Annex 3. The Strategic and Regulatory Framework for HIV/AIDS Prevention in Central Asia

This section reviews approaches to HIV/AIDS prevention and control that are supported or even implemented through legislative and regulatory policy in Central Asia. These are primarily directed through the public health systems, but they involve multisectoral components as befits a multisectoral health challenge. The study considers funding for these approaches, vis-à-vis existing limited evidence as to costs and cost-effectiveness, and where applicable, best practices from other regions.

The policy environment of all five Central Asia Republics regarding HIV/AIDS prevention reflects the previous history of Soviet approaches to communicable diseases. The moral climate related to HIV within the Central Asia Republics depends greatly on religion, economic disruption, the rule of law, and the influence of health over policing policies. This climate has changed considerably since the beginning of the HIV epidemic, but further policy support for tolerance, human rights protections, and appropriate medical and social support for HIV-related medical conditions is needed.

Drug-related laws seem to shy away from specific criminalization for drug use, while making the possession of small amounts of illegal drugs a crime. This sets the stage for both repression and corruption. It also creates a situation in which injecting drug users (IDUs) are segregated from medical and social support systems, allowing HIV infection to become more and more concentrated until it bridges through sexual networks outside the IDU community. In terms of policy on IDU approaches, it is necessary as a priority widespread adoption of harm reduction approaches. These include non-specialized, decentralized, and more freely available substitution therapy for drug use. For this to occur, legislative change is necessary to liberalize the use of methadone and other substitution drugs, perhaps even including medically administered heroin. Narcology Centers should not be the only places authorized to provide this treatment. Needle exchange needs legalization and accompanying authority for providers to implement without fear for security. This approach is insufficiently described in all of the Strategic Plans reviewed.

Policy approaches to commercial sex work (CSW) suggest a need for decriminalization, both in terms of the definition of laws dealing with prostitution, and enforcement practices. Gender issues are not addressed by the Strategic Plans, and this should be an area of concentration for policy work. Users of commercial sexual services are not prosecuted in general, while CSWs (most at risk for STI and HIV) are marginalized and isolated by police practices.

Policies to support expanded outreach medical treatment for STI, IDUs, and young people may need further attention throughout the region. The specialized, medical approach to HIV/AIDS cannot be the only approach to reaching vulnerable groups; whether through legislation, funding, or expanded NGO support, decentralized and culturally appropriate facilities will need supportive policies in order to prevent HIV spread across bridging populations.
Stigma against vulnerable groups and people living with HIV/AIDS (PLWHA) seems to be overwhelming in Central Asia. Thus, policies protecting human rights, confidentiality, and anonymous voluntary counseling and testing (VCT) need to be specifically addressed. However, even written policies will not change the underlying professional, governmental, and individual set of prejudices that seem to be widespread in the region. It will likely take a very concerted, professional public information campaign to change social norms, against which all programs will be implemented. Although all Strategic Plans call for several different levels of educational activity, it is really not enough to simply provide information. More importantly, the political commitment needs to be backed up by credible social marketing, normalization of vulnerable groups, and realistic human rights protections.

Two of the four countries of Central Asia that have obtained GFATM grants – Kazakhstan and Uzbekistan – have new anti-retroviral drugs treatment (ARV) targets for 2005 or 2007; although most of the health systems in ECA more or less guarantee treatment for infectious diseases, the costs of ARV have limited the reality of this guarantee to certain target groups (such as in Kazakhstan, with only children and pregnant women covered before the award of the GFATM grant). The key policy gaps related to ARV have to do with specific financing strategies: negotiations for equity pricing, protocols for treatment based on science and international standards, monitoring of drug resistance, and improvement in laboratory support for ARVs are insufficiently addressed in the Strategic Plans. Data on antiretroviral (ARV) therapy policies and funding are presented in the following table.

It appears as though a substantial investment in policy and legislative modernization is needed in each country. All Strategic Plans suggest the need for cross-sectoral collaboration and action. However, in reality, the territoriality of programs and jurisdictions is very difficult to overcome. The credibility and functionality of the National Coordinating bodies in each country will determine the success of the multi-sectoral activities.

In addition to the Global Fund grants, Central Asia has been benefiting from substantial technical and/or financial assistance from UN agencies, bilateral agencies and international NGOs. UNAIDS recognizes the need for harm reductions strategies and legislative reforms. UNICEF stresses the importance of youth vulnerability, as well as the need to attend to children of AIDS victims (an issue marginally addressed in the Strategic Plans). UNODCCP recognizes the need for improved drug treatment balanced with interdiction approaches, but there really seems to be a lack of commitment to reducing demand for drug use through liberalizing the criminal code. USAID calls for improvements in surveillance, blood safety, and youth-oriented education. Ultimately, the countries will have to decide for themselves how best to change national policy, but the evidence-base provides for substantial support for harm reduction and much more extensive substitution therapy. The evidence is still unclear as to the applicability of decriminalization of drugs as an effective HIV prevention strategy, but it is clear that current legislative approaches do not support effective interventions on IDU-related HIV prevention.
In this study, first we present a brief review of evidence-based strategies to HIV/AIDS prevention and control; many of these strategies have been previously reviewed in detail for the Eastern Europe and Central Asia Region as a whole. Those with particular relevance to Central Asia will be highlighted. Next, we discuss key elements of the UNAIDS-published Strategy for this region, including partner activities by the World Bank, Unites States Agency for International Development (USAID), and the Global Fund to Fight AIDS, TB, and Malaria (GFATM). Third, we synthesize material provided by specific country strategic plans for Kazakhstan, Kyrgyz Republic, Tajikistan, Turkmenistan, and Uzbekistan. Fourth, we discuss Central Asian country HIV/AIDS Strategies with regard to gaps based on evidence to identify other possible inputs. In particular, attention is paid to the intravenous drug use problem in Central Asia, as it not only drives the epidemic in this sub-region but also has geopolitical significance.

**Strategies to Prevent HIV/AIDS in Central Asia**

The key elements characterizing the HIV/AIDS epidemic in Central Asia (CA) are:

- Low HIV prevalence measured by existing reporting systems
- A rapid rise in new HIV infections
- Expanding numbers of injecting drug users (IDUs)
- Increased reported sexually transmitted infections (STIs)
- Increased commercial sex work (CSW)
- Increased migration and mobility throughout the region, including drug trafficking, refugees, human trafficking, war traffic, and commercial transport
- Low levels of awareness of risks, especially among young persons
- High levels of stigmatization against risk groups and infected persons
- Inadequate sentinel and population-based surveillance of HIV, risk behavior, and drug use
- Inadequate health systems response to HIV/AIDS harm reduction, and other preventive and clinical strategies directed to the IDU problem
- Relatively low political commitment and low-level civil society involvement.

These determinants have been thoroughly discussed elsewhere. The epidemic, as in other parts of Eastern Europe and Central Asia, is fueled by heterosexual transmission, is at an early stage of development, and depends largely on the bridging from highly vulnerable groups to the general population. However, the real extent of the epidemic is poorly understood, owing to lack of serologic and behavioral data representative of the highest risk groups (especially IDUs, mobile populations, and CSWs, as well as their needle-sharing and sexual networks). Even though the prevalence of HIV infection in the general population (as well as among highly vulnerable groups) is at present relatively low (highest prevalence is in Ukraine at 1 percent), indications from drug using populations and localized epidemics in Russia, Belarus, and Ukraine

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suggest that the prevalence within pockets of highly vulnerable groups and vulnerable populations is growing rapidly and is likely to be underestimated due to substantial reporting.\textsuperscript{83}

In Central Asia, outbreaks of HIV-related injecting drug use are reported and are cause for concern. Policies to support prevention in low-HIV prevalence countries found in Central Asia are impeded by lack of priority setting, marginalization of vulnerable populations, lack of public knowledge about HIV/AIDS risks, and deterioration of public health systems that need to respond to new infectious disease threats across various sectors.\textsuperscript{84}

**The Evidence Base for prevention of HIV/AIDS in Central Asia**

Evidence to support effective strategies is largely lacking in the region. However, much can be gleaned from Southeast Asia, Western Europe, Americas and Africa regarding the strategic and regulatory framework for HIV/AIDS prevention in Central Asia. A broad view of effective strategies that may be considered in Central Asia are shown in Box 1. Because the HIV/AIDS epidemic is closely related to the epidemic of intravenous drug use, we must also consider specific interventions directed towards this concomitant epidemic. Box 2 considers specific strategies with respect to the drug-use epidemic.

Political and economic changes in the sub-region have created open borders for drug trafficking, and the HIV epidemic has essentially followed, due to burgeoning demand, the traffic in addictive drugs.\textsuperscript{85} More than 90 per cent of all heroin sold in Europe is sourced to Afghanistan through Central Asia, and the highest rates of documented HIV prevalence among IDUs are along the trafficking routes.\textsuperscript{86} In areas growing opium poppies, most users smoke or snort the drug; as the opium is converted to diluted heroin along the traffic route, more injection behavior is seen due to its reduced cost/dose compared to smoking or snorting. An estimated 300,000-500,000 of the 55 million persons living in Central Asia are now IDUs.\textsuperscript{87}

The primary mode of HIV transmission in this region is injection drug use, through needle sharing and unprotected sexual activity. Risk factors also include commercial sex work, social repression of homosexual behavior, and high rates of sexually transmitted diseases, especially syphilis. Thus, the most important strategies related to IDUs are the following:

- harm reduction through needle exchange and substitution therapy;
- drug addiction treatment, detoxification, and counseling;

primary prevention through youth-orientation educational programs;
- changing sexual risk behavior among IDUs through psychosocial interventions;
- social marketing of condoms;
- treatment of STIs among IDUs and their partners; and
- voluntary counseling and testing for HIV for IDUs and their partners (with subsequent referral to treatment for HIV-positives).

Currently, the total number of people living with HIV/AIDS in Central Asia is estimated to be about 90,000, but this number will increase to 1.65 million without effective prevention policies focusing on IDU, sexual and social networks, and young people. Reinforcing this estimate are spot surveys showing a high prevalence of HIV among IDUs, for example, 18 per cent in Kazakhstan. For IDUs, targeted policies that address the social, legal, and environmental determinants of the Central Asia HIV epidemic and many of these specific interventions are necessary. The growth of heterosexual HIV epidemics in Central Asia will depend on how well the IDU-based source of HIV is controlled and how well the bridging to other parts of the population is understood.

**IDU-related HIV Prevention.** The most effective way of preventing HIV transmission among IDUs is the elimination of drug use. However, most programs are oriented towards harm reduction. Harm reduction is a somewhat controversial approach calling for reducing risks and exposures without abstinence of risk behavior; this usually requires extraordinary political resolve for implementation. However, the evidence supports the use of sterile needles, reduced sharing of needles, cookers, and syringes, and encouraging the use of non-injecting forms of addictive substances as effective preventive measures to reduce HIV transmission.

In fact, these methods may be more effective in low prevalence epidemics than when seroprevalence reaches 20 percent or more. In New York, the expansion of community-based syringe exchange programs was also associated with large-scale reductions in risk behavior (including needle sharing and risky sexual behavior), and HIV incidence among drug users showed a steady decline during the 1990s.

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Box 10. Strategies to Prevent HIV/AIDS Epidemic Growth in Central Asia

• **Major public health interventions**
  1. Screening and insuring safe blood supply;
  2. Scaling up voluntary testing and counseling (VCT) among high-risk groups, utilizing outreach through NGOs and government facilities;
  3. Contact tracing with VCT for new HIV cases;
  4. Training and guidelines for parenteral therapies (nosocomial infection prevention);
  5. Harm reduction (HR) including needle exchange among IDUs;
  6. Scaling up oral drug substitution therapy to reduce needle use among IDUs;
  7. Improved STI treatment and education through outreach among CSW;
  8. Improved treatment and referral for STI and HIV by health providers, including syndromic treatment for STIs;
  9. School-based and other channel education among youth;
  10. Condom social market for persons engaging in unsafe sex;
  11. De-stigmatization through professional education for health providers;
  12. Improved Knowledge, Attitudes, and Behavior (KAB) through mass media communication among general population.

• **Legal framework changes in support of HIV/AIDS prevention:**
  1. Decrim inalizing IDU;
  2. Decrim inalizing CSW;
  3. Decrim inalizing MSM;
  4. Increasing availability of oral drug substitution through primary care providers and other non-specialist facilities;
  5. Improving job security, rights, and anti-stigma for HIV/AIDS patients;
  6. Regional cooperation and legal enforcement of human trafficking violations;
  7. Improving confidentiality with respect to VCT, diagnosis, and surveillance;
  8. Prevention: HIV prevention through HR, sero-surveillance, and STI treatment; and social support for released HIV-infected prisoners.

• **Resolving information gaps**
  1. Improving sero-surveillance among high-risk groups to better understand patterns, growth, and true incidence of HIV/AIDS;
  2. Improving understanding of behavioral risks among high-risk groups (needle sharing; unsafe sex; and KAB among youth);
  3. Improving evaluation of interventions through operational research, in particular HR, VCT targeted to high-risk groups, and STI treatment.

• **HIV/AIDS Treatment Issues**
  1. STI Treatment: syndromic therapy, surveillance, and drug supply.
  2. Opportunistic infection treatment: surveillance, referral guidelines, and drugs.
  5. Screening for high-risk women and appropriate treatment of HIV-infected pregnant women to prevent maternal-to-child transmission.
  6. Social support for AIDS patients: nutrition, home care, transport, support groups.

• **Communications strategies**

  • **General public:**
    1. Basic KAB on risks and unsafe sex practices;
    2. Destigmatization for HIV/AIDS patients, IDU, CSW;
    3. Condom social marketing.

  • **Policy makers**
    1. Encouraging political commitment—focus on human capital and economics;
    2. Destigmatization;
    3. Realistic approach to IDUs—focusing on treatment and prevention;
    4. Special attention to prison populations.

  • **High risk groups**
    1. Peer counseling for IDUs, CSWs, migrants;
    2. Soldiers and peacekeeping forces;
    3. Condom social marketing.
In Belarus, a local harm reduction project including needle exchange, public information campaigns, behavioral counseling, legal support, and outreach to high risk groups, proved to be cost-effective in terms of reducing the IDU and non-IDU incidence of new HIV infections. In Sverdlovsk Oblast, Russia, changes in IDU risk behavior have been observed with needle exchange programs, but the results of this study also highlighted the need for more intensive behavioral, political, and resource support to improve outcomes. In Nepal, a highly targeted street-based outreach program reported a cost effective approach to needle exchange and sexual practice behavioral change.

In Southeast Europe (Croatia, Romania, and Bulgaria), several needle exchange and behavioral harm reduction programs have been implemented but not sufficiently evaluated; these have usually been supported by the Soros Foundation/Open Society Institute (OSI), and have involved local municipalities and nongovernmental organizations rather than government agencies. An international analysis reported that HIV prevalence could be reduced by 5.8 percent in cities with needle and syringe projects, compared with a 6 percent increase in HIV incidence in cities without such projects. Consensus is clear that needle exchange schemes are important, and effective means of reducing HIV transmission. Services for IDUs should also include voluntary counseling and testing for HIV (VCT), a proved method of changing risk behaviors. In addition, evidence shows that needle exchange and syringe projects can bridge to

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96 Novotny T, Haazen D, and Adeyi O (2003).

Replacement therapy is another effective measure to prevent HIV infection among drug-using populations. Ideally, all drug users should be referred for treatment including methadone maintenance, and counseling to manage their addiction; in reality, drug treatment programs are still rare, although they are increasing throughout Central Asia. The goal of methadone maintenance therapy is not to achieve total abstinence but rather to minimize the disruptive social effects of drug use and to prevent public health externalities caused by sharing needles and associated unprotected sex. There is overwhelming positive evidence to support expanded use of methadone maintenance as a preventive measure for IDU-based HIV epidemics.\footnote{Drucker E (1995). Harm Reduction: A Public Health Strategy. \textit{Current Issues in Public Health} 1:64-70.} Usually, methadone treatment and maintenance programs in Eastern Europe and Central Asia are based in Narcology Centers, with inpatient-oriented treatment programs that are sometimes regulated in a rather old-fashioned way. Thus, policies and regulatory frameworks need to be modified to diversify treatment, maintenance, and substitution therapy options as well as needle exchange programs. Other drug substitution initiatives include prescribing and administering injecting drugs, such as heroin, under controlled circumstances. In Netherlands, Australia, and Switzerland, this approach has shown promising results.\footnote{Ibid.}

Clearly, all of these approaches to IDU-related HIV prevention require changes in punitive regimes, including the possibility of decriminalization of drug use and needle possession so that drug users are not so marginalized as to be inaccessible to treatment, support, testing, and counseling. In the Netherlands, cannabis has been legal for nearly thirty years; in Canada, medical marijuana has recently been decriminalized; Switzerland and Portugal have also undertaken liberalization of laws concerning use of illegal drugs. Thus far, there has been little evidence of organized crime or violence associated with the domestic legal trade in cannabis. In the Netherlands, the number of hard drug users has declined steadily, and in addition, treatment facilities based in the public health sector have diversified to address hard drug users (perhaps with policing funds no longer needed to enforce cannabis prohibition).\footnote{Ibid.} There will continue to be psychoactive drug use as long as social disruption, economic pain, and fatalism continue to be present in Central Asia; given that these underlying conditions are not likely to show dramatic change in the short term, more aggressive short term approaches to drug use harm reduction are indicated.

\textbf{CSW-related HIV Prevention.} Harm reduction with respect to commercial sex work is another potential policy area of importance in Central Asia. Economic and political changes in Central Asia over the past decade created significant financial hardships, especially for women. This has led to a dramatic increase in migration as well as either voluntary or involuntary involvement in commercial sex work. Often, there is significant overlap in terms of sexual networks with IDUs. In addition, commercial sex work increases risk for STIs, which also lead
to increased risk for HIV. Unless social and economic conditions (as well as the IDU epidemic) are not likely to dramatically change in the near term, other means of primarily or secondarily preventing HIV spread resulting from the exchange of sex for money are needed. Commercial sex work is characterized by criminalization, ostracism (even when migrant CSWs return home), lack of goods and services, lack of power in sexual relationships, and lack of information about preventing HIV infection. In addition, CSWs fear participating in local medical systems due to the potential of identification by police or forced inpatient treatment for STIs.

OSI has supported specific program work to reduce HIV risk for CSWs. These programs are characterized by outreach to places where CSW are working, peer education, consulting with local police authorities, and increasing access to medical services. Interventions included in this program are:

- Information and referral, with condom, lubricants, bleach kits, and literature distribution;
- Counseling and education
- Group counseling and education (including peer education)
- Syringe and needle exchange
- Legal counseling and advocacy
- Professional or vocational training
- HIV testing, STI testing and treatment, gynecological care, and drug detoxification
- Training of clinical, social service, and advocacy group personnel.

The evidence base for CSW interventions is rather limited, but there are some notable successes and positive projections. Thailand has been studied best of all; with the implementation of a 100 percent condom policy in brothels, incidence declined 80 percent compared with rates prior to program implementation. In addition, targeted prevention efforts raised condom use among sex workers in Abidjan from 20 to 80 percent over six years, with a concomitant reduction in prevalence of nearly two thirds. UNAIDS reports other similar successes among CSW in Papua New Guinea, India, and Bangladesh. In Uganda, generalized condom social marketing, a reduction in the median number of sexual partners, and delayed sexual initiation also contributed to success of CSW-related programs. In Africa, peer education projects for CSW cost approximately $5.60 per person educated, with $55 per HIV infection averted. In India, savings of $56 per case with a targeted behavioral intervention for CSWs are reported. In general, safer sex programs that reduce HIV risk through comprehensive means have greater chance of success than simple abstinence-based programs; social and economic conditions will not be conducive to abstinence when women (and men) are forced to seek income or drugs in exchange for sex in Central Asia.

**STI Treatment and HIV Prevention.** Unprotected sexual intercourse is a risk factor for both HIV and STI, and ulcerative STIs such as syphilis can promote infection with HIV. Several approaches have been documented as effective to address STI and its interaction with HIV. These include condom social marketing, syndromic treatment (without necessarily using laboratory tests), outreach clinics for CSWs and young people (as youth-friendly services), and

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104 OSI/Soros Foundation (2002).
voluntary testing and counseling for HIV for those identified as having an STI. The evidence to support more extensive STI surveillance, services, and outreach in Central Asia is substantial. In Asia and Africa, modeling studies among countries with HIV seroprevalence ranging from 4 percent (Tanzania) to 80 percent (Kenya), a combination of syndromic management of STI, and condom social marketing, costs per HIV infection averted ranged from $9.60 to $259.33.\footnote{Ibid.}

A substantial proportion of STIs are asymptomatic, and thus, for especially vulnerable populations such as CSWs, monthly checkups with adequate minimal laboratory back up should be considered. Barriers with respect to STI services include lack of knowledge of HIV risk and of access points for vulnerable groups; lack of coverage for medical treatment for migrants, CSWs, IDUs, and other groups most at risk for both STI and HIV; lack of access or excessive expense for condoms and other contraceptive barrier methods, viricidal lubricants, and woman-controlled preventives; and lack of consistent programmatic linkage to counseling and testing for HIV as a routine preventive intervention for STI patients.

**Educational Programs.** In low prevalence countries, behavior change is the most effective method to avert the further spread of HIV. However, too often primary prevention education is left to school-based resources, which may not in fact be properly trained to provide education on sensitive lifestyle issues to vulnerable youth. A large knowledge, attitudes, and practices (KAP) survey of youth and adolescents in Central Asia revealed that young people have little formal reproductive health education.\footnote{UNFPA (2001). *Peer-led Sexuality Education—Results of the Knowledge, Attitudes, Practices, and Behaviour (KAPB) Survey.* IPPF EN Field Office for Central Asia, Almaty.} They lack information and assistance from adults, and have little access to modern contraception. The most frequent sources of information for young people were their peers. Thus, policies to strengthen formal reproductive health education, including peer education methods, are needed in this region.

There is substantial evidence that behavioral change programs targeted to subpopulations including sex workers and their clients, IDUs, and men who have sex with men (MSM) can slow or lessen spread of HIV. In-depth research and analysis of risk is necessary to understand how to appropriately target these groups, and thus operational research is necessary to determine the distribution of risk in the local settings in Central Asia. Planning to reach these subpopulations requires their participation as well as building generalized support within governments and across sectors to resolve legislative and other barriers. Mobilizing behavioral expertise, using peer educators and better trained health professionals, is key to success in targeted approaches. Stigma and discrimination are key issues to impact through education of opinion leaders or even gatekeepers (such as brothel owners) who are necessary for implementation of policies such as 100 percent condom use for CSWs.\footnote{Hanenberg R S, Sokal D C, Rojanapithayakorn W, Kunasol P (1994); Novotny T, Haazen D, and Adeyi O (2003).}

Peer education involves training members of the drug-using community. In Australia, sustained behavior changes was noted with respect to improvements in self esteem, harm reduction strategies, and social support with such a program. In Central Asia, with the deterioration of educational facilities, peer education projects need to concentrate on out-of-
school youth through non-governmental organizations. In Ukraine, for example, the Hari Krishna organization has developed outreach activities focusing on youth and drugs. Gatekeepers to the drug using community might also be targeted. Health services can also be made more youth-friendly, but efforts to reduce stigma toward IDUs among the health care providers must be a part of this system approach.

Reducing the number of sex partners, using condoms, delaying sexual initiation, and other focused prevention education actions have been shown to be effective in slowing a well established epidemic in Uganda. Nevertheless, focused interventions that use multiple means (STI control, VCT, drug treatment referral, harm reduction) are likely to be the most effective preventive efforts in Central Asia, not simply reliance on behavior change.

**Voluntary Testing and Counseling (VCT).** Currently in Central Asia, most HIV testing occurs among low-risk persons. With the exception of Kazakhstan, which is establishing sentinel surveillance sites throughout the country, and special studies conducted among high risk groups in other countries, such testing does not provide a clear picture of the progress of HIV epidemics in Central Asia. Instead, as discussed above, targeted surveillance (so-called second generation, or sentinel surveillance is needed. This will focus on highest risk groups and provide data for decision making and policy changes specific to the concentrated epidemic situation in Central Asia. VCT can support behavior change necessary to reduce risks stemming from IDU and associated unprotected sexual behavior. Policies and strategies in Central Asian countries must include provision for improvement in data collection, analysis, laboratory support, and reporting of results of such second generation surveillance systems. Without such improvements, policy development is precluded and evaluation of progress is impossible.

**Political and legal system issues.** All five countries have addressed various forms of legal and political reform as they strive toward market economies. In Turkmenistan, political activism is severely curtailed, and Islamic fundamentalism in some countries has been used to justify authoritarian attitudes, especially towards marginalized populations. There are considerable disparities in many of these countries with respect to human rights conventions and legislative implementation to support them. All five countries have passed laws than seek to eliminate discrimination against PLWHA and STI patients, but these are irregularly interpreted. Thus, CSWs, MSMs, and IDUs fear problems with the law, registration (by name) of their HIV status if they are tested, and stigma or loss of confidentiality. In Tajikistan, Turkmenistan, and Uzbekistan, homosexual acts are still criminalized.

AIDS cases are reportable in all five Central Asian Countries. Not all have regulations requiring screening of donated blood products, and some have laws requiring expulsion on the basis of HIV positivity. However, National AIDS committees have been established in all of the Central Asia countries, and it is hoped that a transition to a rights based approach to HIV, IDU,

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110 Defty (2002). *Infrequent Injection Drug Users: Research and interventions with young people at risk* of *HIV, with special focus on CEE/CIS and the Baltics.* Vienna, UNAIDS.


CSW, and MSM will prevail. For more detailed existing policy description, see individual country strategies below.

**National AIDS Strategies and Programs**

All country strategies aim to prevent the spread of HIV/AIDS from a concentrated epidemic to a generalized epidemic by focusing on:

- At risk groups – IDUs, CSWs, and for some, men having sex with men,
- Improving awareness and understanding among at-risk and vulnerable groups, such as young people,
- Improving the accessibility to and quality of medical care, and counseling and support for infected patients,
- Providing the legislative environment that will reduce stigmatization and allow for appropriate protocols to be developed.

To achieve these objectives, attention now needs to be focused on translating leadership on HIV/AIDS into identifying practical steps for implementation; the resources being made available to implement the strategies; and capacity building within the organizations responsible for implementing the strategies.

While there is overall consistency in the approach taken by Central Asian countries in the development of their strategies, there is also variation. This variation tends to focus around the detailed level of objectives with, for example, Kazakhstan’s measures being, on the whole, more specific than other countries.

**Box 11. Kazakhstan HIV/AIDS National Program**

1. Stabilizing the spread of HIV from IDUs by increasing the proportion of IDU involved in prevention programs
2. Increasing VCT among IDUs and CSWs
3. Supporting social and environmental changes for vulnerable groups.
4. Restricting risk groups from donating blood or tissue.
5. Implementing educational programs for youth on safer sex and life without drugs.
6. Providing behavior change education for PLWHA, and providing them with ARV to lower viral load and potential infectivity.
7. Providing social support for PLWHA and also for risk groups.
8. Upgrading the legislative basis for law enforcement practices, civil rights protections, and discrimination against risk groups.
9. Working with risk groups to lower stigma and increase their involvement in solving the problems of HIV transmission.
10. Developing a system of Trust Points for needle replacement, psychosocial support, VCT, and IDU treatment (outside the medical establishments).
11. Supporting outreach to risk groups, mobilizing the community to ensure support for prevention programs for them.
12. Strengthening the work of NGOs in prevention and harm reduction.
13. Supporting peer educational efforts among risk group members.
14. Teacher training for school-based health education, as well as training for military personnel.
15. Condom social marketing and increased availability of prevention supplies to risk groups.
16. Syndromic treatment and expanded access to STI services
17. Protection of the blood supply.
18. Developing appropriate policies to assure drug supply.
19. Developing infrastructure and mechanisms to track HIV and design social protection programs.
20. Ensuring that the right to health is written into national laws and policies to protect PLWHA.
Kazakhstan. The Government of Kazakhstan has recognized the need to intervene to avert the epidemics, has put into place coherent strategies, and secured funds through international donors and the GFATM. However, significant barriers remain to delivering a timely response, including: (i) inadequate staffing levels and training in public health analysis and decision-making at all levels; (ii) inadequate salaries at all levels to allow public health officials to adequately perform their public health functions rather than focusing on income generation; (iii) limited understanding of the true dimensions of the threat posed by the likely trajectory of the HIV epidemics; (iv) existing resources still fall considerably short of those necessary to deliver intervention at a scale sufficient to have significant epidemiological impact; (v) innovative approaches to modernizing and rationalizing drug treatment and STI services are being resisted by some powerful professional groups; (vi) laboratory infrastructure for HIV testing is being improved with CDC support, but little is being done to support STI diagnostics or to develop locally grounded protocols for syndromic diagnosis and management; and (vii) harm reduction activity is patchy among highly vulnerable groups.

Kazakhstan published a decree on the National Program on Counteracting the AIDS Epidemic for 2001-2005 in September 2001. HIV testing had been based on compulsory and not anonymous approaches, but recently, legislation has become less draconian. Compulsory testing is now recognized as inefficient and ineffective in monitoring the state of the epidemic. Behavioral risks for IDUs were addressed through pilot programs for substitution therapy, but research found that these were insufficient to dissuade injecting behaviors. The new objectives for HIV program implementation are summarized below.

Clearly, Kazakhstan has described a comprehensive program. With the award of a GFAM grant and USAID investments in surveillance and blood safety, much of this work can be addressed. However, it does appear to be heavily invested in health education-based approaches, and it is very vague as to specific changes needed in policy. Decriminalization of drug use is not addressed, but prostitution is already decriminalized. There is insufficient specificity on improving drug treatment alternatives and increasing funding for substitution therapy. There is significant mention of confidentiality, improved access to VCT and social support through Trust Points, and a very direct approach to destigmatization.

In 2003, the Country Coordination Mechanism (CCM) received a grant in the amount of $6.5 million from the GFATM for HIV prevention among vulnerable population groups and provision of treatment to people living with HIV/AIDS. Major scheduled activities include development of infrastructure for ART; drug procurement; and funding of NGOs delivering

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prevention work with highly vulnerable groups (20 percent of the budget). However some
difficulties have been reported in relation to its implementation. These included (i) blockage of
the implementation of the proposed syndromic management protocols for STIs by the dermato-
venereal establishment; and (ii) blockage of introduction of methadone substitution treatment by
the narcological establishment.

In addition, it was reported that there is severe fragmentation of the NGOs working in the
field, and an urgent need for support work to develop the capacity of NGOs, promote
consolidation and unified methods, and strategic leadership. The AIDS center works closely with
NGOs, which are financed by the GFATM grant and other donor assistance. Operations of most
NGOs depend on external funding. Termination of funding and/or lack of administrative support
may result in collapse of some NGOs.

Box 12. Kazakhstan GFATM grant

1. Reducing the vulnerability and risk behaviors of IDU, CSW and MSM
   a. Information, education, and counseling
   b. Needle exchange and disinfectants
   c. Substitution therapy
   d. Condom distribution
   e. More supportive legal and social environment
   f. Implemented through Regional AIDS centers, narcology centers, and a few
   nongovernmental organizations.

2. HIV/AIDS prevention interventions among youth
   a. Behavioral education
   b. Students and out-of-school youth
   c. Peer education
   d. Multiple outlets (primary through vocational schools, youth organizations)

3. Proposed policy changes (through advocacy and training)
   a. Softening criminal prosecution for illegal procurement and storage of drugs.
   b. Allowing substitution therapy for the management of opium/heroin addiction
      (now this is prohibited).
   c. Prostitution is now fully decriminalized; however police still harass and arrest
      CSW, and interventions with police are planned.
   d. More supportive and positive articles in the mass media, including when
      politicians are interviewed on this subject.

4. Training of health professionals in behavior change and improved infectious
disease control

5. Improve the accessibility and acceptability of STI treatment.
   a. One stop shopping for reproductive health, HIV testing and counseling, and STI
      treatment.
   b. Youth friendly services encouraged

6. Strengthening analytic capacity of government health system to better monitor
   indicators of success

7. Improve support for PLWH
   a. Expand ARV and opportunistic infection treatment using standard protocols
      and improved laboratory monitoring
   b. Correct antiquated approaches to compulsory HIV testing, deportation of HIV-
      positives, imprisonment of HIV-positives
   c. Public information campaign to eliminate stigmatization.

8. Prisons system project to assure HIV/TB treatment interaction
   a. IEC for prisoners on risks of interaction of these two diseases
   b. No needles, but disinfectant supplies and condom distribution allowed
   c. STI treatment provided

   implemented through Regional AIDS centers, narcology centers, and a few
   nongovernmental organizations.

   1. Reducing the vulnerability and risk behaviors of IDU, CSW and MSM
      a. Information, education, and counseling
      b. Needle exchange and disinfectants
      c. Substitution therapy
      d. Condom distribution
      e. More supportive legal and social environment
      f. Implemented through Regional AIDS centers, narcology centers, and a few
      nongovernmental organizations.

   2. HIV/AIDS prevention interventions among youth
      a. Behavioral education
      b. Students and out-of-school youth
      c. Peer education
      d. Multiple outlets (primary through vocational schools, youth organizations)

   3. Proposed policy changes (through advocacy and training)
      a. Softening criminal prosecution for illegal procurement and storage of drugs.
      b. Allowing substitution therapy for the management of opium/heroin addiction
         (now this is prohibited).
      c. Prostitution is now fully decriminalized; however police still harass and arrest
         CSW, and interventions with police are planned.
      d. More supportive and positive articles in the mass media, including when
         politicians are interviewed on this subject.

   4. Training of health professionals in behavior change and improved infectious
disease control

   5. Improve the accessibility and acceptability of STI treatment.
      a. One stop shopping for reproductive health, HIV testing and counseling, and STI
         treatment.
      b. Youth friendly services encouraged

   6. Strengthening analytic capacity of government health system to better monitor
      indicators of success

   7. Improve support for PLWH
      a. Expand ARV and opportunistic infection treatment using standard protocols
         and improved laboratory monitoring
      b. Correct antiquated approaches to compulsory HIV testing, deportation of HIV-
         positives, imprisonment of HIV-positives
      c. Public information campaign to eliminate stigmatization.

   8. Prisons system project to assure HIV/TB treatment interaction
      a. IEC for prisoners on risks of interaction of these two diseases
      b. No needles, but disinfectant supplies and condom distribution allowed
      c. STI treatment provided
The Kyrgyz Republic. The Government of the Kyrgyz Republic has grasped early the significance of the epidemics of HIV and sexually transmitted diseases for the country, and therefore Government ownership is strong. The Strategic Plan to control HIV/AIDS epidemic in the country was developed through a broad Government and NGO consultation process; and several Ministries have developed sectoral plans. This process was engineered by the Republican AIDS Center, also with technical and financial support from UNAIDS and other UN agencies. Most NGOs specializing on work with CSWs, IDUs, MsM and other highly vulnerable groups, contributed to the development of this strategy along with public institutions. The Kyrgyz Republic was among the first to develop, not only the Strategic Plan, but also sectoral programs based on the national strategy. The central Government commitment to fight HIV/AIDS is in place, but further advocacy is necessary to engage the Presidential Administration and national Government in the control of the epidemic. The GoK has already established coordinating bodies to guide the implementation of sectoral strategic plans to fight HIV/AIDS, TB and Malaria. The Second State program on the prevention of AIDS and infections of sexual and injecting transmission: 2001-2005, is designed to deliver a comprehensive and coherent package of policies and interventions through intersectoral action.

The Strategic Plan covers a number of important areas of policy reform; however, it does not address sufficiently the area of medications and treatment for ARV and opportunistic infections. Human rights issues are not highlighted, and it does appear as though there are substantial problems, not with the letter of the law, but with the enforcement practices related to IDU and CSW. Thus, although educational approaches are enumerated, the greatest challenge to policy effectiveness is likely to be in changing enforcement agency practices and public opinion. It is curious to see the establishment of a special “militia” related to CSW interventions; perhaps this is simply a translation problem, but it does appear as though decriminalization of prostitution is not planned. The new Plan builds on lessons learned from 1997-2000, when measures of compulsory testing and marginalization of vulnerable groups were more or less official practices.

The Kyrgyz Government recognizes the nascent epidemic, “impetuous drug abuse growth,” and social disruption as determinants. Major barriers include insufficient financing, lack of effective education, lack of targeted prevention, weak NGOs, stigmatization, and inappropriate legal structures and discrepant enforcement practices. Targeted interventions began in 1998, and HIV screening moved from universal to focused testing. The new Strategic Plan focuses on youth, IDU, and CSWs. It specifically mentions necessary improvements in the legislative environment, especially the repressive enforcement practices, and improvements in transparency of the response to HIV/AIDS. Blood safety is addressed, including laboratory capacity and personnel training. For youth, measures include behavioral research, school-based education, condom social marketing, teacher training, youth friendly medical services, and mass communication. IDU approaches include behavioral change, peer education, condom distribution, needle exchange, trust points, substitution treatment and rehabilitation program development, and legal protection for IDUs. The CSW objectives include peer education, condom marketing, legal reform, “establishing a specialized militia to assure law and order,” establishing a CSW hot line, establishing legal support for CSWs, and training of enforcement agencies.
Box 13. Kyrgyz Republic GFATM Grant

1. Improve multisectoral approach, including changing legal framework to support HIV programs.
2. Compulsory youth educational programs, youth friendly health services, peer education, and increased condom availability for sexually active youth.
3. Compulsory education for military servicemen.
4. IDUs
   a. Needle exchange programs
   b. Methadone maintenance programs
   c. Confidential testing and counseling for HIV
   d. Sexual behavior change and condom marketing.
   e. Improved clinical service availability for IDUs

2. Reducing vulnerability of CSWs and clients
   a. NGO based clinical service provision
   b. Condom access improvement
   c. STI treatment improvement and monitoring
   d. Peer education

3. Reduce prisoner vulnerability
   a. IEC
   b. Harm reduction (methadone, disinfection, needle exchange
   c. STI treatment improvement

4. Reducing vulnerability of MSM
   a. Preventive medical care
   b. Condom marketing
   c. IEC
   d. Research on behavior, prevention, etc.

5. Ensuring blood safety
   a. Voluntary blood donor program
   b. Improved, universal screening of donated blood
   c. Monitoring and information system

6. Provision of medical support to PLWHA
   a. VCT
   b. Sentinel surveillance and sociological surveys
   c. NGO strengthening
   d. 100 per cent coverage with ARV for those who need it.
   e. Targeting pregnant women who are at risk for HIV.
   f. Psychological counseling

There is a strong reliance on public education and broad based approach to information dissemination, along with special attention to the educational needs of vulnerable groups. STI treatment, sentinel surveillance, CSW outreach, and trust points for clinical services are called for. Special attention is given to counseling and where indicated, testing of pregnant women for HIV. Finally, psychosocial assistance for PLWHA is addressed, but not mentioning ARV treatment.
The Government in association with NGOs submitted a well designed proposed to GFATM: $5 million has been awarded to support the first 2 years of the program, with high levels of support going to NGOs. Targets are ambitious, including 60 percent drugs harm reduction coverage; and 80 percent of demand for methadone substitution to be met by 2007.

The grant areas of work include (with indication of percent of budget allocation): (i) strengthening of political and legal support (2 percent); (ii) reducing vulnerability of young people (20 percent); of injecting drug users (36 percent); sex workers and their clients (6 percent); prison inmates (4 percent); MSM (12 percent); (iii) ensuring safety of donors’ blood (18 percent); and (iv) medical and social support to HIV positive persons (18 percent). However, NGOs complain that no monies have been disbursed to support their work and that this is putting them into a serious funding crisis.

The CCM that was established to apply for the GFATM grant is chaired by the Deputy Prime Minister, and brings together members of the existing collective coordinating bodies: National Multisectoral Coordinating Committee on Prevention of HIV/AIDS, STI and Infections Transmitted by Injections; National Coordinating Committee on TB Control under the Presidential Administration; National Emergency Epidemics Control Commission, as well as members of technical expert groups, NGOs and international partner organizations. Implementation commenced in August 2003.

However, the functionality and effectiveness of the CCM are questioned by national and international stakeholders; and the mechanisms to secure the release of funds to NGOs are lacking. This may be due to weak institutional capacity. The donor community and most NGOs suggest that the CCM requires immediate assistance to become functional and be able to coordinate the multi-sectoral response in these critical areas. These organizations propose the establishment of a CCM Secretariat with well-trained staff to ensure adequate functioning of the CCM. Presently, secretarial functions are assumed by the Republican AIDS Center for the HIV/AIDS Program and by the TB Institute for TB Program. However, both institutions have not yet been able to provide adequate secretarial services, and after receiving the GFATM grants, became unwilling to share information on project activities and funding allocations. This upsets a broad range of national and international stakeholders that are involved in HIV/AIDS epidemic control; it triggers strong opposition, disrupts the necessary collaborative spirit and may become detrimental to the national response. Timely mitigation of the situation seems to be required to move the process back into a collaborative effort. The means to achieve this could be donor financing and support for an independent Secretariat for TB and HIV/AIDS under the Deputy-Prime Minister.

**Tajikistan.** The Tajik policy environment currently appears to be changing through a mix of the GFATM and Strategic Plan actions. The National Program on Prevention and Control of HIV/AIDS until 2007 establishes the National Coordination Committee, and defines financing, multisectoral commitments, and program directions.\(^{115}\) The Strategic Plan is well written and conceived on a scientific and culturally appropriate basis. It spells out specific

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multisectoral responsibilities and recognizes the deficiencies in the legislative/policy environment that need correction.

In 1997, the Government adopted a National Program on HIV/AIDS and STIs Control for the period of 1997–1998; and on 30 December 2000, the Government approved the new version of the National Program for the period up to 2007. Tajikistan’s National Coordination Committee on HIV/AIDS and STD Prevention is led by the Deputy Prime Minister and the importance of protecting IDUs from HIV prevention is accepted at the highest levels, including the Ministry of Justice and Internal Affairs of Tajikistan. However laws criminalizing people who knowingly spread HIV or sexually transmitted infections (STIs), as well as individuals who avoid examination or otherwise attempt to conceal their infection, remain on the books; and, together with police harassment and possible arrest for possession of even a used syringe, drive drug users underground. Actual responses through implementation of interventions have however been rather uncoordinated, and influenced by donor agendas, and coverage remains low.

Tajikistan is a Muslim country, but HIV/AIDS is acknowledged on a political level nonetheless. In this context, there is specific mention that condoms should be used to prevent STI and not as a family planning measure. With respect to HIV, mass screening was previously applied, but the laws now are more consistent with international standards of responsibility by the government for prevention and treatment. The criminal code addresses deliberate spread (i.e., with knowledge of infectivity status) of STIs, and this may create additional stigmatization of HIV infected individuals. Administrative and not criminal statutes address prostitution, but in reality, there appears to be extreme prejudice against CSWs. Narcotic use is illegal, and there is insufficient attention to drug sellers in the criminal code. In fact, even a contaminated syringe will be ground for arrest; thus, needle exchange programs could present a significant risk for both participants and providers. There is a poor supply chain for condoms, and need for improved manufacturing capabilities.

The Strategic Plan of the National Response to the HIV/AIDS epidemics for the period of 2002-2004 was elaborated. Specific attention was addressed to preventive activities among vulnerable groups: intravenous drug users, commercial sex workers, refugees, migrants, military servicemen, and youth as well as on provision for blood safety and prevention of parental HIV transmission. The GFATM grant provides for IDU and CSW interventions, VCT, laboratory strengthening to assure blood safety, and development of multisectoral support.

It is noteworthy that the Strategic Plan has specific recommendations regarding the management of sexually transmitted infections:

“The health reform, which is being prepared for implementation in the country, determines a decentralization of the STD service with a partial devolving of functions on treatment and surveillance over STD patients to common physicians working in the public health service network. An extension of anonymous and free of charge medical services to the population is being planned as well as a wider syndrome approach to the STD patients’ treatment. Establishment of new clinics for vulnerable groups is also
envisaged. However the process of reforming is only being discussed while the existing STD service does not meet requirements of the population.”

Donor support to Tajikistan to fight the HIV/AIDS epidemic has been increasing. UNAIDS has been providing assistance to the Government to develop the Strategic Plan, and adequate policies and legislation for HIV/AIDS prevention. Tajikistan was awarded $1.5 million by the GFATM to support implementation of the National Strategic Plan for two years, starting March 2003. The GFATM funding provides inputs to: (i) upgrade lab capacity with new equipment and supplies (test kits); (ii) carry out outreach work with IDUs and CSWs; (iii) carry out IEC for youth in general; and (iv) assure a safe blood supply in the country. However, the UN-TG has initiated additional resource mobilization, as total funding available is not sufficient.

**Box 14. Tajikistan GFATM Grant**

1. **IDU interventions:**
   a. IEC
   b. Needle exchange, disinfectants, condom distribution
   c. STI treatment
2. **CSW interventions:** IEC, VCT, STI treatment, decreased vulnerability
3. **Educational actions**
   a. Directed towards youth, including “derelict” children
   b. Teacher training
   c. STI, drug abuse prevention, HIV/AIDS prevention
   d. Health professionals
   e. Mass media
4. **Developing a more positive social environment (destigmatization)**
   NGO development; establishment of trust points to assist in needle exchange, VCT, etc.
5. **Laboratory investment to assure a safe blood supply.**
7. **VCT** (purchase of test kits).
8. **Cross sectoral support** from law enforcement, NGOs, health professionals, education, mass media, and government officials.

However, the magnitude of the threat, funding available for critical activities such as harm reduction, and loose coordination impair carrying out an adequate response to the growing epidemic. The donor-driven agenda resulted in clustered interventions, which mainly serve the donors’ agendas and marginally contribute to strengthening the national response. Competition emerges between national institutions and national NGOs for the limited donor funds, further disrupting the national response to HIV/AIDS and adequate coordination among various agencies involved. Immediate attention from the GoT and donors is therefore required. While donor assistance is forthcoming and expected to increase in coming years, HIV/AIDS has not been well understood by politicians at national and subnational level, requiring the GoT to clearly communicate the importance of the issue.
Turkmenistan. A Strategic Plan is not available at this time, although it may be under preparation. The law on HIV/AIDS Prevention was reviewed.\textsuperscript{116} It expressly deals with the rights of citizens and foreigners to confidential and anonymous testing for HIV. However, in other parts of the law, there is specific reference to mandatory testing, even of diplomats, for HIV. In addition, while there is mention of protection of job status for HIV infected persons, there is also specific mention of forcing job changes if there is a perceived threat of HIV spread from infected health system employees. Attention to the blood supply, safety of medications, and social support for HIV infected people are mentioned. Financing of preventive measures is addressed as is assurance of free medications for AIDS outpatients.

Reporting of HIV status appears to be mandatory. The Turkmen policy environment appears to be a mix of persistent Soviet approaches to mandatory testing, particularly of migrants and foreigners, while at least mentioning the right to confidentiality, medical treatment, and preventive measures. It seems as though the Law described above has been drafted to sustain both the previous approach to testing and personal responsibility for infectivity as well as newer concepts of human rights and government responsibility.

Uzbekistan. Given a very well written Strategic Plan, intensive donor assistance, and the GFATM grant that was awarded to Uzbekistan in 2004, the policy environment is likely to change considerably.\textsuperscript{117} The clear focus of the Plan is supported by detailed activities that if implemented and permitted through legislative reform, would have a significant positive effect on the concentrated epidemic. It does appear that there is significant official and public resistance to modern policy approaches, as there appears to be an entrenched culture of exclusion, misinformation, and criminalization of vulnerable groups. This will be perhaps the biggest challenge for the National Coordinating Committee – changing the social normative environment on HIV/AIDS.

\begin{itemize}
  \item Integration of HIV/AIDS into development programs
  \item Reforming legislation to increase attention to vulnerable groups for prevention
  \item Reducing susceptibility of high risk groups to risk behavior
  \item Implementing educational and awareness programs.
  \item Increasing accessibility, and quality of health services related to HIV/AIDS (includes blood safety and condom regulations, 100 percent ARV availability)
  \item Establishing a national coordinating mechanism.
\end{itemize}

The Strategic Plan recognizes the focus for HIV prevention on IDU, CSW, prisoners, and young people. Formally, drug use is not criminal, but in reality, IDUs are treated as criminals because of purchase and possession of illegal drugs. There does not appear to be ready access to replacement therapy, but arrested drug users are forced into compulsory treatment (essentially,\textsuperscript{116} Turkmenbashi S (2001). Law of Turkmenistan on Prophylactics of Disease, Caused by Human Immunodeficiency Virus (HIV-Infection). Ashgabad.\textsuperscript{117} Uzbekistan, Republic of (2002).
withdrawal therapy), which has been found to be ineffective and encourages isolation of drug users from medical, social, and legal systems. The quantity of drugs considered illegal is less than the usual dose for an addicted user. CSWs are also prosecuted under the administrative code, and homosexual acts are illegal. Thus, the legal code does not support a preventive environment for the most vulnerable groups.

HIV-infected persons are segregated in health care and in prisons. Reporting of HIV status is mandatory, and infected persons are subject to extreme control. Mandatory testing is also supported for certain groups, and thus testing is associated with extraordinary social and legal burdens. As for education, surveys show inadequacy of knowledge among young persons, and NGOs conduct most peer education programs. STI treatment is insufficient, centralized, inpatient oriented, and lacking in availability for the most vulnerable groups. ARV therapy is in general unavailable.

The response thus far to the HIV epidemic has been plagued by the previous Soviet system, insufficient governance, weakness of multisectoral coordination, lack of human rights-based approaches, and insufficient care and treatment. Prevention is insufficient as are social support mechanisms. A specific project on prisons has been developed, focusing on changing risk behavior through education, involvement of risk groups, and media communications. It is not clear that any harm reduction or improved therapy is involved in this proposed project.

However, the Government of Uzbekistan has been steadily building its commitment and capacity to respond to HIV/AIDS. Most recently, the government developed and approved the Strategic Program on Counteracting the HIV/AIDS Epidemic in Republic of Uzbekistan for 2003-2006. This document outlines the various roles and responsibilities of the Ministries of Health, Finance, Interior Affairs, Education, Justice and Labor & Social Protection of Population in managing the country’s response to HIV/AIDS. Issues related to HIV/AIDS are also incorporated into the Program for Reforming the System of Health Care in the Republic of Uzbekistan, which was adopted by the Decree of the President of Uzbekistan on November 10, 1998. In 1999, the Parliament passed a law to protect people living with HIV/AIDS from discrimination; the right to equal access to education, employment and social protection is guaranteed by this legislation, as is the right to free care from government health providers. The Republican Emergency Anti-Epidemic Commission for HIV/AIDS and this Commission has provided the foundation for the new multisectoral CCM. Uzbekistan has a general information, education and communications (IEC) strategy on HIV/AIDS, which includes specific initiatives for vulnerable groups most at-risk of contracting HIV. A letter on accelerated access to anti-retroviral drugs was signed by the Minister of Health and sent to WHO and UNAIDS.

In 1999, the Parliament passed a law to protect people living with HIV/AIDS from discrimination; the right to equal access to education, employment and social protection is guaranteed by this legislation, as is the right to free care from government health providers. However, legislative reforms required for adequate implementation of strategic program are far from being complete. Significant issues related to the drug use, CSW and MSM are still not addressed. e.g., every year approximately 7,000 IDUs are incarcerated due to the drug use. Issues related to HIV/AIDS were also incorporated into the Program for Reforming the Health Care System in the Republic of Uzbekistan, adopted by Presidential Decree; and are reflected in the Uzbek Health II Project.
However, there are also a number of negative factors within the risk environment. The Republican Emergency Anti-Epidemic Commission for HIV/AIDS has provided foundation for the new multi-sectoral CCM established prior to GFATM application submission. However, the CCM exists on paper but its effectiveness is questionable. State structures concerned with the prevention and treatment of infectious disease play akin to policing infected individuals; and notably within the Dermatovenereology service, militia are still involved in capturing segments of the population (particularly CSW) and bringing these compulsorily into the DVS. There is an attitude of closure and secrecy in relation to availability of official statistics describing HIV/STI and risk behaviors. The NGO sector exists; but is not flourishing or energetic in the same way as that in Kyrgyz. The Government has responded to the need for harm reduction projects by issuing a decree to set up a large number of ‘trust points’ which should deliver VCT as well as advice and harm reduction commodities; and does not significantly support NGOs in this work. These factors will need to be addressed if an effective scaled-up response is to be achieved. In addition low levels of knowledge on HIV/AIDS are likely to be an impediment to prevention.

The Government applied to GFATM for financial support to implement National Strategic plan and received $5.2 million for two years starting May 2004 (the contract has not yet been signed). The overall goal of the program is to prevent the spread of HIV/AIDS into the general population by reducing its impact on the most vulnerable populations. Objectives are a) effective prevention programs focused on the needs of vulnerable populations; b) access to care, support and treatment for people living with HIV/AIDS; and c) creation of an enabling environment that supports work with vulnerable populations. Activities for the first objective – effective prevention programs focused on the needs of vulnerable populations – include: harm reduction initiatives for IDUs (i.e., needle exchange, condom distribution, IEC campaigns and substitution treatment), outreach and peer education programs with sex workers and MSMs, IEC and condom distribution programs in prisons, school and community-based IEC/BCC programs for young people and improvements in STI services. Activities for the second objective – access to treatment for people living with HIV/AIDS – include: broad-based care and treatment services (e.g., ARVs, treatment for opportunistic infection, psycho-social support and palliative care) and MCTC. Activities for the third objective – development and implementation of policies to ensure that the enabling environment required to work with vulnerable populations exists in the country – include: education and advocacy campaigns targeting policy makers and opinion leaders in Uzbekistan, training for journalists on HIV/AIDS and improvements in surveillance policy and practice. About 60 percent of the funds are earmarked for Government structures and 35 percent for NGOs.

Regional Agreements and Partnership Programs

Experience with regional cooperation in Central Asia is rather limited and somewhat disappointing (a summary of regional Agreements signed by the Central Asia Governments is attached). However, Central Asia Governments have already initiated regional activities to tackle the drug problem that is at the root of the HIV/AIDS epidemic in ECA. In 2002, they met in Tashkent to agree on a drug supply and drug demand-reduction strategy. As mentioned before, most regional Governments have taken early action to prevent and treat HIV/AIDS by approving
appropriate strategies, initiating HIV/AIDS programs based on work with groups at risk (establishment of Trust Points), and securing additional funding from the Global Fund and other sources. In addition, several partner organizations have been actively engaged in advocacy and support to the implementation of the strategies.

After the September 11, 2001, terrorist attacks in the United States, Central Asia became more geopolitically important, and hence the need for political and economic stability has attracted significant international assistance in several different sectors, including military cooperation, humanitarian aid, economic development programs, agriculture, education, and health. The World Bank has made significant investments in health systems development projects and in specific public health projects in this region. Various bilateral donors have made and are considering investments through technical assistance, grants and credits geared towards drug use demand reduction, infectious disease prevention and control (especially sexually transmitted diseases and tuberculosis), and HIV. What is important to recognize here is the need for a broad-based approach that considers structural and environmental approaches (including legislation and policy) at several levels:

- Superstructural, including gender and social inequalities that increase risk for women and other vulnerable groups;
- Structural, including laws or policies at both national and institutional levels that interfere with prevention activities;
- Environmental, including local factors that include lack of access to condoms, lack of status for migrants, or adverse social norms regarding ethnic minorities;
- Individual, including lack of knowledge about risks and lack of access to appropriate services.

Significant support has become available for prevention and treatment of HIV/AIDS in Central Asia. Governments and partner organizations have been providing significant technical and financial assistance. However, there are significant gaps in coverage of highly vulnerable and vulnerable groups. These gaps are partly due to insufficiency of funding, partly to lack of coordination among the different stakeholders and lack of capacity to implement the agreed strategies.

**Regional Drug Control.** Interdiction has been one of the more controversial areas in drug control policy. It is difficult to evaluate whether support for such programs creates honest, efficient law enforcement or only empowers officials involved in trafficking to smuggle better. Certainly the war in Afghanistan opened borders to increased trafficking because of economic pressures and lack of governance. The economy of this country may have more to do with solving the trafficking problem than any law enforcement or public health program. Supply reduction cannot work without a concurrent reduction in demand. With respect to interdiction, a balanced, even-handed political approach is needed. Drug trafficking is ultimately a development issue and thus cannot be addressed by law enforcement alone. It is also closely related to human rights, gender issues, and government corruption. Supply-side programs require

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118 USAID (2003a)
119 UNAIDS Best Practice Collection (2002).
120 Lubin N, Klaits A, and Barsegian I (2002).
greater transparency, coordination, local involvement, long-term funding, and clear linkage to harm reduction and the treatment of drug addiction.

In 1996, Governments of Central Asia signed a Drug Control Agreement, and since 2002 have been carrying out regular assessments through the national Drug Agencies with assistance from UNODC. These national and international agencies have been recently shifting from simple control of drug supply to drug demand reduction (DDR) strategies and prevention of HIV/AIDS. UNODC activities focus on DDR and HIV prevention; border control, law enforcement and strengthening the judicial system. A particular focus is on legal assistance programs and harmonization of legislation.

UNAIDS and the UNODC sponsored a needs assessment on drug abuse in Central Asia. The main findings and recommendations of this study reinforced the background information on socioeconomic disruption, increases in drug trafficking, and difficulties in measuring the exact size of the drug abuse problem. It called for a balance of activities between supply reduction through the legal system and law enforcement systems; and demand reduction through expanded services for drug users and increased prevention work among young people. The political response has shifted somewhat from neglect and punishment to mobilization for prevention. It was noted that governments in the region have demonstrated a willingness to act on drug use as a critical part of HIV prevention.

Kazakhstan has a nationwide network of governmental rehabilitation centers and a research center. The Kyrgyz Republic is the first country to have implemented methadone substitution projects in a decentralized design. The Tajik Drug Control Agency acts as a focal point for supply as well as demand reduction. Turkmenistan has a centralized system of drug abuse control, but most services are provided by NGOs, targeting special populations and prisoners. Uzbekistan has a national system of governmental and NGO Trust Points that serve IDUs with outreach and peer education. In general, there is still authoritarian command, with fear and punishment as hallmarks for ‘prevention’ activities. Counternarcotics efforts often facilitate human rights abuses for marginalized populations. There is also over reliance on the medical approach that depends on facilities and treatments at the expense of outreach prevention and harm reduction. Again, harm reduction, increased substitution therapy, decentralization, improved access to services, destigmatization, and increased education of health providers are key to addressing this co-epidemic for HIV/AIDS.

UNODC currently has 3 projects under the umbrella of drug demand reduction (DDR):

- Diversification of prevention, with a budget of $500,000 for the 5 regional countries (of which $50,000 are grants for each country, and the rest finances regional activities and staff). UNODC works with service delivery institutions and aims at strengthening coverage through needle exchange, drug replacement programs and outreach/community activities, and improvement of quality of services. Pilot regions have been selected in the Kyrgyz Republic (Bishkek and Osh); Tajikistan (Khojand and Dushanbe); Kazakhstan (Shymkent and Krasnodov); and Uzbekistan (Tashkent). In these regions, mapping of

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services, and a training needs assessment is done, and local implementing agencies have been selected (in Tashkent: Narcology Centre);

- Drug prevention, with a budget of $400,000 for 2004-2005 to finance information campaigns to raise public awareness, and work with NGOs;

- Policy advice on DDR to Governments, with a budget of $400,000 for 2004-2005. Under this component it is planned to have a long-term HIV/DDR adviser partly funded by UNAIDS, to be based in the Tashkent office from June/July 2004. Activities comprise raising awareness on prevention and DDR issues of governments that currently concentrate on law enforcement; and

Another project is planned to train professionals in DDR, with an estimated cost of $1.5 million, but funding has not yet been assured. Activities would comprise the development of training courses and integration of focused training into existing curricula. In addition, the UNODC Research Analysis Unit in Tashkent maintains a regional database on main trafficking routes, drug abuse, and HIV/AIDS. The data is collected from local counterparts and law enforcement agencies regularly. UNODC is willing to share this information, including in the context of the pilot partnership that has been developing with the Bank in the region. DFID and the Bank will carry out a regional mapping exercise that will include information on movement of people (CSWs, trafficked people, refugees, labor migrants, traders, truck drivers, travel, customs and law enforcement staff, etc) and goods (especially drugs) along regional corridors – possibly the Northern Corridor and the Silk Route -, and STIs and HIV/AIDS cases. Both agencies – DCA and UNODC – have expressed willingness to assist the development of this regional mapping exercise.

**UNAIDS Regional Strategy.** UNAIDS has developed strategic priorities to control the concentrated and nascent epidemics of HIV/AIDS in Central Asia. In the context of this regional strategy, UNAIDS has been providing support to all countries in Central Asia to approve and implement National Strategic Plans and sectoral strategies, as well as updating the legal framework for prevention of HIV/AIDS. Other UN agencies, such as UNICEF and UNFPA, also have regional programs, but the scope of their HIV/AIDS activities is limited.

UNAIDS Regional Strategy has three main objectives:

- To expand coverage of HIV prevention among injecting drug users to a minimum level of 60 percent;
- To strengthen prevention and care of sexually transmitted infections;
- To develop comprehensive programs for young people’s health, development and protection.

In accordance with these directions, UNAIDS established the Task Force on IDU hosted by UNAIDS in Vienna; the Interagency Group for Young People’s Health Development and Protection, hosted by UNICEF in Geneva; and the STI Task Force hosted by WHO in Copenhagen. These task forces involve numerous multi-lateral organizations, bilateral partners, non-governmental organizations, private foundations, academic institutions, and professional associations. The UNAIDS Task Force on HIV Prevention Among Injecting Drug Users In
Eastern Europe and the Newly Independent States advocates a comprehensive approach to HIV prevention among IDUs involving:

- Information and awareness raising
- Skills building
- Outreach activities
- Peer education and peer support
- Needle exchange
- Condom promotion and counseling
- Effective drug treatment, including substitution therapy.

These approaches are recognized as effective in other regions and should be adapted to the cultural, social, and economic realities of Central Asia. The underlying concept is to influence IDUs to change behavior, both needle sharing and sexual, to reduce the spread of HIV from concentrated populations to the general public through bridge populations such as sexual partners.\(^\text{122}\)

The United Nations produced a consultative report on what UN agencies should do in response to the IDU-related epidemic of HIV/AIDS globally. The main findings of this report are:

- Needle and syringe programs are a component of a comprehensive package for HIV/AIDS prevention among injecting drug users.
- The response to HIV/AIDS should be strengthened within UNODC, and it has a responsibility to scale up activities on HIV/AIDS given its channels of communications to respective government entities and civil organizations. However, specific expertise on HIV/AIDS needs to be added to UNDCP offices.
- WHO has little country capacity specific to HIV/AIDS among drug users, but has the most important role to play in prevention through training and capacity building.
- The country-level response is complex due to differences in the extent of the epidemic among IDUs; the characteristics of the drug users, national laws, legal provisions and policies towards IDUs; public opinion and stigmatization; the status of civil society organizations; and the technical capacities of UN offices in each country.

The report calls for development of country-specific strategies based on common country assessments. Two Central Asian countries - Kazakhstan and Uzbekistan - were included in the assessments made for this report.\(^\text{123}\)

The UN Interagency Group on Young People’s Health Development and Protection seeks to establish a common agenda for programming on adolescent health and development.\(^\text{124}\) This is described as a rights-based approach involving agencies that concentrate on the health of young people. It focuses on advocacy for favorable policies; information, education, and communications strategies; providing adequate and confidential health, counseling, and other

\(^{122}\) UNAIDS (2002 a).
\(^{123}\) Kroll C (2002).
services for young people; research and analysis to evaluate program effects; capacity building and developing best practices; and ensuring the participation of young people in local strategy development. The core mechanisms for efforts in the region have involved joint work plans on peer education and life skills and Youth Friendly Services.\footnote{UNAIDS (2002b). UN Interagency Group for Young People’s Health Development and Protection in Europe and Central Asia (IAG). May 22. UNICEF, Geneva.} Examples of actions to date are:

- Peer education assessments, peer training workshops, and materials development
- Life skills education in several ECA countries, including Central Asia; analysis of out-of-school approaches to life skills training; and assessment of health promoting school programs, life skills, and peer education.
- Assessment and strategic planning on Youth Friendly Services.
- Social mobilization and advocacy training and strategy development.
- Rapid assessment and response (RAR) studies in several ECA countries in preparation for the development of grant applications to the Global Fund to Fight AIDS, TB, and Malaria.

In addition, UNICEF developed a Medium Term Strategic Plan (2002-2005) as an explicit priority for the agency. In conjunction with other core commitments (girls’ education, integrated early childhood care and development, immunizations, health systems development, and child protection), four priority areas are identified for action:

- Prevention of HIV infection among young people (information, life skills, access to services, and safer behaviors);
- Prevention of Parent-to-Child transmission of HIV (PMTCT)
- Providing care for children and parents living with HIV;
- Ensuring protection, care and support for orphans and children in families vulnerable to HIV/AIDS.

In the context of both development and emergency responses, reforms are sought in terms of residential institutions, juvenile justice, community capacities to care for the most vulnerable young persons, and policy advocacy. UNICEF also supports the International Harm Reduction and Development Network (IHRD), which targets needle exchange, substitution therapy, and outreach to marginalized groups. UN involvement is in general weak in this field, but it has potential as emergency response, especially to very underserved minorities such as Roma. Directions for UNICEF include training on IDU programming, development of a common approach among agencies on advocacy, partnership development, focusing PMTCT targeted to IDUs or partners of IDUs through harm reduction networks, and funding pilot/model projects.

For infected young persons, strategies to meet their psychosocial needs as well as health, legal, and employment issues require a continuum of care approach; this should also include orphans of AIDS victims. As such projects are scaled up, it is recognized that greater government ownership is necessary. One particularly important emergency function supported by UNICEF was the Rapid Appraisal and Response research undertaken in several Central Asian countries. However, UNICEF policy is clear in that it will not take on the role of direct service
provision. Rather, it could help to ensure supply and entry points to address young persons. It would not supply needles and syringes for exchange programs.\textsuperscript{126}

The 18 countries originally targeted for STI Task Force work in Eastern Europe in 1998 included the Central Asian countries of Kazakhstan, Kyrgyz Republic, Tajikistan, Turkmenistan, and Uzbekistan. The task force recognized the concurrent epidemics of STIs and unsafe sexual behavior as cofactors for HIV transmission, the issues of trafficking and increased use of intravenous drugs in the region, and the underlying adverse socio-economic factors leading to poverty, sex work, migration, human trafficking, and lack of social cohesion. Funding for the STI Task Force secretariat has been provided by DFID, OSI/Soros Foundation, USAID, WHO, and UNAIDS (WHO Europe 2002). The main recommendations of the STI Task Force involve:

- Increasing access and affordability of services for STIs;
- Humanizing existing STI services;
- Including STI programs in health reform processes, especially case management at the primary care level and strengthening STI services within reproductive health services;
- Reaching out to marginalized groups to insure access to STI/HIV prevention and care, with associated legal and environmental changes needed to implement this activity;
- Promoting knowledge and skills for safer sex, especially among youth.

**USAID Regional Strategy**\textsuperscript{127}. USAID has been providing significant financial and technical support to control of communicable diseases, including HIV/AIDS, STIs and TB, in Kazakhstan, Kyrgyz Republic, Tajikistan, and Uzbekistan. USAID recognizes the rapid rise in HIV incidence in Central Asia and the nature of the concentrated epidemic among highly vulnerable groups, especially IDUs, CSWs, migratory populations, and bridging populations. It has developed a strategic program designed to prevent drug use among vulnerable youth and to control HIV spread among high risk groups. Among other activities, USAID has been financing:

- Control of infectious diseases, including establishment of HIV/AIDS sentinel surveillance (but not STI surveillance), with assistance from CDC.
- The Drug Demand Reduction Program (DDRP) aims at changing attitudes and practices among vulnerable groups of population. The program is financed until the end of 2005, and is implemented by a consortium of five agencies led by the Soros Foundation Kazakhstan.
- The four partner organizations are Population Services International (PSI), AIDS Foundation East-West (AFEW), Internews and Akkord. DDRP includes five components: i) professional training; ii) youth; iii) prisoners and commercial sex workers iv) refugees, migrants, displaced persons, and v) activities aiming at policy development. While the project aims to cover all critical areas, limited funds do not allow reaching fully highly vulnerable and vulnerable groups. There is no harm reduction component to this project.
- Condom Social Marketing is implemented by PSI and aims at increasing demand and improve access to condoms at subsidized price.

\textsuperscript{126} UNICEF (I2001); UNICEF (2002)  
\textsuperscript{127} USAID (2002). *USAID’s Strategy on HIV/AIDS Prevention in Central Asia 2002-2004.* Available at  
The CAPACITY project will focus on capacity building for implementation of grants from GFATM and other large grants. Activities will include training and developing institutions and networks in the CAR to provide technical backup for implementation of HIV/AIDS programs at the national and regional levels.

Certain aspects of harm reduction programs, such as HIV testing and counseling, treatment of tuberculosis and other opportunistic and concomitant infections, syndromic case management of sexually transmitted infections and other ancillary services are financed by USAID. However, the US Government funds are not used to purchase or distribute equipment used for injecting illegal drugs, nor is illicit drug use condoned. Community outreach about the risk of injecting drugs, sharing needles, and the need for HIV testing and counseling is supported. In addition, in conjunction with the US Centers for Disease Control and Prevention (CDC), substantial resources are devoted to HIV/AIDS surveillance system development, blood safety, infant mortality prevention, and epidemiological training.

CDC will implement second generation HIV surveillance in four of the Central Asian Republics, using WHO recommendations to improve collection, analysis, and use of data from highly vulnerable groups. This is what is known as sentinel surveillance, which focuses primarily on injecting drug users and their partners and overlapping risk groups such as CSWs. This depends on the availability of laboratory test kits, which now include oral testing technologies (OraSure). Laboratory development for confirmatory testing procedures as well as surveillance of drug resistance are also high priorities. These also address needs for assuring safe blood supplies in the target countries. In addition, behavioral surveillance for risk factor data will be supported, and policy changes based on these data can be recommended. CDC now recommends HIV testing to be incorporated into routine medical practice when dealing with high risk groups, and thus it is assumed that such recommendations will be incorporated into USAID program inputs.

USAID also supports a Regional research strategy to describe sexual and injection drug use networks in cities with highest HIV incidence. This helps to describe the extent of youth participation in the networks, the AIDS transmission routes and protective behaviors, and exposure by targeted groups to preventive measures.

**DFID Project.** DFID will provide about $12 million over a four-year period (2004-2008) to improve the response to HIV/AIDS in Central Asia. The regional DFID program will support an enhanced regional response and the national programs in four countries (Kazakhstan, Kyrgyz Republic, Tajikistan, Uzbekistan). The grant will: (i) provide flexible and responsive TA to support a harmonized approach in the region supporting the UN principles of one national body, one national program and one national monitoring system; (ii) directly support the implementation of national harm reduction programs building on the capacity of civil society and

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national systems; and (iii) effectively work with the World Bank on design and implementation of the proposed regional project ensuring alignment of efforts. The goal of the DFID funded intervention will be to contribute to the aversion of a generalized HIV epidemic in the Central Asia region. The purpose will be to ensure effective implementation of comprehensive, national HIV/AIDS programs.

The DFID regional HIV/AIDS intervention is fully consistent with DFID’s regional strategy, where HIV/AIDS is identified as a priority area, and the overall DFID policy on HIV/AIDS, as encapsulated in the UK’s ‘Call for Action’ paper. The strategic approach emphasizes an appropriate balance between prevention, care and impact mitigation and the importance of a national response and political leadership. It recognizes the needs and rights of vulnerable groups and highlights the increasingly important role of treatment in national programs with a focus on increased access and equity of distribution.

The key pillars of the proposed DFID program will be:

- Assistance (TA) for effective coordination across the region in the development, implementation and monitoring of national HIV programs, including effective use of Global Funds
- Direct support to implementation of national HIV programs through harm reduction in vulnerable groups (Kyrgyz Republic, Tajikistan, Uzbekistan)
- Assistance (TA) to the proposed regional initiative to support priority civil society interventions (highly vulnerable groups, migration, drug and human trafficking).

The principles of implementation of the DFID grant will be:

- Harmonized approach under national leadership, working towards full alignment behind a single national program. The DFID project will not set up parallel systems.
- Supporting the UN ‘Three Ones’
- Joint monitoring and evaluation missions supporting the national system
- Strengthening existing political commitment across the region
- Supporting the development of an effective civil society reflecting the needs of poor and vulnerable groups

DFID’s grants at the country level will become available towards the end of 2004. Part of the DFID grant will co-finance with IDA the proposed Central Asia AIDS Project, which is expected to become effective in 2005.
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<th>Regional Agreements</th>
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<tbody>
<tr>
<td>CIS AIDS Agreement Emergency action program among Commonwealth of Independent States (CIS) on counteracting the HIV/AIDS epidemic May 30, 2002</td>
<td>Implementation of regional and national strategies for counteracting the epidemic and ensure their implementation with resources from national budgets and other sources, including international assistance</td>
<td>Council of Heads of Government of CIS</td>
<td>Implementation of specific activities through ministries and agencies of CIS countries</td>
<td>CIS states in CAR, except Turkmenistan (which has not endorsed the agreement)</td>
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<tr>
<td>Drug Control Agreement Memorandum of Understanding on drug control cooperation between the Governments of Central Asia countries and UNODC May 4, 1996</td>
<td>Strengthening drug, crime and terrorism control measures through technical cooperation programs and projects</td>
<td>Executive Committee of CIS for coordination of issues related to Program implementation</td>
<td>Yearly Program review by CIS Council on Cooperation in Public Health</td>
<td>All countries in the region</td>
</tr>
<tr>
<td>Central Asia AIDS Declaration Regional Conference on HIV/AIDS Almaty, May 16-18,</td>
<td>Commitment to scale up national responses to HIV/AIDS</td>
<td></td>
<td>Regional office based in Tashkent and country offices</td>
<td>Kazakhstan, Kyrgyz Republic, Tajikistan, Uzbekistan. Turkmenistan was not represented but pledged support</td>
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<td>2001 Central Asian Interstate Commission on Sustainable Development (CA-ICSD) and Central Asia Regional Environmental Center (CAREC) Charter</td>
<td>Preparation and implementation of an agenda and model to address priority environmental, social and economic problems by establishing partnerships between Governments and other sectors for development and implementation of the Central Asian Sustainable Development Strategy and Convention.</td>
<td>ICSD has a coordination and political role</td>
<td>CAREC provides financial and technical support. CA Governments provide technical and institutional support. Private sector and international organizations will also participate in the project.</td>
<td>Kazakhstan, Kyrgyz Republic, Tajikistan, Turkmenistan and Uzbekistan. International organizations: ICSD, CAREC, UNECE, OSCE, UNCSD, UNDP, UNEP.</td>
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<td></td>
<td>Organization of training seminars to disseminate information through an expert network and establish an accessible database.</td>
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<tr>
<td>Central Asian Cooperation Organization (CACO)</td>
<td>Development of cooperation for exchange of information, economic</td>
<td>Elected chairman of the CACO: President of KZ Council of Heads of State</td>
<td>National coordinators for special tasks</td>
<td>Signed by all CAR countries.</td>
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<td><strong>Regional Agreement</strong></td>
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<td>February 2002</td>
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<td><strong>Central Asia</strong></td>
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<td>Transboundary</td>
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<td>Biodiversity Project</td>
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<td>(GEF-funded)</td>
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|                       | co-operation, and long-term action to prepare joint reports and broaden political, social and other ties | Council of Prime Ministers
Council of Ministers of Foreign Affairs | Regional Project Implementation Unit in the Ministry of Environmental Protection of the Kyrgyz Republic | Kazakhstan, Kyrgyz Republic, Uzbekistan |
<p>|                       | Improvement and harmonization of national legal and regulatory frameworks and establishment of a trust fund that could finance long-term biodiversity conservation activities Improved regional coordination and support of a regional trans-national supervisory committee | Regional Steering Committee includes members of National Steering Committees responsible for overall project and trans-national coordination National Steering Committee includes Ministry of Finance Sector Ministries State Environmental Agency Regional authorities scientific community NGOs | Country PMUs in line ministries in each participating country |                                          |
|                       |               |                        |                              |                                          |
| <strong>Central Asia</strong>       |               |                        |                              |                                          |
| University             |               |                        |                              |                                          |
| 1997: International Commission to plan the University |               |                        |                              |                                          |
| 2000: International    |               |                        |                              |                                          |
|                       | Single international institution, private and self-governing university | The Aga Khan is | Board of Trustees also bears full responsibility for its overall direction and day-to-day management. Trustees name a Rector, | Kazakhstan, Kyrgyz Republic, and Tajikistan Other countries can join the treaty at any time |
|                       |               |                        |                              |                                          |</p>
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<td>Several Water-related Treaties Syr Darya River Basin 1990s</td>
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<tr>
<td>Funded by individual donors, private foundations, international corporations, international development agencies and national Governments in the developed world, with University’s endowment of $15 million sponsored by the Aga Khan</td>
<td>All treaties failed because of short-term unilateral planning and weakness of enforcement mechanisms, which created a mentality of non-compliance</td>
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<tr>
<td>Fully independent Board of Trustees governs the University and will have legal ownership of its physical plant and other assets. Board of Trustees comprises representatives of participating countries and from other countries</td>
<td>Interstate Water Coordination Commission</td>
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<tr>
<td>Chancellor of the University</td>
<td>Rector is responsible to the Board of Trustees</td>
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