



USAID
FROM THE AMERICAN PEOPLE

CENTRAL ASIAN REPUBLICS

TECHNICAL REPORT: ASSESSMENT OF INDIVIDUAL, SOCIAL AND STRUCTURAL BARRIERS TO ARV ADHERENCE IN KYRGYZSTAN AND PROPOSED PLAN OF ACTION

September 20, 2011

This publication was produced for review by the United States Agency for International Development. It was prepared by Meaghan Thumath, Aisuluu Bolotbaeva, Danielle Parsons and Dave Burrows for the Quality Health Care Project in the Central Asian Republics.

TECHNICAL REPORT: ASSESSMENT OF INDIVIDUAL, SOCIAL AND STRUCTURAL BARRIERS TO ARV ADHERENCE IN KYRGYZSTAN AND PROPOSED PLAN OF ACTION

Recommended Citation: Thumath, Meaghan, Aisuloo Bolotbaeva, Danielle Parsons and Dave Burrows. 2011. *Individual, Social and Structural Barriers to ARV Adherence in Kyrgyzstan and a Proposed Plan of Action* Bethesda, MD. Quality Health Care Project in the Central Asian Republics, Abt Associates Inc.

Contract No.: AID-176-C-10-00001

Submitted to: Bryn Sakagawa
Deputy Director, Office of Health and Education
USAID Central Asia Regional Mission

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government

CONTENTS

Acknowledgments	vii
Executive Summary	ix
1. Background and Objectives	1
<i>Epidemiology of HIV Epidemic in Kyrgyzstan</i>	1
<i>Access to HIV Treatment and Adherence Situation</i>	1
<i>Terms of Reference</i>	2
2. Methods	5
3. Limitations	7
4. Findings	8
<i>Strengths of the System</i>	8
<i>Access to HIV Treatment and Care, Coverage and Quality of Services</i>	8
<i>Survey on individual adherence strategies Results</i>	8
<i>Findings: Social and Psychosocial Support</i>	10
<i>Findings: Structural Issues</i>	11
5. Gap Analysis	12
6. Recommendations: adherence plan	16
7. Conclusion	Error! Bookmark not defined.
Annex A: List of Key Informants and Stakeholders Interviewed	19
Annex B: Focus Group Topic Guide	23
Annex C: List of focus group attendees and organizations	25
Annex D: Schedule for ARV Adherence Plan Consultancy	25
annex E: Adherence Survey for Health Care Providers and NGO Staff	27
Annex F: Bibliography	v

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
APMG	AIDS Projects Management Group
ARV	Antiretroviral medication
DOT	Directly Observed Therapy (for ARVs or TB)
FMC	Family Medicine Center
GFATM	Global Fund to fight AIDS, Tuberculosis, and Malaria
GIPA	Greater Involvement of People Living with HIV/AIDS
HIV	Human Immunodeficiency Virus
IDU	Injecting drug user
IHI	Institute for Healthcare Improvement
MARPs	Most at Risk Populations
MAT	Medication Assisted Treatment (for opioid dependence)
M&E	Monitoring and Evaluation
MoU	Memorandum of Understanding
MSM	Men who have sex with men
NGO	Non government organization
NSP	Needle and syringe program
PLHIV	Person (people) living with HIV
PR	Principal Recipient (for the GFATM)
RFP	Request for Proposals
STI	Sexually Transmitted Infections
CSW	Commercial sex trade worker
UNAIDS	UN Joint Program on HIV/AIDS
UNDP	UN Development Program
WHO	World Health Organization

ACKNOWLEDGMENTS

This report was developed with input from Pierre de Vasson and Aram Manukyan of APMG. Special thanks to Aida Kereksizova and the numerous HIV/AIDS service organizations and Ministry of Health staff who took time from their busy schedules to meet with the team. Finally, our most heartfelt thanks to the people living with HIV who shared their stories and experiences with us.

EXECUTIVE SUMMARY

This assessment examines key barriers to access to antiretroviral therapy in Kyrgyzstan and recommends a plan of action to improve adherence with a focus on most at risk populations.

The HIV epidemic in Central Asia (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) has accelerated since 2000. This expansion in the epidemic is largely attributable to escalating injection drug use, reflecting central Asia's geographic position along major drug trafficking routes[1]. Although up to 75% of cumulative HIV cases have been among injection drug users (IDUs) so far, HIV infections are increasing in other population groups, including female sex workers and their clients, prisoners, and migrants[2]. Serious barriers to prevention and treatment exist for people who use injection drugs, and the intersecting epidemic of sexually transmitted infections, particularly syphilis, highlights the potential for sexual transmission of HIV to bridging populations. HIV cases in children are escalating, with most resulting from nosocomial outbreaks in hospital settings[3, 4]. Some recent progress has been made towards scaling up prevention, treatment, and care services, including harm reduction for IDUs, although key challenges remain in access and adherence to antiretroviral medications (ARVs) for marginalized groups.

The report also makes recommendations for a more supportive policy and practice environment for those most at risk for poor adherence in Kyrgyzstan.

KEY PRIORITY RECOMMENDATIONS TO SUPPORT ADHERENCE INCLUDE THE FOLLOWING:

1) Individual and Clinical Strategies

Develop devices to aid adherence and improve staff training

Utilize peers on ARV treatment to provide counseling to patients

Develop informational materials on ARV treatment for MARPs

Develop a peer support curriculum for peer navigation and self-management of HIV

2) Social Recommendations

Increase access to HIV testing for MARPs and immediate linkage to care

Formalize support groups for PLHIV and integrate clinicians and peer education

Reduce the vulnerability of HIV positive women and mothers of HIV positive children

3) Structural Recommendations

Introduce case management into AIDS Centers with clearly defined roles, scope and responsibilities

Provide transportation subsidies to all patients

Utilize directly observed treatment (DOTs) paired with existing services such as MAT and TB treatment

Provide incentives for engagement and adherence

Re-orient VCT services to MARPs and lower the threshold for access to services

Improve contact tracing and provide anonymous peer and online options

Improve linkage to care after diagnosis and during monitoring by decentralizing CD4/VL monitoring beyond the AIDS Centres and ensuring efficient lab transport linkages from rural to urban areas

Improve quality of laboratory system for testing and disease progression

Improve linkage to care after short term prison stays [12]

Immediately adopt new WHO guidelines on treatment to limit loss to follow up

Improve procurement and supply management of lab tests

Every door is the right door: Family Medicine Centers (FMCs), needle & syringe programs (NSP), MAT clinics, TB facilities, prisons, STI clinics, OB-GYN service points, inpatient care facilities, and NGOs.

Eliminate user fees for PLHIV

Ensure access to documentation and residency cards for PLHIV

Use multidisciplinary teams to full scope by including functions on ARV prescribing

Decentralize majority of HIV services to primary care level with shared care model and specialist support from AIDS Center

Ensure FMCs, MAT sites and TB sites are financially and clinically supported

The incredible resilience of people living with HIV/AIDS in Kyrgyzstan and the great dedication to this work from the many community and health providers is a great asset to moving this adherence plan into action. What remains is a dedication from all parties to examine the complex underlying determinants of health that influence access to care and treatment in their country and to working together to meet the challenges. The rich experience of partners in the region of Central Asia demonstrates that these complex barriers can be overcome by lowering the threshold of ARV treatment services and providing innovative programs to meet the basic individual, social and structural needs of people living with HIV.

1. BACKGROUND AND OBJECTIVES

EPIDEMIOLOGY OF HIV EPIDEMIC IN KYRGYZSTAN

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

According to official statistics, the HIV prevalence rate in 2009 was 12.8 per 100,000 people in the Kyrgyz Republic. The majority (59 percent) of people living with HIV (PLHIV) are 20 to 39 years old. Although the epidemic is still dominated by injecting drug use (62 percent), recent data indicate a steady increase in a share of HIV transmission through unprotected sex from 3 percent in 2001 to 25 percent in 2009[5]. The percentage of PLHIV who are women has tripled over the last six years: from 9.5 percent in 2001 to 25.5 percent in 2009. The majority of these women were infected by sexual partners who are injecting drug users (IDUs). In 2010, 3,149 PLHIV were cumulatively registered in Kyrgyzstan, while the estimated number of PLHIV is believed to be almost 9,000 people[6].

“ I wish patients were more obedient, some people come in on time, never complain, but the IDUs we have to beg them to come... They are not ready for medication.”
FMC staff member in Osh Oblast, August 2011

According to the country’s latest sentinel surveillance results, HIV prevalence in 2009 was 14.3 percent among IDUs, 1.6 percent among female sex workers, and 7 percent among prisoners. High prevalence rates of viral hepatitis C among IDUs (53.6 percent in 2009) and prisoners (39.3 percent in 2009) indicates that unsafe injection practices are pervasive among key populations at higher risk for acquiring HIV. Prevalence of syphilis in 2009 was 33.8 percent among sex workers, 15.3 percent among prisoners, and 12.6 percent among IDUs; this illustrates high rates of unprotected sex.

ACCESS TO HIV TREATMENT AND ADHERENCE SITUATION

Antiretroviral therapy (ART) was launched in Kyrgyzstan in 2005, and is theoretically decentralized and integrated into primary health care services at the FMC level with some early innovations in multi-disciplinary teams in collaboration with non-governmental (NGO) organizations. ARV drugs are ideally provided by the network of local AIDS Centers as well as FMCs. As of October 1, 2011, 493 PLHIV were receiving ART[5]. ART is provided free of charge for patients and are fully funded by the GFATM grant.

According to the current clinical protocol (updated in 2007), PLHIV are eligible for enrolment on ART when their CD4 cell count is ≤ 350 . However, according to the findings of recent gap analyses by USAID and WHO, in practice many are started much later with advanced HIV disease. A perceived ability of a person to adhere to treatment is reportedly also considered for ART initiation in addition to the CD4 count. Therefore, active drug users not on medication assisted treatment (MAT) are often not started on treatment, regardless of their CD4 counts. The country does have a MAT program (providing methadone), although ARVs and methadone delivery services are not combined and the methadone program does not collaborate effectively with the TB or HIV program, and vice versa.

According to a 2011 unpublished WHO report, a majority of doctors responsible for ART at all levels have received special training organized either by the National AIDS Center or donor-funded projects.

Updated clinical protocols and *prikazes* are sent by the National AIDS Center to all local AIDS centers and oblast FMCs to be further distributed among infectious disease specialists at the FMCs. ARVs are distributed by the National AIDS Center. At rayon-level FMCs, the infectious disease specialist receives ARVs for patients and stores them at the FMC. There are no proper pharmacy conditions to store even small amounts of ARVs at the Bishkek City AIDS Center, so patients from that center are referred to obtain their drugs at the National AIDS Center. PLHIV receive ARVs for one to four weeks at a time, depending on their adherence. Currently, no programs combine ART with other complementary programs, such as nutrition support, TB medication (TB DOTS) or MAT.

Clinical monitoring of PLHIV is theoretically done once every six months based on clinical symptoms and CD4 counts. For Chui Oblast, CD4 counts are run at the Republican AIDS Center, where all FMCs and other AIDS Centers send blood samples for testing. Currently, access to viral load testing is limited due to poor supply chain management. Moreover, access to CD4 monitoring is not always available due to shortage of supplies; the last stockout of tests was in 2010, and lasted for six months. Without regular access to CD4 and VL services, providers are not able to properly monitor PLHIV to assess the need for treatment enrolment, nor for treatment sensitivity for those already on ART. As a result, enrolment onto treatment remains limited; as an example, out of 183 PLHIV registered in Dzhalil rayon as of December 1, 2010, only 2 receive ART[5]. When questioned about the reason for such low numbers, most respondents, including PLHIV themselves, confirmed that lack of access to CD4 counts presents a major barrier to ART enrolment.

In addition to ARV treatment, PLHIV require a range of other health services. Where ARVs are not available together with those other health services, PLHIV are required to travel extensively. Depending on their specific needs, PLHIV are also being referred by the FMC or AIDS Center specialists to different specialized services or other specialists within the FMC (e.g., TB specialists, narcologists, gynaecologists, STI specialists). Treatment of opportunistic infections (OI), excluding TB is provided either by FMC infectious disease specialists or staff at the AIDS Centers. Some medications for OI treatment (antifungal, broad spectrum of antibiotics, antivirals) are procured under the GFATM grant. Medications not procured under the GFATM, or otherwise unavailable on-site, have to be procured by the patient in retail pharmacies. During the 12 months preceding this assessment, there was a 6-month break in supply of medications for OIs, which led to stock-outs of some medications in all oblasts of Kyrgyzstan, including Chui and Bishkek City[5].

Generally, proper diagnosis of OIs, especially those requiring laboratory confirmation, remains challenging due to the low capacity of laboratory specialists and the limited experience of physicians in managing OIs. Hepatitis C testing and treatment is available for patients who can pay for it, however it is considered largely inaccessible due to cost.

TERMS OF REFERENCE

The high level of mortality of PLHIV in Kyrgyzstan, together with the low ARV adherence rate led to this assessment. The terms of reference were to complete a rapid assessment, including a gap analysis, and develop a plan of activities to increase adherence to ART in Kyrgyzstan, taking into account systemic (including procurement/supply management), clinical (including medical education and practice), social (including stigma towards MARPs) and individual factors, and recommending both actions to improve adherence and a timeline in which these actions should be undertaken.

Though the ultimate outcome of this assessment and action plan is to improve adherence to ART, this assessment takes into the entire continuum of care surrounding HIV services, in order to most effectively assess barriers and gaps in care that contribute to poor ART adherence. Figure 1 illustrates a number of different points along this continuum which can positively or negatively affect adherence to ART.

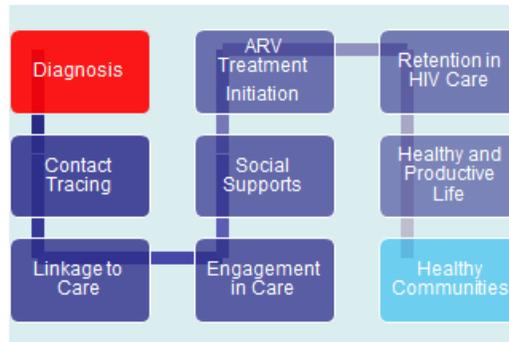


FIGURE 1: CONTINUUM OF HIV FOR PLHIV AND OPPORTUNITIES TO MAXIMIZE ADHERENCE ACROSS THE SYSTEM

2. METHODS

Using appreciative inquiry and a mixed methods approach including qualitative tools such as focus groups and key informant interviews and quantitative tools including a survey of providers, a rapid assessment of adherence barriers was conducted in three weeks in August-September 2011.

Phase One included a desk review of the literature, both published and grey, including unpublished reports provided by USAID (including those from the Quality Health Care Project), WHO, and UNDP.

Phase Two included study design to address gaps unaddressed in the literature review and design of a schedule and tools for interviews

Phase Three included over 20 key informant interviews with stakeholders in Kyrgyzstan, including policy makers, clinicians, NGOs, government, and international agencies. Six focus groups with PLHIV were also conducted including IDUs, CSWs, MSM and women and children. When visiting organizations, LEAN methodologies were used to conduct observations and develop clinical pathways, and A3 sheets were utilized for problem solving access to care and treatment. Spot audits were conducted on-site to assess availability of supplies and services that can influence ART adherence, including ARVs, harm reduction supplies, laboratories, and quality improvement and adherence tools.

Phase Four included a survey to assess the adherence support tools currently being used, or planned to be used in the future, by clinicians and NGOs for ARV treatment and support programs.

3. LIMITATIONS

This rapid assessment of the current situation related to ARV adherence was completed in less than two months. Due to time constraints, it was only possible to speak to clients who are currently accessing services, leaving the need for further study with those most marginalized from care and ARV treatment. It was not possible under the scope of this assessment to complete full mortality and morbidity analyses or independent study of treatment databases, leaving the need for a comprehensive follow-up assessment to examine patterns in ART adherence related to treatment outcomes. Similarly, due to time and budget constraints the sample size of the survey on the use of individual adherence support strategies is very small and it is not possible to generalize findings beyond the scope of this assessment.

The quote below from a young woman living with HIV in a focus group illustrates the complexity of taking antiretrovirals in an environment of poverty, gender based violence and system barriers[7]. Considering the complex social and structural issues surrounding ART adherence, it is possible that some details have been missed or misunderstood during the course of this assessment. However, it is hoped that the larger themes and the voices of people living with HIV are captured herein.

“My husband says you and the kids brought this sickness on me. He did not believe me that I need to go to the regional AIDS Center, he says: you want to go to the city to wear nice clothes and leave me, I don’t believe you need to see the doctor. Then he beats me. So I can’t get my ARVs or my CD4s.” Mama Plus Focus Group Participant, August, 2011, Kyrgyzstan

4. FINDINGS

STRENGTHS OF THE SYSTEM

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

In terms of treatment innovations, the country has begun some early piloting of multidisciplinary team models although these teams have been hampered by their lack of ability to prescribe and dispense ARVs. There is also widespread use of provider initiated routine offer of HIV testing which can improve access to early diagnosis and linkage to care in detoxification services, prenatal clinics and prison. Finally, there is a generally supportive legislative framework for human rights including antidiscrimination laws for PLHIV and MARPs, although challenges remain in human rights and relationships with police and the justice system.

ACCESS TO HIV TREATMENT AND CARE, COVERAGE AND QUALITY OF SERVICES

According to a recent unpublished WHO Kyrgyzstan report, there are a cumulative 2977 PLHIV registered, and currently alive, as of the end of 2010 (WHO, 2011). Of those, only 36% (1074) were seen for care in 2010, meaning that they contacted health system because of their HIV positive status at least once during a one-year period.

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

Moreover, the high percentage of those undergoing CD4 monitoring who are indicated for ART initiation also indicates that, at a population level, the immediate need for ART is significantly higher than the number of people currently enrolled. This unmet need has serious implications for accurate forecasting of ARV needs, to assure that procurements reflect the actual need for medications in country.

According to WHO, of the 548 PLHIV ever started on ART, only 65% (356) of them were enrolled at the end of 2010. Reasons for ART dropout for 192 patients were: 70 (36%) due to death, 25 (13%) due to intolerance and lack of adherence, the rest (97 = 50%) have been lost to follow up. Unfortunately, extremely limited data exist on access to ARVs for specific MARPs. Key informant interviews and experiences in other countries indicate barriers to ARVs are highest for IDUs, CSWs and women with children living in poverty[2, 8], but reliable data are urgently needed to appropriately address access to, and retention on, ART among specific risk groups.

FINDINGS: ADHERENCE STRATEGIES USED IN THE HEALTH SYSTEM

To determine whether a standardized approach is used to support adherence in KR, a brief survey was undertaken of ten (10) people involved in health services for PLHIV in Bishkek. Respondents included three (3) medical staff from the National AIDS Center, three (3) narcologists from the National Narcology

Center, two (2) NGO staff working with multidisciplinary teams and one (1) doctor from a Family Medicine Center.

Within this highly trained and supported group, wide variation was found in approaches to ARV adherence support and even in estimating appropriate levels of adherence. Most of the respondents considered themselves in charge of HIV/AIDS services; half considered themselves as other health providers providing care for HIV patients. The FMC staff member did not consider him/herself involved in provision of HIV services at all, yet this person is a family doctor in a clinic with a substantial caseload of PLHIV. All 10 respondents stated that their health facility provides VCT. Only the Narcology Center provides MAT and social support to assist adherence. ART could be prescribed by only 4 of the 10 respondents, 3 of whom work at the National AIDS Center.

According to the results of the survey, CD4 count, viral load and lymphocyte counts are conducted only in the AIDS Centers. The National Narcology Center and NGO respondents reported involvement in blood sampling for HIV. Only the National AIDS Center and MDTs reported involvement in ARV treatment (5 respondents). In both MDTs interviewed, the physician was from an AIDS Center.

Respondents stated that ARVs are mainly dispensed on a monthly basis or every 2-3 weeks. According to AIDS Center staff, ARVs for established patients can be picked up by a patient, a registered support person, family member or community health worker; however, NGOs representatives report that only patients were allowed to collect their ARVs, and, in exceptional cases, community health workers could be granted permission to do so.

The following are the top 5 data most frequently available in the records for each clinic visit of ARV patients (in descending order):

1. Reported side effects
2. Number of pills of ARV dispensed (by type)
3. Expected days' supply of ARV dispensed (by type)
4. Date of next scheduled clinic visit
5. Providers' impression of recent patient adherence

Only 3 respondents-reported the use of other data for monitoring of patient adherence, which included: a patient medical card; a notebook where the patient was asked to write all feelings and side-effects experienced during ART; CD4 count; VL; patients' knowledge of ARVs (the color of ARVs in the specific regimen, commonly-reported side effects).

All 5 respondents involved in ARV treatment stated that individual patient adherence to ART is mainly monitored by the doctor. Three out of 5 respondents involved in ARV treatment reported that their facility calculates numerical rates of adherence to ART for an individual patient from the patient level monitoring data; however, only 3 reporting this practice were aware of the formula used for such calculations.

While international research suggests 95% adherence to ARVs is required to prevent the emergence of resistant virus¹, only 3 respondents could state what rate of adherence to ARVs is considered to be satisfactory for an individual patient in their facility; answers ranged from 70% to 100%.

Respondents report that adherence to ART is not monitored regularly; only the two MDT respondents could offer data, which were from the end of 2009. These respondents reported overall adherence rates of their clients to be 70% and 100%, respectively.

The majority of respondents involved in ARV treatment stated that their organizations have established systems to follow up with patients who do not appear for a scheduled appointment.

¹ Paterson DL, Swindells S, Mohr J, et al. Adherence to protease inhibitor therapy and outcomes in patients with HIV infection. *Ann Intern Med* 2000;133:21–30

Respondents reported using a wide range, and combination, of interventions to promote patient adherence, indicating a lack of a standard approach. Interventions used by respondents were as follows:

- Adherence readiness counseling before starting ARVs - 10 respondents currently using
- Continuous adherence counseling after starting ARVs - 5 using

Among survey respondents, many were planning to introduce the following methods, already in use by a limited number of respondents:

- Community based health workers or volunteers – 3 using, 2 planning to use
- Require support person/care partner to observe treatment (DOT) – 4 using, 1 planning to use
- Social support – 1 using, 4 planning to use
- Systematic monitoring of medication adherence at the clinic – 3 using, 1 planning to use
- Fast track service at health facility – 2 using, 2 planning to use
- Use of a device to promote adherence (mobile phone alarms, wall charts, pagers or timers) – 3 using, 1 planning to use
- Reminder phone calls – 3 using, 1 planning to use
- Directly observed treatment – 3 using, 3 planning to use
- Medication Assisted Treatment – 4 using, 3 planning to use
- Other financial incentives – 2 planning to use

Four of 10 respondents stated they were using interventions aimed at improving health providers' motivation to promote better patient adherence, including as advocacy work with health providers, mini sessions, and training of health providers' staff. Only 2 respondents stated that their organization has evaluated the interventions employed to promote patient adherence: both stated that the results were positive.

If resources were unlimited, respondents would like to have the following interventions to promote adherence to ART (in order of demand):

- Financial motivation of client
- Financial motivation of service provider
- Information materials for clients
- Peer consultants
- Stationary observations in the beginning of ARV treatment
- Assistance to meet basic needs of the client
- More doctors prescribing & dispensing ARVs
- Provision of ARVs along with MAT
- Psychological assistance
- Reimbursement of transportation costs of client

FINDINGS: INDIVIDUAL AND SOCIAL ISSUES

A positive HIV diagnosis can create a huge psychological burden on the individual receiving the diagnosis and his/her support network, including the parents of HIV positive children. A positive status gives rise to uncertainty in all spheres of life, including the quality of life and life expectancy, the effectiveness of treatment, and the reaction of the community to the changed status of the person.

Reactions to a positive diagnosis are hard to predict, and may include shock, denial, fear, reduction of self-esteem, depression. These emotional states may be recurrent, and adequate psychological support must be available not only during post-test counseling, but throughout the continuum of the patient's lifetime in care, at any time upon request.

Officially each AIDS Center has a psychotherapist in the staff list, but often an existing staff member performs counseling in addition to his/her main job. If a patient needs consultation with a psychotherapist, he/she is referred to an appropriate specialist at a partner NGOs or FMC, or maybe also be seen by a non-psychotherapist physician at the AIDS Center, although these physicians themselves express concern over this practice and note that not everyone is skilled to provide proper psychological support to PLHIV. Furthermore, physicians from AIDS centers cannot prescribe antidepressants, which can be prescribed only by psychotherapists.

Physicians at AIDS Centers, NGO representatives and the participants of focus groups with different MARPs highlighted the need of peer consultants for PLHIV throughout the continuum of care, from immediately post-diagnosis to enrolment and continuance on ART. PLHIV focus group members stated that the best psychological support they receive is from peer consultants.

During focus group discussions, different risk groups were identified as presenting with differing needs for social and psychological support services to assist with ART adherence. Identified needs of specific MARPs included:

NGOs working with IDUs mentioned the need for special psychological support for pregnant IDUs, as pregnancy may cause increased anxiety. Drug users, and NGOs working with drug users, stated that due to experiences of trauma and complex health issues, drug users may experience untreated pain and discomfort. Many people needing ARV treatment may be reluctant to start, due to fear of side effects. It is also important to regulate the dose of methadone for those who start ARV treatment after being enrolled to MAT programs, in order to prevent withdrawal syndrome.

Reduction of the double stigma for IDU and CSW living with HIV. Fear of learning about their positive status stops many young IDU and SW from testing for HIV. They know they are at risk for HIV infection however confidentiality is a major issue, and positive drug users or sex workers fear double stigma.

Dealing with domestic violence for HIV-positive women: HIV positive women and/or mothers of HIV positive children frequently become victims of domestic violence, including psychological abuse. The main aggressors are husbands and mothers-in-law.

Poverty and family issues for IDUs: Most IDUs lose their connection to families when they start using drugs, and most active drug users are not employed and do not have stable income. Food security was also reported as a significant issue for the families of positive IDUs.

Sexuality support for positive MSM: An MSM focus group reported that young MSM especially need psychological support, as they are more vulnerable than other MSM. Food security was also reported as a significant issue for the families of HIV positive children. Families with HIV positive children on average have 4-5 children and have difficulty providing even one hot meal for the family per day, often just potato soup. Children are usually given only tea with bread.

FINDINGS: STRUCTURAL ISSUES

HIV/AIDS treatment and care services have been theoretically decentralized across the country to 9 AIDS Centers and 66 FMCs. However, decentralization of service has not been accompanied with defining roles and responsibilities of different health system levels to ensure continuity and quality of services. During this assessment, the assessment team did not encounter any FMCs that could actually prescribe or even dispense ARVs; all ARVs had to be picked up at the Regional AIDS Center (up to 6 hours away for some patients). Only the National AIDS Center in Bishkek and Osh City AIDS Center can prescribe ART, give out medications to PLHIV, and perform immunological and virological tests (CD4 cell count and VL)[5],

which are essential for decision on timely ART initiation and monitoring its effectiveness. They are also the only providers who can do laboratory confirmations of HIV.

Since other facilities are not permitted to perform laboratory tests and stock ARVs, they have to send blood samples for HIV initial testing and confirmation, and each time they see an HIV infected patient, the patient must be referred to the National AIDS Center or City AIDS Center in Osh for CD4 cell and viral load monitoring, or for obtaining ARV medications.

This creates substantial additional barriers for patients in receiving services, as they have to visit both their local FMC and AIDS Center. It also makes the role of the infectious disease specialists in the FMC very unclear. Even in the innovative MDT teams set up by NGOs, the infectionists cannot actually prescribe or dispense ARVs, which essentially prevents them from achieving their primary goals of supporting PLHIV on therapy.

There are many other structural issues referred to below, best summed up by the lack of a continuum of care for PLHIV, ensuring all their health and support needs can be met at minimal cost in both time and money. There are also specific gaps related to specific MARPs. For example, the shelter for MSM cannot accept people between the ages of 16-18, due to local legislation, at the same time this group cannot receive services from shelters for children either.

5. GAP ANALYSIS

A summary of the gaps observed include:

Individual and Social Gaps

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

Structural Gaps

- Vertical HIV services with little integration into TB, STIs, NSP or OST systems
- Major supply chain and procurement issues (infant formula, food packages, HIV tests, CD4 and VL testing, ARVs, OI drugs, drugs to ease side effects (SE), etc.)
- Quality concerns in all spheres of HIV prevention, treatment, care and support

“Please take care of our children, don’t worry about us. Our lives are already over, just take care of our children... I don’t even cry any more. I have no more tears.”
Mother living with HIV, August 2011, Kyrgyzstan.

- User pay models make services inaccessible for MARPs
- Major barriers to documentation/identification impacting access
- Monitoring and evaluation system weak on outcomes and access for MARPs
- Major issues with infection control and universal precautions

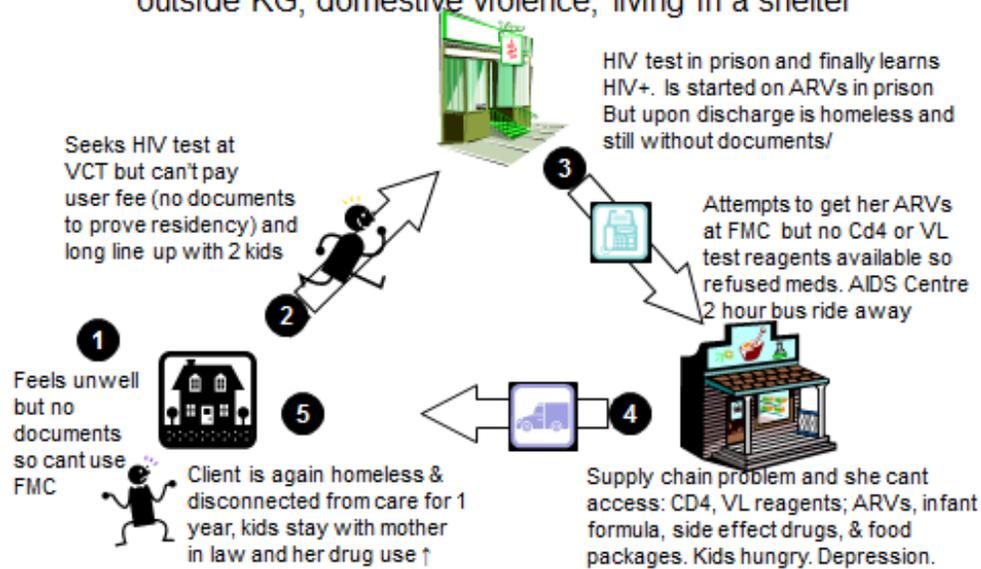
- Poor access to HIV testing for MARPs
- High threshold, high barriers to services
- Accessibility issues: geography, culture, gender
- Weak linkages to care after diagnosis
- Gender sensitive services lacking in most spheres including for women and lesbian-gay-bisexual-transgender (LGBT) communities
- Lack of child and youth friendly services
- Limited linkages to public health and prevention benefits of treatment as prevention
- Stigma and discrimination of MARPs and PLHIV
- Human rights abuses of MARPs

The below case study illustrated the difficulty some people living with HIV face in accessing ARVs and successfully adhering to treatment. It is but one of many powerful stories heard during the assessment that illustrated again and again that barriers in the system rather than lack of patient motivation were the greatest impediments improved ART adherence.

Case Study 1

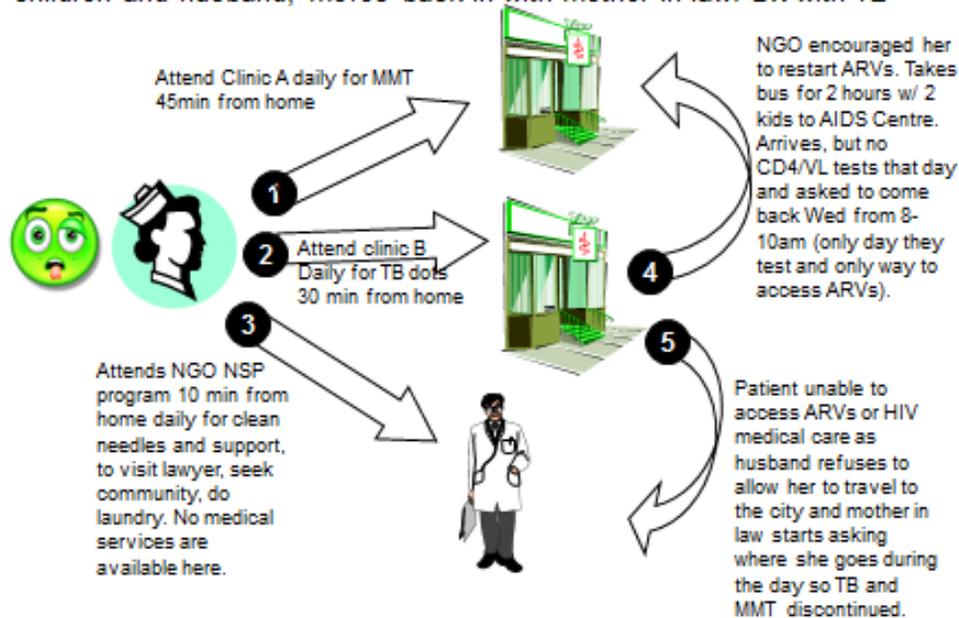
Barriers to ARV Adherence in KG: Value Stream Map of Female IDU:

32 year old female, 2 children, no documents as born outside KG, domestic violence, living in a shelter



1 year later: Connected to NGO for IDUs

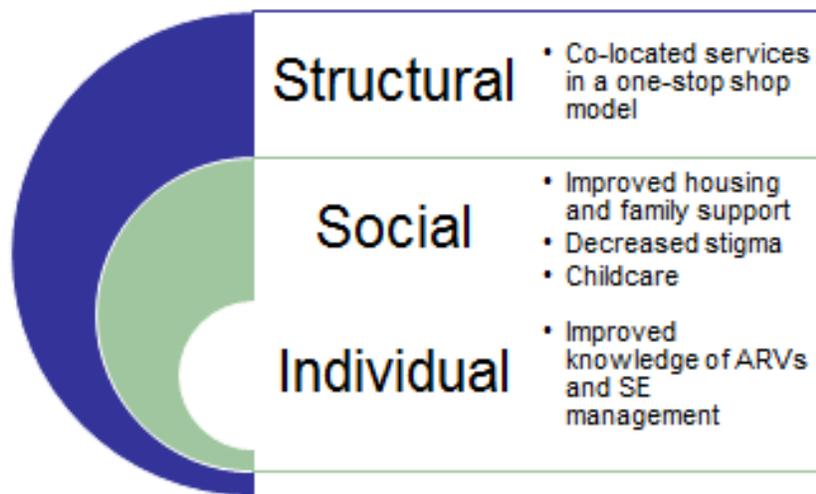
Is started on methadone with NGO support and reconnects with her children and husband, moves back in with mother in law. Dx with TB



The dispensing of weeks or one month of ARVs at a time, while understandable due to the long distances travelled to pick up medications, represents a missed opportunity for MAT/DOT programming. At the same time, the insistence that patients pick up ARVs is also a high barrier to care, especially for patients travelling long distances or with children or working.

In an ideal LEAN² scenario, this client would have access to the right services, at the right time, with minimal wait. Every door for her should have been the right door – through which she could access the services she needed, either from the facility itself or through easy referral from another facility (e.g. TB or narcology services) rather than having to move around the city and face insurmountable obstacles to care and treatment. The below figure highlights an ideal model of service for clients facing multiple barriers of care:

Figure 2: Ideal Access Model for Case Study



² Lean Healthcare (adapted from the world class best practices of the Toyota Production System) is an innovative approach that provides a health care network with efficient, outside the box solutions. It involves employees' participation and it focuses particularly on: Patient needs and satisfaction; reduction in waiting and response times; quality improvement; cost reduction; employee quality of life.

6. RECOMMENDATIONS: ADHERENCE PLAN

A detailed plan of action to improve adherence to ARVs in Kyrgyzstan by addressing the individual, social and structural barriers to care is attached in the appendix using a logical framework. Of critical importance to these recommendations is a philosophical underpinning grounded in the scientific evidence that the biggest barriers to care for MARPs are in fact social and structural and often beyond the individual drug user's control[8, 9]. These barriers can be overcome and many regions around the world including Ukraine, Russia, Canada[10], Brazil, and Australia have successful ARV treatment programs for MARPs that combine social and medical interventions in a one-stop shop model that integrates other needed services with ARVs[11, 12]. In this era of treatment as prevention, where comprehensive social programs that support ARVs for MARPs are associated with decreased community viral load and decreased population levels of HIV, now is the time to invest universal access for all PLHIV[13].

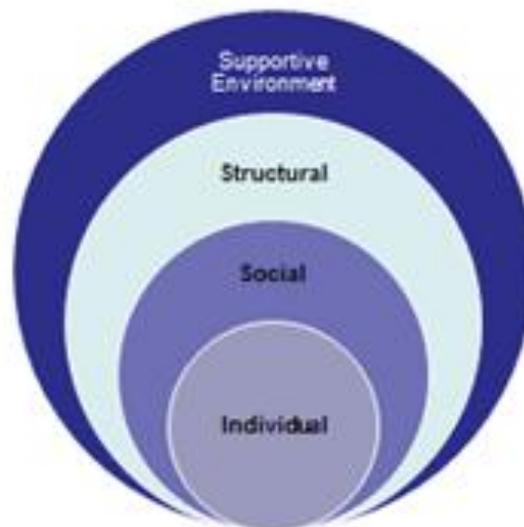


Figure 3 Model of Barriers and Facilitators for ARV Adherence Plan

Similarly, the recommendations incorporate the growing body of literature that supports a chronic disease model approach to treating HIV/AIDS, that incorporates principles of patient empowerment and patient self-management as core components of HIV care[14, 15]. Patient self-management is defined as the ability of patients, in a complementary partnership with their health care providers, to manage the symptoms, treatment, lifestyle behavior changes, and the many physical and psycho-social challenges that are a part of living with chronic diseases[16].

Below is a high level summary of the key recommendations:

1. Recommendations for Individual and clinical strategies

Implement devices to aid adherence -mobile phone alarms, wall charts, pagers or timers

Improving training of medical staff and peers to proactively address side effects (SE) and provide supportive SE therapy especially during treatment initiation

Ensure physicians or nurses are available 24/7 to answer questions about missed dosages or SE

Use peers on ARV treatment to provide peer counseling on ARV adherence

Formalize support groups for PLHIV and integrate clinicians and peer education on ARV treatment

Complete a request for proposals to translate or develop IEC materials on ARV treatment for MARPs including: IDU/CSW/MSM, women & children, prisoners, migrants

Provide adherence support materials in variety of languages and with a low literacy level. Suggestions from PLHIV include: videos of PLHIV on ARVs, cartoons for children, online modules on why take ARVs, health care diaries or log books to record CD4, meds, etc.

Develop a peer support curriculum of peer navigation or self-management of HIV

2. Social Recommendations

Introduce case management into AIDS Centers with clearly defined roles, scope and responsibilities

Provide transportation subsidies to all patients

Pilot directly observed treatment (DOTs) for ARVs paired with existing DOT services such as MAT and TB, often called maximum assisted therapy (MAT).

Expand the scope of NGOs and MDTs to include low threshold ARV programs in community settings not just AIDS Centers.

Provide incentives for engagement and adherence: Vouchers or cash (instead of food packages) for IDUs, CSW, women and families, mobile phone cards for MSM

3. Structural Recommendations

- Re-orient VCT services to MARPs and provide low threshold mobile and NGO based rapid testing paired with attractive services: possibly including abscess care, HCV testing, legal, dental, support services, vaccines, etc
- Improve contact tracing and provide anonymous peer and online options
- Improve linkage to care after diagnosis and during monitoring by decentralizing CD4 and VL testing
- Improve linkage to care after short term prison stays[17]
- Immediately adopt new WHO guidelines on treatment to limit loss to follow up
- Immediately open access to CD4 and VL testing beyond AIDS Centers
- Procure an efficient system for transporting lab samples from NGOs, FMCs, prisons, OST sites, TB sites, etc.
- Improve the quality of CD4 and VL laboratory system
- Add resistance testing for treatment failure concerns
- Improve the procurement and supply management of lab tests including RPR, HCV, HIV monitoring and HIV testing including rapid testing
- Every door is the right door to HIV care and treatment for patients be it NSP, TB, Prison, OST, STI, Hospital, Maternity Services, NGOs, etc.
- Eliminate user fees for PLHIV for vaccines, HCV testing, labor and delivery services
- Ensure access to documentation and residency cards for PLHIV
- Use multidisciplinary teams to full scope by including functions on ARV prescribing and dispensing and enhancing comprehensive services
- Decentralize the majority of HIV services to primary care level with shared care model and specialist support from AIDS Centers
- Ensure FMCs, OST sites and TB sites are financially and clinically supported to provide HIV care including treatment

7.NEXT STEPS

UNDP should seek feedback on these preliminary recommendations from stakeholders and make the necessary revisions to ensure this document is in line with the needs of PLHIV in Kyrgyzstan. Thereafter, a detailed plan of activities needs to be costed by the KG GF project and examined with key actors assigned to each task. Ideally this should be done at a forum or strategic planning day with all stakeholders. There should be feedback on the final adherence plan from stakeholders to ensure buy-in and full participation of PLHIV and MARPs. Ideally the adherence plan will be well integrated into GF funded activities.

The incredible resilience of people living with HIV/AIDS in Kyrgyzstan and the great dedication to this work from the many community and health providers is a great asset to moving this adherence plan into action. What remains is a dedication from all parties to examine the complex underlying determinants of health that influence access to care and treatment in their country and to working together to meet the challenges. The rich experience of partners in the region of Central Asia demonstrates that these complex barriers can be overcome by lowering the threshold of ARV treatment services and providing innovative programs to meet the basic individual, social and structural needs of people living with HIV.

ANNEX A: LIST OF KEY INFORMANTS AND STAKEHOLDERS INTERVIEWED

Anna Chernyshova	Programme Manager	GFATM Grants Implementation Unit in Kyrgyzstan, UNDP
------------------	-------------------	--

Alтынay Arstanbekova	HIV Coordinator	GFATM Grants Implementation Unit in Kyrgyzstan, UNDP
Jyldyz Kurmanalieva	Director	Republican AIDS Center
Aigul Ismailova	Deputy Director	Republican AIDS Center
Altyn Abdyldaeva	Head of Surveillance and Treatment Department	Republican AIDS Center
Erkin Tostokov	Doctor, PMCT Specialist	Republican AIDS Center
Ulan Sarymsakov	Doctor, TB co-infection Specialist	Republican AIDS Center
Erkin Bakiev	Doctor	Republican AIDS Center
Aibek Mukambetov	Programme Director	Soros Foundation Kyrgyzstan
Madina Tokombaeva	Executive Director	Harm Reduction Association of Kyrgyzstan
Andrei Palastrov	Director	NGO “Cairos”
Irina Pugacheva	Director	NGO “Alternativa narcologii”
Iren Ermolaeva	Director	NGO “Asteria”
Nurgazy Toktonazarov	Deputy Director	FMC Karasuu
Baatyr Abdullaev	Narcology Doctor	OST site, FMC Karasuu
Aigul Appazova	Nurse	OST site, FMC Karasuu
Baktygul Abdyraeva	Head of Surveillance and Treatment Department	Osh Oblast AIDS Center
Stalbek Ayilchiev	Doctor	Osh Oblast AIDS Center
Ravshan Majitov	Director	Plus Center
Elmira Osmonova	Coordinator of outreach workers	Plus Center
Stas Karimov	Co-funder, social worker, addiction consultant	Plus Center
Oksana Katkalova	Deputy Head of International Cooperation Department	State Service of Corrections
Adylbek Chotbaev	Senior Inspector-Epidemiologist	State Service of Corrections
Baatyr Kalygulov	Head	Prison #2
Nazgul Abdykalykova	Nurse	Prison #2

Meerim Uzbekova	Nurse	Prison #47
Damira Bibosunova	Regional GFATM Liaison for Central Asia	PEPFAR Office, Consulate General of the United States of America
Dilshat Abasov	Social worker	NGO “Terra Sana”
Ruslan Tokubaev	Director	Republican Narcology Center
Elmira Kalieva	NSP Coordinator	Republican Narcology Center
Aizada Usenakunova	MAT Doctor	Republican Narcology Center
Olga Lyachina	NSP	NSP site, FMC #6
Shailoo Dairakunova	Family medicine doctor	FMC #6
Vera Solomahina	Family medicine doctor	FMC #6
Gulmira Tulekova	Head	FPG
Margarita Sabirova	Project Coordinator	NGO “Mutanazif”
Niazbekova Mahabat	Programme Coordinator	Population Services International
Chinara Bakirova	Executive Director	Anti AIDS Association

List of participants at the presentation of preliminary findings and recommendations at UNDP KG Office August, 2011

Danielle Parsons	Regional HIV Manager	Quality Project
Chinara Seitalieva	Country HIV Director	Quality Project
Meaghan Thumath	Consultant	Quality Project
Aisuluu Bolotbaeva	Regional HIV Specialist	Quality Project
Aida Kereksizova	Interpreter	Quality Project
Saltanat Ashimova	National Coordinator	CARHAP
Cheryl Kelly	Regional Programme Director	CARHAP
Saliya Karymbaeva	HIV/STI Programme Coordinator	WHO
Djamila Alisheva	Country Director	PSI
Altynai Arstanbekova	HIV Coordinator	GFATM Grants Implementation Unit

Anna Chernyshova	Programme Manager	GFATM Grants Implementation Unit
Aibek Mukambetov	Programme Director	Soros Foundation Kyrgyzstan
Batma Estebesova	Director	NGO “Sotsium”
Burul Isaeva	Director	Association of PLHIV “Edinstvo LJV”
Nurdin Almalikov	Doctor	State Service of Corrections
Jyldyz Kurmanalieva	Director	Republican AIDS Center
Dilshat Abasov	Social worker	NGO “Terra Sana”

ANNEX B: FOCUS GROUP TOPIC GUIDE

Please provide a description of the services provided here

What are the barriers in your community to:

HIV testing?

ARV Treatment initiation?

ARV Adherence?

What strategies to do you use to support ARV adherence?

What resources are needed to improve access to ARV treatment and ARV adherence for you and your family or your community?

Probe on specific adherence strategies not yet mentioned and explore cultural relevance

Individual

Social

Structural

ANNEX C: LIST OF FOCUS GROUP ATTENDEES AND ORGANIZATIONS

Name of the organization	Type of clients	Number of Participants and Gender
Harm Reduction Association of Kyrgyzstan	Ex and active IDUs, clients of methadone programme, PLHIV	3 women, 6 men, 1 child
Tais Plus	Sex workers, PLHIV	7 women, 1 man
Terra Sana	PLHIV	2 Males, 3 Females
Mama +	PLHIV, mothers of HIV positive children, pediatric PLHIV	10 Females, 5 children (aged 3-7)
Osh Oblast AIDS Center	PLHIV	5 Males
Anti AIDS Association	MSM and Queer community	5 men, 2 women

ANNEX D: SCHEDULE FOR ARV ADHERENCE PLAN CONSULTANCY

17-27.08.2011

Time	Meeting with	Venue	Comments
Wed, August 18 th			
10:30-11:30	GFATM\UNDP PIU Anna Chernyshova, Ainura Esenamanova	Офис ГФ, Панфилова 142 (# Боконбаева) 0777 91 43 33; 301 110	To discuss in detail the expected final product
11:30 - 12:00	Republican AIDS Center, Jyldyz Muratovna	Логвиненко 8, 62 38 23 (пр)	To update her about the activity and get her political support
12:00 – 13:00	Lunch		
13:30 - 15:30	Doctors and other AIDS center staff involved in ARV forecasting and procurement management, doctors prescribing ARV		
16:00 - 18:00	NGO "Terra Sana", Evgenia Kalinichenko	0557 22 79 79, terrasanakg@gmail.com	FG of PLHIV + Mtg with community based NGO of PLHIV
Fri, August 19 th			
9:30 - 11:00	Harm Reduction Association "Partners' Network", Aibar Sultangaziev*	0555 61 95 58, Адрес 6-5-33	
11:30 - 13:00	Harm Reduction Association, Madina Tokombaeva*	0552 497979 Юг 2, Вефа центр	
13:00-14:00	Lunch		
14:30 - 16:00	FG with IDU*	0552 497979, Юг 2, Вефа центр	
16:30-18:00	NGO "Asteria", Iren Ermolaeva	0557 100 623	Issues of female IDU, first drop-in center for female IDU in CA
Mon, August 22 nd Osh			
10:30-12:00	NGO "Life+", Galieva Altytay	0550 28 51 31	Mothers of HIV+ kids
12:00-13:00	Lunch		
14:30-17:00	NGO "Mama+", Mustafakulova Dulfusa	16, Kalinina, Nookat 0555 74 86 18	FG of PLHIV and mothers of HIV+ kids
Tues, August 23 rd Osh			
09:00 – 10:30	Kara Suu FMC, Baatyrova Gulnara*, Family medicine specialist	0555 01 41 41	
10:30 – 11:30	OST site visit in Karasuu, Drug addiction specialist		

12:00 - 13:00	Lunch		
13:30 – 15:00	Osh Oblast AIDS Center,* Narmatova Elmira	0550 84 03 01	
15:30 - 16:30	Plus Center, Ravshan Majitov*	Моминова 22, 0543 17 50 40	
Wed, August 24 th			
9:30 - 10:30	State penitentiary system, Oksana Katkalova	0772 62 65 81, ГСИН, правда#киевская	
11:00 - 17:00	Visiting prisons #2 (women) and #47 (medical)		
Thurs, August 25 th			
10:00– 11:00	Republican Narcology Center, Tokubaev Ruslan	0777 97 12 62, Тыныстанова 195, проект «Качественное здравоохранение»	
12:00 – 13:00	Lunch		
13:00 – 13:30	FMC #6, * Pamir Muratov	0550 45 21 73, Жукеева пудовкина	
13:30 - 14:30	FMC#6, Shaivo Daironova*	0772 63 22 01	To get more information regarding pregnant women, HIV testing, ARV in FMC
16:00 – 18:00	NGO "Gender Vector", Sergey Kostenko*	0553 204 072, Г. Кара-Балта	FG with MSM in Kara- Balta (1.5 hours of drive from Bishkek)
Fri, August 26 th			
9:30- 11:00	AIDS Service Organizations, Chinara Bakirova*	0555 337412 возле мечети – Шелтер для МСМ	Association that provides services for SW, MSM, PLHIV
11:30 - 13:00	NGO "Tais Plus",* Shahnaz Islamova	Панфилова 36а, 0555 88 93 07	SW FG
14:00 - 16:00	GFATM/UNDP PIU	Офис ГФ, Панфилова 142 (# Боконбаева) 0777 91 43 33; 301 110	Updating about key findings and recommendations, etc
16:30 – 18:00	Association "Unity of PLHIV",* Burul Isaeva	Our office 0555 74 66 01	

ANNEX E: ADHERENCE SURVEY FOR HEALTH CARE PROVIDERS AND NGO STAFF

ВОПРОСНИК

Опрос по приверженности к антиретровирусной терапии на уровне организации здравоохранения

Имя интервьюера: _____ Дата: _____ Место проведения: _____

Название клиники или организации здравоохранения: _____ Имя респондента: _____

1. Какое из нижеследующих описаний соответствует природе и характеру вашей позиции или должности? (Укажите все соответствующие варианты)

- Лицо, ответственное за услуги, предоставляемые в сфере ВИЧ/СПИДа
- Врач, наблюдающий ВИЧ-пациентов
- Провайдер других медицинских услуг, оказывающий уход за ВИЧ-пациентами
- Другое, пожалуйста опишите _____

2. Какое из нижеследующих описаний более всего соответствует природе вашего учреждения? (Отметьте один из вариантов)

- национальная больница третичного уровня
- Областная/районная больница
- Другая организация здравоохранения, пожалуйста опишите: _____
- Благотворительная/миссионерская/религиозная/неправительственная больница
- Другая благотворительная/миссионерская/религиозная/неправительственная организация здравоохранения, пожалуйста опишите: _____
- Частная больница
- Военное медицинское учреждение
- Другой вариант частного медицинского учреждения, пожалуйста опишите: _____
- Общинная организация
- Программа на рабочем месте
- Другое (пожалуйста опишите): _____

Описание (интервьюирование менеджера организации здравоохранения, оказывающей слуги в сфере ВИЧ)

3. Какие услуги в сфере ВИЧ предоставляет ваша организация? (укажите все соответствующие варианты)

- Лечение АРВ препаратами для взрослых
- Лечение АРВ препаратами для детей
- Добровольное консультирование и тестирование (ДКТ)
- Профилактика передачи от матери к ребенку (ППМР)
- Профилактика Котримоксазолом для ВИЧ-инфицированных пациентов
- Профилактика Изониазидом для ВИЧ-инфицированных пациентов
- Уход на дому

I I Другое (пожалуйста опишите): _____

4. Какие из лабораторных тестов ваша организация оказывает на постоянной основе? (Укажите все соответствующие варианты)

- Вирусная нагрузка
- Число CD4 клеток
- Число лимфоцитов
- Другое (пожалуйста опишите):

5. Когда вы начали выдачу АРВ препаратов пациентам?

6. Сколько взрослых на данный момент получают АРВ-терапию на базе вашей организации?

7. Сколько детей на данный момент получают АРВ-терапию на базе вашей организации?

Политики и стратегии в отношении антиретровирусной терапии

Для пациентов уже принимающих АРВ-препараты

8. На какой период времени обычно выдаются АРВ препараты амбулаторным пациентам, находящимся на АРВ-терапии?
(Укажите один из вариантов)

- ежедневно
- еженедельно
- на одну-три недели
- ежемесячно
- на один-три месяца
- более чем три месяца
- не известно

9. Кому разрешается забирать АРВ-препараты для пациентов, находящихся на АРВ-терапии?
(Укажите все соответствующие варианты)

- Пациент
- Зарегистрированное лицо, осуществляющее уход за больным
- Член семьи
- Медицинский работник на общинном уровне
- Другое, пожалуйста опишите: _____
- Не известно

Клинические данные и мониторинг приверженности АВ-терапии

10. Как часто ведется учет следующих данных при посещении вашей клиники АРВ-пациентом (хранятся ли в клинике медицинские записи или записи по учету выданных препаратов)? (Интервьюер должен)

Тип данных	Всегда	Обычно	Иногда	Никогда
График дозировки АРВ препаратов	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Названия других препаратов, принимаемых пациентом	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Сообщения о побочных эффектах	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Самоотчет пациента о приверженности за последний период	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Результаты обзора календаря по приему препаратов пациентом, изложенные провайдером в письменной форме	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Подсчет таблеток находящихся в распоряжении пациента	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Субъективная оценка провайдера в отношении приверженности пациента за последний период	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Количество выданных АРВ-препаратов (кол-во таблеток)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ожидаемое количество дней на количество выданных АРВ-препаратов	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Дата следующего визита в клинику	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
По каждому визиту – насколько он был близок к дате запланированного визита	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Обращался ли пациент за консультацией по приверженности	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Получил ли пациент консультацию по приверженности	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Сообщенные причины по отсутствию приверженности	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Другие данные которые могут использоваться для мониторинга: (пожалуйста попросите предоставить копию медицинских записей и записей по учету выданных препаратов, если таковые имеются)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Уровень приверженности к АРВ-терапии отдельного пациента

11. Каким образом ведется мониторинг приверженности отдельного пациента к АРВ-терапии на базе вашей организации? (укажите все соответствующие варианты)

Измерение уровня приверженности	Клиническим персоналом	Фармацевтом	Не используется
Самоотчет пациента	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Календарь пациента по приему препаратов (проверяемый в учреждении)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Подсчет таблеток	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Субъективное суждение клинициста	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Регулярные визиты пациента к врачу	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Лечение под прямым наблюдением на базе учреждения	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Лечение под прямым наблюдением на дому	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Электронное устройство для приема препарата (например: система MEMS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Другое, пожалуйста, укажите:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Другое, пожалуйста, укажите:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, please specify: [Интервьюер должен попросить предоставить копию используемых форм]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Высчитываете ли вы уровень приверженности отдельного пациента в числовом выражении на основе данных мониторинга за пациентом? *[Соберите примеры используемых форм]*

I I Да , пожалуйста приведите пример подсчета _____

I I Нет Если нет, то пожалуйста, ответьте на вопрос Q. 14

13. Какой уровень приверженности к АРВ-терапии ваше учреждение рассматривает в качестве удовлетворительного для отдельно взятого пациента?

Уровень приверженности к АРВ-терапии на уровне клиники или организации здравоохранения

14. Проводите ли вы мониторинг уровня приверженности к АРВ-терапии на базе вашего медицинского учреждения (то есть, средний уровень приверженности)?

Да

Нет

Если вы не проводите мониторинг приверженности на уровне учреждения/программы, то по каким причинам мониторинг не проводится?

Если нет, то переходите на вопрос Q. 19

15. Какой источник данных используется для подсчета уровня приверженности к АРВ-терапии на базе вашего медицинского учреждения? (укажите все соответствующие варианты)

I I Записи данных по рутинному мониторингу за приверженностью индивидуального пациента

I I Специальный опрос проведенный для мониторинга приверженности

I I Не известно

16. Как вы подсчитываете уровень приверженности к АРВ-терапии на базе медицинского учреждения? (укажите формулу)

[Соберите примеры используемых форм]

17. Каким был один из самых последних уровней приверженности к АРВ-терапии на базе медицинского учреждения?

Уровень приверженности: _____ Дата (месяц, год): _____

18. Какой уровень приверженности к АРВ-терапии клиника рассматривает в качестве удовлетворительного на базе медицинского учреждения? _____

Мониторинг нарушений

19. Информировуют ли пациентов о дате следующего визита?

Да

Нет

20. Существует ли у вас официальная система мониторинга за тем посещает ли пациент, принимающий АРВ-терапию, врача согласно запланированного графика?

- Да
- Нет

Если да, то пожалуйста опишите как проводится мониторинг:

Если нет, то пожалуйста перейдите к вопросу Q. 25

21. Если пациент не посещает, имеются ли у вас способы для наведения справок в связи с чем пациент пропускает посещение – заболел, умер или прервал лечение?

- Да
- Нет

Если да, то пожалуйста опишите каким образом и как ведется учет:

22. На каком этапе пациент рассматривается как нарушитель АРВ-программы или прерванный случай?

I I После того как пациент не смог посещать в течение определенного периода времени, укажите как долго _____

I I После того как пациент пропустил несколько запланированных визитов к врачу, укажите число визитов _____

I I Пациенты никогда не рассматриваются как прерванный случай или нарушитель программы лечения

I I Другое, пожалуйста укажите: _____

23. Вы ведете подсчет общего числа случаев прерванного лечения?

I I Да, пожалуйста укажите текущий уровень прерванных случаев:

- No

24. Включаете ли вы пациентов, получающих АРВ-терапию и не посещающих врача в назначенное время, при подсчете уровня приверженности на базе медицинского учреждения?

- Да
- Нет
-

Если да, то опишите как подсчитывается уровень для таких пациентов: _____

25. Существуют ли в клинике системы для последующего наблюдения за АРВ-пациентами, которые не посещают врача в назначенное время?

I I Да, пожалуйста опишите: Когда пациент пропускает визит к врачу, планируется посещение пациента на дому.

- Нет

Интервенции для продвижения приверженности

26. какие интервенции вы в настоящее время используете или планируете использовать в данной клинике для продвижения приверженности пациента к лечению

Тип интервенции	Уже используется	планируется использовать
Консультирование пациента до начала АРВ-терапии	<input type="checkbox"/>	<input type="checkbox"/>
Повторное консультирование после начала приема АРВ-терапии	<input type="checkbox"/>	<input type="checkbox"/>
Медработники или волонтеры на общинном уровне	<input type="checkbox"/>	<input type="checkbox"/>
Требование к лицу, осуществляющему уход, вести наблюдение а лечением	<input type="checkbox"/>	<input type="checkbox"/>
Социальная поддержка (напр., визиты на дом, продовольственный пакет, дневной уход) **	<input type="checkbox"/>	<input type="checkbox"/>
Системный мониторинг приверженности к приему препаратов на уровне клиники	<input type="checkbox"/>	<input type="checkbox"/>
Амбулаторные услуги на базе медицинского учреждения	<input type="checkbox"/>	<input type="checkbox"/>
Использование устройств для продвижения приверженности (например, дневник, pill box, memo cap) **	<input type="checkbox"/>	<input type="checkbox"/>
Звонки для напоминания о приеме лекарств **	<input type="checkbox"/>	<input type="checkbox"/>
Компенсация дорожно-транспортных расходов, связанных с посещением учреждения		
Терапия под прямым наблюдением (DOT)		
-Терапия метадонном при максимальном содействии (MAT)	<input type="checkbox"/>	<input type="checkbox"/>
Другие финансовые поощрения **	<input type="checkbox"/>	<input type="checkbox"/>

Другие интервенции
**

АРВ? (укажите все соответствующие варианты)

** Пожалуйста опишите любые интервенции такого типа. Визиты на дом в настоящее время проводятся социальным работником медицинского учреждения.

27. Используете ли вы какие-либо интервенции для усиления мотивации провайдера услуг, направленные на продвижение приверженности пациента?

Да, пожалуйста опишите: _____

Нет

28. Проводили ли вы какую-либо оценку ваших интервенций по усилению приверженности к АРВ-терапии на базе данного медицинского учреждения? *[получите копию соответствующих отчетов]*

Да

Нет

Если да, то опишите оценку и результаты: _____

29. Если с наличием ресурсов проблем не наблюдается, то как вы думаете, какие интервенции будут полезными в плане повышения приверженности к АРВ-терапии на уровне вашего

медицинского учреждения?

[также спросите почему вы полагаете что предлагаемые интервенции повысят уровень приверженности и на решение какой проблемы они направлены]

ANNEX F: BIBLIOGRAPHY

1. Thorne, C., et al., *Central Asia: hotspot in the worldwide HIV epidemic*. The Lancet Infectious Diseases, 2010. **10**(7): p. 479-488.
2. Wolfe, D., et al., *HIV in Central Asia: Tajikistan, Uzbekistan and Kyrgyzstan*. Public Health Aspects of HIV/AIDS in Low and Middle Income Countries, 2008: p. 557-581.
3. Satybaldieva, Z., *Nine children, one doctor and a nurse found HIV infected in southern Kyrgyzstan*. Times of Central Asia, The, 2007(061).
4. Utyasheva, L., *Kyrgyzstan: nine health care workers guilty of negligence causing HIV transmission among children*. HIV/AIDS policy & law review/Canadian HIV/AIDS Legal Network, 2008. **13**(2-3): p. 48.
5. Deryabina, A., *Mapping of Key HIV Services, Assessment of Their Quality, and Analysis of Gaps and Needs of Most-at-Risk Populations in Chui Oblast and Bishkek City, Kyrgyzstan*. . 2011, USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.: Arlington, Va.
6. *HIV Surveillance Reports Kyrgyzstan*. 2010, Country Multisectoral Coordination Committee and Ministry of Health [MOH] of the Kyrgyz Republic.
7. Shannon, K., et al., *Social and structural violence and power relations in mitigating HIV risk of drug-using women in survival sex work*. Social Science & Medicine, 2007.
8. Wolfe, D., M. Carrieri, and D. Shepard, *Treatment and care for injecting drug users with HIV infection: a review of barriers and ways forward*. The Lancet, 2010.
9. Mathers, B., et al., *HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage*. The Lancet, 2010.
10. Tyndall, M., et al., *Directly observed therapy programmes for anti-retroviral treatment amongst injection drug users in Vancouver: access, adherence and outcomes*. International Journal of Drug Policy, 2007. **18**(4): p. 281-287.
11. Harris, S., et al., *Outreach, Mental Health, and Case Management Services: Can They Help to Retain HIV-Positive and At-Risk Youth and Young Adults in Care?* Maternal and Child Health Journal, 2003. **7**(4): p. 205-218.
12. Werb, D., et al., *Risk of resistance to highly active antiretroviral therapy among HIV-positive injecting drug users: a meta-analysis*. The Lancet Infectious Diseases, 2010. **10**(7): p. 464-469.
13. Montaner, J., et al., *Association of highly active antiretroviral therapy coverage, population viral load, and yearly new HIV diagnoses in British Columbia, Canada: a population-based study*. The Lancet, 2010.
14. Smith, S.R., et al., *A medication self-management program to improve adherence to HIV therapy regimens*. Patient Education and Counseling, 2003. **50**(2): p. 187-199.
15. Gifford, A.L. and E.J. Groessl, *Chronic disease self-management and adherence to HIV medications*. JAIDS Journal of Acquired Immune Deficiency Syndromes, 2002. **31**: p. S163.
16. Wagner, E.H., *The role of patient care teams in chronic disease management*. Bmj, 2000. **320**(7234): p. 569-572.
17. WHO, U., *EVIDENCE FOR ACTION TECHNICAL PAPERS: INTERVENTIONS TO ADDRESS HIV IN PRISONS HIV CARE, TREATMENT AND SUPPORT*. 2007.