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Two Decades of HIV/AIDS in Tajikistan: Reversing the Tide or the Coming of Age Paradigm?

*Alisher Latypov**

ABSTRACT

Central Asian region has witnessed a dramatic ‘rise of the HIV tide’ over the last decade. This article provides a historical overview, describes the process of domestication, and examines legal, social and political dimensions of the HIV epidemic in Tajikistan in order to highlight existing contradictions and barriers in HIV policy-making and program implementation in that country. The response to HIV/AIDS in Tajikistan has been seriously influenced by pre-existing Soviet policies, crackdown on illegal substance use, and stigmatization of at risk groups and people living with HIV/AIDS. Contradictions between law enforcement and public health approaches in dealing with vulnerable populations are among the most significant factors impeding effective HIV prevention programs in Tajikistan. Without resolving fundamental problems, such as prevention of punitive actions of the police against drug users and commercial sex workers, abolishment of control-oriented registration policies and introduction of substitution therapies HIV programs in Tajikistan are more likely to miss their aims.

Keywords • Tajikistan • HIV/AIDS • Drug Users • Sex Workers • Law Enforcement • Coverage Paradoxes • Policy Analysis.

Introduction

The two paradigms articulated in the title of this essay have been increasingly used to highlight a specific situation or a process related to the HIV/AIDS epidemic. This paper will examine various aspects of the HIV epidemic in Tajikistan and analyze key concepts and factors involved in domesticating and responding to the epidemic. This is in order to answer the question whether, after nearly two decades into HIV, Tajikistan faces a full-blown challenge, or the issue has been adequately

* Alisher Latypov is the Country Manager for Global Initiative on Psychiatry in Tajikistan and formerly UNDP’s Sub-Regional Drug Epidemiology Expert for Central Asia. The author is very grateful to Guy Attewell and Umed Ibragimov for their valuable comments on an earlier draft of this paper and indebted to the Wellcome Trust Centre for the History of Medicine at University College London for its support.

contained. In Central Asian countries HIV/AIDS has been widely considered as a “relatively new” problem, security threat or “the plague of the 21st century”¹ in policy-making, health care, research as well as law enforcement communities. But, as emphasized by Berridge, “how much is continuity and how much change?”² By looking at the making of AIDS policy and reviewing existing paradoxes in responding to HIV/AIDS in Tajikistan this paper will also challenge the “newness” question and argue that, unlike HIV/AIDS problem itself, many HIV/AIDS-related political, epidemiological and programmatic developments were in fact inherent in the pre-existing Soviet period.

The Rise of The Tide

Tajik people learned about HIV/AIDS at the time when their country was part of the Soviet Union and up to 1989, AIDS was not a serious problems either for the society or for the Ministry of Health of the USSR.³ Although as few as 112 people out of 285 million Soviet citizens were officially known to be infected by that date, it seemed to be only part of the overall picture as both research and specialist data on AIDS were originally considered a sensitive issue in the USSR, partially due to the pre-Gorbachev era propaganda labeling AIDS as a bacteriological warfare experiment that went wrong and accusing the U.S. Government of developing the virus in military laboratories.⁴ Initial indications of AIDS ‘penetration’ into the USSR came in 1984. A paper on 275 recent cases of Kaposi’s sarcoma observed in Moscow, of whom 53 (19.3 percent) cases were under the age of 40, was published in Russian journal of *Vestnik Dermatologii i Venerologii*, possibly as a result of censorship oversight.⁵ Although a year later Professor Zhdanov, Director of the Ivanovsky Institute of Virology in Moscow, admitted the existence of AIDS in the USSR in an interview published in *Sovietskaya Kultura*

¹ Svetlana Ancker, “HIV/AIDS: Security Threat in Central Asia?” *China and Eurasia Forum Quarterly* 5, 3 (2007), pp. 33–60.

² Virginia Berridge, “AIDS, Drugs, and History,” in Roy Porter and Mikulas Teich, (Eds.), *Drugs and Narcotics in History* (Cambridge, New York: Cambridge University Press, 1995), pp. 187–198.

³ Zhores Medvedev, “Evolution of AIDS Policy in The Soviet Union. Part I. Serological screening 1986-7,” *British Medical Journal* 300, 6728 (1990), pp. 860–861.

⁴ Zhores Medvedev, “AIDS Virus Infection: A Soviet View of Its Origin,” *Journal of the Royal Society of Medicine* 79, 8 (1986), pp. 494–495; Vera Rich, “Soviets Ponder AIDS Vaccine,” *Nature* 330, 6147 (1987), p. 414.

⁵ A. Kalamkaryan and V. Akimov, “Symptomatology, Clinical Forms and Variations of Kaposi Sarcoma Course,” *Vestnik Dermatologii i Venerologii* 11 (1984), pp. 4–7; John Seale and Zhores Medvedev, “Origin and Transmission of AIDS. Multi-use Hypodermics and The Threat to The Soviet Union: Discussion Paper,” *Journal of the Royal Society of Medicine* 80, 5 (1987), pp. 301–304.

newspaper,⁶ it was only in 1987 when the first HIV case was officially reported in a Soviet medical publication and described as “a homosexual who got infected in East Africa in 1982.”⁷ This man remained the index case until October 1988 when a woman named Olga was posthumously diagnosed with AIDS. This particular case has been widely believed by many Tajiks to come from Khudjand, the second largest city in Tajikistan located in the northern part of the country. According to the Tajik media reports, in 1985 Olga went to Leningrad where she engaged in prostitution, died of AIDS, and was then buried in Khudjand.⁸ This, however, contradicts earlier accounts of the Soviet press whereby Olga was known as “a worker in the central heating network *Teploenergo* and an evening student in one of the Leningrad colleges, who had a long history of many illnesses and had been treated in different Leningrad hospitals many times without being tested for HIV.”⁹ In October 1988 *Sovietskaia Rossiia* published Olga’s full name and picture, also reporting that she had been known by her neighbors to engage in sex with foreigners over a period of nine years.

Soviet authorities introduced mass HIV screening in 1986 and millions of people have been tested annually. Tajikistan reported its first cases in 1991, a few months after gaining its independence. These cases were two persons who returned to Tajikistan from their business trips to African countries. Although by 1993 some 1,200,000 people were tested for HIV,¹⁰ Tajikistan was the poorest of the former Soviet countries and suffered a devastating civil war following the collapse of the USSR from the end of 1992 to 1997. HIV testing declined significantly since 1993 due to the shortages of test kits¹¹ and no new cases were detected until 1997. That year and the subsequent one saw one new case each. Seven more HIV cases were diagnosed in 2000 thus placing Tajikistan, with its

⁶ *Ibid.*

⁷ V.V. Pokrovskii, Z. Iankina and V.I. Pokrovskii, “Epidemiological Investigation of The First Case of AIDS Detected in A Citizen of The USSR,” *Zhurnal Mikrobiologii, Epidemiologii, i Immunobiologii* 12 (1987), pp. 8–11.

⁸ Nargis Zokirova, “SPID Zavoevyvaet Tajikistan. Dve Tysiachi Infitsirovannykh Na Shest’ Mln. Naseleniia, [AIDS Conquers Tajikistan: Two Thousand HIV Infected People out of A Six Million Population], Institute for War and Peace Reporting, November 2002, <<http://www.centrasia.ru/newsA.php4?st=1036531380>> (March 27 2008).

⁹ Zhores Medvedev, “Evolution of AIDS Policy in The Soviet Union. Part II. The AIDS Epidemic and Emergency Measures,” *British Medical Journal* 300, 6729 (1990), pp. 932–934; Svetlana Tutorskaia, “To prevent a tragedy,” *Izvestiia*, October 12 1988.

¹⁰ International Labour Organization, “Overview of The HIV/AIDS Epidemic in Tajikistan,” prepared on the basis of materials provided in November 2002 by Margarita Khagai, NGO “Traditions and Modernity,” <<http://www.ilo.ru/aids/docs/deco2/cis/Tadjikistan-eng.pdf>> (April 2 2008).

¹¹ Karl L. Dehne, Lev Khodakevich, Françoise F. Hamers and Bernhard Schwartlander, “The HIV/AIDS Epidemic in Eastern Europe: Recent Patterns and Trends and Their Implications for Policy-Making,” *AIDS* 13, 7 (1999), pp. 741–749.

cumulative total of 11 registered HIV cases, in a low prevalence category by the end of the millennium. In most of these cases HIV transmission occurred through heterosexual contact, and was mostly “exported to the country from the outside.”¹² It is not clear whether such low incidence was indeed reflective of the actual scale of the problem or whether it rather resulted from the lack of HIV test kits. Nevertheless, in the late 1990s Tajikistan had all the factors in place that could trigger an outbreak of the HIV epidemic. In 2001, thirty-four new cases were reported and it was three times as much as all previous known cases. This alarming data came from the northern part of Tajikistan, where the Khudjand-based Regional AIDS Center for Sogd Province had reached a network of injecting drug users (IDUs) infected with HIV. The situation in other parts of the country remained deceptively stable but many professionals working in the field believed that it was mainly due to the unavailability of HIV test systems. As it was reported by the head of the Republican AIDS Center, the Dushanbe-based laboratory had not been functional from January 2002 until the middle of 2003 due to the lack of testing systems.¹³ Indeed, it was only after the first round grant of the Global Fund to Fight AIDS, Tuberculosis and Malaria was initiated in Tajikistan in May 2003 that HIV surveillance improved. In 2004, Tajik authorities reported 198 new HIV cases, almost a five-fold increase compared to the previous year.

Before 2004 Tajik HIV data, apart from being affected by inadequate health resources, had another major limitation of being almost exclusively based on routine screening of certain occupational groups and blood donors as well as perceived high risk groups including prisoners, STI patients and drug users in contact with health or police authorities. However, due to the highly stigmatized nature of associated behaviors, commercial sex work and drug use being *de facto* illegal in the country as well as discrimination following registration in narcology and venereology services, there was an extreme reluctance to come into contact with these kinds of health clinics and law enforcement, leaving the government ill informed about the actual scale and characteristics of the problem, as will be discussed below. Thus, the data collected through the cross-sectional study in Dushanbe in 2004 was shocking as it revealed 12 percent HIV prevalence in a respondent-driven sample of 489 injecting drug users. HIV prevalence was highest among ethnic Tajiks and HIV

¹² Azamjon Mirzoev, “VICH-Infektsiia v Respublike Tajikistan (Epidemiologicheskaiia Kharakteristika),” [HIV Infection in The Republic of Tajikistan (Epidemiological Characteristics)], Synopsis of a Kandidat Meditsinskikh Nauk Thesis, <[http://www.crie.ru/pdf/avtofef2\(mirzoev\).pdf](http://www.crie.ru/pdf/avtofef2(mirzoev).pdf)> (April 5 2008).

¹³ IRIN, “Tajikistan: Drug Use, Migration and Ignorance Fuel Rise in HIV Infections. Interview with the director of the Republican Center for AIDS Prevention, Dushanbe, 2004, <<http://www.irinnews.org/report.aspx?reportid=23131>> (April 3 2008).

infection was significantly associated with injection drug use at least once a day in the past 6 months (Odds Ratio 2.16); reporting that narcotics were very easy to obtain (OR 2.46); having undergone drug treatment (OR 2.75); and injecting “alone” (OR 3.12).¹⁴ It was obvious that the HIV epidemic had already become established in the drug injecting population. Another interesting finding, which illuminates the initial patterns of the epidemic, was that among 20 HIV positive IDUs with specimens available for typing, 10 had subtype A of HIV-1, 9 had CRF02_AG, and one an A-CRF02_AG recombinant.¹⁵ While subtype A clearly pointed towards eastern European countries of the former Soviet Union, where concentrated HIV epidemic among IDUs had been underway since mid 1990s, the predominance of HIV-1 West African variant, CRF02_AG, had potentially two explanations.

Firstly, its outbreak in Dushanbe could be linked to Afghan heroin trafficking routes between Tajikistan and Russia. In Russia, Nigerians made a deal with local organized crime networks to be allowed to traffic in drugs for a certain percentage of profit, and HIV-1 epidemic in the south of Nigeria was caused by CRF02_AG strain.¹⁶ According to DEA’s information received prior to October 2001, Nigerian drug traffickers, although being mostly oriented towards Southeast and Southwest Asian producers, were known to recruit Russian citizens to transport Afghan heroin to Russia.¹⁷ Russian police reported increasing involvement of Nigerians in drug trafficking since mid 1990s, as they “occupied entire blocks in the suburbs of Moscow.”¹⁸ It was also suggested that Nigerian

¹⁴ Julie Stachowiak, Farida Tishkova, Steffanie Strathdee, Mark Stibich, Alisher Latypov, Vladimir Mogilnii and Chris Beyrer, “Marked Ethnic Differences in HIV Prevalence and Risk Behaviors among Injecting Drug Users in Dushanbe, Tajikistan, 2004,” *Drug and Alcohol Dependence* 82, Suppl. 1 (2006), pp. S7–14.

¹⁵ Chris Beyrer, Jean Carr, Julie Stachowiak, Farida Tishkova, Mark Stibich, Alisher Latypov, Magdi Saad, Zeenat Patel and Stephanie Strathdee, “The Emerging Epidemics of HIV-1 and HCV among Injecting Drug Users in Tajikistan,” in proceedings from the 13th Conference on Retroviruses and Opportunistic Infections, Denver, CO, February 5-8 2006.

¹⁶ John Iliffe, *The African AIDS Epidemic: A History* (Athens: Ohio University Press; Oxford: James Currey, 2006).

¹⁷ Drug Enforcement Administration, Europe/Asia/Africa Strategic Unit of the Office of International Intelligence, “Drug Intelligence Brief: Russian Organized Crime Groups, January 2002,” <<http://www.shaps.hawaii.edu/drugs/deao2004/deao2004.html>> (April 3 2008).

¹⁸ Boris Kalachev, “Nezakonnyi Oborot Narkotikov, kak Sotsialno-Psikhologicheskaiia Ugroza Natsionalnoi Bezopasnosti Rossiiskoi Federatsii,” [Illicit Drug Trafficking as a Socio-Psychological Threat to The National Security of The Russian Federation], in V. Eremenko, (Ed.), *Natsionalnaia Bezopasnost’: Informatsionnaia Sostavliayuschaia* (Moscow: MOSU, 2000), pp. 216–244.

drug trafficking rings had been operational in Central Asia.¹⁹ As it was well documented in other Asian countries including Burma (Myanmar), China, India and Vietnam, overland heroin export routes play a significant role in a dual spread of drug use and HIV-1, often involving “self-testing” of drug quality and sharing of both drugs and injection equipment among buyers and sellers.²⁰ Although such practices are common among low-scale dealers who engage in drug trade in order to support their own drug-using habits, significant consignments of heroin are usually trafficked by people who might be less likely to be involved in using drugs themselves. Nevertheless, interviews with drug users in Dushanbe indicated that in late 1990s, at the onset of the heroin use epidemic in the country, heroin was considered very prestigious and trendy, its “addictive powers” were not well known, and its usage was popular among wealthy people including those involved in cross-border illegal drug trade. According to one of these respondents, he initiated heroin use in 1996 when he was a student at one of the Moscow universities. He used to buy heroin from African dealers near the Moscow University of International Affairs at the price of US\$100 per gram. However, as the price of heroin in Dushanbe became much cheaper, about US\$10,000 per kilogram, he himself trafficked in heroin from Tajikistan to Moscow many times until he was arrested with one kilogram in his possession.²¹ In Nigeria, heroin use has been growing since 1980s, with heroin being particularly popular among urban adolescents.²²

Secondly, the predominance of CRF02_AG strain among drug users in Dushanbe could have resulted from an originally heterosexual spread of the virus through contacts with African students who had studied in many Soviet cities, particularly in Tashkent, Uzbekistan, thus implying a somewhat older HIV epidemic. However, the most recent findings from Uzbekistan and Kazakhstan make the second explanation less likely and almost certainly suggest that CRF02_AG recombinant is a fairly recent epidemic in the Central Asian region preceded by Former Soviet Union (FSU) subtype A. In Uzbekistan, among 142 strains 13 (9.2 percent) clustered with CRF02_AG and were significantly concentrated in

¹⁹ Faridun Abbosov, “Drug Problems in Central Asia,” *Papeles del Este: Transiciones Poscomunismos* 4 (2002), pp. 1–6, <<http://www.ucm.es/BUCM/cee/papeles/04/33.pdf>> (April 5 2008).

²⁰ Chris Beyrer, Myat Htoo Razak, Khomdon Lisam, Jie Chen, Wei Lui and Xiao-Fang Yu, “Overland Heroin Trafficking Routes and HIV-1 Spread in South and South-East Asia,” *AIDS* 14, 1 (2000), pp. 75–83.

²¹ Alisher Latypov and Marydean Purves, Interviews with injecting drug users, October – December 2004, Tajikistan.

²² I. Obot, “Substance Abuse, Health and Social Welfare in Africa: An Analysis of The Nigerian Experience,” *Social Science and Medicine* 31, 6 (1990), pp. 699–704; S. Igwe, “Nigeria's Youth at Risk,” *African Health Journal* 14, 4 (1992), pp. 45–46.

samples collected in 2002 from injecting drug users in Tashkent. They were also monophyletic and probably descended from a single ancestor.²³ Similarly, all four individuals infected with CRF02_AG in Kazakhstan (4.7 percent of the total sample) were self-declared IDUs who stated that their date of seropositivity was between September 2002 and December 2002. Strains from Kazakhstan clustered with similar strains identified in Uzbekistan.²⁴ Although based on the above findings, authors of both studies proposed that the CRF02_AG outbreak began in 2002 among IDUs in Tashkent and further spread out to Kazakhstan, there might be another possible scenario. If CRF02_AG strains from Dushanbe, Tashkent and Almaty and South Kazakhstan Oblasts would be shown to belong to one common cluster and given that (1) in Tashkent the strain could be a molecular marker for one particular drug-using network;²⁵ and that (2) in samples from Dushanbe, the analysis revealed an almost 50 percent prevalence of CRF02_AG, the highest of all three Central Asian countries, it may well be that the CRF02_AG epidemic first occurred in Dushanbe, possibly in early 2000s, and then reached Uzbekistan and Kazakhstan through a particular drug trafficking channel, which was probably controlled by one single cross-regional criminal group. Although no proper HIV-1 typing was performed in Tajikistan on samples collected before 2004, one argument in favor of this hypothesis comes in fact from the law enforcement data. According to the UNODC Regional Office for Central Asia, the major recent drug trafficking routes from Tajikistan include the following three:

- **Route 1:** Dushanbe – Saryasia (Uzbekistan) – Bukhara (Uzbekistan) – Tashkent – Shymkent – Taraz – Almaty – Balkhash – Karaganda – Astana – Kokshetau – Petropavlovsk – Russia;
- **Route 2:** Dushanbe – Saryasia (Uzbekistan) – Bukhara (Uzbekistan) – Tashavuz (Turkmenistan) – Kungrad (Uzbekistan) – Beineu – Opornaya – Makat – Atyray – Ganyushkino – Russia;

²³ Jean K. Carr, Yuka Nadai, Lindsay M. Eyzaguirre, Magdi D. Saad, Mumtaz M. Khakimov, Shavkat K. Yakubov, Deborah L. Birx, R. Ross Graham, Nathan D. Wolfe, Kenneth C. Earhart and Jose L. Sanchez, “Outbreak of A West African Recombinant of HIV-1 in Tashkent, Uzbekistan,” *Journal of Acquired Immune Deficiency Syndromes* 39, 5 (2005), pp. 570–575.

²⁴ Lindsay M. Eyzaguirre, Isidora B. Erasilova, Yuka Nadai, Magdi D. Saad, Natalya G. Kovtuneneko, Peter J. Gomas, Victoria V. Zeman, Boulos A. Botros, Jose L. Sanchez, Deborah L. Birx, Kenneth C. Earhart and Jean K. Carr, “Genetic Characterization of HIV-1 Strains Circulating in Kazakhstan,” *Journal of Acquired Immune Deficiency Syndromes* 46, 1 (2007), pp. 19–23.

²⁵ Carr et al., “Outbreak of A West African Recombinant of HIV-1 in Tashkent, Uzbekistan,” p. 573.

- **Route 3:** Dushanbe – Chorjou (Turkmenistan) – Bekdash – Janaozen – Beineu – Opornaya – Makat – Atyrau – Ganyushkino – Russia.²⁶

As can be seen from the above, Route 1 connects Dushanbe and Russia and lies exactly along Tashkent, southern Kazakhstan and Almaty. Probably, further research on this issue and sharing of relevant information between public health officials and drug control agencies may not only contribute to better understanding of the HIV epidemic in the region but also shed more light on drug trafficking patterns since “generating an accurate picture of the nature of drug trafficking organizations including their trade routes” was perceived in Central Asia as “difficult due to their clandestine nature and the imperfect, fragmentary evidence available.”²⁷

In parallel to this research among drug users in Dushanbe, the practice of sentinel surveillance was introduced in Tajikistan in 2005 through the support of the U.S. Centers for Disease Control. Conducted on an annual basis, these studies enroll various vulnerable groups across few sites and are viewed by domestic and international stakeholders, in the absence of other research, as reflective of the contemporary HIV dynamics in the country. Unfortunately, they reveal an alarming increase in HIV rates and suggest that Tajikistan has a concentrated epidemic. Thus, in 2005 the Dushanbe-based surveillance yielded HIV prevalence rates as high as 17.9 percent among injecting drug users, 6.7 percent among prison inmates, 1.3 percent among commercial sex workers and 0.4 percent among pregnant women. HIV rates in Khudjand were lower across these groups except for pregnant women, considered as representative of the reproductive age general population, who had 0.5 percent prevalence rate.²⁸ As the 2006 sentinel surveillance findings were presented, they indicated that HIV prevalence among IDUs in Dushanbe had reached 24 percent,²⁹ which was a twofold increase as compared to 2004 data collected through the Johns Hopkins’ research project. HIV rates among commercial sex workers increased more than 5 times within one year.³⁰ Behavioral and infectious disease patterns documented by

²⁶ UNODC Regional Office for Central Asia, *Illicit Drug Trafficking in Central Asia*, September 2007,

http://www.dbregional.info/filebox/20/Trends_Central_Asia_final.pdf (April 5 2008).

²⁷ *Ibid.*; see also Beyrer et al., “Overland Heroin Trafficking Routes and HIV-1 Spread in South and South-East Asia,” p. 82.

²⁸ Republican AIDS Center, Tajikistan, Presentations of The Results of 2005 Sentinel Surveillance in Tajikistan, Dushanbe, June 2006.

²⁹ Z. A. Nurliaminova, “Epidemiia VICH v Respublike Tajikistan,” [HIV Epidemic in Tajikistan], Presentation of the Republican AIDS Center, Dushanbe, 2007.

³⁰ UNAIDS, *AIDS Epidemic Update: December 2007*, UNAIDS/07.27E / JC1322E, http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf (April 4 2008).

cross-sectional studies in selected cities of Tajikistan were not encouraging at all and prompted some expectations that HIV/AIDS infection would reach 1 percent of the adult population by 2008.³¹ Meanwhile, UNAIDS suggested that as of 2007, there were an estimated 10,000 [5,000 – 23,000] people living with HIV (PLWH) in Tajikistan.³²

At the start of 2008, the Republican AIDS Center's case reporting database contained 1049 cumulative cases of HIV infection registered in Tajikistan since 1991, of whom 89 have already died of AIDS. HIV cases have been registered in 49 out of 58 districts of the country. HIV infection was most prevalent in 15-49 age group (97.2 percent) and among men (81 percent).³³ Many of these HIV cases were detected at the late stage of infection, in part because various health complications of people living with HIV made their interacting with government authorities more likely.

Four categories were used in Tajikistan to classify these cases by mode of transmission and registered cases were divided as follows: in 226 (21.5 percent) cases HIV was transmitted through unprotected sex, 621 (59.2 percent) got infected intravenously, in 194 (18.5 percent) cases the mode of transmission was unknown and 8 (0.8 percent) cases were attributed to vertical, mother-to-child, transmission.³⁴ Despite such figures were substantially underestimating the number of people living with HIV, they did reflect the 'rise of the tide' (see **Figure 1** below). It is now time to consider historically framed 'qualitative' aspects of that tide in order to get a better insight into what 'drives' the HIV epidemic in Tajikistan.

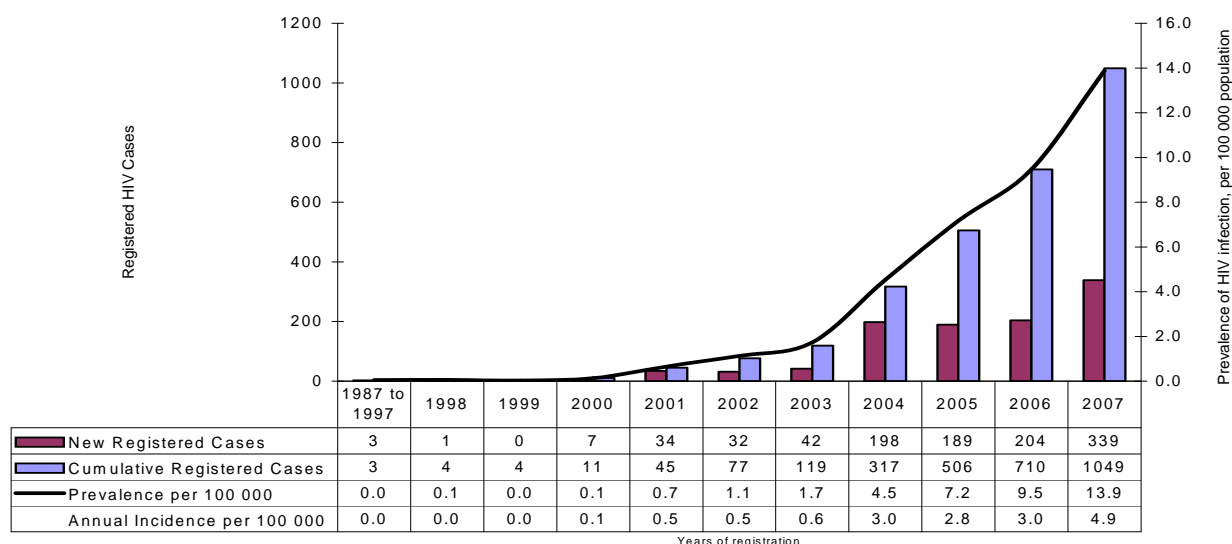
³¹ Umed Ibragimov, "The HIV/AIDS Challenge for Tajikistan," Presentation to The Principals' Meeting, Dushanbe, 2005.

³² UNAIDS, *2008 Report on The Global AIDS Epidemic*, Annex I, HIV and AIDS Estimates and Data, <http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp> (September 15 2008).

³³ The Government of Tajikistan, *Natsional'nyi Doklad o Khode Vypolneniia Deklaratsii o Priverzhennosti Delu Bor'by s VICH/SPID*, [National Declaration of Commitment on HIV/AIDS 2008 Progress Report], <www.ncc.tj> (March 27 2008), also available at <http://data.unaids.org/pub/Report/2008/tajikistan_2008_country_progress_report_ru.pdf>

³⁴ National Coordination Committee for HIV/AIDS, Tuberculosis and Malaria Prevention in Tajikistan, *HIV Statistics*, <http://www.ncc.tj/index.php?option=com_content&task=view&id=50&Itemid=> (March 27 2008).

Figure 1. Officially Registered HIV Cases in Tajikistan, 1 January 1987 through 31 December 2007 (constructed based on the template of AIDS Foundation East-West and Tajik Republican AIDS Center data)



Domestication of AIDS in Tajikistan

A closer examination of the above-mentioned HIV transmission categories operationalized by bureaucratic institutions needs to be undertaken first in order to find out how AIDS, once regarded as “exported from the outside,” was domesticated in Tajikistan. More specifically, this involves answering some of the following questions: which groups of population are subsumed under HIV statistics? How these groups are constructed and perceived by various stakeholders such as local program implementers, international donor agencies, health service providers and state authorities? What implications does it have for HIV prevention efforts in the country? Both this section and subsequent ones will address the above questions in detail.

As elsewhere in the world, the HIV epidemic in Tajikistan is determined by numerous factors. On the other hand, it involves complex, often overlapping, behavioral patterns and identities hidden behind depersonalized figures. This is emphasized in fact by the “unknown” mode of transmission that represents as much as 18.5 percent of all registered HIV cases in Tajikistan. The two other largest transmission categories are key to finding out what experts believe to be “at-risk” groups in Tajikistan. Here, the intravenous mode includes an overwhelming proportion of injecting drug use and a small fraction of

contaminated blood transfusion. Unprotected sex in its turn may include heterosexual, homosexual, bisexual contacts and in national HIV strategies most often involves commercial sex workers (CSWs), migrants and their wives as main vulnerable populations. Although street children have not been formally known to be included as HIV cases to the AIDS Center database yet, stakeholders in Tajikistan widely believe that they might be lured into sex work and engage in drug use as well. Finally, under certain circumstances individual members of these “deviant” minorities in Tajikistan may find themselves institutionalized in a prison setting, and shifted into another vulnerable group. Thus, among all officially registered HIV-infected males, 13 percent were prison inmates at the moment of diagnosis.³⁶

All the above groups are conceptualized in their own, multiple ways depending on the context and determining the responses. As has already been implied in the previous section, injecting drug use has been fueling the HIV epidemic in Tajikistan since the beginning of this century. On the other hand, Tajikistan has been leading a war on drugs since 1996, when the State Narcotics Commission was established through a Presidential Decree and in line with the UN anti-narcotics conventions. That year also marked the first ever heroin seizure in the country. In 1999 the drug war gained significant momentum as the commission, which previously acted as a technical body, was transferred into the UN-funded drug control agency, a fully-fledged law enforcement agency also responsible for the coordination of all domestic and international counternarcotics activities. Those who used drugs were viewed as enemies and were portrayed so in Tajik media as well. Drug use has been an illegal activity since Soviet times³⁷ and although Tajik legislation did not criminalize drug use per se, possessing as little as 0.015 grams of heroin was punishable by as many as 10 years if the arrestee would prove to be a dealer or 5 years if this amount of heroin in possession was for personal consumption only. In 2001, Tajik law enforcement authorities reported 1122 drug offences that involved possession “without the purpose of trafficking” (Article 201 of the Criminal Code of Tajikistan) compared to 544 offences “with the purpose of trafficking” (Article 200) and 96 occasions of detecting “illicit cultivation of prohibited narcotic plants” (Article 204).³⁸ Such a crackdown on drug users made them an extremely

³⁶Lee-Nah Hsu, Mansour Dodarbekov, Sevara Rakhimova, Muallimsho Sinavbarov, Tatiana Bozrikova and Valeria Trupanova, *Outcome Evaluation of HIV programme of UNDP Tajikistan*, Dushanbe, 2007, <http://www.undp.tj/files/ev/ev_report.pdf> (April 5 2008).

³⁷ Medvedev, *Evolution of AIDS policy in the Soviet Union. Part I. Serological screening 1986-7*, p. 861.

³⁸ Alisher Latypov, Sulhiddin Nidoev, Siyar Ramazanov, Elena Semikina, Olga Muravleva, Nadjiba Shirinbekova and Pulod Djamalov, *Tajikistan Drug Situation 2005*,

“hard to reach” population not only for drug enforcement but also for any kind of intervention. It was, therefore, of little wonder that raising heroin possession threshold up to 0.5 grams in 2004 had little impact on changing the culture of fear and, as lamented in the 2007-2010 National HIV prevention program, “law enforcement practices subject drug users to police sanctions and, as a result, IDUs often avoid participating in HIV prevention programs.”³⁹ Drug users themselves were very articulate in providing detailed descriptions of how these sanctions were applied against them in practice:

One day we came to a pusher’s house to buy some drugs, but the place has been well known to police officers. As we entered, the pusher told us to be careful because he knew that police was watching him at that moment. We asked if we could pay him for drugs and inject them at his place and he agreed. Few minutes after we left the house police officers arrested us and brought us to the local militia department. They checked our veins immediately and asked, “Where are the drugs?” Which drugs? We don’t have any drugs! So they kept beating us for three days with rubber truncheons. They made us mop the floors clean in all the offices and corridors during the nights. On the third day, when the presence of drugs in my body liquids was formally confirmed by the narcological center, they told me that unless I give them 100 or 200 dollars I would ‘get stuck’ in a jail. I replied that I didn’t have any drugs on me. “No drugs?! You’ll have them in no time! We will put some drugs in your pocket, ask two witnesses to confirm that they saw drugs being retrieved from your pockets and that’s it dear, you’ve got your term!” Well, I had to call my parents then and they had to pay a hundred dollars bribe to get me out of there.⁴⁰

Such legal framing of drug use largely determined the context of responses by other stakeholders. Since *de facto* drug use was not viewed as a medical problem, drug treatment received no priority in the government agenda regardless of various statements in various strategies. Inherited from the Soviet times, the Tajik narcological system was outdated, lacking qualified staff and limited to provision of full isolation detoxification, which could be described as “medicating IDUs to the point of immobility during withdrawal from opiate dependence.”⁴¹

National Report to UNDP and EMCDDA by Tajikistan National Focal Points (Dushanbe: UNDP, 2007), <<http://www.untj.org/library/?mode=details&id=391>> (September 15 2008).

³⁹ The Government of Tajikistan, *Programma po Protivodeistviu Epidemii VICH/SPIDa v Respublike Tajikistan na Period 2007-2010gg.*, No. 86 ot 3 Marta 2007g., [Program for Countering HIV/AIDS Epidemic in Tajikistan for The Period of 2007-2010, Ref No. 86 as of March 3 2007], <<http://www.ncc.tj/images/stories/program.pdf>> (March 27 2008).

⁴⁰ Latypov and Purves, Interviews with injecting drug users.

⁴¹ V. Mendelevich, *Narcology: Drug Treatment in Russia*. Open Society Institute Briefing on Drug Treatment, HIV, and The Challenge of Reform, 2006.

Although as many as 61 percent of injecting drug users interviewed in Sogd region in 2005 reported a need for drug treatment,⁴² and in Dushanbe 37.2 percent had “some” need and 16.9 percent reported “great” or “urgent” need in 2004,⁴³ speaking in economic terms, “drug demand reduction” that would go beyond one-off “*Tadzhikistan Protiv Narkotikov!*”⁴⁴ actions was in short supply.

Specialized medical drug treatment in Tajikistan was provided exclusively by the network of Narcological Centers with the main center in Dushanbe. However, even there the quality of care was extremely poor as clients reported an average period of 51 days (IQR 3-40) after completing drug treatment before relapsing. Not surprisingly, those who had undergone drug treatment were significantly more likely to report less fear of law enforcement (Adjusted OR: 1.48; 95 percent Confidence Interval: 1.02-2.16).⁴⁵ In the words of one of the “frequent flyers” on the drug treatment program,

...in short, I was treated in a narcological clinic 4 times, at 150 USD on every occasion. Each time when I would leave the clinic I knew that I had access to drugs, as I used to store some drugs at home, for a rainy day. I would usually resume using drugs some 15-18 days after treatment.⁴⁶

In the southern part of the country, interviews conducted in 2006 with three IDUs visiting Kurgan-Tube drug services suggested that all of them wanted to quit using drugs but there was no effective drug treatment or rehabilitation program in the city at all. None of the three respondents has ever been admitted to a narcological center because the center would disclose their data to police and because its medical care was

⁴² AIDS Foundation East-West, *Summary Report of A Rapid Situation Assessment in The Republic of Tajikistan in 2005*, <http://www.afew.org/english/researches/TMF_Tajikistan_RSA_Summary_Report.pdf> (March 27 2008).

⁴³ Julie Stachowiak, Mark Stibich, Farida Tishkova, Vladimir Mogilnii, Alisher Latypov, Steffanie Strathdee and Chris Beyrer, “Experiences with Drug Treatment among Injecting Drug Users (IDUs) in Dushanbe, Tajikistan,” in proceedings from the 17th International Conference on the Reduction of Drug Related Harm, Vancouver, Canada, April 30 – May 4 2006.

⁴⁴ “Tajikistan against Drugs!”

⁴⁵ Julie Stachowiak, Mark Stibich, Farida Tishkova, Vladimir Mogilnii, Alisher Latypov, Steffanie Strathdee and Chris Beyrer, “Experiences with Drug Treatment among Injecting Drug Users (IDUs) in Dushanbe, Tajikistan,” in proceedings from the 17th International Conference on the Reduction of Drug Related Harm, Vancouver, Canada, April 30 – May 4 2006.

⁴⁶ Latypov and Purves, Interviews with injecting drug users.

unaffordable due to high informal cost of about 380 Somoni (about 120 USD) for a 10-day course.⁴⁷

The system of informal payments, defined as “payments to individual and institutional providers in-kind or cash that are outside the official payment channels, or are purchases that are meant to be covered by the health-care system,”⁴⁸ created additional barriers for many other drug users, who were desperate to get any help. This is how one of HIV positive female IDUs described her health care seeking in Dushanbe:

As for our medical institutions, from my experience I can tell you that nobody is going to help you if you have no money. Not even when you are dying. I visited many of those institutions including the Infectious Diseases Hospital, the Narcological Center, the Burn Center, the Central City Clinic, you name it...⁴⁹

In Tajikistan, a very limited number of local and international programs aimed to address the unmet need for drug treatment. As a matter of fact, the response to injecting drug use as a “vector” of HIV infection has been rather heavily influenced by the drug legislation described above as well as pervasive stigma and discrimination against HIV positive IDUs, often involving health care service providers as major discriminators. According to the 2007 National Stigma and Discrimination Study, refusal in treatment by medical facilities was reported by 38.1 percent of PLWH, about 36 percent reported that they were neglected by medical workers and some 20 percent of PLWH confirmed that their HIV status was disclosed by medical staff without their prior consent.⁵⁰ The attack of PLWH on the medical profession was commensurate with the care they received:

...all doctors and nurses must be sacked and only those who can and who know how to communicate and treat other human beings properly should stay.⁵¹

⁴⁷ Alisher Latypov and Pulod Djamalov, Interviews with injecting drug users, June 2006, Tajikistan.

⁴⁸ Jane Falkingham, “Poverty, Out-of-Pocket Payments and Access to Health Care: Evidence from Tajikistan,” *Social Science and Medicine* 58, 2 (2004): 247–58.

⁴⁹ Global Initiative on Psychiatry, *Mental Health and AIDS*. A documentary film directed, recorded and edited by Harrie Timmermans, in proceedings from the Conference on “Double Stigma - Double Challenge: Putting Mental Health and HIV/AIDS on the International Agenda,” The Hague: The Netherlands, November 9 2007.

⁵⁰ Strategic Research Center under President of Tajikistan, *National Study on The Stigmatization and Forms of Discrimination against People Living with HIV*, 2007, <<http://www.untj.org/library/?mode=details&id=354>> (March 27 2008).

⁵¹ Nargis Djuraeva, Manija Khaitova, Hayot Aliev, Pulod Djamalov and Vladimir Magkoev, *Mental Health and HIV/AIDS Services in Tajikistan*, (Dushanbe: Mental Health and HIV/AIDS Center, 2007).

A “magic bullet” designed to address such challenges in Tajikistan was called a “Trust Point” or simply TP. As the title denotes, trust is to be the key issue for succeeding in this intervention. But naming something a trust point does not imply the presence of trust by default. In 2004, drug users visiting TPs in Dushanbe reported that when the TP signboards appeared near the doors of some health clinics every police officer knew what kind of “clientele” it was targeting. As one of drug users recalled,

It was dangerous to go to TPs because police was standing just around the corner. Even though we were known as drug users to the local police in Somoni district, we were running a risk of exposing ourselves to other police officers when we had to visit TPs established in parts of the city different from our place of residence. The moment you enter a TP you let police know who you are. This is what happened to us when we visited a TP of the Railroad District. As we left the TP we noticed a strange man following us. He was a police officer of that district.⁵²

So, trust needs to be built and it should be mutual. Trust is fundamental, but once it is there other interventions should be put in place, as trust alone does not prevent the spread of HIV infection. While non-governmental organizations that involved peer drug users in outreach and service provision had fewer problems in building trust and rapport with their clients, many others had plenty of barriers to overcome. The Global Fund, for instance, supported the establishment of eleven TPs in different parts of the Tajikistan since 2003.⁵³ They were affiliated and coordinated by the Republican AIDS Center. Created from nothing, most of these TPs initially hired state employees of various health clinics who had little or no experience in working with drug users as someone who could be trusted and who they could trust.⁵⁴ There is little surprise that when asked about the challenges they faced in their daily work, four staff members of one of those TPs unanimously reported that they needed trainings on communication skills and building trustful relationships with clients. One of them said that drug users often perceived her as a law enforcement officer based on her outlook and another had almost no knowledge of drug users’ environment yet. They

⁵² Latypov and Purves, Interviews with injecting drug users.

⁵³ UNDP Tajikistan, Grants Implementation Unit. *Support to The Strategic Plan to Prevent HIV/AIDS Epidemics in Tajikistan: Annual Progress Report, Phase II, 1 May 2005 - 30 April 2006*, Dushanbe, 2006.

⁵⁴ Author’s interviews with the staff members of a needle exchange project, March – April 2005, Tajikistan.

believed that having a TP staff ID card would help them in securing more trust from drug users.⁵⁵

Speaking about construction of other at-risk groups such as street children, challenges existed at the very basic level, i.e. in constructing itself. As the outcome evaluation of UNDP Tajikistan HIV Program revealed in March 2007,

...There was no clear definition where the term street children was used in Tajikistan... It was used broadly in Tajikistan to cover what UNICEF had termed “children under difficult circumstances.” The priority, in accordance with the Round 4 proposal, should be to target true [sic] street children in the urban settings... Most of the children covered by the street children projects were not street children as defined internationally. For example, most of these children have a home where they stay, have one or both parents... It [the lack of clear definition] resulted in less effective targeting for outreach and interventions. For example, some young outreach workers simply visited homes to reach female children who did not go to school and were not on the streets. Others reached children who were working, but stayed with families and still attending schools... Taking into account these inconsistencies among youth surveyed on the streets, 10 percent of them were aware of HIV prevention. Based on NGO reports to Grant Implementation Unit of UNDP, 8,567 “street children” were reached with information, education and communication materials and behavioral change education and communication... The pseudo-street children [sic] reached were articulate, well-informed on HIV and preferred to gain more knowledge and receive a greater variety of inputs.⁵⁶

Finally, labor migration in Tajikistan had to be viewed as a “step-wise construction” whereby the migration of workers may occur in four steps: source, transit, destination, and return, each having certain HIV-related implications.⁵⁷ This construct emphasized one crucial point that in order to succeed HIV prevention activities need to cross national boundaries of individual states. Here it is Russia, to which as many as 90 percent of estimated 1,000,000 Tajik migrants are destined,⁵⁸ that is of particular concern because of her fast growing HIV epidemic and the actual number of people estimated to be living with HIV being around 940,000 at the end of 2005 (this estimate remained unchanged for 2007).⁵⁹ In one study

⁵⁵ Alisher Latypov and Pulod Djamalov, Interviews with the staff members of a trust point, June 2006, Tajikistan.

⁵⁶ Hsu et al., *Outcome Evaluation of HIV programme of UNDP Tajikistan*, p. 21.

⁵⁷ UNAIDS, *Population Mobility and AIDS: UNAIDS Technical Update*, 2001, <http://data.unaids.org/Publications/IRC-pub02/JC513-PopMob-TU_en.pdf> (April 4 2008).

⁵⁸ Hsu et al., *Outcome Evaluation of HIV programme of UNDP Tajikistan*, p. 16.

⁵⁹ UNAIDS, *Fact Sheet: Eastern Europe and Central Asia*, 2006,

conducted in Moscow in October 2005 [note how this is comparable to the 2005 UNAIDS estimate] all Tajik migrants self-reported to have had unprotected sex with commercial sex workers in Moscow almost on a weekly basis. According to Weine et al., “they would typically bring one to two women for 10–15 men to have sex with on one night, as it is less expensive and there is less chance of being caught by the police or other potential threats. Furthermore, some reported having sex with “cheap prostitutes” who need only Vodka and food. None used condoms and cited multiple different reasons as to why they do not. They stated that sex with a condom is not “real sex.” “A person has to feel that he is having sex, but with condom you do not feel anything.” “What is the best way of feeling the smell of flower? With open mouth and nose or with gas mask?”⁶⁰

In Tajikistan, labor migration was perceived as a predominantly male issue and this explains why most of the so-called friendly service centers, established for migrants prone to “smelling flowers with open mouth and nose,” were staffed with male doctors. However, as noted in a recent evaluation, migrants were in Tajikistan only in autumn and winter, and “having been away the rest of the year, they were busy catching up with family obligations and chores upon return” rather than visiting those clinics. Yet, for their wives it was totally against the local culture to go to such clinics and to have male physicians perform STI examinations, to say nothing of the need to obtain the permission from a mother-in-law before traveling outside of their villages.⁶¹ Furthermore, as far as “home” was concerned, “migrants generated an estimated US\$660 million remittances annually compared to a state budget of approximately 430 million,”⁶² but at the destination point of Moscow they would normally find themselves in a different frame, being regarded as the lowest rung of the social hierarchy and having no access to HIV prevention services:

“If Russians want they kill you, beat you, or say whatever words they want. A Tajik does not have the right to say a simple word...”; “I see myself in the skin of a slave in Moscow. We do not have any status here. We are illegally living and working here...”; “There are a lot of cases of discrimination of Tajiks. Tajiks are unprotected in Russia. Unprotected by law, which means they do not have any right as a human...”; “Police are very rude. They do whatever they

<http://data.unaids.org/pub/EpiReport/2006/20061121_EPI_FS_EE_CA_en.pdf> (April 6 2008); UNAIDS, *2008 Report on The Global AIDS Epidemic*, Annex I, HIV and AIDS Estimates and Data, p. 224

⁶⁰ Stevan Weine, Mahbat Bahromov, Azamjon Mirzoev, “Unprotected Tajik Male Migrant Workers in Moscow at Risk for HIV/AIDS,” *Journal of Immigrant and Minority Health*, Electronic publication ahead of print, December 10 2007/S10903-007-9103-5.

⁶¹ Hsu et al., *Outcome Evaluation of HIV programme of UNDP Tajikistan*, pp. 19-20.

⁶² *Ibid.*

want, take you to the police station and keep you for as long as they want.”⁶³

The Making of AIDS Policy

Many aspects of policy-making in Tajikistan come into focus only when seen in the longer context of Tajik history as part of the Soviet Union. After gaining its independence in 1991 Tajikistan has passed its own AIDS Law twice, first in 1993 and then in 2005. However, when looking back at the origins of HIV/AIDS outbreak in the USSR, both Tajik laws reveal significant elements of AIDS policies adopted by Soviet authorities since the late 1980s, as discussed below.

In 1986 and 1987 Soviet health authorities carried out two large-scale serological screenings, the first involving 11,567 people in Moscow most of whom were foreign and local students and the second testing almost 80,000 people across several major cities. They suggested that African students were the main risk group as all twenty HIV cases detected during the first screening and 192 out of 226 HIV cases from the second screening were nationals of various African countries.⁶⁴ When the Presidium of the Supreme Soviet of the USSR passed a Decree On Prophylactic Measures Against AIDS Infection on 25 August 1987, these findings were translated into introducing mandatory HIV tests for all foreigners who intended to stay in the USSR for longer than three months. If found HIV positive, they were to be deported. In Tajikistan this provision was embraced in both 1993 and 2005 AIDS laws, articles 6 and 9, respectively.⁶⁵ Taken from the Soviet Ministry of Health’s policy paper on the “Rights to Medical Examinations for HIV” as of 4 October 1990,⁶⁶ there was also a rule that all foreigners and people without citizenship should have their tests within 10 days after arriving in Tajikistan. Elaborating extensively on the rights of people living with HIV, these legislative acts in fact violated the Universal Declaration of Human Rights, adopted by the UN General Assembly on 10 December 1948, which says that “everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or

⁶³ Weine et al., “Unprotected Tajik Male Migrant Workers in Moscow at Risk for HIV/AIDS,” Electronic publication ahead of print.

⁶⁴ Medvedev, “Evolution of AIDS Policy in The Soviet Union. Part I. Serological screening 1986-7,” pp. 860-861.

⁶⁵ Republic of Tajikistan, Zakon “O Profilaktike Zabolevaniia SPID,” [Law “On Prevention of AIDS Disease”], Ref No. 903 as of December 27 1993; Republic of Tajikistan, Zakon “O Protivodeistvii VICH i SPID,” [Law “On Countering HIV/AIDS”], Ref No. 150 as of December 28 2005.

⁶⁶ Darren Headley in collaboration with Lena Abrosimova and Olga Labodo, *HIV/AIDS in Russia* (West Malling, Kent: Charities Aid Foundation, 1996).

social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.”⁶⁷

In the 1980s many countries of the world were in denial of HIV/AIDS. As for the Soviet Union, it adopted a penal approach at the time when HIV/AIDS could be no longer be denied in order to prevent further spread of the virus. The above-mentioned Decree of the Presidium of the Supreme Soviet introduced heavy legal penalties on HIV carriers who knowingly placed others at risk, making it a criminal offence punishable with five years in prison. Actual transferring of the infection would increase the sentence to eight years of “deprivation of freedom.”⁶⁸ In Tajikistan, the 1993 AIDS Law and the one that was adopted nearly 20 years after the Supreme Soviet decree of 1987, both followed the same penal approach. Article 125 of the Tajik Criminal Code entitled “Infecting with HIV” envisaged the following criminal liabilities: (1) Knowingly endangering a person with HIV infection entails restraint of liberty for up to 3 years or imprisonment for up to 2 years; (2) infecting a person with HIV by a person who is aware of one’s own HIV positive status, entails an imprisonment for 2-5 years (the same action committed with regard to two or more persons and/or when being fully aware of the other person being under-age entails an imprisonment for 5-10 years).⁶⁹

Such repressive AIDS policies did not deter the HIV epidemic. All what they did was preventing people from wanting to know their HIV status, promoting the environment of fear and generating even more stigma. As interviews with PLWH revealed, nearly one third of them did not use condoms with their regular sexual partners despite existing penalties. Although there is tendency at the Tajik President’s Strategic Research Center to interpret such findings as “lack of knowledge of criminal liability for intentional infecting,”⁷⁰ knowing is different from doing and the situation may be far more complex. As I was told on numerous occasions by HIV positive IDUs, most of them would not disclose their status when sharing drugs and syringes with their peers as they would immediately be outcast. Similarly, how many times did we

⁶⁷ Universal Declaration of Human Rights, 1948, <<http://www.un.org/Overview/rights.html>> (April 7 2008).

⁶⁸ Medvedev, “Evolution of AIDS Policy in The Soviet Union. Part I. Serological screening 1986-7,” p. 861.

⁶⁹ Alisher Latypov, *Review of Existing Drug Demand Reduction and HIV/AIDS Prevention Policies, Programs and Strategies in Tajikistan: Gaps and Needs for Technical Expertise and Policy Advice*, 2007, <<http://www.untj.org/library/?mode=details&id=355>> (April 7 2008).

⁷⁰ Strategic Research Center under President of Tajikistan, *National Study on The Stigmatization and Forms of Discrimination against People Living with HIV*, pp. 15-16.

all hear that it is their male clients rather than commercial sex workers themselves who decide on condom use, and telling him that she's got AIDS would mean no income tonight, in the best case scenario?!

As a matter of fact, the AIDS Law hardly works in Tajikistan not only because half of the judges and lawyers don't even know that such law exists,⁷¹ but primarily because it fails to do what it aims to, i.e. to protect and support people living with HIV. Despite numerous reports on the breach of confidentiality, discrimination and violation of basic human rights of PLWH, there hasn't been any case in Tajikistan when legal actions were taken against responsible people. Yet, according to the most recent findings, as many as 76 percent of judges and lawyers support compulsory HIV testing, 90 percent believe that people living with HIV and knowingly infecting others should be prosecuted, and some 74 percent favor an isolation of PLWH once they are in jail.⁷² In this regard, the current gap between 132 people with advanced HIV infection receiving ART combination therapy in Tajikistan as of August 2008 and the target number of 250 people,⁷³ for whom such therapy would be made available through the Global Fund grant, is to large extent reflective of the significance of legal and social discouragements, which prevent PLWH from seeking medical assistance and, generally, any kind of contact with state authorities. Therefore, the estimated number of people needing antiretroviral (ARV) therapy, which was 1,300 in 2007,⁷⁴ implies that the fate of the majority of those who are already infected with HIV is probably to die without receiving any HIV/AIDS treatment and care. On the other hand, this figure also points towards profound financial implications for the Government of Tajikistan which it would have to deal with when the environment becomes more favorable for people to be willing to know their HIV status as well as to seek ARV therapy.

Inherited from Soviet times, contradictions between health care and law enforcement systems are paramount in Tajikistan and the power relationship between public health and penal approaches is undoubtedly not in favor of the former. Unless this issue is resolved, it will continue to significantly undermine every HIV prevention effort. Moreover, the longer the status quo is maintained the more resources will be wasted and time to effectively respond to the epidemic will be lost. Take, for example, Tajik prisons, where HIV rates increased from 6.2 percent to

⁷¹ *Ibid.*

⁷² *Ibid.*

⁷³ Tajikistan Grant Performance Report, External Print Version, Fourth Round of GFATM HIV Grant to Tajikistan, TAJ-404-G03-H, <http://www.theglobalfund.org/search/docs/4TAJH_821_314_gpr.pdf> (September 15 2008).

⁷⁴ *Ibid.*

8.4 percent between 2005 and 2006.⁷⁵ So far, penitentiary authorities have been very reluctant to admit drug use in their institutions, hence rejecting a need for needle and syringe exchange programs. Substitution therapy is another notorious issue. Associated generally with substantial reductions in illicit opioid use, criminal activity, deaths due to overdose, and behaviors with a high risk of HIV transmission,⁷⁶ substitution maintenance treatment is illegal in Tajikistan. Thirdly, according to the National HIV Prevention Program, at least 70 percent of commercial sex workers are expected to have received some HIV prevention services by the end of 2010. On the other hand, when one mentions the word “subbotnik” to a female CSW, she would tell that in this context it means that local militia regularly arranges “happy Saturdays” when they “gang rape prostitutes.”⁷⁷ There are many reports when CSWs including those working as outreach workers and volunteers for HIV prevention projects are beaten by police, their money is taken, and they are locked in detention facilities for weeks without any charges.⁷⁸ To make things worse, the management of the Tajik Ministry of Interior is currently pondering a law on fighting against prostitution,⁷⁹ which would make commercial sex workers virtually inaccessible for HIV prevention programs. Finally, even within Tajik health care institutions, the approach is control-oriented as far as client registration is concerned. Introduced during the Soviet era, the system is still in use at mental health, narcology and STI services of Tajikistan, whereby the names and other details of individual patients are permanently stored and shared, in certain cases, with police authorities, employers, educational and other state institutions.⁸⁰ Having no public health benefit, the registration of patients on such terms contributes to stigmatization and discrimination, establishes barriers in accessing certain opportunities and leads to the avoidance of those kinds of institutions by potential clients.

⁷⁵ The Government of Tajikistan, *Natsional'nyi Doklad o Khode Vypolneniia Deklaratsii o Priverzhennosti Delu Bor'by s VICH/SPID*, [National Declaration of Commitment on HIV/AIDS 2008 Progress Report], p. 9.

⁷⁶ WHO, UNODC, UNAIDS, *Substitution Maintenance Therapy in The Management of Opioid Dependence and HIV/AIDS Prevention: Position Paper*, 2004, <http://www.who.int/substance_abuse/publications/treatment/en/index.html> (April 8 2008).

⁷⁷ Author's correspondence with a former director of one of the HIV prevention programs in Tajikistan, April 2008.

⁷⁸ UNESCO, UNICEF, UNAIDS, *Into Focus*. A Central Asian Newsletter for Professionals Working in The Field of HIV/AIDS Prevention, March 8 2003, Almaty.

⁷⁹ Deutsche Welle, S Paneli k Stenke? Vlasti Tajikistana Khotiat Sdelat' Prostitutsiiu Ugolovno Nakazuemym Deianiem, [From 'The Streets' to 'against The Wall?' Tajik Authorities Intend to Criminalize Prostitution], January 2008, <<http://www.centrasia.ru/newsA.php?st=1201727100>> (April 8 2008).

⁸⁰ There are some indications that the situation is changing as far as narcological register is concerned.

In the case of STI clinics, becoming a patient also implies the launch of “epidemiological investigation” of the case, when all sexual contacts of identified patient are traced, their sexual contacts then traced too and so on, without observing confidentiality. Such “adversarial” relationships between state STI services and patients have had many consequences for treatment seeking behavior and management of STIs, crucially important in terms of HIV transmission risk. In 2005, while the rates of syphilis were found to be as high as 20 percent among commercial sex workers, 0.5 percent among pregnant women, 15.6 percent among prisoners, and 11.6 percent among injecting drug users,⁸¹ official Tajik STI authorities registered an outstandingly low number of 620 syphilis cases throughout the entire year.⁸² It is precisely in this context that the above-mentioned Global Fund – supported network of service centers, offering free STI examination and treatment for migrants in various parts of Tajikistan, was named “friendly”. Staffed with the doctors appointed and employed by the Ministry of Health these “friendly” centers differed from “unfriendly” state services in two major ways: they did not register their patients and did not chase their sexual contacts. In this case, rather than addressing the issue by changing surveillance-based registration policies, promoting confidentiality, improving the capacities of existing reproductive health, dermatological, urological and STI services, parallel services were created just for migrants thus threatening to “dilute existing health care system and lacking economy of scale.”⁸³

National AIDS responses in Tajikistan are based on the following universally endorsed “Three Ones” Principles: one agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; one National HIV/AIDS Coordinating Authority, with a broad-based multisectoral mandate; and one agreed HIV/AIDS country-level Monitoring and Evaluation System. In 2007, the Tajik Government’s UNGASS 2001 Progress Report showcased the full introduction of the “Three Ones” Principles as its only success story.⁸⁴ However, it seems to be very important to look beyond the general principles and understand the power relationship question within the “Three Ones.” While these principles might seem to have a connotation of the absence of multiple powers and interests, this is certainly not the case in Tajikistan. Civil society organizations are granted a secondary

⁸¹ Republican AIDS Center, Tajikistan, Presentations of The Results of 2005 Sentinel Surveillance in Tajikistan.

⁸² The Government of Tajikistan, *Programma po Protivodeistviu Epidemii VICH/SPIDa v Respublike Tajikistan na Period 2007-2010gg.*, [Program for Countering HIV/AIDS Epidemic in Tajikistan for The Period of 2007-2010], p. 10.

⁸³ Hsu et al., *Outcome Evaluation of HIV programme of UNDP Tajikistan*, p. 19.

⁸⁴ The Government of Tajikistan, *Natsional’nyi Doklad o Khode Vypolneniia Deklaratsii o Priverzhennosti Delu Bor’by s VICH/SPID*, [National Declaration of Commitment on HIV/AIDS 2008 Progress Report], p. 22.

role in Coordination Committees and only three local NGOs were involved in the National Coordination Committee (NCC) until most recent times. On the other hand, within one policy-making authority, [i.e. the Government of Tajikistan] all the powers are in the hands of the law enforcement community and the voices of others are simply ignored. Failing to admit that as far as substitution treatment is concerned, the NCC and the Ministry of Health keep repeating in their strategies and policy documents that “the issue of introducing substitution therapy in pilot districts will be resolved by 2010”⁸⁵ or that “the issue of introducing substitution therapy should be considered by 2010.”⁸⁶ Given that HIV rates among IDUs in Dushanbe have so far doubled between 2004 (12 percent) and 2006 (24 percent), it is exactly when ‘considering’ and ‘resolving’ will make little sense.

Problems with the Denominator and Other Coverage Paradoxes

In recent years coverage has become a very hot topic on the HIV prevention and harm reduction stakeholders’ agenda. An editorial of the *International Journal of Drug Policy* supplementary issue devoted to coverage of harm reduction programs provided an overview of a dozen papers, whose authors engaged in thinking and rethinking coverage, and reiterated the “debate about how coverage should be defined, what an acceptable level of coverage should be, how it might vary with the intervention type, and how it can be measured.”⁸⁷ In Tajikistan, debating and enacting coverage have been going on substantially since 2005, when the management of the USAID-funded regional CAPACITY Project in Central Asia began advocating the so-called “60 plus” approach. This implies, based on modeling, that “with ensuring 60 percent of safe behavior among key populations – sex workers and their clients, injecting drug users and men who have sex with men – the epidemic could be reversed among those groups.”⁸⁸ This pretty straightforward formula indeed raises many challenging questions. Just to name a few, in order to be able to assert that 60 percent of a target group is reached, we need to know approximately what 100 percent of that group is, and here the issue

⁸⁵ The Ministry of Health of Tajikistan, *Strategic Program of The Ministry of Health for Countering HIV/AIDS Epidemic in Tajikistan for The Period of 2004-2010*, Dushanbe, 2004.

⁸⁶ The Government of Tajikistan, *Programma po Protivodeistviu Epidemii VICH/SPIDa v Respublike Tajikistan na Period 2007-2010gg.*, [Program for Countering HIV/AIDS Epidemic in Tajikistan for The Period of 2007-2010], p. 25.

⁸⁷ Mukta Sharma, Dave Burrows and Ricky N. Bluthenthal, “Improving Coverage and Scale-up of HIV Prevention, Treatment and Care for Injecting Drug Users: Moving The Agenda Forward,” *International Journal of Drug Policy* 19, Suppl. 1 (2008), pp. S1-4.

⁸⁸ UNAIDS, *A Scaled-up Response to AIDS in Asia and The Pacific*, UNAIDS/05.15E (English original, June 2005), <http://data.unaids.org/UNA-docs/REPORT_ICAAP_01July05_en.pdf> (April 4 2008).

of estimating becomes vital. Second, how to ensure safe behavior of a particular target group? Is it by providing a condom, a clean needle, a brochure or certain coverage “package?” Third, what ‘exposure dose’ a target group should receive in order to ensure safe behavior? Current HIV Prevention Program in Tajikistan aims to ensure that “by 2010, 100 percent of prison inmates, not less than 70 percent of the estimated number of sex workers, not less than 60 percent of the estimated number of IDUs, and not less than 10 percent of the estimated number of men having sex with men receive, through trust points and friendly rooms, at least one prevention service per year.”⁸⁹

As this target implies, there are no problems in counting people in prisons of Tajikistan. However, there is no agreed national estimate of any other vulnerable group. Guided by the official client registration database introduced during Soviet times, health authorities in Tajikistan are poorly informed of the actual magnitude of risk behaviors whereas indirect statistical estimation methods are not popular and mostly unknown to local officials. On the other hand, the estimates of vulnerable populations that were proposed in Tajikistan by various individuals and agencies since the early 2000s more often resembled intuitive suggestions. In 2001 UNODC Regional Office for Central Asia produced an estimate of 45,000 – 55,000 problem drug users out of 6,131,000 total population of Tajikistan by extrapolating the findings collected from two cities with high drug use prevalence to the entire country.⁹⁰ It was also suggested that some 38,500 individuals out of those estimated problem drug users might use intravenous drugs.⁹¹ World Bank suggested that based on UNODC data the real number of drug users was some 100,000.⁹² Tajikistan UNDP Global Fund Grants Implementation Unit used its own guesstimate when reporting that “the total number of IDUs reached by HIV/AIDS prevention programs, implemented on the funds of the GFATM grant to the end of April 2006, made 5,356 IDUs or 36 percent of the estimated number of IDUs in the country,”⁹³ hence implying a total of 14,877 IDUs in Tajikistan. However, when in 2007

⁸⁹ The Government of Tajikistan, *Programma po Protivodeistviuu Epidemii VICH/SPIDa v Respublike Tajikistan na Period 2007-2010gg.*, [Program for Countering HIV/AIDS Epidemic in Tajikistan for The Period of 2007-2010], p. 25.

⁹⁰ UNODC Regional Office for Central Asia, *Conference Report. Regional Conference on Drug Abuse in Central Asia: Situation Assessment and Responses*, Tashkent, June 26-28 2002.

⁹¹ CAPACITY, Central Asia Program on AIDS Control and Interventions in Vulnerable Populations, *Universal Access to HIV Prevention in Central Asia: A Technical Working Paper on Reaching High Coverage among Vulnerable Population*, Almaty, 2006.

⁹² World Bank, *HIV/AIDS in Central Asia, 2002*, <http://siteresources.worldbank.org/INTECAREGTOPHIVAIDS/Resources/HIV_Central_Asia_March_2002.pdf> (April 5 2008).

⁹³ UNDP Tajikistan, Grants Implementation Unit. *Support to The Strategic Plan to Prevent HIV/AIDS Epidemics in Tajikistan: Annual Progress Report, Phase II, 1 May 2005 - 30 April 2006*, p. 6.

UNODC conducted follow-up assessment using revised methodology, the new estimate produced for Tajikistan was the lowest in Central Asia, reported as “more than 0.5 percent of the total adult population 15 – 64 years, or 20,000 people, regularly using opiates.”⁹⁴

Similar discrepancies existed with other at-risk groups as well. In the case of commercial sex workers, no national study with sound methodology has been conducted yet. Estimates that are cited in various reports often conflict with each other and do not involve informal sex workers. The most often cited figure was an estimated 5,000 CSWs, but in the years 2000 and 2006 it was applied to the whole country,⁹⁵ and in 2003 it was reported by the City AIDS Center with regard to Dushanbe alone.⁹⁶ However, in 2007, another figure of an estimated 8,000 CSWs was reported by the Tajik Government with reference to “the estimated data of an expert from UNAIDS, used for preparation of the Global Fund proposal in 2003.”⁹⁷ Other sources suggested that as of 2004, 8,000 CSWs nationwide were known to the Tajik Ministry of Interior as well.⁹⁸ This proximity between the rapid assessment data and the number of CSWs officially registered by the Ministry of Interior is potentially indicative of an underestimated data being used in HIV programming.

While problems with the denominator were obvious in Tajikistan, a great deal of other “coverage paradoxes” emanated from the above target of the Tajik HIV Prevention Program of “at least one prevention service per year by 2010.” What in fact does it mean to be “covered” by a prevention service in Tajikistan and what outcome would this entail? In a recent attempt “to track the coverage on the silk road” Gray and Hoffman discuss how “one program in Central Asia” found out that providing at least one significant Youth Power educational contact to youth aged 15-25 was associated with “very positive improvements in knowledge and attitudes related to condom use, *but not in condom use*

⁹⁴ UNODC Regional Office for Central Asia, *Illicit drug trafficking in Central Asia*, p. 17.

⁹⁵ Tajikistan GFATM Round 1 Proposal, *Support to The Strategic Plan of The National Response to The HIV/AIDS Epidemics in Prevention Activities among IDU, SW and Youth and Envisaging Blood Safety*, Dushanbe, 2002; UNDP Tajikistan, Grants Implementation Unit, *Support to The Strategic Plan to Prevent HIV/AIDS Epidemics in Tajikistan: Annual Progress Report, Phase II, 1 May 2005 - 30 April 2006*, p. 7.

⁹⁶ Central and Eastern European Harm Reduction Network, *Sex Work, HIV/AIDS, and Human Rights in Central and Eastern Europe and Central Asia*, 2005, <<http://www.ceehrn.org/index.php?ItemId=15504>> (April 3 2008).

⁹⁷ The Government of Tajikistan, *Natsional'nyi Doklad o Khode Vypolneniia Deklaratsii o Priverzhennosti Delu Bor'by s VICH/SPID*, [National Declaration of Commitment on HIV/AIDS 2008 Progress Report], pp. 6, 29.

⁹⁸ Mirzoev, “VICH-Infektsiia v Respublike Tajikistan (Epidemiologicheskaiia Kharakteristika),” [HIV Infection in The Republic of Tajikistan (Epidemiological Characteristics)], pp. 18-19.

itself,” which remained stable or slightly dropped in all target sites.⁹⁹ Getting back to commercial sex workers, according to the UNDP Global Fund Grants Implementation Unit, as many as 68 percent of the estimated CSWs in the country (3,414/5,000) were reached by HIV and STI prevention services between May 2005 and April 2006. Based on the data available for 266 CSWs living in Khudjand (with a total estimated number of 511 CSWs¹⁰⁰), each of them received on average 257 prevention services within 12 months time including 208 condoms, 5 consultations, and 44 information, education and communication (IEC) materials.¹⁰¹ On the other hand, HIV prevalence among CSWs recruited in sentinel surveillance studies in that city in 2005 (n=150) and 2006 (n=150) increased from 0 to 0.7 percent, respectively.¹⁰² How should one respond to these striking findings? While Gray and Hoffman describe how, in response to theirs, plans to expand to new districts were cancelled and the original coverage goal was revised to provide at least 3 or more educational sessions, situation with CSWs in Tajikistan is indeed puzzling. This is particularly so because the reported difference in HIV rates in Khudjand was not statistically significant ($p > 0.05$). Speaking about cost-effectiveness, what is then sufficient coverage and even if sufficiently covered, what else may contribute to actual condom use? In both 2005 and 2006 sentinel surveillance studies nearly 60 percent of CSWs in Dushanbe and Khudjand responded that a reason for not using condoms was in fact the insistence of their male clients on not using a condom. They also reported that around 60 percent of their clients were police and military men, making it abundantly clear that ‘chasing’ coverage alone is not going to solve all the problems.

As for injecting drug users, major attention has been paid so far to providing drug users with sterile injecting equipment through syringe exchange programs. But, in being excessively involved in discussing the benefits of such programs, there is a tendency to underestimate the fact that in former Soviet countries, unlike in the West, syringes are readily available in any local pharmacy without prescription and at a very cheap price. As highlighted by Sarang et al., some of the key factors that contributed to pharmacy access in Russia included geographic proximity and low cost, and it would be a missed opportunity not to pilot

⁹⁹ Robert Gray and Leah Hoffman, “Tracking Coverage on The Silk Road: Time to Turn Theory into Practice,” *International Journal of Drug Policy* 19, Suppl. 1 (2008), S15–24.

¹⁰⁰ Republican AIDS Center, Tajikistan, Presentations of The Results of 2005 Sentinel Surveillance in Tajikistan.

¹⁰¹ UNDP Tajikistan, Grants Implementation Unit. *Support to The Strategic Plan to Prevent HIV/AIDS Epidemics in Tajikistan: Annual Progress Report, Phase II, 1 May 2005 - 30 April 2006*, p. 7.

¹⁰² M. Dodarbekov, S. Kurbanova, Kh. Saidova and A. Norova, Presentation on The Findings of Sentinel Surveillance: HIV Infection among Commercial Sex Workers in Dushanbe and Khudjand, 2005-2006, Dushanbe, 2007.

pharmacy-based syringe distribution and exchange projects.¹⁰³ Compared to a total of 23 needle and syringe exchange points available in Tajikistan there are hundreds of pharmacies throughout the country, which meet the largest portion of demand for injecting equipment. Many pharmacies seem to have established good relationships with their regular IDU clients, which may even involve lending syringes without an obligation to buy them as some drug users reported that they used to borrow syringes from a pharmacy and return them when they would get free syringes from a trust point.¹⁰⁴

Finally, one should not forget about the brochures that fall under the rubric of the IEC materials. These brochures may be available in Russian or in Tajik, but they rarely have members of the target groups involved at initial design and pre-testing phases. Produced in large quantities at the start of the Global Fund grant for mass distribution during the entire five-year grant period,¹⁰⁵ they were hardly effective when ‘covering’ their audiences. In the words of many trust point counselors and outreach workers

...we don’t understand ourselves the meaning of the Tajik text in some of these brochures designed by the ‘experts’ from Dushanbe.¹⁰⁶

Conclusion

Mobile theaters have recently become a very popular tool for delivering HIV prevention messages to various audiences in independent Tajikistan. Performed in cities and rural communities, they entertain both urban dwellers and villagers and may also be set up to amuse ‘external’ visitors. The scene looks neat: performers are eloquent, a crowd is cheerful, local partners are proud, and donors are happy. But there is a hard feeling that something is wrong in this masquerade. Street children performers are in fact pseudo-street children, a crowd of migrants may also consist of passers-by, no evidence exists that the messages delivered are the right ones, local partners play tricks by promising ‘to consider’ introducing necessary changes in their policies and laws, and donors face difficult dilemmas in deciding how to proceed with program development without having fundamental problems resolved. We call this ‘daily routines of HIV program implementation’ but this may also remind us of the Potemkin village.

¹⁰³ Anya Sarang, Tim Rhodes and Lucy Platt, “Access to Syringes in Three Russian Cities: Implications for Syringe Distribution and Coverage,” *International Journal of Drug Policy* 19, Suppl. 1 (2008), pp. S25–36.

¹⁰⁴ Latypov and Djmalov, Interviews with injecting drug users.

¹⁰⁵ Hsu et al., *Outcome Evaluation of HIV programme of UNDP Tajikistan*, p. 22

¹⁰⁶ Author’s interviews with trust points’ counsellors and outreach workers, June–August 2006, Tajikistan.

HIV/AIDS has come of age in Tajikistan, there is no doubt about it. Whether the tide is going to be reversed or not depends on numerous factors including how soon the contradictions and barriers identified in this paper will be removed. Within a broader “securitization” approach to policy-making, Tajik authorities have yet to abandon their punitive and control-oriented tactics in dealing with vulnerable populations and to embrace the assertion that the danger of spread of HIV/AIDS is a greater threat than drug use, commercial sex work and juvenile delinquency all together.