

Baseline Assessment - Kyrgyzstan

Scaling up Programs to Reduce Human Rights- Related Barriers to HIV and TB Services

October 2018

Geneva, Switzerland

List of Acronyms and Abbreviations

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
BCC	Behavior change communication
CBO	Community based organization
CCM	Country Coordinating Mechanism
CD4	Cluster of differentiation 4
CDC	Centers for Disease Control and Prevention
ECDC	European Centre for Disease Prevention and Control
FMC	Family Medical Centre
FGP	Family group practice
HIV	Human immunodeficiency virus
HTC	HIV testing and counseling
ICAP	International Center for AIDS Care and Treatment Programs
IPT	Isoniazid preventive therapy
LGBTI	lesbian, gay, bisexual, transgender and intersex
LTFU	Lost to follow up
MDR-TB	Multidrug-resistant tuberculosis
MoH	Ministry of Health
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
NGO	Nongovernmental Organization
NSP	Needle and syringe programme
OST	Opioid substitution therapy
PCR	Polymerase chain reaction
PHC	Primary health care
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PWID	People who inject drugs
RAC	Republican AIDS Centre
SFK	Soros Foundation Kyrgyzstan
SOP	Standard operating procedure
STI	Sexually transmitted infection
SW	sex worker(s)
TB	Tuberculosis
TGF	The Global Fund
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	The United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VL	Viral load
WHO	World Health Organization
XDR TB	Extensively drug resistant tuberculosis

DISCLAIMER

Towards the operationalization of Strategic Objective 3(a) of the Global Fund Strategy, Investing to End Epidemics, 2017-2022, this paper was commissioned by the Global Fund to Fight AIDS, TB and Malaria and presents, as a working document for reflection and discussion with country stakeholders and technical partners, findings of research relevant to reducing human rights-related barriers to HIV and TB services and implementing a comprehensive programmatic response to such barriers. The views expressed in the paper do not necessarily reflect the views of the Global Fund.

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I. Executive Summary

Introduction

Since the adoption of its strategy, Investing to End Epidemics, 2017-2022, the Global Fund to Fight AIDS, Tuberculosis and Malaria has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove human-rights related barriers in national responses to HIV, TB and malaria¹. It has done so because it recognizes that these programs are an essential means by which to increase the effectiveness of Global Fund grants. The programs increase uptake of and retention in health services and help to ensure that health services reach those most affected by the three diseases.

In addition to including attention to breaking down human rights barriers to health in all of its allocations to countries, the Global Fund is providing intensive support over the next five years to a set of 20 priority countries to enable them to put in place comprehensive programs aimed at significantly reducing these barriers². Based on criteria involving needs, opportunities, capacities and partnerships in country, Kyrgyzstan has been selected as one of the countries to receive intensive support. This baseline assessment is the first component of the package of support to Kyrgyzstan and is intended to provide the country with the data and analysis necessary to identify, apply for, and implement comprehensive programs to remove barriers to HIV and TB services. Programs are considered “comprehensive” when the right programs are implemented for the right people in the right combination at the right level of investment to remove human rights-related barriers and increase access to HIV and TB services.³

This assessment: (a) establishes a baseline of human rights-related barriers to HIV and TB services and existing programs to remove them; (b) sets out a costed comprehensive program aimed at reducing these barriers; and (c) recommends next steps in putting this comprehensive program in place.

The comprehensive programs proposed are based on the seven key Program Areas identified by UNAIDS and the Global Fund for HIV programs and a set of ten TB Program Areas developed in consultation with international TB programs and technical support agencies. These are set out in the respective program sections below.

Methodology

In April 2017 a literature review of formal and informal literature on the HIV and TB response in Kyrgyzstan was conducted, followed by an in-country assessment. This assessment involved a total of 73 face-to-face and 4 phone interviews carried out with 96 key informants and 247 key population members participating in 24 focus groups in Bishkek, Chui Oblast, Osh and Jalalabad. One completed email survey was received. A standard assessment protocol, developed to be used across the twenty country assessments and standard tools for the key informant interviews and focus groups discussions were used. An Inception

¹ *The Global Fund Strategy 2017-2022: Investing to End Epidemics*. GF/B35/02

² *Ibid*, Key Performance Indicator 9.

³ This definition of “comprehensiveness » for the purpose of GF Key Performance Indicator 9 was developed with the Global Fund Human Rights Monitoring and Evaluation Technical Working Group.

Workshop was held with key stakeholders at the beginning of the data collection process to inform them of the assessment process and to consult with them on focus areas and key informants. This meeting was also used to fill any gaps in the literature review.

Summary of baseline findings: HIV

Key and vulnerable populations

The key and vulnerable populations most affected by HIV in Kyrgyzstan include: (a) people living with HIV, including those co-infected by TB, (b) people who inject drugs (including adolescents and young women who inject drugs), (c) gay and bisexual men and other men who have sex with men, (d) transgender people, (e) male and female sex workers, (f) prisoners, and (g) mobile populations. These are reflected in the Kyrgyzstan National HIV Strategy – along with young people as a particular focus population⁴. Access to HIV services was reported as relatively more difficult for sex workers and mobile populations, particularly in terms of access to ongoing HIV treatment. Access to HIV services was reported as relatively easier for gay and bisexual men and other men who have sex with men, as long as they did not disclose their sexual orientation.

Barriers to HIV services

The most significant human rights-related barriers identified by key and vulnerable populations and the people who work with them were the following:

- a) Illegal police practices including harassment and violence.
- b) Stigma and discrimination, affecting people living with HIV, as well as sex workers, gay and bisexual men and other men who have sex with men, transgender people, people who inject drugs (with women who inject drugs most stigmatized than men) and ex-prisoners.
- c) Gender-based violence, particularly for sex workers, gay and bisexual men and other men who have sex with men and women who inject drugs. Women living with HIV often experience violence from their sexual partners or spouses and in-laws when disclosing their status.
- d) Knowledge of legal rights and access to legal assistance, with women and people using drugs experiencing the greatest problems.
- e) A set of punitive laws and policies that impede access to the services that people from key and vulnerable populations need.

The ways that these barriers impact on the key and vulnerable populations are set out in detail in the findings section of this report.

⁴ State Program for stabilization of the HIV epidemic in the Kyrgyz Republic for 2012-2016, Government of the Kyrgyz Republic 2012 – a new Strategy is in development

Programs to address barriers to HIV services – from existing programs to comprehensive programs

This section summarizes the existing or recent programs that have been implemented in Kyrgyzstan to remove human rights-related barriers to services and provides a summary of the proposed elements a comprehensive program⁵, based on the seven Program Areas set out in the Global Fund HIV, Human Rights and Gender Equality Technical Brief.⁶

The seven program areas are:

PA 1: Programs to reduce HIV-related stigma and discrimination

PA 2: Programs to train health care workers on human rights and ethics related to HIV

PA 3: Programs to sensitize lawmakers and law enforcement agents

PA 4: Programs to provide legal literacy (“know your rights”)

PA 5: Programs to provide HIV-related legal services

PA 6: Programs to monitor and reform laws, regulations and policies related to HIV

PA 7: Programs to reduce discrimination against women and girls in the context of HIV

Currently, several non-government and community-based organizations, as well as government entities, are working to some extent to address human rights-related barriers to HIV. However, the programs they implement do not fully cover each Program Area and lack the resources to be implemented at scale. Such gaps are particularly acute outside of Bishkek. Part of the assessment process involved examining the outcomes and evidence for effectiveness of these interventions, in order to determine which ones would be appropriate to take to scale.

Summary of existing/recent programs and proposed elements of a comprehensive program

PA 1: Programs to reduce HIV-related stigma and discrimination

Current and recent initiatives to reduce HIV related stigma and discrimination included: capacity development and technical assistance to NGOs working with people living with HIV, sex workers, gay and bisexual men and other men who have sex with men and people who inject drugs; summer school for sex workers; community mobilization among the LGLBTI population; supporting NGO/Government dialogue and assistance in the development of advocacy agendas for key populations NGOs. Media briefings and training workshops were also held.

It is proposed that these interventions continue, but at greater scale, and be supplemented by:

- a) Expanding community mobilization and education on stigma and discrimination for all HIV key populations, at least in Bishkek, Osh, Chui Oblast and Jalalabad. The

⁵ Programs to remove human rights-related barriers to services are defined to be *comprehensive* when the *right programs* are implemented *for the right people* in *the right combination* at the *right level of investment* to remove human rights-related barriers and increase access to HIV, TB and malaria services.

⁶ *Technical Brief HIV, Human Rights and Gender Equality*, Global Fund to Fight AIDS, TB and Malaria (April 2017)

People Living with HIV Stigma Index should be completed every two years to track changes to the experience of stigma by PLHIV and members of key populations living with HIV.

- b) Assisting key population NGOs to connect key population members as community monitors to street lawyers and human rights defenders to monitor and advocate in the case of barriers to services; to stand for selection to Civilian Advisory Boards (for Ministries of Health, Justice and Internal Affairs); and to join Community Advisory Boards for health clinics and the Ombudsman's Office.
- c) Assisting the Ministry of Health to work with HIV and KP NGOs on national and targeted campaigns to address stigma and discrimination towards people living with HIV, including promoting clear information about HIV, how it is and is not transmitted, how it is important to get tested and on treatment, and how stigma harms individual and population health outcomes.

PA 2: Programs to train health care workers on human rights and ethics related to HIV

Interventions to date under this program area have included: the use of the MSM Implementation Toolkit (MSMIT)⁷, as well as the Sex Worker Implementation Tool (SWIT)⁸ to train health care workers in comprehensive rights-based HIV and STI prevention, treatment and care among gay and bisexual men and other men who have sex with men; development and roll-out of an on-line training in HIV clinical management and training of health care workers in reducing stigma and other care barriers to care experienced by sex workers. These combined initiatives reached around 550 health care workers.

The comprehensive program in this area takes these initiatives to greater scale and adds the following:

- a) HIV NGOs to review the current courses on medical ethics, confidentiality and HIV to ensure their efficacy and appropriateness, adapted and then used to:
 - Institutionalize training of doctors to the family medicine clinic (FMC) level about HIV and TB and the rights and ethics related to them (e.g. non-discrimination, duty to treat, confidentiality and informed consent), and ensure safe working conditions for FMC staff.
 - Institutionalize a course in undergraduate education for doctors, nurses and health administrators on medical ethics and human rights obligations, with specific reference to reducing stigma and discrimination related to HIV, TB, key populations, as well as sexual orientation and gender identity issues.
 - Institutionalize a similar course for health care administrators.
- b) The Ministry of Health should encourage and provide regulatory assistance to ensure that Multi-disciplinary Teams are used in health clinics (including FMCs) that either employ peer educators/counselors) or work in close collaboration with NGOs with peer educators/counselors on staff to assist key populations through testing onto treatment

⁷ <https://mpactglobal.org/wp-content/uploads/2015/11/MSMIT-for-Web.pdf>

⁸ http://www.nswp.org/sites/nswp.org/files/SWIT_en_UNDP%20logo.pdf

and adherence for both HIV and TB and to monitor discrimination in health care provision.

- c) Community Advisory Boards of key population members at AIDS Centers and narcological clinics should be reinstated to increase access to services and decrease stigma
- d) HIV NGOs should assist and monitor the MoH implementation of its own policies and recommendations including those related to confidentiality of health data. They should advocate for greater government funding of HIV services, including funding to community-led service delivery, specifically to increase quality of counseling, and to increase the availability of HIV services by well-trained professionals through Family Medicine Centers; and for free STI prevention, testing and treatment services, especially for sex workers and gay and bisexual men and other men who have sex with men.

PA 3: Programs to sensitize lawmakers and law enforcement agents

Interventions in this area have included harm reduction training for police at the Police Academy, training of trainers at the Police Academy to take this harm reduction training forward and further training of on-duty police officers on engaging constructively with people from key populations. These trainings reached around 300 police officers in 2016. Kyrgyz Indigo has also been conducting trainings in 2018

The comprehensive package would include:

- a) Significantly expanding the reach and coverage of training for police to reduce the barriers they present for key populations to access services and to increase the individual and populations public health benefits that result from this. This needs to include up to date information to reassure police about effective infection control prevention methods. The training curricula should be reviewed and updated and a particular curriculum developed for senior officers and other means of engagement with Ministry of Justice and Interior officials. The training should be fully integrated into police academy training. Representatives of PLHIV and other key populations should be trained to lead and further evaluate such trainings.
- b) From this activity, these civil society representatives should devise with police ongoing joint activities between police and key populations. This could involve activities such as a hotline for sex workers to report client and police violence, police refraining from using condoms or syringes as evidence, police protection of gay pride marches, police engagement in rapid response when key populations are threatened with violence.
- c) Sensitization of prison management and staff should be done regarding their duties to protect the health of inmates through provision of HIV prevention, treatment and harm reduction but also through protection from violence, rape and discrimination.
- d) Study tours for senior police and prison administration officials to other countries where illegal police practices have been curtailed in the context of HIV.
- e) Developing and implementing mechanisms with the Office of the Ombudsman, Office of the Prosecutor, National Preventive Mechanism on Torture to address the issue both of police behavior towards key populations and of police behavior towards groups that attack key populations. These establishments should assist and monitor MIA implementation of its policies on evaluation of law enforcement staff and police

stations and assist and monitor State Penitentiary Service implementation of its policies.

- f) Providing in-service training for judges particularly judges at the sentencing level who affect the daily lives of members of key populations.

PA 4: Programs to provide legal literacy (“know your rights”)

The only recent initiative in this area was the training of people from key populations in ‘knowing your rights’. This reached around 800 people in 2016.

The proposed elements of the comprehensive program in this area are:

- a) Expanding the scale of “know your rights” education and legal literacy interventions to reach all key populations for HIV with a view to increase community protection and to develop advocacy around health issues.
- b) Supporting HIV NGOs to develop key population members as community monitors to develop a feedback mechanism through street lawyers and human rights defenders, and report annually to the national and technical partners.
- c) The expanded street lawyer program described in the Legal Service section below will also serve to educate HIV KPs on rights, create an advocacy agenda and identify community priorities for activism.

PA 5: Programs to provide HIV-related legal services

Initiatives in 2016 included supporting 37 street lawyers to provide legal assistance, legal aid to almost 1,000 people from key populations and a rapid response program that assisted 60 people from key populations who had been detained by police.

Elements of the proposed comprehensive program for this Program Area include:

- a) Expanding the street lawyer/paralegal program to sufficient coverage to educate and offer services to key populations in Bishkek, Osh, Jalalabad and Karakol and work towards certification and institutionalization of street lawyers/paralegals.
- b) Expanding legal support so that all HIV NGOs working with key populations have access to affordable or pro bono lawyers for casework, legal defense and strategic litigation, where necessary.
- c) Supporting the development of rapid response procedures which involve legal support; human rights defenders; appropriate officers from the General Prosecutor’s Office, Office of the Ombudsman, National Preventive Mechanism on Torture and other agencies; and key population NGOs to respond rapidly to curtail illegal police practices, especially against sex workers and people who inject drugs and to address gender-based violence against sex workers, gay and bisexual men and other men who have sex with men and transgender people.
- d) Publishing an annual report from the Street Lawyers Project and from the Ombudsman and Prosecutors Office, geared at national and technical partners.

PA 6: Programs to monitor and reform laws, regulations and policies related to HIV

Current initiatives in this area include hosting public hearings on law reform affecting key populations, collection of information on human rights abuses among key populations, an audit of laws affecting LGBTI communities and some work on laws in relation to Intellectual property and generic medicines availability.

Elements of the proposed comprehensive program in this area include:

- a) Law monitoring and advocacy for reform: Monitoring developments in proposed laws on the re-criminalization of sex work and on “anti-gay propaganda” (Parliament and Ministry of Justice); the development and implementation of an anti-discrimination law (Parliament); and full implementation of Kyrgyzstan’s accepted recommendations from Universal Periodic Reviews (Parliament and relevant ministries).
- b) Policy advocacy around reform:
 - For women, gender-sensitive HIV services through mainstreaming gender-sensitive services into existing HIV diagnostics and treatment (Ministry of Health and of Women)
 - For adolescents, policies that provide access to health services, HIV information and comprehensive sexuality education, without the need for parental consent (Ministry of Health)
 - For people who inject drugs, removal of the need to register as a drug addict to receive opioid substitution therapy (Ministry of Health)
 - For ex-prisoners, revisiting the issue of providing passports so they are able to continue on ART, OST or TB treatment; and ensure that pre- and post-release programs assist ex-prisoners to gain access to HIV and TB services in the community (Ministry of Health and State Penitentiary Service).
- c) Monitoring of implementation of regulations:
 - Ministry of Health policies and recommendations including those related to confidentiality for people living with HIV and people who inject drugs (Ministry of Health and Office of the Ombudsman)
 - Ministry of Internal Affairs’ implementation of its policies on evaluation of law enforcement staff and police stations (Ministry of Internal Affairs)
 - Connecting key population members as community monitors to street lawyers and human rights defenders so as to monitor and advocate in the case of barriers to services and to stand for selection to Civilian Advisory Boards (for Ministries of Health, Justice and Internal Affairs); and join Community Advisory Boards for health clinics and the Ombudsman’s Office.
- d) Health service delivery advocacy:
 - Greater government funding for HIV and TB services, specifically to increase quality of counseling, and to increase the availability of HIV and TB services by well-trained professionals through Family Medicine Centers and through civil society organizations (Parliament).
 - Free STI services, including for sex workers and gay and bisexual men and other men who have sex with men (Ministry of Health).

- An allowance for food and transport to assist people with HIV and TB to access health services
- Shelters for homeless people who inject drugs, LGBTI people and ex-prisoners in Bishkek (Ministry of Interior)
- Key Performance Indicators related to health, with a monitoring, oversight, and redress system (Ministry of Health, prison authorities, and civil society prisoner advocates).

PA 7: Programs to reduce discrimination against women and girls in the context of HIV

Initiatives in this area were small-scale in 2016 but included immediate support for around 80 sex workers who had experienced sexual violence, assistance to women who inject drugs in accessing health services and training for female sex workers and women who inject drugs in submitting alternative CEDAW reports.

Elements of the proposed comprehensive program in this area include:

- a) Continuing current programs that support women from key populations and vulnerable groups experiencing gender-based violence;
- b) Conducting a more thorough gender assessment and detailed program development exercise in year 1 of the strategy with funds set aside for its implementation in years 1-5, focused primarily on programs that address barriers for sex workers, women drug users and women with HIV, ensuring that this builds on the work being done in the other Program Areas;
- c) Developing tools and guidance on women's rights and HIV;
- d) Developing and rolling out a rapid response procedure that involves appropriate officers (from General Prosecutor's Office, Office of the Ombudsman, National Preventive Mechanism on Torture and other agencies) and key population NGOs in responding to gender-based violence among sex workers.

2016 investments and proposed comprehensive program costs - HIV

In 2016 a total of around USD 1.3 million was invested in Kyrgyzstan to reduce human rights-related barriers to HIV services. This was out of a total of USD15-16 million spent on the national HIV response.⁹

Major funders and allocated amounts for reduction of human rights barriers to HIV services in 2016 were as follows:

Funding source	2016 allocation
Soros Foundation Kyrgyzstan	USD 388,235
US Government (USAID and CDC)	USD 477,889

⁹ Central Asia PEPFAR Regional Operational Plan (ROP) 2016 Strategic Direction Summary: <https://www.pepfar.gov/documents/organization/257618.pdf>

Global Fund	USD 293,967
CADAP	USD 47,000
AIDS Fonds	USD 36,399
CoC BtG	USD 30,223
MPact	USD 20,300
Government	USD 16,400
Other	USD 26,199
Total	USD 1,326,612

Although several funders stated that they were unable to provide exact figures for the amounts allocated to each program area, the assessment team calculated the likely split between program areas by acquiring expenditure data from the funded organizations and matching these to activities under each program area. This gave the following split of funding across program areas to remove human rights-related barriers to services:

HIV Human Rights Barriers Program Area	2016
PA 1: Stigma and discrimination reduction for key populations	\$392,916
PA 2: Training for health care workers on human rights and medical ethics related to HIV	\$65,279
PA 3: Sensitization of law-makers and law enforcement agents	\$224,479
PA 4: Legal literacy (“know your rights”)	\$64,895
PA 5: HIV-related legal services	\$183,610
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	\$36,162
PA 7: Reducing discrimination against women in the context of HIV	\$98,971
Total	\$1,306,312

The costing for the 5-year comprehensive program is set out in the following table:

HIV Human Rights Barriers Program Area	Total
PA 1: Stigma and discrimination reduction for key populations	2,903,020
PA 2: Training for health care workers on human rights and medical ethics related to HIV	454,2599
PA 3: Sensitization of law-makers and law enforcement agents	2,051,199

PA 4: Legal literacy (“know your rights”)	344,450
PA 5: HIV-related legal services	982,370
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	1,081,600
PA 7: Reducing discrimination against women in the context of HIV	1,821,710
Total	9,638,608

Details of yearly costs are set out in the main report below and detailed costing information is available in Annex 3.

Summary of baseline findings: TB

Tuberculosis is a major killer in Kyrgyzstan, particularly in prisons, where rates of infection are significantly higher than in the general population. Kyrgyzstan is among the 30 countries with the highest multidrug-resistant (MDR) TB burden in the world. Key populations include people who inject drugs, prisoners and mobile populations. Key informants consistently stated that mobile populations, including internal migrants, experienced the greatest barriers in terms of access to diagnosis and treatment of TB. While women’s migration for work is higher than men’s, TB treatment success rates and other data are not disaggregated by sex, so it is difficult to tell if women are more likely to be lost to follow-up. Children in families where one or more adults has TB (even if the adult(s) are successfully being treated) are also considered as a population with specific needs that should be met through a combination of changes to medical service provision and reduction of human rights barriers. People living with TB living in rural areas often present to clinics and diagnostic centers very late in their illness due to lack of access to information and diagnostic services.

Barriers to TB services

The most significant human rights-related barriers identified by key and vulnerable populations and the people who work with them were the following:

- a) People with TB, or people assumed to have TB experience high levels of stigma and discrimination from health workers, community members and sometimes from extended family. This is more prominent for people known to have multidrug-resistant TB.
- b) Gender norms and practices and gender-based violence present a significant barrier to services. Men exhibit poor health seeking behavior in relation to TB – not considering their symptoms to be important or serious, so not visiting clinics, while women with TB are reporting gender-based violence from their sexual partners due to their TB status.
- c) There is a set of punitive or unhelpful policies, regulations and practices that contribute to barriers people experience in accessing TB services.

The ways that these barriers impact on the key and vulnerable populations are set out in detail in the findings section of this report.

Programs to address barriers to TB services – from existing programs to comprehensive programs

This section summarizes the existing or recent programs that have been implemented in Kyrgyzstan to remove human rights-related barriers to services and provides a summary of the proposed elements a comprehensive program, based on the ten Program Areas set out in the Global Fund Technical Brief *Tuberculosis, Gender and Human Rights*.¹⁰

The ten program areas are:

PA 1: Reducing stigma and discrimination

PA 2: Reducing gender-related barriers to TB services

PA 3: TB-related legal services

PA 4: Monitoring and reforming policies, regulations and laws that impede TB services

PA 5: Know your TB-related rights

PA 6: Sensitization of law-makers, judicial officials and law enforcement agents

PA 7: Training of health care workers on human rights and ethics related to TB

PA 8: Ensuring confidentiality and privacy

PA 9: Mobilizing and empowering patient and community groups

PA 10: Programs in prisons and other closed settings

Currently there is some small-scale work being done address human rights-related barriers to TB in Kyrgyzstan. The programs that are in place implement do not fully cover each Program Area and lack the resources to be implemented at scale. Part of the assessment process involved examining the outcomes and evidence for effectiveness of these interventions, in order to determine which ones would be appropriate to take to scale.

Summary of existing/recent programs and proposed elements of a comprehensive program

PA 1: Reducing stigma and discrimination

There were few initiatives in this area in 2016, except for a project to have religious leaders encourage people to care for people with TB in their communities and some shelter programs for homeless people with TB. Whilst the second is not strictly a stigma and discrimination initiative, it was put in place to ensure that homeless people with TB could continue their connection with health services. The religious leaders' project reached around 1,800 Imams and the shelter project reached around 54 people with TB in 2016.

Elements of the proposed comprehensive program in this area include:

- a) Support TB NGOs/networks to:
 - Assist nascent TB NGOs to effectively work to reduce stigma and discrimination among key populations

¹⁰ Technical Brief *Tuberculosis, Gender and Human Rights*, Global Fund to Fight AIDS, TB and Malaria (April 2017)

- b) Support TB NGOs/networks (and HIV NGOs working with TB key populations such as PLHIV and people who inject drugs) to:
- Implement campaigns and support groups to reduce community and self-stigma related to TB, and
 - Sensitize and engage opinion and religious leaders to increase tolerance toward and acceptance of people living with TB.
- c) Support to the Ministry of Health to:
- Undertake a national campaign to address stigma and discrimination experienced by people living with TB, including promoting clear information about each disease, how it is and is not transmitted, how it is important to get tested and on treatment, and how stigma is harmful and unnecessary; and
 - Disaggregate TB diagnostics and treatment statistics by sex.

In addition, validated measurements of TB stigma need to be carried out on a regular basis.

PA 2: Reducing gender-related barriers to TB services

While donors claimed that a small amount of funding had been provided to address gender-related barriers to TB in 2016, it was difficult to find any specific activities that would fit into this program area, apart from a TB gender assessment conducted by Stop TB Partnership. There was also support provided for regular meetings of the MoH TB Coordination Council, where issues of gender-related barriers to TB services are also considered.

Elements of the proposed comprehensive program in this area include:

- a) For women, establish gender-sensitive TB services through mainstreaming gender-sensitive services into existing TB and HIV diagnostics and treatment (Ministry of Health and of Women).
- b) Outreach to women in areas with high burden of TB, encouraging them to come forward for testing and early detection.
- c) For men, identify a set of entry points into broader work being done to improve men's health seeking behaviors and work to include awareness of TB symptoms and treatment in these.
- d) Prepare and disseminated a set of plain-language materials that address myths about TB, particularly those that result in stigma and discriminating against women and girls.

PA 3: TB-related legal services

Provision of legal services was regarded as an important service for key populations and vulnerable groups, but it appeared that in 2016 no funds were allocated to TB legal services. To ensure that people with TB have access to legal services, the existing and future TB NGOs need access to legal support to provide legal services as needed. The legal assistance processes established under the HIV comprehensive program should be sufficient to provide most of these services with little additional funding.

Elements of the proposed comprehensive program in this area include:

- a) Expansion of legal support so that all TB NGOs have access to affordable or *pro-bono* lawyers for casework, legal defense and strategic litigation, where necessary

PA 4: Monitoring and reforming policies, regulations and laws that impede TB services

The focus of work in this area in 2016 has been changing clinical protocols to ensure more consistent access to new TB treatment regimes and legal changes to compassionate access programs for people living in extreme poverty. Existing initiatives have largely focused on changing regulations to allow ambulatory care of TB patients and most of these changes to regulations have now been made.

Elements of the proposed comprehensive program in this area include:

- a) Monitoring and reforming laws, regulations and policies relating to TB. In addition, there is a need to ensure confidentiality and privacy related to TB diagnosis, mobilize and empower TB patient and community groups, address overly-broad policies regarding involuntary isolation or detention for failure to adhere to TB treatment, and make efforts to remove barriers to TB services in prisons
- b) Changes to the way that Family Medical Centers doctors and nurses are compensated for working with TB outpatients, together with protective measures to reduce the likelihood of health care workers being infected with TB and appropriate compensation for health care workers who do get infected with TB (Ministry of Health).
- c) Advocacy and mobilization around policy reform regarding:
 - Streamlining the 'change of address' needed for TB treatment for internal migrants (Ministries of Health and Migration)
 - Revisiting the issue of providing passports for ex-prisoners so as to be able to continue on ART, OST or TB treatment; and ensure that pre- and post-release programs assist ex-prisoners to gain access to HIV and TB services in the community (Ministry of Health and State Penitentiary Service).

PA 5: Know your TB-related rights

Initiatives in 2016 in this area focused on cascade training for TB specialist on patient rights, training for journalists on the rights of people with TB and their families and patient training by health care workers on their rights.

Elements of the proposed comprehensive program in this area include:

- a) Expansion of "know your rights", including patients' rights, education and legal literacy for all key populations regarding TB with a view to develop advocacy and mobilization around TB human rights-related issues.

PA 6: Sensitization of law-makers, judicial officials and law enforcement agents

No specific funds were allocated to sensitizing law-makers, judicial officials and law enforcement agents related to TB in 2016. To some extent, some of this activity may have been carried out using HIV funds.

Elements of the proposed comprehensive program in this area include:

- a) Training of police on TB and human rights; ensuring that all new entrants to police receive this training. TB NGOs ensure training includes TB among key populations
- b) Annual report from Ombudsman and evaluations of police stations.

PA 7: Training of health care workers on human rights and ethics related to TB

While some donors reported allocation some funds that in 2016 for the training of health care providers on human rights and medical ethics related to TB, it was difficult to find evidence of the results of this expenditure. It is true that there were many donor-funded programs in recent years to train medical staff in aspects of TB care such as case-finding ambulatory care and in the use of new medicines, but training specifically on human rights and ethics has been a minor part of this larger training program.

It is recommended that a substantial program, linked to the suggested program for HIV, be undertaken to fully institutionalize training of doctors, nurses and health administrators on medical ethics and human rights

Elements of the proposed comprehensive program in this area include:

- a) Institutionalizing the training of doctors to the family medicine clinic (FMC) level about HIV and TB and the rights and ethics related to them (e.g. nondiscrimination, duty to treat, confidentiality and informed consent), and ensure safe working conditions for FMC staff.
- b) Institutionalizing a course in undergraduate education for doctors, nurses and health administrators on medical ethics and human rights obligations, with specific reference to reducing stigma and discrimination
- c) Supporting a consistent of multi-disciplinary team structure across health clinics (including FMCs) that either employ peer educators/counselors) or work in close collaboration with NGOs with peer educators/ counselors on staff to assist key populations through testing onto treatment and adherence for both HIV and TB and to monitor discrimination in health care provision,
- d) Regular monitoring of stigma and discrimination in TB services.

PA 8: Ensuring confidentiality and privacy

It seems unlikely that a stand-alone program attempting to address confidentiality and privacy for TB patients would be effective, given that similar issues exist for people living with HIV and many other diseases. For this reason, it is recommended that confidentiality is emphasized in institutionalized training of doctors on TB and in training and support for NGOs and people from key populations.

PA 9: Mobilizing and empowering patient and community groups

Very little has been achieved to date in mobilizing and empowering patient and community groups working on TB. The CCM includes TB community representation.

What is required is a major expansion of NGOs working on community mobilization among TB patients nationally and in the areas with the highest TB burden.

Elements of the proposed comprehensive program in this area include:

a) Support HIV NGOs/networks to:

- Mentor and foster the development and expansion of NGOs working specifically to advocate for the needs of people with TB.

b) Support to the Ministry of Health to:

- Re-institute Community Advisory Boards of key population members at TB Centers and narcological clinics to increase access to services and decrease stigma.

PA 10: Programs in prisons and other closed settings

Most key informants familiar with the prison system agreed that much good work has taken place there over many years, but issues such as overcrowding and the increasing number of convicted terrorists had resulted in a winding back of peer programs. Prison authorities appear to have severely restricted interactions between prisoners, fearing radicalization of prisoners.

Many also referred to programs that existed in the past for pre- and post-release to help ex-prisoners maintain adherence after leaving prison. The ICRC continues to fund some services related to TB, but it is now more difficult for NGOs to work closely with the prison system. Key informants stated that a previously-funded program of training for medical and non-medical prison staff had led to significant changes in staff attitudes towards prisoners with TB. They believed that this training program should be reinstated and provided nationally.

The only allocation that appears in this program area for 2016 was small allocation for a mobile TB treatments team that played a role in ensuring TB treatments access in prisons.

Elements of the proposed comprehensive program in this area include:

a) Reinstatement training programs on TB for penitentiary staff

2016 investments and proposed comprehensive program costs - TB

It is estimated that a total of USD 478,000 was allocated in Kyrgyzstan to reduce human rights-related barriers to TB services (out of a total expenditure on TB of about \$25 million in 2016¹¹). Major funders for reduction of human rights barriers to TB services in 2016 were as follows:

Funding source	2016 allocation
KNCV (funded by USG)	USD 250,000
Global Fund	USD 23,442
USAID	USD 200,000

¹¹ WHO TB Country Profile Kyrgyzstan

https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=KG&outtype=pdf

Total	USD 473,442
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Although several funders stated that they were unable to provide exact figures for the amounts allocated to each program area, the assessment team calculated the likely split between program areas by acquiring expenditure data from the funded organizations and matching these to activities under each program area. This gave the following split of funding across program areas to remove human rights-related barriers to services:

TB Program Area	2016 funding
PA 1: Stigma and discrimination reduction	USD 30,000
PA 2: Reducing gender-related barriers to TB services	USD 20,000
PA 3: TB-related legal services	0
PA 4: Monitoring and reforming laws, regulations and policies relating to TB services	USD 200,000
PA 5: Knowing your TB-related rights	USD 120,000
PA 6: Sensitization of law-makers, judicial officials and law enforcement agents	0
PA 7: Training of health care providers on human rights and medical ethics related to TB	USD 90,000
PA 8: Ensuring confidentiality and privacy	0
PA 9: Mobilizing and empowering patient and community groups	0
PA 10: Programs in prisons and other closed settings	USD 15,442
Total	USD 473,442

Costs for the recommended interventions for the five-year comprehensive program set out are set out in the table below. Details of yearly budgets are set out in the main report below and costing information is available in Annex 3.

TB Human Rights Barriers Program Area	Total
PA 1: Stigma and discrimination reduction	1,194,000
PA 2: Reducing gender-related barriers to TB services	1,014,000
PA 3: TB-related legal services	413,620
PA 4: Monitoring and reforming laws, regulations and policies relating to TB services	420,960
PA 5: Knowing your TB-related rights	600,000

PA 6: Sensitization of law-makers, judicial officials and law enforcement agents	45,684
PA 7: Training of health care providers on human rights and medical ethics related to TB	497,864
PA 8: Ensuring confidentiality and privacy	141,740
PA 9: Mobilizing and empowering patient and community groups	1,573,980
PA 10: Programs in prisons and other closed settings	165,000
Total	6,165,488

Priorities for scaling up towards comprehensive programs to reduce barriers to HIV and TB services

Given the nature of barriers in Kyrgyzstan, it is recommended that the primary and early focus be on activities to sensitize police and law enforcement, reduce stigma and discrimination in health care settings, and provide legal literacy and legal services to key populations. With regard to police sensitization, the following police should be prioritized for training on HIV and human rights issues - district police officers, drug police and the police involved in criminal investigations. This training should include the reasons it is necessary to support HIV service providers to have proper access to key populations and to ensure key populations do not go into hiding.

Furthermore, in the first two years of expansion of comprehensive programs to reduce barriers to HIV and TB services, activities should include strengthening capacity of HIV, TB and key population NGOs and support them to deliver on their role in reducing barriers related to HIV and TB, in particular how to:

- a) Work with the Offices of Ombudsman and Prosecutor,
- b) Develop community monitoring processes among key population and network members
- c) Build a certification system for street lawyers/paralegals
- d) Work with mobile populations
- e) Play a role in monitoring the work of the Ministries of Health, Justice and Internal Affairs
- f) Build a certification and budget line system for peer educators/ counselors within the health system; and
- g) Ensure an effective social contracting system is in place so that NGOs can be funded to provide peer educators/ counselors to health facilities.

There is also a need to support the Ministry of Internal Affairs and the Office of the Ombudsman to build the capacity of management of police stations on the newly introduced evaluation tools and to support the Ministries of Health and Justice to improve their monitoring of the implementation of their regulations.

Next Steps

Following this baseline assessment, the Global Fund will assist the government, CSOs working with key populations, other stakeholders, technical partners and donors in

Kyrgyzstan to organize a multi-stakeholder meeting at which country will consider the findings of the baseline assessment will be considered and a five-year Strategy will be developed to establish a comprehensive program to remove human rights-related barriers to services. Data from the baseline assessment has also been used to inform the matching fund application of Kyrgyzstan and will inform its grant-making and implementation. Finally, the data will be used as a baseline for subsequent reviews at mid-term and end-term during the period of the Global Fund strategy to assess the impact of scaled up programs in reducing human rights-related barriers to services.

II. Findings of the baseline assessment and costing

Introduction

This report comprises the baseline assessment conducted in Kyrgyzstan to support scaling up of programs to remove human rights-related barriers to HIV and TB services. Since the adoption of its strategy, *Investing to End Epidemics, 2017-2022*, the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove human rights-related barriers in national responses to HIV, TB and malaria. This effort is grounded in Strategic Objective 3 which commits the Global Fund to: “*introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria service*”; and, to “*scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights and investing to reduce health inequities, including gender-related disparities.*”¹² The Global Fund recognizes that programs to remove human rights-related barriers are an essential means by which to increase the effectiveness of Global Fund grants as they help to ensure that health services reach those most affected by the three diseases. The Global Fund is working closely with countries, UNAIDS, WHO, UNDP, Stop TB, PEPFAR and other bilateral agencies and donors to operationalize this Strategic Objective.

Though the Global Fund will support all recipient countries to scale up programs to remove barriers to health services, it is providing intensive support in 20 countries in the context of corporate Key Performance Indicator (KPI) 9 – «Reduce human rights barriers to services: # of countries with comprehensive programs aimed at reducing human rights barriers to services in operation”. This KPI measures “the extent to which comprehensive programs are established to reduce human rights barriers to access with a focus on 15-20 priority countries”.¹³ Based on criteria that include needs, opportunities, capacities and partnerships in country, the Global Fund selected Kyrgyzstan as one of the countries for intensive support to scale up programs to reduce barriers to services. This baseline assessment, focusing on HIV and TB, is the first component of the package of support the country will receive.

The outcomes of this assessment in Kyrgyzstan are: (a) to establish a baseline of human rights-related barriers to HIV and TB services and existing programs to remove them; (b) to set out a costed comprehensive program aimed at reducing these barriers; and (c) to recommend next steps in putting this comprehensive program in place.

The programs recognized by UNAIDS, STOP TB and other technical partners as effective in removing human rights-related barriers to HIV and TB services are: (a) stigma and discrimination reduction; (b) training for health care providers on human rights and medical ethics; (c) sensitization of law-makers and law enforcement agents; (d) reducing discrimination against women in the context of HIV and TB; (e) legal literacy (“know your rights”); (f) legal services; and (g) monitoring and reforming laws, regulations and policies relating to HIV and TB.

¹² *The Global Fund Strategy 2017-2022: Investing to End Epidemics*. GF/B35/02

¹³ 2017-2022 Strategic Key Performance Indicator Framework, The Global Fund 35th Board Meeting, GF/B35/07a - Revision 1, April 2016

Three additional program areas are included for TB: ensuring confidentiality and privacy related to TB diagnosis; mobilizing and empowering TB patient and community groups; and establishing programs in prisons and other closed settings.¹⁴

Programs to remove human rights-related barriers to services are *comprehensive* when the *right programs* are implemented *for the right people in the right combination* under each of the Program Areas set out above, at the *right level of investment* to remove human rights-related barriers and increase access to HIV, TB and malaria services.

The findings of this baseline assessment will be used by countries, the Global Fund, technical partners and other donors to develop a five-year plan by which to fund and implement a comprehensive set of these programs to remove human rights-related barriers to services in Kyrgyzstan. Its data will also be used as the baseline against which will be measured the impact of the interventions put in place in subsequent reviews at mid-term and end-term during the current Global Fund Strategy period.

Methodology

Conceptual framework

The conceptual framework for the baseline assessments (and Global Fund Strategic Objective 3) is the following: (a) Depending on the country and local contexts, there exist human rights-related barriers to the full access to, uptake of and retention on HIV, TB and malaria services; (b) These human rights-related barriers are experienced by certain key and vulnerable populations who are most vulnerable to and affected by HIV, TB and malaria; (c) There are human rights-related program areas comprising several interventions and activities that are effective in removing these barriers; (d) If these interventions and activities are funded, implemented and taken to sufficient scale in country, they will remove or at least significantly reduce these barriers; (e) The removal of these barriers will increase access to, uptake of and retention in health services and thereby make the health services more effective in addressing the epidemics of HIV, TB and the malaria; and, (f) These programs to remove barriers also protect and enhance Global Fund investments, strengthen health systems and strengthen community systems.

Under this conceptual framework, the assessment in Kyrgyzstan has identified:

- a) Human rights-related barriers to HIV and TB services
- b) Key and vulnerable populations most affected by these barriers
- c) Existing programs and KP organizations to address these barriers; and
- d) A comprehensive set of programs to address these barriers most effectively.

Human rights-related barriers to HIV and TB services were grouped under the following general categories: stigma and discrimination; punitive laws, policies, and practices; gender inequality and gender-based violence; and, poverty and economic and social inequality.

¹⁴ See *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*, Guidance Note, UNAIDS/JC2339E (English original, May 2012); ISBN: 978-92-9173-962-2. See also *Technical Briefs HIV, Human Rights and Gender Equality* Global Fund to Fight AIDS, TB and Malaria (April 2017); *Tuberculosis, Gender and Human Rights* Global Fund to Fight AIDS, TB and Malaria (April 2017)

Key populations have been defined as follows by the Global Fund:

- a) Epidemiologically, the group faces increased risk, vulnerability and/or burden with respect to at least one of the two diseases – due to a combination of biological, socioeconomic and structural factors;
- b) Access to relevant services is significantly lower for the group than for the rest of the population – meaning that dedicated efforts and strategic investments are required to expand coverage, equity and accessibility for such a group; and
- c) The group faces frequent human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization – which increase vulnerability and risk and reduces access to essential services.¹⁵

Vulnerable populations are people who do not fit into the definition of key populations, but nevertheless have more heightened vulnerability to HIV and TB and their impact.¹⁶

The design, outcomes and costs of existing programs to reduce these barriers were analyzed and a set of initiatives have been proposed in order to make up a comprehensive program to address human rights-related barriers at scale.

Steps in the assessment process

- a) **Desk Review** - A comprehensive search to assess human rights-related barriers to HIV and TB services in Kyrgyzstan, key and vulnerable populations affected by these barriers and programs to address them was conducted using PubMed, Embase, and Web of Science to identify peer-reviewed literature. Of the 114 articles identified, twenty-two were selected for their relevance to this literature review. In addition, searches were made in Kyrgyzstani and Russian languages, with a total of eight publications found. Emails seeking additional information on programs were sent to several non-government organizations (NGOs) working on HIV and/or TB in Kyrgyzstan to achieve a greater understanding of issues faced by their clients.
- b) **Preparation for in-country work** - From the Desk Review, a list of key informants and types of focus groups was developed to guide data collection in country. Instruments developed for these forms of data collection were translated into Russian and adapted to the circumstances of Kyrgyzstan. Researchers (nationals of Kyrgyzstan) were trained in the use of these instruments and were assigned tasks. APMG contacted the Ministry of Health of Kyrgyzstan about the need for ethics approval and was informed by the relevant Officer that ethical approval was not required for this assessment.
- c) **In country work** - An inception meeting introduced the project to national stakeholders, explained the role of the baseline assessment and data collection procedures, and summarized the findings of the Desk Review. This was followed by key informant interviews and focus group discussions with members of key and affected populations in Bishkek, Chui Oblast, Osh and Jalalabad (the areas of Kyrgyzstan most affected by the HIV and TB epidemics). A total of 73 face-to-face and 4 phone interviews were carried out with 96 key

¹⁵ The Global Fund to Fight AIDS, Tuberculosis and Malaria. *Key Populations Action Plan 2014-17*. Geneva

¹⁶ Greenall M, Kunii O, Thomson K, Bangert R and Nathan O (2017). Reaching vulnerable populations: lessons from the Global Fund to Fight AIDS, Tuberculosis and Malaria. *Bulletin of the World Health Organization* 2017;95:159-161. doi: <http://dx.doi.org/10.2471/BLT.16.179192>

informants; and 247 key population members participated in 24 focus groups. One completed email survey was received.

d) **Data collection** - Data was collected on the following areas:

- Human rights-related barriers to HIV and TB services
- Key and vulnerable populations most affected by these barriers
- Programs carried out presently or in the past that have been found through evaluation or through agreement by many key informants to be effective in reducing these barriers
- Stated needs regarding comprehensive programs to address the most significant barriers for all groups most affected by these barriers
- Funding of all such programs (for 2016 financial year); and
- Costing of effective¹⁷ programs carried out presently or in the past.

e) **Data analysis** - The in-country data were analyzed to explore agreement with or divergence from the Desk Review findings and to add data on barriers and affected populations missing from the Desk Review. This information, together with data on funding in 2016, was used to develop the Baseline Data Summary. Data on effective projects and on stated needs were combined to suggest the comprehensive programs to reduce human rights barriers to HIV and TB services in Kyrgyzstan. The comprehensive programs were costed using costing data from present and previously implemented projects. Draft indicators to measure the impact of the comprehensive programs were developed.

f) **Finalization and next steps** - Upon finalization, this assessment was provided to the Global Fund Secretariat for use as background in preparation of an in-country multi-stakeholder meeting to consider best how to scale up programs to reduce human rights barriers to HIV and TB services in Kyrgyzstan.

Costing methodology

Three sets of costing processes were undertaken for this assessment:

First, all donors and funders who were discovered to have financed any activities in the program areas for HIV or TB were asked to supply details of the amount of funding provided and the program areas in which funding was provided; and, if possible, to state the type of activities and reach or coverage of funded activities. This approach was largely successful in overall terms for HIV, in that most donors were able to state what program areas the funds were directed to, but did not provide details of the funded activities or their reach. For TB, the situation was more difficult, with funders only providing overall amounts and, through discussion with researchers, agreeing to apportion these funds to some program areas. In some cases, for TB, donors were known to exist and be funding activities, but no details were provided by the donors. The expenditure lists and donors are provided in Annex 1.

Second, specific implementers were approached and information was gathered on costs involved in carrying out specific interventions. This process followed the Retrospective Costing Guidelines (available from Global Fund on request). The list of organizations is attached in Annex 1.

Individual costing sheets for services provided by each of the organizations were prepared

¹⁷ Effectiveness is determined either by evaluation or by broad agreement among KIs that a program is/was effective.

Third, from the results of the first two processes, a Prospective Costing of the comprehensive program was carried out. The results of this process are provided in Annex 3. For each type of intervention, an intervention-level cost was assembled.

For interventions that were new or had not been implemented in recent years, assumptions were made about the ways that these differed from interventions whose costs are known. For example, work by the Ombudsman's Department with NGOs was costed by combining known NGO management and outreach worker costs, costs of street lawyers and costs of part of the time of Ombudsman's Department staff.

These costs were used to construct calculation tables (see HIV and TB calculation tables in Annex 3). In these calculations, the number of services to be provided/people to be reached/trained were multiplied by the intervention-level cost to provide an annual cost for each activity. Annual costs are required because some activities only take place every 2 years, such as use of the Stigma Index, and others require capacity building or other activities in the first year that are not needed in later years. Comments boxes to the right of each activity in these calculation tables show where the data came from to construct the calculation. These calculation tables were used to provide overall Program Area and Activity sub-activity budgets (tabs labeled 'HIV' and 'TB' in Annex 3), for each of five years as well as a five-year total. These are the budgets that are used to construct the five-year totals provided in costing columns in Annexes 1 and 2 and in the latter parts of this report.

III. Baseline assessment findings: HIV

Overview of epidemiological context and key and vulnerable populations

According to UNAIDS data, an estimated 8,100 people were living with HIV in Kyrgyz Republic in 2016 out of a total population of 6 million. 7,117 people living with HIV were officially registered as of January 2017.¹⁸ Overall, HIV prevalence remains low in the general population, but Kyrgyzstan is one of countries with the fastest growing HIV epidemics in the last decade.¹⁹ Key populations in Kyrgyzstan who face human rights-related barriers to HIV services include people living with HIV; people who inject drugs, including women who inject drugs; male, female and transgender people, including sex workers; gay men and other gay and bisexual men and other men who have sex with men; adolescent members of these populations; and prisoners.²⁰ The Kyrgyzstan National HIV Strategy identifies people who inject drugs (including prisoners), sex workers, MSM and young people as the key populations for priority attention.²¹

From the most recent IBBS (2014), HIV prevalence among people who inject drugs remains the highest (12.4%), followed by prisoners (7.6%), gay and bisexual men and other men who have sex with men (6.3%) and sex workers (2.2%).²² While prisoners in Kyrgyzstan have access to some of the most advanced HIV services in the region, few pre- and post-release

¹⁸ HIV situation in Kyrgyz Republic. Republican AIDS Center data, 2017

¹⁹ WHO (2014) HIV/AIDS Programme in Kyrgyzstan: Evaluation Report. Copenhagen. December

²⁰ Annex 6.

²¹ State Program for Stabilization of the HIV Epidemic in the Kyrgyz Republic for 2012-2016, Government of the Kyrgyz Republic 2012

²² IBBS report, Republican AIDS Center, 2014

services exist, so ex-prisoners form a vulnerable population. Children who contracted HIV through poor hospital infection control procedures at the beginning of this century constitute a specific group facing a multitude of human rights-related issues as they enter adolescence.²³ As in most countries in the region, adolescents under eighteen face difficulties in accessing medical or social services without parental consent.

Views about which populations experienced the most severe human rights-related barriers to services varied a little among key informants, but in general, access to HIV services was seen as relatively more difficult for sex workers due to their mobility, their loss of official identity documents through police raids and, for those engaged in irregular migration from Uzbekistan, their illegal status in Kyrgyzstan. Access to HIV services was also seen as particularly difficult for mobile populations, especially in terms of access to ongoing treatment. Access to HIV services was regarded as relatively easier for: (a) gay and bisexual men and other men who have sex with men (if they do not disclose their sexual orientation), though this meant that they are unable to access comprehensive sexual health services except through private medical clinics, (b) prisoners,²⁴ and (c) people who inject drugs, with the exception of opioid substitution treatment (OST) services. Barriers did exist for gay, bisexual and other men having sex with men (MSM) who required treatment for anal STIs (as this involved disclosure of male sexual contact) and for prisoners who required OST, as there are limits on availability and use in some prison settings. Condoms are not available in prisons. Syringe exchange programs are available in most prisons.²⁵

Overview of the policy, political and social context relevant to human rights-related barriers to HIV services

Protective laws (with challenges of enforcement)

The Kyrgyzstan Constitution guarantees many rights for its citizens, including freedom of association, political expression, separation of religion and state, prohibition on the formation of militias. In addition to this, there are several protective laws regarding health care and access to services. These protective laws provide a clear and compelling framework to support access to HIV and other health services for all citizens. However, key informants indicated that the problem is that in many cases, and most often with regard to key and vulnerable populations, these protection laws are not enforced and key and vulnerable populations have insufficient knowledge of these laws or of their rights, as well as insufficient access to legal support, so they generally do not advocate for their rights under these laws or seek redress for violations through the justice system.

This section describes protective laws that, if enforced for key and vulnerable populations, would go a long way to increase access to services. It should be noted that while the protective laws described below clearly apply to citizens of Kyrgyzstan, it is less clear that they protect migrants in Kyrgyzstan or the 16,091 refugees and asylum-seekers who were present in the country in 2014, according to the UN High Commissioner for Refugees.

²³ HIV Programme Review in Kyrgyzstan Evaluation report December 2014 Prepared by: Maiken Mansfeld and Matti Ristola (WHO Collaborating Centre for HIV and Viral Hepatitis) and Giedrius Likatavicius

²⁴ At 31 January 2016, 1470 of the 4339 diagnosed PLHIV in Kyrgyzstan were on ART (34%), while 169 of the 301 PLHIV in prison were on ART (56%).

²⁵ <http://www.afew.org/eecaids2018/kyrgyz-prisons-eng/>

The Constitution of the Kyrgyz Republic as of June 27, 2010²⁶ sets out protections for human rights, of which Article 47 states in particular:

- a) Everyone shall have the right to health protection.
- b) The State shall create conditions for medical servicing of everyone and shall take measures to develop public, municipal and private healthcare sectors.
- c) Free medical service as well as medical service on preferential terms shall be ensured within the volume of state guarantees envisaged in the law.
- d) Withholding of facts and circumstances endangering life and health of people by officials shall be subject to liability established by the law.

Other laws with protective stipulations include:

- a) Law on HIV/AIDS (13 August 2005) which guarantees access to confidential and anonymous HIV testing and counseling, access to treatment free of charge or at preferential terms, and emphasizes the rights of people living with HIV to fulfill their sexual and reproductive rights.²⁷
- b) Law on Government Benefits (29 December 2009) which guarantees a monthly social pension for HIV positive children and adolescents under 18, including children who were born from HIV positive mothers until they reach age 18.²⁸
- c) Law on Protection of Kyrgyzstani Citizen's Health (9 January 2005) and the Law on Public Health (24 July 2009) guarantee the rights of Kyrgyzstani citizens to access to quality health care services.^{29,30}
- d) The Law on Narcotic Drugs, Psychotropic Substances and Precursors (22 May 1998, law # 66, changes introduced on July 4, 2005, March 2, 2010 by law #40, July 24, 2013 and Dec 26, 2014) ensures provision of anonymous drug addiction treatment at the patient's request.³¹

Most key informants expressed general support for specific Ministry of Health regulations related to HIV, singling out the following as especially helpful: HIV positive prisoners at Stage IV of the illness can be released from prison as per the Government Decree dated 29 November 2011.³²

Kyrgyzstan has led the Eastern European/Central Asian region (EECA) in adopting laws and regulations to try to ensure that key populations can be reached with HIV services. Importantly, it has maintained these laws in the face of pressures to change them. The following describes the legal situation with regard to drug use, sex work and homosexuality:

- a) Drug use is not a criminal offense in Kyrgyzstan, though possession of drugs is an offence, and there are severe penalties for selling, manufacturing or trafficking in drugs; for cultivating narcotic plants; and for organizing or maintaining a site for the

²⁶ Russian official version: http://www.gov.kg/?page_id=263&lang=ru. Unofficial translation of the constitution: www.legislationline.org/documents/id/5045

²⁷ Accessed at http://www.ilo.org/aids/legislation/WCMS_127903/lang--en/index.htm Nov 29 2017

²⁸ Accessed at http://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=84028&p_country=KGZ Nov 29 2017

²⁹ Accessed at http://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=71833&p_country=KGZ&p_count=274 Nov 29 2017

³⁰ Accessed at http://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=84033 Nov 29 2017

³¹ Accessed at http://adilet.zan.kz/eng/docs/Z980000279_ Nov 29 2017

³² No reference available

consumption of narcotic drugs or allowing premises to be used for this purpose³³. While harm reduction activities are not provided for by law (as some key informants would prefer), all harm reduction activities are described as part of the HIV National Strategic Plan and of the Drug Control Strategy.³⁴

- b) Sex work is legal, but it is illegal to “involve another in sex work using violence, threats and coercion” and to organize or maintain a brothel for prostitution.³⁵ A bill was introduced to re-criminalize sex work, but was defeated. Despite this, raids on sex work areas are increasingly common. The two rationales for these raids provided by police key informants or by key informants and focus groups among the sex worker community who have discussed this issue with the police were that: (1) the Ministry of Internal Affairs (MIA) was concerned that not all sex workers were being tested appropriately for HIV and other sexually transmitted infections and therefore the police were assisting the HIV response by (illegally and forcibly) testing sex workers on a regular basis, and (2) the MIA had received information that young girls were being trafficked into sex work and therefore were rounding up sex workers in order to identify possibly trafficked people.
- c) Sodomy is not illegal. However, there is a bill before the Kyrgyzstan Parliament that would criminalize “gay propaganda”. The bill has been read twice; a third reading has been successfully deferred for more than a year, but there is still a chance that it will pass.

Political and social environment

Though there are many protective and supportive laws and policies, many key informants referred to a problem of lack of accountability at multiple levels throughout the Kyrgyzstan government’s response to HIV. Laws are in place under a well-developed Constitution that guarantees key populations’ access to health services without interference from police. All key informants referred to police behavior as the biggest barrier to services, as described more fully below. Similarly, Ministry of Internal Affairs internal Orders exist in relation to HIV prevention, but these seem to be countermanded by higher-level police or ignored by police in the community. Police appear to be able to act illegally towards key populations without consequences.

The Ministry of Health establishes policies and regulations, but appears to have no systematic way of checking whether those policies are enacted and whether regulations – such as confidentiality of medical data – are obeyed. There appear to be few penalties for disobeying regulations. In prisons, there are good programs, but they are being threatened by other challenges such as overcrowding.

Decentralization of the health system and the movement towards treating people with HIV at Family Medical Centers is leading to major problems in access to services, especially for key populations. The authorities at the Oblast level that should be ensuring that these transition processes are implemented smoothly do not have performance indicators related

³³ The law about narcotic drugs, psychotropic substances and precursors dated 22 May 1998; Administrative Code, article 91-3; Administrative Code, article 191; Criminal Code articles 246, 247, 250, 252. <http://cbd.minjust.gov.kg/act/view/ru-ru/74>

³⁴ Article 2.3.2. “secondary prevention” under Anti-narcotic programme of the Government of KR (decree #54 as of January 27, 2014), State programme to stabilize HIV epidemic in the Kyrgyz Republic for 2012-2016 (decree # 867 as of Dec 29, 2012)

³⁵ Criminal Code articles 260 and 261

to health, so they only concentrate on health issues if these are of personal interest or if strong community lobbying brings these issues to prominence.

In terms of the social context, there is a social movement that is referred to as the ‘Kyrgyz nationalist movement’. It is largely in the south of the country and involves adherence to a more fundamentalist version of Islam and an idealization of past Kyrgyzstani history and its nomadic culture. National groups adhering to this movement have particular views of morality and of the role of women, defining women’s roles narrowly and wishing to restrict women’s work to care of the household and of children. Most key informants were of the view that manifestations of hostility in recent years towards people living with HIV, the LGBTI community and sex workers (in the form of raids on sex workers/sex work establishments) stemmed from this nationalist movement. Some key informants described a divide between those who believe that all people in the country are guaranteed rights under the Constitution and others who feel that Constitutional rights, including to housing and health, should be provided only to those people who behave in mainstream ways (meaning not to gay and bisexual men and other men who have sex with men, sex workers or people who use drugs). Most believed that the majority of Kyrgyzstani people continue to follow the Constitution, but that the nationalist movement is very vocal and its influence is growing.

There are vigilante gangs involved in this nationalist movement who have led many raids on LGBTI NGOs and sex work establishments and have threatened other people in the country who they regard as ‘unsuitable’ to be living in Kyrgyzstan. Social media has been used by such vigilantes and police posing as community members on dating apps and then surveilling, extorting, attacking individuals, community parties. Police and nationalist movement vigilantes also video sex workers and demand money to prevent the video being uploaded on the Internet. Most key informants believe that when law enforcement officers raid sex workers – often illegally – they are doing so to placate both the vigilantes and some politicians who are promoting nationalist ideals. One key informant interviewed in Osh suggested that the lack of interest from police officials in addressing illegal detention of key population members in the south of the country may be explained by both the high turnover of police leadership in the oblast and the fact that many key population members in the South are of Uzbek ethnicity. As there were major clashes between people of Uzbek and Kyrgyz ethnicity in 1990 and 2010, such ethnic differences may continue to cause problems in the region.

Political and funding support for the HIV response

Similar to the protective legal framework, Kyrgyzstan has a well-developed and protective HIV Strategy, but its implementation has been problematic.³⁶ Ongoing economic problems within the country have caused shortfalls in budgets across all areas and HIV services have also been affected. At the time of the assessment, there were serious discussions between the Ministry of Health and the Cabinet about whether major cuts to the HIV budget would be expected later this year. As one of the poorest countries in the EECA region, it is unlikely that Kyrgyzstan will transition soon from external funding, but the funding provided by external donors has been decreasing for several years. UNDP is the Principal Recipient for the GF HIV grant. In addition to an overall funding shortfall, there are activities funded by the Global Fund that are unlikely to be taken up through government funding. In particular, HIV and

³⁶ State Program for Stabilization of the HIV Epidemic in the Kyrgyz Republic for 2012-2016, Government of the Kyrgyz Republic 2012

KP NGOs fear that they will not be funded by government, as there is no social contracting system in place as yet.

Human rights-related barriers to HIV services

The major barriers identified in discussions with key informants and members of key populations in focus groups were:

- a) Illegal police practices including harassment and violence.
- b) Stigma and discrimination, affecting people living with HIV, as well as sex workers, gay and bisexual men and other men who have sex with men, people who inject drugs (with women who inject drugs most stigmatized) and ex-prisoners.
- c) Gender-based violence, particularly for sex workers, gay and bisexual men and other men who have sex with men and women who inject drugs. Women living with HIV often experience violence from their sexual partners or spouses and in-laws when disclosing their status.
- d) Knowledge of legal rights and access to legal assistance, with women and people using drugs experiencing the greatest problems.
- e) A set of punitive laws, policies and practices that were an impediment to service access.

Illegal police practices

According to most key informants, the biggest barrier to access to health services for key populations, including sex workers, people who inject drugs and gay and bisexual men and other men who have sex with men, takes the form of illegal police practices against these populations involving harassment, extortion, arbitrary arrest and detention and violence, including rape. These practices drive these populations underground and erode their trust in government and health services. Several key informants pointed to the lack of oversight of police activities by entities such as the Office of the Prosecutor. One key informant stated that people living in villages were unwilling to bring any type of complaint against the police as they needed to keep living in the same village with the police officer. Several key informants also pointed out that there has been both a massive turnover in the police services, shortage of new recruits and that the law enforcement sector is increasingly attracting less-educated staff. One key informant said that the level of training now required for police is much greater than was the case several years ago because the overall education level of police is now much lower. Other key informants noted that the Ministry of Health does not monitor the impact of laws and regulations (including those relating to its own policies) or law enforcement on HIV prevention activities or access to other services.

There are several branches of law enforcement that engage in illegal activities that hinder access to HIV (and TB) services. All operate under the Ministry of Internal Affairs (MIA). In particular, police are divided into:

- a) *Patrol officers and investigators* – Patrol officers tend to be the least educated and trained and often enter the police service after completing military service. Investigators are usually trained at the Academy and often have a law degree. While most patrol officers should be trained at the MIA Academy, this assessment found that the capacity of the Academy was around 15% of the total annual intake of police (120 places for the 800 police recruited annually). Patrol officers and investigators are on very low wages and most key informants referred to widespread extortion of bribes, with smaller bribes demanded by

patrol officers and larger bribes demanded by investigators. Patrol officers were the most often-mentioned perpetrators of illegal detention, extortion and sexual violence towards sex workers. Specific sub-populations are at greater risk of violence or harassment. For example, Uzbek sex workers in Jalalabad oblast may be in Kyrgyzstan illegally and are therefore easier for police to intimidate. Ex-prisoners are also often detained by police, especially if they are (or were) also people who inject drugs. Younger sex workers are seen as being at greater risk of police violence. In general, most key informants reported that young key population members are more likely to experience police harassment.

- b) *Drugs police* - Under the Drug Control Strategy, the primary role of these officers should be to search for drug traffickers and to intercept large quantities of illicit drugs. However, many key informants pointed out that drugs police routinely follow people who inject drugs to and from opioid substitution therapy clinics and detain them. A 2013 study found that one-quarter of drugs police interviewed stated that they would confiscate injecting equipment from people who inject drugs, despite having no legal basis for this action.³⁷ People who inject drugs experience illegal detention, extortion and violence from both drugs police and ordinary patrol officers. In addition, if a person who injects drugs is in withdrawal, pressure can be placed on them to confess to a crime they did not commit. Several key informants commented that there is, at least in Bishkek, an unofficial order to increase pressure on people who inject drugs. Several key informants pointed to police activities targeting OST patients as the main reason why OST has become less attractive in recent years to people who inject drugs.
- c) *Moral Police (Vice Squad)* - This squad is new and only formally part of the Bishkek City Police as a pilot project, but similar squads exist elsewhere in the country. These police concentrate on trying to stop sex work, and increasingly there are statements in the media from senior police calling for the elimination of sex work in the country. Key informants stated that Moral Police: (i) forcibly test sex workers for HIV and STIs, even if the sex worker has a certificate showing she has recently been tested, (ii) illegally detain and extort bribes, and (iii) more recently, when finding the address of a sex worker, contact the woman's neighbors and ask them to make complaints against her. While sodomy is not illegal and there is no legal basis to arrest or detain gay and bisexual men and other men who have sex with men, key informants from within or working with communities of MSM stated that police harassment and violence against the LGBTI community grew tremendously after discussions in Parliament of the 'anti-gay propaganda bill'. Men who have sex with men are also blackmailed by police.

In addition to the barriers that police behavior presents to key population HIV service access, police often fail to investigate or seek to prosecute others who commit crimes against people from key populations. Most key informants discussing sex work stated that police showed no interest in investigating instances of violence against sex workers. Similar statements were made relating to violence against gay and bisexual men and other men who have sex with men. Where nationalist vigilante groups were involved, police were said to know who had committed this violence but were unwilling or unable to investigate them.

³⁷ Beletsky, L., Thomas, R., Shumskaya, N., Artamonova, I., & Smelyanskaya, M. (2013). Police education as a component of national HIV response: Lessons from Kyrgyzstan. *Drug and Alcohol Dependence*, 132, S48–S52

Stigma and discrimination

The second major barrier to HIV service access is the high level of stigma and discrimination against all key populations. Stigma and discrimination against people with HIV and people assumed to be members of key populations can broadly be found in various locales: in health care settings, by healthcare workers; in the general society; in prisons, among prison staff. A Joint Alternative Report for the United Nations Universal Periodic Review presented at the 21st session of the UPR Working Group under the UN Human Rights Council contained a key recommendation to develop and implement legislation on hate crimes. It cited sexual orientation and gender identity triggers for hate crimes and recommended monitoring of the nature and extent of hate crimes based on sexual orientation and gender identity.³⁸ A group of activists from NGOs Kyrgyz Indigo, Pathfinder, Labris and Yug-Anitlopa is working on a draft anti-discrimination law, but most key informants believe that, if passed, such a law might not have immediate impact unless accompanied by strong measures of enforcement. It will require additional work on implementation mechanisms as well as training of the law enforcement agencies and Office of Ombudsman, conducted by representatives of KP NGOs

In the focus groups, people who inject drugs reported that there are more services available to them now than were available five years ago. Some key informants felt that all key populations were more able to access medical services than 10 years ago (with the exception of adolescents who still need written permission from their parents or guardian to access HIV testing). This was also confirmed during focus groups with sex workers, gay and bisexual men and other men who have sex with men and people who inject drugs. However, most key informants mentioned issues of stigma and discrimination by healthcare workers. In the south, participants reported refusal of services to people living with HIV and there was widespread discussion of issues related to lack of confidentiality of HIV status. The key populations that are most stigmatized and discriminated against in the health system are people who inject drugs (particularly those who are ex-prisoners) and women who inject drugs (particularly those who are pregnant). Sex workers often do not wish to access reproductive health and antenatal care services in their local area due to fears related to lack of confidentiality. Similar concerns were expressed by gay and bisexual men and other men who have sex with men in relation to STI and other HIV services.

Many key population members report that the greatest levels of stigma and discrimination were experienced at Family Medical Clinics (FMCs). Because of this stigma and discrimination, some travel hundreds of kilometers to be treated in an Oblast AIDS or Dermato-Venereology Centre. Many cite lack of confidentiality as a core concern, but others simply believe they will not receive fair and professional treatment at an FMC. Also, FMC doctors tend to believe HIV is not a condition that they should treat and believe they should refer patients to AIDS Centers.

In regard to stigma and discrimination in the general society, several studies have found (and all key informants agreed) that such stigma and discrimination were very important barriers to HIV services.³⁹ The relatively small number of people living with HIV in the country means

³⁸ <https://uprdoc.ohchr.org/uprweb/downloadfile.aspx?filename=1370&file=RussianTranslation>.

³⁹ Stigma index among PLHIV. Analytical report of research results in Kyrgyzstan. Bishkek, 2015. Central Asian PLHIV Association, National Network of PLHIV Kyrgyzstan; Altice, F. L., Azbel, L., Stone, J., Brooks-Pollock, E., Smyrnov, P., Dvoriak, S., Vickerman, P. (2016). The perfect storm: incarceration and the high-risk environment perpetuating transmission of HIV,

that most people do not know someone who has HIV, and many key informants feel that this has led to greater fear of people living with HIV than exists in some other EECA countries. It was said by several key informants that if a person outside a major city finds that he or she has HIV, the first step is to leave the village. This is because their HIV status will rapidly become known among neighbors and also because of fears about the shame that will be brought on the family. They reported that this would likely result in children being refused attendance at school and either isolation within or abandonment by the extended family. HIV is considered by the general public to be shameful. There is a general assumption that people who have HIV have engaged in immoral behavior, and thus it is felt that positive HIV status should be hidden from neighbors and even from extended family members.

For people living with HIV, the most common form of discrimination cited outside the healthcare system was dismissal from employment. In one case, a woman was dismissed because her son had HIV, and only after interventions by several NGOs was she able to get her job back. Another major issue is the disability pension, which can be accessed only at a late stage of AIDS. As one key informant put it, many people die before their pension application is even answered.

For women living with HIV, there can be severe discrimination in the community and even in the family. Community discrimination is important as relatives may not want a woman to get treatment because others in the community will find out about their HIV status, bringing shame on the family. As ART is a lifelong treatment, these issues can arise many times. Of people living with HIV, pregnant women are the most affected: one key informant said a pregnant woman would deny her HIV status even after three confirmatory tests because she fears she will be denied the support of her family, and will be rejected by the community. Often disclosure of positive status to their spouses, sexual partners or in-laws led to gender-based violence for women living with HIV.

Social and religious forces also appear to fuel stigma and discrimination, sometimes leading to violence against key populations. As noted above, nationalist vigilantes not only attack sex workers and LGBTI people, but also advocate for recriminalizing sex work and outlawing 'gay propaganda'. In addition, some mullahs have called during Friday prayers for violence against LGBTI communities, including instructing religious people to kill LGBTI representatives wherever they find them. A key informant mentioned that a fatwa to this effect was published on a semi-formal government website related to religious matters, but was later taken down. Another key informant who had visited all oblasts of the country regionally to examine issues related to HIV prevention and treatment said that, politically at the oblast level, much depends on the personality of the Imam: some are very accepting, but some are very intolerant. Even if instructions are provided by the Central Islamic Authority, these can be ignored at the local level. Key informants from the LGBTI community stated that the main perpetrators of violence towards their community were police, members of certain sports clubs and military school students, with transgender people being the most affected.

hepatitis C virus, and tuberculosis in Eastern Europe and Central Asia. *The Lancet*, 388(10050), 1228–1248; Boltaev, A. A., Deryabina, A. P., Terlikbaeva, A., Gilbert, L., Hunt, T., & Primbetova, S. (2013). Scaling up HIV prevention efforts targeting people who inject drugs in Central Asia: A review of key challenges and ways forward. *Drug and Alcohol Dependence*, 132, S41–S47; LGBT in Kyrgyzstan: Violence and discrimination. Kyrgyz Indigo. Kyrgyzstan, 2015-2016.

Self-stigma was said by most key informants to be greatest among gay and bisexual men and other men who have sex with men and highly prevalent among all members of the LGBTI community. Self-stigma was described by key informants and focus group participants as a reluctance or refusal to access health services or other programs out of a fear that they would be not accepted, humiliated or otherwise treated badly because of their association to a key or vulnerable population.

One informant said that women who inject drugs are more likely to self-stigmatize due to cultural and social gender stereotypes.

Concerns were also raised about a group of children who acquired HIV through poor hospital infection control procedures in the country in the early 2000s. These children are now entering adolescence and for a variety of reasons (e.g. parental wishes to protect them from self-stigma, feelings of family shame and desire to keep the condition hidden) many do not even know their HIV status, despite the fact that they have been on ART for many years. Several key informants expressed concern for this group, both because they may suffer considerable anxiety and anger when they eventually learn of their HIV status and because they will soon become sexually active and will need to be supported to adopt safer sex behaviors. This group is likely to require special efforts and support to protect them and their families from stigma and discrimination.

Gender-based violence and gender inequality

Women in Kyrgyzstan face significant gender inequality that limits their access to HIV services. This takes the form of social, economic and cultural constraints that confine women's roles in the public and private sphere. Lack of social and economic autonomy translates into lack of sufficient autonomy to make decisions and take actions to fully access HIV services. Key informants indicated that economic and educational disempowerment was a major problem for women. Several key informants reported that living with HIV was of secondary importance to most women in Kyrgyzstan and that a lack of access to employment and education were much more important barriers to health for women. The lack of education and employment opportunities beyond the home means that women and girls are less likely to know about, or be able to exercise their rights.

Many women who have migrated to and worked in Kazakhstan or Russia have no wish to return to the village and to their previous, restricted roles, so when they return to Kyrgyzstan they move to large cities. Among barriers, there are gender-based violence and a set of gender norms and practices that limit personal power or decision-making, and also increase vulnerability and decrease access to services. Though child and forced marriage is illegal in Kyrgyzstan, an estimated 12 percent of girls marry before the age of 18, and 1% before they are 15 years old. Gender differences in terms of barriers to services were said by most key informants to be worse in the south of the country. As noted above, female sex workers and the LGBTI community face serious violence at the hands of police, clients and vigilante gangs.

Women who use drugs face compounded stigma, even within the community of people who inject drugs. Many have experienced violence, including sexual violence, as adolescents and are prone to violence due to the culture surrounding drug injecting in Kyrgyzstan. Lack of identification documents limits their access to HIV services and legal support from

governmental structures. Major perpetrators of violence against women who use drugs are police and sexual partners.

Appropriate tools for realizing the basic rights and freedoms of women who use drugs and sex workers do not exist for the following reasons: officially, these groups of women are either invisible to the state or are seen only within the context of criminality and moral condemnation on the pages of the press. Almost 50% of sex workers and women who use drugs in Kyrgyz Republic do not have passports or identity documents due to many reasons: loss, women are routinely released from prison without identity documents, or they never had an identity document because they were not issued a birth certificate. Lack of identity documents means women cannot exercise their basic legal rights.⁴⁰

Lack of legal literacy (“know your rights”) and lack of access to legal services

Though some programs have been put in place to provide legal literacy, understanding of legal rights was found to be very uneven among key and vulnerable populations. People working with people who inject drugs said they are generally better informed about their rights now than they were five years ago, while others said people who inject drugs are in the greatest need for legal services as they require specific documents to access a range of services. One key informant said sex workers rarely knew their rights, and rural and younger sex workers had less knowledge than others.

According to the report of the project “WINGS of Hope” conducted by Global Research Institute (GLORI) with Podruga and Asteria in 2013 and 2014, the level of knowledge on rights and gender-based violence among vulnerable women is very low. In 2016, four more NGOs joined the implementation network for this project (Plus Center, Positive Dialogue, Chance Crisis Center and NGO Socium), and, among all the partners, they have covered 213 women who benefitted from capacity building activities and legal services. Through questioning of clients, this network has found that before marriage 52% were never asked whether they would like to marry; 18% survived *ala kachuu*/bride-kidnapping; and 27% reported that their close friends or relatives were bride-napped. Reasons why women participants do not disclose episodes of gender-based violence were given as: 45% embarrassed, 31% don’t trust anyone, 11% no use, 3% thought that they would be blamed and rejected by family and friends.⁴¹

A needs assessment conducted by NGO Kyrgyz Indigo in Talas, Osh and Chuy revealed that a relatively high proportion of LGBTI community know their rights (40% and above).⁴² However in cases of police harassment or gender-based violence, they preferred not to bring their cases to the court but instead bribe the police to avoid disclosure of their sexual orientation or gender identity. There has been no specific research on knowledge of rights among migrants, but various KIs mentioned that knowledge of rights is lowest among those groups, especially women.

⁴⁰ NGO “Tais Plus”, “Shadow report”. Consideration of third periodic reports of Kyrgyzstan at CEDAW 42 session (2008), p. 3.; Djalbieva I. et al., “Limited services psychosocial factors affecting spread of HIV among women using drugs in the south region in Kyrgyzstan. Research findings”. Foundation “Asteria” (2009), p. 11. Available at: asteria.kloop.kg/files/.../ASTERIA-report_-2009.doc.

⁴¹ Report on project “WINGS of Hope” in Kyrgyz Republic, NGO “Asteria” and Global Research Institute (GLORI), 2016

⁴² LGBT in Kyrgyzstan: Violence and discrimination. Kyrgyz Indigo. Kyrgyzstan, 2015-2016.

While the Constitution and other protective laws provide many specific measures in support of the right to health, poverty is a significant factor in hindering access to HIV treatment, despite most aspects of the treatment being free of charge. In the main cities, out-of-pocket payments for basic medical services have become more rare, but they remain prevalent in rural areas. Added to these are the issues of transport costs (as one patient may need to visit three or more different health facilities, often kilometers apart) and the inflexibility of most medical delivery systems (especially OST and DOTS) that make it very difficult to maintain treatment and to work. Finally, nutritious food is required to optimize ART medications. Many key populations cannot afford sufficient nutritious food, particularly those who are homeless or in insecure accommodation, to maximize the benefits of medications.

While State-funded legal aid is to be provided by law to all who need it, there are few lawyers available, so most people are unable to access the service. There is also a law guaranteeing state legal services for convicted people who cannot afford the services of paid advocates. However, to be eligible for the service prisoners need to provide proof of their poverty, which they usually cannot do as they are already in the detention center or prison. For some key populations there have been programs providing access to street lawyers or paralegals, and in the areas where they are working, street lawyers provide considerable assistance to all key populations. Gay and bisexual men and other men who have sex with men in Bishkek may seem well connected to lawyers. However, some key informants pointed out that lawyers came under political pressure not to pursue cases on behalf of LGBTI litigants.

Punitive laws, policies and practices

Problematic laws

There are a number of laws that reduce incentives to get tested and take up treatment thus hindering access to services and/or contributing to stigma or discrimination towards key populations. These include the following:

- a) Travel and residence restrictions - Before being allowed to migrate for work in other countries (primarily to Kazakhstan and the Russian Federation), Kyrgyzstani people are required to be tested for HIV and be found negative. This HIV «travel restriction» leads many Kyrgyzstani to migrate illegally. Even those who migrate legally often do not have a written employment contract and therefore cannot benefit from health services in the destination countries. Conversely, the Administrative Code (4 August 1998) provides for administrative measures providing for deportation of foreign citizens in Kyrgyzstan who refuse to be tested for HIV.
- b) The Family Code (30 August 2003), as well as the Criminal Code, has articles that envision imprisonment for 3-5 years for intentionally infecting another person with HIV or STIs, or/and knowingly placing another person in danger of contracting HIV. Intentional transmission of HIV to two or more people, or to a minor, is punishable by 5-7 years of imprisonment.⁴³
- c) In the Law on Narcotic Drugs, Psychotropic Substances and Precursors (22 May 1998), compulsory drug treatment can be enforced by a court decision based on a

⁴³ Accessed at http://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=90346&p_country=KGZ&p_count=274 29 Nov 2017

written request from the relatives. Similarly, the Criminal Code (13 December 1999) envisions compulsory drug addiction treatment for prisoners.⁴⁴

- d) By law “On protection of Public Health in the Kyrgyz Republic” (approved by law #6 on Jan 9, 2005, article #74 “Consent to medical intervention”), adolescents generally cannot access most HIV services without permission from a parent.⁴⁵ This particularly affects adolescent gay and bisexual boys and other boys who have sex with boys and trans-adolescents whose families reject them, increasing their vulnerability to police harassment and violence from nationalistic/religious groups. Many engage in ‘survival sex’ and have limited power to negotiate safe sex with older partners. At the same time, staff of NGOs who provide adolescents with HIV services without written consent from their official guardians are at risk of imprisonment for corrupting minors.
- e) Changes made in the Constitution in 2016 include changes to Article 36 that now states that the family is a voluntary union of a woman and a man who reached the age for marriage established by law. The previous version of the Constitution considered a family as the voluntary union of two adults, and thus allowed the possibility of registering same-sex marriages.

In addition, there have been the following developments that could negatively impact the access to health services by key populations:

- a) In 2012, the Ministry of Internal Affairs made a public statement that it had initiated a draft law criminalizing sex work. Civil society members prepared a petition, organized public hearings, and due to strong advocacy, the law was not passed.
- b) In 2014, the draft law on ‘anti-gay propaganda’, based on a similar Russian bill, was registered for consideration of the Parliament: 27 of the Parliament’s 120 MPs were registered as initiators of the bill. In two Parliament hearings (in October 2014 and June 2015), a majority of MPs voted in favor of the Bill. Later the Bill was recalled by its initiators. It is unclear whether they decided not to promote it further or might intend to make it harsher before bringing it back for review and approval.
- c) In 2016, two MPs introduced a Bill that equated any NGO funded by external donors with ‘foreign agents’. If the law passed, all NGOs providing HIV services would automatically be considered as ‘foreign agents’. Due to strong pressure from civil society members, the law did not pass in Parliament.
- d) Many senior medical key informants working on HIV feel strongly that the law on confidentiality of HIV status should be changed to allow for: (i) doctors to openly discuss a patient’s HIV status (to ensure better health care and protection for physicians and to ensure appropriate care for the person with HIV), and (ii) testing the sex partners of people living with HIV (to ensure they know their status), without the consent of the people living with HIV.
- e) Newly advocated changes in patent legislation are not supported by the required orders and ministerial/ customs regulations, so that the importation of generic drugs is still limited.

⁴⁴ Accessed at http://www.ilo.org/aids/legislation/WCMS_127905/lang--en/index.htm 29 Nov 2017

⁴⁵ Accessed at http://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=71833 29 Nov 2017

- f) A new Criminal Code is being planned (to be enacted by 2019), which will include judicial review. While the revision of the Code is generally welcomed by HIV and human rights organizations, there is a risk that other movements, such as those towards re-criminalization of sex work, may influence the new Code.

Problematic regulations

In terms of regulations, the most important regulations that hinder access to services are:

- a) Need for an internal passport to receive health services - the passport links a person to a specific health clinic.⁴⁶ This means that, for a range of services, if a person moves elsewhere, he or she needs to get re-registered at a local clinic, which requires identification and often attendance at the original medical clinic. Many members of key populations (especially ex-prisoners) either do not have, or have lost, this key document. SFK has a project to eliminate the need for an official place of residence (and consequently internal passport) for people receiving services from NGOs. This can allow provision of a certificate that enables people to get medical services at a clinic near the NGO, and receive a social policy number. This is a temporary solution and requires payment of 500 KGS, and has to be repeated every year.
- b) Required registration by narcological services as a drug addict to receive opioid substitution therapy services - several key informants suggested that registration with Narcology is a major impediment to the uptake of OST services as this registration carries implications for employment, driving, etc. and can be shared with the police.
- c) HIV can become a barrier for employment to certain jobs and the list of jobs are approved by the Government of the Kyrgyz Republic (decree # 296 as of April 26, 2006):
 - Medical workers (operating surgeons of all specializations, surgical nurses, obstetrician-gynecologists and midwives of maternity hospitals, traumatologists, staff of hematology departments, dentists, departments of hemodialysis, and those directly working with blood.
 - There are other restrictions on involvement of PLHIV in several specializations and positions that are associated with the development of their opportunistic infections, such as tuberculosis, mycoses and other infections.

Problematic HIV testing policies and practices

Many key informants, most of whom are doctors, including most of the senior HIV doctors in the country, were concerned that the current Law on HIV/AIDS (approved by law #149 as of Aug 13, 2005) which regulates confidentiality (article #7 “Types of HIV testing”) of HIV test results is contributing to HIV transmission and is a denial of the right of sexual partners of people living with HIV to know their HIV status.⁴⁷ This is because the law does not discuss any specific circumstances in which public health specialists would be authorized to inform

⁴⁶ This internal passport is a form of identification required for both security purposes (it must be shown if demanded by uniformed police) and to access a range of government services, including health services. It is usually issued at the age of 16 and contains the person’s residence address at that age. If the person changes cities or towns, he/she has to return to the place named on the passport to either receive health and other services or must officially change residence. To change residence, there must be evidence of housing and the person should have a job. The process of changing one’s residence on the passport is cumbersome and time-consuming so many people always keep their old residence, making it difficult to access services. Internal passports are often lost by people who use drugs, prisoners and homeless people. To replace the passport is even more difficult than to change residence.

⁴⁷ Accessed at http://www.ilo.org/aids/legislation/WCMS_127903/lang--en/index.htm 29 Nov 2017

the sexual partners of people living with HIV that they may have been exposed to HIV transmission, keeping the identity of the HIV-positive person concealed from their sexual partners.

These key informants believe that in Kyrgyzstan it is unlikely that a man who tests HIV positive would disclose his HIV status to his wife or other sexual partners and would not introduce condoms at home, as this might indicate that he has HIV or an STI. Without compulsion, the doctors fear that the man with HIV will pass HIV on to his wife and any children she may bear, as well as potentially other sex partners. A secondary issue is that doctors believe that if they are not allowed to tell each other about a patient's HIV status, they put both the patient's care and the doctor's health at risk. They are advocating for a change to the confidentiality provisions so that:

- a) Doctors can disclose a patient's HIV status during referral to another doctor (without the consent of the patient); and that
- b) If a person is confirmed HIV-positive and does not bring his/ her sexual partners to the clinic for HIV testing within a specified period (14 days has been discussed), then the healthcare worker will be allowed to disclose their status to the person's sexual partners.

However, several focus groups, especially those comprising people living with HIV, stated that in contrast to alleged problems with the confidentiality protections, the most important human rights barrier to be reduced was the unauthorized disclosure by medical personnel of their HIV status.

There are several articles in Kyrgyzstan law related to HIV testing that contradict the WHO *Consolidated guidelines on HIV testing services*⁴⁸ such as: the national law provides for mandatory testing for HIV of all foreign residents and professionals holding specific jobs (mainly medical personnel who are involved in work with blood). Though HIV counseling and testing can be conducted only with the written consent of the person being tested, the refusal to be tested may result in deportation for foreign residents and losing their job for medical personnel. The law also envisions HIV counseling and testing without written consent, if the test was approved by Court decision.

Programs to address barriers to HIV services – from existing programs to comprehensive programs

This section describes existing or recent programs in Kyrgyzstan to reduce human rights-related barriers to services under the seven Program Areas set out in the Global Fund Technical Brief, as well as the comprehensive program that, if put in place at scale, would help to minimize these barriers to service access.⁴⁹ Several non-government and community-based organizations, as well as government entities, have been working to address human rights-related barriers to HIV. However, these activities do not fully cover each Program Area and most are being implemented at a scale that is unlikely to bring about

⁴⁸ WHO (2015) *Consolidated guidelines on HIV testing services*, Geneva

⁴⁹ Technical Brief *HIV, Human Rights and Gender Equality* Global Fund to Fight AIDS, TB and Malaria, April 2017

major change. Kyrgyzstan has institutions, protective laws and civil society organizations that can all be strengthened and engaged to significantly reduce these barriers. However, this will require increased and sustained investment in interventions and activities that provide important human rights-related knowledge and skills to officials and to the populations of those affected by HIV.

There have been many pilot projects, but few of them have been evaluated and taken to scale. Institutionalization of some activities – such as training of practicing doctors in stigma reduction – is underway, but for many other effective or promising interventions there is little likelihood that they will survive the departure of external funders. Programs to reduce stigma and discrimination among healthcare workers have yet to be institutionalized in medical education more broadly, and medical ethics is not a major component of pre- or in-service education for doctors, nurses or health administrators.

Many key informants referred to the important role that NGOs have played in working with key populations, especially in advocacy for the reduction of human rights barriers to services. Some key informants believe that some of the current problems related to rising violence and hostility towards key populations has come about partly from the lack of emphasis on human rights issues by external donors as funding has reduced to the NGO sector in recent years, and has focused more sharply on narrow ‘test and treat’ goals.

Key population NGO representatives reported that the quarterly meetings of key population networks are a very useful vehicle for sharing ideas for advocacy and combined actions, but that there had been no evaluation of the outcomes of these activities to date. One key informant noted that there is strong collaboration between NGOs across the HIV key populations. Another said an effective process had been the participation of key population community members in decision-making processes (including decision making by donors), through the Country Coordinating Mechanism (CCM) and through regular interactions with donors such as Global Fund, PEPFAR and Soros Foundation Kyrgyzstan (SFK), and through the Community Advisory Boards established in the past for some AIDS and OST centers. Many of the interventions described empower and engage key population representatives to be strong advocates for increased access to services and support among law enforcement and health care providers for this access.

A summary description of existing or recent interventions to address human rights-related barriers to HIV services for each Program Area is presented below.

PA 1: Stigma and discrimination reduction for key populations

There are many interventions in place in Kyrgyzstan that involve an element of stigma and discrimination reduction. These range from interventions specifically and explicitly dedicated to stigma and discrimination reduction to those interventions that accomplish these objectives more generally through increased participation, representation and mobilization of key populations and their representatives.

World AIDS Day, International Day Against Drug Abuse and Illicit Trafficking, and International Day against Homophobia and Transphobia (IDAHOT) are marked each year by campaigns that call for greater tolerance towards people living with HIV, people who inject drugs and LGBTI people. Starting in 2016, national stakeholders began to organize special events to celebrate Zero Discrimination Day as well. Most of these annual events focus on Bishkek and may have little impact outside the capital. So far there have been no evaluations

of whether these campaigns have influenced stigma and discrimination experienced by PLHIV and key populations.

Another important activity has been the submission of alternative or shadow reports – LGBTI organizations Kyrgyz Indigo and Labrys reported on the implementation of the provisions of the International Covenant on Civil and Political Rights (ICCPR) related to LGBTI people in Kyrgyzstan; and sex workers organization Tais Plus reported to the third periodic report of Kyrgyzstan to the Committee on Elimination of Discrimination Against Women (CEDAW). Both sex workers and LGBTI community activists stated that they felt empowered by being heard and having the opportunity to discuss the stigma and discrimination they face in their daily life. All three NGOs attempted to include the voices of key populations from areas outside Bishkek.

Several donors have organized trainings and other educational events for media representatives on topics related to HIV, harm reduction and drug demand reduction and various awareness-raising and HIV sensitization events were conducted for Parliament members by different stakeholders. The establishment of a community advisory board (CAB) of people living with HIV and key populations in the Office of the Ombudsman was widely supported by key informants.

Training of religious leaders on HIV and stigma and discrimination has had some impact on improving attitudes towards people who inject drugs, but has faced problems in convincing Islamic religious leaders to help in reducing stigma and discrimination against other key populations, especially sex workers and gay and bisexual men and other men who have sex with men.⁵⁰

The table below provides a summary of current or recent interventions under the program area stigma and discrimination reduction, a brief description of the activities undertaken, the scale, budget, location and implementer.

Focus	Summary	Scale	Budget	Location	Implementer
LGBTI community mobilization	This included an extended package of services at the community center, mini sessions on different subjects including “know your rights” sessions, 1 national conference, 1 regional meeting of LGBT community and CBOs; Social workers, psychologist and peer educators cover stigma and discrimination issues during counseling for LGBTI	80 mini sessions were conducted, each covering 15-20 people in average; 200 MSM received services from the community center; 1 national conference was organized; 1 regional meeting of LGBT community was organized	USD 65,770	Bishkek	NGO “Kyrgyz Indigo”

⁵⁰ Unpublished key informant interview transcripts.

PLHIV community mobilization	Capacity building for NGOs involved in provision of services for PLHIV, trainings	15 NGOs received technical assistance, 40 NGO staff were trained, 290 PLHIV received counseling services, including on stigma and discrimination; National Forum of PLHIV conducted	USD 105,931	Bishkek, Chuy Oblast, Jalal-Abad	NGO “Edinstvo LJV”, Harm Reduction Association “Partners’ Network”
PLHIV Stigma Index	Included training of community members, collecting data by community members	150 PLHIV were interviewed by community members	USD 18,730	Whole country	National Network of PLHIV
People who inject drugs community mobilization	Capacity building of CBOs working with People who inject drugs, trainings for community	15 CBOs received technical support on organizational capacity building, 40 NGO staff members trained, 60 community members received services	USD 40,898	Bishkek, Chuy Oblast	Harm Reduction Association, NGO “Ranar”
Sex worker community mobilization	Summer school for sex workers, technical assistance for NGOs working with sex workers, trainings for the community; advocacy for human rights of sex workers	30 sex workers participated in summer school; 8 NGOs received technical assistance on organizational capacity building; 40 NGO staff members trained; 90 sex workers received various services (trainings, counseling, etc)	USD 153,991	Bishkek, whole country	NGO “Tais Plus”, NGO “Shah Ayim”
Key population representatives in CCM	The current structure of CCM includes 1 representative and 1 alternate for each key population group (LGBT, sex workers, people who inject drugs, PLHIV)	These are voluntary positions, only travel costs are covered for members living outside of Bishkek		Bishkek, whole country	CCM, representative s of key populations. The selection of representative s happen on annual national

					forums of key population communities, separate for each key population group and funded by UNDP/GF
Key population representatives in Public Supervisory Board under Ministry of Health	There is a person who also represents People who inject drugs on the PSB under MoH	This is a voluntary position		Bishkek, whole country	MoH
Key populations representatives in the Community Advisory Board of Ombudsman's Office	There is a community advisory board under Ombudsman's Office, which specifically aims at addressing the issue of gender-based violence against KPs	These are voluntary positions for key populations (often the salaries are covered under different projects for NGOs and from the government for Ombudsman's staff)		Bishkek, whole country	Ombudsman's Office, NGO "Tais Plus", NGO "Asteria", NGO "Kyrgyz Indigo" and other NGOs
Media briefings for journalists Media campaigns	Several NGOs conducted media briefings/campaigns to reduce stigma and discrimination among general population towards their community	6 media campaigns conducted on OST related theme; 4 trainings for LGBT, NGO representatives and journalists were conducted; media campaign conducted dedicated to World AIDS Day	USD 58,000	Bishkek, Chuy Oblast	NGO "Alternative to Narcology", NGO "Kyrgyz Indigo", Harm Reduction Association of Kyrgyzstan

Dialogues between key populations and government officials/decision makers	Local NGO organized a platform for discussion of human rights issues with political parties of KG and representatives of KPs	Dialogues conducted between political parties and key populations representatives on current human rights issues	USD 37,500	Bishkek, whole country	NGO “Kyrgyz Indigo”
			USD 478,820		

The lack of repeated Stigma Index data means that trends cannot be discerned. When asked whether problems related to stigma and discrimination had remained similar or changed over the past five years, key informants and focus group participants very firmly stated that sex workers suffer much greater problems in this area now than in the recent past. This suggests both that the level of programming is not sufficient and that the focus of programming may need to change to reflect the societal shifts towards less tolerance towards some key populations.

Moving to more comprehensive programming

The following recommendations are made to move towards comprehensive programming in stigma and discrimination:

- Continue the major programs set out in the table above – following evaluations and adjustments where these have not been carried out.
- Expand community mobilization and education on stigma and discrimination for all HIV key populations, at least in Bishkek, Osh, Chui Oblast and Jalalabad. The People Living with HIV Stigma Index should be completed every two years to track changes to the experience of stigma by PLHIV and members of key populations.
- Key population NGOs connect key population members as community monitors to street lawyers and human rights defenders to monitor and advocate in the case of barriers to services, to stand for selection to Civilian Advisory Boards (for Ministries of Health, Justice and Internal Affairs) and to join Community Advisory Boards for health clinics and the Ombudsman’s Office.
- Assist the Ministry of Health to work with HIV NGOs on national and targeted campaigns to address stigma and discrimination towards people living with HIV, including promoting clear information about HIV, how it is and is not transmitted, how it is important to get tested and on treatment, and how stigma harms individual and population health outcomes.

PA 2: Training of health care providers on human rights and medical ethics related to HIV

Training of healthcare providers for stigma reduction related to HIV has been carried out as pilot projects (under the USAID Quality Health Care Project), as well as structured programs over several years (funded by CDC). These programs have now been institutionalized within

the Postgraduate Medical Education system (known as Chubakov Institute) resulting in the fact that now a wide range of doctors receive education not only on technical aspects of HIV work, but also on communicating with key populations, in which stigma and discrimination are addressed in some depth.

In a focus group comprised of people living with HIV, trainings for medical personnel of AIDS Centers on communication with people living with HIV and medical ethics were found to have a positive impact, and the group of people living with HIV proposed that such trainings should be conducted on a regular basis

While no evaluations have been carried out, key informants felt the training was useful but only reached a fairly small number of Family Medical Clinic doctors. As HIV patients are increasingly referred to outpatient services at the local level, a much more comprehensive training approach will be required.

Key informants also cited Multi-disciplinary Teams (MDT) as mechanisms that reduce stigma and discrimination towards key populations. These teams usually comprise two or more healthcare workers, together with often a psychologist or social worker and a peer educator/counselor. There have been no evaluations of the impact of these teams, but key informants said that, in sites without MDT, there was a much higher loss to follow-up, especially for key populations on ART, and between HIV testing and linkage to care. MDT have been trialed in ten sites with funding from US CDC, UNAIDS and others, but have yet to move beyond pilot programming. Institutionalizing MDT will involve finding ways to either pay peer counselors through the health system (developing an entry for them on the list of approved health staff, together with qualifications, pay and conditions) or developing social contracting mechanisms so that the MoH can pay salaries of peer counselors working at NGOs.

Gay and bisexual men and other men who have sex with men in focus groups consistently mentioned the usefulness of trainings they had received on self-stigma and called for much wider implementation of these trainings. They also praised the sensitization trainings for medical specialists implemented by LGBTI NGOs, which led to the formation of a network of doctors friendly to gay and bisexual men and other men who have sex with men.

The following table provides current or recent interventions under this Program Area and a brief description of the activities undertaken, the scale, costs, location and implementer.

Focus	Summary	Scale	Budget	Location	Implementer
MSMIT	Series of trainings conducted by LGBT CBO for health care workers on implementation of interventions across the full HIV services continuum, including prevention, treatment, care	115 health care workers	USD 20,300	Bishkek, whole country	NGO “Kyrgyz Indigo”

Focus	Summary	Scale	Budget	Location	Implementer
	and support interventions				
Online training courses for health care workers on HIV	The training curriculum includes issues of medical ethics, legal responsibility for disclosure of medical secrecy, communication skills	224 medical workers went through 3 month on-line course during the 2013-2015	USD 48,790	Whole country via open contest	Chubakov's Institute
Training for health care workers	This training was conducted for health care workers providing services for sex workers to address stigma and discrimination related to HIV and sex work	210 health care workers trained	USD 17,535	Jalal-Abad	NGO "Tais Plus 2"
			USD 86,625		

Given the extent of stigma and discrimination from healthcare workers described by key populations during this assessment, it is evident that the level and type of work carried out on these issues is insufficient. A truly national approach involving multiple levels of health care staff and administrators, from undergraduate to continuing education level, is required as well as methods of encouraging collaborative work between HIV NGOs and healthcare agencies.

Moving to more comprehensive programming

The following recommendations are made to move towards comprehensive programming in training for health care providers on human rights and medical ethics related to HIV:

- a) HIV NGOs to review the current courses on medical ethics, confidentiality and HIV to ensure their efficacy and appropriateness, adapted and then used to:
 - Institutionalize training of doctors to the family medicine clinic (FMC) level about HIV and TB and the rights and ethics related to them (e.g. non-discrimination, duty to treat, confidentiality and informed consent), and ensure safe working conditions for FMC staff.
 - Institutionalize a course in undergraduate education for doctors, nurses and health administrators on medical ethics and human rights obligations, with specific reference to reducing stigma and discrimination related to HIV and TB.
 - Institutionalize a similar course for health care administrators.
- b) The Ministry of Health should encourage and provide regulatory assistance to ensure that Multi-disciplinary Teams are used in health clinics (including FMCs) that either employ peer educators/counselors) or work in close collaboration with NGOs with peer educators/counselors on staff to assist key populations through testing onto treatment and adherence for both HIV and TB and to monitor discrimination in health care provision.

- Community Advisory Boards of key population members at AIDS Centers and narcological clinics should be reinstated to increase access to services and decrease stigma
- HIV NGOs should assist and monitor the MoH implementation of its own policies and recommendations including those related to confidentiality of health data. They should advocate for greater government funding of HIV services, specifically to increase quality of counseling, and to increase the availability of HIV services by well-trained professionals through Family Medicine Centers; and for free STI services, especially for sex workers and gay and bisexual men and other men who have sex with men.

PA 3: Sensitization of law-makers and law enforcement agents

Many key informants referenced police training as one of the most important interventions undertaken to address human rights barriers to HIV services. The harm reduction training course institutionalized at the Internal Affairs Academy was one of the few interventions to be evaluated.⁵¹ The evaluation compared police knowledge and attitudes towards harm reduction services among 313 police, of whom 38% had undergone the training program. They found significant support for access to syringes (63.7%) and condoms (72.3%) after the training program. However, despite being discussed in the training, support for propositions that police should provide public health prevention information to high-risk groups was substantially lower (41.2%). Although a small minority (7.4%) reported lifetime needle-stick injuries (NSI), concern about contracting disease through such injuries was widespread (81.4%). Thirty-five percent of respondents stated they were alarmed that syringe access may increase police occupational risk.

Training was significantly associated with serving in an urban setting, better HIV transmission knowledge, and support for the role of police in educating high-risk groups. Trainees were less likely to report occupational NSI or to back the assertion that syringe access increases occupational risk. They also exhibited better legal and policy knowledge; trainings were associated with lower levels of correct knowledge only on the issue of routine sex worker identification. Those who had undergone training were also more likely to report familiarity and interactions with public health organizations.

Most key informants referred to police training as being a vital component in the enabling environment for work on HIV with key populations, and many called for a re-invigoration and scaling up of police training. There was some disagreement as to whether police training programs should be the same for all types of police and whether all key populations should be covered together in police training or whether separate programs should address issues related to drug use, sex work and sexuality. AFEW's 'friendly police' project was mentioned as an effective intervention, especially the medals they provided for the most friendly police.

One key issue related to police training was the reduction in the numbers trained from around 2003-2009 to the present. A training course on harm reduction was institutionalized in the Internal Affairs Academy in about 2007. Since then, the Academy has trained about 120 police recruits each year (of the 800 people who join the police force each year). In the past, there were several other projects working on training police in specific districts of major

⁵¹ Beletsky L, Thomas R, Shumskaya N, Artamonova I, Smelyanskaya M (2013) Police education as a component of national HIV response: Lessons from Kyrgyzstan *Drug and Alcohol Dependence* 132 (Suppl 1): S48-S52

cities (including senior police station management) by a multi-disciplinary team comprising NGO workers, infectious disease specialists and narcologists. In recent years, no funding has been provided for these activities. Gay and bisexual men and other men who have sex with men, sex workers and harm reduction NGOs occasionally offer training courses or seminars.

The following table provides current or recent interventions under this Program Area and a brief description of the activities undertaken, the scale, costs, location and implementer.

Focus	Summary	Scale	Budget	Location	Implementer
Harm reduction training course at Police Academy (Academy of Ministry of Inner Affairs)	The training was incorporated into the official curriculum of the Academy, it has specific modules addressing issues related to specific key population group (eg. MSM, SW, PWID)	Approximately 120 students annually graduate the Academy, the course is taught for senior students. Additionally, in-service trainings are provided for 320-350 acting police workers	USD 43,912	Bishkek, whole country	Police Academy
Training of Trainers (ToT) for staff of the Police Academy	Local CBO organized a ToT to improve knowledge and skills of the Police Academy staff on issues related to work with LGBT community	15 teachers of the Police Academy	USD 3,040	Bishkek	NGO “Kyrgyz Indigo”
Training of law enforcement	Training for police officers to address stigma and discrimination related to HIV and sex work	270 police officers trained	USD 17,535	Jalal-Abad	NGO “Tais Plus 2”
			USD 64,487		

The interventions to sensitize law enforcement agents, primarily at the police level, have had impact and have been cited as effective by the key populations in reducing the illegal police practices that act as barriers to their uptake on HIV services. However, only a small proportion of the total police force has been trained and there is a serious lack of funding for such training. It is not clear to what degree: (a) the training is consistent and repeated (one-

off training usually has low impact); (b) critical senior officers and police management are also being sensitized to support the training; (c) other activities between key populations and police are supported to result in practical changes in communities; (d) prison management and staff are benefitting from sensitization; and, (e) the degree to which judges could make a difference if sensitized.

Moving to more comprehensive programming

The following recommendations are made to move towards comprehensive programming in sensitization of law-makers and law enforcement agents:

- Significantly expand the reach and coverage of training for police to reduce the barriers they present for key populations to access services and on the individual and populations public health benefits that result from this. Include up to date information to reassure police about effective infection control. The training curricula should be reviewed and updated and a particular curriculum developed for senior officers and other means of engagement with Ministry of Justice and Interior officials should be envisaged. The training should be fully integrated into police academy training. Representatives of PLHIV and other key populations should be ones leading the process of conducting such trainings, in order to continue further work on designing, implementing and evaluating them.
- From this activity, these civil society representatives should devise with police ongoing joint activities between police and key populations. This could involve activities such as a hotline for sex workers to report client violence, police refraining from using condoms or syringes as evidence, police protection of gay pride marches, police engagement in rapid response when key populations are threatened with violence.
- Sensitization of prison management and staff should be done regarding their duties to protect the health of inmates through provision of HIV prevention, treatment and harm reduction but also through protection from violence, rape and discrimination.
- Study tours can be arranged for senior police and prison administration officials to other countries where illegal police practices have been curtailed in the context of HIV. Study tours for senior police officials from subnational level could also be considered.
- Develop and implement mechanisms with the Office of the Ombudsman, Office of the Prosecutor, National Preventive Mechanism on Torture to address the issue both of police behavior towards key populations and of police behavior towards groups that attack key populations. These establishments should assist and monitor MIA implementation of its policies on evaluation of law enforcement staff and police stations and assist and monitor State Penitentiary Service implementation of its policies.
- Provide in-service training for judges particularly judges at the sentencing level who affect the daily lives of members of key populations.

PA 4: Legal literacy (“know your rights”)

Although only one program was found that worked specifically on legal literacy, elements of rights education were also present in the outreach to key populations and in community mobilization.

The following table provides current or recent interventions under this Program Area and a brief description of the activities undertaken, the scale, costs, location and implementer.

Focus	Summary	Scale	Budget	Location	Implementer
Legal literacy trainings for key populations	Legal literacy trainings conducted by various stakeholders for key population representatives.	Local CBO conducts weekly sessions for the men who have sex with men community on different topics, including human rights issues. The sessions usually have around 10-15 participants. 240 SW, 632 PWID (including OST clients) trained.	USD 35,785	Bishkek, Chuy Oblast, Jalal-Abad	NGOs “Tais Plus 2”, “Alternative to Narcology”, “Kyrgyz Indigo”, Harm Reduction Association of Kyrgyzstan
			USD 37,785		

Moving to more comprehensive programming

The following recommendations are made to move towards comprehensive programming in legal literacy:

- Expand the scale of “know your rights” education and legal literacy interventions to reach all key populations for HIV with a view to increase community protection and to develop advocacy around health issues.
- HIV and KP NGOs should also be supported to develop key population members as community monitors to develop a feedback mechanism through street lawyers and human rights defenders, and report annually.
- The expanded street lawyer program described in the Legal Service section below will also serve to educate HIV KPs on rights, create an advocacy agenda and identify community priorities for activism.

PA 5: HIV-related legal services

Provision of legal services was regarded as an important intervention for key populations. The street lawyers program, in which some legal counseling training is provided to selected outreach workers, was widely praised, as was the development of an algorithm on how street lawyers should react to human rights violations among their clients.

The state-guaranteed legal aid in Kyrgyzstan, established based on the 2009 Law, and reconceptualized through the December 2016 law, faces challenges in operationalization. One of the main novelties is introduction of the right for professional legal services in civil and administrative cases, not just in criminal cases. In addition, the new law widened

the circle of individuals who are entitled to receive state guaranteed free legal aid. A center for coordination of the state-guaranteed legal it to be opened under the Ministry of Justice of Kyrgyzstan and will represent an important opportunity for synergies and partnership.

Since 2014, UNDP and the Ministry for Foreign Affairs of Finland have brought together legal institutions, an independent bar association and civil society organizations and set up 14 offices to give vulnerable people in pilot Osh and Chui regions access to free legal aid. A group of lawyers visited 173 villages in the Osh and Chui regions with the “Solidarity Bus,” providing 3,367 free legal consultations to citizens in these remote areas. In 2016, the project provided 18,091 oral and written legal consultations, 98 representations outside the courts and 82 at the courts⁵². While not HIV or TB specific, such efforts increase the potential for people living with HIV and key populations to access legal services.

The following table provides current or recent interventions under this Program Area and a brief description of the activities undertaken, the scale, costs, location and implementer.

Focus	Summary	Activities	Budget	Location	Implementer
Street lawyers	Paralegals providing legal support and documenting human rights violations against key populations	In total, there were 37 street lawyers hired by local NGOs, who provide services to key populations on daily basis.	Included into budget of other projects	Bishkek, Chuy oblast, Osh Oblast and city, Jalal-Abad	25 HIV service NGOs
Legal aid for key populations	Legal aid provided by professional lawyers and street lawyers	310 people who inject drugs (including 30 NGO staff member, 12 OST clients), 345 PLHIV, over 170 sex workers received legal aid	USD 69,621	Bishkek, Chuy Oblast, Osh, Jalal-Abad	10 HIV service NGOs
Community Based Rapid Response Team	This is a group of LGBTI community members who react to urgent calls related to human rights violations	60 clients received support	Team works on voluntary basis, however both are the employees of LGBTI CBO	Bishkek, Chuy Oblast (only outskirts of Bishkek)	NGO “Kyrgyz Indigo” (In past it used to be two people from two local CBOs, unfortunately the person from the second CBO

⁵² UNDP (2017) Legal aid for vulnerable groups in Kyrgyzstan. <http://www.eurasia.undp.org/content/rbec/en/home/ourwork/democratic-governance-and-peacebuilding/successstories/legal-aid-for-vulnerable-groups-in-kyrgyzstan.html>

Focus	Summary	Activities	Budget	Location	Implementer
	against LGBT community. At the moment, the team consists of 2 active members who come to rescue of the LGBT in trouble				left the country and the CBO wasn't able to replace him)
			USD 69,621		

Moving to more comprehensive programming

The following recommendations are made to move towards comprehensive programming in legal literacy:

- Expand the street lawyer/paralegal program to sufficient coverage to educate and offer services to key populations in Bishkek, Osh, Jalalabad and Karakol and work towards certification and institutionalization of street lawyers/paralegals.
- Expand legal support so that all HIV and KP NGOs working with key populations have access to affordable or pro bono lawyers for casework, legal defense and strategic litigation, where necessary.
- Support the development of rapid response procedures which involve legal support; human rights defenders; appropriate officers from the General Prosecutor's Office, Office of the Ombudsman, National Preventive Mechanism on Torture and other agencies; and key population NGOs to respond rapidly to curtail illegal police practices, especially against sex workers and people who inject drugs and to address gender-based violence against sex workers, gay and bisexual men and other men who have sex with men and transgender people.
- Publish an annual report from street lawyers and from the Ombudsman and Prosecutors Office.

PA 6: Monitoring and reforming laws, regulations and policies relating to HIV

The largely protective nature of the legislative and regulatory basis of the response to HIV in Kyrgyzstan was acknowledged by many key informants, including both the so-called 'humanizing' drug law and Ministry of Internal Affairs Order 417 which sets out standards for police action around key population program implementation points.⁵³ Key informants underlined that these aspects of the response, representing gains in the past, were now under threat from the social and political changes of recent years. Order 417 is now over-ridden by other more immediate commands to follow and detain people who use drugs and to raid sex workers.

Underscoring the need for support for monitoring, advocacy and efforts to reform punitive laws and strengthen protective ones, key informants highlighted positive action against these threats including the coalitions that have formed to prevent the re-criminalization of sex work and to fight against the proposed "anti-gay propaganda" Bill and the networking and advocacy around laws against child marriage and bride kidnapping. They also cited the high-

⁵³ Accessed at <https://www.ncbi.nlm.nih.gov/pubmed/23568946> 29 Nov 2017

profile court case against the Director of the Jalalabad AIDS Centre for disclosure of a person living with HIV's status where serious sanctions were imposed on the Director who eventually lost his position.⁵⁴

Key informants also praised two other efforts: (a) the work by NGOs on a shadow report for the Committee on Elimination of Discrimination Against Women (CEDAW) on human rights violations against sex workers, and (b) the alternative report on the implementation of the provisions of the *International Covenant on Civil and Political Rights* (ICCPR) related to LGBTI people in Kyrgyzstan.

Other helpful activities comprised reform of regulations so as to remove needles and syringes from the list of banned items in prisons and thus allow the harm reduction program to operate there. Focused study tours for high-level Government officials, in particular from the Ministries of Internal Affairs and Justice, were regarded as important in developing political support for introducing and expanding HIV services. The new State Program on HIV in development is likely to include a special component on reducing human rights-related barriers for access to HIV services.

A current pilot program involving the Office of the Ombudsman and NGOs working with women who inject drugs and sex workers is working to prevent unlawful detention of these women by police. A rapid response group, including street lawyers and NGO staff, together with Ombudsman staff, attempt to arrive at a detention center where a woman is being held unlawfully within 3-4 hours of her arrest. While there have been no evaluations of the program and some concerns have been aired about whether the project will result in major behavior change, preliminary results appears promising.

The Office of the Ombudsman now has a Community Advisory Board comprising key population members. The National Preventive Mechanism on Torture together with the Ombudsman's office has also conducted unannounced monitoring visits to detention centers, colonies and other closed institutions. In addition, SFK has been working with the Office of the Prosecutor on its changing role under the current reform of the law enforcement sector. SFK is currently designing monitoring and evaluation processes for this and for police training and other activities, and has piloted police behavior monitoring at Talas.

There is a UNODC pilot program of OST in three sites, where the barrier of registering as a person who uses drugs has been removed. While this may lead to greater uptake of OST, in the current environment in which police follow people who inject drugs and 'stake out' OST sites, the innovation is likely to be of limited impact.

Most key informants familiar with the prison system agreed that much good work has taken place there over many years, but that issues such as overcrowding and the increasing number of convicted terrorists have led to the reduction or shut down of peer education programs. A reduction in funding and a reduced focus on health have begun to weaken these effective programs. It was noted in KIIs that while the majority of people living with HIV in prison are on ART, viral load suppression is only at 40%. This indicates either poor adherence to treatment or stock interruptions. Many also referred to programs that existed in the past for pre- and post-release to help ex-prisoners maintain ART adherence after leaving prison.

The following table provides current or recent interventions under this Program Area and a brief description of the activities undertaken, the scale, costs, location and implementer.

⁵⁴ Accessed at <http://www.irinnews.org/news/2006/04/03/criminal-case-following-disclosure-hivaids-status> 29 Nov 2017

Focus	Summary	Activities	Budget	Location	Implementer
Approval of the law obligating governmental media to provide free time for social advertisements	The approval of this law allows HIV service organizations to use free of charge broadcasting of their social advertisements through national media outlets	3 public hearings for 80 parliamentarians and other stakeholders	USD 21,300	Bishkek	NGOs and parliamentarians (public hearings) with support of donors (technical assistance and support of working group)
Community-based data collection on human rights violations against LGBTI	Local CBO routinely collected data about human rights violations against their community	Reports about human rights violations against LGBTI community published; several community consultations conducted; shadow report submitted to the 110 th Session of the Human Rights Committee	USD 84,566	Bishkek, whole country	NGO “Kyrgyz Indigo”
Legal audit of the legislation regulating life of LGBTI community in Kyrgyzstan	The legal audit focused on how the existing laws and their implementation affect the life of LGBTI community in Kyrgyzstan	Based on the results of the audit, advocacy strategy for gay and bisexual men and other men who have sex with men was developed	USD 75,000	Bishkek, whole country	NGO “Kyrgyz Indigo”
Development of anti-discrimination law	The local CBO received small funds to support the working group of local experts to draft anti-discrimination law	The work is in process	USD 3,900	Bishkek, whole country	Coalition of NGOs led by NGO “Kyrgyz Indigo”

Amendment to the law about intellectual property	The local NGO advocated for amendments into existing law about intellectual property to allow TRIPS flexibility and thus improve access to treatment with generic medicines for key populations and PLHIV	The impact of the project has not been evaluated yet	USD 24,780	Bishkek, whole country	Harm Reduction Association “Partner’s Network”

Moving to more comprehensive programming

The following recommendations are made to move towards comprehensive programming in monitoring and reforming laws, regulations and policies related to HIV:

- a) Law monitoring and advocacy for reform: Monitoring developments in proposed laws on the re-criminalization of sex work and on “anti-gay propaganda” (Parliament and Ministry of Justice); the development and implementation of an anti-discrimination law (Parliament); and full implementation of Kyrgyzstan’s accepted recommendations from Universal Periodic Reviews⁵⁵ (Parliament and relevant ministries).
- b) Policy advocacy around reform should include:
 - For women, gender-sensitive HIV services through mainstreaming gender-sensitive services into existing HIV diagnostics and treatment (Ministry of Health and of Women)
 - For adolescents, policies that provide access to health services, HIV information and comprehensive sexuality education, without the need for parental consent. These need to cater to the SOGI issues experienced by LGBT adolescents (Ministry of Health)
 - For people who inject drugs, removal of the need to register as a drug addict to receive opioid substitution therapy (Ministry of Health)
 - For ex-prisoners, revisiting the issue of providing passports so they are able to continue on ART, OST or TB treatment; and ensure that pre- and post-release programs assist ex-prisoners to gain access to HIV and TB services in the community (Ministry of Health and State Penitentiary Service).

⁵⁵ https://www.upr-info.org/database/index.php?limit=0&f_SUR=91&f_SMR=All&order=&orderDir=ASC&orderP=true&f_Issue=All&searchReco=&resultMax=300&response=&action_type=&session=&SuRRgrp=&SuROrg=&SMRRgrp=&SMROrg=&pledges=RecoOnly

- c) Monitoring of implementation of regulations should include:
- Ministry of Health policies and recommendations including those related to confidentiality for people living with HIV and people who inject drugs (Ministry of Health and Office of the Ombudsman)
 - Ministry of Internal Affairs' implementation of its policies on evaluation of law enforcement staff and police stations (Ministry of Internal Affairs)
 - Connecting key population members as community monitors to street lawyers and human rights defenders so as to monitor and advocate in the case of barriers to services and to stand for selection to Civilian Advisory Boards (for Ministries of Health, Justice and Internal Affairs); and join Community Advisory Boards for health clinics and the Ombudsman's Office.
- d) Health service delivery advocacy:
- Greater government funding for HIV and TB services, specifically to increase quality of counseling, and to increase the availability of HIV and TB services by well-trained professionals through Family Medicine Centers (Parliament).
 - Free STI services, including for sex workers and gay and bisexual men and other men who have sex with men (Ministry of Health).
 - An allowance for food and transport to assist people with HIV and TB to access
 - Shelters for homeless people who inject drugs and ex-prisoners in Bishkek (Ministry of Interior)
 - Key Performance Indicators related to health, with a monitoring, oversight, and redress system (Ministry of Health, prison authorities, and civil society prisoner advocates).

PA 7: Reducing discrimination against women in the context of HIV

Much of the work carried out to address issues specifically affecting women's rights in Kyrgyzstan are targeted at all women rather than at women from key and vulnerable population. For example, UN Women funded a national campaign aimed at reducing violence against women (funded at US\$300,000), and whilst this may have had some broad impact on all women, it did not address the specific issues that on female sex workers, women who inject drugs or women living with HIV face in relation to intimidate partner, client, community or police violence. While there are several programs outlined below that have worked on issues affecting women from key and vulnerable populations, the approaches used have generally been small and have lacked an overall strategy. Most activities have centered on recording violations of the rights of women in these populations. Most activities have been restricted to Bishkek and Osh.

The following table provides current or recent interventions under this Program Area and a brief description of the activities undertaken, the scale, costs, location and implementer.

Focus	Summary	Scale	Budget	Location	Implementer
Ensuring access to health services for women who inject drugs	Monitoring access of women who inject drugs to quality reproductive health services;	Not reported	USD 39,912	Bishkek, Chuy Oblast	NGO "Asteria"

	documenting human rights violations against women who inject drugs				
Alternative CEDAW report submission	Several local NGOs combined their efforts to prepare, submit and present at the 60 th session of the CEDAW the alternative report about human rights violations against female members of key populations	The alternative CEDAW report submitted. Community members of female sex workers and people who inject drugs trained on how to prepare and submit alternative CEDAW reports	USD 32,912	Bishkek, whole country	Lead NGO NGO "Tais Plus"
Support to victims of gender-based violence against vulnerable groups	Provision of shelter, friendly legal and psychological services to victims of gender based violence amongst representatives of key populations	Not reported	USD 39,982	Bishkek, Chuy oblast	Crisis Center "Chance"
Support to victims of gender-based violence against vulnerable groups	GLORI provides trainings and mentoring support to other NGOs which provide services for victims of gender based violence	Together with partner NGOs provided services to 80 female sex workers and women who inject drugs	USD 70,000	Bishkek, Osh	Global Research Institute
Support to victims of gender-based violence against vulnerable groups	Legal and psychosocial support for key populations, who experienced gender-based violence	6 cases were chosen for strategic litigation, 4 were brought up to Court's decision	USD 19,863	Osh	NGO "Positive Dialogue"
			USD 202,669		

Moving to more comprehensive programming

Many of the interventions proposed in other Program Areas will benefit women from key populations and vulnerable groups. In addition to this a set of interventions that specifically address the discrimination and service barriers faced by women need to be developed. The HIV Gender Assessment conducted in 2013 was only a preliminary one and it is of course acknowledged that a gender analysis is not just about women but about looking at health and wellbeing and access to health services through the lens of gender.⁵⁶ The Gender Assessment did not contain any recommendations for specific programs aimed at addressing some of the complex gender norms and practices that are root causes of some of the discrimination that women in Kyrgyzstan face.

The following is proposed as a comprehensive program to address the discrimination faced by women in relation to HIV:

- a) Continue current programs that support women from key populations and vulnerable groups experiencing gender-based violence;
- b) Conduct a more thorough gender assessment, also looking into SOGI issues and detailed program development exercise in year 1 of the strategy with funds set aside for its implementation in years 1-5, focused primarily on programs that address barriers for sex workers, women drug users, trans women and women with HIV, ensuring that this builds on the work being done in the other Program Areas;
- c) Develop tools and guidance on women's rights and HIV;
- d) Develop and roll out a rapid response procedure that involves appropriate officers (from General Prosecutor's Office, Office of the Ombudsman, National Preventive Mechanism on Torture and other agencies) and key population NGOs in responding to gender-based violence among sex workers.

Investments to date and costs for a comprehensive program

In 2016 a total of around USD 1.3 million was invested in Kyrgyzstan to reduce human rights-related barriers to HIV services. This was out of a total of USD15-16 million spent on the national HIV response.⁵⁷

Major funders and allocated amounts for reduction of human rights barriers to HIV services in 2016 were as follows:

Funding source	2016 allocation
Soros Foundation Kyrgyzstan	USD 388,235
US Government (USAID and CDC)	USD 477,889
Global Fund	USD 293,967
CADAP	USD 47,000
AIDS Fonds	USD 36,399
CoC BtG	USD 30,223

⁵⁶ Gender Assessment: Access to HIV Services by Key Populations in Kyrgyzstan, AIDSTAR-One, USAID, PEPFAR, 2013

⁵⁷ Central Asia PEPFAR Regional Operational Plan (ROP) 2016 Strategic Direction Summary: <https://www.pepfar.gov/documents/organization/257618.pdf>

MPact	USD 20,300
Government	USD 16,400
Other	USD 26,199
Total	USD 1,326,612

Although several funders stated that they were unable to provide exact figures for the amounts allocated to each program area, the assessment team calculated the likely split between program areas by acquiring expenditure data from the funded organizations and matching these to activities under each program area. This gave the following split of funding across program areas to remove human rights-related barriers to services:

HIV Human Rights Barriers Program Area	2016
PA 1: Stigma and discrimination reduction for key populations	\$392,916
PA 2: Training for health care workers on human rights and medical ethics related to HIV	\$65,279
PA 3: Sensitization of law-makers and law enforcement agents	\$224,479
PA 4: Legal literacy (“know your rights”)	\$64,895
PA 5: HIV-related legal services	\$183,610
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	\$36,162
PA 7: Reducing discrimination against women in the context of HIV	\$98,971
Total	\$1,326,612

Estimated costs for the recommended interventions for the five-year comprehensive program set out are set out in the table on the following page. Detailed intervention areas and costs are set out in Appendix 3.

Costing for 5-year comprehensive program – HIV

HIV Human Rights Barriers Program Area	Year 1	Year 2	Year 3	Year 4	Year 5	Total
PA 1: Stigma and discrimination reduction for key populations	577,404	585,404	577,404	585,404	577,404	2,903,020
PA 2: Training for health care workers on human rights and medical ethics related to HIV	101,143	88,279	88,279	88,279	88,279	454,2599
PA 3: Sensitization of law-makers and law enforcement agents	405,650	406,911	406,911	400,891	400,891	2,051,199
PA 4: Legal literacy (“know your rights”)	68,890	68,890	68,890	68,890	68,890	344,450
PA 5: HIV-related legal services	196,474	196,474	196,474	196,474	196,474	982,370
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	290,940	233,940	201,920	201,920	206,920	1,081,600
PA 7: Reducing discrimination against women in the context of HIV	412,342	352,342	352,342	352,342	352,342	1,821,710
Total	2,052,843	1,932,240	1,892,220	1,894,200	1,891,200	9,638,608

Other interventions

Several other interventions were mentioned as effective or promising and could support the overall effort to reduce human rights-related barriers to services. However, these do not fall within the seven key interventions to reduce stigma and discrimination and increase access to justice. If deemed as important, they would have to be funded out of other funding sources. They include:

- a) Media briefings/trainings on HIV
- b) Training of middle-level local officials on SDG-based strategic planning with a special focus on gender equality and HIV;
- c) Self-support group for women who inject drugs
- d) Trainings for sex workers on safety at work (how to protect themselves, safety tips)
- e) Shelters that provide safe spaces for sex worker victims of gender-based violence
- f) After many years, a training manual for teachers of secondary schools on healthy lifestyles with a focus on reproductive/sexual health and rights, which includes sexuality, sexual health and rights, was officially approved by the Ministry of Education and is part of the extra-curricular education of school children in Grades 6-11.
- g) Rehabilitation services, drop-in centers and re-socializing services.

IV. Baseline Assessment Findings: Tuberculosis

Overview of epidemiological context and key and vulnerable populations

Tuberculosis is a major killer in Kyrgyzstan, particularly in prisons, where rates of infection are significantly higher than in the general population. Kyrgyzstan is among the 30 countries with the highest multidrug-resistant (MDR) TB burden in the world. Key populations include people who inject drugs, prisoners and mobile populations. Key informants consistently stated that mobile populations, including internal migrants, experienced the greatest barriers in terms of access to diagnosis and treatment of TB. While women's migration for work is higher than men's, TB treatment success rates and other data are not disaggregated by sex, so it is difficult to tell if women are more likely to be lost to follow-up. Children in families where one or more adults has TB (even if the adult(s) are successfully being treated) are also considered as a population with specific needs that should be met through a combination of changes to medical service provision and reduction of human rights barriers. People with TB living in rural areas often present to clinics and diagnostic centers very late in their illness due to lack of access to information and diagnostic services.

Overview of the policy, political and social context relevant to human rights-related barriers to TB services

Protective laws and regulations (with challenges of enforcement)

In the section on HIV above, the assessment presents the range of protective laws relating to health that should also benefit TB key populations. The Law of the Kyrgyz Republic of May 18, 1998, No. 65 "On protection of the population against tuberculosis" sets out guarantees to access to quality diagnostic and treatment services as well as provision of legal support in relation to TB. It also contains social support, including assistance with employment, and retraining of TB patients who became disabled due to TB.⁵⁸ TB patients without stable sources of income, including children, are entitled to monthly monetary support from the government. The TB Law was recently updated, including the removal of mandatory treatment mechanisms for MDR and XDR TB patients. However the law is not consistently enforced, and some key informants see the need for more work on its harmonization with other laws.

Most KIs expressed general support for specific Ministry of Health (MoH) regulations related to HIV and TB, singling as especially helpful Government Decree dated 29 November 2011 that provides that prisoners with terminal TB, or active forms of TB that require surgery, or patients who failed MDR/XDR treatment and have cardiopulmonary insufficiency can be released from prison.

There are, however, also laws, policies and practices that create barriers to TB services. They are described in detail below.

⁵⁸ <http://cbd.minjust.gov.kg/ru-ru/npakr/DocumentList?documentListId=60817dc8-92de-4581-aa71-a286222f3f69> (amendments #138 as of July 31,2017; amendment #16 as of April 21, 2011, amendment #94 as of June 30, 2016)

Political and social environment/political and funding support for the TB response

Kyrgyzstan has approved its new national TB Strategy in October 2017, but implementation of the previous strategy was inconsistent. Ongoing economic problems within the country have caused shortfalls in budgets across all areas, and TB services have been affected. UNDP is the Principal Recipient (PR) for the Global Fund TB grant. In addition to an overall funding shortfall, there are activities funded by the Global Fund that are unlikely to be taken up through government funding. In particular, TB NGOs fear that they will not receive government funding as there is no social contracting system in place, and the Ministry of Health has shown little interest in funding NGOs that work on TB.

Human rights-related barriers to TB services

Overview

The major barriers set out below were found to be prominent in discussions with key informants and with members of key populations in focus groups. Depending on the key informant's specific work area, various populations were seen as having more or fewer barriers, but overall:

- a) People with TB, or people assumed to have TB experience high levels of stigma and discrimination from health workers, community members and sometimes from extended family. This is more prominent for people known to have multidrug-resistant TB.
- b) Gender norms and practices and gender-based violence present a significant barrier to services. Men exhibit poor health seeking behavior in relation to TB – not considering their symptoms to be important or serious, so not visiting clinics. Women with TB reporting gender-based violence from their sexual partners due to their TB status.
- c) There is a set of punitive or unhelpful policies, regulations and practices that contribute to barriers people experience in accessing TB services.

Stigma and discrimination

Fear of TB infection appears to be a serious source of the stigma surrounding it. As it is airborne, TB is sometimes more feared than HIV, and many people believe that just being near someone who has or has had TB will make them ill. Furthermore, TB is considered by the general public to be shameful as TB is believed to be prevalent among or related to people who are poor and/or dirty. As such, many feel TB infection should be hidden from neighbors and even from family members.

Most key informants mentioned issues of stigma and discrimination by healthcare workers who have high levels of fear of becoming infected with TB. The TB key populations that are most stigmatized in the health system are people who inject drugs, particularly those who are ex-prisoners, and women who inject drugs (especially those who are pregnant).

Many key population members felt that the highest levels of stigma are experienced at Family Medical Clinics (FMCs). Because of this, some will travel hundreds of kilometers to be treated at an Oblast TB Center. Many cite confidentiality as a core concern, but others simply believe they will not receive fair and professional treatment at the FMC. Also, FMC doctors tend to believe TB is not a condition that they should be treating and believe they should refer patients to specialist TB Centers.

Gender norms and practices and gender-based violence

Men and women in Kyrgyzstan present different sets of barriers that affect the timely diagnosis and treatment initiation and adherence. One of the key gaps in defining gender sensitive responses in TB programming is the lack of data that would allow for gender-sensitive prevention messaging and TB health service delivery⁵⁹. In order to strengthen monitoring and evaluation systems to capture gender dimensions of TB, a gender analysis has been undertaken to make key interventions more gender responsive. The 2016 Kyrgyzstan gender assessment conducted for the StopTB Partnership identified a set of barriers to TB prevention, diagnosis and treatment services that had a gender dimension.⁶⁰ These included:

- a) Even though stigma and discrimination was experienced by all people interviewed for the gender assessment, a higher burden was identified among women and girls:
 - Women expressed fears about reproductive health and the perception by their husbands, family and community about their ability to have healthy children and therefore their legitimacy as ‘mothers’.
 - Single women feared that disclosure would mean that they would never be able to marry.
 - Some women interviewed had been rejected by husbands and had lost access to their children.
- b) There is a strong set of gender stereotypes operating in Kyrgyzstan that set up an expectation that women will be mothers, running a household and bringing up children, and that men will have a decision-making and breadwinning roles. This affects the freedom that women have to access health services if their husband does not permit it and the freedom they have to spend family money on their own health.
- c) Women often put themselves ‘last in line,’ for health service access in the family, particularly if funds are scarce.
- d) Men do not exhibit health seeking behavior in general in Kyrgyzstan, (attributed to notions of strength and masculinity) and tend to ignore symptoms or self-treat.
- e) General high levels of alcohol use among the male population was also linked to family poverty, men’s general ill-health and gender-based violence.
- f) Many women affected by TB interviewed in the gender assessment report violence by husbands and other family members when they were diagnosed with TB.
- g) Some women reported coerced abortions by health workers who told them that their child would be born with birth defects as a result of their TB diagnosis and treatment.

Punitive laws, policies and practices

Problematic laws

Some laws relating to TB were found to hinder services or contribute to stigma or discrimination towards key populations vulnerable to TB:

- a) Travel restrictions relating to TB - Kyrgyzstani people migrating for work to other countries (primarily Kazakhstan and Russian Federation) are required to get testing for TB and must test negative before migrating. This requirement leads many Kyrgyzstani

⁵⁹ As recommended in the Technical Brief Tuberculosis, Human Rights and Gender Equality. Global Fund (2017). https://www.theglobalfund.org/media/6349/core_tbhumanrightsgenderequality_technicalbrief_en.pdf

⁶⁰ Kyrgyzstan Gender Assessment, Stop TB Initiative, 2016

people to migrate illegally. Even those who migrate legally often do not have a written employment contract and cannot benefit from health services, including TB services, in the destination countries. However, draft bilateral agreements have been developed between Kazakhstan and Kyrgyzstan and between Kyrgyzstan and Tajikistan to ensure the migrants have access to TB services while they work outside their home countries. These agreements have not yet been signed.

- b) In the Law on Narcotic Drugs, Psychotropic Substances and Precursors (22 May 1998), compulsory drug treatment can be enforced by a court decision based on a written request from the relatives. Similarly, the Criminal Code sets out compulsory TB treatment for prisoners.

Problematic regulations and treatment provision

Though the laws provide for TB treatment, care and support, as well as workers' compensation for medical personnel in the case of acquiring TB in the workplace, there are several problems with consistent implementation of these protective laws, as well as with the nature of the provision of treatment. Many populations are disadvantaged in accessing TB treatment and some regulations hinder access further:

- a) **DOTS provision** - The lack of flexibility surrounding the way Directly Observed TB Treatment (DOTS) is implemented means that many people on TB treatment are forced to choose between securing or staying in employment, or maintaining the full course of TB treatment. With regard to MoH regulations on TB medications, especially for drug-resistant TB, Medecins Sans Frontieres (MSF), Koninklijke Nederlandse Chemische Vereniging (Royal Dutch Chemical Association or KCNV) and International Committee of Red Cross/Red Crescent (ICRC) are piloting the use of medications that would make long-term outpatient DOTS for DR-TB patients more manageable for both doctors and patients.
- b) **Worker compensation** – There is lack of clarity and lack of enforcement regarding the compensation to be provided if a doctor or nurse acquires TB at work. As the change from hospital-based to ambulatory treatment of TB patients accelerates, there are likely to be many more people with active TB seeking testing and treatment at poly-clinics and family medical clinics. If a doctor or nurse acquires TB from a patient, there is difficulty in receiving compensation, yet the healthcare provider will lose income and will have to pay for parts of the treatment (such as X-rays, etc). This is a great source of fear among family doctors and causes many to refuse to treat TB patients as outpatients. By law, the healthcare worker should receive 120 months' pay as compensation, but this is rarely if ever provided. Clinic directors generally dismiss the worker before he or she can claim compensation.
- c) **Imprisonment** is a barrier in itself. TB infection rates among prisoners are significantly higher than among the general population. Prevention of TB transmission in prisons is given a low priority. While TB treatment is generally available in most prisons, serious treatment disruptions occur when prisoners are transferred between facilities and when they are released from prison.
- d) Need for an **internal passport** to ensure access to health services - Many key population members (especially those who are ex-prisoners) either do not have, or have lost, this key document. The passport links a person to a specific health clinic at their place of residence and means that, for a range of services, including TB services, if they move elsewhere, they

need to get re-registered at a local clinic, which requires identification and often requires attendance at the original medical clinic.

- e) **Challenges for mobile populations, including internal migrants:** These populations often move from rural villages to large urban centers and perhaps move several times during the 18-month course of TB treatment. They often begin drug-resistant TB treatment in their home village and are lost to follow-up when they move. The change from hospital-based to ambulatory care at family medicine clinics would assist this population, but there also needs to be (i) changes in MoH regulations regarding the need for passports, identification papers and approval from the “home” medical clinic where treatment began; (ii) family doctors in the nearby area need to be willing to provide treatment which is often not the case; and (iii) for the person to remain employed, DOTS may need to be delivered outside working hours which is often not possible.
- f) **Challenges for children and adolescents** - Children face specific barriers. As part of the national policy and guidelines on TB care, children in families where one or more adults has TB are often forcibly sent to a sanatorium for six to nine months (reduced recently from two years). This is done to protect the child from catching TB from the parent, but has a very disruptive effect on the family. This situation is an unfortunate byproduct of the move towards greater ambulatory care. Formerly, when the adult with TB was forcibly hospitalized, the child could stay at home. Representatives of international TB technical advisory organizations admitted that the problem of how to assist children in this situation is the subject of intense debate globally. However, there are several ways that housing can be set up to ensure the safety of a child while continuing to live with an adult with TB. Adolescents, on the other hand, generally cannot access most TB services without permission from a parent. TB patients with tuberculosis of the osteoarticular system, urogenital tuberculosis, or central nervous system tuberculosis cannot be an adoptive parent or guardian for a child as per the Government Decree about adoption of children by Kyrgyzstani citizens or foreigners dated 27 October 2015.
- g) **Challenges for ex-prisoners** - Upon release, ex-prisoners who may be on TB treatment, ART, and/or opioid substitution therapy often have no identification papers and there are no mechanisms in place to support them to continue the treatment they have begun in prison. Many ex-prisoners end up homeless and extremely ill on the streets of Bishkek without any agency having the mandate to assist them. The Republican Narcology Hospital sometimes admits homeless people as narcology inpatients (even if they are not interested in stopping their drug use), just to give them a bed, food and a chance to stabilize their treatment and infections.
- h) **Challenges for people who use drugs** – TB disproportionately affects people who use drugs, who are required to register with narcological services as a person who uses drugs in order to receive OST services (with which DOTS treatment is combined in some places). Several key informants suggested that registration with Narcology is a major impediment to the uptake of opioid substitution therapy services as this registration carries implications for employment, driving, etc. and discrimination can result if this information is shared with the police.
- i) **Problematic hospital regulations** - While Kyrgyzstan is moving towards greater outpatient care for TB, many people are still initiated on TB treatment (especially DRTB) in hospitals. Patients are removed from treatment after a single breach of hospital rules. This often happens to people who inject drugs. Many TB hospitals and clinics do not

provide OST so people who are dependent on drugs leave the hospital to acquire or use drugs. If the patients inform their respective OST site, OST sites can arrange weekly deliveries of methadone to the hospital. However, sometimes doctors forget to take into account the effect that some TB medicines have on reducing the effectiveness of methadone, increasing the likelihood of withdrawal. Furthermore, methadone can increase severity of side effects from some TB medicines. For these reasons, some TB hospitals require OST patients to stop OST before starting their TB treatment as some hospital staff do not want to deal with the medicines that requires special storage measures.

- j) **Challenges for people living in poverty** - Poverty is a significant factor in hindering access to TB treatment, despite most aspects of the treatment being free of charge. In the main cities, out-of-pocket payments for basic medical services have become rarer, but they remain prevalent in rural areas. In addition, there are several costs which are routinely charged but cause problems for key populations: X-rays before TB treatment can begin; contraception; STI counseling, diagnosis and treatment. One key informant estimated that most TB patients pay 15,000 KGS (USD 220) per year for ‘side expenses’. Added to these expenses are the issues of transport costs (as one patient may need to visit three or more different health facilities, often kilometers apart), and the inflexibility of most medical delivery systems (especially opioid substitution therapy and DOTS) that make it very difficult to maintain treatment and to work. Finally, nutritious food is required to optimize TB treatment (especially DRTB) medications. Many key populations, particularly among those who are homeless, cannot afford sufficient nutritious food to cope with the medications. It was mentioned that it would be important to have shelters for homeless people where they can continue to receive TB treatment.
- k) Having TB can be a barrier for employment in a wide range of jobs.⁶¹

Lack of knowledge of rights

Very few people that have TB or their families know their rights or the laws related to health and TB. This prevents them from organizing around those rights and laws to stop discrimination and get better health care.

Illegal police practices

Few key informants reported specific problems with law enforcement related to TB services. However, two of the largest populations in need of TB services in Kyrgyzstan are people who inject drugs and prisoners. As described above in the HIV section, these key populations face serious illegal police practices that affect their access to all health services, including those related to TB.

Lack of access to legal services

This assessment found no evidence of systematic provision of either education about legal rights or legal services to people with or at risk of TB. Some key informants working with people who inject drugs said people who inject drugs generally are better informed about their rights now than they were five years ago, while other key informants said people who inject

⁶¹ Decree of the Government of the Kyrgyz Republic No. 294 (dated May 31, 1999) (contains a long list of jobs that prohibited for people with TB)

drugs are in the greatest need for legal services as they require specific documents to access a range of services.

Current and recent interventions to reduce human rights-related barriers to TB services

This section describes the current or recent programs that have been implemented in Kyrgyzstan to remove human rights-related barriers to TB services and proposes a comprehensive program based on the ten program areas set out in the Global Fund *HIV, Human Rights and Gender Equality Technical Brief*.⁶²

The ten Program Areas are:

PA 1: Reducing stigma and discrimination

PA 2: Reducing gender-related barriers to TB services

PA 3: TB-related legal services

PA 4: Monitoring and reforming policies, regulations and laws that impede TB services

PA 5: Know your TB-related rights

PA 6: Sensitization of law-makers, judicial officials and law enforcement agents

PA 7: Training of health care workers on human rights and ethics related to TB

PA 8: Ensuring confidentiality and privacy

PA 9: Mobilizing and empowering patient and community groups

PA 10: Programs in prisons and other closed settings

Currently, several non-government and community-based organizations, as well as government entities, are working in TB awareness, case finding, treatment support and on addressing some of the human rights-related barriers to TB services. However, the programs they implement do not fully cover each program area, are being implemented at a relatively small scale.

PA 1: Stigma and discrimination reduction

There does not appear to have been many specific interventions to reduce stigma and discrimination related to TB. One key informant noted the project involving religious leaders in raising awareness and tolerance towards TB patients. Last year, on TB Treatment Day, there were 1,770 Friday Prayers conducted all over the country, where TB specialists together with imams provided information about TB. Budget information for existing and current interventions was extremely difficult to obtain.

The following table provides current or recent interventions under this Program Area and a brief description of the activities undertaken, the scale, costs, location and implementer.

⁶² Technical Brief *Tuberculosis, Gender and Human Rights*, Global Fund to Fight AIDS, TB and Malaria (April 2017)

Focus	Summary	Activities	Budget	Location	Implementer
Involving religious leaders in raising awareness and tolerance towards TB patients.	Defeat TB project conducted sensitization round tables with imams on rayon level, and trained imams of the mosques on TB and stigma and discrimination issues	1,770 supportive messages at Friday prayers	USD 30,000	Bishkek, Osh, Kara Suu, Jalal Abad	Defeat TB
Shelters for homeless TB patients	In order to improve the continuum of TB care, homeless TB patients are provided shelter for the period of their outpatient treatment	54 patronage clients 10 clients are living any time at the shelter		Bishkek, Chuy Oblast	NGO "Alternative to Narcology" funded by Defeat TB project
			USD 30,000		

Much less work is being carried out to reduce barriers to TB services caused by stigma and discrimination than is done for barriers related to HIV. A large part of the reason for this seems to be the dearth of NGOs working on these issues in Kyrgyzstan. While some HIV-focused NGOs who work with PLHIV and people who inject drugs also advocate for stigma reduction related to TB, this is very much an adjunct to their core work on HIV. A small number of very new NGOs have been formed recently to work specifically on increasing access for key populations to TB services.

Moving to more comprehensive programming

In order to reduce stigma and discrimination related to TB, increased support needs to be provided to expand activities to measure stigma and discrimination against people with TB and to advocate for policies and practices that will reduce such stigma and discrimination in communities. It is recommended that community mobilization and education on stigma and discrimination be expanded for all TB key populations, at least in Bishkek, Osh, Chui Oblast and Jalalabad. The following activities are recommended:

- a) Support TB NGOs/networks to:
 - Assist nascent TB NGOs to effectively work to reduce stigma and discrimination among key populations

- b) Support TB NGOs/networks (and HIV NGOs working with TB key populations such as PLHIV and people who inject drugs) to:
 - Implement campaigns and support groups to reduce community and self-stigma related to TB, and
 - Sensitize and engage opinion and religious leaders to increase tolerance toward and acceptance of people with TB.
- c) Support to the Ministry of Health to:
 - Undertake a national campaign to address stigma and discrimination experienced by people with TB, including promoting clear information about each disease, how it is and is not transmitted, how it is important to get tested and on treatment, and how stigma is harmful and unnecessary; and
 - Disaggregate TB diagnostics and treatment statistics by sex.

In addition, validated measurements of TB stigma need to be carried out on a regular basis.

PA 2: Reducing gender-related barriers to TB services

While donors claimed that a small amount of funding had been provided to address gender-related barriers to TB in 2016, it was difficult to find any specific activities that would fit into this program area, apart from a gender assessment of TB services available in Kyrgyzstan conducted by Stop TB Partnership. The Defeat TB Project supports regular meetings of the MoH TB Coordination Council and issues of gender-related barriers to TB services are considered there.

Moving to more comprehensive programming

- a) For women, mainstream gender-sensitive TB and HIV services into existing TB and HIV diagnostics and treatment and antenatal care. Systematic collaboration among TB, HIV and maternal and child health service providers is recommended for optimizing women's access to TB services and information. (Ministry of Health and of Women).
- b) Outreach to women in areas with high burden of TB, encouraging them to come forward for testing and early detection.
- c) For men, identify a set of entry points into broader work being done to improve men's health seeking behaviors and work to include awareness of TB symptoms and treatment in these.
- d) Prepare and disseminated a set of plain-language materials that address myths about TB, particularly those that result in stigma and discriminating against women and girls.

PA 3: TB-related Legal Services

Provision of legal services was regarded as an important service for key populations and vulnerable groups, but it seems that in 2016 no funds were allocated to TB legal services.

The state-guaranteed legal aid in Kyrgyzstan, established based on the 2009 Law, and reconceptualized through the December 2016 law, faces challenges in operationalization. One of the main novelties is introduction of the right for professional legal services in civil and administrative cases, not just in criminal cases. In addition, the new law widened the circle of individuals who are entitled to receive state guaranteed free legal aid. A center for coordination of the state-guaranteed legal it to be opened under the Ministry of Justice of Kyrgyzstan and will represent an important opportunity for synergies and partnership.

Since 2014, UNDP and the Ministry for Foreign Affairs of Finland have brought together legal institutions, an independent bar association and civil society organizations and set up 14 offices to give vulnerable people in pilot Osh and Chui regions access to free legal aid. A group of lawyers visited 173 villages in the Osh and Chui regions with the “Solidarity Bus,” providing 3,367 free legal consultations to citizens in these remote areas. In 2016, the project provided 18,091 oral and written legal consultations, 98 representations outside the courts and 82 at the courts⁶³. While not HIV or TB specific, such efforts increase the potential for people with TB and key populations at risk of TB to access legal services.

To ensure that people with TB have access to legal services, the existing and future TB NGOs need access to legal support to provide legal services as needed. The legal assistance processes established under the HIV comprehensive program should be sufficient to provide most of these services with little additional funding.

Moving to more comprehensive programming

- Expansion of legal support so that all TB NGOs have access to affordable or *pro-bono* lawyers for casework, legal defense and strategic litigation, where necessary

PA 4: Monitoring and reforming laws, regulations and policies relating to TB services

Though many key informants acknowledged that the legislative and regulatory basis of the response to TB contains some good protective provisions, there was a clear need to address some of the lack of enforcement of these provisions as well as address some of the harmful policies impeding access to treatment described above. Though UNODC, ICRC, MSF and KfW are involved in addressing legal and regulatory issues related to TB, few or no TB NGOs or representative groups of people with TB and their families are supported to be involved in such efforts.

Stop TB Partnership and Kyrgyz Coalition against TB conducted a national legal audit of legislation and normative acts regulating access to TB diagnosis and treatment in Kyrgyzstan.

Recently, Kyrgyzstan has developed several strategic documents addressing TB prevention and care through a health systems approach, such as the “TB Roadmap” on optimization of TB services, and “Tuberculosis 5”, a national 5-year TB programme, where people-centered TB care is provided for, and a meaningful reduction of excessive TB bed capacity and further implementation of ambulatory models of treatment is strengthened. A blueprint on “A people-centred model of tuberculosis care” has been developed in the frame of the GF-funded Tuberculosis Regional Eastern European and Central Asian Project (TB REP) that also includes Kyrgyzstan. Among planned follow-up is considering and addressing possible legislative barriers and bottlenecks preventing further progress towards more people-centeredness in TB services in the country

The following table provides current or recent interventions under this Program Area and a brief description of the activities undertaken, the scale, costs, location and implementer.

⁶³ UNDP (2017) Legal aid for vulnerable groups in Kyrgyzstan. <http://www.eurasia.undp.org/content/rbec/en/home/ourwork/democratic-governance-and-peacebuilding/successstories/legal-aid-for-vulnerable-groups-in-kyrgyzstan.html>

Focus	Summary	Activities	Budget	Location	Implementer
Legal audit	Stop TB Partnership and Kyrgyz Coalition against TB conducted legal audit of legislation and normative acts regulating access to TB diagnosis and treatment in Kyrgyzstan.	Audit of existing legislation was conducted	USD 8,000	Whole country	STOP TB partnership
Changing the clinical protocols to improve access to new generation drugs with better treatment success rates	By introducing the new clinical protocols, advocacy for including new generation TB drugs into national list of essential medicines and advocating for changes in legislation that would enable use of compassionate treatment programs, KNCV is removing some legal barriers TB patients face in accessing health care services	Clinical protocols updated, new national list of essential medicines includes bedaquiline, amendments to the law about medicines is being discussed	USD 190,000	Bishkek, whole country	
			USD 198,000		

Existing programs have largely focused on changing regulations to allow ambulatory care of TB patients and most of these changes to regulations have now been made.

Moving to more comprehensive programming

- a) Monitoring and reforming laws, regulations and policies relating to TB. In addition, there is a need to ensure confidentiality and privacy related to TB diagnosis, mobilize and empower TB patient and community groups, address overly-broad policies regarding

involuntary isolation or detention for failure to adhere to TB treatment, and make efforts to remove barriers to TB services in prisons

- b) Changes to the way that Family Medical Centers doctors and nurses are compensated for working with TB outpatients, together with protective measures to reduce the likelihood of health care workers being infected with TB and appropriate compensation for health care workers who do get infected with TB (Ministry of Health).
- c) Advocacy and mobilization around policy reform regarding:
 - Streamlining the 'change of address' needed for TB treatment for internal migrants (Ministries of Health and Migration)
 - Revisiting the issue of providing passports for ex-prisoners so as to be able to continue on ART, OST or TB treatment; and ensure that pre- and post-release programs assist ex-prisoners to gain access to HIV and TB services in the community (Ministry of Health and State Penitentiary Service)

PA 5: Knowing your TB-related rights

Legal literacy, "Know your rights", trainings for TB patients were mentioned by several key informants.

The following table provides current or recent interventions under this Program Area and a brief description of the activities undertaken, the scale, costs, location and implementer.

Focus	Summary	Activities	Budget	Location	Implementer
Cascade of the trainings for the public health specialists on primary health care level had been delivered	TB-Defeat project (USAID) and Republican Health Promotion Center	The guideline including "know your TB-related rights and responsibilities" for primary health care institutions had been developed and trainings according to new guideline was delivered for 36 partner organizations	USD 60,000	Rural health care committees in Osh, Jalal Abad, Chui Oblasts	Defeat TB
Contest on "know your TB-related rights and responsibilities" among journalists, contest among	TB-Defeat project (USAID) and Republican Health Promotion Center	During the contest reporters and mass media delivered number materials via TV channels, radio etc. As a result of the contests		Whole country	Defeat TB

TB patients, Round Tables		the Project and the Republican Health Promotion Center (RHPC) posted 10 videos via social networks			
Trainings for the patients through the medical staff of family medicine centers and TB hospitals	KNCV Tuberculosis Foundation	Partner organizations – staff of the family medicine centers and TB hospitals delivered cycle of trainings on ‘know your TB related rights’	USD 60,000	Osh, Jalal Abad, Chui Oblasts, Bishkek	KNCV
			USD 120,000		

While it was estimated by donors that substantial funds were invested in these programs, focus groups and key informant discussions found there were serious deficits in knowledge of rights among a wide group of key populations. Given that large numbers of people with and at risk of TB are living in rural areas, a large-scale program of rights education is required, including use of media and outreach through a variety of community groups and associations.

Moving to more comprehensive programming

- Expansion of “know your rights”, including patients’ rights, education and legal literacy for all key populations regarding TB with a view to develop advocacy and mobilization around TB human rights-related issues.

PA 6: Sensitization of law-makers, judicial officials and law enforcement agents

It is estimated that, in 2016, no specific funds were allocated to sensitizing law-makers, judicial officials and law enforcement agents related to TB. To some extent, some of this activity may have been carried out using HIV funds.

Moving to more comprehensive programming

- Training of police on TB and human rights; ensuring that all new entrants to police receive this training. TB NGOs ensure training includes TB among key populations
- Annual report from Ombudsman and evaluations of police stations.

PA 7: Training of health care providers on human rights and medical ethics related to TB

While some donors reported allocation some funds that in 2016 for the training of health care providers on human rights and medical ethics related to TB, it was difficult to find evidence of the results of this expenditure. It is true that there were many donor-funded programs in recent years to train medical staff in aspects of TB care such as case-finding ambulatory care and in the use of new medicines, but training specifically on human rights and ethics has been a minor part of this larger training program.

It is recommended that a substantial program, linked to the suggested program for HIV, be undertaken to fully institutionalize training of doctors, nurses and health administrators on medical ethics and human rights

Moving to more comprehensive programming

- Institutionalize training of doctors to the family medicine clinic (FMC) level about HIV and TB and the rights and ethics related to them (e.g. nondiscrimination, duty to treat, confidentiality and informed consent), and ensure safe working conditions for FMC staff.
- Institutionalize a course in undergraduate education for doctors, nurses and health administrators on medical ethics and human rights obligations, with specific reference to reducing stigma and discrimination
- Supporting a consistent involvement of multi-disciplinary team structure across health clinics (including FMCs) that either employ peer educators/counselors) or work in close collaboration with NGOs with peer educators/ counselors on staff to assist key populations through testing onto treatment and adherence for both HIV and TB and to monitor discrimination in health care provision,
- Regular monitoring of stigma and discrimination in TB services.

PA 8: Ensuring confidentiality and privacy related to TB

It seems unlikely that a stand-alone program attempting to address confidentiality and privacy for TB patients would be effective, given that similar issues exist for people living with HIV and many other diseases. For this reason, it is recommended that confidentiality is emphasized in institutionalized training of doctors on TB and in training and support for NGOs and people from key populations.

PA 9: Mobilizing and empowering TB patient and community groups

The Anti-AIDS Association of legal entities, the local implementing partner in the GF-funded Tuberculosis Regional Eastern European and Central Asian Project (TB REP), has convened in September 2016 17 CSOs which constituted the national platform of NGOs working on TB⁶⁴.

However, very little has been achieved to date in mobilizing and empowering patient and community groups working on TB. The CCM includes TB community representation.

What is required is a major expansion of NGOs working on community mobilization among TB patients nationally and in the areas with the highest TB burden.

⁶⁴ Success Story within the framework of the "Kyrgyzstan Free of TB" project of the Anti-AIDS Association (AAA) of legal entities of the Kyrgyz Republic, http://www.tbcoalition.eu/wp-content/uploads/2017/02/Kyrgyz_SS_En.pdf

Moving to more comprehensive programming

The following initiatives are recommended:

- Support HIV NGOs/networks to:
 - Mentor and foster the development and expansion of NGOs working specifically to advocate for the needs of people with TB.
- Support to the Ministry of Health to:
 - Re-institute Community Advisory Boards of key population members at TB Centers and narcological clinics to increase access to services and decrease stigma.

PA 10: Programs in prisons and other closed settings

Most key informants familiar with the prison system agreed that much good work has taken place there over many years, but issues such as overcrowding and the increasing number of convicted terrorists had resulted in a winding back of peer programs. Prison authorities appear to have severely restricted interactions between prisoners, fearing radicalization of prisoners.

Many also referred to programs that existed in the past for pre- and post-release to help ex-prisoners maintain adherence after leaving prison. The ICRC continues to fund some services related to TB, but it is now more difficult for NGOs to work closely with the prison system. Key informants stated that a previously-funded program of training for medical and non-medical prison staff had led to significant changes in staff attitudes towards prisoners with TB. They believed that this training program should be reinstated and provided nationally.

The only allocation that appears in this program area for 2016 was small allocation for a mobile TB treatments team that played a role in ensuring TB treatments access in prisons.

Moving to more comprehensive programming

- Reinstatement training programs for penitentiary staff

Investments to date and costs for a comprehensive program

It is estimated that a total of USD 478,000 was allocated in Kyrgyzstan to reduce human rights-related barriers to TB services (out of a total expenditure on TB of about \$25 million in 2016⁶⁵). Major funders for reduction of human rights barriers to TB services in 2016 were as follows:

KNCV (funded by USG)	USD 250,000
Global Fund	USD 23,442
USAID	USD 200,000
Total	USD 473,442

⁶⁵ WHO TB Country Profile Kyrgyzstan

https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=KG&outtype=pdf

Although several funders stated that they were unable to provide exact figures for the amounts allocated to each program area, the assessment team calculated the likely split between program areas by acquiring expenditure data from the funded organizations and matching these to activities under each program area. This gave the following split of funding across program areas to remove human rights-related barriers to services:

TB	2016
PA 1: Stigma and discrimination reduction	USD 30,000
PA 2: Reducing gender-related barriers to TB services	USD 20,000
PA 3: TB-related legal services	0
PA 4: Monitoring and reforming laws, regulations and policies relating to TB services	USD 200,000
PA 5: Knowing your TB-related rights	USD 120,000
PA 6: Sensitization of law-makers, judicial officials and law enforcement agents	0
PA 7: Training of health care providers on human rights and medical ethics related to TB	USD 90,000
PA 8: Ensuring confidentiality and privacy	0
PA 9: Mobilizing and empowering patient and community groups	0
PA 10: Programs in prisons and other closed settings	USD 15,442
Total	USD 473,442

As can be seen from the descriptions of interventions provided in the section above, very few effective interventions and activities have been put in place. Coverage of affected populations is insufficient and not clearly strategic across barriers and populations affected by them.

It should be underlined that many key informants referred to the important role that NGOs have played in working with key populations on HIV issues, but few NGOs have so far worked on removing human rights barriers to TB services.

Estimated costs for the recommended interventions for the five-year comprehensive program set out are set out in the table on the following page. Detailed intervention areas and costs are set out in Appendix 3.

Costing for 5-year comprehensive program – TB

TB Human Rights Barriers Program Area	Year 1	Year 2	Year 3	Year 4	Year 5	Total
PA 1: Stigma and discrimination reduction	239,600	242,600	234,600	234,600	242,600	1,194,000
PA 2: Reducing gender-related barriers to TB services	270,800	185,800	185,800	185,800	185,800	1,014,000
PA 3: TB-related legal services	82,724	82,724	82,724	82,724	82,724	413,620
PA 4: Monitoring and reforming laws, regulations and policies relating to TB services	122,192	77,192	72,192	77,192	72,192	420,960
PA 5: Knowing your TB-related rights	120,000	120,000	120,000	120,000	120,000	600,000
PA 6: Sensitization of law-makers, judicial officials and law enforcement agents	21,684	6,000	6,000	6,000	6,000	45,684
PA 7: Training of health care providers on human rights and medical ethics related to TB	145,864	88,000	88,000	88,000	88,000	497,864
PA 8: Ensuring confidentiality and privacy	28,348	28,348	28,348	28,348	28,348	141,740
PA 9: Mobilizing and empowering patient and community groups	314,796	314,796	314,796	314,796	314,796	1,573,980
PA 10: Programs in prisons and other closed settings	33,000	33,000	33,000	33,000	33,000	165,000
Total	1,379,008	1,178,460	1,165,460	1,170,460	1,173,460	6,165,488

Costing limitations

The costing component of the baseline assessment was a rapid investment analysis, therefore it should not be viewed as a full-fledged resource need estimation. The retrospective costing has informed the estimation of intervention-level costs, hence the limited data collected through the baseline assessment inherently affected the prospective costing.

The baseline assessment encountered certain limitations in the costing component both as pertaining to HIV and TB programs aimed at removing human rights-related barriers:

- Certain key stakeholders were not able to take part in the data collection due to competing priorities. As a result, an important viewpoint on human rights barriers and on the effectiveness of current efforts to address them may be missing from the analysis. Stakeholders that could not participate also included a number of bilateral partners and, as a result, the description of current efforts to address and remove barriers may not include what these entities are currently funding or undertaking directly.

More specific limitations and challenges to the collection of financial data included:

- It appeared that a number of organisations felt that the information requested was too sensitive to share even though it was indicated in the invitation messages that the data would be consolidated and anonymised at the implementer level.
- Some organisations appeared to take the position that the benefit of completing the exercise was not worth the level of effort required, given other pressures on them.
- Most funders and intermediaries appeared to be unable to disaggregate their investments in combination prevention interventions to the level where funding for programmes addressing human rights barriers could be identified.
- Finally, as the analysis has noted there is a large gap in current and comprehensive quantitative data on a number of the human rights barriers identified by the assessment. As a result, there may be an over-reliance on individual or anecdotal accounts or perspectives which may not, in some cases, be an accurate reflection of an overall, country-wide trend.

The prospective costing of the comprehensive response to removing human rights-related barriers will inform the development of the five-year strategic plan and will therefore likely to change throughout the country-owned participatory plan development process.

Next steps

This baseline assessment will be used as the basis for dialogue and action with country stakeholders, technical partners and other donors to scale up to comprehensive programs to remove human rights related barriers to services. Towards this end, the Global Fund will arrange a multi-stakeholder meeting in country to which it will present a summary of the key points of this assessment for consideration and discussion towards using existing opportunities to include and expand programs to remove human rights-related barriers to HIV and TB services

V. Setting priorities for scaling up interventions to reduce human rights-related barriers to HIV and TB services

Given the nature of barriers in Kyrgyzstan, it is recommended that the primary and early focus be on activities to sensitize and engage police and law enforcement through effective interventions, reduce stigma and discrimination in health care settings, mobilize and empower TB community groups, and provide legal literacy and legal services to key populations. With regard to police sensitization, the following police should be prioritized for developing capacities on HIV, TB and human rights issues - district police officers, drug police and the police involved in criminal investigations. Such systematic engagement and capacity building should include the reasons it is necessary to support health service providers to have proper access to key populations, information necessary to provide referrals to HIV and TB providers, and role of police in upholding rights, good health and ensuring key populations do not go into hiding.

Furthermore, in the first two years of expansion of comprehensive programs to reduce barriers to HIV and TB services, activities should include building capacity of HIV, TB and key population NGOs to better understand the role they can play in reducing barriers related to HIV and TB, in particular how to:

- a) Work with the Offices of Ombudsman and Prosecutor,
- b) Develop community monitoring processes among key population and network members
- c) Build a certification system for street lawyers/paralegals
- d) Work with mobile populations
- e) Play a role in monitoring the work of the Ministries of Health, Justice and Internal Affairs
- f) Build a certification and budget line system for peer educators/counselors within the health system; and
- g) Ensure an effective social contracting system is in place so that NGOs can be funded to provide peer educators/ counselors to health facilities.

There is also a need to support the Ministry of Internal Affairs and the Office of the Ombudsman to build the capacity of management of police stations in selected locations most affected by HIV on the newly introduced evaluation tools and to support the Ministries of Health and Justice to improve their monitoring of the implementation of their regulations.

In Kyrgyzstan there are a number of institutions and processes that are seeking to ensure that law enforcement efforts are based on the law and on the Constitution. These provide real opportunities for more supportive policies and regulations, and greater accountability to and protection of key and vulnerable populations. These include:

- a) Office of the Ombudsman: a relatively small group of investigators and lawyers whose work focuses on corruption and on whether government employees (including law enforcement staff) are working within the Constitution. The Ombudsman is the official

representative of Parliament that monitors the implementation of laws by governmental officials. When laws are violated, the Ombudsman has the right to inform respective governmental agencies (State Committee of National Security, Prosecutor's Office, Ministry of Internal Affairs) and report on the violations to the Parliament. The Ombudsman has representatives in each oblast.

- b) General Prosecutor's Office: a very powerful organization that brings mostly criminal charges against citizens other than government employees (as this has been seen to date as a potential conflict of interest). The General Prosecutor's Office is responsible for overseeing the precise and uniform execution of laws and other normative legal acts of the Kyrgyz Republic. Any citizen or resident of the country can directly apply to the Prosecutor's Office. In case of a violation of a law or the Constitution, the prosecutors can take the case to Court and request punishment for the accused person or agency. The General Prosecutor's office has wide representation all over the country, with prosecutors at each rayon level.
- c) Various National Preventive Mechanisms, including one on torture: this mechanism has been used by NGOs and the Ombudsman's Office to investigate unlawful detention (especially of sex workers) carried out by police.
- d) A Decree from the President has called for the reorganization of the whole law enforcement system, including the role of the Prosecutor, in readiness for the new Criminal Code. This represents a major opportunity for significant changes to the ways that police, in particular, act towards key populations. Both the Office of the Ombudsman and of the Prosecutor showed willingness to be involved in programs to reduce human rights-related barriers. Work on these changes is moving slowly, but it is likely that, as part of these changes, the Office of the Prosecutor will be able to concentrate on government staff. Also as part of this process, a new methodology of evaluation of police staff has been introduced with:
 - Evaluations made by heads of Internal Affairs departments every quarter;
 - Local police stations evaluated by public prevention centers (NGOs registered under municipalities and funded by municipalities) every six months;
 - Population confidence index, a study conducted annually by research institutes.

It is unclear at this time whether these evaluation activities have been fully implemented.

The other major opportunity presented in Kyrgyzstan is the strong NGO sector that has shown that it is willing to work with agencies of the State to address some of the most important barriers related to law enforcement and with health care providers on stigma and discrimination in health care settings. Government health services and NGOs are working together on multi-disciplinary teams and on training doctors. NGOs are meeting regularly across the key populations to discuss advocacy and other strategies. It should be noted that almost all of this work is being carried out in relation to HIV.

Activities, such as legal literacy and legal services, monitoring and reforming of policies and regulations, and stigma reduction can provide civil society and affected populations with the skills, knowledge and support to advocate for and mobilize to engage these government institutions and processes. There should be special efforts to see that women members of key populations benefit from these activities so that real change can be made in their lives. Activities, under the program areas "sensitization of law-enforcement" and "training of health

care providers in human rights and medical ethics” can further help to support the involvement of and oversight by these institutions.

However, to seize these opportunities and build toward comprehensive programs to remove barriers to HIV and TB services, capacity building will be required in the first and second year of the five-year plan with regard to the following:

- a) HIV key population NGOs need to understand the role they can play in reducing human rights barriers related to TB and in reducing barriers related to both TB and HIV for mobile populations; how to work with the Offices of Ombudsman and Prosecutor; how to develop community monitoring processes among key population members; how to build a certification system for street lawyers
- b) HIV and TB NGOs more generally need to understand how to play a role in monitoring the work (as noted above) of the Ministries of Health, Justice and Internal Affairs; how to build a certification and budget line system for peer educators/ counselors within the health system (and/ or how to ensure an effective social contracting system is in place so that NGOs can be funded to provide peer educators/ counselors to health facilities;
- c) The Ministry of Internal Affairs and Office of the Ombudsman may require technical assistance to build the capacity of management of police stations on the newly introduced evaluation tools. Similarly, the Ministries of Health and Justice may require capacity building to improve their monitoring of the implementation of their regulations.

VI. List of Annexes

Annex 1: Chart - Comprehensive Programs to Reduce Human Rights-related Barriers to HIV Services in Kyrgyzstan

Annex 2: Chart - Comprehensive Programs to Reduce Human Rights-related Barriers to TB Services in Kyrgyzstan

Annex 2: Chart - Comprehensive Programs to Reduce Human Rights-related Barriers to TB Services in Kyrgyzstan

Intervention	Specific Activities	Coverage/ Location	Expected results/ Comments	Approximate 5 year Cost
Program Area 1: Stigma and Discrimination Reduction				
Increase community mobilization & education on TB stigma & discrimination for all PLHIV and PWID, including addressing stigma and discrimination reduction with families	Peer education and support by TB NGOs, PLHIV and PWID NGOs By phone and Internet	Bishkek, Jalalabad, Osh and Chui Oblast Rest of country	Increased reach of community mobilization to 6000 PLHIV, 12,000 PWID	\$333,000
Capacity building of TB NGOs	Assistance from HIV NGO managers to TB NGOs	Bishkek, Jalalabad, Osh and Chui Oblast	4 NGOs supported	\$25,000
TB NGOs conduct communication sessions with opinion leaders	KP NGOs train PLHIV, PWID and people with TB in public speaking and communications skills Old communication sessions with community leaders	National, concentrating on Bishkek, Jalalabad, Osh and Chui Oblast	100 PLHIV, 100 PWID, 100 people with TB trained in in public speaking and communications skills Communication sessions held with community leaders	\$150,000
Implement TB Stigma Index (if available)	Research carried out by TB, PLHIV and PWID NGOs	National	Stigma Index reports in Years 2 and 4	\$21,000
Continue currently funded activities	See programs list In Baseline Assessment Report	Bishkek, Jalalabad, Osh and Chui Oblast		\$150,000

Intervention	Specific Activities	Coverage/ Location	Expected results/ Comments	Approximate Cost
Program Area 2: Reducing gender-related barriers to TB services				
Mainstream gender-sensitive services into existing TB diagnostics and treatment	NGO collaboration with health services	Bishkek, Jalalabad, Osh and Chui Oblast	Increased access by women KPs to HIV services	\$54,000
Continue currently funded activities	See programs list In Baseline Assessment Report	Bishkek, Jalalabad, Osh and Chui Oblast		\$100,000

Intervention	Specific Activities	Coverage/ Location	Expected results/ Comments	Approximate Cost
Program Area 3: TB-related legal services				
Expand street lawyer program to work with all TB KPs on rights; develop and implement certification program; evaluate program	TB NGOs to use services of street lawyers	Bishkek, Jalalabad, Osh and Chui Oblast	Legal services for TB KPs in need	\$349,000
Advocate for free legal aid	Advocacy activities	National	Advocacy carried out	\$64,000
Ensure access pool of lawyers at each HIV NGO for legal services for clients and strategic litigation	Establish linkages between NGOs and pool of trained lawyers	National	Linkage established and lawyer pool used	o (if HIV comprehensive approach fully funded)

Intervention	Specific Activities	Coverage/ Location	Expected results/ Comments	Approximate Cost
Program Area 4: Monitoring and reforming laws, regulations and policies relating to TB services				
Policy Development	Evaluate and, if approved, institutionalize multi-disciplinary teams with peer educators/counsellors	Bishkek, Jalalabad, Osh and Chui Oblast	MoH to evaluate, then hire peer educators/counsellors in all clinics serving significant populations of KPs	\$410,000
	Advocate for access to legal and health services,	National	Laws and policies redrafted	

	<p>comprehensive sexuality education and friendly HIV and TB information for adolescents without parental consent; for greater government funding of TB services, specifically to increase quality of counselling, and to increase the availability of TB services by well-trained professionals through Family Medicine Centres; for removal of the need to register as a drug addict to receive OST; for an allowance for food and transport to assist people with TB to access medications and cope with side effects & for shelters for homeless PWID and ex-prisoners in Bishkek</p> <p>Assist & monitor MIA implementation of its policies on evaluation of law enforcement staff and police stations</p> <p>Develop & implement mechanism with Office of the Ombudsman, Office of the Prosecutor, National Preventive Mechanism on Torture and to address the issue both of police behavior towards key populations, and of police behavior towards those groups that attack key populations</p>	<p>National</p> <p>National</p> <p>National</p> <p>National</p>	<p>Evaluation reports developed in conjunction with KP NGOs</p> <p>Mechanism developed, and used to police behavior towards key populations, and of police behavior towards those groups that attack key populations</p> <p>Anti Discrimination Bill introduced</p>	
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	<p>TB and HIV NGOs to lead advocacy activities to introduce Anti-Discrimination Law</p> <p>TB NGOs to advocate for changes to the way that FMC doctors and nurses are compensated for working with TB outpatients, together with protective measures to reduce the likelihood of HCW catching TB, and appropriate compensation for HCW who get TB</p>		Advocacy carried out	
Legal audits (laws and policies)	As part of Midterm and End term Assessments	National	Audits carried out	\$10,000

Intervention	Specific Activities	Coverage/ Location	Expected results/ Comments	Approximate Cost
Program Area 5: Knowing your TB-related rights				
Use expanded street lawyer program to educate all HIV KPs on rights	TB NGOs to use services of street lawyers for educating staff and clients	Bishkek, Jalalabad, Osh and Chui Oblast		o (if HIV comprehensive approach fully funded)
Continue currently funded activities	See programs list In Baseline Assessment Report	Bishkek, Jalalabad, Osh and Chui Oblast		\$600,000

Intervention	Specific Activities	Coverage/ Location	Expected results/ Comments	Approximate Cost
Program Area 6: Sensitization of law-makers, judicial officials and law enforcement agents				
Training of all active police on HIV and Human Rights; ensure all new entrants to police receive this training	Ensure new curriculum adequately addresses TB issues and TB KPs	National	Increased sensitization of law enforcement to TB issues and human rights	\$12,000 (if HIV comprehensive approach fully funded)
Extend HIV rapid response procedure which involves appropriate officers (from Office of the	TB NGOs to join HIV NGOs in setting up and operating this procedure	Bishkek, Jalalabad, Osh and Chui Oblast	Rapid response procedure in place and responding to illegal detention and other forms of	\$33,000 (if HIV comprehensive approach fully funded)

Ombudsman, Office of the Prosecutor, National Preventive Mechanism on Torture and other agencies) and key population NGOs in responding to illegal detention and other forms of abuse (harassment, violence, extortion, failure to protect), especially of PWID and other people with TB			abuse of PWID and other people with TB	
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Intervention	Specific Activities	Coverage/ Location	Expected results/ Comments	Approximate Cost
Program Area 7: Training of health care providers on human rights and medical ethics related to TB				
Curriculum development	Review current training program at Chubakov Institute to ensure TB included in Human Rights and Medical Ethics training	National	New curriculum developed	13,000
TB NGOs assist in carrying out training of HCW	TB NGOs assist in carrying out training of HCW	National	HCW training includes TB NGO managers as trainers	15,000
Train health care workers in Human Rights, Medical Ethics	Train health care workers in Human Rights, Medical Ethics	National	Train 5000 doctors, nurses and health administrators (as a part of post-graduate courses)	\$470,000

Intervention	Specific Activities	Coverage/ Location	Expected results/ Comments	Approximate Cost
Program Area 8: Ensuring confidentiality and privacy				
Assist & monitor MoH implementation of its own policies and recommendations including those related to confidentiality of health data	Train KPs to assist in evaluation processes	National	Evaluation reports developed in conjunction with KP NGOs	\$64,000
Continue currently funded activities	See programs list In Baseline Assessment Report	Bishkek, Jalalabad, Osh and Chui Oblast		\$77,000

Intervention	Specific Activities	Coverage/ Location	Expected results/ Comments	Approximate Cost
Program Area 9: Mobilizing and empowering patient and community groups				
Community monitoring	Develop key population members as community monitors to develop a feedback mechanism through street lawyers and human rights defenders; report annually TB NGOs assist and train TB KPs to join Civil Advisory Boards and Community Advisory Boards	Bishkek, Jalalabad, Osh and Chui Oblast Bishkek	Mechanism developed, annual reports Increased number of train KPs on Civil Advisory Boards and Community Advisory Boards	\$74,000
Engage people with TB in advocacy	TB NGOs to set up advocacy groups; hire advocacy officers; engage with people with TB and advocate for changes they need	National, with specific emphasis on Bishkek, Jalalabad, Osh and Chui Oblast	Advocacy agenda developed and implemented	\$1.5m

Intervention	Specific Activities	Coverage/ Location	Expected results/ Comments	Approximate Cost
Program Area 10: Programs in prisons and other closed settings				
Community monitoring	Assist & monitor State Penitentiary Service implementation of its policies	National	Evaluation reports developed in conjunction with KP NGOs	\$15,000
Advocacy	Advocate for Ministries of Health and Justice to revisit the issuing of providing passports at least for ex-prisoners continuing on ART, OST or TB treatment; and for pre- and post-release programs assist ex-prisoners to gain	National	Advocacy undertaken	o (if HIV comprehensive approach fully funded)

	access to TB services in the community			
Trainings for prison staff (both medical and non-medical) specifically on issues related to TB	Involvement of TB NGO managers in training	National	Training programs carried out	\$150,000

Annex 3: Baseline indicators and value: barriers to HIV and TB services

Barriers to HIV services

Overview of social, political and legal environment

Overview of barriers/populations affected

Overview of programs (content, coverage, location, costs)

	2016	2019	2021
Total no. of police trained in working with key populations	120		
No. narcologists trained in working with KPs	n.a		
No. dermato-venereologists trained in working with KPs	n.a		
No. infectionists trained in working with KPs	n.a		
No. gynecologists trained in working with KPs	n.a		
No. FMC doctors trained in working with KPs	n.a		
No. FMC nurses trained in working with KPs	n.a		
No. street lawyers (paralegals) employed by HIV NGOs	37		
No. qualified lawyers employed by HIV NGOs	15		
No. peer educators/ counsellors employed as part of multidisciplinary teams in health services	5		
No. peer educators/ counsellors employed as part of multidisciplinary teams in NGOs			
No. of cases brought by the Prosecutor's Office related to unlawful detention	0		
Funding for reduction of human rights barriers (HIV)	USD1.07m		
% of funding from any Kyrgyzstani Government authority	0.15%		
KP members trained in legal literacy			

HIV Stigma Index (2015) ⁶⁶			
% reporting denial of any medical service	9.1%		
% refused employment/ fired/ pressured to leave work	35.7%		
% feel ashamed (self-stigma)	53.5%		
% women reporting pressure to abort	20%		

Barriers to TB services

Overview of social, political and legal environment

Overview of barriers/populations affected

Overview of programs (content, coverage, location, costs)

	2016	2019	2021
Total no. of police trained in working with key populations	120		
No. narcologists trained in working with KPs	n.a		
No. infectionists trained in working with KPs	n.a		
No. phsthiologists trained in working with KPs			
No. gynecologists trained in working with KPs	n.a		
No. FMC doctors trained in working with KPs	n.a		
No. FMC nurses trained in working with KPs	n.a		
No. street lawyers employed by TB NGOs	0		
No. qualified lawyers employed by TB NGOs	0		
Funding for reduction of human rights barriers (TB)	USD0.47m		
% of funding from any Kyrgyzstani Government authority	0		
KP members trained in legal literacy			
TB Stigma Index			
% reporting denial of any medical service	n.a.		
% refused employment/ fired/ pressured to leave work	n.a.		
% feel ashamed (self-stigma)	n.a.		
% women reporting pressure to abort	n.a.		

⁶⁶ It is assumed that these figures have not changed from 2015 to 2016.