HIV in Central Asia: Tajikistan, Uzbekistan and Kyrgyzstan

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Chapter 25

HIV in Central Asia: Tajikistan, Uzbekistan and Kyrgyzstan

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Introduction

The Central Asian Republics of Tajikistan, Kyrgyzstan and Uzbekistan vary in size, gross national product, social and political organization, and ethnic composition. Nonetheless, a number of factors argue for their inclusion in a single chapter on Central Asian responses to HIV. The territories of the three countries overlap, with national borders originally demarcated under Stalin interlocking like a jigsaw puzzle. All three of the republics experienced disruption of social supports in general and health care financing in particular

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following the collapse of the Soviet Union, as well as large scale internal and external migration. All sit on drug trafficking routes for opiates produced in Afghanistan and moved through Central Asia toward markets in Russia, Eastern and Western Europe. All reported sharply increasing rates of injection drug use and sexually transmitted diseases (STDs) in the early 1990s, and rapidly growing HIV epidemics concentrated among injecting drug users (IDUs) from 2000 onward. While HIV prevalence in all three republics remains relatively low, the growth of new cases in all three countries is among the fastest in the world. Finally, international donors such as the United States Agency for International Development (USAID), the United Kingdom's Department for International Development (DFID) and the World Bank have frequently treated the Central Asian republics as a unit for HIV prevention, giving grants meant to support similar activities in multiple countries.

Recently published material has examined what might be termed structural "drivers" of the Central Asian HIV/AIDS epidemic, including migration, drug trafficking, and sex work (Mounier et al., 2007; Renton et al., 2006). In addition to offering a brief overview of these underlying causes and related trends in HIV infection rates, this chapter will also detail *responses* to the HIV/AIDS epidemic in Uzbekistan, Tajikistan, and Kyrgyzstan, with a particular focus on programs intended to reach IDUs, among whom HIV cases remain overwhelmingly concentrated [see Figure 25.1]. The three countries vary in the quality and quantity of HIV prevention interventions, with differences structured in part by differential participation of governments, non-governmental organizations (NGOs), and international donors. A balance of these three elements is likely to shape the degree to which countries are able to respond effectively to HIV.

In keeping with analysis that urges a move beyond the individual to understand determinants of risk of HIV for IDUs (Rhodes et al., 1999), the chapter also focuses on the narcological dispensary, a structure central to government

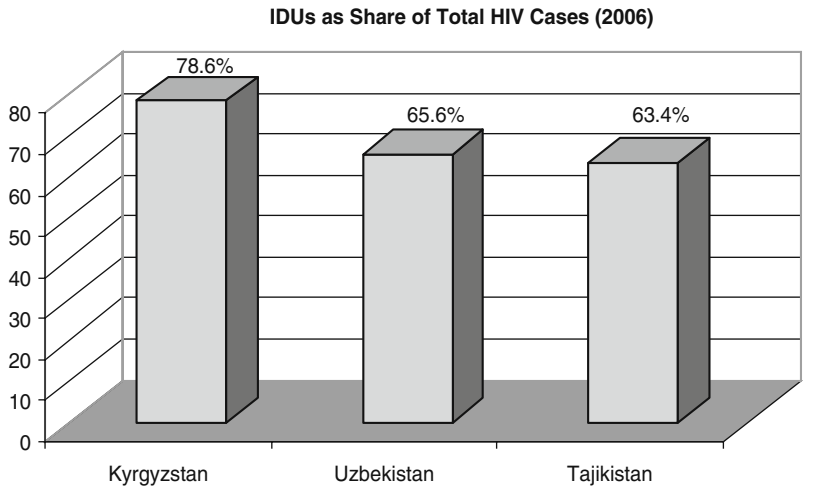

Figure 25.1 IDUs as share of registered HIV cases, Uzbekistan, Kyrgyzstan, Tajikistan. Sources: Kyrgyzstan State Plan 2006–2010; Republican AIDS Centre Tajikistan; Republican AIDS Centre of Uzbekistan.

response to IDUs in all three countries. Narcologists serve as a primary point of contact between IDUs and the state, and so are central to an effective response to an HIV/AIDS epidemic concentrated among IDUs. Discussion of services for IDUs in the three countries includes examples of promising practices from each.

Spread of HIV

Political and Economic Background

The degree to which HIV risk can be considered a social rather than individual phenomenon is clear in Central Asia, where increases in opiate addiction, sexually transmitted infections (STIs), and HIV infection coincided with the collapse of the Soviet Union. The dissolution of the USSR delivered a series of economic shocks that resulted in hyperinflation and cuts in government spending at precisely the moment that newly independent national governments were called upon to articulate new structures and social supports. All three Central Asian Republics considered here experienced sharp declines in gross domestic product and public spending between the proclamation of their independence in 1990 and the marked increases in HIV infections a decade later. Between 1990 and 1997, public spending declined by approximately 67% in Kyrgyzstan and 48% in Uzbekistan (Pomfret, 2002). In Tajikistan, a five year civil war beginning in 1992 resulted in more than 60,000 killed, severe disruption of government and private sector economic activity, and precipitous declines in government spending (Godinho et al., 2005; Olimova & Bosc, 2003). By 1998, expenditures on social services had fallen to 15% of their 1990 levels (Pomfret, 2002).

The opening of borders and resurgence of national loyalties resulted in mass migration in Central Asia, including by Russian ethnics seeking to return to the motherland. All three countries experienced severe disruption of labor markets, pension systems, and salary payments to government employees. The result has been further population movement, primarily from rural areas to urban ones, and from poorer countries to richer ones within Central Asia and from Central Asia to Russia (Renton et al., 2006). Estimates from the International Labor Organization, the International Organization for Migration and national studies suggest that more than 150,000 people from Uzbekistan, 50,000 from Kyrgyzstan, and 100,000 Tajiks work in Kazakhstan, and as many as 2 million Central Asians are temporary labor migrants in Russia (Renton et al., 2006). In Tajikistan, nearly one in five individuals (18%) of employable age was estimated to have worked abroad between 2000 and 2002 (Olimova & Bosc, 2003). A 2005 study found that nearly 40% of women in Tajikistan reported that their husbands had left the country in search of work, and that three in four of these saw their husbands once a year or less (CARHAP, 2006a).

In Central Asia, the simultaneous weakening of national economic markets and the emergence of neighboring Afghanistan as the world's leading producer of illicit opiates encouraged illegal economic activity. In Tajikistan, where a third of the national border, much of it mountainous and difficult to police, is shared with Afghanistan, estimates suggest that 30–50% of economic activity is connected to the opiate trade (Parfitt, 2003; Stachowiak et al., 2006). Sex work

is another hallmark of post-Soviet economies in Central Asia: Uzbekistan has an estimated 25,000 sex workers, while Tajikistan and Kyrgyzstan each have an estimated 5,000 (Godinho et al., 2005). In all three countries, vulnerability to illegal activity is facilitated by illegal status. Uzbekistan, Tajikistan, and Kyrgyzstan all retain the *propiska* system that requires legal authorization for residence. Tens of thousands of internal migrants are de facto illegal, excluded from social supports and health care.

STD and HIV Epidemiology

Economic and social transitions in newly independent Central Asian republics coincided with what a World Bank working paper termed four interlocking epidemics of STDs, drug use, tuberculosis, and HIV (Godinho et al., 2005). In Uzbekistan, for example, rates of syphilis notification by 1997 were 30 times that in 1990. Increases in Kyrgyzstan and Tajikistan were even more severe, with notification rates in 1998 increasing by nearly ninety fold in the same period. While increases had leveled off by 2003, annual STI notifications remained between six and 30 times higher than the number in 1991 (Renton et al., 2006).

Opiate injection, previously almost unknown in the region, also accompanied independence. Locally grown opiates had been used in medicinal teas or smoked recreationally in Central Asia for centuries, and plantations and manufacturing facilities in Kyrgyzstan provided medications for use in the USSR until 1973 (Zelichenko, 2004). Controlled by family and cultural norms or the state, reported drug abuse had been limited to solitary cases of hashish and opium dependence (Kyrgyz Republic, 2001; Open Society Institute, 2003). The mid-1990s marked a shift to injection of homemade preparations known as *khanka* or *khimshirka,* derived primarily from poppy and opium smuggled in from Afghanistan or from Tajikistan into southern Kyrgyzstan (UNODC, 2002; Zelichenko, 2004). The development of heroin processing facilities in Afghanistan led to use of smaller, prepackaged doses of heroin powder, which required less preparation and which could be more easily injected alone and in a variety of settings. At the start of 2000, for example, 70–80% of IDUs in Bishkek, Kyrgyzstan used *khanka*; by year's end, only 26% of users reported *khanka* use, while 76% reported use of heroin (Estebesova, 2003). While comparative data on HIV risk for heroin versus *khanka* injection remains limited, a study of injectors in Tajikistan found that recent injectors, as well as those injecting alone, were significantly more likely to be HIV-infected (Stachowiak et al., 2006).

Reports of all forms of drug use, and particularly opiate injection, have continued to grow rapidly after independence [see Figure 25.2]. Rates of registered drug use in Kyrgyzstan increased more than 600% between 1991 and 1999; IDUs were 10% of registered drug users in 1991, but 73.1% of all drug users by 2000 (Kyrgyz Republic, 2001). In Uzbekistan, the number of officially registered drug users increased by 800% between 1991 and 2005 (Godinho et al., 2005). In Tajikistan, the number of registered drug users increased more than 900% between 1995 and 2005, with 7,576 registered as of the close of 2005. Of those, 6,004 (79%) were heroin users, and the majority of these heroin injectors (CARHAP, 2006a).

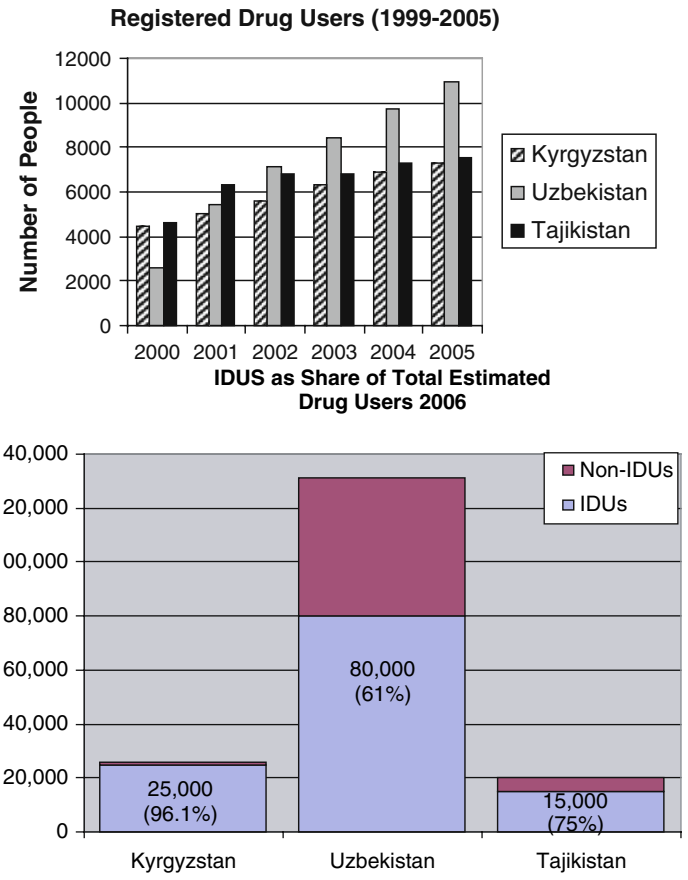

Figure 25.2 Registered drug users in Uzbekistan, Tajikistan, Kyrygzstan.
Source: Godhino et al. (2005); Republican Narcological Centres of Uzbekistan, Tajikistan and Kyrygzstan, 2006.

Rapid assessments have found substantial HIV risk among IDUs. A United Nations (U.N.) rapid assessment in 2003 reported rates of needle sharing between 20 and 40% in Kyrgyzstan, 30% in Tajikistan, and 70% in Uzbekistan (UNODCCP, 2003). A 2005 study in Uzbekistan found that 31% of IDUs had used another person's syringe in the past month (CARHAP, 2006c). In Kyrgyzstan, 59% of IDUs with HIV had shared needles in the past month in 2006 (Kyrgyz Republic, 2006). Condom use among IDUs is also inconsistent. One study in Uzbekistan found that nearly four in five IDUs reported inconsistent condom use, though the study did not distinguish between HIV-positive or negative IDUs and excluded those participating in needle exchange programs (Todd et al., 2007).

Between 1999 and 2003 all three countries reported explosive increases of HIV infection [see Figure 25.3] driven by injection drug use. In Uzbekistan, where only 51 cases of HIV had been diagnosed prior to 1998, there were a total of 800 registered cases in 2001, and more than 3,500 in 2003 (Gotsadze, 2004). By January 2007 there were more than 10,015 cumulative cases, with some

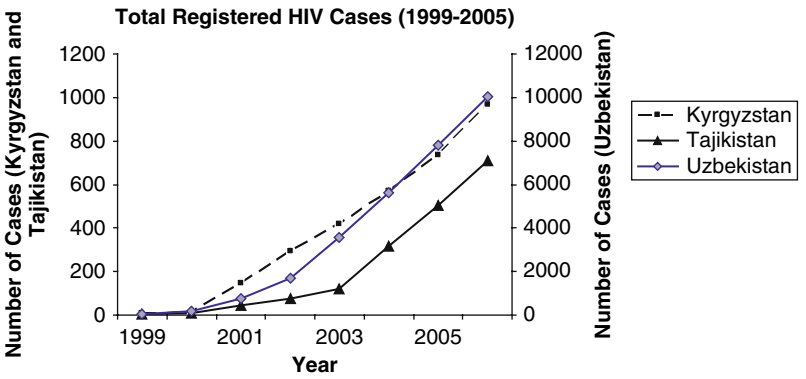

Figure 25.3 Registered HIV cases in Kyrgyzstan, Tajikistan, and Uzbekistan. Source: AIDS Foundation East-West, based on data from Republican AIDS Centres.

60% of these transmitted through injection. Kyrgyzstan, which was considered the last HIV-free country by the World Health Organization (WHO) in 1995, and which saw the first case of HIV diagnosed among a Kyrgyz citizen in 1996 (Bashmakova et al., 2003), experienced a nearly ten-fold increase in HIV cases between 2000 and 2001, and a fifteen fold increase between 2001 and 2006 (CARHAP, 2006b). As of January 2006, 826 cases of HIV had been registered, with 76% among IDUs (CARHAP, 2006b). In Tajikistan, there were seven diagnosed cases in 2000, 34 in 2001, and 710 cases by November 2006, 66% of them among IDUs.

Surveys have reported HIV prevalence among IDUs in Uzbekistan as high as 46% (Kurbanov et al., 2003), with sentinel surveillance data from 2004 showing HIV prevalence of 22% among IDUs in Tashkent (CARHAP, 2006c). In Tajikistan, a 2006 study of 489 active adult IDUs found overall prevalence of 12%, with infection rates higher among Tajiks (19%) and lower among Russians and Uzbeks (3.4%) (Stachowiak et al., 2006). Sentinel surveillance from Dushanbe and Khujand in 2005 reported prevalence of 15.8% among IDUs (Republic of Tajikistan, 2007b). In Kyrgyzstan, prevalence among IDUs, estimated at 6.4% in a CDC study in 2004, had reached 8% by 2005 (Kyrgyz Republic, 2006).

While HIV prevalence rates among sex workers are significantly lower than those among IDUs, high STI rates and frequency of sex work have led governments in all three countries to identify sex workers as target groups for HIV prevention. In Tashkent oblast in Uzbekistan, sentinel surveillance in 2004 found that 52.4% of sex workers had at least one symptom of an STI in the previous six months, and a prevalence of HIV of 3.6% (CARHAP, 2006c). In Kyrgyzstan, where cumulative contacts between sex workers and clients was estimated at more than a million annually, HIV prevalence data from Osh and Bishkek suggests an HIV prevalence of 2% (CARHAP, 2006b). Sentinel surveillance in Dushanbe and Khujand, Tajikistan found HIV prevalence of 0.7% among sex workers, and syphilis prevalence of 20% (NCC of Tajikistan, 2006). Sex workers who are also IDUs are at particularly elevated risk for both HIV and STIs. Sentinel surveillance in Taskhent found that sex workers who inject drugs in Tashkent oblast had an HIV prevalence of 57.7%, more than

fifteen times that of non-IDU sex workers, while 60% of sex worker IDUs in Tajikistan reported no condom use (CARHAP 2006a,c).

Limitations of Data

Collected at a time of legal and social transition, data on drug use, HIV and STIs in the three Central Asian Republics raise multiple caveats about the relationship between changes in testing patterns and actual incidence of disease. In Tajikistan, for example, no HIV tests were performed during the civil war from 1992 to 1997, and in-country confirmation of positive HIV test results was unavailable until 2002 (NCC of Tajikistan, 2006). In Kyrgyzstan, positive HIV test confirmation in-country was not available until 2001, and voluntary testing in 2000 accounted for fewer than 1% of all those tested (Kyrgyz Republic, 2001). Support from the US Centers for Disease Control, the World Health Organization (WHO), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and other donors have helped to strengthen laboratories and create sentinel surveillance systems that comply with UNAIDS guidelines in all three countries, though the scope of such systems is limited (Godinho et al., 2005). Voluntary testing, while more available than before, is inconsistently implemented, with a lack of pre- and post-test counseling commonly reported (CARHAP, 2006a,d; Kyrgyz Republic, 2006).

Barriers to Services

Independence in Central Asia did not mean freedom from Soviet concepts of health law. Governments of the new republics adopted many of the stringent requirements of the earlier era, including compulsory registration and treatment requirements for "socially dangerous" conditions such as alcoholism, drug addiction and STIs. These mandates, however, were no longer backed up by the same level of government resources: public health efforts, and health care more generally, were hampered by a lack of funds and infrastructure to procure or deliver medicines, conduct screening, or provide care. Even by the standards of post-independence Central Asia, health workers remained among the lowest paid workers. The fact that the *propiska* system continued to tie eligibility for care to legal residence further impeded efforts to allocate funds to or control health conditions like HIV or STIs that were concentrated in and spread among mobile or migrant populations.

Where funding shortfalls exist in the Central Asian healthcare system, it has often fallen to patients and their families to close the gap, either through informal payments for services that are officially free, or by provision of their own medicine, bedding, and food (EMCDDA, 2002). Informal payments to medical professionals had long been a feature of care in Soviet times, but independence marked a greatly increased burden on patients in Central Asia. A 1994 survey found that the cost of a single episode of inpatient treatment in Kyrgyzstan exceeded household monthly income about 20% of the time, while in Tajikistan costs of such an episode exceeded annual income for the poorest citizens (EMCDDA, 2001). This rise in fees occurred at a time when many were losing the ties to friends and relatives through whom such unanticipated expenses had traditionally been met (Kuehnast & Dudwick, 2004).

These general barriers to health care have been matched with particular disincentives for those seeking HIV testing or treatment, despite a move to establish "friendly clinics" offering counseling and confidential testing. Laws criminalize individuals who knowingly spread HIV or STIs while those who avoid medical examination are also criminalized. AIDS centers can provide only limited immune monitoring or treatment and until 2005, antiretroviral treatment (ART) was not available in Kyrgyzstan, Tajikistan, and Uzbekistan. Stigma toward people with HIV, IDUs, and sex workers has been commonly reported, and media portrayals and health campaigns frequently link active IDUs with death, disease, and inhumanity (Drug Control Agency of Tajikistan, 2007; Friedman et al., 2007).

While NGOs led by people living with HIV/AIDS (PLWHA) in all three countries have sponsored trainings and workshops aimed at diminishing negative portrayals in the media and reducing discrimination in health care settings (Kyrgyz Republic, 2007; Republic of Tajikistan, 2007a; Republic of Uzbekistan, 2007), fear of stigma continues to curtail public disclosure of serostatus. Indeed, even those working for NGOs of PLWHA rarely reveal their positive status publicly: fewer than half a dozen individuals in the three countries combined, for example, have been publicly identified as HIV-positive in the media. Involuntary disclosure of status by AIDS centers, by contrast, has been frequent. In Kyrgyzstan, regarded as the Central Asian country with the longest history of civil society involvement and most liberal government policies toward HIV, one third of people living with HIV report forced testing, violation of medical confidentiality, refusal of care, and other rights violations. Despite a 2005 law banning discrimination, social sanctions against those with HIV are powerful enough that no one has yet sought protection through the courts (Kyrgyz Republic, 2006). In Uzbekistan and Tajikistan, anecdotal reports suggest widespread stigmatization of IDUs and people with HIV (Gotsadze, 2004; Open Society Institute, 2003).

Legal vulnerability and vulnerability to HIV remain entwined in all three countries. All conduct *medicomilitzia* (doctor-police) raids, in which IDUs and sex workers are forcibly tested by police order. Those testing positive for STIs or illicit drug use are registered on government lists and can be subject to mandatory treatment, follow-up observation and in the case of STIs, future testing. Those with STIs are also required to disclose their previous sexual contacts to authorities, and police involvement in the process of contact tracing means that employers and community members may also be notified (Godinho et al., 2005). Registration as a drug user means forfeiture of driver's license and certain employment opportunities. In Osh oblast in the south of Kyrgyzstan, the majority of those taking HIV tests until 2002 had been forced to do so through *medicomilitzia* raids (Bashmakova, 2003). In Uzbekistan, those with syphilis can be detained for treatment for up to 28 days and STI clinics continue to rely on collaboration with the police to fill their beds. Raids in Tashkent oblast found 80 sex worker "dens," in 2006 (CARHAP, 2006e), and an estimated 3,000 sex workers were registered by police and subjected to regular compulsory examinations at the dermatovenereology service in Tashkent city alone (Boltaev, 2006). In Tajikistan, the criminal investigation department of the Ministry of Interior, working with medical institutions, registered more than 1,000 women with STIs in 2005 (CARHAP, 2006a).

The blurring of police enforcement and health care provision has fueled popular distrust of government systems, hampering efforts in all three countries to increase voluntary testing and treatment. Sex workers seeking to avoid registration or forced treatment, for example, have increasingly turned to "self treatment" of STI symptoms using medications obtained at pharmacies (CARHAP, 2006a; Godinho et al., 2005). A 2006 rapid assessment in Tajikistan speculated that declines in registration of drug users might reflect distrust of narcological treatment centers, rather than any actual decrease in incidence (CARHAP, 2006a). Registration practices are in flux: in Kyrgyzstan, narcologists have agreed to dispense with registration of clients voluntarily seeking drug treatment while continuing to register those brought by the police (Wolfe, 2005). In Uzbekistan, IDUs who can afford voluntary treatment in private facilities are not registered (Open Society Institute, 2003; CARHAP 2006c).

Homosexual activity is also criminalized in Tajikistan and Uzbekistan, a fact which likely contributes to the absence of officially reported HIV cases among or reliable estimates of men who have sex with men (MSM) in those countries. Despite their illegal status and the lack of good data on MSM, Global Fund grants in both countries include distribution of educational materials and condoms (and in Uzbekistan, 33,000 bottles of lubricant) to MSM (NCC of Tajikistan, 2004; Republican Emergency Anti-Epidemic Commission, 2003). In Tashkent, 34% of the registered HIV cases at the close of 2005 were of unknown origin (CARHAP, 2006e), which may reflect reluctance to reveal risk behavior to the authorities. Kyrgyzstan, where homosexual acts are not criminalized and where the government estimates there are as many as 36,000 MSM, is the only one of the three Central Asian countries considered here that has an officially registered NGO led by MSM. HIV prevention activities conducted since 1998 have included a hotline, educational events, and condom promotion activities (Kyrgyz Republic, 2006). Nonetheless, pressure from law enforcement and cultural norms prevent many from speaking openly about their sexual preferences (van der Veur, 2004). Widespread discrimination may help explain why, as of mid-2006, none of those with HIV in Kyrgyzstan reported infection via homosexual sex (Kyrgyz Republic, 2006).

Responses to the Epidemic: Government, NGOs and International Donors

Governments in each country have taken action to address the challenge of the HIV/AIDS epidemic. Each has a multisectoral committee chaired by high-level politicians and has passed legislation meant to safeguard the rights of people with HIV to free treatment, equal access to education, and protection from discrimination (CCM of the Kyrgyz Republic, 2002; Gotsadze, 2004; NCC of Tajikistan, 2004; Republican Emergency Anti-Epidemic Commission, 2003). Each country signed the Declaration of Commitment emerging from the 2001 U.N. General Assembly Special Session on HIV, in which member states pledged to increase harm reduction interventions and HIV treatment. Each country has received one or more grants from the Global Fund to strengthen HIV care, treatment and support, formed a country coordinating mechanism including non-governmental and governmental representatives, and supported

a particular focus on prevention among sex workers and IDUs. Each has supplemented Global Fund support with additional monies from international donors for drug demand reduction, HIV prevention, and drug control, and begun efforts to establish services conducive to serving sex workers, including confidential HIV testing and integration of services with reproductive health.

These similarities, however, obscure significant variation in how the three countries have responded to HIV epidemics concentrated among IDUs. A closer look at the availability of opiate substitution treatment, needle exchange, and peer outreach that is most effective in addressing HIV epidemics concentrated among IDUs underscores the degree to which context shapes Central Asian responses to HIV.

Uzbekistan

HIV treatment in Uzbekistan is supported by the Global Fund, with 277 people living with HIV/AIDS (PLWHA) receiving ART at the start of 2007 out of a government target of 700 (Republic of Uzbekistan, 2007). CD4 measurement is available only in Tashkent, requiring long trips for those people with HIV outside the capital, though the government is committed to expansion of immune monitoring services.

Government commitment to harm reduction is also clear and explicitly highlighted in the state program for HIV. In July of 2003 the Ministry of Health (MoH) endorsed the creation of 221 "*punkt daveria*," or "trust points" for needle exchange at narcological dispensaries, polyclinics and AIDS centers across the country. International donor support, including from the Swiss Agency for Development and Cooperation, the Japanese International Cooperation Agency, the UK's Department for International Development, the U.N. Office on Drugs and Crime (UNODC), USAID, the World Bank, the Red Crescent, and the Soros Foundation network have supported trainings, materials, and programs aimed at reducing HIV transmission in Uzbekistan. While donors have their own particular focus and restrictions – U.S. government funds, for example, cannot be used to pay for sterile syringes or injection equipment – many have included support for or trainings on work with IDUs. Drug demand reduction projects including those funded by the U.S., have also included harm reduction approaches, including a "break the cycle" training to discourage IDUs from initiating new users into injection (DDRP, 2006).

Official establishment of trust points, however, has not been synonymous with establishment of trust with IDUs. This is in part because trust points in Uzbekistan have dispensed with the street outreach and "user friendly" approaches that have been central features of harm reduction programs elsewhere. In Uzbekistan, emphasis at the trust point is on administration, with a room organized around a large desk on which accounting ledgers are prominently featured, and in which numbers of needles exchanged and returned is the central concern. Staff are frequently untrained, and often uninterested, in work with active IDUs. As with many Soviet-era government initiatives, expressions of political commitment were not accompanied by allocations of funding to realize them: many trust points lack a regular supply of needles and syringes (Boltaev, 2005), while some do not even have furniture, telephones, or the capacity to deliver anything but HIV testing (CARHAP, 2006d).

While an essential approach of successful harm reduction programs is to ensure a low threshold for services and to "meet users where they are," (Needle et al., 2004), trust points in Uzbekistan frequently understand their mission as more directive in nature. One trust point, for example, demonstrated efficacy by producing dozens of letters signed by IDUs in which they promised not to share their injection equipment with peers (Boltaev, 2005). Lack of outreach continues despite studies demonstrating the effectiveness of peer-based approaches, and research estimating that use of outreach workers could reduce costs by a factor of eight for each HIV infection averted (Boltaev, 2003).

International donors have supported efforts to strengthen links between government trust points and NGOs familiar with the needs and inclinations of IDUs, though these have been limited primarily to cities such as Tashkent and Samarkand. A regional AIDS center in Samarkand, for example, working with an NGO, offers needle exchange, counseling, a drop-in center and place to drink tea to more than 1,000 IDUs, and distributes more than half of its injection equipment through secondary exchange where IDUs themselves take sterile injection equipment to others (CARHAP, 2006d). In the period following the popular unrest and political changes known in Ukraine and Kyrgyzstan as "the color revolutions," however, NGO activities in Uzbekistan have been constrained due to government concern that NGOs were deviating from their charters. As in Russia, the Uzbekistan government has required that NGOs undergo complicated processes of re-registration with the government, and in some cases in Uzbekistan has impeded NGO ability to withdraw funds from banks. Some local NGOs, including those serving sex workers or IDUs were required to collaborate closely with government entities or to cease work, and multiple NGOs engaged in HIV prevention programs have closed. Many international NGOs in Uzbekistan have also stopped work following court hearings that found they had exceeded their mandates (Friedman et al., 2007).

If ties between NGOs and trust points are weak, links between the trust points and the police are strong. Compulsory treatment is the engine of narcological treatment and STI treatment for sex workers in Uzbekistan, and police are required by regulation to be present at narcological dispensaries where many trust points are located (CARHAP, 2006c). Police express confusion about a system that criminalizes the residue in a used syringe on the one hand and encourages IDUs to bring in used syringes to exchange for clean ones on the other (CARHAP, 2006d). Not surprisingly, IDUs report that they are less likely to use trust points the longer they have been using drugs (Boltaev, 2005).

The number of IDUs reached by HIV prevention programs in Uzbekistan falls far below levels needed to contain the epidemic. A 2006 assessment found that the six trusts points in Kattakugran had not exchanged a single syringe in the six months prior to the assessment, while others, such as that in Termez, were staffed only by a nurse and volunteer outreach workers (CARHAP, 2006d). Since October 2006 DFID funding has supported ten trust points in Tashkent to strengthen ties to NGOs and implement new services including counseling, detoxification, self-help groups and legal support. These efforts will help to improve needle exchange rates in the country where estimates consistently suggest that no more than 1 to 2% of active IDUs are participating in needle exchange (Boltaev, 2006; Republican Emergency Anti-Epidemic Commission, 2003).

Tajikistan

If the experience of Uzbekistan underscores the importance of strengthening NGO involvement in providing services to IDUs, Tajikistan's highlights the importance of significant engagement by the state. The poorest of the former Soviet Republics, Tajikistan has faced substantial challenges in multiple areas of health care provision and economic development. As of 2002, more than three of every four citizens in Tajikistan lived on less than USD 2.5 a day (Olimova & Bosc, 2003), and by one estimate approximately one third of all citizens of working age had no employment (Republic of Tajikistan, 2002). Of 177 countries ranked by the United Nations in its 2006 Human Development report, only three spent a lower percentage of GDP on public health (UNDP, 2006).

International support for HIV prevention and treatment efforts includes grants from the Global Fund, USAID's Drug Demand Reduction Program, the World Bank, DFID, AIDS Foundation East West, UNODC, and the Soros Foundation networks. These efforts have not been sufficient to close basic gaps in infrastructure or to compensate for minimal health care spending (NCC of Tajikistan, 2006). Hospitals lack masks and gloves for protection against infection, and tests of donated blood are unable to detect recent infections (Republic of Tajikistan, 2007b). More than one in five of all those with HIV in Tajikistan were in the penal system in 2007 (Republic of Tajikistan, 2007b), yet government authorities had yet to institute HIV treatment or opiate substitution treatment there. Needle exchange in prison, supposed to be piloted under the terms of the 2004 Global Fund grant, was unavailable as of March 2007, while condoms and lubricants, to be made available to all prisoners under the terms of the same grant, remained restricted in 2006 to rooms for conjugal visits, with those carrying them outside liable for punishment (CARHAP, 2006a). Total government spending on HIV as of 2006 totaled around USD 310,000 or less than 4% of estimated need (NCC of Tajikistan, 2006).

State budget shortfalls are matched by limited government support for NGOs: while several NGO representatives, including one from the only registered association of people with HIV in the country, sit on the national coordination committee for HIV, the state strategy for 2007–2010 suggests that NGOs are unreliable partners, noting that they frequently fail to meet professional standards (Republic of Tajikistan, 2007b). In 2007, the government of Tajikistan required NGOs to re-register with the government, a move that parallels similar processes in Russia and Uzbekistan. Even prior to this tightening of controls, government authorities have limited NGO engagement in HIV prevention in sensitive areas, such as penitentiary institutions, though limited activities such as staff training, friendly clinics for STI treatment, and peer education have been conducted there for some time (Lapytov et al., 2006).

Tajikistan's response to HIV has changed as the epidemic has grown. In the provision of ART, Tajikistan has achieved its targets: 67 patients, or an estimated 90% of those in need, were receiving medication as of January 2007 (Republic of Tajikistan, 2007b). Anecdotal accounts, however, suggest that virtually none of those on ART are active IDUs, who make up the largest share of those infected. HIV testing and counseling has also increased sharply, with more than 124,000 tests delivered as of 2007 (Republic of Tajikistan, 2007a).

Further, despite some sensitivity around NGOs, the Tajikistan government has not exerted excessive control over international donor support or NGO activities, allowing for local variation and creativity in responses to problems of HIV prevention. While Global Fund support has been used to establish a network of government trust points for needle exchange that reached 1,656 IDUs as of April 2006; an additional network of NGOs, funded primarily by the Open Society Institute, reached more than twice as many IDUs and sex workers as the government clinics, although they have fewer needles and condoms to offer them (Lapytov et al, 2006).

Tajikistan is also increasing its commitment to reaching those who are the greatest share of HIV cases. The national program of 2007 calls for the opening of trust points for IDUs in all regions by 2010, for annual medical exams for 90% of registered people with HIV, and for provision of support to assist 100% of those on ART in adhering to their treatment regiments. The plan also calls for consideration of "the problem of introduction of substitution treatment and needle exchange in prisons" (Republic of Tajikistan, 2007b). The country's Global Fund application pledged sharp expansion of services for both IDUs and sex workers, including the establishment of 17 "friendly clinics" that will offer sex workers STI and gynecological treatment by trained staff equipped with proper medical equipment, medications, and condoms.

To date, however, the reach of HIV prevention services for IDUs and sex workers alike is extremely limited. Needle exchange is offered in only 12 cities and regions when HIV has been detected in 44, and even there reach only an estimated 8–16% of those in need (CARHAP, 2006a; Republic of Tajikistan, 2007a). Despite the establishment of eight "friendly clinics", the government estimates that nearly two thirds (60%) of sex workers in Tajikistan are not reached by any HIV prevention efforts (Republic of Tajikistan, 2007a).

The slow pace of providing HIV prevention in the country has provoked international alarm. In its November 2006 report, the U.N. Committee on Economic, Social and Cultural Rights expressed concern about the rapid spread of HIV among IDUs, prisoners and sex workers in Tajikistan, and urged the government to "establish time-bound targets for extending the provision of free . . . harm reduction services to all parts of the country" (U.N. Committee on Economic and Social Rights, 2006). While the national program in Tajikistan has in fact established such targets, it remains to be seen whether the government will have the resources or political will needed to achieve them (NCC of Tajikistan, 2006).

Kyrgyzstan

Kyrgyzstan has frequently been cited as one of the most progressive former Soviet Republics, and the one with the greatest commitment to reform and health sector innovation (Godinho et al., 2005). While spending on social services plunged by nearly half between 1991 and 2000, by the end of 1996 the government spent more per capita on social programs than any Central Asian Republic except for far wealthier Uzbekistan (Pomfret, 2002). This appears to be the result both of a willingness to turn to foreign donors and of greater governmental flexibility. Unlike Uzbekistan, for example, Kyrgyzstan had few natural resources to sell in international markets, and some analysts suggest that

the country's nomadic past and relatively late entry into the Soviet Union left its government more flexible and less centralized (Wolfe, 2005). The emergence of the country's NGO sector, the most developed in Central Asia (USAID, 2001), was rapid after independence, and included the formation of a number of active HIV organizations. Representatives from these organizations sit on the national committee coordinating the country's response to HIV/AIDS.

Kyrgyzstan further laid the groundwork for fighting HIV/AIDS by repealing laws criminalizing homosexuality and "voluntary adult prostitution" in 1997 and 1998, respectively (Godinho et al., 2005). A 1998 law also removed penalties for being a drug user, although possession of even the amount of drugs in a used syringe continued to carry harsh criminal consequences (Wolfe, 2005). The Kyrgyz state program on HIV/AIDS from 2006 to 2010 emphasizes the development and expansion of a network of harm reduction programs as a major goal, acknowledges that "the main driving force of AIDS in the Kyrgyz Republic is drug use," and calls for alternatives to incarceration for drug related crimes that are limited to possession of small doses of drugs for private use (Kyrgyz Republic, 2006). In June 2007, the President signed reforms meant to "humanize" Kyrgyz legislation that included removal of criminal penalties for possession of small amounts of drugs, though as of this writing the new amounts punishable by incarceration had yet to be specified.

Needle exchange and sex worker projects in Kyrgyzstan have been profiled in domestic and international studies of best practices of HIV prevention (UNAIDS, 2006; Wolfe, 2005), and include peer- and clinic-based exchange, a pharmacy-based initiative in Bishkek, as well as confidential counseling and testing and treatment for HIV. NGO efforts to reach sex workers, which have included peer outreach, hotlines, counseling, referrals to free, confidential treatment for STIs, and a mobile STI clinic offering consultations, blood tests, and STI prevention information, report remarkable levels of coverage: a Bishkek NGO, Tais Plus, reports that 85% of sex workers in Bishkek have participated in its HIV prevention activities. Sex workers surveyed by Tais Plus in 1999 found only 13% condom use in more than 500 encounters with clients; by 2000, 81% reported condom use with their last client, and by 2002 the percentage reporting condom use in their last commercial encounter rose to 89.6% (UNAIDS, 2006). In a 2006 rapid assessment, sex workers reported rates of condom use for commercial clients of 92.6% (CARHAP, 2006b).

Kyrgyzstan was the first country in Central Asia, and remains the only country besides Moldova and Belarus in the Commonwealth of Independent States (CIS), to implement needle exchange in prisons. Begun with the support of the Ministry of Justice, these services have been expanded to 13 prison colonies in the country, and two colonies also have drug-free prison programs run by an NGO that includes former drug users as staff (Zelichenko, 2006). In 2002, Kyrgyzstan became the first country in the CIS to offer methadone maintenance treatment to opiate addicts (Wolfe, 2005). Following disruptions in supply that resulted in dismissal of half of the country's nearly 200 methadone patients in 2005, clinics in Bishkek and Osh have returned their enrollment to earlier levels. Additional methadone programs, each serving fifty individuals, are scheduled to open in Bishkek in 2007, as are new clinics in Tokmok, Kan, and Kara-Balta. The Global Fund grant calls for 1,500 to receive methadone by the end of 2008 (CCM of the Kyrgyz Republic, 2002).

In almost all instances, these innovations in HIV prevention have been the result of collaboration between government, international donors, and NGOs. While international donor support accounts for the vast majority of funds for harm reduction, Osh oblast and the city of Bishkek have both contributed funds to needle exchange efforts. The Ministry of Internal Affairs has been supportive of substitution treatment and of needle exchange in prisons, and has worked actively with NGOs to ensure provision of sterile injection equipment in penal institutions. Cooperation between the government and NGO sectors has been reflected in the movement of staff between the NGO and government sectors, as well as between sectors of the government. For example, the head of the largest NGO providing harm reduction services in Bishkek was formerly deputy of the city's narcological dispensary, the head of the AIDS center at the start of Kyrgyzstan's first Global Fund grant was formerly Deputy Minister of Health, and the governor of Osh oblast who allocated funds for needle exchange was formerly the Minister of Health.

These advances in HIV prevention, however, have not been consistent or complete. Centralized procurement of needles for prison-based needle exchange programs, for example, has meant shortages of supplies in a number of prisons far from the capital (Zelichenko, 2006), and NGO involvement in the program has been curtailed under a new Minister of Justice. The legal environment remains challenging, with police arresting or harassing needle exchange and substitution treatment clients. In 2007, Bishkek NGOs reported that police had launched "Operation Butterfly" to roundup and perform compulsory HIV and STI tests on those suspected to be involved in drug trafficking and sex work (SWAN, 2007). Drug users experiencing overdoses from heroin, particularly common during the "seasons of death," that mark the arrival of purer heroin after the harvest in Afghanistan, remain reluctant to call for medical assistance, fearing that information will be shared with police (Soros Foundation Kyrgyzstan, 2007).

Further, while varying estimates of the number of IDUs and sex workers make it difficult to decisively assess the extent of coverage, programs remain at limited scale. Programs providing sterile injection equipment are estimated to reach no more than 22.5% of IDUs, while coverage of sex workers is estimated at 40% (Kyrgyz Republic, 2007).

Civil Society Responds in a Former Soviet Union State: Ukraine and Harm Reduction

The first country in the former Soviet Union to experience a widespread HIV outbreak, Ukraine has also been a regional leader in harm reduction and HIV treatment. The country has a well-established and highly organized network of people living with HIV whose advocacy helped highlight treatment interruptions and mishandling of the first Global Fund grant, which was subsequently transferred to a non–governmental organization. Syringe exchange programs under the Global Fund have grown from a handful supported by private foundations to more than 250 points covering an estimated 118,000 IDUs across the country (International HIV/AIDS Alliance in Ukraine, 2007), though definitions of "coverage" appear to emphasize quantity over quality. Recent innovations include a pharmacy-based exchange in Kiev that operates 24 hours, as well as a peer-based approach that draws on drug users' social networks to bring the increasing numbers of injectors of *vint*, a homemade amphetamine, into contact with harm reduction (IHRD, 2008).

While Russia and Central Asian countries have used registration requirements to constrain NGOs from receiving international support, the Ukrainian response to HIV/AIDS is largely NGO-led and internationally funded. A USD 151 million Global Fund grant, given jointly in 2007 to the International HIV/AIDS Alliance and the All Ukrainian Network of People Living with HIV/AIDS, is the largest ever awarded in the former Soviet Union. More than half of the funds will support HIV prevention, and the grant includes measures such as drop-in centers and integration of addiction and HIV treatment to increase the access of active drug users to ARVs (Country Coordinating Mechanism of Ukraine, 2007).

Treatment with methadone and buprenorophine, a linchpin for both prevention and treatment of HIV among IDUs, while not banned as it is in Russia, remains minimal in Ukraine. Buprenorphine treatment began in 2005; by 2007 nearly 550 individuals in the capital and eight regions were receiving medication, though without the take-home doses or pharmacy prescription that are the norm in Western Europe or the U.S. (IHRD, 2008). Under pressure from the All Ukrainian Network of PLWHA and other local advocates, the minister of health and the deputy prime minister for humanitarian issues have signed orders to authorize provision of methadone, a more affordable medication, and to allow expansion of treatment to some TB and HIV treatment centers. Global Fund targets call for provision of substitution treatment to up to 11,000 IDUs by 2011, with 3,500 patients supposed to receive methadone by the end of 2007 (Country Coordinating Mechanism of Ukraine, 2007). With no patients receiving treatment by September of 2007, this short-term target seems unlikely to be met. Ukraine has also yet to address the absence of substitution treatment in hospital wards, which essentially forces patients who get sick with HIV to give up the most effective treatment for their opiate dependence.

As elsewhere in the former Soviet Union, police and public health approaches are in tension in Ukraine. In April, 2007, each patient in a support group at an Odessa buprenorphine clinic had a story of police harassment (IHRD, 2008). "We have changed," one patient noted sadly, "but the police have not." Needle exchange points report regular police harassment, including extortion and use of painful withdrawal symptoms to coerce confessions for unsolved crimes. A project supported by the International HIV/AIDS Alliance is educating police about ARVs after reports that officers, insisting that any pills in the possession of drug users must be illegal, confiscated them.

Russia, Kyrgyzstan, and Tajikistan have relaxed drug penalties, but those caught with small amounts of opiates are still imprisoned in Ukraine in facilities where drug use continues and where needles, sometimes sharpened with glass by desperate inmates, are repeatedly shared. The United Nations' Human Rights Committee decried Ukrainian prison conditions in 2006, expressing concerns about the high incidence of HIV/AIDS and TB among detainees (UN Human Rights Committee, 2006). HIV prevalence among those incarcerated in Ukraine rose from 9% in 2003 to 14% in mid-2006 (IHRD, 2008). HIV treatment is extremely limited and methadone and buprenrophine are unavailable. Despite several memoranda committing to pilot needle exchange in two correctional facilities, the state penitentiary department has yet to start such programs. Improved services in prisons, and greater access to substitution treatment services, are among the demands being advanced by a growing network of drug user groups in the country.

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Treatment for Opiate Dependence

Narcological Dispensaries

Analysts of HIV prevention for IDUs in this region have increasingly urged attention to the structural, rather than individual, factors that help to determine the "risk environment" (Rhodes et al., 1999). One such structure in Central Asia is the narcological dispensary, often the first point of contact between drug users and the state. A subdiscipline of psychiatry, narcology is a legacy of the Soviet era, when the state committed addicts and alcoholics to locked facilities for blood purification procedures, aversion therapies, and, when deemed necessary, forced labor (Gilinsky & Zobnev, 1998; Rouse & Unnithan, 1993). The narcologist's reach historically extended well beyond the clinic: in Soviet times, each addict or alcoholic was required to have their names added to a central registry, to make periodic visits to the narcological center for follow-up observation, or to submit to home inspections to gauge conformity with social norms.

While work camps and medical inspections in Russia largely collapsed with the Soviet Union, narcology's emphasis on highly medicalized detoxification and monitoring as a variant of care remains intact in Central Asia. Although Tajikistan's compulsory treatment system is essentially defunct (Lapytov et al., 2006), those apprehended by the police are subject to forced treatment in both Uzbekistan and Kyrgyzstan. Some dispensaries remain open day and night to test those suspected of drug use by police and to register and prescribe treatment to those who test positive. The centrality of registration to narcological practice and social standing is such that all citizens in each country are required to visit narcologists to determine their registration status prior to obtaining a driver's license, a marriage license, or certain kinds of employment. Drug users and their families report that fear of registration is a major disincentive to seeking services (Elovich, 2007). Those who wish to avoid registration pay significantly higher fees at the few clinics providing private treatment (CARHAP, 2006d; Open Society Institute, 2003).

As with AIDS centers prior to the introduction of ART, narcologists' power to monitor frequently exceeds their power to treat. Medications such as methadone or buprenorphine are among the best studied and most effective means of reducing illicit opiate use (EMCDDA, 2001), yet these medications were available to fewer than 150 people in Kyrgyzstan (Subata & Pkhakadze,

2006), 150 in Uzbekistan, and none at all in Tajikistan in 2006. Despite repeated studies finding that detoxification alone "is not a treatment for drug-seeking behavior" (Gerstein & Harwood, 1990) and "an inadequate use of limited resources," (Center for Substance Abuse Treatment, 2006), many narcological dispensaries in Central Asia offer nothing beyond detoxification. Theoretically free, in practice detoxification is only available for fees that can be as high as twice the average annual per capita income (Open Society Institute, 2003). The process often involves medicating IDUs to the point of immobility for weeks with high doses of tranquilizers and anti-psychotics, and offering little or no psychosocial counseling. While the professional rationale is to minimize the pain of withdrawal, the social effect is to reinforce the idea that IDUs and those in their social networks have little role to play in chemical dependence treatment (Wolfe, 2007).

Part of a highly vertical health system in which different specialists claim exclusive authority to diagnose, monitor, and medicate, narcological dispensaries also operate independently of services to treat HIV, tuberculosis, or STIs. Of 18 million condoms sent by international donors to Kyrgyzstan between 1997 and 2000, for example, none went to narcological dispensaries (Kyrgyz Republic, 2001). IDUs who are co-infected with HIV or tuberculosis, a relatively common phenomenon in a country like Tajikistan, where those with a history of drug treatment are twice as likely to be HIV-positive (Stachowiak et al., 2006), may find themselves registered in multiple clinics but shunted from one to the next when they are in need of comprehensive care. It frequently falls to IDUs themselves to negotiate the geographic and metaphoric distances between clinics, and to determine what makes a desirable patient in each.

Where treatment is compulsory, opiate users are treated more according to legal requirements than to personal needs. An analysis of those in forced treatment in a Bukhara Narcological dispensary in Uzbekistan, for example, found that more than half were receiving levels of clinical interventions that did not respond to their treatment needs and that were more intensive than those indicated by individualized diagnostic assessment (Boltaev et al., 2004). While USAID, DFID, and UNODC have supported training opportunities for narcologists, these remain limited. In Tajikistan, for example, a rapid assessment found that 70% of that country's narcologists had received no in-service training or professional development in 14 years (CARHAP, 2006a). Limited staffing further impairs treatment delivery. In Ferghana in Uzbekistan, for example, one doctor is responsible for 60 voluntary and 90 mandatory treatment beds (CARHAP, 2006d).

As with HIV prevention and treatment services, most of those in need do not access even the rudimentary services offered for chemical dependence. A U.N. study of drug treatment in the three countries from 2003 to 2005 found that narcological clinics reached fewer than 10% of registered users in Bishkek and Tashkent (UNODC, 2006). Patients reported a four to six year period between starting drug use and accessing treatment, a gap which reflects the extent to which HIV prevention and drug dependence treatment opportunities are being lost.

Means of addressing drug use may have been inherited from Soviet times, but they have not necessarily remained static. Indeed, while narcology generally retains an emphasis on doctor-centered, highly medicalized treatment,

there are multiple examples of innovations at individual clinics or at programs that have reconceptualized treatment to include interventions performed outside the clinical setting. A case study from each country helps to underscore the ways that drug treatment is being reshaped into something more responsive to international best practice and patient needs.

Promising Practices in Opiate Dependence Treatment

Methadone and Buprenorphine at the Tashkent (Uzbekistan) Narcological Dispensary

In February 2006, more than 200 IDUs in Tashkent began to receive treatment with buprenorphine, a prescription medication shown to decrease cravings for and reduce illicit injection of opiates. The program, begun by the Tashkent narcological dispensary and endorsed by the MoH, was a pilot that sought to evaluate the viability of substitution treatment. Each case was discussed among a panel of doctors, resulting in a treatment plan including psychosocial and family counseling components. In October of 2006, another, smaller group of patients in Tashkent began receiving methadone treatment on a similar trial basis.

These programs are the culmination of work by local experts and international donors which began when officials from Uzbekistan's MoH took study tours to Asian and European countries to look at the feasibility of opiate substitution treatment. A Parliamentary motion in 2001 authorized exploration of a pilot project, and eventually procurement of medication was supported by the Global Fund. Preliminary results with those in treatment suggest improved family relations, decreased injection, and other favorable HIV risk related outcomes.

Difficulty enrolling enough HIV positive patients to meet Global Fund targets led the narcologist at the Tashkent dispensary to negotiate with the MoH and the Global Fund to relax entry criteria to include HIV-negative patients. Guidelines were also relaxed to allow interested patients to use treatment provided as a step toward abstinence from all drugs, as opposed to continuing on daily maintenance. As of February 2007, about 250 patients, about half of whom were PLWHA, had received methadone or buprenorphine; of the buprenorphine patients, half had transitioned to drug-free status. This has further enhanced the reputation of the program among IDUs and their relatives, and there is now a waiting list of approximately 100 patients. Substitution treatment patients in Tashkent are also informed about the availability of needle exchange, and some of those who relapse to heroin use become clients at a trust point. Plans call for expansion of maintenance treatment to other regions of Uzbekistan, with the goal of improving access to treatment in rural areas.

Needle Exchange, Drop in Centers, and Drug-Free Rehabilitation in Khujand (Tajikistan)

In the West, drug use is often conceived of as an individual disorder, with sharing analyzed in terms of injection equipment or drug doses. In contrast, in Central Asia, drug users are frequently not a subculture so much as folded into existing structures, often including brothers, sisters, parents, and wives.

It is not uncommon to find a group preparing drugs in the kitchen while the mother sits in the living room. *Khanka* and *khimshirka* are prepared by small groups of IDUs according to different local recipes. Group members frequently organize themselves in different roles, with one member providing the money needed to purchase raw materials, another securing injection equipment, a third going to secure the chemical ingredient to break down the poppy and a fourth volunteering his home for the cooking (Friedman et al., 2007).

DINA, a NGO in Tajikistan, recognizes the value of social engagement in its efforts to rehabilitate patients from drug use. Its drug-free rehabilitation center in Palass, outside the city of Khujand, uses a therapeutic community approach where patients live and attend groups together, and tend to cattle and geese on a small farm that provides work therapy and sustains the community. What began as a treatment effort started by one brother for another grew to include friends of the family, and eventually, participants from all over the region.

Unlike traditional therapeutic communities in the West or the coerced treatment centers elsewhere in Central Asia, there is little emphasis at Palass on confinement or confrontation. While low stone walls line the property, they serve to mark out the boundaries of the facility rather than to lock patients in. Further, DINA sees drug-free rehabilitation as one point on a continuum of services for IDUs: the same organization runs a street outreach program in the city of Khujand providing clean needles, condoms, and HIV education and a drop-in center where IDUs and sex workers can come for crisis intervention and consultations with a physician and psychologist. The center, which has eight beds, allows people to remain for hours, days, or even weeks in an environment where drugs are not exchanged or consumed, but where participants do not have to be drug free or even committed to behavior change to attend.

A Continuum of Needle Exchange, Overdose Prevention, and Drug Free Treatment in Bishkek (Kyrzyzstan)

A wooden board at the entrance of Sotcium, a harm reduction NGO, displays examples of the variety of injection equipment that IDUs in Bishkek have turned over to the organization: thick spoons and wider gauge needles for *khanka*, smaller and thinner ones for heroin solution, one-time use needles, insulin needles, and homemade injection apparatus. The display serves as proof that drug injection practices of IDUs are varied, and a reminder of the importance of building services based on what IDUs need, rather than on what a centralized fund has purchased or what a management office has determined is appropriate.

Sotcium provides needle exchange (with different gauge needles), secondary exchange by active drug users able to go places where outreach workers cannot, wound care, psychological support, referrals to physicians offering confidential counseling, STI testing and treatment, and a 24 hour hotline staffed by trained counselors to answer questions. Sotcium's needle exchange program utilizes cars and outreach workers who take sterile injection equipment to the houses of IDUs, as well as office based exchanges in city polyclinics where IDUs are able to slip in without being noticed. In 2007, Sotcium piloted an overdose prevention program with naloxone, a medication able to reverse the effect of opiates, and a pharmacy-based needle exchange that allowed drug users to present vouchers, similar to regular prescriptions, for sterile needles.

The pharmacy-based needle program had 600 clients shortly after its formation. The effort is too new for evaluation, though earlier studies found that rates of needle sharing among syringe exchange participants at Sotcium dropped from more than two thirds to only 18% in the first year of operation. Reuse of injection equipment also dropped, with 98% reporting multiple use before the start of the program and only a third doing so after twelve months (Estebesova, 2003).

Sotcium views drug free approaches, opiate substitution treatment, and needle exchange and overdose prevention as complementary. The main Bishkek office was established only steps away from the government-run methadone dispensary in Bishkek, some methadone patients work as needle exchange volunteers, and Sotcium's director is the former deputy of the narcological dispensary. The turn to needle exchange has not diminished commitment to support for abstinence: twelve step meetings are held in the same building where needle exchange is conducted, in the same room used for staff meetings that include salaried counselors (many of whom have family members who are drug users), former drug using clients, and professionally trained psychologists. Sotcium has also begun intensive outpatient treatment for those seeking to abstain from drug use.

Conclusion

A structural analysis of responses to HIV/AIDS in Central Asia could easily focus on institutions other than those providing drug treatment. Prisons and pre-trial detention centers, for example, contain between 11 and 21% of those with HIV in the three countries (Open Society Institute, 2003; Republic of Tajikistan, 2007b), and so are critical to the course of the HIV epidemic. Only Kyrgyzstan offers needle exchange services in prison, none of the three countries has methadone or buprenorphine in penal institutions, and none offers HIV treatment in prison. Regulations and practices that aggregate infected and uninfected individuals in environments where high-risk behaviors continue and where protections against HIV are unavailable, as well as state failure to provide HIV treatment to those incarcerated or institutionalized, might thus be said to "cause" Central Asia's AIDS epidemic as much as individual patterns of injection and condom use.

Attention to the factors that structure the priorities and operations of international donors supporting HIV prevention and treatment in Central Asia is also needed. Despite a strikingly similar modus operandi among donors, including country and regional assessments followed by grants to support HIV prevention and treatment, coordination of effort has proved difficult. If a blend of NGO, government, and international donor commitment is desirable to address the HIV epidemic in Central Asia, so is a coordinated effort that prevents duplication and competition.

Responses to HIV in Central Asia highlight the difficulties and the possibilities of response to an epidemic concentrated among IDUs. Uzbekistan, Tajikistan, and Kyrgyzstan all demonstrate the tension in post-Soviet states between law enforcement and public health, and the importance of moving from highly specialized, siloed health care delivery to a more integrated approach

based on patient needs. Realizing universal access to HIV treatment in Central Asia, a goal to which all three governments have committed, will likely require measures such as those piloted by NGOs in parts of Russia, where drug users and people with HIV work as peer counselors to improve patient adherence and make the health system more responsive to patient needs. In this model, IDUs have been reconceptualized as partners in treatment rather than populations to be controlled. Sex workers and MSM, similarly, are likely to remain unreached by HIV prevention or treatment so long as they are regarded as socially suspect. Needle exchange, substitution treatment, and safer sex promotion can work in Central Asia, but only when attention is paid to the legal environment, professional regulations and practices that are a primary determinant of how or whether criminalized populations get any kind of care.

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