NATIONAL REPORT

2023

GENDER ASSESSMENT OF THE NATIONAL HIV RESPONSE

REPUBLIC OF KAZAKHSTAN


СТОП СТИГМА
Бюро в Алматы

AUTHORS AND ACKNOWLEDGEMENTS

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CONTENTS

ABBREVIATIONS AND ACRONYMS

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral (medicine)
CAAPL	Central Asian Association of People Living with HIV
CCM	Country Coordinating Mechanism
CEDAW	United Nations Committee on the Elimination of Discrimination Against Women
HIV	human immunodeficiency virus
HPV	human papillomavirus
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
IVF	in vitro fertilization
KP	key population
MSM	men who have sex with men
MTCT	mother-to-child transmission (of HIV)
NGO	non-governmental organisation
OAMT	opioid agonist maintenance therapy
PEP	post-exposure prophylaxis
PrEP	pre-exposure prophylaxis
PMTCT	prevention of mother-to-child transmission of HIV
PWID	people who inject drugs
SRH	sexual and reproductive health
STI	sexually transmitted infection
SW	sex workers
TG	transgenders
WHO	World Health Organization
UNAIDS	Joint United Nations Programme on HIV/AIDS
YHC	youth health centres


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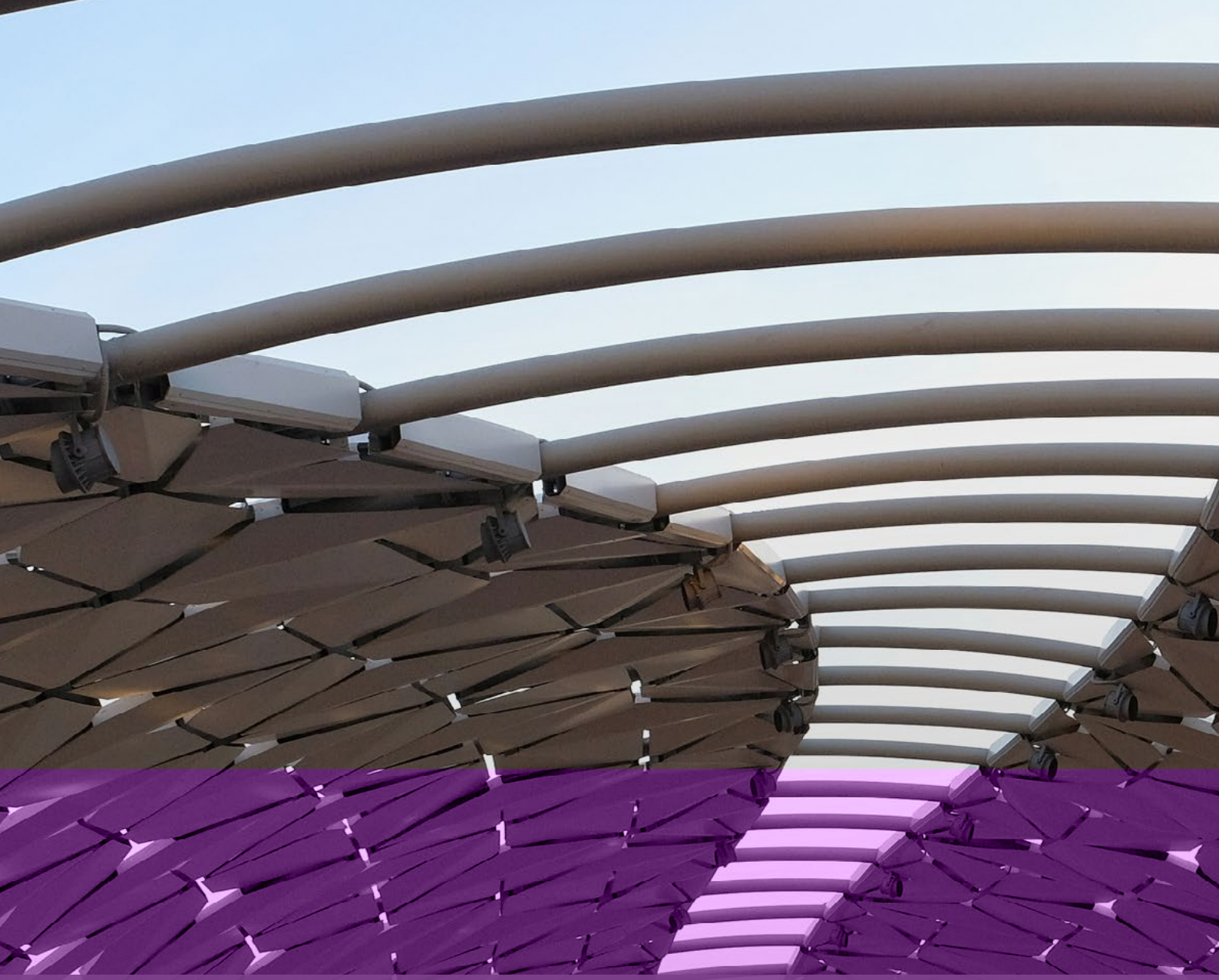
INTRODUCTION

In 2023, a gender assessment of the HIV response was carried out in Kazakhstan using the UNAIDS tool's methodology. The assessment was performed by a national consultant in a desk review format featuring interviews, focus groups with NGOs, key populations, and PLHIV representatives. The UNAIDS regional and national office offered technical support to complete the gender report. The following aspects of the response were examined from a gender perspective: epidemiology, prevention, health and social services, sexual and reproductive health, discrimination, women's status, gender-based violence, and civil society participation.

It is important to acknowledge that the Republic of Kazakhstan has made progress towards bringing its laws regarding the adoption of children by people living with HIV up to par with international norms.

Gender-specific interventions should be incorporated into Kazakhstan's current HIV prevention and treatment policies and programmes in order to establish a gender-transformative, equitable, and rights-based HIV response.



1. HIV EPIDEMIC IN THE REPUBLIC OF KAZAKHSTAN

In Kazakhstan, HIV is primarily transmitted among key populations. 74.7% of HIV cases are transmitted through sexual contacts. 66.8% of cases amount to sexual transmission through heterosexual contacts, compared to 7.9% through homosexual contacts. The share of parenteral transmission of HIV through injecting drug use is decreasing from year to year, totalling 20.3% in 2022.

38 600

Estimated number of people living with HIV in Kazakhstan

1 .1 PREVALENCE

HIV prevalence among key population groups is as follows: 1.4% in SW (2021), 6.9% in MSM (2021), and 7.6% in PWID (2022).

The total number of people living with HIV who died in 2022 from AIDS-related causes was 178; among them, 104 were men, 74 females, one child under the age of 15, and 177 children older than 15 years of age[1].

It is noteworthy that the majority of newly diagnosed cases in 2022 accounted for the age group of 20–60 years (see graph):

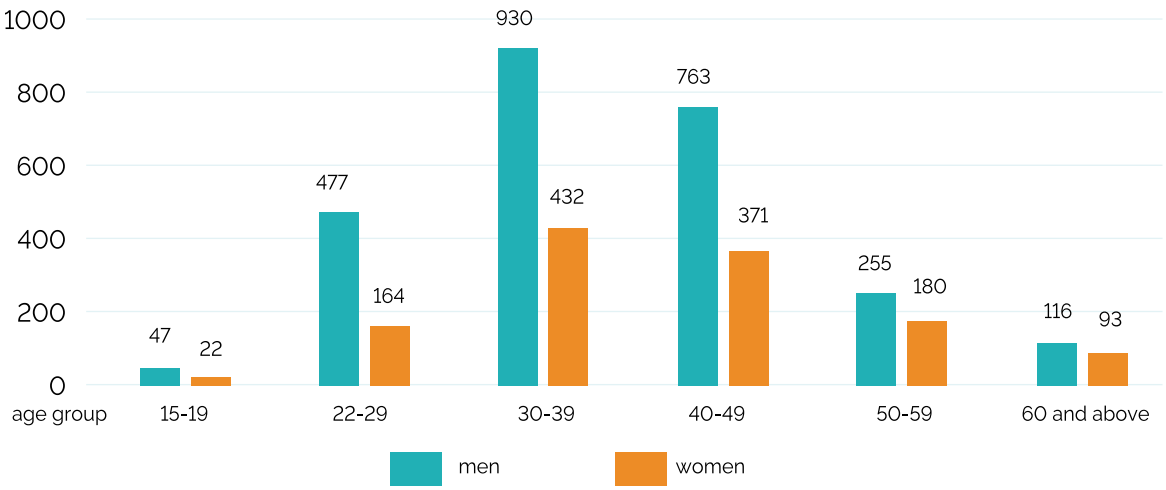
- 35.1% (11.14% of women) aged 30–39
- 29.2% (9.5% of women) aged 40–49
- 16.5% (4.2% of women) aged 20–29
- 11.2% (4.6% of women) aged 50–59
- 5.4% (2.4% of women) aged 60 and above
- 1.8% (0.6% of women) aged 15–19

178

Total number of AIDS-related deaths in 2022

FIGURE 1

Age and sex of new HIV cases in 2022 in the Republic of Kazakhstan



The majority of those diagnosed in 2022 were not working (50.5%), of whom 18% (701) were women. 38.8% of PLHIV were employed, of whom 11.14% (432) were women. Pensioners (3.7%), of whom 1.8% (71) were women, ranked third in terms of social standing. The main mode of HIV transmission in 2022 was sexual transmission through heterosexual contacts (66.8%), and this trend has been maintained for more than 5 years. Injection drug use accounted for 20.3% of the second most common mode of HIV transmission. Sexual transmission of HIV through homosexual contacts accounted for 7.9%.

Regarding the distribution of HIV cases among women, the general pattern is still the same: heterosexual transmission (85%) and HIV transmission through injection drug use (9%) are the most prevalent modes of transmission.

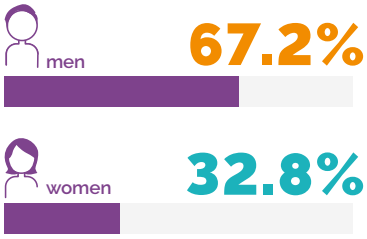
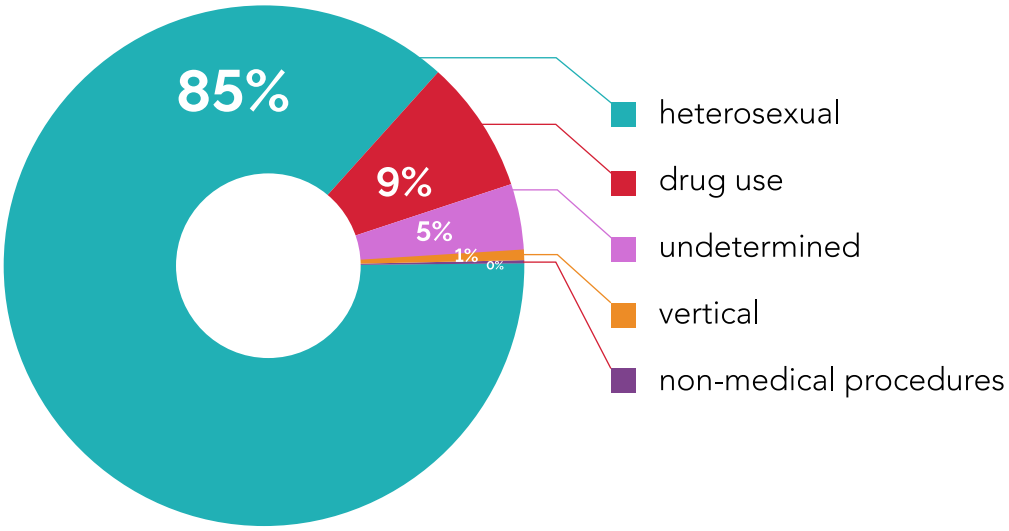


FIGURE 2
Distribution of HIV cases by modes of transmission in 2022



The preliminary findings of the 2022 study on the time of infection showed that among key populations, men who have sex with men had the largest percentage of recent HIV infections (32%), followed by people who inject drugs (20.4%) and sex workers (11%).

1.2 POPULATION SIZE

The sizes of key populations are estimated every two years: in odd-numbered years, sex workers (hereinafter referred to as SW) and men who have sex with men (referred to as MSM); in even-numbered years, people who inject drugs (hereinafter referred to as PWID) are estimated. The latest estimates of key population size as of 2021–2022 are: SW – 21,800 (2021); MSM – 62,000 (2021); and PWID – 79,900 (2022).

1.3 INCIDENCE

TABLE 1

HIV incidence in the 15–49 age group during the 12 months of 2021–2022 in the Republic of Kazakhstan

Regions	HIV incidence rate in the age group 15–49 years for 12 months 2021 (%)	HIV incidence rate in the age group 15–49 years for 12 months of 2022 (%)	Detected in 12 months of 2021 among the age group 15–49 years old (abs.)	Detected in 12 months of 2022 among the age group 15–49 years (abs.)
Abay	0.00	0.02	34	49
Akmola	0.03	0.03	94	92
Aktobe	0.01	0.02	51	67
Almaty	0.02	0.03	182	215
Atyrau	0.01	0.02	36	56
East Kazakhstan	0.05	0.10	283	324
Zhambyl	0.01	0.02	52	102
Zhetysu	0.00	0.03	60	83
West Kazakhstan	0.03	0.03	81	88
Karaganda	0.05	0.07	328	388
Kostanay	0.06	0.05	236	219
Kyzylorda	0.01	0.01	25	35
Mangistau	0.02	0.02	62	64
Pavlodar	0.06	0.06	210	213
North Kazakhstan	0.06	0.04	145	97
Turkestan	0.01	0.01	72	89
Ulytau	0.00	0.02	9	17
Almaty city	0.04	0.05	484	564
Astana city	0.05	0.05	303	314
Shymkent city	0.02	0.02	124	131
Total	**0.03**	**0.04**	**2871**	**3207**

In Akmola, West Kazakhstan, Kyzylorda, Mangistau, Pavlodar, Turkestan regions, Shymkent and Astana cities, the incidence remained at the same level. In Kostanay and North-Kazakhstan regions, the incidence decreased.

In other regions, the incidence increased by 0.01–0.02%. The area of East Kazakhstan was the exception, where there was a brief rise in incidence of 0.05%.

1.4 TREATMENT

As of December 31, 2022 the share of PLHIV receiving ART was 84% or 25,642 PLHIV including 292 children. Of these, 8,717 women and 11,956 men achieved undetectable viral loads. ART efficacy was 87%, or 20,673 PLHIV.

TABLE 2

Compared ART coverage and adherence rates among key populations

Key populations	Number of PLHIV in key populations	Number of people of key populations in ART	Percentage of people in ART last 12 months	Detected in 12 months of 2022 in population of 15–49 years
SW	327	234	**72%**	49
MSM	1566	1411	90%	92
PWID	9618	7859	82%	67
transgenders	14	11	79%	215
prisoners	1461	1372	**94%**	56

Thus, the data in Table 2 shows that the group least covered by ART are sex workers (72%), of whom more than 95% are women. The highest ART coverage is among prisoners; 95% or more of this group are men.

TABLE 3

People living with HIV receiving ART in the last 12 months

PLHIV among KP	Number of PLHIV among KP	Number of people from key populations in ART	Percentage of people in ART last 12 months
Women	9841	8717	**89%**
Men	13915	11956	86%
Prisoners	1273	990	78%
PWID	7256	6165	85%
SW	225	193	**86%**
MSM	1246	1120	**90%**
TG	10	8	**80%**
Pregnant women	165	148	**90%**

When comparing the two tables (#2 and #3), the following conclusions can be drawn: the

MSM group and pregnant women are the most adherent to ART, with women ranking second in terms of adherence. Men and sex workers rank third in adherence, their share is 86%. The number of PLHIV who, 12 months after ART initiation, were receiving treatment was 3 358 (85%), and the number of PLHIV who initiated ART 12 months before was 3 968. The data is relevant to the end of 2021.

According to the Kazakh Scientific Centre for Dermatology and Infectious Diseases, men stay in ART longer than women.

The preferred ART regimens are TDF+3TC (or FTC) + DTG (tenofovir+emtricitabine+dolutegravir). DTG can be used by women and adolescent girls of reproductive age, provided they are informed about the benefits and risks of the drug[2].

SECTION CONCLUSIONS

1. Epidemiological data collection is not always sex-disaggregated among people who inject drugs, sex workers, and incarcerated populations, making it difficult to analyse the current situation for girls and women, and therefore planning programmes for this group becomes more challenging.

2. Antiretroviral therapy coverage among sex workers is lower (72%) than for other key populations.

2. HIV PREVENTION

2.1 LAWS REGULATING HIV PREVENTION IN THE REPUBLIC OF KAZAKHSTAN

Access to HIV prevention and harm reduction programmes for key populations and the general population is regulated by several legislative acts:

- **The Health Code[3].** The legislation governs a wide range of activities: informing various population groups about HIV infection through informational materials, social networks, and mass media; integrating HIV prevention topics into the education system and addressing them at workplaces; providing key populations with treatment and prevention services at drop-in centres and friendly waiting rooms; preventing mother-to-child transmission of HIV; providing pre-exposure and post-exposure prophylaxis; and providing ART.

- Law of the Republic of Kazakhstan "On Narcotic Drugs and Measures to Counteract Their Illicit Trafficking and Abuse"[4].

- Order of the Ministry of Health of the Republic of Kazakhstan No. KR DSM-224/2020. "On Approval of the Standard of Organisation of Medical and Social Care in the Field of Mental Health to the Population of the Republic of Kazakhstan"[5].

- Order of the Ministry of Health of the Republic of Kazakhstan No. KR DSM-137/2020 "On Approval of the Rules for Arranging HIV Prevention Activities»[6].

Codes and laws do not reference OAMT (Opioid Agonist Maintenance Therapy). Information about OAMT is contained only in the subordinate legislation[7] and the roadmap[8].

2.2 POPULATIONS COVERED BY THE NATIONAL HIV RESPONSE

- **Women who use drugs receive services[9],** through programmes for PWID services. There are no dedicated gender-specific services. PWID can use syringe exchange points to obtain sterile syringes and condoms.
- **Sex workers** are included in prevention programs. There are trust points for this group, where free STI screening and treatment and condoms are available. Male condoms are available through pharmacy networks in all 20 regions of the Republic of Kazakhstan.
- **Women living with HIV** receive services through general programmes for PLHIV; no dedicated gender-specific services are provided.
- No special services for **people with disabilities** are envisaged..

Prevention of mother-to-child transmission of HIV is specified in the Health Code (Paragraph 7, Article 99) and in the subordinate legislation[10]. At the same time, PMTCT services can be received not only by women permanently residing in the territory of the Republic of Kazakhstan (having a certificate or residence permit), but also by female migrants: "Foreign women living with HIV have the right to free testing before and during childbirth. In cases of a positive PCR test result (HIV RNA) in pregnant women in the third trimester, ARV therapy is prescribed free of charge. After delivery, the mother living with HIV and the child are followed up at the AIDS Centre. However, the child is followed-up and examined regularly free of charge up to 18 months or up to two years of age, depending on the

results of HIV testing. A woman is examined and receives ARV only if she is a citizen of the Republic of Kazakhstan, a refugee, a foreign citizen, or a stateless person permanently residing in the territory of the Republic of Kazakhstan"[11].

If HIV is detected during pregnancy, pregnant HIV-positive women continue ART after delivery.

Children born to mothers living with HIV have the right to receive free adapted milk formula in accordance with established nutritional norms[12]. The legislation of the Republic of Kazakhstan does not specify separate norms that take into account the gender specificities of adolescent girls in the framework of HIV response.

National prevention programmes do not address specific gender issues in relation to women living with HIV, drug users, and female sex workers. Programmes aimed at reducing stigma and discrimination are also not gender-sensitive and are only implemented within some international organisations' projects.

Gender-sensitive programmes exist only for pregnant women living with HIV to prevent mother-to-child transmission of HIV. There are no links to programmes addressing violence and women's rights. The HIV roadmap does not include items on gender-based and sexual violence. All expenditures on the programme for prevention of mother-to-child transmission of HIV are provided for in the state's budget as part of the HIV roadmap.

In general, the relevant organisations of the Republic of Kazakhstan (the Kazakh Scientific Centre of Dermatology and Infectious Diseases, the Ministry of Health) use the Political Declaration on AIDS, as well as WHO recommendations, to introduce new practices and policies to reduce the burden of HIV infection in the country. As for non-core organisations and departments (Ministry of Social Protection, Ministry of Internal Affairs, the Committee of Criminal Executive System, etc.), the introduction of innovations is much slower and requires greater efforts from both civil society and the core organisations.

2.3 HIV TESTING

Г Citizens of the Republic of Kazakhstan, kandases[13], foreigners, stateless persons, refugees, and asylum seekers permanently and temporarily residing in the territory of the Republic of Kazakhstan have the right to voluntary, anonymous, and/or confidential medical examination and counselling on HIV issues[14]. There is no information that HIV testing should be exclusively voluntary, but mandatory confidential HIV testing is stipulated by law.

The obligation to test for HIV before marriage is not stipulated in the legislative framework of the Republic of Kazakhstan.

The 'Health Code' prohibits employers from requesting HIV testing results, with the exception of medical professionals who are exposed to blood, other biological fluids, and biomaterials, and therefore are required to undergo preliminary and periodic medical check-ups[15]. However, there are certain regulations in Kazakhstan's legislation that provide for mandatory testing of law enforcement personnel, the military, and some other categories of civil servants (for more information, see the discrimination section).

According to the Law of the Republic of Kazakhstan "On Migration"[16] and the rules for obtaining a residence permit[17], HIV testing is not mandatory. HIV infection is also not specified as a reason for refusal of a residence permit in the Republic of Kazakhstan. Thus, even if the migration officer requests additional documents (an HIV test), legally the presence of HIV infection cannot be a reason for refusal. In fact, unfortunately, the presence of HIV infection can greatly delay the process of obtaining a residence permit. HIV testing is mandatory for the following groups[18]:

- donors of organs (part of an organ) and (or) tissues (part of a tissue), germ cells;
- recipients of biological material;
- persons on haemodialysis;
- sexual partners of HIV-infected persons and partners in joint injection drug use;
- key populations seeking care from health care providers; people who inject drugs;
- people under arrest and convicted persons upon admission to pre-trial detention centres and penal institutions (twice);
- children born to HIV-infected mothers, or mothers with undetermined HIV status;
- Individuals who have been affected by an emergency;
- medical workers who performed invasive methods of diagnostics and treatment;
- military personnel serving in state aviation or territorial defence, internal affairs, national security, other troops, and military formations of the Republic of Kazakhstan, as well as those entering military service under contract and conscription, including applicants to military educational institutions;
- pregnant women;
- persons at the request of the prosecutor's office, investigation, and/or court;
- sexual partners of a pregnant woman;
- persons from a nosocomial focus;
- children under 16 years of age when their mother is identified with HIV, when HIV is detected in children under 16 years of age, to identify cases of infection in a woman in the postpartum period with a risk of infecting a breastfed baby.

The law stipulates administrative responsibility for test avoiders[19].

2.4 USE OF CONDOMS AMONG KEY POPULATIONS

TABLE 4

Condom use among key populations

Populations	2022	2018	2013
PWID	69	61	**71**
SW	170	398	**390**
MSM	153	183	**194**
TG	269	no data	**no data**

* Number of condoms distributed per person covered by prevention programmes

SEX WORKERS

In 2021, the sample size was 3 256 sex workers. The share of sex workers who indicated that they had used condoms, was the following:

- 96.4% during sexual intercourse with their last client in the Republic of Kazakhstan
- increased from 88.6% in 2019 to 97.1% in 2021 during their most recent sexual intercourse with a commercial partner (2021 survey)
- decreased from 73.6% (2019) to 67.9% during the most recent sexual intercourse with an occasional partner (2021 survey)
- also decreased compared to 2019 from 60.3% to 45.2% during the last sexual intercourse with a regular partner[20].

PEOPLE WHO INJECT DRUGS

The percentage of people who inject drugs reporting the use of a condom in 2020:

- 30.6% (1,195 out of 3,905) the last time they had sexual intercourse with a regular partner
- 40.3% (1,574 out of 3,905) the last time they had sexual intercourse with an occasional partner
- 94% (268 out of 285) the last time they had sexual intercourse with a commercial partner[21].

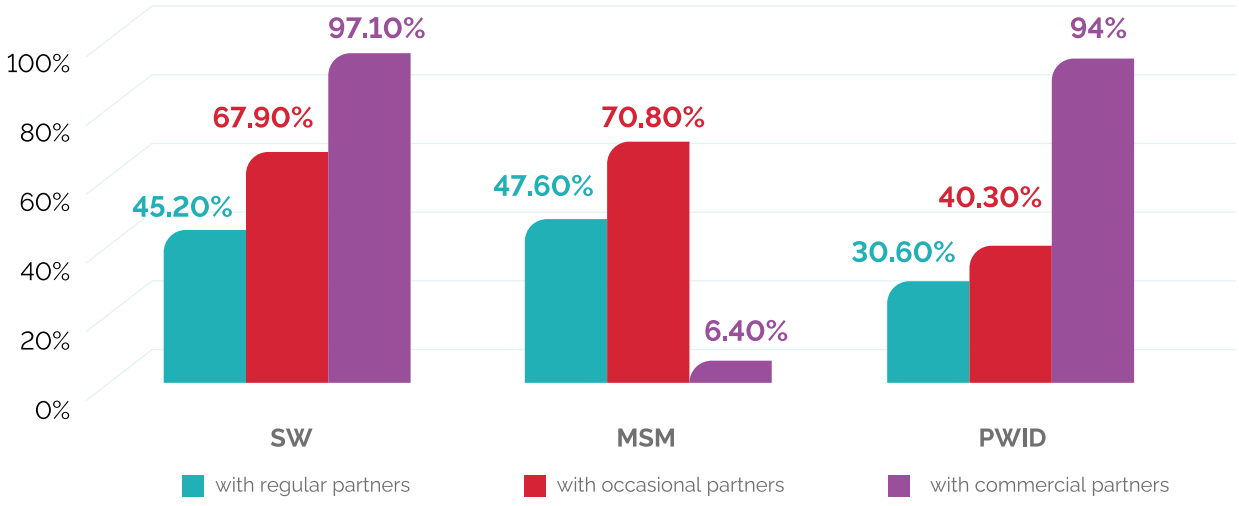
MEN WHO HAVE SEX WITH MEN

In 2021, the sample size was 1,308 men who have sex with men. Percentage of men who have sex with men reporting the use of a condom:

- 47.6% of men who have sex with men used a condom the last time they had sexual intercourse with a regular male partner (compared to 48.6% in 2019)
- 70.8% used a condom the last time they had sexual intercourse with an occasional male partner (compared to 62.9% in 2019)
- 7.1% used a condom with a commercial male partner (compared to 6.1% in 2019)
- MSM who used condoms the last time they had sexual intercourse with a woman:
- 23.2% with regular partners
- 55.8% with occasional partners
- 6.4% with commercial partners.

FIGURE 3

Condom Use



YOUNG WOMEN (15-24 YEARS OLD)

A 2018 UNFPA study shows that among the 4,360 young people surveyed, 80.4% used condoms the last time they had sexual intercourse[22].

COVERAGE OF KEY POPULATIONS BY HIV PREVENTION PROGRAMMES

There is no data available for the Republic of Kazakhstan that breaks down the population by age and sex in all of its regions. Notionally, all MSM are men; the percentage of women among sex workers is 95% or higher.

TABLE 5

Key population's coverage of by HIV prevention programmes

Year	2022			2018	2013		2013		
Population	Est. size [23]	Covered by PP	%	Est. size	Covered by PP	%	Est. size	Covered by PP	%
PWID	85 300	53 153	62	12 050	55 968	4	11 2740	89 490	79
SW	21 500	18 373	85	18 350	16 882	92	19 943	18 561	93
MSM	62 000	15 071	24	62 000	8 590	14	28 840	10 000	35
TG [24]	233								

PP – prevention programmes

PEOPLE WHO INJECT DRUGS[25]

HIV testing coverage (UNGASS indicator) was defined as the proportion of PWID who have been tested for HIV in the last 12 months and know their results. The weighted average indicator of coverage of female PWID in the Republic of Kazakhstan was 79.1%. In the majority of sentinel sites (15 out of 21) coverage of women is higher than coverage of men. According to the 2020 epidemiological surveillance of the HIV prevalence data, the coverage of PWID with prevention programmes in the sample was 63.1%. The average coverage of female PWID in the Republic is 71.2%.

In 2020, the proportion of PWID who reported using sterile injecting equipment in the last month was 62.2% (2657 out of 4269 PWID who injected drugs in the last 30 days). In 2020, among female PWID of the Republic of Kazakhstan, the prevalence of safe injecting drug use was 62.3%.

According to the Republican Scientific and Practical Centre for Mental Health[26], in 2022, out of 11,625 PWID, 2.9% (342 PWID) were on opioid agonist maintenance therapy.

In 2020, of the total number of patients enrolled in OAMT programmes, 20% were female and 80% were male; 31.7% were 40–44 years old, with a median age of 43.3 years. The number of OAMT clients with a confirmed HIV diagnosis increased from 28.2% in 2016 to 40% in 2020. The number of PLHIV in the programme was 112, of whom 98 (87.5%) were in ART[27]. 25 women living with HIV were receiving OAMT (100% of all PLHIV receiving OAMT)[28].

In the 2020 sample of PWID, 8% (380 out of 4761) reported having STI symptoms in the previous six months. Of the 380, PWID with STI symptoms under 25 years were 6.3% (24 persons), 93.7% (356) were aged 25 and above, and 33.2% (126) were female. Among 380 PWID with STI symptoms, 6.8% (26) had a positive test for syphilis, 7.6% (29) had HIV, and 53.9% (205) had tested positively for hepatitis C. Of those with STI symptoms, 286 out of 380 PWID, or 75.3%, sought medical attention from health care providers. 12.9% were self-treated (49), 11.6% remained untreated (44), and 0.3% did not respond to the question (1). Of the 286 who sought treatment for STI, 6.9% of PWID (20) visited an STI clinic, 67.6% (194) visited a dermatology clinic, 12.5% (36) saw a private doctor, 6.3% (18) talked to a familiar health worker, 6.3% (18) saw a urologist/gynaecologist, and 0.4% gave other answers (1). This illustrates why "PWID-friendly waiting rooms" are needed. 24.7% of PWID (94 out of 380) did not seek treatment for STI symptoms in medical organisations[29].

SEX WORKERS[30]

The largest percentage of sex workers covered by preventive programmes nationwide is 93.2% for condom distribution, and the smallest percentage is 2% for syringe and needle distribution, due to lower uptake in this population. 91.8% of the sex workers who were surveyed were involved in preventive programmes, meaning that situation has essentially improved since the 2019 round of epidemiological surveillance of HIV prevalence (compared to 86.6% baseline).

In 2021, 59.3% of sex workers under 25 who had STI symptoms went to a healthcare facility for treatment (compared to 87% in 2019). In 2021, 66.2% of sex workers 25 years of age and older reported having STI symptoms and were referred to a doctor (compared to 91% in 2019). Out of the 592 sex workers seeking treatment for sexually transmitted infections, 6.4% (38) went to a STI clinic, 66.9% (396) went to a dermatology clinic, 14.2% (84) saw a private doctor, 2.5% (15) went to a known health worker, 8.9% (53) went to a gynaecologist/urologist, and 1% provided alternative answers (6). This illustrates why sex workers need "friendly waiting rooms". 34.8% of PWID (316 out of 908) did not seek treatment for STI symptoms at medical organisations[31].

Additionally, sex workers reported forced testing in the course of coordinated raids by law enforcement officers and the AIDS Centre[32].

PEOPLE IN PRISONS OR OTHER CLOSED SETTINGS

As of January 1, 2023 the Republic of Kazakhstan planned to completely transfer prisoners' health care into the public health care system[33]. Previously, care to prisoners living with HIV in correctional institutions was provided on a quarterly basis by regional AIDS centres, as well as by local NGOs working on specific projects of international organisations. The statistical data indicates that prisoners are a distinct population in terms of new cases and social status of PLHIV; however, they do not have access to any specific preventive programmes.

2.5 PRE- AND POST-EXPOSURE PROPHYLAXIS

Since July 2021, the country has been implementing a programme to provide pre-exposure prophylaxis for HIV prevention (PrEP or PEP) to those in need from all populations living with HIV. For the year 2022, 908 clients of "friendly waiting rooms" received pre-exposure prophylaxis for HIV, of which 26% were covered by intermittent PrEP and 74% by a continuous PrEP regimen. Of the total number of people who received PrEP, 27% were women, 73% were men, 97% were in the age group of 15–49, including 68% from the risk group (men who have sex with men). The PrEP coverage among MSM was 1% of the estimated number[34].

In 2022, post-exposure prophylaxis was provided to 383 individuals who had been exposed to HIV infection. 98% of those in need received preventive care.

PMTCT

For the 12 months of 2022, 406,739 pregnant women were listed in the Register of Pregnant Women and Women of Childbearing Age[35]. Their coverage of HIV testing amounted to 99.6% in the Republic of Kazakhstan. The coverage of women at each stage of PMTCT in 2022 was as follow[36]:

- twice: once upon registering for pregnancy and once at 28–30 weeks; 445 507 tests (under code 109.1)
- before termination of pregnancy in case of abortion, spontaneous miscarriage, or frozen pregnancy; 59 802 tests (under code 109.4)

- 6,102 tests were performed on those admitted to obstetric organisations for delivery without the results of double HIV testing (under code 109.3)
- examined once more than three weeks before admission to labour and delivery units; 399,612 tests (under code 109.2) were carried out
- women who gave birth outside of obstetric care organisations
- women from key populations

1,339 pregnant women living with HIV were not registered at the antenatal clinics: 214 home births were reported, and 30 women had been registered for primary care but not examined. Name-based monitoring of HIV screening for pregnant women has been introduced.

In the 12 months of 2022, the number of births among HIV-infected women was 469, there were twelve babies born with HIV, and the risk of perinatal transmission was 2.6%. 98.9% of women living with HIV received antiretroviral drugs to reduce the risk of mother-to-child transmission of HIV in 2022.

In 2021, there were 486 women living with HIV who received drugs to reduce the risk of mother-to-child transmission of HIV[37], 7 cases of mother-to-child transmission were recorded (1.4% of the total number of pregnant women living with HIV).

In 2022, 192 pregnant women living with HIV were newly diagnosed in the Republic of Kazakhstan, 8 of them were PWID. 353,915 births were registered nationwide in total.

NEWLY DIAGNOSED CASES BY AGE GROUPS (192):

15–19 years: 4 cases (2.1%), in 2021: 16 (8.6%) decrease by 12 cases;

20–29 years: 71 cases (37.0%), in 2021: 77 (41.4%), decrease by 6 cases;

30–39 years: 102 cases (53.1%), in 2021: 83 (44.6), increase by 18 cases;

40–49 year: 15 cases (7.8%), in 2021: 10 (5.4%), increase by 5 cases.

The PLHIV community participates in peer counselling initiatives to improve adherence to PMTCT therapy[38]. There are no specific PMTCT protocols that address the need for social support for women who use drugs and sex workers under PMTCT programmes.

"Breastfeeding is not recommended. In case a woman insists on breastfeeding, increased monitoring of clinical and virological parameters of both mother and infant is recommended"[39].

If a woman living with HIV decides to breastfeed without taking ARVs, she may be prosecuted under the criminal law for endangering infection and direct transmission of HIV infection to a minor when approached by the AIDS Centre or other interested parties[40].

From the reports of women living with HIV: "At the beginning of the year, we frequently see interruptions in the delivery of food for babies. There is only one sort of formula available, with no choice[41].

Sexual partners of pregnant women are tested once when a pregnant woman is linked to care[42]. At the end of 2022, 70.6% (285715) of sexual partners were tested, which contributed to the detection of 129 new cases of HIV infection. Of the 129 partners, 86 had negative test results. PrEP was prescribed to 50 women out of 86 (58.1%). In other cases, barrier contraception and monthly follow-up at the AIDS centres were recommended.

2.6 COSTS OF PREVENTION PROGRAMMES

2022 costs:

– 22,539,189,640.00 million tenge from the Republican budget (88.8%)

– 2,246,361,453.70 million tenge from international donors (11.2%), including

– 731,000,000.00 million tenge (25.4%) from GFATM

TABLE 6

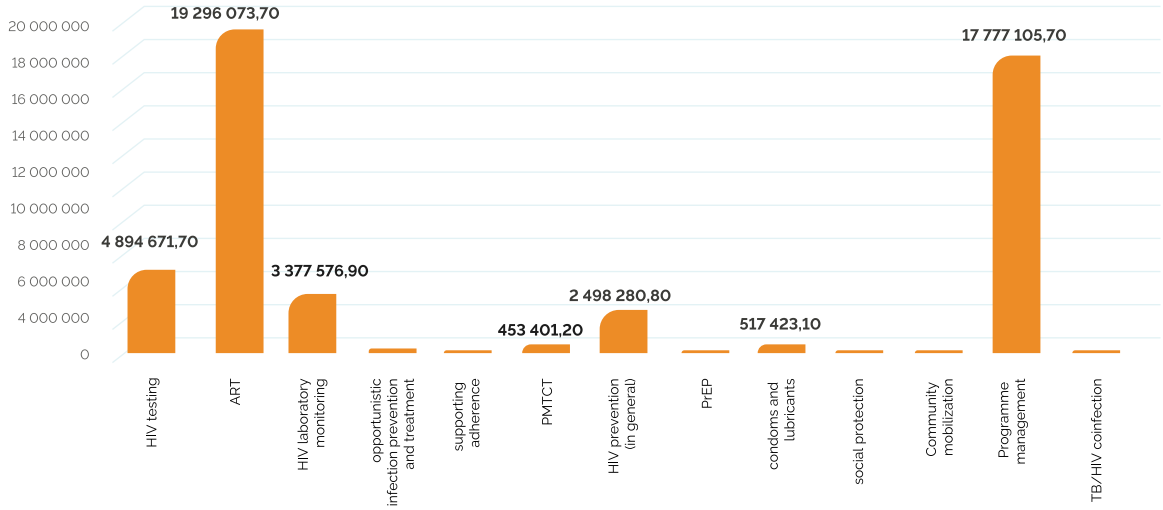
Spending on prevention programmes in 2022

N°	Activities	Budget of the Republic of Kazakhstan (in Kazakhstani tenges)	Budget of the Republic of Kazakhstan (in US dollars)	Indicator of government's HIV budget execution
1	Treatment, care and support costs	12 857 599 610.00	27 922 167.3	99,6%
	HIV testing and counselling costs	2 253 898 426.00	4 894 671.7	
	Antiretroviral therapy costs	8 885 456 000.00	19 296 073.7	
	HIV laboratory monitoring costs	1 555 306 626.00	3 377 576.9	
	Costs on prevention and treatment of opportunistic infections	113 873 556.00	247 293.2	
	Costs on supporting adherence to treatment	49 065 000.00	106 551.9	
2	PMTCT	208 782 184.00	453 401.2	100%
3	HIV prevention	1 150 408 350.00	2 498 280.8	100%
	PrEP costs	16 024 983.20	34 800.6	
	Costs of condoms and lubricants	238 263 000.00	517 423.1	
4	HIV social protection	73 896 000.00	160 476.0	100%
5	Community mobilization	49 642 361.44	107 805.7	100%
6	Programme management	8 186 001 616.00	17 777 105.7	99,2%
7	TB/HIV coinfection, diagnosis and treatment	12 359 520.00	26 840.5	100%

Upon closer examination, it can be noted that the major share of costs is for the procurement of ART, followed by the costs of diagnostics, both for the general population and for HIV monitoring and treatment, prevention programmes, and other costs.

FIGURE 4

The Republic of Kazakhstan's 2022 state budget expenditures in dollars

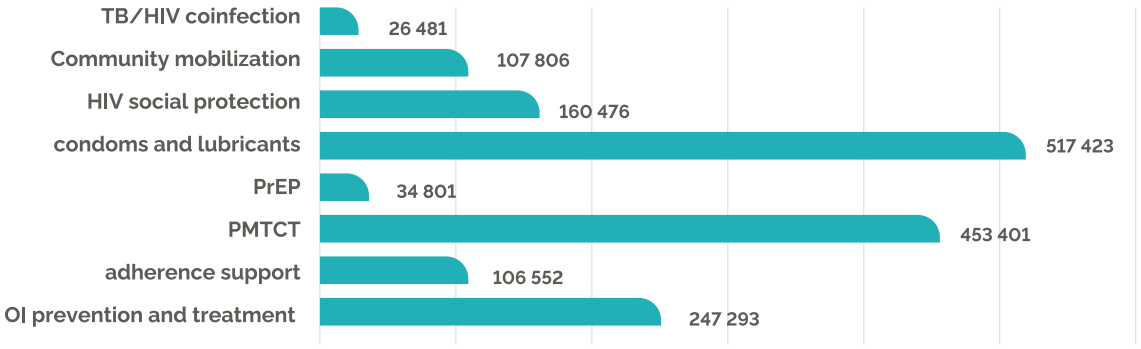


For better understanding, another graph is given, without indicating the biggest costs. The data presented clearly show that the costs of materials (condoms and lubricants) are once again the highest. They are followed by costs for PMTCT and the treatment of opportunistic infections. There is no budget line item for gender-specific services; the sole "women-only" service is PMTCT, which focuses on one of women's functions—giving birth to healthy children.

All other items contain data on costs "as a whole", without a breakdown by gender.

FIGURE 5

The Republic of Kazakhstan's 2022 state budget expenditures



OI — opportunistic infections

SECTION CONCLUSIONS

1. Information on OAMT is only contained in subordinate legislation.

2. The applied HIV prevention programmes are developed without regard for the gender-specific needs of female key populations (PWID, SW, PLHIV), and adolescent girls living with HIV.

3. There are no specific guidelines on social support for the prevention of mother-to-child transmission of HIV, which would take into account the needs of women who use drugs and female sex workers. It is necessary to specify methods of labour pain management for women who use drugs and pain management for females with drug addictions.

4. The task of implementing recommendations of the Political Declarations on AIDS is not prioritised by non-core ministries, special social services and care organisations, and the correctional institutions. Legislative reforms in non-core ministries necessitate many years of labour and huge efforts from communities, state agencies, international organisations, and the United Nations.

5. Surveys and reporting documents on key populations typically lack sex-disaggregated data, making it impossible to analyse the current situation for women in key populations. Implementing gender-sensitive services without understanding statistics on women in key populations is ineffective.

6. Despite all of the efforts to promote condom use, many populations continue to engage in risky behaviour. New approaches must be developed, such as expanding the PrEP programme among key populations, to curb the HIV epidemic.

7. The number of women on PrEP is insufficient (27%), the PrEP programme for women needs to be expanded.

8. It is critical to expand index testing programmes for MSM/PLHIV clients given the low rates of condom use in the MSM group by both men and women. The only prevention programmes "for women" that exist are the prevention of mother-to-child transmission of HIV, which focuses on a woman's reproductive functions, "carrying and giving birth". But, even in this case, the programmes address only preventive issues (prevention of HIV transmission), without taking into account the needs of women (lactation cessation, psychological support). It is necessary to introduce programmes to support pregnant women with HIV, and to ensure their access to cost-free lactation cessation.

9. Taking into account the percentage of women and men on opioid agonist maintenance therapy (OAMT) in the Republic of Kazakhstan, as well as separate evidence from civil society, it can be concluded that OAMT is not attractive to women who use drugs. Strengthening the gender-specific approach to service delivery for female clients would help to attract more women to the OAMT programmes.

10. There are various reasons for the lack of a gender-specific budget: at this stage of the epidemic in the Republic of Kazakhstan, women are a smaller group than men, which makes it impossible to emphasize the importance of working with this group, since all interventions are evaluated only in terms of reducing the number of new HIV cases. The small size of the group also results in a lack of sex disaggregated data within each key population.

3. HEALTH AND SOCIAL SERVICES

3.1 LAWS GUARANTEEING ACCESS TO HEALTH AND SOCIAL SERVICE EXPERIENCE

The Republic of Kazakhstan's Code "On Health"[43] and other subordinate legislation govern the provision of social, medical, and psychosocial services to people living with HIV. All health and psychosocial services, listed in the Code, are provided free of charge within the framework of the Guaranteed Scope of Free Medical Care. Refusal of HIV treatment is an administrative offense[44]. People living with HIV are not eligible[45] for special social services provided in specialized institutions of the Ministry of Social Protection, because AIDS is a contraindication for receiving such services for all age groups from infants to the elderly, including the incapacitated, as well as women victims of violence[46].

Menopausal and elderly women are not covered by national HIV prevention measures or international programmes.

National legislation lacks an action plan for providing medical, psychological, and other services to key populations and PLHIV during armed conflicts, as illustrated in January 2022, when unrest broke out in Almaty and evolved into a mass protest. Prevention programmes in Almaty were discontinued; only the OAMT website prolonged its function until 5 p.m. daily[47].

SOCIO-ECONOMIC FACTORS AFFECTING WOMEN'S ACCESS TO ARV TREATMENT, RETENTION IN TREATMENT AND ADHERENCE TO TREATMENT

13 women, or 7.6%, answered that they could obtain ARV medicines from a clinic or drugstore (but were unable to travel or lacked the requisite documents).

41 women, or 24% of respondents, indicated that they cannot tolerate side effects from HIV treatment. 27 women, or 15.8%, indicated that they do not feel the need for treatment.

80 women (16.9%) postponed ART initiation so that their partner, family, and friends would not find out. 88 women, or 19.7%, skipped the following dosage of medication because they were concerned that someone might find out about their HIV status.

12 women, or 8.6%, interrupted treatment because they were afraid that someone would find out about their status[48].

According to the pereboi.kz website, there were no reports of a lack of HIV and SD-4 testing systems in several regions this year.

About 54% of women avoid going to their local outpatient or antenatal clinics. Gynaecologists employed by AIDS centres (to whom 58.8% of respondents went) and by hospitals outside of their neighbourhoods (10.8%) provide alternatives for them. Apart from the gynaecologist's objective reason for not being present at the local medical facility (18.8%), and aside from the fact that 11.5% of residents were unhappy with the qualifications and ethics of the medical personnel, there were also specific issues: in 20.9% of cases, women expressed fear about having their HIV status disclosed in public and about information being shared with friends and neighbours. Every tenth respondent noted that she was denied gynaecological services at the local medical facility[49].

3.2 SERVICE EXPERIENCE FOR KEY POPULATIONS AND PEOPLE LIVING WITH HIV

WOMEN LIVING WITH HIV[50]

- In the past 12 months: 10.1%, or 23 women, were denied health services because of their HIV status,
- 12.5%, or 59, women chose not to seek health care services,
- 15.9%, or 36 women, felt that people avoided physical contact with them/used extra precautions (such as a second pair of gloves) because of their HIV status,
- 3.8%, or 18 women, were advised by health professionals to terminate their pregnancy,
- 1.9%, or 9 women, were denied contraception/family planning services,
- 1.9%, or 9 women, were sterilized without their knowledge or consent,
- 1.44% of women were forced to undergo an HIV test without their consent,
- 12.8% of female respondents indicated that their status was disclosed without consent;
- 3.4%, or 16 women, indicated that they had felt pressured in the past 12 months to use a particular type of contraception,
- 10.24% chose not to seek medical care,
- In the last 12 months, six women have been refused shelter due to their HIV status..

Almost 30% of women think that they do not have access to free infertility treatment, assisted reproductive technologies (e.g., IVF), every fourth respondent reported the lack of free contraceptives, 22.3% believe they do not have access to safe, and free, or inexpensive abortion (if necessary), about 17% believe they do not have access to free post-abortion care. About 23% believe that they do not have access to free preventive check-ups (including tests for early diagnosis of cervical cancer) and mammologist services, 14.2% of surveyed women believe that they do not have the opportunity to get advice on safe conception (how to get pregnant without exposing themselves or their partner to the risk of HIV or STI transmission). The sample size was 148 female respondents.

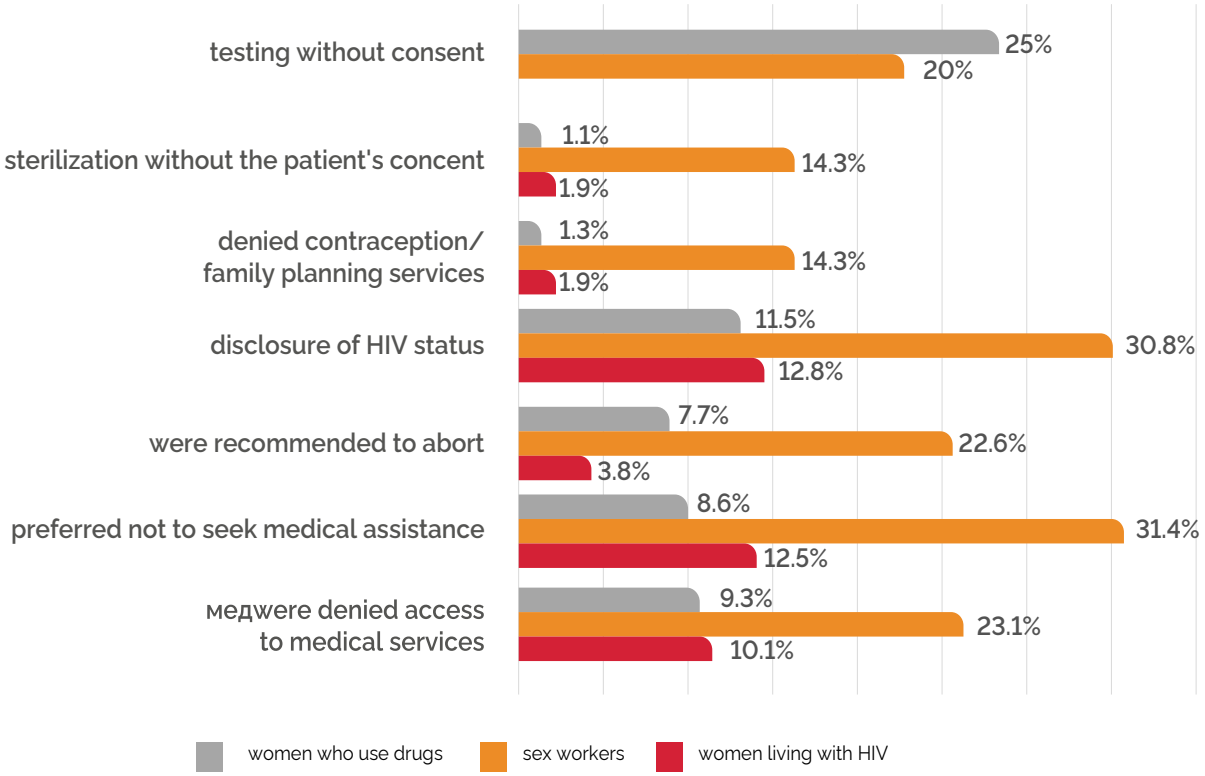
SEX WORKERS[51]

- 14.3%, or 5 sex workers, were denied contraception/family planning services,
- 22.6%, or 7 women, were recommended by health professionals to terminate their pregnancies,
- 14.3%, or 5 sex workers, were sterilised without their knowledge or consent,
- Sex workers had a significant percentage of affirmative answers to the question on HIV tests without the respondents' knowledge or consent (20.0%, or 7 women);
- 23.1% of women, or 6 sex workers, were denied health services because of their HIV status,
- 30.8% of sex workers, reported that their HIV status was disclosed without their consent,
- 26.9% of sex workers, were advised against having sex because of HIV status; 16.1%, or 5 women, in the past 12 months were forced to use an undesired form of contraception,
- 31.4% of sex workers, preferred not to seek medical care.

WOMEN WHO USE DRUGS[52]

- Health professionals recommended pregnancy termination to 7.7%, or 14 women,
- 1.3%, or 7 women, who use drugs, were denied contraception/family planning services,
- 1.1%, or 6 women, who use drugs, were sterilized without their knowledge or consent,
- Women who use drugs provided a significant percentage of affirmative answers to the question on HIV tests without the respondents' knowledge or consent (25%, or 131 women),
- 9.3% or 25 women were denied medical services due to their HIV status,
- 40% of women who took part in the survey said that treatment by medical personnel during labour and delivery was noticeably unfriendly and unprofessional,
- A few instances of anaesthesia not being provided were noted,
- 11.5%, or 31 women, faced disclosure of their status without the patient's consent,
- 4.8%, or 13 women, were advised not to have sex, forced to use an undesired form of contraception for 3.9%, or 7 women, in the past 12 months,
- 8.6% avoided medical care in the past 12 months because they were worried that someone might find out about their drug use.

FIGURE 5
Key population's experience of receiving health services



The Figure illustrates how relevant it is to continue fostering tolerance for women from key populations as well as women living with HIV.

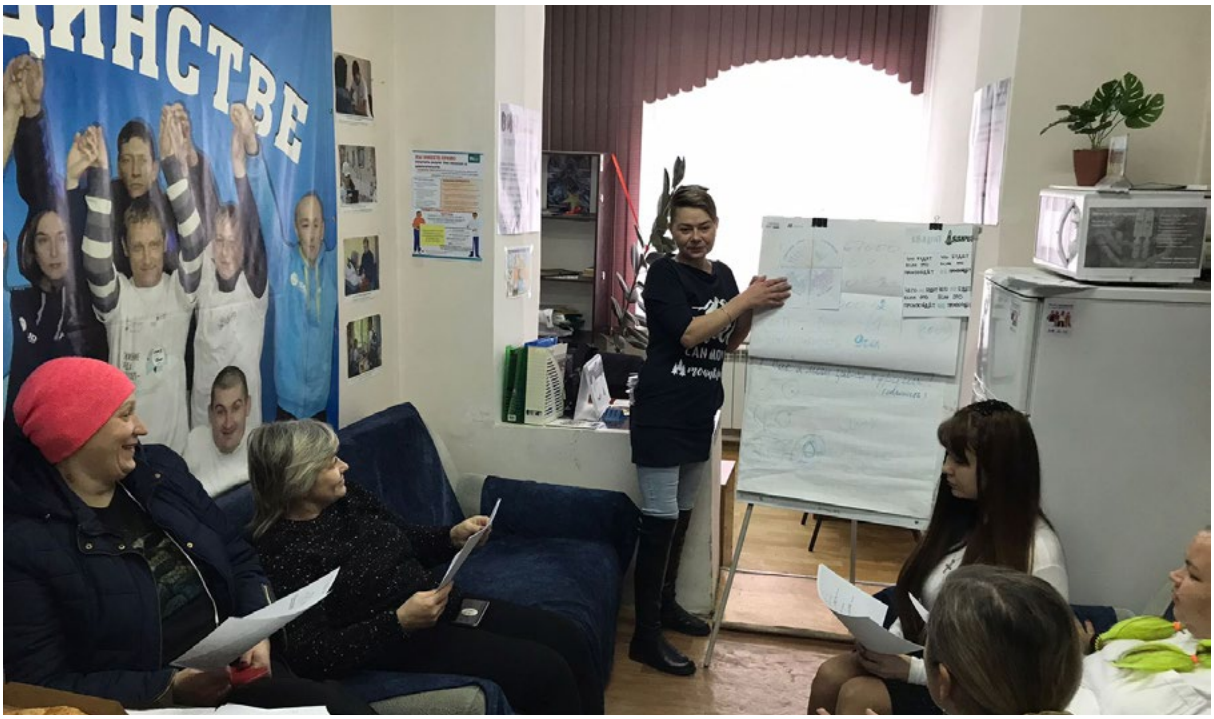
CERVICAL CANCER

In Kazakhstan, national efforts are made to prevent cervical cancer[53]. In 2020, the Government of the Republic of Kazakhstan revised and developed a draft decree on the approval of the list of diseases that require preventive vaccinations. The draft decree also specified groups of the population subject to preventive vaccinations and the rules of vaccination under the Code of the Republic of Kazakhstan No. 360-VI dated July 7, 2020, "On People's Health and the Health Care System". According to the Rules approved by the Government of the Republic of Kazakhstan, human papillomavirus (HPV) vaccination for girls over 16 and cervical cancer immunisation every ten years were added to the Vaccination Calendar. Women over 35 were offered preventive screening for cervical cancer.

HIV infection is listed as a risk factor for cancer in the analytical review[54] for policy formulation, which was developed by the Republican Centre for Health Development as part of the Strategic Development Plan. The Republic of Kazakhstan's HIV Response Roadmap for 2023–2026[55] does not include cervical cancer. Screening for cervical cancer is indicated in the studies for patients with clinical symptoms of HIV infection, as well as in the section "Reproductive Health"[56].

In 2019, in Kazakhstan, the planned screening coverage for cervical cancer of the target population was 89% of the Assigned Population Register, while breast cancer screening coverage was 60% of the Register.

Disaggregated data are not available for women living with HIV, although they are subject to screening. Within the framework of cytologic screening for cervical cancer, 954,322 women aged 30-70 years were screened, which was 95.5% of the plan, exceeding the number of women screened in 2018 by 3% (929,465—96%)[57].



There are no initiatives in place to enhance the proportion of HIV-positive women who get checked for cervical cancer. Given that not all patients are familiar with HIV clinical protocols, patients often lack information about the need for cervical cancer testing. Doctors in local polyclinics are not informed about HIV diagnoses, therefore, they are unable to determine whether cervical cancer screening is necessary. At the same time, all women, regardless of their HIV status, are invited for testing by polyclinics when they reach the age of 35. According to the latest WHO recommendations, "women living with HIV should be screened every 3 years, starting at age 25". In addition, WHO suggests a regular screening interval of every 3 to 5 years among women living with HIV[58].

Data about the human papillomavirus vaccination, cervical cancer screening, treatment, and palliative care, as well as anal cancer screening for women living with HIV, are not gathered or analysed.

There are 29 "friendly waiting rooms" in the Republic of Kazakhstan that offer screening, diagnosis, and treatment of sexually transmitted infections.

SECTION CONCLUSIONS

1. Legislative acts such as the Administrative Violations Code and Orders No. 379 and No. 1079 must be brought into compliance with international recommendations.

2. Activities to foster tolerant attitudes and the rights of women living with HIV/AIDS at medical facilities and social service providers need to be included as a separate budget line.

3. An algorithm must be created to ensure continuous services to women living with HIV in times of military conflict.

4. An algorithm must be created to ensure services for menopausal women living with HIV. (Menopausal women's counselling should address the interaction between menopausal hormone medication and antiretroviral therapy. ART drugs suitable for menopausal women ought to be widely accessible on the pharmaceutical market).

5. It is imperative to devise strategies to enhance the quantity of cervical cancer screenings among women living with HIV beginning at age 25, with a screening frequency of every three to five years. Data should be collected on this category of examinations.

6. For women living with HIV and women from key populations, access to safe medical abortions as well as other forms of abortion must be ensured, while the women's informed consent is a must for all forms of abortion.

4. ACCESS TO SEXUAL REPRODUCTIVE HEALTH

4.1 LAWS REGULATING SEXUAL REPRODUCTIVE HEALTH SERVICES

All women are entitled to the rights enshrined in the Health Code[59], regardless of whether or not they belong to key populations. Citizens of the Republic of Kazakhstan enjoy the right to:

- free reproductive choice;
- reproductive health and family planning services;
- reliable and complete information on the state of their reproductive health;
- free choice and usage of contraceptive methods.

The clinical guidelines "Protocol for Management of Physiologic Pregnancy"[60] also provide counselling on contraception in the postpartum period without specifying key populations, i.e., for all women in the postpartum period.

Contraception can be obtained at the community health clinic, emergency contraception can be obtained on a general basis, as part of the clinical protocol for abortion[61]. For key populations, condoms are also available at the drop-in centres[62].

Diagnosis of STI and HIV is provided as part of the mandatory laboratory tests in the clinical protocol for pregnancy management[63]. Additionally, the Protocol provides medical workers with the following clarification: "HIV-positive female patients do not pose a risk in everyday life to staff and other women, nor to their babies, and therefore should not be isolated in the antenatal and postnatal periods".

In case the physician suspects intimate partner violence: "Clinicians should try to see the woman alone and inquire about any potential violence. Even if the patient does not choose to disclose the violence at this time, they will know that the physician is aware of the problem and can address it at a later time." Further algorithms of behaviour are presented in the protocol on gender-based violence[64].

The phrase "family planning" is used in the Republic of Kazakhstan's standard for the organisation of obstetric and gynaecological treatment, including for teenage females. However, the normative document does not address the subject of consent to sex. Everything depends on whether the doctor or nurse considers it necessary to touch upon this topic[65].

Counselling, testing, or referral for abortion is provided as part of the clinical protocol for abortion, regardless of affiliation with key populations[66].

Infertility treatment and access to assisted reproductive technologies are also available on a general basis. The Protocol does not include HIV infection in the contraindication section, but in real life, women living with HIV are consistently turned down when they apply to private clinics and state institutions (even when referenced by quota).

The recommendations of the 2017 WHO Consolidated Guidelines on Sexual and Reproductive Health and Rights of Women Living with HIV are mostly implemented in the Republic of Kazakhstan.

4.2 ACCESS OF ADOLESCENTS AND YOUNG PEOPLE TO SRH SERVICES

The Health Code[67] states that HIV prevention activities are carried out by incorporating HIV prevention into the educational system and awareness initiatives at the workplace.

HIV infection issues are made known to various population groups using mass media, social media, and educational materials[68].

The AIDS centres in the regions engage with young people, informing them on HIV prevention[69].

ADOLESCENTS

Health organisations offer young people and minors between the ages of 10 and 18 discreet, all-inclusive care that includes medical, psychosocial, and legal services. Free condoms are also provided in youth health centres. (YHC)[70]. Minors aged 10 to 18 years and young people aged 18 to 29 years have access to reproductive and mental health services and facilities without a referral from primary health care providers.

As of the end of 2022, according to the data of the National Centre for Reproductive and Mental Health of the Ministry of Health of the Republic of Kazakhstan, there are 191 YHC in all regions of the Republic of Kazakhstan. A total of 728,628 adolescents and young people applied to the YHC specialists. The United Nations Population Fund (UNFPA) has created standards specifically for the delivery of health services in YHC[71].

It is important to note that no authorised training programmes on HIV and SRH prevention exist in the legislative framework. All information is offered electively during homeroom sessions; external lecturers may be invited at the teacher's request. In some regions (Astana). In some regions (e.g., Astana), the work on educating students is based on the 2018 Methodological Recommendations on SRH developed by UNFPA[72].

Rural populations are particularly vulnerable because they are unaware of how HIV spreads, and there are no programmes in schools that teach about HIV/AIDS or sex education[73].

Programmes specifically designed for girls living with HIV do not exist. In some regions, where HIV prevalence among children and adolescents is high, funding for such projects[74] comes from a variety of sources, including the national budget, the "state social order" awarded by the Ministry of Labour and Social Protection, and from UN agencies (UNAIDS, UNICEF), as well as other donors. Guidelines on self-help groups are available for adolescents living with HIV[75].

There is a Law on Youth Policy in the Republic of Kazakhstan[76], but this document does not contain information on youth policy. This law, however, focuses more on issues of youth self-governance and youth leisure activity organisation than it does on access to medical and other services. Youth health centres offer medical services specifically targeted at SRH, other medical services are also generally prescribed by the legislative acts of the Republic of Kazakhstan.

TESTING AND TREATMENT OF ADOLESCENTS

The Code of the Republic of Kazakhstan "On People's Health"[77] contains a provision that allows adolescents to be tested without gender restrictions, but parents will still be involved when adolescents are linked to care: "Medical examination of minors for HIV infection shall be conducted with the consent of their legal representatives or at their request" (paragraph 3, Article 162).

Minors aged sixteen and older have the right to informed consent or refusal for preventive, counselling, and diagnostic assistance, with the exception of surgical interventions and artificial termination of pregnancy, which are performed with the consent of their parents or legal representatives (paragraph 2, Article 78).

There are no laws requiring spousal consent for married women to access HIV testing in the Republic of Kazakhstan.

The specifics of reproductive health services provided to minors aged 10 to 18 and young people are stipulated in a chapter on the above law as part of both HIV prevention and pregnancy prevention[78].

One of WHO's 2018 recommendations for SRH reads as follows: "Countries are encouraged to examine their current consent policies and consider revising them to reduce age-related barriers to HIV services"[79]. The Republic of Kazakhstan's laws do not yet fully incorporate this recommendation, since testing for HIV is only permitted after the age of 16 without parental consent.

SERVICE EXPERIENCE. EARLY MARRIAGES:

7% of women got married before the age of 18: 8.4% in rural areas, 6% in urban areas.

An average of 1,200 underage girls were married annually in the nation over the previous five years[80].

UNINTENDED PREGNANCY AMONG ADOLESCENTS AND THE UNMET NEED FOR CONTRACEPTION

In Kazakhstan, the fertility rates for girls between the ages of 15 and 19 are still unacceptably high. According to the UNFPA survey[81], for every 1,000 girls of this age, 25 give birth. In 2014, the rate was 35 cases per 1,000 people.

Young people aged 15–19 provided the following data:

- Adolescents are deeply concerned about their sexual debut and pregnancy (23 percent and 29 percent, respectively);
- 65% of respondents aged 15–19 stated that they do not use contraception;
- 63.5% of teenagers aged 15–19 indicated they know nothing about contraception because it is uncommon (shameful) to discuss this issue in the family;
- 27.0% of adolescents aged 15–19 stated that they know nothing about contraception because they do not have a trusted person to discuss this issue;
- 20.9% of adolescents aged 15–19 knew nothing about contraception because there was no private place where teens could obtain information on contraception.

Condom use during last sexual intercourse: 80.4% of adolescents aged 15–19 who have ever had sexual contact indicated that they used a condom during their last sexual intercourse.

Teen Pregnancy: 16.7% of girls who indicated they had been sexually active indicated they had been pregnant at some point in their lives:

- Many of them (62%) indicated they had given birth.
- 22% had an induced abortion.
- 16% had a spontaneous miscarriage.

SEXUALLY TRANSMITTED INFECTIONS (STIS):

- 14.8% of adolescents who indicated sexual activity stated that they had at least one symptom of an STI in the past 12 months;
- However, a large proportion (62.6%) of them did not seek treatment for STIs at health facilities.

AWARENESS AMONG ADOLESCENTS:

- Only 34.4% of adolescents aged 15–19 knew that condoms – when used correctly – can both prevent unwanted pregnancy and reduce the risk of STI, including HIV.
- Only 35.3% of respondents were aware of the importance of STI treatment.
- 85% of surveyed adolescents stated that they seek information about sexual and reproductive health, STIs and HIV mainly on the Internet and social media.
- 73.5% of surveyed adolescents did not know where they could get anonymous HIV testing.
- Low awareness was more prevalent among young people living in rural areas, among girls, and among adolescents aged 15–17.
- 47% of the total number of adolescents surveyed were unaware of the consequences of unsafe abortion, and 46% were unaware of the consequences of contracting an STI.
- 21.1% or 271 people, ages 15–19, who did not use a condom the last time they had intercourse and who gave one of the following reasons:
- no money to buy it (3.7%, or 10 people)
- no place to buy it (11.1%, or 30 people).

4.3%, or 4 respondents, were girls.

SEEKING MEDICAL TREATMENT FOR STI:

- 52.6% or 100 young people with STI symptoms who did not seek health care services (a STI clinic, antenatal clinics, private clinics) or "friendly waiting rooms" for diagnosis and treatment of STIs. There they might obtain the complete scope of health services: a patient's chart; medical examination; treatment, and counselling (including partner notification, condom use, and HIV and STI tests).
- 10%, or 19 respondents, said they do not remember or do not know if they have been treated.
- The majority (62.6%) of young people aged 15–19 with STI symptoms did not seek medical services for STI at health facilities.
- 65.9%, or 56, of them were female.
- The dominant majority (90.8%) of young people aged 15–19 did not go to "youth health centres". An analysis was carried out on the subject of STI symptoms in sexually active young people (n = 1284). Among those who went to these centres, 26.7% had STI symptoms. Among those who had STI symptoms, 23.2% went to youth health centres before; the majority with STI symptoms (76.8%) did not go to these health centres.

THE REASONS WHY YOUNG PEOPLE DID NOT GO TO HEALTH CENTRES ARE:

- 27%, or 31, indicated a lack of confidentiality;
- 26%, or 29 people, indicated shyness,
- 25%, or 28 people, indicated that they were afraid of medical procedures,
- 24%, or 27 people, are worried about private information being leaked,
- 21%, or 24 people, indicated a lack of money to pay for treatment or examination,
- 18%, or 20 people, worried about being taunted by medical staff .

Information about methods of contraception is not specifically available from a common source. Respondents indicated that their sources of information were as follows:

- 48% mass media,
- 47% health workers,
- 42% social networks,
- 40% friends,
- 23% parents,
- 6% teachers.

Overall, 85% of young people aged 15–19 indicated that they do get information about sexual and reproductive health, including HIV and STI, from some source of information. Of those, 13.3% or 278 girls, did not receive information on SRH, HIV and STI. Furthermore, 20.8%, or 557 females, were Kazakh-speaking and 5.9% or 98 females, were Russian speakers.

In Kazakhstan, there have been no studies that confirm or deny the use of various types of contraception by the population. The primary concern with contraception has always been the use of condoms.

SECTION CONCLUSIONS

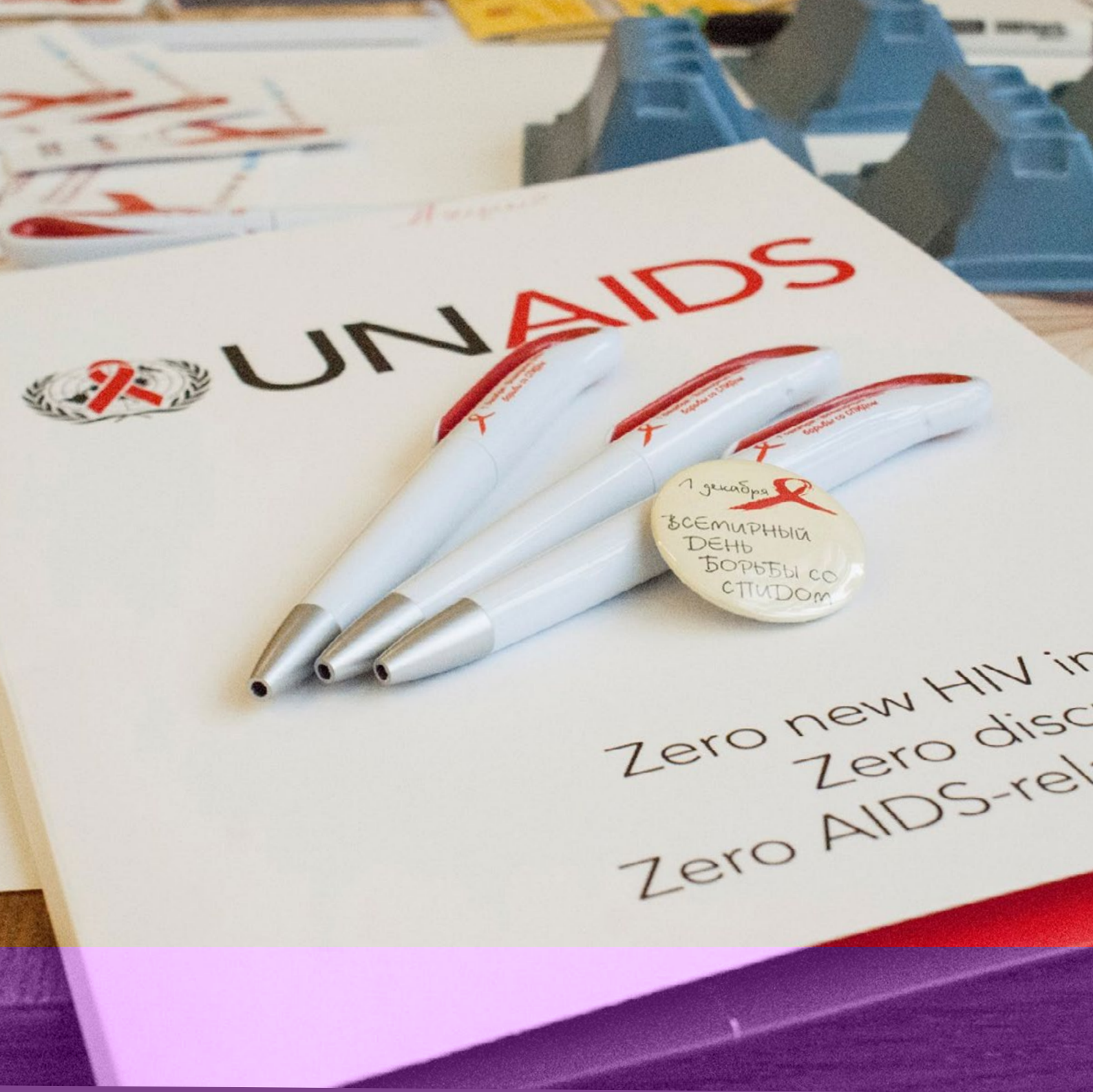
1. Women of reproductive age must be informed on all forms of contemporary contraception, including hormonal contraception and how it interacts with ART based on WHO qualifying criteria.

2. Reproductive technology denials for HIV-positive women have been reported. Ensuring that PLHIV have access to IVF programmes is essential.

3. Given the presented data on the insufficient awareness of schoolchildren on SRH issues, it is crucial to intensify efforts to raise schoolchildren's awareness in all regions of the Republic of Kazakhstan. In 2018, UNFPA developed the SRH education guidelines for schoolchildren, but only a few areas implemented these guidelines, with the backing of international organisations. The 2018 SRH education guidelines must be approved in order to be implemented into the compulsory school curriculum across all regions of the Republic of Kazakhstan at state expense.

4. The current law restricts early treatment of adolescents living with HIV (only after the age of 18) without first notifying their parents, because not all teenagers have a trustworthy relationship with their parents and because they are rarely willing to talk about their risky behaviour. The age at which adolescents living with HIV are eligible to be linked to care and start treatment without parental consent shall be lowered to 16 years.

5. In Kazakhstan, there have been no studies that confirm or deny the use of various types of contraception by the general population and women living with HIV in particular. The primary concern with contraception has always been the use of male condoms.



5. DISCRIMINATION

5.1 DISCRIMINATION AT THE LEGISLATIVE LEVEL

CRIMINALISATION OF DRUG USE

Kazakhstan imposes neither administrative nor criminal sanctions for drug use with the exception of non-medical consumption in public places, which is punishable by fines, correctional work, community service, or arrest for up to 20 days (Article 296 p. 1. of the Criminal Code of the Republic of Kazakhstan); criminal liability has been introduced for other drug-related activities without the purpose of sale, including drug possession (Article 296 of the Criminal Code of the Republic of Kazakhstan, pp. 2–4).

"Two draft laws have been developed to reduce penalties for non-medical drug use. That is, persons who use and store drugs in small quantities will not be held criminally liable, but administratively liable," said Bakhytzhan Amirkhanov[82], head of the Department for Combating Drug Crime of the Ministry of Internal Affairs.

A citizen who, due to alcohol or drug abuse, puts his/her family in a difficult financial situation may be restricted in his/her legal capacity by a court[83]. Getting a driver's license and finding a job are both impacted by registration for substance misuse[84].

Drug addiction constitutes grounds for denial of adoption, guardianship, and custody[85].

CRIMINALISATION OF HIV TRANSMISSION

The Criminal Code of the Republic of Kazakhstan[86] contains Article 118 on HIV infection, without specifying the routes of transmission (i.e., including vertical transmission). Article 118 of the Criminal Code of the Republic of Kazakhstan applies only in the case of the non-disclosure of HIV. If the partner has been notified, the person who caused HIV infection and put them at risk of HIV infection is exempt from criminal liability. For the period from 2019 to the 9 months of 2020, there were three cases handled by courts that resulted in convictions for HIV transmission under p. 3. of Article 118 "HIV infection transmitted to two or more persons or to a known minor" (the mode of transmission is not specified)[87]. The 2023–2026 HIV Roadmap[88] provides for the withdrawal of paragraph 1 of Article 118 on putting people at risk of HIV infection.

CRIMINALISATION OF SEXUAL ORIENTATION AND/OR GENDER IDENTITY

Sexual orientation and gender identity are not criminalized. At the same time, Article 93 of the Criminal Code of the Republic of Kazakhstan contains such a coercive measure as "treatment of sexual preference disorder"[89].

CRIMINALISATION OF SEX WORK

Engaging in sex work is not an offense. In the real world, sex workers are administratively prosecuted for "solicitation in public places".

RESTRICTIONS ON ENTRY, STAY, AND RESIDENCE FOR PEOPLE LIVING WITH HIV

Legal restrictions on entry, stay, and residence are excluded from the legislative acts. There are testimonies of PLHIV who have been unable to obtain citizenship for a long time due to their HIV-positive status, as the human factor also influences the decision to grant citizenship.

RESTRICTIONS ON LABOUR RIGHTS DUE TO HIV STATUS

In Kazakhstan, employees of special state agencies, law enforcement, the military, and civil aviation pilots, had their employment rights infringed because of HIV infection[90].

RESTRICTION OF PARENTAL RIGHTS, RESTRICTION IN THE RIGHT TO ADOPTION, GUARDIANSHIP.

Since December 2022, adoption restrictions for people living with HIV have been removed.

5.2 LAWS TO PROTECT AGAINST DISCRIMINATION

The Constitution[91] prohibits discrimination: "No person may be subjected to any discrimination on the grounds of origin, social, official, and property status, sex, race, nationality, language, attitude to religion, beliefs, place of residence or any other circumstances."

As it can be seen, occupation (meaning sex work) and sexual orientation are not separately stipulated in the Constitution; these paragraphs can be referred to as "under any other circumstances". There are no other legal acts concerning non-discrimination against sex work, as well as the existence of the profession itself.

With regard to sexual orientation: the motive "sexual orientation" is not an aggravating circumstance in the commission of a crime or offense[92]. Article 174 of the Criminal Code of the Republic of Kazakhstan on incitement to hatred does not contain the attribute of "sexual orientation". "No person may be subjected to any discrimination in the exercise of labour rights on grounds of origin; social, official or property status; sex, race, nationality, language, attitude towards religion, beliefs, place of residence, age or physical disabilities, membership in public associations or other circumstances"[93]. Sexual orientation is not specified separately and can be considered only in the paragraph "or in other circumstances".

The HIV Roadmap does not address issues of gender identity and sexual orientation .

DISCRIMINATION PREVENTION PROGRAMMES

The Central Asian Association of People Living with HIV (CAAPL) conducts trainings for police officers and medical staff in Almaty on stigma and discrimination against people living with HIV as a dedicated project[94]. Although these trainings are not institutionalised, efforts are being made to approve the module for use in postgraduate education programmes.

Training of doctors of all specialties, including those working in penitentiary institutions, on stigma and discrimination was included in the 2023–2026 HIV Roadmap[95]. Regretfully, the roadmap indicators did not take into account the number of individuals with this type of training.

5.3 STEREOTYPES AND PUBLIC PERCEPTIONS

PERCEPTIONS OF SEX WORK AND WOMEN WHO USE DRUGS

Online publications show less than positive attitudes towards key populations: "It is shocking that a large number of girls among drug users are willing to trade their bodies for mephedrone."[96]

Drug use is commonly regarded as "inappropriate behaviour" in Kazakhstan, where it is a cause of discrimination in various forms. Due to stigmatisation, pregnant drug-dependent women are reluctant to seek medical care and receive necessary medical services, including drug dependency treatment, prenatal and postnatal care. Due to social expectations that women should be well-behaved mothers and housewives, female sex workers and drug users are more likely to face discrimination. They are less likely to seek services because they risk losing parental rights or going to prison[97].

The Akim (mayor) of Almaty banned sex workers from working on the streets after a resident's appeal[98].

Gender norms are largely shaped by tradition. Women are considered to be under the care of male relatives until marriage, when they become the financial and moral responsibility of their spouse. Female sexuality is central to moral respectability and honour; moreover, it is embedded in a woman's family, reflecting both her character and that of her husband and family. Similarly, the only morally acceptable expression of female sexuality is limited to the context of marriage. Although Islam and other religions also hold the same standards for male sexuality, the cultural coercion is not the same, and men are granted greater leniency. Fear of rejection, anger, and partner violence discourage women from initiating condom use, especially when the woman is financially dependent on the man. Male rejection may, for some women, translate into a man not providing a woman with enough food to feed herself and her children. A wife who asks her husband to use a condom may be considered unfaithful, disrespectful, and distrustful of her husband, and lacking in marital piety[99].

5.4 DISCRIMINATION EXPERIENCE

WOMEN LIVING WITH HIV

- 3.6%, or 17 women, were excluded from family activities because of their HIV status[100];
- 12.2% of respondents indicated that some of their family members had faced criminal charges for domestic violence (sample of 148 women respondents)[101].
- 7.4%, or 35 women, were reprimanded, verbally abused by another person (e.g., yelling, swearing) because of their HIV status, and other people (non-family members) spoke negatively or gossiped about them because of HIV status in the past 12 months.
- 1.3%, or 6 women, were physically abused by another person (e.g. poking, pushing, hitting) because of their HIV status.
- In the past 12 months, 10.1%, or 23 women, were denied health services because of their HIV status.
- 12.5%, or 59 women, chose not to seek medical care.
- 20.3%, or 96 women, chose not to have sex.

- 16.7%, of cases or 38 women, were the subject of gossip or negative talk because of HIV status.
- 15.9%, or 36 women, experienced avoidance of physical contact because of HIV status or people used extra precautions such as a second pair of gloves because of HIV status.
- 2.2%, or 5 women, were physically abused (pushed, punched, hit or otherwise physically assaulted) because of their HIV status.
- 3.8%, or 18 women, were recommended by health professionals to terminate their pregnancy.
- 1.9%, or 9 women, were denied contraception/family planning services.
- 1.9%, or 9 women, were sterilized without their knowledge or consent.
- 1.44%, of women, were forced to undergo an HIV test without their consent.
- 12.8% of female respondents, indicated that their status was disclosed without consent.
- 9.7% of women were forced to use a particular type of contraception, 3.4%, or 16 women, in the last 12 months.
- 10.24% chose not to seek medical care.
- 6 women were denied shelter in the last 12 months because of their HIV status.

Almost 30% of women think that they do not have access to free infertility treatment, assisted reproductive technologies (e.g., IVF), every fourth respondent reported the lack of free contraceptives, 22.3% lacked safe, free, or inexpensive abortion (if necessary); about 17% missed free post-abortion care. About 23% of respondents believe that they do not have access to free preventive check-ups (including tests for early diagnosis of cervical cancer) and mammologist services, 14.2% of surveyed women believe that they do not have the opportunity to get advice on safe conception (how to get pregnant without exposing themselves or their partner to the risk of contracting HIV or other STIs). The sample size was 148 female respondents.

SEX WORKERS

- 14.3%, or 5 sex workers, were denied contraception/family planning services.
- 22.6%, or 7 sex workers, were advised by health professionals to terminate their pregnancies.
- 14.3%, or 5 sex workers, were sterilised without their knowledge or consent.
- 20.0%, or 7 sex workers, had a high rate of positive test responses without the respondent's knowledge or consent.
- 23.1%, or 6 sex workers, were denied health services because of their HIV status.
- 6.2%, or 12 sex workers, were badmouthed or gossiped about because of their HIV status.
- 23.1% of sex workers were verbally harassed (yelled at, swore at, called names, or otherwise verbally abused) because of their HIV status.
- 30.8% of sex workers experienced disclosure of their HIV status without their consent.
- 26.9% of SW sex workers were advised not to have sex because of their HIV status;
- 16.1%, or 5 women, in the last 12 months were forced to use a particular type of contraception;
- 31.4% of sex workers preferred not to seek medical care.

WOMEN WHO USE DRUGS

- 7.7%, or 14 women, were advised by health professionals to terminate their pregnancies.
- 1.3%, or 7 women, who use drugs were denied contraception/family planning services.
- 1.1%, or 6 women, who use drugs were sterilised without their knowledge or consent.
- PWID had a high rate of positive test responses without the respondent's knowledge or consent (25%, or 131 women).
- 9.3%, or 25 women, were denied medical services due to HIV status.
- 19.0% of female respondents to the Stigma Index survey indicated that they had been verbally harassed in the past 12 months because of their drug use.
- 8.6%, or 45 women, who use drugs and living with HIV have been verbally reprimanded or verbally abused by another person (e.g., yelling, swearing) because of their HIV status.
- 40% of the women, who participated in the survey said that treatment by medical personnel during labour and delivery was noticeably unfriendly, unprofessional.
- Some cases of not providing anaesthetics were reported.
- 11.5%, or 31 women, faced disclosure of their status without the consent of the patient.
- 4.8%, or 13 women, were advised not to have sex, forced to use a particular type of contraception, 3.9%, or 7 women, in the last 12 months.
- 8.6% avoided medical care in the past 12 months because they were worried that someone might find out about their drug use.

SECTION CONCLUSIONS

1. The criminalisation of drug use and possession without intent to sell restricts women who use drugs' access to harm reduction programmes. This has an impact on the spread of HIV infection among people who inject drugs. The use of non-medical drugs in public and their possession without the intent to sell must no longer be criminalised.

2. The criminal penalties for HIV transmission have a negative impact on the uptake of HIV testing for people who engage in risky behaviours; this law increases discrimination against people with HIV and puts women living with HIV in a vulnerable position. A specific article on criminal penalties for exposure to or transmission of HIV should be eliminated. This offence, according to international guidelines, should be considered under general criminal law when intent is proven.

3. The absence of a direct instruction to "exclude HIV" from the grounds for refusal to obtain a residence permit, citizenship of the Republic of Kazakhstan, negatively affects the timing of obtaining these documents by people living with HIV. An important factor in this issue is that access to free treatment for people living with HIV is possible only if these documents are available. It is necessary to make appropriate changes in legislative acts to exclude the possibility of "personal decisions" or "delaying the process" by migration officials.

4. The current ban on employment in military units, special state and law enforcement agencies, and civil aviation violates the rights of people living with HIV. It is necessary to introduce changes, according to which, in the case of HIV detection, employees of these areas are transferred to "a work not involving a risk of skin damage".

5. The absence of an approved training module on stigma and discrimination against people living with HIV and key populations in postgraduate programmes for healthcare professionals, as well as the absence of approved hours for conducting this training, makes little progress towards improving discrimination against women living with HIV in healthcare facilities. It is necessary to approve the module and include training hours for health workers on "stigma and discrimination against people living with HIV and key populations" in postgraduate education.

6. The Republic of Kazakhstan does not have any programmes promoting tolerant attitudes, with the exception of small-scale initiatives supported by international funding.

   It is essential that the state budget set aside funding specifically for initiatives aimed at encouraging public tolerance towards key populations and people living with HIV. Moreover, key populations and people living with HIV, must be engaged in the development of such campaigns and activities.

6. STATUS OF WOMEN

6.1 LAWS REGULATING THE STATUS OF WOMEN

The Constitution provides rights and access to social and medical services, education, and employment for all citizens of the Republic of Kazakhstan, regardless of gender.

A few pivotal events in the Republic of Kazakhstan's history served as the primary turning points in the development of gender policy[102]:

- In 1995, the Council on Family, Women, and Demographic Policy under the President of the Republic of Kazakhstan was established.
- In 1997, the Concept of State Policy for the Improvement of the Status of Women in the Republic of Kazakhstan was approved.
- In 1998, as part of his Address to the People of Kazakhstan, the President named gender equality as one of the areas of democratic reform. In the same year, Kazakhstan acceded to the United Nations Convention on the Elimination of All Forms of Discrimination Against Women. The Council was transformed into the National Commission on Family and Women's Affairs under the President of the Republic of Kazakhstan, which oversaw the development of a National Action Plan for the Improvement of the Status of Women in the Republic of Kazakhstan in 1999.
- Kazakhstan adopted the "Concept of Family and Gender Policy until 2030" in 2017 as an extension of its gender policy, solidifying its stance on women's economic empowerment[103]. Gender indicators are taken into consideration when drawing up the state budget as well as developing plans and programmes.
- In 2020, Constitutional Law was signed that ensured a 30 percent quota for women and youth on electoral party lists..

From December 12, 1995, when the Majilis (lower house) of the Parliament of the Republic of Kazakhstan held its first deputies' election, until the 2004 election campaign, the percentage of women elected to the chamber has averaged between 11 and 12%. However, women made up, on average, 14% of the nominated candidates in those elections. At the end of 2022, the share of women in the Parliament of the Republic of Kazakhstan was 24.7%[104]. In the 2019 World Economic Forum's Gender Gap Index, measuring the extent of women's economic engagement, our nation ranked 37th among 153 states. These results demonstrate Kazakhstan's gender policy's systematic evolution. But, unfortunately, gender policy and HIV prevention at the moment are not interconnected at the proper level; they exist in "parallel worlds" in the Republic of Kazakhstan. One "world" involves women's NGOs and general women's achievements in the country, and the other world is the world of HIV prevention and treatment; gender-specific activities are limited to preventing HIV transmission from mother to child..

The gender strategy pursues the following objectives:

1. lowering the gender gap in men's and women's life expectancies
2. decrease in the percentage of divorces
3. reduction in the number of cases of artificial pregnancy terminations
4. reduction in the number of cases of domestic violence against women and children
5. reducing the difference between the average salary of men and women
6. increasing the share of women owning material assets
7. increasing the share of women in executive, representative and judicial bodies, state, quasi-state and corporate sectors in decision-making positions
8. increasing women's share in peace and security.

As it can be noted, the strategy does not establish goals in the field of education because there is little disparity based on gender in the field of education[105]. The World Economic Forum (WEF) estimates that gender gaps in education are quite low in Kazakhstan. "The share of women and girls in the total mass of students is 49.5%, and the share of men and boys is 50.5%. The minimum gender gap is characteristic of the levels of secondary schools, technical and vocational education and higher education. At the level of postgraduate education, the share of women exceeds the share of men by 1.7 times. According to the WEF Global Gender Gap Index, Kazakhstan ranks first in terms of enrolment in secondary schools and higher education institutions"[106].

In higher education, as a variable component of educational programmes in the areas of "Education", "Humanities", "Law", "Social Sciences, Business and Economics", elective courses on gender equality have been developed and introduced.

The strategy lays out objectives to raise women's economic standing and stop sex-based violence and discrimination. The strategy does not address issues of equality in intimate relationships.

6.2 WOMEN'S ECONOMIC EMPOWERMENT[107]

In Kazakhstan, women who want to start their own businesses can also rely on financial support[108]. Thus, in 2022, about 80,000 women took courses on the basics of entrepreneurship. As a result, about 13,000 of them received grants.

Kazakhstan has a Silver Age programme, under which people of pre-retirement age can get a job. According to the Ministry of Labour, about 50% of the 3,000 people employed last year were women.

Measures to promote motherhood and childhood include maternity allowances, monthly childcare allowances for children up to 1.5 years of age, and payments to the mothers of many children.

GENDER PARITY

Women account for more than 70% of employees in the health, education, and social protection sectors, while women's representation in the financial and public sectors is slightly more than half. Traditionally, these types of sectors are less profitable compared to "male-dominated sectors" such as construction, oil and gas, mining, transportation, etc. According to 2020 data, the share of women in the construction sector is 23.3%, 31.7% in industry, 42.4% in agriculture, forestry, and fisheries, 23.3% in transportation and warehousing, 49.9% in the sphere of professional, scientific, and technical activities, 72.1% in education, and 72.3% in health care. Information on gender parity in HIV care and support services is not collected by NGOs and other entities.

The Republic of Kazakhstan's Labour Code was amended in 2021 in accordance with the Republic of Kazakhstan's Law "On Amendments and Additions to Certain Legislative Acts of the Republic of Kazakhstan on Issues of Social Protection of Certain Categories of Citizens" in terms of abolishing the list of jobs a list of jobs that forbid using women's labour. The progressive decision to remove the list is intended to guarantee that men and women in the workforce have equal rights and opportunities.

Marriage requires the free and full consent of the man and woman who are to be married when they reach the age of 18[109]. The age of marriage may be lowered by two years in the event of pregnancy or the presence of a shared child. The consent of both spouses and their parents is required.

In the Republic of Kazakhstan polygamous marriages are not allowed, as well as marriages between:

- persons of the same sex;
- close relatives;
- adoptive parents and adopted children, children of adoptive parents and adopted children;
- persons at least one of whom is recognized as incapable due to mental illness or dementia by a court decision that has entered into legal force.

HIV testing does not depend on the spouse, everyone can be tested regardless of gender. But it is interesting that when future spouses undergo a voluntary medical examination, the medical worker has the right to report diseases that pose a threat to the other spouse without his or her consent. The list of such diseases is not designated.

The Republic of Kazakhstan does not allow for the denial of women's property rights or inheritance.

As can be seen from the documents listed above, Kazakhstan is actively working to introduce into legislation the issues highlighted in the Beijing Declaration and the Convention on the Elimination of All Forms of Discrimination against Women.

6.3 REFLECTING GENDER INEQUALITIES IN HIV POLICIES. FINANCING

The lack of gender-specific HIV programmes in Kazakhstan, which only exist at the level of international funding, suggests that gender inequality is not sufficiently acknowledged. At the state level, only crisis centres for victims of violence have been introduced so far, which, regrettably, do not provide services to women living with HIV. Programmes aimed at preventing the spread of HIV do not take into account issues such as:

- Inequalities of women and girls compared to men and boys
- Inequalities between transgender women and transgender men
- Gender inequalities in care and support at home and community levels
- Men's involvement in women's issues (including caregiving)
- Training and support in palliative care
- Concepts of masculinity can lead to an increased risk of HIV infection.

This situation may be due to the lack of training programmes for decision makers on "gender equality and HIV" and the resulting lack of understanding of the need for such programmes.

Training programmes for health care providers: In HIV postgraduate education, advanced training focuses more on HIV transmission, PMTCT, and infection safety than on issues such as gender equality, human rights, and stigma and discrimination.

6.4 GENDER STEREOTYPES

Men still hold the stereotype that women should not pursue politics because it keeps them from being mothers and wives and because political activity is too demanding for women[110].

Considering the opinions of Kazakhstani people about the tradition of "bride kidnapping", quite a large number (20.8%) of respondents were ready to reconcile with the situation. 5% of respondents chose the answer option "I will count on compensation for material and moral damage from the groom", apparently considering such a situation possible and acceptable. Meanwhile, there are more people who live in rural areas who will tolerate this kind of behaviour. The overwhelming majority of respondents answered that they do not know about the punishment for the crime of " bride kidnapping". Only 8.5% know about the existence of Article 125 of the Criminal Code of the Republic of Kazakhstan, and 3.9% of respondents were sure that such punishment did not exist. At the same time, 48.2% of women did not know anything about the punishment for bride kidnapping.

Answering the question whether it is possible for a girl to get married if her parents are against it, the majority of respondents noted the answer option "don't know/depends on circumstances", but also 35.1% think that "no, rather not"; only 19.9% think that a girl can go against the will of her parents. This demonstrates the fact of the hierarchy of relations between generations, and the situation of subordination of women to older relatives of both sexes.

When assessing the situation when an unmarried woman with limited financial resources will have an unplanned pregnancy, the majority of respondents (85.1%) considered it necessary to give birth to the child regardless of the woman's marital status.

Only 7.2% believe that in such circumstances, a woman should have an abortion. This distribution of opinions demonstrates to us unambiguously traditionalist attitudes regarding the role of a woman who should be, first of all, and in spite of everything, a mother[111].

49.4% of respondents consider premarital sexual relations to be unacceptable. The majority of respondents, both men and women, have a negative attitude towards premarital sex. When it comes to marriage age, the Kazakhstanis have a stereotype that a man should be older and have social status, and a bride should primarily be young[112].

Religious law forbids people from engaging in sexual relations outside of marriage, yet in the context of culture, this prohibition mostly targets women. Polygamy among men is considered something obligatory in society, men having relations with other women outside of marriage is tolerated and sometimes even welcomed as it "reflects" masculinity and pride. 62% of 1,110 girls believe that having sexual relations before marriage is wrong[113].

These norms and practices increase the level of risk for HIV transmission to women, as a submissive, mistreated, and reliant on a man for several needs, woman cannot insist on condom use. This is evidenced in the recommendations of the Household Survey on Violence against Women in Kazakhstan linking HIV and gender-based violence: "Ensure that violence against women is addressed in multiple health initiatives, i.e., reproductive health, adolescent health, maternal health, child health, mental health, and HIV prevention".

CULTURAL PRACTICES

According to Gaziza Moldakulova, National Programme Coordinator of the United Nations Population Fund (UNFPA), an average of about 1,200 underage girls married annually over the past five years in Kazakhstan. The share of early marriages in the total number of marriages consummated in the country is about 7%[114].

SECTION CONCLUSIONS

1. Government programmes aimed at preventing the spread of HIV do not address such issues as inequalities of women and girls compared to men and boys, gender inequalities in care and support at home and community levels, male involvement in care, and palliative care training and support. Concepts of masculinity can lead to an increased risk of HIV infection.

2. Existing gender norms exacerbate women's vulnerability to HIV transmission. It is necessary to introduce awareness-raising programmes for the general population, which should contain information about women's health rights and dispel gender stereotypes and negative cultural practices.

3. For gender-specific HIV prevention, care, and support programmes to be successfully implemented, decision-makers must receive training on women's rights and gender equality in the field of HIV.

7. GENDER-BASED VIOLENCE

7.1 POLICIES AND LAWS TO ADDRESS GENDER-BASED VIOLENCE

In Kazakhstan, the law[115] defines domestic violence, which includes the concepts of sexual, psychological, economic, and sexual violence. At the same time, the law regulates relations not only among those who are officially married: 'Domestic violence is an intentional unlawful act (action or inaction) of one person in the sphere of family and domestic relations against another (others), causing or containing a threat of causing physical and (or) mental suffering;" family and domestic relations are relations between spouses, former spouses, persons living or living together, close relatives, persons having a shared child (children);"

Thus, regardless of whether the partner is former or present, or whether the relationship is legalised, protection against violence is provided.

The Criminal Code does not provide for a separate penalty for spouses. According to the legislation, marital rape is dealt with under the general criminal article 120 on rape[116].

The legislation of the Republic of Kazakhstan does not provide for separate norms protecting key populations and women living with HIV from violence; general criminal legislation is used to address cases of violence against key populations or women living with HIV and police abuse. Within the framework of measures to prevent torture and ill-treatment in closed institutions, a special preventive mechanism[117] has been created that allows the identification of violations in this area and submit reports to the Commissioner for Human Rights.

Primary psychological support is provided by contacting crisis centres[118]. The "Zhan-Saya" crisis centre in Almaty offers significant support to women who are victims of violence. There are 44 such centres in Kazakhstan[119], but women living with HIV are not always accepted there, as the official contraindication for receiving services is "infectious diseases", to which the management of the centres refers HIV infection[120].

Some HIV-service NGOs[121] also offer social, psychological, and legal services as part of a range of initiatives funded by the state social order, private foundations, and international companies. However, rather than helping the victim of violence, this support is typically provided by professionals who work with the key populations or people living with HIV.

Registration of cases of violence among key populations is carried out on a general basis[122]. Among all HIV-service NGOs, only public association "Amelia," which represents sex workers, documents incidences of assault.

Some NGOs provide temporary accommodation services for women from key populations, including victims of violence, in some regions of Kazakhstan (Temirtau, Almaty)[123]. Awarding state social order to fund such NGO services in Almaty was a success.

The UNAIDS office provided financial and technical support to the Public Association "Revanche" in order to develop the Standard on the Provision of Special Social Services to Key Populations. It enables the continuation of advocacy efforts to approve criteria for the delivery of special social services to key populations, such as the issue of granting access to women living with HIV to crisis centres[124].

Public Association "Answer" implemented a mentorship programme for women living with HIV and from key populations. The programme includes setting up self-help groups for women in

four areas of Kazakhstan, with technical and financial support from UNAIDS[125].

Emergency contraception for women, safe abortion, and post-exposure prophylaxis of sexually transmitted infections and HIV are provided within the framework of the state standard on the diagnosis and treatment of gender-based violence[126].

It is important to understand that the situation with access to crisis centres has been going on for quite a while. Kazakhstan even received recommendations from the United Nations Committee on the Elimination of Discrimination against Women (CEDAW) to address this violation of rights based on the civil society shadow report in 2019[127]. However, this matter remains pertinent.

NGOs, state entities, and international organisations have partner relationships, but "violence and HIV" is not typically a topic to address in these relationships. Moreover, violence against women from key populations has not yet been identified as a separate problematic area. In 2022, the Kazakh Scientific Centre for Dermatology and Infectious Diseases worked closely with community participation on the HIV Roadmap. The document was adopted in 2023, but despite the involvement of key populations in its creation, it does not include a focus area on HIV and gender-based violence.

7.2 STEREOTYPES ABOUT GENDER-BASED VIOLENCE

Quite often, the victim becomes the centre of attention rather than the abuser and their violent actions. Almost inevitably, they ask what she has done, what she is like. That is, the worldview of others is built on the idea that the use of violence in relationships is acceptable and justified by the partner's shortcomings. From society's point of view, you have to be perfect, or at least moderately good, in order to be forbidden to be raped. Otherwise, society will be on the side of the rapistΩ[128].

According to a UNFPA survey[129] conducted in 2021, almost one in five men (21%) share the view that women must tolerate violence to keep their families together. Among women, there are also those who agree with this opinion (9%), but compared to men, they are half as many. There are also more people who agree with this statement in rural areas (21%) than in cities (12%); more in Shymkent (38%), Turkestan (43%), and Atyrau regions (30%). Despite the fact that the majority of men (67%) and women (81%) share the opinion that men and women have equal rights and opportunities in Kazakhstan, the majority of men (68%) and women (83%) believe that further work is needed in our country to achieve equality between women and men.

According to the majority of respondents, women and their children are the most frequent victims of violence. The most common forms of violence are:

- physical violence (66.5%),
- psychological violence (57.7%),
- sexual violence (45.9%),
- 19.8% of respondents mentioned economic violence[130].

7.3 SURVIVORS' EXPERIENCE OF VIOLENCE

GENERAL POPULATION

In the last 12 months, 5.3% of women in Kazakhstan experienced physical violence from an intimate partner, and 1.2% of women in Kazakhstan experienced sexual violence. 2.9% of women in Kazakhstan experienced physical violence by a person other than an intimate partner[131].

WOMEN LIVING WITH HIV

The survey data collected by NGOs[132] (a sample of 148 female respondents) shows the prevalence of severe forms of physical violence against women, such as:

- hitting with their fists, throwing objects at them (noted by 38.7% of women married or in a relationship with a partner,
- kicking, beating (33.1%),
- threats or actual use of weapons against them (32.5%),
- strangulation, causing burns (32.3%),
- 37.1% of interviewed women (in relationships) were forced to have sex against their will.
- 45.2% of women surveyed had been slapped or had objects thrown at them that could hurt them.
- 40.3% of respondents reported that they had been pushed or had their hair pulled.

Psychological violence (controlling behaviour) by a husband or partner is common:

- 1 in 2 women were insulted,
- 40.3% were intimidated and threatened,
- 41.9% of women have been kicked out of the house,
- 38.7% hear threats of physical violence,
- 54.8% of women are insulted,
- 21.8% of respondents had cases where their husband or partner threatened to take away their children.

From 18 to 49% of women are subjected to various types of economic violence by their husband/partner/partner, in particular, they are denied money for household, personal expenses, groceries, and children's expenses, even if their partner has free financial resources:

- 48.4% of female respondents noted that their husband or partner refuses to give them enough money for household expenses, even if he/she has money for other expenses.
- 37.9% of female respondents said that household income is hidden from them and they do not have access to it.
- For 29.7% of female respondents, husbands or partners do not give money for groceries.
- 23.4% of women do not receive money from husband or partner for necessary expenses for children.
- In 37.9% of cases, husbands or partners do not give women money for personal expenses (clothes, shoes, and hygiene items).
- In 17.7% of women, the husband or partner has taken away documents, and they do not have access to them.

Sexual violence: 37.1% of the interviewed women were forced to have sex against their will. The sample size was 148 female respondents.

28.4% of respondents said that their husbands, partners, or spouses were criminally liable for family violence.

SEX WORKERS

There were two cases recorded in 2020 of violence against a sex worker, and a transgender female sex worker.

Since February 2021, 36 sex workers have contacted the Public Association "Amelia" for assistance related to violence by a client or cohabitant[133].

PEOPLE IN PRISONS OR OTHER CLOSED SETTINGS

According to the reports of the Public Supervisory Commission in Kazakhstan, the conditions of detention of women in correctional institutions do not meet the established standards: the buildings are dilapidated (the National Preventive Mechanism report indicates 3 locations); the temperature regimen is not observed (very cold); there are shortages of basic equipment (no clean mattresses); there are no conditions for women's hygiene; there are violations of labour rights; and the personnel of the organisation do not know how to deal with transgender people.

The rape of a transgender woman was documented in 2019.

In 2016, S.N. (a transgender woman) became a victim of sexual violence in the institution LA-155/18 of the Department of Penal Correctional System of Almaty. S.N. claimed that staff members at that institution had developed a sort of "criminal business," forcing female prisoners to provide sexual services to incarcerated criminals of privileged standing in the criminal hierarchy of inmates[134].

SECTION CONCLUSIONS

1. Given the prevalence of violence in the country and the vulnerability of women living with HIV and women from key populations to this issue, every effort should be made to implement measures to support women from key populations and women living with HIV who have survived violence:

2. Order No. 1079, which regulates the access of survivors of violence to crisis centres, must be modified.

3. Introduce NGO support programmes to provide these services to female survivors of violence at community-based organisations through government services and international funding.

4. Ensure that challenges faced by women are acknowledged and the potential risk of violence against women is assessed when counselling on voluntary disclosure of status, and that referrals to violence prevention and victim support services are provided wherever necessary

8. PARTICIPATION OF CIVIL SOCIETY

8.1 WOMEN'S PARTICIPATION IN DECISION-MAKING

Women living with HIV, women who use drugs, and sex workers are involved in policy development as representatives of their entire community, without regard to gender. This is reflected in the roadmap, which records indicators at the community level, irrespective of gender. The participation of women living with HIV in the elimination of mother-to-child transmission of HIV was codified by the Order of the Ministry of Health in 2017[135].

The Country Coordinating Mechanism (CCM)[136] includes a representative of women living with HIV. There is also a working group of women living with HIV[137] under the CCM. When a group representative brings up relevant topics at a meeting, the issues are addressed and taken into consideration. In turn, the representative should coordinate all issues on the agenda with their community. For example, after bringing an issue to the CCM, a joint visit by CCM members to the Ombudsman regarding the issue of women who have survived abuse and are living with HIV being denied access to crisis centres. The Health Code was modified to allow for further advocacy on changing the subordinate legislation. These regulations also contain restrictions on other social services, so it was decided to include the entire group of people living with HIV when writing the letter[138].

NGO REGISTRATION

The civil society organisations involved in HIV response, including organisations of women living with HIV, are not singled out as a separate group and are registered on a common basis [139] Organisations of women who use drugs can also be registered, furthermore, there is no need for a license for any of these community-led organisations to offer services[140].

At the legislative level, an obstacle to registration for sex workers' organisations is that the term "sex worker" does not exist in Kazakhstan's legislature, which prevents sex workers from incorporating provisions in their statutes on the protection of their rights and offering services to other sex workers.

Funding is provided to civil society organisations as part of the state social order and grants, as well as international grants[141].

Currently, the Foundation of Women Living with HIV in Kazakhstan is registered in Kazakhstan[142]. It operates across the nation. The Foundation is funded by both international and governmental organisations, UN agencies, and private donors. Activities range from HIV prevention (including PMTCT), direct provision of social and psychological services, temporary accommodation to community development, advocacy for women living with HIV, and women from key populations (including people who inject drugs and people in prisons or other closed settings).

The interests of sex workers are represented by the Public Association "Amelia". Funding is provided by international organisations. The organisation is engaged in the development of the sex worker community in Kazakhstan, the protection of rights, and the promotion of the interests of the sex worker community.

The interests of women who use drugs are represented by the initiative group "Forum LUN", (stands for "Forum of People Who Use Drugs"). Due to the fact that there is no official registration yet, funding is usually provided through friendly partner organisations. The organisation is engaged in the development of the PWID community in Kazakhstan, the protection of rights, and the promotion of the interests of the PWID community.

8.2 COMMUNITY-LED MONITORING

Prior to 2022, civil society found it challenging to keep track of indicators because they were all contained in separate documents related to the HIV response. The "90-90-90" and then "95-95-95" targets were considered the main indicators for an extensive period of time. If the HIV Roadmap is approved, every indicator can be tracked, including the PMTCT rate, which is the only gender-specific indicator to date.

Separate reports on the HIV response have been reviewed by the community of people living with HIV in terms of procurement and meeting the demand for ARV medicines and diagnostics, as well as analysing legislation and discrimination against people living with HIV. A systematic analysis of all indicators in the field of HIV response by the community of people living with HIV has not yet been conducted.

The country regularly conducts a stigma index[143], which allows people living with HIV to directly participate in monitoring the situation with discrimination against people living with HIV. Regular reports on the procurement of ART[144] and diagnostics are also drawn up, which allow the community of people living with HIV to monitor the real state of affairs in these areas (this type of analytics does not imply highlighting gender differences in access to treatment and diagnostics, but addresses the general degree of service accessibility).

Access to treatment, diagnostics, and other medical services online is provided through the platform pereboi.kz and the website Justice for Everyone[145]. These tools are used by people living with HIV and key populations in cases of rights violations; the website, which has been financed for three years as part of international projects, enables applicants to obtain legal assistance.

Representatives of PWUD Forum have the chance to participate in training on how to utilise the tool "Implementation of comprehensive HIV and Hepatitis C virus programmes for people who inject drugs: a practical guide for collaborative efforts" (IDUIT)[146].

Members of a sex worker organisation (Public Association "Amelia") have been conducting trainings on the use of the Sex Worker Programming Implementation Tool (SWIT) since 2018. Ten training sessions were attended by 200 participants, both at the national and regional levels[147].

The interests of adolescent girls and young women are represented by the Peer-to-Peer Plus NGO, which focuses on implementing SRH and HIV prevention programmes among adolescents and young people, including girls living with HIV (Teenergizer movement).

In 2018, a shadow civil society report on discrimination and violence against women living with HIV, women who use drugs, sex workers, and women in prisons was prepared and filed[148]. Based on the report, the CEDAW committee made recommendations for each key population[149]. Regrettably, only a few of the suggestions have been implemented and included in normative acts.

Representatives of women living with HIV, women who use drugs, and sex workers are actively involved in international movements such as EWNA, ENPUD, SWAN, and ITPC.

SECTION CONCLUSIONS

1. Despite the presence of women living with HIV and key populations' representatives at events dedicated to the development of HIV policy and HIV prevention programmes, the implementation of gender-specific services has not received adequate attention, and advocacy for the inclusion of such services has been insufficient. In this regard, it is necessary to empower women living with HIV and women from key populations through advocacy training for the inclusion of gender-specific programmes and other aspects of women's vulnerability in the context of HIV, as well as the implementation of programmes to monitor the rights of women living with HIV and women from key populations.

2. The community of women living with HIV and women from key populations needs further development.

The preliminary results of gender assessment were presented and discussed at the CCM platform for key populations with the participation of governmental, non-governmental and international organizations, including representatives of the PLHIV community and women living with HIV, on April 11, 2023. The final results of the gender assessment and report will be discussed at the country level by the end of 2024. A decision will be made to develop a results-oriented plan to include gender-sensitive activities at the country level..

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