue. The lack of information on TB treatment being free of charge can prevent people from seeking care and getting treatment in time. This suggests the importance of including and reinforcing the message that TB drugs provided to TB patients free of charge into education programs and IEC materials for target groups.

6.1.4. Motivators for care seeking and getting TB treatment

i. If you had TB what would motivate you to seek care and get treatment?

Seeking care is important for all informants. SWs, IDUs and PLHIV emphasized the importance of support from family and friends. For the MSM groups, their health is more important for them. SWs displayed a sense of responsibility and rationality in this question ("*Caring for family in order not to infect them*"). Financial support is sufficient for the majority of respondents from all groups as well.

> *"Having documented evidence that TB drugs are free of charge will be very useful for us to demand it from doctors."*
>
> (37 year-old woman, SW, Vahdat)

Support from family and friends would be the most often helpful for the treatment seekers according to the opinion of our respondents. IDUs and PLHIV highlighted understanding and the positive attitude of medical staff as one of the motivators to seek care. The factors mentioned as main motivators for seeking care and getting TB treatment should be considered during development of IEC materials and of targeted education programs. The family members and friends of the MARPs should be included in the program as a second target for TB education programs.

6.1.5. Stigma and discrimination

i. Who can get TB? What kind of people?

According to the opinion of the majority of participants, prisoners are the high risk group for getting TB. Other answers were: smokers and drinkers; those who don't eat well; those who spend a lot of time in the cold. PLHIV mentioned compromised immunity as a great factor to get infected. IDUs and SWs also mentioned migrants as a risk group for getting TB. None of the participants indicated the family members of TB patients as a risk group for getting TB.

ii. What do you think about TB patients?

The majority of informants feels compassion and think that TB patients need attention and

support ("*They are very vulnerable and need support*"). In general, other members of the group showed tolerance toward such people admitting that they are like the others. On the other side, PLHIV and MSM are more skeptical and tough in that sense by indicating that they are feeling fear ("*They are dangerous and should be isolated*").

iii. Do you know somebody with TB?

At least one participant in each group knows somebody with TB, specifying that it's a relative or friends or someone who has died already. Most of the examples given were people who died from TB, which influences the belief in the incurability of TB.

iv. Would you be friends with someone who has TB?

In accordance with prior comments, the majority said that they would be friends with someone who has TB. A few respondents from the group of IDUs mentioned close relationships, spiritual support and friendships. The rest said that they will support and interact as usual but with precautions such as not eating from a common dish, wearing a mask, etc.

> *"My father-in-law had TB and died. I was taking care of him and used disinfection. But anyway, both of my children got TB."*
> (PLHIV, from Vahdat)

This shows how people are mistaken toward TB transmission. The response of 'No or only by phone' was said by representatives from the MSM group, which can sometimes contribute to negative attitudes and behaviors toward the patients.

6.1.6. Need for additional information on TB

A summary of responses to FGD questions by MARP group:

i. What additional information about TB would you like to receive?

IDUs
- How TB is transmitted
- Means of TB prevention
- What kind of treatment exists against TB

PLHIV
- Easier and more accessible forms of information

MSM
- Information about how dangerous TB is
- TB transmission

- How to recognize TB

SWs
- How TB is transmitted
- Means of TB prevention
- What kind of treatment against TB exists?
- How long is the treatment in order to cure TB? Is TB curable?

ii. In what language?

Information is required in both Tajik and Russian languages. IDUs and SWs from Kyrgan-Tube asked to have information also in Uzbek (with a larger Uzbek population).

iii. In what form would you like to receive this information?

The preferred forms of receiving TB information named by majority of the respondents were as follows:
- Printed materials with illustrations, booklets
- Videos, short videos on TV
- Seminars and trainings
- Health education sessions on TB in schools and universities

SW would like to have TV spots on TB on DVD as most of the time they watch DVDs. Printed materials are the most needed among all 4 groups. Groups of IDUs and PLHIV pointed out that it would be good if TB materials would be colorful with pictures like materials on HIV/AIDS. Video materials, especially on TV, were the second choice of participants.

6.2. Results from the In-depth interviews

Ten in-depth interviews were conducted among PLHIV who were either former TB patients or currently undergoing treatment for TB. Five interviews were conducted by the representative of the local NGO Guli Surkh working with PLHIV in Dushanbe and the other five were conducted by the Project HOPE Regional ACSM specialist. Five of the PLHIV were in the intensive phase of treatment and the other five patients had already finished their treatment. Seven of the respondents were male and three were female. All patients interviewed had pulmonary TB. The mean age of the respondents was 37 years.

Most of the males interviewed had become sick while working in Russia. All had returned to Tajikistan for treatment due to the limited access to TB services in Russia and the high cost of services when they were available. The study showed that the family of the respondents suffered more due to TB/HIV co-infection. Seven out of 10 families were broken (2 females became widows, 1 female and 4 males got divorced). The majority of the participants did seek care from a health facility with a delay due to financial shortage and

fear of being revealed as HIV patients. Almost all of the TB patients who received treatment at the hospital weren't satisfied with the conditions and food available at the hospital. The improvement of interaction with health providers and quality of information provided by them was a key suggestion from participants of the interviews.

A case description of each of the 10 PLHIV/current or former TB patients interviewed at two interview locations is given below:

6.2.1 Machiton TB Hospital Interviews conducted by Project HOPE

Patient 1 is a 55 year-old homeless male who is divorced and his family left for Russia, leaving him without place to live. He thinks that he got TB from his brother, who died from TB in 1992. After feeling ill for one week, with coughing and fever, he went to a policlinic and had a sputum examination. From the policlinic, he was escorted by ambulance to Machiton where he has been receiving treatment for TB for 4 months. In the beginning he was put in the new building of the hospital where the conditions were very good, but after 2 months he was transferred to the old building which is in a much worse condition. He doesn't know the reason for being transferred and thinks that it could be that he is HIV-positive. He thinks that TB can be cured only through an operation. He is satisfied with the treatment and care, but wish that nurses could speak Russian as he could not understand the information he was receiving from the health providers.

Patient 2 is a 35 year-old divorced male who is undergoing TB treatment and had worked in Russia for 6 years. He did divorce his wife after being diagnosed as a TB patient, as he did not want to infect her and their child. After one week of feeling ill with cough and fatigue, his mother took him to the TB Dispensary where he was first diagnosed with TB and referred to Machiton hospital. He has been undergoing TB treatment for 40 days now and feels better. He would prefer to get treatment at home, as the condition of the hospital is very bad and all the food should be brought by relatives. The suggestion he gave is to have better food in the hospital and that all manipulation (including injection) should be done on time. He doesn't believe in the curability of TB, as he has not seen anybody in this hospital being released as cured. He indicated that the doctor in charge is very supportive, the nurses are rude, but the hospital cleaners are very kind and helpful. He would like to receive more information on TB and have discussions with health providers on his treatment.

Patient 3 is a 32 year-old married male who had worked for six years in Russia as a construction worker who was diagnosed with TB in January 2010 in a TB Dispensary after an x-ray examination. He was sent to the domiciliary policlinic for sputum examination. After examination he was diagnosed as a TB patient and commenced TB treatment at Machiton Hospital. He has been undergoing TB treatment for 2 weeks and thinks that in 50 days will be cured. He thinks that he got TB from his wife as she has been feeling ill for a long time. She is in Kulyab and he has asked his relatives to take her to the doctor. One year ago, in Kulyab he went to see a doctor with the symptoms of fever, night sweats and

fatigue where the doctor after x-ray examination told him that he could have TB. He had treatment for 2 weeks in Kulyab TB hospital and after 2 weeks was released and told that he doesn't have TB. This time he felt ill again and decided to see a doctor in Dushanbe as he now lives in Dushanbe. Only his sister knows that he has TB as he is concerned that if their neighbours will find out that he has TB they would stop all communication with him and his family. A few days ago he was sent from Machiton to the AIDS Center to repeat a blood test for HIV and doesn't know the result yet. He was very scared and hoping that the result would be negative (the patient didn't know about his HIV status at the time of interview so the questions regarding HIV were not covered). Although the TB drugs were provided free of charge, diagnostics such as x-ray as well as intravenous solutions and vitamins had to be paid for, creating a financial burden for the patient. His family needed to sell some livestock to cover the costs of his treatment. He was generally satisfied with the information he was receiving regarding his treatment but would like more regular education sessions from the health providers.

Patient 4 is a 34 year-old separated male who had worked five years for a construction project in Russia. He was diagnosed as a HIV-positive 4 years ago, and asked his wife to leave him as didn't want to infect her and his 3 children. He was diagnosed with TB by x-ray examination in the policlinic one month ago, but does not want to believe that he has TB. He has been in the Machiton hospital for 2 days now. He thinks that he is in Machiton not for TB, but for being an HIV-positive patient. He told the people who share his room in the hospital that he has HIV as he wants them to know and prevent themselves from being infected. He does not know TB symptoms and thinks that one can get TB form cold water. He is not satisfied with the condition of the hospital as all services have to be paid for and the food is not good.

Patient 5 is a 37 year-old widowed female who was first diagnosed with TB in 2008 in Machiton after her husband had already died of TB. Her mother-in-law also had died from TB. Her husband got TB in Russia, where he was working as a labour migrant for 5 years. After feeling ill he returned to Tajikistan, where he was diagnosed with TB and died after 5 months of treatment. After 2 months of feeling ill with cough and loss of weight, she was taken by her brothers to Machiton (Republican TB hospital) as her husband got treatment there. She received 8 months of treatment of which 3 months were in Machiton and the rest of the 5 months at home. She learned about her status of being HIV infected in Machiton. Although she was satisfied with the treatment received in the hospital, she indicated that the doctors were too busy to answer the patients' questions about their treatment and could be more supportive to patients. Brochures and booklets on TB are available for patients as a source of information in the hospital. Her family has suffered due to the burden of paying for the symptomatic treatment. Her brothers who are working in Russia are helping her with money. She received social support from the NGO Guli Surkh.

6.2.2. NGO "Guli Surkh" Interviews

Patient 6 is a 28 year-old single male who was in prison and thinks that got TB there. He is an Injection drug user and was referred to the policlinic by the outreach workers from the

NGO Spin Plus after 2 weeks of being ill with cough and night sweats. He was scared of being revealed as an HIV-positive patient and thus did not want to seek help in a policlinic. He was referred to a doctor that the outreach worker knew and trusts (a TB specialist from the DOTS Center close to the NGO location). He was diagnosed with TB by x-ray and sputum examination and commenced treatment. He has been undergoing TB treatment for 2 weeks in the infectious disease hospital and the doctor let him go home for a few days. He doesn't believe in the curability of TB and thinks that the drugs can just stop the disease for a short time and then it will return again. He is happy with the information and the support he was receiving from outreach workers.

Patient 7 is a 40 year-old widowed female who was diagnosed with TB in 2008 in a policlinic where she went after 2 months of feeling ill. She got TB from her husband who was in prison and died from TB 2 years ago. She became ill with coughing, weight loss and fever. She didn't seek medical care for 2 months due to financial constraints. She was diagnosed with TB by x-ray and sputum examination and commenced treatment at home. She did refuse to be hospitalized due to the high cost of transportation and lack of food in the hospital. She was on treatment for six months and for another six months she took Isoniazid. She learned about being HIV infected during the treatment for TB. She felt the information provided to her regarding TB by the nurses and from brochures was good.

Patient 8 is a 44 year-old divorced female who worked for two years in Russia and was first diagnosed with TB in 2005 by x-ray and sputum examinations. She was deported from Russia and commenced TB treatment in Machiton Hospital and then at home. In total, the course of treatment was 19 month as she was told by doctors she had started treatment very late. In two months in Russia she didn't go to see a doctor as the symptoms she had were the same as a simple flu, and after being deported she spent about 2 months at home before going to the policlinic. She has two daughters and both of them had TB. One was cured, but the second one is still ill. As she had to pay for x-ray and vitamins, she had suffered a lot and had to borrow money for her treatment and for her daughters. She is not satisfied with the condition and food in Machiton. The hospital building is in disrepair with inadequate bathroom facilities which are located away from the main building. She was not satisfied with the information she was receiving regarding treatment from health providers and would suggest to have more regular education sessions from the health providers.

Patient 9 is a 37 year-old married male who had worked for 10 years as a labourer for a construction company in Russia. In January 2009, he was diagnosed with TB in a policlinic after feeling ill for 2 weeks and then returning home. He was diagnosed as a TB patient after x-ray and sputum examinations which with the help of outreach workers from NGO Guli Surkh were done free of charge. Due to lack of financial means he refused to be hospitalised and received treatment at home. He regularly took his pills and was cured after 6 months of treatment. If the condition of the hospital would be better and all services would be provided free of charge, he would prefer to be hospitalised as it prevents family from being infected with TB. He was satisfied with the information he was being provided by the health providers in terms of interviews and brochures.

Patient 10 is a 32 year-old married male who had worked 8-10 months a year for 6 years as a labourer for a private construction company in Russia. In May 2008, he was diagnosed with TB by x-ray in the TB Dispensary in Dushanbe where he was referred by outreach workers from Guli Surkh. After being diagnosed he commenced treatment for 9 months starting in Machiton hospital, which was followed by treatment at home taking drugs from Sharora hospital which is far from his home. He had to spend 2 somoni for transportation every time for taking TB drugs that was considerably high in relation to his income. He had suggested giving TB drugs to the patient for at least one-month of treatment. He had to borrow money to pay for treatment mostly for x-ray, transportation and drugs (other than TB drugs). He was not satisfied with the information on TB he had received and would like to have access to booklets or brochures on TB.

7. Conclusion

In conclusion, all of the FGDs and In-depth interviews identified a low level of accurate knowledge about TB transmission, services and that TB is curable. This lack of knowledge, and associated costs for care, can be significant barriers to seeking and receiving treatment for TB among all of the MARP groups. Increasing the availability of information and reaching out to members of these groups can contribute to earlier care-seeking and a demand for accurate and timely treatment.