This summary highlights the experiences, results and actions from implementing the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages in Kyrgyz Republic. The tool – developed by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives in 2009 – supports national assessments of the bi-directional linkages between sexual and reproductive health (SRH) and HIV at the policy, systems and services levels. To date, some 16 countries have rolled out the tool, gathering and generating information that will help to determine priorities and shape national plans and frameworks for scaling up and intensifying linkages. Countries’ experiences and best practices will also inform regional and global agendas.

1. This summary is based upon: Report on the Results of Rapid Assessment for Sexual and Reproductive Health and HIV Linkages in Kyrgyzstan, Reproductive Health Alliance, IPPF and UNFPA, November 2010.

RECOMMENDATIONS

What recommendations did the assessment produce?

Strategy and planning:
The principal recommendation was to use the opportunity of the 2010–11 end date for many of the relevant strategies to apply a more integrated approach to the development of future plans and ensure that they address gender equality, the rights of vulnerable populations and issues of violence, stigma and discrimination. The assessment also recommended:

- Reviewing and harmonizing legislation in order to remove barriers to SRH and HIV programming and integration.
- Developing a specific strategy and action plan to tackle stigma and discrimination of people living with HIV (PLHIV) and vulnerable groups, paying attention to human rights protection and ensuring provision of legal services where necessary.
- Strengthening the action of civil society organizations, particularly those working with vulnerable populations, in relation to SRH and HIV.

Financing:

- Mapping programmes and projects and developing national accounts to evaluate financial expenditure on SRH and HIV programmes.
- Developing a strategy to mobilize resources from local businesses and private individuals.
- Developing a single partnership stream to harmonize the support from governmental, public, charitable and donor sources on SRH and HIV.

Partnerships:

- Developing joint action plans to improve SRH and HIV service provision, in accordance with the state strategies on SRH and HIV.
- Strengthening cooperation with non-governmental organizations (NGOs), particularly to better support work with PLHIV, sex workers, men who have sex with men (MSM) and people that use drugs.
- Instituting joint planning of SRH and HIV programmes by governmental organizations, international organizations and donors, as well as joint mechanisms for management and accountability.
Staffing, human resources and capacity development:
- Ensuring health care workers are informed about normative legal documents.
- Developing efficient systems for pre- and in-service training of health care workers, with particular attention to training on services for people that use drugs, sex workers and MSM, and issues of confidentiality and stigma.
- Addressing other critical human resource issues such as workload, salaries and staffing levels.

Logistics/supplies:
- Improving systems for forecasting of needs for products and commodities.
- Improving capacity to forecast and manage supplies as well as material and technical support requirements at health facility level.
- Improving quality control of laboratory diagnostics by introducing external quality control.

Monitoring and evaluation:
- Developing integrated monitoring and evaluation covering all institutions and departments and covering SRH and HIV.
- Increasing efficiency and productivity of specialized programmes/projects – by developing mechanisms to incorporate monitoring and evaluation of programmes into the state system.
- Developing licensing and accreditation mechanisms to increase involvement of private sector providers, as well as NGOs, in SRH and HIV programming.

Provision of integrated SRH and HIV services:
- Developing appropriate integrated protocols.
- Strengthening infrastructure for provision of confidential SRH and HIV services.
- Ensuring provision to service providers of SRH and HIV information materials, as well as contact details for related services for referrals.
- Expanding the network of youth-friendly services, PLHIV and vulnerable groups.
1. Who managed and coordinated the assessment?
   • The assessment was funded by IPPF and UNFPA and carried out by Reproductive Health Alliance of Kyrgyzstan (RHAK).

2. Who was in the team that implemented the assessment?
   • The assessment was carried out by trained specialists (41 people) and volunteers of Reproductive Health Alliance.

3. Did the desk review cover documents relating to both SRH and HIV?
   • The desk review covered 112 documents relating to both SRH and HIV.
   • Analysis of secondary documentation included national strategies on reproductive health (RH) and HIV prevention, situational analysis of SRH and HIV services, evaluations, behavioural survey results, national legislation, policy documents and programme documents of key partners, including UNICEF, UNAIDS, USAID and UNFPA.

4. Was the assessment process gender-balanced?
   • The research team included both men and women.
   • Of the 128 service providers interviewed, the majority (110) were women.
   • Of the service users, 120 were women and 22 men. Female researchers interviewed female service users and male researchers interviewed male service users.

5. What parts of the Rapid Assessment Tool did the assessment use?
   • All sections of the Rapid Assessment Tool were used, with several adaptations made. For example: the service provider questionnaires combined the specific questions designed for SRH and HIV services; providers were asked additional questions on logistics and laboratory support [taken from the policy/systems questionnaire]; focus groups were conducted with service users; and policy- and systems-level surveys were conducted via self-administered questionnaires.

6. What was the scope of the assessment?
   • The assessment was carried out in six of the country’s seven oblasts (administrative regions).
   • Of the facilities where interviews took place, 88 per cent were public sector, 3 per cent private sector and 9 per cent NGOs. They included public medical institutions providing SRH and HIV services, including National AIDS Association, maternity and child protection facilities, HIV and sexually transmitted infections (STIs) dispensaries, family medicine centres and public hospitals, as well as a number of private clinics.

7. Did the assessment involve interviews with policy-makers from both SRH and HIV sectors?
   • Policy-makers from both SRH and HIV sectors were surveyed, primarily through self-administered questionnaires.
   • Interviews were carried out with different health care organizations of the Ministry of Health (MOH), such as those covering HIV, RH, STIs and maternal and child health (MCH).
   • Interviews were also carried out with NGOs working on SRH and HIV.
8. Did the assessment involve interviews with service providers from both SRH and HIV services?

- Both SRH and HIV service providers were interviewed.
- A broad range of service providers were interviewed, including paediatricians, obstetrician–gynaecologists, urologists, dermatologists, infectious disease doctors, doctors specializing in services for young people, outreach workers, social workers and psychologists.
- In total, 128 service providers were interviewed from 30 public institutions, six NGOs and clinics, and three private clinics.

9. Did the assessment involve interviews with clients from both SRH and HIV services?

- A total of 142 clients (of whom 120 were women) were interviewed after accessing SRH or HIV services.
- Questions to clients covered access to services, quality of services, type of service provision and the sources from which clients get information about SRH and HIV.
- The questions also covered clients’ levels of satisfaction with the services provided.

10. Did the assessment involve people living with HIV and key populations?

- Focus groups were planned for representatives of vulnerable groups, including PLHIV, men who have sex with men, sex workers and people that use drugs, to obtain supplementary qualitative data. A focus group was conducted with members of PLHIV Solidarity, a PLHIV association.

FINDINGS

1. Policy level

National policies, laws, plans and guidelines:

- The Country Development Strategy 2009–11 is designed to enable the Kyrgyz Republic to achieve the Millennium Development Goals. Key priorities include improving the quality of health care, with particular focus on prevention of ill health, promotion of MCH, and responding to HIV.
- National laws support a number of rights that are key to SRH and HIV, such as reproductive rights (guaranteed in the Constitution), equal rights for men and women and the right to assistance for victims of violence. The law on reproductive rights guarantees, among other things, access to contraception (although in practice such access is not universal, due to high costs). Termination of pregnancy is permitted under Kyrgyz law, although the requirement of parental approval means that young people can feel forced to seek unsafe abortions.
- In terms of laws specifically related to HIV, concealment from a spouse of HIV or another STI can be used as grounds for annulment of marriage, and reckless transmission of HIV is a criminal offence. However, discrimination on the grounds of HIV status is prohibited, and other positive legal changes include the abolition of laws against sex between men and sex work.
Law enforcement practices sometimes contradict the laws in place and violations of the rights of PLHIV persist, particularly in terms of confidentiality and access to treatment and social assistance.

Although at a policy level there are no links between SRH and HIV, there is a national RH strategy (running until 2015) which particularly focuses on developing systems to improve MCH and family planning (FP). This also outlines the relationship between SRH and HIV. However, insufficient resources have been made available to implement the strategy, and there are no mechanisms for integrated SRH and HIV planning at the operational level.

The main SRH issues addressed in the national HIV policy are: FP for PLHIV; prevention of mother to child transmission (PMTCT); and provision of condoms for HIV and STI prevention.

Interviewees commented that people working in international agencies and NGOs are often more aware of the existence of guidelines and policies on SRH and HIV than the employees of government organizations.

Funding and budgetary support:

Health is, in general, underfunded in the Kyrgyz Republic. Less than 3 per cent of gross domestic product is reported as allocated to health expenditure — although the actual proportion is probably higher (as health accounts do not cover all services and institutions).

SRH and HIV service provision is funded by the state. Free health care is available to pregnant and post-partum women.

The state also funds blood screening for HIV, and HIV and STI treatment, although these are not available free of charge due to lack of funds.

Financing by international donors considerably exceeds state financing, as it covers over 90 per cent of national SRH and HIV budgets.

Grants by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) have ensured gradual increases in overall funding for HIV programming in recent years. Other sources of funding are: World Bank, USAID, UNFPA, German development bank KfW and private foundations.

Although many of these donors fund both SRH and HIV, they tend to channel resources through separate contracts rather than in an integrated way. Financial support for improving the integration of SRH and HIV is provided primarily by UNICEF and UNFPA.

More funding proportionately is provided for HIV than for SRH.

2. Systems level

Partnerships:

Key international partners are UNAIDS, UNDP, WHO, UNFPA, UNICEF, USAID, the Centers for Disease Control and Prevention (CDC), GFATM, UN Office on Drugs and Crime, Central Asian AIDS Project, and Central Asian Regional HIV and AIDS Program. Each has specific areas of technical or programmatic interest.

Nationally, public and NGO facilities are the main providers of SRH- and HIV-related services, although some SRH provision is also available within the private sector.

The national response to HIV is characterized by the participation of leaders of communities of PLHIV, MSM, sex workers and people that use drugs, although these communities are still emerging and do not as yet present cohesive networks.

Planning:

National planning, management and administration of SRH and HIV are led by the MOH.

At project level, planning, management and administration are carried out in accordance with donor requirements. There is no mechanism for joint national planning of SRH and HIV programmes, although the development of national funding proposals (e.g. to the GFATM) can provide an opportunity to discuss integrated planning.

General coordination of SRH and HIV programming is carried out by coordinating committees. HIV is largely coordinated by the Country Coordinating Mechanism (CCM), with some level of decentralized coordination also taking place.
In all oblasts under local authorities, there are inter-sectoral RH coordinating committees that include representatives of local authorities, media, NGOs, religious leaders, justice departments, health care facilities and other relevant stakeholders.

**Human resources and capacity building:**

- The health workforce faces significant problems, due in large part to internal migration and outflow of specialists to other countries. SRH- and HIV-related specialists are in short supply at the level of primary medical care – a situation that has deteriorated in recent years. In some administrative sectors, no specialists are available at all.
- Respondents stated that the motivation of health care workers is very low due to low salaries, acute shortage of personnel and high workload.
- In terms of capacity building, new programmes have been introduced, such as training in perinatal and postnatal care for obstetricians and low-grade medical workers. Appropriate guidelines have been developed, but not yet published due to lack of funds. PMTCT training has also been supported recently.
- In general, however, there is a lack of in-service training for general practitioners and RH specialists. The training that is provided is ad hoc rather than being an integral part of service training. The following areas were cited as being particularly neglected: stigma and discrimination of key populations and PLHIV; gender; male-friendly services; youth-friendly services; and confidentiality.

**Logistics, supply and laboratory support:**

- Procurement and distribution of products and medicines for SRH and HIV is generally carried out centrally by the MoH, according to the guidelines of donors and the State Procurement Commission of the Ministry of Finance.
- According to respondents, the logistics system does not facilitate SRH and HIV integration since funding and technical support for these two areas are entirely separate. Because SRH and HIV products and medications are procured separately, their management and monitoring is also separate. Customs clearance problems also cause delays and stock-outs.

Recent improvements have occurred in laboratory support for SRH and HIV programmes through updating of equipment and improvements to the systems for procuring testing kits and commodities. However, although there is reasonably good provision of laboratory facilities, the lack of well-qualified personnel means that quality and coverage are not always assured. For instance, quality control of donor blood screening has deteriorated in recent years as not all laboratories had External Quality Assurance and not all laboratories provide the full range of SRH and HIV tests.

**Monitoring and evaluation:**

- For each individual component of each programme there is a separate monitoring system. The overall monitoring system is therefore fragmented, with no integration between SRH and HIV. The system is functional for public institutions, but NGOs tend not to participate in the collection and analysis of information about SRH and HIV with the same indicators or processes.
- The existing system does not facilitate evaluation of service availability, quality or coverage. When information on these factors is required, additional research has to be carried out.

3. **Services level**

**A. SERVICE PROVIDER PERSPECTIVES:**

- Service provider interviews indicated that there is no planned or effective integration of SRH and HIV services. This is linked to the general gap in provision of specialized services.
- There are considerable gaps in provider capacity on specialist topics related to both SRH and HIV, such as contraception, STIs, infertility, pregnancy management, childbirth and infant feeding for children born to HIV-positive mothers. In addition, there are chronic shortages of equipment and consumables for medical procedures. As a result, practitioners do not systematically bring up related issues with patients.
Many service providers are forced to use non-certified medications or to perform services that do not adhere to protocols, due to lack of supplies and training.

Many facilities are not designed in a way that makes it easy to guarantee confidentiality since two or more practitioners often share the same consultation room and see patients simultaneously.

According to respondents, providing even basic services such as contraception can also be problematic since it often requires a referral to a specialist (i.e. it cannot be provided through general practice). The need for complex referrals makes it even less likely that clients will receive the service they require or that they will receive related SRH and HIV services.

In general, although there is very little integration of SRH and HIV services, the more significant issue seems to be the overall lack of comprehensive SRH or HIV service provision. The individual components of SRH and HIV are themselves fragmented, and even basic components, such as information provision, are considered to be specialisms.

B. SERVICE USER PERSPECTIVES

Interviews with service users revealed very low levels of correct information on matters related to SRH and HIV, even in relation to issues such as disease prevention and contraception. For instance, a large proportion of respondents confused emergency contraception with methods to prevent HIV and STIs. The poor level of knowledge is substantiated by information on practices – with the prevalence of contraceptive use reducing in recent years.

Service users confirmed the findings of interviews with service providers – that accessing most SRH- and HIV-related services is complicated by the need for referrals from general practitioners and, therefore, multiple appointments (as well as additional time and costs to the user). Consequently, respondents confirmed that effectively there is no integrated provision of SRH and HIV.

Service users stated that they faced confidentiality issues, with PLHIV reporting that their HIV status often provoked stigma and refusal of treatment from service providers. These reports contradicted what most service providers had said – that they did not breach confidentiality or discriminate against patients on the basis of HIV status or on other grounds.

Other issues raised by service users were the perception that HIV testing is obligatory for pregnant women, and the requirement to pay for services that are supposed to be free of charge (according to national policy).

Overall, levels of user satisfaction were relatively high. According to the researchers, this may be due to the lack of experience of better quality services.

Some users expressed a preference for attending private clinics due to less waiting time, more modern equipment, better levels of confidentiality and a broader range of services.

In terms of access to services for specific groups, the PLHIV that were interviewed confirmed that antiretroviral (ARV) treatment is provided free of charge. However, the same is not true of treatment for opportunistic infections or psychosocial support. As such, these are missing from the overall package of care.

It was confirmed that in some regions there are clinics that target specific or most-at-risk populations such as MSM, sex workers, people that use drugs and young people. However, little information was gathered on the extent to which they provide an integrated package of SRH and HIV services.
1. What lessons were learned about how the assessment could have been done differently or better?

- Within the questionnaire for service providers, the combination of questions designed specifically for SRH and HIV services may have limited the extent of the assessment’s findings on the integration of SRH into HIV services and vice versa.
- Data in the assessment report is primarily presented in a narrative form. The inclusion of more quantitative data could have helped to provide a fuller picture of the scale and extent of some views and issues.
- A four to five-month timeframe for such an assessment would allow sufficient time for developing an assessment tool, training staff and carrying out the analysis.

2. What ‘next steps’ have been taken (or are planned) to follow up the assessment?

- The results of the assessment were presented at a round table in August 2010. The participants included the MOH and national and international partners.
- The assessment report was presented at a meeting of the Technical Sector on Monitoring and Evaluation of the government’s Country Multi-Sectoral Coordination Committee, with recommendations to use the results in the development of the State Programme on HIV for 2012–16.
- A thousand copies were made and presented to all national partners, including the Country Multi-Sectoral Coordination Committee, the MOH, leading organizations coordinating the State Programme on HIV and SRH, and organizations involved in developing country proposals for the GFATM, as well as to the Health Summit participants.

3. What are the priority actions that are being taken forward as a result of the assessment, at the:

   - policy level?
   - systems level?
   - services level?

   **Policy level:**
   - The results of the assessment will be taken into consideration in the development of the State Programme on HIV for 2012–16, as well as the sectoral programmes of the MOH health reform programme *Den Sooluk* (formerly called *Manas Taalimi* 2). The strategy to integrate SRH and HIV services will go through all components of the State Programme on HIV prevention and will be included in the health reform programme.

   **Systems level:**
   - The results of the assessment will provide the basis for SRH and HIV integration in primary health care for the future *Den Sooluk* (*Manas Taalimi* 2) health reform programme.

   **Services level:**
   - The results of the assessment will be used when preparing the country proposal to Round 11 of the GFATM, focusing on access to SRH and HIV services for vulnerable groups.

4. What are the funding opportunities for the follow-up and further linkages work?

- Due to limited resources, the country proposal to Round 10 of the GFATM included recommendations on provision of SRH and HIV services for PLHIV, as well as support for PMTCT programmes, provision of substitute methadone treatment for pregnant PLHIV who use drugs, and STI services for sex workers and MSM.
- The country is planning to develop a proposal to Round 11 of the GFATM, focusing on enhancing the provision of SRH and HIV services to vulnerable groups, namely women of reproductive age, youth and the migrant labour force.
Abbreviations

AIDS acquired immune deficiency syndrome
ARV antiretroviral
CCM Country Coordinating Mechanism
FP family planning
GFATM Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP+ Global Network of People Living with HIV
HIV human immunodeficiency virus
ICW International Community of Women Living with HIV/AIDS
 IPPF International Planned Parenthood Federation
MCH maternal and child health
MOH Ministry of Health
MSM men who have sex with men
NGO non-governmental organization
PLHIV people living with HIV
PMTCT prevention of mother to child transmission
RH reproductive health
STI sexually transmitted infection
SRH sexual and reproductive health
UNAIDS Joint United Nations Programme on HIV/AIDS
UNFPA United Nations Population Fund
UNICEF United Nations Children’s Fund
USAID United States Agency for International Development
WHO World Health Organization

FOR FURTHER INFORMATION, PLEASE CONTACT:
Aida Maatkazieva, Reproductive Health Alliance of Kyrgyzstan,
a.maatkazieva@gmail.com