



Gender and HIV/AIDS In Eastern Europe and Central Asia

Part I: A literature Review of Evidence
Part II: Case studies from Estonia, Russia and Kyrgyzstan

Anna Mia Ekström
Anders Ragnarsson
Anna Thorson

Division of International Health (IHCAR)
Department of Public Health
Karolinska Institute
Stockholm, Sweden

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Abbreviations and Acronyms

AISC	Aids Information and Support Centre
AIDS	Acquired Immune Deficiency Syndrome
APC	AIDS Prevention Centre (Estonia)
ART	Antiretroviral Treatment
CCM	Country Coordinating Mechanism
EEK	Estonian Kroons (local currency in Estonia)
ESPO	Estonian Positive People Society
FPA	Family Planning Association
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria, “Global Fund”
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
IDU	Intravenous Drug Use
IDUs	Intravenous Drug Users
IHCAR	Division of International Health, Karolinska Institutet, Stockholm
KAB	Knowledge, Attitudes and Behaviour
KZN	the Kyrgyz Republic or Kyrgyzstan
LFT	Living For Tomorrow
MoE	Ministry of Education
MoH	Ministry of Health
MoSA	Ministry of Social Affairs (Estonia)
MSF	Medicine Sans Frontiers
MSM	Men who have Sex with Men
NGO	Non-Governmental Organisation
MTCT	Mother-To Child Transmission
OI	Opportunistic Infections
PC	Personal Communication
PLWHA	Persons Living With HIV/AIDS
STI	Sexually Transmitted Infection/s
SW	Sex Workers
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNIFEM	United Nations Development Fund for Women
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
YCC	Youth Counselling Centre

Executive summary

Gender mainstreaming is not costly in terms of financial resources, but it requires an increased awareness of the importance of creating gender-sensitive HIV-prevention, care and surveillance programmes. This is important not only for the sake of equity but because large groups of vulnerable people are not reached by current campaigns and services that often lack sensitivity both in terms of gender and ethnicity.

Eastern European and Central Asian societies display traditional gender norms. Men tend to ignore or seek risks associated with drugs or high-risk sex, while women have less power in sexual relationships and their bodies are thought of as potential transactional goods. HIV is still largely considered a “drug-users disease” and has yet to be taken seriously in the region by policy makers and health practitioners. At the policy level, HIV/AIDS issues have only recently become prominent, following the availability of increased funding. However, HIV is still prioritised among “health and social issues” rather than as national concern.

A very high prevalence of drug-related risk-behaviours among young people, mostly men, is triggering the HIV/AIDS epidemic in the region. Discrimination against young intravenous drug users (IDUs), in terms of attitudes and denial of monitoring and antiretroviral treatment (ART), may fuel protest and further escape-related risk-behaviours. Laws prohibiting discrimination are in place, but not enforced or practised by health care providers. IDU is not merely a consequence of poverty, societal disruption or fatalism, but to a large extent driven by gender stereotypes that push young men to experiment with drugs, to display their macho-behaviour through injection and peer solidarity through needle sharing. Young women are often introduced to drugs by their boyfriends.

The number of sex workers (SW) and the trafficking of young women have increased significantly in the region during the last decade. The large numbers of temporary female SW have a very high risk of HIV exposure and risk spreading HIV to the general population. In some cases, unemployed women may see sex work as their only possible source of income to support their children or drug abuse habits. Dreams of a better life make many young women vulnerable to deception and result in their being trafficked abroad or in larger cities where they are exploited. These women are extremely powerless in terms of changing their own situations, but tackling trafficking appears to be of surprisingly low priority for legislators.

Estonia has seen an extremely rapid spread of HIV among young male IDUs. Several factors indicate that a generalised heterosexual epidemic is emerging, for example there are an increasing number of HIV-infected young girls (15-19 year-olds) who make up 42% of new HIV infections.

The majority of HIV infections occur among very young men in the Russian-speaking minority where gender stereotypes with strong macho ideals prevail and language barriers and discrimination have caused high unemployment. Despite being born in Estonia, many unemployed HIV-positive young people of Russian ethnicity lack health insurance. This implies that they do not have access to HIV monitoring and cannot be put on ART when their immune status fails. Russian-speaking men and women must be targeted, both in terms of drug prevention and sexual education in schools.

When the AIDS Prevention Centre (APC) in Tallinn was moved to the Merimetsa hospital in May 2003, voluntary counselling and testing (VCT) declined by 50% indicating that the true incidence in 2003 may be higher than reported.

Women IDUs, especially those with children, are underrepresented in needle exchange due to stigma and fear of being arrested by the police. This study identified as an urgent priority the need to increase the accessibility to VCT by supporting drop-in testing both in city centres and in areas where many

IDUs live. It is important to include young ex-IDUs of both sexes, Russians as well as Estonians, in outreach needle exchange and peer education in order to gain respect among youth and to effectively convey HIV prevention messages. Needle exchange must be legalised in prison facilities to avoid the rapid spread of HIV between young male IDUs who frequently spend time in prison for drug-related crimes.

As a society undergoing ideological, economic, social and structural transformation, the **Russian Federation** is very vulnerable to the epidemic manifesting itself and faces a rapid increase in new HIV infections. So far, HIV issues have not received enough attention, and HIV has largely been viewed as a problem associated with certain risk-groups. This view may not only have contributed to an underestimation of the epidemiological potential of HIV spread into all layers of society, but it has also helped to externalise people who already are in a weak position and fuelled the notion of “we and them”. New and innovative multidisciplinary strategies to tackle HIV/AIDS in Russia are urgently needed throughout all levels, from surveillance to care of the people infected and affected.

A gender dimension is missing both in guidelines for monitoring and evaluation, in legislative acts as well as in health service strategies. Gender awareness would improve the overall understanding of users of health services. First, there is a need to generate sex-disaggregated data on the oblast-level to provide information on demographic indicators such as sex, age, socio-economic status, and ethnic origin to illuminate differences and potential inequalities. Further, on a programme and policy level, impact and anticipated outcomes should be systematically identified and include gender-specific indicators. Such data could become a pertinent tool for the Ministry of Health in order to improve prevention and surveillance. Today, NGOs and “grey literature”, i.e. unpublished internal reports and documents provide most of the information and knowledge on HIV/AIDS.

Donor initiatives based on imported ideologies may not always be suitable for the Russian context. A more open and vibrant dialogue on HIV/AIDS related issues between national and international actors is essential. Also, more research is needed to grasp contemporary sexual behaviours, practices, norms and values in Russia today in order to tailor efficient and equitable policies for prevention and care.

In **Kyrgyzstan** the incidence of HIV shows an exponential rise, whereas the reported case burden in absolute numbers still is less than 500 and the HIV prevalence below 0.1%. More than 80% of all cases are men and the epidemic is seemingly limited to risk behaviours like IDU. Still the majority of active IDUs have not been tested for HIV. Testing facilities are focused on health care personnel and to a lesser extent pregnant women. The current health care insurance system excludes parts of the population who are unemployed or without a formal employment. The change from a social security system to an insurance-based system has disproportionately affected women, who have lower access to regular health care services including HIV testing. Following the economic transition and increased social disparities the number of IDUs and female SW with low access to care and information have dramatically increased.

The epidemic has not yet spread to the general population, which could be seen as a window of opportunity for prevention and introducing ART. The existing state policy identifies the major problem areas, but lacks specific gender considerations. Future interventions should consider the patriarchal structure of the Kyrgyz society and female disempowerment reflected in sexual risk behaviour. Existing and future initiatives must also take into account the rapidly changing expectations on males in a transitional economy and possibly related detrimental health behaviours, in the Kyrgyz society exemplified by a steep increase in IDU. Innovative forms of VCT and health care services (drop-in, outreach VCT) should be expanded and joint initiatives with informal collaborative structures such as NGOs together with MoH and MoE will be needed to boost resources while the window of opportunity still is open.

Preface

This report is the result of a study on how gender influences the HIV/AIDS epidemic in Eastern Europe. The study was undertaken by the Division of International Health (IHCAR), Karolinska Institutet during October-December 2003 and commissioned by the WHO Regional Office for Europe (WHO/EURO). It is divided into two parts. Part I is a thorough review of the literature on HIV/AIDS in Eastern Europe and Central Asia from a gender perspective. Part II consists of case studies from Estonia, the Russian Federation and Kyrgyzstan, three countries at different stages of the epidemic and with different economic and social resources at hand to tackle HIV/AIDS. Each country study, performed through interviews with key actors, ends with specific recommendations for how to integrate a gender perspective into future HIV/AIDS programmes, a process referred to as “gender mainstreaming” (*WHO September 2001*).

How is the term “gender” different from “sex”?

The term ‘sex’ is used to refer to biological characteristics. Beyond the physical determinants of sex, gender is defined as the deeply rooted, socio-culturally constructed expectations of women and men that influence their behaviours and opportunities in society. Gender is socially constructed, produced and reproduced through peoples’ actions, i.e. dynamic and possible to change (*Vlassoff et al. 1998, Thorson 2003, Krieger 2002, WHO June 2002*).

In the HIV/AIDS epidemic, gender norms and dynamics play important roles in determining many key aspects of a person’s risk and response to HIV/AIDS including: an individual’s vulnerability to infection, perceived risk and actual risk-taking behaviour, differential exposure to HIV, knowledge and access to health information, health-seeking behaviour, the utilization of services for treatment, and the ability to cope when infected or affected by HIV/AIDS.

Gender analyses aim to acknowledge societal power structures of importance for both men and women. In the area of HIV/AIDS, such analyses are crucial because gender inequality and decision-making power in sexual relationships are key factors in the global spread of HIV (*World Bank 2003*). Previously, gender studies have often focussed on identifying inequities from female perspective. However, and pertinent to Eastern Europe, a gender perspective also includes identifying how risk-behaviours linked to masculinity such as unsafe sex, drug abuse and bad social networks affect the risk of HIV. Gender relations are also closely linked to ethnicity and social class (*Rathgeber 1993, Thorson 2003*).

Why does gender matter for illness and premature death?

Despite the male dominance in virtually all power structures, men in Eastern Europe live on average 10 years less than women. In almost all societies, men are more likely to smoke, drink alcohol, drive without seat-belts, eat unhealthily and are often less aware of medical conditions. Globally, women’s health is strongly related to power, or rather, the lack of power. Most women in the world are not allowed to make decisions about their own bodies, a fact that has major consequences for women’s sexual and reproductive health. Almost half of all women have sometimes been victims of domestic violence, and, the majority of the world’s poor are women. These gender patterns are often taken for granted, but only a small share of the differences between men and women in terms of illness and premature death can be explained by biological differences. Gender roles are believed to account for most of the other discrepancies.

A man’s degree of masculinity, and his ranking among other men, is often defined by a denial of weakness or vulnerability combined with emotional and physical control. Men are expected to have a ceaseless interest in sex, perform high-risk activities and to be aggressive. Hence, masculinity is often defined against positive health behaviour, especially amongst men themselves. Both women and men

adopt different culture-specific, health-related behaviours and use these for demonstrating femininity and masculinity.

Men who have had their masculine identity and self-esteem undermined by men or women with higher status in terms of ethnicity, economic status, educational level or sexual orientation, use other available means, often dangerous, compulsive or self-destructive, to reconstruct their masculine positions. For identity-seeking, socially disadvantaged young men, dismissing the risks associated with drug use, needle sharing and unprotected sex, may be ways to protest and assert their masculinity. When a variety of psychosocial factors were controlled for in a longitudinal study of health-behaviour among young men aged 15-23, traditional beliefs about masculinity (gender norms) emerged as the strongest predictor of risk-taking behaviour in terms of smoking, high-risk sexual activity and use of alcohol and other drugs (*Courtenay 2000*).

Part I: Literature review

A gender approach to HIV/AIDS in Eastern Europe

by Anna Mia Ekström

1.0 Introduction

The HIV epidemic in Eastern Europe and Central Asia is accelerating faster than anywhere else in the world. The number of persons living with HIV, estimated to 1.3-1.8 million in the end of 2003, has multiplied in only a few years with the majority diagnosed only during the last 18 months (*UNAIDS 2003, Kelly and Anmirkhanian 2003*). In this report we will try to answer the following questions: How is this escalating epidemic related to gender? And why does it matter?

So far, very young men or teenage boys bear the major burden of the epidemic, but recent statistics indicate that HIV is spreading rapidly among young women as well. Most young people are aware that HIV spreads via intravenous drug use (IDU) and the sharing of drug equipment. Still, a surprisingly large number of young people engage in such high-risk behaviour. Most young people are also aware that HIV may be transmitted via unprotected sex. Still, only a minority of sexually active youth always use condoms with their partners. Since young people often associate condoms with distrust, infidelity and HIV, condoms are often not even used when a partner is known to inject drugs or to have multiple sex partners, for example through sex work.

Sex work and the trafficking of young women and children has rapidly increased in the region during the last decade (*Hyland 2000, Transatlantic partners 2003*). Apart from those who engage in sex work more or less voluntarily, an estimated 200,000 women and children are trafficked annually from Eastern Europe (*Tyler 2003, OSCE 2003*). Poverty in combination with cultural gender expectations that women's bodies may be for sale, make women vulnerable to the sex industry despite the fact that, for most women, selling sex is the most shameful of all possible sources of income.

As formal economies fail to employ young people and basic support structures in society are cut short, more young women and men turn to informal, illegal and potentially health-threatening activities to earn a living. HIV thrives where there is poverty, hopelessness and fatalism, but the above examples also show that gender stereotypes strongly influence the risk of HIV. Gender patterns also affect access to harm reduction and care. Whether you are a woman or a man matters greatly in terms of your likelihood of sharing needles with peers, injecting drugs at a party, having the power to say 'no' to sex, and having the courage to go for needle exchange or voluntary counselling and testing (VCT), particularly if you are a parent. Gender structures also affect someone's likelihood of going to prison, exchanging sex for money and accessing anti-retroviral treatment (ART).

2.0 Background

Overall, 80% of Persons Living With HIV/AIDS (PLWHA) in the region is less than 30 years of age. In Belarus and Estonia about 60 to 75% of new HIV infections occur among people less than 24 years of age. Approximately three-quarters of all HIV-infected individuals are men, but the number of new HIV infections among women in Eastern Europe has increased more than five-fold between 1997 and 2001. Although, the assumed dominant mode of infection is through risk-behaviours associated with IDU, the number of women infected through an unknown mode of transmission is almost as large as those infected through IDU and is increasing even more rapidly (*UNAIDS 2003, MoSA Estonia 2003, pc Dr Eramova WHO/EURO, 2003*).

Today, Eastern Europe has all of the prerequisites for a quick transition from an IDU-associated HIV epidemic to a heterosexual epidemic. Recreational intravenous drug use is widespread among young and sexually active people. Many of these young people are still in school or work, and are, thus, actively part of social networks. As a result of diminished resources for surveillance of sexually transmitted infections (STIs), the prevalence of syphilis and gonorrhoea is very high in the region. Sex work among women who are non-IDUs has also increased dramatically in conjunction with increased unemployment, trafficking and changing societal attitudes (*Kelly and Anmirkhanian 2003*).

In fact, a decreasing proportion of IDUs amongst the newly infected (e.g. in Estonia from 94% in 2001 to 73% in 2002) corresponds with a proportional increase of women in cases of new HIV infections. This trend, as well as a sharp increase in the numbers of infected newborns in countries with more advanced epidemics such as Russia and the Ukraine, indicates that heterosexual spread is already well underway.

In countries with very recent HIV/AIDS outbreaks, such as Kyrgyzstan and Uzbekistan, the number of HIV infected individuals is still low. However, these countries in Central Asia share the same enabling factors as many other countries in the former Soviet Union¹ only with a greater and possibly growing gender imbalance. In addition, Central Asian republics often have less financial capacity to handle the epidemic and even basic prevention is sometimes lacking. For example the fact that Tajikistan did not HIV test 40% of blood donors in 2002 (*UNAIDS 2003*), entails an increased risk of infection, especially for women, since blood transfusion is common after childbirth.

3.0 Sexuality

Sexuality is thought of as a multidimensional and dynamic social construction of a biological drive. Depending on gender and age, strong explicit or implicit rules are imposed on and reinforced by both women and men. Gender structures profoundly influence an individual's sexuality and are crucial for differences in men's and women's vulnerability to the sexual transmission of HIV (*Dixon-Mueller 1993, Zeidenstein and Moore 1996, Parker and Aggleton 1999 in WHO June 2002*).

3.1. Interaction between biological sex, gender and risk of HIV

Biologically, the risk of HIV infection during unprotected vaginal intercourse is at least four times higher for women than for men. This is largely because women have a larger surface area of mucous membrane exposed during intercourse, and also because they are exposed to a larger quantity of infectious fluids, semen, which contains a higher concentration of HIV than vaginal secretions and may remain in the vagina or rectum for hours after intercourse. Micro-lesions that occur during intercourse may also serve as entry points for the virus. The majority (50-80%) of persons with a vaginal, anal or rectal STI have no symptoms or have symptoms that cannot easily be recognised. However, viral load in plasma (and correspondingly in sexual fluids) appears to be the most important factor for the sexual transmission of HIV-1 (*WHO March 2003*).

A biological vulnerability is unfortunately often reinforced by social and cultural vulnerability. Especially young women oftentimes lack the power needed to avoid STIs (*WHO March 2003*). Women diagnosed with an STI may be stigmatised as promiscuous. The same goes for anal STI among men who have sex with men (MSM). Thus, many persons prefer to bear the pain and discomfort of STIs rather than to be exposed to the shame associated with seeking treatment. In Kyrgyzstan, societal norms strongly condemn premarital sex. To avoid social stigma many girls

¹ The former Soviet Union includes the Baltic States (EST, LAT, LIT), the countries of Caucasus and Central Asia (ARM, AZE, GEO, KAZ, KYR, TAJ, TUR, UZB) and the European Newly Independent States (BEL, MOL, RUS, UKR).

therefore still avoid seeking medical care for any type of pelvic diseases and menstrual problems. This is especially remarkable in a context in which 31% of premarital sexual encounters for schoolgirls are reported to be the result of rape (*UNIFEM 2003*).

3.2. HIV and gender effects of economic hardship

Economic factors are especially important for the risk of women to contract HIV infection. Financial or material dependence on men limits women's control over when, with whom and in what circumstances they have sex. Regular or occasional sex work may provide economic survival. Temporary sexual relationships in exchange for economic security have also become more common in many parts of the region (*Rhodes et al 1999*). However, not only women, but also boys and girls who live in the streets must exchange sex for material favours, drugs or sheer daily survival. This type of exchange, or transactional sex, outside of formal sex work is rarely recognised in HIV preventive work. Many poor women also view transactional sex as one of the few ways of providing for themselves and their children (*WHO June 2000*).

The number of sex workers (SW) has increased dramatically since the collapse of the Soviet Union (*Transatlantic partners 2003*). In addition to exposing themselves to extremely high risks of HIV, these women also constitute an important bridge population for transferring HIV into the general population as demonstrated by the following figures.

- In Estonia, an estimated 4,000 women are involved sex work. Of these, 2,000 work in brothels and another 1,500-2,000 women, often IDUs, are involved in street prostitution (*pc Juri Kalikov, AISC*).
- In Kyrgyzstan, at least 3,000 women sell sex for a living including 1,600 in Bishek, 750-1,000 in Osh, and about 200 in Jalal-Abad. With an average of 1-2 clients per SW per day, total SW visits sum up to 1-2 million per year, corresponding to an estimated 300,000–500,000 individual clients (*CCM 2002, Irinnews November 2003*).
- A recent estimate places the number of SW in Moscow at 70,000 (*Dehne 2002*). A survey from Saratov oblast in Russia showed that the annual number of SW contacts per 100,000 persons in the general population ranged from a low estimate of 33,000 to a high estimate of 730,000. A study in St Petersburg showed that 10% of teenage girls and young women consider prostitution to be an acceptable and legal way of making money (*Afanasyev and Skorobogatov 1995 in Atlanti 2000*).

Trafficking of young women and children has exploded in the region during the last decade (*Hyland 2000*). An estimated 200,000 individuals are trafficked annually from Eastern Europe, a significant proportion being children (*Tyler 2003, OSCE 2003*). Women from Russia and Estonia are mainly trafficked to the Nordic countries and Western Europe, but also to destinations such as Thailand, Japan, and the USA. Trafficking also occurs within countries from rural to urban areas such as in Kyrgyzstan where Uzbek young women have reportedly been trafficked to Osh for sex work. The women and sometimes children may be sold directly to the traffickers by parents, boyfriends or pimps. Many are deceived into sex slavery when responding to job ads for striptease or modelling. Once abroad, the women often find themselves in a country where they have no legal permission to stay, have been deprived of their passports, are financially dependent on their employers for a return ticket and are threatened with violence and blackmail to not abscond (*Kalikov 2002, Irinnews November 2003, Hyland 2000, Tyler 2003*).

3.3. Un-safe sex practices from a gender perspective

Aside from economic dependency, social and cultural gender norms often make it more difficult for women to argue for safer sex, no sex, or fidelity. Women are not expected to discuss or make decisions

about their own sexuality. Fear of repercussions such as violence or accusations of infidelity may prevent women from negotiating condom use or refusing unwanted intercourse. The many forms of violence used against women in private relationships as well as in transactional sex, show that sex is often coerced. Since coercion causes mucosal tearing, it is in itself a risk factor for HIV transmission.

Also men, particularly young men, report that they are afraid of being accused of drug addiction, infidelity, or for not being trusting enough towards their partners, if they suggest condom use. Sexual behaviour studies show that both heterosexual and homosexual men, single as well as married, have more partners (including visits to SW) than women (*WHO June 2002*). Multiple partners are culturally accepted or even expected, but increases the risk of STD/HIV for the men involved as well as for their partners (*WHO June 2000*). In Kyrgyzstan, polygamy is often approved of and if a man has an extra-marital child this may be regarded with hidden respect (*UNIFEM 2003*).

3.4. Men who have sex with men

Only recently have gay communities become more visible in Eastern Europe and in most countries, MSM remains highly stigmatised, hidden or illegal. Since the HIV/AIDS epidemic affected MSM before it spread among IDUs, gay communities have had some time to respond to the epidemic. However, prevention has been hampered by stigma, small numbers of activists, weak organisational structures and little government support.

A survey in 2000 among men entering gay-identified venues in St Petersburg, showed high levels of risk-behaviour. These men had an average of three partners in the past three months, 38% had engaged in unprotected anal intercourse and 23% of MSM sold sex to other men. Almost 80% of MSM also had female sexual partners in their lives, and 36% reported recent bisexual behaviour (*Kelly and Amirghanian, 2003*).

MSM who are infected with HIV face the dual risk of stigma and discrimination when they need to seek care or support. Also, due to their associated shame (and sometimes illegality), gay encounters are often performed hastily, in an unplanned manner or in secrecy, where the chances of condom use are less likely. Biologically, the risk of HIV transmission of the receptive partner is increased during unprotected anal intercourse due to tearing of the thinner rectal mucous membranes, the enhanced presence of macrophages, and the reception of sperm.

3.5. Sexual education and awareness

Prevailing social norms of masculinity show that boys are expected to be knowledgeable and more sexually experienced than girls. Such expectations encourage young men to deny risks and prevent them from admitting their lack of knowledge (*UNAIDS 1999 in WHO June 2002, UNIFEM 2003*). In rural Kyrgyzstan, the prevailing opinion is that sexual education has a negative impact on young people's morale and talking about sex is taboo in most families. However, even though most young people do not perceive themselves to be at risk of HIV, adolescents in rural areas are better informed about HIV/AIDS/STIs than their parents. The United Nations Development Fund for Women (UNIFEM) reports that a majority of female respondents in Kyrgyzstan were unaware of the existence of laws that promote women's rights to sexual and reproductive health, equal access to education, and the elimination of harmful social norms and traditions that constrict women's societal privileges (*UNIFEM 2003*). A report from the United Nations Population's Fund (UNFPA), showed an alarming spread of segregation and seclusion of women, polygamy and early marriage for girls (from age 15, often for economic reasons, preventing girls from obtaining secondary education) (*UNFPA 200, Irinnews December 2003*).

In most countries in the region, issues of family planning, sexual behaviour and relationships are seldom discussed in school. Sex education primarily focuses on abstinence or on women's reproductive health. Even when school-based sexual education is provided, like in Estonia, the gender stereotypes displayed in media, as well as the increased access to pornography on the Internet, may have more influence on young people (*pc Triin Raudsepp, social worker at the FPA in Estonia*).

Having the correct knowledge and awareness about sex and HIV is not enough to enable young women to be proactive in negotiating safer sex. Society expects a woman to be naïve or passive in sexual matters and knowledge about sex is considered to reflect sexual experience or even promiscuity (*UNAIDS 1999 in WHO June 2002*). Data from Moscow and St Petersburg shows that 40-45% of 15-18 year olds are sexually experienced and that 80% are sexually active by age 19. The sexually experienced 15-17 year olds in St Petersburg had had an average of 3.4 partners, only 29% reported consistent condom use, and 40% said they preferred vaginal intercourse without a condom (*Kelly and Amirkhanian 2003, MSF 2000*). Our interviews with Russian-speaking youth in Estonia also indicate that condom-use nowadays may raise suspicion of HIV, making protective behaviour difficult to enact.

4.0 Gender aspects of intravenous drug use

Along the drug trafficking routes through Central Asia and Eastern Europe, where heroin sometimes costs less than alcohol, the number of intravenous drug users (IDUs) in Kazakhstan, Kyrgyzstan, Russia, Ukraine and the Baltic States, has rapidly increased (*Kelly and Amirkhanian 2003, UNAIDS 2003*). In May 2003, the Russian Ministry of Education estimated that four million young people were using illicit drugs, one million of them were drug-dependent and that 8% of Russia's youth bought illegal drugs every day (*RIA Novosti 2003, Transatlantic partners 2003*). However, other sources estimate there could be as many as three million IDUs in Russia today. A Moscow survey from 2000 performed among 15-18 year olds showed that 8% overall and 12% of young males had injected drugs (*MSF 2000*) while according to other and a more recent studies half of Russia's college students have injected drugs (*Kramer 2000, Kelly and Amirkhanian 2003*).

The drug situation in Russia's neighbouring countries is similar or worse. It is estimated that there are 600,000 IDUs in Ukraine and 200,000 in Kazakhstan. In Estonia and Latvia 1 % of the adult population injects drugs compared to 2% in Kyrgyzstan. Thus, the number of IDUs adds up to at least four million in the aforementioned countries alone. The majority of IDU's are young men. Statistics from a needle exchange programme in Narva, Estonia, showed that 67% of the clients were male, 75% under 25 years of age (*MoSA Estonia. Overview of HIV statistics 1988-2002*). Since the break-up of the Soviet Union, state enforcement of anti-drug policies has deteriorated along with shortages of social services and recovery programmes for drug users. At the same time, drug demand has increased by 400% between 1992 and 2002 according to the Russian Ministry of Health (*Transatlantic partners 2003*). Drug distribution networks are now major economic forces involving local sales and international trafficking routes that connect the expanding areas of traditional opium poppy cultivation in Afghanistan and its bordering Central Asian republics with Eastern Europe. The acceptance/preference for administering drugs by injection rather than through inhalation or ingestion, especially among young men, appears to be very high and increasing (*Rhodes et al 1999*). Reports from Russia, Ukraine and Estonia suggest that injection is not viewed as strange or complicated by youths but is perceived as masculine behaviour and also is less expensive than oral drugs. In Kyrgyzstan, only 10% of illegal opiates were injected in 1991, compared to 70% in 1999 (*UNAIDS-Central Asia January 2001*.)

Sharing injecting equipment appears to be the norm, often to affirm trust among peers (showing that the one trusts one's friends to be free of e.g. HIV and hepatitis). In Moldova 80% and in Moscow 75% of IDUs shared injecting equipment. Only 10% of IDUs cleaned their needles before re-use by boiling

or bleach, while 76% tried to clean them but using inefficient methods. Nearly 30% had shared needles outside their personal friendship network (*Reilly et al 2000*). Apart from needle sharing, other drug-related behaviours have facilitated the rapid spread of HIV since the 1990s. For example, dealers have reportedly added their own blood to improve or check the quality of the drug when preparing liquid opiates (*Dehne et al 1999, Atlanti 2002, Bolekham et al 1998*). Also, young and inexperienced users tend to buy pre-packaged drugs, sometimes in liquid form, which may come in used or non-sterile syringes. Dealers sometimes keep the drugs in contaminated reservoirs and IDUs may also refill by frontloading from the dealer's syringe or share a single syringe in a group by repeatedly back-loading it (*Dehne et al 1999, Atlanti 2000, Bolekham et al 1998*).

It appears less common that young women meet in groups and inject, probably because drug use is much more stigmatising for women and not associated with increased status among friends or boyfriends. Women are underrepresented in the statistics that originate from needle exchange points partly because many women with IDU behaviour, and especially those with children, fear being arrested by the police. Many also fear being publicly associated with IDU, since female IDUs are often associated with sex work, something that appears to be even more stigmatising than the drug use per se (*pc Convictus, Estonia*).

5.0 HIV in pregnancy and Mother-To-Child-Transmission

The dominant global ideology of femininity casting women as vectors of disease or merely as bearers of unborn children has greatly influenced the design of HIV/AIDS interventions. In order to protect the health of the child, pregnant women are usually tested for HIV. Although it is illegal to test for HIV without a woman's consent, reports indicate that pregnant women who refuse an HIV-test may be sent to give birth in special HIV-units where the likelihood of stigma and discrimination is high. In Estonia, more than 60% of women of childbearing age do not use any method of contraception and only 16% use condoms (*Estonian abortion registry 2003*). There is no data as to whether contraceptive use differs between HIV-negative and HIV-positive women.

Studies from high-income countries indicate that pregnancy does not affect the progress of the infection in HIV-positive women without symptoms, but little research has been done in middle and low-income countries (*WHO March 2003*). Pregnancy-related complications, such as haemorrhage, expose women to the risk of HIV infection related to blood transfusion, particularly in some countries in Central Asia where a minority of blood donors are screened for HIV (*UNAIDS Epidemic update 2003*).

In terms of access to ART, pregnant women, or rather their unborn children are usually a priority group. In spite of this and mainly for economic reasons, Kazakhstan cannot offer any of its HIV-positive pregnant women ART prophylaxis to prevent mother-to-child-transmission (MTCT). In Russia, pregnant women must be treated with ART according to federal law, but there is no data on whether they actually receive such prophylaxis (*pc Dr Eramova WHO/EURO*). However, it is known that the percentage of children born to HIV-positive mothers that become infected varies from 3% to 15% between the regions of Russia. A total of 7,591 children were officially registered HIV-positive in Russia as of December 2003 (*pc AIDS Infoshare Moscow*), indicating ineffective prevention of MTCT.

As of the beginning of 2003, the overwhelming majority of HIV-infected children in the region were born in the Ukraine (56%) and Russia (43%), the two countries with the most advanced epidemics (*pc Dr Eramova WHO EURO*). Estonia, and most likely also the other countries in the region, has an incomplete surveillance system to follow-up HIV-status among children born to HIV-positive mothers (*pc Dr Zilmer, Merimetsa hospital, Tallinn*). This indicates that the hidden numbers of HIV-positive children that do not get access to ART may be substantial.

It is not clear whether pregnant women with on-going or past drug abuse get access to ART in any country in the former Soviet Union. In the Ukraine, where the majority of the region's HIV-positive children are born, the proportion of HIV-positive women who were infected through IDU declined from 34% in 1997 to 25% in year 2000.

Stigma and dilemma associated with the use of infant formula instead of breastfeeding among HIV-positive women could possibly become less of a problem in Europe than in Africa. One reason for this assumption is the tradition of early weaning since a high proportion of women are formally employed. Other reasons are associated with the fact that the need to breastfeed is lower in Eastern Europe than in Africa given the relatively lower infant mortality rates and the high access to improved water sources as well as access to alternative nutritional sources for babies.

6.0 Risks and consequences of HIV among male and female prisoners

The isolation of men, for example through incarceration, greatly increases the numbers of heterosexual men who engage in (often unsafe) sex with other men. One survey demonstrated that 85% of Russian inmates (of which 90-95% are men) with 1.5 to 10-year sentences had had sexual encounters while in prison (*Holley in Transatlantic partners 2003*). The high rate of imprisonment² in many of the former Soviet countries greatly exacerbates the risk of HIV transmission among young men. According to the 2003 statistics from the Russian Ministry of Justice, an estimated 1% of the population aged 20-64 were incarcerated, mainly due to IDU and drug-related crimes. These same statistics estimate that 37,200 prisoners, or 4.2% of prisoners, are HIV-infected (*Moscow Center for Prison Reform*). In Estonia, 89% of prisoners are male. In 2002, 27% of all new HIV infections were diagnosed in prison, the majority among men aged 15-24, in other words, men expected to be sexually active following their release from prison (*MoSA Estonia. Overview of HIV/AIDS statistics in Estonia 1988-2002*).

Of men and women incarcerated in Russia in 1999, at least 45% were incarcerated for theft-related crimes as Russian law prescribes minimum sentences of 3 years, even for such minor crimes. In larger cities, the proportion of IDUs among women on trial has increased as a result of the increasing numbers of female IDUs in society, as well as more severe sanctions for the possession of narcotics. Those charged for IDU, even first-time offenders i.e. probably those who would benefit most from treatment, may be sentenced to up to 8 years imprisonment.

A study of 184 incarcerated Russian women, mothers of 305 children, illustrates that separation from their children is one of their greatest challenges for imprisoned mothers (*Alpern 2000*). According to Russian prison regulations, convicted mothers have the right to a seven-day trip beyond the confines of the penal colony in order to place the child in the care of relatives or in an orphanage. The study showed that these rights do not apply to women with tuberculosis (TB), women with untreated STIs or women who are HIV positive. Furthermore, women with TB and/or HIV were not allowed any visits and several of them had not seen their children for over 4 years (*Alpern 2000*). To our knowledge, nobody has investigated how men and their children are affected by the imprisonment of the father, but the emotional impact of separating children from their parents is likely similar regardless of gender.

² On January 1, 2003, institutions of GUIN (Chief Department of Penalty Execution) of the RF Ministry of Justice held 877,000 prisoners, of which 145,000 persons were imprisoned at SIZOs (pre-trial detention facilities). Additionally, 641,000 persons of which 32,000 were underage, were sentenced to penalties that did not involve imprisonment. The number of prisoners was 600/100,000 population to be compared to approx. 710/100,000 in the US (*Moscow Center for Prison Reform*), and 60/100,000 population in Sweden (*WHO 2000*).

7.0 Conclusions

How gender affects health, and the risk of contracting HIV/AIDS in particular, is striking and must be taken into consideration for effective planning and surveillance. Eastern Europe and Central Asia represent unique HIV contexts, very different from the situations in Sub-Saharan Africa or Western Europe. The region faces considerable challenges in order to stop the accelerating spread of HIV among very young women and men, as well as to improve the inadequate prevention of MTCT and the incomplete and often discriminating follow-up and care for PLWHA.

Eastern European and Central Asian societies display traditional gender norms where men are expected to ignore or even seek risks associated with IDU or high-risk sex. Women on the other hand often lack the power to choose their sexual relations and their bodies may be considered as potential transactional goods. The threat of HIV has not yet been taken seriously by governments or by the general population and HIV is still regarded as a “drug-users disease” that IDUs themselves are responsible for. Due to recent increased funding, the HIV issue has become more prominent at policy level, but it is still prioritised among “health and social issues” rather than seen as a national concern.

A very high prevalence of IDU related risk-behaviour among young people, particularly men, is triggering the epidemic, and the socially marginalized status of the majority of HIV-positive individuals makes secondary prevention activities difficult. Attitudes of discrimination against young IDU are widespread including the denial of monitoring and ART to IDUs with HIV. This discrimination exacerbates this group’s feelings of unimportance and social marginalisation, in turn fuelling protest and escape-related risk-behaviours. Laws prohibiting discrimination are already in place, but they are not enforced by governments or practised by providers.

IDU is not a moral issue, neither is it merely a consequence of poverty, societal disruption, hopelessness or fatalism. IDU is, to a large extent, driven by gender stereotypes that push young people, predominantly men, to seek risks and experiment with drugs, and to display their macho-behaviour through injection and peer solidarity through needle sharing. Many girls appear to be introduced to drugs through their boyfriends. Among the youngest age group, the proportion of IDUs who are girls appears to be increasing, but whether this is due to increasing abuse or more openness among young women is not known.

Sex work and the trafficking of young women and children have exploded in the region during the last decade, exposing the involved individuals to very high risks of STI and HIV. Due to the large numbers of young women who pass through the commercial sex industry, the risk of spreading HIV to the general population either through their clients or through their own partners is obvious. Unemployed women with families to support or with on-going drug abuse habits may see sex work as their only source of income. This view is steered by cultural gender expectations that women’s bodies may be sold. Dreams of a better life or more money make many young women and girls vulnerable to deception into trafficking abroad or to relocation to larger cities where they are exploited in the sex industry. These women are very disempowered in terms of changing their situation, still, they receive little help from the police and their destiny is of surprisingly low priority for legislators.

Gender mainstreaming is not costly in terms of financial resources but it requires an increased awareness of the importance of creating gender-sensitive HIV prevention, care and surveillance programmes. This is not only important for the sake of equity, but because large groups of vulnerable people are not being reached by current campaigns and services which often lack sensitivity both in terms of gender and ethnicity. Thus, in order to effectively reduce the drug-mediated spread of HIV, the potential for sexual transmission into the general population, as well as the provision of just and equal care to all women and men affected and infected by HIV, gender aspects should be taken into account for successful implementation and design of programmes for HIV/AIDS prevention and care.

Part II. Country Case Studies

The case studies are based on interviews with key actors (policy makers, providers of prevention and care, and, the users/target groups of these services) in Estonia, the Russian Federation and Kyrgyzstan. The studies focus on following levels of intervention:

1. Policy and legislation
2. Resources in terms of finances, health care staff and knowledge and awareness
3. Direct services for prevention and care

Each country study ends with recommendations on how to make prevention, access to counselling and testing, harm reduction, monitoring and treatment more equitable and effective for both women and men. Table 1 provides a comparative overview of HIV/AIDS and gender issues in the three countries.

Table 1. Country comparison of HIV/AIDS and gender statistics

	Estonia	Russia	Kyrgyzstan
Total population (million) ⁶	1.4	145	5
GDP per capita (US\$)	4051	2141	308
Population living < \$4/day (1990 PPP US\$)	18%	53%	88%
Female/Male life expectancy at birth (years)	77 / 66	73 / 61	72 / 64
Female/Male adult literacy rate	99.8% / 99.8%	99.4% / 99.7%	-
Female/Male combined school enrolment 1 ^o , 2 ^o and 3 ^o	93% / 85%	82% / 75%	80% / 79%
Female/Male (15-24 yrs) unemployment (% of labour force)	26% / 19%	26% / 24%	-
Female economic activity rate (as % of male rate, age 14+)	82%	82%	84%
Ratio of estimated female to male earned income, 2001	0.63	0.64	-
Female legislators, senior officials and managers	35%	37%	-
Seats in parliament held by women (2003)	18%	8%	10%
Gender-related development index (GDI) ²	0.83	0.77	-
Gender empowerment measure (GEM) value ³	0.56	0.44	-
Maternal mortality per 100,000 live births ⁴	39	64	113
Physicians per 100,000	307	423	288
Births attended by skilled health personnel ¹	-	99%	98%
Contraceptive prevalence rate ⁴	70%	73%	60%
Health expenditure per capita (PPP US\$)	540	405	145
Population with sustainable access to affordable essential drugs	95-100%	50-79%	50-79%
HIV prevalence adult population (low estimate) ⁵	1% ⁵ -2% ¹⁰	0.9% ⁵ - 2% ⁹	<0.1%
Female/Male HIV prevalence rate (age 15-24) ⁴	0.62% / 2.5%	0.66% / 1.85%	F:M ratio 1:5-8
Children with HIV/AIDS ¹⁰	not known	7591	not known
People living with HIV/AIDS, adults (age 15-49), 2003 ^{5, 8, 9}	3,500	0.6 - 2 millions	500 - 825 ¹²
Injecting drug users ⁵	10-12,000	3 millions	2% or 100,000
Syphilis / Gonorrhoea incidence per 100,000 ⁷	43 / 62	164 / 121	87 / 46
Access to ART: any/HAART in November 2003	58 / 58 ¹⁰	2,800 / 1,200, ^{8,11}	0 / 0 ⁸

Main Source: Human Development Indicators 2003 (www.undp.org). 1) World Development Report 2003 (www.worldbank.org), 2) GDI, the Gender Development Index is the human development index (life expectancy, literacy & GDP/capita) adjusted to account for inequalities between men and women. (www.undp.org). 2001. 3) GEM. Index of gender inequality: economic participation, decision-making, political participation & decision-making & power over economic resources. (www.undp.org). 4) State of world population 2003 (www.unfpa.org). 5) UNAIDS Epidemic Update: December 2003 (www.unaids.org). 6) CIA (www.cia.gov/cia/publications/factbook). 7) WHO Regional office for Europe. Programme on STI/HIV/AIDS. Copenhagen, DK. December 2002. 8) Injecting Drug Users, HIV/AIDS, Treatment & Primary care in Central and Eastern Europe and the Former Soviet Union. Central European Harm Reduction Network. July 2002. 9) Transatlantic partners against AIDS, 2003. 10) Personal Communication with Dr Zilmer, November 2003, Merimetsa Hospital. 11) Dec 2003, AIDS Infoshare 12) Less than 100 women.

Case Study of Gender and HIV/AIDS in Estonia

by Anna Mia Ekström

1.0 Introduction

A visit to Estonia was made in October/November 2003 in order to interview selected key-informants on gender aspects of the HIV/AIDS situation, including legislative and policy issues, education and public campaigns, voluntary counselling and testing (VCT), harm reduction, prevention of mother-to-child transmission (MTCT), access to antiretroviral treatment (ART) and other care perspectives. This case report puts the information gathered in the interviews into a wider context where HIV trends and risk behaviours are also described and analysed from a gender perspective. Finally, some concrete action points to improve prevention and care of HIV/AIDS for both women and men are suggested.

2.0 Background

Starting from a dozen cases, an unprecedented and extremely rapid spread of HIV has occurred during the last 3 years in Estonia resulting in the highest population prevalence of HIV in the region. By the year 2003, 3500 Estonians had been registered with HIV, but both policy makers and medical experts estimated that the real number of persons living with HIV/AIDS (PLWHA) is 2-3 times higher. Even in today's near absence of AIDS, life expectancy for men in Estonia is 12 years shorter than for women (65 vs.77 years) and death rates for young men are 5-10 times higher than for women in the same age group (below 30 years of age) (*www.stat.ee*).

Drug-related spread of HIV is still the major source of transmission in Estonia, but several factors indicate that a generalized heterosexual HIV epidemic is imminent (*UNAIDS 2003*). One such indicator is the increasing number of HIV-infected young women. Women account for 27% of new HIV infections, but among 15-19 year-olds, as many as 42% of new infections are among women (*Table 2*). Since intravenous drug use (IDU) is more common among young men, these observations show that heterosexual transmission is increasingly important. Adolescent girls are socially as well as biologically most vulnerable to HIV infection either as the sexual partners of male IDUs or as sex workers (SW). Dr Kai Zilmer, the head of the HIV/AIDS department at the West Tallinn Central Hospital (Merimetsa) where the great majority of HIV positive patients are referred, estimated that the sex ratio of males: females among new HIV infections has changed from 8:1 to 2:1 during recent years (*pc Dr Zilmer in November 2003*).

The potential for a transition from predominantly IDU-related transmission to heterosexual transmission of HIV is huge. Most HIV infections (64%) have occurred among young people (15-24) in their most sexually active age when they are less likely to be in stable relationships (*Table 2*). Surprisingly many young IDUs are part of functioning social networks and engage in recreational use of intravenous drugs, i.e. do not view themselves as "junkies". Because of this, they may also not be reached by prevention campaigns targeted towards more established IDUs. The high prevalence of other sexually transmitted infections (STIs) in Estonia not only indicates that unsafe sex is common, but ulcerative STIs such as syphilis, increase the risk of HIV infection during vaginal sex by 10-50 times from a man to a woman, and 50-300 times from a woman to a man. A 2003 survey commissioned by the Ministry of Social Affairs (MoSA) among 15-24 year-olds showed that during the last 12 months 54% of those surveyed had engaged in high-risk sex, either sex without condoms or commercial sex. Only 53% correctly knew how HIV is transmitted (*Global Fund Agreement 2003*).

Table 2. HIV-positive diagnoses January 1st-October 8th, 2003.

Age	Men	Women	Total
0-2		1	1
13-14	5	2	7
15-19	98 (58%)	70 (42%)	168
20-24	195 (76%)	61 (24%)	256
25-29	91 (80%)	23 (20%)	114
30-34	48 (90%)	5 (10%)	53
35-39	14	7	21
40-44	18	5	23
45-49	4	1	5
50-54	2		2
Unknown age	9	6	15
Total	484	181	665
			(82% <30 yrs)

Data provided by Olev Lumiste, AIDS Testing cabinet, Merimetsa hospital.

Of the two major ethnic population groups, Estonians (65%) and Russians³ (28%) (CIA 2003), the latter has been much more severely affected by HIV. The epidemic spread of HIV in Estonia began in year 2000 in Narva, Ida-Viru County, where the majority of inhabitants are Russians.

Estonia's failure to integrate the children born to second-generation Russian immigrants into the Estonian society has resulted in a large group of under-stimulated, frustrated and poor youth. Language barriers, non-citizenship and sometimes overt stigmatisation of Russians for historic reasons, have contributed to fewer career opportunities and lower self-esteem among many young Russians. More than one quarter of 15-25 year-olds in Ida-Viru County are unemployed and out-of-school. In 2001, Narva had a 4.5 times higher rate (599/100,000) of new HIV infections compared to the Tallinn. One year later, as many as 475 cases of HIV were diagnosed in the towns of Narva and Kothla-Järve in Ida-Viru, to be compared to 377 cases in all of the capital city of Tallinn. During this same year, only 46 cases of HIV were found in other parts of Estonia (MoSA, Health Protection Inspectorate 2003).

Thus, an interaction between gender and ethnicity in terms of HIV vulnerability is evident. For some young women, selling sex has become one of few alternate sources of income, money they need to support their children and/or unemployed partner or to buy drugs. A significant deal of despair and low self-esteem is generally needed for women to expose themselves to this type of stigmatised and dangerous work.

The tendency for men who have had their self-esteem undermined by ethnic discrimination, low economic or social status to regain their masculine positions through risk-taking (Courtenay 2000) is apparent also among men in Estonia. Interviewees agreed that the gender dynamic differs between ethnic Estonian and Russian cultures. Russian-speaking men were said to have stronger traditional masculine (macho) ideals and to take more risks than Estonian males, particularly in terms of drug injection. For some adolescents, high-risk sex and drug-injection is a way of opposing existing adult norms and living conditions. Drug use becomes an escape as well as a protest.

³ For practical reasons, and throughout the Estonian case study, "Russians" will be used interchangeably with "Russian-speaking minority".

3.0 Risk behaviour from a gender perspective

3.1. Intravenous drug use

An estimated 10,000-12,000 Estonians use intravenous drugs (*pc Convictus*). More than two-thirds of these people are men under 25, more than half of them are unemployed or out-of-school, and the great majority are of Russian-speaking ethnicity (*Figures 1-3*).

The reason why more young men than women inject drugs is not clear cut. There are no clear gender differences in terms of accessibility of drugs. The expansion of drug trafficking through Central Asia has dramatically lowered the price of heroin for everyone, both men and women. Also, men are not disadvantaged in terms of poverty and unemployment compared to women, on the contrary, and, a large share of adolescent IDUs are still in school or work (*Figure 3*).

Interviews with young people show that the IDU gender discrepancy is closely related to ethnicity in Estonia. Russian-speaking young men were said to be more likely than ethnic Estonians to inject drugs, because Russian ideals of masculinity appear to be more traditional than Estonian ideals, and, Russians consider “injection” to be more “macho” than taking pills. Also, injectable drugs (usually heroine) are less expensive than oral drugs. It has been shown that for young men, traditional beliefs about masculinity are the strongest predictors of risk-taking behaviour such as smoking, high-risk sexual activity and drug use (*Courtenay 2000*).

For socially disadvantaged young men, performing illegal and dangerous activities such as injecting drugs may be the most accessible mean to affirm their masculine identities. For many, drugs or drug dealing become one of few alternatives to achieve self-satisfaction and economic freedom. Male peer pressure, rather than the lack of injection equipment, may force young men to share needles with each other as a sign of courage and trust.

Using statistics derived from needle exchange programmes, the MoSA estimates that only 14% of IDUs in Estonia are female (*MoSA 2002-2005*). However, such statistics may underestimate the true proportion of female IDUs, which NGOs believe is closer to one-third of all IDUs in Estonia (i.e. 3,000-4,000 women) (*pc AISC and Convictus*). If, in fact, women are under-represented in terms of access to harm reduction services, the high proportion (40%) of female teenagers who went for needle exchange in 2003 stands out as a remarkable trend shift and indicates a rapid increase in the number of young female IDUs, since only 25% among 20-24 year-olds, and only 5% of even older IDUs coming for needle exchange, were women (*Figure 1*).

Young ex-IDUs state that IDU is less common among young women because “girls study more, have children, are afraid to inject, want stability”, and, that at least half of all young female IDUs start to use drugs because their boyfriends do. According to the interviewed ex-IDUs, many young men fear to be alone when they become dependent on drugs and need a girlfriend to be dependent along with them. Interviewees said that more counselling opportunities, improved socio-economic standards and work therapy would be the most useful ways to prevent IDU and HIV among young Russians in Estonia.

Despite falling heroin prices, a regular IDU needs about 1,000 EEK per day for drugs, a sum far above the salary for an average Estonian worker. Most young men finance their abuse through theft, drug dealing or other crimes. Selling large quantities of drugs is illegal, but one may also be arrested and brought to a medical facility for carrying needles. On the third occasion of such an arrest, IDUs can be sentenced to 3 months imprisonment. The majority of prisoners are young men who serve time for drug-related crime (*pc Convictus*) and imprisonment rates in former Soviet Union are generally much higher than in Western Europe (*Moscow Center for Prison Reform*). In prison, young male IDUs run an extremely high risk of being infected with HIV due to the high prevalence of HIV and abundant

needle sharing in Estonian prison facilities. Drugs are readily available in prison, and either thrown over the wall to prisoners or sold by prison staff with low salaries (*pc Convictus*). Substitution treatment (e.g. methadone) is not available in prison and needle exchange is prohibited.

Figures 1-3: Demographics 461 first visitors to needle exchange programmes in Tallinn and Ida-Viru, April-June 2003. Data provided by Aire Trummal, National HIV/AIDS programme.

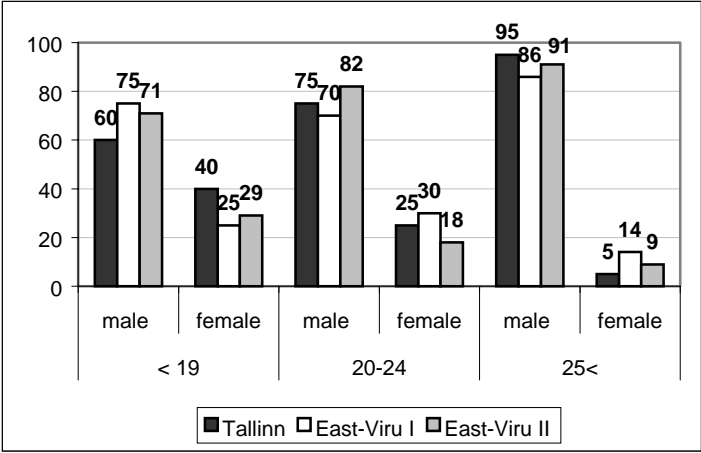


Figure 1: by age and gender.

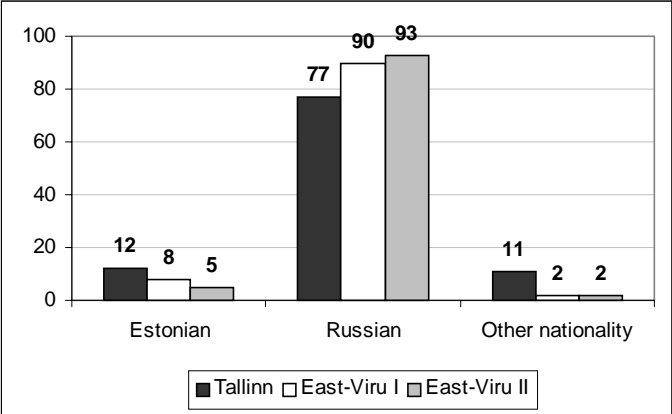


Figure 2: by ethnic group

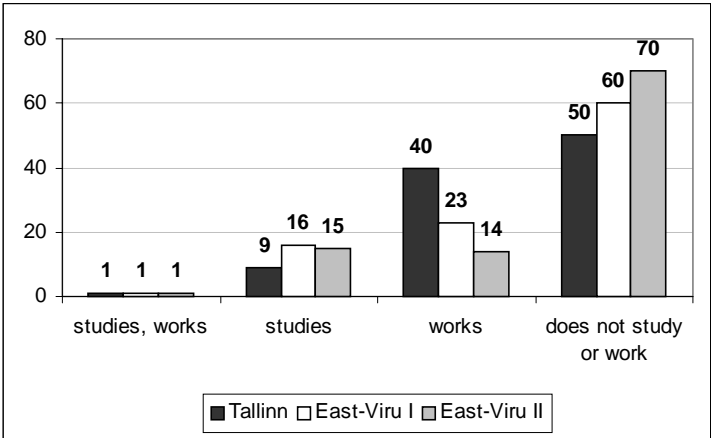


Figure 3: by profession

3.2. Sex work

For many women IDUs, sex work is a legal income alternative to theft that keeps them out of trouble with the police. However, brothel-owners refrain from hiring IDUs to avoid police razzias and less than an estimated 15% of the women who work in brothels use intravenous drugs. However, out of Tallinn's 3,000-4,000 female IDUs, more than 50% sell sex (in the street or in bars) to finance their abuse and up to 70% are estimated to be involved in some type of sexual transactions for drugs or cash. Still, out of denial, shame or ignorance, most of the 500 women who go for needle exchange at the NGO AIDS Information and Support Centre (AISC) in Tallinn and Ida-Viru, do not view themselves as SW or "drug addicts", thus, often do not identify themselves as being at-risk of HIV. Therefore, condoms are often not used with regular sex partners or with commercial sex clients (*pc Juri Kalikov, AISC*).

The sex industry has expanded in Estonia during the last decade. Striptease is now openly and frequently advertised on large posters and in taxis. It is estimated that 2,000 women are employed in the organized sex business in Estonia and 50-70 brothels with 5-20 girls in each brothel have opened in Tallinn alone. Sex work is also being openly marketed in Narva, Pärnu and Tartu.

The AIDS Information and Support Centre (AISC) surveyed 382 SW between 1996 and 1999 and found that a great majority of those who perform sex work in Estonia are very young women. The majority (46%) were between 18-24 but more than 25% were less than 18 years. Most were of Russian-speaking ethnicity (83%) and only 11% were of Estonian ethnicity. The level of education was high, 77% had graduated from high school. Many of the surveyed female SW also had families to support; 44% were married or cohabitating, 26% were divorced and 39% were mothers, many single breadwinners. Sex work is a short-term occupation; 62% of SW had worked less than six months and only 19% more than one year. This means that a fair proportion of young women in Estonia pass through the commercial sex market and are exposed to high risks of being infected with STI/HIV. Only 74% of SW reported consistent condom use and 6% never used condoms (*Kalikov J 2002*).

Very few female SW work independently. A trafficker, driver, pimp, brothel- or bar-owner usually mediates their contacts with clients. The SW are usually dependent on the mediators and are threatened with the deprivation of freedom, financial/ social punishment (withdrawing money for travel, visas, food or informing relatives), or violence and sexual abuse. The AISC survey showed that 40% of SW had been sexually abused during work and that 30% had been abused during childhood (*Kalikov J 2002*).

The migration of SW across borders to Sweden, Finland and Germany has increased with the Schengen agreement and among migrating SW, women of Estonian ethnicity dominate. Trafficking of women is also common both inside the country (mostly from the Russian-speaking parts, with higher rates of unemployment) and abroad. There are no specific legal restrictions that prohibit the trafficking of women and the concern from state institutions to introduce new laws has been weak (*pc Juri Kalikov, AISC*).

3.3. Men who have sex with men

Sex between men (men who have sex with men, MSM) has been legal in Estonia since 1991 but is still highly stigmatised. The first sauna for gay men opened in Tallinn in 2001. In 2003, UNAIDS estimated that between 1,000-2,000 MSM live in Estonia but the Estonian Positive People Society (ESPO), estimates that the size of the gay community is three times larger, around 5,000 MSM. ESPO is an NGO composed of about 30 (27 male) volunteers mainly involved with the support of PLWHA who have not been infected through IDU. During the 1990s almost all new HIV infections were diagnosed among gay men (*pc Dr Zilmer*), but since then the gay community has spread information

about safer sex practices and, as of now, the incidence of new cases among MSM is constant. The National HIV/AIDS programme does not target MSM directly but relies on ESPO to do preventive work within this group. However, ESPO receives very little funding and has difficulties financing a drop-in office in central Tallinn. Although no data exists, ESPO's representatives believe that there is little overlap between MSM and IDU, and that sex work among MSM is uncommon (*pc ESPO*).

4.0 Policy, prevention and access to services from a gender perspective

4.1. Policy and priorities in HIV/AIDS prevention

Since 2002, HIV has been a priority for the Ministry of Social Affairs (MoSA) responsible for Estonia's HIV policy. According to the 2003 agreement with the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM or "the Global Fund"), the overall goal for Estonia is to stop the progressive spread of HIV/AIDS by 2007 through:

- A reduction of risk behaviour among young people, IDUs, MSM and SW
- A reduction of vertical transmission from mother-to-child
- Preventing HIV transmission in prison
- Improving the quality of life for PLWHA
- Improving institutional capacities of the agencies that do HIV/AIDS work
- Cooperation and new partnerships between the state and local governments, NGOs, and other state programmes

Gender is not mentioned in the National HIV/AIDS programme for 2002-2006 and so far gender issues have been low priority (*MoSA National HIV/AIDS Prevention Programme for 2002-2006*). However, all health care data including data on HIV testing and diagnosis are disaggregated by sex. Only women, predominantly of Estonian ethnicity, are working on social and health care issues including HIV/AIDS at the national policy level. Policy makers themselves believe that this is because HIV/AIDS matters are still seen merely as "care issues" which traditionally have been handled by women in Estonia.

Involving representatives for young people, especially young men and women of Russian ethnicity, in the planning process and not only in surveys would probably be beneficial in terms of making information campaigns more relevant and services better targeted to the group most affected by HIV.

The public funding available for HIV prevention has been inadequate, but additional resources have recently (2003) been granted from the Global Fund that will triple Estonia's HIV/AIDS budget to 3,908,952 USD during 4 years. The money is to be used for needle exchange, counselling, prevention of HIV transmission among SW, ART, monitoring and evaluation. Forty-four percent (44%) of the funds in year 1, and 52% in year 2, must go to NGO activities (*Global Fund Agreement 2003*).

NGOs expressed ambiguity in relation to the Global Fund money and feared that their present collaboration would be harmed by competition. NGO representatives were also frustrated about having to write the extensive applications required for the 34 different tenders announced for HIV/AIDS. There was also fear that the Global Fund agreement puts too much emphasis on monitoring, evaluation and capacity building within the government rather than on improving direct services.

Such scepticism among NGOs has partly been fuelled by the closing of the AIDS Prevention Centre (APC) in May 2003. The APC was formerly a focal point for Estonia's preventive work for youth and offered anonymous drop-in free-of-charge VCT at the AIDS Cabinet. When the APC closed and the AIDS cabinet moved to the Merimetsa Infectious Disease hospital, no free-of-charge VCT was

available in Tallinn until the cabinet reopened in September 2003. This means that the total number diagnosed with HIV during the year 2003 likely is an underestimation of the true number.

Most HIV/AIDS NGOs⁴ were greatly concerned that closing the APC had harmed real access to VCT and led to loss of experienced staff. According to Tiia Pertel, former manager of the National HIV/AIDS Programme, the reason for the reorganisation was to create a more coordinated approach and to integrate HIV/AIDS prevention into the newly created National Institute for Health Development, under which the HIV/AIDS Programme now operates. In November 2003, a new APC, now run by the NGOs themselves, was planned to open as an umbrella organisation for the major HIV/AIDS NGOs in Tallinn.

4.2. Prevention through education, public campaigns and life skills training

HIV/AIDS information is part of the school curriculum throughout Estonia, but appears to be more or less emphasized depending on school. According to the Family Planning Association (FPA), drug abuse is well addressed in schools but sexual matters are less well covered. Sexual education, a fairly recent and less prioritised subject in Russian-speaking schools, is largely oriented toward girls and often only involves the distribution of written information (*pc Anti-AIDS Association and FPA*).

Roughly 25% of Russian-speaking youth were unable to recall any school-based sexual education (*pc Anti-AIDS Association*). Policy makers also acknowledge that mostly Estonian-speaking youth have been targeted by HIV preventive activities so far, and partly blame this on the lack of Russian-speaking peer-educators (*pc Pertel and Trummal at the National HIV/AIDS Programme*).

A “Knowledge Attitudes and Behaviour” survey of 6,000 youth was recently (2003) performed by the National Institute for Health Development. It showed that 80% of young people wanted HIV-positive persons to inform their partners, but that they themselves would end the relationship if their partner were HIV-positive. Young Estonians are aware of HIV/AIDS, but 20% have erroneous ideas about modes of transmission e.g. believed that HIV spreads through sharing towels. In this survey, 46% of young people said they always use condoms during sex and that the main reason for not using condoms was because they trusted their partner. One third of those who suspected that they had an STI did not seek treatment (*Lõhmus, Trummal and Harro 2003*).

Girls and young women appear more knowledgeable about HIV than boys and young men, but the men usually decide when to have sex. The sexual debut age is 16-17 for girls and somewhat earlier for boys. A third of all high-school boys who attend FPA training sessions had watched pornography while girls tend to learn about sex through magazines and through parents. Most young people do not consider risk of HIV during sex and tend to think of HIV as a “drug-users disease” (*pc T Raudsepp, FPA YCC*).

During the summer of 2003, a nation-wide prevention campaign against HIV “Be safe” was initiated by the National HIV/AIDS Programme. Messages such as “Be normal”, “Same but different” and “Life is beautiful: take care!” were displayed on posters, key-rings and through TV commercials.

NGOs were concerned that only ethnic Estonian and not Russian role models were featured on HIV prevention posters, despite the fact that the Russian-speaking youth are at higher risk of HIV according to all available statistics. The way that young people perceived this campaign has not been evaluated, but there was concern that young IDUs would feel more marginalized by e.g. the “Be normal” message

⁴ NGOs active at the former APC: AISC (the AIDS Information and Support Centre), ESPO (the National society for PLWHA in Estonia), the Estonian Anti-AIDS Association, and Living for Tomorrow. Convictus only started their work in Estonia in October 2003, and FPA (the Family Planning Association) had separate facilities.

on condom key-rings that had pictures of a crossed over drug syringe. Young Russians pointed out that HIV/AIDS prevention campaigns for Estonian youth should not simply be translated into Russian, but that the message must be tailored differently in order to reach young Russians. For the future, both NGOs and National HIV/AIDS Programme representatives wished for more collaboration with the Ministry of Education (MoE).

In terms of life skills training, the FPA offers a popular on-line counselling service on sexual and reproductive health matters through its website. Thirty people are hired part-time to respond to questions and in 6 months they have received 1,100 questions (30% from boys) without advertising (*pc M Seeblum, FPA*). Twice a year, the FPA Youth Counselling Centre (YCC) also invites all schools in the Tallinn region to send their students for interactive training sessions in sexual and reproductive health. Most students that attend these lectures are of Estonian ethnicity. Only 10% of schools that respond to the FPA invitation are Russian and then usually only girls are sent to the workshops. For the younger age groups (14-16 year-olds) boys and girls are separated to make it easier to ask questions and male FPA-trained staff is available for the boys on demand. Older students (17-19) usually prefer mixed groups in which gender issues are discussed. The FPA YCC also offers HIV sessions on demand (*pc T Raudsepp, FPA YCC*). Interviews with Russian respondents (NGOs and youth) indicate that the FPA is primarily seen as an Estonian institution, which might explain why fewer Russians use their services.

Since 1997, the Anti-AIDS Association trains young people interested in learning how to teach their peers about HIV-related issues through workshops and summer camps. Topics such as healthy sexual behaviour, HIV/AIDS/STI, unwanted pregnancy, self-assertion and how to avoid drugs are addressed through interactive behavioural skills training. Young male and female participants explore each other's attitudes and practice how to "say no" to unsafe sex or drugs through group work, videos and role plays in their mother tongue (both Russian and Estonian).

The NGO Living for Tomorrow (LFT) also does life skills training for young people with a clear gender focus. They teach HIV/sexual safety, raise awareness about how conventional gender systems reinforce risk-behaviours, stimulate peer education and try to get volunteers to work with and for PLWHA. Workshops run over 2 months (spring and fall) once weekly with 30 participants aged 15-17. English is used to be on neutral ground for both Russian and Estonian-speaking youth. The LFT concept is to make young people talk about gender roles and associated risk-behaviours, sexuality (behaviour, safe sex, real practice training to buy condoms and ask questions), sex work and human rights. PLWHA and former IDUs sometimes join the workshops. Many young people who dream about making money abroad are at risk of being sexually exploited. The LFT informs about trafficking and warns youth against giving away their passports. A 2002 campaign against trafficking led several trafficking companies to move deceptive job advertisements from newspapers to the internet (*pc S Blumberg, LFT*).

4.3. Voluntary counselling and testing

There are 5 government-run VCT cabinets in Estonia where HIV testing is offered anonymous and free-of-charge. All blood donors are subject to mandatory HIV screening. Most prisoners and pregnant women are also offered HIV tests, but testing without consent is illegal.

According to Olev Lumiste, male counsellor responsible for VCT at the AIDS cabinet at Merimetsa hospital, more men than women come for VCT, but the proportion of men has declined from 80% to 60% in the last year(s). Those who seek VCT services due to IDU are usually between 20-24, thus hidden numbers of HIV-positive IDUs in younger age groups is likely. Most women seek VCT after unprotected sex; some have only recently learnt that their male sex partner has used drugs. Only about 10% of women who come for VCT are IDUs. The AIDS cabinet staff has noticed an increase in the

sexual transmission of HIV among 15-19 years olds, particularly among very young women. In addition, the average age of SW appears to have declined. Already at increased risk of HIV through their drug use female IDUs tend to accept clients' demands for sex without condoms more often than other SW (*pc Olev Lumiste, AIDS cabinet*).

When the AIDS cabinet was moved from the APC downtown (please see section 4.1) to the Merimetsa hospital, the number of visitors dropped by 50% from about 25 to 10 visitors per day, and according to ESPO, the only site for anonymous, and truly free-of-charge HIV testing in Tallinn was then removed. According to ESPO, VCT clients pay 50 EEK at the hospital entrance unless they inform that they have come for an HIV test, which many feel too embarrassed to do. For an IDU, 50 EEK pays for half a dose of heroine, i.e. this fee, in addition to the cost of transport to the hospital may deter some IDUs from testing.

According to all interviewed NGOs, the most important reason for the decline in HIV testing is the current inconvenient location of the cabinet at the Merimetsa Infectious Disease hospital outside of the city centre. Many, not only IDUs, are afraid of the hospital setting, afraid to be registered as HIV-positive and afraid of staff attitudes. Further, no drop-in testing is offered and VCT clients must make an appointment by calling the cabinet beforehand. Young people (mainly girls, non-IDUs) who at-first did not consider themselves to be at risk of HIV used to drop by the APC to get more information and would later chose to get tested. NGO representatives were concerned that this group of young women now may be selectively lost to HIV testing (*pc AIDS cabinet, LFT, ESPO, Anti-AIDS Association and AISC*).

In contrast, VCT and hospital staff emphasized that HIV tests are still completely free-of-charge. Olev Lumiste, from the AIDS cabinet, said that all who come for free HIV testing must make appointments and that drop-in or an unknown purpose of visit is not possible. Further, neither mode-of-transmission nor ethnicity are registered for confidentiality reasons, to keep patient's trust and for fear that data on ethnicity could be used in a discriminatory fashion by, for example, journalists. Strict confidentiality even between medical doctors is practiced, even when HIV-positive patients are referred for surgery. They assume that more people will come for VCT as soon as the new location becomes more known.

All who test positive for HIV, regardless of where they are tested, should be referred for follow-up at the Merimetsa hospital. After the AIDS cabinet was moved to the hospital, the share of those with a positive HIV test who come for follow-up at the hospital has increased from 60% to 100% (*pc Olev Lumiste, AIDS cabinet*). About 700 patients with a positive HIV test have come to the Merimetsa for at least one follow-up visit (confirmatory testing, counselling or monitoring), but 200 of these have not returned for a second visit. Newly referred patients with HIV must sign a document at the hospital in which they confirm having received information that the intentional transmission of HIV is illegal and may lead to imprisonment (*pc Dr Zilmer, in charge of HIV/AIDS care at the Merimetsa hospital*). This law has not been enforced since Estonia's independence, but many are still afraid, something that may influence post-test follow-up according to ESPO.

The NGO AISC is located on Kopli street, near the central station, and open to the general public for drop-in information and anonymous HIV testing. An HIV and syphilis test package costs 90 EEK and the test result is received in-person the next day. To test for all STIs, including HIV, costs 450 EEK. The manager of AISC, Juri Kalikov, agrees that the price of the test may deter some young IDUs, but states that many prefer to pay at AISC rather than going to the hospital for free testing. Both men and women come for HIV tests at the AISC Kopli clinic, which also provides a special drop-in service for SW by Russian-speaking female nurses.

The government funded FPA also offers VCT at 15 YCC throughout Estonia. The staff is predominantly Estonian and female. The great majority of the FPA clients are also Estonian and

female; 96% are young women aged 19-21 and 96% of these come to the YCC to get a prescription for oral contraceptives. A total of 20,000 individual visits in the year 2002 show that approximately 10% of all girls in Estonia seek FPA services. STIs tests, including HIV, are rarely demanded by the girls themselves, but are, instead, conducted upon suggestion from a gynaecologist. The most common STIs at the FPA YCC are chlamydia, herpes, HPV, and trichomonas. Despite the large number of sexually active young girls that pass through the main FPA YCC in Tallinn, only between 1-10 HIV tests per week are performed, and only 4 cases of HIV and 2 cases of syphilis have been diagnosed during the last two years. Clients receive the test results in person 6 days after testing.

Only 4% of FPA clients are male. This is still an increase attributed to a recent initiative by one YCC in Tallinn and one in Tartu to offer separate drop-in counselling with a male doctor for boys one afternoon per week. Most male clients ask for HIV tests or seek medical care because of STI symptoms. There is need for more counselling services that target young men. The FPA website *www.amor.ee* is becoming more popular with approximately 5-10 male web-visits per week. The reason so few men seek FPA services directly, may be because they associate the FPA with oral contraceptives and the fact that the YCC is located at a well-known maternity hospital with an antenatal care clinic upstairs (*pc T Raudsepp YCC FPA and M Seeblum, FPA*).

4.4. Needle exchange and substitution (methadone) treatment

Outside of prison, needle exchange and methadone treatment is now legal in Estonia but the demand is huge and only 10-20% of IDUs are covered by these programmes. The NGO AISC provides needle exchange at a clinic in Erika Street, close to an area with many IDUs. They also do outreach needle exchange through two mobile clinics in two poor suburbs, Lasnamäe and Mustamäe, where many IDUs live (*pc J Kalikov, AISC*).

In October 2003, Convictus also opened a stationary needle exchange point in central Tallinn, but, so far, most needles are exchanged through street outreach work by male, Russian-speaking volunteers. These young men, former IDUs recruited by Convictus in prison, are well-suited for contacting young IDUs since they know where to find them (where the dealers are), have adequate knowledge about drugs, and are respected by other IDUs.

During Convictus' first month of services they had 3 times more visits than expected. Most clients are young men (83%), many are unemployed with little or incomplete education and several have been imprisoned for drug-related crimes. Quite a few of the young IDUs that come for needle exchange are homeless HIV-positive youth. These people are encouraged to protect themselves against other infections by using new needles (*pc staff at Convictus needle exchange site*).

Since women are thought to make up one-third of all IDUs, needle exchange statistics indicate that they are under-represented. Women who inject drugs are very difficult to reach and highly stigmatised, not only for their drug abuse but also because they are assumed to finance their drug habits through sex work. Women responsible for children appear to be particularly afraid of being registered at hospitals or being arrested by the police for carrying drug equipment near needle exchange points. Female IDUs prefer to talk to female staff at Convictus' stationary point.

In order to reach more female IDUs, Convictus needs female volunteers (preferably ex-IDUs) for outreach work in the streets. There is also a demand for a day-centre for the increasing number of homeless, young female IDUs who are very vulnerable in the streets. The fact that the government does not allow Convictus to pay ex-prisoners for their work is an obstacle for attracting more volunteers (*pc J Winckler, Convictus*).

The youngest clients are 14, but most IDUs who go for needle exchange are older. Occasional drug users or beginners will not come because they do not yet identify themselves as “junkies”. The gender distribution at the AISC Tallinn needle exchange differs by age and there are more girls in the younger age groups (*Table 2*).

Both AISC and Convictus see a demand for more stationary exchange points where young people have access to both needle exchange and HIV testing, since needle exchange creates a demand for knowing one’s HIV status. Opening up stationary exchange points in Lasnamäe and Mustamäe appears urgent.

The government runs a methadone programme free-of-charge and a small clinic for children IDUs who are treated with Subutex (more expensive than methadone but less addictive). AISC offers methadone treatment at the Erika Street clinic at a cost of 2,000 EEK/month. This price includes counselling from a psychiatrist and a narcologist and the stricter government programme is said to have stricter criteria than AISC for PLWHA.

The fact that only men work at the AISC Erika street needle exchange/ methadone clinic may affect real access for women; not surprisingly, most IDUs who go for treatment are also male. The gender imbalance in terms of real access to needle exchange is transferred into substitution treatment, since methadone clients usually are recruited through the needle exchange programmes. After successful completion of the needle exchange and methadone programmes some IDUs get the opportunity to go to an AISC-run rehabilitation home outside of Tallinn, but so far only about 100 individuals have been given this chance (*pc J Kalikov AISC*).

The lack of drug rehabilitation programmes for non-insured IDUs is a serious problem for the fight against HIV/AIDS (*pc Dr Zilmer, Merimetsa hospital*).

4.5 Immune status monitoring, antiretroviral treatment and quality of care

Since 2001, the MoSA provides ART free-of-charge for all. Highly active antiretroviral therapy (HAART) is initiated at a CD4 count of 200 or a viral load above 10,000. As of November 2003, 58 patients were on ART at a cost of 100,000 EEK per patient per year. For those with health insurance, monitoring of immune status (viral load and CD4 counts) is performed once a year according to European standards in order to know when to initiate ART.

However, since many HIV-positive patients lack health insurance, they do not have access to monitoring (unless they are pregnant) and in practice this means they cannot be started on ART (*pc Dr Zilmer, Merimetsa hospital*). Since health care costs for Estonian citizens are covered by national health insurance, in turn financed through the taxation of employers, unemployed individuals who are not citizens are not insured (*MoSA www.sm.ee*). Many of Russian-speaking ethnicity are neither Estonian nor Russian citizens despite being born to second-generation Russians in Estonia. This group is also often discriminated in the work market.

Only a minority of regular IDUs are employed. Additionally, many HIV-positive IDUs believe that they are not entitled to ART and, according to both Convictus and ESPO, policy makers have publicly announced that IDUs will not get access to ART since it is considered a “waste”. ESPO claims that ART has never been prescribed to an HIV-positive IDU. Patients must call a doctor to make an appointment; the 3 doctors who work with HIV at Merimetsa can be difficult to reach also for non-IDUs. Thus, many PLWHA refer their questions about treatment and medicines to ESPO. Dr Zilmer, responsible for ART at the Merimetsa hospital, does not reject the need for ART for IDUs, but explains that, in practice, monitoring of treatment is very difficult among those with on-going drug

abuse. Consequently, since most HIV-infections thus far have occurred among IDUs and young Russian men, a large share of PLWHA in Estonia do not have access to monitoring and ART⁵.

Uninsured HIV-positive patients may apply to the local government to cover some of their health care costs such as monitoring of immune status. But a written request from an infectious disease doctor is required, a process that many find bureaucratic and frustrating (*pc Dr Zilmer and ESPO*). During September-December 2003, HIV-positive persons without insurance have temporarily been entitled to HIV monitoring at the Merimetsa Hospital. However, according to Convictus, this information has not reached those in-need and many HIV-positive patients without insurance have been heavily charged for hospital services or refused care without being informed that they can receive free care at the Merimetsa hospital (*pc AISC and Convictus*). At the time of writing this report it was still uncertain whether this temporary opportunity for monitoring would continue in 2004. Health insurance issues and how this affects access to monitoring and treatment for most PLWHA is not mentioned in the National HIV/AIDS Prevention Programme for 2002-2006.

All HIV-positive pregnant women have the right to free ART during pregnancy and delivery. By law, gynaecologists must report when a pregnant woman tests positive for HIV (approximately 80 women in 2003). Thereafter, surveillance is incomplete and both the total number of pregnant HIV-positive women in Estonia who decide to give birth (assumed to be 50%) as well as the HIV-status of their children is unknown. This is serious since, without testing the children, ART up to six-months of age following European recommendations cannot be initiated for HIV-positive children in need and the woman may not get the social support she needs to care for her baby.

ESPO that pushed for ART to become free-of-charge in 2001, believes that only half of those in need get ART today. ESPO expects that ART demand will increase rapidly, but feel sceptical about the quality of ART used in Estonia, as well as concerned about future possibilities to sustain ART with uncertain funding. At on occasion in year 2000, all ART stocks in Estonia were suddenly depleted, forcing PLWHA on ART to either buy their medicines abroad or to interrupt their treatment with the risk of developing resistance. ESPO is also concerned that Estonia lacks laboratory facilities to test for ART drug resistance.

In terms of access and quality of care, ESPO thinks that staff attitudes are more important than gender awareness, opening hours or user fees. Stigma and discrimination are major issues and many are afraid to inform health care personnel about their HIV status (except at the Merimetsa hospital where staff is said be understanding). Very few HIV-positive persons are open about their HIV-status, even among close friends. Relative poverty is another problem for many HIV-positive patients who are unemployed and not covered by health insurance. They receive 500 EEK/month from the social department but this amount fails to cover basic living expenses such as rent and food, and cannot be used for health care. Dental care, for example, is very expensive without insurance and often inaccessible. Many HIV-positive individuals also feel discriminated against when they are forced to go to a particular hospital and a particular dentist for treatment of medical conditions that are unrelated to their HIV status.

⁵ Unless they are below 19 years of age or in need emergency care. All children are covered and all are entitled to emergency care regardless of insurance.

Voices of young people in Tallinn:

Why are so many young people in Estonia at risk of HIV?

“Lack of sex-education in school (in Soviet times there was no education) and parents don’t talk about sex”

“The state only now realises that this is a big problem, they have disregarded it for long time. Problems mainly start when school is over at 18 years of age. Many Russian-speaking young people also fall out of school early and Russians must speak Estonian very well to get a job or to study.”

“Young people (Russian) have too much spare time/no hobbies and parents lack money to do meaningful things with their children”

“Estonian kids feel they are bought out by their parents. One group of IDUs come from rich families where parents work too long days, because they are afraid of losing their jobs.”

“14-15 year olds still think it is cool to use drugs and to brag about it. Many start on pills like amphetamine and ecstasy (marihuana is similar to alcohol), then go onto iv drugs. Most young IDUs do not use drugs every day (and therefore won’t go to needle exchange).”

“Estonians use convenient drugs for recreational purposes and Russians use drugs to forget”.

“80-90% of school youth have tried drugs in Russian schools and a couple in each class inject. Studies don’t show this because young people are afraid to tell the truth”

“ No teachers at school can talk about these problems. Better to teach peers teach young people.”

“Needle sharing is common and people are less afraid of this than of unprotected sex!”

“ Condoms are associated with HIV and many are afraid to use them because of friends spreading rumours.”

“Integration policies have failed. The 2002 campaign poster of a Russian woman with her mouth stitched together saying “Learn the language, then you can speak” was awful. “

5.0 Conclusions

The majority of HIV infections have occurred through IDU among very young men in the Russian-speaking minority where gender stereotypes with strong macho ideals prevail and language barriers and discrimination have caused high unemployment. However, the increasing number of HIV-infections among young women indicates that a generalized heterosexual epidemic is emerging. Preventive efforts to target the Russian-speaking minority have been insufficient and HIV campaigns have mainly been directed towards Estonian-speaking youth.

Many young women involved in sex work and trafficking have little power to protect themselves against HIV. Legal efforts to prevent sex work and trafficking (except for minors) have been weak.

When the only free-of charge government-financed VCT cabinet in Tallinn was moved from the city centre to the West Tallinn Hospital (the Merimetsa) in May 2003, HIV testing declined by 50%. This indicates that the true incidence rate of HIV may be higher than reported. Since this cabinet requires an appointment for testing, there was no *drop-in VCT free-of charge* in Tallinn as of October 2003.

Despite being born in Estonia, many unemployed HIV-positive persons lack national health insurance and therefore do not have access to monitoring of CD4 counts and viral load. Consequently, many PLWHA and especially young Russians will not receive ART when their immune status fails.

Prevention of MTCT is not mentioned in the Global Fund objectives but Estonia could afford ART for all children in-need. Today, however, surveillance is incomplete and the number of HIV-positive children born to HIV positive mothers is unknown. Consequently, HIV positive children and their mothers may not have access to adequate care and support.

Women IDUs, especially those with children, are underrepresented in needle exchange due to stigma, lack of female outreach staff and fear of being arrested by the police. As a consequence, drug-rehabilitation and substitution treatment, to which access in general is very limited, may be especially difficult to access for women. Needle exchange is illegal in prison and there is no access to bleach for sterilising needles, or to condoms, despite the rapid spread of HIV between young men who serve time for drug-related crimes.

6.0 Recommendations

Short-term

The national HIV/AIDS Prevention Programme should estimate the acceptability and cost of existing and new forms of free-of-charge VCT, and try to identify services that are truly accessible to vulnerable young people, IDUs and homeless youth.

Medium-term

Increase the accessibility of HIV testing/VCT by expanding these services to places where the demand is high such as in the city centres and suburbs where many IDUs live (e.g in Lasnamäe and Mustamäe outside of Tallinn), as well as to major stationary points for needle exchange.

Needle exchange should be scaled up and made much more accessible, in particular to women:

- Involve more young ex-IDUs in outreach needle exchange e.g. through earmarked financial support (from MoSA/GFATM) to salaries and training organised by Convictus or AISC.
- Ex-prisoners who volunteer for this type of work should also be allowed to be financially rewarded since they are particularly well suited to target young men with high-risk behaviours.

- Identify mechanisms to provide needle exchange, bleach and condoms to convicts in prisons in non-stigmatised fashion to decrease spread of HIV between prisoners. E.g. Convictus that has the experience and contacts needed within prisons could help implement this.
- In order to reach more female IDUs, a special effort is needed to train and support female out-reach workers who are underrepresented in needle exchange today. Convictus and possibly AISC could be engaged in these activities.
- The police should avoid arresting IDUs who carry needles near needle exchange points in order to increase true accessibility to these services especially for women with children.

On a government level, regulations must be changed so that those who lack national health insurance also have access to free monitoring of CD4 counts and viral loads at regular intervals in order to really make ART available to all in need.

Improve sero-status surveillance of newborns to HIV-positive women, also IDUs, in order to provide these children with ART as needed and the mothers with social support. This may possibly be implemented by public hospitals.

Long-term

Preventive efforts must be differentiated and tailored to appeal to men and women of both Estonian and Russian ethnicity in order for the message to be conveyed effectively:

- HIV prevention work that is initiated by the government/GFATM should involve the group most affected by HIV, i.e. young men and women of Russian ethnicity, in planning and management of HIV/AIDS programmes, not only in workshops or surveys.
- Identify and provide optimal funding for NGOs that teach life skills to young people such as Living For Tomorrow, the Anti-AIDS Association and the Family Planning Association.
- Drug abuse and safer sex must be a prioritised part of school-curricula also in Russian-speaking schools where these subjects still seem to be of low priority.
- Evaluate existing drug rehabilitation and substitution treatment (offered by the government and by AISC) and identify new approaches in order to scale-up and increase access particularly for women who are underrepresented in programmes today

More efforts must be made to prevent trafficking of women within Estonia and abroad:

- Legislators must review the implementation of existing laws to make them more efficient.
- Information about trafficking and the potential consequences of sex work abroad should be more widely distributed e.g. through media. The HIV/AIDS Prevention Programme, e.g. in collaboration with LFT and AISC, could take the initiative for these types of action.
- Young women, especially those living in poor areas with high unemployment, should be specifically targeted with information e.g. through schools and/or by earmarked support the NGOs LFT and AISC with experience in this area.

HIV/AIDS work in Estonia would benefit from a closer collaboration between NGOs and the government, including the Ministry of Education. NGOs are doing important work and complement each other and the government in different sectors.

Case Study of Gender and HIV/AIDS in the Russian Federation

by Anders Ragnarsson

1.0 Introduction

This assessment, conducted during the fall of 2003, broadly explores the HIV/AIDS situation in the Russian Federation from a gender perspective. So far, few interventions have been implemented to curb the development of the HIV/AIDS epidemic in the country, and no coordinated gender-sensitive surveillance has been undertaken to provide sufficient information related to HIV/AIDS in the area. However, some key actors in the Russian Federation, mainly NGOs, have collected a lot of information and knowledge on HIV/AIDS and gender in order to enhance the understanding of the epidemic.

This report concentrates on some specific key areas that affect the HIV/AIDS situation for men and women in the contemporary Russian society. The focus on current trends and on-going activities aims to promote an overall understanding of the HIV/AIDS scenario, to map out and illuminate important key areas, to identify gaps, and, to make some recommendations for future initiatives.

2.0 The Russian context – background and contemporary status

Together with other former Soviet Union states, the Russian Federation has been identified as the new epicentre of the HIV-pandemic, with one of the world's fastest growing rates of new infections. The first HIV case in the Russian Federation was reported in the mid-1980s. By August 2003, there were more than 245,000 officially diagnosed cases of HIV in Russia, over 80% of which were reported in the last three years (*Transatlantic Partners Against AIDS 2003*). The recent increase of HIV infections has taken many by surprise. During the Soviet-era, health authorities did not believe that HIV/AIDS would pose a serious threat to their region. The number of new infections diagnosed annually also remained very low until the mid-1990s (*Kelly and Amirkhanian 2003*) supporting expectations of finding random cases in certain risk-groups. Epidemiological strategies for the region were consequently developed based on the estimation that no large HIV/AIDS outbreak would occur.

2.1. Gender effects of economical, political and socio-cultural changes

Russia has undergone dramatic economic, political as well as socio-cultural changes during the last decade due to the fall of the Soviet Union. The country is going through a reorientation in mindset and culture, from a structure based on ideology towards a new economic order where the informal illegal economy plays a significant role. This reorientation has imposed new lifestyles on the Russian society, which has become more stratified. The transition towards a market economy has increased the inequality between men and women.

An overall situation of deprivation has had great implications on the labour market, especially for Russian women who used to be an integral part of the paid labour force. With more competition, women now have more difficulties accessing jobs. Women's educational level, among the highest in the world, has been equal to men's, but this is also changing due to the weakened economy. Due to societal changes, there are fewer women representatives in parliament, and women are underrepresented in decision-making positions, i.e. have fewer advocates for their needs and interests. The negative economic trends have resulted in increased vulnerability for both women and men. For

women, economic dependency and insecurity are at the core of the gender dynamics of HIV, reducing the possibilities to negotiate safe sex practices or break relationships perceived to be violent and risky, and increasing the need to exchange sex for money. Men are also suffering from increasing rates of unemployment, alcohol use, and diagnosed depression. Life expectancy for men has markedly declined in recent years, indicating a dramatic negative change in health status and revealing an underlying stress on male identity.

Like never before, individuals are being exposed to alternative lifestyles that incorporate new orders for manliness and womanliness. Changing family relationships and instability in terms of exacerbated social health problems such as alcoholism, self-destructive behaviours, violence (not least domestic), as well as liberalized values related to sex and substance abuse, create a risk environment for transmission of HIV (*Kelly and Amirkhanian 2003*).

A perceived generation gap has arisen, where new and independent youth cultures find alternative and more westernised lifestyles thereby dismissing parental and societal guidance. This has been fuelled by increased mobility and access to the global media flux, and now understood as the Russian new era (*Atlantis et al 2000*). Young people are active agents in cultural creation who develop new gender characteristics carrying old stereotypes mixed with new symbolic values, norms and behaviours. This has to be taken into consideration in future initiatives since it has both positive and negative public health implications on the HIV/AIDS epidemic. The new economic situation creates risk environments that, in the worst-case scenario, will fuel the HIV epidemic and shape the spread and control of the disease (*Rhodes et al, 2003*).

2.2. Behaviours and the risk-group concept in the Russian Federation

From the beginning of the fairly new HIV-epidemic, the government focused its response on different risk-groups. The risk-group concept relates to the rapid spread of HIV in subpopulations. In Russia these were mainly intravenous drug users (IDU), commercial sex-workers (SW), prisoners, men who have sex with men (MSM), migrant workers and other mobile groups in the society. These risk-groups have essentially been seen as isolated from the rest of the society. However, HIV has been identified all over Russia, in all oblasts (districts) and among different socio-economic groups. The focus on risk-groups can be problematic for many different reasons and may influence the way that people view their own risk and understand HIV/AIDS.

The risk-group concept used in the Russian Federation may be illustrated by looking at IDUs and SW. Economic and social constraints has put large groups in vulnerable positions and triggered a high incidence of IDU among very young persons, as compared to other countries (*Transatlantic Partners Against AIDS, 2003*). Specific characteristics related to the contemporary Russian drug culture include a rapid diffusion of injecting drugs, high levels of mixing between people from different social networks, and, regular sharing of injecting equipment within and between networks, creating an environment for rapid and widespread transmission of HIV. Further, drug production and distribution practices such as drugs sold in pre-filled syringes, distribution through back-loading and front-loading and, as it has been reported, adding blood to the actual preparation of drugs as a neutralising agent are other key factors for the rapid progress of the HIV epidemic (*Burrows et al 2000, Dehne et al 1999, Des Jarlais et al 2002*).

Research shows that commercial sex work is increasing in Russia due to the economic and social situation in the country (*Atlanti 2000*). Little is known about the women (and men) involved in sex work, but the sexual commerce is present and very prevalent in the street, in hotels and many other venues. According to two NGOs working with street SW in Moscow, approximately 70.000 women are selling their bodies in the street (*pc AIDS Infoshare and Accent*). Other groups of SW operate in

hotel lounges or as an informal service at hotels that often have a structure to offer commercial sex to single (male) guests. These services are easily accessible, sometimes the SW calls the guest up or knocks on the door to offer sexual favours. Businessmen are a mobile workforce often exposed to SW while travelling. High rates of transient sexual encounters were also revealed among Russian businessmen, of which more than 20% reported more than one new sexual partner per week (*Goodwin et al 2003*). HIV knowledge appears to be high among high-class SW at hotels, saunas, and massage parlours, compared to among women who work in the street; understandably, the latter is the group with higher HIV prevalence (*Mashkilleyson and Leinikki 1999*). In addition, condom use seems to be very low, exceedingly dependent on the will and attitude of clients (*Atlanti 2000*). The overlap between different social networks in society is obvious since SW find clients from all parts of society. Varying levels of negotiation skills and risk-perception interact with other underlying cultural and gender-driven factors to create risk encounters that we know very little about.

Sexual behaviours and trends are not well known in Russia, especially not now after the transition to a new independent state and there has been little research on the topic (*Grassy et al 2003*). Large proportions of SW are from neighbouring countries or from the countryside, which makes them extremely vulnerable. Women from foreign countries, who usually lack legal and social support as well as access to health care, live under constant threat of being harassed by the police. Civil society programmes for SW tend to be under-resourced and cannot meet the needs of the SW. Organisations also express that they lack policies and legislations that could assist them in being more effective in their work and help protect SW.

The HIV epidemic is not an isolated phenomenon, and the risk-group concept does not correlate well with the high incidence other sexually transmitted infections (STIs) in Russia that indicate a high prevalence of unprotected sexual networks and risky behaviours. Another such indicator could be that as many as 2 million abortions are performed in the country every year (*pc Mikhail Narkevich*). The high incidence and prevalence of STIs is important also from a biological point of view since co-infection with STIs can facilitate the transmission of HIV (*Kelly and Amirkhanian 2003*). This scenario forces us to move beyond the isolated risk-group concept. There are no clear-cut groups but, rather, risk behaviours and risk environments where gender is a pertinent factor .

Externalisation of potential risks seems to be key in the way people comprehend the HIV epidemic in Russia, where the attitude “I am not at risk” is prevalent. Even though information and factual knowledge about the HIV epidemic is communicated, there are still obstacles to people changing their lifestyles and behaviours. Knowledge is just one determinant for behaviour change and other more distal factors that steer attitudes and practices should be further researched. Recent studies show that newly adapted behaviours, such as more liberated and open sexual lifestyles, have not been influenced by preventive information and that people, especially youths, do not feel that they are at risk (*Kelly and Amirkhanian 2003, Goodwin et al 2003*). Even though young people are in a phase when identities are shaped and sexuality explored, they are rarely addressed in HIV policy and research in Russia. Sexual matters seem to be quite absent in school curricula. Information is mostly given through mass media and communication vehicles produced by different NGOs that predominantly target or selected subgroups or areas.

2.3. Structure of HIV/AIDS healthcare system in the Russian Federation

The health care system has seen a general deterioration the last years and health indicators have declined sharply, which can be related to dysfunctions in the social structure and socio-economic deprivation (*Cubbins and Szaflarski 2001, Lowndes et al 2003, Atlanti 2000, Rhodes et al 1999*). Further, low political commitment, as shown by the allocation of national funds in annual budget proposals, indicates that HIV/AIDS has played a minor role in Russia. On average, less than US 16

dollars per year is spent per case diagnosed with HIV (*Transatlantic Partners 2003, Webster 2003, Grisin and Wallander 2002*).

HAART (Highly Active Anti-Retroviral Treatment) is not provided to all PLWHA in need of antiretroviral treatment (ART). According to the federal law, pregnant women must have access to ART. However, prevention of mother-to-child-transmission (MTCT) in practice does not correlate with policy. Between 3%-15% (depending on region in Russia) of children born to HIV-positive women become infected with HIV. All babies born to HIV-positive women are followed and tested for HIV and, as of December 2003, 7591 HIV-positive children were living in the Russian Federation (*Data from December 2003 provided by AIDS Infoshare*).

HAART drugs need to be imported and Russian authorities pay a higher price than their western European colleagues do; 10,000-12,000 USD per person per year (*pc AIDS Infoshare*). There is no official policy regarding the access of HAART to IDUs, but unofficially IDUs with an on-going drug abuse must go through anti-drug treatment e.g. with methadone before they can access ART. However, since substitution treatment with methadone is illegal, most of those registered as IDUs (as part of the risk group concept), i.e. the majority of those who would need HAART, do not actually receive it. Thus, only a small fraction of PLWHA are actually on medication with a triple combination of drugs. In total, about 1200 are on ART in Russia (*pc AIDS Infoshare*).

The health budget only covers those of Russian origin and the Russian Federation provides few medical and social services for foreigners residing on its territory, including no or little access to health care, HIV testing or information (*Transatlantic Partners 2003*). This means that a large population of immigrants are excluded from essential support creating, yet another, very vulnerable situation where large numbers of mobile and illegal residents are not easily targeted for HIV services or testing. This dynamic is known to be key in the spatial transmission of HIV and individual vulnerability.

The structure of HIV prevention and care seems to lack genuine coordination as well as consensus between key actors in the country, including those responsible for surveillance. Staff working on programme development and targeted interventions agree that this is a problem for finding ways to effectively combat the epidemic (*Burrows et al, 2000*). Further, there are no clear and defined relations between different academic disciplines or groups in the Russian Federation for a broader, in-depth understanding of the epidemic. There seems to be little sharing of information between institutions and organisations working with HIV/AIDS-related issues, both locally and internationally. This has, however, started to change slowly with new initiatives such as the Advisory Council on HIV/AIDS. One major reason for the lack of collaboration could be that the Russian Federation is young a state without any history of collaboration between various health services on one single issue. Nor is there any history of collaboration between health departments/organisations and other agencies. This is especially true in terms of law enforcement (*Burrows et al 2000*).

The newly established collaborations include the upcoming body of NGOs that work actively on HIV/AIDS with a broader network of key actors in the Russian Society. The NGO and the civil society sector are just in their infancy of being established and have to work hard to be seen and act as powerful agents in the battle against HIV/AIDS. The NGO sector still has little influence on national decision-making (*Atlantis et al 2000*). However, NGOs have been successful in many other countries around the world, and Russia would probably benefit from incorporating NGOs into the formal government system. NGOs are often better linked to the grassroots of society and are more sensitive to the environment where people live and enact their everyday lives.

The work performed by NGOs includes advocacy, support to infected and affected people, legal advice as well as communication initiatives to the general population and targeted subgroups. PSI, an international NGO, provides peer education with close links to the school system for behaviour change

communication (BBC) and is stressing the message of “ABC”, i.e. Abstain, Be faithful and use a Condom (*pc Nicola Morgan*). Another group, Accent, is targeting people in uniforms such as the military and police force. Other NGOs, such as AIDS Infoshare, are working with street SW, a group vulnerable due to several factors mentioned above. AIDS Infoshare has its own network that can perform cost-free voluntary counselling and testing (VCT) for those who are outside the formal system, providing information hotlines, care and support and even specific interventions targeting women.

In Russia, a number of NGOs are now working on HIV/AIDS issues. Although, civil society organisations and NGOs are, as earlier expressed, in their infancy, they are becoming more established as a resource. To a large extent, NGOs are spearheading the field and could evolve to become topic experts that, aside from human rights issues, also could incorporate gender-related topics into HIV/AIDS. No gender policies and guidelines based on gender theoretical frameworks exist. Instead actions taken by NGOs are intuitive in response to obvious needs within the target audience. Women’s groups, with good knowledge about contemporary Russian society are working on several pertinent gender-related issues.

A context in which NGOs can act as active and recognised partners in dialogue with the government is just being developed. The newly established Advisory Council works as a consulting body to the Ministry of Health with the aim of coordinating activities and optimising the collaboration between state and public organisations working in the area of prevention of HIV/AIDS. The Council consists of a wide range of actors including 6 ministries, 12 NGOs, and 6 regional AIDS centres, aiming to be the hub of activities and to coordinate actors and to optimise prevention initiatives. Although the Advisory Council does not emphasize or even mention gender in their programmes today, there may be openings for a gender perspective to be incorporated in the future. Such a development should be encouraged by those who advocate such perspectives, e.g. NGOs and the WHO. There is still a need for funds to be allocated to make all bodies within the system more powerful.

2.4. Structure of HIV surveillance

Projections of Russia’s HIV/AIDS epidemic are based on estimates produced by the Federal AIDS Centre. Under the intermediate scenario, a cumulative total of 11 million people will have contracted HIV in Russia by 2025 (*Transatlantic Partners 2003*).

However, caution must be taken in interpreting HIV data from Russia. Like all former Soviet countries, Russia inherited an expensive infrastructure for HIV (and syphilis) testing and reporting that aimed to control HIV through case-finding and continuous surveillance of those infected (*Dehne et al 1999*). The development of affordable and effective HIV surveillance systems has not been a priority in many regions and inaccurate statistics are likely due to the fact that many infected people are engaged in illegal activities and fear criminal prosecution (*Kelly and Amirkhanian 2003, Grisin and Wallander 2002*). The current gap in available data makes it difficult to give more precise predictions of the future scale and characteristics of the epidemic.

There is a tradition of mass testing in the Russian Federation and approximately 20 to 25 million people have been tested annually. Although mass screening may not be the most cost-effective method from an HIV-surveillance point-of-view, such data provides some information on numbers of new infections and on likely routes of transmission (*Lowndes 2003*), although the validity of seroprevalence data based on mass screening of so-called “high-risk” groups may be questioned.

Most clinics and hospitals in urban centres in Russia have facilities and resources to perform HIV-tests free-of-charge, while some private clinics charge 2.50 USD for a test. For a person to be registered as HIV-positive, a confirmatory test needs to be taken after a first positive test. The pre-test counsellor asks the person to come back to receive the result personally. If the person does not come back for a

second test, the first positive test is not reported as a case of HIV. This means that there might be a number of people who are lost and will, as a result, fail to fulfil reporting requirements (*Atlantis et al 2000*) The size or importance of this “drop-out rate” is not known (*pc AIDS Infoshare*). Reporting of cases in most eastern European countries includes recording of the tests result and referral to health institutions for infected persons to obtain the person’s background and history for advice and official registration. This also mean reclassification according to identified transmission categories and that people are thus classified according to the risk-group concept (*Dehne et al, 1999*).

A recent study showed that the male to female ratio of reported cases in one site had declined from 4:1 to 2:1 from 1997 to 2002 (*Lowndes 2003*) and new data (*Lowndes et al 2003*) indicates that the HIV prevalence among women has increased. This could, of course, indicate that more women are now being infected (through IDU or sexually), but also that the surveillance system now incorporates women more effectively and is more gender-sensitive. Previously, mostly IDUs, prisoners, etc. were HIV tested, which could be seen as a male-biased surveillance structure. However, the system needs further development to produce more reliable sex-disaggregated data to enable trend analyses. Interviewees say that unpublished sex-disaggregated data exists at the federal AIDS centre, but that only the total number of registered men and women infected was published.

Both quantitative and qualitative sex-disaggregated data is needed, taking existing gender differences in sexual behaviours into account and addressing risk and vulnerability factors for male and females, such as age, socio-economic status, physiological as well as other more distal factors. However, both qualitative and quantitative data is available through NGOs as they are doing formative research in programme and material development. It could be important to extract this information in a more systematic way.

2.5. Policies and legislation

In his annual presidential speech in 2003, the Russian president Vladimir Putin declared that HIV/AIDS represents a threat to Russia’s national security, a statement that hopefully will enhance political commitment to confront the epidemic also at district level. This is needed in order to hamper an escalating HIV epidemic reaching wider societal circles and entering other fractions of the Russian population that have not been exposed or identified before (*Transatlantic Partners 2003*).

Since 1995 there is a Federal Law on AIDS that addresses a wide range of issues related to HIV testing, confidentiality, anti-discrimination measures and the right to medical treatment (*Transatlantic Partners 2003*). Russia has also ratified several international conventions committing to incorporate gender equality issues in policy documents and legal regulations (*Schalkwyk and Woroniuk 1999*). The true picture of commitment and actions taken is probably far from what is pledged due to inadequate implementation of federal AIDS laws or contradictions between this new law and other laws. As Russia is using the risk-group concept for registration of individual IDUs and the route of transmission of others, an externalised view on the HIV epidemic has occurred. Similar to many other countries, Russian politicians and government officials have been reluctant to address a problem that appears to affect mainly marginalized groups and which has not yet caused the economic and social havoc that a generalised epidemic would inflict.

After years of negotiation, Russia will now receive a USD 150 million loan from the World Bank for TB and HIV/AIDS. Of this total amount, USD 50 million will be directed by multilateral outside donors to be allocated to support, capacity building, surveillance, programme development and intervention for prevention and care for a five-year period (*Transatlantic Partners 2003*).

Foreign donors and bilateral/multilateral organisations need to be careful when making suggestions regarding Russia's HIV policy or programmes. It is unclear what role outside donor organisations should play, and there was obvious frustration both within the MoH and among many NGOs regarding outside directories and goals to be reached. Interviewees thought that foreign directions on how Russia should handle the HIV epidemic would be problematic due to lack of cultural sensitivity among external actors with too little knowledge about Russia's unique situation. A recent conflict that created further tension between different actors on the HIV/AIDS arena in Russia occurred when the Global Fund agreed to fund a consortium of NGOs (consisting of AFEW, AIDS Infoshare, OHI, Focus Media and PSI) i.e. bypassing the government that has failed to create a solid and functioning "Country Coordinating Mechanism" (CCM).

Most multilateral and bilateral donors stress gender issues to a larger or smaller extent. The emphasis is usually on gender mainstreaming, i.e. that gender should be an integral part of any programme implementation, and incorporated into plans and actions as one basic criterion for funding. In discussions with organisations and departments, the notion of gender seemed to be of little interest mostly due to lack of knowledge about the concept and its theoretical premises. Even among multilateral organisations active in Russia, a clear strategy for gender specific action seems absent, despite the fact that gender is said to be important and should be part of all intervention strategies for HIV/AIDS today.

3.0 Conclusions

As a society undergoing ideological, economic, social and structural transformation, the Russian Federation is very vulnerable to the epidemic manifesting itself and faces a rapid increase in new HIV infections. So far, HIV issues have not received enough attention, and HIV has largely been viewed as a problem associated with certain risk-groups. This view may not only have contributed to an underestimation of the epidemiological potential of HIV to spread into all layers of society, but it has also externalised people who already are in a weak position and fuelled the notion of "we and them".

New and innovative multidisciplinary strategies to tackle the HIV epidemic in Russia are urgently needed throughout all levels, from surveillance to care of people infected and affected by HIV/AIDS.

A gender dimension is missing both in guidelines for monitoring and evaluation, in legislative acts as well as in health service strategies. Gender awareness would improve the overall understanding of users of health services. First of all, there is a need to generate sex-disaggregated data on the oblast-level to provide information on demographic indicators such as sex, age, socio-economic status, and ethnic origin to illuminate differences and potential inequalities. Further, on a programme and policy level, impact and anticipated outcomes should be systematically identified and include gender-specific indicators. Such data could become a pertinent tool for the Ministry of Health (MoH) in order to improve prevention and surveillance.

Today, NGOs and "grey literature", i.e. unpublished internal reports and documents provide most of the information and knowledge on HIV/AIDS. Donor initiatives based on imported ideologies may not always be suitable for the Russian context. A more open and vibrant dialogue on HIV/AIDS related issues between national and international key actors, is essential. Also, more research is needed to grasp contemporary sexual behaviours, practices, norms and values in Russia today in order to tailor more efficient and equitable policies for prevention and care.

4.0 Recommendations

The gender concept is fairly new and has not been considered or fully integrated into HIV actions and policies in the Russian Federation. Capacity building, more support and a functioning infrastructure is needed in order to mainstream gender in future HIV/AIDS strategies. Key recommendations include:

Short term

- Sex disaggregated data generated at oblast and national level should be accessible and available to organisations, researchers, mass media, ministries and other key actors for analysis to further stimulate an open and dynamic structure providing information on HIV/AIDS as well as gender-related issues. The MoH should define suitable actors and networks for dissemination of data as well as provide open, transparent and accessible publications of data and findings.
- Suitable NGOs and networks should be identified to help carry out more in-depth qualitative data for a better understanding of the context in which people, young and adults in a reproductive age, act and enact their sexual lives and drug habits. This incorporates normative views as well as the dynamics in behaviour change processes related to new orders in the Russian society. Support should be given to interdisciplinary research to enhance the information base for national actors.

Medium term

- The Advisory committee in collaboration with the MoH should assist in identifying key actors and organisations within different sectors at oblast level as well on a national level to build a more extensive structure for all types of HIV related work. Such a structure would also facilitate dissemination and use of gender-related indicators among actors.
- NGOs stand out as important key actors and advocates, but are not yet fully identified in the formal structure of HIV work. It is pertinent that these organisations get support to help facilitate the overall work on HIV/AIDS and gender nationally. Ideally such initiatives should come from the Advisory Council in collaboration with the MoH.
- There is a need to rethink the risk-groups concept to form a new and more holistic understanding of interrelated factors that have an impact on the HIV epidemic, to ideologically stimulate the mainstreaming in all sectors.
- Human rights and gender issues should be incorporated into policies, legislations as well as daily routines for service providers. Also, measurable components to safeguard that objectives are met in accordance with international agreements should be developed.

Long term

- Due to general social and economic constraints, actions taken must be cost-effective. A gender perspective should be an integral part of any policy to reach efficacy in set objectives. As the use of a gender-based perspective tends to pinpoint weaknesses in systems, it is important to have a gender-and context-sensitive outset in all HIV/AIDS interventions.
- Affordable medical interventions for those infected and an increased access to medical care to people in-need, not least the more marginalized groups in society must be further investigated.
- Sexual education should be incorporated into the school curriculum for future health communication programmes including gender sensitive interventions to be sustainable and effective.

Case Study of Gender and HIV/AIDS in Kyrgyzstan

by Anna Thorson

1.0 Introduction

A visit to Kyrgyzstan was made in November 2003 in order to interview selected key-informants on gender aspects of the HIV/AIDS situation, including legislative, surveillance, treatment and care perspectives. This report has been compiled using the information gathered in the interviews together with selected additional references⁶. The gender assessment of the HIV/AIDS epidemic is put into a wider societal context, with an aim at highlighting likely determinants of the future HIV epidemic among women and men in Kyrgyzstan.

2.0 General facts

The Kyrgyz Republic or Kyrgyzstan (KZN) is one of the poorest countries in Central Asia with a population of 4.9 million. The major ethnic group in the country are the Kyrgyz, followed by Russian, Uzbek and several other ethnic minority groups. Close to 90% of the population live on less than \$4 per day and the reported GNP per capita was 398 USD in 2001 (*UNAIDS Epidemic Update 2003*). Similarly to many other former Soviet Union states, the reorientation of societal organisation during the last 15 years has led to increased socio-economic disparities and poverty and, in its wake, increased criminality and marginalisation of selected groups.

Despite facing severe economic problems, the KZN government is considered to represent solid leadership based on democratic values, which is shown, for example, in protective actions towards the country's ethnic minorities, such as the Russian and Uzbek population groups. Whereas neighbouring countries have legislation, such as those against speaking Russian and severe problems with internal conflicts between ethnic groups, the situation in KZN is judged comparably stable. KZN is recognised as one of only a few Central Asian countries to have adopted international conventions regarding human rights. Free public education still exists, whereas changes towards an insurance-based health care system have led to inequities in health care access.

2.1. Reported data on the HIV/AIDS epidemic

The HIV/AIDS epidemic in KZN is reportedly still smaller compared to other countries. There were a total of 392 notified HIV cases in 2003, 40 women and 352 men, with a prevalence estimated at less than 0.1% (*UNAIDS 2003*), although notification rates are increasing sharply. A high number of reported HIV cases are young persons; 70% are less than 30 years (*UNAIDS 2003*). The epidemic is mainly associated with risk behaviours, especially IDU. About 85% of all HIV cases are reported to be IDUs and about 95% of IDUs are men (*CCM 2002*).

2.2. Gender in Kyrgyzstan

The communist party ideology that prevailed in KZN until the disruption of the Soviet Union includes recommendations to ensure gender equality in society. However, studies in another communist Asian

⁶ Unless a reference is given within brackets, information stems from the interviews in KZN. Please find the list of key-informants last in this section.

country, Vietnam, have shown how traditional gender structures with traditional female subordination are intertwined with communist party rhetoric in a complex creation of current gender perceptions. The resulting “gender blindness” among health care providers yields firm statements that men and women are treated equally, whereas gender inequities were clearly elucidated (*Thorson 2003*).

The KZN society provides a similar mixture, with a traditional gender structure that partly has been changed during the communist period, but even more have been hidden. In addition, the presence of several ethnic and religious groups creates another dimension of intricate gender differences between sub-groups of the population.

Another issue of importance are the urban-rural differences in life conditions for women and men. The population who lives in the remote rural areas maintain more traditional views on gender and sexuality. Men and women in urban areas have adapted to more mixed influences of the contemporary KZN society.

The changing economic system of society in KZN has, been described as, proceeding from a ‘market shock’ to a ‘poverty shock’. The increased poverty has led to significant unemployment for both women and men. Many women do not have formal employment, or have been at home on maternity leave and, thus are especially vulnerable to this development (*Kuehnast 2002*). Reported findings also suggest a change of gender roles and disempowerment of men is ongoing in the transitional Kyrgyz society. Studies on rural families report that the woman is the ‘bread winner’ working with market business and the man stays at home to attend the family. These men reported themselves as weakened and suffering from a lack of status (*Women’s support centre for UNIFEM 2003*).

2.3. Sexuality, and, sexual and reproductive rights

Gross inequities are reported in the perceptions of sexual rights for men and women. Women should not display knowledge in safe sex matters or require condom use, whereas men have the right to require sexual intercourse on their conditions. Women who share knowledge or interest in sexual activities with their partner are at risk of being considered ‘dirty, bad women’. A strong stigma is attached to HIV and women are seen as reservoirs of HIV infection. Despite more than 80% of all cases being male, women are victimised and blamed for the epidemic.

3.0 The Kyrgyz HIV/AIDS policy

According to the KZN state, programme priorities for reducing HIV spread in the population include: 1) Focus on collaboration, improvement and coherence of the national policy. 2) Strong focus on prevention (as opposed to treatment or testing), especially among vulnerable groups including youths, sex workers (SW) and intravenous drugs users (IDUs). 3) Prevention of vertical transmission MTCT, 4) Prevention of blood transmission and 5) Medical and social support to HIV/AIDS patients and families, although anti-retroviral treatment (ART) is not included. Gender aspects are not specifically discussed in the proposal. Policymakers acknowledge the different needs of women and men in prevention and care as far as they are represented in the major risk groups, SW are mainly women and IDUs mainly men. Men who have sex with men (MSM) are mentioned as a priority in terms of reducing vulnerability to HIV but no specific strategy goal exists. The number of men and women working at policy level with HIV/AIDS is equal.

No evaluations exist yet of this policy adopted in 2001. The strategy is based on a multi-sectorial approach involving various ministries, the state health care system, NGOs and UN agencies. Collaborations between state policy makers and NGOs in outreach initiatives targeting SW and IDUs will help to ensure that preventive measures reach the most vulnerable groups.

Awareness of the prevailing HIV/AIDS policy among health care providers appears high, however it is difficult to judge practice by stated awareness of policies and stated practice.

A lack of financial resources is the major hindrance against enforcing and disseminating the policy. Another obstacle is public opinion. The negative attitudes against SW and activities targeted towards this group have been especially strong among ethnic Kyrgyz people and Kyrgyz media whereas attitudes are less judgmental in the Russian media. Public opinion has also been negative towards treatment of IDU and against prevention campaigns in this group.

3.1. Legislation

Better coherence to the international laws adopted is a major point in the AIDS prevention strategy, as well as to provide better and free legal support to the vulnerable groups, SW and IDUs. Still, existing legal practices are said to violate a variety of international agreements regarding HIV. Individual interpretations of the current legislation and the public opinion works against vulnerable groups such as SW and IDUs. Raids among IDUs and SW by health care representatives and the military police are described, where forced HIV testing is performed. Although these actions are illegal, they may still be pursued by officials and are supported by the public.

Drug sale and use is illegal, but substitution treatment with methadone and needle exchange is legal, including in prisons. Sex work is illegal. Pregnant SWs are allowed to take care of their children. Homosexuality is legal but MSM is highly stigmatised. Contraception/condom promotion to under-age persons and prisoners is legal.

It is illegal to intentionally transmit HIV, though the current legislation is still reported as under development. A law for contact tracing exist for other STIs and is practised for HIV within the National Health Care system.

4.0 HIV testing and surveillance

4.1. Accessibility and interpretations of notified rates

The reported notification rates of HIV are still low in KZN. To what extent these numbers represent the real prevalence is difficult to estimate. The actual number of annual HIV tests performed in KZN has decreased since involuntary testing was forbidden. Given the steep and exponential rise of the epidemic curve, an underestimation of the actual number of cases is likely. Data on testing for HIV/AIDS is sex disaggregated, but no data is available on service attendance or the treatment of opportunistic infections. The mode of HIV transmission by risk groups is not registered, although IDUs who receive treatment for substance abuse are registered by diagnosis, i.e. HIV status is included. According to earlier reports, the epidemic is mainly restricted to male IDUs.

HIV testing is free of charge, and is recommended to be confidential, although exceptions occur. A regular VCT system including pre-test counselling is not yet established, staff report they would answer questions on demand. All blood-donors should be tested, though financial constraints have impaired the process. The rate of tested donors is estimated to have increased from 40% to 90-97% during the last couple of years, although the blood of donors may be tested retrospectively.

So far a majority of those getting voluntary testing are health care personnel, who are forcefully recommended to receive testing every year, and individuals going abroad needing confirmation of a negative HIV status to obtain an entry permit.

Pregnant women are not routinely tested. Among those where another sexual transmitted infection (STI) is diagnosed, HIV testing is recommended. However, since testing is not routinely performed within health centres offering antenatal care, referral to the AIDS centre is required. A feedback system is lacking to follow-up whether a test is actually performed. HIV and STI are highly stigmatised diseases in KZN, and the perceived and enacted stigma is described as stronger for women. Thus, cases may be lost to testing due to a fear of being stigmatised by an association with the AIDS centre.

In the capital, Bishkek, 12.000 men and 32.000 women were tested during the first three quarters of 2003, among those 84 men and 12 women tested positive. The positive predictive values of an HIV test in this selected population were 0.7% among men and 0.04% among women. These significant differences in predictive values are likely to reflect not only the, so far, low prevalence of HIV among women in KZN, but also the requirements on the – mostly female – health care personnel to get tested. These figures may also be interpreted as a failure to accurately reach individuals with risk behaviours.

4.2 Sexually transmitted infections

STI rates are commonly used as indicators for the potential for heterosexual spread of HIV. During the 1990s syphilis increased by 77 times with a peak in 1997 and has since stabilised at a very high rate, 87/100,000. More female than male cases are reported. Given that the number of children born with syphilis increased from previously being non-existent it is also thought that possibly only 60% of cases are registered (*CCM 2002*). The increase is likely partly explained by a high prevalence of STI among female SW.

In general, men are described as visiting the hospital or STI clinic directly if symptomatic, whereas women would wait. There are also socio-economic differences interacting with gender; those who can afford to seek services at a private clinic where STI cases are not registered. Poorer groups are restricted to use the National Health Services. Due to the strong attached stigma women, in particular, would be reluctant to seek care openly.

5.0 Risk behaviours

5.1. Intravenous drug use

KZN is situated in the middle of drug transport routes between Afghanistan, Tajikstan and Eastern Europe, which has had a devastating effect on IDU in the country. Drugs are now cheap and easily accessible: a heroin portion in Osh city costs 0.5 USD and in Bishkek city 2 USD (*CCM 2002*).

From occasional cases of opium or hashish use in the eighties, currently about 2% of the KZN population are IDUs. The steep increase of IDU in KZN during the last few years is practically unique. The number of IDUs is estimated at about 80,000-100,000, although official reports state lower numbers. Ninety-five percent of IDUs are men and 5% women.

The especially high number of male IDUs could be explained by the traditional requirements on stereotyped masculinity that men face, which puts them at greater risk for engaging in high-risk behaviours, such as IDU. In addition an increased vulnerability among young men in particular, due to unemployment and poverty interacts in promoting health hazardous behaviours.

Most of the IDUs do not have access to needle exchange or methadone programmes. Funding is limited and only the special harm reduction programmes, supplied by NGOs, reach this population. They hardly ever access the community health centres within the state health care and IDUs are considered a 'closed population' that is very difficult to reach. A fear of legal actions and harassment by the police in their contact with officials adds to the reluctance to seek the national health care services.

Health care providers within the national health care system perceive that the greatest obstacle against safe drug use is the sharing of drug equipment and the low access to needle exchange and methadone treatment programmes. They are also concerned about the lack of drug rehabilitation centres for the referral of IDUs. According to the adopted policy, plans are to increase the coverage of methadone programmes from the current levels of less than 5% to about 80% of the officially reported IDUs by 2007.

About 85% of the reported HIV cases in KZN are IDUs, and HIV prevalence is highest in the Osh oblast, which is also the drug trafficking centre of KZN. A survey of blood left in syringes used by IDUs showed an HIV prevalence of 12% - 18% in Bishkek and 32% - 50% in Osh oblast. From these figures it was calculated that the number of HIV infected IDUs may be as high as 6550 in Bishkek and 2050 in Osh (*CCM 2002*). Another survey showed that 90% of IDUs were sexually active (*Strategic plan for national response 2000*).

The prevalence of HIV among prison inmates in 2002 was 776/100,000 and more than 55% of all new registered HIV cases were among prisoners. More than 50% of the convicts are IDUs and drugs are available in all correction facilities. Sharing of needles is a common phenomenon in prisons, reported by 70-80% of IDUs. The overwhelming majority of convicts are young men.

The very high estimated rates of HIV among IDUs and prison convicts, together with the reports of a quickly growing marginalised IDU community that has low access to IDU treatment programmes and HIV prevention and testing facilities, is a serious threat to the success of the KZN HIV policy. The situation paints a grim picture of the future HIV epidemic in KZN unless urgent actions are taken. So far, IDU and HIV are restricted mostly to men. However, if IDU and HIV prevalence continue to increase exponentially, the epidemic will soon enter a stage where rapid heterosexual spread of HIV within the general population is likely to occur.

5.2. Sex work

The great majority of sex workers (SW) are women, about 3000-5000 are reported in Kyrgyzstan, most of them active in Bishkek and Osh oblast. The majority of SW are rural young women or refugees from neighbouring countries who come to the city completely lacking awareness of protection against HIV or STIs. Ten percent of SW are minors. The major obstacle for SW women to practice safer sex seems to be ignorance and disempowerment, in so far that they need to follow the wishes of their customer regarding condom use. Also, few SW have access to condoms. Between 300,000-500,000 clients are estimated to buy services from SW every year. The prevalence of IDUs among SW is estimated to about 10-30%. There is no information yet of any SW in Kyrgyzstan being HIV positive. There appear to be very few male SW and it is difficult to get information about them. This may partly be due to stigma and fear among MSM.

The SWs clinic in Bishkek is a unique example in KZN in the way that it provides free anonymous care as well as HIV prevention to SW for free. Treatment and care includes testing for STIs and HIV, antibiotic treatment of STIs, free condoms (though supplies are varying with time and at the time of visit, only a few condoms were available). Peer support groups for SW, arranged by NGOs, are available at the clinic and are used for reaching targeted individuals. The 'pimps' and 'brothel mothers' bring 'their SW' to the SW clinic in Bishkek, knowing that the care provided there

guarantees patient anonymity and no legal hassles. SW patients are positive towards the clinic and appreciate the care provided. Currently WHO funding of the clinic is phasing out and no additional funding has been provided for the future. This is, thus, a threat to those, mostly female SW using this clinic.

The SW, mostly women, is a group engaging in serious risk behaviours regarding potential HIV and other STI infections. Many SW live non-registered in Bishkek, without access to national health services, and are completely in the hands of a 'pimp'. The combination of disempowerment, dependence on a 'pimp', very low awareness of HIV prevention and protection against unwanted pregnancies and STIs in general, in combination with increasing IDU makes SW an especially vulnerable group in terms of HIV infection. Instead of phasing out financing of the SW clinic, the need for expansions of these kinds of health care services in Bishkek as well as in other oblasts such as Osh seems evident. In addition, more effective awareness-raising actions and support and empowerment projects are needed in this group.

6.0 Health system capacity

6.1. Health care access for women and men

In theory men and women have equal access to health care facilities, sterile medical equipment, educated staff and different types of treatment.

However, due to the ongoing economical transition of society and the change to an insurance financed health care system including user fees, people's health care seeking pattern has changed and there is an increase of unofficial payments within the system.

Apart from the SW clinic in Bishkek, women have less access to exemptions from user fees due to the fact that they less often are covered by the existing health insurance scheme, which mainly targets official employees. The exception is HIV-testing which is free of charge.

To get access to primary health care an individual needs to be registered in the respective oblast where he or she lives. Many SW and IDUs move around without proper housing or registration, often from rural to urban areas. Lack of local registration means literally no access to health care, which affects a large proportion of the particularly vulnerable poor women and men in urban areas who are involved in high-risk behaviours. In addition, many women are migrating market workers who are not registered in the area in which they work and, thus, face the same access problems to health care.

Apart from the earlier mentioned STI or HIV-associated stigma, another reason that may further impair access to both primary health care and HIV testing is fear of legal punishment as a SW or IDU. Both sex work, drug use and selling are illegal, and the WHO supported SW clinic in the capital Bishkek is the only clinic offering completely anonymous care.

Misuse of the current legislation by police and health care staff, by actively enforcing HIV testing in these groups has been reported and is likely to also work against these men's and women's willingness to seek the national health care services. However, it should be mentioned that staff at all levels in the interviews expressed great respect and concern for their patients.

In a commissioned qualitative study, gender roles and health seeking were investigated (*Women's support centre 2003*). Included in the female gender role is the responsibility for the children and family that, in turn, leads to a situation in which the woman's own needs are least prioritised. In the rural areas, access to health care services is definitely a problem and women are described as more

likely to stay at home and wait with health seeking. Men seem to be more likely to wait until symptoms are serious and then seek national health care, whereas women at an earlier stage might seek out traditional healers.

Transport costs from the periphery to the centre of the rayons, in addition to initial fees at the services, create financial barriers to health seeking. In addition, the post-Soviet development with less resources to invest into child-care and education means less time available for women's personal needs. This is mentioned as a problem especially for older women.

One study commissioned by the governmental gender office shows that earnings from clinics targeted at female reproductive health services are decreasing, whereas earnings from general health services are not, which could indicate a gender-biased decline in health care use. Also, pregnant women are decreasingly attending antenatal care clinics following the health care reforms.

A very strong stigma is attached to STIs. Syphilis treatment is free. Women and men are equally represented among patients seeking care at national health care service STI-clinics, but more female than male cases of adult syphilis are reported. Patients who use private clinics, usually those with higher socio-economic status, will not be officially registered as STI cases.

6.2. Funding and resources available for HIV/AIDS

The ongoing health sector reforms have reduced the number of staff and hospital beds. This reorganisation has had a negative impact on the treatment and care offered to many patient groups including HIV and TB patients.

Providers of both sexes are available but females are in the majority among doctors as well as among general health care staff. There are no practising urologists or andrologists. User preferences regarding gender of provider are usually not considered.

The State programme has budgeted 4,051,200 USD for the prevention of HIV/AIDS during 2001-2005. Kyrgyzstan has been granted 17,000,000 USD from the Global Fund divided over 5 years with increasing amounts to be spent for each year of scaling-up the response against HIV/AIDS. The budget does not include spending for ART, except for some very few cases (<5) of MTCT prevention. The focus is on preventive activities. Antibiotics and knowledge in treating opportunistic infections have more or less been non-existent, but clinical guidelines regarding treatment are being developed.

Among health care providers there are generally high levels of knowledge about transmission and prevention, but providers' knowledge about treatment options including opportunistic infections, and the awareness about possible gender barriers to access treatment, is lower. Some health care providers acknowledge financial barriers and stigma attached to STIs and HIV/AIDS for both men and women.

6.3. Awareness and prevention among women and men

In terms of awareness and knowledge regarding safe sex, women are less informed due to existing gender structures, where common attitudes include 'women are not supposed to have knowledge about these issues'. While women cannot require safe sex, as these are 'men's decisions', women are responsible to adjust to male wishes. The gender structure is described in a similar way for all religious and ethnic groups.

HIV/AIDS awareness is considered high among youth that go to school. A special focus on educational interventions has been shown successful. An open discussion of HIV/AIDS problems in mass media is considered possible and there is transparency regarding official statistics on STD/HIV/AIDS (*Strategic plan for national response 2000*). Most people get their HIV information

through media campaigns. There is concern that the productive generation not having been to school recently, and especially those living outside of urban areas who often lack access to TV, have low awareness and knowledge in these issues. Traditional, religious and moral taboos associated with reproductive health issues are common in all ethnic and religious groups, affecting access to knowledge of HIV for both women and men but taboos for women are much stronger. General health awareness among women is also described as low.

Youths, singles, IDUs and SW have low access to condoms, but the HIV/AIDS policy aims to change this. Condoms are very expensive and not acceptable in couples' relations, certainly not for women to suggest. Intrauterine devices and sterilization are the most common methods of contraception

Condoms have been distributed at family planning centres, but not at NGOs working with IDUs where the need is perceived as greater. This is, however, officially acknowledged and subject to change by defining vulnerable groups and NGOs to reach individuals engaging in risk behaviours such as IDU. UNFPA works specifically with Muslim religious leaders in order to reach men in Muslim communities regarding awareness of STI and reproductive health issues.

7.0 Some organisations and NGOs with specific gender and health related projects

The presidential administrative gender office

There is a gender office on the "Presidential administrative" level. Their main activities aim to improve the position of women. A ratification of women's rights and a national plan of action on gender equality were adopted in 2002. The newly appointed director is a medical doctor. There is ongoing work on gender aspects of health care services, focussing on prevention of 'social diseases' (i.e. diseases classified as public health threats, like TB, HIV and STIs), oncology and anaemia. The director states that gender aspects of law and rights are well developed, whereas practical implications, such as within the health care system, are still missing. Prisons are a problem due to their lack of proper health care services.

A study is planned to take part in two rayons, in Tju Oblast and in Bishkek, both at hospital level and at patient level. The focus will be on perceptions of quality of care, ability to pay, and the new insurance policy.

The women's support centre

This NGO has been working with gender education since 1996. The team includes sociologists and MDs. Commissioned qualitative studies on women's vulnerability to HIV were conducted in 2002-2003 at the initiative of UNIFEM.

UNIFEM

Worked with women's support centre on the earlier mentioned study. UNIFEM focuses on health communication, training in health education and gender awareness specifically related to HIV/AIDS. Male IDUs transmitting HIV to female partners are now seen as the greatest risk by UNIFEM. They also plan to inform and educate health care providers in hospitals, clinics, VCT, prisons. Workshops for journalists and the training of HIV/AIDS awareness trainers are underway and a manual has been developed on the rights of women in the HIV epidemic.

UNDP

UNDP very recently began applying a gender mainstreaming policy to all of their programmes. They work with four major issues: poverty reduction; local governance; preventive development (conflict prevention, early warning system); and national governance.

The SOROS foundation

This NGO works with harm reduction and prevention among IDUs and is also involved on a higher level with the ongoing penalty reform and TB/HIV in prisons. The Soros foundation is also part of the Global Fund 17 million USD grant for HIV. Smaller community-based projects are planned, which are steered by the wishes of the communities.

8.0 Conclusions

The transitional society in KZN of today is experiencing increasing socio-economic disparities. Health system reforms have led to inequities in health care access due to the recently introduced user fees and health insurances. More women than men are unemployed or work outside of the formal system. More women than men suffer from a lack of affordable health care services. Women's inferior status allows them less access to money and may promote inefficient health care utilisation, such as, the use of traditional healers, who provide low quality care at a lower cost.

The HIV epidemic, with a prevalence of less than 0.1%, is seemingly limited to risk behaviours such as IDU. Still, a majority of active IDUs are not tested for HIV. Testing facilities are instead focused on health care personnel and, to a lesser extent, blood donors and pregnant women. Exceptionally high HIV rates in some studies among IDUs together with steeply increasing IDU indicate that the actual HIV prevalence may be grossly underestimated. IDU is strongly linked to males and risk-taking behaviours, although IDU is increasing among women. There are an increasing number of female SW, a vulnerable group in which female disempowerment is particularly evident. Both IDUs and SW are marginalised groups in the KZN society, with very limited access to HIV and STI information, prevention and health care.

The State policy is ambitious and identifies the major problem areas, however its implementation and coverage is still low and it does not take into account the patriarchal structure of the Kyrgyz society and female disempowerment, which is reflected in sexual risk behaviour. The current policy also fails to account for the expectations on men in a transitional society where traditional expectations on masculinities, fuelled by low access to financial resources and societal deprivation, lead to risk behaviour and health hazards. In addition, a discussion about the vulnerability that seems to have been created by the interactions between gender and ethnicity in some parts of KZN is lacking.

9.0 Recommendations

The epidemic has not yet spread to the general population; this is a rare window of opportunity for prevention. However, the exponentially increasing rates of both HIV prevalence and IDU underline the urgency of taking necessary actions before the epidemic is generally spread.

Short -term

- Boosted resources for implementing a gender sensitive HIV policy requires informal collaborations between MoH, MoE, NGOs and international agencies. An active group with participants from these partners should quickly be identified in order to ensure a transparent communication and information flow.
- Free, outreach VCT testing campaigns among IDUs and SW should be organised by the national health services together with established NGOs that have built up trust and have access to these communities. Fear of legal retributions and stigma could accordingly be reduced.

Mid-term

- HIV awareness-raising projects among SW and IDUs, which should be combined with the distribution of free condoms and free needles, should be organised by established NGOs working with these sub-groups as well as clinics such as the WHO run SW clinic in Bishkek.
- IDU rehabilitation and treatment needs to be scaled-up within the national health care services. These services, including methadone treatment, should be free-of-charge.
- The existing WHO financed clinic for SW in Bishkek is both appreciated and unique in its format. It is strongly recommended that funding from the WHO to this clinic be continued. These types of clinics should be scaled-up to reach more SW in other parts of the country including Osh oblast and, preferably, combined with outreach activities to increase the attendance at and awareness of services.
- VCT services needs to be available in the entire country and knowledge of the existence of this service should be spread to the whole population. This could be organised by the national and community health services together with established NGOs
- Health care providers need to be targeted with special education on how to handle VCT, potential HIV patients, and clinical treatment of opportunistic infections. Gender sensitive measures should also be included in this education so that providers can easily identify risk behaviours as well as patients where stigma or the current gender structure creates difficulties in accessing examinations or appointments. The MoH should take a leading role in this work.
- The number of HIV cases is still low and requirements on resources for introducing ART is, thus, still relatively low. All efforts possible should be made in order to start ART and monitoring in existing cases. Current sexual patterns imply that women in heterosexual relations have very low possibilities of requiring condom use. With the increasing, mostly male and sexually active, number of HIV cases, the epidemic is likely to spread increasingly through heterosexual transmission. ART at this stage could, together with other measurements, offer not only treatment of individual benefit, but also a major reduction of the risk of further spread of the disease. The MoH, national health care services together with international agencies need to prioritise implementing ART.
- The presence of male health workers who can provide counselling as well as innovative forms of supplying health care in the whole country (drop-in, outreach VCT) should be taken into consideration when planning services. The possibilities to access VCT at antenatal care clinics and at STI clinics should increase. This is a responsibility of employers within national and local representatives of the national health services.

Long-term

- School curricula successfully have included sex education. A gender perspective should be added and contextualised. The MoE together with MoH should be responsible.
- More information and better distribution of HIV awareness campaigns is needed, especially to reach vulnerable groups and rural parts of the country. Actions aimed at reducing stigma associated with HIV and STIs should be taken through involving, not only health care providers and media, but also community and religious groups' representatives in HIV prevention. Again, informal collaborations between all the groups mentioned are needed.

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Annex 1. Contact details

Authors

Karolinska Institutet

Department of Public Health Sciences
Division of International Health (IHCAR)
SE- 171 76 Stockholm, SWEDEN

Anna Mia Ekström, MD, MPH, PhD

Tel: + 46 8 5177 07 18, Mobile: +46-(0)73-6274884
Fax: + 46 8 31 15 90
E-mail: anna.mia.ekstrom@phs.ki.se

Anders Ragnarsson, BA, Master of Social Science

Tel: +46 70-761 46 27
Fax: + 46 8 31 15 90
E-mail: anders.ragnarsson@phs.ki.se

Anna Thorson, MD, MPH, PhD

Tel: +46 8 51776542 Mobile: +46 (0)739-953972
Fax: +46 8 31 15 90
E-mail: anna.thorson@phs.ki.se

List of key-informants interviewed

In Estonia:

National HIV/AIDS Prevention programme

Tiia Pertel, former (as of April 30th 2004) manager, and
Aire Trummal monitoring/evaluation coordinator
National Institute for Health Development
Hiiu 42, Tallinn 11619
Tel: +372 670 7188
E-mail: aire@tervis.ee

West-Tallinn Central Hospital

Dr **Kai Zilmer**, head of HIV/AIDS department, and,
Olev Lumiste, counsellor AIDS Counselling Cabinet
Merimetsa Infection Centre
Paldiski mnt. 62, Tallinn
Tel +372 658586 (Zilmer), +372 6455555 (Lumiste)

Estonian Positive People Society

Vjatsëslav Vassiljev, manager
Mardi 3, Tallinn
Tel +372 52 56 449 (mobile)
Email: aek@aids.ee
Web: <http://www.aids.ee>

Estonian Family Planning Association

Maria Seeblum, executive director
Kotka 2 , Tallinn 11315
Tel: +372(6) 552 754 , (6) 55 27 55
Fax: +372(6) 552 755
Email: eppl@amor.ee
Web: www.amor.ee

Triin Raudsepp, social worker
Youth Counselling Centre of FPA
Sõle 23, Tallinn
Tel +372 6665810
Email: triin@amor.ee

Living for Tomorrow

Sirle Blumberg, director
E-mail: sirle@aids.ee
Web: <http://www.aids.ee>

Anti-AIDS Association

Dr Ljudmilla Priimägi, manager
Dept of Virology, Institute of Experimental & Clinical
Medicine, Hiiu 42, EE-11619 Tallinn, Estonia.
Tel: +372 6514 360.
Fax +372 6 706 814,
E-mail: dr.priimagi@mail.ee.
Web: www.hot.ee/antiaids

AIDS Information and Support Centre

Juri Kalikov, manager
Kopli 32, 10412 Tallinn
Tel/fax +3726413165, Mobile +37256474501
E-mail: tugikeskus@hotmail.com

Convictus

Julia Vinkler, manager
Merivälja tee 1pk 102, 11911 Tallinn
Tel +372 53410437
E-mail: julia.vinckler@convictus.org,

Žanna Beregovskaja, responsible for needle exchange
Narva Mnt 46, Tallinn

Young volunteers

In the Russian Federation:

Ministry of Health

Larisa Dementieva, Head Specialist of HIV/AIDS unit
Mikhail Narkevich, professor, former Head of HIV/AIDS unit

Advisory Council and Your Choice

Viecheslav Smolenskii, programme coordinator for Your
Choice and Executive secretary of the Advisory Council
Your Choice (NGO)
Vagzhanova st., 170000 Tver
Tel/fax: +7 (0822) 480075
Email: vibor@tvcom.ru

AIDS Infoshare

Irina Kruzhkova, coordinator for a sex workers project
AIDS Infoshare Russia
Moscow 105037 PO Box 51
Tel/Fax: 7 095 110 2460 or 7 095 383 7553
Email: infoshare@glas.apc.org or mail@infoshare.ru
Web: www.hiv-aids.ru/ or www.spiral.com/infoshare/

PSI

Nicola Morgan, Programme coordinator
Center for Social Development and Information/PSI
House 36, Building 21, 6th floor offices 630-643
Leningradsky Prospekt, Moscow 125167
Tel: 011-7-095-212-2372
Fax: 011-7-095-213-4898
E-mail: nicola@psirusia.ru
Web: www.vozmissoboi.ru or www.zhivi.ru

Accent

Marina Shegay, Director
Accent
Room N°101, Komsomolskyi prospect, 13a, Moscow
Tel: +7 095 247 50 36 or +7 095 247 53 03
E-mail: accent@avallon.ru

UNAIDS

Alik Khachatryan
UNAIDS Office c/o UNHCR
6 Obukh Lane, Moscow 103064
Tel: +7 095 232 5599
Fax: +7 095 232 9245

In Kyrgyzstan:

Republican Center on HIV/AIDS

Dr Ainagul Osmonova, Deputy Director
Tel: 312 625790

STI Clinic

Dr Djamal Nurgazieva, Chief Doctor STI Clinic
Tel: 312 425994

Patients

Sex Workers' Clinic

Ms Irina Tulainova, Director

Patients

WHO

Dr Oscon Moldokulov, WHO Liaison Officer
Tel: 312 298798

UNIFEM

Ms Nurgul Djamankulova, Coordinator
Tel: 312 666528
Web: www.unifemcis.org

UNDP

Ms Anastasia Toropova, Coordinator UNDP Social
Governance Programme on Gender
Tel: 312 660418
Web: www.sgp.undp.kg

UNFPA

Ms Gulnara Kadyrkulova, Coordinator of Reproductive
Health Sub-programme
Tel: 312 611213

UNAIDS

Ms Larisa Bashmakova, National Expert Joint UN Agencies
Programme on Expanded Response to HIV/AIDS in Kyrgyz
Republic
Tel: 312 611213

Annex 2. Terms of Reference and Study Design

Terms of Reference

- To define the main objectives of the study together with the gender mainstreaming and HIV programmes at WHO
- To review the existing information on gender and HIV in Eastern European countries
- To design the methodology for the country case studies
- To visit three specified countries and undertake interviews with key actors/organisations
- To prepare a final report with the literature review and the three country case studies

Study Design

The study, including planning, literature review, country visits and report writing took place during October through December 2003.

Part I contains a review of selected literature relevant for HIV/AIDS and gender in Eastern Europe and Central Asia. Policy documents, peer reviewed papers, teaching material, statistics and gender theory were reviewed in order to analyse and summarize the situation in the region. The aim has been to display certain risk behaviours and areas of specific interest for the transmission of HIV/AIDS in Eastern from a gender perspective. However, for some areas of interest (specifically access to VCT, monitoring and ART) the available literature did not provide enough information to allow a proper gender analysis. We therefore chose to limit our gender analyses to policy issues and services where we had access to primary data retrieved during our visits to Estonia, Russia and Kyrgyzstan. Special emphasis has been put on these three countries throughout the review, partly because our case study observations naturally feed into the secondary data (literature) review, but also because each of these countries may be seen to represent groups of surrounding countries in the region with similar HIV/AIDS scenarios and resources.

The three case studies in **Part II**, attempt to describe the HIV/AIDS situation in Estonia, Russia and Kyrgyzstan from a gender-perspective. Each study ends with concrete intervention suggestions that aim to make prevention, access to services for counselling and testing, harm reduction, monitoring and treatment more equitable, and thus effective, for both women and men. The case studies focus on the following levels of potential intervention:

- Policy and legislation
- Resources in terms of finances, health care staff and knowledge and awareness
- Direct services for prevention and care

To achieve a coherent structure for the collection of gender-specific qualitative and quantitative information in all three countries, we created a **matrix** of questions (see below) to be used during the interviews with key informants at three levels:

- Policy makers (in government/HIV/AIDS programmes)
- Providers (at hospitals, out-patient clinics, NGOs)
- Users/target groups of prevention and education, harm reduction and treatment including youth, PLWHA, people engaged in IDU and/or high-risk sex and/or key representatives of these groups

Annex 3. Matrix for data collection during country visits

Policy level: government, multi-/bi-lateral donors

Providers: clinics, hospitals, NGOs

Users: PLWHA/individuals at high risk of HIV

Policy and legislation

1. Numbers of W&M staff at policy level	1. Does registration of IDU, MSM, CSW, under-age exist?	1. Knowledge of govt policy and legal issues relating to HIV among W&M, certain risk groups?
2. Is there a gender policy ? Are HIV & Gender related issues emphasized?	2. Awareness of policy correct?	2. Policy vs. practice coherence? Perceived risk of punishment when breaking the law among W&M?
3. Are the following activities illegal?: <ul style="list-style-type: none"> • HIV transmission (if known HIV+) • Involuntary testing of migrants, prisoners, pregnant women, IDUs seeking care, CSW, military recruits, hospital staff etc? • Drug sale/use? • Sex work for W&M? • Homosexuality (activity, organiz., public prevention campaigns)? • Contraception/condom promotion to under-age youth? Prisoners? • Substitution treatment • Needle exchange legal (in prison) 	3. Policy vs practice coherence?	3. Hindering/promoting factors to seek VCT/care due to involvement in illegal activities or non-citizenship?
4. Blood-screening laws/practice?	4. Perceived risk of punishment when breaking the law?	4. Does fear and/or perceived or actual consequences of legal policy differ b/w W&M (of different age) regarding: <ul style="list-style-type: none"> • Provider/police registration? • Non-anonymous or forced testing • Access to VCT • Condom accessibility/use • Needle exchange/Methadone • Access to youth friendly services • Commercial sex (selling & buying) • Safer sex practices for SW • Access to treatment of OI, STI • Access to and follow-up of ART
5. Who has the right to VCT, antibiotics for OI and ART (all IDU, prisoners, un-insured non-citizens, children or pregnant women only)?	5. Is testing and counselling free, anonymous, voluntary and accessible for all W&M incl. IDU, MSM, SW, minors & prisoners	
	6. Treatment and care (as above)?	
	7. Obstacles to enforce policy due to cultural norms and prejudices	

Resources in terms of finances, health staff and knowledge & awareness

1. \$ for HIV (public/priv.)	1. Staff (# of M&F)	1. Access to money or social subsidies to buy: <ul style="list-style-type: none"> • Condoms • Clean syringes or safer drugs • User fees • Testing • Treatment....among W&M?
2. Are policy makers aware of importance/ extent of HIV epidemic and risk behaviours among W&M?	2. Knowledge & awareness about HIV-epidemic, transmission, preventive methods, treatment options, possible gender barriers and stigma?	2. Knowledge & awareness among W&M about HIV, modes of transmission, prevention, treatment options?
3. Is staff doing planning, monitoring, evaluation of programmes gender aware?	3. Do W&M have equal access to: <ul style="list-style-type: none"> • Examination facilities/ hospital beds • Sterile medical equipment • VCT educated staff • Screened blood • ART (mono, triple, imported or locally produced) • Antibiotics for STDs and OI • Needle exchange • Methadone treatment • Condoms & lubricants distributed • HIV Information 	3. Perceived gender-related barriers or stigma in relation to: <ul style="list-style-type: none"> • Safe sex knowledge • Safe sex practice such as to abstain from un-wanted sex, condom use and avoidance of high risk partners • Syringe exchange • Methadone or drug rehab treatment • Access to and info received at VCT • Access and monitoring of ART • Antibiotics for STI and OI
4. Asking policy makers: <ul style="list-style-type: none"> • Is gender equity for users an important? • Who are at greatest risk of HIV? • Most effective way to stop HIV spread in the population? • How should different "at risk" groups be targeted? 	4. Are traditional/moral norms inhibiting an open discussion/ campaign/ programme to prevent HIV?	

Direct services for prevention, VCT, harm reduction, monitoring and treatment

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| <p>1. Does policy acknowledge different needs of W&M in terms of :</p> <ul style="list-style-type: none"> • Aims of Prevention & Care? • Informing and educating providers (hospitals, clinics, VCT, prison)? | <p>1. Awareness of gender issues?</p> <p>2. Does sex and age disaggregated data exist (if so how is it used?) on:</p> <ul style="list-style-type: none"> • service attendance & completion/continuation (of VCT cycle, treatment)? • morbidity and mortality related to STI/OI/ HIV/AIDS? <p>3. Are both M&F providers available and user preferences re. gender of provider considered?</p> <p>4. Are counsellors trained in supporting victims of gender-based violence and sexual assault?</p> <p>5. Is VCT/harm reduction/prevention offered in a <i>range of settings</i> acceptable and accessible to <i>all</i> W&M incl. non-citizens, street kids, students, IDU, SW?</p> <p>Consider:</p> <ul style="list-style-type: none"> • Location • Opening hours • Costs • Confidentiality • What is communicated at VCT • Perceived respect <p>6. Do IDUs get info to prevent sexual transmission as well as drug-related transmission?</p> <p>7. Greatest perceived obstacle against safe drug use/safe sex among W&M?</p> <p>8. Drug rehabilitation centres for referral available for both W&M?</p> <p>9. Is STI diagnosis/treatment available for both W&M?</p> <p>10. Are young people registered or reported to parents/institutions?</p> <p>11. Promotion of services to W&M?</p> <p>12. Does staff include PLWHA, youth peers, (ex)-IDUs or is there referral to peer support groups?</p> <p>13. Is monitoring of immune status and OI/ART available, accessible and affordable for all in need?</p> | <p>1. Does <i>risk awareness or willingness to seek VCT and treatment</i> differ between W&M of different age (incl. under-age youth out of school and non-citizens)?</p> <p>2. Do W&M think that they are treated with respect regardless of HIV-status, drug use, work, sexual preferences, age and citizenship?</p> <p>3. Do M&W think they are at risk of HIV during sex? How do they classify “high risk sex” if this is an issue?</p> <p>4. Do both W&M feel they can influence safe sex? If no, why not?</p> <p>5. Are condoms available and affordable to both W&M of all ages?</p> <p>6. Are M&F IDU equally aware that they may catch and transmit HIV thru contaminated drugs/needle sharing?</p> <p>7. Are sterile drugs/drug equipment available and affordable to both W&M?</p> <p>8. Are M&F IDU aware that they may catch and transmit HIV during sex?</p> <p>9. Do SW want to practice safer sex? If yes: obstacles today? If no, why not?</p> <p>10. How prevalent/open are male CSW and what is their awareness of HIV?</p> <p>11. How common is iv drug use/needle sharing among CSW?</p> <p>12. Do IDU/SW have regular sex partners and are condoms with these?</p> <p>13. To what extent do IDU/SW have responsibility for children?</p> <p>14. Awareness of other STI in relation to risk of HIV among M&F SW?</p> <p>15. Is there a need and does it differ b/w W&M, for more info on HIV/AIDS?</p> <p>17. How did people get their HIV info (school, media, friends, campaigns etc)?</p> <p>18. Are HIV+ W&M equally aware of/ have access to monitoring of CD4/viral load and the need to seek health care at symptoms?</p> |
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