REPORT
ON THE
OPERATIONAL
RESEARCH

REACHING TRANS* PEOPLE, WHO ARE NOT COVERED WITH PREVENTION PROGRAMMES, USING THE PEER-TO-PEER METHODOLOGY IN BISHKEK, THE KYRGYZ REPUBLIC AND EVALUATION OF EFFICIENCY OF THIS METHOD

Developed by the staff and counsellors from the Kyrgyz Indigo NGO and the Partnership Network Association in collaboration with the Alliance for Public Health (Kiev, Ukraine) as part of the project "Sustainability of Services for Key Populations in the Eastern Europe and Central Asia Regions" supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Bishkek 2020

Карипова Аида/Мусазов Фархад. **«Выход на неохваченных профилактическими программами транс* людей в Кыргызской республике, г. Бишкек с помощью методики «Внедрения силами равных»**/Общественное объединение "Кыргыз Индиго" Бишкек, Кыргызская Республика, 2020 - 57 стр. *(Karipova Aida/Musazov Farkhad. "Reaching trans* people, who are not covered with prevention programmes, using the Peer-to-Peer methodology in Bishkek, the Kyrgyz Republic"/Civic Association Kyrgyz Indigo)*

The study has been designed and conducted by LGBT+ communities, in particular transgender people, to engage trans*people in the prevention programmes, and it explores and addresses issues of provision of HIV prevention, health and social services for trans*people, identifying gaps in service provision, determining the level of stigma and discrimination in society towards trans*people, etc.

The document contains terms in the singular and plural that can be understood as words of the masculine gender, e.g. respondents, representatives, allies. Due to the fact that the inclusion of feminatives - feminine nouns - would make the text difficult to read, please understand that people in the document may identify themselves as male, female, non-binary and gender non-conforming people.

About the Partnership Network Association

The Partnership Network Association is a non-profit organisation, which was established and operates in accordance with the Law of the Kyrgyz Republic 'On Non-Profit Organisations' and the Organisation's Charter.

The mission of the Association is to assist in reducing the spread of socially significant diseases (HIV, TB, hepatitis C) in the Kyrgyz Republic and to promote favourable conditions for the implementation of prevention, treatment and care programmes through capacity building of network members, service systems, and advocacy of rights and interests of target groups

Activity areas:

I. To improve access to HIV, tuberculosis and hepatitis prevention, treatment and care services and facilitating the fulfilment of the state's obligations in responding to the spread of these diseases.

II. To improve availability of medicines for treatment of socially significant diseases and to contribute to the improvement of state policy in the area of pharmaceutical provision.

III. To increase the meaningful participation of civil society in the activities related to health programmes and protection of the rights of vulnerable groups.

About Kyrgyz Indigo

Kyrgyz Indigo is one of the largest human rights organisations not only in Kyrgyzstan but also in the Central Asia, solidifying comprehensive efforts to promote equality and improve the quality of life of LGBT+ people. The organisation confidently and purposefully builds partnerships and raises the visibility of LGBT+ people among organisations and state institutions, positively and sustainably impacting the lives of LGBT+ people. The organisation works in two directions, one of which is advocacy through the development of a democratic society, and the other is the empowerment of LGBT+ communities.

Acknowledgements

The publication was prepared by the "Partnership Network" Association in collaboration with the Public Association " Kyrgyz Indigo" and published within the framework of the regional project "Sustainability of services for key populations in the EECA region", implemented by a consortium of organizations from the EECA region under the leadership of the ICF "Alliance for Public Health", with financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The views expressed in this publication are solely those of the authors and may not reflect the views of all organizations in the consortium and the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Global Fund to Fight AIDS, Tuberculosis and Malaria was not involved in the preparation and approval of neither the material itself, nor the possible conclusions arising from it.

DISTRIBUTED FREE OF CHARGE.

CONTENT

LIST OF ABBREVIATIONS

HIV	Human immunodeficiency virus
BBS	Bio-behavioural study
STI	Sexually transmitted infections
KP	Key populations
PWID	People who inject drugs
MSM	Men having sex with men
RDS	Respondent-driven sampling
RC AIDS	The Republican AIDS Centre
SOP	Standard operational procedures
SW	Sex workers
TLS	Time-location sampling
IDI	In-depth interview
UIC	Unique identification code
FGD	Focus group discussion
TG people	Transgender people
HCV	Hepatitis C virus
HCB	Hepatitis B virus
PLH	People living with HIV
SOGI	Sexual orientation and gender identity
CA	Civic association
UROM	A Uniform Register of Offences and Misdemeanours
PDI	Peer Driven Intervention)
LGBT+	Lesbian, gay, bisexual, transgender people and others

GLOSSARY[1]:

Gender Identity – is defined as a personal conception of oneself as male or female, a person of alternative identities or their combinations. The gender identity may coincide or not coincide with the biological sex defined at birth.

Gender violence – any act of violence that results, or is likely to result, in a physical, sexual or psychological harm to a person because of his/her gender.

Discrimination – any distinction, exclusion, restriction, deprivation, preference which is based on different grounds and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons of equal rights and freedoms. People can be discriminated against on grounds such as race, ethnicity, gender, sexual orientation, gender identity, HIV status, etc.

Body correction – a set of medical procedures to change one's own body in order to express one's gender identity.

Transition – is the process transgender people undertake to acquire their gender identity. Transition may involve a change in appearance, dress, behaviour or name used in everyday life. This change is sometimes referred to as a 'social transition'. Transition can also involve medical interventions that help link a person's anatomy to their gender identity. These interventions are sometimes referred to as a 'medical transition'. These may include feminising or masculinising hormone therapy, soft tissue filling or surgery. However, transition is not defined by the medical procedures undertaken or not undertaken.

Transgender (trans*) girl/woman – is a person whose gender identity (internal sense of one's own gender) is different from the male gender assigned at birth.

Transgender (trans*) boy/man – is a person whose gender identity (internal sense of one's own gender) is different from the female gender assigned at birth.

Transgender person, trans* person – is a person, whose gender identity do not coincide wit the biological, anatomical sex.

Trans* competent services – this term refers to the provision of services, especially health services, to trans* people in a way that takes into account all their specific characteristics. That is, services should be provided in a technically competent, highly professional manner that demonstrates the clinician's awareness of gender identity, human rights, the special situation and the needs of TG people.

Transphobia – fear, hatred, aversion or dislike of real, perceived or assumed trans* people, often due to various prejudices against them.

Feminising medicines – are the same as "feminising hormone therapy"; hormones that produce stereotypical "feminine" appearances.

1 The terms used in this glossary are taken from the research 'Mapping of services available to trans people in health facilities in Kyrgyzstan'/ Orsekov D., public association « Kyrgyz Indigo». – Bishkek, 2019. – 59 p.).

Masculinising medicines – are the same as "masculinising hormone therapy"; hormones that produce stereotypical "masculine" appearance.

A cisgender person, cis-person is someone whose gender identity is the same as their biological, anatomical sex.

Transgender transition is the process of adjusting a person's gender role and body to their internal sense of self - perception of their gender identity. Transgender transition can include both socialisation into a new gender role, a change in passport name and legal gender, as well as medical procedures to change one's visual sex characteristics.

Hormone therapy for transsexuality is hormone replacement therapy with the aim of changing trans people's sex characteristics in the desired direction. It is carried out by taking hormonal medicines[2].

THE LOCATION OF THE RESEARCH AND THE SOURCE OF FUNDING

LOCATION OF THE RESEARCH:	CA "Kyrgyz Indigo", Bishkek, the Kyrgyz Republic
Source of funding:	The Global Fund through the Partnership Network Association and Alliance for Public Health

2 Material from Wikipedia, the free encyclopaedia

1. RESEARCH GOAL AND RATIONALE

1.1. HIV epidemic in the Kyrgyz Republic

As in other countries of Eastern Europe and Central Asia, the HIV epidemic in the Kyrgyz Republic is in its second concentrated stage. The spread of HIV infection predominantly occurs among key populations at higher risk of infection. However, there is a risk of HIV transmission from key populations to the general population, which requires the strengthening of prevention programmes in these areas. Despite measures taken by the government agencies, nongovernmental and international organizations, HIV infections in the Kyrgyz Republic continue to increase, with the number of cases almost doubling between 2013 and 2019, from 4,819 cases in 2013 to 9,135 cases in 2019. HIV prevalence is 142.9 cases per 100000 population.[3] An estimated number of key populations' representatives is (but not limited to) 25,000 PWID, 7,100 sex workers and 16,900 MSM[4]. An estimated number of people living with HIV according to the Spectrum software is 10,129 people.[5]

1.2. Situation with TG people in the KR

TG people started to be actively considered in the context of HIV about 10 years ago; while other key populations like people who use drugs, men who have sex with men and sex workers have been the active subjects of epidemiological review as activists, patients and partners for about 30 years.

One of the main questions that trans* people, their parents, medical professionals, and officials are interested in is the number of trans* people in the world. There is a number of different calculation methods that give different figures based on the quantitative estimates. A major UNAIDS report, The Gap Report (2014), suggests that according to country estimates, the population of trans* people may be between 0.1% and 1.1% of the adult population of reproductive age.

In the context of human rights, trans* people are mentioned as part of the LGBT+ community in the 2014 Universal Periodic Review submitted to the UN Committee by the Kyrgyz Republic. Also, LGBT+ persons are included in the country's 2021 national human rights action plan, which outlines specific activities and responsibilities for implementing recommendations made to the country by various UN committees

3 Data from Republican AIDS Centre
4 Public Foundation "Health Policy Analysis Centre", Population Size Estimate of Injecting Drug Users (PWID) in the Kyrgyz Republic (2014); MVector company, commissioned by UNDP GF with technical assistance from the ICAP project in Kyrgyzstan "Size Estimation of Sex Workers in the Kyrgyz Republic" (2013).
5 Spectrum is a software for estimates and projections -UNAIDS

"The Gap Report (UNAIDS, 2014) states that many trans* people experience social exclusion and marginalisation because of their gender identity. Globally, trans* people do not have access to legal recognition of their gender (sex) and therefore lack personal identification documents. Without appropriate identity documents, trans* people have no access to education and employment. In addition, trans* people face discrimination, violence and lack of access to appropriate health care. All of these factors contribute to trans* people's increased vulnerability to HIV. In some settings, a significant proportion of trans* women engage in sex work. This is often a result of social exclusion, economic vulnerability and difficulties in finding employment[6]. A study of economic vulnerability of trans* women (Kyrgyz Indigo, 2019) shows that 73%, of respondents were only involved in sex work and 88% had experienced violence and discrimination, 35% of respondents had consumed cocaine and its derivatives.

1.3. HIV infection and TG people

A second issue of concern to the trans* people's environment, and sometimes to trans* people themselves, is the spread of HIV and other STIs in the community. The TRANSIT Toolkit for Implementing Comprehensive HIV and STI Programmes with TG People suggests a disproportionate level of risk, with trans* women being 49 times more likely to live with HIV than adult cis males and females[7]. The Gap Report estimates that globally, 19% of trans* women are living with HIV. According to a study on the economic vulnerability of trans* women in Kyrgyzstan, conducted by the NGO Kyrgyz Indigo[8], 19% of trans* women who are in labour migration in Russia are living with HIV[9].

Practical Guide for Implementing Comprehensive HIV and STI Programmes with Trans* People (WHO, UNFPA, 2016)[10] The practical toolkit shows that stigma, discrimination and violence against trans* people increase their vulnerability to HIV and that HIV prevention interventions are not effective without building the capacity of the trans* community and working to remove legal barriers and protect their rights in general. The Guide also explores medically and socially relevant issues that increase trans* people's vulnerability to HIV, such as vaginal atrophy in trans* men as a result of masculinising hormone therapy, or the reluctance of trans* people to refuse unprotected sex for fear of being left alone without emotional and romantic contact. The Guide also highlights the important topic of the interaction between antiretroviral drugs and hormone therapy, as in Kyrgyzstan, for example, according to a service mapping study, trans* women living with HIV may prefer hormone therapy over ART, believing that they cannot be taken together.[11]

Other documents that mention trans* people provide some insight into the community and offer

6 See footnote 2.
7 Baral S, Poteat T, Ströhmdahl S, Wirtz AL, Guadamuz TE, Beyrer C. Worldwide burden of HIV in transgender women: a systematic review and metaanalysis. The Lancet. 2013;13(3):214–222.
8 https://indigo.kg/
9 Kalbaev T. Challenges and barriers in migration as a consequence of the economic vulnerability of trans * women in the Kyrgyz Republic / Public Association "Kyrgyz Indigo", Kyrgyzstan, Bishkek, 2019
10 See footnote 3.
11 See footnote 19.

guidance on the cascade of HIV services among trans* people are the "Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations"[12] (WHO, 2014), and "Transgender people and HIV. Policy brief" (WHO, 2015). Policy brief "HIV and young transgender people"[13] indicates that there are more trans* women than trans* men in the world.

Trans* people in the Kyrgyz Republic are mentioned in several national-level documents and are identified as a separate key group in the "State Programme to Combat HIV Infection for 2017-2021[14]. They are also mentioned in the country's application to the Global Fund for HIV-related activities. Trans* people are part of the key populations in the service standards, which are a supplementary package to the social service contract law.

1.4. Research relevance and background

An operational research among TG people in the Kyrgyz Republic was attempted for the first time in order to engage TG people in prevention programmes and to monitor their effectiveness.

PDI is a model for attracting and educating new clients to HIV/STI prevention projects that uses active engagement of clients from their usual environment to the programme's (stationary) sites in order to get prevention services on a regular basis. PDI uses the connections and influence of social media to provide information related to HIV, TB and HCV prevention and treatment through an educational module. PDI can also be used to interview clients about their social and economic status, HIV risk behaviours, and use of health services. PDI can include screening for HIV (and other infections), in order to estimate HIV prevalence among the engaged clients.

PDI is based on the theory of Group Social Control and Markov random walk assumptions. In this protocol we look at the PDI model developed by Robert Brodhead. Over the years of implementing PDI in different socio-cultural contexts, an evidence base has been compiled and it confirms the effectiveness of this model.

The potential impact of this intervention is high. Engaging hard-to-reach groups of trans* people and implementing interventions aimed at reducing risk behaviour can reduce HIV prevalence among trans* people and their sexual partners, and in some cases they can prevent new HIV infections. Knowledge gained from PDI model implementation can help design interventions to address HIV and other infectious diseases.

Previously, the Central Asia Regional HIV/AIDS Programme (CARHAP) tested and adapted a peer outreach model among PWID in the Kyrgyz Republic through the NGO Sotsium Trust Points Project in 2008-2009 and proved the effectiveness of this approach. These interventions were part of the CARHAP operational research programme. Afterwards, based on existing experience, the German Agency for Technical Cooperation used this tool to reach hard-to-reach target groups - young PWID under 26 years old and female PWID.

12 https://www.who.int/hiv/pub/guidelines/keypopulations/ru/
13 https://www.who.int/hiv/pub/toolkits/hiv-young-transgender/en/
14 http://www.old.gov.kg/?p=110543&lang=ru

2. RESEARCH GOALS AND OBJECTIVES

2.1. Research goal

The goal is to evaluate the effectiveness of the PDI methodology in quickly reaching the new clients who are not covered by prevention programmes. Also, the research aimed to assess the situation with coverage and quality of service provision for the trans* people group and to provide recommendations for improving this situation to plan the future programmes. In addition, the research helped to cover a certain number of trans* people in the study with prevention programmes and to provide access to treatment.

2.2. Research objectives

- to describe the socio-demographic data of TG people;
- to assess the risk behaviour patterns that determine the likelihood of acquiring HIV infection;
- to identify barriers to accessing health and social services;
- to identify barriers to HIV prevention and treatment services;
- to identify the needs of TG people in prevention and treatment services;
- to assess the availability of HIV prevention commodities;
- to ensure coverage of prevention activities;
- to ensure coverage of voluntary HIV testing;
- to monitor the violations of human rights of TG people;
- to describe the experience of engaging transgender people in prevention projects in the Kyrgyz Republic, using Bishkek as an example.

3. RESEARCH DESIGN

A one-stage cross-sectional research among TG people in Bishkek, including behavioural and serological components - conducting interviews and rapid testing for HIV by saliva upon the consent of the study participants. While implementing the research the following activities will be carried out: 1) conducting a survey among TG people to collect behavioural data; 2) collecting serological data to study HIV prevalence among TG people.

4. THE RESEARCH OBJECT

A transgender person, trans* person - someone whose gender identity is not the same as their biological, anatomical sex.

4.1. Inclusion criteria

Inclusion criteria	**VERIFICATION METHOD**
18 y.o. and older at the moment of participation in the research	Self-declaration, visual inspection of participants
Consent to behavioural and biological components	Oral consent confirmed by the signature of an interviewer
Gender identity, does not correspond to sex registered at birth: For trans* women - male sex at birth, and identification as female at the time of research For trans* men - female sex at birth, and self-identification as male, at time of research.	Self-declaration
Adequacy of the research participant, ability to understand the questions asked.	Visual inspection by the research staff.

4.2. Exclusion criteria

Exclusion criteria	VERIFICATION METHOD
Under 18 y.o. at the moment of participation in the research	Self-declaration, visual inspection of participants
Previous participation in this research	Self-declaration, visual inspection of participants
Alcohol or drug intoxication (which prevents a person from participation in the research and can pose a threat to himself/ herself or for other participants).	Visual inspection by the research staff

5. RESEARCH SUBJECT (VARIABLES BEING STUDIED)

The results of the survey should be used to determine indicators that characterise the population of TG people in Bishkek, including prevalence of HIV infection, risk behaviours, coverage of HIV testing, prevention interventions, etc.

5.1. Serology indicators

- HIV prevalence: the proportion of people who tested positive for HIV antibodies on an expert test kit among the number of screened TG people who agreed for a rapid test.

5.2. Social and demographic indicators

- Gender and age structure;
- Social status;
- Marital status;
- Education;
- Occupation;
- Nationality;
- Assessment of financial situation;

5.3. Behavioural indicators

Drug injecting behaviour

- Percentage of TG people who have ever used non-injectable drugs.
- Percentage of TG people who have ever injected drugs.
- Percentage TG of people who have injected drugs in the past 12 months.

If the sample has 10% and more TG people who are injecting drugs, the following indicator should be calculated:

- Percentage of TG people, who do not share injecting equipment including the pre-prepared drug solution in the past month.

Sexual behaviour

- Percentage of TG people who had commercial sex partners who were paid for sex services;
- Percentage of TG people who had commercial sex partners who paid them for sex services;
- Percentage of TG people who had non-regular sex partners;
- Percentage of TG people who had regular sex partners;
- Percentage of TG people who were involved in the provision of sex services
- Percentage of TG people who used condoms with commercial sex partners at the last intercourse
- Percentage of TG people who used condoms with non-regular sex partners at the last intercourse.

- Percentage of TG people who used condoms with regular sex partners at the last intercourse.
- Percentage of TG people who used condoms with an intimate partner who paid them for sex.

5.4. Coverage with testing for HIV

- Percentage of TG people who were tested for HIV in the past 12 months and know their last test result.

5.5. Coverage with prevention programs

- Percentage of TG people covered with prevention programs, i.e. those, who gave an affirmative answer to the following 2 questions:

  1. Do you know where people can be tested for HIV?
  2. Have you received condoms in the past 12 months?

5.6. Case determination in the research

Determination of HIV case:

Positive result of a saliva screening test for HIV, followed by confirmation of positive result on an expert test kit.

Determination of risky sexual behaviour case:

Failure to use a condom at the last anal sexual contact.

5.7. Research location

Bishkek was selected as a pilot city because previously such interventions among TG people had not been conducted in the country, and local NGOs have programs and services aimed specifically at TG people. In addition, the staff of organizations working with MSM noted that Bishkek has the largest concentration of TG people. Kyrgyz Indigo has facilitated recruitment of the target

group through its networks in Bishkek.

Kyrgyz Indigo has repeatedly participated in various studies among the LGBT+ community, implements HIV prevention projects in the country, and has staff members who have been trained by the Republican AIDS Centre to conduct rapid testing. The organisation has a separate room for testing as well as for conducting interviews as part of this operational research.

Duration of the field stage (data collection) was planned to be completed by the end of September 2020, but due to the epidemiological situation in the country as well as the social unrest and the change of the government, the field stage was delayed and was completed at the end of October 2020.

5.8. Data collection methods

The PDI among the TG people consisted of two stages: 1) the field stage (interviewing and collecting serological data among the TG people; and 2) data analysis and preparation of an analytical report.

Interviews with TG people

Individual semi-structured face-to-face interviews were conducted with representatives of the TG people in order to (1) collect behavioural data (2) collect serological data (with the respondent's consent).

Serological data collection

The serological stage of the PDI consisted of rapid saliva-based testing for HIV. The OralQuick rapid tests are single-use, qualitative immunoassays for the detection of antibodies to human immunodeficiency virus types 1 and 2 (HIV-1/2).

5.9. Data collection tools

Interviews with TG people

A semi-structured questionnaire will be used to interview sentinel group representatives. The questions of the questionnaire were aimed at collecting the socio-demographic data, information on sexual and injecting behaviour of TG people, receipt of health and social services and HIV testing.

Serological data collection

As was mentioned above, it was planned to collect serological data with the use of OralQuick rapid tests.

5.10. Sample size

Interviews with TG people

As part of the research implementation, a survey was conducted with 209 TG people to analyse and describe the situation in the group of TG people in order to plan further prevention work with the group of TG people in the country.

Serological data collection

All participants in the rapid assessment were asked to participate in the serological phase of the PDI. TG people who agreed to participate in the survey but did not agree to rapid testing were not excluded from the project and this did not affect their further participation in prevention programmes.

5.11. Sampling method

Interviews with TG people

The main sampling method chosen in this study is RDS sampling, which allows for collection of representative data on a hard-to-reach population group, such as TG people.

Behavioural data was collected through individual structured interviews (a face-to-face method). A standardised questionnaire was developed for data collection, enabling the identification of key socio-demographic data, behavioural risk factors, coverage of prevention programmes and assessment of service needs.

Serological data collection

The sampling at the serological stage is different from the sampling in the survey, as the rapid testing was planned only for those respondents who agreed to undergo the serological stage. At the end of the operational survey, no participants wished to be tested for HIV due to the fact that the vast majority of TG people who participated in the survey had already been tested.

5.12. Research algorithm

Actions/steps of the research implementers and PDI intervention:

1. Getting to know the participant, informing them of the goals and objectives of the research;
2. Obtaining informed consent to participate in the research;
3. Screening for eligibility to participate in the research;
4. Conducting the interview;

5. Obtaining consent to recruit 3 participants;
6. Recruitment training;
7. Issuing coupons for distribution to respondent's contacts (3 coupons);
8. Referral to VCT/express testing;
9. Needs assessment of a research participant;
10. Issuance of prophylactic consumables;
11. Issuance of remuneration for participation in the interview;
12. Farewell to the client;
13. Issuance of the second remuneration for the successful recruitment (no more than 3).

6. ETHICAL ISSUES

6.1. Confidentiality and data safety.

All ethical principles of the operational research were respected: confidentiality of information, security, anonymity and voluntary participation, potential benefits, minimisation of risks. The staff recruited to conduct the research ensured that the key group of participants was not disclosed and that the confidentiality of the data collected was protected as much as possible.

6.2. Voluntary participation and an informed consent.

Participation in the research was voluntary. The informed consent was obtained from all participants. Possible risks to participants included breaches of confidentiality and minor psychological discomfort, which might be caused by the sensitive nature of some of the interview questions.

Respondents could stop participating at any time and at any stage. Prior to the interview, each potential respondent was informed about the goals, objectives and procedures of the PDI. As identifying personal data is not collected, the respondents' consent based on the information provided to them about the conditions of participation was only taken verbally and applied to all stages of data collection (interviews, rapid testing).

The potential respondent's refusal to participate in the research or any of its components (e.g. from answering certain questions or interviews in general, from rapid testing, from taking a coupon at RDS) had no impact on the possibility to receive prevention and other services envisaged for TG people.

6.3. Potential benefits of participation in the research

Direct benefits to participant included:

Counselling on reduction of behavioural risks.

In case of a positive HIV test result, the participant would be referred to appropriate health care facilities where HIV diagnosis, treatment and counselling services would be provided if needed.

Provision of condoms, syringes, information materials according to the participant's needs.

If additional service needs arose, PDI staff would refer the participant to medical, social or other nongovernmental organizations.

6.4. Indirect benefits

The PDI results will be taken into account when planning prevention programmes for TG people. In this way, all TG people will ultimately benefit in the future.

6.5. Remuneration

Each study participant received a remuneration as compensation for participating in the study, covering the costs of travel and recruiting other respondents from their social network. This increases respondents' motivation to actively participate and recruit more effectively.

A primary remuneration is given for personal full participation (after the interview and biomaterial collection), a secondary remuneration is given for each "recruited" person (1 to 3 TGs) after their full participation in the study.

Each participant in the research was given a remuneration of 300 mobile units for participating and being interviewed, approved by the project. For recruiting another person into the project and provided that the recruited participant (recruit) meets the inclusion criteria, a reward of 300 mobile units was given to the recruiter (the one who recruited) for each recruit approved within the project. Intangible rewards included counselling, information, getting tested and counselled for HIV and getting the test result, referrals to other services, etc..

7. DATA ANALYSIS, DISTRIBUTION AND USE

The primary survey data analysis was done with the use of an online Syrexcloud software. All the data collected in the Syrexcloud online survey were sent to the researchers in Excel format, for further processing in SPSS, Epi-Info. The results of the survey will be summarised in this report.

Descriptive statistics and stratified analysis (gender, age, occupation, safety behaviour, service needs, etc.) were prepared for the whole sample of TG people.

8. STAFF INVOLVED IN THE PROJECT IMPLEMENTATION

The NGO Kyrgyz Indigo was the main implementer of the PDI project. The organisation was responsible for monitoring the quality of the data collected, and in addition, a researcher was involved in the research, providing methodological support, summarising the data analysis and preparing the report.

9. RESEARCH OUTCOMES

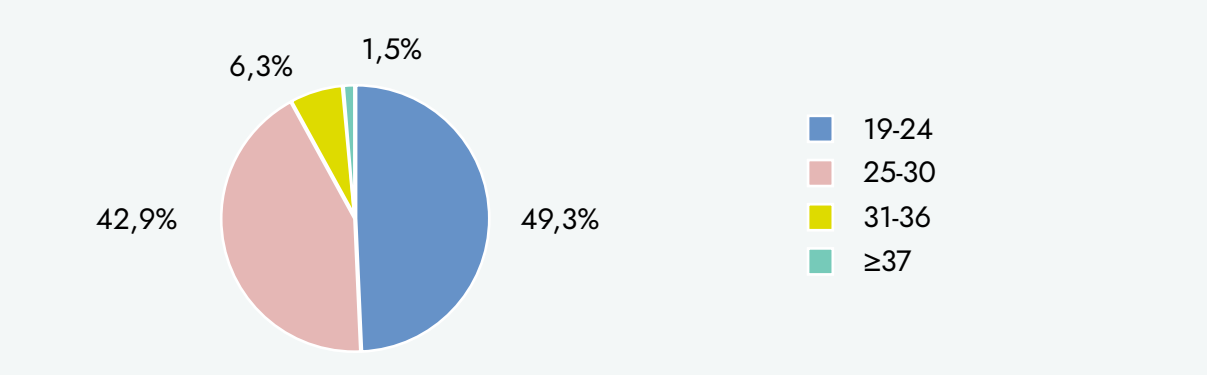
9.1. Results of interviews with transgender people

A total of 209 TG people (including both trans* women and trans* men) were recruited into the research. During the screening phase, 4 participants were excluded from the research and 205 participants were included in the analysis. A total of 142 trans* women, 60 trans* men and 3 non-binary people participated in the research.

9.2. Social and demographic indicators

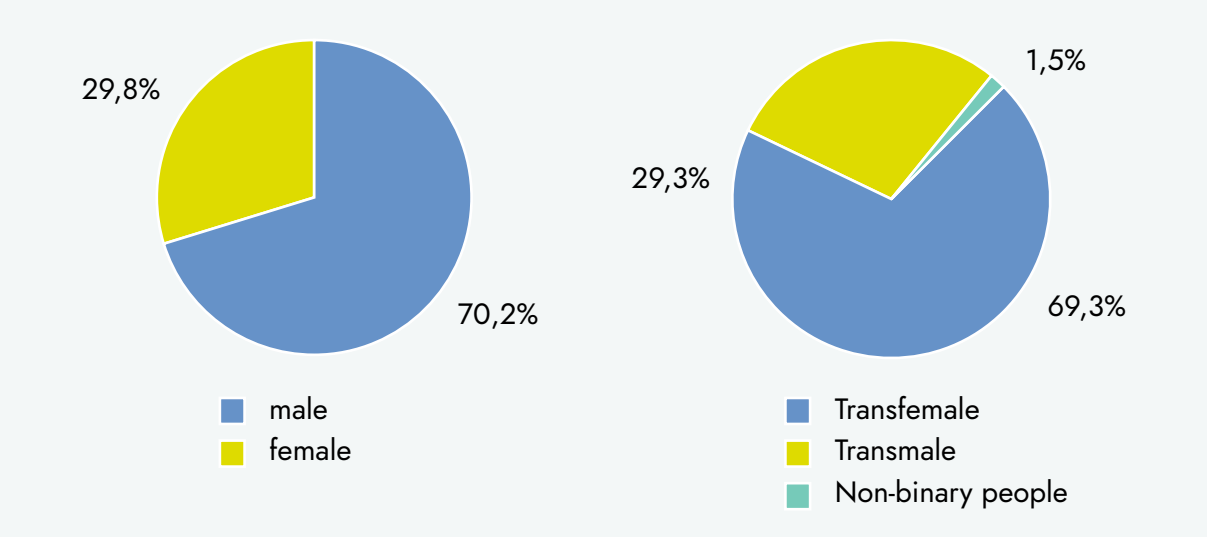
Almost half of the project participants (49.3%) are in the 19-24 years age group, and participants in the 25-30 years age group account for 42.9%, i.e. the proportion of respondents aged 19-30 years is 92.2%. The older age category of participants (31 years and above) was only 7.8%. The fact that younger TG people are more represented may be due to the fact that they are more willing to contact the organisation, respectively the research team, and have shown a willingness to take part in the survey being conducted.

Fig. 1. Respondent age groups, n=205.



The sex at birth was reported as male by 70.2% of respondents and, correspondingly 69.3% were trans* women and only 1.5% non-binary people (3 people) by their gender identity.

Fig. 2. Respondents' sex at birth and gender identity, n=205.



40% of survey participants have secondary education, about a quarter (23.9%) have secondary specialised/technical education and almost the same number (21.5%) have incomplete secondary education. Only 11.7% of the participants have a basic higher education, which significantly reduces the possibility of finding employment and having a stable income. 2.9% of survey participants had a completed higher education (specialist/master's degree).

Table 1. Education of the PDI research participants, n=205.

Education	**#**	**%**
Incomplete secondary	44	21.5%
Secondary	82	40.0%
Specialised/technical secondary	49	23.9%
Basic higher education (bachelor degree)	24	11.7%
Complete higher educations (specialist or master's degree)	6	2.9%
Total	**205**	**100.0%**

An overwhelming majority of participants have never been married (94.1%), due to the context of the country, legislation, patriarchy, cultural and religious phobia of LGBT+ people in the Kyrgyz Republic.

Table 2. Marital status of the research participants, n=205.

Marital status (legal)	**#**	**%**
Has never been married	193	94,1%
I am in a registered marriage with a woman	2	1,0%
I am in a registered marriage with a man	2	1,0%
Divorced	8	3,9%
Total	**205**	**100,0%**

Only 5 participants indicated that they had 1 child, while 2 respondents live with children.

Table 3. Having children, n=205.

Having biological children	**#**	**%**
Yes, they live with me	2	1,0%
Yes, but they don't live with me	3	1,5%
No	200	97,6%
Total	205	100,0%

Most respondents indicated that they were born in rural areas (40.5%), and a third of the survey participants were born in the capital, Bishkek (29.8%).

Table 4. Place of birth, n=205.

Place of birth	**#**	**%**
Capital city	61	29,8%
Oblast centre, city/village	26	12,7%
City	27	13,2%
Village	83	40,5%
Other country	8	3,9%
Total	**205**	**100,0%**

At the same time, the majority of respondents (67.8%) indicated that they currently reside in the capital city. This trend is due to the fact that due to trans* people's sexual orientation and gender identity (SOGI) and changing gender markers, employment for this group is almost impossible in the regions. In Bishkek, trans* people often find alternative employment options, including providing commercial sex services, where the trans* community faces the same discrimination, but to a lesser extent thank in the regions. Also, finding services for trans* people can also cause such migration from the regions to the capital of the country.

Table 5. Place of residence, n=205.

Place of residence	**#**	**%**
Capital city	139	67,8%
Oblast centre, city/village	17	8,3%
City	38	18,5%
Village	5	2,4%
Other country	, 6	2,9%
Total	**205**	**100,0%**

Half of the respondents had lived in rented accommodation in the last 90 days (51.7%). Only a third of respondents (30.2%) had lived in their own home and there were also those who had no permanent place of residence (9.8%). This is a common situation for trans* people with regard to their place of residence. Due to the fact that trans* women are often forced to engage in commercial sex work, there are frequent conflicts with landlords. Sometimes the clients themselves pose a threat to trans* sex workers, forcing the key group to frequently change accommodation for safety and livelihood. Moreover, renting accommodation in the capital is difficult even in good times, when the rent starts at $150 or more[15] and is conditioned by factors such as "distance from shopping and commercial centres", "infrastructure development", "neighbourhood prestige" and other factors. The situation has been further exacerbated by the COVID-19 epidemic in the world as well as political events in the country where many people have lost their stable income.

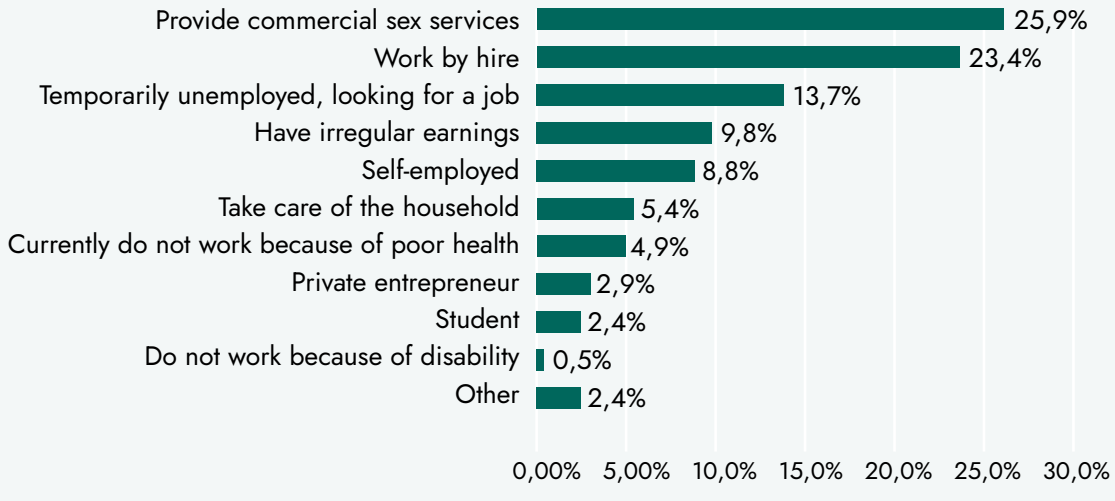
15 https://m2.kg/read/articles/full/34.html

Table 6. Housing conditions of the respondents, n=205.

Housing conditions in the past 90 days	**#**	**%**
Own home	62	30,2%
Live with relatives/friends (do not pay rental fee)	32	15,6%
Rented accommodation (renting alone/with someone)	106	51,7%
At any random place (change housing often)	20	9,8%
Hard to say	3	1,5%
Total	**205**	**100,0%**

For example, a quarter of respondents indicated that they engaged in the provision of sex services (25.9%), with a similar number are working for hire (23.4%). 21.5% of the unemployed, who at the time of the survey were looking for work, have a disability or health condition that prevents them from working and/or studying. The remaining respondents were self-employed, engaged in housekeeping, private entrepreneurship or had occasional part-time jobs. It is possible that the difficulties with employment are caused by the fact that the respondents' gender identity does not correspond to official documents (passport), therefore most trans* people can only work in illegal jobs (sex work, irregular part-time work, etc.). In the case of trans* women, their transition is more visible outwardly and therefore elicits more negative reactions from others, family members as well as employers, which forces trans* women to become involved in providing sex services.

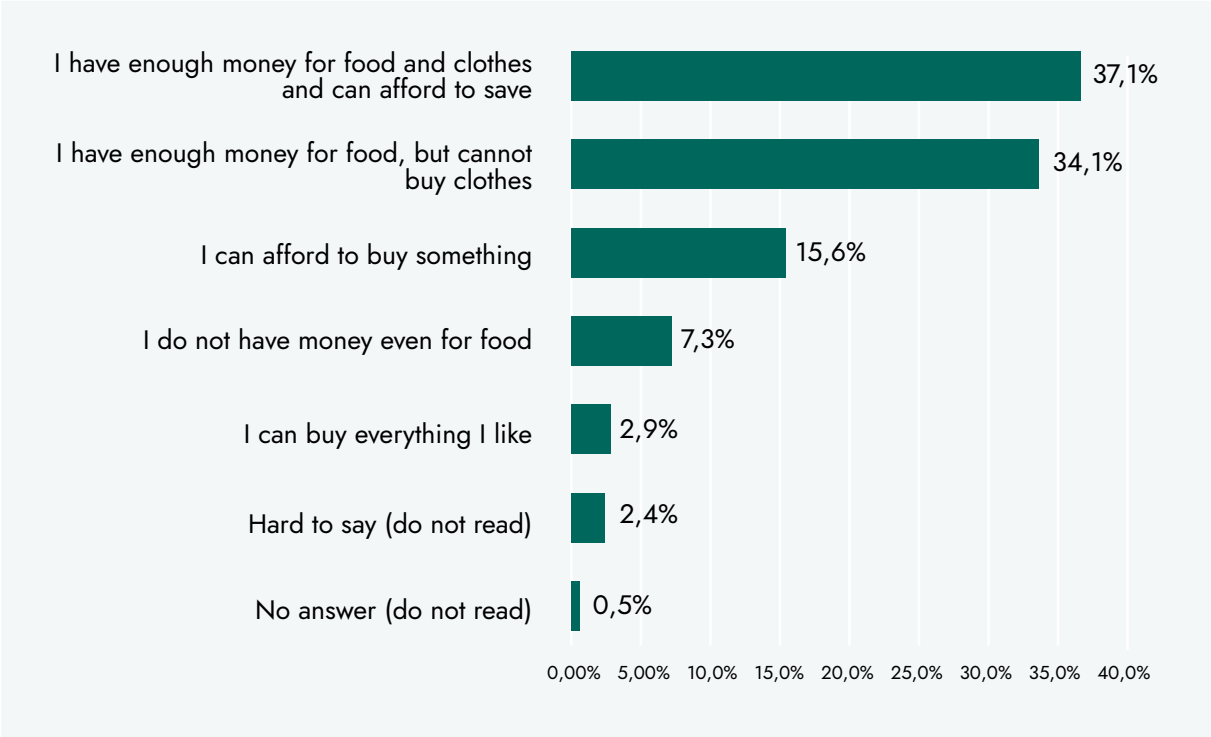
Fig. 3. Occupation of the respondents, n=205.



All the survey participants were asked to assess their financial situation, with 37.1% of the respondents indicating that they have enough money for food and clothing and can still save. Approximately the same number (34.1%) indicated that there is enough money for food, but it is already difficult to buy clothes, i.e. only the basic need, the need for food, is covered. At the same time, 7.3% (15 people) indicated that there was not even enough money for food. Trans* people's economic vulnerability is also related to the lack of employment opportunities. At the same time, the average monthly income of a third of the interviewed trans* people was 4,000 soms, less than 100 USD. The financial situation has been further exacerbated by the COVID-19 epidemiological situation worldwide, as well as political developments in the country.

Fig. 4. Material situation of the research participants, n=205.

Link



Conclusions on the Section:

1. The vast majority of respondents were in the 19-30 age group. The majority of respondents identified their biological sex as male, with trans* women comprising the majority in terms of gender identity.

2. Almost half of the respondents had secondary education, about a quarter had secondary vocational/technical education and almost the same number had incomplete secondary education. Only 14.6% of participants have a basic or completed higher education, which significantly reduces the possibility of finding a job and earning a steady income, but the main barrier is the mismatch between the gender marker and passport data, which prevents legal employment.

3. The vast majority of participants have never been married, due to the context of the country, legislation, and patriarchy, cultural and religious values of LGBT+ phobic society in the Kyrgyz Republic.

4. Just under a half of the respondents were born in the countryside, and a third in the capital; the majority of the respondents live in the capital due to their study in the educational institutions and job search; also, one of the migration factors may be related to the search of friendly services for trans*people.

5. Half of the respondents had lived in rented accommodation in the last 90 days. Only one third of the respondents lived in their own dwelling and there were also those who did not have a permanent place of residence.

6. A quarter of the respondents are involved in providing sex services, about the same number are employed. About a quarter of respondents do not currently work for one reason or another.

7. Slightly more than a third of the respondents said that they had enough money for food and clothing and could still save. Approximately the same number indicated that there was enough money for food, but it was difficult to buy clothes. 15 people said that there was not even enough money for food.

9.3. Hormone therapy and surgical interventions

Hormone Replacement Therapy (HRT) is the process of administering hormones through intramuscular injections, orally or transdermally, i.e. through the skin. For transgender and gender-nonconforming people, this can be an important step in finding oneself. Many transgender people start taking hormones on their own or based on the experiences of trans* people they know, often without even realising that this is a rather gross intrusion into the body's working system, in an attempt to cure gender dysphoria. Before starting HRT, it is a good idea to have a medical check-up and to start taking the medication under the supervision of a doctor[16].

Thus, 58.6% of the TG people surveyed take hormonal medicines, 37.1% take tablets, 21.5% patch or gel, and 41% do not take anything, see Table 5.

Table 5. Taking hormonal medicines, n=205.

Types of hormonal medicines	**#**	**%**
Yes, tablets	76	37,1%
Yes, patch or gel	44	21,5%
No, I do not take anything	85	41,0%
Total	205	100,0%

Among participants who were taking hormones in tablet form, 48.7% reported taking Progynova, a third (30.3%) were taking Mediana, and 22.4% were taking Diane-35. 97.7% of respondents who use patches or gels reported taking Omnadren.

16 HORMONE THERAPY FOR TRANSGENDER PEOPLE. INTERVIEW WITH ENDOCRINOLOGIST O.A. GOLOVKINA, 31.10.2019.

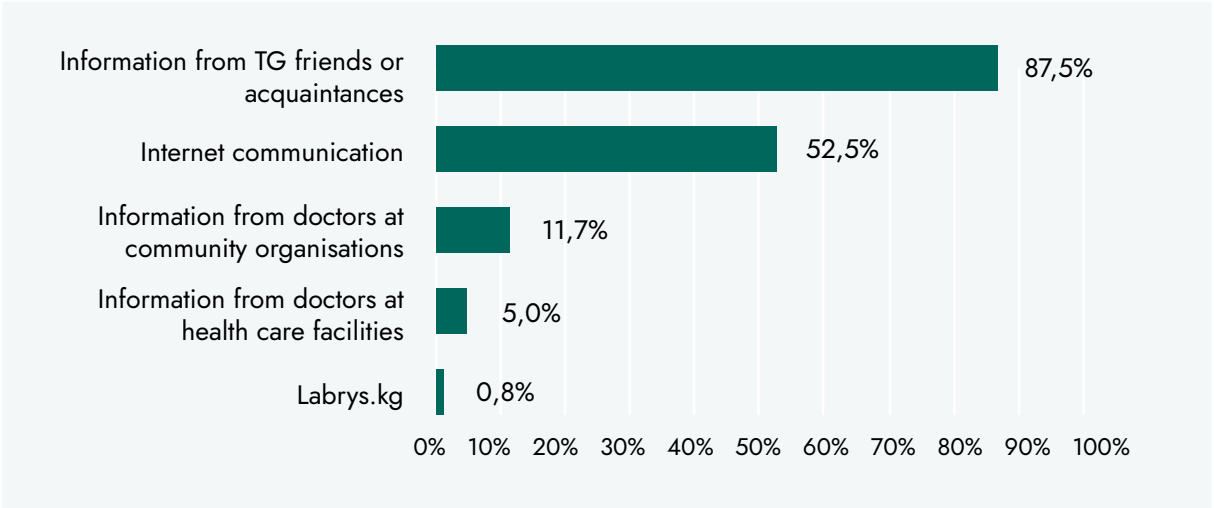
Table 6. Description of hormonal medicines.

#	Medicine name	Description according to instructions for use, pharmacodynamics and pharmacokinetics
1	Progynova	The active ingredient, Estradiol Valeriate, is estrogen (female sex hormone) which, when taken orally, is converted in the human body into natural 17β-estradiol. There is no change in hormone synthesis in the body itself and no suppression of oocyte retrieval from the ovary, so Progynova and ovulation are compatible.[17]
2	Mediana	Active ingredients: drospirenone 3 mg, ethinylestradiol 0.03 mg. Combined oral contraceptive drug containing ethinylestradiol and drospirenone. The contraceptive effect is based on the interaction of various factors, the most important of which are the inhibition of ovulation and changes in the endometrium.
3	Diane-35	A combined low-dose monophasic oral contraceptive with an antiandrogenic effect containing the estrogen ethinyl estradiol and the antiandrogen with gestagenic activity cyproterone acetate. Cyproterone acetate contained in Diane-35 inhibits the effect of androgens, which are also produced in the female body. This makes it possible to treat diseases caused by increased production of androgens or specific sensitivity to these hormones
4	Omnadren	Omnadren contains four varieties of male hormone that have an effect on each other, replenishes testosterone coefficients, and helps build muscle mass. Testosterone is an antagonist of the female sex hormone, estrogen. Causes inhibition of gonadotropic function of the pituitary gland and suppresses mammary gland function in women.[18]

So, the vast majority of respondents (87.9%) indicated that they received information about hormone therapy from friends, other TG people, as well as from acquaintances (Figure 6). Half of the participants (52.5%) named Internet resources as a source of information and only 16.7% received information from medical professionals, medical and public organizations. Information obtained from unverified sources may not always be reliable and may not take into account individual characteristics of a person, therefore, the provision of quality services from service providers is important

17 https://spravtab.ru/proginova/
18 https://instrukciya-otzyvy.ru/lekarstva/6308/

Fig. 6. Sources of information about hormone therapy, n=120.



Hormone therapy and therapy monitoring should go hand in hand and be carried out at the same time. There are great risks associated with hormone therapy for the person who takes hormones. It should be remembered that hormones have both positive and negative effects in terms of side effects. Thus, risk factors include age, e.g. if a person is over forty or an active smoker, the selection of hormone therapy should be made more responsibly, because the risk of thrombosis increases in such a person.

If the patient has a history of heart attacks and strokes, these factors need to be taken into account, as does any coagulopathy (an abnormal condition of the body due to clotting disorders): varicose veins, thrombosis, haemophilia and other blood disorders that can be affected by hormone therapy[19].

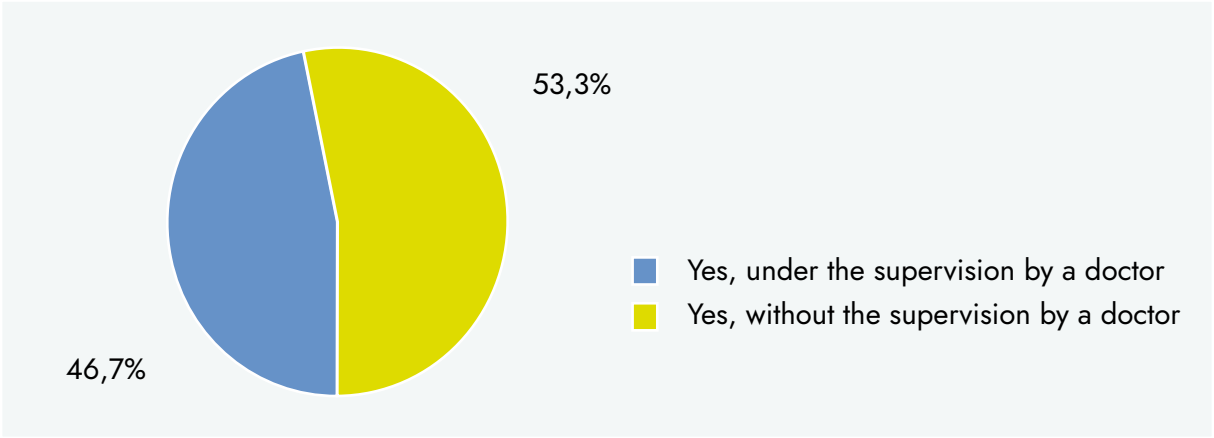
To minimise side effects, there must be a specific strategy developed by the health care professional and the patient; there is a need to be able to cope with complications and to adjust the treatment regimen to the individual patient.

The hormone regimen can be divided into hormone therapy for trans* women and hormone therapy for trans* men. Each of these types of hormone therapy occurs in three stages: stimulation therapy, pre-operative therapy and post-operative therapy.

However, almost half (46.7%) of those who take hormones, do so without the supervision of a medical professional, which can cause complications and adverse effects for the person taking the hormones.

19 https://spravtab.ru/proginova/

Fig. 7. Hormone therapy and involvement of medical specialists, n=120.



When asked why do you take hormones without doctor's supervision, one third of respondents (33.9%) indicated that it was expensive to go to doctors, the same number of respondents (30.4%) indicated mistrust of doctors, slightly more than a quarter (28,6%) indicated that there were no qualified doctors in the country. 16.1% of respondents indicated that there was stigma on the part of medical professionals towards TG people.

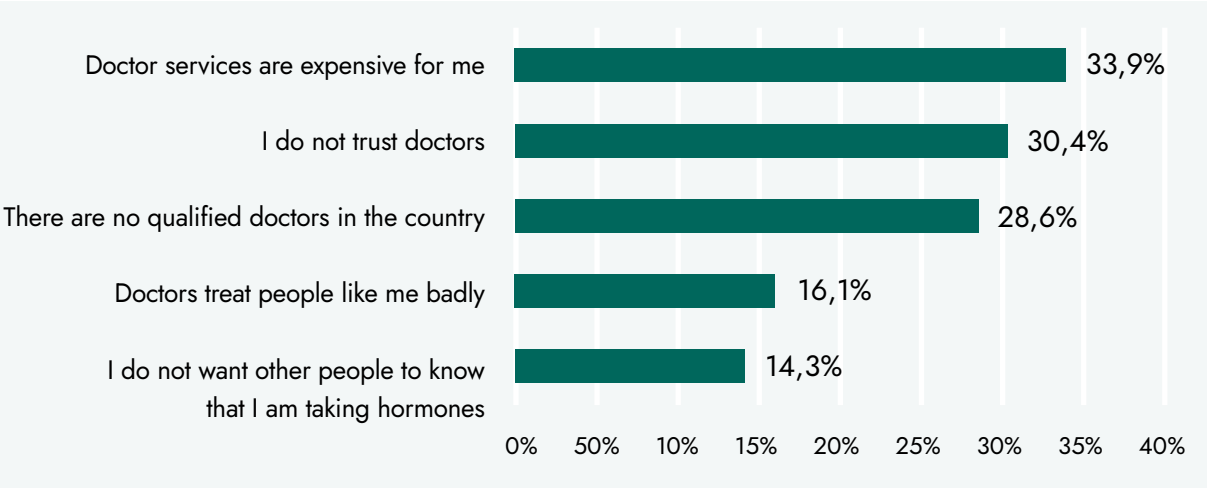
The study "Monitoring of the level of homo/bi/transphobia and quality of services provided to LGBT community at the governmental health institutions[20]" also found a discriminatory attitude of health service providers. This study was based on the participant observation method — a qualitative study method that allows for conducting of field study people in their natural environment and in their daily life situations, as well as on the 'secret client' approach to evaluate the quality of services being provided, developed by the Eurasian Coalition on Male Health. After the coming-out the trans* people informed about the following reaction and behaviours of health personnel:

> *She didn't look in my direction for a very long time and wouldn't listen to me, or examine, just took notes from what I said.*
>
> Secret client – Transgender heterosexual girl, 28 years

> *After my coming-out, in a couple of minutes, the woman who was sitting in the reception area started burning an archa (juniper) in the reception room.*
>
> Secret client – Transgender bisexual man, 22 years.

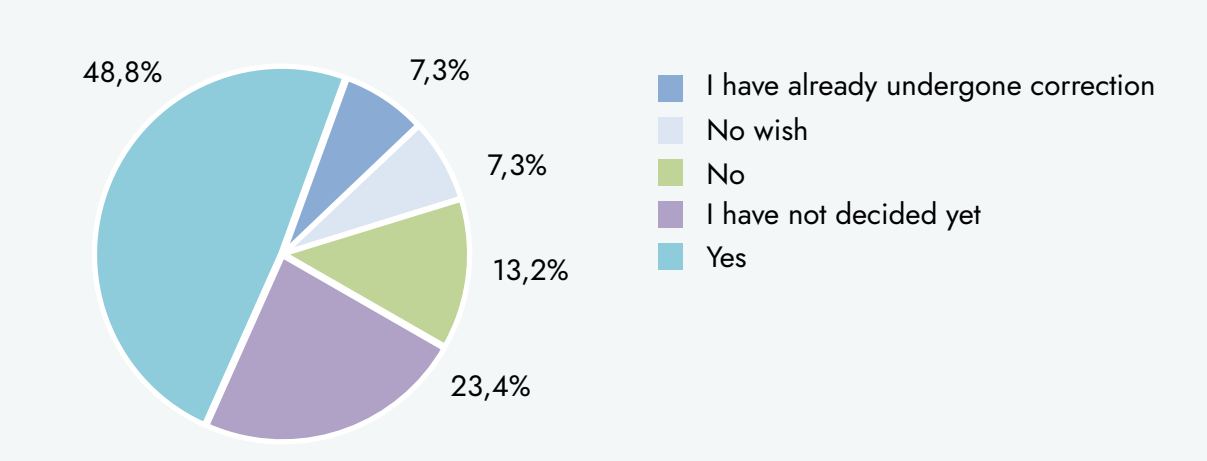
20 Musazov F. Assessment of the level of homo / bi / transphobia and the quality of services provided in state medical institutions among the LGBT community using the "Secret Client" methodology / Public Association "Kyrgyz Indigo," Bishkek, Kyrgyzstan, 2019 - 5-28 p.

Fig. 8. Reasons for not seeking specialist health care, n=56.



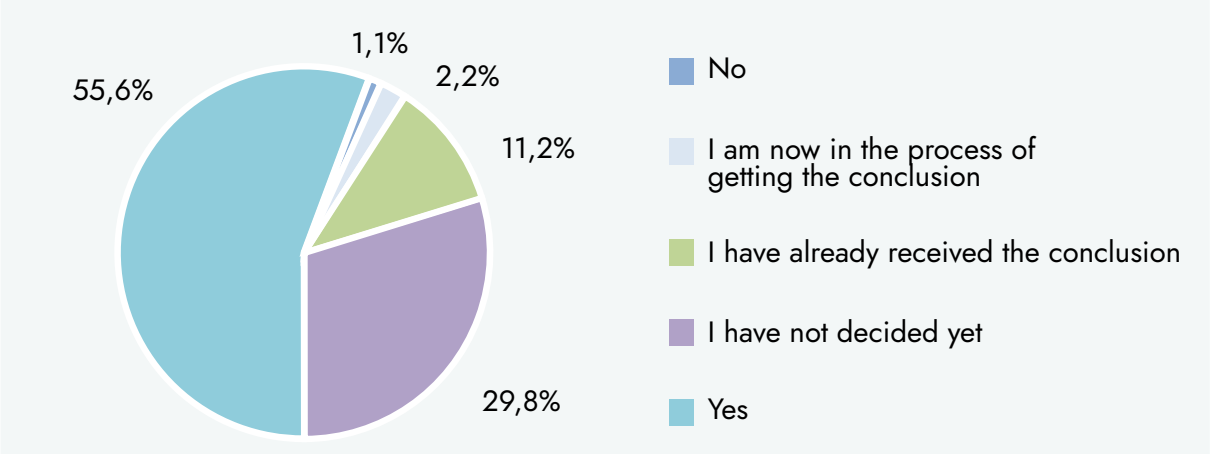
Almost half of all respondents (48.8%) indicated that they plan to make a transmasculine/transfeminine transition (surgical intervention), 7.3% indicated that they have already had their gender corrected and an equal number reported an unwillingness to make the transition. A quarter (23.4%) of those surveyed indicated that a final decision on transition had not yet been made.

Fig. 9. Transmasculine/transfeminine transition, n=205.



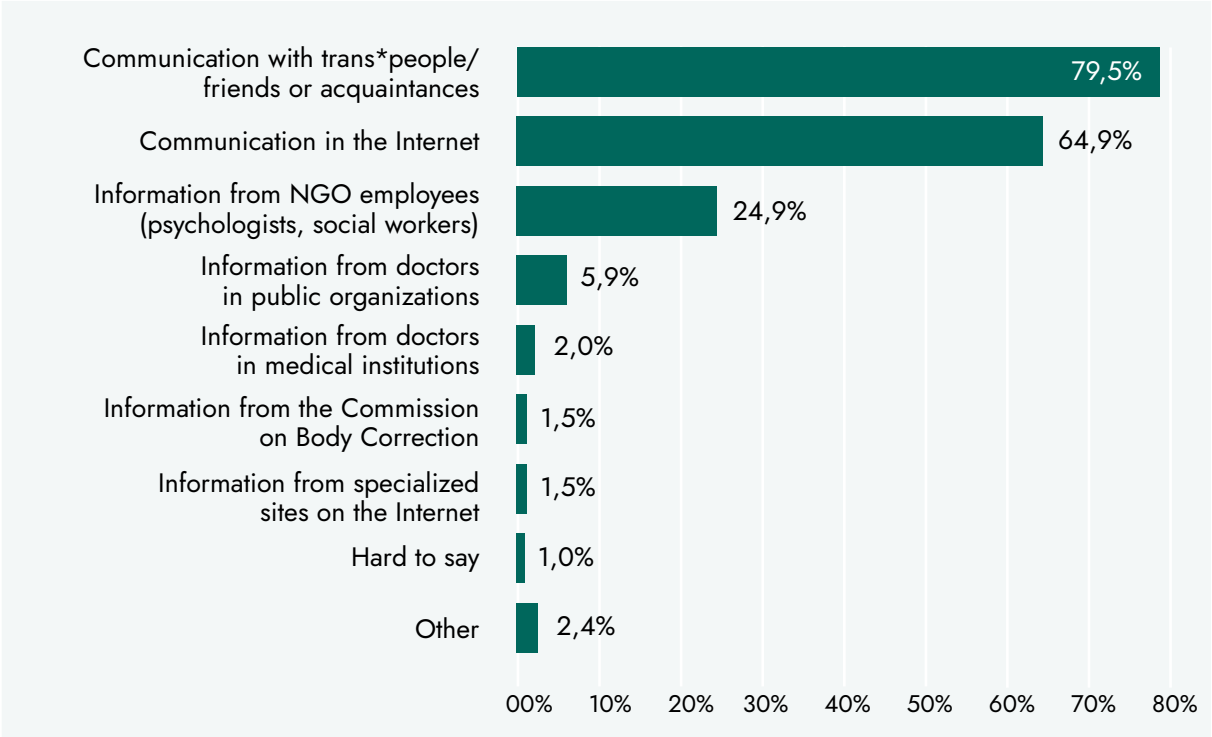
More than half of the respondents (55.6%) reported that they planned to receive a resolution of the Gender Marker Change and Body Correction Commission, one third of the respondents (29.8%) have not yet made a final decision, and only 11.2% of the respondents indicated that such resolution had already been received (Figure 10). It should be noted that Jogorku Kenesh adopted the Law on Civil Status Acts on June 17, 2020 and it entered into force on August 1, 2020. The law has been streamlined and shortened. Under this law trans* people were deprived of the right to change their gender marker on the basis of a medical certificate on gender reassignment.

Fig. 10. Getting the resolution of the Gender Marker Change and Body Correction Commission, n=205.



The vast majority of respondents (79.5%) indicated that they received information about transgender transition through communication with TG people/friends, acquaintances, see Figure 11. More than half of the participants (64.9%) indicated Internet resources as a source of information and only 9.4% of respondents received information from medical professionals from medical and social organisations, the Commission on Body Correction.

Fig. 11. Sources of information about transgender transition, n=205.



Conclusions on the Section:

1. Slightly more than half of respondents take hormonal medicines, slightly more than a third in tablet form, and about a third use patches or gels, and slightly less than half do not take hormones at all. Of those who take hormones, half take Progynova and a quarter take Diane-35. The most popular of the patches is Omnadren.

2. The vast majority received information about hormone therapy from friends, other TG people, as well as from acquaintances. Half of the participants named Internet resources as a source of information and only less than a quarter of those surveyed indicated that they received information from medical professionals and community organizations. Of those who take hormones, almost half do so without the supervision of a medical professional.

3. Half (48.8%) plan to make a transmasculine/transfeminine transition, 7.3% indicated that they have already had a sex correction, and an equal number reported a reluctance to make the transition. A quarter of respondents have not yet made a final decision about transition.

4. Half of the respondents plan to receive a resolution from the Gender Marker Change and Body Correction Commission, one third have not yet made a final decision, and only 11.2% have already received an opinion. However, at the moment it is no longer possible to obtain the resolution of the Commission, because on June 17, 2020 the Jogorku Kenesh adopted the Law on Civil Status Acts, which entered into force on August 1, 2020. According to this law transgender persons lost the right to change their gender marker on the basis of a medical opinion on gender reassignment. The old Civil Status Act No. 60 of 12 April 2005 contained a provision that allowed for changing the gender marker.

5. The majority of respondents received information about transgender transition when communicating with TG people/friends, acquaintances. More than half of the participants indicated Internet resources as a source of information, and only 9.4% of the respondents received information from medical specialists of medical and public organisations, the Body Correction Commission.

9.4. Sexual practices

In the last 12 months, 69.8% of all respondents had sexual contacts. Of those who had sexual contacts, 74.8% had a cisgender male sexual partner and 28% had sexual contacts with a cisgender female. And only 7% had trans* males and trans* females as partners (Table 6).

Table 6. Gender identity of sexual partners in the last 12 months, n=143.

Gender identity of partners	**#**	**%**
Cisgender male	107	74,8%
Cisgender female	40	28,0%
Transgender female	5	3,5%
Transgender male	5	3,5%
Total	**143**	**100,0%**

90.4% of respondents who had sex in the last 12 months had a regular sexual partner[21]. 83.6% of respondents reported having had sexual contact with casual sexual partners in the last 12 months.[22] 73.3% reported that they had commercial sex partners who gave certain remuneration for sex.[23]

21 Regular sexual partners were defined as partners with whom the respondent had regular sexual contacts.
22 Occasional sexual partners include unfamiliar partners with whom the respondent has had casual sexual contact but has not paid/received material remuneration.
23 We define commercial sexual partners as those whom the respondent has remunerated for sexual intercourse or from whom the respondent has received remuneration for sexual intercourse. By remuneration we mean: money, food, things, alcohol, drugs, protection, etc.

Table 7. Categories of sexual partners in the last 12 months, n=143.

Categories of partners in the last 12 months	#	%
Regular partner/s	94	90,4%
Occasional partner/s	46	83,6%
Commercial partner/s (whom you gave remuneration for sex)	2	50,0%
Commercial partner/s (who gave you remuneration for sex)	44	73,3%

Table 8 presents data on the number of sexual partners in the last 12 months. Thus, the number of regular sexual partners ranged from 1 to 25. The average was 7. The number of occasional sexual partners ranged from 1 to 50, with an average of 13. The number of commercial sexual partners who paid for sex ranged from 1 to 2, with an average of 2. The number of commercial sex partners who gave remuneration for sex ranged from 1 to 300, with an average of 300

Table 8. Number of sexual partners in the last 12 months, n=119.

Number	Regular partners	Occasional partners	Commercial partners who were remunerated for sex	Commercial partners who gave remuneration for sex
min	1	1	1	1
max	25	50	2	300
average	7	13	2	48,5
n	94	46	2	44

The majority of respondents (73.1%) had a regular sexual partner in the last 12 months. Almost every second respondent had an occasional sexual partner (48.7%) and a commercial one (49.6%).

Table 8. Having a sexual partner in the last 12 months, n=119.

Partner categories	**yes**		**no**		**Did not have such a partner**	
	#	%	#	%	#	%
Regular partner	87	73,1%	22	18,5%	10	8,4%
Occasional partner	58	48,7%	6	5,0%	55	46,2%
Commercial partner (who was remunerated for sex)	3	2,5%	2	1,7%	114	95,8%
Commercial partner (who gave remuneration for sex)	59	49,6%	1	0,8%	59	49,6%

Condom use in the last 12 months was most frequently practiced with regular sexual partners (69.7%), almost as frequently with occasional sexual partners (68%), and with commercial sexual partners who gave remuneration for sex (59.7%). With those to whom respondents paid for sex services it was practised in half of the cases (48.7%), and these practices cannot be characterised as safe (Table 9).

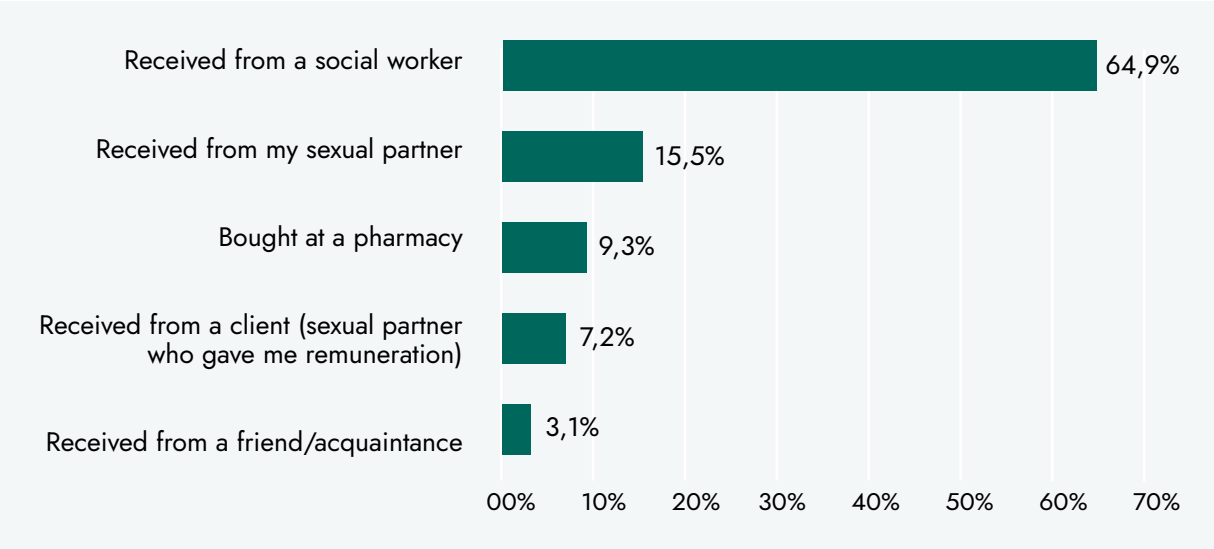
Table 9. Condom use every time at sexual intercourse in the last 12 months, n=119

Sexual contacts in the last 6 months	**#**	**%**
yes	120	83,9%
no	16	11,2%
I did not have sexual contacts	1	0,7%
No answer/refused to answer	6	4,2%
Total	**143**	**100,0%**

Those who reported using a condom the last time they had sex were asked where the condom was purchased. The majority of those who used a condom indicated that the condom had been provided by a social worker of a community organization (64.9%), which shows the coverage of prevention programmes. In Bishkek, most trans*topic work is currently carried out by the following organizations that provide prevention services to the LGBT+ community, including transgender people: Kyrgyz Indigo, which was used to collect data, Labrys, Anti-AIDS, which responds to and meets the needs of trans* people and employs trans* people who are involved both in decision-making and in implementing trans*topic plans and programs.

Other variants of answers included provision by a sexual partner, purchase at a pharmacy, etc.

Fig. 12. Condom sources, n=205.



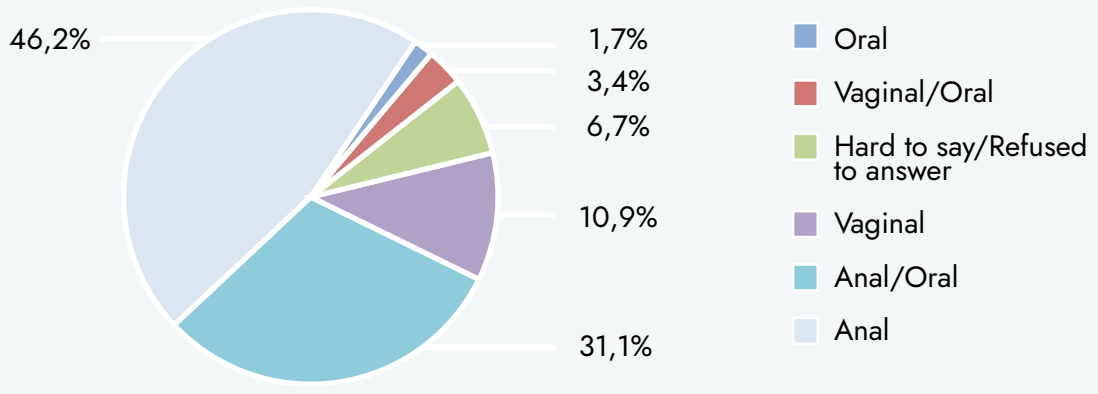
17.5% of respondents did not use a condom during their last sexual intercourse, in the last 6 months. The first reason for not using a condom was confidence in the health of one's partner and oneself (71.4%), which is a subjective assessment. Other options voiced included laziness, lack of necessity, not having a condom on hand, and the fact that using a condom reduces sensitivity and causes erection problems. It should be noted that given the life realities of trans* people in the Kyrgyz Republic, in the case of commercial sex, a client may require a trans* person to have sex without a condom or pay an additional fee for it.

Table 11. Reasons for not using a condom at last sexual intercourse, n=21.

Reasons for not using a condom	**#**	**%**
I have been under the influence of drugs	1	4,8%
The partner insisted on not using a condom	2	9,5%
I was sure that both me and my partner were healthy	15	71,4%
I have been under the influence of alcohol	1	4,8%
I played an active role and did not see a risk for myself	1	4,8%
Other	4	19,0%
Total	**21**	**100,0%**

Those who had sexual contacts in the last 6 months were asked what kind of sexual contact they had last had. Almost half of the respondents (46.2%), of those who had sexual contacts in the last 6 months, indicated that the sexual contact was "anal", 31.1% indicated that the contact was "anal/oral", i.e. 77.3% of the respondents had had "anal" sexual contact in one way or another.

Fig. 13. Type of a most recent sexual contact, n=119.



75.6% of respondents indicated that the last sexual contact was with a regular sexual partner, 39.5% indicated that the partner was a commercial one (who gave remuneration for sex).

21% of respondents indicated that the partner was occasional.

Table 12. Partner category at the last sexual contact, n=119.

Partner category	**#**	**%**
Regular partner	90	75,6%
Occasional partner	25	21,0%
Commercial partner (who you remunerated for sex)	1	0,8%
Commercial partner (who gave you remuneration for sex)	47	39,5%
Total	**119**	**100,0%**

When considering last sexual contact and gender identity of a sexual partner, 79% of respondents reported that this contact was with a cisgender man and 20.2% had a contact with a cisgender woman.

Table 13. Gender identity of a sexual partner at the last sexual intercourse, n=119.

Gender identity of a partner	**#**	**%**
Cisgender male	94	79,0%
Cisgender female	24	20,2%
Transgender female	1	0,8%
Total	**119**	**100,0%**

Conclusions on the Section:

1. In the last 12 months, most of all respondents had sexual contacts. The majority had a cisgender male sexual partner and just over a quarter had a cisgender female partner. And only 7% had trans* males and trans* females as partners.

2. The vast majority of those interviewed, of those who had had sexual contacts in the last 12 months, had regular, casual, commercial sexual partners who gave remuneration for sex.

3. The number of regular sexual partners ranged from 1 to 25, with an average of 7. The number of occasional sexual partners ranged from 1 to 50, with an average of 13. Number of commercial sexual partners who were paid for sex ranged from 1 to 2, the average being 2. Number of commercial sex partners paid for sex ranged from 1 to 300, the average being 300.

4. The majority of respondents had a regular sexual partner in the last 12 months. Almost every second had an occasional sexual partner, as well as a commercial one.

5. More than half of the respondents indicated that they had used condoms in the last 12 months with regular, occasional or commercial (who were paid for sex) sexual partners. With sexual partners, who paid respondents for sex services, it was practiced in half of the cases.

6. Of those who had sexual intercourse in the last 12 months, most had used a condom at the last intercourse (97 out of 120).

7. Thus the majority of those who had used a condom indicated that the condom had been provided by a social worker from a community organisation, indicating that the majority of surveyed TG people sought services from an NGO.

8. 17.5% of those who had sexual contacts in the last 6 months did not use a condom during their last sexual intercourse. The reason for not using a condom in the first place was that they were confident about their partner's and their own health, which was indicated by the majority of respondents.

9. Almost half of the respondents who had sexual contacts during the last 6 months indicated that the sexual contact was "anal", one third indicated that the contact was "anal/oral", i.e. most of the respondents practiced "anal" type of sexual contact in one way or another.

10. Sexual contacts with occasional sexual partners were practiced by almost a quarter of those who had sexual contacts in the last 6 months. At the same time the majority of respondents indicated that the contact was with a cisgender man, almost a quarter had contact with a cisgender woman.

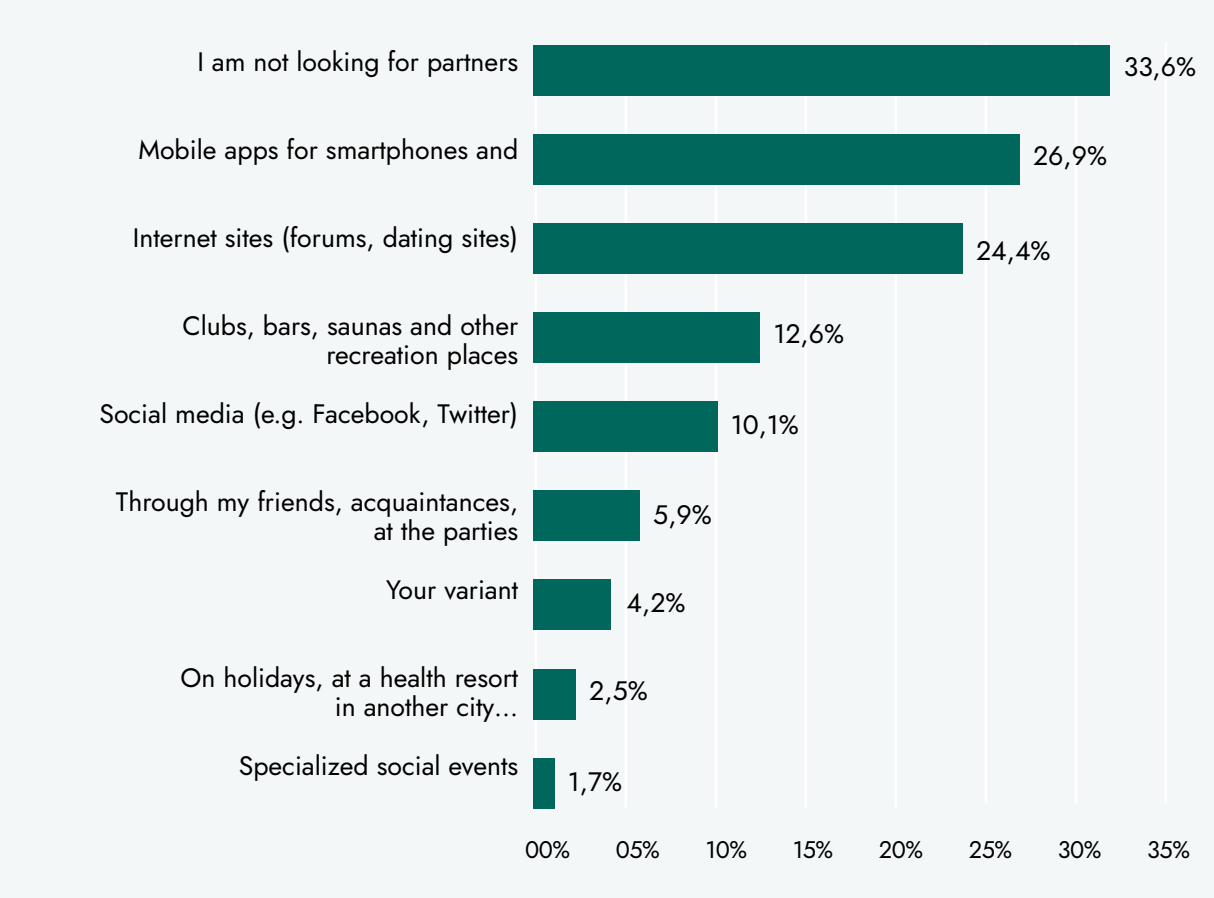
11. Data showed high risk behaviours among trans* people that can lead to risk of HIV infection. Prevention programmes cannot cover the entire trans* community and sustainable and effective programmes, at national level, are needed.

9.5. Partner-seeking options

Internet is being actively used to find partners, including sexual partners. There are various mobile applications, Internet sites, forums, dating sites, and social networks for this purpose and they have taken one of the leading places in the life of a modern people.

A third of those surveyed (33.6%) said they were not currently looking for a partner, a quarter (26.9%) mentioned that they use various mobile applications, approximately the same number (24.4%) used Internet sites, and 10.1% mentioned social networks. Accordingly, 61.4% in one way or another were using Internet resources to find a partner. 22.7% indicated that they were meeting in clubs/ bars, through acquaintances and friends, on holidays or at specialized social events for TG people (Fig. 14). In addition, among other response options, a website for sex work was mentioned.

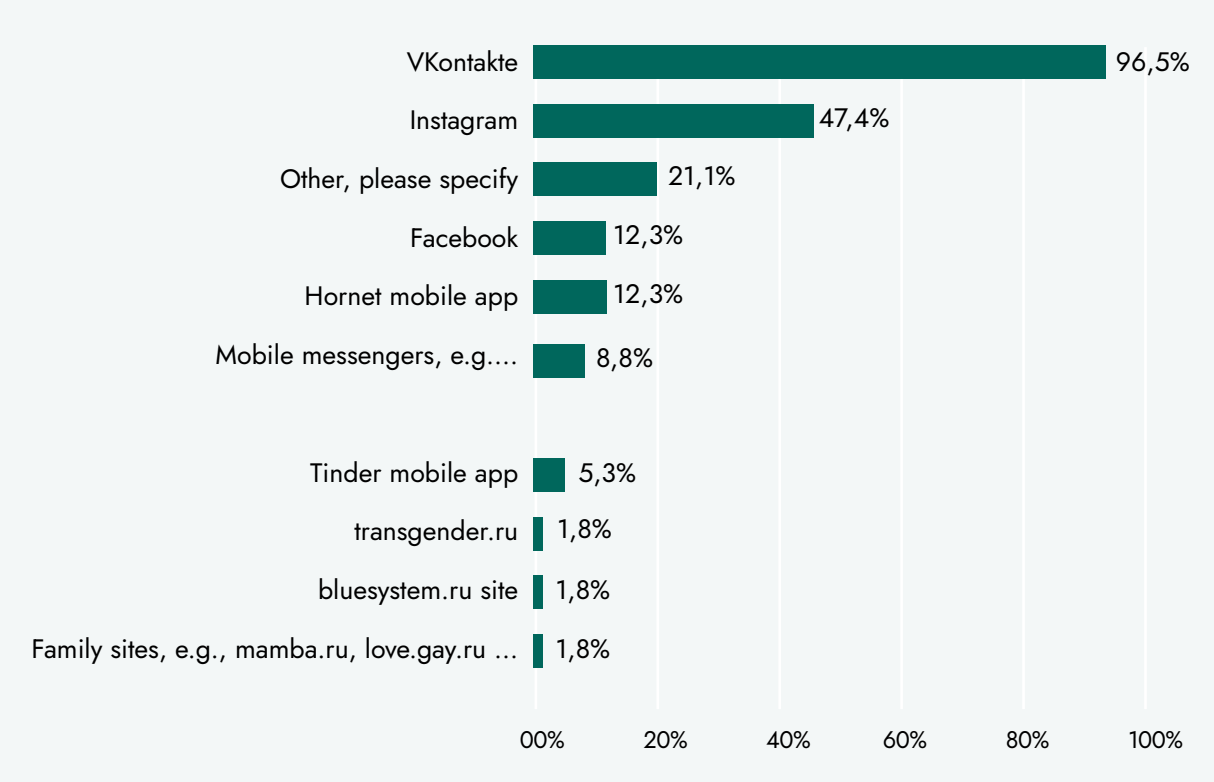
Fig. 14. Partner-seeking options, n=119.



Those respondents who noted the use of websites/mobile applications, social networks were asked to indicate the names, so the vast majority noted "VKontakte" (96,5%).

The second most popular choice was Instagram, which was mentioned by 47.4% of the users of Internet resources to find partners, see Figure 15. Among the other options were Badoo (dating site), VIP Bishkek, gaymoscow, etc.

Fig. 15. Partner-seeking options, n=119.



First of all, let's note that account and profile are all synonyms that reflect the same thing, namely that a person is registered on a certain resource, having specified some data about him/herself and having created a unique combination of login and password to log in.

As far as social networks are concerned, an account (profile) is a personal page where various information, video, audio and other materials are posted, including personal information about oneself.

What exactly will be shown on your profile, how the information will be presented in your social networking account depends on each person who has registered, and no one can guarantee that the information will be truthful. Taking advantage of this feature, many people create two or three profiles. One may be real and the others are used for whatever purpose, such as finding sexual partners, including commercial ones.

The number of profiles mentioned above in the partner-seeking channels varies from 1 to 8. Each of the above-mentioned channels in Table 10 has at least 1 profile.

Thus, 16.4% of users of the social network "VKontakte", 7.4% of users of "Instagram" and 60% of users of mobile messengers, collective chats in Vyber, WhatsApp or Telegram had 2 profiles.

20% of users of mobile messengers, Vyber, WhatsApp and Telegram also had 2 profiles and 3.6% of VKontakte users had 3 or more profiles.

Table 14. Number of profiles in social media, mobile applications and web-sites.

Social media, websites, mobile apps	One profile	2 profiles	3 and more
Family websites mamba (mamba.ru, love.gay.ru, facelink.ru, love.mail.ru)	100,0%	0,0%	0,0%
Website bluesystem.ru	100,0%	0,0%	0,0%
Mobile app Hornet	100,0%	0,0%	0,0%
Mobile app Tinder	100,0%	0,0%	0,0%
Vkontakte	80,0%	16,4%	3,6%
Facebook	85,7%	0,0%	0,0%
Instagram	92,6%	7,4%	0,0%
Mobile messengers, e.g. collective chats in Viber, WhatsApp, Telegram	20,0%	60,0%	20,0%
transgender.ru	100,0%	0,0%	0,0%
Other, please, specify:	9,1%	0,0%	27,3%

Those channels that have been used in the last 30 days are shown in Table 15. Thus, social networks VKontakte and Instagram are the most popular for TG people, as noted above, which is further confirmed by the fact that these channels were used by respondents in the last 30 days to find partners.

Conclusions on the Section:

12. The majority of respondents use Internet resources to find a partner. About a quarter mentioned that they met in clubs/ bars, through acquaintances and friends, on holiday or at specialised social events for TG people.

13. Social media "VKontakte" is used by the vast majority of respondents. The second most popular media is Instagram, cited by almost half of the respondents. The number of partner search profiles varies from 1 to 8.

9.6. Use of psychoactive substances (PAS).

Psychoactive substances (PAS) are chemical and pharmacological agents that "have an effect on mental processes, such as the cognitive or affective spheres, when consumed".[24]

The psychological effects of cannabis (a general term for psychoactive cannabis products) include euphoria, exacerbated laughter, and a state of oneiroidism, calmness and drowsiness (or insomnia, which depends on the individual). This disorder is classified as cannabis intoxication.

Marijuana increases sensitivity to external stimuli, allows you to detect details that previously went unnoticed, makes colours more vivid and rich, and enhances your perception of music and art. The sense of taste and smell is heightened. Time seems to slow down, and one begins to notice that there is a lot going on at any given moment.

There is also the hypothesis that marijuana in medium quantities enhances orgasms in both men and women, and at the same time delays ejaculation[25].

In addition, substance use allows for temporary detachment and forgetting current problems and countless difficulties faced by trans* people, ranging from financial problems, rejection and transphobia of society, significant others, stigma and discrimination.

For example, 42% of trans* people surveyed reported using substances other than by injection, and 21% of those surveyed had used substances in the past 30 days.

24 WHO definition.
25 Material from Wikipedia.

Table 16. Use of any psychoactive substances except injectable drugs, n=205.

Fact of PAS use	**#**	**%**
Yes, I used them in the last 30 days	43	21,0%
Yes, I used them in the last 12 months (not in the last 30 days)	31	15,1%
Yes, I used them more than a year (12 months) ago	12	5,9%
I have never used or even tried them	110	53,7%
Hard to say/Refused to answer (do not read)	9	4,4%
Total	**205**	**100,0%**

Only 80.2% (69) of those who use drugs by non-injection were able to name the drugs, most of those who use drugs by non-injection use hashish/marijuana (65.2%). In other words, the remaining 34.8% presumably use synthetic drugs, pharmacological preparations and salts, which have become popular among young people in the capital over the last 2-3 years. The second most frequently abused drug is mephedrone (meth) (18.8%). Unfortunately, data on chemsex in the EECA region has not yet been researched, but there is a high trend of substance use among trans* people.

Table 17. Use of any non-injectable PAS, n=69.

Types of non-injectable drugs	**#**	**%**
Anasha (marijuana, hashish, Issyk-Kul grass, joint)	45	65,2%
Acytominophen	1	1,4%

Dunk	1	1,4%
Glue	1	1,4%
Crystals	5	7,2%
Ice	1	1,4%
Methedrone (meth)	13	18,8%
Organics	2	2,9%
Synthetic drugs	1	1,4%
Salts	5	7,2%
Spice	5	7,2%
Decyclomine	1	1,4%
Total	**69**	**100,0%**

None of the respondents interviewed reported injecting drug use, with only 5 participants in the study indicating that they found it difficult to answer this question. It can be assumed that these 5 respondents had ever tried injecting drugs, but chose not to disclose it in the current survey.

Conclusions on the Section:

1. Non-injecting substance use was reported by about half of the respondents, and almost a quarter of the respondents had used substances in the past 30 days.
2. Most of those who use surfactants indicated that they use marijuana. That is, the remaining third presumably use synthetic drugs, pharmacy preparations and salts, which have become popular among young people in the capital over the last 2-3 years. None of the interviewed respondents reported injecting drug use, and only 5 survey participants indicated that they found it difficult to answer this question.

9.7. Stigma and discrimination

According to the study to evaluate the needs of transgender people[26], conducted in four Central Asian countries, they all have the laws and draft laws containing homo/transphobic policies that have an impact on the lives of TG people in the context of ongoing rights violation and discrimination, hindering access to social, medical, psychological and legal services. For instance, according to a study of violation of human rights of LGBT+ community in Kyrgyzstan[27], transgender people may experience multilevel discrimination. According to the qualitative data, trans* people are more vulnerable to physical and sexual violence, discrimination, harassment, threats and intimidation. Much of the violence is compounded by hatred based on both transphobia and sexism. Transgender people have been more exposed to hate-based violence in public spaces. A study to assess the needs of transgender people in Kyrgyzstan found that over 50% of respondents did not feel safe and had experienced violence[28]. According to this study, the risk of discrimination or violence is particularly high for trans* people if they have not changed their passport, have different appearance or behaviour that deviates from socially constructed gender norms about men and women, are involved in sex work and have no support from their close relatives. If all of these issues apply to one person, the risk of violence from a stranger or a relative is extremely high, and there is a sense of impunity for both the perpetrator and the professionals who refuse to provide appropriate support.

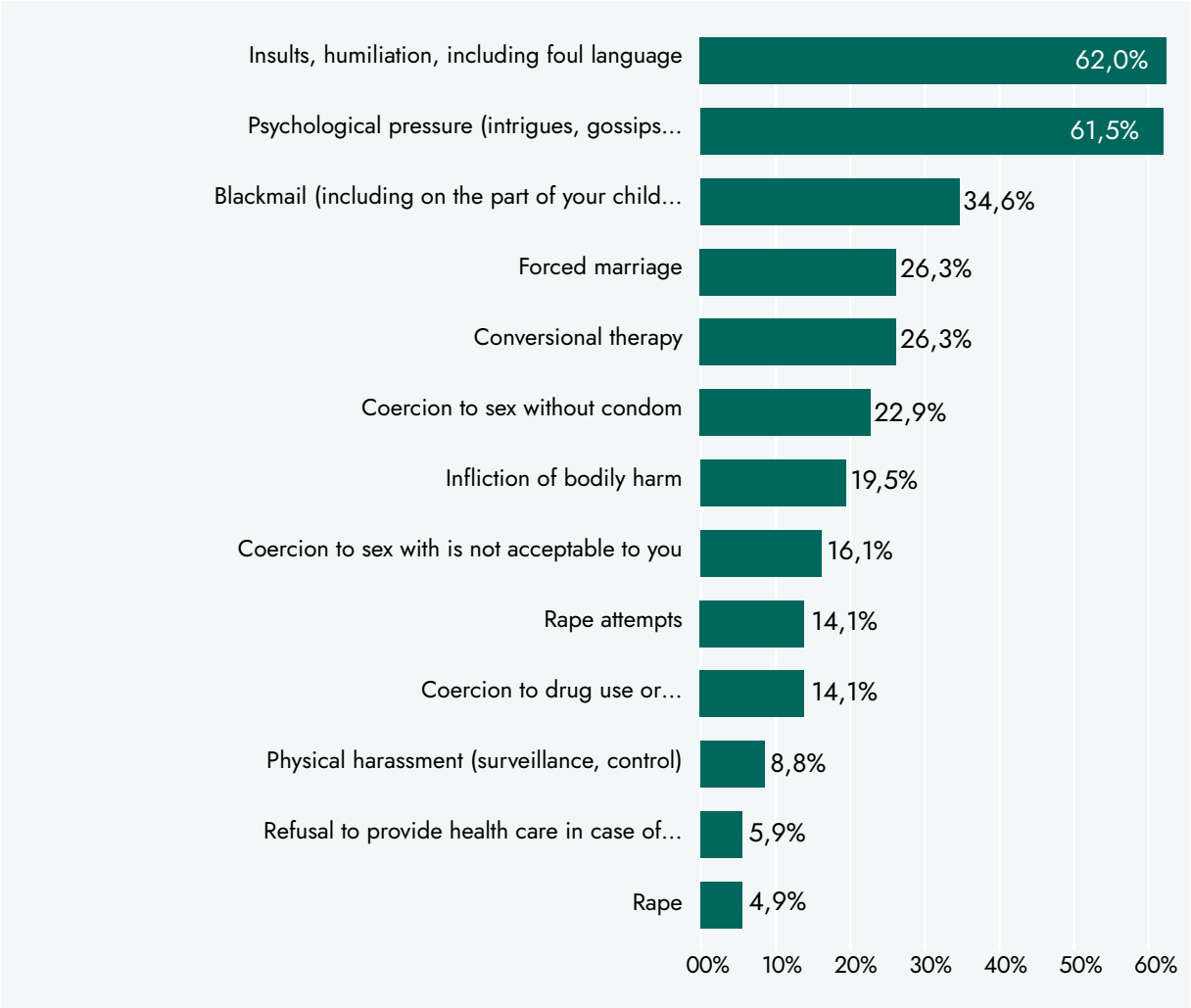
In recent years, trans* girls have found themselves in the spotlight because of the many derogatory videos that have been produced by police, journalists and others in order to blackmail, extort and condemn them. These videos have motivated both insecurity and distrust of the police among trans* people, as well as an awareness of injustice among cisgender people willing to become allies. Violence and discrimination against trans* people is mainly based on a patriarchal world order, where all people are divided into men and women with specific behaviours and roles. Such attitudes produce sexism and misogyny, which can manifest in gender-based violence against trans* people. The whole patriarchal system is greatly reinforced by the lack of adequate information that can broaden the established awareness of the world around us[29].

The World Health Organization states that an increased risk of mental disorders among transgender people is associated with transphobia, discrimination and violence. In this case, a significant stress can be caused by difficult access to resources that allow free expression of one's gender identity (such as hormone therapy and other medical procedures), social rejection, discrimination and attacks. As experts have noted, it is precisely because of these circumstances that anxiety, depression and other mental health problems are more common among transgender people than among cisgender people[30].

26 http://indigo.kg/wp-content/uploads/2017/07/Needs-Assessment-T.pdf
27 http://indigo.kg/wp-content/uploads/2017/07/Issledovanie-po-nasiliyu_Ki.pdf
28 Orsekov D. Mapping services available to trans people in medical institutions in Kyrgyzstan / Public Association "Kyrgyz Indigo". - Bishkek, 2019. - 85 p.
29 Orsekov D. Mapping services available to trans people in medical institutions in Kyrgyzstan / Public Association "Kyrgyz Indigo". - Bishkek, 2019. - 85 p..
30 http://www.euro.who.int/en/health-topics/health-determinants/gender/gender-definitions/whoeurope-brief-transgender-health-in-the-context-of-icd

Data in Figure 16 shows that there is a high level of stigma and discrimination in its various manifestations against TG people in Kyrgyzstan. For example, most of the study participants have had difficult experiences of discrimination and prejudice because of his/her gender identity: rejection of family, loss of employment, ridicule by neighbours, psychological pressure, wry glances and physical violence.

Fig. 16. Cases of stigma and discrimination towards TG people, n=205.



One in four respondents experienced job rejection due to a mismatch between the gender marker on their passport and the appearance of trans* people in their career advancement, 26.8% of respondents reported this. A third of respondents (33.2%) said that they had been refused promotion due to a mismatch with their passport data.

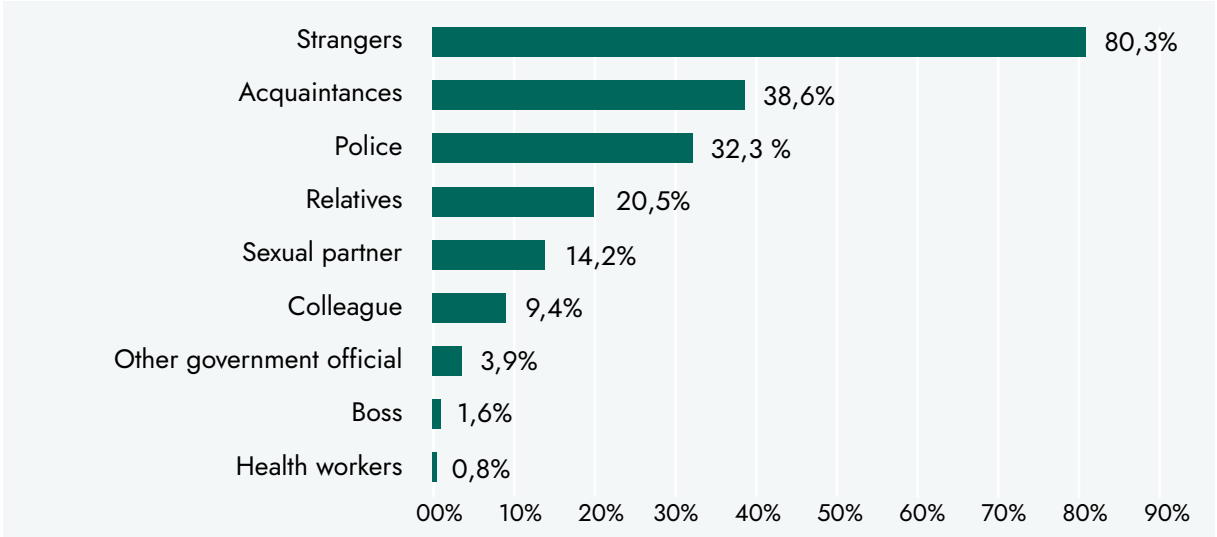
Table 18. Cases of stigma and discrimination against TG people, n=205.

Have you faced the following situations in the last 12 months:	#	%
You have been refused a job because of your gender identity	55	26,8%
You were not promoted because of your gender identity	55	26,8%
You were not promoted because of mismatch in your passport data	68	33,2%
Total	**205**	**100,0%**

The next block of questions will be about the time period over the last 12 months. Thus, 62% of those surveyed (127 people) indicated that they had experienced insults, humiliation (including foul language, criticism, hurtful nicknames), n=205. And 80.3% of those who had experienced this noted that it was most often from strangers. In addition, more than a third of those who have experienced this, noted that it also came from acquaintances in 38.6%, as well as from representatives of law enforcement agencies (32.3%) (Figure 17).

That is, stigma and discrimination against TG people is a frequent phenomenon and there is a need to work to reduce stigma and discrimination with the involvement of the community of TG people. The baseline assessment of MSM and trans* people community participation in HIV decision-making processes in Armenia, Belarus, Georgia, Kyrgyzstan and Macedonia suggests that addressing stigma and improving the quality of health services for TGHIV will have little impact if TGHIV themselves are not actively involved, remaining invisible or rejected when their special health needs and needs for other services are not known.

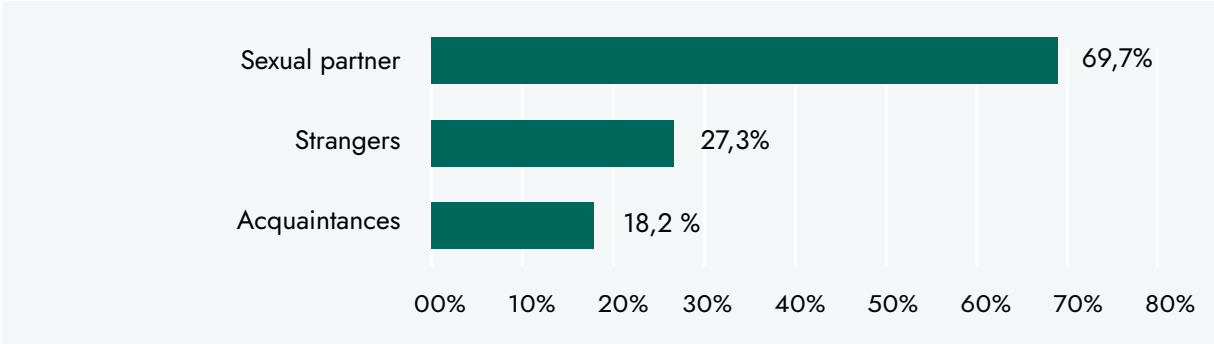
Fig. 17. Incidents of insults, humiliation (including foul language, criticism, hurtful nicknames) towards TG people, n=127.



16.1% indicated that in the last 12 months there had been cases of coercion to sex in a form that was not acceptable/disliked by respondents (including in perverted forms, with physical violence, group sex, etc.), n=205.

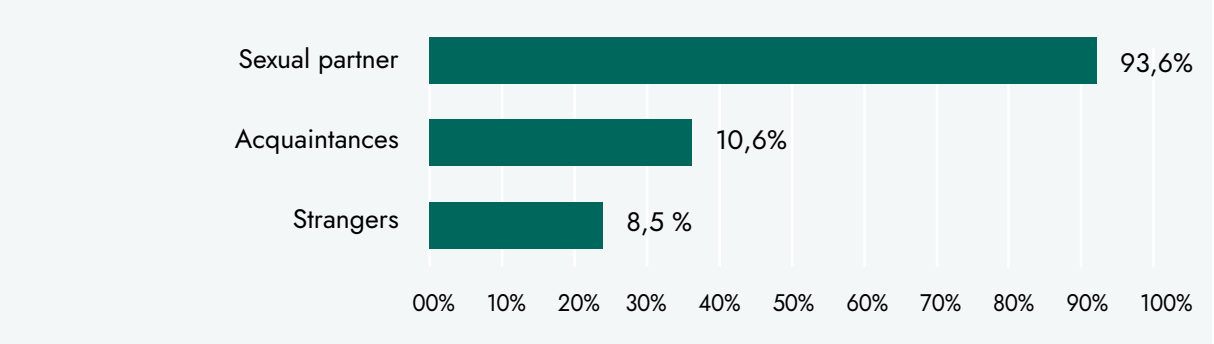
Cases of coercion to have sex in an inappropriate form were mainly from sexual partners, reported by 69.7% of respondents, 27.3% of those surveyed noted that it was from strangers.

Fig. 18. Instances of coerced sex in a way that is not acceptable/disliked by TG people, n=33.



22.9% of participants reported having been forced to have sex without a condom in the last 12 months, n=205.

Fig. 19. Incidents of coerced sex without a condom among TG people, n=47.

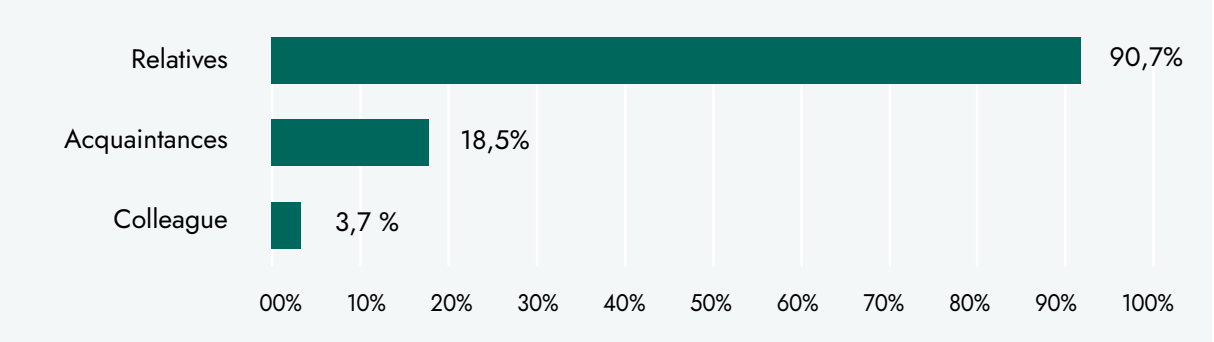


Reparative therapy, also known as "conversion", "reorientation" or "differentiation" therapy, is a set of techniques aimed at changing a person's sexual orientation from homosexual and bisexual to heterosexual[31].

31 Material from Wikipedia

26.3% of the interviewed TG people indicated that conversion therapy had been attempted, n=205. And it is quite logical that these cases were most often observed on the part of relatives who are in the closest environment of TG people (90.7%). And also 18.5% of those who had experienced it noted that it was from acquaintances, which demonstrates rejection and transphobia even from close and familiar trans* people.

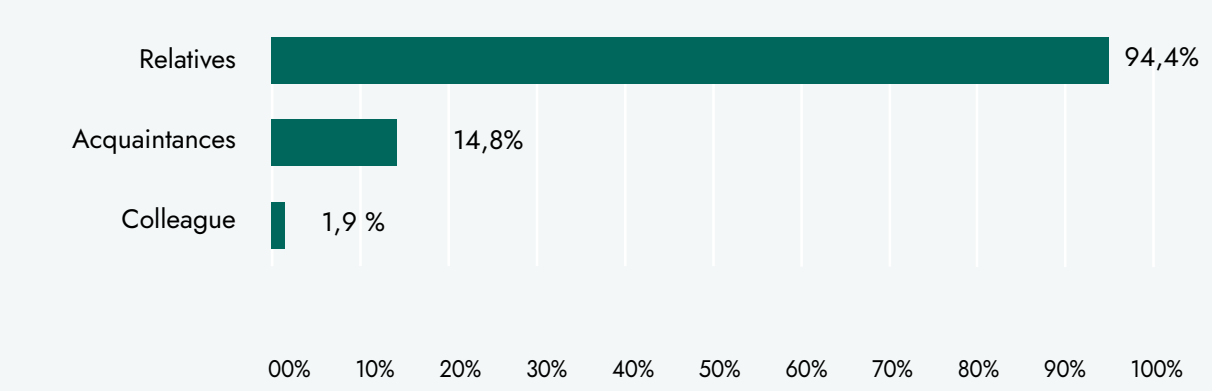
Fig. 20. Cases of coercion of TG people to conversion therapy, n=54.



A forced marriage is a marriage union in which one or both spouses enter into without consent or against their will.

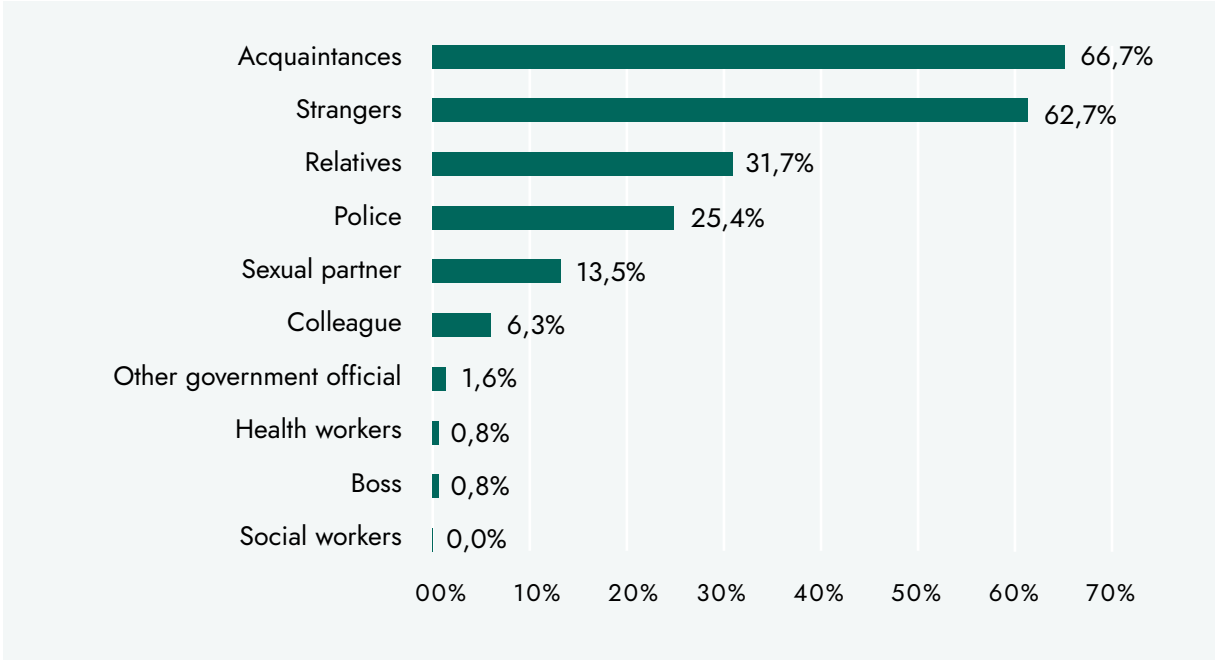
Thus, according to the results of the PDI survey, a quarter of respondents (26.3%) indicated that there had been forced marriages, n=205.

Fig. 21. Cases of coercion to the forced marriage, n=54.



Over the last 12 months, 61.5% of the TG respondents (n=205) reported psychological pressure (intrigues, gossip, "hit-and-run"). 66.7% and 62.7% of respondents noted that this had been observed on the part of their acquaintances and strangers, respectively. In addition, a third of the PDI survey participants who had experienced this phenomenon had experienced it from their own relatives (31.7%). Often this is performed by representatives of law enforcement agencies, as indicated by a quarter of those (25.4%) who had experienced cases of psychological pressure on themselves. This indicates that law enforcement officials are confident that they will remain unpunished by actively displaying transphobia - an aversion to people who do not conform to generally accepted norms.

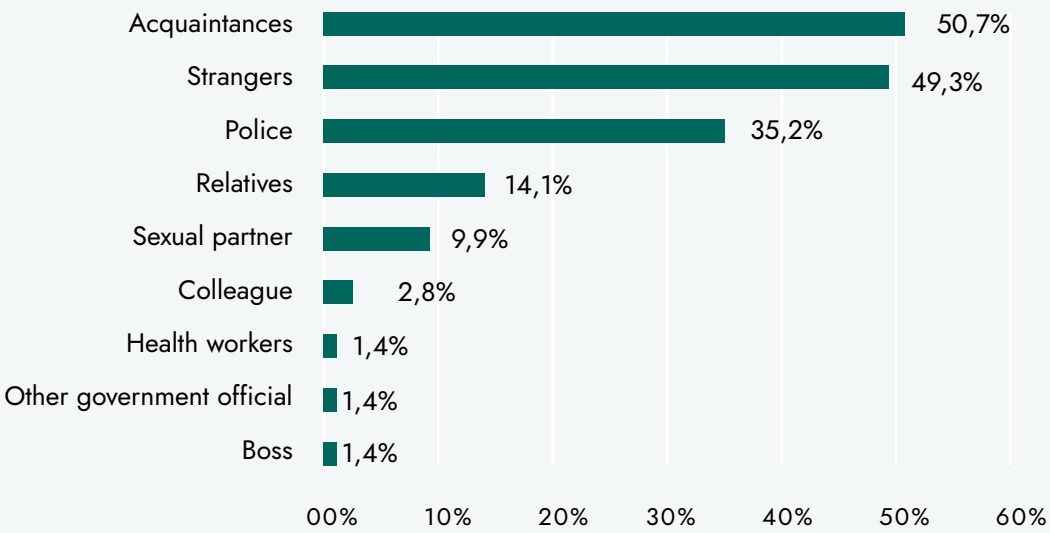
Fig. 22. Cases of psychological pressure, n=126.



Blackmail, extortion, threats and intimidation were reported by 34.6% of respondents, n=205, including in relation to their children.

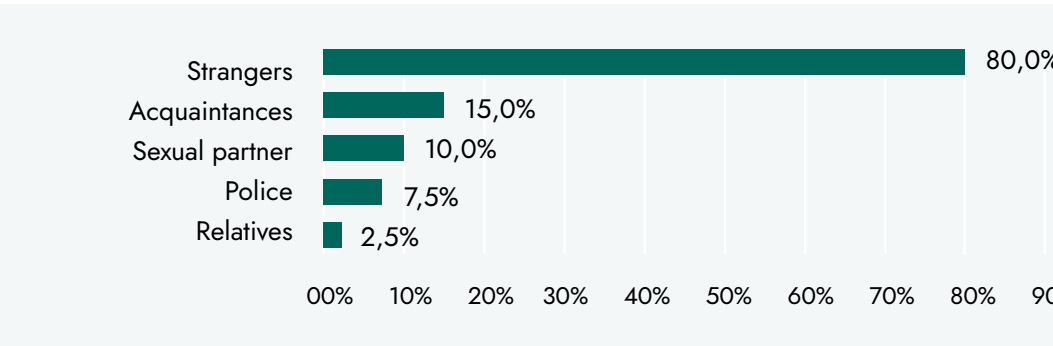
Half of those who reported that they had been subjected to such incidents in the past 12 months said that it had been committed by acquaintances (50.7%) as well as by strangers (49.3%). In addition, more than a third (35.2%) indicated that it had been committed by representatives of law enforcement agencies.

Fig. 23. Cases of psychological pressure, n=71.



19.5% of respondents indicated that in the last 12 months there had been cases of bodily harm/ physical pain (beatings, strangling, kicking and other injuries), n=205. And 80% of those who indicated that there had been such incidents noted that it had been committed by people they did not know.

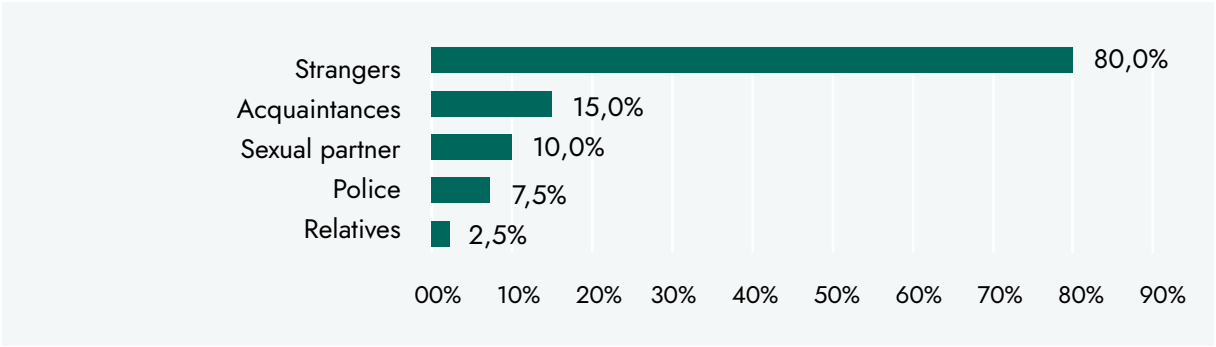
Fig. 24. Incidents of infliction of bodily harm/physical pain, n=40.



8.8% of respondents indicated that they had been physically harassed (stalked, controlled) in the last 12 months, n=205. 33.3% of those who had been stalked and controlled indicated that this had been committed by strangers and relatives. In other words, the perception of transgenderism in the society remains as something unnatural, unhealthy, or even seen as a disease that needs to be controlled and cured.

On 18 June 2018, the World Health Organization (WHO) officially released the International Classification of Diseases Revision 11 (ICD-11). According to ICD-11, all categories relevant to transgenderism have been removed from the section on mental and behavioural disorders and moved to the new section on sexual health. In particular, the diagnosis F64.0 "Transsexualism" has disappeared from the new classification.

Fig. 25. Incidents of physical harassment, n=40.



14.1% of respondents indicated that they had been forced to consume alcohol or psychoactive substances in the last 12 months, n=205. In half of the cases it was from acquaintances (51.7%), and 44.8% indicated that it was from a sexual partner/partner, n=29.

5.9% of respondents indicated that there had been cases of denial of medical care, n=205. And in more than half of the cases this was committed by medical professionals (58, 3%), n=12. This indicates a rejection of transgenderism by medical professionals and a lack of willingness to provide services to trans* people.

Cases of rape were reported by 4.9% of respondents, n=205. In five cases it was committed by strangers, along with sexual partners (3) and acquaintances (2), n=10.

In addition, 14.1% of respondents reported that there had been attempts of rape, n=205. There were 29 such cases in the last 12 months, and in half of them the attempts were made by sexual partners as well as by strangers. In two cases it was by law enforcement officials.

Unfortunately, due to the context of the country, trans* people often do not report such violations to the police, fearing a worsening of the situation and harassment by law enforcement agencies[32]. The country Ombudsman also highlighted this situation of trans* people in her 2016 report[33] in a section on women facing intersecting forms of discrimination, noting that "the most egregious

32 Orsekov D. Review of trans * communities and contexts of 12 countries of Eastern Europe and Central Asia / ECOM - Eurasian Coalition on Health, Rights, Gender and Sexual Diversity (ECOM). - Tallinn, Estonia, 2020 .-- 83 p.
33 https://ombudsman.kg/files/docs/reports/2016/the-report-of-akyykatchy-ombudsman-of-the-kyrgyz-republic-for-%202016.pdf

episodes of violence are committed against trans* people" and describing a case in which perpetrators received 2 years in prison for attempted murder, with a typical penalty for such crime of 12 to 15 years in prison.

Conclusions on the Section:

1. One in four people in the TG community have experienced job rejection due to gender identity and career promotion, reported by a quarter of respondents. A third of respondents indicated that they had been denied promotion due to a mismatch with their passport details.
2. The results of the survey show that a high level of stigma and discrimination in its various manifestations persists in relation to TG people in the Kyrgyz Republic. Most of the survey participants have at least once in their lives had a difficult experience of discrimination and prejudice because of his/her gender identity: rejection of family, society, loss of job, ridicule, psychological pressure, wry glances and even physical violence.

9.8. Analysis of the increasing human rights violations in the KR

As part of access to health services, trans* people are mentioned in the Law of the Kyrgyz Republic "On Acts of Civil Status" about the possibility of making changes to civil status records when "changing sex". The procedure of "sex change" is simple and involves obtaining a certificate of "Transsexualism" (Code F64.0 in the International Classification of Diseases, Version 10) after which a trans* person can change his/her documents. This procedure was regulated by Order No. 42 of the Ministry of Health of the Kyrgyz Republic and by approved Manual until August 1, 2020[34].

Trend of LGBT+ rights violations and discrimination at decision-making levels.

Changes in the situation of LGBT+ people are affected by the country's political situation and the state's failure to eradicate homophobia and transphobia. So far, Kyrgyzstan has no legislation protecting people from discrimination on the grounds of sexual orientation and gender identity, although recommendations have been made by UN committees that an anti-discrimination law should be developed. An anti-discrimination law has been drafted by the Coalition for Equality, but it is wary of being brought to the Jogorku Kenesh for discussion, as it was deputies who initiated numerous discriminatory bills.

34 Manual on provision of medical and social care for transgender, transsexual and gender nonconforming people for medical professionals of all levels of the Kyrgyz Republic healthcare system and other institutions, 2017. http://labrys.kg/ru/library/full/25.html

On 17 June 2020, the Jogorku Kenesh adopted the Law on Civil Status Acts and it entered into force on 1 August 2020. The law was streamlined and shortened. Under this law trans* people lost the right to change their gender marker on the basis of a medical certificate on gender reassignment. The old Civil Status Act No. 60 of 12 April 2005 contained a provision allowing for changing the gender marker: "A conclusion on correcting or amending the civil status record shall be drawn up by the civil status body in case of the following:

- if the civil status record contains incorrect or incomplete information or spelling errors;
- if the civil status record is made without taking into account the rules established by the laws of the Kyrgyz Republic;
- if a document in the prescribed form on a change of sex issued by a medical institution is submitted (art. 72).

Also, in recent years, government representatives have politicised the topic of LGBT+ people and systematically created a negative image of LGBT+ persons for the purpose of political manipulation. There have been calls for violence against LGBT+ people by politicians, including JK MPs, in connection with the peaceful march on 8 March 2019-2020, as well as other civil actions against corruption. The tendency to use LGBT+ people as an enemy image was actively used during the JK election race to "discredit" certain political parties on social media and in the mass media. This is evidenced by an incident that took place on 29 September 2020. A video material containing information about the private life of LGBT+ citizens was published in the groups and pages of Facebook, Instagram, Telegram and Vkontakte social networks by unknown persons. The dissemination of the video can be considered as a violation of privacy under the Criminal Code of the Kyrgyz Republic, a violation of human rights and incitement of intolerance, hatred and pressure against groups and individual activists.

9.8.1. Trends in LGBT+ rights violations and discrimination by law enforcement agencies and private individuals

The police are a major threat to the safety, life and health of LGBT+ people. Many LGBT+ people have repeatedly been victims of violence, threats, extortion and blackmail. Police officers are also homophobic and transphobic: transgender persons are subject to greater discrimination and violence by police and other officers, particularly trans* women who work in commercial sex. There was a case when the investigator did not take statements from trans* women but initiated criminal proceedings against them themselves and detained them.

The case documented by CA Kyrgyz Indigo

Private information is not presented for the sake of safety.

*«On 1 October 2020, a verbal altercation occurred between trans*girls and other passengers on public transport. The minibus driver started demanding that trans*girls should get out of the minibus and the male passengers shouted abuse at the trans*girls. The driver grabbed the trans*girl by her hair and threw her out of the bus and the other passengers started hitting her. A second trans*girl then joined in and a group*

*fight ensued. The trans*girls threw a rock and it hit the car window and the shoulder of one of the women and the men beat the trans*girls. After the fight, the driver brought trans*girls to the police station. The driver and the female passenger wrote a statement and registered it in the Single Registry of Offences and Misdemeanours. The trans*girls were not explained their rights, were not given an opportunity to invite their own lawyer, and the investigator invited a lawyer from the State-guaranteed Legal Aid service. Also, the investigator did not accept the trans*girls' statement. The investigators bullied the trans*girls. The trans*girls were detained for 48 hours. On 3 October, there was a court hearing to review the lawfulness of the detention and the choice of a preventive measure and, as a result of the hearing, a measure - detention for a period of 2 months - was announced».*

Punctuation and spelling of the case are preserved.

District police officers are illegally evicting trans* women from their rented flats and threatening that criminal proceedings will be initiated against them. There was an incident during the state of emergency: a patrol police officer threatened LGBT+ people with outing and demanded money. But due to the emergency, the victims were not able to appeal against the illegal actions of the officers.

The trend of clients violating the rights and committing offences against trans* women sex workers continues. Trans* women become victims of such crimes as: extortion, infliction of bodily harm and injury, robbery, threatening. During the research period alone, nine cases of human rights violations were documented, including by law enforcement agencies.

9.9. Health services

48.3% of the respondents indicated that they had sought some form of medical care in the last 12 months, n=205.

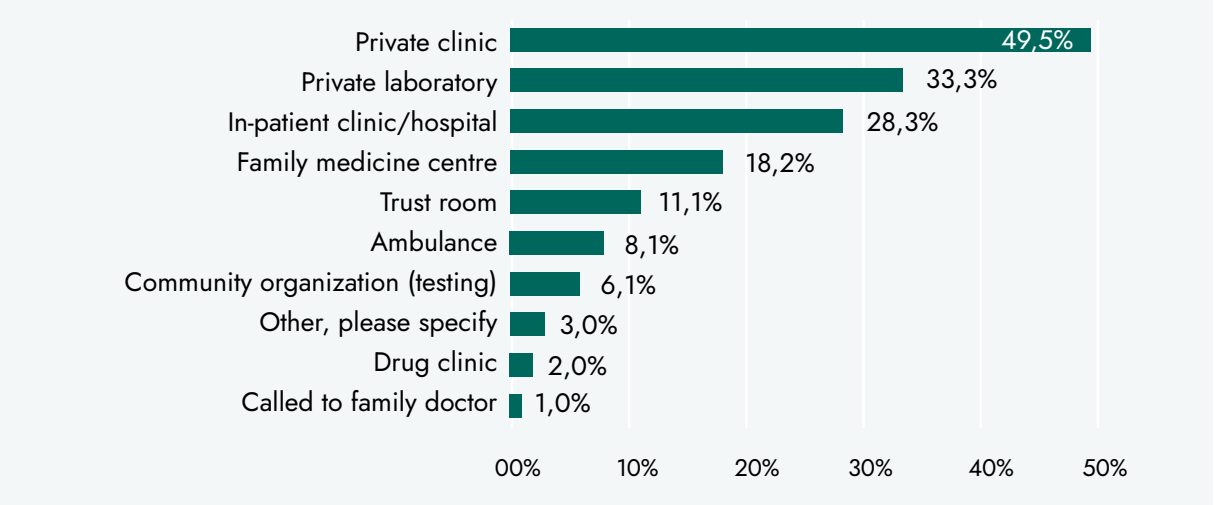
In half of the cases they turned to private clinics in the city (49.5%), as well as 33.3% mentioned private laboratories and almost the same number went to a state hospital. It is possible that the frequency of referrals is still connected with the general epidemiological situation with COVID-19 in the world and in the country, when in July-August 2020 there was a significant increase of cases among Bishkek residents.

According to the results of the study on assessment of attractiveness of services conducted by Kyrgyz Indigo, it was noted that some respondents, from among transgender people noted that TG people are usually addressed by the name specified in their passport and not by the name corresponding to their identity and this is one of the main barriers to visiting state institutions in order to receive services. Other respondents indicated that they were afraid to go to public family medicine centres, as doctors might not know the specifics of trans* people's health and may

therefore treat them unfriendly and/or provide unprofessional services[35], which is also confirmed by the study data. Assessment of homo/bi/transphobic attitudes and quality of services provided in public health institutions among the LGBT community using the Secret Client method:

During 46% of consultations, 'secret clients' did not feel they had privacy, attributing their choice to feelings of anxiety, ambiguous reactions from health workers and the presence of third parties in the office. 3.5% of service providers distanced themselves after coming-out of their secret clients[36].

Fig. 26. Health care facilities to which participants of the PDI study turned in the last 12 months, n=99.

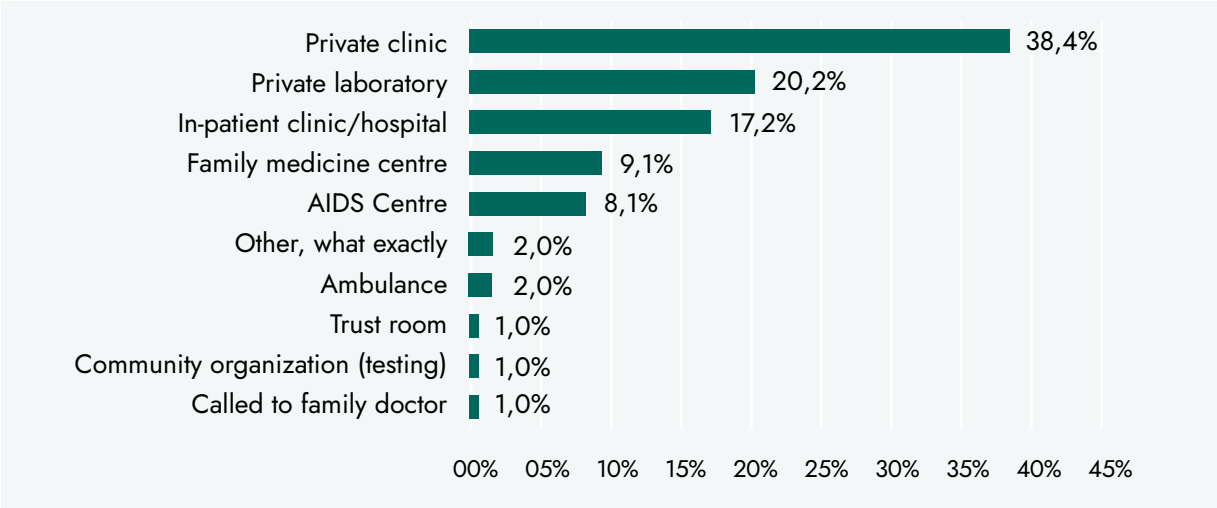


Judging from the experience with health care facilities which the respondents have turned to last time, a similar situation can be observed with regard to visits to health care facilities in the last 12 months. Thus, 38.4% of those who had sought medical care had gone to private clinics and 20.2% – to private laboratories (Fig. 26). As mentioned before, this may be due to the quality of services, but also to the fact that private medical institutions tend to have a more client-oriented approach, a friendly staff, and consequently less stigma and discrimination in the provision of services.

35 Study to assess the attractiveness of services for gay, bisexual, transgender people and men who have sex with men in Bishkek and surrounding areas / Kyrgyz Indigo Civic Association, Kyrgyzstan, Bishkek, 2019

36 Musazov F. Assessment of homo-/bi/transphobic attitudes and quality of services provided in state medical institutions to LGBT community using the Secret Client methodology / Kyrgyz Indigo Public Association, Bishkek, Kyrgyzstan, 2019

Fig. 27. Health care facilities to which participants of the PDI study turned most recently, n=99.



Conclusions on the Section:

1. Most respondents indicated that more TG people go to private health care facilities and this may be due to both the quality of services and the fact that private health care facilities tend to have a more client-centred approach, where patients' needs come first, more friendly staff, respectively less stigma and discrimination, and less transphobia in service provision.

9.10. Coverage with HIV testing

Many HIV prevention activities in the country have been carried out with technical and financial support from various international organisations: UNAIDS, UNICEF, USAID, CDC, WHO, ICAP, UNDP, AFEW and others. Since 2004 the Global Fund to Fight AIDS, Tuberculosis and Malaria has been providing financial and technical assistance to address many health and social problems associated with HIV infection in Kyrgyzstan. Accordingly, everything is being done to achieve the 90-90-90 goals, where the main focus of the country's efforts is on detection, i.e. testing for HIV, strengthening motivation to initiate ART and increasing adherence to treatment.

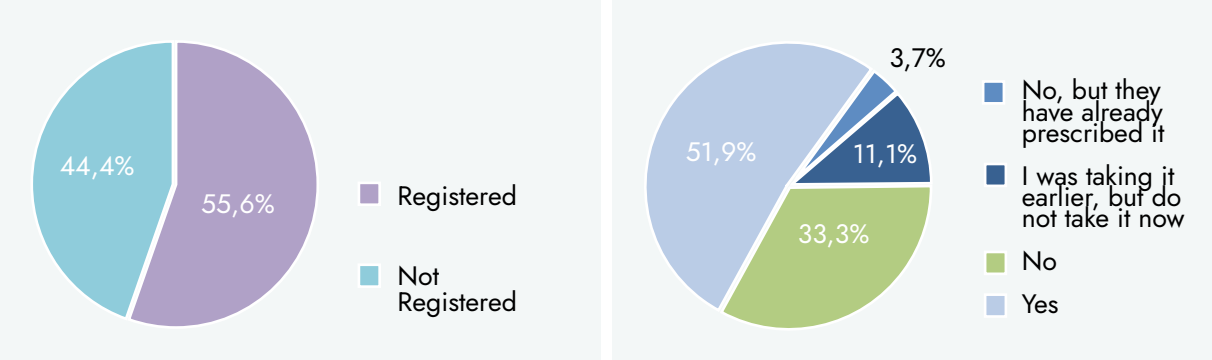
For example, 96.1% of respondents in the survey indicated that they knew where they could get tested for HIV. At the same time, 70.7% of those surveyed said that they had ever been tested for HIV, respectively 30% had never been tested in their lives, n=205. Based on the above, it can be assumed that the majority of respondents were participants of prevention programmes and turned to NGOs to receive various services, including HIV testing, while those who had not been tested for HIV needed more thorough motivational counselling from peer counsellors and psychologists.

Of those who were tested for HIV, 98% received the test results and understood its meaning, which may indicate the quality of post-test counselling in Bishkek by both NGO staff and government agencies, which can also be accessed by anyone, including representatives of key populations (KAPs), if necessary. 76.6% of those who received HIV test results said that they were aware of the results, n=145.

24.3% of those who reported test results indicated that the result was "positive". When this question is broken down by trans* women and trans* men, the rate was 18.3% among trans* women and 1.7% among trans* men, which is confirmed by the results of a study on the economic vulnerability of Kyrgyz trans* women conducted by the NGO Kyrgyz Indigo[37], where it was determined that 19% of TG women, who were working as labour migrants in Russia, were living with HIV[38]. The difference of 0.7% is probably due to the fact that not all participants in the PDI survey reported their HIV test results.

Only half of those who reported their HIV-positive status (55.6%) were registered at the AIDS centre (15). Nearly a half (44.4%) were not registered and did not receive any medical services related to their HIV status (12). 51.9% (14) were on ART, 33.3% (12) were not on ART and 11.1% (3) had interrupted their treatment. More thorough motivational work with those who are not registered, not receiving ART/interrupted ART should be done with both peer educators and psychologists.

Fig. 28. Enrolment in care and taking ART, n=27.

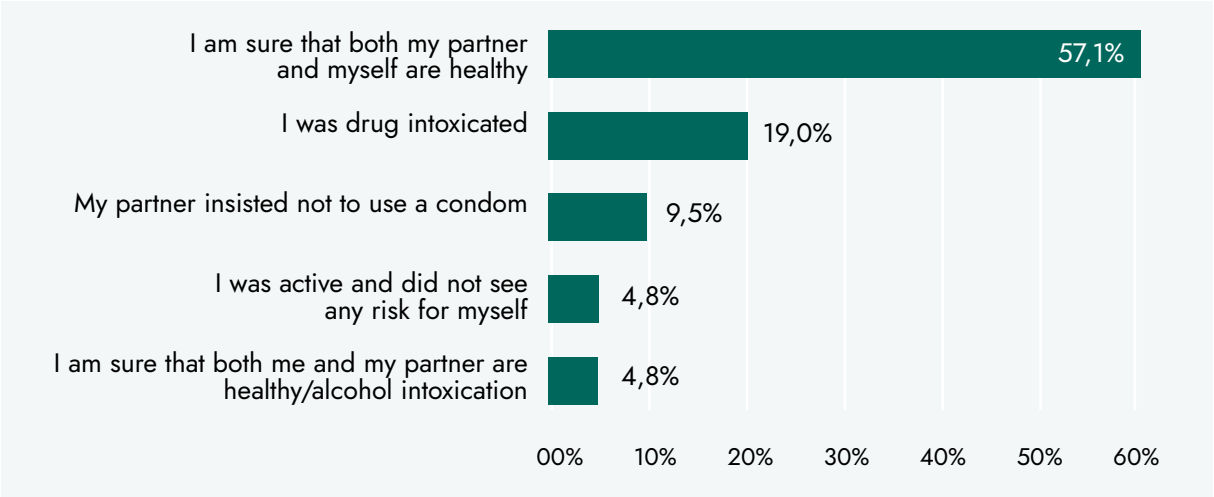


63.3% of those who did not take the test indicated that their sexual behaviour was safe and therefore they did not take the test; almost half (48, 3%) indicated that they had no desire to do so, see Figure 29.

37 https://indigo.kg/

38 Kalbaev T. Challenges and barriers for migrant workers as aconsequence of economic vulnerability of trans* women in theKyrgyz Republic / Kyrgyz Indigo Civic Association, Kyrgyzstan, Bishkek, 2019

Fig. 29. Reasons for not being tested for HIV, n=60.



17.5% of all respondents reported having been tested for hepatitis B and C, n=205. Of those who had been tested, 97.1% knew the test results, n=35.

In the 2018-2019 *Analysis of HIV service cascade among gay, bisexual, other MSM and trans* people*[39] , an HIV cascade among TG people was also not compiled due to the lack of relevant statistics, suggesting that recommendations on health service provision and equal opportunities for the trans* community were ignored by various institutions in the international community. However, circumstantial evidence suggests that there may be an active spread of HIV infection among TG people, confirming the risk behaviours identified in this study. Lack of targeted outreach to trans* people exacerbates the HIV situation, and prevention programmes remain less accessible at the country level.

Conclusions on the Section:

1. The vast majority of respondents indicated that they knew where to get tested for HIV. However, the majority of those surveyed indicated that they had ever been tested for HIV, while a third of those surveyed had never been tested in their lives.
2. Most respondents have been tested for HIV and know their results. A quarter of those who reported test results indicated that they were positive. Presumably, the prevalence of HIV among trans* women was 28.8%, among trans* men - 4.8%, then among all TG people who reported their test results it was 24.3%. The figures require further investigation as part of the integrated bio-behavioural study, where HIV testing is a prerequisite to participation in the study; while in PDI study HIV testing was not a mandatory component.

39 Musazov F., Masumova N. Analysis of HIV service cascade among gay, bisexual, other MSM and trans*people for 2018-2019/ Kyrgyz Indigo Civic Association. - Kyrgyzstan, Bishkek, 2019.

3. Only half of those who tested positive were registered with the AIDS centre (15), thus almost half are not registered, do not receive any medical services related to their HIV status (12), half take ART, one third do not take it and three people have interrupted their treatment.

4. Thriving transphobia among service providers is a significant barrier to accessing health services for trans* people.

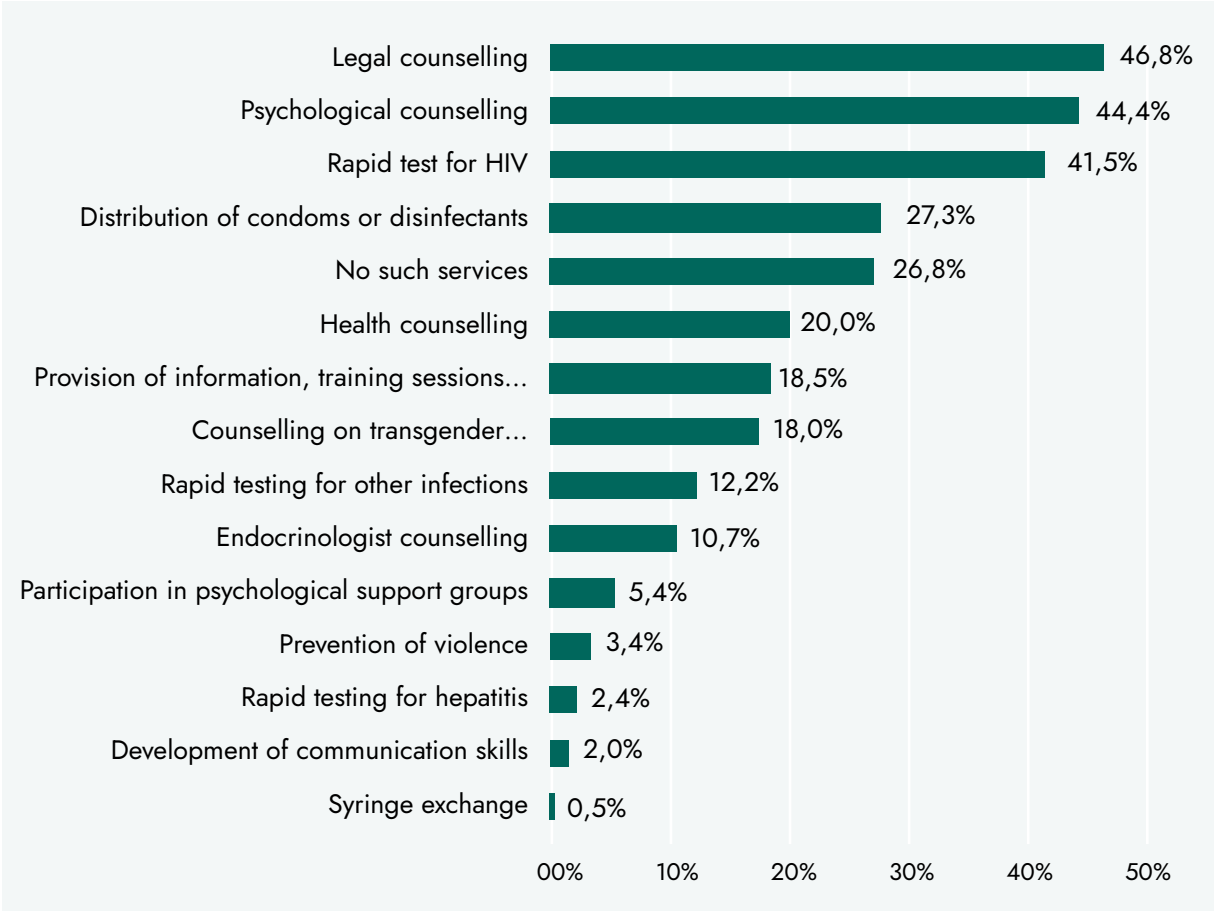
9.11. Coverage with prevention programmes

55.6% of PDI survey participants received free condoms during the last 12 months, i.e. these are TG people who are covered by prevention programmes, receive services at HIV prevention organisations and are more or less accessible, open for communication and participation in research. Whereas the other half of the survey participants remained unreached by prevention programmes and require more thorough work to involve them in the prevention programmes.

Only 10.7% reported having bought condoms for themselves or their sexual partner in the last 30 days, n= 205. The number of condoms purchased per month ranged from 1 to 72, with an average of 15 condoms. The largest number, of those who bought condoms were TG people who bought 10-12 condoms per month (36.2%).

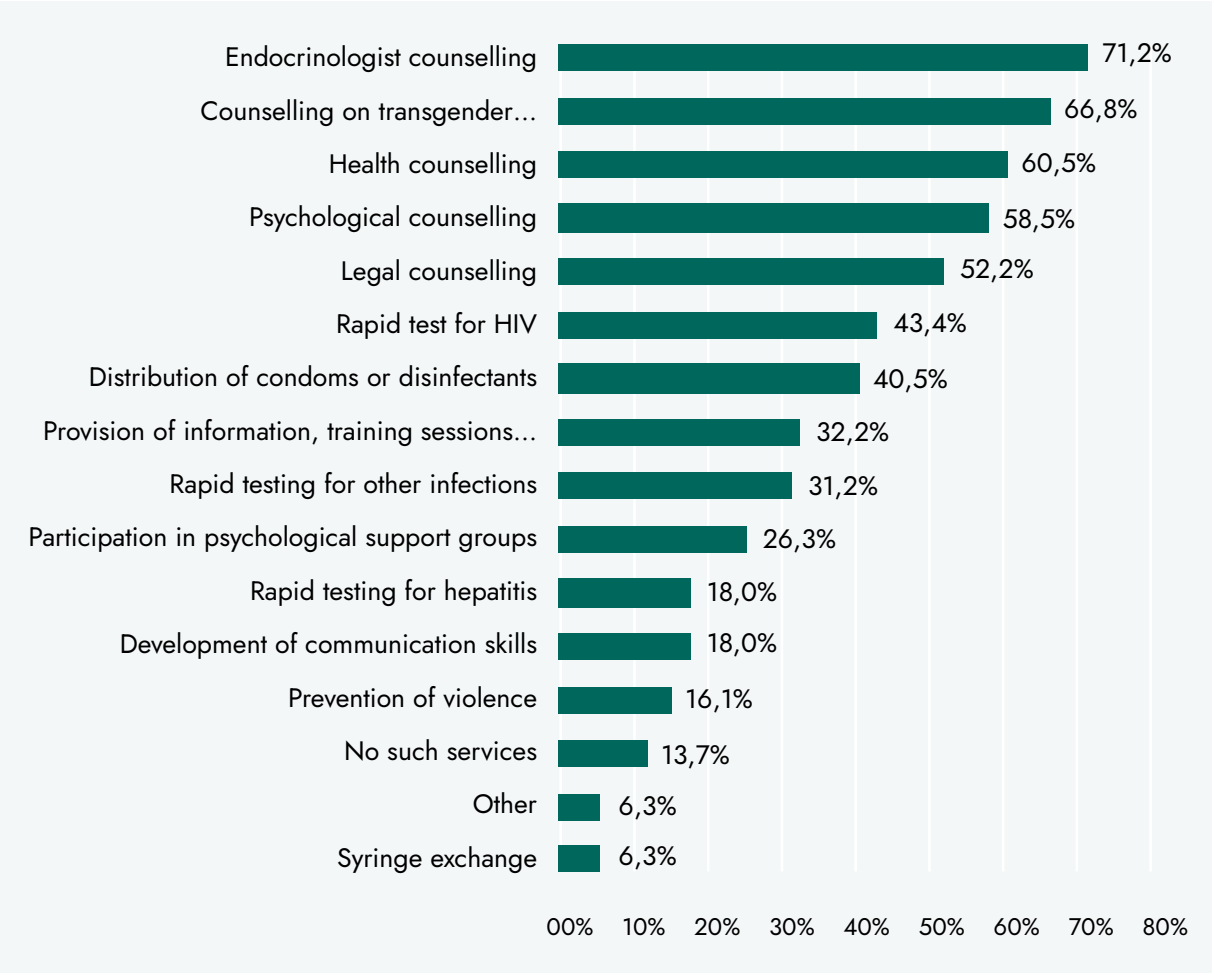
46.8% of those surveyed reported receiving legal counselling as part of the HIV prevention programmes at HIV service organizations; approximately the same percentage (44.4%) received psychological counselling and 41.5% had rapid testing for HIV; see Figure 30. That is, approximately half of the respondents at the time of the survey did not actively approach the organisations to receive services.

Fig. 30. Services received at HIV service organizations by the study participants, n=205.



When asked "What services would you like to receive on the basis of community organisations", the most demanded service was endocrinologist consultations - this was reported by 71.2% of participants, with transgender transition consultations in the second place (66.8%), n=205. This may indicate that the above services remain inaccessible to transgender people and the reasons may be related to the financial situation of TG people and, as noted above, that there may be stigma and discrimination against TG people in medical institutions due to transphobic attitudes of medical professionals.

Fig. 31. Services that study participants would have liked to receive, n=205.



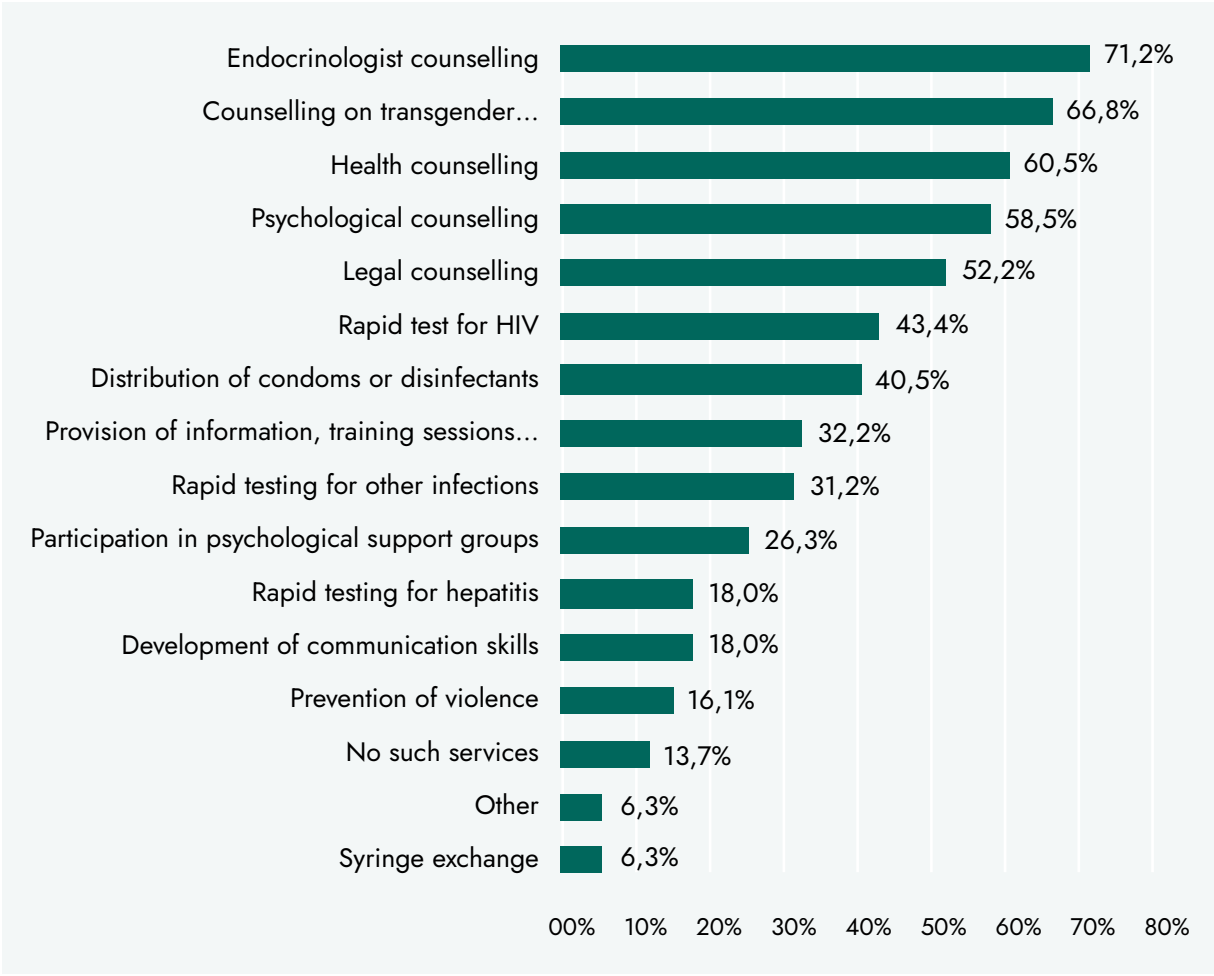
Among other requests for services was the provision of hormonal medication, reported by 5 people. Hormonal treatment requires daily, continuous taking of hormonal medication and this may not be available to those who have irregular part-time jobs, are studying, looking for work or are unable to work for health reasons. Therefore, providing hormonal medicines to TG people and proper attention to their health issues by the state may solve this problem.

The majority (75.1%) of respondents indicated that they would like to use the services of NGOs providing services to TG people and 13.7% already received services from organizations on a regular basis; only 5.4% did not want to receive services from NGOs. That is, NGO services are attractive for TG people and if we take into account the needs of TG people, the majority is ready to turn to the NGOs.

When asked how participants in the PDI survey would like to receive services from HIV service providers, 73.7% would prefer to receive services from an organisation. In the light of recent developments in relation to COVID-19, HIV service providers have refocused and changed their service delivery format, with a greater frequency of online and telephone counselling. Telephone counselling is the second most frequently mentioned service, reported by 61.5% of respondents, and receiving services at home or at community meeting places

was also attractive for TG people (58%), n=205. Taking into account the opinion of the majority of respondents, the key services should be provided in the former format, i.e. based on organisations, and at the same time not exclude the provision of services in an online or telephone format, which can certainly reduce the time spent on travel and transport costs of the organisations' clients.

Fig. 32. Preferences of the format and location of service provision by HIV service organizations, n=205.



Conclusions on the Section:

1. Half of the participants in the PDI survey had received free condoms in the last 12 months, i.e. these are TG people covered by prevention programmes, and only 10.7% had bought condoms for themselves or their sexual partner in the last 30 days.
2. About half of those surveyed reported having received legal counselling through HIV prevention programs at HIV service organizations and about the same number had received counselling by a psychologist and had rapid HIV testing.
3. The most demanded service was counselling by an endocrinologist - this was reported by the majority of participants, with transgender transition counselling coming in second place.
4. The majority of respondents indicated that they would like to use the services of NGOs that provide services to TG people, as well as they would like to receive services based on community organisations.
5. A significant part of the work with trans* people is carried out by NGOs, which are also involved in activities aimed at reducing transphobia among public and state health care workers.

9.12. Evaluation of the size of TG people network

As part of the survey, all participants were asked how many people who considered themselves trans* people the respondent knew by name, and they knew them too. Thus the majority (89.3%) indicated that they knew and interacted with other TG people, and 10.7% found it difficult to answer this question. This indicates that the social capital of TG people in Bishkek is a single social capital, whose members interact closely with each other, which makes it possible to conduct such types of recruitment as "snowball" or "RDS", used for "closed" population groups. But it should be noted that while this was possible with some TG people, we had to interview some TG people, in particular trans* women, not at the NGO base as was initially planned, but we had to travel to places of residence/sex service provision to meet them, and these nuances need to be considered in the future research among TG people to select the recruitment method.

Table 19. Presence of a social network, n=205.

Knowing other TG people	#	%
Yes	183	89,30%
Hard to say	22	10,70%
Total	**205**	**100,00%**

The minimum number cited was "3", the maximum "300", with an average of 60 people.

The majority of respondents (64.5%) have a social network size of 1 to 40 people, 13.7% have a network size of 41 to 80 people.

Table 20. Size of the respondents' social network, n=183.

Social network size	**#**	**%**
1 - 40	118	64,5%
41-80	25	13,7%
81-120	12	6,6%
121-160	12	6,6%
161-240	6	3,3%
241-300	10	5,5%
Total	**183**	**100,0%**

Conclusions on the Section:

1. The majority of respondents indicated that they knew and interacted with other TG people, with the number of TG people they knew ranging from 3 to 300, with an average of 60 people. Most respondents had a social network size of 1 to 40 people, with 13.7% having a network size of 41 to 80 people.

10. CONCLUSIONS

1. A quarter of those interviewed are involved in providing sex services, and a similar number are employed or not currently employed for one reason or another.

2. The financial situation of most TG people is difficult, which has become even more complicated in light of recent global and national events, given also the challenges that trans* people face in renting their housing.

3. Just over half or respondents take hormonal medicines. Half of those taking hormonal drugs take Progynova and a quarter take Diane-35. Omnadren is the most popular of the patches. And the vast majority receives information about hormone therapy from friends, other TG people as well as from acquaintances. Only less than a quarter of respondents indicated that they received information from medical professionals and community organizations.

4. Half of the respondents plan to make a transmasculine/transfeminine transition, but at the moment it is no longer possible to obtain the Commission's approval due to the fact that on 17 June 2020 the Jogorku Kenesh adopted the Law "On Civil Status Acts", which entered into force on 1 August 2020. According to this law, transgender persons lost the right to change their gender marker on the basis of a medical conclusion on gender reassignment. The old Act No 60 of 12 April 2005 on Civil Status Acts contained a provision that allowed for the changing of the gender marker. The [new] law prevents the development of a national clinical protocol on gender transition, hormone therapy for transgender people in the country and accordingly the range of services provided by community organisations cannot include hormone therapy counselling for TG people and the provision of hormone medication for TG people.

5. The vast majority of respondents were sexually active, with most of respondents having a cisgender male sexual partner and just over a quarter having a cisgender female partner. Most respondents, of those who had sexual intercourse in the last 12 months, had a regular, occasional or commercial sexual partner who gave them remuneration for sex.

6. The number of regular sexual partners among TG female sex workers in the last 12 months ranged from 1 to 25, with an average of 1 partner. The number of casual sexual partners ranged from 1 to 50, with an average of 9 partners. The number of commercial sex partners who were paid for sex ranged from 1 to 2, the average being 2. The number of commercial sex partners who gave remuneration for sex ranged from 1 to 300, the average being 25. But here we need to take into account a memory error, the question covered 12 months, so there could be inaccuracies in the respondents' answers.

7. The most frequent condom use in the last 12 months was with regular sexual partners, almost as frequent was with casual and commercial sexual partners who were paid for sex. With sexual partners who gave respondents remuneration for sex services it was practised in half of the cases. Similar situation was observed with sexual contacts in the last 6 months.

8. Most of those who had sexual intercourse in the last 12 months used a condom the last time they had intercourse. Most of those who had used a condom indicated that the condom had been provided by a social worker from a community organisation. The reason for not using a condom in the first place was that there was confidence in the health of the partner and one's own health, this was indicated by the majority of respondents.

9. The majority of respondents use Internet resources in one way or another to find a partner. VKontakte social media are used by the vast majority of those surveyed who used social media/messengers/mobile applications. The second most popular platform was Instagram, cited by almost half of the respondents. The number of partner search profiles varies from 1 to 8. Accordingly, popular social networks should be used for prevention programmes.

10. Non-injecting substance use was reported by just under half of those surveyed and about a quarter had used substances in the past 30 days.

11. Most of those who use surfactants by non-injection are marijuana users. That is, the remaining third presumably use synthetic drugs, pharmacy preparations and salts, which have become popular over the last 2-3 years among young people in EECA. None of the interviewed respondents reported injecting drug use, only 5 survey participants indicated that they found it difficult to answer this question.

12. One in four representatives of TG people have experienced being denied a job and career promotion due to gender identity - it was reported by a quarter of respondents. A third of respondents indicated that they had been denied promotion because of a mismatch with their passport details.

13. In general, TG people go to private health facilities for health services, possibly because private health facilities are more client-oriented; private facilities are also more attractive because there are no queues, friendly staff, therefore presumably lower levels of stigma and discrimination and less transphobia.

14. The vast majority of respondents indicated that they knew where to get tested for HIV. However, the majority of respondents indicated that they had ever been tested for HIV, while a third of those surveyed had never been tested in their lives.

15. The estimated HIV prevalence among trans* women was **28.8%**, among trans* men - **4.8%,** then among all TG people who reported being tested it was **24.3%.** The figures require further investigation as part of the integrated bio-behavioural study, where HIV testing is a prerequisite for participation in the study, while HIV testing was not a mandatory component in the PDI survey.

16. Only half of those who tested positive were registered with the AIDS centre (15), thus almost half were not registered and did not receive medical services related to their HIV status.

17. About half of those surveyed received services from HIV service organisations. The most popular service was counselling by an endocrinologist, as reported by the majority of participants, with transgender transition counselling in the second place.

18. Most of respondents indicated that they knew and interacted with them, with the number of TG people they knew ranging from 3 to 300, with an average of 60 people. Most respondents had a social network size of 1 to 40 people, with 13.7% having a network size of 41 to 80. I.e. community of TG people in Bishkek is one social network with close social ties, which should be used for recruitment in the research.

11. RECOMMENDATIONS

1. Further work is needed to recognise transgender people as citizens with the right to health protection and care through access to health services, care and treatment, including access to health products and services, emergency health care, other health-related services, and to improve access to health services in the public, municipal and private health sectors by training health professionals on how to work with key populations, in particular transgender people, as well as in the provision of health services for transgender people.

2. To develop, adopt and enforce mechanisms that prohibit discrimination on various grounds, including on the basis of gender identity;

3. To work to reduce stigma and discrimination and transphobia against TG people by raising awareness among the general population, health care providers and law enforcement officials. To establish precedent-setting and high-profile cases against those who violate the rights of TG people to express their gender identity;

4. There is a need to include trans* people as a key population that requires intervention and close attention due to the high prevalence of HIV infection among this group, in particular among TG women in the government's HIV programme to be reviewed in 2021;

5. To initiate and support research on transgender people, including on HIV prevention and factors affecting their vulnerability and risk of HIV, such as migration, involvement in sex work, stigma and discrimination, as this key population remains under-researched in comparison with other key populations;

6. Given the general trend in the region of Eastern Europe and Central Asia, including Kyrgyzstan, there is need to initiate research on substance use, and to provide information on substance use, training of service providers for KGN on substance use (countermeasures, places of treatment, prevention, etc.) on the basis of this research results;

7. As part of an integrated bio-behavioural study, there is a need to clarify the number of sexual partners among female TGs, in particular among sex workers, and to use a shorter timeframe to study this issue in order to avoid inaccurate counts. And the issue of HIV prevalence, as well as estimates of the number of TG people, needs to be studied more thoroughly among TG people in the IBBS, in particular among TG women.

8. Initiate the inclusion of transgender issues and the specific health needs of trans* people in pre- and post-graduate medical education programmes;

9. Inform transgender people about the availability of various health and social services through the most popular social networks used by TG people. Consider different channels for informing transgender people who do not have access to NGOs or are unwilling to access them, for example through trans* people who are respected in the TG community;

10. To intensify information and prevention efforts on HIV infection among trans* people, as HIV prevalence among trans* women is believed to be around 28.2%. This issue needs to be further explored in the framework of the planned integrated bio-behavioural study among TG people;

11. To ensure that trans* people's health and social services are accessible and responsive to the specificities and needs of trans* people through community-based organisations, in particular to provide for endocrinologist consultations, with a focus on information on hormone therapy and transgender transition;

12. Given the material situation of trans* people in disadvantaged and transphobic societies, it is recommended that the provision of humanitarian support, transport, hormone tests for safety and prevention of discrimination should be considered when designing prevention programmes;

13. Provide training to outreach workers and social workers on motivation for testing, as well as motivation to disclose HIV status, get registered and start taking ART.