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GENDER ASSESSMENT:

ACCESS TO HIV SERVICES BY KEY POPULATIONS IN KYRGYZSTAN

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

MARCH 2013

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AIDS Support and Technical Assistance Resources Project
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ACRONYMS

AIDS	acquired immunodeficiency syndrome
CDC	Centers for Disease Control and Prevention
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
FSW	female sex worker
FWID	females who inject drugs
HTC	HIV testing and counseling
HIV	human immunodeficiency virus
GBV	gender-based violence
LGBT	lesbian, gay, bisexual, and transgendered persons
MSM	men who have sex with men
MWID	males who inject drugs
NGO	nongovernmental organization
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission of HIV
PWID	people who inject drugs
SRH	sexual and reproductive health
STI	sexually transmitted infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development

EXECUTIVE SUMMARY

PURPOSE AND OBJECTIVES

The HIV pandemic in Central Asia is concentrated in key populations[1] of which women and girls comprise a growing minority. The principal mode of HIV transmission in Kyrgyzstan continues to be injection drug use (60 percent), followed by heterosexual sexual transmission (33 percent). One-fourth (25 percent) of the cumulative HIV infection cases in the country are among females and the rates of HIV among females is growing – from 9.5 percent of all registered HIV infections in 2001 to 30 percent in 2010 (ICAP 2012). Historically, HIV-related funding has not fully addressed women's vulnerabilities, particularly those faced by females who inject drugs and the sexual partners of males who inject drugs. Unprotected sex between men is responsible for a small share of new infections in Eastern Europe and Central Asia (UNAIDS 2010).

This gender assessment was conducted in Kyrgyzstan to inform and guide the design and formulation of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR)/Central Asia Region (CAR) gender strategy. The strategy will provide a set of practical recommendations for incorporating a gender perspective in a concentrated HIV epidemic to address gender-based factors that hinder access to HIV prevention, care, and treatment services by key populations. This was not an assessment of any specific agency's projects, or a thorough organizational assessment of the PEPFAR Program in Kyrgyzstan. Rather, it serves as a broad assessment of the gender norms and dynamics that affect access to HIV services by key populations in Kyrgyzstan. This assessment is the first step of a longer process by PEPFAR/CAR to collect and analyze data on how gender norms and inequality affect access to HIV services and programs by key populations in the region. The objectives of the gender assessment were fourfold:

1. To identify the gender-based constraints to equitable participation of male and female members of key populations to access HIV/AIDS programs and services.
2. To identify strategies and approaches PEPFAR can use to enhance the accessibility and equitability of its HIV/AIDS programs to both male and female members of key populations and their sexual partners.
3. To assess Kyrgyzstan government gender-related policies and programs, and identify opportunities for collaboration and strengthening gender-based approaches.
4. To identify HIV/AIDS gender activities that will have the greatest potential impact in a concentrated HIV epidemic.

METHODOLOGY

This assessment was developed and implemented using participatory, appreciative inquiry, and utilization-focused approaches, as well as gender analysis. Data collection occurred in September and October 2012 using document review and in-depth interviews in Kyrgyzstan. Thirty-five (35)

[1] The following groups are considered key populations in Kyrgyzstan: men who have sex with men, people who inject drugs, sex workers, and migrants. However, there are no reliable or official data on migrants.

interview sessions were conducted with 60 people from governmental organizations, PEPFAR agencies, other donors, United Nations organizations, nongovernmental organizations, and implementing partners. All respondents agreed to be quoted anonymously.

FINDINGS

Several policies exist in Kyrgyzstan with the potential to address the gender needs of key populations and facilitate their access to HIV prevention, care, and treatment programs and services. These include the Law on HIV/AIDS in the Kyrgyz Republic, the National HIV Prevention Program (2012-2016; pending approval), the Oblast Level HIV Prevention Program (2012-2016), Treatment Protocols, Law articles related to key populations and people living with HIV (PLHIV), and the National Gender Policy. There seems to be limited political will and capacity for implementation by both the government and nongovernment sectors and a poor understanding of the gender needs of key populations. The latter may be due to lack of data collected or monitored by sex within key populations. As a result, male and female members of key populations continue to encounter barriers to HIV prevention, care, and treatment programs (such as requirements for Identification Cards with *propiska,*[2] providers' lack of understanding of gender norms and related health needs of key populations) and factors that put women at risk (bride kidnapping and other forms of violence).

Five major areas emerged as needing to change for male and female members of key populations to have increased participation in and access to HIV programs and services:

- Recognize that individuals do not always fall neatly into one key population. Collect data and track differences by sex and multiple at-risk behaviors to improve understanding of the specific needs and barriers unique to men and women who engage in multiple at-risk behaviors (e.g., sex workers who inject drugs, men who have sex with men who migrate to engage in sex work, females who inject drugs who provide sex for money or drugs).
- Reduce gender-based violence, especially by police, that increases HIV risk and potentially pushes key populations further "underground."
- Address gender norms for men and women and reduce gender-based violence against key populations that hinder access to services and perpetuate risky behavior.
- Integrate HIV, sexual and reproductive health, children's health, and social and rehabilitation services to address the complex needs of female members of key populations.
- Increase access to HIV testing and counseling for returning migrant workers to decrease HIV transmission from HIV-positive migrants to their sexual partners.

[2] *Propiska* is a Russian word meaning "Registration by Place of Residence." In Kyrgyzstan, official registration "by place of residence" is indicated in an internal passport called an Identification Card. An Identification Card and *propiska* are both required to receive **free** health services.

RECOMMENDATIONS

A range of recommended activities is provided that PEPFAR may want to implement in response to the assessment findings. Listed below, in order of priority, are the five most urgent and critical actions PEPFAR should take to address gender-based needs that hinder access to HIV prevention, care, and treatment programs and services by key populations:

1. Conduct an in-depth gender analysis (using dynamic and participatory group discussions) with key populations and their sexual partners in several *oblasts*,[3] including both those who access HIV services and those who do not.
2. Strengthen government strategic information systems to collect and analyze data on key populations by sex (male and female), gender (transgender, lesbian, gay), and behavior (sex work, PWID, MSM) including data on the multiple roles played by members of key populations.
3. Provide technical support to the Ministry of Health, including implementation of Orders No. 145 and 206, to address the barriers to accessing free health services that key populations face due to requirements for Identification Cards with *propiska*.
4. Develop and implement a capacity building strategy around gender norms, human rights, legal rights, gender-based violence, and HIV for implementing partners, police officers, health providers and policy makers.
5. Support research and strategic information on the role of male and female migrants in the HIV epidemic through the existing Dialogue on HIV and TB and SUPPORT (HIV Technical Support Program in Central Asia) Projects.

[3] *Oblasts* are administrative regions or provinces in Russia and some former Soviet Union countries, including Kyrgyzstan.

BACKGROUND

Eastern Europe and Central Asia are the only regions in the world where HIV incidence is still unmistakably rising. Between 2001 and 2011 the estimated number of people living with HIV (PLHIV) in these regions increased from 970,000 to 1.4 million (UNAIDS 2012). The HIV pandemic in Central Asia is concentrated among key populations,[4] of which women and girls comprise a growing minority. People who inject drugs (PWID) account for the largest number of new HIV infections. While PWID are predominately male, their sexual partners play an important role in potentially moving the Central Asian HIV epidemic from one concentrated among key populations to the wider society. An estimated 35 percent of women living with HIV in Eastern Europe and Central Asia probably acquired the virus through injecting drug use, while an additional 50 percent were most likely infected by partners who inject drugs. As the HIV epidemic spreads from PWID to their sexual partners, the proportion of women living with HIV in the region is growing. Unprotected sex between men is responsible for a small share of new infections in Eastern Europe and Central Asia (UNAIDS 2010).

Overall HIV prevalence in Kyrgyzstan remains low, but there has been a significant increase in HIV incidence driving the cumulative number of HIV cases from 826 registered PLHIV in 2005 to more than 3,200 in 2011. The principal mode of HIV transmission in Kyrgyzstan continues to be injection drug use (60 percent), followed by heterosexual sexual transmission (33 percent). One-fourth (25 percent) of the cumulative HIV infection cases in the country are among females, and the rates of HIV among females are growing—from 9.5 percent of all registered HIV infections in 2001 to 30 percent in 2010 (ICAP 2012). Historically, HIV-related funding has not fully addressed women's vulnerabilities, particularly those faced by females who inject drugs (FWID) and the sexual partners of men who inject drugs (MWID).

Violence against key populations, specifically female sex workers (FSWs), FWID, and men who have sex with men (MSM), is a serious reality. A 2009 review of studies in Kyrgyzstan focusing on violence against FWID and FSWs revealed that almost half the respondents had experienced violence from police. Respondents reported having to pay bribes, inform on others, and provide free sexual services to avoid police violence (EHRN 2010). Outreach workers from U.S. Government-funded programs in Kyrgyzstan reported that FSWs are harassed and abused by police an average of five to six times a month.

Within this context, AIDSTAR-One conducted a gender assessment in Kyrgyzstan to inform and guide the design and formulation The U.S. President's Emergency Fund for AIDS Relief (PEPFAR)/Central Asia Region (CAR) gender strategy. AIDSTAR-One was asked to provide a set of practical recommendations for incorporating a gender perspective in a concentrated HIV epidemic in the form of a work plan and timeline for PEPFAR/Kyrgyzstan to address gender-based factors that hinder access to HIV prevention, care, and treatment services by key populations. This was not an assessment of any specific agency's projects, or a thorough organizational assessment of the PEPFAR Program in Kyrgyzstan. Rather, it served as a broad assessment of the gender norms and dynamics that affect access to HIV services by key populations in Kyrgyzstan. This assessment is the first step of a longer process by PEPFAR/CAR to collect and analyze data on how gender norms and inequality affect access to HIV services and programs.

[4] The following groups are considered key populations in Kyrgyzstan: men who have sex with men, people who inject drugs, sex workers, and migrants. However, there are no reliable or official data on migrants.

PEPFAR GENDER STRATEGY

Biological, structural, and cultural conditions that affect men and women differently, such as gender norms, impact expectations and behaviors for both men and women that can either reinforce or detract from HIV prevention, care, and treatment efforts.

In many countries, women and girls are disproportionately affected by the HIV epidemic. Gender inequalities limit women's power over family and sexual relationships and contribute to economic, legal, and educational inequities that place women and girls in situations where they cannot protect themselves from HIV infection. Women who lack access to other economic opportunities may engage in transactional sex for a range of reasons, from survival to obtaining status-enhancing material goods. Women and girls who are denied the opportunity to attend school often miss important opportunities to learn about HIV transmission and prevention.

The impacts of culturally-driven harmful gender norms may be most apparent for women and girls, but they have a significant impact on men as well. Men and boys are affected by gender expectations that may encourage risk-taking behavior, discourage use of health services, and narrowly define their roles as partners and family members. Rates of HIV testing and treatment are lower among men compared to women. Gender norms around masculinity and sexuality put MSM at increased risk for HIV by creating additional stigma and discrimination that can prevent them from seeking and accessing services. Globally, MSM are 19 times more likely to be infected with HIV compared to the general population (PEPFAR n.d.). Men are also essential partners in efforts to engage in national and community-level changes that address the impact of harmful gender norms. Male leaders are often the ones with the power and platform to convince others to change behavior, policies, and cultural norms.

PEPFAR's definition of gender was used for the assessment (see Box 1). The assessment team used the PEPFAR Gender Strategy as a framework for analyzing data, developing the findings, and providing recommendations. The PEPFAR Gender Strategy promotes gender equality and mitigates structural and other gender inequalities through a two-pronged approach: 1) gender integration into all HIV prevention, treatment, and care, programs, and 2) programming to address the following five cross-cutting gender strategic areas (PEPFAR 2012b):

- Increasing gender equity in HIV/AIDS programs and services, including access to reproductive health services
- Reducing violence and coercion
- Engaging men and boys to address norms and behaviors
- Increasing legal protection for women and girls
- Increasing women and girls' access to income and productive resources, including education.

Box 1. PEPFAR's Definition of Gender

Gender refers to a socially defined set of roles, responsibilities, entitlements, and obligations associated with being a man and a woman, as well as the relationships between and among men and women. The social definition and expectations of what it means to be a man or a woman varies across cultures and over time. Transgender individuals, whether they identify as men or women, can be subject to the same set of expectations (PEPFAR 2012b).

GOALS AND OBJECTIVES

This gender assessment focused on Kyrgyzstan to provide recommendations to PEPFAR/Kyrgyzstan, which would in turn inform the development of a PEPFAR/CAR gender strategy. The objectives of this gender assessment were fourfold:

1. To identify the gender-based constraints to equitable participation of male and female members of key populations in and access to HIV/AIDS programs and services
2. To identify strategies and approaches that PEPFAR can use to enhance the accessibility and equitability of its HIV/AIDS programs to both male and female members of key populations and their sexual partners
3. To assess Kyrgyzstan government gender-related policies and programs, and identify opportunities for collaboration and strengthening gender-based approaches
4. To identify HIV/AIDS gender-related activities that will have the greatest potential impact in a concentrated HIV epidemic.

To address the goal and objectives outlined in the Statement of Work, the assessment aimed to identify gender needs[5] and gaps in existing HIV/AIDS programs relating to key populations and their sexual partners, and national programs and policies that facilitate or hinder participation in and access to HIV/AIDS programs and services by key populations and their sexual partners. Table 1 outlines the two themes and key questions (and sub questions) developed by the assessment team in collaboration with USAID/Kyrgyzstan and used in formulating the interview guide. Each question corresponds with one of the four objectives listed above.

[5] Gender needs arise from gender roles and gender-related division of labor, access, and power relations. Since men and women have different gender roles, do different types of work, have different degrees of access to services and resources, and experience unequal relations, the needs of men and women are different (Parker, Lozano, and Messner 1995).

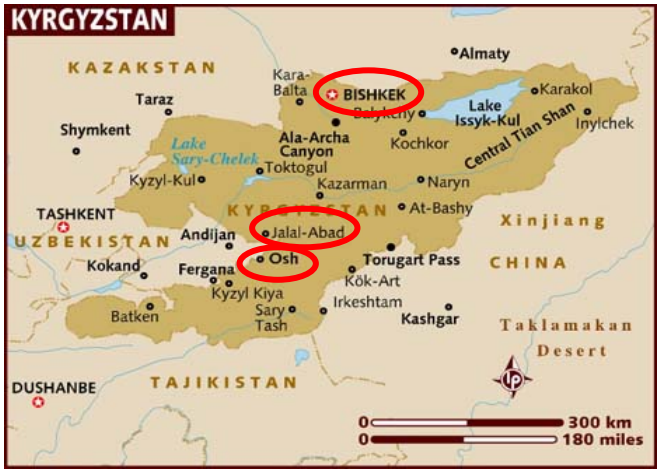
Table 1. Assessment Questions and Corresponding Objectives

Key Question	Sub Questions	Corresponding Objective
Theme: Gender Analysis of Government Policies and Programs		
What barriers or opportunities exist within current government policies, programs, and gender strategies to ensure equitable access for MWID, FWID, FSW, MSW, MSM, and their sexual partners to HIV prevention, care, and treatment programs and services?	What policies (national or regional/city levels) currently facilitate access for these groups to HIV/AIDS programs and services?	Objective 3
	What policies (national or regional/city levels) currently hinder access for these groups to HIV/AIDS programs and services?	Objective 3
	How can PEPFAR programs better support the development and implementation of government policies and programs that are positive for key populations?	Objective 4
	How can PEPFAR programs better work with the government to address harmful policies and programs?	Objective 4
Theme: Gender-Based Needs of Key Populations Related to HIV services		
What needs to change for MWID, FWID, FSWs, MSWs, MSM, and their sexual partners to participate fully in and access HIV prevention, care, and treatment programs and services?	What factors (political, economical, cultural, social psychological) facilitate access for these groups to HIV/AIDS programs and services in Kyrgyzstan?	Objective 1
	What factors (political, economical, cultural, social psychological) hinder access for these groups to HIV/AIDS programs and services in Kyrgyzstan?	Objective 1
	What activities that PEPFAR is able to support can have the greatest potential impact on the HIV epidemic among key populations and their sexual partners in Kyrgyzstan?	Objective 2
	What strategies and approaches can PEPFAR use to enhance accessibility and equitability of its HIV/AIDS programs and services for male and female members of key populations?	Objective 2

METHODOLOGY

The assessment team applied participatory, appreciative inquiry, and utilization-focused approaches as well as gender analysis to developing and implementing this assessment. Assessment activities were conducted in September and October 2012. The team reviewed key documents before, during, and after the field visit and developed and utilized summaries of each during the data analysis. Documents were provided by PEPFAR/Kyrgyzstan, PEPFAR/CAR, and respondents during or after the interview sessions (Appendix A lists the documents reviewed).

Figure 1. Map of Kyrgyzstan with cities visited



The assessment team traveled to Kyrgyzstan from October 15 to 25, 2012 and conducted individual and group interviews in the capital city, Bishkek, and the outskirts of Kant in the north, and in Osh and Jalal-Abad cities in the south (see Figure 1).

A list of key informants was developed in collaboration with USAID/Kyrgyzstan and additional interviewees were identified during the in-country data collection. The assessment team conducted 35 interview sessions with 60 people from governmental organizations (Ministry of Health, health facilities); PEPFAR agencies (USAID, Centers for Disease Control and Prevention (CDC), Peace Corps, PEPFAR/CAR); other donors; United Nations organizations (the Joint United Nations Programme on HIV/AIDS [UNAIDS], the United Nations Development Programme [UNDP], the United Nations Population Fund [UNFPA], and the United Nations Children's Fund [UNICEF]); nongovernmental organizations[6] (NGOs); and implementing partners as detailed in Table 2. Interviews were semi-structured[7] and followed an interview guide approved by USAID/Kyrgyzstan (see Appendix B).

All interview data were transcribed during the interview with necessary cleaning up and elaboration performed afterwards. Information from document review was extracted and likewise coded, as appropriate. Data were housed on a password-protected space to which only the assessment team had access. All data regardless of source were coded and analyzed. The assessment team developed an initial coding framework specific to each assessment question and based on shared experiences during data collection. Qualitative analysis focused on content and thematic analysis within a gender analysis framework and responded to the key assessment questions in Table 1. Data were triangulated across sources and stakeholders, and all respondents agreed to be quoted anonymously.

[6] NGOs interviewed work with women and key populations; interviewees included former sex workers and PWID, as well as people living with HIV, MSM, and lesbians.

[7] Over half of the interviews (60 percent) were conducted in Russian; these interviews were led by a native Russian speaker, and an interpreter translated the responses and any follow-up questions for the non-Russian speaker.

Table 2. Interviews Conducted for Kyrgyzstan Gender Assessment

Type of Organization	Number of Interview Sessions	Number of Persons Interviewed
Government organization	8	9
PEPFAR agency	4	5
Other donors	2	3
UN organizations	4	4
NGOs*	13	32
Implementing partners	4	7
Total	**35**	**60**

*__Note:__ 13 interview sessions were conducted with 15 NGOs because 2 sessions had 2 NGOs represented.

FINDINGS

Most of the data from respondents and document review provided only general information about key populations without distinction by sex. Data that were specific to gender norms and gender needs of key populations were culled out during the data analysis and organized by the two assessment themes and key questions described in Table 1. The findings are presented under each of these themes and questions. The quotes exemplify what many respondents shared and are substantiated by document review. Sources of interview data are coded and referred to only by stakeholder group to ensure confidentiality.

GENDER ANALYSIS OF GOVERNMENT POLICIES AND PROGRAMS

What barriers or opportunities exist within current government policies, programs, and gender strategies to ensure equitable access for MWID, FWID, FSW, MSW, MSM, and their sexual partners to HIV prevention, care, and treatment programs and services?

Kyrgyzstan experienced a violent ousting of President Kurmanbek Bakiyev in April 2010 (the country's second revolution in five years) and a new constitution, approved in June 2010, laid the foundation for a parliamentary democracy. The current government (established in September 2012) is the fourth in two years. This political instability has caused loss of institutional memory within government institutions working on the HIV response resulting in poor collaboration with NGOs. Several NGO respondents remarked on the constant rotation of staff, which has led to a lack of trust with the Ministry of Health.

Governmental instability and lack of policy implementation have resulted in few government programs implemented, and very few that address the gender needs of key populations. When asked about government-sponsored, gender-related, HIV programs, many respondents mentioned that the Prevention of Mother-to-Child Transmission of HIV (PMTCT) Order requires that doctors be trained, and that pregnant women be tested for HIV and receive an examination at least once during pregnancy. Respondents remarked that the Ministry of Health pays attention to mother and child health, but very few respondents knew of any gender-related HIV programs.

Some reported that gender is a focus of projects funded through The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), which provides funding to the government for laboratory strengthening and procurement of drugs, but a large proportion of funds that address gender inequality go to NGOs. Many respondents cited the multi-donor-supported Central Asian Region HIV/AIDS Program (CARHAP) as a successful program model, but this program ended in 2012.

GOVERNMENT, POLICIES, PROGRAMS, AND STRATEGIES THAT COULD SUPPORT ACCESS TO SERVICES FOR KEY POPULATIONS

Several policies, programs, and strategies exist in Kyrgyzstan that have the potential to support the gender needs of key populations, but most are either implemented partially, or not at all. Respondents cited the following policies as facilitating access for key populations to HIV programs and services: Law on HIV/AIDS in the Kyrgyz Republic; National HIV Prevention Program (2012-16; pending approval); Oblast Level HIV Prevention Program (2012-16); Treatment Protocols; Law articles related to key populations and PLHIV; and the National Gender Policy. The National Gender Policy released three programs for implementation: Ayalzat and two National Plans. The Program of State Guarantees was also cited, but key populations are not indicated as a separate group. The National HIV Prevention Program (2012-16) is reportedly aimed at the general population and includes the needs of key populations, but there is no indication that gender needs have been taken into account. Until this Program is approved and implemented its potential impact remains unknown.

> *State programs do not have different programs for men and women. They have separate programs for PLHIV, but they do not distinguish between men and women so prevention is only for the general population.* – Government Respondent #1

The PMTCT Order includes a separate protocol for women living with HIV that requires a four-week treatment for pregnant women to avoid vertical HIV transmission. The government is in the process of developing a new protocol to meet the special needs of pregnant FWID and pregnant FWID who are also sex workers. When finalized and approved, it is expected that the protocol will become binding for all medical institutions.

Policies that support gender needs and gender equality include the Convention on the Elimination of all forms of Discrimination against Women (CEDAW), which Kyrgyzstan ratified and acceded making it legally binding. NGOs translated CEDAW into Kyrgyz and disseminated it to rural areas, but national reports have not been submitted since 1998. UNFPA has helped the government strengthen gender-related policies and develop the State Gender Program (2012-20). They also supported development of the National Action Plan for the Gender Program, and are providing technical assistance to the Ministry of Youth and Labor to coordinate the implementation of the Plan across ministries, including the Ministry of Health. In spite of the existence of the Gender Program and UNFPA's role, respondents raised the same concern about political will and capacity for implementation by both government and nongovernment sectors. Kyrgyzstan has only a few gender specialists who understand gender needs and what needs to be changed or monitored. What is more, the State Gender Program considers only the general population and addresses neither key populations, nor gender and HIV-related issues such as gender-based violence:

> *The Gender Program is aimed at the whole population and included in national policy. However, the two issues of HIV and gender-based violence are not connected to each other in the program. We have to implement a more integrated approach to those exposed to HIV risks and violence.* – United Nations Respondent #1

Bride kidnapping[8] is illegal under Article 155 of Kyrgyzstan's Criminal Code with punishment of up to three years in prison. Many people think it is still legal, and prosecutions are extremely rare. Bride

[8] Bride kidnapping in Kyrgyzstan is the act of abducting a woman to marry her and includes a variety of actions, ranging from consensual eloping to kidnapping and rape (Amsler and Kleinbach 1999).

kidnapping and other forms of forced marriage, although not tracked by the government or well researched, are believed to have increased in Kyrgyzstan since independence, and continue to be widespread, especially in the south. The practice of bride kidnapping puts the kidnapped woman in an extremely vulnerable position, making forced, unprotected sex with kidnapping men very likely, which increases the risk of HIV and other sexually transmitted infections (STIs).[9] Respondents frequently mentioned as a concern the lack of enforcement of the bride kidnapping law. They reported that many bride kidnappings are done by Kyrgyz migrants of a certain age who are only in Kyrgyzstan for a few weeks and under pressure by their families to marry before they return to their country of employment. Respondents added that migrants often do not know their HIV status, and may infect the kidnapped girl, who is kept at home by the boy's family without access to health services until she becomes pregnant, at which time her HIV status is discovered during antenatal testing. The lack of enforcement of the bride kidnapping law poses an HIV risk for both victims of kidnapping and their partners:

> *Stress more attention to the bride kidnapping because it relates to HIV. In this case the girls are not protected from HIV. Bride kidnapping is illegal but it's not enforced.* – Implementing Partner Respondent #1

Sex work in Kyrgyzstan is neither a crime nor an administrative offence; the criminal code forbids forcing someone into sex work or organizing places of prostitution. Government efforts to criminalize sex work may further marginalize sex workers creating more barriers to HIV prevention, care and treatment services among women who are at increased risk for HIV (due to both biological and social vulnerabilities) and their profession (higher pay for unprotected sex and increased risk for violence). Criminalizing sex work may push sex workers further underground, leading to an increase in new sexually transmitted HIV infections as fewer sex workers access HIV prevention services, such as female and male condom distribution points and HIV testing and counseling (HTC). Respondents shared concern about recent government efforts to criminalize sex work:

> *The Ministry of Social Affairs has just released an updated Order related to administrative penalties for sex workers. Sex work is not prohibited and not allowed. We need decriminalization of sex work to provide better prevention activities.* – Implementing Partner Respondent #1

> *Never will a sex worker go to a doctor on her own because she will expose herself to stigma; normally our sex workers are afraid to be seen.* – NGO Respondent #1

When asked about policies that support key populations and the different needs of men and women, most respondents said that Kyrgyzstan has signed almost all of the international conventions and has written "beautiful policies" but has implemented very few of them. Respondents stated that this lack of implementation was due to instability and lack of capacity. Nongovernmental organizations in particular raised concern about the extent to which the government can consider gender needs of key populations because policies do not distinguish between men and women in general, much less when it comes to key populations. Government instability, high staff turnover, and financial dependency on donors contribute to the lack of implementation of existing policies.

> *From the whole range of government policies it has signed a number of international documents, but when looking at implementation the government lacks capacity understanding and commitment.*
> – Donor Respondent #1

[9] Because bride kidnapping is not tracked by the government or well-researched, no data exist on the prevalence of HIV among kidnapped women and girls.

I don't know exactly about the policies and whether they work for women, but the ubiquitous problem is that there is no distinction between men or women or PWID, and if they specify PWID they don't distinguish between men and women. – NGO Respondent #2

There is a national program for health care, called Den sooluk, that has one module related to HIV infection and some measures including both vulnerable groups and key populations. They will not tell you there is a distinction between men and women; they target the population in general. – Government Respondent #2

GOVERNMENT POLICIES, PROGRAMS, AND STRATEGIES THAT HINDER ACCESS TO SERVICES FOR KEY POPULATIONS

Propiska is a barrier to HIV prevention programs and services, especially for women. The most frequently mentioned policy barrier cited by all respondents is the requirement of an Identification Card with propiska to access free programs and services for HIV prevention and other health needs. This related mostly to women's health services such as family planning, STIs, maternal and child health, safe abortions, antenatal care, and gynecology:

HIV positive FWID often do not have Identification Cards with propiska and without that document they cannot access services. – Government Respondent #1

A pregnant woman should have comprehensive care and there should be one maternity home assigned for FWID without permanent place of residence so they can continue their treatment: antiretroviral therapy and methadone replacement therapy. – NGO Respondent #3

Due to factors such as migration[10] (internal and external), lack of permanent residence, exchanging documents for money and drugs, and violence, many key populations may not (ever or any longer) have Identification Cards with *propiska*. The government provides budgets for health facilities to cover patient costs. Those budgets are based on the number of people registered within each facility's jurisdiction. Facilities are unwilling to accept clients who are members of key populations because they are "difficult" patients, and doctors will not be paid for providing services to unregistered patients (they are paid for each client who has documents). Identification Cards are often used to justify violence against PWIDs (especially females), FSWs, and MSM for not having their cards with them, or police steal the Identification Cards under threat of violence or intimidation (see more on who perpetuates the violence and how in the section on reducing gender-based violence (GBV) against key populations on page 14). Lack of an Identification Card with *propiska* is a barrier to free HIV prevention, care, and treatment services and programs for all at-risk groups, but for single mothers the requirement also hinders access to education, health, and other critical social services by their children. For example, if a woman does not have an Identification Card with *propiska*, her children cannot attend school or social protection services, which furthers the cycle of vulnerability and likelihood of engaging in behavior that puts them at risk for HIV and other STIs:

There are FWID who do not have permanent residence, their children can't attend school. – NGO Respondent #3

[10] There are two kinds of external labor migration in Kyrgyzstan; one is official and the other is unofficial. Official migrants are documented and legal. Unofficial migrants are undocumented, and therefore do not have *propiska* for the location in which they work.

Recently the Ministry of Health issued two Orders[11] that help increase access to health services by members of vulnerable groups who do not have Identification Cards with *propiska*. Through these Orders, the Ministry of Health requested that Family Medicine Centers and Public Health Centers provide services to members of key populations without requiring Identification Cards with *propiska*. When members of these groups arrive at a Public Health Center, with or without a voucher, they are registered as "having an Identification Card without *propiska*" and coded according to the International Disease Classification for key populations: 102 for PWID, 105 for sex workers (Ministry of Health 2010; Ministry of Health 2012).

Stigma, discrimination, and lack of confidentiality among health providers affect the quality of HIV programs for key populations

Members of key populations are reluctant to frequent public health facilities because of internal and external stigma and discrimination, which seems to be most acute against FWID and FSWs. Stigma and discrimination was often cited as a reason for women's reluctance or inability to access HIV/AIDS programs and services. This is related to gender norms that perceive FWID more negatively than MWID because women are expected to be more responsible fulfilling their role as mothers, daughters, wives, and sisters. A FWID may not adhere to antiretroviral therapy or opioid substitution therapy regimens because of reluctance to return to the facility for their next course. FSWs may not access health services because of health workers' negative attitudes towards them. Lesbians and MSM reported that gynecologists, dermatologists, and proctologists are intolerant towards them and lack knowledge and understanding about their unique health needs. Stigma and discrimination also fuels breaches of confidentiality among primary health providers, including during HTC:

> *The issue of confidentiality is not observed and also our doctors need to be more tolerant towards those vulnerable groups.* – Government Respondent #3

> *Traditionally women are more reluctant to come to services. Women are mothers sisters … and need to keep the household and FWID are afraid to apply for help because of stereotypes.* – Government Respondent #2

Few doctors are trained to be friendly to members of key populations. Respondents suggested that doctors should be trained in interpersonal skills, human rights, gender norms, and the health needs of these populations. The limited training that doctors do receive was reported to be insufficient (too short, and without follow-up or refresher training):

> *We've had training so that's why we know about stigma, but we need more than a three-day training. We need refresher seminars once a month. There are seminars for medical staff and NGO staff, we get to know each other and share information.* – Government Respondent #4

> *Society (health institutions law enforcement agencies, etc.) should have more knowledge. More training is needed for them in HIV prevention and work with key populations.* – PEPFAR Respondent #1

[11] Order No. 145 dated March 17, 2010 "On improving measures to fight HIV/TB co-infection in the Kyrgyz Republic." (translated from Russian) and Order No. 206 dated April 25, 2012 "On implementing models of comprehensive approaches in providing TB, drug dependency and HIV services in republic healthcare organizations on out-patient and in-patient levels" (translated from Russian).

Poor data and surveillance of key populations by sex and gender (e.g., transgender) leads to unaddressed needs

Many respondents said that there is an absence of reliable, national data or tracking of HIV cases among PWID, MSM, and migrants, particularly female migrants. Data from oblast[12] AIDS Centers and NGOs show that there are HIV-positive cases among female migrants, but the government is not tracking HIV cases among this population nationally. Respondents also expressed concern about HIV among PWID in the north.

> *I'm interested in the exact number of FWID. Initially they [government] said 80,000, then 100,000, then 45,000. Maybe they take numbers out of the air. I want them to pay more attention to women, according to harm reduction programs the percentage of women is increasing because the coverage of women is increasing.* – NGO Respondent #4

Summary of Findings on Government Policies, Programs, and Strategies that Hinder or Support the Gender Needs of Key Populations to Access HIV Services

Several policies exist in Kyrgyzstan with the potential to address the gender needs of key populations and facilitate their access to HIV prevention, care, and treatment programs and services. There seems to be limited political will and capacity for implementation by both the government and nongovernment sectors, and a poor understanding of the gender needs of key populations. The latter may be due to lack of data collected or monitored by sex within key populations. As a result, male and female members of key populations continue to encounter barriers to HIV prevention, care, and treatment programs (Identification Cards with *propiska*, providers' lack of understanding of gender norms and related health needs of key populations), and factors that put women at risk (bride kidnapping and other forms of violence).

[12] *Oblasts* are administrative regions or provinces in Russia and some former Soviet Union countries, including Kyrgyzstan.

GENDER-BASED NEEDS OF KEY POPULATIONS RELATED TO HIV SERVICES

What needs to change for MWID, FWID, FSWs, MSWs, MSM, and their sexual partners to participate fully in and access HIV prevention, care and treatment programs and services?

The findings under this question discuss the unique gender-based needs of males and females who inject drugs, engage in sex work, are MSM, or are lesbian, gay, bisexual or transgender persons (LGBT). Most respondents did not have information on differences either by sex, or movement of men and women across various at-risk groups; thus there were few findings on unique gender-related barriers to men and women in each key population.

PROGRAMS AND SERVICES THAT UNDERSTAND AND RESPOND TO THE DIVERSITY OF KEY POPULATIONS

The majority of respondents (60 percent) engaging directly with key populations work with only one group (e.g., PWID, sex workers, MSM, PLHIV, LGBT), and perceive these populations as distinct at-risk groups, but homogenous within each group. For example, all PWID are viewed as being the same without consideration of differences by sex, residency (e.g., migrant or resident), or other cultural factors. Respondents did not recognize or consider that individuals' risky behaviors do not always fall neatly into one category. When asked about MSM engaged in sex work or injecting drugs, sex workers who inject drugs, or PWID who engage in sex work, NGO respondents replied, *"*We don't work with them.*"* For example, if an organization works with PWID they do not track or consider whether these individuals may be sex workers or MSM, and what their unique needs might be; all clients are seen only as PWID. Similarly, there is no tracking of differential access to services by men and women or recognition of the different barriers that each faces. When probed, respondents stressed that they treat everyone the same:

> *We don't distinguish between female or male PWID, all PWID are our clients equally.* – NGO Respondent #5

> *We should not distinguish between different vulnerable groups; we should not distinguish between men and women.* – NGO Respondent #6

This lack of monitoring, population size-estimation, or tracking by sex resulted in respondents unable to provide specific information on differences in access to HIV/AIDS programs and services by male and female members of key populations or by LGBT populations. In many cases, respondents were ready to provide information about their clients' access to services, but could not provide this information by sex. In the few cases where this information was available, respondents did not know how to interpret or use it to inform their programming:

We did something in [our project] to strengthen work in gender related issues. What kind of specific needs should be addressed and how? For example, do we need to strengthen our outreach work to address gender issues? … If 10 percent of FWID have access to methadone assistance treatment, is it enough? We don't know. – PEPFAR Respondent #2

REDUCTION IN GBV AGAINST KEY POPULATIONS, ESPECIALLY BY POLICE

There is mounting evidence that GBV is both a cause and consequence of HIV infection. Violence, or fear of violence, can be barriers to accessing HIV programs and services limiting individuals' ability to learn their status and adopt and maintain protective measures such as negotiating safer sex to getting and staying on treatment. Globally, very few programs are integrating a GBV response into programs with key populations and their intimate partners (Khan 2011).

Violence against all key populations, both male and female, was cited multiple times by respondents as a barrier to accessing services. Few investigations of violence inflicted by police are made due to fear of further violence. Respondents told several stories of violence by family members, siblings, friends, and health workers, but violence from police is the most damaging because if key populations feel that there is no one to protect their rights and safety, they move further underground, making it more difficult for HIV programs and services to reach them.

Most often, violence against key populations is fueled by perceptions of transgression against accepted gender norms and behaviors. For example, FSWs and FWID are more susceptible to violence than their male counterparts because they are seen as engaging in "unacceptable female behavior." In one study, almost half of the FWID surveyed had experienced violence from police officers. FSWs reported having to pay bribes and provide free sexual services to avoid police violence. Only a small minority of sex workers felt that they could report violence to the police (EHRN 2010).

Respondents reported that police often treat sex workers as criminals, conduct regular raids and forced STI tests, and extort money from them by threatening them with arrest for not having their Identification Card. Cases in which police are clients of FSWs further complicate the gender power dynamics. If FSWs inject drugs, or FWID engage in sex work, their risk for violence is increased because they are engaging in multiple "unacceptable behaviors."

For us the biggest barrier is law enforcement. They conduct raids of saunas and collect soms [local currency] from sex workers and when we ask sex workers to go to the clinic they say they need to earn 1000 soms to pay a police officer. We want training for policemen because they serve as the main barrier to our target group. – NGO Respondent #1

If sex workers reveal they use drugs they can be beaten even by clients. Even if she doesn't inject drugs she'll experience violence. A policeman will violate her… Sex workers almost never apply for help for violence. They are afraid. Today if a policeman violates her rights and she complains, tomorrow the policemen will terrorize her so the girls are scared.
– NGO Respondent #5

Violence against MSM was reported to happen first by family and close relatives then by persons in the community. Isolated by their families, MSM lack a social safety net, furthering their vulnerability and reducing their access to HIV programs and services. Violence against MSM by police was reported as being acute, deliberate, and premeditated, with perpetrators going to great lengths to harass and enact violence against MSM:

At the moment we're more concerned about the law enforcement because cases have increased recently. […] It could be a law enforcement guy who offers to meet you and when you come to the meeting the police pretend to arrest you but they beat you. – NGO Respondent #6

Violence against MSM, lesbians and transgender persons, such as "corrective rape" against lesbians, was reported as resulting from the perception that these groups did not comply with accepted gender norms of femininity or masculinity:

I think it depends on masculinity tradition. My personal view the general [view of masculinity] in Central Asia they are patriarchal: gays humiliate the tribe, it is a shame for a tribe. – NGO Respondent #6

We've got another big problem, violence. Police can beat us, take money away, and stop a person just because they [transgender or lesbian] are dressed differently. LGBT people won't file a complaint because they have to indicate the reason they were beaten and there will be discrimination. – NGO Respondent #7

A growing body of literature is exploring the relationship between GBV against MSM, and negative health outcomes such as HIV infection, poorer mental health, barriers to medical care, and substance abuse. There is also some evidence that stigma and discrimination are barriers to the uptake of HTC services by MSM, and to effective prevention and care services for MSM (Spratt 2010).

Many respondents spoke of the need for the government to comply with the human rights conventions it has signed and uphold the policies it has put in place to eliminate the violence inflicted against key populations. Training and awareness-raising of police and law enforcement bodies is needed in human rights, legal rights, stigma and discrimination, gender norms, GBV and HIV. Some NGOs are doing this, but more is needed:

We try to provide training in human rights for law enforcement staff. They say they agree it is necessary but when they leave the training room they continue their evil practice. – NGO Respondent #8

I think it is impossible to train the law enforcement, I don't think they'll change. – NGO Respondent #6

INCREASED ATTENTION TO MALE NORMS THAT HINDER ACCESS TO SERVICES AND PERPETUATE RISKY BEHAVIOR

Research provides strong evidence that globally men are disadvantaged by gender norms. Studies repeatedly show that men who adhere to rigid notions of manhood; equate masculinity with risk taking, dominance, and sexual conquest; and view health-seeking behaviors as a sign of weakness experience a range of poor health outcomes (Peacock et al. 2009). Studies also show that male norms of dominance may inhibit men's willingness to insist on safe sex or safe injecting practices (Spratt 2010). Specific barriers cited by respondents to accessing HIV programs and services focused primarily on FWID, but gender barriers for MWID do exist. Like men globally who view health-seeking behaviors as a sign of weakness, MWID are less likely to access health services and social escorts are often required to ensure that MWID access referrals:

It's such a big problem for us working with PWID because without social escorts MWID won't go the referral system, which works great for everyone except MWID; they're waiting for mobile clinics. – Implementing Partner Respondent #1

When asked if men face barriers to accessing health services, respondents replied that most men in general do not seek healthcare services, but they did not link this gender norm to MWID, MSM, or MSWs. Others spontaneously spoke of the need for health services to be more male-friendly:

> *We clearly demonstrated that men do not apply to health care institutions. There are stereotypes. They are our way of life.* – NGO Respondent #9

> *We need to pay attention to men as well. Maybe the Ministry of Health can arrange some sort of services for men, maybe clinical protocol for men. In any case men infect women so my wish is that men in future get attention.* – Government Respondent #1

Male norms can also be barriers for women, because men may keep their partners from accessing services such as harm reduction programs, HTC, and HIV and STI prevention. Men may perpetuate harmful behaviors and influence women to do the same. For example, studies from a number of countries indicate that in many instances women are likely to be initiated into drug use by their spouses or sexual partners, and are strongly influenced in their drug-using behaviors (Spratt 2010). Respondents from governmental and UN organizations and implementing partners mentioned examples in which husbands can hinder their wives' access to "friendly health services," HIV prevention training, and HTC:

> *A woman cannot apply to some friendly services because of negative pressure from her husband.* – Government Respondent #3

> *Men do not come to HIV trainings themselves and do not let their wives come either.* – United Nations Respondent #2

> *Nobody pays attention to work with men to simply explain to them how, for instance, their attitudes towards women, to HIV, to STI prevention could impact their families and children. If men don't allow their wives to receive medical services, HIV testing, or participate in some programs HIV spread will continue.* – Implementing Partner Respondent #1

Men who inject drugs may be embarrassed that their partner injects drugs and will not allow them to access services. These gender norms exist across the country, but were reported to be more acute in Osh and Jalal-Abad than in Bishkek because of cultural factors such as religion and ethnicity:

> *[Male] drug users apply to us and get information but they rarely tell their female partners because it's in his interest to keep her ignorant; so it's hard to reach women.* – NGO Respondent #2

INTEGRATION OF HIV AND SRH SERVICES FOR FEMALE MEMBERS OF KEY POPULATIONS, ESPECIALLY FWID

Studies in Kyrgyzstan show that specific needs of FWID are not being met. This is true especially for their sexual and reproductive health (SRH), including prenatal counseling services and ability to negotiate safe sex. Specific SRH training and programs targeting FWID are absent, except in one center for women in Bishkek (Bivol et al. 2011). Low integration of HIV and maternal and child health services, as well as irregular training for gynecologists and STI specialists in HIV, are structural barriers to accessing high quality services (Deryabina 2011).

After Identification Cards with *propiska*, unaddressed women's SRH was the second most often cited barrier to accessing HIV services by key populations. Respondents related examples of FWID not accessing SRH services (which are opportunities for accessing HIV programs and services) because

their status as a person who injects drugs instills fear of losing their children and creates an inability to access maternity services, which is compounded by the need for Identification Cards with *propiska*:

> *Very often most of them [FWID] have children but are afraid that when her status [as a PWID] is revealed her children will be taken from her because she'll be accused of being a bad parent.… We have had a number of cases where women get pregnant. It is very difficult for her to apply for medical services. If she is a drug user it is a barrier to apply to service if they know her status as a drug user and pregnant.* – NGO Respondent #2

Females who inject drugs often have irregular menstrual cycles thus are less likely to recognize early stages of pregnancy. In one analysis, prevention of unintended pregnancies seemed to be an issue among clients because of their poor access to appropriate family planning and safe abortion. Females who inject drugs seem to avoid contact with antenatal services, and present late at maternity houses for delivery. If they do present, maternity houses often avoid admitting active drug users and refuse to provide appropriate care (Bivol et al. 2011).

Respondents stated that maternity centers are not set up to meet the needs of pregnant FWID and doctors do not know how to treat babies born with neonatal abstinence syndrome (NAS) or do not have the medicines or capacity to support them. Conversely, narcology centers are not set up to deal with pregnancy. Females who inject drugs who do access maternity centers often do not reveal their status as a PWID because of stigma and discrimination, so their babies born with NAS go untreated. Respondents said that it is very difficult for FWID to apply for medical services because of stigma as a pregnant drug user. Another problem is finances, and many FWID do not have Identification Cards with *propiska* to access free services. Some doctors will not ask for money, but the visits still present an emotional stress:

> *No one is addressing pregnant women [who inject drugs]. There should be observation during the pregnancy, counseling, and education on the necessary skills.… There are no services for the babies [with NAS] and doctors don't know how to care for them or treat them. One of my client's husband brought drugs to the maternity hall for the baby.* – NGO Respondent #2

Several respondents identified comprehensive services for FWID that link HIV prevention, care, and treatment with SRH as a critical factor for reaching FWID and meeting their overall health needs. This includes maternity wards, shelters, and rehabilitation centers where staff understand the needs and circumstances of FWID. Nongovernmental organization respondents said that they do not know where to refer FWID for rehabilitation, because all the wards are for men, and that only one center exists in Bishkek that provides services to pregnant injecting drug users:

> *FWID cannot come to needle and syringe programs (NSP) due to women's status… Female clients cannot go to NSP and opioid substitution therapy points, but can go to gynecologists and STI specialists. Harm reduction services can be provided through theses specialists as well.* – Donor Respondent #2

> *A pregnant woman should have comprehensive care and there should be one maternity home assigned for FWID without permanent place of residence/propiska so they can continue their treatment (e.g. antiretrovirals methadone replacement therapy).* – NGO Respondent #3

> *Our surveys show that social services and hostels are valued and needed by FWID to receive services register as pregnant receive free condoms and access free childcare.* – NGO Respondent #4

Clinical and social services are predominantly set up to meet the needs of men. Women, and women with children, are reluctant to access those services, or the services are ill equipped to meet their needs. Females who inject drugs who need rehabilitation do not have a place to go, especially HIV-positive FWID. Social institutions that provide services to women may discriminate against FWID, and FWID may also discriminate against each other. Lesbians are often refused by social centers altogether. Without female-only social services, women lack a place to discuss their concerns as a group without men present:

> *Some things women can discuss amongst themselves and some they can't discuss in a group where there are men. We can establish self-help groups, trainings about safe behavior to remove stress or tension, talking about co-addiction.* – NGO Respondent #2

The lack of shelters is also a concern for FWID. Currently there is only one center for FWID, and sobriety-focused community centers[13] mostly accept only male clients. While setting up special shelters for women may be required in some areas, others suggest that existing services should be used at least initially to accommodate both female and male clients (Bivol et al. 2011).

INCREASED HIV TESTING FOR KYRGYZ MIGRANTS

Respondents from PEPFAR, other donors, the Ministry of Health, and implementing partners cited Kyrgyz male migrants who work in Russia, Kazakhstan, and other countries as an at-risk group in terms of HIV infection for themselves and transmission to their wives and sexual partners. There are no reliable data on the number of labor migrants (male or female) and their sexual partners, or on HIV prevalence within these two groups. However, there is increased concern about the role of migrants in Kyrgyzstan's HIV epidemic based on anecdotal evidence (e.g., Russian websites). This evidence implies that the majority of migrants are men, that they are not accessing HTC, and that they often contract HIV and other STIs abroad and infect their wives when they return to Kyrgyzstan.

External and internal migration in Kyrgyzstan is uncontrolled. Migrants are not included as a target group in the state prevention program, and HIV cases among male-migrants and their wives or partners are not well tracked. Unofficial labor migrants are not tested for HIV in Kyrgyzstan or abroad, and are unaware of their HIV status as a result. They do not have access to medical institutions outside the country, and are not educated in HIV prevention (e.g., safe sex and condom use) in Kyrgyzstan due to the lack of HIV prevention programs aimed at the general population:

> *We do not include migrants as a target group in the state program and migration is uncontrolled. People leave the country unofficially and return unofficially. Official migrants take a drug test but unofficial migrants can take a train and go; we don't know how many left and how many arrived.*
> – Government Respondent #5

> *We don't have real data to prove the situation with HIV cases among male migrants it is not tracked well.*
> – Implementing Partner Respondent #3

> *Men and women work abroad and have partners there. When they come home they infect their partners. We think that the biggest vulnerable group is migrants, men and women, because they have unprotected contacts abroad. The majority of migrants are men. I can't tell you exactly how many migrant women exist but there are many cases.* – Government Respondent #1

[13] These are centers that provide support to PWID after they leave rehabilitation to help them stay clean and sober.

In the south, men may leave the country to find a job and come back to their family with HIV or other STIs. They may infect their wives without knowing their status. In most cases, migrants' wives or sexual partners only become aware of their HIV status during pregnancy, because of mandatory HIV testing during antenatal care. In some cases, if they test positive for HIV they can experience violence from their husbands and other family members, and may be kicked out of their home. Given this reality, female partners of male migrants have difficulty disclosing their status to their family, community, and medical providers:

> *Men are infected outside of the country and women become infected inside. In the south more traditional cultural things and fundamentalist views influence gender roles. If a woman is infected, she cannot tell anyone about it. She can't get help.* – Implementing Partner Respondent #3

Summary of Findings on What Needs to Change for Male and Female Members of Key Populations to Participate Fully and Have Access to HIV Prevention, Care, and Treatment

Five major areas emerged as needing to change for male and female members of key populations to have increased participation in and access to HIV programs and services:

- Recognize that individuals do not always fall neatly into one key population. Collect data and track differences by sex and multiple at-risk behaviors to improve understanding of the specifics needs and barriers unique to men and women who engage in multiple at-risk behaviors (e.g., sex workers who inject drugs, MSM who migrate to engage in sex work, FWID who provide sex for money or drugs).
- Reduce GBV, especially by police, that increases HIV risk and potentially pushes key populations further underground.
- Address gender norms for men and women and reduce GBV against key populations that hinder access to services and perpetuate risky behavior.
- Integrate HIV, SRH, children's health, and social and rehabilitation services to address the complex needs of female members of key populations.
- Increase access to HTC for returning migrant workers to decrease HIV transmission from HIV-infected migrants to their sexual partners.

LIMITATIONS

Data presented in this report should be interpreted and used considering the following limitations:

- Focus group discussions with representatives of key populations who access or do not access services would have provided greater understanding of their perceived barriers and facilitating factors for accessing services. However, this was not possible because of the need to obtain Institutional Review Board approval.
- High levels of stigma, discrimination, and violence against key populations may have restricted the level of openness among some interviewees.
- Most interviews were organized and recommended by USAID and PSI, which may have skewed the balance across PEPFAR agencies with an emphasis on organizations funded by USAID. CDC and Peace Corps had less representation in the interviews, and the assessment team did not meet with the World Health Organization, which was reported as a major HIV player in the country.
- Most organizations participating in interviews work with specific key populations focused on PWIDs or FSWs, so findings may be skewed towards those two groups. However, the epidemiology in Kyrgyzstan shows that HIV is most prevalent among PWID and FSWs, so it is understandable that most organizations and donors are working with these groups.
- Political instability in Kyrgyzstan has caused a high turnover among Ministry of Health staff. As a result, many government employees interviewed had only been in their position for a few days, weeks, or months, resulting in a lack of depth in the Ministry's perspective on the government programs and policies being implemented.
- Organizations were not always apprised of the purpose of the assessment before the interview, so in some cases the most appropriate person to interview was unavailable or was not scheduled. As a result, the desired depth of the interview was not always achievable.
- Gynecologists were not interviewed, which may have provided a better understanding of FSWs and FWID medical needs and gaps.
- Interviews were translated into English and transcribed simultaneously, but were not audiotaped, so some nuances may have been lost.

RECOMMENDATIONS

This gender assessment is an important first step for PEPFAR/CAR and PEPFAR/Kyrgyzstan towards a greater understanding of how gender inequality is hindering access to HIV prevention, care, and treatment services by male and female members of key populations in Kyrgyzstan. There is limited political and social commitment to understanding and addressing gender norms that perpetuate stigma and discrimination against key populations and impede their access to HIV and other health services. PEPFAR has an important role to play with the Ministry of Health, and with key populations themselves, to increase understanding of the varied gender norms that affect the diverse at-risk groups in Kyrgyzstan.

The document review and interviews only "scratched the surface" of the challenges that need to be addressed and the opportunities for PEPFAR to move forward in working with the government and other donors. PEPFAR needs to consider its unique niche and the added value of addressing the HIV epidemic in Kyrgyzstan in the context of the large number of donors in the country and the huge presence of the Global Fund, which is working with the government and NGO sectors, and has committed USD $31 million over three years.

The following recommendations are organized around the two assessment themes and according to each PEPFAR implementing agency. The action plan that follows lists the five priority actions for PEPFAR/Kyrgyzstan in fiscal year 2013. The planning, design, and implementation of any activity should include the active participation of male and female members of key populations as well as government counterparts. This will not only improve program outcomes and likelihood of sustainability, but also will help to reduce stigma and discrimination by demonstrating the value and import of the contributions of male and female members of key populations.

OPPORTUNITIES TO STRENGTHEN GOVERNMENT POLICIES AND PROGRAMS AND STRATEGIES

Reaching key populations with effective HIV prevention, care, and treatment services is critical to achieving PEPFAR goals. Because these populations are highly stigmatized and PEPFAR government partners may be reluctant to invest in programming for them, PEPFAR teams should prioritize breaking down these barriers for both policy and programs to address the epidemic most effectively (PEPFAR 2012a).

PEPFAR currently works closely with the government of Kyrgyzstan to build the capacity and quality of the country's HIV/AIDS programs and services. Through the SUPPORT Project (HIV Technical Support Program in Central Asia) CDC provides technical assistance to strengthen and expand strategic information (surveillance, monitoring and evaluation, and informantics) and improve utilization of strategic information by the Republican AIDS Center. CDC also provided technical assistance to develop the new national HIV program. USAID's Quality Health Care Project provides technical assistance in quality improvement methodologies at all levels of health services management, financing, and implementation of medical services for tuberculosis, HIV, and primary health care (including maternal and child health services). Given this and PEPFAR II's focus on country ownership, PEPFAR/Kyrgyzstan is well positioned to build the government's capacity to understand gender norms that impede access to HIV programs and services by key

populations, and to use those data to understand and address their epidemic better in terms of the different needs of male and female members of key populations. Within this context, PEPFAR agencies may want to consider the following actions:

CDC

- Provide technical support and capacity building to the government to strengthen their strategic information systems, so they can better understand the differences between male and female members of key populations in terms of access and use of services and apply that information to the national HIV program. This includes disaggregating data by sex (male and female) and gender (transgender, lesbian, gay) as well as behavior (PWID, sex work, migrants, MSM) to understand the different needs of males and females within each key population and subgroup, and to identify among what populations and sex the epidemic is concentrated. Help the government use these data to develop a response to the epidemic now, predict where the epidemic may be moving (e.g., into the general population via migration) and develop appropriate mitigation strategies for the future. This should include tracking, collecting, and analyzing data on the multiple roles of key populations (i.e., individuals whose behaviors fall into multiple key populations). This information should be used to ensure that the gender needs of key populations are incorporated into national HIV strategies and action plans.
- Fund research or build government capacity (or both) to collect date on incidence and prevalence of bride kidnapping and its impact on the HIV epidemic.
- Examine the extent to which the new, pending HIV healthcare program, *Den sooluk*, addresses gender norms and gender needs of key populations. Provide technical assistance to integrate gender needs into the HIV national strategic plan and healthcare program.

USAID

Add to current projects or develop new projects to:

- Provide capacity building and technical assistance to the government to develop an implementation plan for the bride kidnapping law, and collaborate with UNFPA to provide technical support to the Ministry of Health on implementation of the National Action Plan for the Gender Program.
- Provide technical support to the Ministry of Health to address barriers that prevent members of key populations from accessing free health services because of requirements to present Identification Cards with *propiska*, including implementation of Order No. 145 dated March 17, 2010, "About improving measures to fight HIV/TB co-infection in the Kyrgyz Republic" and Order No. 206 dated April 25, 2012, "About implementing models of comprehensive approaches in providing TB, drug dependency and HIV services in republic healthcare organizations on out-patient and in-patient levels."
- Provide training on gender norms and the connection between GBV and HIV to Ministry of Health and Ministry of Internal Affairs policymakers, so that they support policies and training for their staff in these interconnected areas.

PEACE CORPS

- As safety and security allow, place Volunteers with NGOs that work with key populations, and advocate with the government for implementation of government policies and programs that support the gender needs of key populations.

HIV/AIDS ACTIVITIES THAT ADDRESS GENDER-BASED NEEDS OF KEY POPULATIONS

In the context of an unstable and unpredictable government, donors have focused on fostering and building the capacity of NGOs working with key populations. The result is a very strong key population- and PLHIV-focused NGO community. These NGOs, supported by several donors including the Global Fund, are now stronger than the government in many respects and either well-positioned now, or will be in the near future, to advocate and collaborate with the government. Now effort is warranted to build the government's capacity to address the needs of, and work with, key populations so that they can respond to and work with the increasingly strong NGO sector. PEPFAR is well-positioned to fill this niche.

PEPFAR/KYRGYZSTAN

- Fund an in-depth gender analysis with key populations and their sexual partners to understand more deeply their needs related to HIV prevention, care, and treatment services. The gender analysis should include in-depth focus group discussions with key populations and their partners in several oblasts, including participants who access services and who do not access services, to understand what HIV services are needed, and what will support access to such services. The results of this gender analysis should be used to inform the PEPFAR/CAR gender strategy, and be incorporated into existing projects to address gender norms that hinder access by key populations (male and female) to HIV and other health services.

USAID AND CDC

- Train staff and implementing partners on gender norms, gender analysis, and the PEPFAR Gender Strategy. The training should include theory and practice, so that staff and implementing partners know why they are required to collect sex-disaggregated data; why data should be disaggregated by sex, age, and key population; and how to analyze, interpret, and use those data to inform their existing projects.
- Support research and strategic information on the role of male and female migrants in the HIV epidemic through the existing Dialogue on HIV and TB (USAID) and SUPPORT (CDC) Projects.

USAID

- Provide training for health providers that last more than three days, are held frequently, and include gender equality (gender norms and needs and how these relate to their work), how to screen for GBV, and training to reduce stigma and discrimination against all key populations and PLHIV.

- Train Kyrgyzstan National Police officers, through the Ministry of Internal Affairs, on human rights, legal rights, stigma and discrimination, gender norms and HIV, and the connection between GBV and HIV so that they uphold the rights and safety of members of key populations.
- Provide technical support to the government to collaborate with the private and nongovernmental sectors to establish comprehensive social and health services. These low-threshold services should include needle and syringe programs and harm reduction programs, methadone replacement therapy and opioid substitution therapy (especially for pregnant women), rehabilitation services, SRH services (maternity houses), STI diagnosis and treatment, HIV prevention information and provision of condoms (male and female), and drug overdose and detoxification treatment. The services should take into account sex workers who inject drugs and FWID who are sex workers as well as other overlapping population groups; and should provide referrals and safe spaces, such as drop-in centers, shelters, and childcare, for female members of key populations, especially FWID.
- Incorporate activities into existing projects that address gender norms that hinder access by key populations to HIV and other health services, prioritizing populations or specific issues that come out of the in-depth gender analysis.

PEACE CORPS

As safety and security allow, place Volunteers with NGOs to:

- Integrate the needs of key populations into current gender and HIV activities such as Volunteer Activities Support and Training (VAST) grants, Domestic Violence Toolkit, Camps GLOW (Girls Leading Our World) and TOBE (Teaching Our Boys Excellence), and HIV education camps that integrate a gender perspective.
- Provide HIV and drug prevention information to primary and secondary school students and out-of-school youth, and develop alternative options to sex work (e.g., vocational training).
- Develop HIV prevention information (information, education, and communication materials), HTC, and referrals for migrants and their wives and sexual partners.

These recommendations include a range of activities in which PEPFAR may want to engage in response to the assessment findings. Table 3 provides the five most urgent and critical actions for PEPFAR to address gender-based needs that hinder access to HIV prevention, care, and treatment services by key populations.

Table 3. Suggested Action Plan for PEPFAR/Kyrgyzstan

Activity	Lead Agency	Output or Outcome
1. Conduct in-depth gender analysis (using focus group discussions) with key populations (including migrants) and their sexual partners in several oblasts, including both those who access HIV services, and those who do not.	PEPFAR / Kyrgyzstan	Incorporate activities into existing projects that address gender norms that hinder access by key populations (male and female) to HIV and other health services, prioritizing populations or specific issues that come out of the gender analysis.
2. Strengthen government strategic information systems to collect and analyze data on key populations by sex (male and female), gender (transgender, lesbian, gay), and behavior (sex work, PWID, MSM) including data on the multiple roles played by members of key populations.	CDC	Sex-disaggregated data that show the different needs of males and females within each key population and subgroup, and among what populations and sex the epidemic is concentrated. Data are used to inform the national HIV response.
3. Provide technical support to the Ministry of Health, including implementation of Orders No. 145 and 206, to address the barriers to accessing free health that key populations face due to requirements to present Identification Cards with *propiska*.	USAID	Increased access to HIV prevention services by key populations, assuming that services are also friendly to these populations.
4. Develop and implement a capacity building strategy around gender norms, human rights, legal rights, GBV, and HIV for implementing partners, police officers, health providers, and policymakers	PEPFAR / Kyrgyzstan	• Reduced GBV by police against key populations • Reduced human rights violations against key populations by health providers and police officers • Increased understanding of gender norms, HIV, and key populations by implementing partners, health providers, police and policymakers
5. Support research and strategic information on the role of male and female migrants in the HIV epidemic through the existing Dialogue (USAID) and SUPPORT (CDC) Projects.	USAID and CDC	Generate reliable data on the role of male and female migrants on the HIV epidemic.

RESOURCES

PEPFAR/CAR, PEPFAR/Kyrgyzstan and their implementing partners may find the following resources useful for integrating gender into existing projects and implementing some of the recommendations above:

"Follow the Voice of Life": HIV Prevention and Empowerment of Men Who Have Sex with Men in Orenburg, Russia

Filippau, Dzmitry, and Inna Vyshemirskaya. 2011. Case Study Series. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Gender inequality is a major contributor to vulnerability to HIV among MSM. Understanding the gender dynamics of MSM, as well as their specific sexual identity issues and concerns, is important for delivering effective HIV services. This case study describes how an NGO in Russia created an MSM-supportive environment and provided free access to HIV services through its "Follow the Voice of Life" program.

Available in Russian at: http://www.aidstar-one.com/sites/default/files/AIDSTAR-One_CaseStudy_GenderMARPs_Russia_RU.pdf.

Available in English at: http://www.aidstarone.com/sites/default/files/AIDSTAROne_Case_Study_GENDERMARPS_NewLife_Russia.pdf (accessed March 2013).

What Works for Women and Girls: Evidence for HIV/AIDS Interventions

Gay, J., M. Croce-Galis and K. Hardee. 2012. Second edition. Washington DC: Futures Group, Health Policy Project.

This website reflects a comprehensive review, spanning 2,500 articles and reports with data from close to 100 countries, that has uncovered a number of interventions for which there is substantial evidence of success: from prevention, treatment, care, and support to strengthening the enabling environment for policies and programming. It also highlights a number of remaining gaps in programming. The section on Prevention for Key Affected Populations provides strategies for work with female sex workers, women who use drugs and female partners of men who use drugs, migrant workers and female partners of male migrants, and transgender women and men, among others.

These resources are available at: http://www.whatworksforwomen.org/ (accessed March 2013).

Gender-based Violence and HIV: A Program Guide for Integrating Gender-based Violence Prevention and Response in PEPFAR Programs

Khan, Alia. 2011. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Like HIV, gender-based violence (GBV) has implications for almost every aspect of health and development. This guide serves as a tool for program managers to not only begin to address GBV within their programs, but also to plan for greater integration and coordination within country teams when designing workplans and budgets. The guide is divided into several smaller parts and readers

are strongly urged to review all parts of the guide to take advantage of the full range of opportunities to address GBV and achieve greater linkages among activities for HIV prevention, treatment, care, and support.

Available at: http://www.aidstarone.com/sites/default/files/AIDSTAR-One_GBV_Guidance_Sept2012.pdf (accessed March 2013)

SANGRAM's Collectives: Engaging Communities in India to Demand their Rights

Kundu, Nandita Kapadia. 2011. Case Study Series. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Integrating strategies to address gender inequity and change harmful gender norms is an increasingly important component of HIV programs. However, gender integration among programs targeting most-at-risk populations (MARPs) is much less prevalent. This case study reviews how SANGRAM, a women-led network of collective empowerment groups in India, is developing and administering projects that promote and protect the rights—and health—of MARPs.

Available at: http://www.aidstarone.com/sites/default/files/AIDSTAR-One_CaseStudy_GenderMARPs_SANGRAM_India.pdf (accessed March 2013).

STIGMA Foundation: Empowering Drug Users to Prevent HIV in Indonesia

Spratt, Kai. 2010. Case Study Series. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Integrating strategies to address gender inequity and change harmful gender norms is an increasingly important component of HIV programs. However, gender integration among programs targeting most-at-risk populations (MARPs) is much less prevalent. In Indonesia, the STIGMA Foundation uses a peer outreach model to help men and women who inject drugs live safer, healthier, more productive lives through community organizing, advocacy, and networking.

Available at: http://www.aidstarone.com/sites/default/files/AIDSTAR_One_CaseStudy_Gender_STIGMA_Foundation_Indonesia.pdf (accessed March 2013).

Technical Brief: Integrating Gender into Programs with Most-at-Risk Populations

Spratt, Kai. 2010. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Integrating gender strategies into programs targeting most-at-risk populations (MARPs) which include men who have sex with men, transgender people, injecting drug users, and male, female and transgender sex workers, whether in mixed or concentrated epidemic countries is much less prevalent. The purpose of this Technical Brief is to provide program managers and planners with an overview of the recent research literature on gender-related constraints effecting MARPs, future program approaches, and gender-related challenges that should be considered in programs to reduce HIV risk among MARPs.

Available in Russian at: http://www.aidstar-one.com/sites/default/files/AIDSTAR-One_TechBrief_IntegratingGender_MARPs_RU.pdf.

Available in English at: http://www.aidstar-one.com/sites/default/files/Tech%20Brief_Integrating%20Gender%20into%20Programs%20with%20MARPs_web.pdf (accessed March 2013).

Breaking New Ground: Integrating Gender into CARE's STEP Program in Vietnam

Spratt, Kai, and Quach Thi Thu Trang. 2011. Case Study Series. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Gender norms affect the behavior and life choices of both men and women. In Vietnam, these norms sometimes drive people into situations where they are at increased risk of violence, STI acquisition, and/or incarceration. This case study examines CARE International's STEP program, which seeks to ensure that both men and women PWID and sex workers have equal access to services to prevent STIs, safeguard their health, avoid gender-based violence, and participate in income-generating activities.

Available at:
http://www.aidstarone.com/sites/default/files/AIDSTAROne_Case_Study_GENDERMARPS_STEP_Vietnam_0.pdf (accessed March 2013).

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APPENDIX A

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APPENDIX B

INTERVIEW GUIDE

Date:

Name/Title/Affiliation of Respondent:

Contact information of Respondent:

Interviewer:

INTRODUCTION:

Thank you for making the time to talk with me today.

Before we begin this interview, I want to let you know that any information or examples we gather during this interview process will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses to be either quoted in the evaluation report, or otherwise attributed to you. You are also free to not respond to any of our questions or stop the interview at any time.

We are conducting a gender assessment to inform and guide the design and formulation of the Central Asia Regional PEPFAR gender strategy. The assessment will provide a set of practical recommendations for incorporating gender activities in a concentrated HIV epidemic in the form of an action plan that will include immediate, medium and long terms steps that can be integrated into existing programs, identify gaps, make recommendations that build on strengths and address gaps. Your input will help PEPFAR consider how to integrate better gender into existing programs.

The interview will take about one hour.

Before we begin, do you have any questions about this interview?

BACKGROUND

1. What is your role or relationship with the PEPFAR Program in Kyrgyzstan AND / <u>OR</u> your relationship with the Kyrgyz HIV/AIDS response?

GENDER NEEDS OF KEY POPULATIONS

For concentrated/low-level epidemic settings, most at-risk populations drive HIV transmission. PEPFAR defines most-at-risk populations or key populations as: People who inject drugs (PWID), men who have sex with men (MSM), and sex workers. The next three questions relate to gender dynamics and key populations, as defined by PEPFAR.

2. Describe a program or activity you participated in that was successful in reaching key populations and facilitating access to HIV/AIDS programs and services? What made it successful? *PROBE for examples of successful strategies and approaches, specific activities, any differences in how the program reached/ worked with males and females?*
3. What are the key risk factors or drivers for HIV transmission among key populations in Kyrgyzstan? What differences in risk factors exist between males and females?
4. How do sociocultural roles, relations, dynamics, perceptions serve as barriers to access to services and programs by key populations?
5. What programs are you involved in or know about that have been successful in facilitating access to HIV programs and services for male and female members of key populations? What strategies have they used? Why do they work?

GOVERNMENT POLICIES AND PROGRAMS

The next six questions focus on government policies and programs.

6. To what extent do you feel the Kyrgyz government's approach to the HIV epidemic is helping to address the key drivers?
7. What government gender-related policies and programs exist? What MARP-related policies and programs exist? If no policies, what barriers exist to getting these policies in place?

   Are there policies in place that are harmful or hinder access to HIV services for these groups?

   What needs to be strengthened (in terms of policies) to address better the needs of male and female members of key populations in Kyrgyzstan? (Are they being fully implemented? If not, why not?)
8. In what ways is the government's overall HIV response addressing most at risk populations?

   Probe for:
   - *Including key populations in the national HIV surveillance system*
   - *Directly funding for MARP-focused programs*
   - *Changing punitive laws and policies*
   - *Addressing stigma and discrimination against key populations*
   - *Ensuring appropriate prevention, treatment and care and support services are available*
9. To what extent is a human rights approach currently informing the national HIV response to meeting the needs of key populations?
10. In what ways does the government's HIV response seek to change sociocultural norms that influence risk behaviors and increase vulnerability among key populations?

    If an example is needed: *Gender norms are social beliefs and attitudes about how men and women should behave or what they are allowed to do. So for example, society condones sex only between men and women, not between men or between women. Or, gender norms encourage men to have many sex partners, but this puts men at risk for HIV. Or, society says that women have to have sex whenever their partner wants it, which may put women at risk. Or, communities may think that gender-based violence against a woman by her male partner is acceptable even though violence reduces a woman's ability to negotiate condom use with her steady partner.*
11. What else could or should the government, donors, NGOs or others do to prevent or mitigate the HIV epidemic among key populations?

CONCLUSION

As we conclude this interview, we have a few final questions, and we'd like you to reflect back on what you've shared so far as you respond.

12. If you were granted three wishes that would strengthen what the government and civil society are trying to do to mitigate the HIV epidemic in Kyrgyzstan and address the needs of key populations, what would those three wishes be?
13. If you were granted three wishes that would strengthen what PEPFAR is trying to do to mitigate the HIV epidemic in Kyrgyzstan and address the needs of key populations, what would those three wishes be?
14. Is there anything else that you want to tell me but didn't because I didn't ask the right question? Any other comments/insights/questions you would like to share?
15. Just before we finish the interview I would like to know if you can recommend the most current resources on the state of the epidemic in Kyrgyzstan, copies of relevant policy documents and recent situational analysis of the national HIV programs, especially those looking at MARP programs.
16. Do you have any questions for me?

THANK YOU VERY MUCH FOR YOUR TIME AND INSIGHTS.

Interviewer Notes
Are there any comments, impressions or special information about the person or organization interviewed or interview process?

For more information, please visit aidstar-one.com.

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