SUMMARY REPORT

INTERSECTING ISSUES, IDENTITIES, AND BARRIERS IN ACCESS TO HEALTH CARE, HIV SERVICES & SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AMONG KEY POPULATIONS IN CENTRAL AND EASTERN EUROPE & CENTRAL ASIA

2024

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LIST OF ABBREVIATIONS

ART/ ARV - Antiretroviral therapy /Antiretroviral drugs

CEECA - Central & Eastern Europe & Central Asia

GF - Global Fund to Fight AIDS, Tuberculosis and Malaria

HCV - Hepatitis C

HIV - Human Immunodeficiency Virus

ECOM - Eurasian Coalition for Health, Rights, Gender and Sexual Diversity

EHRA - Eurasian Harm Reduction Association

EWNA - Eurasian Women's Network on AIDS

LGBT - Lesbian, gay, bisexual and transgender

MSM - Men who have sex with men

NGO - Non-governmental organization

OAT - Opioid agonist treatment

PLHIV - People living with HIV

PWUD - People who use drugs

SRH – Sexual and reproductive health

SW - Sex workers

SWAN - Sex Workers' Rights Advocacy Network

TB - Tuberculosis

UNAIDS - Joint United Nations Programme on HIV/AIDS

UPR - Universal Periodic Review

WHO - World Health Organization

I. ABOUT THE RESEARCH

The Sex Workers' Rights Advocacy Network (SWAN), Eurasian Coalition for Health, Rights, Gender and Sexual Diversity (ECOM), Eurasian Harm Reduction Association (EHRA), and Eurasian Women's Network on AIDS (EWNA) undertook cross-regional consultations to collect and assess existing experiences in the ways that intersecting identities – including lesbian, gay, bisexual and transgender (LGBT), people who use drugs (PWUD), sex workers (SW), and people who live with HIV (PLHIV), might affect people's lives, access to health services, and agency in light of the structural inequalities, social injustice, violence, stigma and discrimination. **'Intersectionality' in this context refers to belonging to two or more of these communities or identities.** The term "multiple or intersecting identities", which is interchangeably used in the text, refers to the concept that an individual's identity consists of multiple, intersecting factors, including but not limited to gender identity, gender expression, race, ethnicity, class (past and present), religious beliefs, sexual identity and/or sexual expression.

Intersectionality is a framework for conceptualizing a person, group of people, or social problem as affected by multiple levels of discrimination. It takes into account people's overlapping identities and experiences in order to understand the complexity of the stigma, prejudices, marginalization, and/or criminalization they face. Intersectional theory asserts that people are often disadvantaged by multiple sources of oppression: their sex, race, ethnicity, class, gender identity, disability, sexual orientation, religion, physical appearance, and other identity markers. Intersectionality recognizes that identity markers and identity that a person is expressing or sharing with others (e.g. "woman" and "sex worker"; or "gay man" and "drug user") do not exist in a vacuum - each experience informs the others, creating a complex convergence of oppression. Namely, while intersecting forms of stigma and discrimination are a common reality, they remain poorly understood. Thus, understanding intersectionality is essential to combatting the interwoven stigma, prejudices, stereotypes, and marginalization people face in their daily lives.

Intersectionality is a concept that has emerged to characterize the convergence of multiple stigmatized and marginalized identities within a person or group and to address their joint

effects on lived experiences. While inquiry into the intersections of race, class, and gender serves as the historical and theoretical basis for intersectional stigma and prejudices, there is little consensus on how best to characterize and analyze intersectional stigma and discrimination, or on how to design interventions to address this complex phenomenon. Evidence from the existing scientific literature suggests that people in diverse settings experience intersecting forms of stigma and discrimination that influence their mental and physical health and corresponding social behaviors. As different stigmas and prejudices are often correlated and interrelated, the health impact of intersectional stigma and discrimination among key populations with multiple identities is complex, generating a broad range of vulnerabilities and risks.

The concept of Intersectionality has theoretical origins, but it is also intended to be put into action. Activists and community organizations are calling for and participating in more dynamic conversations about the differences in experience among those with overlapping identities, as stigmatized identities, while often analyzed in isolation, do not exist in a vacuum. Without an intersectional lens, events and movements that aim to address injustice toward one group may inadvertently perpetuate systems of oppression toward another.

Qualitative, quantitative, and mixed methods approaches are required to reduce the significant knowledge gaps that remain in our understanding of intersectional stigma and discrimination, shared identity, and their effects on health among key populations with intersecting identities. The development of instruments and methods to better characterize the mechanisms and effects of intersectional stigma and discrimination in relation to various health outcomes among key populations with multiple identities is vital. To this end, intersectionality shall fully inform SWAN's, ECOM's, EHRA's,, and EWNA's work, by encouraging nuanced conversations around inequity in Central and Eastern Europe & Central Asia (CEECA) region. This initiative aims to illuminate the health disparities faced by marginalized groups such as LGBT individuals, people who use drugs (PWUD), sex workers (SW), and people living with HIV (PLHIV). By fostering an understanding of identity among community leaders, it becomes an essential tool for the advocacy efforts they champion. Through this understanding, healthcare providers, public health officials, and advocates can develop interventions that leverage the strengths of shared identities, thereby mitigating the impact of stigma and discrimination on these intersecting communities in the CEECA region.

Guided above all by the defined goal and objectives of the topical research, the following tools for collecting feedback from the key populations with multiple identities were applied:

A Survey Questionnaire for collecting the views and obtaining in-depth findings among key populations in the CEECA region. The survey was designed to gather information from selected representatives of the key populations in regard to the following outcomes:

(i) To explore how intersecting vulnerabilities, issues, and identities among key populations affect their sexual and reproductive rights and their access to HIV, sexual and reproductive health (SRH), and other related services; and

(ii) To examine how intersectionality affects the narratives around key population with multiple identities, thus ultimately informing on better programming.

Focus group discussions were conducted with selected representatives from key populations as end-users of HIV, sexual and reproductive health (SRH), and related services to gather in-depth insights into their experiences, including instances of criminalization and human rights violations. These discussions captured their opinions and expectations, with the ultimate goal of informing future enhancements to service delivery processes and rights-based programming.

To this end, between September and October 2023 SWAN, EHRA, ECOM, and EWNA held **14 focus group discussions with a total of 103 individuals**, both onsite and online. **In order to reflect intersectionality among key populations, only individuals with multiple identities were engaged in the focus group discussions**. The focus groups were conducted as part of the network's member organizations involved in the project related to the development of a Briefing Paper on intersecting issues, identities, and barriers in access to health care, HIV, SRH, and other related services among key populations in the CEECA region.

In terms of the **geographic scope**, the focus of the research was on countries from Eastern and Central Asia, including Armenia, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Moldova, North Macedonia, Russian Federation, Tajikistan, Ukraine, and Uzbekistan.

The applied methodological tools were not exclusive to each other, but rather complementing. The goal was to develop a briefing paper providing recommendations and directions for better programming and advocacy. The resulting document should inform on advocacy opportunities and targets, the potential for improvement in service provision, rights-based programming, community and civil society approaches, and opportunities and areas for further discussion of the issues raised in interviews and consultations.

II. KEY FINDINGS

- NGOs (community-led organizations or service providers) can offer better-suited and more friendly HIV, SRH, and other health-related services, thus there is a relatively high awareness of them among the survey respondents. Primarily due to the type of services available at their place of living, to cater to their needs, the majority of the interviewed respondents said that they often visit LGBTI or PLHIV-led groups and service providers, followed by SW -ed organizations and harm reduction programs. Participants repeatedly said they feel more protected in self-organized settings where they are not afraid to talk openly about themselves and their needs.

- Key populations with more than one intersecting identity are more likely to face increased difficulties when **accessing healthcare services,** yet might experience more instances of discrimination than those with a single identity. Female and transgender sex workers who use drugs appear to be the ones who most often do not seek health care following incidents of violence unless they have suffered serious injuries and trauma. Limited or complete lack of services was likewise noted for HIV+ sex workers. The same finding can be applied to groups of HIV+ men who have sex with men (MSM) who also cross-identified as sex workers.

- Lack of health insurance, or problems with obtaining it, served as one of the major limiting factors in trying to access various, especially more specialized health services such as psychological support. Psychosocial support and other mental health services are critical for key populations who experience additional discrimination, abuse, homophobia, transphobia, criminalization, and even hate crimes due to their intersecting identities.

- **Stigma, discrimination, and violence** against key populations with multiple identities remain pervasive across CEECA. Besides multiple identities, various cases of stigma and discrimination were reported by the participants at focus group discussions based on other factors, such as comorbidities (HIV, Hepatitis C - HCV, tuberculosis - TB), history of mental health conditions, and/or family violence. Women – regardless of

which group they belong to – experience discrimination more often than men, facing racism, sexism, etc. Gender-diverse communities and migrant women face multiple and intersecting forms of discrimination that increase their vulnerability to violence.

- A significant proportion of key populations with multiple identities reported to be victims of discrimination and violence, and said they refrained from submitting complaints to the law enforcement authorities. Participants were pessimistic that doing so would produce any results, or else afraid of a breach of confidentiality. This turns out to be particularly true for transgender and drug-using and alcohol dependent sex workers who often face higher levels of prejudice, harassment, physical violence, and abuse compared to the rest of the key populations with multiple identities.

- The majority of the interviewed respondents with some experience of activism were well aware of their rights and the available legal mechanisms at their disposal to defend and protect those rights (e.g., free legal aid, para-legal services, etc.). Yet, meaningful **access to justice and judicial mechanisms** is still lacking, as courts and legal services are often not affordable and accessible to all communities. Thus intersecting inequalities, including those based on sexual orientation, gender identity, sex, race, health status, involvement in sex work, and socio-economic status, are hindering access to justice for key populations.

III. INTRODUCTION

The CEECA region is well known for its profound political, economic and social change over the past three decades. Recently, it has also been impacted by increased **migration flows.** According to **2022/23 Amnesty International report on Europe and Central Asia**[1], following the Russia-led full-scale military invasion of Ukraine almost 7 million people were displaced within Ukraine, 5 million fled to Europe and 2.8 million left for Russia and Belarus. Russia's war against Ukraine has intensified the negative human rights trends of previous years, leading to increased insecurity and inequality. Consequently, authoritarianism has gained momentum, using the situation as a pretext for further restrictions on basic freedoms.

These same powers were emboldened to articulate and often implement racist, xenophobic, misogynistic, and homophobic agendas. **Violence against women and domestic violence** persisted at high levels across the CEECA region. **Sex work** remains criminalized in some form in every country in CEECA. **LGBT people's rights** continued to be severely repressed. Russia extended the prohibition of "propaganda of non-traditional sexual relations, pedophilia, and gender reassignment" from minors to all age groups. Turkmenistan and Uzbekistan continued to criminalize consensual sexual relations between men, and a discriminatory draft law was submitted in Uzbekistan allowing police to conduct mandatory HIV testing for men who have sex with men. Likewise, **criminalization of drug use and possession** across the CEECA region remains very high.

Stigma, discrimination, and patriarchy continue to threaten the safety and well-being of key populations in different ways. Due to criminal status, **key populations of people living with HIV, sex workers, LGBT and people who use drugs are not always considered in national policies or are not regularly involved in policy design and implementation**, which only makes their lives more challenging. In addition to punitive laws in many countries across CEECA, the harsh legal and policy environment is made worse by the lack of political will and leadership to address challenges faced by key populations.

1 https://www.amnesty.org/en/location/europe-and-central-asia/

According to **2023 EWNA Women-led Gender Assessment report**[2], which was conducted in 15 countries across South-Eastern Europe and Central Asia (SEECA), and **ECOM's Analysis of national legislation related to LGBT and HIV rights in 12 CEECA countries**[3], the most punitive and/or restrictive legal environments are in the following areas:

- **Laws criminalizing drug use exist in 10 countries** (Albania, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, Moldova, North Macedonia and Ukraine);
- **Restrictions that block women who use drugs from being able to access shelters when they experience violence exist in 12 countries** (Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Montenegro, Serbia, Tajikistan, Ukraine, and Uzbekistan);
- **Punitive regulations of sex work exist in 12 countries** (Albania, Armenia, Azerbaijan, Belarus, Georgia, Moldova, Montenegro, North Macedonia, Serbia, Tajikistan, Ukraine and Uzbekistan);
- **Laws criminalizing HIV transmission, non-disclosure, or exposure exist in 13 countries**, including HIV-specific articles (Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Serbia, Tajikistan, Ukraine, and Uzbekistan), or sanctions for the intentional transmission of infectious disease (North Macedonia) in criminal codes, or within HIV Law (Albania).
- **Laws criminalizing consensual same-sex sexual acts exist in 2 countries** (Uzbekistan and Tajikistan) and de-facto death sentence for same-sex relationships is enforced in Chechnya, Russia.
- **Laws restricting freedom of expression of LGBT people and penalizing with administrative and penal limitations**, exist in 4 countries (Belarus, Georgia, Kyrgyzstan and Russia) under pretense of "ban of gay propaganda" or similar.
- **Law enforcement practices oppressing LGBT people are implemented in most countries** in addition to existing criminal and punitive laws.
- **Prohibition and criminalization of gender-affirming procedures for transgender people exist in 2 countries** (Belarus and Russia)

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2 https://ewna.org/wp-content/uploads/2023/07/ewna-gender-assessment-report_2023_eng.pdf

3 https://ecom.ngo/library/analysis-of-national-legislation-12-countries

- **Highly restrictive inhumane gender-affirming procedures for transgender people are in force in all other countries** where they are available: psychiatric diagnosis as the basis for changing one's gender marker in all countries; mandatory sterilization procedure is required in 2 countries (Georgia and Kazakhstan).
- **Prohibition of gender neutral (same-sex) marriage exists in 7 countries** (Armenia, Belarus, Georgia, Kyrgyzstan, Moldova, Russia, and Ukraine).
- **Prohibition of blood donation for transgender people exists in all countries and for men who have sex with men in 1 country** (Belarus); **restrictions in blood donation for men who have sex with men exist in 4 countries** (Armenia, Kazakhstan, Turkmenistan and Ukraine).
- **Restrictions that prevent adoption and guardianship for people who use drugs exist in 12 countries** (Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, Moldova, North Macedonia, Tajikistan, Ukraine and Uzbekistan);
- **Restrictions of parental rights for people who use drugs exist in 12 countries** (Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan, Ukraine and Uzbekistan);
- **Laws criminalizing drug possession for personal use exist in all CEECA countries** (in some form).

Despite global progress in responding to HIV, **in the past decade, the CEECA region has also seen increases in annual HIV incidences**. A key driving factor for this is that the majority of CEECA countries do not have the harm reduction services in place that could make a difference to the epidemic, predominantly among people who inject drugs and their sexual partners. With inadequate HIV treatment and prevention, the CEECA region has seen the largest increase in HIV incidence and mortality globally, exceeding Southern and Eastern Africa.

In 2021, key populations (sex workers and their clients, gay men and other men who have sex with men, people who inject drugs, transgender people) and their sexual partners accounted for 70% of HIV infections globally. The risk of acquiring HIV is 35 times higher among people who inject drugs than adults who do not inject drugs and 30 times higher for female sex workers than adult women. Joint United Nations Programme on HIV/Aids (UNAIDS) 2022 [4]

4 Dangerous inequalities: World AIDS Day report 2022. Geneva: Joint United Nations Programme on HIV/AIDS; 2022. Licence: CC BY-NC-SA 3.0 IGO

As also documented by the World Health Organization (WHO)[5], **key populations are not only disproportionately affected by HIV, but they are also put at risk by a range of barriers, including stigma, discrimination, human rights violations, systematic disenfranchisement, social and economic marginalization, and criminalization**. In order to document all these challenges, in 2023 SWAN, ECOM, EHRA, and EWNA began a common quantitative and qualitative data collection effort. Together with the network's member organizations, data was collected from selected key populations across 11 countries in CEECA. The results highlighted the extent of a crisis that sees key populations frequently subject to ridicule, privacy violations, and medical gaslighting.

The findings from this research underscore the complex and interconnected challenges faced by key populations across CEECA. Addressing these challenges requires a comprehensive and multi-faceted approach that is sensitive to the complexity of vulnerabilities, issues, and identities. By doing so, better programming can eventually be developed to safeguard the sexual and reproductive rights of those with intersectional identities and thus improve their access to vital HIV, SRH, and other related services.

5 WHO/The Global Fund TFATM, State of Inequality: HIV, Tuberculosis and Malaria, Geneva, 2021. p. 7

IV. ABOUT THE DATA

This report has been developed using a combination of qualitative and quantitative data collected through member organizations of SWAN, ECOM, EHRA, and EWNA across the CEECA region. Members of key populations who participated in the research were self-identified through the online survey questionnaire and onsite focus group discussions.

The survey questionnaire consisted of a series of questions to which the respondents could choose one or more options from predefined answers offered, as well as open fields in which opinions, attitudes, and suggestions could have been entered. The questions that the participants were asked were structured in 5 general parts:

(i) demographics and personal data;

(ii) safe and supporting environment;

(iii) access to services;

(iv) laws, stigma, prejudices, and discrimination;

(v) social, legal, and political change.

A total of 136 surveys were taken across 11 countries in CEECA between August and October 2023, as outlined in Table 1.

Table 1 - Survey demographics

PER COUNTRY	TOTAL OF RESPONSES
Armenia	1,47% (2)
Belarus	5,88% (8)
Bulgaria	0,74% (1)
Cyprus	0,74% (1)
Estonia	0,74% (1)
Georgia	2,94% (4)
Hungary	0,74% (1)
Kazakhstan	5,15% (7)
Kyrgyzstan	4,41% (6)
Lithuania	0,74% (1)
Moldova	1,47% (2)
The Netherlands	0,74% (1)
North Macedonia	5,88% (8)
Russian Federation	4,41% (6)
Tajikistan	1,47% (2)
Ukraine	54,41% (74)
Uzbekistan	1,47% (2)
Other (unspecified)	0,74% (1)

SELF-IDENTIFIED AS	TOTAL OF RESPONSES
SW	13,97% (19)
LGBT	32,35% (44)
PWUD	22,79% (31)
PLHIV	59,56% (81)
None	4,41 % (6)
Prefer not to answer	2,21% (3)

AGE	TOTAL OF RESPONSES
Under 18	0,74% (1)
18 – 25	2,94% (4)
25 – 30	7,35% (10)
30 – 40	33,82% (46)
40 – 50	41,91% (57)
Over 50	11,76% (16)

GENDER IDENTITY	TOTAL OF RESPONSES
Cisgender (man & woman)	66,18% (90)
Transgender (man & woman)	8,09% (11)
Non-binary person	3,68% (5)
Other gender identity	4,41% (6)
Prefer not to answer	14,71% (20)

ADDITIONAL KP IDENTITIES	TOTAL OF RESPONSES
Homeless/houseless	5,88% (8)
Migrant (documented & undocumented)	9,56% (13)
Nomadic/traveler	2,94% (4)
Living with disability (including mental illness)	31,62% (43)
Member of national/ethnic/linguistic minority	5,15% (7)
Survivor of domestic abuse, psychological, economic, physical or sexual violence	47,79% (65)
In active addiction, or in recovery from alcohol use	13,97% (19)
Released from prison/former prisoner	4,41% (6)

RELATIONSHIP STATUS	TOTAL OF RESPONSES
Single (with multiple, or no sexual partners)	26,47% (36)
Married	30,15% (41)
Divorced	11,76% (16)
Widowed	7,35% (10)
In a relationship (monogamous & multiple)	26,47% (36)
Other (unspecified)	2,94% (4)

EMPLOYMENT STATUS	TOTAL OF RESPONSES
Employed	72,06% (98)
Unemployed	20,59% (28)
Other (unspecified)	8,09% (11)

Table 2 - Additional survey analysis on intersecting identities among key populations

Group	SW (n=19)	Gay, bisexual and other MSM (n=18)	Lesbian, bisexual and other women who have sex with women (n=18)	Trans or non-binary person (n=8)	PWUD (n=31)	PLHIV (n=81)
SW	-	3	1	3	10	4
Gay man, bisexual man, or other man who has sex with men	3	-	0	3	5	6
Lesbian, bisexual woman, or other woman who has sex with women	1	0	-	1	5	5
Trans or non-binary person	3	3	1	-	2	1
PWUD	10	5	5	2	-	11
PLHIV	4	6	5	1	11	-
Total	**21**	**17**	**12**	**10**	**33**	**27**
Different key populations' identity burden per group	1,1	0,9	0,7	1,3	1,1	0,3

Table 3 - Other types of intersecting identities/experiences

Group	SW (n=19)	Gay, bisexual and other MSM (n=18)	Lesbian, bisexual and other women who have sex with women (n=18)	Trans or non-binary person (n=8)	PWUD (n=31)	PLHIV (n=81)
Homeless/houseless	4	1	0	0	3	2
Documented migrant	4	3	4	2	7	6
Undocumented migrant	0	0	0	0	0	1
Nomadic/traveler	0	1	2	0	2	0
Living with a disability	4	1	1	1	6	17
Living with a mental illness	3	4	5	5	10	8
Member of national/ ethnic/linguistic minority	1	3	2	4	4	1
Survivor of domestic abuse	5	3	9	2	9	15
Survivor of psychological, economic, physical or sexual violence	9	5	11	2	15	19
In active addiction, or in recovery from alcohol use	2	4	7	1	11	9
Released from prison/ former prisoner	2	0	1	0	3	5
Total	**34**	**25**	**42**	**17**	**70**	**80**
Identity burden per group	1,79	1,39	2,33	2,13	2,26	0,99

Focus group discussions consisted of three general sets of questions aimed at assessing participants' experience with access to services, criminalization, and human rights violations, as well as securing participants' perspectives for the improvement of the overall process of service delivery. SWAN held 4 focus group discussions with a total of 39 participants from Armenia, Kazakhstan, Kyrgyzstan, and Ukraine in September 2023. ECOM held 3 focus group discussions with a total of 15 participants from Armenia, Kyrgyzstan, and Uzbekistan, as well as 4 individual interviews in Kyrgyzstan in October 2023. EHRA held 6 focus group discussions with a total of 32 participants from Kazakhstan, Kyrgyzstan, Moldova, and Ukraine in September 2023. EWNA held 1 focus group discussion with a total of 13 participants from Armenia, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Russian Federation, Poland, Ukraine, and Uzbekistan in October 2023. Cumulative demographics are outlined in Table 2.

Table 4 - Focus group demographics

PER COUNTRY	TOTAL OF RESPONSES
Armenia	15,53% (16)
Belarus	0,97% (1)
Estonia	0,97% (1)
Georgia	0,97% (1)
Kazakhstan	15,53% (16)
Kyrgyzstan	30,1% (31)
Moldova	5,83% (6)
Poland	0,97% (1)
Russian Federation	1,94% (2)
Ukraine	19,42% (20)
Uzbekistan	6,8% (7)

MULTIPLY SELF-IDENTIFIED AS	TOTAL OF RESPONSES
SW	36,89% (38)
LGBT	32,04% (33)
PWUD	22,33% (23)
PLHIV	49,51% (51)
Prefer not to answer	2,91% (3)

AGE	TOTAL OF RESPONSES
Under 18	0,97% (1)
18 – 25	23,3% (24)
25 – 30	13,59% (14)
30 – 40	20,39% (21)
40 – 50	17,48% (18)
Over 50	7,77% (8)

GENDER	TOTAL OF RESPONSES
Cisgender (man & woman)	53,4% (55)
Transgender (man & woman)	14,56% (15)
Non-binary person	8,74% (9)
Other gender identity	1,94% (2)
Prefer not to answer	2,91% (3)

ADDITIONAL KP IDENTITIES	TOTAL OF RESPONSES
Homeless/houseless	3,88% (4)
Migrant (documented & undocumented)	8,74% (9)
Living with disability (including mental illness)	22,33% (23)
Member of national/ethnic/linguistic minority	1,94% (2)
Survivor of domestic abuse, psychological, economic, physical or sexual violence	34,95% (36)
In active addiction, or in recovery from alcohol use	15,53% (16)
Released from prison/former prisoner	7,77% (8)

RELATIONSHIP STATUS	TOTAL OF RESPONSES
Single (with multiple, or no sexual partners)	36,89% (38)
Married	9,71% (10)
Divorced	9,71% (10)
Widowed	3,88% (4)
In a relationship (monogamous & multiple)	20,39% (21)

EMPLOYMENT STATUS	TOTAL OF RESPONSES
Employed	59,22% (61)
Unemployed	18,45% (19)

In order to focus on intersectionality among key populations, only individuals with multiple identities were engaged in the focus groups. For example, the focus group discussion that SWAN and its local partner non-governmental organization (NGO) Tais Plus conducted with 9 sex workers in Kyrgyzstan included 2 trans* sex workers and 7 cisgender sex workers, out of which 2 also self-identified as PWUD and 1 as PLHIV. Similarly, the focus group discussion and individual interviews that ECOM conducted with 9 LGBT persons in Kyrgyzstan included: 1 trans* sex worker who self-identified as a migrant; 2 lesbian/bisexual women who self-identified as survivors of psychological, economic, physical, or sexual violence; 4 gay/bisexual men, out of which 2 also self-identified as migrants and 1 as PLHIV; and 2 persons self-identified as non-binary.

Overall, the combined methodology of this regional consultation which consisted of a survey questionnaire and focus group discussions, helped the consortium to collect and assess existing experiences in the ways that intersecting identities - including LGBT, drug users, sex workers, and those living with HIV, might affect people's lives, access to health services, and agency in light of the structural inequalities, social injustice, violence, stigma and discrimination. The following sections of this report will elaborate in more detail on the wealth of information gathered through the topical research, as well as provide a set of recommendations for improvement of the overall process of service delivery and rights-based programming.

V. STIGMA AND SHIFTING IDENTITIES IN SHIFTING CONTEXTS

(THE IMPACT OF SINGLE-ISSUE APPROACHES IN NGOs)

Community-led data collection was essential to understanding how intersecting identities, including gender identity or sexual orientation, drug use, participation in sex work, educational achievement and marital status, interplay with stigma, discrimination, and harassment against key populations, as well as with their uptake of HIV/SRH services and health outcomes. Collecting this type of multi-layered information was particularly important to understand the multiple and intersecting forms of stigma and discrimination, including structural ones, that impede the provision of and access to health services.

Some survey respondents mentioned that services are accessible on a more limited basis for clients if they belong to various intersectional groups. Part of those are well aware **that many services are tied up to HIV services, or provided only within the context of GFATM-funded HIV programs**, which is a limitation for people with multiple identities excluding the one based on HIV+ status. This is mainly due to the positioning of the existing system of service provision, where all planned coverage of HIV prevention and testing services are planned, implemented, and reported by each community group separately. Such a systemic positioning neither supports nor encourages intersectional cooperation between different service providers thus inherently discourages responding to the unique needs of individuals with intersectional identities.

According to the service protocols, instructions, and practices across the CEECA region, PWUD can receive basic harm reduction packages at a specific organization. However, if the person who uses drugs is also a sex worker or member of the LGBT community, s/he would instead need to approach another organization(s) to get the required service. An additional burden is the fact that not all these organizations exist in every city, and the referral system does not properly work everywhere.

As a result, **people with multiple identities are likely to experience more instances of discrimination when accessing services than those with a single identity**. This can result in individuals being shunted back and forth between services, effectively allowing the most marginalized and vulnerable to "fall through the cracks". For example, in many CEECA countries, no gender-specific services are available in prison settings. Furthermore, a case was described at the focus group discussions conducted by EHRA where receiving opioid agonist treatment (OAT) for trans* people was fraught with difficulties. In one case due to the discrepancy between document and physical appearance after gender transition, a doctor refused to prescribe OAT. As a result, the transgender patient's treatment was interrupted for 2-3 weeks, and this person was forced to use street drugs during this time.

Chart 1. Survey respondents reporting on the main reasons why they do not get services anywhere (chart is displayed in absolute numbers; total number of respondents answering the question is 58)

During the data collection, many individuals from key populations told us about their past negative experiences. PWUD reported being subjected to misunderstandings or ignorant comments about their drug use. Some spoke of staff at the state clinics who disclosed their HIV status, or the HIV status of other people in the waiting areas.

> *"I do not go to AIDS center clinics because they're not safe. I cannot disclose my sexual identity there without risk of breach of confidentiality and anonymity, as well as subsequent transfer of data to other state authorities."*
>
> (survey respondent, self-identifying as a PLHIV and LGBT)

Many trans* people also spoke of feeling humiliated during medical consultations by receiving unwanted or unnecessary comments about their bodies. Notwithstanding, certain encouraging developments in terms of attitude changes were likewise being noticed.

> *"I have a long history of opioid addiction and have been drug-free for more than 14 years. The attitude of medical staff is changing, but I can't say for sure this is only due to the drug use cessation. Perhaps young doctors are getting more information about HIV infection, they have a different attitude towards PLHIV."*
>
> (survey respondent, self-identifying as a PLHIV and PWUD)

NGOs (community-led organizations or service providers) can offer better-suited and more friendly psychosocial, SRH, and other health-related services, thus there is a relatively high awareness of them among the survey respondents. Primarily due to the type of services available at their place of living, to cater for their needs the majority of the interviewed respondents stated that they often visit LGBTI or PLHIV-led groups and service providers, followed by SW-led organizations and harm reduction programs. They feel more protected in self-organized settings where they are not afraid to talk openly about themselves and their needs.

> *"I attend a group led by PLHIV where I receive important information that interests me, and I have a pleasant time with people who have a similar problem. I'm always confident in the quality of services, the warmth and joy which they provide me."*
>
> (survey respondent self-identifying as a PLHIV and PWUD)

The research did not definitively demonstrate that members of the LGBT community consistently feel safe at harm reduction sites. However, it indirectly indicated that without specific LGBT organizations, a significant portion of them might opt for services provided by sex-worker-led instead. This trend was also observed among sex workers, possibly due to effective cooperation programs between LGBTI organizations and self-organized sex worker groups. These programs foster mutual recognition and support, facilitating joint outreach efforts such as HIV testing and counseling, as well as the distribution of condoms and lubricants.

On the other hand, PWUD community-based organizations appear to be highly specific in their area of work and thus focused on the sole needs of the community they're serving. Besides the potential lack of knowledge and understanding of the needs of people with multiple identities, it seems that harm reduction sites remain quite unpopular for the majority of the key populations with multiple identities (aside from PWUD), due to the additional layers of stigma attached to drug use.

Furthermore, negative past experiences, as well as concerns around anonymity are among the main barriers experienced by key populations when trying to access services. It is exactly through social and medical services that the personal data of key populations is most often leaked. Therefore, **many of the key populations with multiple identities prefer not to inform healthcare workers at the state clinics about their HIV status, and even less often to inform them about their drug use and/or sexual practices. In other words, research showed that many of the key populations with multiple identities would rather disclose their HIV+ status than their drug use and/or sex work when seeking access to SRH and other related healthcare services at public health facilities.**

For example, one of the participants at the focus group discussion that SWAN community member Legalife conducted in Ukraine shared a story about how healthcare workers passed information about her HIV status and drug use to law enforcement authorities. The police then raided her flat and tried to unjustifiably prosecute her for drug distribution.

This finding was also supported by the participants at the focus group discussion that ECOM conducted in Uzbekistan, where sex between men is punishable by up to three years in prison. All of them believed that personal data demanded by medical staff at AIDS centers was requested not to provide a service tailored to their specific needs as members of the LGBT community, but rather to pass that data to law enforcement authorities.

One of the participants, after being diagnosed with HIV, was referred to an epidemiologist at the AIDS Center in Tashkent who told him that he did not look like a young man who prefers to have sexual contact with biological women. The epidemiologist asked him to disclose information about his sexual orientation and his partner(s), stating that it would be confidential, using the entirely false justification that there are different types of antiretroviral treatment (for heterosexuals, for homosexuals, and for people who use drugs). After that, the young man confessed his sexual orientation, wrote the names of all the partners with whom he had sexual contact, and the epidemiologist asked him to sign the paper on which he wrote their data. 3 months later the young man was summoned to the city Department of Internal Affairs, and a decision was made to prosecute him under Article 120 of the Criminal Code of the Republic of Uzbekistan. As a result, he was sentenced to 2 years of imprisonment.

Another participant at the group discussion shared the experience of his acquaintance who was diagnosed with HIV, after which his parents were summoned to the AIDS Center. As a result of the pressure exerted on the young man by his parents, he was forced to confess his homosexuality, and disclose the data of those with whom he had sexual contact, but also forced to provide information about all the people he knows with homosexual orientation. As a result, a decision was made to prosecute the young man under Article 120. A few days before the trial, the young man, unable to withstand the psychological pressure, committed suicide by hanging.

Services for all key populations are concentrated in bigger cities and therefore there are obvious challenges with access to such services in smaller towns and villages, where anonymity is lower and levels of stigma and discrimination tend to be higher. Consequently, out of fear of their status/identity being disclosed to community members, friends, relatives, and even their own families, individuals are dissuaded from seeking medical or social services even in cases of emergency.

> *"In Moldova we have a more or less normal attitude towards female sex-workers but if it's the case of LGBT and trans* people providing sex services – very tough, lots of consequences."*
>
> (FGD participant, PWUD, Moldova)

"In Kyrgyzstan, the most complicated cross-identity would be trans women and girls involved in sex work and using drugs, they face lots of problems."*

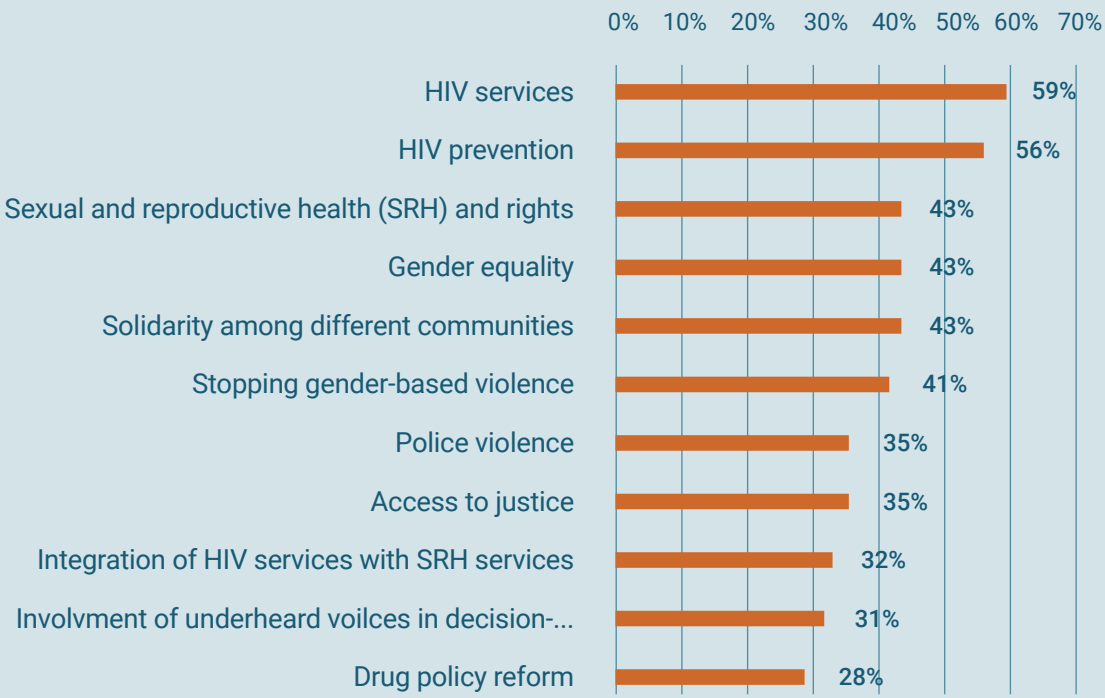
(FGD participant, PWUD, Kyrgyzstan)

According to the findings from the focus group discussions that EHRA conducted in Kyrgyzstan, **women – regardless of which group they belong to – experienced all forms of discrimination more frequently than men and if a woman had these multiple identities, with every identity added – sex-worker, HIV status, use of drugs - she would be *"moving further and further up on this discrimination scale towards the peak end."* Gender-diverse communities and migrant women face multiple and intersecting forms of discrimination that increase their vulnerability to violence.**

Participants from the focus group discussion likewise noted **a limited or complete lack of services for HIV+ sex workers. The same finding can be applied to groups of HIV+ MSM who are also cross-identified as sex workers.** While some services are very high-threshold, others are almost nonexistent (e.g. while services for women – survivors of various types of violence – are mostly available across the CEECA region, similar services for men are not). Without urgent intervention to ensure state clinics provide friendly, dignified, confidential, and safe services, key populations will continue to be pushed out of care.

The research also showed that the sense of safety and security among key populations with intersectional identities is influenced by their socialization experiences, social stereotypes, laws, and enforcement practices, such as the criminalization of HIV, sex work, and drug use. When it comes to the changes that key populations want to see in order to feel more comfortable and safe, **over 50% of the survey respondents prioritized the HIV service provision and HIV prevention, followed by sexual and reproductive health and rights, achieving full gender equality and increasing solidarity among different communities.**

Chart 2. Survey respondents reporting on what they think should be a priority action (data is displayed in %, N=136)



The safety of community activists requires special attention. In some CEECA countries they are often subject to bullying, threats and blackmail, which is reinforced by institutional violence from the state (totalitarian regime, repressive laws, lack of anti-discrimination and protective legislation, political and/or humanitarian crises). This was particularly emphasized at the focus group discussion that EWNA conducted with participants from various CEECA countries:

> *"As an activist, I was often bullied by journalists, neighbors, teachers, and classmates for narcofeminism when my membership in the community was revealed. It was a difficult period. I already have children."*

Participants frequently described how their increased visibility as activists left them more vulnerable to existing forms of stigma and discrimination, such as drug use and mental health stigma. This unfortunately was the case even within activist communities, illustrating how even within supposedly supportive spaces, prejudice and bias can hinder collaboration and support.

> *"As an activist, I post openly on social media about my substance dependency and people know that I use drugs. I am still faced with the fact that men from larger community organizations are discussing whether they can work with me, or whether I am an adequate and reliable partner. I know for sure that there are other activists that have changed their minds about working with me because of these conversations."*

> *"As a woman with a mental disorder who's engaged in community activism I don't feel safe because this is a good trump card for the totalitarian regime I live in. I could be forcibly committed to a psychiatric hospital at any moment, on the pretext that mania and psychosis I suffer from represent a threat to my own and the lives of those around me. I always remember this, because punitive psychiatry is still used in my country."*

Fear of state repression and institutional violence looms large, and shifting political contexts such as war add another layer of complexity and danger, with activists facing threats to themselves and their families, surveillance by state authorities, and pressure to self-censor in order to avoid repercussions. This environment of constant surveillance and intimidation creates a sense of duality, where activists must navigate between appeasing the state and fulfilling the demands of donors, all while fearing sudden and drastic changes in the political landscape.

> *"I don't feel safe as an activist, especially not after my twenties. From that time on, a wave began to spread that all community activists were to blame for losing the war in Nagorno-Karabakh...I don't post photos of my children on social media networks either, so that they don't become a target as well."*

> *"There were cases of threats to me and my family, including my children. There were cases of calls from unfamiliar numbers and calls from the FSB related to my social activities. I have to live in a situation of duality. We have to rewrite reports. There are some reports for the donors and different ones for the state. I can't write about what worries me. There was an inspection by the Ministry of Justice, where I was told not to criticize the authorities or the state anywhere...An environment is created as if nothing is prohibited, but at any moment everything can change dramatically."*

VI. MARGINALIZED BODIES IN MEDICINE

(SOCIAL NORMS, ATTITUDES AND EXCLUSIONARY PRACTICES)

The findings from the focus group discussions conducted by EHRA serve as an illustrative example of the challenges linked to the continuously developing notion of intersecting identities. On the one hand, some participants mentioned that they encountered no problems with receiving services, even with multiple identities:

> *"In my city everything is fine with receiving services, even when I disclose my HIV+ status."*
>
> (FGD participant, PWUD, Kazakhstan)

> *"Attitude of doctors have changed. Compared to 5-10 years ago, they treat us in a more human way. Can't say that I was ever refused services, however, the specific attitude towards PWUD is still felt."*
>
> (FGD participant, PWUD, Moldova)

On the other hand, it is notable that instances of discrimination increased once these identities manifest more physically, in terms of outward appearance or traces on the body. Remaining tolerant when merely informed about someone's HIV status, drug use or LGBT identity is very different to the ways participants felt they were treated when they were showing visible signs of drug use, homelessness, or were visibly queer:

"In terms of services for people with multiple identities – no difference. Medical staff would rather pay attention to the outward appearance, to the way people are dressed and smell."

(FGD participant, PWUD, Ukraine)

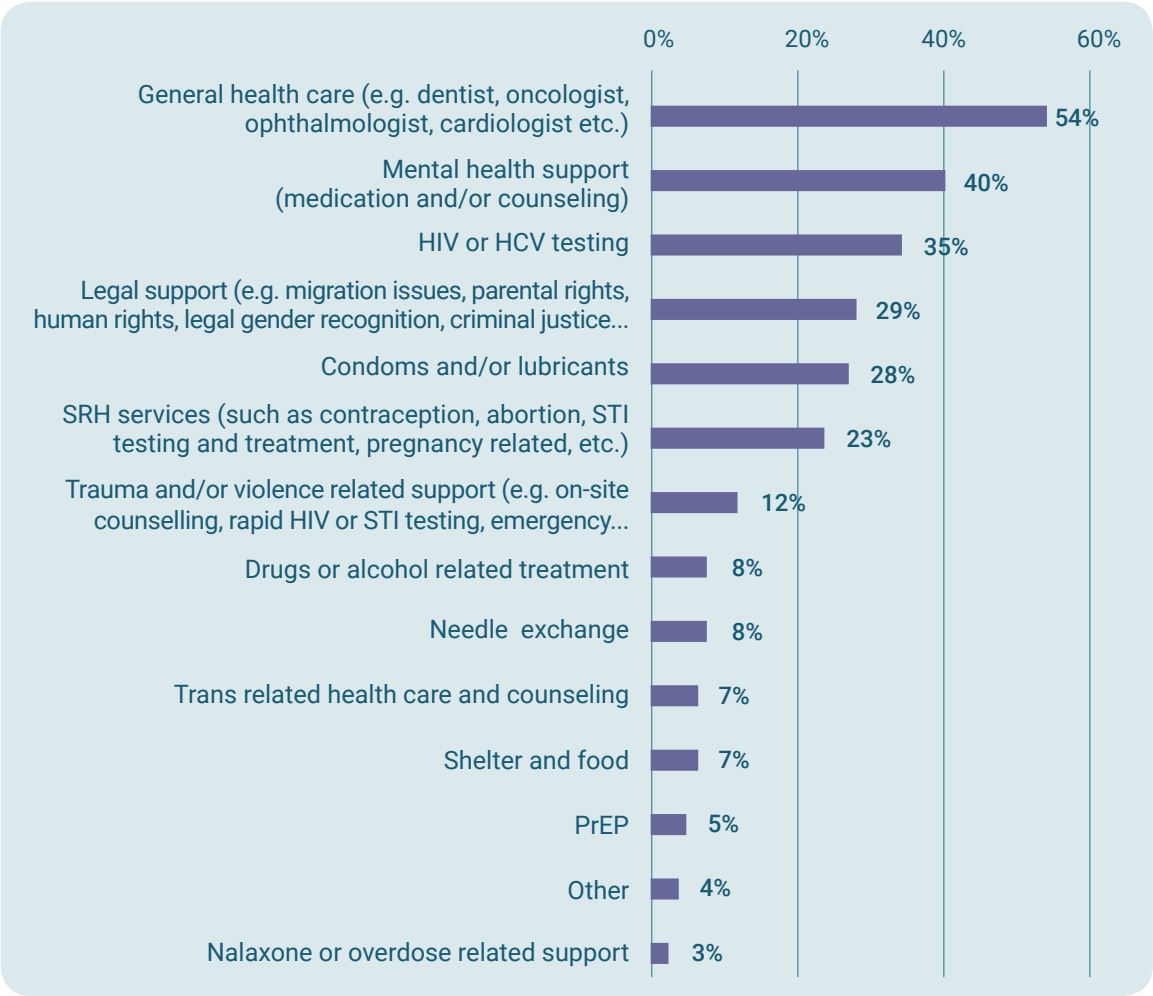
"I would not say there are differences in receiving services. The only thing is when people are more marginal, concentrated on their dependency. Then health comes as a second priority, and they only come for services when there are some serious issues."

(FGD participant, PWUD, Kyrgyzstan)

Survey results showed that **for the majority of key populations with intersecting identities the experience at State Clinics for Infectious Diseases, where most of them usually receive their HIV treatment and care, is often untenable**. Too often staff are insensitive, unfriendly, and hostile. Many participants said that they had been subjected to ignorant comments or misunderstandings about their sexual orientation, gender identity and/or HIV status, and some said the stigmatizing and demeaning attitudes towards their sexual health practices, as well as their number of sexual partners, have been off-putting enough for them to prefer to go without or seek available health services at NGOs (community-led organizations or service providers).

Cumulatively, **SRH, condom distribution, general health care, as well as mental health support are among the services most frequently used, needed and/or visited by the interviewed respondents. Psychosocial support and other mental health services are critical — especially for key populations who experience additional discrimination, abuse, homophobia, transphobia, criminalization, and even hate crimes due to their intersecting identities**. E.g. the mental health of HIV+ LGBT people was emphasized as a particular concern at the focus group discussion that ECOM conducted in Kyrgyzstan. Similarly, survey responses show us that **obtaining services from psychologists and psychiatrists is challenging for many key populations with intersecting identities**, primarily due to the high cost and limited availability of community-friendly psychologists and psychiatrists.

Chart 3. Survey respondents reporting on type of services they frequently use, need, and/or visit (data is displayed in %, N=136)



Challenges in access to more specialized services such as reproductive health services (including PAP smear), or the opportunity to visit specialists (e.g. vascular surgeons, phlebologists, proctologists, endocrinologists, etc.) were also reported during the focus group discussions. Trans* people in particular explained the difficulties of having to travel to major cities to access hormone therapy and gender-affirming services.

"There are not very many obstacles for female sex workers. The main obstacle is expensive gynecologist services in private clinics and examination of children."

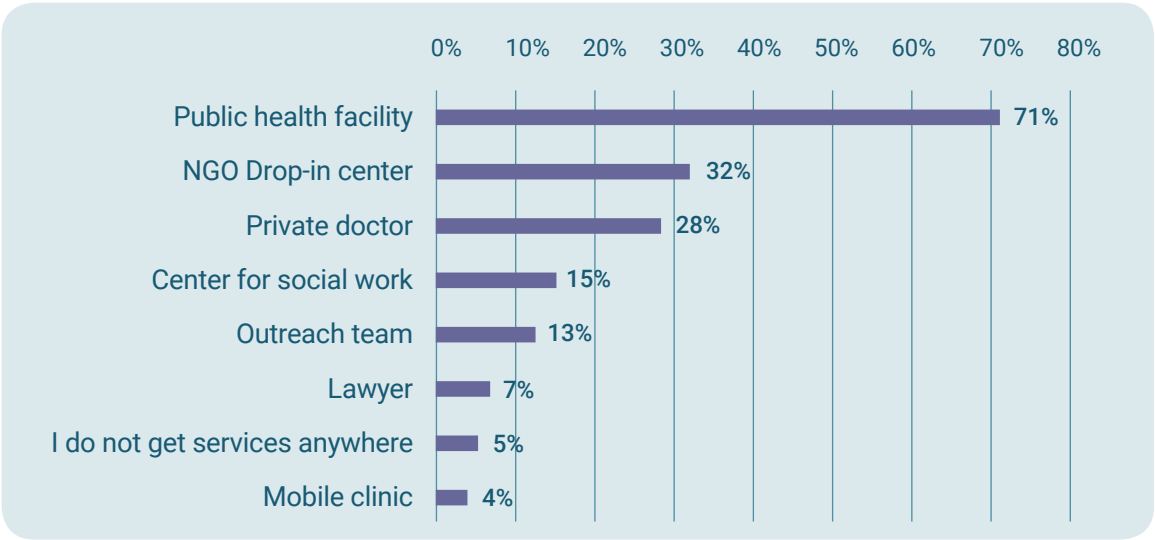
(FGD participant, sex worker, Kyrgyzstan)

"For trans sex workers in Kyrgyzstan, the main problem is the endocrinologist, since there is only one friendly endocrinologist in the country who accepts trans* people and you can get to him for free only 1 time per year. There are also no specialized hormonal drugs for trans* people in the country, everyone is prescribed regular hormonal drugs that are usually registered as contraceptives for women."*

(FGD participant, trans sex worker, Kyrgyzstan)

Although the general consensus among the survey respondents is that both the public and private health sectors have limited to no community-friendly services, the reality is that public health facilities remain the entry point for most key populations to get the healthcare they need. The majority of the interviewed respondents stated that they are using public health facilities for their healthcare needs.

Chart 4. Survey respondents reporting where do they go for their services (data is displayed in %, N=136)



The preeminence of public health facilities in the responses can be attributed to the substantial presence of 81 respondents identified as people living with HIV (PLHIV), who predominantly seek ARV treatment and related care from state medical facilities.

Upon excluding the 81 PLHIV respondents and analyzing the remaining 55, public health facilities still emerge as the preferred choice, with 56% of respondents favoring them, followed closely by NGOs at 44%.

However, among the PLHIV subgroup, public health facilities exhibit a higher dominance, comprising 86% of responses, while NGOs drop to 25%.

Yet, key populations are too often treated poorly by clinic staff who show a lack of compassion and professionalism. Some of the survey respondents noted that they have faced harsher and more humiliating attitudes from nurses and junior medical personnel than from the doctors.

Besides multiple identities, various cases of stigma and discrimination were reported by the participants at focus group discussions based on other factors, such as comorbidities (HIV, HCV, TB), history of mental health conditions, family violence, etc.

> *"There is a high level of stigma and discrimination in state clinics. If I need to donate blood, I will never go to a state clinic again. They ask inappropriate questions, why there are no veins, and in front of strangers called me a drug addict. They were squeamish. There was a case when I asked for help from an infectious disease specialist because I had hepatitis C. I told her I was probably infected because of my drug use. She refused to examine me until I provided her with a certificate of my HIV status."*
>
> (FGD participant, PWUD and HCV patient, Moldova)

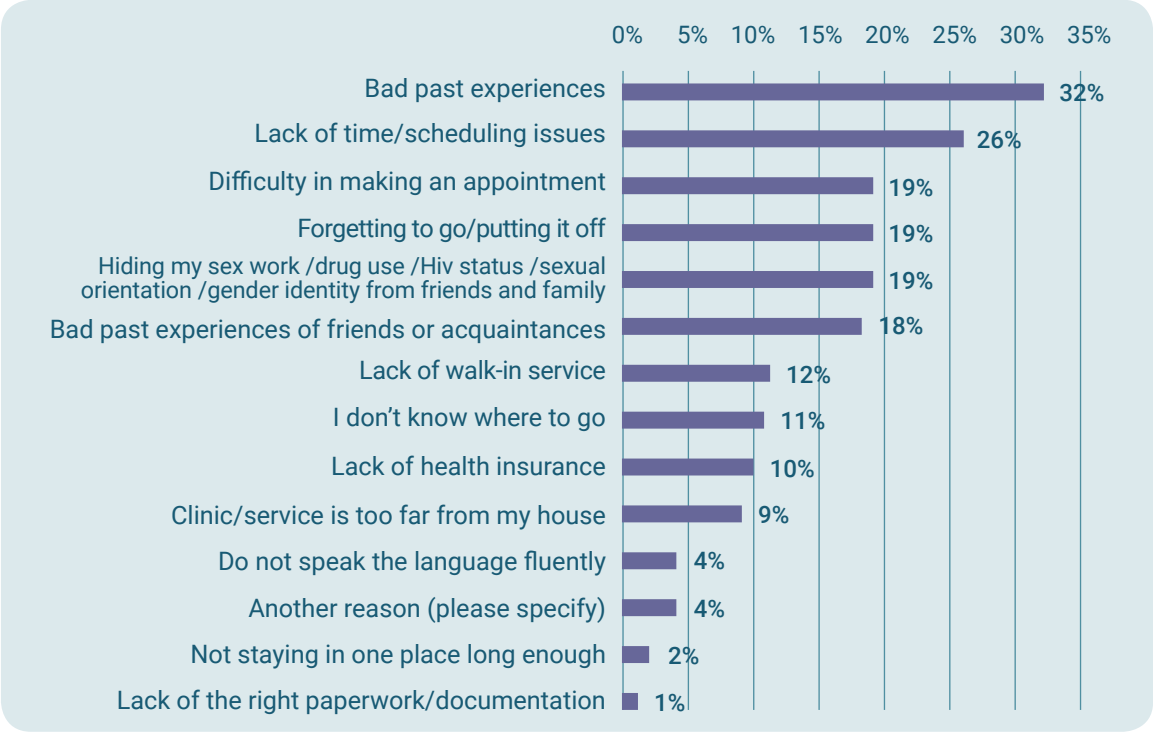
Table 5 - Survey respondents reporting on the negative experience(s) when accessing the services

ANSWERS TO QUESTION "Have you ever had any of the following negative experience(s) when accessing the services? (Select all that apply)"	QUANTITY	PORTION, N=136
Ignorant comments or misunderstandings about my HIV status	57	42%
Staff enter the room without knocking during a consultation/check up	34	25%
Not having my symptoms taken seriously	30	22%
An unfriendly or hostile attitude	30	22%
More than one person is being consulted or counseled in the same room	29	21%
Not being able to afford treatment	28	21%
Staff disclose mine or other peoples HIV status in the waiting area	27	20%
Feeling upset or triggered after the procedure	26	19%
People who live with HIV are separated from other patients	25	18%
Ignorant comments or misunderstandings about my drug use	24	18%
Unwelcome or unnecessary comments about my body	23	17%
Feeling pain during the procedure	23	17%
Ignorant comments or misunderstandings about my sexual orientation	21	15%

Healthcare workers call other staff into the consultation room to share my medical issues without my consent	20	15%
Being refused treatment	18	13%
Ignorant comments or misunderstandings about my physical appearance	17	13%
Stigmatizing attitudes towards the number of my sexual partners	17	13%
Stigmatizing attitudes towards my sexual health practices	12	9%
An unwelcome sexual attitude and or/sexual comments	12	9%
Being touched without my consent	11	8%
Not being properly talked through the medical checkup procedure (e.g. swab or speculum insertion)	11	8%
Ignorant comments or misunderstandings about my gender presentation	10	7%
Ignorant comments or misunderstandings about my disability	10	7%
Ignorant comments or misunderstandings about my race, ethnicity or nationality	8	6%
Not speaking my native language/mother tongue	7	5%
Other negative attitude and/or experience (please specify):	7	5%
Staff disclose mines or other people's sexuality in the waiting area	6	4%
Security guards check patients' medicines when they are leaving the facility	2	1%

Experiences like in the table above, where patients are shouted at, humiliated, scared, or even refused support and care at the state clinics, clearly have a deterrent effect on the most vulnerable populations' choice to access SHRH services. The majority of key populations who refrain from going to the state clinics confirmed it was because of this poor treatment, a fear of exposure, a lack of privacy, and a lack of safety. **Female sex workers who use drugs appear to be the ones who most often do not seek health care after incidents of violence unless they have suffered serious injuries and trauma**. As also stated in the **2022 EHRA's Report on Integrating Assistance to Women Affected by Violence into Harm Reduction Programs**: "Women who use illicit substances are not only exposed to high levels of violence by parents, intimate partners, and even their children but also regularly subjected to sexualized violence, torture, and abuse by police."[6]

Chart 5. Survey respondents reporting on other barriers they experience when trying to access the services (data is displayed in %, N=136)



6 https://old.harmreductioneurasia.org/wp-content/uploads/2022/08/2022-07-11_GenderBasedViolence_EHRA-ENG.pdf

Sadly, the data shows a high number of participants suffer discrimination, lack of empathy from staff, and/or legal barriers that hinder their access to healthcare and social services in the majority of state clinics. In particular the availability of gender-affirming services for those who need them is critically compromised. In addition to the psychological impact of gender dysphoria, in the context of CEECA, access to hormone therapy can mean life or death:

> *"I underwent gender reassignment surgery (GRS) illegally, because there is no law in Armenia that regulates this, I paid a Russian doctor who came to Armenia, did the surgery by giving some money to the state clinic and left. I was really afraid as I was not registered at the hospital as a patient undergoing GRS and if something went wrong, no one would bear responsibility. Also, I did not know if I woke up, I would be arrested or fined, who would care about my wounds, it was really difficult for me."*
>
> (FGD participant, trans sex worker, Armenia)

In conclusion, safety issues, privacy violations, and poor staff attitudes towards key populations are seen widely across CEECA. **Participants with more than one intersecting identity were most likely to face increased difficulties when accessing services. Being perceived as a member of a key population due to physical appearance was frequently mentioned as a main factor in receiving poor treatment from medical staff.**

VII. GENDER-BASED VIOLENCE AND ACCESS TO JUSTICE

(LAWS, POLICIES, PROGRAMMES AND RESOURCE ALLOCATION)

Stigma, discrimination, and violence against key populations with multiple identities remain pervasive across the CEECA region. Regarding cases of discrimination and human rights violations, the **majority of the respondents noted that they rarely seek legal assistance, and avoid submitting complaints to law enforcement agencies or independent state institutions**. The main reasons given for this were that the processing of cases is often unreasonably delayed; complaints are not examined properly, cases are dismissed, and individuals face secondary victimization by the system, all together discouraging participation in an already lengthy and inherently emotionally difficult process.

Access to justice and courts is especially crucial for key populations with intersectional identities and provides a unique tool to counter the discrimination (and oftentimes disrespect, lack of dignity, or even violence) that they face. However, those who need effective access to justice and courts most are the ones most frequently encountering barriers to it.

> *"Even after the rape, I didn't go to the police because I was scared. I already had bad experiences with cops when I did nothing. And here I was afraid of being traumatized even more. I didn't have the strength to fight back."*
>
> (survey respondent, anonymous)

In cases of stigma and discrimination, the **majority of survey respondents reported that usually, they do not seek legal help in these situations, as they are pessimistic that it may produce any results, are afraid of breaches of confidentiality, or are simply unaware that such services** (free legal aid, paralegal, etc.) **even exist**. Also, **individuals who were victims of human rights violations do not want to complain officially, as they are afraid of subsequent consequences** (e.g. disclosing their HIV status, and/or further victimization based on their multiple identities).

"Clients usually do not turn to police for help. Out of 60 cases of sex workers, including trans people, who suffered discrimination and/or violation of their human rights, none of them approached the police."*

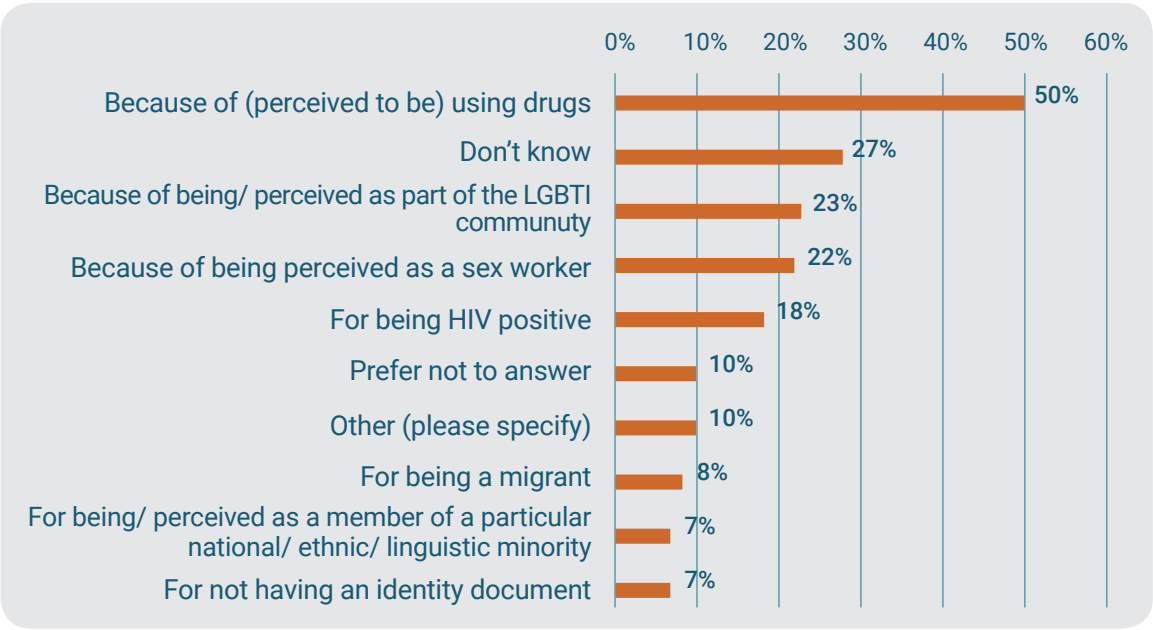
(FGD participant, PWUD, Ukraine)

"MSM or LGBT persons may rarely contact police in cases of hate crimes or direct attacks, but SW and PWUD never do, under any circumstances, even if it involves receiving passports, documents, etc., as police does not usually react: You are drug users, you'll handle it yourself".

(FGD participant, PWUD, Moldova)

Furthermore, **trans* people, sex workers, and drug users particularly face high levels of prejudice, harassment, violence, and abuse every day in CEECA as a whole**, especially from the police.

Chart 6. Survey respondents reporting on what they think the main reason is for such police conduct (data is displayed in %, N=60 - respondents answered "yes" to the question "Have you ever been apprehended and/or interrogated by the police?)



Participants reported that police had stopped them on the street with unjustified threats or claims, conducted illegal searches and arrests, and withheld water or phone calls upon apprehension. For example, a participant at the focus group discussion that SWAN community member Legalife conducted in Ukraine described how police officers illegally searched her on the street and seized a 10-day supply of substitution therapy medication, leaving her without treatment for a long period of time. **Transgender sex workers in particular were frequently subject to police harassment.**

> *"On the street I will certainly feel unprotected, and, of course, there will be fear that someone will beat me up and videotape that I am a trans woman. This fear inside that you live with, the fear that you can be punched in the face, you can be called a faggot, and you can't get help from the police or the state, because the same policemen will bully you."*
>
> (FGD participant, trans sex worker, Kazakhstan)

More than half of the interviewed sex workers reported having experienced physical violence. **Women who use drugs face the highest levels of physical and sexual violence**. A recent Russian survey of women who use illicit substances likewise found extremely high rates of violence among this group – nine out of ten participants (89%) reported having experienced violence in the past. Of these women, 78% had been affected by domestic violence, 73% by police violence, and nearly half (49%) by both.[7]

Similarly, **trans women engaged in sex work often face higher levels of discrimination and physical violence compared to the rest of the interviewed participants**. Trans* people often do not report transphobic violations and crimes against them as many are afraid of possible negative consequences and publicity, or do not believe in the possibility of obtaining justice in such cases. This applies even more strongly to crimes involving non-physical violence crimes, especially verbal and emotional abuse, which is unfortunately perceived as the norm across the CEECA region. High rates of violence against trans* people and PWUD have also been reported in the countries where research has been conducted.

In addition, focus group discussions conducted by the consortium partners also revealed key themes related to laws and practices, and how intersecting vulnerabilities, issues, and identities among key populations affect sexual and reproductive rights and access to HIV,

7 Фонд им. Андрея Рылькова (2021). Все еще не человек. Насилие в отношении женщин, употребляющих наркотики в России. Отчет об исследовании.

SRH, and related services. E.g. The focus group discussion that SWAN community member Right Side NGO conducted in Armenia highlighted concerns about legal frameworks that affect key populations. Laws related to sex work, gender reassignment surgery, and drug use were mentioned as restrictive and discriminatory.

Similarly, the focus group discussion that SWAN community member Amelia Public Association conducted in Kazakhstan revealed that the concept of gender identity is not recognized as a non-discrimination ground in the national legislation, as much as the hatred (i.e. hate-motivated or gender-based violence) is not considered as an aggravating circumstance during investigations and judicial proceedings.

> *"Only victims of domestic violence can go to crisis centers, which means that a woman must be actually beaten, raped by her husband, civil partner or cohabitant, call the police, record the fact of violence, make a forensic examination, and only after the conclusion of the district inspector, can be referred to a crisis center. At the moment, drug dependent sex workers do not have the opportunity to seek help. There are no crisis centers for men or transgender persons in Kazakhstan."*
>
> (FGD participant, sex worker, Kazakhstan)

Female and trans* sex workers who use drugs appear to be particularly vulnerable as a result of the criminalization of sex work and drug use. Some focus group participants felt that these legal barriers hindered their access to healthcare and social services, thus they expressed fear of legal consequences and discrimination because of their involvement in sex work and/or drug use.

> *"During my drug use, I was regularly subjected to sexual and physical violence by police officers, so I saw no point in turning anywhere for help. After all, when you are using, there is no faith that you can go through all the procedures and receive state protection, or a competent lawyer who will not discriminate against you"*
>
> (FGD participant, woman living with HIV and PWUD, EWNA)

Similar findings that women who use illicit substances rarely seek help, due to criminalization and stigma, have been already documented in Russia, where out of 51 women who experienced domestic violence, more than half (51%) did not seek help, only

a quarter sought help from their relatives, 22% turned to law enforcement, and only 4% (two women) sought help at crisis centers (shelters).[8]

Likewise, **the overwhelming majority of key populations with multiple identities (SW, PLHIV, PWUD) in Ukraine and some other CEECA countries stated that existing criminal legislation related to HIV transmission and exposure, sex work and/or drug use, as well as its application in practice, ultimately lead to increased stigma and discrimination that prevents key populations from enjoying their guaranteed civil and human rights on an equal basis with other citizens**.

> *"As a woman living with HIV, I do not feel safe because my country criminalizes HIV. This criminal article implies that all infected people are potentially criminals. The article does not provide for any protective mechanisms."*
>
> (FGD participant, woman living with HIV, Uzbekistan)

HIV criminalization in the EECA region is directly connected with other types of criminalization – use and possession of drugs, sex work, same sex relations that exacerbate the burden of discrimination, violation of rights and violence against women living with HIV.

One of the arguments in favor of the existence of criminal liability for HIV transmission is the alleged "protection" of women in situations when their husbands or partners infect them with HIV. Still, criminalizing HIV does not eradicate gender and other forms of violence and social inequality that lie at the heart of women's vulnerability to HIV. On the contrary, the risk of violence in women's lives is increasing, and gender inequality is growing. Women living with HIV can be criminalized if they have sex or choose to breastfeed. When considering cases, the judiciary often ignores condom use, suppressed viral load (undetectable equals untransmittable principle), scientific evidence set out in the scientific consensus on the risks of HIV transmission[9].

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8 Andrey Rylkov Foundation for Social Justice and Health (2020). Report for the List of Issues in relation to 9th Periodic Report of the Russian Federation CEDAW/C/RUS/9.

9 HIV criminalisation scan in EECA for 2018-2022. EWNA, 2023 https://ewna.org/wp-content/uploads/2023/04/ewna-hiv-criminalization-scan_.pdf

Women in homosexual or bisexual relationships, trans* women, sex workers, women who use drugs often face many barriers to accessing HIV prevention, testing and treatment, care and support. Due to their pre-existing "criminalized" status, criminalization of HIV transmission for these groups of women is one of the key obstacles in accessing health services and other types of social assistance, posing the threat of prosecution under several articles – for "criminal behavior" and for the assumed "threat" of HIV transmission[10].

In Tajikistan, sex workers are often affected, even when the "injured party" has no claims against them and HIV was not transmitted. Media headlines in Tajikistan are often full of stigmatising phrases about women living with HIV and make them responsible for spreading the infection[11]. In Uzbekistan, trans* people living with HIV are subject to double criminalisation - HIV and homosexual relationships[12].

This situation, as in some other CEECA countries, is additionally fueled by the absence of more specific anti-discrimination provisions. In order for these to be put into place, key populations would first need to be fully aware of their rights and have meaningful access to justice and judicial mechanisms. Accountability and oversight mechanisms help realize people's right to health and ensure that breaches of those rights are remedied. Courts and legal services should be affordable and accessible to all, and communities should be able to bring cases as individuals and as organizations.

However, even the existence of these kinds of laws does nothing to guarantee that they are enforced consistently.

> *"Women in Belarus do not feel safe in principle, since our laws regarding violence against women do not work. When detaining a woman, any security forces can use sexual and physical violence against her with impunity. Even if we know the law and appeal the decision in court, not a single case will be proven, and the culprit will not be punished."*
>
> (FGD participant, community activist and PLHIV, Belarus)

10 Women Leadership in issues of HIV decriminalisation: experience of the EECA region. EWNA, 2022 https://ewna.org/wp-content/uploads/2022/04/ewna_hiv-decriminalization_womenlead_compendium_2022_eng.pdf

11 Ibid

12 Alternative report on the implementation of the CEDAW concerning women living with HIV by the Republic of Uzbekistan for the 81st session of the UN Committee on the Elimination of Discrimination against Women, Geneva, Switzerland, 07 – 25 February 2022 https://ewna.org/2022/03/03/cedaw-recomendation-to-uzbekistan/

The first societal enabler is to remove discriminatory and punitive laws and policies that create barriers to accessing HIV and SRH services, including the removal of laws criminalizing sex work, drug use and possession for personal use, consensual same-sex sexual activity and HIV criminalization. As stated at the focus group discussion that EWNA conducted with participants from various CEECA countries:

> *"As a woman who uses drugs, this prevented me from seeking help in a case of domestic violence. When I had substances in my home, I was beaten by my partner. When I said that I would call the police, he threatened me that he would tell them where the drugs were. That's why I didn't call them."*

> *"Last year at our community center we had a case where a 13-year-old girl who used pharmaceutical stimulants was raped by her brother. Then we were faced with the fact that we could not assign her to any crisis centers due to her age. We wrote a statement to the police, but it was not followed up. It is very difficult to get any kind of justice if a woman who uses drugs is sexually assaulted."*

When law reform is pursued through legislative channels with active consultation and collaboration with affected communities, the resulting reforms are more likely to safeguard their rights effectively and fully implement decriminalization. The creation of an inclusive society fosters trust and fosters closer ties among diverse segments of the population. Increased public awareness and understanding of various communities contribute to greater acceptance and respect for their rights and identities.

VIII. HOUSING, EMPLOYMENT AND PRECARITY

(ACCESS AND CONTROL OVER RESOURCES AND OPPORTUNITIES)

While friendly NGOs (community-led organizations or service providers) should be scaled up, they will never be a cure-all for all the challenges faced by key populations. Access to HIV and SRH services is hindered by much deeper societal problems with their roots in poverty, and these problems are more keenly felt by those in key populations who encounter higher levels of stigma and discrimination.

> *"I hardly earn money these days to feed my child and my mother, whenever I need healthcare, I prefer to cure myself by self-medication as nowadays it is so expensive to go to hospital, even checkups cost a lot, let alone medication and surgeries."*
>
> (FGD participant, sex worker, Armenia)

Lack of health insurance, or problems with obtaining it, serves as one of the major limiting factors in trying to access various, especially more specialized health services such as psychological support. Otherwise, the only solution for an individual would be to turn to private clinics for costly care that are unaffordable to most, or receive available services at the friendly NGOs (community-led organizations or service providers). Due to lack of social contributions, health insurance and pension savings, which affects their ability to receive social benefits, entitlements, assistance and protection by the state, sex workers appear to be one of the most vulnerable categories in this respect.

"I can't afford a really good psychotherapist, and I probably don't have one in my town."

(FGD participant, sex worker, Kazakhstan)

Legal protections against stigma and discrimination are a critical element in reducing discrimination. Within the criminalised legal framework of this region, **sex workers** are seen as immoral and deserving of punishment, and therefore denied access to health care, education, and housing. Their **access to housing is additionally influenced by factors such as race, ethnicity, migration status, sexual orientation, gender identity, drug use, and HIV status**.

"As a trans woman engaged in sex work, I often have to rent apartments, but to secure a place to live, I have to conceal my true gender identity and present myself as a man when negotiating with the owner because otherwise I'll be denied housing. There were instances when the owners of the flats, after learning about my gender identity, demanded my eviction."*

(FGD participant, trans sex worker, Armenia)

Similar experiences emerged from the focus group discussion that SWAN community member Amelia Public Association conducted in Kazakhstan, where, again, shifting political and economic contexts such as the war in Ukraine have made key populations more vulnerable to stigma and discrimination:

"It is difficult for sex workers to get housing, and even more difficult for those with migrant status. Due to the military actions of the Russian Federation and Ukraine, rental housing prices have increased 3 times…In order to work and live, sex workers are forced to rent daily or monthly housing. If the landlords find out that there are sex workers in the apartment, they will kick them out immediately."

(FGD participant, sex worker, Kazakhstan)

"During my stay in the Russian Federation, I was a visible migrant due to my poor knowledge of the Russian language. I also had to work unofficially, due to the risk of HIV detection and my subsequent blacklisting in the Russian Federation. Following the adoption of the amendment to the Criminal Code related to HIV restrictions, yet not to jeopardize myself, I was forced to leave the Russian Federation in January 2023. During my stay, I likewise had to hide my sexual orientation and gender identity."

(FGD participant, migrant LGBT person living with HIV, Kyrgyzstan)

The already difficult economic conditions in CEECA compounded by the war in Ukraine, rising authoritarianism and increased militarization in the region create an overall atmosphere of precarity, where those with intersectional identities are more likely to suffer eviction and homelessness. Those with less access to traditional employment due to these same kinds of stigma and discrimination are further incentivized to enter sex work, in turn making their access to basic amenities like housing and health insurance even more precarious. These interviews paint a picture of how life with an intersectional identity plays out in that it is highly complex and individual, subject to many interconnected political and economic factors that compound each other. The net results of this cannot only be examined through the lens of access to SRHR and HIV services.

IX. SELF-IDENTITY, SELF-STIGMA AND INTER-COMMUNITY STIGMA

(AGENCY, COMMITMENT, KNOWLEDGE, AND SKILLS)

Some of the survey respondents also mentioned a problem of internal stigma within their own communities. E.g., **HIV+ MSM might experience a prejudiced attitude within the wider LGBT community, or in some cases even stigmatizing attitudes from NGO staff**. In view of the respondents, this is mainly due to the lack of or low level of knowledge on HIV within communities themselves.

According to the cumulative survey statistics, over 40% of the survey respondents would feel very afraid about disclosing or "coming out" to their friends and/or family if they identify as either SW; gay, bisexual and other MSM; trans* or non-binary person; and/or PWUD. At the same time, over 20% of the survey respondents would feel very comfortable disclosing or "coming out" to others as either lesbian, bisexual and other women who have sex with women, or as PLHIV.

In terms of the acceptance of identity/multiple identities by respondents' partner/family/relatives/friends, the survey results from the following table show somewhat divided opinions. E.g., except in Ukraine where the acceptance rate by others is assessed at 69%, in the rest of the CEECA region full acceptance is rated at 37%, while 42% of the respondents answered that their identity/multiple identities are accepted by others only to a certain extent. On the other hand, over 50% of the survey respondents stated that they would feel very comfortable being around someone else who identifies as either of the majority identity groups.

Throughout the CEECA region, HIV stigma and intersectional stigma are serious obstacles to providing adequate medical care to PLHIV. Key populations that have higher HIV prevalence, such as men who have sex with men, people who inject drugs, transgender individuals, and sex workers, experience additional stigma and discrimination based on their behavior and identities. This contributes to the concentrated HIV epidemics seen in these populations in many CEECA. The stigma is exacerbated by punitive legislation that criminalizes HIV transmission and penalizes sexual orientation, drug use, gender identities, and sex work.

> *"I have wanted to change my documents for a long time, probably about 5 years now. I did not want and I still do not want to undergo a sex reassignment surgery…It is not safe, it will harm my health, and I do not want it in principle. These are the reasons why I can't change my documents. It turns out I have to do what the state wants me to do just to be myself. Doctors say to me, if you want to become a woman, change your sex, do genital correction."*
>
> (FGD participant, tran sex worker, Armenia)

Stigma and discrimination were mentioned in various contexts, including healthcare settings, workplaces, and within families. **Most often it is in the state social and medical institutions, that key populations with multiple identities encounter intolerant attitudes and discrimination**. This social stigma discouraged individuals from accessing HIV and SRH services. Thus, discrimination was identified as a major barrier to self-identification and disclosure of sexual orientation, gender identity and/or HIV status.

CONCLUSIONS AND RECOMMENDATIONS

Understanding of the concept of intersecting identities is still developing. As an illustration of the challenges associated with the issue of intersectionality are the varying perceptions about its relevance among key populations themselves.

Violence, including economic, psychological, physical, and sexual, was highlighted as a prevalent concern among key populations with multiple identities. Stigma and discrimination in society perpetuate violence, making it difficult for individuals to seek help or report incidents. **The cases of violence or domestic abuse were especially emphasized by transgender people who were engaged in sex work**.

Safety and security were also highlighted as a paramount concern, especially for those who were homeless, engaged in sex work, or faced violence at home. **Many key populations with multiple identities emphasized the fact that the lack of security contributes to their increased vulnerability to HIV and other health-related risks**.

Thus, the issue of intersectionality should be explored further as intersecting identities are just beginning to be recognized as challenges, by affected communities, society, and at a legislative/regulatory level. **Key populations with intersectional identities are more likely to experience multiple instances of discrimination than those with singular identities or suffer more intense forms of discrimination that make them even more vulnerable**. Another challenging aspect is that key populations with multiple identities are likely to experience stigma and discrimination within their own groups or communities.

Notwithstanding, the barriers that key populations with multiple identities face in getting healthcare services are dire and unacceptable. **Staff at state clinics who are unfriendly, openly hostile, or even abusive, cause key populations with multiple identities to feel uncomfortable and unsafe using public health facilities**. This, together with disgraceful privacy violations, drives key populations away from accessing critical HIV, SRH, and other related services.

Reflecting upon and summarizing views among key populations related to criminalization, human rights, access to HIV, SRH, and other related services, as well as access to justice and rights-based programming, the following **key recommendations** should be taken into consideration:

I. ACCESS TO SERVICES

(i) Advocate for introducing more comprehensive and inclusive healthcare services that are available, affordable, and accessible to all individuals and communities with multiple identities (e.g. through organizing and conducting capacity-building activities for service providers aimed at understanding the needs of people with multiple identities; introducing changes in the indicators system to allow reporting not only the primary target group but also additional ones; initiating awareness raising activities and joint community trainings for peer-outreach workers from different communities etc.);

(ii) Support community-based healthcare initiatives that offer low-cost or free-of-charge services to those in need;

(iii) Train healthcare providers to increase their competencies in providing inclusive healthcare and offering barrier-free access to services.

II. LAWS AND PRACTICES

(i) Reform laws in a manner that achieves the aim of removing the barriers to enjoying the highest attainable standard of health, including the removal of laws criminalizing same-sex sexual activity, all aspects of sex work, possession of drugs for personal use, gender identity and expression, specific and overly broad criminalization of HIV exposure, non-disclosure and transmission, laws imposing travel restrictions, laws requiring parental or spousal consent to access HIV and SRH services.

(ii) Reform laws in a manner that achieves the aim of removing vagrancy and petty offence laws, and punitive administrative penalties.

(III) Reform laws in a manner that achieves the aim of introducing the concept of hate crime/hate speech.

(IV) Increase access to justice and remedies for violations for all individuals and communities, including by reducing barriers such as cost, lack of legal literacy or legal representation.

(V) Organize and conduct training and awareness-raising initiatives for law enforcement authorities on human rights and non-discrimination.

(VI) Establish mechanisms for reporting and addressing police harassment and violence.

(VII) Advocate for wider use of all available mechanisms for implementing recommendations submitted as a commitment of individual countries to Universal Periodic Review (UPR) and other UN Treaty Bodies.

III. STIGMA AND DISCRIMINATION

(I) Repeal discriminatory laws and policies that increase vulnerability to HIV among key populations.

(II) Develop and implement programs that will reduce stigma and discrimination, taking into account multiple and intersecting forms of discrimination (e.g. based on HIV status, sexual orientation and gender identity, sex work, substance use, etc.).

(III) Raise awareness about the impact of stigma and discrimination on HIV and SRH service provision, by conducting anti-stigma campaigns in healthcare settings, workplaces, and within communities themselves.

(IV) Develop and implement anti-discrimination legislation, by recognizing and introducing gender identity as a prohibited ground for discrimination.

IV. VIOLENCE

(i) Design tailor-made interventions aimed at preventing and responding to gender-based violence and its interlinkages with HIV.

(ii) Establish redress mechanisms to address violence against key populations and people living with HIV and provide justice.

(iii) Apply a gender transformative approach by transforming harmful gender norms and masculinities that undermine the health and well-being of all individuals and communities with multiple identities.

V. SAFETY AND SECURITY

(i) Collaborate with local organizations and governments to establish shelters for survivors of gender-based violence, as well as safe spaces and harm reduction programs tailored to the specific needs of the key populations.

(ii) Develop adequate social and subsidized housing programs that take into account the specific needs of the key populations and people living with HIV, yet primarily target homeless individuals within these communities.

VI. INTERSECTIONALITY

(i) Recognize and embrace intersectionality as a fundamental aspect of human experiences and identities. Service providers, NGOs, and human rights advocates should tailor their efforts to address the unique challenges faced by individuals and communities with multiple identities.

(ii) Promote research and data collection that highlights the layered impact of stigma and discrimination on individuals and communities with multiple identities.

VII. NGO APPROACHES

(i) Strengthen the capacity of NGOs (community-led organizations and service providers) to provide comprehensive support, including legal and psychosocial services to the key populations, by respecting their dignity and being responsive to their needs.

(ii) Involve key populations and people living with HIV in the organization's activities (service planning and quality assurance), and build their capacities through volunteering and engagement.

(iii) Reach key populations in their diversity, set targets (based on local health and social specifics), and foster collaboration and coordination among NGOs (community-led organizations and service providers) to ensure a holistic approach to addressing the multifaceted challenges faced by individuals and communities with multiple identities.

(iv) Develop tools and set of best practices for larger and better community involvement (where missing), to ensure their needs are fully met.

(v) Support community-led research initiatives to gather data on the specific needs and challenges of individuals and communities with multiple identities, thus use the data gathered to inform evidence-based programs and policies aimed at improving the everyday lives of key populations.

(vi) Explore alternative financing mechanisms to ensure the sustainability of the programs for a successful transition from GFATM and other donor support to reliance on national funding.

SWAN
SEX WORKERS' RIGHTS ADVOCACY NETWORK

ehra
eurasian harm reduction association

ECOM

Eurasian Women's Network on AIDS