An Assessment
of the HIV/AIDS Epidemic in Central Asia
and
the Central Asia AIDS Control Project

Establishing Regional Mechanisms
to Support National HIV/AIDS Programs

Nedim Jaganjac
Boris Sergeyev
The World Bank, 2011
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preface</td>
<td>i</td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>i</td>
</tr>
<tr>
<td>List of Abbreviations</td>
<td>ii</td>
</tr>
<tr>
<td>List of Figures</td>
<td>iii</td>
</tr>
<tr>
<td>List of Tables</td>
<td>iii</td>
</tr>
<tr>
<td><strong>Executive Summary</strong></td>
<td>1</td>
</tr>
<tr>
<td><strong>Introduction</strong></td>
<td>8</td>
</tr>
<tr>
<td><strong>Part 1: The HIV/AIDS Epidemic in Central Asia</strong></td>
<td>12</td>
</tr>
<tr>
<td><strong>Socio-Economic Context</strong></td>
<td>12</td>
</tr>
<tr>
<td><strong>Drivers of the HIV Epidemic in Central Asia</strong></td>
<td>14</td>
</tr>
<tr>
<td>Behavioral Drivers</td>
<td>14</td>
</tr>
<tr>
<td>Injection Drug Use</td>
<td>14</td>
</tr>
<tr>
<td>Heterosexual Transmission</td>
<td>16</td>
</tr>
<tr>
<td>Sex Work</td>
<td>17</td>
</tr>
<tr>
<td>Men Who Have Sex with Men (MSM)</td>
<td>18</td>
</tr>
<tr>
<td>Mother-to-Child Transmission (MTCT)</td>
<td>18</td>
</tr>
<tr>
<td>Structural Drivers</td>
<td>18</td>
</tr>
<tr>
<td>Unsafe medical procedures</td>
<td>18</td>
</tr>
<tr>
<td>Lack of Financial Resources</td>
<td>20</td>
</tr>
<tr>
<td><strong>National Responses to the HIV/AIDS Epidemic</strong></td>
<td>22</td>
</tr>
<tr>
<td>International Support and Regional Civil Society Organizations</td>
<td>22</td>
</tr>
<tr>
<td>National Health Systems and HIV/AIDS</td>
<td>24</td>
</tr>
<tr>
<td>Financing HIV/AIDS Activities in Central Asia</td>
<td>25</td>
</tr>
<tr>
<td><strong>Part 2: The Central Asia AIDS Control Project and Regional Cooperation</strong></td>
<td>28</td>
</tr>
<tr>
<td><strong>Background</strong></td>
<td>28</td>
</tr>
</tbody>
</table>
Project Design and Approach

Implementation of CAAP

Specific Achievements of the CAAP Program

Component 1 - Regional coordination and policy development
- Regional System of Sentinel Surveillance for HIV
- Electronic Surveillance (ES) System on HIV Infection
- The Central Asian Inter-Regional Parliamentary Working Group on HIV
- The Central Asian Islamic Conference on HIV/AIDS
- The Journalists’ Training Program on HIV Awareness and Stigma Reduction
- Regional Training of Trainers Centers

Component 2 – Regional AIDS Fund
- Primary Prevention among Youth
- Public Awareness Campaign at Uzbekistan Airlines
- Increasing Coverage of Vulnerable Groups: The TUMAR Project
- HIV Prevention among Migrant Workers in Central Asian Countries
- Linking HIV Prevention and Social Development Projects
- HIV Testing among Migrants and their Family Members in Bukhara
- Providing Legal Help to Members of Vulnerable Groups
- The Department for Planning, Analysis, Response and Coordination

Regional cooperation

Lessons from CAAP: Comparative Advantages of the Regional Approach

Annex 1. Brief information on the activities of international partners in the field of HIV/AIDS in Central Asian region

Bibliography
Preface

This paper is prepared by the group of specialists led by Nedim Jaganjac, Senior Health Specialist of the World Bank, and with participation of Boris Sergeyev (Consultant of the World Bank), Zakir Kadirov, Bekzod Parmanov and Tatyana Surdina (Central Asia AIDS Control Project - CAAP). Other staffs of CAAP at regional and national levels also provided their support in arranging interviews with key experts, providing epidemiological data and project-related information.

Acknowledgments

The team would like to express its gratitude to key experts who shared their assessments and views about CAAP’s contributions to stemming the spread of HIV in the region. Special thanks go to the Ministries of Health and the National Centers for Prevention and Control of AIDS in Kazakhstan, Kyrgyz Republic, Tajikistan and Uzbekistan, who were directly involved in implementing the Central Asia AIDS Control Project. Team also highly appreciate the contributions of international partners working in the area of HIV and AIDS who took an active part in preliminary discussions and shared their valuable comments during the preparation of this report. The Bank’s senior management conceived importance of this study and provided its support and guidance in undertaking the assessment.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>CAAP</td>
<td>Central Asia AIDS Control Project</td>
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<td>CAD</td>
<td>Cardiovascular disease</td>
</tr>
<tr>
<td>CARISA</td>
<td>Central Asia Regional Information System</td>
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<tr>
<td>CCM</td>
<td>Country Coordination Mechanism</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CIS</td>
<td>Commonwealth of Independent States</td>
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<tr>
<td>CMCC</td>
<td>Country Multi-sectoral Coordination Committee</td>
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<tr>
<td>CRIS</td>
<td>Country Response Information System</td>
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<tr>
<td>DFID</td>
<td>Department for International Development of United Kingdom</td>
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<tr>
<td>DOTS</td>
<td>TB Directly Observed Therapy Short-Course</td>
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<tr>
<td>EurAsEC</td>
<td>Eurasian Economic Community</td>
</tr>
<tr>
<td>GFATM</td>
<td>The Global Fund for AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HR</td>
<td>Harm Reduction</td>
</tr>
<tr>
<td>IDA</td>
<td>International Development Association</td>
</tr>
<tr>
<td>IDU</td>
<td>Intravenous Drug Users</td>
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<tr>
<td>IOM</td>
<td>International Organization for Migration</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MoU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>MTCT</td>
<td>Mother-to-Child Transmission</td>
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<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>NTEC</td>
<td>National Technical Evaluation Committee</td>
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<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
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<td>RAF</td>
<td>Regional AIDS Fund</td>
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<tr>
<td>RPMU</td>
<td>Regional Project Management Unit</td>
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<tr>
<td>RSC</td>
<td>Regional Steering Committee</td>
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<tr>
<td>RTEC</td>
<td>Regional Technical Evaluation Committee</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>SW</td>
<td>Sex Worker</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Program on HIV/AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Program</td>
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<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<tr>
<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1</td>
<td>Reported new HIV infections among Central Asian population, 2000-2010</td>
<td>1</td>
</tr>
<tr>
<td>Figure 2</td>
<td>Number of People Living With HIV Globally 2000-2009</td>
<td>8</td>
</tr>
<tr>
<td>Figure 3</td>
<td>Number of New Cases Globally 1990 – 2009</td>
<td>9</td>
</tr>
<tr>
<td>Figure 4</td>
<td>Newly Registered Cases in Central Asia, 2000-2010</td>
<td>10</td>
</tr>
<tr>
<td>Figure 5</td>
<td>Transmission Sources by Region, 2008</td>
<td>14</td>
</tr>
<tr>
<td>Figure 6</td>
<td>Transmission Sources in Central Asia: Injecting Drug Use vs Sexual</td>
<td>17</td>
</tr>
<tr>
<td>Figure 7</td>
<td>HIV transmission routes among citizens of the Kyrgyz Republic, 2010</td>
<td>19</td>
</tr>
<tr>
<td>Figure 8</td>
<td>Dynamics of disbursement under small grants – RAF</td>
<td>38</td>
</tr>
</tbody>
</table>

LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Newly Registered HIV Cases in Central Asia</td>
<td>10</td>
</tr>
<tr>
<td>Table 2</td>
<td>GFATM’s Funding for HIV-related Programs in Central Asia</td>
<td>27</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

Newly-diagnosed infections are rising rapidly in Central Asian countries, with particularly sharp and recent increases registered in Kazakhstan, the Kyrgyz Republic and Uzbekistan, in one instance representing a 4-fold jump in only six years. Although Central Asian epidemic is still largely at the concentrated stage, there is clear evidence that the epidemic is also spreading to the general population. This report reviews the HIV/AIDS situation in Central Asia, assesses the status of key issues which act as pillars of an effective response, and reviews the effectiveness of the World Bank’s Central Asia AIDS Program (CAAP), which provides lessons learned for an effective regional response to the epidemic.

Figure 1: Reported new HIV infections among Central Asian population, 2000-2010

Drivers of the HIV Epidemic in Central Asia

Injection drug use is one of the most significant behavioral drivers. Geographic proximity to the opium-growing areas in Afghanistan places the region along significant drug-trafficking routes, with an increasing volume of heroin being consumed inside the Central Asian transit countries. Although the
link between HIV and drug use varies by country, HIV prevalence among drug users in some countries raises the question of whether the epidemic has reached the point where it is self-perpetuating within certain populations. Unsafe injection practices are common, and regional programs for IDU behavior modification and rehabilitation are woefully inadequate.

**Heterosexual transmission is another key behavioral driver.** The steady trend across Central Asia is a growing share of HIV cases attributable to sexual transmission. Women are increasingly becoming infected, with sharp increases in some countries over a very short time period. Unprotected sexual contact between drug users and their non-drug-using partners increases the potential for the epidemic to spread to the general population.

**Sex work also plays a role.** Although there are religious and legal restrictions against sex work in Central Asian countries, commercial sex workers exist in significant numbers across the region. The overlap between sex work and injection drug use is also considerable. Sexually transmitted infections among sex workers are high in some countries. Other behavioral drivers that the paper considers include men who have sex with men and mother-to-child transmission of HIV.

**Unsafe medical procedures,** including blood transfusions, have been implicated in a large number of HIV infections. Inadequate testing also comprises the safety of blood and blood products. Even when safety procedures exist (such as a requirement to dispose single-use syringes) they cannot be followed because of resource constraints.

Epidemiological surveillance has improved, but serious concerns remain. The region’s surveillance system may not be robust enough to detect sudden increases in infection. Monitoring and evaluation (M&E) practices could also be improved. While regional M&E data is often collected, its analysis rarely leads to changes in national or local programs.

**National Responses to the HIV/AIDS Epidemic**

**National health systems in the region have struggled to effectively respond to the HIV/AIDS epidemic and use evidence based practices.** The region faces extremely complex challenges and resources are often limited. National programs typically fall short, even with civil society and donors support. International support for the region’s HIV/AIDS prevention and treatment programs is considerable, yet not without flaws. International support often focuses on discrete aspects of the epidemic and fails to address broader issues like system-wide weakness.
Civil society and NGOs play an important role, although their activities are often limited by governments. NGOs are relatively new phenomena in the region. Technical capacity is frequently limited, and sustainability is questionable. Sometimes governments exert considerable control over the activities of NGOs. However, civil society organizations as well as NGOs manage to provide a wide range of support to people living with HIV/AIDS (PLHIV) in Central Asia.

**National Health Systems and HIV/AIDS**

The ability of the region’s health systems to effectively confront HIV/AIDS is seriously limited because of poor management, scarce funding and the challenges inherent in policy-making.

Ineffective management causes system weaknesses throughout the region. Public institutions utilize outdated management models that do not produce incentives which could improve performance.

Funding is among key constraints. Lack and unpredictability of funding affects the operation of local health institutions, as well as technical capacity. Under critical funding constraints, governments struggle to prioritize service activities and system reforms. The most salient feature of HIV/AIDS financing in the region is the overwhelming reliance on international financial support for national programs. National governments have been unable to fund programs that would reverse the current trends of the epidemic. This dependence on donor programs raises serious concerns about the viability and sustainability of current programs. Across the region, funding from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) plays a significant role, especially in anti-retroviral (ART) programs, but there are drawbacks. Before GFATM funding began in 2005, ART treatment was unavailable in the region. However, the sustainability of this funding is a concern. National programs fail to consistently meet GFATM standards, causing interruptions in the availability of drugs. There is also some general uncertainty about the utility of HIV/AIDS funding.

**The World Bank’s Funded Central Asia AIDS Program Focused on Regional Coordination and Harmonization of National HIV/AIDS Responses**

**Project Design and Approach**

Covering four countries of Central Asia – Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan – CAAP was designed to contribute to controlling the spread of HIV/AIDS by establishing regional mechanisms to support national HIV/AIDS programs. CAAP focused on regional activities that would benefit all countries involved. The project also sought to target underserved and hard-to-reach populations. The
project design took into account the region’s existing challenges, addressed common epidemic drivers and constraints, and took advantage of economies of scale. Operating with two principal components, CAAP focused on 1) promoting regional coordination, policy development and capacity strengthening; and 2) providing financial and technical support through the Regional AIDS Fund (RAF). Many activities focused on sharing best practices for the prevention and control of the disease.

Implementation of CAAP

In spite of its careful design, CAAP’s implementation was challenging. Although the project focused on regional issues, CAAP had to rely on existing national programs for implementation. The project frequently struggled to secure national-level funding and political commitment.

The Regional AIDS Fund was a bright spot. Although not all activities supported by the RAF have been successful, the vast majority of them have achieved their objectives. The RAF funded number of activities that became self-sustaining or which were converted into government policies with far-reaching positive effects. Nearly US$13 million in grants was disbursed over four funding rounds during CAAP’s implementation.

Specific Achievements

The project achieved many discrete objectives and had a number of successes. However, the most significant achievement by far was building a constituency for change across the region.

The project successfully mobilized policymakers across the region. CAAP sponsored several regional conferences for parliamentarians. As a result of the first conference, the Central Asian Inter-Parliamentary Working Group on HIV was established, with representation from the four Central Asian republics and Azerbaijan. This group worked on increasing the involvement of government officials in HIV/AIDS response; developing and strengthening regional strategies; and strengthening legislation.

In addition to direct project-related outcome, CAAP generated significant political benefits. In 2009 the Inter-State Council initiated the development of the so-called Target Program (officially called “Health of the EurAsEC’s Population”), aimed at promoting cooperation across EurAsEC countries on access to medical services and health indicators. The Program places special emphasis on the trans-border risk of infectious diseases including HIV and TB.

More importantly, in November 2009 EurAsEC adopted a critical regional strategy – the Regional
Strategy to Prevent Infectious Diseases in Central Asia. The goals of this strategy include 1) halting the spread of infectious diseases; 2) promoting involvement of civil society in providing these services; 3) improving and harmonizing methods for collection, analysis and dissemination of HIV-related data; and 4) enhancing regional cooperation and harmonizing legal regulations with respect to service provision to PLHIV.

**CAAP promoted the involvement of religious leaders in HIV prevention.** The project organized conferences, speakers and outreach to religious leaders across the region. As a result, an emerging group of regional Islamic leaders have dedicated themselves to spreading HIV prevention messages within their communities.

**CAAP trained journalists on HIV awareness and stigma reduction.** The project placed a priority on working with journalists and established several activities to support and provide training for them. Training seminars and writing competitions sought to provide a robust background on HIV/AIDS issues for working journalists.

**The project established four Regional Training of Trainers (TOT) Centers.** Each country’s TOT Center focuses on a different technical area related to HIV/AIDS. Many regional/national training sessions were held, resulting in hundreds of specialists trained. However, full sustainability of these Centers after CAAP funding ends is a concern.

**CAAP provided financial and organizational support for establishing sentinel surveillance studies in the four Central Asian republics.** These studies are the primary source of information on HIV and hepatitis prevalence rates among vulnerable groups. However, the sustainability of these studies beyond CAAP funding is questionable.

**CAAP supported the establishment of a database to track HIV/AIDS patients in Central Asia.** Prior to the project’s implementation, individual data on each patient was only recorded at the time each HIV case was formally registered, severely limiting the ability of physicians to monitor treatment effects or make changes.

**The Regional AIDS Fund supported several hundred projects submitted by national institutions, international institutions and NGO sector.** The RAF’s funding criteria placed priority on prevention services for members of vulnerable groups such as IDUs, CSWs, MSM, prisoners and migrants. Primary prevention programs targeting the general population or assisting in the provision of ART were also supported. Selected programs receive financial support from the RAF for 12 to 24 months.
Examples of RAF-funded programs included in this paper include prevention activities among youth; a public awareness campaign conducted at an airline company; increasing service coverage for vulnerable groups; HIV prevention and testing among migrant workers; linking HIV prevention and social development projects; and providing legal help to members of vulnerable groups.

**Lessons from CAAP: Comparative Advantages of the Regional Approach**

HIV/AIDS remains a serious and significant challenge in Central Asia. However, the apparent failure to fully control the epidemic should not overshadow the achievements and lessons learned under CAAP. Six lessons emerging from CAAP’s experience are a valuable resource for other regional initiatives:

- **A regional approach to HIV/AIDS provides a framework to raise sensitive yet critical issues that have been difficult to address within individual countries. A regional focus can leverage peer pressure to encourage policy change and harmonization of policies, and often enhances policy dialogue.**

In addition to the numerous socio-economic, cultural and funding issues that have restrained HIV/AIDS response in the region, at times political issues make the challenges even greater. However, the CAAP project showed that politically risky public health issues that are difficult to raise at the national level, can be successfully addressed at the regional level, resulting in harmonization of policies and further enhancements of preventive measures.

- **Having a framework for political cooperation established at the regional level is an important condition for collaboration in the health sector.**

Having agreements for regional cooperation in place makes it easier to national governments and their agencies to agree to collaboration. Under CAAP, regional structures allowed national governments and agencies to more easily take part in designing and implementing disease prevention programs including data sharing, dedication of experts and specialists, and provision of co-funding.

- **A robust, coherent and accurate public awareness campaign about HIV/AIDS is critical; in addition, public acknowledgement by high-level politicians of the seriousness of HIV/AIDS promotes cooperation from all levels of government.**

CAAP’s work on harmonization of key messages and collaborating with opinion influencers such as journalists and religious leaders contributed to building public awareness and demystifying the HIV/AIDS
epidemic. In addition, CAAP’s activities showed the significance of involvement and public messaging by top-level political officials.

- **Members of parliament may be very responsive to outreach about HIV/AIDS projects or activities, and may represent effective way to seek government collaboration.**

As government funding is the only stable source of support for health-related activities in Central Asian countries, CAAP’s experience proved that maintaining direct dialogue with policy makers is critical in order to ensure the sustainability of the project initiatives. Support from members of parliament improved the lines of communication with the executive branch and provided a platform for advocacy actions on a national scale.

- **In a resource-scarce environment like Central Asia, virtual networks of regional experts can substitute for low capacities at national levels.**

CAAP found that sharing experiences accumulated by individual specialists through a regional platform had multiple benefits. This approach could be widely used in other HIV/AIDS programs as well as in other sectors, given the financial limitations and limited institutional capacities throughout the region.

- **Regional cooperation and coordinated policy development are more likely on issues that emerge from common socio-economic problems that cross regional borders.**

Given that the main drivers of the epidemic – including trafficking of people and drugs, sex work and economic migration – have region-wide ramifications, CAAP found that the respective measures to counteract the epidemic can be best addressed from the regional level. Awareness of cross-border linkages increases the likelihood that national governments will support regional initiatives to prevent communicable diseases.
INTRODUCTION

The HIV/AIDS epidemic in Central Asia is one of the fastest-growing HIV/AIDS epidemic in the world. Although communicable diseases are no longer a leading cause of death in Central Asia, new HIV/AIDS cases in the region are rising sharply and appear to be spreading into the general population. At the same time, funding for the region’s HIV/AIDS programs is dwindling. Political instability and economic challenges over the past two decades have resulted in a sharp drop in regional public financing. Technical and administrative capacity within government institutions, including health care systems, has also declined, reducing institutional capacity to respond to new challenges. This combination of factors could be pushing the region toward epidemiological disaster.

Urgent action to address HIV/AIDS in Central Asia is required. Conditions for the spread of HIV virus beyond concentrated groups resemble the pattern of the epidemic in the Russian Federation in the early 1990s, demanding urgent action for HIV/AIDS control in the region. National programs are in desperate need of financial and technical support.

While country-level interventions are necessary, a regional approach that considers Central Asia’s history and socio-economic context may be the most prudent way forward. This paper summarizes the trajectory of the epidemic in the region, analyzes the drivers affecting HIV/AIDS, and presents the lessons learned from the World Bank’s Central Asia AIDS Project (CAAP) as examples of effective collaboration.

Figure 2: Number of People Living With HIV Globally 2000-2009
The urgency surrounding the region’s epidemic is better understood when it is placed within the global HIV/AIDS context. In spite of significant and coordinated efforts, the number of people across the world infected with HIV continues to rise (See Figure 2) and in 2009 it was estimated that over 33 million people globally were living with HIV, with 2.7 million new infections and 2 million HIV-related deaths annually. The rise in the total number of people living with HIV masks the relative global success in controlling HIV/AIDS due to the increased access to life-saving antiretroviral therapy (ART).

However, although the number of new cases continues to rise, the pace of new cases has leveled off since 2000. Global efforts to control the HIV epidemic have resulted in the decrease of new cases reported annually as presented in Figure 3.

Figure 3: Number of New Cases Globally 1990 – 2009

However, this trend does not apply to Central Asia, where, in contrast to the rest of the world, the number of newly registered cases has been growing since the early 2000’s. Figure 4 shows that annual newly-diagnosed infections rose across the four Central Asia republics between 2001 and 2008, with particularly alarming increases registered in Kazakhstan, the Kyrgyz Republic and Uzbekistan between 2005 and 2007.

These increases have had drastic effects. As of January 1, 2011, the cumulative number of registered HIV cases in the region stood at 40,674; nearly half of these cases were registered in Uzbekistan (See Table 1). Kazakhstan is not far behind. Yet even in the remaining two republics (Kyrgyz Republic and Tajikistan), the number of new HIV cases witnessed more than a 4-fold jump between 2001 and 2010.
These indicators are worsening in Central Asia in spite of several response efforts that have been underway for years. International agencies began cooperating on HIV/AIDS with regional counterparts in early 1990. Since then, bilateral donors, non-governmental organizations (NGOs) and private foundations have been working with national authorities and local governments, while some have been supporting newly-formed Central Asian NGOs.

Figure 4: Registered Cases in Central Asia, 2000-2010

Table 1: Newly Registered HIV Cases in Central Asia

<table>
<thead>
<tr>
<th>Country</th>
<th>Reported in 2001</th>
<th>Reported in 2009</th>
<th>Reported in 2010</th>
<th>Cumulative Official Total</th>
<th>Estimated number of PLHIV</th>
</tr>
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<tbody>
<tr>
<td>Kazakhstan</td>
<td>1175</td>
<td>2081</td>
<td>1987</td>
<td>15771</td>
<td>10,500-14,500</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>149</td>
<td>687</td>
<td>570</td>
<td>3288</td>
<td>4500</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>34</td>
<td>431</td>
<td>1004</td>
<td>2857</td>
<td>3000</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>549</td>
<td>3351</td>
<td>3795</td>
<td>18758</td>
<td>25,000-30,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1907</td>
<td>6550</td>
<td>7356</td>
<td>40674</td>
<td>43,000-52,000</td>
</tr>
</tbody>
</table>

1 Source: National Ministries of Health/ Republican AIDS Centers
The World Bank played a key role in these efforts, and prepared several detailed analytical reports to inform policymaking, including the 2003 study *Averting the AIDS Crisis in Eastern Europe and Central Asia*. This analysis was followed in 2005 by the Central Asia AIDS Project (CAAP), a US$25-million grant from the International Development Association (IDA) to four Central Asia countries to support regional HIV/AIDS prevention programs. CAAP was further strengthened by a US$1.9 million grant from the Department for International Development of the United Kingdom (DFID). Covering four countries in Central Asia – Kazakhstan, the Kyrgyz Republic, Tajikistan, and Uzbekistan2 – CAAP was designed to contribute to controlling the spread of HIV/AIDS by establishing regional mechanisms to support national response programs.

In an effort to better understand the worsening situation in Central Asia, the World Bank prepared this report, which aims to: (i) give a brief overview of the HIV/AIDS situation in Central Asia including its socio-economic context and regional drivers; (ii) assess the regional status of the key issues which act as the pillars of effective HIV/AIDS response; and (iii) review the effectiveness of CAAP and analyze its usefulness as a model for future engagement. The authors believe that CAAP exemplifies the type of regional approach that holds the most potential for reversing the current grim trajectory of HIV/AIDS in Central Asia, and is one which should be rapidly and robustly funded.

This report relied on desk reviews, structured questionnaires and open-ended informant interviews to formulate conclusions about the current situation regarding the HIV/AIDS epidemic as well as CAAP’s role in promoting regional responses. National Governments and technical experts collaborated on the preparation of this report and have provided valuable information that made its production possible. The staff of CAAP’s Regional Project Management Unit (RPMU) provided insights into CAAP achievements and, as experts in this field, have been peer reviewers of the draft report. The United Nations Children’s Fund (UNICEF) provided useful comments and helped strengthen the quality of the report.

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2 Note that Turkmenistan was not included into the study as it does not belong to EurAsEC, the formal recipient of the World Bank IDA grant for the CAAP project.
PART 1: THE HIV/AIDS EPIDEMIC IN CENTRAL ASIA

Socio-Economic Context

Central Asia’s HIV/AIDS epidemic is evolving within a socio-economic context that has a significant effect on both the trajectory of the disease and the responses that have been formed. This regional context and the epidemic’s drivers are exacerbating the challenges posed by HIV/AIDS. National health systems cannot adequately respond, even with international support and collaboration from the civil society.

The countries of Central Asia share a common recent history. While economic and cultural links date back to the Great Silk Road, for most of their recent history – from the 1870s to 1991 – Central Asian countries were part of the Russian Empire and then the Soviet Union, a fact that has left a major imprint on the region’s economic and social life. As an example, a large majority of medical professionals and decision-makers who are shaping HIV response in the four Central Asian countries were trained under the Soviet education system. This means that these professionals can easily communicate among themselves in Russian; they also share a common history that can make it easier to maintain personal ties or to collaborate on professional issues.

Economically, the region is still undergoing a profound transition. The collapse of the Soviet Union and the subsequent disruption of ties among the former Soviet republics resulted in severe and widespread upheaval. The living standard of the population fell drastically, largely due to an abrupt dismantling of a social safety net that covered a range of services including government subsidies for essential goods, housing, and health care. The socio-economic consequences of this collapse are still being felt, and have a considerable effect on health issues across the region.

The region is largely poor and increasingly unequal. Despite recent economic improvements, poverty remains extensive across Central Asia. One of the summary measures of the UNDP’s Poverty Index is “Intensity of Deprivation”, which reflects the percentage of weighted indicators in which an average poor household is deprived. These numbers are high in Central Asia. Compared to developed nations which usually have a score of 0, Kazakhstan has an Intensity of Deprivation score of 36.9%, the Kyrgyz Republic has a score of 38.8%; Uzbekistan’s is 36.2% and Tajikistan’s is 40% (the 2008 data available at http://hdrstats.undp.org/en/indicators/38506.html). Contributing to poverty in former Soviet republics is the highly unequal distribution of wealth, where the richest 10% of the population may control more than 25% of the national wealth, while the poorest 10% have only 3%.
Natural resources have played an important role. Economic restructuring in Central Asia has largely been driven by the extractives sector; thus, the visible benefits of market economics are concentrated in Kazakhstan, the country with the largest mineral deposits. According to UNDP’s 2009 Human Development Report, Kazakhstan ranks 82 out of 182 countries, the highest ranking for the Central Asian region.³ In 2008, the country had a GNI per capita of 9.2, which exceeds that of neighboring countries (Uzbekistan, 8.0; Kyrgyz Republic 7.7 and Tajikistan, 7.6).

The wealth of natural resource endowments found in Kazakhstan is not shared across the region. The three other republics covered in this study face considerable challenges in terms of economic resources. These limited resources are reflected in each country’s ranking on the 2009 Human Development Index: Uzbekistan ranks 119, the Kyrgyz republic 120, and Tajikistan 127.⁴ The differences with respect to economic opportunities available in the respective countries are also reflected in the amount of remittances — monetary transfers made by migrants working abroad to immediate family members in the country of origin. In 2007 remittances amounted to US$251 per capita in Tajikistan, US$134 in the Kyrgyz republic and only US$14 in Kazakhstan.

Limited economic opportunities force many to move in search of work. Measuring the scale of labor migration within Central Asia can be difficult, due to the fact that there are few visa requirements for intra-regional travel. In addition, a majority of migrants tend to work for cash without applying for work permits. Yet the scale of labor migration within Central Asian countries appears to be in the millions. In Tajikistan alone, it is estimated that every year 500,000 citizens leave the country in search of work (UNGASS Country Progress Report, 2008). The International Organization for Migration (IOM) estimates that between 800,000 to 1.5 million Uzbeks migrate each year (IOM, 2005). On the receiving end, Kazakhstan officially registered almost 3 million migrants in 2007, which amounted to 19 percent of its total population. Russia was the largest destination country for economic immigrants, with over 12 million arriving in 2007.⁵

Migration can have effects that go beyond economics. Key informants in this study indicated that the increasing volume of migration has HIV-related ramifications, as most of the labor migrants from Central Asia go to countries with much higher HIV prevalence rates such as Russia. The 2006 serological study conducted among 407 migrants in Tajikistan established the HIV prevalence among them at 2.2%, with most HIV-positive women in the country being married to those who had been working abroad.⁶ Cases of women being infected with HIV by their spouses returning from working abroad have also been noted in Uzbekistan and Tajikistan.⁷

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³ Human Development Report 2009 – Country Fact Sheets – Kazakhstan
⁴ Human Development Report 2009 – Country Fact Sheets – Uzbekistan
⁵ Human Development Report 2009 – Country Fact Sheets – Kazakhstan
⁶ UNGASS Country Progress Report, 2008
⁷ Interviews with key informants of this study
Drivers of the HIV Epidemic in Central Asia

In addition to the socio-economic context described above, the epidemic in Central Asia is growing more serious because of behavioral drivers as well as systemic and structural drivers. Both are discussed below.

Behavioral Drivers
Injection Drug Use (IDU)

Central Asia’s geographic proximity to the opium-growing areas in Afghanistan places the region along significant drug-trafficking routes to Eastern and Western Europe. An increasing volume of heroin supply is being consumed inside these transit countries. As a result, a primary driving force behind the regional HIV epidemic is the activity of injecting drug users (IDUs), which account for large percentages of registered HIV cases in each country: 46% in Uzbekistan, 55% in Kazakhstan, 51% in Tajikistan and 66% in the Kyrgyz Republic. In Figure 5 below, the primacy of IDUs in HIV transmission in Asia is clear. As noted by Godinho, drug trafficking and drug use have increased dramatically since the war began in Afghanistan in 2001 (Godinho et al, 2004).

Figure 5: Transmission Sources by Region, 2008

If trends continue, drug use could cause the epidemic to become entrenched. The rate at which drug use has been spreading in the region suggests that the pool of potential users has not yet been exhausted. In the Kyrgyz Republic, for example, the number of registered IDUs increased by more than 24% from 2005

The World Bank
to 2008. The link between drug use and HIV varies by country: according to the results of the 2008/2009 sentinel surveillance studies, HIV prevalence among the region’s IDUs was 2.9% in Kazakhstan, 14.3% in Kyrgyz Republic and 17.6% in Tajikistan. Experts believe that once HIV prevalence reaches 10-20% within a high risk group, the epidemic is likely to become self-perpetuating (Friedman et al 2000).

Drug injection often leads to contact with contaminated blood, which causes the majority of HIV transmission among drug users. Unsafe injection practices occur on alarming scale. The reported use of sterile injecting equipment ranges from 81.6% in Uzbekistan to 63% in Kazakhstan and Tajikistan. The considerable extent to which injection paraphernalia is shared is also underscored by the prevalence of hepatitis C among drug users. For example, the results of the 2009 Sentinel Surveillance study put the prevalence of hepatitis C at 54.2% among drug users in the Kyrgyz Republic, 60.3% – in Kazakhstan, 32.6% – in Tajikistan.

Programs for IDU behavior modification and rehabilitation exist in the region, but at a level far below of what is needed. The number of needle exchange points per 1,000 IDUs in 2008 ranged from one in Kazakhstan and Tajikistan, to two in Kyrgyz Republic to seven in Uzbekistan. In the region, needles and syringes are provided as part of the projects funded by the Global Fund for AIDS, Tuberculosis and Malaria (GFATM). In Kazakhstan funding for these activities also comes from the national budget. The annual quantity of needles/syringes provided per IDU in 2009 was 486 in Tajikistan, 350 in Kazakhstan and 153 in the Kyrgyz Republic (SS 2009). Note that WHO rank provision of fewer than 100 per IDU per year as “low” while that between 100 and 200 as “medium” (WHO, 2009, p.19).

Opioid substitution therapy (OST) is still very much under discussion in Central Asia and has been scaled up only in the Kyrgyz Republic (0.7 OST distribution points per 1000 IDUs). Since 2008 Kazakhstan has also carried out a pilot methadone substitution therapy at two sites, each of which covered 25 clients. In 2010 the coverage of the two original sites increased to 50 clients and third pilot site added. The issue of further expanding the substitution therapy program in Kazakhstan is still under discussion. A Buprenorphine program was piloted in Uzbekistan in 2009, but then scaled down. Tajikistan approved the idea to introduce opioid substitution therapy, but the exact implementation plan is still being discussed. In summary, coverage with OST is quite modest in the region, considering that the WHO Technical Guide rates 20% of opioid injectors using OST as a “low” target (WHO, 2009, p.21). Even more importantly, some Central Asian countries are still resisting the use of OST despite clear evidence of its effectiveness. Although there are efforts by several countries in the region to introduce some

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8 UNGASS Country Progress Report, 2010
9 UNGASS Country Progress Report, 2010
10 UNGASS Country Progress Report, 2010
11 The WHO, UNODC, UNAIDS Technical Guide for countries ranks provision of fewer than 100 syringes per IDU per year as “low”, and between 100 and 200 syringes as “medium”. (WHO 2009, p. 19)
pharmacotherapy such as haloperidol to reduce the pool of drug users, there is no empirical evidence suggesting effectiveness of such therapy.

**Heterosexual Transmission**

While the majority of drug users in the region are young and sexually active, there are also clear indications that HIV infection is spreading beyond these networks through sexual contacts between IDUs and their spouses or partners. Needless to say that unsafe sexual practices play an important role in this respect. The 2009 Sentinel Surveillance studies registered reported condom use at last sexual intercourse among IDUs between 28.1% with permanent partner and 87.1% with commercial partner in Kazakhstan; 37.8% and 73.0% in the Kyrgyz Republic; 22.3% and 42.9% in Tajikistan respectively. Meanwhile, the 2008 UNGASS report from the Kyrgyz Republic reflects that a vast majority of HIV infected women got the virus from their drug-using husbands or partners.

There is growing evidence in the region for a transition from an epidemic that is heavily concentrated among drug users to the one that is increasingly being driven by sexual transmission. Comparing the UNGASS reports from 2008 and 2010 reveals that all countries in the region are registering larger proportions of HIV infections attributed to transmission routes other than IDU, suggesting a shift away from predominantly an IDU-driven epidemic. The percentage attributed to IDUs out of total HIV infections diminished in all four Central Asian countries: in Kyrgyz Republic this share dropped from 72% in 2007 to 67%; from 73% to 55% in Kazakhstan; from 57% to 46% in Uzbekistan and from 58% to 55% in Tajikistan. Further evidence supporting the trend is that in the Kyrgyz Republic, sexual transmission accounted for 3% of the registered HIV cases in 2001 while in 2009 this figure went up to 25%. The 2009 statistics for Kazakhstan, Tajikistan and Uzbekistan are at 27.2%, 35.5%, and 32.2%, respectively. Although the data suggest that the share of cases attributable to injecting drug use has been shrinking, this transmission route is still dominant across all four Central Asian republics.

As a consequence, more women are getting infected, which serves to further open the doors for the virus to spread to the general population through sexual route. In Kazakhstan women accounted for 26.2% of infections in 2006 while in 2007 this share climbed to 29.5 percent. In Tajikistan the respective rate went up from 16.3% in 2004 to 25.6% in 2006 (UNGASS Country Progress Report, Tajikistan 2008). In Uzbekistan, women accounted for 46% of cases of HIV registered in 2009, which is the highest proportion among Central Asian countries.

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12 SS 2009
13 Des Jarlais et al., 2009
15 UNGASS Country Progress Reports, 2010
17 UNGASS Country Progress Report, Uzbekistan, 2010
As previously indicated, sexual contacts between injecting and non-injecting partners creates the potential for spreading the virus beyond drug-using networks into the general population. The extent to which this scenario has been occurring in Central Asia deserves a special study.

**Figure 6: Transmission Sources in Central Asia: Injecting Drug Use vs Sexual**

Despite religious and legal restrictions, commercial sex workers (CSW) exist in significant numbers across Central Asia. Estimates range from 8,000 in Uzbekistan to 12,500 in Tajikistan\(^\text{19}\) and 13,500 in Kazakhstan.\(^\text{20}\) The overlap of sex work and injection drug use is also significant – some studies indicate that about 10 percent of sex workers in the Kyrgyz Republic are IDUs. Unprotected sex is a dominant transmission route, especially given the extreme economic vulnerability of many sex workers, who sometimes provide sexual services in exchange for food or drugs. As revealed by results of the 2009 Sentinel Surveillance study in Tajikistan, condom use also varies by partner type: while 84% of sex workers reported using condom with commercial partners, only about 32% did so with regular partners. It is worth noting here that a vast majority of sex workers (66%) claim to have permanent partners.\(^\text{21}\)

The prevalence of unsafe sex is also revealed by the high syphilis rates among sex workers. For example, according to the 2009 Sentinel Surveillance study, 11.5% of CSW in Tajikistan, 18.2% in Kazakhstan, 31.3% in the Kyrgyz Republic had been infected with syphilis.

\(^{18}\) Ottosson, 2009  
\(^{19}\) UNGASS Report, 2010  
\(^{20}\) UNGASS Reports, 2008  
\(^{21}\) UNGASS Report, 2010
**Men Who Have Sex with Men (MSM)**

MSM are one of the most hard to reach groups in terms of regional HIV research, as legal provisions in a number of Central Asian countries carry criminal charges for men who have sex with other men. However, MSM are included in Sentinel Surveillance studies in Kazakhstan and the Kyrgyz Republic and thus it is possible to conclude that members of this group are numerous and that unsafe sexual practices are typical to MSM as well. For example, in Kazakhstan the estimated number of MSM exceeds\(^{22}\) 30,000 while the 2009 Sentinel Surveillance study in the Kyrgyz Republic established the syphilis rate among MSM at 13.0%. More specifically, the behavioral study among MSM in Tajikistan established a high prevalence of unprotected sex and commercial sexual contacts in this group.\(^{23}\) MSM not only constitute a priority population for prevention interventions, but may also serve as an important epidemiological bridge that facilitates further expansion of the epidemic into general population.

**Mother-to-Child Transmission (MTCT)**

With the growing number of women infected with HIV, the prevention of vertical transmission from mother to child becomes an urgent problem for health care systems in Central Asia. Although the share of HIV cases attributable to MTCT is modest, ranging between 0.9 percent in the Kyrgyz Republic to 3.6% in Uzbekistan,\(^{24}\) these numbers are likely to increase in the very near future. In some cases HIV-positive women belong to vulnerable groups such as sex workers or IDUs; such women often decline to seek medical care during their pregnancies or do not have access to it. Furthermore, in countries like Kyrgyz Republic there were no legal provisions that required pregnant women to undergo HIV testing until 2007. In that year, only 18 percent of pregnant women were tested in the Kyrgyz Republic, with 3 cases of HIV being detected (UNGASS Country Progress Report, 2008). On the other hand, health care systems in Central Asia do not have adequate resources to deal with this issue. For example, during interviews with key informants it was mentioned that sufficient funding is unavailable to procure breast milk substitutes, even in Kazakhstan.

**Structural Drivers**

*Unsafe medical procedures*

Interviews with key informants and media reports suggest that HIV infections resulting from unsafe medical procedures have also contributed to the rise in the number of HIV infections in Central Asia.

\(^{22}\) GFATM, 2008  
\(^{23}\) UNGASS Report, 2010  
\(^{24}\) UNGASS Report 2010
countries, revealing serious deficiencies in the region’s health care systems. These reports have come from Kazakhstan, the Kyrgyz Republic, and Uzbekistan.

Deficiencies in the organization of health care systems are also revealed by cases of HIV infections attributable to unsafe medical procedures such as blood transfusions. The extent of this problem is difficult to define in a precise manner, especially given the high number of registered HIV cases with unknown transmission routes. Media reports reveal that patients, including children, have been infected with HIV in hospitals in Kazakhstan, the Kyrgyz Republic, and Uzbekistan. The breakdown of registered HIV cases by transmission route in the Kyrgyz Republic in 2010 serves to illustrate this point (Figure 7).

Figure 7: HIV transmission routes among citizens of the Kyrgyz Republic, 2010

These transmissions occurred as a result of transfusions of contaminated blood or from medical staff re-using medical equipment designed for single use, such as syringes. In a vast majority of these cases, safety procedures prohibiting such practices were in place, yet frequently could not be followed due to lack of resources.

Inadequate testing for infectious diseases also compromises the safety of blood and blood products in Central Asian hospitals. For example, a recent World Bank/CDC study revealed undetected cases of HIV

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25 The route of transmission in a relatively large percentage of cases is unknown (18.5 percent of HIV cases registered in Tajikistan in 2007 and 17.9 percent cases in Uzbekistan). UNGASS Country Progress Reports, 2008
and hepatitis B and C in blood products that had been previously screened in local laboratories (Marquez et al, 2008). Regional medical authorities acknowledge this problem, pointing out certain issues that need to be addressed immediately to prevent further HIV transmissions inside health institutions: 1) the inadequate training of laboratory staff; 2) lack of equipment and reagents; and 3) general low level of quality in testing systems.\textsuperscript{26}

Perversely, a “positive” side effect of these institutional transmissions is increased awareness of the HIV epidemic among top-level policy makers, which often motivates them to take action. However, some actions may result in policies that are driven by political rather than technical solutions. The 2008 Presidential Decree on additional measures to counteract the spread of HIV in Uzbekistan was adopted under such circumstances.

Although epidemiological surveillance for HIV in Central Asia improved in recent years, serious concerns remain. International agencies such as UNAIDS often report estimates of the number of HIV cases that are higher than those quoted by national governments. Recent advances enhanced the reliability of epidemiological estimates in the region and expanded the evidence base upon which national HIV strategies are premised (UNAIDS 2009). However, the quality and frequency of surveillance, and consequently its sensitivity, may still be too low to identify sudden increases in infections, as people who are most at risk may not be tested.

Adding to the problem of unsafe medical practices, monitoring and evaluation (M&E) of HIV prevention strategies in Central Asia is weak and inadequate. Currently, the M&E data collected in the region is intended, primarily, for global reporting and its analysis rarely leads to changes in national or local programs. Quite often, national authorities premise their planning for HIV programs exclusively on reports from past activities, and thus forego the opportunity to provide integrated approach in implementing prevention, care and support services programs. Gathering accurate data can also affect supply management: countries in the region experience stock-outs of ARTs and sometimes face situations when the ART regimens must be changed because the shelf-life of the available drugs is expiring. The same situations occur in the implementation of harm reduction programs and OST.

\textit{Lack of Financial Resources}

\textbf{Lack of funding for Anti-retroviral Therapy (ART) is a critical constraint which could derail the progress that has been made.} As is the case with most countries in the world, countries in the Central Asian region have also expanded access to antiretroviral therapy, although treatment coverage still did

\textsuperscript{26} UNGASS Country Progress Report, Kyrgyz Republic, 2008
not reach 80%. Low treatment retention rates also indicate the poor quality of treatment programs. Available evidence suggests that injecting drug users – the population most at risk of HIV infection in Eastern Europe and Central Asia – are often the least likely to receive antiretroviral therapy when they are medically eligible.\textsuperscript{27}

Further commitment from the governments is essential for successful control of the epidemic. As government funding is the only reliable source of support, and as the number of people living with HIV increases, securing commitment from national sources to HIV prevention and ARV treatment represents a challenging yet the only sustainable option. Despite modest increases in funding from government sources observed in recent years, overall levels of financing for HIV programs comprise only a fraction of government health expenditures with small if any funding for harm reduction programs and support for NGOs.

There are only a few effective mechanisms to provide for predictable and sustainable financing for HIV/AIDS in fragile and low- and mid- income countries in Central Asia. Increases in national spending for HIV/AIDS control is the only option for the future to sustain efforts to control the HIV epidemic. Scarce resources need to be utilized efficiently. Vertical programs for HIV control should be carefully examined and followed by comprehensive reforms of the health system. Economies of scale should be promoted to maximize investments and regional cooperation should be encouraged to complement national efforts.

**Harm reduction activities are also chronically under-funded, leaving vulnerable groups at high risk.** In terms of the efficient use of limited resources, the dynamics of the HIV epidemic in Central Asia clearly indicate that without reducing the pool of drug users, efforts to contain the spread of HIV are not going to be effective. There is no evidence of the effectiveness of phytotherapy or hypnosis, which are frequently used in the region during the detoxification period, while OST is neglected or banned. Only limited actions aimed at primary prevention, limiting the demand for drugs or tertiary prevention, such as reintegration of IDUs into society and their social rehabilitation, are a part of the national programs to respond to HIV in Central Asia.

Another example of the resource shortage is limited funding either from governments or donors available for treatment of drug users including detoxification or their rehabilitation. In Kyrgyz Republic, receiving detoxification is often prohibitively expensive for drug users as it requires a co-payment while support for rehabilitation services through medical insurance is limited to only two weeks.

International support for prevention and treatment activities is highly selective as it is focused on “harm reduction” services for drug users, CSW, MSM and prisoners, and includes syringe exchange and substitution therapy. However, external funding for a number of treatment programs related to drug use and sex work still remains limited. More generally, however, international support for multi-sectoral action has the potential to have an impact on the HIV epidemic only if it serves as a supplement to national funding. Yet in the Central Asian countries this funding tends to substitute rather than supplement national support.

**National Responses to the HIV/AIDS Epidemic**

The national health systems of the region have struggled to respond to the HIV/AIDS epidemic. As noted above, the region faces extremely complex challenges. National programs have often fallen short, even with civil society and international support.

Some of this difficulty is due to the nature of HIV/AIDS itself. No other disease preferentially kills breadwinners and the most economically productive population, destroying families and social structures, like AIDS. Life-long treatment for HIV infection puts additional strain on families and society in general. National and local governments in the region find themselves in a situation where they face competing demands with very limited public resources.

The state of national health systems themselves also presents a serious problem. Specifically, annual health care expenditures in the three Central Asian countries (apart from Kazakhstan) are quite modest, ranging from US$177 per capita in Uzbekistan\(^2^8\) to US$127 in the Kyrgyz Republic,\(^2^9\) and US$71 in Tajikistan.\(^3^0\) Limited financial resources available to health care systems raise the issue of their ability to respond effectively to the spread of infectious diseases such as HIV, which require substantial prevention and treatment costs.

**International Support and Regional Civil Society Organizations**

International support for the region’s HIV/AIDS prevention and treatment programs is considerable. In addition to GFATM financial support for local implementers, there are a number of programs designed and implemented by international organizations. Annex 1 provides information on several organizations and programs that are representative of the international support that currently exists.

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\(^{28}\) WHO | Uzbekistan  
\(^{29}\) WHO | Kyrgyz Republic  
\(^{30}\) WHO | Tajikistan
However, international support often focuses on discrete aspects of the epidemic. There is often little or no donor support for addressing broader – yet critical – issues like systemic weaknesses in policy making institutions; broader governance reforms including the reorganization of delivery services; or training national institutions on how to maximize the use of limited resources.

Civil society and non-governmental organizations also play an important role, although they often face limitations on their activities. NGOs are new phenomena in the former Soviet republics. Most are funded primarily by external sources. As such, the sustainability of their programs is questionable. Many have an inconsistent track record. Furthermore, the technical and organizational capacities of a vast majority of existing NGOs remain limited. However, several networks linking NGOs from different Central Asian countries have been operating in the region, and are attempting to address these issues. These networks include the East European Harm Reduction Network, and the Central Asian Association of PLHIV.

In general, the legal environment for NGOs includes some restrictions, primarily due to government concerns about NGO roles and influence. NGOs can face restrictions on their activities, lengthy registration procedures and financial management constraints, although the extent of these restrictions varies by country. In Kazakhstan, the Kyrgyz Republic and Tajikistan, the authorities have adopted a relatively balanced approach towards NGO registration and reporting. In contrast, in Uzbekistan the system of control over NGO activities is much tighter. In 2005 the Uzbek government forced international funding for NGOs to be channeled through two government-appointed banks, whose responsibilities included assessing the “appropriateness” of funded activities. As a result of the challenging environment, Uzbekistan witnessed a drastic drop in the number of NGOs in recent years, although some of the NGOs involved in HIV prevention have managed to operate.

Yet, in spite of the existing limitations, civil society organizations, including NGOs, have made important contributions in providing HIV prevention and treatment in all Central Asian countries. Mobilization of civil society (promoting the NGO sector and involving PLHIV and representatives of vulnerable groups in HIV) is one of the focal areas of Kazakhstan’s national program. With the arrival of support from the Global Fund in early 2000s, the number of NGOs in Kazakhstan, Kyrgyzstan and Tajikistan increased substantially – in the Kyrgyz Republic alone, more than 200 NGOs working in the health field were registered.

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31 Batyrbekova, 2009
32 Most of the remaining organizations are part of the National Association of NGOs in Uzbekistan (NANOUz) that has been established as an umbrella organization. The NANOUz is affiliated with the National Fund, the government’s grant-giving agency, and receives support from this source.
A wide range of services are provided by the region’s NGOs. Most of these organizations provide HIV prevention services to members of vulnerable groups including the distribution of information materials, condoms, syringes, the provision of psychosocial support, and referrals of their clients to medical institutions. A number of NGOs provide legal advice, and assist in arranging health insurance, passports and other documents for their clients. In recent years, self-support groups and NGOs assisting in maintaining adherence to ART and providing care and support services for PLHIV have also been registered. However, as a general rule, those services that require licensing or certification (such as medical care) cannot be provided by NGOs.

**National Health Systems and HIV/AIDS**

Although the four Central Asian countries have launched health sector reforms, their ability to effectively confront the HIV/AIDS epidemic remains seriously limited because of poor management, scarce funding and the challenges of policymaking. In addition, the countries face significant and rapid changes within their respective political and economic systems, including instability caused by the region’s prolonged transition to a market economy. Many social institutions are also stretched beyond capacity.

Ineffective management causes system weaknesses throughout the region. Central Asian health institutions inherited Soviet-style models of organization and approaches to delivery of health care services. Public institutions continue to be governed in a rigid manner which does not produce incentives to improve performance. Financial and other incentives are tied to public sector salary scales that are based on norms and standards, rather than outcomes or performance. In addition, organizational arrangements and managerial hierarchy inherited from the Soviet system pose additional constraints on the transformation of health institutions and their ability to respond to changing environments.

Scarce funding is a key issue region-wide. There has been a significant decline in overall funding, and many health facilities are inadequately funded and cannot perform their mandated functions. The operation of local health institutions requires the availability of funding for recurrent costs and maintenance. While national governments in the region allocate budgetary funds to cover equipment and staff costs, it is the regional and municipal counterparts who are responsible for funding all operational, recurrent and maintenance costs for local health institutions. In most cases, funding does not match existing needs, resulting in fewer tests, an inadequate supply of disposable syringes, weaknesses in blood safety and other deficiencies. Further, due to ineffective management of both primary and secondary care institutions, the costs of maintaining infrastructure are rising.
Funding also affects technical capacity. The health sector, higher education institutions, and research centers are faced with serious resource constraints and outward migration of skilled staff. Monetary remuneration for medical staff contains inadequate performance incentives and is often so low that the social status and professional morale of medical staff are negatively affected. As a result, medical professionals choose to migrate to other countries or abandon their careers in favor of non-medical pursuits. According to key informants, in 2008 alone almost 700 physicians left Kyrgyz Republic, lowering the doctor/assigned population ratio to 1 to 20,000 in rural areas.

Under serious funding constraints, governments struggle to prioritize activities and reforms that would yield the greatest results. In doing that, however, policymakers often overlook that many constraints in controlling an HIV epidemic are due to shortcomings of the broader health system. Many programs designed to address specific diseases have the same underlying constraints, such as inadequate funding mechanisms, delivery models, regulatory frameworks, organizational settings, and payment mechanisms for providers among others. Fragmentation of services in vertical programs further adds to increasing costs and decreasing quality. Likewise, donor-funded HIV/AIDS programs often focus on one narrow aspect and not the health system as a whole. As a result, the region is still in need of large-scale efforts to reform health systems that would allow to deal effectively with specific diseases such as HIV.

**Financing HIV/AIDS Activities in Central Asia**

Financing is a critical issue in the fight against HIV/AIDS, and is cause for serious concern in Central Asia. Lack of adequate funding for prevention and treatment, both of which are required to fully contain the epidemic, increases the risk that HIV/AIDS will continue to spread.

The most salient feature of HIV/AIDS financing in the region is the overwhelming reliance on international financial support for national programs. The region’s governments have thus far been unable to fund programs that would reverse the current trends of the epidemic. Especially in regards to ARV treatment, the countries’ dependence on donor funding raises serious concerns about the viability and sustainability of both current and future programs.

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33 A note about financing for HIV/AIDS programs: Analyzing the overall expenditures for AIDS, authors frequently consider only very specific activities directly related to control of HIV/AIDS known as vertical interventions. Despite acknowledgements that the control of HIV/AIDS is in nature multi-sectoral, expenditures in other sectors to control HIV/AIDS epidemic are difficult to measure and are rarely presented when discussing total financing for HIV/AIDS. Even direct health sector expenditures such as equipment maintenance, blood safety measures, prevention of intra-hospital infections are rarely taken into the account when assessing total cost of control of the epidemic. Despite the fact that at times large investments are made in very specific interventions directly related to control of the epidemic, deficiencies in the financing of the health systems and their effectiveness as a whole contributes to the overall inadequate results. Therefore, when qualifying the adequacy of expenditures for HIV/AIDS, distinctions should be made between funding for vertical interventions directly related to HIV/AIDS control and funding for health systems and effectiveness.
Uzbekistan’s case is typical of the region’s heavy reliance on international financial resources: of the US$8.3 million that was available in 2008 for HIV prevention and treatment in Uzbekistan, almost 70% came from international sources, primarily from GFATM. The bulk of the Uzbek government’s health budget goes toward maintaining infrastructure and the salaries of medical staff, while international donors support various prevention and anti-retroviral treatment (ART) programs. Currently about additional 1400 PLHIV are in need of ART within the country.34

Across the region, GFATM funding plays a significant role, especially in ART programs. Since 2005 the numbers of people in need of ART in Central Asia has grown dramatically, yet before GFATM funding began in 2005, ART treatment was unavailable in the region. Since then the GFATM has become the main sponsor of ART in the Central Asian countries except in Kazakhstan, where since 2009 partially, and from 2011 onwards ART drugs are entirely purchased from State budget. Due to the high cost of this treatment, GFATM is currently the only source for this type of treatment, although some government’s initiatives on this issue may appear in the future. And yet, in spite of the GFATM funding, current demand exceeds supply for ARV treatment in the regions. For example, only 56% of patients in this category were treated in Tajikistan in 2007. By early 2011 the situation changed for the better side and coverage of ARV therapy comprised: 75% in Kazakhstan, 77% in Kyrgyz Republic, 94% Tajikistan and over 70% in Uzbekistan. However, 100% coverage is not achieved up to date.

Failure of GFATM applications and lack of support from government budgets for ARV treatment means that there were interruptions in the availability of critical drugs, and several countries have recently stopped enrolling new HIV patients in ARV therapy. In addition, even though the number of PLHIV receiving ART is over 4500 in the region (for information: ART application as of 01.01.2011 in Kazakhstan received 1336 PLHIV, in Kyrgyz Republic – 356, in Tajikistan – 321, in Uzbekistan – 2653), the Central Asian countries have yet to establish national systems to monitor treatment of HIV and opportunistic infections.

In spite of the challenges described above, several GFATM programs are active in the region (Table 2). As of January 2010, there is a project underway in Kazakhstan aimed at scaling up access to HIV prevention services among vulnerable groups and fostering partnerships among government, NGOs, and private actors. More than US$32 million for this initiative came from GFATM’s Round 7. In Kyrgyz Republic, the GF allocated over US$23 million to a project promoting access to HIV prevention, detection, treatment, care and support among youth, vulnerable groups and PLHIV (Round 7). In Tajikistan over US$6 million has been provided to support national AIDS response by scaling up HIV prevention and care services (Round 6); another US$20 million was contributed to strengthen

34 Country Statistics and Disease Indicators – UZBEKISTAN & the Global Fund to Fight AIDS, Tuberculosis and Malaria
the supporting environment and scale up HIV prevention, treatment and care services (Round 8). In Uzbekistan the HIV Prevention and Treatment Project from Round 3 (US$43 million) has been extended for three years; and the funds will be available starting in 2011.

Table 2: GFATM’s Funding for HIV-related Programs in Central Asia35

<table>
<thead>
<tr>
<th></th>
<th>Round 1</th>
<th>Round 2</th>
<th>Round 3</th>
<th>Round 4</th>
<th>Round 5</th>
<th>Round 6</th>
<th>Round 7</th>
<th>Round 8</th>
<th>Round 10</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Kazakhstan</td>
<td>-</td>
<td>2 028 667</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>32 710 239</td>
<td>-</td>
<td>2 404 755</td>
<td>55 403 661</td>
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<tr>
<td>Kyrgyzstan</td>
<td>-</td>
<td>17 073 306</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>24 586 151</td>
<td>-</td>
<td>11 207 840</td>
<td>53 149 297</td>
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<tr>
<td>Tajikistan</td>
<td>2 425 245</td>
<td>-</td>
<td>-</td>
<td>8 076 667</td>
<td>6 327 429</td>
<td>-</td>
<td>20 028 140</td>
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<td>36 857 481</td>
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<tr>
<td>Uzbekistan</td>
<td>-</td>
<td>-</td>
<td>42 870 611</td>
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<td>-</td>
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<td>9 519 645</td>
<td>52 390 256</td>
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<tr>
<td>Total</td>
<td>2 425 245</td>
<td>37 361 973</td>
<td>42 870 611</td>
<td>8 076 667</td>
<td>6 327 429</td>
<td>57 578 390</td>
<td>20 028 140</td>
<td>23 132 240</td>
<td>197 800 695</td>
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</table>

In addition to the financing challenges outlined above, some general uncertainty about the utility of HIV/AIDS funding has emerged. Although the threat of a massive global epidemic never materialized (outside Sub Saharan Africa and parts of the Caribbean and Pacific regions), funding for HIV control faces criticism and skepticism from some who argue that the high level of resources programmed in recent years is undermining national health systems and leaving other serious diseases neglected. Critics point out that AIDS kills fewer people than pneumonia or heart disease on a global level; and that AIDS contributes to 4% of deaths in low– and mid– income countries, yet consumes 25% of international aid for health. There is growing concern that funding for AIDS can contribute to a distortion in allocation of resources, overwhelming national health care systems.

For all of the reasons discussed above, it is imperative that the Central Asian countries establish and/or develop reliable and sustainable sources of funding for HIV/AIDS programs.

35 GFATM Data
PART 2: THE CENTRAL ASIA AIDS CONTROL PROJECT AND REGIONAL COOPERATION

The World Bank’s Central Asia AIDS Control Project (CAAP) was carefully designed to encourage regional cooperation on HIV/AIDS issues. During project implementation, obstacles and challenges arose, many related to national programs. However, several specific activities were successfully realized under the project. In addition, important lessons learned were identified, all of which should inform future regional HIV/AIDS interventions. CAAP’s design, implementation, outputs and lessons learned are discussed below.

Background

HIV emerged in Central Asia in 1987. As discussed in Part 1 of this paper, the number of new HIV cases in the region has grown exponentially and now represents one of the highest rates of infection in the world. Despite slow starts in responding to the HIV/AIDS epidemic, governments, NGOs and partner organizations were able to prevent a major epidemic early on. Central Asian countries, with the exception of Turkmenistan, prepared country strategies covering multiple sectors, which have helped them to secure funds from GFATM. However, available and planned funding across the region, including funding from the GFATM between 2005 and 2009, covered less than 25% of groups at risk, and did not cover cross-border populations such as migrants. Central Asian governments have also started implementation of national HIV/AIDS strategies prepared with assistance from UNAIDS. Beginning in 2001, the Bank has carried out analytical sector work in the region on HIV/AIDS, Sexually Transmitted Infections (STIs) and Tuberculosis (TB).36

Encouraged by the positive experience of Bank-financed regional HIV/AIDS projects like the Abidjan-Lagos Transport Corridor AIDS Project and the Regional HIV/AIDS Program in the Caribbean Region (CARICOM), the Bank and DFID initiated discussions in 2003. The two donors conferred with Central Asian governments about the financing of a regional operation that would further assist implementation of the regional and country-specific strategies to control HIV/AIDS, specifically focusing on regional

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coordination and harmonization of responses to HIV/AIDS. The resulting operation, the Central Asia AIDS Control Project (CAAP), which emphasizes the importance of regional collaboration. The multi-country grant became effective on July 1, 2005 as a Sector Investment Loan financed by an IDA (The World Bank) grant of US$25 million, a DFID grant of US$1.9 million, and counterpart financing of US$0.8 million. The grant was expected to close on December 31, 2010. However, it was envisaged in the Project Document that if the project’s performance is satisfactory, and additional funding is identified, the project implementation period could be extended.

**Project Design and Approach**

Covering four countries of Central Asia – Kazakhstan, Kyrgyz Republic, Tajikistan and Uzbekistan – the Central Asia AIDS Control Project was designed to contribute to controlling the spread of HIV/AIDS by establishing regional mechanisms to support national HIV/AIDS programs. CAAP focuses on regional activities that would benefit all countries involved, leaving country-specific programs to be financed from other sources such as individual governments, GFATM, and multilateral and bilateral organizations, including the World Bank’s country-specific operations. The project team recognized that HIV/AIDS prevention and control efforts in Central Asia require strong national programs. However, the project explicitly rejected working only at the country level, as it was considered to be less cost-effective and lacking the potential to create economies of scale across the region. Certain country-level interventions were included, but only those that strengthened or supported the regional activities. In addition, it was expected that a coordinated regional response to the AIDS epidemic would address the limited and uneven distribution of human and financial resource capacities available in Central Asia.

The project also aimed to enable governments and NGOs to cover certain underserved populations (such as migrants), as well as regional corridors and cross-border epidemiological hotspots identified by the mapping study carried out during project preparation.

The project design phase took into account the region’s existing challenges, including those described earlier in this paper. The design team recognized that scarce funding required a project that used resources in the most efficient manner possible. Other regional challenges were considered, including the disputes in various issues existed between neighboring countries.

CAAP was designed to address drivers of the epidemic common to the four countries; and to take advantage of economies of scale for procurement and training. The design also sought to facilitate the sharing of best practices to reduce the risks of knowledge gaps, as well as to address prevention
and control strategies that would be inadequate unless the countries moved in a coordinated manner. Further, at the preparation phase, it was expected that, once established, the Regional HIV/AIDS Fund would eventually be co-financed by other donors, including by the private sector, to ensure the sustainability of financing for HIV/AIDS in Central Asia.

The project has two principal components: the first component is focused on promoting regional coordination, policy development, and capacity strengthening. This is frequently referred to as the “policy component”, although this informal title does not give proper credit to the value and contribution of the second component to policy formulation.

CAAP’s second component focuses on providing financial and technical support for specific HIV-related activities through the Regional AIDS Fund (RAF). The second component is informally referred to as the “grants component”, since the RAF provided grant support to national institutions, international institutions and the non-governmental sector in the development of HIV/AIDS services and prevention activities.

Both components provide substantial support to policy development using different instruments and approaches, and by targeting different audiences. The policy component has substantially contributed to regional capacity-building and policy formulation, through building networks and regional cooperation and by establishing an evidence-based approach to policy formulation, including setting sentinel surveillance as one of the key advances in understanding the dynamics of the HIV epidemic. Promoted by CAAP are regional initiatives in the political field such as the Central Asian Inter-Parliamentary Group on HIV; capacity-building efforts such as the Regional Training of Trainers’ Centers; and data-collection instruments such as the regional system of sentinel surveillance.

Operationally, CAAP operated under the auspices of the Eurasian Economic Community (EurAsEC) that unites the former Soviet republics of Belarus, Kazakhstan, Kyrgyz Republic, Russia, and Tajikistan. Uzbekistan, a former member of EurAsEC, suspended its activities in the group in 2008. Representatives of the four governments of the Central Asian states along with those from UNAIDS comprise the Regional Project Steering Committee (RPSC), the ultimate decision-making body of the project. Day-to-day operations of the project were implemented and/or coordinated by the Regional Project Management Unit (RPMU), which also serves as the RPSC’s Secretariat.

**Implementation of CAAP**

In spite of its careful design, the implementation of CAAP has been challenging at early stage. Internal
periodic World Bank reviews have often rated progress as “unsatisfactory”. In addition to other issues, assessments carried out during implementation deemed the Project Development Objectives (PDOs) overly ambitious and unrealistic, and the project’s implementation structure too complex. As recognized during the design of the project, developing a robust regional approach would require several multifaceted interventions at the national level. However, the project encountered multiple challenges at the national level, especially in securing funding and political commitment. Activities at the national level simply did not match efforts made at the regional level. Given these difficulties, regional efforts provided by the RPMU team, even under the exceptional leadership of the former Minister of Health of the Kyrgyz Republic, could achieve only limited results. The project could not prevent the deterioration of the HIV/AIDS situation in the region.

The Regional AIDS Fund was a bright spot. Although not all activities funded by the RAF have been successful, the vast majority have achieved their original objectives. However, there have been only a limited number of AIDS service organizations that were ready to work with RAF. Political developments in Uzbekistan, described above, resulted in a drastic reduction in the number of NGOs in the country. As a result, the majority of the RAF’s grant recipients in certain countries were government organizations. Although not a key priority for the RAF, given the political situation, cooperation with government-run organizations had advantages in that it made project-supported activities more sustainable. This funding enabled institutions that were ready for change to move forward and implement activities that had been previously stalled by lack of operating budgets, a common constraint in the region. Many activities became self-sustainable or were converted into government policies with far-reaching positive effects. The RAF gave priority to funding projects focused on HIV prevention among highly vulnerable groups. During the life of the project, almost US$6.4 million was approved under the Small Grant scheme and US$7.3 million under the Large Grant scheme.

**SPECIFIC ACHIEVEMENTS OF THE CAAP PROJECT**

CAAP’s key activities are presented below, both those that resulted in important achievements as well as those that represented significant challenges.

**Component 1 – Regional coordination and policy development**

*Regional System of Sentinel Surveillance for HIV*

Under a Memorandum of Understanding (MoU) with the U.S. Centers for Disease Control (CDC), CAAP provided financial and organizational support for establishing sentinel surveillance studies in the four
Central Asia AIDS Control Project

**Sentinel surveillance is the backbone of the UNGASS Progress Reports and evidence-based policies. Sustainability of sentinel surveillance merits the attention of regional stakeholders, including national MoHs, NGOs and international organizations.**

Central Asian republics. Sentinel surveillance studies are the backbone of the UNGASS Progress Reports and evidence-based policies. They are the primary source of information on HIV and hepatitis prevalence rates among vulnerable groups such as IDUs, CSWs, MSMs, prisoners and migrants, as well as on the prevalence of their high-risk behaviors. In the region, sentinel surveillance studies are conducted on an annual basis and their results are presented at national conferences that attract the attention of medical authorities and political decision-makers. CAAP supported sentinel surveillance in 18 regions in the four Central Asian countries, with GFATM playing the role of principal sponsor and with CAAP providing financial and technical support (training, tests, and operational expenses at sponsored sites). Furthermore, with RAF support, training courses for sentinel surveillance have been included in the curriculum of the Tashkent Institute for Advanced Medical Studies.

The sustainability of regional sentinel surveillance merits attention from regional players, including national MoHs, NGOs and international organizations. Taking into account that sentinel surveillance studies have been implemented in Central Asia since 2004, it is safe to assume that both organizational arrangements and trained specialists are in place to monitor the trends of the HIV epidemic in the region. However, the sustainability of this research is uncertain as the region’s governments are unlikely to absorb the operational costs of these studies once CAAP is finished. Kazakhstan, is the exception as Sentinel Surveillance is institutionalized at the national level and is supported from government’s budget.

**Electronic Surveillance (ES) System on HIV Infection**

CAAP has supported the establishment of a database to track HIV/AIDS patients in Central Asia. Maintaining a database of registered patient responses to ART therapy, as well as the emergence of complications or development of opportunistic infections, has become a necessity given the rising number of HIV cases. Before CAAP, individual data on each patient (such as CD4 cell counts and prescribed treatment) were being recorded only at the time of registration of an HIV case, and these electronic files were not updated on a regular basis. As a result, medical specialists were severely limited in their ability to monitor the effects of ART and lacked the ability to make changes in prescribed drugs when necessary.

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37 The CD4 count measures the number of CD4 cells. Along with other tests, the CD4 count helps to tell how strong immune system is, indicates the stage of HIV disease, guides treatment, and predicts how the disease may progress.
Such spotty surveillance could have led to the emergence of drug-resistant forms of HIV or high numbers of unnecessary complications and negative side-effects. CAAP financed the purchasing of hardware and the development of software for an electronic surveillance database to be installed at the national and regional (oblast) AIDS Centers. Seventy specialists from pilot sites have been trained to use the software, and databases have been created and tested in two pilot sites in Kazakhstan (Temirtau and Karaganda). In 2011, the use of the software was expanded in pilot sites in Tajikistan and Uzbekistan. The Electronic Surveillance is fully operational in 25 pilot sites, including 17 pilot sites in Kazakhstan, 3 pilot sites in Kyrgyz Republic, 3 pilot sites in Tajikistan and 2 pilot sites in Uzbekistan. In Tajikistan, Ministry of Health issued a decree to expand the electronic surveillance at the national level. In Kazakhstan, decree was approved by Ministry of Health to expand the electronic surveillance throughout the country. CDC supported ICAP project to continue implementation and supporting of electronic surveillance system in AIDS service centers of Kazakhstan, Kyrgyz Republic and Tajikistan. Similar support is being provided through GF funded project in Uzbekistan.

**The Central Asian Inter-Regional Parliamentary Working Group on HIV**

One of the principal contributions of CAAP in terms of shaping an effective response to the epidemic has been to raise HIV awareness among policymakers in the region. As previously noted, government budgets remain the only stable – albeit limited – source of funding for health-related programs, meaning that government support is essential to ensuring the sustainability of HIV prevention and treatment efforts. Furthermore, with political tensions among some Central Asian countries growing, the opportunities for politicians and government officials to understand what is happening in neighboring countries have been limited. Under these circumstances, the regional projects like CAAP are well-positioned to facilitate communication among law-makers, law-enforcement officers, and medical professionals so that experiences, standards and practices can be shared with regional colleagues.

CAAP’s mobilization of parliamentarians started with the sponsoring of an international conference titled “The HIV Epidemic in the Countries of Central Asia and Eastern Europe: Legislative Measures and Priorities for Interregional Cooperation,” held in Bishkek in September 2006. As a follow-up to the conference, the Central Asian Inter-Parliamentary Working Group on HIV was established, with representation from the four Central Asian republics and Azerbaijan. The Group includes two representatives from the parliaments of member-states and its objectives are defined as follows:

- Increase involvement of law-makers and government officials in HIV/AIDS response;
- Develop and strengthen the regional strategy for responding to the HIV/AIDS epidemic;
- Strengthen legislation to support control of HIV/AIDS in Central Asia.
Between 2006 and 2010, five Inter-Parliamentary Conferences on HIV were organized. In addition, several Parliamentary hearings advocated changes that would establish a legal environment to promote effective prevention and treatment of HIV/AIDS, and reduce stigma and discrimination. Legal achievements included: (a) revisions to the Law on HIV in Tajikistan in October 2008, including removal of the provision for the deportation of HIV-positive foreigners; (b) development of a legislative proposal for a new Law on Preventing Drug Addiction in Kyrgyz Republic; and (c) revisions to the Law on AIDS in Uzbekistan. It is noteworthy that the revisions of the Uzbek Law on AIDS affect over 50 percent of its provisions; thus, in practical terms, the revisions formally qualify as introducing a new law. If this law is passed, it will be the first legislative regulation introduced by members of Parliament (MP) rather than the executive branch in Uzbekistan. It is worthwhile to noted that, CAAP financed Inter-Parliamentary Working Group also covered representatives of Azerbaijan. Members of the TWG from Azerbaijan took the leading role in amending the law on HIV/AIDS in their country which was approved in summer 2010.

Members of regional parliaments who participated in CAAP’s Inter-Parliamentary Working Group stated that they appreciated the opportunity to familiarize themselves with the respective laws of neighboring countries, as well as Russia and Azerbaijan. Participants reported that this regional legal knowledge was reflected in the legal measures they proposed in their own countries. To facilitate parliamentarians’ access to legislative information from neighboring countries, CAAP initiated the development and publishing of a compendium entitled “Collection of Laws on HIV-related Issues in Central Asia”.

**The Central Asian Islamic Conference on HIV/AIDS**

CAAP promoted the involvement of religious leaders in HIV prevention as one of its top priorities. Since the collapse of the Soviet Union, the influence of religion, especially Islam, has been on the rise in Central Asia. As such, convincing young people to practice HIV-safe behaviors requires cooperation from religious leaders and organizations. The first step in this direction was the organization of a round-table discussion (“Islamic Humanism and Responses to the HIV Epidemic”) in Dushanbe in December 2006. Islamic leaders as well as representatives of government agencies overseeing religious affairs and ministries of health from the four countries took part in this event, the goal of which was to raise the awareness of Islamic leaders regarding the growing HIV epidemic in Central Asia. As a follow-
up to this event, the 2007 Central Asian Inter-Confessional Conference on HIV/AIDS brought to Bishkek nearly eighty leaders of religious associations, governmental, non-governmental and international organizations from Kazakhstan, Kyrgyz Republic and Tajikistan. As a result, an emerging group of regional Islamic leaders have dedicated themselves to spreading HIV prevention messages within their communities. Reports of imams addressing HIV issues have come from Kazakhstan, Kyrgyz Republic and Tajikistan. To facilitate the discussion of the links between Islamic principles and HIV prevention, and to assist religious leaders in presenting HIV-related material, CAAP also conducted a series of regional seminars and national workshops on HIV prevention.

CAAP supported presentations by and discussions with a noted Islamic scholar who discusses issues surrounding HIV in an open and constructive manner. An international consultant, an Islamic scholar who had extensive experience with HIV prevention projects in the Middle East, gave presentations as well as facilitated several national seminars organized by CAAP. Because developments in the Middle East often serve as a reference point for Central Asian religious leaders, the facts and arguments provided by the scholar carried particular weight. As a follow-up to these discussions and with support from CAAP, the Islamic authorities in Kyrgyz Republic developed a handbook on HIV/AIDS for those imams who wanted to discuss the issue within their communities. Also, a curriculum for HIV/AIDS was developed under the auspices of EurAsEC and CAAP; which is being integrated into training programs at the Islamic education centers in Kazakhstan, Kyrgyz Republic and Tajikistan. Both documents address issues of maintaining healthy lifestyles, abstinence, spousal obligations under marriage, and disease prevention. They also present the position of Islam on the use of contraceptives and use of drugs. The curriculum has been revised by the regional technical working group that includes religious leaders, medical specialists and government officials. After that it was further reviewed and agreed with the State Committee/Council on Religious affairs in the respective countries.

The Journalists’ Training Program on HIV Awareness and Stigma Reduction

CAAP has placed a priority on working with journalists and established several activities to support and provide training for them. The project’s Journalist Training Program on HIV Awareness and Stigma
Reduction reaches out to the general population with mass-media HIV prevention messages. The objective of the program was to train a group of media professionals so that they can knowledgeably cover the HIV-related aspects of health and social issues. As a first step, a program covering both medical aspects of the HIV epidemic as well as best examples of media coverage of these issues had been offered in the four project countries by a team of media experts from Kazakhstan. Later, partner organizations such as the Independent School of Journalists in Tajikistan were selected to conduct training seminars on covering HIV-related issues at the national level. CAAP also invited local journalists to take part in annual competitions for best coverage of HIV/AIDS issues. The project established a working relationship with the government-run Radio Corporation in Uzbekistan, which aired presentations and discussions on HIV-related issues across the country almost every week. Some of CAAP’s activities for journalists were also being supported by UNESCO within the framework of its program “Training of Trainers in HIV and AIDS Reporting in Central Asia”.  

Regional Training of Trainers Centers

CAAP activities built training capacity in the region, but questions remain about sustainability of these efforts. CAAP’s Regional Training of Trainers Centers project has resulted in the establishment of four Regional TOT (training of trainers) Centers in the participating countries. Each country’s TOT Center focuses on a different technical area. Specifically, Center for Epidemiological Surveillance over HIV infection was established in Kazakhstan; The Center for Harm Reduction in Kyrgyz Republic; The Center for Prevention of HIV among Migrants in Tajikistan; and Center for treatment, care and support of PLWH in Uzbekistan. The Center in the Kyrgyz Republic was established and registered as a non-government organization supported by the Association of Harm Reduction of the four participating countries, two government organizations from Kyrgyz Republic and the Eurasian Harm Reduction Network. The remaining TOT centers have been established on the basis of existing public institutions such as the Republican AIDS Centers in Kazakhstan and Uzbekistan, and the National Center for Healthy Lifestyle in Tajikistan. In the three countries establishment of the TOT Centers was supported by the respective decisions of their Ministries of Health.

All developed training manuals have been reviewed by national and international experts, approved by the countries Ministry of Health’s and/or Ministry of Education’s special commissions and are integrated into the curricula of public institutions for postgraduate studies. During the project life, 38 training sessions were conducted at regional and national levels, as a result of which about 900 professionals have been trained. Education at the regional level includes training of trainers, training conducted with mandatory invitation of international experts from partner organizations: AIHA, IOM,

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38 Li, 2009
UNESCO, UNODC, CDC. In addition, within the scope of activities of each center, project supporting training of leading experts abroad on advanced training base. An important step in this direction is that training programs have been approved and adopted by relevant ministries (MoH, MoE) in all of the four countries.

Ensuring the sustainability of these Centers is unlikely to be achieved by the end of the project’s lifetime as this requires establishing a clientele base in Central Asian countries, a process that may take several years. With the exception of Kazakhstan, where TOT Centers have been established under government institutions that absorb costs, sustaining these Centers is difficult without external funds or greater commitment from national authorities. Ideally, funding would come from medical institutions and NGOs in other countries that may be interested in receiving trainings at the regional centers. Such an arrangement would be more likely if the training programs were professionally recognized within the medical and NGO communities in the Central Asian countries, a process which could take an additional three to five years. As a first step, the regional TOT Centers could target GFATM-funded programs in Central Asian countries, a majority of which involve provision of services to migrants and other vulnerable groups, as well as ART for HIV patients. The costs of these training courses would then have to be included in the budgets of the respective GFATM-funded programs, and arrangements would have to be established between country coordination mechanisms (CMM) at regional levels. This approach was implemented successfully in Tajikistan where support for the TOT Center was included into the country’s application for GFATM’s support in Round 8 and the application was subsequently funded. In other words, support from the GFATM will ensure the sustainability of this institution in Tajikistan, when CAAP completed.

Furthermore, the sustainable operations of the regional TOT centers also require that their diploma or certificates be recognized by health authorities in other countries, which can only be arranged at the regional level. Given that EurAsEC is taking steps in introducing common standards in the medical field, discussions about the status of diplomas issued by these Centers should be included.

**Component 2 – Regional AIDS Fund**

CAAP’s second component is a demand-driven Regional HIV/AIDS Fund that provides grant support to national institutions, the NGO sector, and entrepreneurs who are focusing on the development of HIV/AIDS services and/or prevention activities.

The RAF gives priority to proposals that are focused on prevention services for members of vulnerable groups such as IDUs, CSWs, MSM, migrants or prisoners. Primary prevention programs targeting the
general population or assisting in the provision of ART are also supported. Proposals submitted to the RAF are evaluated by the Regional Technical Evaluation Committee (RTEC) composed of representatives from national governments, bilateral organizations, international organizations and NGOs. Selected programs receive financial support from the RAF for 12 to 24 months. During the project implementation four grant rounds were completed.

Several hundred programs have been funded through the RAF, the majority of which have achieved outstanding results. CAAP collaborated with the USAID-funded CAPACITY project and implemented a community mobilization strategy which focused on capacity-building for potential service providers in project design, management and M&E. As a result, over 220 organizations from participating countries have been trained and were able to successfully participate in the RAF program. Below are some highlights of the activities of the RAF-supported programs that have region-wide implications.

**Primary Prevention among Youth**

The RAF-supported primary prevention program among Uzbek youth is a good example of activities aimed at preventing HIV infection among general population. The proposal for this program came from the Ministry of Higher Education of Uzbekistan (MoE), whose specialists participated in developing a curriculum on HIV prevention. The MoE specialists also conducted training seminars for teachers of medical and biological subjects at higher education institutions across the country; 70 universities and colleges took part in this program. As a way of extending this activity, a program on HIV prevention was developed by MoE specialists and integrated into the curriculum of public universities in Uzbekistan. From 2009 onwards, this mandatory course has been taught at all universities and is fully funded by the government of Uzbekistan. Thus, by selecting its partner strategically, the RAF provided an incentive for the Ministry of Higher Education to introduce its HIV prevention program for students because the RAF was training specialists to teach this subject, an activity for which the Ministry had limited funds available. This combination of efforts between the RAF and a government agency resulted in an effect that is likely to be comprehensive and long-lasting, and can be used as a model in other countries.
Public Awareness Campaign at Uzbekistan Airlines

Transportation companies, by virtue of the activity of moving people across borders and regions, contribute to the transmission of infectious diseases. The structure of these companies includes medical departments that both provide services to their own employees and perform sanitary control functions. However, most companies, even if they are run by the government, may hesitate to get involved in the response to communicable diseases like HIV. Yet, in Uzbekistan the government-run airline company played a key role in an important public service campaign. In December 2008 the President of Uzbekistan issued a decree promoting inter-agency cooperation in the fight against HIV, and established a committee headed by the Prime Minister to tackle the issue. In response, the medical specialists at Uzbekistan Airlines submitted a proposal to the RAF to provide training seminars on HIV prevention for pilots and other crew members, as well as more than 1500 passengers who regularly flew with Uzbekistan Airlines. Passengers who used the Tashkent airport were also included in the planned activities. To produce and disseminate informational materials that would target passengers required support from the company’s management, since commercial rates for placing advertisements at airports or in-flight TV programs were prohibitively high.

In spite of the costs, the airline’s management recognized the importance of the message and expressed full support for the proposal to distribute HIV prevention brochures on board Uzbekistan Airlines flights. In addition, brief public service messages were included during in-flight broadcasting and at the Tashkent airport. Uzbekistan Airlines management negotiated the details of placing HIV prevention messages with an advertisement company with no charge to the project. As a result, passengers flying with Uzbekistan Airlines have been receiving brochures on HIV transmission and prevention methods; the TV spot also informs passengers where HIV tests can be done. Although it is difficult in this example to determine what were the drivers behind the successful outcome, top-level politicians clearly played a role in motivating the management of this government-run company to support the informational campaign. The experience of Uzbekistan Airlines illustrates the potential for implementation of HIV prevention programs if the respective efforts of donor-sponsored projects are reinforced by local political leaders.

Increasing Coverage of Vulnerable Groups: The TUMAR Project

A key challenge for HIV prevention programs in Central Asia is increasing access to information and medical
The importance of accessible services for vulnerable groups has been highlighted by the results of a 2009 study sponsored by the AIDS Foundation East West. Members of vulnerable groups often face difficulties in accessing services, especially when it comes to arranging residence and disability documents, job training, and drug treatment programs (Zhusupov, 2009). The RAF-sponsored TUMAR project provided a successful example of promoting access to a package of HIV prevention services. TUMAR, one of the biggest projects sponsored by the RAF, was active at seven sites in Kazakhstan, Kyrgyz Republic, Tajikistan and Uzbekistan, and included provision of a continuum of information, prevention and medical services to IDUs and CSWs. Specifically, under the auspices of this project, clients were provided with sterile syringes, condoms, information materials, lodging, and bathing facilities offered at the Drop-in Centers, one-on-one counseling sessions on HIV prevention and early detection of STI, as well as medical referrals.

More than 10,000 clients received services through TUMAR, resulting in a coverage rate for the seven selected sites of 84 percent. Furthermore, more than half of the clients (56%) received services 5 times or more, with the number of these repeat clients increasing steadily over the project’s lifetime. In other words, the project has managed to reach out to a considerable number of vulnerable individuals and has maintained stable ties with many of them. In combination, these two factors expand the possibilities for promoting HIV-safe modes of behavior among these hard-to-reach groups.

To target specific infection diseases like HIV through the corporate mechanisms requires political will on the part of company’s management. The factors to which company’s directors may respond in targeting HIV are numerous but, as the Uzbek experience reveals, one of them is signals from top-level political administrators.

A key factor contributing to smooth delivery of HIV prevention services through the TUMAR project was cooperation with local administrations both in the form of their offering political support as well as specific contributions such as provision of medical treatment to clients. At every site TUMAR managed to establish Working Groups responsible for overseeing the project’s implementation.

to the reasons behind the success of this program, the role of outreach workers as both recruiters and providers of services needs to be highlighted. The vast majority of clients were contacted through outreach workers who provided some services on the spot, – e.g., syringe exchange – but who also referred clients to medical and social services such as HIV testing. Given the central role of outreach workers, considerable efforts have been invested in selecting these staff members and providing them with additional training on health-related issues and presentation techniques. Specifically, the project’s
Central Asia AIDS Control Project

The World Bank staff has developed eight training modules which cover a range of topics, from explaining the need for HIV testing to effectively presenting the project’s services to a client. These training modules have been translated into local languages and now are available in each project country.

Another key component of TUMAR project’s success in delivering services was cooperation from local administrations both in the form of political support as well as specific contributions such as provision of medical treatment to clients. At every site, TUMAR established working groups which were responsible for overseeing the project’s implementation. The groups included representatives from medical institutions, law-enforcement agencies, religious organizations and local authorities, all of whom knew the local conditions well.

HIV Prevention among Migrant Workers in Central Asian Countries

Acknowledging the growing risks of exposure to HIV and other infectious diseases among migrant workers, the RAF supported response activities. In one example, RAF collaborated with the regional offices of the International Organization for Migration (IOM) in Kazakhstan and Tajikistan in an initiative to establish a sustainable mechanism for HIV prevention among migrant populations. The IOM’s initiative includes supporting and promoting the Regional Training and Coordination Center for Migrants in Dushanbe developing and updating a manual on HIV prevention among migrants to be taught at the Republican Centers for Promoting Healthy Lifestyles of Tajikistan and other educational institutions; promoting and enhancing the potential of the NGOs who provide services to migrants; and arranging for the provision of medical and social services to migrants in Kazakhstan, as a recipient country. A major highlight of this project is its explicit effort to promote synergy among government, international agencies and NGOs in tackling this regional issue. For example, the Regional Training and Coordination Center is being established under the auspices of the MoH of Tajikistan within the Healthy Lifestyle Center, so that the credentials issued to trainers from other republics can be accepted in their neighboring countries. At the same time, the IOM has also mobilized international experts to train medical professionals, religious leaders, and NGO staff from Central Asian countries so that the latter can then serve as regional consultants who train national counterparts working with migrants. NGOs taking part in this initiative also play a central role in implementing behavioral surveys among migrant workers in Tajikistan and Kazakhstan.

Cooperation with NGOs established by lawyers provides a cost-effective way to deliver legal services to people living with HIV.
**Linking HIV Prevention and Social Development Projects**

CAAP activities recognize that HIV prevention projects should link with social development initiatives in order to respond to client employment needs, as many clients are members of disadvantaged groups. Among the RAF-supported projects in Tajikistan is the NGO Healthy Pulse, which has been providing reproductive health services and STI/HIV testing for more than 700 CSWs. Healthy Pulse has been working in the capital of Dushanbe and the cities of Vakhdad and Evan since 2002. Healthy Pulse includes medical professionals who also conduct group and one-on-one discussions with their clients and patients. Healthy Pulse reported that a considerable number of clients would prefer to leave the sex business, but they do not see viable alternative sources of income to support their families. To address this issue, the NGO’s clients came up with the idea of opening a textile workshop that would provide an alternative way to earn an income. Even though the NGO did not manage to obtain the necessary funds to rent premises and buy sewing equipment, they are working on establishing an employment center for women. Without having other sources of income or moving to a different environment, CSW are likely to return to sex work or drug use.

**HIV Testing among Migrants and their Family Members**

CAAP activities draw upon local customs to serve hard-to-reach groups. Due to their mobility, migrants are often a difficult group to reach for HIV prevention or testing. However, as demonstrated by the Bukhara AIDS Centre, relying on community structures such as mahallya in Uzbekistan can expand the reach of HIV testing among specific groups. Mahallya is the traditional form of self-organization in local neighborhoods, centered around community elders who carry moral authority and may perform some administrative functions. Operating at the grass-root level, these leaders are well-informed about the developments in their neighborhoods and, if necessary, can call on family loyalties to ensure that community members do what is expected of them.

To conduct HIV testing among migrants and their family members, the Bukhara AIDS Center mobilized support from the mahallya leaders by discussing the rationale for the program and developing a plan...
of action. Political authorities also indicated their support for HIV testing among this target group. With the mahallya leaders mobilized, HIV testing among migrants and their family members was quite successful, as the heads of local communities not only had the means to identify those who had returned from work assignments abroad but also could convince them to be tested. During twelve months of operation, the testing program reached 20,000 migrants and family members in Bukhara.

Providing Legal Help to Members of Vulnerable Groups

Provision of legal assistance to people living with HIV (PLHIV) can be challenging due to the complicated nature of the problems that surround their disease and each person’s willingness to address them, as well as the high costs associated with legal services. CAAP’s RAF proved to be an effective mechanism to deliver legal services to PLHIV. Through its grants, the RAF supported the activities of the NGO Adilet, which was established by legal professionals in Kyrgyz Republic. Adilet maintains a hotline for PLHIV, where they can voice their concerns and seek legal advice. During the first year of operation, 128 clients received consultations. In addition, 50 clients were represented by lawyers in civil and criminal cases. Adilet’s lawyers also provided assistance by informing law-enforcement agencies, medical professionals and representatives of NGOs about the rights and obligations of PLHIV, and of the legal status of “harm reduction” projects in Kyrgyz Republic. Several training seminars and a round-table discussion on these issues were conducted by specialists from Adilet. The overall budget of this project was below US$20,000, proving that such services can be provided in a quite cost-effective way.

The Department for Planning, Analysis, Response and Coordination

As noted earlier, gathering and analysis of data has long been a weak point in Central Asia. National coordination in the field of HIV/AIDS tends to be concentrated under Ministries of Health, who sometimes lack authority to ensure the gathering of relevant data – especially financial data – from other ministries involved in responding to HIV/AIDS. Against this backdrop, the breakthroughs made by the Department of Planning, Analysis, Response and Coordination (PARC), another CAAP grant recipient, merit attention. Originally, this Department was established under the Republican Coordination Commission on HIV (CCM) in Uzbekistan to monitor the implementation of a program to counteract the spread of HIV. As this program involved several ministries and government agencies, PARC was charged with the responsibility to collect each agency’s data. To fulfill this task, PARC developed an M&E manual, which was approved by

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39 When discussing funding for HIV-related programs in Central Asian countries, in 2004 Godinho and her colleagues were not able to find a coherent source of data and concluded that “most FSU governments are not able to report on expenditures to address HIV/AIDS and STIs” (Godinho et al, 2004).
the CCM of Uzbekistan. This document defines the key indicators to be applied to monitor the program, the agencies responsible for data collection, deadlines for reporting, and templates for data analysis. Furthermore, the political authorities in Uzbekistan support the implementation of this document, so that PARC has now accumulated the most complete data on the implementation of the Strategic Program including financial reporting from government and non-government organizations, both local and international. In selecting and defining key indicators, the Manual can serve as model for national or local bodies charged with coordinating response to HIV. PARC’s experience of collecting data on HIV from non-medical institutions is of relevance to country coordination structures established in other Central Asian republics.

**Regional cooperation**

In addition to direct project-related outcome, CAAP generated significant political benefits. In 2009 the Inter-State Council initiated the development of the so-called Target Program (officially called “Health of the EurAsEC’s Population”), aimed at promoting cooperation across EurAsEC countries on access to medical services and health indicators. The Program places special emphasis on the trans-border risk of infectious diseases including HIV and TB, and proposes several actions in response: 1) coordinating health care policies across member states including the introduction of unified testing, treatment and rehabilitation protocols; 2) promoting primary health care services and disease prevention methodologies; 3) establishing unified methods and protocols to monitor infectious diseases and implementing joint programs by sanitary control services; 4) developing joint strategies to respond to communicable diseases; and 5) launching unified training programs for medical professionals (EurAsEC, 2009). In other words, the document establishes the political framework for cooperation in HIV/AIDS response at the regional level and specifies priority areas where this cooperation is especially encouraged.

More importantly, in November 2009 EurAsEC adopted a critical regional strategy – the Regional Strategy to Prevent Infectious Diseases in Central Asia. The goals of this strategy are numerous: 1) to stabilize the spread of infectious diseases through increasing the accessibility of prevention, support and care programs for mobile groups within the region’s population; 2) promoting involvement of civil society in providing these services; 3) improving and harmonizing methods for collection, analysis and dissemination of HIV-related data; and 4) enhancing regional cooperation and harmonizing legal regulations with respect to service provision to PLHIV. The strategy also reflects the concern among regional policymakers regarding the increased potential for outbreaks of infectious diseases as the volume of labor migration grows. In response, the strategy recommends better awareness of HIV and STI prevention methods and improved possibilities for migrants to obtain medical care in host countries.
The strategy also envisions the establishment of a unified reference source on HIV/AIDS-related issues by extending the possibilities of the CAAP-sponsored information system CARISA. While the specific mechanisms to implement these declared goals are yet to be defined, the strategy calls for the establishment of a regional body who would focus on turning the written strategy into an action plan.\(^\text{40}\)

\(^{40}\) Meimanaliev, 2009
LESSONS FROM CAAP: COMPARATIVE ADVANTAGES OF THE REGIONAL APPROACH

HIV/AIDS remains a serious and significant challenge in Central Asia. However, the apparent failure to fully control the epidemic should not overshadow the achievements and lessons learned under CAAP. Within the region, the added value of the regional approach is not yet fully recognized or is often misunderstood. However, experiences from CAAP present a valuable resource for other regional initiatives. Six lessons learned that emerged from the project are discussed below.

- A regional approach to HIV/AIDS provides a framework to raise sensitive yet critical issues that have been difficult to address within individual countries. A regional focus can leverage peer influence to encourage policy change and harmonization of policies, and often enhances policy dialogue.

As described earlier in this paper, on top of the numerous socio-economic, cultural and funding issues that have restrained HIV/AIDS response in the region, at times political issues have made these challenges even greater. Some governments place a tight control on public health information that they may deem a threat to public order, or governments simply may not be willing or able to fund critical activities if they perceive the activities to be politically risky. For example, news of communicable disease outbreaks are frequently suppressed in Central Asia, as illustrated by the fact that some countries in the region did not report any cases of the H1N1 pandemic. Several countries have legislation that prevents them from sending specimens of contagious agents to WHO reference laboratories for further analysis. Reports in 2010 about HIV infections occurring at health care facilities due to unsafe medical practices caused a severe reaction from national authorities and unfortunately resulted, in some cases, in a dramatic reversal in policies for HIV/AIDS control. However, the CAAP project showed that politically risky public health issues can be successfully addressed at the regional level, resulting in harmonization of policies and further enhancements of preventive measures. For example, CAAP’s supported Sentinel Surveillance on annual basis and data obtained on the epidemiological surveillance were presented on a regional conference that allowed countries to exchange information on epidemiological situation at national level. Regional-level meetings between members of parliament allowed politicians to see alternative ways of dealing with specific issues, and resulted in positive legislative changes.

Similarly, prevention and treatment of communicable diseases proved to be an area where regional cooperation was relatively easy to achieve. While some countries initially chose to suppress information on disease outbreaks, CAAP’s activities encouraged cooperation and resulted in more transparency and
access to the information within individual countries. Politicians saw regional cooperation as the logical approach, since the sources of infection were often located outside national borders, and the high volumes of cross-border migration increased the risk of outbreaks in every country in the region.

- **Having a framework for political cooperation established at the regional level is an important condition for collaboration in the health sector.**

Having agreements for regional cooperation in place makes it easier to national governments and their agencies to establish collaboration. Under CAAP, regional structures allowed national governments and agencies to more easily take part in designing and implementing disease prevention programs including data sharing, dedication of experts and specialists, and provision of co-funding. This framework was originally provided under CAAP by Central Asian Countries Organization (CACO) and subsequently by EurAsEC.

- **A robust, coherent and accurate public awareness campaign about HIV/AIDS is critical; in addition, public acknowledgement by high-level politicians of the seriousness of HIV/AIDS promotes cooperation from all levels of government.**

The harmonization of key messages and collaborating with those who shape public opinion such as journalists and religious leaders can contribute to building public awareness and demystifying the HIV/AIDS epidemic. Without training and sensitization, journalists often exploit and sensationalize HIV/AIDS, instead of using more objective reporting methods to fight stigma and shape public policies.

In addition, if top-level political officials make public statements that characterize HIV as a threat to national security and well-being, the public may shift their perception of the problem from being a purely medical issue to a social and multi-sectoral one. Furthermore, such public statements also send the message that HIV-related issues are being monitored by the country’s highest offices, thereby creating the incentive for lower-level government officials to cooperate with HIV prevention initiatives. As illustrated by the example of the HIV prevention activities launched at Uzbekistan Airlines (described earlier in this paper), presidential decrees appeared to motivate this government-run company to collaborate.

- **Members of parliament may be very responsive to outreach about HIV/AIDS projects or activities, and may represent the most effective way to seek government collaboration.**

As government funding is the only stable source of support for health-related activities in Central Asian
countries, maintaining direct dialogue with policy makers is critical in order to ensure the sustainability of the project initiatives. Due to strong links to their constituencies, CAAP found that members of parliament tended to be willing to align themselves with HIV/AIDS prevention initiatives. In the absence of other contacts in government structures, future projects may be best advised to start collaboration with the legislative branch. Support from members of parliament improves the chances to establish lines of communication with the executive branch and provide a platform for advocacy actions on a national scale.

- In a resource-scarce environment like Central Asia, virtual networks of regional experts can substitute for low capacities at national levels.

CAAP demonstrated that sharing experiences accumulated by individual specialists through a regional platform had multiple benefits. This approach could be widely used in other HIV/AIDS programs as well as in other sectors, given the financial limitations and limited institutional capacities throughout the region. Research activities in the field of HIV prevention and treatment are quite costly and require a well-developed infrastructure that most Central Asian countries currently lack. Under these circumstances, stimulating HIV-related research and updating response strategies requires bringing experts from other areas of the world where programs have been operating successfully. Given the costs involved in organizing these events, holding them at the regional level is considered prudent and efficient, especially if the experts share experiences on issues of relevance to every health care system in the region. Discussing issues and experiences at the regional level will also contribute to the international experience being better adapted to local conditions, as participants from Central Asian countries will have a chance to assess the relevance and implications of the presented findings or conclusions.

Existing technical specialization fits in well with this approach. Individual countries in the region have already developed specific areas of expertise around HIV; sharing experiences and knowledge can have widely-applicable benefits. Even in the days of the Soviet Union, there were differences among health care systems in the various republics in terms of areas of expertise. During the post-Soviet period, these differences among countries have increased, due to the divergence of national political priorities, variations in economic development, and country-specific social issues. As a result, specialists from different Central Asian countries have greater expertise in some aspects of HIV prevention; this expertise is often relevant to neighboring countries where similar issues exist.

CAAP established Regional Training Centers with Kazakhstan as a focal point for sentinel surveillance; Kyrgyz Republic focusing on “harm reduction” approaches; Tajikistan on HIV prevention among migrants; and Uzbekistan on treatment, care and support for PLWH – all supported by CAAP and to
some extent by GFATM. Furthermore, some of the sensitive issues related to HIV prevention activities among vulnerable groups (like needle exchanges in prisons) are politically sensitive and may fall victim to political disputes that unfold in specific countries. However, health professionals still need the ability to assess the positive and negative sides of these prevention methods. Regional cooperation provides such an opportunity. This sharing of experiences and technical cooperation requires the establishment of regional platforms; the involvement of international experts where required; addressing health system deficiencies contributing to the spread of HIV; and mitigating social consequences of the epidemic.

- **Regional cooperation and coordinated policy development are more likely on issues that emerge from common socio-economic developments that cross regional borders.**

Given that the main drivers of the epidemic --including trafficking of people and drugs, sex work and economic migration-- have region-wide ramifications, the respective measures to counteract the epidemic can be best addressed from the regional level. There is a clear understanding among policymakers and medical professionals in Central Asian countries that effectively responding to communicable diseases requires cooperation at the regional level as the infectious diseases do not recognize national borders. Both country-donors of labor migrants such as Tajikistan and country-recipients such as Kazakhstan bear considerable costs as a result of outbreaks of infectious disease in the region. Awareness of these linkages increases the likelihood of regional initiatives to prevent communicable diseases among migrants being supported by national governments in the region. As the intensity of migration is unlikely to diminish in the foreseeable future, the only effective strategy is to establish a “safety perimeter” in the region as a whole, with timely exchanges of information about the outbreaks of infectious diseases, implementation of joint exercises to prevent communicable diseases, especially in the border areas, and the introduction of common standards for disease prevention, containment or treatment activities.
Annex 1

Brief information on the activities of international partners in the field of HIV/AIDS in Central Asian region

The Global Fund to Fight AIDS, Tuberculosis and Malaria

Starting from in 2002, the Global Fund (GF) to Fight AIDS, Tuberculosis and Malaria is the largest donor in the region whose funding activities aimed at combating the spread of the HIV epidemic in the region by providing significant support to countries to implement national strategies in combating HIV / AIDS. GF provides grants to all the countries of Central Asia in support of technically sound and cost-effective prevention and treatment, care and support for people living with HIV / AIDS and those directly affected by the disease. First of all, the Global Fund finances activities aimed at ensuring access for AIDS patients to antiretroviral therapy. It should be noted here that prior to the implementation of GF grants in the region, antiretroviral therapy was not available. Another most significant directions of funding is to support harm reduction programs for vulnerable groups (IDU, SW, MSM), including the distribution of disposable syringes, condoms, information and educational literature, etc. At present, with full support of the Global Fund opioid substitution therapy is being implemented in the region.

The funds of GF significantly improved technical capabilities of AIDS services (purchase of computer equipment, vehicles, laboratory equipment and supplies). Considerable attention is also paid by GF on strengthening national monitoring and evaluation, and training matters. It should be noted that the efforts of GF apply both to support the activities carried out in the civilian sector, and in penitentiary systems. Over the past few years, there has been significant improvement in coordination of efforts by the Global Fund and other international partners at the Republican AIDS level in the countries. During the implementation of CAAP, for example, there was a mutual coordination on the issue of awarding sub-grants in order to avoid duplication of funding of certain activities.

UN Agencies

UN agencies are involved in the organizational and researches in the field of HIV, in accordance with their mandates. Regional offices of UNAIDS providing technical support to national partners in the preparation of country reports on key indicators adopted by the Special Session of the General Assembly on HIV / AIDS (UNGASS), which are available once in 2 years. UNAIDS also assists in promoting the policy response to HIV on the basis of Three Ones principles and helps to strengthen monitoring systems at the national level. UNDP is the principal recipient of Global Fund grants for HIV / AIDS in Tajikistan, Kyrgyz Republic and Uzbekistan, but also receives funding from the Global Fund to support the Country
Coordinating Mechanism in Kazakhstan. In addition, this agency implements the Central Asian Drug Action Program (CADAP), funded by the European Union. The aim of CADAP is to assist in developing strategies on controlling trafficking and ensuring a sustained reduction in drug use at the regional level. CADAP is being implemented in the five Central Asian countries and supports range of services, from outreach works to treatment from drug use, motivational interviewing, social and vocational rehabilitation. However, its three-year budget is limited to U.S. $ 1.4 million, so most likely its impact on providing services to drug users will be very modest. Some works in this area carried out by UNODC by implementing regional initiatives on drug treatment, aimed at ensuring the availability of these services among drug users. With regard to PMTCT programs in Central Asia, considerable technical support in implementation is provided by UNICEF.

Centers for Disease Control and Prevention, USA

In accordance with its mandate, the Central Asian regional office of the Centers for Disease Control and Prevention of USA (CDC) is involved in various activities to prevent the spread of HIV in the region, including improving surveillance systems, ensuring the safety of medical procedures and blood products, raising the level of laboratory services in the countries of Central Asia. Much of this support comes in the form of technical assistance from CDC, and financing related activities comes from other sources. In particular, CDC provides technical support for the inclusion of other vulnerable groups such as migrants into sentinel surveillance system and increasing the number of pilot sites where sentinel surveillance studies are carried out. In working with national partners, CDC is also involved in creating a system of electronic surveillance for HIV. In addition, CDC experts train their colleagues in countries on the practices of safe injection and blood safety, assisting ministries of health in improving the national standards in this area.

CDC is assisting countries in the region to assess equipment needs, and existing operating procedures in medical laboratories with the aim to assist public health professionals in countries to meet the needs of the estimation and the procurement of modern equipments. CDC also provides training for staffs on proper use of laboratory equipments.

In particular, CDC, along with the divisions of Columbia University, is involved in the «SUPPORT» project in Kazakhstan, Kyrgyz Republic, Tajikistan and Uzbekistan. Funded through the President’s Emergency Plan for AIDS Relief (PEPFAR), this project seeks to support introduction of the prevention and treatment procedures, associated with HIV, in medical institutions, including strengthening laboratory services, as well as development of systems for the collection of strategic information (through sentinel surveillance studies and monitoring) and its use in political decision making. Within the scope of project it is planned to develop a sentinel surveillance and electronic surveillance system in the Central Asian countries, in other words activities that were formulated with the participation of CAAP.
**U.S. Agency for International Development**

U.S. Agency for International Development (USAID) has been operating in the region directly or through regional offices of CDC, as well as through partner NGOs such as PSI. USAID has contributed significantly in fighting with infectious diseases in Central Asia: their current portfolio of programs includes projects on prevention of avian influenza and combating the spread of tuberculosis with multidrug-resistant. Of particular interest is the Quality Health Care Project, aimed at strengthening the capacity of health systems in Central Asia to better meet the health needs of vulnerable groups, funding of which is U.S. $72 million. In addition to providing technical assistance, training, and supply of equipment and goods, the project helps improving governance, funding, training and implementation of health services for TB, HIV / AIDS, as well as primary health care. The components of the project include improving care and maternal health and child.

In addition to the activities of the Quality Health Care Project, the Agency also supports the “USAID Dialogue on HIV and TB Project”, aimed at the development of services for prevention and treatment of HIV and TB among high risk groups, such as drug users, sex workers, prisoners, men who have sex with men, people living with HIV and migrants. Being implemented from 2009 to 2014, the project aims to provide technical assistance, and promote the development of outreach services and cooperation between NGOs and public health agencies in the areas of systems directed to providing services to the representatives of risk groups. These efforts should reduce the prevalence of risky behaviors and increase the detection of tuberculosis, as well as increase their adherence to treatment among the representatives of vulnerable groups in all five republics of Central Asia.

**Department for International Development, UK**

Extended until November 2012 and sponsored by the UK Department for International Development, Central Asia Project on HIV / AIDS (CARHAP) continues to provide financial support for harm reduction services in Kyrgyz Republic. Much of its work is currently aimed at improving the technical capacity of NGOs and «trust points» by providing their employees additional training on harm reduction and improving the use of M&E tools. Also, CARHAP assists NGOs in searching financial support of Global Fund, as DFID funding will soon be completed. In addition, project provides technical assistance to improve national policies on HIV / AIDS in Kyrgyz Republic and Tajikistan.

**German Agency for Technical Cooperation – GTZ**

German Agency for Technical Cooperation (GTZ), is involved in economic development, training
projects, and in the field of ecology in Central Asia since the early 1990s. Recently, the organization also started moving towards the implementation of regional programs in the health sector. In late 2009, GTZ announced launching five-year regional project in the field of public health, which includes HIV prevention component. Covering Kyrgyz Republic, Tajikistan and Uzbekistan, the program includes two main modules: «Health Care Systems Development » and «Prevention of drug use and HIV/AIDS prevention», focusing on (1) to improve reproductive health and health care for mothers and children, (2) promote the development of diagnostics and treatment of tuberculosis (3) to raise awareness of HIV prevention methods among the general population and youth, and (4) reduction in risk behavior among vulnerable groups for HIV. Planned duration of the project is upto ten years with a total budget of 23,0 million Euros.

AIDS Foundation East-West

AIDS Foundation East-West (AFEW) is implementing two regional programs aimed at ensuring access to health and social services for vulnerable groups and people living with HIV. One of them is the « Project ACCESS: joint efforts in the field of HIV and TB in Central Asia, » focusing on the implementation of social support for vulnerable groups and people living with HIV / TB in pilot areas in Kazakhstan, Kyrgyz Republic, Tajikistan, and is funded by the Ministry of Foreign Affairs of Netherlands. Another main objective of this project is to promote multisectoral collaboration between HIV and TB services and penitentiary systems that supports IDU, SW or people with HIV. To achieve these goals, AFEW conducts information and education campaign among decision makers, conducts training workshops and other activities to improve skills and capacity of service providers in some regions, as well as HIV prevention and referral services directly through their social bureaus.

Another regional initiative of AFEW, «Increasing access to HIV prevention, treatment, care and support for vulnerable groups in Central Asia, » aimed at creating and strengthening the network of providers for vulnerable populations. The network includes medical, psychological, social and legal and support services provided through the social bureaus that are operating in seven regions across Central Asia. Service providers also receive additional training and information materials developed by specialists AFEW. Financial support for this initiative was also provided by CAAP in the past.
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