ENGAGING UNDER-SERVED KEY POPULATIONS IN KYRGYZSTAN: WHAT WORKS?

RESEARCH REPORT

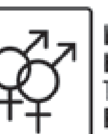
Aids Fonds

The Bridging the Gaps programme addresses the human rights violations and challenges faced by sex workers, people who use drugs, and lesbian, gay, bisexual, and transgender (LGBT) people, in accessing HIV and other essential health services. The Bridging the Gaps programme works with more than 90 local partner organisations which collaborate with four Dutch non-governmental organisations: Aids Fonds, AIDS Foundation East-West (AFEW), COC Netherlands, and Mainline, and with five global networks: the Global Network of People Living with HIV (GNP+), the International Network of People who Use Drugs (INPUD), the International Treatment Preparedness Coalition (ITPC), the Global Forum of MSM and HIV (MSMGF), and the Global Network of Sex Work Projects (NSWP).

3 KEY POPULATIONS:

SEX WORKERS

PEOPLE WHO USE DRUGS


LESBIAN, GAY, BISEXUAL AND TRANSGENDER PEOPLE

1 MISSION:

OUR MISSION IS TO ACHIEVE UNIVERSAL ACCESS TO HIV/STI PREVENTION, TREATMENT, CARE AND SUPPORT FOR KEY POPULATIONS

BRIDGING THE GAPS

BY LINKING:

COMMUNITY WORK WITH GLOBAL ADVOCACY

3 KEY POPULATIONS

HUMAN RIGHTS AND HEALTH

COLLABORATING INSTITUTIONS

Aids Foundation East-West
Socium Public Foundation
Asteria Public Foundation
Labrys Public Association
Kyrgyz Indigo Public Association
Yug-Antilopa Initiative Group
Girlfriend Public Foundation
Tais Plus Public Foundation
Freedom House, human rights organisation
Bishkek Feminist Collective SQ

November 2015

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immunodeficiency syndrome
AFEW	Aids Foundation East-West
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HCB	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
IBBS	Integrated Biological and Behavioral Surveillance
IEM	Informational-educational material
PWID	People who inject drugs
LGBT	Lesbian, gay, bisexual and transgender
MoH	Ministry of Healthcare
MSM	Men who have sex with men
NGO	Non-governmental organisation
PLHV	People living with HIV
PWID	People who inject drugs
PWUD	People who use drugs
RC AIDS	The Republican Center on Prevention and Control of AIDS
SS	Sentinel surveillance
STD	Sexually transmitted diseases
STI	Sexually transmitted infections
SW	Sex worker
TB	Tuberculosis
UNDP	United Nations Development Programme

EXECUTIVE SUMMARY

Background
Within the framework of the programme "Bridging the Gaps: Health and rights of key populations", an operational research was conducted among the representatives of people who inject drugs (PWID), sex workers (SW) and lesbian, gay, bisexual and transgender people (LGBT), as well as outreach workers and managers of Bridging the Gaps and The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) country partner organisations. The aim of this research was to study the factors that motivate and attract new members of the community to join HIV prevention programmes in Bishkek and Osh. This is the first study in the Kyrgyz Republic to examine means of attracting the key populations and the impact of outreach to increase the motivation to participate in prevention programmes.

In the Kyrgyz Republic, the HIV infection rate per 100,000 was 10.8% in 2011, 12.5% in 2012, 8.5% in 2013, and 10.5% in 2014. According to the date of the sentinel surveillance (SS) in 2013, the prevalence of HIV among key populations was 12.4% for PWID, 2,2 % for SW, 6.3% for men who have sex with men (MSM), and 7.6% for convicts.

The development of the epidemic is caused by infection transmission (parenteral, sexual, from mother to child), a prevalence of risky behaviour, and limited access to prevention programmes and health care. The creation of a favourable environment plays an important role in improving the efficacy of prevention programmes. The country has ratified a number of normative documents, which promote further adherence to the human rights of the key populations. The Kyrgyz Republic has ratified the most important international agreements, including the International Covenant on Civil and Political Rights. The 2012-2016 State programme on HIV includes provisions to realise the aims of the 2011 UN Political Declaration on HIV, which includes securing the rights of key populations. However, despite these actions to control the HIV infection, there is minimal efficiency in suppressing it. According to data from national experts, one of the main causes of the rate of HIV infection among key populations is insufficient access to prevention programmes for these groups.[1]

The current situation thus reflects the need to study what factors can influence key populations to enter prevention programmes.

Methods
In order to achieve the aims of the research, a combination of quantitative and qualitative methods of data collection were used. The main method utilised was the semi-structured in-depth interview, and formal interviews were also conducted.

437 representatives of the three key populations – PWID, SW, LGBT – were studied, aged 18 years old and older, with experience of participation in HIV prevention programmes. In addition, 10 outreach workers and four managers of non-governmental organisation (NGO) partners also participated, totally 450 respondents. Data collection was carried with the help of trained interviewers and community representatives.

Results
Services such as legal support, temporary housing, and screening for HIV, sexually transmitted infections (STI) and tuberculosis (TB) increase the attractiveness of prevention programmes, and generally have a positive impact on the motivation of clients, but such services are not prioritised.

The most popular services are the provision of medicines, detailed medical examination, legal support during trial and detention, assistance in finding a job, assistance in the recovery of documents, and obtaining permanent residence. However, in most cases, these services remain inaccessible, which could adversely affect the motivation levels of the key populations.

Outreach can be an effective strategy to raise awareness and reach key populations with prevention services. The assessment revealed that outreach workers are the main source of information on prevention programmes, organisations and services (87% - PWID, 61% - SW, 51% - LGBT). Likewise, means of prevention are often received from outreach workers (84% - SW, 81% - PWID, 68% - LGBT).

To increase awareness, survey participants suggested using active and wide-ranging advertisements of organisations and services, and increasing the number of outreach workers and/or volunteers. The approach of having outreach workers build personal networks is recognised by respondents as the most effective method of providing key populations with access to preventive services.

The work conducted by organisations and outreach workers was generally evaluated as "good". At the same time, this study attempted to identify the aspects of preventive work which require improvement. According to respondents, such improvements include explaining in detail what services are available and that services are free and confidential, expanding the range of services, and creating more favourable conditions for accessing services (e.g. convenient office location/point of trust, lack of nearby police stations, etc.).

With respect to improvements that could be made by the outreach workers themselves, respondents mentioned a lack of motivation to work and a lack of sufficient skills in psychosocial counselling and interpersonal communication, resulting in turnover of trained staff within organisations. These issues negatively impact the quality of outreach work and the process of informing and counselling key populations, as well as reduce opportunities to improve prevention programmes.

Conclusion
In conclusion, it should be noted that community based outreach work is an essential approach allowing contacting key populations, getting them interested in participation in HIV prevention programs through opening personal experience, empathy and nonjudgmental acceptance of people. Based on the results of this assessment, a profile of the ideal outreach worker was defined, along with recommendations to improve the effectiveness of outreach work. The main barriers to accessing prevention services were identified as fear of being identified, harassment by law enforcement officials, and a mismatch between the demand and supply of services.

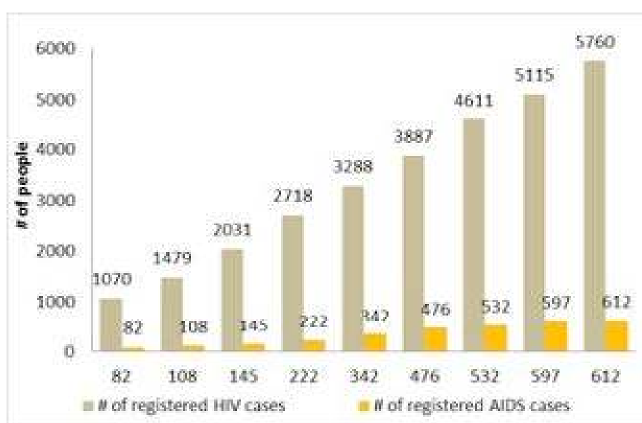
1 The Republican Center on Prevention and Control of AIDS. (2014). Country report on the progress made in the global response to HIV. Kyrgyz Republic, http://www.unaids.org/ru/regionscountries/countries/kyrgyzstan

1. INTRODUCTION

1.1 HIV IN THE KYRGYZ REPUBLIC

The Kyrgyz Republic located in Central Asia, is one of the few places in the world where there is still a rapid growth of the HIV epidemic. According to official statistical data from the Republican Center on Prevention and Control of AIDS (RC AIDS), the Kyrgyz Republic had a total number of 5,760 cases of HIV infections as of 1st January 2015. Between 2006 and 2014, the number of officially registered cases of HIV infections in the country rose 5.4 times.

Figure 1. Cumulative number of registered cases of HIV/AIDS, 2006-2014

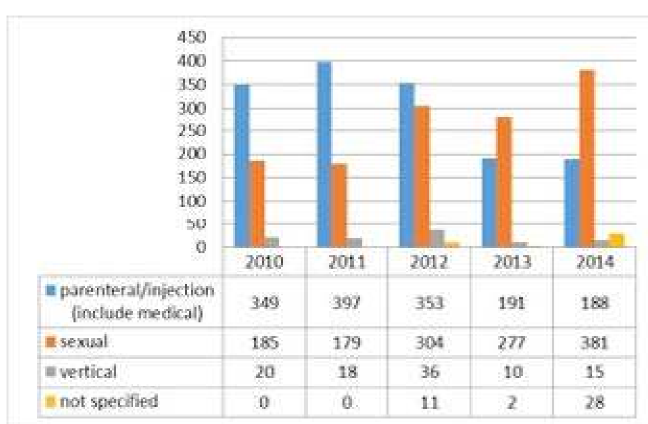


Active work in the field of HIV prevention began in the Kyrgyz Republic in 1996, when prevention programmes were launched with the aim of providing a whole range of services. The key objective is to slow the spread of HIV infection by reducing the risky behaviour practiced in the key populations, to be achieved through the implementation of well executed programmes. Achieving this goal requires the active involvement of the key populations. However, preventive actions are constrained by their low accessibility, and teams of outreach workers were created to address this issue. Outreach work is aimed at establishing and maintaining direct contact with hard-to-reach groups at locations where they can usually be found, preventing risky outreach by new members of key populations, and maintaining their commitment and attention to prevention programmes.

Within the framework of the programme "Bridging the Gaps: Health and rights of key populations", an operational research was conducted among the representatives of people who inject drugs (PWID), sex workers (SW) and lesbian, gay, bisexual and transgender people (LGBT), as well as outreach workers and managers of Bridging the Gaps and The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) country partner organisations. The aim of this research was to study the factors that motivate and attract new members of the community to join HIV prevention programmes in Bishkek and Osh.

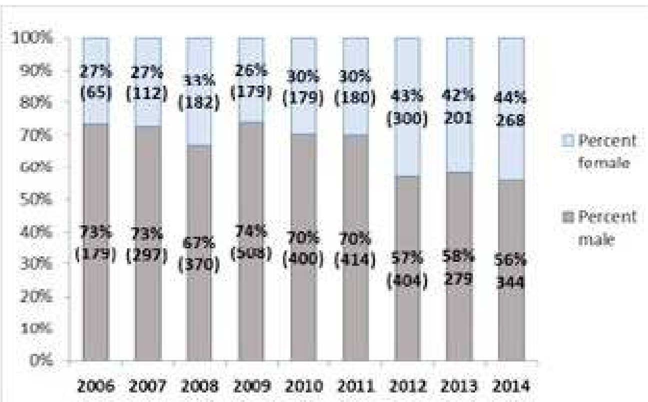
As the data from 1st January 2015 indicates, 2,991 persons (68%) out of 4,409 living with HIV (PLHV) in Kyrgyzstan have experience of consuming injecting drugs in the past, or have been classified as people who use drugs (PWUD). At the same time, the statistical data shows that there was a notable growth in sexual transmittance of HIV during the past five years.

Figure 2. Transmission of HIV, 2010- 2014



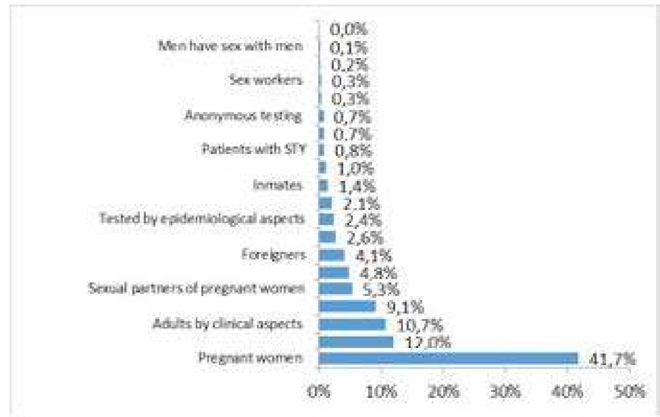
The division by gender of the newly registered cases of HIV infection has also changed – in 2006 the distribution of male to female was 2.8:1, while in 2014 it became 1.3:1. This is due to a 1.6 fold increase in the number of women infected with HIV.

Figure 3. Distribution of the new cases of HIV/AIDS by gender



More than 500,000 blood samples are tested for the presence of HIV infection in Kyrgyzstan, which constitutes approximately 10% of the total population of the country. Yet test coverage of the key populations remains insufficient. Of the total number of the population taking HIV tests, PWID constitute 0.7%, people having an uncontrolled number of sexual partners represent 3%, and gay and bisexual (GB) men 0.1%. There is currently a functioning working group within the Ministry of Health to review the testing programmes, which is related to The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) reducing their funding.

Figure 4. Contingents tested for HIV in KR, 2014



While there is a major concentration of HIV infection among key populations, the most effective tool for epidemiological surveillance is IBBS's sentinel surveillance (SS), which allows the study of risky behaviour, as well as the prevalence of antibodies to HIV, hepatitis C virus (HCV) and syphilis, depending on the socio-demographic and behavioural characteristics of representatives of the key groups (PWID, SW, MSM, and prison inmates).

As HIV epidemics are mostly concentrated amongst key populations, a population quantity assessment, both on national and local levels, is a strategic resource for making decisions on what measures should be undertaken to curtail the HIV epidemic. The results of the assessment are necessary to properly implement prevention and treatment programmes, particularly with regard to:

- Defining/correcting the aims of prevention programmes on regional and national levels,
- Calculating the supply needs for prevention programmes on regional and national levels (such as individual means of protection (condoms, syringes) and informational-educational materials [IEM]). The Kyrgyz Republic has conducted a series of research initiatives assessing the population scales of the key populations. According to the gathered data, the number of PWID[3] is 25,000, MSM[4] is 22,000 and SW[5] is 7,100.

Rapid growth of the HIV epidemic, a significant growth in transmittance through sexual behaviour, an annual augmentation of the number of new female cases of infection, and a significant distribution of HIV, HCV and syphilis among key population, together imply that there is a high threat of the epidemic taking over the general population. This threat requires certain actions to be taken.

Table 1. Distribution of HIV, HCV and syphilis among key populations /IBBS (SS), 2013, KR

PWID	**HIV**	**HCV**	**Syphilis**
Bishkek	10.9%	69.7%	10.95%
Osh region	16.8%	39.2%	8.8%
Chui region	11.5%	43.2%	7%
Jalal-Abad region	17.0%	34%	7%
Batken region	6%	33.3%	-
Issyk-Kul region	0%	32%	8%
Naryn region	8%	160%	2%
Total: 904	**12.3%**	**45.1%**	**8.3%**
SW	**HIV**	**HCV**	**Syphilis**
Bishkek	1.6%	2.8%	33%
Osh region	2%	4%	22.5%
Chui region	2%.	0%	30%
Jalal-Abad region	6%	4%	19%
Batken region	2.3%	6.8%	-
Issyk-Kul region	2%	4%	12.2%
Naryn region	0%	0%	8%
Talas region	0%	0%	2%
Total: 854	**2.2%**	**3.1%**	**20.8%**
MSM[2]	**HIV**	**HCB**	**Syphilis**
Bishkek	13.3%	2.2%	13.3%
Osh region	0%	1%	3%
Total: 190	**6.3%**	**1.6%**	**7.9%**

2 Note that MSM/GB communities are "closed" groups and the data gathered by SS is representative for Bishkek only.

3 Skutelnichuk, O. & Karipova, A. (2013). Population quantity assessment using injecting drugs (IDU) in Kyrgyz Republic. http://aidscenter.kg/ru/biblioteka.html

4 "M-Vector. (2013). Assessment of the population of men practicing sex with men in Kyrgyz Republic, Bishkek: The Global Fund to Fight AIDS, Tuberculosis and Malaria.

5 M-Vector. (2013). Assessment of the number of sex workers in Kyrgyz Republic. Bishkek: The Global Fund to Fight AIDS, Tuberculosis and Malaria.

The results of the epidemiological surveillance of PWID, SW and MSM/GB were used in this research as additional data on the effectiveness of prevention programmes aimed at reducing injection drug use and risky sexual behaviours through the provision of information and prophylaxis. This data is outlined per key population in Section 3: Results.

1.2 BRIDGING THE GAPS IN KYRGYZSTAN

In Kyrgyzstan the Bridging the Gaps programme for PWID, implemented by AFEW Kyrgyzstan with country partners, is based on the social support to clients aimed at conscious change in their risk behaviour. Within the Bridging the Gaps programme Kyrgyz LGBT-led organisations – with financial and technical support from COC The Netherlands – provide HIV prevention and other services, and engage in lobby and advocate to uphold the rights of LGBT people. SW in Bridging the Gaps are supported by a Kyrgyz SW-led organisation financed by the International Treatment Preparedness Coalition (ITPC).

The programme's country partners have created teams of outreach workers, funded by Bridging the Gaps and GFATM, to establish and maintain contact with marginalized and under-served members of their community, with the aim of preventing risky patterns of behaviour and motivating these persons to access medical, social and juridical support services.

1.3 HIV INFECTION PREVENTION PROGRAMMES AMONG KEY POPULATIONS[6]

Prevention of HIV infection is one of the top priority goals in the health protection sphere, and requires careful and thorough planning, an integrated approach, wide coverage, and continuity of activities. The majority of the currently provided prevention services, care services, and treatment of HIV for key populations in Kyrgyzstan are provided by state medical institutions and local non-governmental organisations (NGOs), and are funded by GFATM and the United Nations Development Programme (UNDP).

By the end of 2013, UNDP had funded direct contracts with 40 sub-recipients. In Chui region it has worked with MSM/LGBT communities, and with SW and PLHV groups in Naryn region. The total number of places where PWID could acquire a minimal package of services has reached 46, up from 27 in 2012.

The second half of 2013 was marked by widening of cooperation with the non-governmental sector in the provision of services for SW and MSM/LGBT communities. During the period July-December 2013, 9 NGOs in all seven regions of Kyrgyzstan, as well as including Bishkek and Osh, have been involved in prevention programmes. A total of 3,020 SW were provided with a minimal package of services for HIV prevention during this period. Two new NGOs have joined the programme – ZiOM 21, operating in Talas, joined during the reporting period and Kyrgyz Indigo joined in October 2013, working in Bishkek with the MSM/LGBT population aged 18-27 – and Ayan Delta widened its services on provision of services for SW.

6 The Global Fund to Fight AIDS, Tuberculosis and Malaria & United Nations Development Programme. (2013). Annual report on implementation of grants provided by the Global Fund to fight AIDS, Tuberculosis and Malaria in Kyrgyzstan – 2013. Retrieved from www.kg.undp.org/content/kyrgyzstan/en/home/library/hiv_aids/annual-report-on-the-implementation-of-grants-provided-by-the-gl.html

2. METHODS

2.1 RESEARCH OBJECTIVES

The topic of the current operational research was determined and approved by a workgroup composed of 13 representatives from Bridging the Gaps and GFATM country partner organisations. These organisations provide services to and promote and protect the rights and interests of the key populations. The workgroup included members of the following organisations:

- Aids Foundation East-West, Bishkek, PWUD (Natalya Shumskaya)
- Socium Public Foundation, Bishkek, PWUD (Batma Estebesova, Elmira Kazaeva)
- Asteria Public Foundation, Bishkek, PWUD (Renata Bayazitova)
- Labrys Public Association, Bishkek, LGBT (Kurmanov Sanjar, Marina Temirova, Nazik Abylgazieva)
- Kyrgyz Indigo Public Association, Bishkek, LGBT (Daniyar Orsekov, Temir Kalbaev)
- Yug-Antilopa Initiative Group, Osh, LGBT (Mamir Zakirov)
- Girlfriend Public Foundation, Osh, PWUD/SW (Nadejda Sharonova)
- Tais Plus Public Foundation, Bishkek, SW (Shahnaz Islamova, Svetlana Lim)
- Freedom House, human rights organisation, Bishkek (Askat Dukembaev)
- Bishkek Feminist Collective SQ, Bishkek (Galina Sokolova)

During the course of the workgroup meetings, participants mapped out existing research methods and tools for attracting representatives of key populations, and analysed existing barriers. This led to the determination of the topic of the research, which is important for all three of the key populations. The selection of the topic was a transparent process and reflects the reality of the situation on the ground.

A number of **research objectives** were identified:

1. To assess social-economic status of key population members
2. To assess barriers and facilitators of access to services (including health, juridical, and psychosocial services).
3. To determine the level of satisfaction and expectations of the key populations with regard to prevention programmes (specifically in relation to the variety of provided services, the interaction with NGO staff, and the provision of information materials).
4. To study the quality of services provided by outreach workers with regard to:
   - Providing information about organisations and programmes that work with key populations;
   - Distributing medical and hygiene tools;
   - Providing consultations on HIV, sexually transmitted diseases (STDs), HBV, HCV, and TB;
   - Distributing IEMs, and providing information on their operation and quality;
   - Providing referrals to medical institutions and other organisations;
   - Building trust.
5. To study possible barriers which can negatively influence willingness to participate in a programme.

2.2 LITERATURE REVIEW

In the course of this evaluation, an inventory and analysis of existing research on key populations that practice risky behaviour in relation to HIV infection was conducted. These studies were aimed at evaluating the spread of infection connected with injection drug use and sexual activity (HIV, HCV and syphilis), the awareness and behaviour of key populations, the population size of key populations, and needs assessments. None of the studies (a list can be found in Appendix 1) researched the question of motivating and recruiting new members of the community to participate in prevention programmes. Nevertheless, there is information in the materials of these studies that could be considered useful for this research. All information related to prevention programmes was studied in the study reports. The following aspects of prevention programmes were included in other research:

1. Age and experience of the respondents.
2. Prevention programme coverage of key populations.
3. Impact of prevention programmes on the awareness, behaviour and access to services of the key populations.

Under the auspices of the United States Agency for International Development (USAID) Dialogue on HIV and TB in Central Asia project, the continuous tracking of results research among the SW, PWID, MSM/GB groups focused on monitoring key behaviours. The research was conducted with the goal to make a provisional assessment of key behaviour factors. The recommendations of this research were mainly connected to improving access to services as well as improving the behaviours and increasing awareness among key population groups.
Results of this study show that it, who know where to go for HIV test services are more likely to be tested for HIV. Continuing to promote the availability of such testing services, increasing the number of key population (KP) will be able to pass the test and get the results. Also KP which supports society in the use of HIV test services, are more likely to be tested for HIV. This study has shown the high level of knowledge about HIV and AIDS, are more likely to be tested for HIV.

2.3 RESEARCH DESIGN

The research was conducted in the two largest cities in the Kyrgyz Republic – Bishkek and Osh – reflecting the epidemiological situation and the geographic coverage of the Bridging the Gaps programme.

A cross-sectional research approach was taken, and qualitative and quantitative methods of data gathering were used. Considering that certain respondents can be hard to reach, it was decided to conduct interviews using pre-prepared questionnaires. In addition, in-depth face-to face interviews were conducted with representatives of the key populations, outreach workers, and managers of Bridging the Gaps and GFATM country partner organisations.

In order to achieve the objectives of the research, four questionnaires were developed. Questionnaires (both structured and semi-structured with open ended questions) consisted of questions regarding needs, accessibility of services, assessment of the quality of services, assessment of the outreach work, recommendations on improvement, and on sharing difficulties and limitations experienced by programme participants. The questionnaires also included questions to assess satisfaction on the key principles of confidentiality, anonymity and security, as well as on general friendliness. The structured questionnaire for clients in prevention programmes can be found in Annex 1 of this report.

A number of guides were prepared to guide the interviews and are annexed to this report:

- **Annex 3: A guide for the in-depth interviews with outreach workers.** These interviews addressed issues such as their knowledge of functional responsibility, work load, personal and professional motivation, limitations in work, and their qualifications (Annex 3)
- **Annex 3: A guide for the in-depth interviews with the managers of partner NGOs.** These interviews focused on attracting clients, dealing with a lack of personnel, and on how to improve outreach work (Annex 3).
- **Annex 4: A guide for the in-depth interviews with representatives of key populations,** to support an assessment by interviewers of the social-economic condition of the representatives, their capacities and barriers, their level of satisfaction and expectations from prevention programmes, their view on the quality of services provided by outreach workers, as well as possible barriers they may experience, which could negatively influence their willingness to enter a programme (Annex 4).

These research instruments were developed by the team of researchers, with the active participation of representatives from the partner organisations. All research tools for data gathering were pilot tested with respondents from the key populations prior to the commencement of the field work, in order to identify incomprehensible questions and other potential issues. The pilot field work was successful and all questionnaires were approved without major adaptations.

2.4 RESEARCH SUBJECTS AND ETHICAL CONSIDERATIONS

There were a number of fixed criteria for participation by PWID in this research:

- Aged 18 years or older;
- Consumption of drug substances through injections had taken place within the previous 12 months;
- Oral informed consent to participate had been provided.
- A valid invitation (recruitment) coupon to participate.

Criteria for inclusion of LGBT in the research:

- Aged 18 years or older;
- Identifying as LGB and/or T, intersex (I) or queer (Q);
- Oral informed consent to participate had been provided;
- A valid invitation (recruitment) coupon to participate.

Criteria for inclusion of SW into the research:

- Aged 18 years or older;
- Belonging to a key population;
- Oral informed consent to participate had been provided;
- A valid invitation (recruitment) coupon to participate.

Prior to the commencement of the interviews, respondents were asked to provide written consent to participate. All data gathered during screening and interviews were coded, and participants were assigned individual numbers to prevent identification. Each interviewer also signed a confidentiality agreement on the non-disclosure of information acquired during the research.

The bioethics committee of the Institute of Global Research of the Columbia University in Kyrgyzstan approved the research methodology, protocol and tools used in the operational research.

Table 2. Research sample

	Bishkek		Osh		Total	
Key populations	**Questionnaire**	**In-depth interviews**	**Questionnaire**	**In-depth interviews**	**Questionnaire**	**In-depth interviews**
PWID (10% are women)	77	22	41	11	118	33
LGBT (30% are women)	67	21	44	4	111	25
SW (100% are women)	77	22	39	11	116	33
Outreach workers		5		5		10
Managers		3		1		4
Total	**221**	**73**	**124**	**33**	**345**	**105**

2.5 SAMPLE

The sample size was determined based on the available resources of the current operational research (in terms of both personnel and time), and Table 2 outlines the samples.

The recruiting process used to attract PWID and LGBT representatives utilised a sampling method called respondent-driven sampling, which is formed by respondents themselves. This method was chosen because target groups are often hard to reach. The creation of respondent samples began with primary respondents ("seeds") who attracted other members of the target group through recruiting coupons. Each primary respondent would eventually form a recruiting chain, and the dissemination of information about the commencement of the study was carried out by representatives of the targeted NGOs and outreach workers. The selection of primary respondents was based on fixed criteria – age, sex, engagement with a targeted NGO, and possession of a number of contacts within the key population (particularly those younger than 25 years of age and women). Each site employed a number of primary respondents to ensure disbursement of numbered invitations to participate within the key population.

In order to exclude respondents who were not members of target groups, a screening procedure using specific questions were used. For SW, it was determined which locations, days and times would ensure the highest physical representation of SW, and the process of data collection was carried out according to this information.

2.6 DATA COLLECTION AND ANALYSIS

Interviewers involved in the process of data collection were employers of Bridging the Gaps and GFATM country partner organisations. The interviewers were fluent both in Russian and Kyrgyz languages, were representatives of target groups or allies, and were instructed on the content of the research protocol and tools for data collection.

Upon completion of the data gathering, a process of verification of questionnaires, data input (transcripts) and coding was carried out. The input data also underwent a process of editing and corrections. A special statistical data analysis program called Epi Info was used to process the quantitative data. Frequency analysis and cross tables, which are a standardised set of methods for description statistics, were specifically adapted to the data analysis.

2.7 RESEARCH LIMITATIONS

It should be noted that this research studied the opinions of the three key populations (PWID, SW and LGBT). The questionnaire was standardised and had to take into account the characteristics of all three groups. It is important to note that the Bridging the Gaps programme does not cover the SW group in Kyrgyzstan. It also grew evident that HIV prevention programmes vary for different groups. The major donors supporting the HIV/AIDS prevention activities are the GFATM, USAID and Fond Soros Kyrgyzstan (SFK), and their criteria for programme coverage are respectively different. As a result, difficulties arose during the discussion and preparation of the

structured questionnaire. There were difficulties when defining the research questions, leading to lengthy debates and disputes during development of the tools, which led to an extension of the preparation phase.
The influence of interviewers must also be mentioned. Although trust was ensured during the interviews by training peers/community liaisons/outreach workers to conduct interviews, this may have caused some social desirable answers among clients. The limited time and availability of human resources also impacted the research, rendering it unfeasible to have an analysis inside each key population (sex, age, segments of L, G, B, T, for example).

There were high levels of intolerance and discrimination displayed towards the researched key populations by law enforcement agencies and other governmental structures, and by the society in general. There are two particularly vivid examples of this. First, there has been systematic gathering of data on raids on SW conducted by law enforcement agencies in the south of the country, which led to a prolonged process of data gathering among this key population. And second, the work of LGBT organisation "Labrys" was slowed down due to an intentional fire in the office, which also lead to delays in data gathering, as there was no safe space for meetings with respondents.

Finally, despite being unable to conduct a very in-depth study of issues relating to stigma and discrimination towards key populations, the researchers were able to observe these issues, and come to the conclusion that these issues represent serious obstacles to improve motivation to participate in prevention programmes. Legal aspects also have not been considered in this report, as this topic requires a focused approach and analysis, and should the topic of another research. It is important to note that Aids Foundation East-West Kyrgyzstan has initiated research to assess legal knowledge and rights violations among PWID.

3. RESULTS

The results per key population are outlined in this chapter. Each section opens with a brief summary of the results of the sentinel surveillance and a 'social portrait' of the respondents. During the process of discussing research tools with members of the workgroup, it was decided to include such a portrait, or 'snapshot' of respondents, as the financial status and level of education might influence the needs and motivations of members of the key populations to participate in programmes.

3.1 SEX WORKERS[7]

3.1.1 Sentinel surveillance

Half of all respondents (54%) have been engaged in sex work for a period of between one and three years, while the rest have been SW for either four to seven years (28.1%) or eight or more years (12.4%). So called "rookies" (engaged in sex work for less than one year) amounted to just 5.5%. There was a two-fold increase in the spread of syphilis among SW in comparison to the results of a 2010 study – from 10.4% to 23.6% – which may indicate a spread in dangerous sexual behaviours by all age groups. The largest number of clients in one month, as reported by one of the SW respondents, was 630. Sex worker respondents indicated to have had up to nine permanent sexual partners (35.7% used condoms) and up to 51 non-permanent sexual partners (only 25.9% used condoms).

The majority of SW (91%) used condoms with their clients. The main reasons for not using a condom are unwillingness of a client (68%) and a belief that a given client is "reliable" (23%). More than half of respondents (56.6%) said that they receive condoms from outreach workers. A third of SW (36%) had symptoms of an STI, and only of third of those with symptoms went to a friendly clinic (33.1%). Despite awareness among SW of the means of infection and protection from HIV increasing from 9% in 2010 to 21% in 2013, awareness still remains at very low levels.

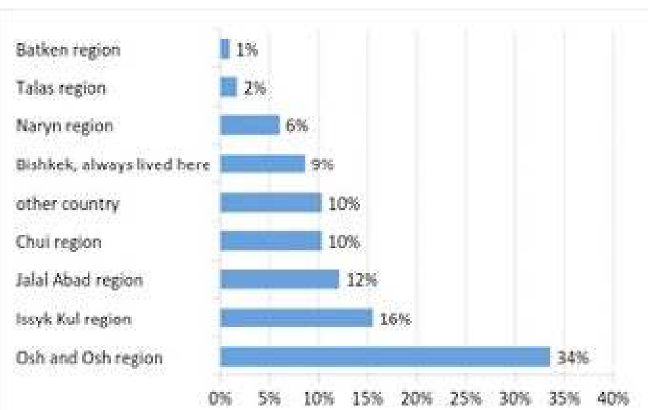
The number of SW participating in prevention programmes remains low (24.4%) and distribution of minimal services (27.2%). Half of SW are provided with condoms by prevention programmes (56.6%), but a third of SW purchase condoms at pharmacies and commercial establishments (35%). As a whole, access in the Kyrgyz Republic to testing dropped by 10% since 2010 and remains at a low level (56%). Testing coverage with complete consultations also remains at low levels (39%). Preliminary data of a study with UNFPA support show that almost 80% of sex workers reported that they received the minimal package of services during the last 3 months (condoms, IEM, referral to STI and/or to VCT).

3.1.2 Social portrait

A majority of SW (81%) have secondary or incomplete secondary education. A total of 12% of SW are married or in a civil marriage, and 88% are single. A sampling of SW has mostly covered those of Kyrgyz (62%), Uzbek (16%) and Russian (10%) ethnicities, while 12% are represented by other ethnicities (Kazakh, Uighur, Ukrainian, and Tatar).

Almost all of the interviewed SW (95%) live in rented apartments (60%), or in guest houses (35%). This can be attributed to the fact that 81% came to Bishkek from other regions of Kyrgyzstan – with 46% coming from the southern regions of Osh and Jalal Abad – and 10% from other countries (Figure 5).

Figure 5. Place of origin of SW, N=116

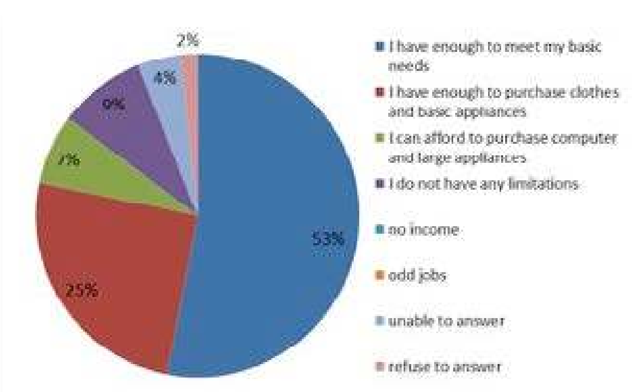


The majority of the SW representatives are solely engaged in sex work (91%), while 9% combine sex work with studies and 11% have left the country during the past 12 months for the purposes of earning money.

Half (53%) of the SW representatives noted that their monthly income barely covers their basic minimal needs, while 25% have a higher income and can afford to buy clothes and household utilities. 9% described themselves as having no financial limitations, and 5% stated that they do not have any income at all.

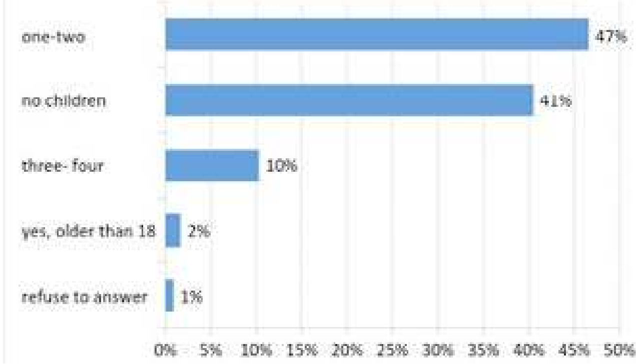
7 The Republican Center on Prevention and Control of AIDS .S (2013). Research SS (sentinel surveillance) for HIV infection among SW. Bishkek: The GlobalFund to Fight AIDS, Tuberculosis and Malaria. aidscenter.kg/ru/biblioteka.html

Figure 6. Monthly income of SW, N=116



As a majority of the SW representatives (57%) appeared to have minor children, it is important to note that most SW do not have permanent employment (other than sex work) nor live in their own houses.

Figure 7. SW with children, N=116



3.1.2 Needs, access and satisfaction with services

The major goals of outreach work are to establish a stable rapport, raise knowledge of the key populations and their partners, foster safe behaviour, influence risky drug and sexual behaviour by spreading means of individual protection and IEM, provide referrals to AIDS-service organisations, and provide assistance in social adaptation and other services.

As seen in Table 3, the most needed services for SW are:

- Receiving condoms and lubricants (77%),
- Referrals to medical institutions (76%),
- Discussions on safe behaviour (60%),
- Provision of IEM (50%).

The services deemed most accessible strongly correlated with the most required services:

- Receiving condoms and lubricants (100%),
- Access to self and group help (100%),
- Referrals to medical institutions (96%),
- Discussions on safe behaviour (96%)
- Provision of informational-educational materials IEM (97%).

An analysis of the gathered data showed that it is necessary to study the quality of all services, with the exception of the provision with condoms and lubricants, as a low evaluation of certain received services could be perceived as indicating quality problems (Table 3).

Table 3. Evaluation of needs of SW, N=116

Services	Needed	%	Received among those needing services	%	Useful for those who received services	%
Detox therapy	1	1%	0	0%	0	0%
Groups of self-, and mutual help	5	4%	5	100%	1	20%
Psychological consultations	26	22%	9	35%	6	67%
Provision of food packages and hygienic supplies	42	36%	32	76%	28	88%
Acquiring medical drugs	48	41%	33	69%	19	58%
Temporary housing, domestic services	51	44%	29	57%	27	93%
Juridical support	54	47%	35	65%	25	71%
IEM	58	50%	56	97%	35	63%
Discussions on safe behaviour	69	60%	66	96%	41	62%
Referrals to medical institutions	88	76%	84	95%	61	73%
Receiving condoms and lubricants	89	77%	89	100%	80	90%

3.1.3 Results of in-depth interviews

Results of the in-depth interviews indicate that the most motivations for entering the programme are the provision of free condoms, lubricants and medical services or consultations. Consultations on safe behaviour, medical examinations, and tests for HIV, STD and TB were categorised as priority services, and are mostly perceived as additional, rather than primary services.

“ Most of the sex workers do not need anything, except for a stable income. Their health is not a priority for themselves – they are irresponsible when it comes to their own health ”

– NGO Manager, Osh.

“ Our target group is always busy, they do not have much free time. They have to earn money. Time is money. That is why it is very difficult to persuade them to have HIV, STI tests. It is usually only possible through financial motivation ”

– Outreach worker, Osh.

“ Some girls are too busy to come to organisations and get tested. They are not serious about their own health ”

– SW, Bishkek.

“ Our girls do not need anything. They only need to earn a lot of money and not get caught by police during a raid ”

– SW, Osh.

Services such as legal support, restoration of documents, access to temporary housing, and acquiring medical drug make the programme more attractive, but due to the programme’s limited resources, they are not always accessible.

“ After all I did not manage to get a residence permit in the city, put my child in a kindergarten nor find a cheap babysitter ”

– SW, Osh.

“ I could not find a place, where I could temporary register to get a passport ”

– SW, Bishkek.

“ I would also want to get financial assistance to get a medical examination or to buy medical drugs, which are not necessarily related to STDs. So with help, I could turn to doctors with various other illnesses ”

– SW, Bishkek.

“ There is a need to provide assistance in dealing with police officers. Police often subject us to extortion, discrimination. They oblige us, humiliate us, and there is nothing we can do about it. I once filled a complaint form in the past, but it never brought any results ”

– SW, Osh.

Most of the interviewed SW evaluated the work of the NGO as “good” or “excellent”. This evaluation applied particularly to parameters such as kindness and openness, confidentiality and safety, and the establishment of trusting relations. Services such as peer-to-peer consultations and access to medical examination were evaluated as “bad” by 17% of respondents. It is interesting to note that one fifth of respondents negatively evaluated peer-to-peer consultations.

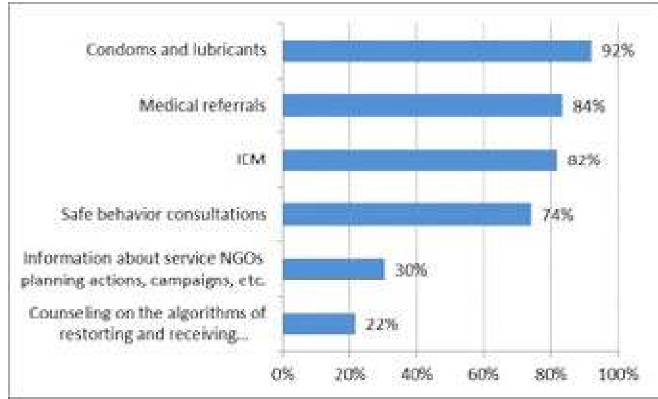
Table 4. Evaluation of services provided, where SW have received prophylaxis services, N=116

Characteristics of evaluation	Bad	Average	Good	Excellent
Friendliness, openness of service provider	0%	2%	41%	57%
Peer-to-peer consultations	17%	5%	47%	32%
Need assessment	1%	11%	54%	34%
Individual approach	0%	6%	58%	36%
Access to information	2%	5%	59%	34%
Trust towards service provider	0%	12%	43%	45%
Access to examinations and diagnostics	2,6%	3,4%	56,0%	37,9%
Perceived confidentiality, safety	0%	1%	40%	60%

3.1.4 Interaction with outreach workers

Outreach workers are described as the main sources of information about health and for acquiring condoms. SW have noted that they mostly receive information about HIV/AIDS services and/or human rights organisations either from their friends and acquaintances (61%) or from outreach workers (60%).

Figure 8. Services provided by outreach workers to SW, N=116



It is necessary to note that outreach workers are described by SW as the main source (80%) for acquiring information about medical institutions (where and how they can be diagnosed and receive treatment) health issues, means of transmission, and means of protection (87%). However, respondents also often turn to their friends and acquaintances for information (40%), and this fact could be used to circulate necessary information between SW friends and acquaintances. About one third of SW receive information from medical specialists (28%), which is likely attributable to the referrals of SW to medical institutions.

Figure 9. Sources of information on health issues (HIV, STI, TB) and medical institutions among SW, N=116

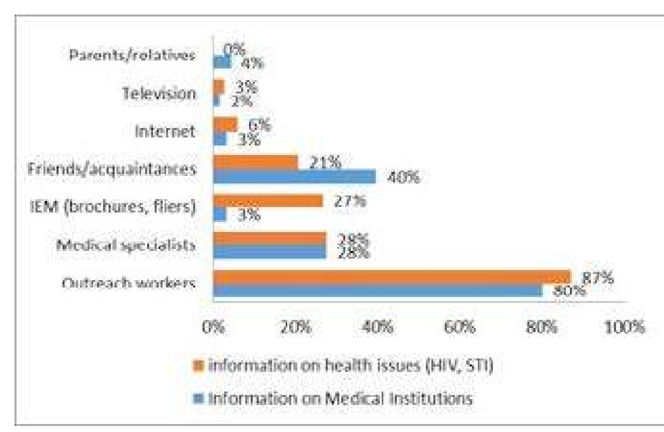
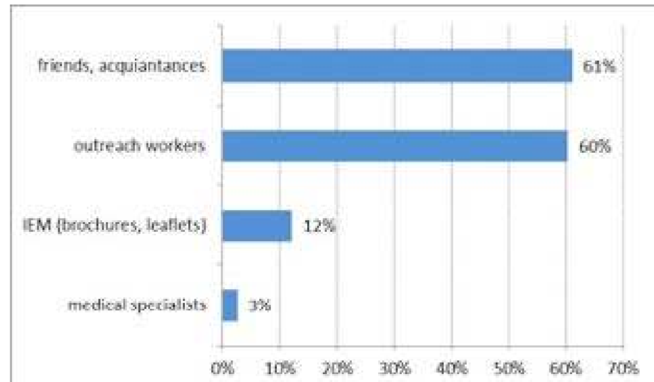


Figure 10. Sources of information about Bridging the Gaps and GFATM country partner organisations among SW, N=116



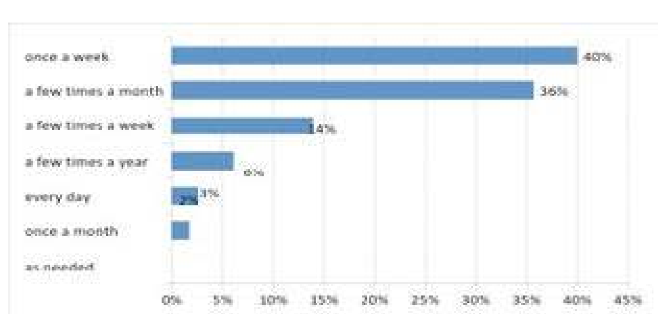
According to the data received, outreach workers also provide condoms and lubricants, IEM, consultations on safe behaviour and referrals to medical institutions. As noted above, legal support (consultations, retrieval of documents) are amongst the most needed services for SW. As shown in Table 5, 88% of respondents noted that they particularly turn to outreach workers when seeking legal aid, who in turn can refer them to the relevant organisations.

Table 5. Who do SW turn to for legal aid?

Sources	abc	%
Friends who are lawyers	0	0%
Legal companies	1	1%
Private lawyer	0	0%
Relatives who are lawyers	0	0%
To organisations, through outreach workers	59	88%
To organisations through acquaintances	1	1%
Nowhere, I don't know where to	6	9%
Hard to answer	0	0%
Total	**67**	**100%**

The frequency of meetings with the key population is another important component in attracting participants to join programmes. According to the quantitative analysis, many outreach workers organise meetings with SW quite often – 14% noted that meetings take place several times a week, 36% of respondents stated that meetings take place several times a month, and half of SW (40%) meet with outreach workers once a week – yet it is noteworthy that 8% meet outreach workers only once a month or several times a years. The optimal frequency of meetings is at least one time per week (Figure 11).

Figure 11. Frequency of contacts with outreach workers, SW, N=116



While conducting in-depths interviews, SW who did not have frequent contact with outreach workers displayed a willingness to meet with them more often.

“ Have more contact with us. Meet us twice a week, preferably in groups. Outreach workers should know about our health and help us. Outreach workers should have a sense of humour, and be our peer ”

– Outreach worker, Osh.SW, Osh.

“ I recommend to come to us more often. To remind us about services, and take an interest in our problems. I would want her to call us once a month. I would come and talk to her. I would want to have some brochures ”

– Outreach worker, Osh.SW, Bishkek.

“ I would want them to come more often, at least two times a month and tell us more. What are other ways of helping us? ”

– Outreach worker, Osh.SW, Bishkek.

“ They should come more often. If they come rarely, girls would forget the information they tell us. We have many new girls, and they should know this information too. There is no need to change anything else. It would be good to have more condoms ”

– Outreach worker, Osh.SW, Bishkek.

“ I wish they would come more often and have conversations with girls. I know that many girls do not understand, but it would be so good if they knew to use medical services, knew how to protect themselves, and their clients. When you talk to them, they do not have time to come here. That is why it would be much better if outreach workers would come to the here to provide their consultations ”

– Outreach worker, Osh.SW, Bishkek.

“[I wish that] the outreach worker would tell about infections in more detail, and would come to us more often”

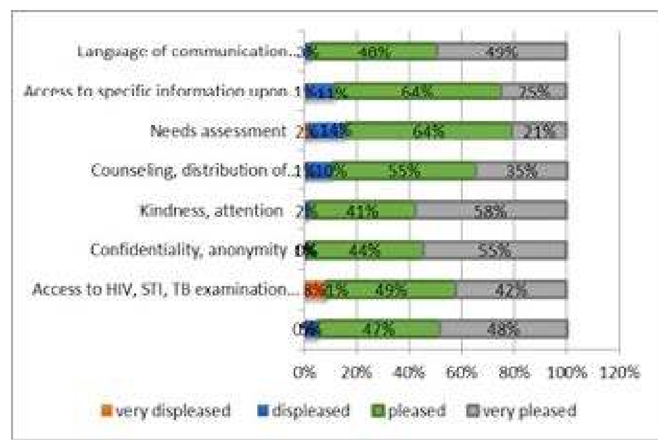
– SW, Os.

While evaluating the quality of the outreach work, respondents were asked to evaluate factors such as:

- access to examinations;
- confidentiality and anonymity;
- friendliness and sympathetic attitude;
- the process of having consultations;
- receiving information;
- taking the specific needs of a target group into consideration;
- addressing any language barriers.

In most cases respondents responded positively on these criteria.

Figure 12. Evaluation of the parameters of services provided by the outreach worker, %, N=116



The fact that outreach workers are peers, and representatives of the key population was revealed to have a significantly positive effect on the efficacy and quality of work. Outreach workers possess first-hand experience about the difficulties and problems faced by members of the key population. They understand the means of communication, the frequently visited places, and the lifestyle. They share their own success stories – and the stories of others – and support participants during difficult times.

“I like that she never hides anything. Even if something happened, she would just take me aside and tell me what is wrong, or explain the situation. She would motivate a person, and a person could decide for themselves whether they needs it or not. She approaches sex workers from the perspective of a service recipient... When an outreach worker explains it in a good and calm way, a person would most likely listen to him. And if you shout at a person, it would negatively affect you”

– SW, Osh.

“I often turn to outreach workers with personal issues. More than a year ago I told one of them about my health issues, and that I have independently talked to a gynaecologist in a private medical centre, where instead of helping and curing me, they hurt me and made things worse. The outreach worker advised me, and referred me to another doctor, where I was provided with good treatment. I trust him a lot after this. I communicate with many outreach workers, but I only trust him”

– SW, Bishkek.

A strong majority of the in-depth interview participants mentioned that outreach workers are highly trusted, and that they never doubt the information they provide. Even in cases when the outreach worker was wrong, respondents tended to view the organisation as being at fault, for failing to provide quality education and training to the outreach workers.

“I do not trust the outreach worker 100 percent. I would not be able to trust him and tell something very personal. But I think that the information he gives us is trustworthy. He would not be able to make up things and lie to us. Why would he do that?”

– SW, Bishkek.

“Yes, I fully trust her. She told me that she was a sex worker herself in the past. If there was another person coming and telling me things, I would not have trusted them. I think she is trained and that's why her information can be trusted”

– SW, Bishkek.

When asked what the best thing about outreach workers is, the majority of respondents replied that because they were members of the key population, they never judge, humiliate or force them to something. There were many stories of how outreach workers had discussions and talks with respondents, asking them about their lives and about the needs of the key population.

“Outreach workers are closer to the community and are more aware about the needs of community members”

– SW, Osh.

“Outreach workers are mediators between community members and organisations, They find a way to reach new people and are able to find out the needs of the hard to reach members of the community”

– SW, Bishkek.

“They never refuse and say they are busy. They wouldn't ask you to come later, they would come up to you and start a conversation…. They ask you what your needs are. They can talk to you about everything. We can tell them about how clients are offending us, about lawyers, about police officers that should be punished. They advise us to start studying and leave sex work. No one refuses and no one is being rude”

– SW, Bishkek.

The role of the outreach worker was described as important by all participants. Many turn to outreach workers at the first sign of problems, to consult with them and to talk about difficulties encountered in their lives. That is why it is important that outreach workers are competent professionals, to motivate sex workers to join the programme.

“I think they are the most important persons for us. They inform us. They suggest that we go for a free medical examination. They accompany us, give free condoms and, most importantly, we do not spend our own money”

– SW, Osh.

“Yes, very important. Because you cannot approach your girlfriend or anyone else and tell them about these problems. But I would gladly approach the outreach worker and he would help me to solve my problem”

– SW, Osh.

“It is very much needed, because they are the only ones who come and help us. Others treat us badly, but these are the people who understand us”

– SW, Bishkek.

According to the respondents, outreach workers should possess good communication skills, an understanding of the psychological particularities of their target group, and an ability to quickly and accurately determine people's motives. In order to more effectively motivate members of the key population to participate in prevention programmes, it was suggested that more detailed information about the consequences of HIV infection, late diagnostics, late commencement of treatment, and neglected illnesses should be provided. Such information should contain more vivid details and photos, in order to focus the attention of key population members on changing their risky behaviour. In addition, confidentiality must be assured, and services should be free.

“They should tell about horrible illnesses, and scare us with consequences. Show videos. We will get scared and turn to organisations so we would take care of our own health”

– SW, Bishkek.

“Outreach worker should understand our situation, be more sympathetic, be a peer consultant, know a lot of information, and know as much about illnesses as a pharmacist knows about drugs”

– SW, Osh.

“He should always be friendly, understanding, and be attentive to sex workers, so when one has problems he is able to talk to her separately. For example, I had some health issues, I had furuncles. I was ashamed to tell others, and asked an outreach worker to talk to me separately from others. She never refuse. She came up to me and gave me some recommendations.
They should not be rude, and be peers with us. And say “Would you please”.
They should always have a mutual understanding with us”

– SW, Osh.

One in five respondents said there should be an increase the number of outreach workers, as well as an increase in their salaries to strengthen their motivation, which would allow them to improve the quality of their motivating consultations.

“More outreach workers would [mean that they could] attend new places, and have consultations. For instance, I know a sauna with girls working in it. I could show it to you, so you could reach them”

– SW, Osh.

“Their salaries are low. They should have higher salaries for the work that they do”

– SW, Osh.

“It is important to have more volunteers from the community, who would be able to explain to SW that there are such centres, where one they can get help”

– SW, Bishkek.

“When meeting a person for the first time, outreach workers should be able to have approximate understanding of what kind of a person is standing before him and establish a rapport with him. I often observe that when an outreach worker approaches, a girl would simply turn away... he should be smart and know at least some psychological terms”

– SW, Bishkek.

“Outreach worker should demonstrate that they love their job. To tell people and motivate them. If a person has motivation, it doesn’t matter who he is, he will reach his goal and will be able to inspire. I was inspired myself and was full of emotion”

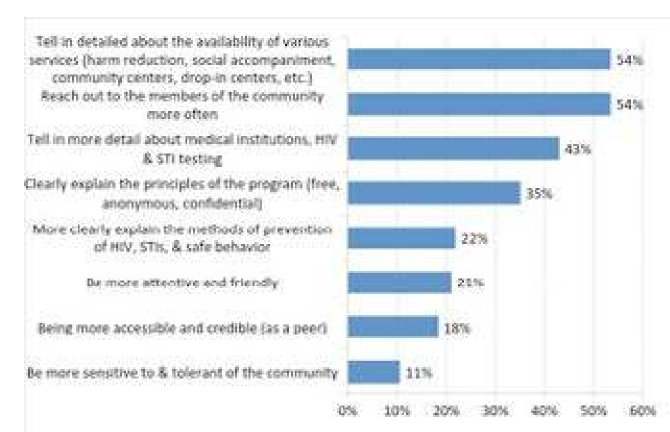
– SW, Bishkek.

“Invite [us] for a cup of tea at the office, and right there, in the office, tell us about STIs and give more condoms”

– W, Osh.

Figure 13, below, clearly illustrates that SW representatives recommend that outreach workers have more frequent contacts with key populations, and provide more details about the existence of relevant programmes (harm reduction, social referrals, community centres, drop in centres etc.).

Figure 13. Recommendations of SW to improve the efficacy of outreach workers, N=116



It is therefore important to attract new staff capacity (outreach workers, volunteers, key population peer representatives) to provide a wide range of key population members with the necessary information about available services, referrals to medical institutions and friendly doctors. There were also suggestions to use the principle of network recruiting when seeking to attract clients, thus mobilising all available resources.

“Advertise in social media and with a help of “human radio” - this is what will help with reaching out to new people”

– SW, Bishkek.

“You should have more volunteers from the community, which would explain sex workers that there are centres where they can get help”

– SW, Bishkek.

“You should invite them. Sex workers who have been provided with services should be more active in telling about the organisation”

– SW, Bishkek.

It was also mentioned that key figures among SW should be involved in the process of developing and attracting target groups into prevention programmes.

“Mamas [author’s note: “Mamas” are pimps] should be involved. Everyone would listen to then, [so] you should work with them”

– SW, Bishkek.

“It depends on how they perform their work. There are people who work alone, others work with mamas. You should be working with mamas”

– SW, Bishkek

“You should negotiate with mamas, so they allow us to go to the hospital. You should come twice a month. You should tell us more about all services, which we can get, we might need them in the future. You should be more friendly and involved”

– SW, Bishkek.

All respondents said that they had advised their acquaintances to seek support from organisations, and many of them have brought, and are continuing to bring, members of their social circles to the organisations. Respondents understand that they are vulnerable to HIV, and believe that it is everyone’s responsibility to help others to stay healthy and functioning.

3.1.7 Barriers and limitations

The most important barrier preventing members of the community from receiving services is a fear of negative consequences (being seen” and of “becoming a target” for violence at the hands of law enforcement), police raids, stigma and discrimination from family and/or society, or from a lack of awareness. Interview participants therefore expressed the need for a particular emphasis on confidentiality and anonymity.

The challenges of nightly work schedules create additional difficulties in visiting organisations and accessing services. It is not uncommon for an outreach worker engaged in sex work to meet with girls “on the corner” during a night shift, and to not have sufficient time to provide a consultation or other services due to a sudden influx of clients. Only exclusive and/or high-demand services, such as the distribution of necessities, can create a high level of interest.

Law enforcement agencies also play an extremely negative role in the lives of the respondents and the key population as a whole.

“Outreach workers often come by, but I don’t always meet with them because I am not always in the same place. They gave us condoms, brochures and information. The girls are afraid of raids and do not always listen attentively as they [have to] run from place to place”

– SW, Bishkek.

“ Our girls do not need anything right now. They need to make more money, not get swept up in a raid, and that is all ”

– SW, Osh.

“ A lot of sex workers are afraid that their status will become known. Among them are young students, and they do not understand that your work is anonymous ”

– SW, Osh.

“ First of all, not everyone knows about you. Secondly, sex workers are afraid that they will be insulted and humiliated again ”

– SW, Bishkek.

“ Many don’t know about you. You need to somehow better inform people about the organisation ”

– SW, Bishkek.

“ The raids are constant. We’re sick of them. Because of them, we hide and barely work. Outreach workers cannot find us if they do not work with us on the corner ”

– SW, Bishkek.

3.2 LESBIAN, GAY, BISEXUAL AND TRANSGENDER PEOPLE

3.2.1 Sentinel surveillance among men who have sex with men/gay and bisexual men[8]

This sentinel surveillance was not conducted with lesbian and bisexual women and transgender people, but is included here because it provides valuable insight into MSM/GB.

Research indicates that there is a relatively high level of coverage for MSM/GB by prevention programmes (distribution of IEM and condoms). Among all groups, 76.3% of MSM/GB men were covered (68.9% in Bishkek and 88% in Osh City). The availability of prevention programmes led to a noticeable increase in the levels of awareness and HIV testing. But although more than half of MSM/GB men (57%) correctly understand the means of transmitting HIV and the means of protection, this awareness has minimal impact on sexual behaviour (OR 0.54; CI 0.24-1.17; P-value > 0.05). There is also no connection between receiving the complete range of services and the practice of using condoms (OR 1.47, CI 0.70-3.18, P-value >0.05). Additionally, while MSM/GB men are reasonably well covered by prevention programmes, there is an insufficient level of coverage of testing and counselling services for this key population. 41% of MSM/GB men have been tested for HIV in the past 12 months and know their results, and only 17.9% received counselling before and after their testing.

The majority of MSM/GB men (80%) have had sexual relations with more than one partner in the past 12 months. Considering 63% of MSM/GB men live with a wife or a female partner, this illustrates a high risk of transmitting HIV to the general population through the wives and partners of MSM/GB men.

The majority of MSM/GB men with HIV and syphilis are clients of prevention programmes (75% and 94% respectively), which may be evidence that the key population is provided with sufficient access to diagnostic services upon entering a programme.

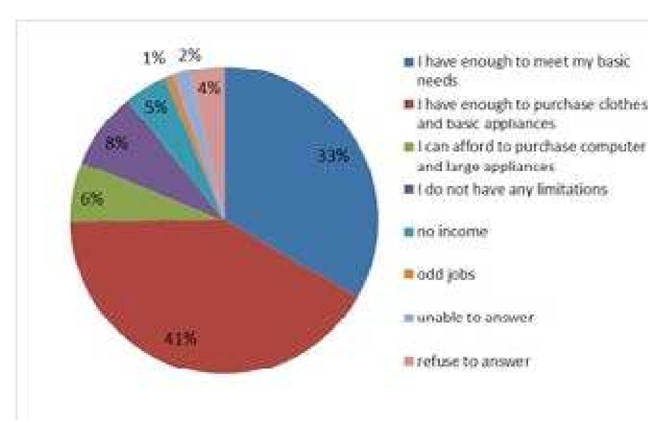
3.2.2 Social portrait

70% of respondents were ethnic Kyrgyz, 14% ethnic Russian and 13% ethnic Uzbek. 65% were men, 18% were women, and 17% were transgender. A third of respondents have higher education (34%) and 27% percent have incomplete higher education. 67% of interviewed representatives of the LGBT people have never been married, 24% are married, and 6% are in civil marriages.

Among the LGBT community the vast majority (74%) live in their own homes, while 24% live in rented apartments, and just 2% live in social housing. Among the respondents of three key populations examined in this study (SW, PWID, LGBT), members of the LGBT community live in the best conditions. Many own their own homes and more than half of the respondents (62%) are employed. Just 8% are unemployed and 16% are students. 80% of the LGBT respondents have never been outside the country. 41% are able to purchase clothes and basic appliances and only 5% have no means of income.

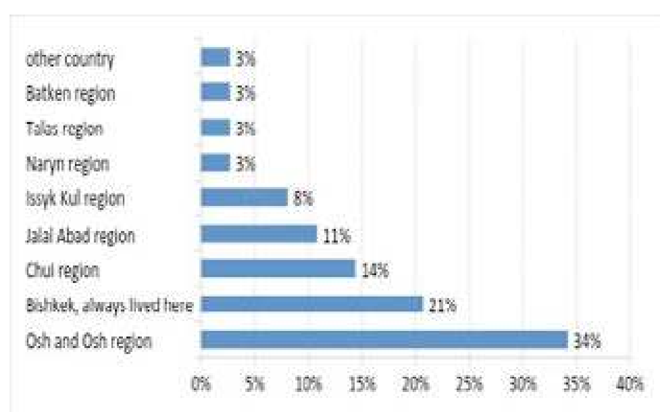
8 The Republican Center on Prevention and Control of AIDS. (2013). Research SS (sentinel surveillance) for HIV infection among MSM/GB. Bishkek: The Global Fund to Fight AIDS, Tuberculosis and Malaria. aidscenter.kg/ru/biblioteka.html

Figure 14. Monthly income of LGBT respondents, N=111



75% of LGBT respondents stated that they did not have children, and 25% of respondents have underage children (from one to four years old). 34% of respondents are residents of Osh City and Osh oblast, 21% have always lived in Bishkek, 41% moved from other oblasts within the country, and 3% emigrated to Kyrgyzstan from another country. According to the data, there is a lower level of migration compared to the other key populations, and the majority of migrant respondents originate from Osh City and Osh oblast (figure 15).

Figure 15. Region of arrival of LGBT respondents, N=111



3.2.3 Needs, access and satisfaction with services

As can be seen in Table 6, the following five services had the most demand:

- Medical referral (57%)
- Consultation regarding safe behaviour (52%)
- Distribution of condoms and lubricants (45%)
- Psychological counselling (42%)
- Distribution of informational and educational materials (38%).

The most accessible services aligned with those which the respondents needed the most:

- Consultation regarding safe behaviour (98%)
- Distribution of condoms and lubricants (96%)
- Medical referral (93%)
- Distribution of informational and educational materials (90%)
- Legal support (83%)
- Psychological counselling (76%).

The provision of psychological counselling appeared to be least accessible despite the project defining psychological support as of paramount importance for the wellbeing of target groups. This might be explained by the fact that there is a reluctance within the LGBT community to turn to psychologists, and this issue should be addressed within the framework of future research.

The provision of medication, support with temporary housing and living services, and the distribution of cleaning supplies and food were deemed the most useful services; this was confirmed by 100% of respondents who had ever received any these services. In addition, services such as referrals to medical institutions (97%), distribution of condoms and lubricants, and consultations on safe behaviour (94%) also proved to be useful.

Table 6. Assessments of the demands and needs of LGBT respondents, N=111

Services	Needed	%	Received among those needing services	%	Useful for those who received services	%
Distribution of cleaning supplies and food	1	1%	0	0%	0	0%
Purchase of medication	4	4%	3	75%	3	100%
Temporary housing and living services	8	7%	3	36%	3	100%
Legal (juridical) support	10	9%	6	60%	6	100%
Mutual support and self-help groups	12	11%	10	83%	9	90%
IEM	20	18%	15	75%	13	87%
Psychological counselling	42	38%	38	90%	34	89%
Distribution of condoms and lubricants	47	42%	36	76%	34	94%
Consultation on safe behaviour	50	45%	48	96%	45	94%
Medical referral	58	52%	57	98%	50	88%
Personal escort to medical institutions	63	57%	59	93%	57	97%

The results of a qualitative analysis among LGBT respondents supports the conclusion that a majority of the target group representatives do not have many material needs, and are more in need of psychological counselling and services of a purely preventative nature (i.e. distribution of prophylactics and information on HIV).

“ I am not in need of services, because everything is fine and I am a self-sufficient person ”

– LGBT, Bishkek.

“ I needed information on existing LGBT bars and clubs in the city, because I was abroad for half a year ”

– LGBT, Bishkek.

“ Lubricants and information about clubs where people relax ”

– LGBT, Bishkek.

“ Psychological support, help in purchasing hormones and the services of allied medical specialists ”

– LGBT, Bishkek.

Psychological services, employment assistance, and legal services are considered the least accessible services as they are limited in scope and do not always satisfy the demands of the target group.

“ I was unable to go to a psychologist that I could trust. I am closeted and am afraid of disclosing my orientation for fear of losing my job ”

– LGBT, Bishkek.

“ There is a lack of a few important components; there are legal services but they are inaccessible. It would be better if legal services were accessible and provided on a moment's notice ”

– LGBT, Bishkek.

“ Things aren't great when it comes to finding employment and receiving help in replacing documents ”

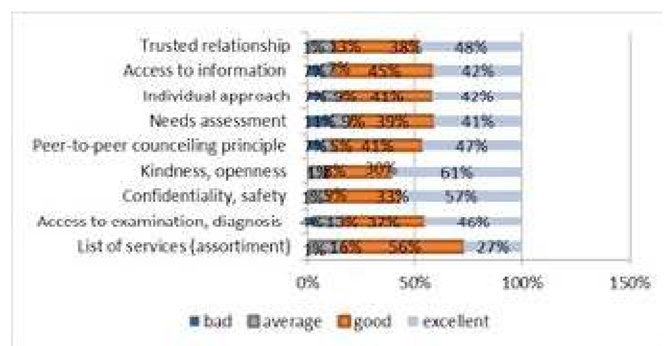
– LGBT, Osh City.

“ Residence permits and registration for social services [are services that I need] ”

– LGBT, Osh City.

In Figure 16 it is clear that the majority of LGBT respondents positively rate the work of NGOs, in particular in relation to factors such as friendliness and openness when providing services, respect for confidentiality and safety, trusted relationships with representatives of the LGBT community, and respecting the principles of peer counselling.

Figure 16. Evaluation of the work of BtG and GF in-country partner organisations, N=111



3.2.4 In-depth interview results

“ Extremely high quality. I was never left unsatisfied with the organisation's services. They have always provided timely information about security, events and the work of the outreach workers as a whole is at a sufficient level ”

– LGBT, Bishkek.

“ I really like that I can receive help with anything at any time of the day. Everything from informational and medical to entertainment services was provided in necessary amounts. Maybe it would be better if there were more outdoor activities and field trips ”

– LGBT, Bishkek.

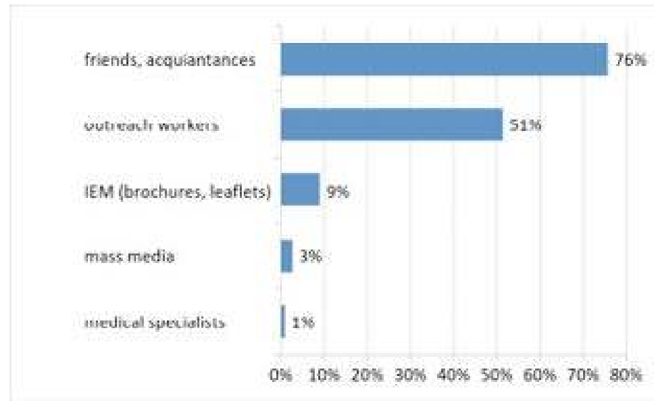
However, all things considered, there are isolated negative responses with regards to needs assessments (11%), an individual approach (7%) and respect for the principles of peer counseling (7%).

“ The quality of services is subpar. They give out, and they work, but not to completion. More attention needs to be paid to people, to follow up with the person's condition after they first approach the organisation and not forget about them. Each person is in need of a particular approach. Before you provide any sort of services, you must hold a consultation. For example, when it comes to hormonal therapy, one must talk to the person in a very detailed manner before you provide medication ”

– LGBT, Bishkek.

According to the respondents, LGBT people find out about service-providing NGOs from each other (76%) more often than from outreach workers (51%). It is possible that the LGBT community is generally more aware of HIV services and/or human rights organisations or, having formed a tight-knit social network, they more closely communicate with each other. It is also possible that outreach workers are simply better able to build up and access their wider network. Whatever the reason, this particular trait of the LGBT community can be utilised to effectively draw new members of the key population to join prevention programmes.

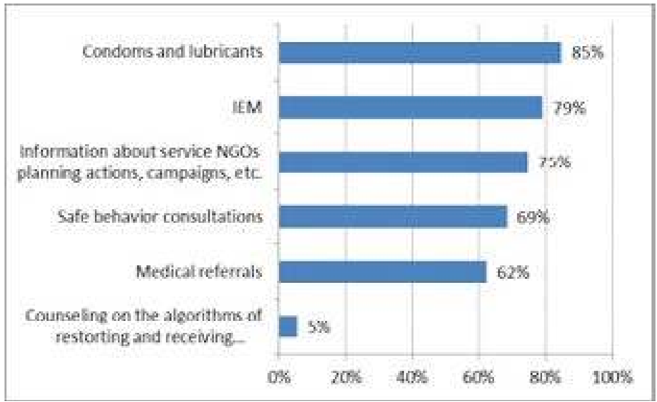
Figure 17. Sources of information about prevention programmes and organisations, N=111



3.2.5 Interaction with outreach workers

Outreach workers are the main source of prophylaxis and lubricants for the LGBT community. This is how 85% of respondents from the LGBT community received condoms and lubricants. 79% of respondents received informational and education materials from outreach workers and 75% received information on events planned by NGOs (figure 23).

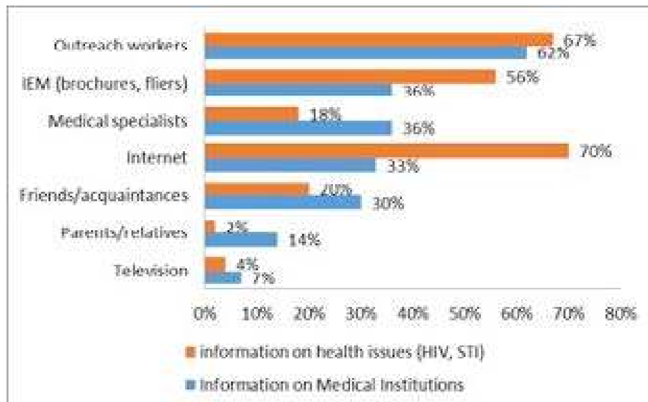
Figure 18. Services provided by outreach workers, N=111



Among LGBT respondents the most common source of information is the internet (70%), while 67% received information from outreach workers. It is possible that this is due to the fact that the LGBT community is more educated in comparison to the PWID and SW communities, and also maintains a higher material and social status, which facilitates access to information from the internet or other paid resources.

Outreach workers are the main sources of information about medical institutions, diagnostics and treatment (62%), but more than a third of LGBT respondents (36%) turn directly to medical institutions for answers on these topics, and a third (30%) reach out to friends and acquaintances.

Figure 19. Sources of information regarding health (HIV, STI, TB) and medical institutions for LGBT respondents, N=111



In evaluating the quality of information on organisations and available services, respondents were asked how outreach workers provided this information. 74% of LGBT respondents stated that outreach workers answered all of their questions while 67% stated that they focused on free and anonymous services, but 8% stated that they did not receive this information.

Those in need of legal aid approach specialised organisations more often than they approach outreach workers (32%). 26% of LGBT respondents have friends that are lawyers, which supports the conclusion that the LGBT community is more socially adapted.

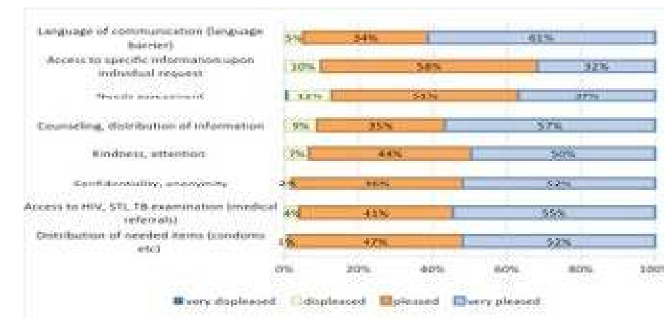
Table 7. Where and to whom do LGBT respondents go for legal assistance, 2015

Sources	abc	%
Friends that are lawyers	18	26%
Law firms	1	1%
Private attorneys	8	12%
Relatives that are lawyers	8	12%
An organisation through an outreach worker	22	32%
An organisation through acquaintances	5	7%
Nowhere to go	3	4%
Unable to respond	3	4%
Total	**107**	**100%**

60% of LGBT respondents stated that they meet with outreach workers a few times a month, 14% stated that these meetings happen a few times a week, and 12% meet with outreach workers daily. During the qualitative analysis of the outreach work, respondents were asked to rate the quality of the work based on parameters such as access, confidentiality and anonymity, friendliness and attentiveness, quality of consultations and information, how well the needs of the target group are met by outreach workers , and whether or not there is a language barrier when approached by outreach workers.

Figure 20 shows that respondents were "very pleased" at how outreach workers addressed language requirements when providing information (i.e. there is no language barrier). 55% were very pleased with access to examinations for HIV, STI and TB, as well as with maintaining the confidentiality and anonymity of clients (52%).

Figure 20. Evaluation of the parameters of interacting with outreach workers, %, N=111



Attention should be paid that 12% of respondents did not like how to assess needs with them and 10% displeased access to specific information upon individual request. During the course of the in-depth interviews, respondents noted that the fact that outreach workers come from the key population itself has a positive impact on the effectiveness and quality of their work. This is because they have personal experiences with the problems faced by the key population, they know how best to approach people, they understand how the community socialises, and so forth.

" In theory the outreach worker told me about what Labrys does and where I can go for help, but I did not need this. I have always handled things myself "

– LGBT, Bishkek.

" They talk about partner organisations and I went to different organisations based on their advice. When it comes to the services of the organisation, I probably was not interested, because we didn't chat about these topics. That being said, they would have told me if I had wanted them to "

– LGBT, Bishkek.

" It is necessary to concretely, concisely and eloquently describe the services to the community, and, I am certain, that about 90 percent would agree to come to the organisation and participate in programmes "

– LGBT, Bishkek.

" I like that they are able to approach the community and [we] more or less now understand the essence of their work. And I feel that the outreach work has improved. But sometimes they may miss an important part, such as the list of services, and talk about something else, but this is mainly due to the human element "

– LGBT, Bishkek.

The vast majority of interview participants stated that outreach workers are highly trusted and the information they receive from outreach workers is unquestioned. Even when outreach workers made mistakes, respondents felt that this was the fault of the organisation, due to a lack of appropriate training for the outreach worker.

" I admire them, because they are committed to us knowing more. Timely work. Everything was smooth. There weren't any failures or hitches. There were never any moments when they were unable to handle their responsibilities. There weren't any incidents, during which I would have been able to doubt the competence of the outreach worker "

– LGBT, Bishkek.

“ I have no reasons to not trust them. I trust them completely. With regards to information, they also get their information from somewhere, so if they make a mistake, it's not their fault. Nonetheless, there were no incidents of an outreach worker giving false information ”

– LGBT, Bishkek.

“ I trusted the outreach worker…. With time I understood that he wants to help me and helps me with all of his strength ”

– LGBT, Osh City.

Respondents were near unanimous in agreeing that outreach workers are friendly and answer all questions.

“ I met the outreach worker at an event at the organisation. He told me about the organisation, about testing and gave me protection. After that we regularly saw each other in the club and became friends. I later came to the organisation through him”
LGBT, Bishkek.

“ I went through a period of apathy and insomnia and did not want to do anything. I can't give a reason and don't know if it was connected to sexual orientation and gender identity in some way. Coming from this, I was in need of peer-to-peer counselling to determine my next steps. Due to certain circumstances, I needed a place to live and this stemmed from my condition. In this situation, [the outreach worker] helped me. He conducted peer counselling and referred me to a someone who could help me ”

– LGBT, Bishkek.

There was also negative feedback received on the outreach workers, which can be considered as a valuable source of information for developing strategies to remedy the issues mentioned. A large role is played by individual personalities, with some respondents noting that there were incidents in which the outreach workers were arrogant and passive. This underlines the necessity for outreach workers to possess certain skills, such as an ability to find common ground with everyone they encounter during the course of their work.

“ Some outreach workers turn up their noses and do not even want to approach us. Sometimes it seems to me that they hire inappropriate people to be outreach workers ”

– LGBT, Bishkek.

“ I didn't like anything about the work of the outreach worker, seeing as how I never saw any activity from him. They, in my view, basically did not work, passively work, or cover only an narrow range that is familiar to them. If they did cover new people, I'd probably have seen this ”

– LGBT, Bishkek.

“ It sometimes seems to me that inappropriate people are hired to be outreach workers. [An outreach worker] is the face of the organisation and must be adequate and educated. There was an incident, when one outreach worker misbehaved outside of the organisation. Personal qualities and good behaviour are also important ”

– LGBT, Bishkek.

Respondents expressed the opinion that outreach workers can lack commitment and motivation. They are not always active, and can lack creativity and a desire to do their own work and present it in the best light. There were comments suggesting a passive approach by outreach workers when distributing items and IEM, and there was considerable support for an increase in the motivation of outreach workers. Respondents felt that if an outreach worker themselves is not committed and active, they will be unable to interest and motivate others. Meetings are productive when the outreach worker has a positive outlook, a sense of humour, and is friendly and cheerful. This all impacts the motivation of young members of the key population to meet with an organisation and receive services.

“ Not all outreach workers work equally. For example, there is one outreach worker I consider strong. He works in the clubs, approaches each and every table, talks about the organisation and introduces himself to everyone. Not that long ago I saw how the outreach worker sat down with each guest, talked with them, got their contact information and offered help. I cannot praise him enough ”

– LGBT, Bishkek.

“ The thing is that more time must be set aside for psychological training of outreach workers. They should have knowledge on how to gain the trust of other people. They must overcome the internal complexities of daily life in the community ”

– LGBT, Bishkek.

“ Based on my previous experiences, I rate it highly, but at the moment I feel that the work of Labrys has become less effective. Employees do not try to rally people, and the “fire in their eyes” has died down. We see that there is little motivation. The employees need to be sent to trainings in Europe ”

– LGBT, Bishkek.

As a whole, the work of outreach workers is recognized as incredibly important and is valued by the key population. That is the reason why professionalism and competency of outreach workers is important, as it influence on the level of trust displayed by the SW in the programme.

“ Of course, it’s necessary. I personally think, that an organisation is a big house, where each and every member of the community is happy to come. The role of the outreach worker is in providing information, because even if we find it ourselves, we’d probably not understand. That’s why the outreach worker is important. They send (people) to shelters and help in a material way. When there is an organisation, I feel under protection. The outreach worker is a bridge between medical institutions, human rights organisations, social services and people from the community. I wouldn’t be able to approach these institutions myself without an outreach worker ”

– LGBT, Bishkek.

“ Of course, they’re necessary. They are an essential part of the organisation, because they are the only people from the organisation that have a connection to the community ”

– LGBT, Bishkek.

“ Necessary of course, because there are a lot of people that do not know about the organisation. The advantage of people being informed about the organisation, is that it will be easier for them to receive various types of services from their own organisation than from a hospital ”

– LGBT, Bishkek.

“ They are needed. You could do without them, but it would be difficult. They are the link between the organisation and the community. Their advantage is that the community trusts them more than any other employees of the organisation. You can read information online, but you won’t understand everything ”

– LGBT, Bishkek.

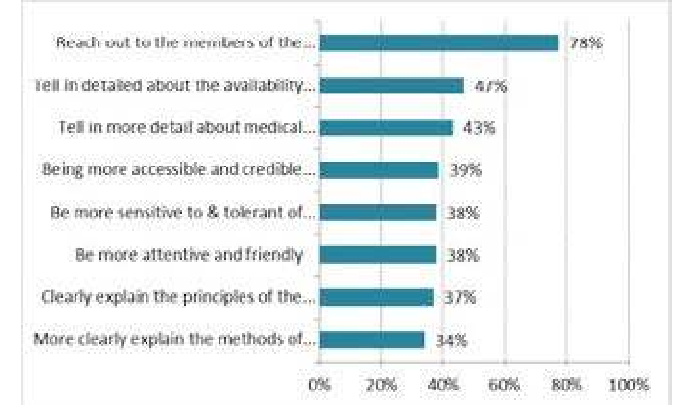
“ Without a doubt, because the outreach worker is always in sync with the community. And only he can communicate the needs of the community to the rest of the organisation’s staff. And he is the first person we approach from the organisation, so the outreach worker is the “bridge” between the community and the organisation ”

– LGBT, Bishkek.

For improving the effectiveness of outreach work, 78% of respondents recommended meeting more often with members of the LGBT key population, and 47% recommended more frequently informing the key population about available programmes and projects in the field of HIV prevention.

According to those surveyed, outreach workers must have good communication skills, understand the psychological characteristics of the target group, and present sufficient information about national HIV infection within the key population.

Figure 21. Recommendations of LGBT respondents for improving the effectiveness of outreach workers, N=111



“ Be active. In general, they must have a desire to work as an outreach worker. Some outreach workers could fill in the indicators themselves. They must help people. I’d recommend that they go to the clubs. There are a lot of new people there, and they could be included. Let them mix work and pleasure. They need to describe the available services in a more detailed way; they need to talk about the growing HIV epidemic among the gay community. I found out that quite a lot of people are HIV positive today. Before, HIV positive people were almost like a fairy tale to me. Outreach workers must talk frequently about safe practices based on examples and statistics. STIs also shouldn’t be forgotten. And they should talk about personal safety, because it is very topical. They have information, let them share it ”

– LGBT, Bishkek.

“ The outreach worker] must be flexible and be able to adapt to an individual, find common ground, and earn trust, which would lead to people coming to him for help. He needs to be mobile, confident, and quick in order to cover a lot of [people] ”

– LGBT, Bishkek.

“ The outreach worker] must be knowledgeable about their work, outgoing, pleasant. They need to be cute and liked by a lot of people, and befriend everyone so people listen to him and trust him. He should also be straightforward ”

– LGBT, Bishkek.

“ First, to know psychology, jurisprudence, psychology, and the society in which they work. To have skills in public speaking, positioning, privacy, and security. And to not have a relationship with their clients. Not to lead an amoral life, and he shouldn’t be a nationalist. To be politically independent, but socially active ”

– LGBT, Bishkek.

Other than this, it was also suggested that outreach workers tell the key population members more about their own work, so that they knew who to reach out to when necessary. It was also specified that outreach workers be more active in evaluating the needs of clients in prevention programmes.

“ It is revealing that people don’t talk about their personal problems to outreach workers. An elementary example: outreach workers do not ask me if I have condoms. Even if I do not need this type of help, they should offer it. Maybe one day I will be in need of this service, and I’d go to them for help. Additionally, outreach workers must talk about what they do so that people know that they can ask them for help. It’s possible that they work in their own circles, and this is not good. The entire community should know him; he needs to be visible ”

– LGBT, Bishkek.

“ They are closed groups and do not want to socialise. They hang out with their own, have sex with each other and, in theory, do not want to go to the organisation. This stems from a lack of information. They need to be told about anonymity and confidentiality. Maybe this would help ”

– LGBT, Bishkek.

There were suggestions about using the tactics of “effective marketing”, when the principles of network recruiting are widely employed in efforts to attract members of the key population.

“ It is ineffective to walk out somewhere, search for people and bring them to the office. It is easier to attract new people through those who already go to the organisation ”

– LGBT, Bishkek.

“ Outreach workers can approach new people through their own friends. If they directly try to meet people without the help of friends and acquaintances, it is unlikely that they will have good coverage ”

– LGBT, Bishkek.

"There are outreach workers that have their own complexes, are unsure of themselves and closed off and this is reflected in their work… It is necessary to tell guests that they should bring their own friends. This would be much more effective, because people are afraid to go to an organisation by themselves, but they trust their friends and can come with them"

– LGBT, Bishkek.

"There are outreach workers that are not always that sociable. Maybe when outreach workers are selected it would be good to hold an election within the community and not just choose someone from among the organisation's employees. Now there are not that many outreach workers and fewer sessions are held on questions of health and HIV. It seems to me that outreach workers now very rarely talk about HIV as an epidemic. Maybe this is why the epidemic is growing. Now, many young people are not covering it, but it was covered [when we were young]"

– LGBT, Bishkek.

It is therefore necessary to actively inform the key population about available services in organisations, and to try to take the views of the key population into consideration when hiring staff, holding information events and communicating about the situation with regard to HIV infection. Organisations are also advised to maximise the use of all available resources (outreach workers, volunteer movements, and community leaders) so that the largest possible amount of people can be informed about the types and scope of available services, and about referrals to medical institutions and doctors.

Every single survey participant stated that they recommend their friends to go to the organisations. Many of them have brought and continue to bring their circle of friends.

"I recommend it. Many think that they don't need [to go to] organisations, due to the stereotypes that they have. I recommend that they go at least for the atmosphere and a safe space. They receive services later, once they are already drawn into the life of the organisation. That's what I recommend to many [friends]. They come and they do not regret coming. Many of the guests do not have a concrete goal of receiving services. They simple come"

– LGBT, Bishkek.

"Yes, I've already done that and have brought my friends to the office. My motivation is that others would become free, behave the way they want, and receive support from other people like them"

– LGBT, Bishkek.

"And if I were asked for help, I would send them to you, give them your telephone number and tell them what kind of support you would provide"

– LGBT, Bishkek.

3.2.8 Barriers

A number of barriers may prevent members of the community from actively receiving services in organisations. These include fears of negative consequences on the part of individuals with a high level of anxiety, or fears of experiencing high levels of stigma and discrimination from those in the individual's social environment. Therefore, the majority of in-depth interview participants noted that any information given about a programme must emphasise confidentiality and anonymity. Additionally, many respondents stated that a majority of key population members live a quite concealed life, speaking only with a limited circle of people, and do not want to frequent new places. Only exclusive and/or highly demanded services, as well as the distribution of needed materials, can attract sufficient interest for individuals to overcome their fear and personal complexes. The younger members of the key population are quite distrustful and suspicious and this is undoubtedly a barrier in attracting them to join programmes.

"Misinformation is the main thing. As well as fearing for their own safety, if someone is new they might be shy. When I first came to the organisation, I did not want to come back. I probably expected more from the organisation. I also wanted to get out of the community [and] out of my internalised homophobia. And then afterwards, thanks to trainings, seminars, and new friends, I began to become involved in the life of the organisation"

– LGBT, Bishkek.

"The community has a low level of awareness of the organisation. Some know but are too nervous to go to the organisation. It is possible that they do not want many other people to know about them. But if an outreach worker were to approach everyone and attract them to the organisation, I do not think anyone would turn him down"

– LGBT, Bishkek.

"First, it's the stereotypes. They think that it's an office, which is not a safe zone. Some news about attacks on the office can also [discourage people]. They do not want to be open, and they think that if they come to the office people would immediately know all about them. And others think that they do not need it"

– LGBT, Bishkek.

"Some are simply closeted. The organisations do not interest them and they are too shy to come. For some reason they are not shy in the clubs, but are too nervous to go to organisations. I see barriers and problems only with the community, not in the work of outreach workers"

– LGBT, Bishkek.

3.3 PEOPLE WHO INJECT DRUGS

3.3.1 Sentinel surveillance[9]

The sentinel surveillance included a small number of PWID with less than one year of experience of using drugs (2%), which is an indicator of inadequate access to this group. The PWID groups that are the least covered by prevention programmes are those that have the least experience with intravenous drug use and who were the youngest age group. There therefore remains a large portion of the PWID community that practices dangerous injection behaviours, while among PWID that have constant access to new needles (84.4%) there were noticeably fewer individuals practicing risky injection behaviours. The main reasons for limited access to new needles were lack of money (34%) and distance from a pharmacy (21%). When asked what were the primary places for finding new needles over the past twelve months, PWID respondents noted pharmacies (54%), outreach workers (38%), employees of trust centres (13%) and other PWID (95%).

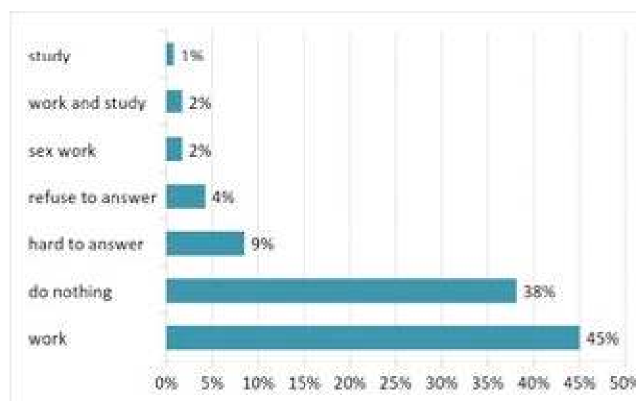
The coverage of PWID by prevention programmes remains at low levels (28.2%) with a notable decrease by nearly a factor of two in Bishkek, where a large number of the AIDS services and/or human rights organisations are concentrated.
The highest coverage by prevention programmes was found in Osh City (41%). Studying the impact of coverage with prevention programmes, in particular the minimal package of services for PWID (distribution of IEM, needles and condoms) on injection behaviours, shows a lack of a statistically relevant connection between these factors. As a whole, access in the Kyrgyz Republic to testing with the provision of results remains low (43%), which can also be said about testing coverage with provision of results and complete consultations (33.3%). A decrease in indicators is noticeable in Bishkek and Chui oblast.

3.3.2 Social portrait

The majority of surveyed PWID were men (91%). 40% were ethnic Russians, 27% ethnic Kyrgyz and 10% ethnic Uzbek. The majority of surveyed PWID were single (66%) and PWID who were married or cohabitating with a partner constituted just 27% of respondents. 42% have a secondary education, 23% have secondary vocation education, and only 9% of respondents had a higher education. Only 42% of PWID surveyed live in their own homes, with the remaining living in social housing (22%), rented apartments (10%), in a shelter (8%) or on the streets (2%). 42% of PWID stated that they are employed but the majority have odd jobs as opposed to permanent employment, and 38% are unemployed. 86% of PWID surveyed have never left the country.

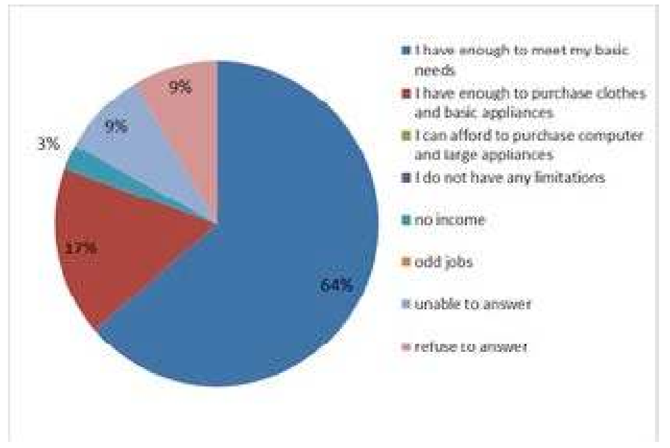
9 The Republican Center on Prevention and Control of AIDS .S (2013). Research SS (sentinel surveillance) for HIV infection among IDU. Bishkek: The GlobalFund to Fight AIDS, Tuberculosis and Malaria. aidscenter.kg/ru/biblioteka.html

Figure 22. Occupation of PWID respondents, N=118



64% of PWID surveyed stated that their monthly income covers only their basic needs. 17% are able to purchase clothing and basic appliances, and 3% stated that they have no source of income.

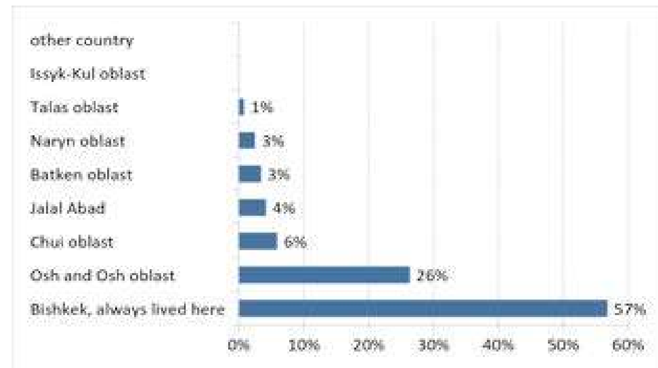
Figure 23. Monthly income of PWID respondents, 2015 (N=118)



At the time of this survey, 58% of respondents specified that they do not have children. However, 37% have between one and four children, which is cause for concern as the risk of developing an addiction to psychoactive substances in families with a parent addicted to narcotics is several times higher than in families without a parent addicted to narcotics. In addition to this issue, PWID might have other specific needs which should be studied for inform future strategies and planning.

The survey was conducted in Bishkek and Osh City, but respondents were asked about their origins. According to the information received, 57% of PWID respondents have always lived in Bishkek and 26% are representatives of Osh City or Osh oblast.

Figure 24. Region of arrival of PWID respondents, N=118



3.3.3 Need for, receipt of and satisfaction with services

As is visible in the Table 8, the services in the highest demand from PWID respondents before applying to partner NGOs were:

- distribution of cleaning supplies and food (78%),
- distribution of medications due to health problems common among PWID (77%),
- needle exchange services (74%),
- referrals to medical institutions (64%),
- consultations on safe behaviour (63%).

The most accessible services aligned with those most needed by respondents:

- distribution of condoms and lubricants (100%),
- needle exchanges (99%),
- psychological counselling (97%),
- IEM (97%),
- consultation on safe behaviour (97%),
- medical referral (97%).

When asked what the most helpful services offered were, PWID respondents noted:

- distribution of cleaning supplies and food (99%),
- needle exchanges (97%),
- detox therapy (97%),
- legal aid (97%),
- referrals to medical institutions (97%).

Table 8. Satisfaction with the services provided by the organisation, N=118

Services	Needed	%	Received among those needing services	%	Useful for those who received services	%
Detox therapy	40	34%	31	78%	30	97%
Legal aid	41	35%	31	76%	30	97%
Mutual support and self-help groups	51	43%	47	92%	39	83%
Distribution of condoms and lubricants	57	48%	57	100%	50	88%
Temporary housing and living services	60	51%	52	87%	50	96%
Psychological counseling	71	60%	69	97%	65	94%
IEM	71	60%	69	97%	56	81%
Consultation on safe behavior	74	63%	72	97%	66	92%
Medical referral	75	64%	73	97%	71	97%
Needle exchanges	87	74%	86	99%	83	97%
Purchase of medication	91	77%	72	79%	66	92%
Distribution of cleaning supplies and food	92	78%	86	93%	85	99%

The results of the in-depth interviews showed that a quarter of respondents need comprehensive medical examinations, including all forms of medical specialists, but that this need was not being addressed.

“Additional services are needed so that people want to visit an organisation. They welcome us in, but all we receive are needles, and too few at that. We buy more anyway. (We get) medicines if we are lucky. And IEM, [but] nobody reads those anyway”

– PWID, Bishkek.

“It’s difficult for many to make it down to the organisation because they don’t want to waste money on transportation. We’re glad to get the needles but they aren’t enough, as we have to buy more. There aren’t any more reasons [to go to organisations], we already received analysis. It’d be another story altogether if there were dentists and medication [available]”

– PWID, Bishkek.

“The majority of addicts are in poor health. We need comprehensive diagnostics and medical examinations, preferably with specialists”

– PWID, Osh City.

Employment services and legal assistance were described by respondents as inaccessible or barely accessible. The majority of respondents were also unable to meet have their needs met by these services. The need for treatment of HBV and HCV also goes unmet.

“I have had hepatitis C for over five years, but I am not taking anything because it is so expensive. If there were medicines, even support, the prices wouldn’t be affordable for the programmes. As things are, the only help given are clean needles, and there aren’t enough of those”

– PWID, Osh City.

“We’d like comprehensive medical examinations in one location so we don’t have to travel around the city”

– PWID, Bishkek.

> “There aren’t enough medications, and more needles would be nice”
>
> – PWID, Osh City.

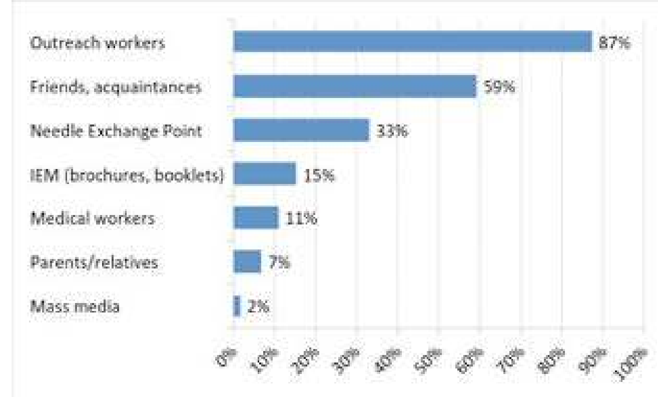
In the table below, it is clearly visible to what extent respondents are satisfied with the work of NGOs. The majority of PWID respondents rated the work of NGOs as “good” or “excellent”, but it is important to note that some parameters were rated as “poor”, such as the range of services, safety, access to information and trusted relations. Therefore, in interacting with the community it is necessary to emphasise confidentiality and provide more information on services and organisations, so as to build trust with PWID.

3.3.4 Interaction with outreach workers

The respondents identified outreach workers as the main source of information on questions relating to health, AIDS services and/or human rights organisations, and the distribution of needles. But it is necessary to stress that one third of respondents learned about an organisation from a friend.

87 % of PWID respondents stated that they learned about organisations from outreach workers, 59% were informed by friends and acquaintances, and 33% found out about the organisations at needle exchange points.

Figure 25. Sources of information about prevention programmes and organisations, N=118



47% of PWID respondents state that they most often obtain needles from outreach workers and 33% obtain them at needle exchange points (Figure 26.

Figure 26. Location of obtaining new instruments for injecting for PWID, N=118

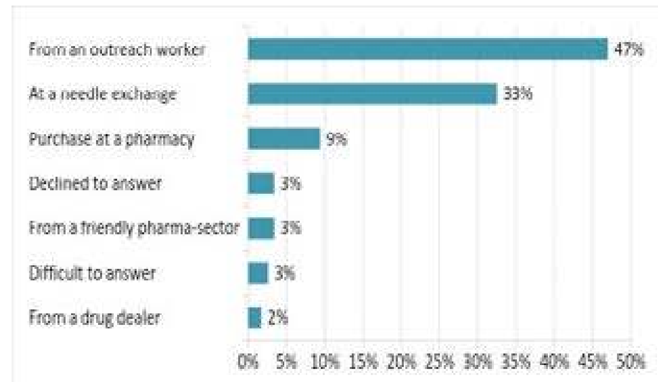
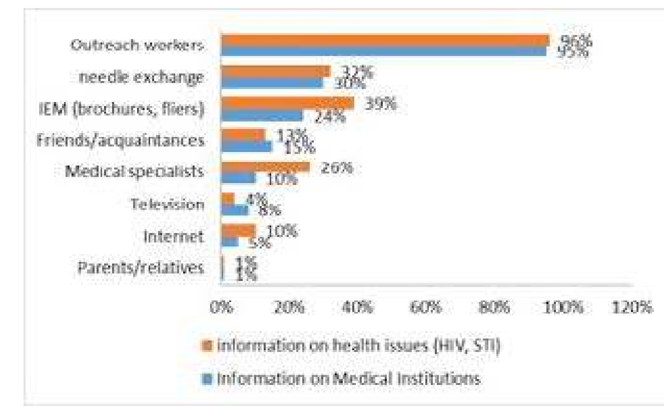


Table 9. Evaluation of the work of organisations, where PWID respondents received services in a prevention programme

Services	Poor	Average	Good	Excellent
Range of services	1%	15%	71%	13%
Access to examinations and diagnostics	0%	16%	68%	16%
Confidentiality and safety	1%	7%	64%	28%
Friendliness, openness	0%	3%	59%	37%
Principle of peer counseling	0%	20%	61%	20%
Needs assessment	0%	25%	64%	12%
Individualized approach	0%	5%	65%	30%
Access to information	2%	21%	54%	23%
Trusted relations	1%	19%	49%	31%

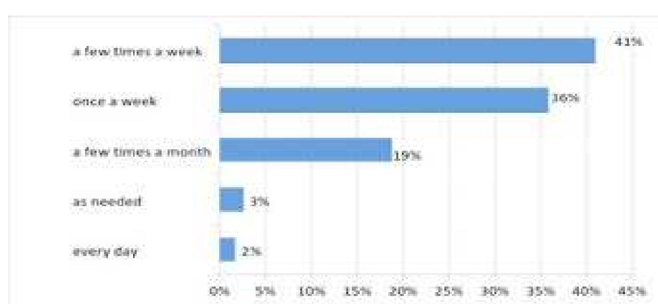
PWID most often receive information about health from outreach workers working for prevention organisations (96%) and 39% receive this information from educational and informational materials. It is possible that, due to their material and social status, PWID have limited access to the internet and media, and outreach workers are therefore their first point of contact for health information.

Figure 27. Sources of information regarding health (HIV, STI, TB) and medical institutions for PWID respondents, N=118



41% of PWID respondents meet with outreach workers a few times a week, while 36% meet with them once a week. It is clear therefore, that meetings between outreach workers and members of the LGBT and SW communities take place less frequently than with PWID.

Figure 28. Frequency of meetings between outreach workers and PWID respondents, N=118



In evaluating the work of outreach workers, 85% of PWID respondents noted that the outreach workers emphasised that the available services were completely free and anonymous. 67% stated that the outreach workers listed all of the services offered by the NGO.

The vast majority of interview participants agreed that the outreach workers and the information they provide are highly trusted. They shared in a detailed manner their impressions of the HIV-related consultations they received. Many feel that the outreach workers are well trained and experienced in their given field. It was also stated that the outreach workers adequately inform PWID about the organisations and medical institutions where they can receive necessary services.

> “He engenders a sense of trust. Thanks to him, I am able to meet some of my needs”
>
> – PWID, Bishkek.

> “A trust-based relationship. I trust the information. We know that he is experienced. He knows me, I trust him, and he accompanies me to medical exams”
>
> – PWID, Bishkek.

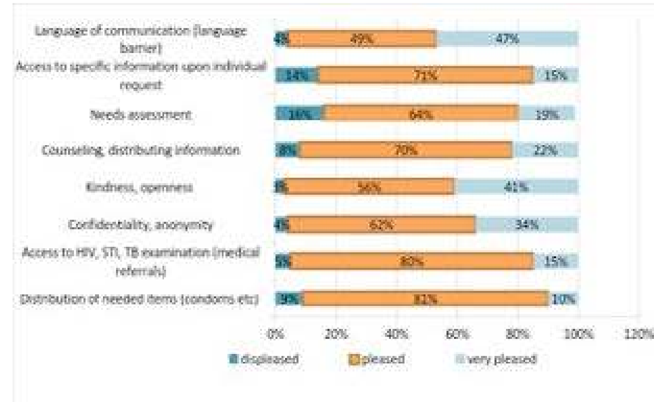
> “Yes, he earns trust, because we are able to talk to him openly without fear of discrimination in his dealing with [us]”
>
> – PWID, Osh City.

> “They can be trusted. But when they promise more than they can deliver, we begin to lose trust in them. There have been moments in which they did not fulfil their promises”
>
> – PWID, Osh City.

In evaluating the quality of the work of outreach workers respondents were asked to do so on the basis of a number of criteria. In Figure 29 below it is clear that those surveyed were “very pleased” with the absence of a language barrier (47%), that the services were offered in a friendly environment (41%), that confidentiality was maintained (34%), that the necessary products were distributed, and there was access to medical examinations.

The availability of needs assessments and access to specialised information upon individual requests were the two criteria rated the lowest, by 16% and 14% of respondents respectively.

Figure 29. Evaluation of the parameters of interacting with outreach workers, N=118



Respondents noted that outreach workers are equal consultants and representatives of the community is a positive moment. This positively impacts the effectiveness and quality of their work. An absolute majority was united in feeling that outreach work was essential for the community.

> The outreach worker has led me to trust him. He is a peer consultant and his work is needed and essential. He is able to explain to, help, and inform an addict. You can go to him with any question "
>
> – PWID, Bishkek.

> " He acts as a bridge between members of the community and medical services as well as other services. If there weren't outreach workers, I would probably still walk around without documents and I would have nowhere to live "
>
> – PWID, Osh City.

> " Thanks to outreach workers, the number of [PWID] participating in HIV prevention programmes has increased. Simultaneously, the organisations are paying more attention to our opinions on improving their services for [PWID] "
>
> – PWID, Osh City.

According to the opinion of respondents, for **outreach work to be improved**, it is critical that outreach workers belong to the key population and talk in more detail about the consequences of risky behaviour.

> " An outreach worker] needs to know the needs of the clients, delve into their problems and needs to be an equal"
>
> – PWID, Osh City.

> " To speak to members of the PWID community as an equal, to be more precise on the basis of peer-to-peer. This is for a deeper understanding of the community's problems"
>
> – PWID, Osh City.

> " They need to demonstrate more visual examples of what happens to people that shoot up Dimedrol"
>
> – PWID, Bishkek.

There were many requests for efforts to increase the number of outreach workers, and raise their salaries to increase motivation levels, thus positively impacting on the quality of the motivational counselling they provide.

> " At the moment, I am content with everything. It'd be possible to meet more often if there were more outreach workers. It'd be nice to hear more information from them. To more clearly explain various methods "
>
> – PWID Bishkek.

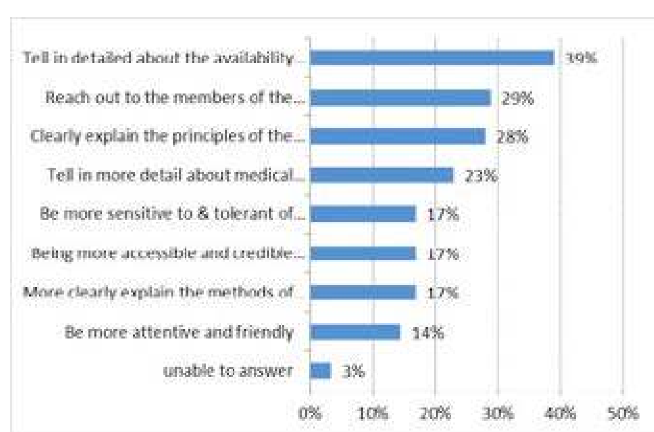
> " Outreach workers themselves are in need of a few services. It's hard to help others when you yourself are living in poverty "
>
> – PWID, Bishkek.

> " They are already doing good deeds. Increase their salary "
>
> – PWID, Osh City.

> " It seems to me that they do not make much. They need to be paid more "
>
> – PWID, Osh City.

As outlined in Figure 30%, 39% of surveyed PWID recommended that outreach workers talk in more detail about the availability of certain programmes (harm reduction, social support, community centres, drop-in centres etc.). 29% noted that is necessary to be in more frequent contact with members of the community, although according to the results received from PWID respondents, outreach workers are already in quite frequent contact, with 41% of respondents stating that outreach workers contact them a few times a week.

Figure 30. Recommendations from PWID respondents for increasing the effectiveness of outreach workers, N=118



A third of all respondents recommended that material stimulus and an increase in the scope of services would lead to a wider coverage and increased attraction of new members.

> " Increase the scope of medical services, learn more about your client and about his health "
>
> – PWID, Bishkek.

> " Word of mouth, tell people where they need to go "
>
> – PWID, Bishkek.

> " Interest people with benefits (health insurance, pension assistance, etc.). Young people won't go though, because they don't need these benefits. They go for needles. Young people hide more often than not. Nobody trusts anybody. But I think sooner or later everyone will go to programmes "
>
> – PWID, Bishkek.

" Motivational groups of various events in the framework of preventing HIV/AIDS "

– PWID, Osh City.

" Materially stimulate (participation)… phone units, packages and what not "

– PWID, Osh City.

3.3.5 Results of in-depth interviews
Participants of in-depth interviews stated that they would like it if discussion about programmes focused on confidentiality and anonymity. Many respondents mentioned the inaccessibility of PWID. The following comments were related to how one could access a larger number of PWID.

" Participating in HIV prevention programmes, I realised how vulnerable I am and how withdrawn from reality I am. My advice to members of the community is to participate in HIV prevention programmes, over time you will understand how much better your life will become "

– PWID, Osh City.

" Everything that HIV service organisations do is aimed at preventing HIV and improving the quality of life of people who inject drugs. Because the [PWID] community is a vulnerable group, I would advise my friends to participate in these programmes, at least for our children's future "

– PWID, Osh City.

" It is necessary to not be shy and to explain that it [causes] death. Motivating care packages, phone units, clothes and at least temporary are needed "

– PWID, Bishkek.

Every single respondent noted that they will advise their friends and acquaintances from the PWID community to receive services from AIDS services or human rights organisations, and a majority have brought and continue to bring their circle of friends. Respondents understand that they are vulnerable to HIV and feel that simply informing people about health issues can lower the risk of HIV infection.

" Yes, I tell everyone. So that every one of us would understand to what extent we lead a dangerous lifestyle and so that at least a small part of our community would consider leading a safer lifestyle, so that we could become full members of society in the future "

– PWID, Osh City.

" Of course, I recommend it, but many are afraid of coming out into the public as if it is better to ride this out. Therefore you can only really lure people in with giveaways "

– PWID, Bishkek.

" I've brought members of the [PWID] community, and going forward will recommend it. Thanks to the free services at the NGO I receive, I feel like a complete person "

– PWID, Osh City.

Young people from the PWID key population remain quite inaccessible, so it is necessary to devise mechanisms for working with this group. Law enforcement plays a large role in impacting the motivation of young PWID to seek help or information from an organisation. Consequently, it is necessary to work with law enforcement to lower the risk of PWID being arrested while receiving services.

" Young people are afraid and they are not ready to walk openly, and reach out to people they don't know, let alone an organisation "

– PWID, Osh City.

" Young people don't trust. If someone brings them, maybe they would come for some sort of hand-out, but they would never just come on their own "

– PWID, Bishkek.

3.3.6 Barriers
There are a number of barriers preventing members of the PWID key population from actively receiving services in organisations. These include a fear of negative consequences stemming from participating in the harm reduction program, harassment from law enforcement, publicity and rejection by relatives, stigma and discrimination from the public, and self-stigmatisation. Low awareness of a programme's principles is also a barrier to participation.

" Not everyone knows and they are afraid of being public. There needs to be more awareness, maybe televise that there is such an organisation and these are the services it provides "

– PWID, Bishkek.

" Stigma and discrimination from the public, police and medical professionals. A lack of awareness on the part of the [PWID] community "

– PWID, Osh City.

" Law enforcement and the parents of users do not understand. You need to work with the relatives "

– PWID, Osh City.

" Self-abasement. Pride is misleading them. The sense of mistrust and the unknown. Work with outreach workers is needed "

– PWID, Bishkek.

" Until a person on their own recognises that they need certain services, it is doubtful that you can attract them to the organisation "

– PWID, Osh City.

3.4 OUTREACH WORKERS

According to the GFATM guidelines, large coverage is considered a key factor in the success of a programme aimed at preventing and treating socially significant diseases among the PWID, SW and LGBT key populations. Reaching a large number of those vulnerable to HIV infection is difficult due to their inaccessibility. Outreach work is a necessary component of prevention programmes to address the obstacle of inaccessibility, and should be included in the project-planning stage.

During the course of the research, documents that describe the organisation and its outreach work were analysed. There appears to be no concrete national standards, but organisations tend to rely on the following documents in their work:
1. Batyrbekova, A., Ermolaeva, I. & Rybina, N. (2014). *Guide for outreach workers in teaching harm reduction strategies for working with IDU.*
2. Sauranbaeva, M. & Davlettalieva, T. (2010). *Guide to conducting outreach work. Educational module for outreach workers.*
3. Klimenko, M. & Kostenko, S. (2014). *Guide for outreach work among MSM/LGBT groups in the Kyrgyz Republic.*

The aforementioned guide set forth the following basic guidelines for outreach work:
1. An increase in the level of knowledge of the target group and their partners
2. The formation of safe behaviour skills.
3. The distribution of means of self-protection.
4. The distribution and presentation of informational and educational materials.
5. Referral of the members of the target group.
6. The promotion of social adaptation.
7. The development of outreach work.
8. The conducting of psychosocial counselling on issues relating to HIV infection.
9. Provide assistance to Ministry of health (MoH) and AIDS centres to undertake various forms of examination.
10. The monitoring of the effectiveness of programmes.

In total, ten outreach workers from NGOs operating in Bishkek and Osh City were interviewed. The outreach workers are funded by GFATM, except for two targeting LGBT who are financed by the Bridging the Gaps programme. The table below illustrates the regional distribution of outreach workers in the key populations, with visible concentrations in Bishkek, Chui oblast, Osh City and Osh region. Among PWID, outreach workers are represented as NGOs and healthcare organisations (family medical centres where syringe exchanges can be organised). When measuring the number outreach workers against the estimated number of each key population, it can be argued that there is a lack of outreach workers, primarily in the SW and the LGBT key populations.

Table 10. Distribution of outreach workers across the regions, financed GFATM

	PWID		LGBT	SW
Sources	**MoH**	**NGOs**	**NGOs**	**NGOs**
Bishkek	60	11	7	7
Chuy region	38	15	4	1
Osh and Osh region	8	24	5	4
Naryn region				2
Talas region			2	3
IssykKul region		3		3
Djalalabad region		2	1	4
Total	**106**	**55**	**19**	**24**

It is important to remember that there are no written regulations on how to select candidates for outreach work, and each organisation makes its own decisions on this matter. Deciding how to conduct outreach work depends on the current local situation, and the capacity of the organisation to employ people from different groups. It generally optimal to employ a person who was or is affiliated with a given group, and a critical criterion for selection is to have access to the key population. While applying for a job, a potential outreach worker should also be in possession of an ID card, identification number and a bank account.

Outreach workers who work with PWID are generally identifying themselves as "former" or "present" PWID. Although this proximity to the key population members can have a negative effect on the quality of work, due to a high likelihood of breakdowns and potential difficulty in filling out papers and handling reports, yet it also ensures wider and open access to the key population.

Organisations working with SW and MSM employ outreach workers mostly from their communities. An important criteria is to have a wide social network among community members and to be able to maintain solid contact with the organisations.

Outreach work is either done individually or in a team (two workers to a site). All new outreach workers complete a training session and are taught by more experienced colleagues about outreach skills.

Outreach workers are responsible for:

- searching, establishing contacts and supporting key populations
- gathering data on practices of risky behaviour and factors that influence him/her
- providing information on health and means of prevention for less dangerous means of taking drugs and practicing safe sex
- referrals to medical-social and legal support services
- attracting key populations into prevention programmes and medical-social support programmes,
- distributing IEM, condoms, syringes and other means of protection.

There is a single form of reporting documentation (Annex 7) for PWID, regardless of the organisation.

As one of the main missions of the outreach workers is to search and maintain contact with key populations in order to widen the coverage. Reached (coverage) clients are those who have been provided with at least one service. GFATM's minimal service package includes the following components:

1. Provision of information on HIV, risky behaviour and means of protection provided in an oral form (individual or group counselling/mini sessions), or through leaflets.
2. Provision of means of individual protection related to risky behaviour, such as syringes, needles, tissues for safe injections and condoms for safe sex.
3. Referral to HIV and/or STI check-up services for groups practicing risky sexual behaviour[10].

Knowledge and Qualifications

All outreach workers could clearly articulate their duties. They map an assigned area, estimate the number of members of the target group, plan an output schedule, and designate points for the distribution of the preventive materials. Prior to beginning work, the outreach worker receives an explanation from the organisation on the principles and rules of the work. Outreach workers consider the key parts of their work to consist of the distribution of medical supplies (needles and napkins), condoms and lubricants, the distribution of IEM, and the provision of information about HIV infection.

Informing people about the organisation and the services on offer is conducted on a case-by-case basis and the search for and recruitment of new members is passively undertaken: only if the member comes on their own initiative to the place of contact with the outreach worker. The exception to this are the occasions when the recruitment is more active – when potential clients are approached through clubs and social networks. In the vast majority of cases, the recruiting of new members occurs through communication via members of the key population that are already involved and have experience with the outreach worker and in receiving services from the organisation.

Each organisation provides training on basic issues: HIV, AIDS and STIs (prevention, diagnosis, treatment and counselling), (PWID) harm reduction programmes, and legal aspects. There is a regular and well established training process, occurring weekly or monthly on specified days. Regardless of this, outreach workers admit that they are not sufficiently informed, and that there is a need for systemised training on new methods of recruiting and motivating members of the key population, on communication skills, as well as on the treatment and diagnosis of socially significant infections. Periodically, typically once a quarter, a coordinator will conduct a certification of the outreach worker and go into the field with them for monitoring purposes.

The workload of outreach workers varies, but one outreach worker is assigned an average of 100 people in an assigned area, depending on the concentration of the key population (Bishkek is much more densely populated in comparison to Osh City).

Unfortunately, there is a large turnover among PWID outreach workers, and there were cases in which the outreach workers left after one month, due to low wages and overly high expectations from management. A few of the outreach workers surveyed stated that they were tired, suffering from emotional burnout, and admitted that they are searching for a new place of work. Prestige and respect are also issues, as a significant majority of the outreach workers stated that the work they do is not considered prestigious and they are not viewed as peers by the other employees. It was observed that this fact is not reflected at the workplace, where outreach workers are officially included in the processes and procedures of the organisation, and they take part in elections, planning and meetings. Yet the outreach workers specified that this is felt informally, through the behaviour and less respectful attitudes of their colleagues.

According to the respondents, this is attributable to the stereotypes about outreach work – that it is a job for those who are low-skilled, who cannot find a better-paying and/or prestigious job, and that it is only managers who conduct the important work.

"We participate in planning meetings once a week on Mondays. We can express their opinion, [they] listen to us. But of course, I feel that we are the lowest link in the organisation"

– Outreach worker, Bishkek.

The main motivations for outreach workers lie in fulfilling their assignments and receiving financial compensation (guaranteed salary), as well as in having a sense of importance, feeling useful to society, and participating in the fight against an epidemic. Outreach workers were unanimously dissatisfied by their salary, and it was expressed that the financial investments do not match the expectations of management.

"We work for four hours a day in the field and 4 hours in the office. They expect us to actively recruit new and young members of society, and we do try. We ask all of our other clients, but we don't actively search for them. There is no money for transportation and our salary is tiny"

– Outreach worker, Osh City.

"The salary is small, and it's hard to live in the city on that amount of money. If something better paying turns up, I'll leave without hesitation"

– Outreach worker, Bishkek.

10 The Global Fund to Fight AIDS, Tuberculosis and Malaria & United Nations Development Programme. (2013). Annual report on implementation of grants provided by the Global Fund to fight AIDS, Tuberculosis and Malaria in Kyrgyzstan – 2013. Retrieved from www.kg.undp.org/content/kyrgyzstan/en/home/library/hiv_aids/annual-report-on-the-implementation-of-grants-provided-by-the-gl.html

Limitations for outreach workers

Overall, outreach workers are not faced with any limitations or risks to their personal safety in the carrying out of their tasks. Many stated that the main obstacles to completing effective work are the specific nature of sex work (schedules and the amount of work) and difficulties with law enforcement. Other obstacles mentioned were the passivity and disinterest of the key population itself, their lack of responsibility and care for their own health, and a consumerist attitude towards the employees and the programme.

> “ If you don't motivate the PWID and don't give them something material, they won't even begin talking to you ”
>
> – Outreach worker, Osh City.

> “ It became hard to convince people to come to the organisation, so it was good that we were allowed to conduct quick field testing of saliva for HIV infection. That made our work much easier ”
>
> – Outreach worker, Osh City.

4. DISCUSSION AND CONCLUSION

As the results of this research showed, the most highly demanded and most commonly offered services are the distribution of means of self-protection, the formation of safe behaviour skills, the distribution and presentation of IEM, and the referral of members of the target group. Overall, there is alignment between the accepted standards of outreach work, the required demanded services, and the services that are actually provided. Yet outreach workers feel unappreciated and require a strengthening of their positions, an increase in their salaries, and continued professional development. Simplified methods for providing services – such as field testing and the ability to provide services outside of the office – makes their work easier, and increases access to the programme for members of the community.
According to the results of surveys with the key populations, the ideal outreach worker has the following characteristics and skills:

- A member of the community and possesses an understanding of the specific needs of the target audience;
- Has sufficient work experience, which allows for the outreach worker to understand their audience and adequately react to the situation at hand;
- Has sufficient communication skills to easily win over a customer and identify their needs, while being friendly, open and fostering a sense of safety;
- Has counselling skills and be able to conduct an efficient counselling session, maintain long-term contacts, and build connections to expand their network (i.e. the snowball effect);
- Understands the organisation and its services and medical institutions, as well as allied doctors, lawyers and psychologists;
- Understands the system of referrals to other organisations and partner agencies;
- Understands national laws and regulations and includes them in their work counselling the key population;
- Has the ability to establish contacts with a group leader, which is of particular importance when undertaking outreach with SW, as leaders are the key figures in these situations;
- Maintains distance and be impartial, while also being adequately responsive;
- Does not enter into any relationships with clients, especially financial ones,
- Does not spread unverified information or share information about clients to other members of the key population;
- Does not act aggressively, is not unduly intrusive, and does not force decisions by the target group.

It is clear that a systematic improvement and strengthening of the skills of outreach workers is required to improve the quality of service provision.

The operational research studied the factors influencing the attraction and motivation of key populations, and the role of outreach workers. It became clear that attracting new community members cannot be conducted by outreach workers alone. Although outreach work is an effective evidence-based method to work with, to reach and to attract key populations, there are also external factors – such as political stability, safe mobility and the condition of the key population – which significantly influence the success of outreach work and the participation of key populations in programmes. Stigma and discrimination, and the prevailing legal context, are also key barriers, and underline the huge need to address these and create an enabling environment. This can be achieved in part through strengthening the capacity of NGOs/CBOs to advocate on these topics.

The most effective instrument to gain access to key populations are professional, qualified, committed and motivated outreach workers, who establish solid contacts and inform potential key population participants about programmes. Despite this, outreach work alone is not sufficient to attract hard to reach members of the key populations, and there is a complex system of limitations and obstacles to address. These mainly concern the community itself, and its readiness to be “visible” and open to cooperation. Additional important factors include the provision of wide-reaching and quality services, and the carrying out of regular needs assessments. Finally, it is not services alone that attract participants. Of equal importance is the opportunity to talk and communicate with staff, and not only about HIV and health matters.

As the research has shown, each key population has its own specificities and priorities. Despite the fact that there are clear intersections between the needs of each of the groups, there are also clear differences. This are most visible in the social portraits of each group, where it was clear that a majority of the LGBT key population is young and socially adapted, and actively uses the internet. This group has many representatives who are capable of independently satisfying their own needs, to support themselves, and to be self-sufficient. They are educated, they live together with their families, and they enjoy the support of their close relatives. They are primarily require help is finding friends and partners, and safe spaces for leisure. As a result, it is logical to develop interactive, intellectual and sporting events for these groups, as a venue to provide information about the programme and means of protection from socially important infections.

Yet despite these positive traits, LGBT do not feel secure, and are afraid of coming out to even their close relatives, due to a fear of being judged. The question of tolerance was a hot topic for all groups, and it is necessary to further develop advocacy work to address this.

On the opposite side, the PWID key population is considered to be indigent. It needs material support, medication, medical instruments, as the majority of this population is unemployed, do not have close relatives, and have poor health. Considerable number of PWID does not turn to medical institutions and social support agencies due to a fear of being caught by law enforcement agencies. As a result, access to this key population is highly limited, and most prophylaxis work should therefore be implemented during outreach work with PWID and their social environment. Outreach is one of the main, and sometimes the only, method of maintaining contacts with this key population.

The top priorities identified by SW are a lack of free time, a lack of finances, and the risk of violence from law enforcement agencies. With SW, outreach is also one of only methods of maintaining contacts. Effective outreach work requires high flexibility, and is best implemented during week-days, as SW are typically busy on Fridays and during weekends. A majority of SW are migrating, and these high levels of migration further complicate outreach work. It is important to regularly engage with newcomers and encourage irregular SW to join prevention programmes.

In order to study the causes of low access to services, and ways these issues could be addressed, it is recommended to conduct focus group discussions among key populations. And to prove the hypotheses developed during these discussions, it might be relevant to include such hypotheses into questions and research instruments utilised by national quantitative researchers (e.g. sentinel surveillance).

During the analysis of previous research on needs assessments (see References) and the level of access to various kinds of services, no significant differences have been identified. The results of the research have shown that it is necessary to widen the types and quantity of services provided by organisations, possibly at the cost of widening partner networks, including healthcare organisations and other NGOs.

Most of the interviewed respondents noted the importance of the work of an outreach worker in lowering the risk of infection among people practicing risky behaviour. The most effective outreach work is carried out by former or present PWUD, SW and LGBT, as they are well informed about the environment, needs, culture and traditions of key populations and accept them as they are. It is obvious that being an active outreach worker is not the only important factor influencing the efficacy of the work. Outreach workers provide protection instruments – one-shot syringes, condoms, information educational material – but for effective implementation of outreach work, it is also necessary to be skilled in psychosocial counselling, establishing rapport, and motivating potential and actual participants of prevention programmes. In addition, outreach workers must be well informed about ways of HIV transmission, and of the situation relating to HIV infection in the region.

The **key conclusion** is that outreach work is not a stand-alone activity, but is part of a comprehensive package, and if the other elements are not there, it cannot be effective to involve new members of community. In addition:

1. **High demand services** in the Kyrgyz Republic are accessed through outreach workers, which prove the effectiveness of providing service through this method.

2. The fact that outreach workers identify themselves as being **members of the key populations** eases their access to key populations and assists in establishing trustful relations.

3. It is necessary to arrange a **routine collection of feedback** from key populations in order to identify changing needs, to assess the quality of provided services, as well as to detect barriers that hinder access to services.

4. In order to improve the quality of outreach work it is **essential to carefully select outreach workers** with the correct profile and experience, along with timely and periodic training to raise their capacities.

5. In order to enhance efficacy, it was suggested to **implement more active information** about the types of programmes that are provided.

6. The main **factors that limit respondents** to become involved with prevention programmes are:
   - A limited number of outreach workers and, consequently, a limited amount of contact with the key population;
   - Current outreach workers are poorly motivated and require professional development;
   - Low levels of awareness of organisations, prevention programmes, and services;
   - Passivity and low levels of self-care amongst the key population (for example, health issues are not a priority for most respondents)
   - Fear of "being seen" and of "becoming a target" for violence at the hands of law enforcement.
7. To improve outreach work, outreach workers should provide more frequent contacts and prophylactic services.
8. The most needed services are:
   - Prophylaxis instruments (syringes, condoms, napkins) and medication;
   - Legal support and court escorts;
   - Medical examinations;
   - Provision of temporary accommodation;
   - Consultations on HIV, STD, TB and safe behaviour.

RECOMMENDATIONS

The following are recommendations for each target group as to how they could strengthen their outreach work, to ensure more effective attraction new members of key populations into HIV prevention programmes:

Funding organisations
1. Consider approaches for strengthening the motivation of outreach workers (e.g. by increasing the number of outreach workers and their salaries).
2. Systematically provide professional development for outreach workers in the areas of psychology and interpersonal communication to improve their professional capabilities.
3. Have more holistic approach in order to balance achievement indicators, quality of work and context (legal, NGO capacity).

Programme managers
4. Widen partnership networks with medical institutions and doctors, and create 'unified centres' for providing medical services.
5. To increase coverage and awareness of the organisation and services by the key population, capitalise upon all possible human resources (volunteers, leaders, key individuals), and actively use networking principles in outreach work (via engaged key members).
6. To draw the younger generation into the discussion on prevention of HIV infection, it is recommended to conduct large scale events with active marketing of service organisations and offered services.
7. Focus more on events related to law enforcement agencies, and on advocacy to reduce stigma and discrimination in the society.
8. Involve outreach workers in organizational life and decision making, treat outreach team as partners, to create opportunities for group self-education which will result in strengthening skills of trainers, counselors. Outreach workers should have space to discuss and reflect their own experience in a group.

Outreach workers
9. In as much detail as possible, inform the target group of what services are offered by the organisation
   and under what conditions.
10. Stress that coming to the organisation is safe, that the services are free, and that information on the organisation's clients is strictly confidential due to maximize overcome fears opening status.
11. Attract key individuals who are capable of mobilising their peers, which would make outreach work more efficient and effective.
12. Systematically work on raising one's own awareness (self-education), in order to understand the needs and problems of key populations and to more effectively address them. Outreach workers should include into practice more communications related to different topics.

RECOMMENDATIONS FOR FUTURE RESEARCH

General recommendations:
1. Communities should participate in all stages of research: design, planning, implementation and analysis
2. Different research data should be compared for triangulation.
3. A study on the differences, if any, between the segments of the LGBT community and how it affects motivation and involvement in HIV prevention programmes.
4. Assess the quality of services in Bridging the Gaps and GFATM country
   partner organisations.
5. Assess the effectiveness of social support (case-management) for customer loyalty to the programmes.
6. Assess the capacitiy and willingness of NGOs and CBOs need to be assessed in future studies to develop a community based approach related to all types of work under new conditions when donor funding is decreasing.

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Health and rights
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