

**THE CAPACITY PROJECT QUARTERLY TECHNICAL REPORT
FIRST YEAR – SECOND QUARTER REPORT**

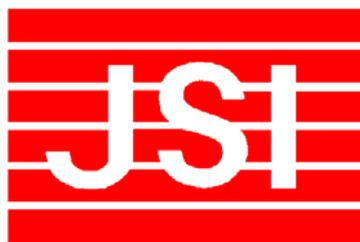
**JSI Research & Training Institute, Inc. (JSI)
THE CAPACITY PROJECT**

“Central Asia Program on AIDS Control and Intervention Targeting Youth and High-Risk Groups”

**QUARTERLY TECHNICAL REPORT
USAID Cooperative Agreement No.:
176-A-00-04-00014-00**



**Second Quarterly Report – First Year
1 January 2005 – 31 March 2005
Submitted April 30, 2005**



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I. CAPACITY PROJECT OVERVIEW

The CAPACITY Project is designed to support USAID/CAR Strategic Objective 3.2 by utilizing the four key strategies outlined in the Cooperative Agreement.

**USAID/CAR Strategic Objective 3.2:
Increased Utilization of Quality Primary Health Care for Select Populations**

Strategy 1: Improving Stewardship of National HIV/AIDS Programs

Strategy 2: Educating and Empowering High Risk Populations

Strategy 3: Improving the Quality of HIV/AIDS Services

Strategy 4: Improving Resource-Use to Integrate HIV/AIDS Services

II. PROJECT START-UP ACTIVITIES CONTINUE

From the programmatic aspect, the second quarter focused on development and implementation of the project's initial assessment, leading to the Project's strategic planning meetings planned for the beginning of the third quarter.

From the operational aspect, the second quarter was devoted largely to further completion of the project's operational start-up activities in Kazakhstan and Uzbekistan while making initial research into operational start-up in Kyrgyzstan and Tajikistan.

A. Second Quarter Programmatic Activities

1. Finalized Initial Implementation & Assessment Plans

The Revised CAPACITY Initial Implementation Plan to USAID/CAR on January 15. The Revised CAPACITY Initial Assessment Plan was developed and draft submitted to USAID/CAR on January 15th. A finalized version was submitted beginning of March and is attached here. All submitted documents were approved shortly thereafter granting CAPACITY the green light on proposed activities through May 2005.

2. Developed Assessment Overview Process & Protocols

The bulk of January through March was devoted to the development, review, pre-testing and finalization of the assessment protocols for each of CAPACITY's eight technical areas. The details of this process are outlined in the CAPACITY Assessment Overview Document attached here. The end result of this process was the development of protocols to assess the each of CAPACITY's technical areas (listed below) during the ensuing Country Assessment Meetings held in each of four country capitals during March and April. The final versions of all protocols are attached here.

I.1. Global Fund CCM

I.2. Global Fund Principal Recipient

I.3. Global Fund Selected Sub Recipients

I.4. International Organizations Involved in HIV/AIDS Activities

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- II.1. High-Risk Groups
- II.2. NGO Capacity Building (Please See Below)
- III.1. Voluntary Counseling & Testing, Care and Support
- III.2. Antiretroviral Treatment
- III.3. HIV & Tuberculosis

3. Conducted NGO Capacity Assessment

The International HIV/AIDS Alliance conducted assessment of NGOs working on HIV/AIDS activities and programs in Central Asia as part of the initial assessment of NGOs. At the same time, the CAPACITY team worked with IHAA to develop, finalize and implement the NGO High-Risk Group assessment and questionnaire. The questionnaire was pre-tested during NGO CAPACITY Assessment Meeting on 7-8 February in Bishkek. The results of that meeting are highlighted in IHAA’s partner report attached here and the finalized NGO Questionnaire is also attached. During this quarter, the NGO Capacity Questionnaire was distributed to 181 NGOs in each of the five countries. The results, as shown below, are 114 total responses were received for analysis to be completed during April.

Country	Disseminated	Received
Kazakhstan	45	24
Kyrgyzstan	58	49
Tajikistan	23	7
Turkmenistan	10	9
Uzbekistan	45	25
Region Total	181	114

4. Conducted Initial Visits to KG, TJ, and TU

To supplement the development of the assessment plan and protocols, CAPACITY’s Chief of Party, Lev Khodakevich, conducted initial visits to Kyrgyzstan, Tajikistan, and Turkmenistan to meet local stakeholders, inform them about the CAPACITY Project and to gain their critical input into our assessment process. In addition, Deputy Chief of Party, David Hausner, conducted initial trips to Bishkek and Tashkent to meet stakeholders and obtain input on assessment teams and assessment protocols. The staff activity reports from each visit are attached here.

5. Implemented HIV/AIDS Central Asia Desk Review

To further supplement the initial assessment that would be conducted by CAPACITY, the project undertook an internal assessment or “desk review” of the current situation in Central Asia. The CAPACITY Desk Review consisted of two parts: 1) A compilation of activities implemented by donor and coordinating agencies in each country and 2) A desk review of the current HIV/AIDS epidemiological situation, implementing actors and activities in each country. The results of the internal desk review are extensive reports for each of the five countries. These reports are being used in conjunction with results of country assessments to inform the development of the CAPACITY Strategic Plan. The finalized version of each country desk review is attached here.

6. Implemented Initial Assessment Activities

In developing our assessment plans, teams, and dates, CAPACITY consulted closely with our partners at USAID, UNAIDS, and the Republican AIDS Centers in each country. In addition, CAPACITY held several roundtable meetings with key

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stakeholders in each country to review our plans and develop our country assessment team. These roundtable meetings were supplemented with one-on-one meetings with USAID Health Officers as well as email communication with stakeholders to obtain their input into our process. As a result, CAPACITY was able to construct a transparent and participatory, yet quick, assessment plan. The first result of that plan was the Uzbekistan Country Assessment Meeting in March.

7. Held Uzbekistan Country Assessment Meeting

On March 29th, CAPACITY held its first Country Assessment Meeting in Tashkent, Uzbekistan. There were 112 participants at the meeting which was opened by US Ambassador Jon Purnell and First Deputy Minister of Internal Affairs, Mr. Radgab Kadirov. The meeting received media coverage from several agencies, including the Associated Press and BBC announcing the launch of USAID's \$13m HIV Prevention Program in Central Asia. The meeting was a success for CAPACITY as it achieved all of its objectives:

- Introduce CAPACITY to key HIV/AIDS Stakeholders;
- Outline CAPACITY's assessment process and objectives;
- Outline CAPACITY's strategy design process and objectives; and
- Obtain stakeholder input and technical assistance requests.

The results for the Tashkent meeting will be used to develop the Uzbekistan Country Assessment Report and the country assessment meeting model implemented in Tashkent is the basis for CAPACITY's meetings in Dushanbe, Almaty and Bishkek in April.

8. Continuation of Outreach to High-Risk Groups

Population Services continued outreach activities to sex workers, injecting drug users and vulnerable youth, building on lessons learned from previous USAID prevention activities. The details of their activities this quarter are included in the attached PSI partner report.

9. Built Relationship and Collaboration with Counterparts

Critical to CAPACITY's work is our connection within the HIV/AIDS and larger donor-funded and development community. Accordingly, this quarter, CAPACITY spent considerable time meeting with key stakeholders and participation in meetings relevant to our project, including, but not limited to:

- DFID Regional HIV/AIDS Project Bishkek Roundtable – February 3rd-4th
- Kent Hill Visits to Kazakh Republican AIDS Center – February 4th
- Drug Demand Reduction Program Partner's Meeting – February 15th
- Uzbekistan UN Theme Group Meeting – February 28th
- AIHA Knowledge-Hub/PMTCT Regional Meeting – March 1st
- Kyrgyz CCM Meeting (Unified Coordinating Body) – March 7th
- AFEW Kyrgyz Country Meeting – March 9th
- AFEW Kazakh Country Meeting – March 15th
- USAID/CAR MOH TB Roundtable – March 31st

Further details of CAPACITY's participation in key meetings and development of relationships within the HIV/AIDS community is reflected in attached January,

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February and March CAPACITY monthly calendars. As a result of our transparent assessment development process and building of relationships within our community, CAPACITY has received several key requests for technical assistance (in advance of completing our assessment) which indicate we have developed a level of trust and respect with our counterparts. CAPACITY will continue to develop and cultivate these relationships in order to further our opportunities for working on areas of programmatic importance for the project.

B. Second Quarter Operational Activities

Several key operational activities were implemented during second quarter of the project, including the following highlights:

- CAPACITY Chief of Party, Lev Khodakevich, attended JSI's Chief of Party Orientation held in Boston and Washington from 3rd-13th January. Please see attached trip report.
- The JSI's Key Personnel Chief of Party, Deputy Chief of Party, and Regional Operations Director, arrived in Almaty by January 25.
- JSI/PSI finalized the recruitment of Prevention Specialist. As a Key Personnel position, Mr. Bell, was proposed to and approved by USAID/CAR early in January 2005. Marty Bell joined the project on the ground on February 7th.
- JSI/CAPACITY company registration paperwork was filed with the Kazakh Ministry of Foreign Affairs on February 16th. The registration process is anticipated to take 2 months.
- CAPACITY reached agreement with World Bank (Tilek Meimanaliev and Joana Godinho) to co-locate its country staff in KZ, KG, TJ, and UZ. Accordingly, World Bank will locate its "Country Representatives" in each of these countries in the CAPACITY offices. Note: The WB Regional Program Management Unit will remain separate from CAPACITY.
- JSI/IHAA finalized the recruitment of the NGO Capacity Building Specialist. Ms. Viktoriya Ashirova was approved as the Regional NGO Capacity Building Specialist for IHAA. She will officially join the project as of June 1st.
- JSI finalized the initiated and finalized the recruitment of several key positions within the regional and country offices, including:
 - Regional M&E Specialist: Anna Deryabina, July 11th
 - Regional Finance Manager: Bulat Sukurov, July 1st
 - KG Country Director: Elvira Muratalieva, June 1st
 - KG Finance Manager: Aisuluu Kasymbekova, June 1st
 - TJ Country Director: Pending Finalization – TBD
 - TJ Finance Manager: Nilufar Davlatova, June 1st
- CAPACITY established its regional office at 54 Lugansky Street on March 22nd. The final networking and phone lines to be completed early in April. In the interim period, ZdravPlus hosted the CAPACITY Project at its Almaty office.

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- CAPACITY established full office operations in Tashkent, including its office located at 18 Bozbozor Street, #5, its operational bank accounts and hired all local staff including:
 - UZ Finance Manager, Loziza Ismoilova, May 15th
 - UZ Program Coordinator, Zafar Osipov, April 1st
 - UZ Program Assistant, Yussup Karagadialev, March 1st
- The JSI Boston CAPACITY Project Coordinator made initial visits to Bishkek, Kyrgyzstan and Dushanbe, Tajikistan from 1 March – 14 April 2005 to set-up initial operations and hire project staff. Results of this trip will be reflected in the next quarterly report and used as basis for finalizing operations in KG and TJ in June by Regional Operations Director.

C. Anticipated CAPACITY Project Activities Next Quarter

The following (illustrative) project activities are anticipated to be implemented during the period of April 1, 2005 – June 30, 2005:

- CAPACITY's Country Assessment Meetings (CAM) held in Kazakhstan, Kyrgyzstan and Tajikistan during April.
- CAPACITY's Initial Assessment Report (Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan) finalized and disseminated with key stakeholders.
- CAPACITY's Strategic Planning Development & Consensus Meetings held in Almaty from 2nd-13th May.
- CAPACITY Strategic Framework, First Year Workplan and Monitoring & Evaluation Plan submitted to USAID/CAR for approval by May 31st.
- Lev Khodakevich and David Hausner participation in JSI International Division Meeting and JSI Eastern European/Eurasian Regional Meeting from 6th-10th June in Washington, DC.
- Technical assistance provided to Uzbekistan Republican AIDS Center regarding ARV procurement and development of monitoring indicators for NGO performance.
- Technical assistance provided to Kyrgyzstan Country Coordination Mechanism regarding development of its structure and by-laws.
- Technical assistance provided to the Government of Kazakhstan in development of its 5th Round Global Fund Application.
- Technical assistance to Tajikistan in conducting trainings around anti-retroviral drugs, treatment and therapy.
- JSI/CAPACITY will receive its company registration in Kazakhstan and Uzbekistan; company registration is pending in Tajikistan.

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D. Quarterly Technical Report Attachments

1. CAPACITY January 2005 Calendar
2. CAPACITY February 2005 Calendar
3. CAPACITY March 2005 Calendar
4. Revised Initial Implementation Plan
5. Revised Initial Assessment Plan & Timetable
6. Initial Assessment Overview Document
7. Khodakevich Staff Activity Report – Boston
8. Khodakevich Staff Activity Reports – Bishkek
9. Khodakevich Staff Activity Report – Dushanbe
10. Khodakevich Staff Activity Report – Ashgabat
11. Bell Staff Activity Report – Bishkek
12. CAPACITY Assessment Protocols (English & Russian)
13. CAPACITY/IHAA NGO Capacity Questionnaire
14. CAPACITY Kazakhstan Desk Review Report
15. CAPACITY Kyrgyzstan Desk Review Report
16. CAPACITY Tajikistan Desk Review Report
17. CAPACITY Turkmenistan Desk Review Report
18. CAPACITY Uzbekistan Desk Review Report
19. Abt Associates/ZdravPlus Technical Report
20. Boston University Specialist Technical Report
21. International HIV/AIDS Alliance Technical Report
22. Population Services International Technical Report
23. Second Quarter Financial Report – SF269

The CAPACITY Project Monthly Calendar – January 2005

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
					1	2
3 JSI/Chief of Party Orientation in Boston	4 JSI/Chief of Party Orientation in Boston	5 JSI/Chief of Party Orientation in Boston	6 JSI/Chief of Party Orientation in Boston	7 JSI/Chief of Party Orientation in Boston	8	9
10 JSI/Chief of Party Orientation in WDC	11 JSI/Chief of Party Orientation in WDC	12 JSI/Chief of Party Orientation in WDC	13	14 Audrey Departs to Almaty	15 Audrey Arrives Almaty	16
17 Submit Finalized IIP & Assessment Plan to Andreas	18 Continue Review of Assessment Plan	19 Continue Review of Assessment Plan	20 Continue Review of Assessment Plan	21 Continue Review of Assessment Plan	22	23
24	25 Lev Arrives Almaty	26 David Arrives Almaty	27 TB Mtg.	28 TB Mtg.	29	30
31 Submit 1 st QTR & QFR to Andreas						

The CAPACITY Project Monthly Calendar – February 2005

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
31 Lev Departs for Bishkek	1 Initial Introductory Meetings with Key Stakeholders in Bishkek (Lev) USAID/Almaty SO Level Discussions (Audrey)	2 Marty Bell Arrives in Almaty Introductory Meetings in Bishkek (Lev) Kent Hill Visit in Bishkek (Lev)	3 Kent Hill Visit in Almaty (David/Audrey) DFID Roundtable in Bishkek (Lev)	4 Kent Hill Visit in Almaty (David/Audrey/Gulya) DFID Roundtable in Bishkek (Lev)	5 NGO Capacity Building Specialist Interviews in Bishkek (Lev)	6 Lev Returns to Almaty Audrey Departs to Bishkek
7 IHA Pre-Assessment Planning Meeting in Bishkek	8 IHA Pre-Assessment Planning Meeting in Bishkek Lev Departs for Bishkek	9 CCM Meeting in Bishkek (Lev)	10 Lev Returns to Almaty	11 Meeting with Andreas at USAID	12	13
14 Happy Valentine's Day!	15 -12NOON-Chernaiski Meeting at USAID -3pm – CAPACITY Present at DDRP -9pm – Conf Call to discuss Strategic Planning Meeting	16	17 7:00pm in Almaty – 8:00am East Coast Country Support Team Conf Call with Boston (Lev, David, Audrey)	18 10:00am – Mtg. with Sheila, Asta, Gita re: ZdravPlus Linkages	19	20 Marty to Bangkok
21 Assessment Protocols to Audrey by COB	22 Lev to Dushanbe Assessment Protocols Emailed to HQs for Review by COB in Almaty	23 -Lev Meetings in Dushanbe -Assessment Protocols Emailed back to Almaty by COB in USA -UN Theme Group Mtg. in Bishkek	24 Lev Return from Dushanbe Assessment Protocols Reviewed & Finalized David's Birthday!	25 Assessment Protocols Reviewed & Finalized	26	27 Marty return from Bangkok
28 -Assessment Protocols Reviewed & Finalized -Protocols to Audrey by COB for translation and finalization -UN Theme Group Mtg. in Tashkent						

NOTE: Audrey to travel to Tashkent, UZ as soon as registration documents are received.

The CAPACITY Project Monthly Calendar – March 2005

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Note: Matt Habinowski in CAR all month for setting-up operations in KG & TJ.	1 Assessment Protocols translated & finalized AIHA PMTCT Mtg. at Hotel KZ Room "A" (Lev)	2 Assessment Protocols translated & finalized	3 Assessment Protocols emailed to HQ for review & UZ for pre-testing 7:30pm Dinner with Ruslan Malyuta	4 UZ Assessment Team Mtg. to discuss pre-testing & assessment process	5 WORKING DAY	6
7 Women's Day Holiday 10AM-Bishkek Mtg. Re: Unified HIV Coordinating Body (Marty)	8 Women's Day Holiday Lev Departs to Ukraine & Russia	9 Protocol Pre-Testing in UZ AFEW Meeting in Bishkek (Marty)	10 US Ambassador's Media Tour at RAC (David) AFEW Meeting in Bishkek Protocol Pre-Testing in UZ	11 Protocol Pre-Testing in UZ AFEW Meeting in Bishkek	12 Matt H. departs to Bishkek	13 Lev Returns to Almaty
14	15 AFEW Meeting in Almaty Lev Departs to UZ/TU	16 AFEW Meeting in Almaty David departs to Bishkek	17 AFEW Meeting in Almaty Bishkek Roundtable	18 David Returns to Almaty	19 WORKING DAY Marty Departs to USA	20 Lev Returns to Almaty
21 Spring Equinox Holiday	22 Spring Equinox Holiday	23 Audrey Departs to Tashkent	24 JSI Monthly Conf Call 7pm Almaty & 8am Boston	25 Audrey Returns to Almaty at COB 3-5pm KZ CAM Roundtable at CAPACITY office	26	27 Lev Departs to Tashkent
28 TPM – Tashkent CAPACITY Office	29 -CAM – Tashkent Radisson Hotel -Matt departs to Dushanbe -Invitations Sent to Stakeholders Re: CAMs	30 Lev Returns to Almaty Invitations Sent to Stakeholders Re: CAMs	31 USAID & MOH Roundtable (Lev & Leila) at USAID/CAR office Gulya departs to Dushanbe			

Week Start	Week End	Program & Operational Activities
October 4	October 8	CAPACITY Project Cooperative Agreement Issued, Reviewed & Signed/Key Personnel & Partner Organizations Notified/Begin Recruitment of Prevention Specialist
October 11	October 15	Participate in JSI Eurasian Regional Meeting in Moscow, Russia/Initial Internal Meetings Regarding Start-Up & Overall Program/Continue Recruitment of Prevention Specialist
October 18	October 22	Continue Initial Internal Meetings Regarding Start-Up & Overall Program/Hold Initial Conversations with Partner Organizations/Begin Development of JSI HQ Financial Systems & Structure/COP, DCOP & Ops Manager Contracts Finalized
October 25	October 29	Continue Initial Conversations with Partner Organizations/Issue Letter Subcontracts for Partner Organizations/Continued Development of JSI HQ Financial Systems & Structure
November 1	November 5	Finalize Plans for Upcoming Trip for Operations Manager & COP/Development of Initial Implementation Plan/Continue Initial Conversations with Partner Organizations
November 8	November 12	Hold CAPACITY Project Partners Headquarter Meeting in Boston, MA/Development of Initial Implementation Plan
November 15	November 19	Operations Manager Preliminary Visit to Tashkent, UZ/Begin Developing Operations (Registration/Banking/Office/Staffing) in UZ/Submission of Initial Implementation Plan/Development of Initial Assessment Plan

November 22	November 26	Operations Manager & COP Preliminary Visit to Tashkent, UZ/Continued Development of Operations (Registration/Banking/Office/Staffing) in UZ/Development of Initial Assessment Plan
November 29	December 3	Operations Manager & COP Preliminary Visit to Almaty, KZ/Begin Developing Operations (Registration/Banking/Office/Staffing) in KZ/Development of Initial Assessment Plan
December 6	December 10	Operations Manager & COP Preliminary Visit to Almaty, KZ/Continued Development of Operations (Registration/Banking/Office/Staffing) in KZ/Development of Initial Assessment Plan
December 13	December 17	Operations Manager Preliminary Visit to Almaty, KZ/Continued Development of Operations (Registration/Banking/Office/Staffing) in KZ/Development of Initial Assessment Plan
December 20	December 24	HQ Discussions Re: Initial Exploratory Trips to CAR/Begin Formal Recruitment of NGO Capacity Building Specialist
December 27	December 31	HQ Discussion Re: Initial Exploratory Trips to CAR/Finalize COP Orientation Plans/Continue Formal Recruitment of NGO Capacity Building Specialist
January 3	January 7	Hold Lev Khodakevich's COP Orientation in Boston, MA/Revise Initial Implementation Plan/Revise CAPACITY Project Staffing Oganogram/Develop Assessment Protocol Format/Project MAP Workshop/Inventory of Condom stock/Registration of Import License for New Condoms/Warehousing/Preparation of Presentation for Dissemination Meetings for KAP (2004)/Conduct Peer Education and Outreach for Vulnerable Groups
January 10	January 14	Hold Lev Khodakevich's COP Orientation in Washington, DC/Finalize Revised Initial Implementation Plan/Finalize Revised CAPACITY Project Staffing Oganogram/Develop Assessment Protocol Format/Operations Manager Arrives In Almaty/Analyze of Sales History 2002-2004 of FAVORITE Condoms/Preparation of Presentation for Dissemination Meetings for KAP (2004)/Conduct Peer Education and Outreach for Vulnerable Groups/MOH Registration of Youth and CSW Manuals

The CAPACITY Project Initial Implementation Plan - (Revised Dated 25 January 2005)

January 17	January 21	Finalize Revised Initial Implementation Plan to USAID for Review & Approval/ Finalize Revised CAPACITY Project Staffing Oganogram/Prepare First Quarter Technical & Financial Report/Develop Assessment Protocol Format & Assessment Tools/MBO 2005 for KZ & KY & HRZ Sales Planning/Preparation of Presentation for Dissemination Meetings for KAP (2004)/Conduct PE & Outreach/Develop Database Tracking System for SW, IDU & Youth
January 24	January 28	Develop Assessment Protocol/Start Collecting Other Assessment & Annual Reports/COP & DCOP Arrive in Almaty/Finalize First Quarter Technical & Financial Report/Cataloging of Current HIV/AIDS NGOs & Civil Society in CAR/Getting Import License for Condom FAVORITE Condoms/Research Dissemination Meeting for KAP (2004) in KZ/Conduct PE & Outreach/Distribution of CSW & Youth Manuals to NGO & GO Partners
January 31	February 4	Develop Assessment Protocol/Continue Collecting Other Assessment & Annual Reports/Participate in DFID HIV/AIDS Project Roundtable Meeting in Bishkek/Prevention Specialist Arrives in Almaty/PSI Begins Development of CAPACITY Logo/Begin Local Staff Recruitment in KZ & UZ/Sales & Distribution Plan 2005: Wholesalers, Retailers & High Risk Zones in KZ,KY,UZ,TJ/Preparation of Packaging Contract & Approval of Packaging Budget/Research Dissemination Meeting for KAP (2004) in KY/Conduct PE & Outreach
February 7	February 11	Review & Analysis of Assessment Protocols to CAPACITY Team/IHA's Pre-Assessment Meeting in Bishkek with Regional Assessment Team for NGO Activities/Initial Meetings with Key Stakeholders in KY & TJ/Finalizing Operations in UZ/Analyze Collected Reports and Begin Gap Analysis/Initiation of NGO Assessment Questionnaire (PSI&IHA)/Continue Local Staff Recruitment in KZ & UZ/Import of 20,000 Gross of Condoms (Customizing, Warehousing, Printing of Packs)/Development of "FAVORITE SHOPPING" Promotional Campaign for HRZ Outlets/Research Dissemination Meeting for KAP (2004) in UZ/ Targeted Outreach and PE Activities/Begin Building PE & Outreach Databases/Hire New IPC Manager
February 14	February 18	Collect Feedback & Finalize Assessment Protocols/Finalizing Operations in UZ/Monthly Country Support Team Conference Call/Complete Gap Analysis of Collected Reports/Continue Local Staff Recruitment in KZ & UZ/Certification of New Condoms/Printing of Packs/Promotional Campaign for HRZ: Mystery Client/Implement Targeted Social Marketing of Condoms at HRZ/Finalization of FAVORITE SHOPPING/Research Dissemination Meeting for KAP (2004) in TJ/Targeted Outreach and PE Activities/Test M&E Forms for IPC for New Databases
February 21	February 25	Hold Pre-Assessment Preparatory Meeting in Almaty Office/CAPACITY & ZdravPlus Meeting To Discuss Integrating HIV with Health Reform and PHC Activities/Moving Into CAPACITY Regional Office in Almaty/Continue Local Staff Recruitment in KZ & UZ/Analysis of Feedback From NGO Assessment Questionnaire/Promotional Campaign for HRZ: Mystery Client & Salint Valentine Disco Events Around HRZ/CSW Entertainment Events/Implement Targeted Social Marketing of Condoms at HRZ/Implementation of FAVORITE Shopping/Preparation of RFP for Project MAP/ Targeted Outreach and PE Activities/Evaluate M&E Test Forms
February 28	March 4	Conduct Initial Assessments/Finalizing Office Operations in KZ/JSI HQ Project Coordinator Visit to KZ/In-Depth Phone Interviews with Selected NGOs As Follow-Up to Assessment Questionnaire/Initial Meetings with Key Stakeholders in TU/Packaging of New Condoms/Evaluation & Analyze of Mystery Client Campaign/Review Monthly Sales & Marketing Report/Implementation of FAVORITE Shopping/Distribution of RFP for Project MAP/Targeted Outreach and PE Activities/PSI Test Databases on Sites
March 7	March 11	Conduct Initial Assessments/Finalizing Office Operations in KZ/Establishing Office Operations in KY-Local Staff Recruitment (JSI HQ PC)/IHA Regional Meeting in Bishkek to Review Results of NGO Assessment/Packaging of New Condoms/Evaluation & Analyze of Mystery Client Campaign and Submit Report/Review Monthly Sales & Marketing Report/ Implementation of FAVORITE Shopping/Distribution of RFP for Project MAP/Review of Submitted Proposals for Project MAP/Targeted Outreach and PE Activities/Begin Creating Manual for IDU Outreach

The CAPACITY Project Initial Implementation Plan - (Revised Dated 25 January 2005)

March 14	March 18	Conduct Initial Assessments/Monthly Country Support Team Conference Call/Establishing Office Operations in KY-Local Staff Recruitment (JSI HQ PC)/IHA's NGO Support Mechanism (NSM) Selection Visit to Bishkek/Import of Condoms to UZ/Promotional Campaign for Wholesalers/Implement Targeted Social Marketing of Condoms at HRZ/Preparation of HRZ Place Database for Mapping/Signing of POP Contract/Selection of Research Agency/Preparation and Review of Contract/Targeted Outreach and PE Activities/Continued Work on Manual for IDU Outreach
March 21	March 25	Conduct Initial Assessments/Establishing Office Operations in TJ-Local Staff Recruitment (JSI HQ PC)/Final Compilation of Results of NGO Assessment/CAPACITY Logo Development Process Completed/Promotional Campaign for Wholesalers/TOT for Pharmacies and Owners of Hotels and Saunas "Social Marketing Workshop"/ Preparation of HRZ Place Database for Mapping/Production of POP and Approval of POP Distribution Plan/Training of Fieldworkers/Preparation of FGDs Guide for Testing IEC Materials/Targeted Outreach and PE Activities/Continued Work on Manual for IDU Outreach
March 28	April 1	Finalize Initial Assessment Results Reports/Establishing Office Operations in TJ-Local Staff Recruitment (JSI HQ PC)/Finalize IHA's NGO Assessment Report/Import of Condoms to TJ & KY & Import of POP Materials/Promotional Campaign for Wholesalers/Implement Targeted Social Marketing of Condoms at HRZ/Writing of IEC with IPC Manager/Preparation of HRZ Place Database for Mapping/Collaboration w/Research Agency on Data Collection/Conduction of FGDs in KZ & KY/Targeted Outreach and PE Activities/Continued Work on Manual for IDU Outreach/Ongoing TA on SM and Targeted Communications
April 4	April 8	Hold Pre-Strategic Framework Meetings in Almaty Office (Facilitator: Andrew Fullem)/Develop Project Monitoring & Evaluation Plan/JSI HQ PC to Assist with Planning of Strategic Planning Meetings in KZ/Writing of IEC & Preparation of Focus Group Guide Together with Research Manager/Submit of Existing HRZ Place Database to Research Manager for Further Mapping/Review of Quarterly Sales & Marketing Report/Collaboration w/Research Agency on Data Collection/Conduction of FGDs in TJ & UZ/Targeted Outreach and PE Activities/Prepare TOT for PE, Outreach and M&E
April 11	April 15	Hold Strategic Framework Meetings in Almaty Office (Facilitator: TBD)/Develop Project Monitoring & Evaluation Plan/Export of Condoms to KY/Export of Condoms to TJ/Import of POP Materials to UZ/Conduction of FGD of IEC in FG in KZ & KY Together with Research Manager/Collaboration with Research Agency on Data Collection/Preparation of FGDs Report on Testing of IEC Materials/Targeted Outreach and PE activities - TOT on Peer Ed, Outreach, M&E in KZ
April 18	April 22	Finalize Strategic Framework Report & Project Workplan/Prepare Second Quarter Technical & Financial Report/Finalize Project Monitoring & Evaluation Plan/Develop SOWs and Subcontracts with Partner Organizations/Certification of Condoms in KY/Certification of Condoms in TJ/Conduct FGD of IEC in FG in UZ & TJ Together with Research Manager/Collaboration with Research Agency on Data Collection/Preparation of FGDs Report on Testing of IEC Materials/Targeted Outreach and PE Activities/Continued Work on IDU Manual
April 25	April 29	Submit Finalized Strategic Framework & Workplan to USAID Review & Approval/Submit Finalized Project Monitoring & Evaluation Plan to USAID for Review & Approval/Prepare Project Launching Presentation & Materials/Submit Second Quarter Technical & Financial Report/Finalize Subcontracts with Partner Organizations/Collaboration with Research Agency on Data Entry and Cleaning/Targeted Outreach and PE Activities/Begin Testing of IDU Manual Modules
May 2	May 6	Finalize Project Launching Presentation & Materials/Preparation of FGD Report on Testing IEC Materials/Review of Monthly Sales & Marketing Report/Assist Research with TOT for SM/TOT of Organization Working with Vulnerable Groups on SM & Research in Collaboration w/Marketing Manager in Almaty/Monitoring of Initial NGOs Training/Data Analysis for Project MAP/Targeted Outreach and PE Activities/Testing of IDU Manual Modules

May 9	May 13	Hold Official CAPACITY Project Launching in Almaty & KZ. Country Specific Roundtable/Begin Development & Meetings Re: Country-Specific Workplan for KZ & MOU Development/Monthly Country Support Team Conference Call Assist Research with TOT for SM/TOT of Organization Working with Vulnerable Groups on SM & Research in Collaboration with Marketing Manager in Karaganda/Monitoring of Initial NGOs Training/Data Analysis for Project MAP/Targeted Outreach and PE Activities/Testing of IDU Manual Modules
May 16	May 20	Hold 1-Day Country Roundtables in UZ & KY/Begin Development/Meetings Re: Country-Specific Workplans for UZ & KY & MOU Development/Assist Research with TOT for SM/TOT of Organization Working with Vulnerable Groups on SM & Research in Collaboration w/Marketing Manager in Pavlodar/Monitoring of Initial NGOs Training/Data Analysis for Project MAP/Targeted Outreach and PE/Revise IDU Manual Based on Testing and Prepare for Vetting by IDU Experts
May 23	May 27	Hold 1-Day Country Roundtables in TJ & TU/Begin Development/Meetings Re: Country-Specific Workplans for TJ & TU & MOU Development/Assist Research with TOT for SM /Preparation of Evaluation Report of NGOs Trainings/Report Writing for Project MAP/Targeted Outreach and PE/Evidence Based Outreach in KZ
May 30	June 3	Lev Khodakevich & David Hausner Attend JSI's International Mtg in WDC/Lev & David Present Initial Assessment Findings to USAID/Washington/Design of IEC/Review of Monthly Sales & Marketing Report/Report Writing for Project MAP/Targeted Outreach and PE
June 6	June 10	Finalize Development of Country-Specific Workplans for KZ, KY, TJ, TU, & UZ/David Hausner's DCOP Orientation to JSI in Boston, MA & WDC/Report Writing for Project MAP/Targeted Outreach and PE Activities/TOT on Peer Ed, Outreach, M&E in KY
June 13	June 17	Finalize Development of Country-Specific Workplans for KZ, KY, TJ, TU, & UZ/Monthly Support Team Conference Call/Report Writing for Project MAP/Targeted Outreach and PE Activities/TOT on Peer Ed, Outreach, M&E in KY/Writing RFP for KAP Tracking Survey/Developing of Questionnaire for KAP/Targeted Outreach and PE/Begin Drafting Final IDU Manual
June 20	June 24	Finalize Development of Country-Specific Workplans for KZ, KY, TJ, TU, & UZ/Implementation of HRZ Targeted Promotional Campaign: FAVORITE Shopping/Work with Research on SM TOT/TOT of Organization Working with Vulnerable Groups on SM & Research Collaboration with Marketing Manager in Tashkent/Monitoring of Initial NGOs Training/Distribution of RFP Among Research Organizations/Developing of Questionnaire & Targeted Outreach and PE Activities/TOT on Evidence Based BCC Outreach & Targeting of Vulnerable Groups-KY & UZ
June 27	July 1	Initiate Activities in 7 Technical Areas as Outlined in Country-Specific Workplans/Implementation of HRZ Targeted Promotional Campaign: FAVORITE Shopping/Work with Research on SM TOT/TOT of Organization Working with Vulnerable Groups on SM & Research in Collaboration with Marketing Manager in Fergana/Monitoring of Initial NGOs Training/Review of Submitted Proposals/Targeted Outreach & PE/Finalize IDU Manual, Prepare for Production

July 4	July 8	Initiate Activities in 7 Technical Areas as Outlined in Country-Specific Workplans/Promotional Campaigns/ Implementation of HRZ Targeted: FAVORITE Shopping Promotional Campaign/Conduct Initial NGO Trainings/Review of Quarterly Sales & Marketing Report/Preparation of Evaluation Report of NGOs Trainings/Selection of Research Agency/Preparation of Contract/Close Cooperation with Research Agency on Translation of Questionnaire into Relevant Languages/Targeted Outreach & PE/Produce Manual and Distribute to Partners
July 11	July 15	Continue Activities in 7 Technical Areas as Outlined in Country-Specific Workplans/Monthly Country Support Team Conference Call/Promotional Campaign for with Sales Marketing and Targeted Communication Campaigns/Conduction & Monitoring of Initial NGO Trainings/Review of Calendar Plans for 2005 - NGOs Trainings)/Training of Fieldworkers/Pilot Testing of Questionnaire for KAP/Targeted Outreach & PE/Monitoring of Partner Outreach and PE Activity
July 18	July 22	Prepare Third Quarter Technical & Financial Report/Continue Activities in 7 Technical Areas as Outlined in Country-Specific Workplans/Promotional Campaign for HRZ Outlets: FAVORITE Shopping/Close Cooperation with Research Agency on Field Work/Targeted Outreach and PE Activities/TOT on Evidence Based BCC Outreach & Targeting of Vulnerable Groups-TJ
July 25	July 29	Submit Third Quarter Technical & Financial Report/Continue Activities in 7 Technical Areas as Outlined in Country-Specific Workplans/Promotional Campaign for HRZ Outlets: FAVORITE Shopping/Review of Monthly Reports on NGOs Trainings/Review of Calendar Plans for UZ NGOs for 2005-NGO's Trainings on SM and Research/Close Cooperation with Research Agency on Field Work/Targeted Outreach & PE/Monitoring of Partner Outreach and PE Activity
August 1	August 5	Continue Activities in 7 Technical Areas as Outlined in Country-Specific Workplan/Evaluation and Analyze of Promotional Campaigns and FAVORITE Shopping/Development of Design of OOH Image for Promotional Activities Around Hot Spots/Review of Monthly Sales & Marketing Report/Production of OOH and Placement Around Hot Map/Close Cooperation with Research Agency on Field Work/Targeted Outreach and PE Activities/TOT on Peer Ed, Outreach, M&E in TJ
August 8	August 12	Continue Activities in 7 Technical Areas as Outlined in Country-Specific Workplans/Social Marketing and Targeted Communication Campaigns/Disco Events Around Hot Map "Last Days of Summer" for Vulnerable Youth Using Bingo Module/CSW Edu Tainments/Close Cooperation with Research Agency on Field Work/Data Entry and Cleaning/Targeted Outreach & PE/Monitoring of Partner Outreach and PE Activity
August 15	August 19	Continue Activities in 7 Technical Areas as Outlined in Country-Specific Workplans/Monthly Country Support Team Conference Call/Social Marketing and Targeted Communication Campaigns/Disco Events Around Hot Map "Last Days of Summer" for Vulnerable Youth Using Bingo Module/CSW Edu Tainments/Below the Line Events Around Hot Map/Assist Research with TOT for SM/TOT of Organization Working with Vulnerable Groups on SM & Research in Collaboration with Marketing Manager in Bishkek/Monitoring of Initial NGOs Training/Close Cooperation with Research Agency on Data Entry and Cleaning/Targeted Outreach & PE/Monitoring of Partner Outreach and PE Activity
August 22	August 26	Continue Activities in 7 Technical Areas as Outlined in Country-Specific Workplans/Social Marketing and Targeted Communication Campaigns/Evaluation and Analyze Research Results Based on Questionnaires and Comparison with Pre Tests/Assist Research Agency with TOT for SM/TOT of Organization Working with Vulnerable Groups on SM & Research in Collaboration with Marketing Manager in Osh/Monitoring of Initial NGOs Training/Recruiting of Consultant on Data Analysis/Close Cooperation with Consultant on Data Analysis/Targeted Outreach & PE/Prepare Evaluation Reports on Partner Outreach and PE

August 29	September 2	Continue Activities in 7 Technical Areas as Outlined in Country-Specific Workplans/Review Monthly Sales & Marketing Report/Assist Research with TOT for SM/TOT of Organization Working with Vulnerable Groups on SM & Research in Collaboration with Marketing Manager in Khojand/Monitoring of Initial NGOs Training; Close Cooperation with Consultant on Data Analysis/Targeted Outreach & PE/Disseminate Results of Evaluations to Partners/Prepare Next Round of Follow-Up TA Based on Results
September 5	September 9	Prepare for Year II Detailed Workplanning & Budgeting Meetings/Continue Activities in 7 Technical Areas as Outlined in Country-Specific Workplans/Assist Research with TOT for SM/TOT of Organization Working with Vulnerable Groups on SM & Research in Collaboration with Marketing Manager in Dushanbe/Monitoring of Initial NGOs Training/Close Cooperation with Consultant on Report Writing/Targeted Outreach and PE/Prepare for Youth PE Exchange
September 12	September 17	Conduct Year II Detailed Workplanning & Budgeting Meetings in Almaty Office/Monthly Country Support Team Conference Call/Preparation of Evaluation Report of NGOs Training/Close Cooperation with Consultant on Report Writing/Targeted Outreach and PE/Regional Youth PE Exchange
September 19	September 23	Finalize Year II Detailed Workplan & Budget/Review of Monthly Reports-NGOs Trainings/Review of Calendar Plans for 2005-NGOs Trainings/Close Cooperation with Consultant on Report Writing/Targeted Outreach & PE
September 26	September 30	Submit Finalized Year II Detailed Workplan & Budget to USAID for Review/Preparation of Evaluation Report on NGO's Trainings/Revising of Report with Consultant Help/Targeted Outreach & PE/Receive and Analyze Monthly M&E Reports from Partners

CAPACITY PROJECT INITIAL ASSESSMENT PLAN

ASSESSMENT OBJECTIVES:
<ol style="list-style-type: none"> 1. To identify the partners involved into the response to HIV/AIDS epidemics in the CAR countries from: (A) Governments, (B) National NGOs, (C) National associations, (D) International organizations; and 2. To identify the target populations and technical, administrative and geographical areas of each partner in response to the epidemics; 3. To develop a data base on the investments of various funding agencies, national and external, by technical area, geographic areas, target populations and time frames; and 4. To identify the needs of various partners in technical assistance, communication and networking from the CAPACITY Project that would provide a basis for developing a detailed technical assistance plan.
ASSESSMENT AREAS: (Note: Organized By Project's Main Technical Areas/Strategies)
STRATEGY I: IMPROVING STEWARDSHIP OF NATIONAL HIV/AIDS PROGRAMS I.1 Assessment of Country Coordinating Mechanisms (CCMs) and Principle Recipients (PR)
STRATEGY II: EDUCATING AND EMPOWERING SELECT POPULATIONS TO PROTECT THEIR HEALTH II.1. Work with the high-risk groups II.2 Strengthen local NGO capacity building mechanisms/Engaging Civil Society for greater representation and advocacy concerning the design and implementation of national responses to the epidemic including GFATM projects
STRATEGY III: IMPROVING THE QUALITY OF HIV/AIDS SERVICES III.1. Expand options for Voluntary Counseling and Testing III.2. Increased Access to Antiretroviral Therapy, Care and Support III.3. Integrate HIV and TB Services
STRATEGY 4: IMPROVING RESOURCE-USE TO INTEGRATE HIV/AIDS SERVICES WITH PRIMARY HEALTH CARE AND OTHER HEALTH SERVICES IV.1 The activities will be linked to and implemented in cooperation with the USAID and other international partners in the CAR countries

STRATEGY I: IMPROVING STEWARDSHIP OF NATIONAL HIV/AIDS PROGRAM

I.1: Assessment of Capacity & Effectiveness of GFATM Country Coordinating Mechanisms (CCMs) and GFATM Principal Recipients (PRs)

Strategy I.1 Program Objectives	Assessment Activities	Assessment Participants & Assessment Team	Assessment Tools/Formats	Assessment Outputs	Timeframe & Next Steps
<p>1. Foster an environment of transparency and inclusiveness with the CCMs and PRs</p> <p>2. Assist in the development and implementation to improve management of CCMs and PRs</p> <p>3. Strengthen the ability to measure progress in achieving expected goals.</p>	<p>A CAPACITY Review Team will meet with CCM Members, PRs, Donor Organizations, Stakeholders and Partners in each of the four GFATM countries to examine operating capacity, including the following aspects:</p> <ul style="list-style-type: none"> • Perceived and actual role of the CCM and PR in the national response; • Membership and structure, including assessment of NGO participation and representation and issues of gender and high risk group representation; • Organizational operating procedures for consensus building and process for dissemination of decisions; • Systems review of: (1) finance; (2) program planning; (3) monitoring and evaluation; (4) data management and use; • Operational and management review of systems, such as procurement procedures, tendering procedures, grant selection procedures and staffing; • Partners and counterparts working in the program; and • Communication systems. 	<p><u>Participants</u></p> <ol style="list-style-type: none"> 1. CCM Leader 2. CCM Members 3. PR Leader 4. PR Members 5. WB Rep. 6. DFID Rep. 7. CDC Rep. <p><u>Assessment Team</u></p> <ul style="list-style-type: none"> -COP -DCOP -External Reps. <p>KZ: TBA UZ: TBA KG: TBA TJ: TBA TU: TBA</p>	<ol style="list-style-type: none"> 1. Interview Questionnaire 2. Organizational Checklist 	<p>The CAPACITY Review Team will seek to identify ways in which CCMs and PR activities can be strengthened in each of these areas or replicated in other countries. Reports and action plans will be developed based on analysis of interview responses and checklists. The results will be presented back to CCMs and PRs to be used as the basis for developing a proposed detailed technical assistance plan and memorandum of understanding (MOU) between CAPACITY and the CCMs and PRs in order to detail the expected inputs of each of the stakeholders, a timeframe for activities and the outcomes that will be achieved.</p>	<p><u>Timeframe</u> 2 Weeks Per Country February-March 2005</p> <p><u>Next Steps</u></p> <ul style="list-style-type: none"> -Collect list of CCM Members -Collect list of PR Info -Review GF Apps & Workplans -Develop List of Interviewers -Develop Tools -Obtain Feedback from CCM/PRs

STRATEGY II: EDUCATING AND EMPOWERING SELECT POPULATIONS TO PROTECT THEIR HEALTH

II.1: Assessment of Opportunities for Working with High-Risk Group/Populations (PSI)

Strategy II.1 Program Objectives	Assessment Activities	Assessment Participants & Assessment Team	Assessment Tools/Formats	Assessment Outputs	Timeframe & Next Steps
<ol style="list-style-type: none"> 1. To assess NGO capabilities and capacity building needs in area of HIV prevention among HRGs. 2. To assess gaps/needs in prevention activities among HRGs. 	<ol style="list-style-type: none"> (1) Assess HIV prevention NGOs' capacities in the prevention areas of peer education, outreach, geographic reach, monitoring and evaluation, etc. (2) Map locations of high risk activities in (initially) Almaty and Osh (3) Map prevention work taking place in and around the areas of high risk activity in Almaty and Osh. (4) Quantitative and qualitative research on the barriers to behavior change among IDUs. (5) Dissemination of tracking survey results on knowledge, attitudes and behaviors of at-risk youth 	<p><u>Participants</u> Regional HIV prevention NGOs</p> <p><u>Assessment Team</u> - PSI Local & Regional Staff</p> <p>Note: NGO Survey being implemented jointly with IHA.</p>	<ol style="list-style-type: none"> 1. NGO Survey 2. Mapping software and systems 3. Quantitative and qualitative research tools and surveys 	<ol style="list-style-type: none"> 1. A plan identifying capacity building needs of NGOs 2. Identification of a series of workshops designed to address the capacity building needs of the NGOs 3. Data to identify the quality and quantity of prevention work currently taking place among HRGs. For Osh and Almaty, maps showing the overlap between this prevention work and the locations of high risk activities. 4. Dissemination workshops on at-risk youth tracking survey planned and underway. 	<p><u>Timeframe</u> February – April 2005</p> <p><u>Next Steps</u> -Finalize NGO Survey with IHA</p>

STRATEGY II: EDUCATING AND EMPOWERING SELECT POPULATIONS TO PROTECT THEIR HEALTH

II.2.1: Assessment and selection of an NGO Support Mechanism

Strategy II.2.1 Program Objectives	Assessment Activities	Assessment Participants & Assessment Team	Assessment Tools/Formats	Assessment Outputs	Timeframe & Next Steps
<p>Objective of strengthening local NGO capacity building mechanisms and engaging civil society for greater representation and advocacy concerning the design and implementation of national responses to the epidemic including GFATM projects, with specific objectives of:</p> <p>1.To improve local capacity to implement effective HIV interventions and services targeted at vulnerable populations.</p> <p>2. Increase civil society engagement and representation in the response to the HIV epidemic.</p>	<p>1. Assessment and selection of an NGO Support Mechanism (NSM): The aim of the assessment process is to select a locally based NGO, which will act as an NGO Support Mechanism to develop on-ward technical support functions to NGOs and CBOs working on HIV/AIDS at the field level. Their current and potential capacity to provide quality on-ward technical support will be gauged and measured against a set of criteria including the following broad areas:</p> <p><u>HIV/AIDS Technical Capacity/Expertise</u></p> <ul style="list-style-type: none"> -Commitment to the promotion and participation of people living with HIV/AIDS and other affected communities; -Current technical areas of work, including themes, populations, and locations; -Strategies and methods of working; -On-ward technical support provision; and -Future areas of work. <p><u>Organizational Structure & Capacity</u></p> <ul style="list-style-type: none"> -NGO Organisational Structure; -Leadership and Strategic Guidance; -Project management Systems; -Personnel Management/HR Systems; -Financial Management and Systems; and -Legal Status. 	<p><u>Participants</u></p> <p>National NGOs working in HIV prevention and care.</p> <p><u>Assessment Team</u></p> <p>-IHA Associate Consultant & In-country Support Coordinator</p> <p>Note: NGO Survey being implemented jointly with PSI.</p>	<p>1. Adapted NGO Support Mechanism selection questionnaires and criteria;</p> <p>2. Selected tools from the Alliance toolkit ‘Capacity analysis for NGO support organisations’</p>	<p>1. Selected NGO Support Mechanism with the required and potential capacity to provide on-ward granting and technical support to implementing NGOs and CBOs.</p>	<p><u>Timeframe</u></p> <p>February - March 2005</p> <p><u>Next Steps</u></p> <ol style="list-style-type: none"> 1. To analyse the capacity and technical support needs of the selected NSM. 2. To develop an agreed workplan and technical support plan together with the selected NSM. . 3. Finalize NGO Survey with PSI.

STRATEGY II: EDUCATING AND EMPOWERING SELECT POPULATIONS TO PROTECT THEIR HEALTH

II.2.2: Assessment of Technical Support & Capacity Building Needs & Gaps in the Provision of HIV/AIDS Technical Support & Capacity Building Activities in Prevention of HIV Transmission, Voluntary Counseling and Testing, and ARV Treatment, Care and Support Programs

Strategy II.2.2 Program Objectives	Assessment Activities	Assessment Participants & Assessment Team	Assessment Tools/Formats	Assessment Outputs	Timeframe & Next Steps
<p>Objective of strengthening local NGO capacity building mechanisms and engaging civil society for greater representation and advocacy concerning the design and implementation of national responses to the epidemic including GFATM projects, with specific objectives:</p> <p>1.To improve local capacity to implement effective HIV interventions and services targeted at vulnerable populations.</p> <p>2. Increase civil society engagement and representation in the response to the HIV epidemic.</p>	<p><u>NGO Institutional Reviews</u> Current NGOs providing technical support in the region will be interviewed to identify their current and future technical support provision activities in the region, to ensure that the proposed NGO program activities will complement those activities. IHA, jointly with local civil society stakeholders, will identify programmatic and organizational capacity gaps and needs in prevention of HIV transmission, voluntary counseling and testing, and ARV treatment, care and support programs in order to develop a regional technical support provision plan.</p> <p><u>1. Programmatic Needs</u> -Key areas of HIV/AIDS work -Organization’s self-perceived strengths and weaknesses -Technical support and training received (aims, themes, techniques/methods of delivery, timing, quality) -Informational provision and availability (themes, quality) -Gaps in technical support and training</p> <p><u>2. Organizational Needs</u> -Project management systems -Personnel management and systems and human resources -Financial management and systems -Partnerships with other agencies and systems -Organization’s self-perceived strengths and weaknesses -Areas of organizational support and training received (themes, techniques/methods of delivery, timing, quality) -Gaps in organizational support and training</p>	<p><u>Participants</u> -Existing technical support providers.</p> <p>-NGOs and CBOs NGOs and CBOs working on HIV/AIDS at the field level.</p> <p><u>Assessment Team</u> -NGO Capacity Building Specialist -IHA Associate Consultant -PSI</p>	<p>- Literature review of current technical support activities.</p> <p>-Selected tools adapted from the Alliance NGO Capacity Analysis toolkit</p>	<ol style="list-style-type: none"> 1. A list of technical support providers and main activities 2. A list of the NGOs, national associations and community based associations, willing to participate in the Project implementation 3. An overview of the needs of these organizations in the strengthening their capacities and expansion of their activities 4. Agreed workplan including a technical support provision plan 5. Basic information on the composition, skills and capacity of these organizations (very detailed and a lot of info to have this for all 5 countries) 6.Basic information on their funding sources 7. Information on the populations and geographic areas covered with activities by these organizations 	<p><u>Timeframe</u> January - March 2005</p> <p><u>Next Steps</u></p> <ol style="list-style-type: none"> 1. To report the findings to CCMs, PRs and the international partners in CAR for developing plans for upgrading the operations. 2. Implementation of regional technical support workshops.

STRATEGY II: EDUCATING AND EMPOWERING SELECT POPULATIONS TO PROTECT THEIR HEALTH

II.2.3: Assessment of Regional Civil Society Representation & Capacities in Prevention of HIV Transmission, Voluntary Counseling and Testing, and ARV Treatment, Care and Support Programs

Strategy II.2.3 Program Objectives	Assessment Activities	Assessment Participants & Assessment Team	Assessment Tools/Formats	Assessment Outputs	Timeframe & Next Steps
<p>Objective of strengthening local NGO capacity building mechanisms and engaging civil society for greater representation and advocacy concerning the design and implementation of national responses to the epidemic including GFATM projects, with specific objectives:</p> <ol style="list-style-type: none"> 1. To improve local capacity to implement effective HIV interventions and services targeted at vulnerable populations. 2. Increase civil society engagement and representation in the response to the HIV epidemic. 	<p>CAPACITY will work closely with existing and emerging civil society coalitions and networks in order to define the potential for more consistent representation and the greater role of civil society in the design and implementation of responses to the HIV epidemic at national as well as regional levels, particularly in relation to specific large scale HIV/AIDS prevention initiatives such as the projects supported by the GFATM.</p> <p>The Alliance will aim to raise additional resources to meet identified technical assistance and other support needs and implement specific activities aimed to promote greater participation of civil society in the development, implementation, management, and strategic stewardship of national and regional responses to the epidemic.</p>	<p><u>Participants</u> -Civil society coalitions and networks -NGOs and CBOs working on the field of HIV/AIDS -Coordinating and governing bodies</p> <p><u>Assessment Team</u> -NGO Capacity Building Specialist -IHA Associate Consultant (To Take Lead Until NGO CBS is identified.)</p>	<p>-Literature review of existing coordinating bodies at the national and regional level; -Selected tools from the Alliance toolkit 'Capacity analysis for NGO support organisations'</p>	<p>-Agreed workplans developed by regional NGO coalitions and networks.</p>	<p><u>Timeframe</u> January - March 2005</p> <p><u>Next Steps</u> -To report the findings to CCMs, PRs and the international partners in CAR for developing plans for improving the operations. -Implementation of planned activities is supported through other financial support mechanisms.</p>

STRATEGY III: IMPROVING THE QUALITY OF HIV/AIDS SERVICES

III.1: Assessment of Opportunities to Expand Options for Voluntary, Counseling and Testing (VCT)

Strategy III.1 Program Objectives	Assessment Activities	Assessment Participants & Assessment Team	Assessment Tools/Formats	Assessment Outputs	Timeframe & Next Steps
<p>1. Strengthen the capacity of the existing VCT services;</p> <p>2. Introduce new testing technologies;</p> <p>3. Establish new VCT services in non-governmental settings;</p> <p>4. Integrate VCT into primary health care settings; and</p> <p>5. Increase demand for VCT, particularly among high-risk groups.</p>	<p>RACs & PHCs Institutional Assessment</p> <ol style="list-style-type: none"> 1. Review the existing VCT facilities including trained counselors, HIV testing techniques and HIV laboratory quality control 2. Primary Health Center Facility Reviews <p>In selected oblasts, CAPACITY and local partners will work with AIDS centers and the rayon level of PHC clinics to identify ways to integrate VCT into existing services. Multi-disciplinary teams will work with selected PHCs to:</p> <ul style="list-style-type: none"> • Identify target populations for VCT services • Opportunities for integration of services that meet needs of target groups • Examine Staffing needs • Assess current physical infrastructure • Examine Laboratory capacity • Review VCT policies and procedures • Review existing VCT curriculum • Review supply chain and procurement of test kits and other necessary materials • Identify community-based partners for referral of patients for other services. 	<p><u>Participants</u></p> <ul style="list-style-type: none"> -Republican AIDS Centers -Targeted Primary Health Care Facilities <p><u>Assessment Team</u></p> <ul style="list-style-type: none"> -CAPACITY staff -VCT CAPACITY specialist - Professionals from AIDS Centers on the laboratory diagnosis and counseling 	<p>-Questionnaire and Interviews for RACs and PHCs & other key stakeholders.</p>	<p>A report detailing the needs at each PHC and potentials for involving NGOs in this activities will be developed. As part of the report a suggested technical assistance plan will be developed which will detail essential inputs that are needed in order to being VCT services.</p>	<p><u>Timeframe</u></p> <p>February-April 2005, 1-2 days per a rayon PHC site</p> <p><u>Next Steps</u></p> <p>-Finalize Assessment Questionnaire & Interview Tool</p>

STRATEGY III: IMPROVING THE QUALITY OF HIV/AIDS SERVICES

III.2: Assessment of Opportunities to Expand Options Increase Access to Antiretroviral Therapy, Care & Support (ART)

Strategy III.2 Program Objectives	Assessment Activities	Assessment Participants & Assessment Team	Assessment Tools/Formats	Assessment Outputs	Timeframe & Next Steps
<p>Our approach is to provide sites and programs with a set of criteria to assess a site's readiness to implement ART and to identify key areas that need strengthening prior to or at the same time as ART initiation. Assessments should not be seen as a barrier to sites but rather to offer an opportunity to work towards start-up</p> <ol style="list-style-type: none"> 1. Integrate ART into existing PHC services. 2. Link PLWHAs with other non-clinical services 	<p><u>Institutional Assessment</u> The assessment will start from the (Republican) AIDS Centers and determine their capacity, workload, patients eligible and served and projected for the coming five years, including:</p> <ul style="list-style-type: none"> • Level of site leadership to implement ART • Model of care • Treatment protocols exist • HIV services are currently provided, including services to promote initiation of ARVs and adherence to ARVs • HIV services currently in place • Physical space • Community involvement • Health management information systems • Program management monitoring and evaluation • Staffing (Pharmacists & Technicians) • Training and skills development needs (Prescribers & Dispensers) • Management, supervision and staff retention plans • Laboratory capability and quality standards (Quality of Medicines) • Drug management and supply chain (Quantification, Budgeting, Accounting, Inventory Control, Storage, Transport, & Distribution) • Pharmacy management (e.g. Dispensing practices, counseling, role in fostering adherence) • Financial resources 	<p><u>Participants</u> -Republican AIDS Center Facilities</p> <p><u>Assessment Team</u> -CAPACITY staff -ARV treatment Boston University Specialist - Professionals from AIDS Centers on ARV treatment</p>	<p>-Tailored ART Site Readiness Tool</p>	<p>The assessment will identify gaps at identified sites and lead to development of concrete technical assistance plans that will address those needs. Site specific reports with detailed recommendations for technical assistance needs to enhance site readiness.</p>	<p><u>Timeframe</u> May-June 2005, 2-3 days per rayon PHC site, 2 days per an NGO</p> <p>(Must Follow AFTER Assessment III.1)</p> <p><u>Next Steps</u> -TBD</p>

STRATEGY III: IMPROVING THE QUALITY OF HIV/AIDS SERVICES

III.3: Assessment of Opportunities to Expand Link/Integrate HIV and TB Services

Strategy III.3 Program Objectives	Assessment Activities	Assessment Participants & Assessment Team	Assessment Tools/Formats	Assessment Outputs	Timeframe & Next Steps
<p>The initial objective of the CAPACITY Project to address the concomitant HIV and TB epidemics in CAR will be to expand case detection opportunities in currently separate vertical programs. JSI will work with local partners to integrate the introduction of simple screening tools and referral mechanisms to ensure that individuals presenting at a variety of related services are assessed for HIV and TB.</p>	<p><u>Institutional Assessments</u> A team of health managers/physicians experienced in both HIV and TB issues will visit selected oblasts for:</p> <ul style="list-style-type: none"> • Study the activities, achievements and obstacles faced by the HOPE Project in developing cooperation of the HIV and TB service providers • Identify the institutions providing the HIV diagnostic services and TB diagnostic and treatment services in geographic areas selected for this activity. • Collect relevant epidemiological data on the two infections in HIV infected populations and among TB patients at present and possibly projections for these indicators for the coming five years • Identify the needs of both services in improvement of cooperation, communications and developing/strengthening referral system between them 	<p><u>Participants</u> -HIV/AIDS Service Providers -TB Service Providers</p> <p><u>Assessment Team</u> -CAPACITY staff -CAPACITY TB specialist - Professionals from AIDS Centers on the opportunistic infections/epidemiology - Professionals from the TB Services providers (TB dispensaries)</p>	<p>-Questionnaire and Interviews with Service Providers & Other Key Stakeholders.</p>	<p>A report that would provide a basis for developing a technical assistance plan for designing a strategy of cooperation between the services and a protocol for cooperation and referral system.</p>	<p><u>Timeframe</u> February-March 2005, 4 days for the field assessment in one oblast, 1 week for preparation of a country report</p> <p><u>Next Steps</u> -Developing a strategy and a technical assistance plan of cooperation between the services and a protocol for cooperation and referral system. -Finalizing Questionnaire (Interview) Tool</p>

STRATEGY IV: IMPROVING RESOURCE-USE TO INTEGRATE HIV/AIDS SERVICES WITH PRIMARY HEALTH CARE AND OTHER HEALTH SERVICES

IV.1: Assessment of Opportunities for Integrating HIV/AIDS Services With Primary Health Care Services

Strategy IV.1 Program Objectives	Assessment Activities	Assessment Participants & Assessment Team	Assessment Tools/Formats	Assessment Outputs	Timeframe & Next Steps
<p>The HIV/AIDS strategies and interventions should be integrated into these efforts to strengthen the health system and reform the health service delivery structure—particularly by integrating certain HIV/AIDS services into PHC. Doing so has the double benefit of bringing services closer to the people and thus enhancing utilization, while also avoiding the creation of another costly and inefficient vertical system to address the epidemic.</p>	<p>A multi-professional team will work in the country capitals and visit selected oblasts to:</p> <ul style="list-style-type: none"> • Assess the institutional structure, roles, and relationships related to HIV/AIDS within the Ministries of Health and among other Government sectors, the Global Fund CCMs and Prime Recipients and service providing NGOs. • Assess what this institutions/organizations designed to do and what do they do. • Assess the needs of PHC for training on prevention, VCT, ARV, care and support for PLWHA • Assess the needs for planning and implementation efforts to help the SES reform its institutional structure to improve services related to (1) HIV/AIDS prevention, (2) health promotion in partnership with Centers for Healthy Lifestyles and PHC centers, and (3) disease surveillance and control. • Assess the government budget funds allocated to HIV/AIDS services included in health funding pools at the oblast level. 	<p><u>Participants</u> -TBD</p> <p><u>Assessment Team</u> -Subrata Routh -Others TBD</p>	<p>-TBD</p>	<p>A report would provide a basis for designing the strategies on integration of HIV/AIDS services with Primary Health Care and other services.</p>	<p><u>Timeframe</u> Autumn 2005. 3 days assessment at the state capitals level, 4 days for the field assessment in one oblasts, 1 week for preparation of a country report.</p> <p><u>Next Steps</u> -TBD</p>

THE CAPACITY PROJECT
INITIAL ASSESSMENT OVERVIEW
FINAL VERSION – 22 March 2005

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1. Introduction

In order to complement multi-partner expanded response to the rapidly spreading HIV/AIDS epidemics in the countries of Central Asia, fueled by increasing numbers of injecting drug users and concurrent sexually transmitted infection and tuberculosis epidemics, the USAID- funded CAPACITY Project initiated its operations at the end of 2004. CAPACITY stands for “Central Asian Program on AIDS Control and Intervention Targeting Youth and High-Risk Groups.” The Program is being implemented JSI Research & Training Institute, Inc. (JSI) in partnership with Abt Associates, Boston University, Howard University, International HIV/AIDS Alliance, and Population Services International (PSI) in all of the five countries of the Region over the five year period of 2004-2009.

CAPACITY will work closely with the governments, civil society, international donor and regional organizational entities by offering a “menu” of technical assistance to:

- Build capacities in the following key technical areas:
 - 1) HIV/AIDS Prevention in Target Groups,
 - 2) Voluntary Counseling and Testing Care & Support,
 - 3) Antiretroviral Treatment and
 - 4) Linkage between HIV/AIDS & TB Services;
- Strengthen the institutional capacity of non-governmental organizations and Civil Society to prevent and control HIV/AIDS;
- Ensure sufficient attention to the key target groups and affected regions, such as Injecting Drug Users, Prostitutes and Youth at Risk; and
- Develop models to advance integration of HIV/AIDS prevention and control efforts with ongoing health sector reforms in Central Asia.

Considering the multi-faceted character of the Project design and broad variability of each country’s technical assistance needs, CAPACITY’s first objective is to initiate an initial assessment aimed at institutional review and identification of the particular needs within the aforementioned technical areas for four countries of the region. Due to logistical challenges (long period needed to obtain visas) this initial assessment in Turkmenistan will be implemented at a later date.

2. Initial Assessment Goal and Objectives

The goal of the CAPACITY Initial Assessment is to develop the strategy and workplan for the implementation of the Project. The objectives of this assessment are as follows:

1. To understand the current functioning of the Country Coordinating Mechanisms (CCMs), Principal Recipients (PRs) and selected Sub-Recipients and to identify potential needs/areas for technical assistance.
2. To understand the current situation with regards to each of the technical areas and to identify the potential areas of technical assistance within each organization involved.
3. To map/understand current donor activities and funding on HIV/AIDS in Central Asia and to identify needs/areas for technical assistance by CAPACITY.

4. To map/understand current activities and funding of implementing organizations, government and NGOs on HIV/AIDS in Central Asia and to identify needs/areas of technical assistance.
5. To collect specific information about target populations (IDUs, Prostitutes, Youth-at-risk and PLWHA) in terms of their geographic distribution and size estimation.

3. Desk Assessment

In January 2005, the CAPACITY/Almaty team initiated a desk assessment of the documents collected from various stakeholders in the region. The overall objective of the desk assessment is to document the current overall HIV/AIDS situation, including recent developments in the epidemic, and to understand what strategies and activities are being implemented to combat the spread of the epidemic in each country. In addition, CAPACITY viewed the results of the desk assessment would supplement the results of the initial assessment in helping to identify technical assistance needs in each of the countries. The assessment was conducted from available documents of stakeholder and implementer websites, databases, presentations, press releases and reports. (All sources have been cited in the desk assessment country reports.) The structure of the desk review documents was as follows:

- I. HIV/AIDS Situation in the Country
- II. Current Response to HIV/AIDS Epidemic in the Country
- III. Current Assessments About Epidemic and Response in the Country
- IV. Gaps in Response to HIV/AIDS Epidemic in the Country

4. Field Assessment

Prior to the initiation of the country assessment activities, CAPACITY project staff visited all four countries and discussed the assessment objectives, assessment schedule and the contents of selected protocols. In addition, CAPACITY sought specific input regarding the assessment from representatives of USAID, UNAIDS and the Republican AIDS Center in each of the four countries. Principal acceptance for the assessment was received from these three entities as well as some international organizations and key NGOs.

5. Assessment Areas and Protocols

From December 2004 to February 2005, the Almaty team in consultation with the JSI R&T HQ and selected national and international partners in Central Asia, developed draft assessment protocols for the following Project areas¹:

- I.1. Global Fund CCM
- I.2. Global Fund Principal Recipient
- I.3. Global Fund Selected Sub Recipients
- I.4. International Organizations Involved in HIV/AIDS Activities
 - II.1. High-Risk Groups
 - II.2. NGO Capacity Building (Please See Below)
 - III.1. Voluntary Counseling & Testing, Care and Support
 - III.2. Antiretroviral Treatment
 - III.3. HIV & Tuberculosis

¹ The assessment of the integration in the Primary Health Care, (Protocol IV.1) will follow in several months after the implementation of other thematic activities has been initiated.

The first drafts of the protocol were distributed to the international partners for comments in late February and early March and the Russian versions were used for the protocols pre-testing in Uzbekistan during March. The pre-testing was organized by the Tashkent CAPACITY team with the following objectives:

1. To determine the composition of the groups to be interviewed on each of the nine protocols;
2. To identify unclear questions and modify them to be understandable;
3. To remove any irrelevant questions those are to the CAPACITY activities and to attempt to shorten the protocol itself.
4. To select a more suitable version of the protocol for the International partners²;
5. To incorporate additional points that may come up during the testing;
6. To number the protocols sections;
7. To identify/confirm the list of organizations to be intervened on each protocol;
8. To identify the time required for implementing each protocol; and
9. To check the Russian translation.

The pre-testing comments and the external partner's recommendations were incorporated into the drafts, which were finalized for the field implementation. At the same time, the Brighton based International HIV/AIDS Alliance (IHAA), one the CAPACITY sub-contractors responsible for the NGO capacity building, developed a respective protocol (NGO Capacity Assessment), consulted and pre tested it with nine national consultants in Bishkek in 7-8 February 2005, consulted with the Almaty team and initiated the protocol implementation in early April.

6. Field Assessment Teams

For each country, an eleven-member assessment team has been formed from the CAPACITY staff members, several stakeholders working in the countries including ZdravPlus, USAID, UN agencies, NGOs and, when possible National Republican AIDS Centers. Nine members of the team were to work on each of the thematic areas and two additional members were reserved in case some core members could not participate. The team leaders were assigned from the CAPACITY staff and national team leaders from the members of the assessment team. The composition of the country assessment teams is shown in the Annex 2 and their SOW in the Annex 3

7. The Stakeholders

In February, USAID offices, UN agencies and the National Republican AIDS Centers were approached with a request to submit a list of the AIDS Program Partners to be interviewed during the assessment exercise. The final versions of the assessment protocols were circulated to these organizations with a request to collect the necessary information prior to the country meetings and to participate in the meetings. The time-table of the meetings was also coordinated with the same agencies. The CAPACITY Organizing Committee of the country assessment meetings sent invitation letters with detailed instructions where the meeting is to take place and on how to contribute the best into the assessment process. Please see Attachment No.:1-Detailed List of Country Stakeholders.

8. Country Assessment Meetings (CAM)

Meeting the program stakeholders in each country was considered the most efficient way for rapid collection of the information on the situation and assessment of the partners needs in technical assistance from the CAPACITY Project.

The CAM Objectives include:

² Initially two versions of the protocols for International partners were developed. The field testing of both was aimed at selection of a more friendly and suitable version.

- Introduce CAPACITY to key HIV/AIDS Stakeholders;
- Outline CAPACITY’s assessment process and objectives;
- Outline CAPACITY’s strategy design process and objectives; and
- Obtain stakeholder input and technical assistance requests.

Team Planning Meeting: The assessment team members will hold a pre-meeting the day prior to the Country Assessment Meeting to be briefed on the assessment methodology, acquainted with the assessment protocols and each member will be assigned as facilitator to a particular stakeholder group.

9. Country Assessment Meeting Agenda³.

Time	Session & Speaker Meeting Chair: Country Assessment Team Leader
8:30 – 9:30	Registration (Coffee/Tea & Danish)
9:30 – 10:00	Inaugural Welcome Addresses -US Embassy/USAID Official -Government Representative -CAPACITY Chief of Party, Dr. Lev Khodakevich
10:00 - 10:15	The CAPACITY Project Overview Presentation -Dr. Lev Khodakevich
10:15 – 10:30	The CAPACITY Project Assessment Plan Overview Review of Meeting Objectives -Country Assessment Team Leader
10:30 – 11:00	Break (Coffee/Tea & Danish) Media Interview Session Conducted During Break
11:00 – 11:15	Small Group Plan – Country Assessment Team Leader -Division into working groups -Allocation of the facilitators and space -Timeframe for the group work -Selection of NGO for VCT small group -Explanation of Requested Interviews
11:15 – 13:30	Small Group Work on Technical Areas: Support Provided by Country Assessment Team Members
13:30 – 14:00	Closing Statements Country Assessment Team Leader CAPACITY Chief of Party, Dr. Lev Khodakevich
14:00 – 15:30	Reception/Lunch

Note: Media representatives are invited to stay during coffee break to have a question and answer period with speakers. Other stakeholders are welcome to enjoy coffee break and/or listen in on the media interview session.

10. Small Work Groups Allocation and Instructions

Small Work Group Allocation:

³ The Protocol pretesting exercise showed that filling in each protocol may take from one to two hours.

Arrangements for the interviews and input into protocols. All stakeholders are to be organized into 8 working groups to cover each of the CAPACITY technical area, as shown below:

Assessment Area	Number of Respondents	Organization(s)
Area I.1 – CCMs	3-5	-CCM Members (2) (Govt. & Civil Society) -International Organization/Donor -Republican AIDS Center
Area I.2 – PRs	2-5	-The Principal Recipient(s) -Republican AIDS Center
Area I.3 – SSRs	2-4	-One organization from NGO sector and one Governmental organization
Area I.4 – IOs	15-25	-International Organizations involved in HIV/AIDS activities
Area II.1 – HRG	5-10	-NGO (5-10) -Regional AIDS Center -Republican Narcology Center -Republican Dermato-Venereological Dispensary
Area III.1 – VCT	3-6	-NGOs -Republican/Regional AIDS Center -PHC Institution
Area III.2 –ART	3-6	-Republican AIDS Center -Infectious Diseases hospital -Ministry of Internal Affairs/Justice (Penitentiary Medical Department) -MCH Department of MOH
Area III.3 – HIV/TB	3-6	-Republican AIDS Center -Republican TB Dispensary/Institute -Project HOPE TB Programme

Small Work Groups Instructions:

- The country assessment team leader and assistant should ensure that correct number of protocols are prepared as handouts for each of the small group assignments detailed below.
- Each group will have a Facilitator who would chair these groups, answer the questions and assist in completing the assessment protocols. During this work the facilitators will note down gaps (unanswered items) due to lack of information available with the participants.
- At the end of the work group session the Facilitators will agree with these participants on the schedule (time and place) for the follow-up interviews within a day or two following the assessment meeting and will note down the contacts (address, phone etc). The type of the missing information and schedule for the follow-up meetings will be reported back by the facilitators to the country assessment team leader at the end of the meeting.

- If some groups finish the work early, the members are to be strongly encouraged to join other groups of their specific interest. If the Facilitator is in a group that does finish early, s/he will invite and encourage members to join other groups in order to ensure that everyone stays until the end of the group work session.
- Eventually, after the Assessment meeting and where ever necessary individual post-meeting interviews Facilitator will submit the assessment reports to the Country Assessment Team Leader for analysis.
- The sections below provides further details on the groups' composition and work. The expected number of persons working in each group is shown in the table above and will vary by country.

-Global Fund/CCM, Protocol I.1.

Three to five persons from the CCM, CCM Secretariat, CCM working group will take part during Country Assessment Meetings. It is desirable among CCM members to have representatives from both the government sector, civil society and donor community representative. One facilitator will work in this group introducing one copy of the protocol. The questions will be discussed by the group and recorded either by the facilitator or by a member of the group into that one document.

-Global Fund/Principal Recipient, Protocol I.2.

It's appropriate for the Principal Recipient to send 2-3 persons who will be able to cover PR Global Fund issues. One facilitator will work in this group introducing one copy of the protocol. The questions will be discussed by the group and recorded either by the facilitator or by a member of the group.

-Global Fund/Selected Sub-Recipients, Protocol I.3.

At least two Sub-Recipients should be interviewed, one representing the Government sector and one representing Civil Society, several persons from each, to be determined on the basis of the recommendations from the countries. It is expecting that AIDS centers will send their professionals to take part in these working groups. The Republican AIDS center is to determine which of the AIDS Centers (municipal, oblast) would work in this group. One facilitator will work with each sub-recipient, each introducing one copy of the protocol. The questions will be discussed by the group and recorded either by the facilitator or by a member of the group. In the end, one document will be completed for each organization represented.

-HIV/AIDS International Organizations, Protocol I.4.

Depending on the size of the group one or two facilitators may help this group or two groups if they are to be divided into two sub-groups. The facilitator(s) will clarify any issues and questions and will help to answer the questions. Each organization represented at the group will have to fill in one copy of the protocol. This group should sit in a separate quite space during the small group work period.

-High-Risk Groups, Protocol II.1.

One facilitator will assist NGOs to fill their protocols. Each organization represented at the group will have to fill in one copy of the protocol. The protocols will be filled by each NGO independently. It's expected that AIDS centers will send their epidemiologists from the municipal or oblast centers to take part in this working group. Several (5-10) NGOs who know the NGO networks in the country should be involved in the interviews. Also the Narcology Services, AIDS Centers and Government organizations coordinating preventive interventions in vulnerable groups can provide important information.

-Voluntary Counseling & Testing, Care and Support, Protocol III.1.

The Republican AIDS Center and Municipal/Oblast AIDS Centers are the key figures here. An Oblast AIDS centre from a HIV/AIDS higher prevalence area should also participate in the assessment along with the Republican Centre. One NGO experienced in or intending to work on VCT may be selected for this group during the plenary session. One facilitator will assist this group to fill in their protocols. One copy of the protocol will have to be filled by this group after the group members' opinions are collected and discussed. Note: It is expected that AIDS centers will send their professionals to take part in this working groups. The Republican AIDS center is to determine which of the AIDS Centers (municipal, oblast) would work in each group. In addition, ZdravPlus has been requested to send a representative to this small group to input their expertise gained from working in health reform.,

-Antiretroviral Treatment, Protocol III.2.

For this area the Republican AIDS Center and Oblast AIDS Centers are again the key figures and the institutions that are presently involved or may be potentially involved in the ARV treatment/care are to be invited. They include Infectious Disease Hospitals, Medical departments of the ministries of Justice or Interior, which supervise and provide technical assistance to the prisons clinics, Chiefs of the prisons clinics, MCH Department of MoH. The organizations coordinating the health reforms, especially those involved in the development of the family physicians' services will be interviewed on their potential role in decentralization. One facilitator will assist this group to fill in their protocols. One copy of the protocol will have to be filled by this group after the group members' opinion were collected and discussed. Note: It is expected that AIDS centers will send their professionals to take part in this working groups. The Republican AIDS center is to determine which of the AIDS Centers (municipal, oblast) would work in each group. In addition, ZdravPlus has been requested to send a representative to this small group to input their expertise gained from working in health reform.,

-HIV & TB, Protocol III.3.

For this area representatives of the Republican/municipal AIDS Center will work with the National Tuberculosis Services (the Republican TB Institute or the Republican TB Dispensary) and the HOPE project to find out their views on the linkages between the two services. One Facilitator will assist this group with understanding all questions and one copy of the protocol will have to be filled by this group after the group members' opinion were collected and discussed. Note: It is expected that AIDS centers will send their professionals to take part in this working groups. The Republican AIDS center is to determine which of the AIDS Centers (municipal, oblast) would work in each group. In addition, ZdravPlus has been requested to send a representative to this small group to input their expertise gained from working in health reform.,

11. Review of the Country Assessment Results

The results of the country assessment meetings will be summarized by country assessment team leaders into summary report with attached annexes. The format of the country assessment report should follow the following skeleton.

NOTE: THIS FORMAT IS TO BE DETERMINED FOLLOWING THE UZBEKISTAN COUNTRY ASSESSMENT MEETING.

12. The Results of the CAPACITY Initial Assessment

The assessment teams should keep in mind that the future results of the work of country assessment meetings and subsequent follow-up interviews will be used as the basis for development of the CAPACITY Strategic Plan during strategic planning meetings from 2-13 May 2005. The results of the strategic planning meeting will be the development of the CAPACITY Project's strategic vision, upcoming implementation plans, and the project's monitoring and evaluation plan.

Annexes

Annex 1. The CAPACITY Country Assessment Meeting Dates and location, Team Planning Meeting (TPM) & Country Assessment Meeting (CAM)

TPM/CAM	City, Country	Date	Location
TPM	Tashkent, Uzbekistan	Monday, March 28	CAPACITY Office
CAM	Tashkent, Uzbekistan	Tuesday, March 29	Radisson Hotel
TPM	Dushanbe, Tajikistan	Monday, April 4	Avesto Hotel
CAM	Dushanbe, Tajikistan	Tuesday, April 5	Avesto Hotel
TPM	Bishkek, Kyrgyzstan	Monday, April 11	Pinara Hotel
CAM	Bishkek, Kyrgyzstan	Tuesday, April 12	Pinara Hotel
TPM	Almaty, Kazakhstan	Monday, April 18	CAPACITY Office
CAM	Almaty, Kazakhstan	Tuesday, April 19	Alatau Resort

Annex 2. Composition of Country Assessment Team Members

Country	Team Leader	Team Members
Uzbekistan	Rakhima Nazarova	Please see Attachment No.: 1
Tajikistan	David Hausner	Please see Attachment No.: 1
Kyrgyzstan	Marty Bell	Please see Attachment No.: 1
Kazakhstan	Lev Khodakevich	Please see Attachment No.: 1

Annex 3. Country Team Member Roles & Responsibilities

Role	Responsibilities
Team Leader	<ol style="list-style-type: none"> 1. Outline schedule for country-specific team meetings and country team program of work; 2. Collect names and contact information for stakeholders to be invited to Country Assessment Meeting; 3. Outline scopes of work and deadlines of work to be completed by each team member; 4. Brief the team on the assessment plan/timeline and on assessment protocols; 5. Assist with sending invites & protocols to stakeholders for Country Assessment Meeting; 6. Follow-up with stakeholders to ensure attendance to meeting and clarity re: protocols; 7. Work with Program Assistant to arrange all specifics of Country Assessment Meeting; 8. Serve as “facilitator” and “presenter” at the Country Assessment Meeting; 9. Work with country team to develop follow-up interview plan and schedule; and 10. Review and finalize country-specific assessment report by requested date.
Team Members	<ol style="list-style-type: none"> 1. Work with Team Leader to implement your specific scope of work on team; 2. Read preparatory documents (desk review/assessment plans/protocols 3. Assist with all aspects of preparation for the Country Assessment Meeting; 4. Participate in ½ day pre-meeting briefing with entire team before Assessment Meeting; 5. Participate as Small Group Facilitator for the Country Assessment Meetings; 6. Identify gaps (unanswered items) from small group sessions & schedule follow-up interviews; 7. Conduct follow-up interviews as outlined in country-specific interview schedule; 8. Assist with writing, editing and finalization of the assessment report; and 9. Work with partners in group in clarifying protocol and filing in protocol.
Program	<ol style="list-style-type: none"> 1. Provide administrative support to country assessment team, including scheduling

Assistant	meetings, arranging transportation and typing report/minutes at meetings; 2. Arrange logistical details of ½ day briefing meeting and one-day assessment meeting to take place in capital of each country, including all meals/breaks, room layout, document preparation, AV equipment and translation needs, etc. 3. Assist team with preparation of final assessment report, including taking meeting notes, editing sections, final formatting, copying, emailing, etc.
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Annex 4. Country Assessment Meeting Handouts

The country assessment team leader and assistant should ensure that correct number of handouts are prepared based on number of participants.

- Country Assessment Meeting Agenda – English & Russian
- CAPACITY Project Presentation – English & Russian
- CAPACITY Project Description Sheet – English & Russian
- CAPACITY Partners Brief – English & Russian
- Country Assessment Meeting List of Participants
- Other – TBD

CAPACITY staff activity report

(briefing, meeting, negotiation, round table, interview)

Reporter's Name: Lev Khodakevich, Date: 20.01.05

Country/place/organization visited/participated and contacts:* **Boston, Massachusetts 2-7 January 2005
Washington, DC 10-12 January 2005** (names and program in the attachment)

Purpose of the visit: **CAPACITY Project Chief of Party Orientation**

Persons involved and their contacts* _____

Report distribution (a, b, c, d, e, g)**

A summary of the issues discussed and outcome	Follow up: person(s) and actions
<ul style="list-style-type: none">- Learned the history, locations, staffing pattern, key staff, Human resource policy, pattern of work and inter-personal communication of JSI.- Got insights on the work of the JSI International Division- Learned on the Role of the CAPACITY Project Coordinator and Senior Advisor and on the new pattern of the Project support team at JSI Boston- Learned on the work of the JSI's Deliver Project- Was introduced to the key persons of JSI in Boston, the JSI Director and specialists related to the Capacity in WCD- Studied the JSI Basic Management Package- Learned the JSI M&E approaches- Learned on the JSI intranet system and its use, JSI Communication Standards & Resources, JSI Library Resources- Briefed on the PEPFAR Program - Briefed on the surveillance among IDUs in the Massachusetts state- Learned the history and working basics of the HOPE Program and JSI component in CAR - Learned the basic activities and potentials of the Howard University and discussed the University cooperation with the CAPACITY - Reviewed the Allowance Manual, E-Timesheets, EVS, Consultant Contract - Completed the formalities related to the contract with JSI	<p>The University has reach experience in several areas of the CAPACITY activities. Based on the briefing on the CAPACITY HU will submit soon a proposal on the</p>

<ul style="list-style-type: none"> - Discusses with the <i>CAPACITY staff</i>: <ul style="list-style-type: none"> Project Staffing and Management Strategic Planning Finalizing the Work plan for the year one of the Project Initial Assessment Plan, procedures, tools, time-table - Discussed with Boston University the instruments for the initial assessment for CAPACITY Project - Made a Brown Bag presentation on the CAPACITY Project - Discussed with PSI office in WDC the SoW, selection and recruitment of the prevention specialist, work plan for the CAPACITY year one activities. <p>Acknowledgment. My thanks to the whole CAPACITY team for initiation and arranging the briefing and the staff of JSI for their time and attention. Special thanks to Matt Habinowski for arranging the briefing and careful travel schedule.</p>	<p>expertise that can be offered to CAPACITY</p> <p>BU submitted an extended plan of participation in the initial assessment process. Their contribution will be incorporated in the general CAPACITY Plan and submitted to the Project.</p> <p>PSI welcomed the clearance of Marty Bell as a CAPACITY Prevention Specialist and agreed:</p> <ul style="list-style-type: none"> - Marty would work 80% of this time for CAPACITY - Marty will report on these activities to the CAPACITY COP - SOW would be adjusted accordingly to cover both the PSI RC activities and JSI activities.
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Lev Khodakevich

The Orientation Schedule

Boston, Massachusetts 2-7 January 2005

Washington, DC 10-12 January 2005

Sunday, 2 January

Arrival to Boston from Moscow

Monday, 3 January 2005

09:00 – 12:00 Matt Habinowski

01:30 – 03:30 Joanne McDade

Topic: JSI Company Wide Orientation

03:30 – 04:30 Theo Lippeveld, VP of Intl Division

04:30 – 05:00 Matt Habinowski

Topic: General Overview – Boston International Group

Tuesday, 4 January 2005

09:00 – 9:30 “Meet and Greet Breakfast” with International Division

Topics: Personal Introductions & History

09:30 – 10:00 EE/FSU Project Coordinators

Topic: Details of JSI projects in EE/FSU

10:00 – 11:00 Stewart Landers, Health Services (JSI/Domestic)

Topic: Health Services Work with High-Risk Groups

11:00 – 12:00 Ray Pelletier or Chantang Ros

Topic: JSI Human Resources Orientation

12:00 – 01:00 LUNCH

01:00 – 03:00 Presentation Preparation

03:00 – 03:30 Information Systems Group (ISG)

Topic: Intro to JSI Information Systems

03:30 – 05:00 Meet with **Brenda Waning, Boston University (BU)**

Topic: BU’s involvement in CAPACITY

Wednesday, 5 January 2005

09:00 – 10:00 Joel Lamstein, JSI President

Topic: Overview of JSI and CAPACITY briefing

10:00 – 11:00 Penelope Riseborough, Director of Communications

Topic: JSI Communication Standards & Resources

11:00 – 11:30 John Carper, JSI Librarian

Topic: JSI Library Resources

12:00 – 01:00 Brown Bag Presentation on the CAPACITY

02:00 – 03:00 Report preparation

03:00 – 05:00 Audrey Seger Sprain, Matt Habinowski

Topic: Intro to JSI Basic Management Package

Thursday, 6 January 2005

09:00 – 12:00 Matt Habinowski, Audrey Seger Sprain & Andrew Fullem

Topics:

CAPACITY Project Management

Strategic Planning

Finalizing the Work plan

Initial Assessment Plan

Staffing Plan

Role of Project Coordinator and Senior Advisor

01:00 – 05:30 CAPACITY Meetings (continued)

Topic: CAPACITY

Friday, 7 January 2005

08:45 – 09:30 JSI/WEI Bagel Breakfast

Location: 4th Floor Employee Lounge

09:30 – 10:00 **Matt Habinowski**

10:00 – 11:00 **Pat David, Center for Health Information Monitoring & Evaluation (CHIME)**

Topic: M&E of JSI Projects

11:00 – 12:00 **Matt Habinowski**

01:00 – 05:00 **Matt Habinowski**

Topic: Review of Allowance Manual, E-Timesheets, EVS, Intranet, Consultant Contract

Saturday, 8 January 2005

Flight to Washington, DC

Sunday, 9 January 2005

Free day in Washington

Notes

John Snow, Inc. (JSI)

1616 N. Fort Meyer Drive, 11th Floor

Arlington, Virginia 22209-3100

Phone: 703.528.7474

Fax: 703.528.7480

Monday, 10 January 2005

09:00 – 10:00 **Yasmin Chandani and Dragana Veskov**

Topic: DELIVER's work with HIV/AIDS

10:00 – 11:00 **Carrie Hessler-Radelet**

Topic: Working with GFATM in Romania

11:00 – 12:00 Notes

02:00 – 05:00 **PSI: David Reene, Vice President, Asia and New Initiatives, John Berman, Senior Director, Steven Chapman, Research Director and Shannon England. Present: Andrew Fullem, Matt Habinowski.**

Topic: PSI work in the region and potential activities in CAPACITY

Tuesday, 11 January 2005

09:00 – 10:00 **Lisa Hare**

Topic: Program development in Romania, Situation analysis, NGO capacity assessment

10:00 – 11:30 **Jeff Sanderson**

Topic: JSI's work on the Project HOPE TB Project in CAR; results of completed assessments in Kazakhstan, Tajikistan and Turkmenistan and challenges of upcoming assessments in Uzbekistan and Kyrgyzstan

11:30 – 12:00 Notes

02:00 – 03:00 Meet with **Michael McGunnicle**, Financial Manager

Topic: Overview of JSI Financial Systems

03:00 – 05:00 Notes

Wednesday, 12 January 2005

10:00 – 12:00 **Dr McNeil and Goulda Downer** from Howard University. Present: **Matt Habinowski**

Topic: Howard University involvement in CAPACITY

12:00 Departure to NY-Moscow

The CAPACITY Project - Staff Activity Report

Activity Date(s)	9.02-10.02.05
Reporter's Name	Lev Khodakevich
Country	Kg
Activity Name/ Organization(s)/	Visit to Bishkek See below
Purpose	To attend CCM meeting, and USAID meeting with V. Chernyavskiy, GFATM Portfolio Manager
Contact Person(s)	See below

NOTE: Please attach activity agenda and/or list of attendees. Please submit and distribute activity report within 7 business days of activity date.

Issues Discussed and Outcomes/Follow-Up/Deadlines/Persons

9.02.05

10:00-12:30

CCC (Country Coordination Committee) meeting.

Mtg was chaired by Ms. T. J. Aitikeeva, -PM and Chair of CCC Kg. Agenda was made available in a hard copy in Russian only.

The Agenda included:

- Opening by Ms. T. J. Aitikeeva

- Welcome by V. Chernyavskiy.

V. Chernyavskiy greeted Kg on the achievements, briefed on the new regulations of the GF developed in No 2004 (pls. see web site ... boardmeeting9) and on the 5th Round of funding. The 5th Round will be announced on 17 March. In July the CCC Chair will get a letter from GF offering an expansion of funding for the next 3-5 years. The applications for the 5th round will be accepted if the conditions of the new regulations are fully met. So far proposals from 5 countries out of 30+ were turned down due to noncompliance to these demands.

Moldova and Georgia reached a 100% treatment coverage by ARVs and Kg is expected to come soon to this achievement. Tj already got two grants for AIDS. Some countries in the region have found the ways of effective work of their CCCs (Moldova and Armenia).

GF Level of indicators:

1. No. persons treated
2. No. organizations involved
3. No. persons trained

- Report on the GF TB Component implementation

The Program objectives:

Case detection

Treatment control

Drug resistant case treatment.

For some reasons patient with HIV were excluded from the TB treatment.

TB showed notable decreases in the Incidence and Mortality rates since the DOTS as introduced in 1998.

Though the project proposal for the TB Component was developed jointly with the AIDS Centre apparently no relations at the working level were established.

- Approval of Budget for the next phase of the TB Component
- Report on the GF AIDS Component implementation

AIDS Centre is the PR and there are 50+ sub-grantees.

Coverage of IDUs grew up from 3% to 7.2%. only a couple of hundred of persons being reached. 35 AIDS patients on the record, 14 with TB.

- Approval of Budget reprogramming for the next phase of the AIDS Component
- Discussion.

The reports and Budgets were approved with several comments:

From the Chair: high cost of the management in the TB component, duplication of the activities after the establishment of the AIDS Sector in the Gvt.

From participants: Need for better information exchange; Provision of the documents in advance of the meetings; Inclusion in the agenda subjects proposed by NGO group.

Comments by Reporter:

1. Composition of CCC.

The 30 members Committee, according to the list of the invitees, consists of:

- Gvt representatives – 11, including V-PM and 6 Dy ministers
- National NGOs – 4
- National associations – 2
- Religious organizations – 2
- Consulting group – 1
- UN agencies – 5
- International donors – 5

The Chairman of the National Red Crescent Society (counted among the national associations) is Co-Chair of the CCC.

There was no possibility to establish who actually took part in the meeting. A list will be probably circulated with the meeting proceedings.

The share of the NGO community and Civil society is obviously lower (8 or 27%) instead of the 40% required by GF.

The voices of the discussion participants belonged to the Ministry of Health officials, the AIDS Centre and three national NGOs.

Follow up: CAPACITY will have to work with CCCs on their composition. This would require some modifications to meet the criteria set up by GF, developing mechanism for assessment of the contribution of individual members of the Committee, adapting a mechanism for changing of the membership may be through the rotation of the members, especially NGOs. As the number of the organizations involved in the Programme is growing and considering the obvious need to increase the participation of the Civil Society and PLWA, the Committee membership can grow indefinitely to an extent that it may be hard to maintain it as a policy working mechanism. Some models have to be developed to tackle this issue. A study of the successful examples of other countries mentioned by V. Chernyavskiy may be of help.

It appears that the ARV treatment coverage is one of the leading (and major) indicators of GF in assessment of the GF supported Programmes!

Other meetings.

Damira recommended a person as a national consultant (Nurgul') for the CAPACITY in the Project development stage. She will have CV to us.

Follow up: Lev, Audrey.

Gulnara Kurmanova, a member of CCC from the NGO and coordinator of the Social organization "Tais Plus". She participated in the IHA NGO regional workshop for NGOs to be involved in the CAPACITY initial assessment. The workshop was successfully completed and the draft assessment protocols finalized. Julia will send the updated protocol for approval by CAPACITY and report on the workshop.

An e-copy of the presentation on CAPACITY was shared with the Gvt AIDS Sector (Dr. Isakova)

10.02.05

9:00-10:00 USAID. Participation in the discussion of Cliff, Damira and Chernyavskiy.

10:00-11:00 Participation at the state press-conference. CCC Chair reported on the CCC meeting and the developments; AIDS and TB services on the projects achievements and Chernyavskiy on cooperation of GF and KG Gvt, stressing the role of media in support to the national programme; I shortly presented the CAPACITY thematic areas.

11:30-12:30 Participation in the discussion of Chernyavskiy with the Kg GF Manager, AIDS Centre and the Audit company. The meeting concentrated on the proper financial planning and arrangements for smooth disbursements.

14:00 Departure to Almaty

The CAPACITY Project - Staff Activity Report

Activity Date(s)	31.01 – 4.02.05
Reporter's Name	Lev Khodakevich
Country	Bishkek, Kyrgyzstan
Activity Name/ Organization(s)/	Initial visit to Bishkek See below

NOTE: Please attach activity agenda and/or list of attendees. Please submit and distribute activity report within 7 business days of activity date.

Issues Discussed and Outcomes/Follow-Up/Deadlines/Persons
<p>31.01.05-On route Almaty-Bishkek</p> <p>Briefing from Sheila? on the Zdrav+ activities. Mainly the reform of PHC through developing the Family Group Practices (FGP), and the Zdrav++ plans. AID had included the TB component in the forthcoming Project activities that makes it a common area with CAPACITY. VCT integration is not on the Zdrav agenda and participation in it would require further clearance from AID. Agreed to continue a dialogue in Almaty in order to establish cooperation between the two projects.</p> <p>A lengthy discussion on the integration of AIDS Services and STI Services with the SES system and PHC, rational, potential benefits and consequences. Agreed that such initiatives should be carefully weighted in relation to the level and a degree of the integration as well as the timing for each action for each level.</p> <p>On arrival Sheila introduced me to David N. Burns, MD, MPH, Director of the Infectious Diseases and Clinical Guidelines Development, USAID/Zdrav Plus.</p> <p>I briefed David on the CAPACITY developments and learned on the some activities of Z+ in Kg.</p> <p>Z+ made efforts in introduction of the Syndromic approach for STI management and trained a number of physicians. The Project did not develop on a broad scale mainly due to the poor economic situation of the population that could not afford buying the medicines. NB. for assessment.</p> <p>At the same time in two pilot districts where the drugs were procured through the funds of external donors the project achieved good results.</p> <p>The Project initiated developing VCT services for HIV/AIDS. Lack of trained counselors was a major obstacle to implement this initiative. Follow-Up: for the assessment.</p>

Efforts should be made to integrate VCT with STI services.

As far as David knows the Government had not developed criteria for ARVT.

Follow-Up: for the initial assessment.

The CAPACITY efforts to support CCM and PR should be very carefully planned and offered as there are people who clearly realize the need in technical assistances and there are some who would object it for certain reasons.

David kindly agreed to review the HIV/TB assessment protocol and comment on it.

Bishkek, 1.02.05

9:00-10:15 USAID-Bibosunova Damira Ilyasovna. MD, PHD, Health Specialist.

She is facilitating some 20 country and regional health USAID funded Projects in Kg. Within the Z+ project the aims are to decrease the number of hospitals and hospital beds in the system inherited for the Soviet time and introduction of the services based on FGP and investments and re-investments.

The problems encountered are the frequently changing Gvt executives including those in MoH. The recent innovation is creation of the position of the State Secretaries at the level of Vice Minister in each ministry. The State Secretaries, among other duties would advise the PM office on the appointment of the key figures in the ministry, including the highest echelon. A positive development is that the Gvt created a sector on HIV/AIDS within the Dpt of Social and Cultural Dvt, led by the Vice PM on the Social Environment.

For the staff selection Damira advised that the eds should be published in the local News Papers.

Follow-Up: Audrey, this is the second signal from Kg on this matter. We MUST follow this advice.

I shortly briefed Damira on the CAPACITY.

Clifford Brown, USAID Kyrgyz Republic Country Rep.

One obstacle that may be faced by CAPACITY is acceptance of the Project by Gvt. Earlier the Director of the Republican AIDS Center stated to Clifford that KG does not need any more external technical assistance. Clifford (a member of the CCO Executive Board) also advised that the Gvt does not understand that it is not a single owner of the GF grants, which should be governed by the consortium of the partners joined by CCO.

The Board did not meet for a long time and the delays are apparently created by the AIDS Center. The huge membership of CCM also lacks proper leadership. NGOs did not benefit from the two initial GF tranches, but got some funds from the third one.

11:00-12:00

The White House (Gvt HQ)

Issakova Aimagul' Uraimovna, Chief, the Sector of Coordination and Monitoring of HIV/AIDS Prevention and Control Programs.

Mamyrov Mirlan, leading Specialist on M&E of the Sector.

The Sector has just being created, funded from non-budgetary funds but hosted and provided with the working facilities by Gvt in the Gvt HQ's building. The

Sector, the fourth among the others within the Dpt of Social and Cultural Dvt under the Vice PM Aimukeyeva Toltoosh Djekmekovna, is aimed at coordination of the activities among various Dvt sectors involved in HIV/AIDS activities. It is expected to work with the 39 members National Committee on HIV/AIDS and the 29 members CCO that according to Aimagul' should be significantly reduced. The SoW was developed for the Sector and is expecting approval by the Prime Minister. It will be shared with CAPACITY after approval.

I briefed the Sector on the CAPACITY structure staff and plans and left an electronic copy of the presentation on the Project. Aimagul' asked for a Russian version of the Project that she would present to the V-PM.

Follow-Up: To sent ASAP.

The group had glanced at the draft protocols of the CAPACITY Initial Assessment areas I.1, III.1 and III.3, found them useful and asked for further details on the assessment teams, agencies/organizations to be assessed and more specific time frame for the assessment. They would have to be informed on these details in the nearest future.

Follow-Up: In early Feb, in consultations with CAPACITY subs, we will have to:

- form the assessment teams by country and area
- assign the CAPACITY assessment coordinators by country and area
- identify the country partners to work on the assessment
- develop a detailed time table for each country
- inform the partners on the time table and expected participants of the assessment
- make arrangements with the country partners

Finally the Sector welcomed the Project and promised to support it in case some obstacles are faced in its implementation.

14:00-14:30

Ministry of Health

Mamytov Mitalip Mamytovich, Minister of Health, Kyrgyz Republic

Kangel'diyeva Aigul' Amangetovna, the First Vice Minister

Shteinke Lyudmila Vasil'yevna, Vice Minister responsible for Communicable Diseases Control

Shapiro Boris Moiseyevish, Director, the Republican AIDS Center

Chief of the Ministry Dpt of Foreign Relations

Kerry Pelzman, USAID Almaty

Bibosunova Damira Ilyasovna, USAID B-k

Kerry briefed the group on the USAID supported Health Programs in Kg and introduces my.

I briefed the group on the CAPACITY.

The Minister stressed the importance to enforce the work against the threatening HIV/AIDS epidemics and welcomed the Project. He also emphasized the needs to improve the work on demand reduction, prevention of tuberculosis epidemic and on education of general population apart from the vulnerable groups.

15:00-16:00

Ministry of Education

The planned meeting with the First vice Minister of Education responsible for foreign relations did not take place as she was busy at a Gvt meeting.

2.02.05

10:00-11:00

The World Bank

Dinara Djoldosheva, Country Officer,
Asel Sargaldakova, Operations Officer

In previous years the Bank supported the Health Reform Program in Kg aimed at developing the family physicians system and reduction of the number of hospitals, hospital beds and medical staff. It also supported the creation of the health insurance system and the Health Benefit Package. The Bank though did not support the First and the Second National Programs in Kg. The forthcoming Third Program will be supported by the WB US\$25 mln Regional Program. The program is likely to be supported by KfW, the German Agency with the amount of EURO 6 mln and by the Swiss Red Cross for STI treatment and rapid tests. At present the Bank is working on the SWAP (Sector Wide Approach) in several areas including health. WB does not support the policy of the National AIDS Centre that is trying to strengthen the vertical structure and expanding the specialized services to the district level.

The GF grant is US\$17 mln for AIDS and US\$2 mln for TB.

The CCO does not work or works poorly due to lack of leadership. This opinion was expressed by the Bank and other partners that have been recorded in various documents, some given to me.

Some problems are related to the National AIDS Center that has a narrow view on the problem.

The third trench of the FG Grant is under threat due to the inefficiency and lack of activities of |CCO.

The group expressed a concern that while we are promoting integration of the activities that Bank is establishing its offices in each country and CAPACITY does the same. An integral approach should be considered by these organizations. An appropriate approach was reflected in the doc called "Harmonization" given to me.

Follow-Up: Subject for discussions with the Bank RO and other partners.

I briefed the participants on the CAPACITY and on the Initial CAPACITY Assessment Plan and shared with them the assessment protocols for the areas I.1, III.1 and III.3. They promised to comment on the protocols.

11:15-13:30

The National Association "AIDS" (the National AIDS Centre)

Boris M. Shapiro, Director General of the Asstn. (nac@elcat.kg). ph. 62-57-90

Osmanova Ainagul Asanaliyevna, Dy Director General

Sunanbaev Talgat Kafanovich, Programme Manager, Project Implementation Unit GFATM, AIDS Component.

I briefed the participants on the CAPACITY and on the Initial CAPACITY Assessment Plan and while we discussed it several issues have been clarified by the

participants, particularly:

- A protocol for the ARV treatment was developed by the Centre earlier (a copy given to me) and a new version, based on the WHO recommendations was prepared (in Russian) and now it is with WHO EURO for comments and approval.

Follow-Up: The Centre will find out if there is an English version made by WHO that would be sent to CAPACITY.

- A Methadone Substitution therapy was approved by the Kg Gvt and being implemented among some 50 IDUs.

Follow-Up: A good advocacy for the other CAR countries which face obstacles in the legalization of the DST.

- The Centre received ARV drugs sufficient for treatment of 30-50 patients during 1.5 years. The Center will provide technical assistance to the Infectious Disease Hospital, the Narcology Services institutions and delivery homes and through family physicians where the treatment will be actually applied.

Follow-Up: An example of decentralization and integration of the AIDS Services.

- In the past Kyrgyzstan pioneered in introduction of inter-sectoral cooperation (establishing the National AIDS Committee), the harm reduction among IDUs, HIV/STI prevention work among FSWs and DST.
- The FSWs coverage already exceeded 60% but it is as low as 8% among IDUs.
- As the Program expanded the Centre felt that it would not be able itself to coordinate all activities and it initiated and supported the creation of the HIV/AIDS Prevention Sector within the Vice PM Office.
- The Centre feels that the preventive activities carried out in Kg already delayed the development of the epidemic that resulted in only 600 HIV cases on the record instead of expected several thousands. The centre asked for assistance for expertise to assess the economic cost-benefit of the HIV preventive activities

The Centre informed that a CCM meeting is planned for 9 or 10 Feb. V Chernyavskii will take part in the meeting. An invitation was sent to AID, Damira.

Follow-Up: CAPACITY has to plan participation in the Meeting and to get invitation through AID Kg.

The Centre requested assistance:

- in procurement of the doc on the South-East Asian NGO Communication network a UNAIDS BP Study, and
- facilitate a study in Kg on the cost benefit of the HIV preventive activities among IDUs and broader groups.

Follow-Up: Lev to follow up both.

I shared with the group the assessment protocols for the areas I.1, III.1 and III.3. They promised to comment on the protocols.

17:00-18:30

UN office

Ekaterina Paniklova, Programme Manager, Joint Programme on Expedited Response to HIV/AIDS

Meerim Sarybaeva, Project Specialist, HIV/AIDS programmes among Uniformed Services

Aynur Mukhaedgalieva, Programme Associate

Kubanysh Takyrbashev, UNAIDS Programme Officer

The UN team worked in the policy development, inter-sectoral cooperation development, support to NGOs, building NGO network, National and now heading to a regional network development, with religious leaders. Assisted in building NGO capacity that resulted in some 70 organizations applying for the GF grants. A very enthusiastic team with good achievements as reported by the group.

I briefed the participants on the CAPACITY and on the Initial CAPACITY Assessment Plan and shared with them the assessment protocols for the areas I.1, III.1 and III.3. They promised to comment on the protocols.

3.02.05

9:00-18:00

The Regional Round Table, Presenting the Design of the DFID-funded CAR HIV/AIDS Programme

The opening session was chaired by Toktosh Jekshenovn Aitikeeva, the vice-PM for social affairs.

At the opening session DFID (Jason Lane) declared its UKP 6.4 mln grant for the CAR Region. UKP 1.3 mln goes as co-funding of the WB Program and UKP 5.1 mln (~US\$ 9 mln) for the activities in the three countries (KG, TJ and UZ), (the meeting agenda and list of participants are attached).

Clifford Brown in the opening address presented the CAPACITY Project and the COP.

The speakers at the opening session stressed the need for pursuing the Three Ones principals, regional harmonization, regional cooperation, multisectoral approach, support to NGOs and PLWA groups and health reform.

Scaling up the Harm Reduction is the leading component of the DFID supported interventions. The component Two is aimed at support to the national HIV/AIDS Programmes and include 3 main output areas:

1. Support to the “Three Ones”
2. Policy advocacy and legislative review
3. Coordination with World Bank Regional HIV/AIDS Project

The component three, the Management and M&E includes setting the Regional and country offices. The Reg. office consists of:

- Progr. Director
- Progr. Manager
- H Red Adviser
- M&E Adviser

The country offices are to have:

- Exec. director
- National Manager
- Progr. Coordinators
- Finance & Adm.

Among the other presentations the lack of a unified info collection and lack of M&E systems were mentioned, especially within the harm reduction projects.

At 16:00 hours I made a presentation on the CAPACITY, structure, staffing and plan for the initial assessment.

Some people met at the meeting.

Ainura Bekkoenova, Ass-t. Project officer, UN Off on Drugs and Crime. The program is aimed at demand reduction, and it has a harm reduction component. Would like to cooperate with CAPACITY.

Olga Gorovenko, KFW expert Kg. The Project works on social marketing of condoms and syringes, over US\$3 mln. Provision of diagnostic equipment and TB programmes in Tj, Kz, Uz and Kg.

She stressed a need for creation of a database on the activities of all partners involved in the programmes.

Follow-Up: To be involved in the CAPACITY initial assmnt.

Gulnara S. Sheisheeva, Senior Legal Adviser, sh_gulnara@mail.ru, legal@elcat.kg. She has been working for several years on the legal issues related to HIV/AIDS.

Follow-Up: A resource person for a consultancy related to the legal issues for the CAPACITY.

Raushan Abdidaeva, Min of Justice, Kg. Promoted and established needle exchange and methadone subst. therapy in prisons in Kg. Wants to establish regional training centers on these issues for the region and probably for CIS countries.

Follow-Up: To seek support from the WB Regional Program for establishing training centers.

Follow-Up: Subject for BP case studies by CAPACITY.

In some discussions people, especially NGOs mentioned that WB, DFID, CAPACITY and other international organizations are establishing their regional and country offices in the countries of CAR. This creates an impression that these agencies, while speaking of integration within the countries (Three Ones), create their own autonomies with quite similar objectives.

Follow-Up: This is a subject for consideration by the donor agencies and international NGOs on integrating their managerial and operational structures.

4.02.05

9:00-11:00 participation in the RT meeting

11:00-16:00 Discussion with the IHA team (Julie Banks and Slava Kushakov) on the CAPACITY initial assessment. Details follow. ?

The Tj delegation asked about the time of a CAPACITY visit to Dushanbe.

Follow-Up: Thought the security conditions do not allow AID Almaty to go there a trip should be planned by a CAPACITY staff.

USAID informed that a CCO meeting will be held in B-k on 9 Feb. and AID meeting with Valery E. Chernyavskiy on 10 Feb.

Follow-Up: CAPACITY to attend these meetings. Damira will send details and invitations.

Regional IHA consultants:

Regional Consultants	
Sergey Yarulin	Kyrgyzstan (Bishkek) – tbc
Dmitry Dey	Kazakhstan (Konstanai)
Nurali Amanzholov	Kazakhstan (Temirtau) – tbc
Viktoria Ashirova	Uzbekistan (Samarkand)
Sergey Uchaev	Uzbekistan (Tashkent)
Murtazokul Khidirov	Tajikistan (Dunshanbe)
Tachnabat Annamuradova	Turkmenistan (Ashgabat)

Report Distribution:

Project Positions	(X)
Chief of Party	X
Deputy Chief of Party	X
Operations Director	X
Regional Specialists	X
Country Managers	
Country Specialists	
All Regional Project Staff	
All Project Staff	

CODING: PERSON'S INITIALS-COUNTRY CODE-MONTH-YEAR // Example: ASS-KZ-Nov-04

The CAPACITY Project - Staff Activity Report

Activity Date(s)	24-27.02.05
Reporter's Name	Lev Khodakevich
Country	Tajikistan
Activity	Visit to Dushanbe
Purpose	Initial visit to TJ, introduction to USAID, and other key partners, briefing on the CAPACITY, on the CAPACITY initial assessment, elaboration of details for the initial assessment
Organization(s)/	See below
Contact Person(s)	See below

NOTE: Please attach activity agenda and/or list of attendees. Please submit and distribute activity report within 7 business days of activity date.

Dates/Issues Discussed and Outcomes/Follow-Up/Deadlines/Persons
<p>25.02.05. Meeting with USAID officials at Z+ office Peter Argo, Ashley Moretz. I briefed the officials on the CAPACITY and on the CAPACITY initial assessment plan. USAID has committed full support to the initial assessment exercise.</p>
<p>The Republican SES Office, Chief – Dr. Samardin Aliev. The SES initiated integration of the TB surveillance with TB Services through the Minister order. There is lack of surveillance data, X-ray diagnostic equipment and laboratory support. DOTS has been introduced in several pilot areas covering 13% of the country population. HOPE trained TB specialists and PHC physicians on the DOTS implementation. Introduction of DOTS, was followed by a significant increase of the TB registered morbidity and significant increase of the recovery rates. CDC supported in electronic monitoring of the Surveillance. The HIV/AIDS surveillance data are also routed through the SES Office. Brucellosis is highly prevalent in the country due to the changed pattern of the animal husbandry. The malaria epidemic developed due to migration from Afghanistan reached the incidence of 30 000 cases annually some years back, but this figure was brought down to 6 000 by the last year.</p>
<p>UN Office Igor Bosc, UNDP Deputy Resident Representative; Muratboki Beknazarov, UNDP, the Manager, GFATM Grants Implementation Unit; Saleban Omar, UNDP Officer for HIV/AIDS</p> <p>The CCM consists of 34 members, 14 from the Gvt sectors and 14 from NGO and donors. CCM is meeting twice a year. It lacks a coordination and communication mechanism for the country programmes. The UN Office developed a proposal for improving the situation through establishing a secretariat and technical groups and will submit a proposal to CAPACITY for support.</p> <p>For follow up by CAPACITY: to receive the proposal for consideration of support.</p> <p>The UN TG core group includes only UNAIDS cosponsors. There is an other forum of “Principals” that includes the donors investing over \$ 1 mln. to national HIV/AIDS programs. The National Coordination Committee working for 1997 has 17 Dy ministers. It also lacks coordination and needs a support.</p>

Dr. N. Faysoulloev, the Minister of Health

The Minister raised several issues with expectation of support from the CAPACITY:

1. The CCM requires support by a secretariat of 4-5 persons and CAPACITY has to play an exclusive role in this support.

For follow up by CAPACITY.

2. The fin/cons group did not recommend the MoH to be The PR for GF due to lack capacity for fin/adm. Management. Support is required for enhancement of this capacity.

For follow up: Z+ expertise to be considered for this activity

3. The MoH Dpt for reform and planning does not have trained personnel and resources for developing proposals for GF. (That could be the reason of GF for rejecting the proposal on malaria control submitted for the last round, though two countries in the region with far lower malaria incidence gained grants). There is a need for creating a group for developing proposals in the future.

For follow up: to be considered by CAPACITY as an integral part for the CCM secretariat.

The Minister also requested informal support from CAPACITY for obtaining a grant for malaria under the 5th round.

4. One CD4 level diagnostic unit was purchased by the GF grant, one more is required for the Pamir area.

For follow up: not in the CAPACITY agenda

5. A PCR diagnostic unit is required for the country. A unit can be procured under the USA/Tj military cooperation and the unit will be used by the Republican AIDS Centre for a broad range of population groups.

For follow up: CAPACITY – to support the initiative.

6. ARV drugs are expected to be provided under the GF grant. The Minister requested to increase the amount of drugs.

For follow up: This issue would require an additional study and justification as even the presently estimated number of eligibles (for among the 317 registered HIV+ persons) was questioned by some partners.

7. The Minister indicated that most of the general population especially in rural areas is poorly educated on HIV transmission and risk practices. The education can be considered through the pupils of the high secondary schools a well expanded network in the country. In 2003 a national programme on Healthy Life Styles was approved by the Gvt and there are indications that the Asian Development Bank may support the initiative.

For follow up: This issue should be considered a priority in the CAPACITY work plan.

The republican AIDS Centre

Dr. Adamjohn Mirzoev, Chief of the Centre and Ms. Gulraftor Turakhanova, Tajik-Swiss Health Sector Reform and Family Medicine Support Project, Healthy Life Style Coordinator.

So far only one survey for HIV in IDUs was carried out through the needle exchange points by the John

Hopkins University. The linked survey with pretest counseling was (as reported by other agencies) aimed to study the virus strains circulating in Tj included 500 drug users, a half of them IDUs. The strains similar to those found in Africa, Ukraine and Russia were identified. The HIV prevalence was found at 13% (not to be quoted before the data are published).

The implementation of HIV sentinel surveillance in Tj has just been approved by MoH and technical support is expected from CDC.

The centre has on the records 317 HIV+ persons. Mirzoev admitted that this figure does not represent a real situation and the estimated number could be in the range of 5 000-6 000. There is no way for a better estimate unless the sentinel surveillance is developed on a wide scale among the leading vulnerable groups.

The AIDS Centre does not apparently have close working contacts with the NGOs working with IDUs and SWs.

Dr Mirzoev noted:

- Lack of continuum for treatment of AIDS patients;
- Lack of reviewing capacity the intervention among vulnerable populations;
- Lack of mechanism for financial monitoring of the NGOs activities; and
- Lack of indicators for the preventive projects implementation among vulnerable populations.

For follow up: Lev, to discuss with CDC the development of sentinel surveillance in Tj and to identify the role of CAPACITY in it.

Ms Turakhanova briefed on the activities of the Republican Health Promotion Centre.

For follow up: To study further a potential role of the Health Promotion network institutions in counseling of PLWAs.

In the afternoon two round tables were arranged by USAID at the Z+ Office, for the USAID health partners and for the HIV/AIDS working groups and NGOs. I briefed them on the CAPACITY and the assessment plan, clarified several issues and sought support in the assessment.

The list is attached

After these sessions we worked with Aziza, Aziz and Zarina Musaeva on the assessment details. The list of the assessment meeting participants and the list of the 11 member assessment team (one per the assessment area and two to back up if some one fails to attend the meeting) were discussed. These lists will be forwarded by Aziza to me on Monday. The local team leader and a candidate for the country director position was also discussed. A CV will also be sent to us on Monday.

During this discussion some issues were raised by the participants:

- Payment of the services of the assessment team members

For follow up: Audrey, to determine the rates and inform countries ASAP

- In the assessment meeting agenda the introductory session to be reduced to 1.5 hours to allow more time for work in groups.
- The agenda to include a subject on a schedule for individual interview meetings on the days following the round table, with the partners who did not have sufficient information at the meeting, with the time, addressees, names and contacts of the interviewees.
- A short cocktail party should be arranged at the end of the assessment meeting

For follow up: The CAPACITY regional team to finalize these issues and modify the agenda accordingly.

26.02.05

Visit to the NGO association on H Reduction and NGO RUN.

Mourtazokoul Khidirov, Chair of the Association

The Association is working on various funds, from USAID, Soros, Global Fund, UNFPA, European Union. The NGO runs four outreach units, which serves some 4 000 IDUs and SWs, with about 30% of them through direct contacts at the units and through volunteers and with the rest through secondary contacts. They provide information materials, syringes and needles on exchange basis, and condoms. The ed materials and condoms supplies are irregular. The condoms were supplied by UNFPA (from Korea, the highest quality), PSI, the Favorite (medium quality) and through the GF money (from India, the poorest quality).

7 045 IDUs are registered in Tj, 5 200 of them in Dushanbe, 39% of them are injecting. A survey carried out by ODCP estimated the number of drug users in 2001 at 45 000-50 000, 70% of them injecting and 60% living in Dushanbe. Of the IDUs registered 4% are women, 15% - according to the estimates and 27% according to the records of the servicing organisations.

The Gvt also opened 11 needle exchange units at AIDS centers and district OPDs. They serve some 800 IDUs.

The major issue of the NGOs and the Association is unstable financial support and lack of reliable supplies.

For follow up: The Association network can provide support for the estimates on the populations size and on HIV prevalence in IDUs, two important indicators for measuring the coverage levels and HIV epidemic development. Both should be on the top in the CAPACITY agenda.

All visits and meetings were arranged by Ms. Aziza Khamidova, USAID Regional Mission, Project Manager Specialist/Health. She also participated in all the meetings. This support and assistance are highly appreciated.

Persons met during the trip to Dushanbe

Name	Organization	Position	Contacts (address, phones)	Email
Nusratullo Faizulloevich Faizulloev	Government of the Republic of Tajikistan	Minister of Health	69 Shevchenko Street (992 372)21 18 35 (992 372)21 75 25 (fax)	vazir@tojikiston.com
Gulraftor Turakhanova	Tajik-Swiss Health Sector Reform and Family Medicine Support Project	Healthy Life Style Coordinator	30 Ibn Sino Street (992 372)23 13 28 (992 372)34 19 02 (home), (992 93)555 27 19 (mobile)	Gturakhonova@mail.ru
Ghafur Khodjamurodov	Ministry of Health of the Republic of Tajikistan Republican Center of Reconstructive Surgery	Chief Specialist of the department for foreign relations	Medgorodok, 4 th floor Sanoi Street, 33 (992 372) 24 54 59, 24 32 94 (992 372) 23 50 07 (fax) (992 917) 70 38 46 (mobile)	gafur@tojikiston.com ; ghafurk@hotmail.com
Muratboki Beknazarov	UNDP, The GFATM Grants Implementation Unit	Manager	4 Academicheskaya Street, 2 passage (992 372) 21 99 11 23 28 88, ext. 105	No info of the business card

			(992 372) 23 29 00 (fax) (992 917) 70 50 13 (cell)	
Igor Bosc	UNDP	Deputy Resident Representative	39 Aini Street (992 372)21 06 85 (992 372)51 00 21 (fax) (992 917)72 71 66 (mobile)	Igor.bosc@undp.org
Samardin Aliev	State Sanitary Epidemiological Supervision	Chief doctor	8 Chapaev Street (992 372)27 35 13 (992 372)27 49 47 (fax)	Aliev_Sanardin@hotmail.com
Peter Argo	USAID Regional Mission	Tajikistan Country Representative	C/O US Embassy 10 Pavlov Street (992 372)210 348/50/52 (992 372)241 560, ext. 2203 (992 372)510 049 (fax) (992 917)704 606 (cell)	pargo@usaid.gov
Ashley Moretz	USAID Regional Mission	Deputy Tajikistan Country Representative	C/O US Embassy 10 Pavlov Street (992 372)210 348/50/52 (992 372)241 560, ext. 2205 (992 372)510 049 (fax) (992 917)708 256 (cell)	amoretz@usaid.gov

Participants of the meeting of the USAID health partners

Aziza Khamidova	USAID Regional Mission	Project Manager Specialist/Health	C/O US Embassy 10 Pavlov Street (992 372)210 348/50/52 (992 372)241 560, ext. 2176 (992 372)510 049 (fax) (992 917)708 079 (cell)	Akhamidova@usaid.gov
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	project			
Marian Sheridan	Zdrav/Plus	Resident Representative	10 Chapaeva Street (992 372)23 17 17, (992 372)21 95 39 (fax) (992 93)505 550 79 (mobile)	marian@zplus.tj www.zplus.kz
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Tarik Kadir	Merlin	Country Manager	(992 372)24 57 24	cm@merlin.tajikistan.org
David Patterson	Save the Children	Acting PM HF Project	(992 917)500 7001	david@savechildren.tj
Sohiba Rahimova	PSI	Educational Programs Coordinator	(992 372)24 31 63	srahimova@rambler.ru ; salima@psi.taj sogdien.com

Participants of the meeting of the HIV/AIDS working groups and NGOs

Maria Boltaeva	UNAIDS	National Official/employee	(992 372) 61 48 49 (992 372) 21 99 11	
Zarina Abdullaeva	OSI Tajikistan	Coordinator	(992 372) 21 32 60 (992 372) 24 30 81	
M. Khidirov	NGO "PAN"	Director	(992 372) 27 15 16 (992 372) 21 81 95	
D. Pirov	Center for Legal Assistance/Support of the Youth	Director	(992 372) 27 58 98 (992 372) 27 70 31	
Nazira Artykova	WHO	Office Manager, ERB WHO	(992 372) 23 45 65	
Olim Kasymov	NGO "Peshgir"	Chairman	(992 372) 21 22 67	
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Sebor Komilova	NGO "Guli Surzh"	Director	(992 372) 36 91 66	
Rukhshona Kurbanova	IOM, TJ	HIV/AIDS Focal Point Program Assistant	(992 372) 21 03 02 (992 917) 72 22 80 (cell)	
Gulchekha Ibrakhimova	UNICEF	Program Assistant	(992 372) 21 82 61 (992 917) 70 08 75 (cell)	

Nigera Abidzhanova	OSI Tajikistan/DDRP	DDRP Director for Tajikistan	(992 372) 24 83 16 (992 917) 70 80 75 (cell)	

The CAPACITY Project - Staff Activity Report

Activity Date(s)	17-20 March, 2005
Reporter's Name	Lev Khodakevich
Country	Turkmenistan
Activity	Visit to Ashgabat
Purpose	Initial visit to TU, introduction to USAID, and other key partners, briefing on the CAPACITY initial assessment, exploring a possibility to develop a proposal for a GFATM grant for HIV/AIDS
Organization(s)/	See below
Contact Person(s)	See below

NOTE: Please attach activity agenda and/or list of attendees. Please submit and distribute activity report within 7 business days of activity date.

Dates/Issues Discussed and Outcomes/Follow-Up/Deadlines/Persons

Background

A month back the Ministry of Health on TU sent a request to WHO for assistance to develop applications for GFATM on AIDS, Tuberculosis and Malaria. The WHO Regional office for Europe agreed to work on the applications for TB and Malaria and applied to USAID to take care of AIDS. CAPACITY Project was involved in this activity, started identifying consultants and an exploratory mission to Ashgabat on this issue was delegated to the CAPACITY COP.

Report

During the mission I met several representatives of the international community, including: USAID Almaty, USAID Ashgabat, WHO Liaison Officer, WHO (EURO) Regional adviser on Malaria, UNDP National Programme Officer on HIV/AIDS, COUNTERPART, ZdravPlus and the Chair of the UN Theme Group on HIV/AIDS.

Due to the very recent personnel reshuffling in the Ministry of Foreign Affairs, and in spite of tremendous efforts made by the USAID staff from Almaty and Ashgabat I could not meet any national officer. The procedures in TU require a clearance from MFA for a meeting of any foreign citizen with the national officials.

The interviews revealed the following picture.

The epidemiological situation.

According to official records one HIV positive was registered in TU. Informal reports and estimates indicate that actual prevalence may match the neighboring CAR countries, where the number of reported cases increased from threefold to 17-fold in the last years. Presence of drug trafficking, injecting drug users, multi-partner sex and a wide spread of STIs are good proxy indicators of suitable conditions for HIV transmission. The actual situation has yet to be assessed as no special efforts were made to establish HIV surveillance.

Response

National agencies.

An inter-sectoral committee on HIV/AIDS was formed in 2002 and it consists of several ministries and national associations. When the Ministry of Health learned that granting from GFATM requires establishing CCM this Committee was presented as one to work with the GF grants.

The first National Programme on HIV/AIDS was completed in 2004 and the second, for 2004-2009 has been submitted to the Cabinet of Ministers for approval. After several adjustments it is expected to be cleared within a couple of weeks.

Apparently the technical branches of the Gvt agencies are eager to expand the response, but the officialdom declared that the country does not need external assistance.

International partners

The USAID Health Officer advised that after the MFA staff rearrangements are completed the dialogue with MOH on the application for a GF grant may continue and an initiative is expected from MOH.

The UNICEF Rep, also AIDS UN Theme group Chair reported that the health sector is in a poor state due to lack of funds and equipment. There is a great degree of denial in relation several diseases including STIs HIV infections. However he feels that understanding and the relations with the national counterparts are gradually improving. Considering this trend it is not advisable to make movements that would have adverse effects on the cooperation with the Government. The Chair of the TG had an impression that CAPACITY was not planning any activities in TU, and he was briefed according to the Project plan.

The WHO Regional office reacted positively to the request to develop application for malaria and Dr. Ejoy (who is presently running a training course on malaria) said that they could easily develop a technical proposal, but the national counterparts will have to assure other arrangements to meet the GF requirements.

COUNTERPART running several programmes in the country, out of 25, 15 have been completed. Among them there were training sessions on HIV/AIDS issues. It has broad connections with civil society throughout the country and may provide linkage to populations for implementing HIV/STI prevention activities.

The ZdravPlus officials showed their working facilities and the organisation is prepared to offer office space in case CAPACITY starts operations in TU.

Summary

De facto the absence of CCM, the delays in the approval of the National Program on HIV/AIDS and the internal situation causes serious doubts that a proposal can be successfully developed for the 5th Round of the GFATM. However considering the serious epidemiological situation, though not declared, further collective efforts should be made to support the Gvt for preparation of a proposal probably for the next round.

Outcomes

Though we could not meet national authorities and achieve all mission objectives the visit had its impact as the CAPACITY interest to the country was clearly demonstrated and this was brought to the knowledge of the national authorities by the international agencies briefed by me.

Follow-Up

Lev:

- During the coming week to communicate with the USAID/TU and if positive changes are reported to continue the arrangements for the CAPACITY mission to TU as planned for the end of April - beginning of May.
- To continue working with USAID for developing assistance to TU.

I would like to express my gratitude to Ms. Elena Samarkina, the USAID Health Project Manager for the arrangements related to this trip, her efforts to assist in success of the Mission and participation in all meetings.

Persons met during the trip

Name	Organization	Position	Contacts (address, phones)	Email
Makhym Orazmukhammedova	Counterpart Turkmenistan	Country Program Manager, HNCBI, Healthy Community	26 Academic Petrova, (2013), (993 12) 35 70 05, 35 71 20, 35 71 25, 34 60 74/62	makhym@cpa-rt.org
Yazgylych Charyev	Counterpart Turkmenistan	Country Director	26 Academic Petrova, (2013), (993 12) 35 70 05, 35 71 20, 35 71 25, 34 60 74/62	yazgylych@cp-art.org
Bahtygul Karriyeva	WHO	Liaison Officer/Turkmenistan, c/o Ministry of Health	Mahtumkuly pr. 90, (993 12) 39 19 33, 35 02 48	bba@online.tm
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Elena Samarkina	USAID Regional Mission	USAID Health Project Manager	1 Yunus Emre Street, Int'l Business Center, (993 12) 45 61 30	esamarkina@usaid.gov
Mahboob Shareef	UNICEF	Representative	UN House, 40 Galkynysh Street, (993 12) 42 56 81/82/85/86, (993 66) 308847/333-234 9760 (cell)	mshareef@unicef.org
Mikhail Ejev	WHO	Regional Coordinator, Roll Back Malaria Programme	8 Scherfigsvej, Denmark, Copenhagen, +45 39 17 15 54	mej@euro.who.int , mej@who.dk
Regina Urmanova	ZdravPlus	Health Marketing Specialist	43 Gyrogky Street, apt. 4, (993 12) 34 42 42	rurma77@yahoo.com
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The CAPACITY Project - Staff Activity Report

Activity Date(s)	March 7-9, 2005
Reporter's Name	Marty Bell
Country	Kyrgyzstan
Activity	Visit to Bishkek
Purpose	<p>Primary purpose: to attend the Meeting with Representatives of the International Donor Community regarding the Structure of a Unified national Coordination Committee on HIV/AIDS, Concomitant Infections and Malaria to be named the Country Multisectoral Coordination Committee (CMCC).</p> <p>Agenda and Draft Proposed Structure Attached. Hard Copies only.</p> <p>Secondary Purpose: Attend AFEW Launch of their Dutch funded Project. Long list of attendees/invitees attached. Also Program for the 3-day meeting attached. Hard copies.</p> <p>Third Purpose: to meet the Kyrgyzstan PSI Team</p>
Organization(s)	<p>Vice-Prime Minister of Kyrgyz Republic, Aitikeeva T, Dj Head of Unit, Office of Prime Minister, Dept or Social and Cultural Development, AIDS Centre USAID, AIHA, UN Office on Drugs and Crime, UNFPA, UNICEF, GITEC, Global Fund, DFID Others.</p>
Contact Person(s)	Ainagul Iskova ai@aid.gov.kg Tel. 996 312 664 155
Persons Attending	<p>Vice-Prime Minister of Kyrgyz Republic, Aitikeeva T, Dj Head of Unit, Office of Prime Minister, Dept or Social and Cultural Development, Ainagul Iskova ai@aid.gov.kg Tel. 996 312 664 155 Dr. Shapriro, AIDS Centre USAID, Damira Bibosunova AIHA, Zhamilya Nugmanova UN Office on Drugs and Crime: Ross Ballantyne UNFPA, Gulmara Kadyrkulova UNICEF, Richard Young GITEC, Dr. Klaus Peter Schnellbach (KFW Consultant) Global Fund, DFID, Jason Lane, Others</p>

NOTE: Please attach activity agenda and/or list of attendees. Please submit and distribute activity report within 7 business days of activity date.

Dates/Issues Discussed and Outcomes/Follow-Up/Deadlines/Persons

Monday, March 7

Attended this meeting. First speech by Aitkeeva, then presentation of draft structure of this new coordinating mechanism. (all attached) by Iskova. Followed by a fair bit of discussion as attendees tried to understand the structure and purpose and many questions as to how the Global Fund fits in. Not very clear. Also there was a fair bit of discussion as to how these bottom boxes and committees would/could be constructed. Aitkeeva seemed quite open to making changes and requested any suggestions could also

be forwarded to them in writing. Also several donors expressed their support of the idea that the Presidium only include reps from 3 International Organizations. This seemed very important to the speakers, kind of a posturing litany.

The best part of the meeting for me was meeting and talking with **Damira Bibosunova** of USAID. She was very helpful and introduced me to the meeting and some about CAPACITY, mentioning Lev too.

It was also worthwhile that I had a few minutes to talk with **Ainagul Iskova**. I met her at the AIHA meeting in Almaty the week previously. Her presentation was well organized. How this CMCC will actually work and who reports to who with regards to the CCM and the Global Fund is confusing.

I also greeted **Dr. Shapiro** who smiled brightly as I brought him greetings from **Lev** and CAPACITY. I talked briefly with him again at the AFEW meetings where he made a speech.

That evening I had dinner with **Ross Ballantyne** and his Program Manager, **Altainai**. Ross has some interesting and strong views about drug demand reduction. Ross is an Aussie, military, intelligence type, linguist, speaks about a dozen languages. He would like to see the establishment of a one-stop treatment centre that includes testing, counseling and treatment.

Follow-Up: I think the best person for now to follow-up with is Damira and once we have CAPACITY reps in Bishkek, then to be sure they are invited to these meetings.

Tuesday, March 8

International Women's Day. Had coffee with a professor at the American University of Central Asia, Dr. **Nancy Leland** (old friend) Nancy teaches Computer Science, then dinner with Dr. David Burns and his wife, Bonnie. An opportunity to catch up and talk some more about **CAPACITY**.

Wednesday, March 9

Attended opening session of *AFEW* Launch of it's new Dutch Funded Project (2.8 M Euros). Well organized and very well attended. *AFEW* is very good at these things. I talked some more with Damira and at her request, I asked our interim PSI Kyrgyzstan Projects Manager. Djamila Alisheva to attend more of the meetings on behalf of CAPACITY.

Evening Meeting with Dr. Tatyana Vinichenko. World Bank Assessment team member.

Follow-Up: We simply need to be in regular contact with *AFEW*

KAZAKHSTAN:

I. HIV/AIDS SITUATION IN THE COUNTRY:

XXVI: From:

[http://wbln0018.worldbank.org/ECA/ECSHD.nsf/ECADocByUnid/540336358112962585256DEF00762D01/\\$FILE/1758-06R_Ch04.pdf](http://wbln0018.worldbank.org/ECA/ECSHD.nsf/ECADocByUnid/540336358112962585256DEF00762D01/$FILE/1758-06R_Ch04.pdf)

HIV/AIDS and TB in Central Asia: Kazakhstan Country Profile

Chapter 4: Country Profile: Kazakhstan (p. 25-37)

Joana Godinho, Thomas Novotny, Hiwote Tadesse, Anatoly Vinokur. World Bank, November 2003.

Distinguished by its large territory and relatively high annual per capita (US \$1,250), Kazakhstan has a population of 15 million, of which more than 50 % are aged 15-49 years. Approximately one-third of the population now lives below the poverty line, but 65 % report a daily income of less than \$4 per capita.

HIV/AIDS Epidemiological Profile:

Kazakhstan has a reported HIV/AIDS prevalence (0.14 percent) that is higher than its four neighboring countries combined. Since the first case was reported in 1987, the number of officially reported HIV cases has grown to 3,448 by March 2003.

Factors such as poverty, high migration from neighboring areas of conflict and out of Kazakhstan, and involvement of the Army in regional peacekeeping missions increase the risks for HIV/AIDS spread. Approximately 70 % of HIV-infected persons are aged 15-29 years; approximately 80% are males, although incidence is increasing among women. Official data report that 83% of HIV infection cases are due to risk behavior with drug injection, while sexual transmission accounts for 9% of the cases. Officially, in 2002, 85 people has AIDS, and 72 have died (however, UNAIDS estimated that 300 have died from AIDS). HIV-positive women have given birth to 44 infected children. Although all regions have HIV cases, the two main oblasts affected are Karaganda and Pavlodar, which account for about 70% of the cases.

Kazakhstan is at the center of intensive drug trafficking routes, and the number of drug users continues to increase annually. By 2002, the number of drug users registered in rehabilitation services numbered over 45,000. However, a rapid assessment response (RAR) carried out by UNAIDS in 1998-2002 suggested that the number of IDUs may exceed 250,000. According to official estimates, 3% of the Kazakh population injects drugs, which would bring the number of IDUs to about 450,000. About 3-4% of IDUs would be infected with HIV.

The age of drug users is decreasing, and women and children are becoming active in trafficking and consumption of drugs. Now, the majority of drug users are aged 20-25 years, and 85% are male. The majority of IDUs belong to the poorest groups, which limits their access to services including information, medical services, and clean needles.

Preliminary results of sentinel surveillance in selected populations show that prevalence of HIV (collected through VCT) in Karaganda is about 5%, in Urals City 2 % and in Almaty 0.3%.

Behavioral surveillance is important in monitoring the spread of the HIV risk factors. Surveys performed by UNAIDS show that IDUs are actually aware of HIV prevention measures: 88% know that single-use syringes are protective against HIV transmission, and 95% know that condoms can be protective. Nevertheless, many still practice unsafe ISU and have multiple casual sexual contacts without condoms; regular reported condom use does not exceed 20%

This is consistent with self-reported data on a history of ever having an STI (20%). Over half of the CSW reportedly do now use condoms, and they are not aware of other methods to prevent HIV. A survey in Almaty has also shown that 80% of MSM do not use condoms, that 25% have STIs, that 10% inject drugs, and that only 30% have adequate knowledge about HIV transmission. These behavioral risks assure the spread of HIV from the IDU/CSW population to the general population unless effective measures are taken to reduce such risks.

It is important to understand the knowledge, attitudes, practices, and beliefs of young people in order to understand the vulnerability of this population. Interviews of school students in Almaty have shown that 13% of 15-year-olds have had sexual relations, 4% have tried drugs, 23% consume alcohol, and 9% of the sexually active have had an STI. According to the Demographic and Health Report of Kazakhstan, 17% of young men and 33% of young women aged 15-19 years do not know how to prevent HIV transmission and 27% of men and 65% of women do not use condoms during sexual intercourse with non-regular partners. UNICEF confirms that 74% of young men aged 15-29 and 46% of young women of the same age group are aware of use of condoms as a means of HIV prevention, and 54% of the poorest Kazakhs aged 15-49 are aware of the need to use condoms to prevent HIV transmission.

In summary, the HIV/AIDS epidemic in Kazakhstan is now characterized by:

- Concentration among highly vulnerable populations (IDUs, CSWs), but also spreading to other vulnerable groups (prisoners, youth, migrants, truck drivers)
- The most common mode of transmission is through the use of infected syringes and needles when injecting drugs. The potential for continued rapid spread among IDUs is enormous, as the country may have as many as 450,000 injecting drug users; their sex partners are at particular risk as well.
- Geographic concentration. The worst affected are the regions of Karaganda, Pavlodar, Kostanay, Almaty and Uralsk. However, all oblasts now have reported HIV cases.
- Disproportionate impact on youth, and especially young men. Over half of HIV-infected persons are aged 20-29 years. Almost 90% are aged 15-29 years, and about 80% are men.

Vulnerable and Highly Vulnerable Groups:

General knowledge on reproductive health issues in general, HIV/AIDS, and STIs is very low, as shown by behavioral surveys in both the general public and youth. According to national surveys, only 15% of young people have an adequate knowledge of HIV prevention, and only 10% of schools have integrated programs on HIV/AIDS, STIs, and drug use into their curricula. The population has a very low perceived risk of HIV infection because people do not believe that the disease will affect them personally. Currently, there are no programs on mass media regarding HIV/AIDS, but the HIV/AIDS coordination Committee is planning to launch an information, education and communication (IEC) campaign to raise public awareness.

The country has 21 AIDS centers operation in all regions and major cities. The AIDS Centers and NGOs have established 98 Trust Points, which provide highly vulnerable groups with syringes, condoms, brochures, and pre- and post-testing counseling. Trust Points use volunteers who are former drug users to provide appropriate education and information.

However, many people who are HIV-positive IDUs do not use them for fear of being harassed, and the performance of these points varies throughout the region. For example, health professionals consider that Trust Points work well in Pavlodar, but are not very efficient in Almaty. HIV positive people were considered criminals, and in general they do not contact the AIDS Centers or NGOs for assistance.

NGO and Partner Activities:

The Government intends to increase the participation of civil society, including NGOs and the private sector, in the implementation of the HIV/AIDS Program. However, the Government is not yet allowed to contact NGOs to carry out work with vulnerable and highly vulnerable groups, which has been undertaken by the AIDS Center with support from UN agencies and International NGOs such as Soros Foundation/OSI. However, the MoH recently contracted two local NGOs (Equal to Equal and East to West) to discuss cooperation between AIDS Centers and NGOs. The local NGOs would like to have a forum to improve communication and cooperation among these organizations, but funding for such coordination is lacking.

All UN agencies have assisted the Government of Kazakhstan, technically and financially, in implementing HIV/AIDS prevention activities. In particular, UNAIDS has been assisting the Government of Kazakhstan on policy issues. The Bank and the Government are carrying out a review of the HIV/AIDS and STIs services under a sector study jointly financed by the Government and the Bank. According to other partners and NGOs, the Bank could have a potential role in carrying out epidemiological and economic projections of the epidemic, and assisting the development of STI case management and clinical protocols for prevention and treatment of HIV/AIDS. The procurement of pharmaceuticals was also mentioned as an area that needs further financial support.

Funding:

In 2001, the Government allocated about \$370 million to the health sector (about \$25 per capita per year), and out-of-pocket expenses for the population were \$28 million (about \$2 per capita per year). The Government estimates that costs of the HIV/AIDS Program at about \$150 million for period 2001-2005. In 2001, **the Government** allocated **\$2.5 million** to the implementation of the HIV/AIDS Program, and in 2002 **\$2.7 million**. However, **funding is not actually disbursed**, and most of the AIDS regional centers carry out their prevention program through grants from NGOs and bilateral organizations. The Government estimates that about \$11 million will be available from different sources for HIV/AIDS control in the next three years, but additional funding is necessary in 2002-2007. Therefore, **the Government**, through the Coordinating Committee, **has submitted a grant proposal to the GFATM in the amount of \$23 million for HIV/AIDS and an additional \$4.5 million for HIV/TB for the coming five years**. The Global Fund has approved **\$6.5 million** for the initial two years.

NGOs and other multi-national organizations have also provided significant programmatic funding for HIV/AIDS prevention. **UN agencies finance approximately \$830,000** worth of HIV/AIDS Prevention and healthy lifestyles programs. **Soros Foundation/OSI** has invested **\$600,000** in harm reduction programs in 1998-2001, and this helps support more than 90 Trust Points in 2002. These prevention programs are expanding nationwide. **USAID** provides a **\$6.7 million** prevention program in Kazakhstan, in the context of which the CDC is helping to develop sentinel surveillance activities. This includes substantial training to improve data collection, management, and behavioral surveillance. Population Services International carries out condom social marketing and IEC. **UNICEF** has been carrying out a **\$4.5 million** program for 2000-2004 to support children and youth health activities, including HIV/AIDS prevention and education.

II. From <http://www.eurasiahealth.org/resources/mdlDoc/1527.pdf>

UNAIDS/WHO epidemiological fact sheet on HIV/AIDS and Sexually Transmitted Infections, 2004 Update

*Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections: Kazakhstan
By UNAIDS, UNICEF and WHO*

The two most affected oblasts in Kazakhstan are Karaganda and Pavlodar (northern cities close to the Russian border) which account for about 70% of the reported cases. Also the former capital city Almaty and the trading city Shymkent have high rates of infection. Preliminary results of sentinel surveillance in selected population shows that HIV prevalence in Karaganda is about 5%, in Uralsk city – 2% and Almaty – 0.3%.

VIII: From www.unaids.org/en/geographical+area/by+country/kazakhstan.asp
 By Country: Kazakhstan
 Country Situational Analysis

Drug injectors were still predominant among newly registered HIV-positive cases in Kazakhstan in 2003 (75%), while about one fourth of them had been infected by sexual transmission - 50% more than in 2002.

Adult (15-49) HIV prevalence rate	0.2% (range: 0.1%-0.3%)
Adults (15-49) living with HIV	16 400 (range: 5700-34 000)
Adults and children (0-49) living with HIV	16 500 (range: 5800-35 000)
Women (15-49) living with HIV	5500 (range: 2000-12 000)
AIDS deaths (adults and children) in 2003	<200 (range: <400)

Source: 2004 Report on the global AIDS epidemic

A 2003 sentinel survey found 3.8% HIV prevalence among injecting drug users; 4.7% among commercial sex workers; 0% among men who have sex with men; 0.5% among prisoner and 0.05% among reproductive health clinic clients belonging to none of the above groups (to be extrapolated to the general population aged 1-49 years, totaling 6 500 000).

Over 700 registered people with HIV/AIDS do have clinical manifestations of the infection and are eligible for antiretroviral therapy. 5% of them were covered by this treatment as of 1 Jan 2004.

Kazakhstan has developed and adopted a **multisectoral strategic program of response to HIV/AIDS for 2001–2005, which serves as a national HIV/AIDS action framework**. The three **key strategies are**: HIV prevention among particularly vulnerable groups through harm reduction interventions; HIV prevention among youth through education, information and communication; and providing treatment, care and support to people with HIV/AIDS.

Since 2001, the government has been able to significantly scale up the national response to the HIV/AIDS epidemic, through the implementation of the National Strategic Program.

UNAIDS assisted the government with developing and updating the national strategic program and sectoral strategic programs to combat HIV/AIDS (2001–2005) with the programs for the cultural and labor and social protection sectors being finalized in 2003.

In cooperation with UNDP, technical, consultation and managerial assistance was provided to key national stakeholders in developing and expanded implementation of HIV prevention interventions among priority groups of the population within the framework of projects supporting the national strategic program: namely, HIV prevention among injecting drug users; commercial sex workers; men who have sex with men; the prison population; and in the armed forces.

X: From
<http://www.euro.who.int/aids/ctryinfo/DatabaseExtraction?Country=KAZ&CtryName=Kazakhstan&language=>

Data summary: Kazakhstan

HIV/AIDS

Indicator	2000	2001	2002	2003	2004
AIDS - Cumulative total reported cases	25	25	25	25	n/a
HIV - Cumulative total reported HIV infections	1347	2522	3216	3648	n/a
Syphilis, Total - Incidence rate (per 100,000 population)	148.38	n/a	n/a	n/a	n/a

STI

Indicator	2000	2001	2002	2003	2004
AIDS - Incidence (cases per 100 000 population)	0	0	0	0	n/a
Hepatitis B - Number of cases	3331	2374	2245	1958	n/a

XV : From <http://www.afew.org/english/countries/kazakhstan.php>

UNAIDS Estimates, end 2003

Adults age 15-49 with HIV/AIDS	16,400
New HIV infections	No data
Adult HIV prevalence (%)	0.2
Women age 15-49 with HIV/AIDS	5,500
Children with HIV/AIDS	No data
AIDS orphans (ages 0-14)	No data
AIDS deaths	<200

XXV: From: <http://hivinsite.ucsf.edu/global?page=cr03-kz-00&post=19&cid=KZ#Youth>

Kazakhstan: Comprehensive Indicator Report

General HIV/AIDS

(Source: UNAIDS, 2004: *UNAIDS 2004 Report on the global AIDS epidemic*
<http://www.unaids.org/bangkok2004/report.html>)

Indicator	Year	Kazakhstan	Eastern Europe & Central Asia	World	Source
Adults and children (ages 0-49) living with HIV/AIDS	2003	16,500	1,400,000	39,400,000	UNAIDS, 2004
Adults (ages 15-49) living with HIV/AIDS	2003	16,400	1,300,000	37,200,000	UNAIDS, 2004
Women (ages 15-49) living with HIV/AIDS	2003	5,500	490,000	17,600,000	UNAIDS, 2004
Children (ages 0-14) living with HIV/AIDS	2003	nd	8,100	2,200,000	UNAIDS, 2004
AIDS orphans currently living (ages 0-17)	2003	nd	nd	15,000,000	UNAIDS, 2004
Adults and child AIDS deaths (ages 0-49)	2003	<200	60,000	3,100,000	UNAIDS, 2004
Adults and children newly	2004	nd	210,000	4,900,000	UNAIDS,

infected with HIV					2004
nd = No data					

HIV Prevalence

(Source: UNAIDS, 2004: UNAIDS 2004 Report on the global AIDS epidemic
<http://www.unaids.org/bangkok2004/report.html>)

Indicator	Year	Kazakhstan	Eastern Europe & Central Asia	World	Source
Adult (ages 15-49) HIV prevalence (%)	2003	0.2	0.8	1.1	UNAIDS, 2004
HIV prevalence, sex workers, capital city (median %)	Various Years	nd	nd	nd	UNAIDS, 2004
HIV prevalence, injecting drug users, capital city (median %)	Various Years	0.0	nd	nd	UNAIDS, 2004
nd = No data					

HIV Knowledge and Behavior

(Source: UNAIDS, 2004: UNAIDS 2004 Report on the global AIDS epidemic
<http://www.unaids.org/bangkok2004/report.html>)

Indicator	Year	Kazakhstan	Eastern Europe & Central Asia	World	Source
Know that a healthy-looking person can have HIV (female, ages 15-24) (%)	Various Years	63	nd	nd	UNAIDS, 2004
Reported higher-risk sex (male, ages 15-24) in the last year (%)	Various Years	78	nd	nd	UNAIDS, 2004
Reported higher-risk sex (female, ages 15-24) in the last year (%)	Various Years	27	nd	nd	UNAIDS, 2004
Used a condom the last time they had higher-risk sex, of those who had high-risk sex in the last year (male, ages 15-24) (%)	Various Years	65	nd	nd	UNAIDS, 2004
Used a condom the last time they had higher-risk sex, of those who had high-risk sex in the last year (female, ages 15-24) (%)	Various Years	32	nd	nd	UNAIDS, 2004
nd = No data					

Access to Care and Treatment

(Source: WHO Health Services Coverage, 2004:
http://www.who.int/tb/publications/global_report/en/)

Indicator	Year	Kazakhstan	Eastern Europe & Central Asia	World	Source
Percent of adults receiving VCT in last year	2003	1.8	1.5	nd	WHO Health Services Coverage, 2004
Number of VCT clients per year	2003	150,000	1,042,637	6,000,000	WHO

					Health Services Coverage, 2004
Number of VCT sites	2003	131	1,136	nd	WHO Health Services Coverage, 2004
Percent of pregnant women offered PMTCT services	2003	5	37	8	WHO Health Services Coverage, 2004
Percent of HIV+ pregnant women receiving ARV prophylaxis	2003	2	6	3	WHO Health Services Coverage, 2004
Number of sites offering PMTCT services	2003	49	969	37,513	WHO Health Services Coverage, 2004
Estimated coverage of antiretroviral therapy (est. %)	2003	nd	11	nd	WHO Health Services Coverage, 2004
Number of public sector patients receiving antiretroviral therapy	2003	49	5,352	nd	WHO Health Services Coverage, 2004
Number of sites offering antiretroviral therapy services	2003	8	27	nd	WHO Health Services Coverage, 2004
Coverage of cotrimoxazole prophylaxis for adults (est. %)	2003	0	4	nd	WHO Health Services Coverage, 2004
Number of adults receiving cotrimoxazole prophylaxis	2003	nd	1,826	190,000	WHO Health Services Coverage, 2004
Coverage of cotrimoxazole prophylaxis for children (est. %)	2003	0	32	nd	WHO Health Services Coverage, 2004
Number of children receiving cotrimoxazole prophylaxis	2003	nd	1,095	28,000	WHO Health Services Coverage, 2004
Coverage of isoniazid prophylaxis for adults (est. %)	2003	0	1	nd	WHO Health Services

					Coverage, 2004
Number of adults receiving isoniazid prophylaxis	2003	nd	432	36,000	WHO Health Services Coverage, 2004
Percentage of population living in areas with DOTS coverage	2002	100	nd	nd	WHO TB Control Report, 2004
Number of TB cases registered for treatment under DOTS	2001	8,894	nd	nd	WHO TB Control Report, 2004
nd = No data					

Mortality

(Sources: World Population Data Sheet 2004 of the Population Reference Bureau: http://www.prb.org/pdf04/04WorldDataSheet_Eng.pdf

UNICEF: www.unicef.org, UNDP: www.undp.org, UNFPA: www.unfpa.org)

Indicator	Year	Kazakhstan	Eastern Europe & Central Asia	World	Source
Life expectancy at birth (years)	Various Years	64	68	67	PRB Data Sheet, 2004
Infant (Ages 0-1) mortality rate (per 1,000 live births)	2003	63	34	54	UNICEF, 2005
Under-five mortality rate (per 1,000 live births)	2003	73	41	80	UNICEF, 2005
Maternal mortality ratio (per 100,000 live births)	2000	210	nd	nd	UNFPA, 2004
Probability at birth of surviving to age 65, female (% of cohort)	2000-2005	76.7	80.6	72.9	UNDP, 2004
Probability at birth of surviving to age 65, male (% of cohort)	2000-2005	53.1	58.8	64.4	UNDP, 2004
nd = No data					

General Population

(Sources: World Population Data Sheet 2004 of the Population Reference Bureau: http://www.prb.org/pdf04/04WorldDataSheet_Eng.pdf)

Indicator	Year	Kazakhstan	Eastern Europe & Central Asia	World	Source
Total population (millions)	mid-2004	15.0	299	6,396	PRB Data Sheet, 2004
Total projected population - 2025 (millions)	2025	15.8	281	7,934	PRB Data Sheet, 2004
Total projected population - 2050 (millions)	2050	14.8	243	9,276	PRB Data Sheet, 2004

Rate of natural increase (%)	Various Years	0.6	-0.5	1.3	PRB Data Sheet, 2004
Percent urban		57	68	48	PRB Data Sheet, 2004
nd = No data					

Youth

(Sources: World Population Data Sheet 2004 of the Population Reference Bureau: http://www.prb.org/pdf04/04WorldDataSheet_Eng.pdf)

Indicator	Year	Kazakhstan	Eastern Europe & Central Asia	World	Source
Population ages 10-24 (millions)	2000	1.4	71	1663.0	PRB Youth Data Sheet, 2000
Percent of total population ages 10-24	2000	28	23	27	PRB Youth Data Sheet, 2000
Percent of total population under 15	mid-2004	27	16	30	PRB Data Sheet, 2004
nd = No data					

General Health

(Source: UNDP: www.undp.org, UNICEF: www.unicef.org; WHO: http://www.who.int/tb/publications/global_report/en/)

Indicator	Year	Kazakhstan	Eastern Europe & Central Asia	World	Source
Health expenditure, private and public (US\$ per capita)	2001	204	nd	nd	UNDP, 2004
Physicians per 100,000 people	1990-2003	345	nd	nd	UNDP, 2004
Births attended by skilled health staff (%)	1995-2002	99	97	58	UNDP, 2004
Malaria cases per 100,000 people	2000	nd	nd	nd	UNDP, 2004
Prevalence of child (ages 0-5) malnutrition (%)	1995-2003	4	6	27	UNICEF, 2005
TB treatment success rate, new smear-positive cases-DOTS (% of cases)	2001	78	nd	nd	WHO TB Control Report, 2004
nd = No data					

Fertility

(Sources: UNFPA: www.unfpa.org; World Population Data Sheet 2000 of the Population Reference Bureau: <http://www.prb.org/Template.cfm?Section=PRB&template=/ContentManagement/ContentDisplay.cfm&ContentID=8500>)

Indicator	Year	Kazakhstan	Eastern Europe & Central Asia	World	Source
Total fertility rate (number of children)	2000-2005	1.95	nd	2.69	UNFPA, 2004

Births per 1,000 women (ages 15-19)		45	nd	50	UNFPA, 2004
Percent of TFR attributed to births by ages 15-19		12	14	12	PRB Youth Data Sheet, 2000
Percent giving birth by age 20		29	nd	31	PRB Youth Data Sheet, 2000
nd = No data					

Education

(Sources: UNICEF: www.unicef.org)

Indicator	Year	Kazakhstan	Eastern Europe & Central Asia	World	Source
Gross primary school enrollment ratio, male	1998-2002	100	101	104	UNICEF, 2005
Gross primary school enrollment ratio, female	1998-2002	99	98	97	UNICEF, 2005
Gross secondary school enrollment ratio, male	1998-2002	90	90	66	UNICEF, 2005
Gross secondary school enrollment ratio, female	1998-2002	88	85	61	UNICEF, 2005
nd = No data					

From the meeting minutes distribution materials provided by the UN Theme Group on HIV/AIDS Update on the current situation of HIV/AIDS in Kazakhstan, by the Republican AIDS Center

According to findings of second generation epidemiological surveillance the following are the most recent figures on HIV positive:

3,8% (out of 200,000) of IDUs; about 4.7% (out of 20,000) of sex workers; 0.5% (out of 100,000) of MSM; and 1% (out of 70,000) prisoners. The number of people currently living with HIV can be estimated at around 12,000 and 900 of them are in need of antiretroviral treatment. 261 persons developed AIDS. The number of children born to HIV infected mothers increases rapidly. There is 20% increase in HIV cases this year compared to the year before and 75% of people are infected through injecting drugs use. It is worth noting that presently one-fourth of newly registered HIV cases have contracted the virus through sexual contact, and 85% of HIV positive people are young people. The share of HIV infected women reached 20%. HIV cases are now registered in all regions of the country, not only in urban but also in rural areas.

The Republican AIDS Center received the second Global Fund transfer. Global Fund means enabled to organize several workshops for the representatives of Republican and Oblast AIDS Centers and NGOs, to provide trust points with syringes and condoms. This year it is planned to provide antiretroviral treatment for 300 people. Running cytometers have been procured for exposure of the treatment effectiveness and they will be installed in Karaganda, Pavlodar, Shymkent and Uralsk. CDC assists the Republican AIDS Center with standard equipment for monitoring the effectiveness of antiretroviral treatment.

From Terms of Reference.

UN Theme Group on HIV/AIDS, Kazakhstan distribution materials

Background:

Kazakhstan has the highest number of reportedly registered HIV cases among the Central Asian countries. This development has been fuelled by a dramatic increase in injecting drug use

among young people, in which group the majority of HIV cases can be found. Other important factors contributing to the spread of HIV/AIDS are poverty, unemployment and disillusionment, leading to increased recruitment to subgroups engaging in high-risk behavior, like commercial sex workers and IDUs. This has been combined with a gradual breakdown of traditional family values, and the last decade has seen a dramatic increase in STI prevalence, indicating a high amount of unprotected sex, and high potential for spread of the epidemic within the general population.

A 2003 sentinel survey found 3,8% (CI 2,8-5,2%) HIV prevalence among injecting drug users (estimated number 200,000); 4,7% (CI 3,1-6,9%) prevalence among sex workers (estimated number 20,000); 0% (CI 0-3,6%) prevalence among MSM (estimated number 100,000); 0,5% (CI 1,1-1,3%) prevalence among prisoners (70,000) and 0,05% (CI 0,0-0,1%) prevalence among reproductive health clinics' clients that belong to neither of the mentioned groups (to be extrapolated to general population of 15-49, 6,500,000). In addition it has been calculated that 10-100 children were born to HIV infected mothers, who has not been enrolled in PMTCT. Thus, overall estimated number of people living with HIV/AIDS (PLWHA) in the country nowadays varies from 8,500 to 20,000. The total number of reportedly registered HIV cases since 1987 reached 4004 as of Jan 1, 2004 with 25% growth to the number as of Jan 1, 2003. Drug injectors were still predominant among newly registered HIV positive persons in 2003 (75%), while about one-fourth of newly registered PLWHA had been infected through sexual route, which was a half more than in 2002. Over than 700 HIV positive people are known to have clinical manifestations of the infection and are eligible to highly active antiretroviral treatment. Only five percent of them were covered by such treatment as of Jan 1, 2004.

On Sep 14, 2001 the Government of Kazakhstan adopted the "Programme on Counteracting the AIDS Epidemic in the Republic of Kazakhstan for 2001-2005", (National Strategic Programme), outlining the main objectives in HIV/AIDS prevention work. The Programme was prepared in close cooperation with UNAIDS. In 2003 the country received US\$ 22,4 million grant from the GFATM according to the proposal to support the National Strategic Programme having been developed by country Coordination Mechanism with comprehensive assistance of UNAIDS.

a. HIV PREVALENCE RATES (GENERAL):

*IV: From: <http://www.unaids.org/en/geographical+area/by+country/kazakhstan.asp>
UNAIDS Geographic area: Kazakhstan*

Kazakhstan undertook a health-sector reform that allowed for a general shift from curative to preventive medicine, promotion of primary care, decentralization and a stronger focus on community participation. There is a greater understanding of HIV/AIDS at the political, community and individual levels. But the country's ability to effectively confront the HIV/AIDS epidemic is still limited. **The central Government allocates US\$2.7 million to the implementation of the 2001–2005 National Strategic Plan. In 2002 Kazakhstan obtained a US\$22 million grant from the Global Fund, which provided substantial additional support to HIV prevention activities among high risk groups and youth, as well as provision of antiretroviral treatment to people living with HIV/AIDS.**

VI: From: www.rbec.undp.org/hiv/?english

UNAIDS estimated HIV prevalence in Kazakhstan in 2001 at 0.1-0.3 percent, while the other Central Asian countries reported prevalence rates below 0.1 percent.

Some 3,700 new cases had been reported in Kazakhstan by 1 July 2003, as well as 85 AIDS cases and 80 AIDS deaths. Of the cases with documented transmission routes, 90 percent have been attributed to injecting drug use, 10 percent to heterosexual sex, and 0,5 percent to

male homosexual and bisexual sex. As in other countries, the proportion of cases reportedly due to heterosexual contact is slowly growing, reaching 19 percent of the annual total reported in 2002.

XVI : From Power Point presentation of AFEW project manager, Saltanat Sartaeva, Counselling Project

- According to the official data (the Republican AIDS Center) in Kazakshtan there are 4577 registered cases of HIV-infection, including patients with AIDS-210 (on 1st of Nov, 2004)
- 100 children were born to HIV infected mothers
- Estimated number of PLWHA in the country nowadays varies from 8,500 to 20,000
- Currently only 1% of PLWHA in need of HAART are covered (only 9 people out of 900), which is 7 times lower of the average world indicator (7%)

*XXII: From: http://www.unaids.ru/index_ru.php?id=aids_epidemic_update_eng-5&nm=4
UNAIDS: Key Materials: Eastern Europe and Central Asia*

By some estimates, there could be up to 200,000 **injecting drug** users in Kazakhstan.

In Ukraine, 25% of those diagnosed with HIV are younger than 20, in Belarus 60% of them are aged 15 - 24, while in Kazakhstan and Kyrgyzstan upwards of 70% of HIV-positive persons are under 30 years of age.

These patterns highlight the need for a more vigorous and comprehensive response that diminishes the vulnerability of young people, and enables them to reduce drug injecting and risky sexual behaviour. **That means greater access to information, as well as to prevention tools and services.** Harm reduction forms a cornerstone of such a comprehensive response, and should be broadened quickly to address the needs of young drug injectors who face immediate and high risks of HIV infection. Special attention should be paid also to their predominantly female sexual partners, to men who have sex with men, and to the young women and men who engage in sex work. The prevention of mother-to-child transmission is a new and urgent priority. But the growing treatment and care needs of people living with HIV can no longer be overlooked.

The most recent HIV outbreaks in the region are to be found in Central Asia, where reported HIV infections have grown exponentially from 88 in 1995 to 5,458 in 2002. This is mainly due to the sharp rise in infections recorded in Kazakhstan, Kyrgyzstan and Uzbekistan. HIV has now spread to all regions of Kazakhstan, while the majority of cases reported in Kyrgyzstan are concentrated in the Osh region, which serves as a drug transit route for neighboring countries. Given that the five Central Asian republics straddle major **drug trafficking routes** into the Russia Federation and Europe, it is no surprise that the majority of infections currently are related to injecting drug use. Indeed, in some parts, heroin is now believed to be cheaper than alcohol. As elsewhere in the region, young people are the worst-affected, with those on the margins of the economy particularly vulnerable. In Kazakhstan, for example, three-quarters of people diagnosed with HIV were **unemployed**.

These epidemics are very recent and can be halted if prevention efforts are targeted at those who are currently most affected - injecting drug users and sex workers - and are supported by prevention work among young people generally. In some instances, even more elementary prevention steps are required - such as screening blood donations for HIV. Tajikistan, for example, reportedly did not test 40% of those who donated blood in 2002.

XXV: From: <http://hivinsite.ucsf.edu/global?page=cr03-kz-00>

HIV/AIDS in Kazakhstan	
Adults age 15-49 with HIV/AIDS, 2003	16,400
New HIV infections, 2004	nd
Adult HIV prevalence (%), 2003	0.2
Women age 15-49 with HIV/AIDS, 2003	5,500
Children with HIV/AIDS, 2003	nd
AIDS orphans (ages 0-17), 2003	nd
AIDS deaths, 2003	<200
nd = No data	

Source: **UNAIDS**

b. HIV PREVALENCE RATES (WITHIN THE COUNTRY, BY REGIONS):

III. From <http://www.eurasiahealth.org/resources/mdlDoc/1172.pdf>

AIHA, American Int'l Health Alliance

An Assessment of HIV/AIDS and the Prevention of Mother-to-Child Transmission of HIV in Kazakhstan

Temirtau:

The Temirtau AIDS Center works together with NGOs who coordinate syringe exchange at "trust points" (six hospital-based and one mobile) for IDUs. The trust points were financially supported by UNAIDS, but are currently experiencing significant financial difficulties.

Local NGO "Shapagat" for people living with HIV/AIDS (PLWHA), which has received grants from the Soros Foundation-Kazakhstan since July 2002, and is highly experienced in outreach work among IDUs and PLWHA.

However, at the same time, all specialists need training in counseling. The AIDS Center needs computers and laboratory equipment to determine CD4 counts.

Karaganda:

The HIV epidemic in Karaganda (pop. 436,900 in 2001) has been officially recorded since 1997. By the end of 2003, 1,296 HIV+ individuals were officially registered; of these, approximately 30% were women of child-bearing age. An overwhelming majority of HIV+ individuals are IDUs and the prevalence of HIV among IDUs in Karaganda is 2.5%.

The active identification of HIV-infected individuals in Karaganda, including pregnant women, is pursued through the "trust point" for IDUs. Their activities are coordinated by the AIDS Center, and have been financially supported by the Soros Foundation-Kazakhstan (up to 2001-2004) and through the municipal budget. The offices implement syringe exchange and the dispensing of condoms.

However, at the same time: special staff trainings are needed, there is no equipment for running PCR or determining CD4 counts in local AIDS Center. In addition, the Center does not promote the activities of NGOs that are working with HIV risk groups and PLWHA. Stigmatization and discrimination of HIV+ among medical personnel is a serious problem. There is no system of psychosocial support for HIV+ and there is no unified computerized database of HIV+ individuals.

Pavlodar:

Since the beginning of the epidemic in 1996, 782 HIV+ persons have been officially registered in Pavlodar (pop. 300,500 in 2002); of these, 150 were women.

The AIDS Center in Pavlodar is the organizational leader of HIV/AIDS efforts in the region. AIDS Center staff work with two local NGOs:

- “Turan” deals with the problem of HIV + tuberculosis patients;
- “Anti-SPID” (Anti-AIDS) deals with the problems of commercial sex workers (CSWs). It is funded by Soros Foundation-Kazakhstan and UNAIDS.

However, at the same time: there is no unified, computerized database of HIV+ individuals. The AIDS Center does not have the necessary equipment to measure CD4 counts. There is no system of psychosocial support of HIV+.

*From: Harm Reduction News
Newsletter Focus
Fall 2002 – Volume 3, Issue 3
p.15: HIV and AIDS Treatment in Central Asia
By Jay Dobkin*

Official statistics indicated virtually no HIV cases in Central Asia before 1997 when an outbreak of several hundred HIV cases was reported in the city of Temirtau, Kazakhstan, and the surrounding area. In the last two years several other Kazakhstan cities have detected clusters of cases and outbreaks have been noted in Kyrgyzstan, Uzbekistan, and Tajikistan.

The question of how and why the HIV outbreak occurred in Temirtau have been endlessly discussed and cannot be answered definitely but the region's recent history seems to give a clue. During Soviet times the great coal deposits in the area were exploited and the region became a major mining and steel production center: Temirtau prospered as one of the largest steel centers until the Soviet Union broke up in early 1990s and the inefficient mill struggled through several management changes before closing entirely. According to local observers, the social fabric in this city of 125,000 came apart with explosive increases in alcoholism and drug use, even by pre-teenaged children.

Among several probable factors in the Temirtau HIV outbreak are the rapid growth of drug use and the large number of young users. The role of psychological factors such as the hopelessness triggered by economic upheaval leading to risky patterns of drug use and sexual activity is more speculative.

Since HIV infection proceeds silently for several years before the clinical illnesses known as AIDS begin to appear, there is a lag time before the impact of new epidemics is felt. The new HIV infections that have occurred in the last few years will begin to translate into illness and death over the next five to 10 years. This time can be used to delay or prevent much of the morbidity and mortality of HIV.

*From:
HIV/AIDS
Social and Economic Consequences in Countries of the Commonwealth Of Independent States
Indicators for the World of Work
Report of a Tripartite Seminar
Moscow, 10-12 December, 2001*

By Mr. Baurzhan Zhusupov

Temirtau, a small industrial town with a total population of 180,000 in Kazakhstan's Karaganda region. Ispat-Karmet, now a private company located in Temirtau, employs approximately 30,000 people – thereby playing a pivotal role in the city's economic and social life. The management of the company is aware of its responsibilities outside the company walls and has traditionally been involved in various social and cultural activities in the city and the region. With the arrival of HIV in Temirtau, Ispat-Karmet's management realized that an effective response could not be left to the government alone but required the resources and expertise of the company. The management was aware that effective HIV/AIDS prevention in the city would be in the company's best interest.

The HIV/AIDS epidemic in Temirtau broke out during the second half of 1996 with injecting drug use as the most prevalent mode of HIV transmission. It peaked in 1997 with 385 new infections. Since then, the number of new infections has steadily declined to 40 new infections in the 2001. the total number of registered people with HIV is 960. Currently, the city has approximately 8,000 IDUs. The recent decline in the number of newly-registered HIV cases is attributed to steps taken to prevent the spread of HIV.

The relative seriousness of the HIV/AIDS situation, combined with the high prevalence of injecting drug use, prompted the management of Ispat-Karmet to take up issues related to the prevention of HIV/AIDS. The company participated in the development of a strategic plan for HIV/AIDS prevention and mitigation in the city. Under that plan, a project entitled "Promotion of Multisectoral Effective Response to the HIV/AIDS and STD Epidemic and Drug Use Spread in Karaganda Oblast and Nationwide" was developed, and the company provided a financial contribution of US\$ 100,000 for its implementation. In addition, the company provided further material support and assisted in the organization of the project.

Ispat-Karmet also became involved in other HIV/AIDS prevention activities. The company sponsored educational work within with city population, utilizing mass media outlets such as television, the print media and poster displays. It was a member of the municipal committee for coordinating activities to prevent the spread of HIV and provided organizational, technical and financial support for the Coordinating Committee's decisions. Ispat-Karmet continued to contribute to the strategic planning to combat HIV/AIDS in the city as well as at the national level.

At the company level, Ispat-Karmet addressed HIV/AIDS prevention in various ways: information and education on HIV/AIDS was provided to all employees, voluntary counseling and testing on the basis of anonymity was offered, condoms were distributed and their use was explained and demonstrated.

The factors that contributed to Ispat-Karmet's cooperation in Temirtau's HIV/AIDS prevention campaign: the company was traditionally involved in the city's HIV/AIDS prevention activities. For the city government, the company is the key partner in social and economic policies and consequently it involved the company management in strategic planning and in the implementation of actions at an early stage. That was done through consultations between city government officials and the management where it was made clear to the management that HIV/AIDS must be an issue of top priority for the city as well as for the company. HIV/AIDS should not be addressed through a single, "one-short" intervention but through a sustained campaign, and as a consequence, company personnel became members of the coordinating committee on HIV/AIDS.

Ispat-Karmet's participation in HIV/AIDS prevention in Temirtau is a best practice example that could serve as a model for many similar industrial cities in Kazakhstan as well as in other CIS countries. The lessons learned from this example should be widely distributed to attract partners from the business community in HIV/AIDS prevention and mitigation and to encourage them to get involved at an early stage in strategic planning of policies and activities, as well as in the implementation of comprehensive plans.

c. HIV PREVALENCE RATES (VULNERABLE GROUPS):

II. From <http://www.eurasiahealth.org/resources/mdlDoc/1527.pdf>
UNAIDS/WHO epidemiological fact sheet on HIV/AIDS and Sexually Transmitted Infections,
2004 Update
Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections: Kazakhstan
By UNAIDS, UNICEF and WHO

The vulnerable groups are mainly **IDUs, SW, prisoners** (there is a large HIV pos population in national penitentiary institutions in total of 1227). Kazakhstan being located on the main route of drug trafficking creates supportive conditions for the annual increase of drug users. Despite the officially registered 45 000 IDUs results of RAR conducted in 1998-2002 suggested that the number of IDUs may exceed 25 000. In accordance with national estimates 3% of Kazakh population inject drugs which would bring the number of IDUs to 450 000. The involvement of women and children in drug use and trafficking which will follow most likely by the increase of HIV cases in those groups. Estimated number of FSW is 20 000-50 000 and 30% of them are IDU.

In accordance with National HIV/AIDS Centre data at least 1% of SW are HIV infected. Available behavioral data suggest that despite the fact that almost all IDUs know about the protective measures, great majority continues unsafe injecting drug use and sex with multiple casual partners. Over half of SW and about 80% of respondent MSM do not use condoms; about 25% of MSM have had STI, only 30% have adequate knowledge about HIV transmission, 10% being IDU.

The described above behavioral risks proofs the potential of massive spread of HIV infection into the general population unless preventive measures are applied speedily enough.

XI: From www.euro.who.int/eprise/main/who/mediacentre/PR/2004/20041130_1

Injecting drug use drives the HIV/AIDS epidemic in Eastern Europe and Central Asia. Over 80% of those infected are under 30.

The starting of drug-injection equipment contaminated with HIV remains one of the critical activities fuelling the epidemic among drug users and others in Eastern Europe and Central Asia.

Experts estimate that there are 200 000 drug users in Kazakhstan. Most of these drug users are **male**.

From: Fanning the Flames
How Human Rights Abuses are Fueling the AIDS Epidemic in Kazakhstan
Human Rights Watch
June 2003, Vol. 15, No. 4(D)

p. 14: HIV/AIDS in Kazakhstan

Youth:

Although nearly all young people and adults in Kazakhstan have been shown in various surveys to have some awareness of HIV/AIDS and much more awareness of HIV/AIDS than of other STIs, young people's understanding of HIV transmission is wanting. UNICEF's recent survey of 1028 teenagers (aged thirteen to eighteen) around the country showed that 26% believed HIV was transmitted by sharing dishes or spoons, by insects, by kissing or by casual contacts, and 20% through "repressive and punitive actions" against persons with AIDS were necessary to

contain the epidemic. Only 15% of the children said they had received information on safer sex in school. The need to conduct broader campaigns among young people is vividly clear: in Pavlodar alone, about 80% of HIV cases are reported to be among fifteen- to twenty-nine-year-olds. In 2002 thirteen schoolchildren (ranging in age up to seventeen years) in the area were registered with HIV.

d. MAJOR TRANSMISSION ROUTES:

I. From <http://www.eurasiahealth.org/resources/mdlDoc/1467-e.pdf>
AIDS Epidemic Update: December 2004

Eastern Europe and Central Asia: p. 47 to 56

According to one study done in the nine largest Kazakh cities, as many as 42% of drug-injecting women and 6% of their male counterparts also sell sex (Republican AIDS Centre, 2001). Studies among sex workers in the cities of Karaganda, Pavlodar, Shymkent and Uralsk have found that overall 14% injected drugs and 42% said they sold sex for drugs (Republican AIDS Centre, 2004).

Sexual transmission accounts for a growing share of HIV infections in Kazakhstan, where more than 25% of newly-registered infections in 2004 have been attributed to unprotected sex. This seems in line with the low levels of condom use reported in the country – just 58% of 15-24 year-old said they used condoms with casual partners, according to one recent study.

Available research therefore highlights a potentially volatile mix of behaviors that could sustain the region's epidemics – unless addressed now with effective prevention efforts that reach drug injectors, sex workers, their clients and regular partners.

p. 54:

In Kazakhstan, where a total of just over 3600 HIV cases had been reported by mid-2003, sentinel surveillance conducted in 2003 has shown prevalence levels of 3.8% in **injecting drug users** and **4.6% in sex workers** but there are **no data concerning men who have sex with men** (EuroHIV, 2003).

The proportion of people living with HIV in Kazakhstan rose from 19% in 2001 to 24% in 2003. These epidemics are growing at a fearsome pace and are concentrated currently among young people who inject drugs and/or engage in commercial sex.

Because the epidemics are still in their early stages, they can be halted with prevention strategies that concentrate on reaching those who are currently most at risk of exposure to HIV.

p. 54:

N.B. Current case reports reflect the situation only among those people and groups (chiefly injecting drug users) who come into contact with HIV testing programmes. Consequently, little is known about HIV spread among people who do not engage with the authorities and/or testing services.

In many countries the likely role of sex between men in the epidemic is not being recognized.

p. 56:

In Kazakhstan fewer than 5% of people in need of antiretroviral therapy are getting it, and treatment for drug injectors is not yet supported by substitution therapy.

II. From <http://www.eurasiahealth.org/resources/mdlDoc/1527.pdf>
UNAIDS/WHO epidemiological fact sheet on HIV/AIDS and Sexually Transmitted Infections, 2004 Update

Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections: Kazakhstan
By UNAIDS, UNICEF and WHO

p.2: As of 1 April 2004 the total number of reported HIV cases amounted to 4172, and the total number of AIDS cases is 168.

The predominant route of transmission is IDU (about 80%), transmission through **heterosexual contact**, and bi/homosexual contacts about 0,5%. The most affected group is 20-29 years old (54,3%). The great majority of infected population are male, just as much as 207 women are detected to be HIV positive but there is a tendency of increase. 101 children were born to HIV positive mothers, 6 out of them are HIV pos, and other are still under the control.

III. From <http://www.eurasiahealth.org/resources/mdlDoc/1172.pdf>

AIHA, American Int'l Health Alliance

An Assessment of HIV/AIDS and the Prevention of Mother-to-Child Transmission of HIV in Kazakhstan

As of March 1, 2004, there were a total of 4,107 HIV cases registered by the Republican AIDS Center, including 202 HIV+ pregnant women and 99 infants born to HIV+ women. Of the infants, 7 have a confirmed HIV+ status, 19 are seronegative, and 69 are still under observation.

XIII: From AFEW Press Release

New Developments in the HIV/AIDS epidemic in Kazakhstan

Call for New Approaches to Prevention

During the past few years, trends in the HIV epidemic in Kazakhstan have mirrored those seen earlier in other countries of Eastern Europe and Central Asia, with the virus leaving the confines of social groups traditionally associated with risky behaviour. The number of cases of HIV transmission through **unprotected sexual contact** is increasing year by year. While in 2003 the percentage of new infections attributed to **heterosexual contact** was 10%, in 2004 this has risen to 13.4%. At the same time, the percentage of cases stemming from **injecting drug** use has fallen from 82% to 78%.

From: Harm Reduction News

Newsletter Focus

Fall 2002 – Volume 3, Issue 3

p.17: Given a Chance, Police Favor Harm Reduction

By Toulesh Ergaliev, lieutenant colonel at the Department of Drug Control, Interior Affairs, Region of Western Kazakhstan

Heroin was seized for the first time in Uralsk, the regional center for western Kazakhstan close to Russia's border, in 1998. Since then, law enforcement agents have been regularly detaining drug users and heroin dealers. Drugs come into the city through Russia from the Chechen Republic and from the southern parts of Kazakhstan, where it is trafficked from Tajikistan and Turkmenistan.

By July 2002 the local narcological hospital has registered 1,211 "drug addicts". The city has registered 112 people living with HIV. In response to the HIV epidemic, IHRD technical advisor Nurlan Disonov set up an NGO for needle and syringe exchange called *Movement*. There is some uncertainty in the public mind in Uralsk about the legality of needle exchange. It is widely believed that drug users are criminals and a threat to public order because they use drugs in the backyards and doorways of houses and sometimes commit crimes.

On an IHRD stud tour for policemen last year, Toulesh visited a harm reduction project in Poland. The project was interesting and novel for him, especially the way it gave hope and

optimism to drug addicts. What he saw in Poland persuaded him that the state is not the only entity that can deal with the drug problem.

Many drug users are afraid of the police and law enforcement officials because current legislation mandates that police charges them with illicit drug trafficking. And more policemen are in favour of isolating and incarcerating drug users. If they knew more about hard reduction they would understand that it enables drug users to stop violating the law and return to society as useful people.

e. ACCESS TO TREATMENT:

UNAIDS/WHO epidemiological fact sheet on HIV/AIDS and Sexually Transmitted Infections, 2004 Update

Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections: Kazakhstan
By UNAIDS, UNICEF and WHO

p.9: a set of well-established health care indicators may help to identify general strengths and weaknesses of health system. Specific indicators, such as access to testing and blood screening for HIV, help to measure the capacity of health services to respond to HIV/AIDS related issues.

Access to health care:

Number of adults (15-49) with advanced HIV infection receiving ARV therapy as of June 2004

Adults at treatment:

Number: 49

Source: WHO

Estimated number of adults (15-49) in need of treatment in 2003

Adults needing treatment

Number: 460

Source: WHO/UNAIDS

IX: From <http://www.euro.who.int/document/mediacentre/fs0603e.pdf>

HIV/AIDS treatment: antiretroviral therapy

Fact Sheet EURO /06/03

WHO Europe

Copenhagen, 1 Dec 2003

Access to ART:

Central and Eastern Europe (CEE) and the newly independent states (NIS) are the most in need of ART in the WHO European Region. As the epidemic progresses, the number of people needing treatment will raise exponentially. The epidemic is still in its early stages throughout most of the Region. Most of the estimated 1.2 million people currently infected in CEE and the NIS are still in the relatively early stages of HIV disease; most of them have no symptoms of illness and most do not yet require ART. But they will.

Coverage is low in the Caucasus and Central Asian countries (15%) and lowest of all in the European NIS (6%). Generally speaking, those countries and regions in greatest need of ART have the lowest coverage.

In Eastern Europe and Central Asia, 7000 people receive ART, which is 9% of the patients who need it in the Region.

Table 1: Coverage of antiretroviral therapy (ART) in poorer countries, Dec 2002

Region	Number of adults on ART	Estimated number who need ART	Coverage (%)
Eastern Europe and Central Asia	7 000	80 000	9

ART costs remain an important barrier to treatment, although progress has been made to lower them. While the initial price for an antiretroviral three-drug regimen was about US\$ 10 000 per patient per year, high-quality drug regimens can now be obtained for as little as US\$ 300 a year.

Table 2: Access to antiretroviral therapy (ART) in Central Asia

Country	Estimated number of people who need ART	Estimated coverage (%)
Kazakhstan	100	55.0
Kyrgyzstan	10	0.0
Tajikistan	5	0.0
Turkmenistan	0	0.0
Uzbekistan	100	0.0

The WHO Regional Office for Europe's 2003 survey reveals that countries are still paying high prices for antiretroviral drugs.

Table 3: Average cost in US\$ per patients per year in selected countries in 2002

Kazakhstan	7 140
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From: Harm Reduction News

Newsletter Focus

Fall 2002 – Volume 3, Issue 3

p. 9: Kyrgyzstan: Leading the Way on Methadone, by Tynchtykbek Asanov

Methadone News

In July Kazakhstan legalized the use of methadone as a drug replacement therapy, making it the second Central Asian country to do so, and one of an increasing number of former Soviet countries to adopt or consider methadone in the last year. Two pilot programs were approved, and are scheduled to begin operation in late 2002 in Pavlodar and Karaganda with approximately 80 patients.

From: Harm Reduction News

Newsletter Focus

Fall 2002 – Volume 3, Issue 3

p.15: HIV and AIDS Treatment in Central Asia

By Jay Dobkin

Little treatment for HIV is available in Central Asia and this is not likely to change any time soon. The regions is wracked by political and economics turmoil and other, more immediate, health crises. There is little time or attention for the HIV epidemic, which is in its early stages and has not reached the critical dimensions of sub-Saharan Africa. Further, the primary affected group – drug users and their partners – are severely marginalized and often viewed as expendable.

The AIDS centers in Central Asia that do try to meet these challenges have found that comprehensive care for HIV infected patients has four components: general health promotion, substance abuse treatment, opportunistic infection prevention, and anti-retroviral treatment.

Since most patients are young and free of chronic diseases, little general health care is needed unless STIs or complications of drug use are present. Substance abuse treatment, however, may be the most critical step in successfully dealing with HIV infection because it often requires complex regimes with daily medications.

Most of severe infections that complicate the advanced stages of HIV disease (so-called “opportunistic infections”) can be prevented or delayed with simple oral medication. A single daily dose of the antibiotic trimethoprim/sulfamethoxazole, for example, is highly effective in preventing two of the most common complications: pneumonia and toxoplasmosis. The medication is inexpensive (less than one US dollar a month in some former Soviet countries).

The urgency of anti-HIV therapy in areas like Central Asia may be hard to grasp especially compared to much larger, more advanced epidemics. But the potential for HIV treatment to limit the spread of the epidemic is real – by decreasing the infectivity of those who are treated and by drawing many of those who fear it into preventative care. It is also urgent that the policy makers and caregivers begin to confront the nuances of working with drug users rather than excluding them as a group.

II. CURRENT RESPONSE TO HIV/AIDS EPIDEMIC IN THE COUNTRY

a. GOVERNMENT

V: From: <http://www.unaids.org/nationalresponse/result.asp>
National Strategic Framework

Status

NSP completed for period 2001–2005. Also sectoral plans appeared in educational, health, military, interior, penitentiary, labor/social protection and culture/mass media sectors.

Priority action areas

- 1) Primary prevention of HIV
- 2) Decrease of vulnerability
- 3) Epidemiological surveillance
- 4) Treatment and care
- 5) Management capacity-strengthening for coordination and implementation of HIV/AIDS programmes.

Multisectoral involvement/key partnerships

Partners in the HIV/AIDS response in Kazakhstan include several national NGOs, private sector, PLWHA, as well as the international community, UN agencies and international NGOs.

Implementation plan

Status

Operational Plan for 2002–2005 in place

Costed

US\$150 million for 5 years.

Nationwide

Yes.

M&E component

Incorporated.

Political commitment

National financial support

Government resources: approximately US\$2.7 million
(US\$310,000 from national budget and US\$2.3 million from local budget).

National policies

National HIV/AIDS policy, including specific legislation against discrimination, is in place.

Government decrees (2000/01) on strong leadership, multisector approach, prevention, essential rights.

High-Level government support

There is commitment at the highest level.

Institutional status

Coordination mechanisms

Central/Regional Cross-sectoral Coordination Committees chaired by Deputy Prime Minister and Deputy Governors. Country Coordination Mechanism was set up to govern the Global Fund Project.

Management capacity

The country has appropriate infrastructures at national and regional levels to address all programme management aspects nation-wide. However, strengthening of the technical and institutional capacities still is needed.

XIV: *From Kaiser Daily HIV/AIDS Report*

Global Challenges, April 30, 2003

Kazakhstan Health Minister Calls for More Funds for HIV/AIDS Program

Kazakhstan has developed a **national AIDS prevention program**, which is scheduled to run through 2005. The program will be financed by approximately **\$203,000 from the national budget and approximately \$2.4 million from local budgets**. Kazakhstan would also use **\$22.36 million assigned from the Global Fund**. However, it was also suggested that to implements the national program within four years \$151 million are needed.

XXIV: From: http://www.youth-policy.com/Policies/Kazakhstan_AIDS_Law.cfm

Law of the Republic of Kazakhstan 'Preventing AIDS' Law on Preventive Measures Against AIDS-Text of Law

954KO220A Almaty SOVETY KAZAKHSTANA in Russian 27 Oct 94 p 3 FBIS-USR-94-122
96 CENTRAL ASIA

[Law: "Law of the Republic of Kazakhstan `Preventing AIDS""]

[FBIS Translated Text]

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10 November 1994

Article 1. Concept of AIDS

AIDS-acquired immune deficiency syndrome-is an especially dangerous infectious disease that is linked with infection with the human immune deficiency virus [HIV].

Article 2. Agencies, Institutions, and Organizations That Carry Out AIDS Prevention and Treatment

The agencies, institutions, and organizations that carry out, with the support of the mass media and public associations, the prevention and treatment of AIDS include: the Republic of Kazakhstan Ministry of Health; public health sections and departments; centers to prevent and fight AIDS; blood transfusion stations; the Republic of Kazakhstan Ministry of Internal Affairs; and other ministries and departments.

The state assumes the obligations of carrying out a series of necessary measures and the legal protection of citizens in implementing this Law. Persons who are guilty of violating this Law bear responsibility in conformity with the legislation that is in effect.

Article 3. Centers to Prevent and Fight AIDS

The republic center and the oblast and city centers to prevent and fight AIDS are special-type specialized prevention and treatment institutions that carry out a series of diagnostic-and-treatment, preventive, and anti epidemiological measures that are aimed at the prompt recognition and treatment and the prevention of the spread of AIDS.

Article 4. Financing of Measures to Prevent and Fight AIDS

The financing of measures to prevent and fight AIDS is carried out at the expense of the republic and local budgets and voluntary contributions by enterprises, organizations, and institutions regardless of the form of ownership, public associations and citizens, donations, philanthropic aid, as well as funds from international foundations.

Article 5. Right of Citizens of the Republic of Kazakhstan, Foreign Citizens, and Persons Without Citizenship to Receive Medical Examination for AIDS

Citizens of the Republic of Kazakhstan, as well as foreign citizens and persons without citizenship who are residing or are located on territory of the republic, have the right to voluntary, confidential, anonymous medical examination in state public health institutions to detect infection with HIV.

Article 6. Obligations of Citizens of the Republic of Kazakhstan, Foreign Citizens, and Persons Without Citizenship to Undergo Medical Examination for AIDS

Citizens of the Republic of Kazakhstan, foreign citizens, and persons without citizenship are obliged to undergo medical examination in the event that there are sufficient grounds for assuming that those persons may be infected with HIV.

The grounds and procedure for sending citizens for examination and treatment are regulated by Republic of Kazakhstan Law entitled "Protecting the Health of the Nation in the Republic of Kazakhstan."

Employees of diplomatic, representational, and consular institutions of foreign states and other persons who enjoy, on the territory of the Republic of Kazakhstan, diplomatic privileges and immunity are examined for infection with HIV only with their consent. The recommendation concerning the necessity of examining them is first coordinated by the Republic of Kazakhstan Ministry of Health with the Republic of Kazakhstan Ministry of Foreign Affairs.

Persons infected with HIV are informed of this in writing by public health institutions that have established the fact of infection. Those persons are obliged to observe measures to prevent the spreading of the disease which have been established by the Republic of Kazakhstan Ministry of Health.

Foreign citizens residing on the territory of the republic, in the event that they refuse examination or preventive observation, or in the event of infection with HIV or with AIDS, are deported from the Republic of Kazakhstan.

Foreign citizens whose husband or wife is a citizen of the Republic of Kazakhstan are not subject to deportation.

Article 7. Social Protection of Persons Infected With HIV

Citizens of the Republic of Kazakhstan and persons without citizenship, in the event of infection with HIV, have the right to free medical support, out-patient and in-patient assistance in state public health institutions, and the compensation of expenses involved in traveling back and forth at the expense of the public health institutions at the place of residence. For children up to the age of 16 years who are infected with HIV or who are AIDS patients, a state monthly grant in aid is established in the amount of 80 percent of the minimum wage.

Uninterrupted work longevity is preserved for one of the parents in the event that he or she cancels a labor contract in order to take care of children aged up to 16 years who have been infected with HIV or who are AIDS patients.

Children or adolescents who are infected with HIV or who are AIDS patients are provided with instruction in school or other educational institutions.

It is not allowed to fire, to refuse to hire, to refuse to admit into preschool institutions or educational institutions, or to infringe upon other rights or lawful interests of persons who are infected with HIV or who are AIDS patients, or to infringe upon the housing or other rights of their parents or relations.

Article 8. Measures to Prevent Infection With AIDS With Respect to Individuals and Occupations

Medical and pharmaceutical workers and workers in the personal services sphere who are infected with HIV are to be removed from the execution of their official duties and to be transferred to another job. Persons who are infected with HIV are prohibited from being donors of blood, tissues, or organs.

Article 9. Responsibility For Infecting Someone With HIV

The deliberate placing in danger of infection or the infecting of another individual with HIV by a person who knew about the fact that he had that disease results in responsibility in accordance with the legislation that is in effect.

Article 10. Responsibility of Individuals for Negligent Execution of their Professional Duties

Medical workers and workers in the personal services sphere who have taken a negligent attitude toward their professional duties which results in the infecting of other individuals with HIV are brought to the responsibility that has been established by legislation.

Article 11. Observance of Medical Secrecy

Medical workers and other persons who, as a result of the execution of their official duties, have learned information about persons who are infected with HIV or who are AIDS patients are required to keep that information a secret that is protected by law.

Article 12. AIDS as an Occupational Disease

The infecting of medical and pharmaceutical workers, as well as workers at scientific-research institutes and in the personal services sphere during the execution of their official and professional duties is considered to be an occupational disease.

Article 13. Insuring Medical and Other Workers Against Occupational Infection With HIV or AIDS

Medical and other workers the execution of whose official duties can lead to the contracting of AIDS as an occupational disease are subject to mandatory state insurance. In the event of infection, disease, disablement, or death as a result of AIDS, they are paid a lump-sum grant in aid in conformity with Republic of Kazakhstan Law entitled "The Protection of Labor."

The right to this grant in aid is also enjoyed by persons whose infection with HIV or AIDS occurred as a result of the improper execution of duties by medical workers or workers in the personal services sphere.

Article 14. Benefits Payable to Medical Workers Employed in the Prevention and Treatment of AIDS

Medical workers, employees and technical workers at centers to prevent and fight AIDS, other public health institutions and departments, and medical and scientific-research institutes who are directly engaged in preventive, diagnostic-and-treatment, and scientific research work with AIDS, have the right to work a reduced 6-hour work day, an additional paid vacation lasting 24 working days, and additional hazardous work pay in the amount of 60 percent of the established wages.

[Signed] N. Nazarbayev, president of the Republic of Kazakhstan
Almaty, House of Parliament 5 October 1994 No. 176-XIII

Decree on Enactment

954KO220B Almaty SOVETY KAZAKHSTANA in Russian 27 Oct 94 p 3

[Decree: "Decree of the Republic of Kazakhstan Supreme Soviet, `Procedure for Implementing Republic of Kazakhstan Law Entitled `Preventing AIDS'"]

[FBIS Translated Text] The Republic of Kazakhstan Supreme Soviet decrees:

- 1 . To implement Republic of Kazakhstan Law entitled "Preventing AIDS," effective the day of promulgation.
2. To establish that, pending the putting of the Republic of Kazakhstan legislation into conformity with the Law "Preventing AIDS," the acts of Republic of Kazakhstan legislation that are in effect are to be applied insofar as they do not contradict this Law.
3. The Republic of Kazakhstan Cabinet of Ministers is instructed, within a two-month period:
4. To put the Government's decisions into conformity with the Republic of Kazakhstan Law entitled "Preventing AIDS";
5. To guarantee the review and cancellation by Republic of Kazakhstan ministries and state committees of their normative acts that contradict the Republic of Kazakhstan Law entitled "Preventing AIDS";
6. To take urgent steps to reinforce the material technical base of the centers to prevent and fight AIDS;
7. To search for the necessary appropriations, including those in currency, for providing the centers to prevent and fight AIDS and blood transfusion stations with laboratory equipment;
8. To review the question of building a Republic center to prevent and fight AIDS.

[Signed] A. Kekilbayev, chairman of the Republic of Kazakhstan Supreme Soviet Almaty, House of Parliament 5 October 1994 No. 177-XIII

From:

<http://lnweb18.worldbank.org/ECA/ECSHD.nsf/ExtECADocByUnid/471E2C00273BE59485256C830059A254?Opendocument>

HIV/AIDS in Kazakhstan

- **Kazakhstan has more cases of HIV/AIDS than in its four neighboring countries.**
- **Registered cases have almost doubled each year since 2000.** The first case was reported in 1987. By mid-2003 the number of registered cases had grown to over 3,600. Sentinel surveillance conducted in 2003 has shown prevalence levels of 3.8% in injecting drug users and 4.6% in sex workers but there are no data concerning men who have sex with men.
- **All oblasts now have confirmed HIV+ cases.** The worst affected regions are Karaganda, Pavlodar and Kostanay, and Almaty city.
- **Young people, especially young men, have been disproportionately affected.** Over half the infected people are between 20-29 years, almost 90% are between 15-39 years, and almost 80% are men.
- **The most common mode of transmission is infected syringes and needles while injecting drugs.**
- **The potential for continued rapid spread among injecting drug users is acute.** There are 43 thousand registered drug users although the true number is probably five times greater.
- **The virus is concentrated among unemployed youth and prisoners.** Almost 75% of affected persons were unemployed at time of infection. The disease is also increasing rapidly among prisoners.

Government Response

The Government has recently accelerated its actions against HIV.

The National Program for 2001-2005 was approved in 2001. The program has three primary objectives:

- to prevent the virus from spreading into the general population from high-risk groups,
- to reduce the growth of the HIV-vulnerable groups, especially the youth,
- to ensure that at least 80% of HIV-infected persons are covered with medical and social programs to reduce their contagiousness.

Government Strategies

To meet these objectives, the following main strategies of response against HIV were developed:

- Improving the legal base in connection with the HIV/AIDS issue. This includes strengthening measures to ensure the constitutionally-guaranteed rights and freedoms of citizens, including those who engage in risky behaviors and HIV-infected persons;
- Improving national policy and practice to support relations between the Government, civil society, and groups which engage in risky behavior;
- Developing and implementing educational programs and establishing an information environment which promotes an understanding of the HIV/AIDS issue and the hazards of risky behavior;
- Improving the performance of health services, ensuring quality control of medical and hygienic goods, and monitoring and evaluation of the situation with respect to the HIV/AIDS epidemic;
- Strengthening the management, coordination and performance of preventive programs on HIV/AIDS.

Obstacles

The obstacles that have been identified by the Government, include:

- The prevalence of concurrent epidemics of injecting drug use and sexually transmitted infections,
- Not enough tolerance for activities of vulnerable segments of the population,
- Slow progress in changing the focus from clinical treatment, toward promotion of healthy lifestyles and prevention activities,
- Insufficient resources.

From: UNDP HIV/AIDS in Kazakhstan report

Response:

a. Government HIV/AIDS Control:

A Central Asia Conference on HIV/AIDS/STI Control was held from May 16-18, 2001 in Almaty by UNAIDS, UNICEF and USAID, which brought together various government officials from the region, donors and non-governmental organizations. The conferences, specifically government officials of Kazakhstan and other Central Asian countries, approved the Central Asia Declaration on HIV/AIDS. They undertook to expand the response to the HIV/AIDS epidemic and live up to the key political and social commitments regarding relevant priority action by implementing the national strategic HIV/AIDS control plans. These priorities included:

- HIV prevention among injecting drug users
- STI prevention and treatment
- Promotion of healthy lifestyles among youth

The above Declaration defined the commitment to respect the protection of human rights in all HIV control efforts being made. The signing of this Declaration is one more step forward to stemming the advance of HIV in the region.

A network of specialized public health institutions, i.e. AIDS control centers, has been established in Kazakhstan's health sector. This network includes the National AIDS Control Center, the central service provider, coordinating the Oblast (regional) and city (Almaty, Astana, Temirtau, Zhezkazgan) branch centers, which, together, form the entire public HIV/AIDS control service. As a rule, an AIDS control center includes a medical department performing tests for HIV and monitoring the HIV-infected, an epidemiological surveillance and HIC control department (data collection and evaluation, programming, etc.), a technical support department and a testing lab.

The AIDS centers interact and coordinate their activities with the services engaged in drug user rehabilitation, control of sexually transmitted infections, maternal and child health, blood transfusion, TB control, health promotion and other similar activities.

Health promotion, including drug use and unsafe sexual behavior prevention, is carried out by the public company in trust (Ministry of Health): the National Health Promotion Center and its ten regional branches. Its objectives include relevant policy development, coordination of other public institutions of respective competence, planning of educational campaigns, etc. In addition, the ministries of education and science; cultures; information and public consent; defense; and interior; transport and telecommunication s deal with HIV/AIDS.

The ministries of defense and the interior issued executive orders on mandatory HIV/AIDS primary preventive action by the agency-based medical services among servicemen, penitentiary workers and convicts. Also, since 2000, twelve penitentiaries in Karaganda Oblasts have been implementing a pilot project introducing untraditional HIV/AIDS prevention interventions (outreach work) for convicts, including training using video-tapes, delivery of educational material, peer education programmes, and condom and disinfectant supplies, which are common at both pretrial detention facilities and penitentiaries.

Since 2000, the Kazakhstan Strategic Planning Agency guided the development of the National AIDS Control Concept. This Concept prioritized for the first time high-risk groups for preventive action and defined six strategic areas (support for constitutional civil rights, outreach work, collaboration with non-governmental organizations, improvement of educational programs and medical services, including more access to treatment of sexually transmitted infections and the public AIDS control service reform).

The HIV/AIDS Control Coordinating Committee (government) is called upon to organize and arrange the relevance inter-sector effort. This Committee is made up of representatives of the government and the ministries of health, the interior, finance, education and science, culture, information and public consent and other institutions. The AIDS Center acts as the secretariat. This Committee was initially chaired by the Vice-Premier. At present, after certain reshuffles of the Health Affairs Agency, which, overall, reduces its importance and ability to influence non-health government agencies. At the regional (Oblast, city) level, similar committees coordinate HIV/AIDS control (also drug abuse and STIs in certain regions). In some regions, these committees exist only formally for the most part, while in others they are fairly efficient, e.g. Pavlodar Oblast and Shymkent.

In recent times, however, HIV/AIDS control has come on the agenda of the Presidential Administration, which organized an inter-sectoral meeting of vice-ministers and deputy heads of regional/municipal administration on October 23, 2001 in Temirtau. This meeting passed a resolution, which, inter alia, called for the reestablishment of the national and local HIV/AIDS control coordinating committees to be chaired by local government leaders.

b. Legislation:

There is a set of legislative and regulatory acts in Kazakhstan defining AIDS control areas, including the 1994 law *On AIDS Control*, and a package of relevant government resolutions. Aspects of HIV/AIDS control are reflected in the law *On Health Protection in Kazakhstan*, the National Health for People Programme, illicit drug trade control policy and other regulations. On September 14, 2001, the government approved the AIDS Control Programme for Kazakhstan for 2001-2005.

In recent years, there has been a pronounced trend toward rejection of the current punitive practices regarding risk groups, a tendency which is being codified into law. The new 1996 Criminal Code of Kazakhstan is free of the clauses punishing voluntary homosexual relationships. Commercial sex is no longer regarded by the 2001 Administrative Code as punishable. The law prosecutes organized commercial sex. Grounds for sex workers detainment, which are fairly often used in practice, may be unregistered residence, lack of ID or suspected sexually transmitted infections. The compulsory actions with respect to sex workers comprise testing for and treatment of HIV and STIs.

Therefore, the existing legal framework still does not facilitate HIV/AIDS prevention among groups with behavioral health-risk deviations, and encourages their members to avoid contact with government institutions.

The approval of the new National AIDS Control Programme for 2001-2005 confirms the awareness by the government of the large scale of the HIV/AIDS problem and the

ineffectiveness of the current action. Furthermore, the priority goal of this Programme is HIV control among IDUs, while the related objectives are non-punitive. The Programme identifies three respective goals in total:

Goal 1: Stabilize the HIV epidemic at its concentrated stage while precluding transition of it to the generalized stage. As planned, HIV incidence among injecting drug users should not exceed 5 per cent by 2005, with not more than 20 per cent to be infected by sexual transmission.

Goal 2: Reduce the replenishment of HIV-risk groups with new young members; decrease the rate of unsafe sexual behavior among youth

Goal 3: ensure coverage of a minimum of 80 per cent of people living with HIC by medical and social support programmes, downscaling their infecting potential.

c. Services:

Antiretroviral therapy is not provided, as a rule, to the HIV-infected at the expense of the State budget. Only seventeen persons, or less than 10 per cent of those in need of it, received symptom-based therapy. Pregnant women with HIV are not covered in full with prevention services, although certain efforts are being made to that end. Thus, the viral load in the HIV-infected on file remains high, which predetermines their high infection rate.

The HIV prevention practices used so far do not differ essentially from the traditional techniques used for other communicable diseases and was aimed at detecting as many people living with HIV as possible, tracking back the transmission chain, identifying the contacts and cutting the infection transmission by intervening in the epidemiological process. Once learning about his/her HIV-positive status, a person may be taken to criminal court for his/her acts, which may potentially result in infecting other people. Convicts with HIC are segregated strictly from other convicts. Thus, HIV imposes an additional burden of responsibility on infected people. This is why there are not motivated to be informed of their respective status.

These practices are being revised as required by the government resolution of September 14, 2001 and considering relevant international experience and local expertise in HIV/AIDS control gained in the pilot projects implementation with the assistance provided by the UN Theme Group on HIV/AIDS.

Currently, thirteen of the sixteen regions of Kazakhstan are carrying out outreach work among injecting drug users. The outreach work envisions the provision of information, educational programmes, counseling, syringe and needle exchange, distribution of disinfectants and condoms, as well as access to free anonymous treatment for most common sexually transmitted infections. There are 60 centers for drug addicts all in all in the republic (sixteen in Pavlodar Oblast, eleven in South Kazakhstan and five in Karaganda Oblast and North Kazakhstan). 800,000 syringes and 900,000 condoms have been distributed among IDUs in the last two years. The outreach coverage of IDUs, however, does not exceed 5 per cent all over Kazakhstan (the indirect coverage is, obviously, broader, but needs to be identified specifically).

Because of budget constraints, local administration are unable to pay compensation to social workers (e.g. in Temirtau, this job is referred to public works for the unemployed) and bonuses to volunteers and procure syringes, needles, disinfectants, condoms and medications for ambulatory treatment of patients with STIs.

Thus, there are circumstances hindering the transition of such programmes to financing by the central and local budgets, namely:

- Low awareness of the HIV/AIDS problem by politicians

- Current accounting arrangements for supplies does not cover syringes or condoms
- Lack of volunteer compensation from the State budget if current rules are followed

Psychosocial counseling offices have been opened at certain AIDS centers (e.g. in Almaty), employing medical psychologists. Other specially trained health workers, the HIV-infected and risk group members also are drawn upon for this work. Hotlines have been established at the majority of AIDS centers. Free counseling programmes are offered to people living with HIV who are invited to participate in free condom, syringe and needle distribution programmes. However, motivation of the HIV infected remains low.

d. Government benefits:

As required by the law *On AIDS Prevention*, residents of Kazakhstan and persons without permanent residency, if infected with HIV, are entitled to free drugs, outpatient and inpatient medical care provided by public health institutions, as well as cost reimbursement for travel to and health institution and back at the expense of the referral care provider of residence. The HIV-infected and AIDS patients may not be laid off, or refused a job or admission to a children's pre-school facility and school, or subjected to an infringement of their other rights and lawful interests including the right to housing, as well as other rights of this kin and relatives. However, people living with HIV are stigmatized. Current common practice segregates and discriminates their relatives, too.

Antiretroviral therapy is not affordable due to its high cost. No items are provided for that cost in the State or local budgets. An exception is given to clinical trials, but this may not be deemed a medical service.

b. DONOR ORGANIZATIONS

XII: From www.who.int/hiv/facts/focus/en/index1.html

WHO "3 by 5" focus countries:

Table 1:

High burden country	WHO focus country	Estimated # of people living with HIV/AIDS (0-49 years), end 2003	Estimated adult prevalence of HIV/AIDS (15-49 years), end 2003	Estimated annual deaths from AIDS (0-49 years), 2003	Estimated total number needing antiretroviral therapy in 2005
	Kazakhstan	16 500	0.20%	<200	48
	Kyrgyzstan	3 900	0.10%	<200	48
	Tajikistan	<200	>0.1%	N/A	N/A
	Uzbekistan	11 000	0.10%	<500	770

Table 2:

WHO focus country	"3 by 5" treatment target (50% of estimated need)	Antiretroviral therapy target declared by country for end 2005	Estimated # of people receiving antiretroviral therapy (15-49 years) June 2004	Antiretroviral therapy coverage
Kazakhstan	230	Not declared	49	10.70%
Kyrgyzstan	24	Not declared	0	0.00%

Tajikistan	N/A	Not declared	0	N/A
Uzbekistan	385	Not declared	0	0.00%

*XVI : From **UN Millennium Development Goals** in **Kazakhstan 2002 Report**, p. 46*
Target 7 : the spread of HIV/AIDS – have stopped by 2015, and begun to reverse

Compared with many other countries in the world, Kazakhstan has a relatively low prevalence of HIV. However, there is no reason for complacency, especially when one looks at the rate at which infection has been spreading since the first HIV case was registered in 1987.

By the beginning of the year 2000, **there were registered cases in all oblasts of Kazakhstan**. In total, 3,093 HIV-positive persons were registered nationwide by 1 Oct 2002. However, the real number is estimated to be closer to 23,000 cases. More than one third of the registered cases are in **Karaganda** oblast.

In 85% registered cases, HIV transmission occurred among **injecting drug users** through the sharing of infected injecting equipment. In addition, there has been a growing trend of **sexual transmission of HIV** : in 2001 it accounted for 5.3% of HIV transmissions and in the first eight months of 2002 – 14.8%. These figures are in line with the dramatic spread of sexually transmitted infections in general over the last decade, indicating a high level of **unprotected sex** within the general population, which can facilitate the spread of HIV.

The 1999 Demographic and Health Survey showed that there was almost universal **awareness of the existence of HIV/AIDS** among the population in the age group 15-59. However, only about 70% of men and about 37% of women were able to cite **condom use** as one of the ways to protect themselves from HIV infection, and the actual use of condoms was even lower 18% for men and 4% for women.

Which **groups** are most **vulnerable** to HIV infection ?

About 85% of registered cases are found among injecting drug users (**IDU**), and a 2002 sentinel surveillance conducted in 8 oblasts revealed that the HIV-prevalence among IDU is on average close to 3-4%. This corresponds to data on HIV prevalence among IDU tested in prison in 2001, which showed a prevalence of 3%.

Official number of injecting drug users in Kazakhstan is 46,000 but in fact is estimated to be around 250,000. Matching these data with the HIV prevalence data among IDU, it can be assumed that there are 7,500-10,000 HIV positive IDU in Kazakhstan.

The largest HIV/AIDS group is the **young** (15-29 of age), who constitute 69% of all cases. It is estimated that the relative risk of HIV infection among youth aged 18-23 is 2.5 times higher than among the older population.

The number of female street **sex workers** in the towns of Kazakhstan exceeds 20,000. They are estimated to have in total more than 1.5 million sexual contracts annually, and condom use among them does not exceed 20%. The reasons for this low figure can be the lack of awareness about HIV ; lack of financial means to buy condoms ; and frequent refusal by clients, who often pay higher price to have unprotected sex. Examination of sex workers in different cities revealed that no less than 80% have at least one sexually transmitted infection and that 10 to 30% inject drugs.

By the end of 2000, 30 out of 10,000 **imprisoned** people had HIV. This rate is five times higher than the prevalence of HIV in the total population. In 2001, while people in custody made up less than 1% of the population, 25% of all registered HIV positive people were from the prison population. Contributing factors to this high number are the compulsory testing of all prisoners

upon imprisonments and the high amount of injecting drug users among inmates. Unprotected homosexual relations in prison are also widespread.

There is **no available data** on the HIV prevalence rate among **men who have sex with other men**, but the risk of HIV infection is estimated to be very high among this group, especially for those who have unprotected sex with multiple partners.

As of October 2002, there were **39 children born to HIV-positive mothers**, but only 4 children were diagnosed HIV-positive. Only HIV-positive pregnant women receive anti-retroviral therapy.

What are the **main challenges** ?

It is believed that most people with HIV are unaware of their HIV-positive status. Currently, the estimated number of HIV-infected persons is approximately 23,000.

Until 2002, the testing policy in Kazakhstan was largely on a compulsory basis. The proportion of anonymous tests for HIV in 2000 was only 1.5%, in 2001 – 2.3% of all tests. The main bulk of resources allocated for fighting HIV/AIDS has been used mainly for detecting HIV, instead of for preventive efforts.

The widespread stigma and discrimination that HIV-infected persons and members of vulnerable groups often experience, both from officials and general society, render people reluctant to come forward to seek prevention and information services.

So far, there had been a general lack of measures promoting safer conduct among vulnerable groups and raising awareness among the general public, especially the youth. This can be seen as a serious omission that needs to be corrected. Since vulnerable groups are not closed communities, if the epidemic is not effectively dealt with within these groups, it will easily spread to the general population.

What is being done in Kazakhstan to fight HIV/AIDS ?

As soon as AIDS emerged as a problem in Europe, from 1987 a network of state institutions dealing with AIDS control has been initiated throughout Kazakhstan. The main activities of these centers include **coordination of government, private and non-government sectors' HIV prevention activities, preventive work within vulnerable population groups and surveillance**. Since 1996, **the Multi-Sectoral Coordination Committee on HIV/AIDS Prevention has been operational under the Prime Minister's office, chaired by the Vice Prime Minister**. The committee comprises key ministries and agencies, non-governmental organizations, people living with HIV/AIDS and representatives of international organizations.

The Law on AIDS Prevention of 1994 guarantees rights of people with HIV and of representatives of vulnerable groups and stipulates that the government is to provide free treatment and social protection to HIV-infected people, to supply the population with HIV/AIDS information and to perform required prevention interventions.

Among measures directed against drug addiction and drug dealing was the adoption **of the Strategy of Fight against Drug Addiction and Drug Dealing in Kazakhstan** for 2001-2005. The Programme on Treatment and Prevention of Drug Addiction for 2001-2005 is designed to improve the system of prevention and medical treatment of drug addiction in the country. It is hoped that the activities of this programme will have a positive effect on the HIV situation in the country.

The Government of Kazakhstan with the support of UNAIDS has developed the Programme on Counteracting the AIDS Epidemic for 2001-2005. The main objective of the programme is the creation of an effective system of HIV/AIDS prevention in the country. It is envisaged this will occur through prevention activities among vulnerable groups, limiting the

spread of HIV to the general population ; reducing the number of young people joining vulnerable groups ; and provision of medical and social programs to HIV-infected people.

Seven ministries, with the support of UNAIDS, prepared their sectoral programmes on HIV/AIDS prevention. These include the Ministries of Education, Justice, Interior, Health, Defense, Labour and Culture&Information.

UNDP and UNAIDS actively assist the Government in preventing the spread of HIV/AIDS in Kazakhstan through a joint project on Healthy Lifestyle Development and a number of sub-projects on HIV/AIDS prevention among vulnerable groups.

The collaboration of the Government with the UN Theme Group on HIV/AIDS and other donors has resulted in the development of the above-mentioned rational strategic programme, as well as the development of sectoral program on HIV/AIDS for the military, penitentiary and educational sectors. The activities targeting vulnerable groups include information, counseling, provision of condoms, disinfectants and sterile injecting equipment for drug users, treatment of sexually transmitted infections and access to voluntary anonymous HIV testing.

The Rules of medical examination for exposure of HIV infection adopted in 2002 abolish the earlier compulsory testing of selected population groups and contact-tracing, and introduced voluntary testing with pre-and post-test counseling. All test results are now confidential and are used only for surveillance. There is still compulsory testing of donors of blood and other biological fluids and tissues.

XVII : From <http://www.undp.kz/projects/files/117-19266.htm>

For project: KAZ/02/006 "Support to the Programme on Counteracting the AIDS Epidemic in the Republic of Kazakhstan for 2001-2005".

Period covered: April 2003 – December 2003

Project Performance - Contribution to the SRF Goals

SRF Goal: Economic and social policies and strategies focused on the reduction of poverty

Outcomes

- a) National development plan, poverty reduction strategies and budgetary allocation address the impact of HIV/AIDS on development and poverty eradication.
- b) Institutional capacity built to plan and implement multi-sectoral strategies at both national and sub-national levels to limit the spread of HIV/AIDS and mitigate its social and economic impact on poor people and women.

Update on Outcomes:

In the past years the political movement to tackle AIDS has grown. The national policy regarding the HIV/ AIDS issue already exists in the Republic of Kazakhstan. For example: the Government of the Republic of Kazakhstan with support from UN HIV/AIDS Theme Group under the leadership of UNAIDS, UNDP has already developed the Programme on Counteracting the AIDS Epidemic in the Republic of Kazakhstan for 2001-2005, it was issued and approved by the Resolution of the Government of RK

№ 1207, as of September 14, 2001. Moreover, under the umbrella of the Programme several line Ministries elaborated their own strategic programmes in response to HIV/AIDS epidemic (Ministry of Health, Ministry of Justice, Ministry of Internal Affairs, Ministry of Defence, Ministry of Education, Interior Troops of Interior Ministry).

In 2003 the UNDP, under the leadership of UNAIDS has been provided assistance to the national authorities in developing the Programmes on counteracting the HIV/AIDS of Ministry of Labor and Social Protection and Ministry of Culture, Informational and Public Concord.

The Programme of Ministry of Culture, Informational and Public Concord of the Republic of Kazakhstan on HIV/AIDS Response in the Republic of Kazakhstan for 2002-2005 was issued and approved by the Resolution № 74, as of 23 March, 2003. The Strategic Programme on

Counteracting HIV epidemic and providing of social support to people living with HIV for 2003-2005 was issued and approved by the Resolution № 55-п, as of 31 March, 2003.

Progress Outputs:

SRF Sub Goal: Human and income poverty addressed in national policy frameworks

1. Reform of policy and legislation in line with international guidelines and strengthening of national coordination mechanisms
2. Establishment of sustainable support and harm reduction mechanism targeting vulnerable groups.

Update on Outputs:

Strategic Area of Support: Comprehensive strategies to prevent the spread and mitigate the impact of HIV/AIDS

In order to achieve the objectives laid down in the Programme on Counteracting the AIDS Epidemic in the Republic of Kazakhstan for 2001-2005, the Government reformed the Coordination Committee. This Committee mandated to oversee and coordinate the implementation of the Programme, the work of the Coordination Committee supported by technical assistance from UNAIDS and UN Joint Project on the regular basis.

In 2002-2003 medical specialists of 14 regional AIDS Centers were trained on principals of the second generation sentinel surveillance during epidemiological surveillance conducted in 14 regions of the Republic of Kazakhstan. A series of capacity building seminars on pre- and post-test counseling was conducted for healthcare specialists. During these seminars 40 participants, including specialists from regional AIDS Centers of Aktau and Atyrau cities, doctors of narcological and STI dispensaries, were trained on counseling techniques.

Access to comprehensive care and treatment for HIV/AIDS is very important. Moreover, access to care is a basic necessity in programming in every setting-from the wealthiest to the poorest-and needs to encompass the full continuum, including home-based and palliative care, treatment of opportunistic infections and antiretroviral therapy. Therefore a Central Asian conference on adaptation of WHO protocols on antiretroviral and palliative therapy of HIV/AIDS was organized in November 2003 with the assistance of UNDP project staff and with technical and financial support from UNAIDS. At the present, the National protocol on antiretroviral therapy of HIV/AIDS in the Republic of Kazakhstan is being ratified.

Assessment survey of PLWHA needs was conducted in Temirtau/ Kazakhstan in February 2003 with the technical and financial support from UNDP and Joint UN Programme on HIV/AIDS (UNAIDS). A report was prepared by an international consultant Mr. Zhovtyak/ Chairman of All-Ukrainian net of people, living with HIV, with the assistance of Mr. Amanzholov/ President of "Shapagat" Public Charity Fund and with the technical support from UNAIDS. Results of the conducted survey were presented to the Republican AIDS Center, the regional AIDS Center (Temirtau city) and regional administration.

The Project provided support for establishment of 2 non-governmental organizations, working with people, living with HIV/AIDS, in Almaty and Pavlodar cities. At the present, the "Begin a New Life" NGO together with the Republican AIDS Center are giving training to volunteers of these NGOs on building capacity and mobilizing resources.

Within collaboration with the Fund "Soros-Kazakhstan" pilot centers for methadone substitution therapy were defined in Karaganda and Pavlodar cities. The UNDP Project financed a study tour to Bishkek city/ Kyrgystan Republic for 10 specialists of the 2 pilot centers for methadone substitution therapy.

Within the Pilot Project in the Armed Forces of RK, training was conducted for educational officers of the Armed Forces of RK and cadets of military academies. As a result of the training, 30 participants were prepared as trainers on HIV/AIDS prevention, stigma and discrimination issues. Besides, a 3-day training seminar on STI syndromic case management was organized

for medical officers. During the seminar 30 medical officers from different regions of Kazakhstan were trained.

Training session on HIV/AIDS incorporated in cadet curriculum in 4 schools (Almaty, Aktobe, Aktau, Shuchinsk).

During realization of the project on support of vulnerable groups of population (IDU, CSW, MSM, PLWHA) and within the framework of harm reduction activities, an assessment survey was conducted by an international consultant in the following cities:

1. among IDU – in Aktau, Atyrau, Uralsk and Taldykorgan cities;
2. among CSW – in Almaty, Aktobe, Taldykorgan and Aktau cities;
3. among MSM – in Astana, Shymkent, Pavlodar and Aktobe cities;
4. among PLWHA – in Temirtau city.

Results of the surveys and recommendations from the international consultants were presented to the Republican and regional AIDS Centers for improvement of the work in these regions.

National training seminar aimed at improvement of communication skills for HIV prevention among sex workers was held on June 22-26, 2003 in Shymkent city. The training covered 20 participants, including experts from 14 regional AIDS Centers, NGO and volunteers, working with vulnerable groups of population.

During 2000-2003 sub-managers of the Pilot Project “HIV/AIDS prevention in penitentiary system of RK” conducted about 1000 training seminars on “peer-to-peer” education for staff, doctors of the medical service and volunteer convicts at penitentiary institutions.

The Project supported a competition for the best self-made placate on HIV/AIDS, stigma and discrimination theme in penitentiary institutions in 8 regions of Kazakhstan (Astana, Almaty, Karaganda, Pavlodar, Petropavlovsk, Shymkent, Taraz, Ust-kamenogorsk). The best placates made by convicts will be used for illustration of informational materials which will be used in penitentiary system.

Reasons if Progress below Target:

Unfortunately, factors driving the epidemic in the Republic of Kazakhstan are still too seldom analyzed systematically. As a result, HIV/AIDS responses rarely rest on a clear understanding of infection patterns or the behaviour and needs of particular high-risk group. There is low level of trustship between vulnerable group of population (such as injecting drug users, sex workers, men who have sex with men, people, living with HIV/AIDS) from one hand and AIDS Center from another hand. Steps to be undertaken: The Project continues seeking possible partners among NGOs and try to establish network between NGOs-vulnerable groups- AIDS centers. Also, Project provides technical and financial supports to NGOs are working with vulnerable group of population.

It is obviously that the mismatch between need and findings is one of the biggest obstacles to controlling the epidemic. Steps to be undertaken: with support and under leadership of UNAIDS Almaty office, the Government of the Republic of Kazakhstan/ Republican AIDS Center has received from the Global Fund to fight AIDS, Tuberculosis and Malaria the financial support in amount of \$22 million 360 thousand US to reducing the impact of the HIV/AIDS epidemic in Kazakhstan.

While great strides have been made in strategic planning regarding HIV/ AIDS issue such as Governmental Statement proclaims confidentiality of HIV testing and refusal from registration of people with HIV/ AIDS in 2003 was approved a new version of the Law regarding the HIV infection. According to the new law a personal information about people with HIV positive status is a subject to reporting from the Republican and Local AIDS centers to the Ministry of Health, regional Health departments and sanitary epidemiological stations. Steps to be undertaken: focusing on legislation and regulation issues regarding HIV/AIDS.

There is a lack of national experts specializing on HIV/AIDS issue particularly on Injecting Drug Users; Sex workers; MSM; people, living with HIV/ AIDS. This affects the quality of research, analysis and recommendations.

Update on Partnership Strategies:

1. The project continues to provide support to the Programme on Counteracting the AIDS Epidemic in the Republic of Kazakhstan for 2001-2005. The main objectives of the Programme will be achieved through:
 - Multi-sectoral approach, managed and coordinated by the Coordination Committee;
 - Legislation and policy reform;
 - Partnerships and support structures involving the public sector, civil society and vulnerable groups;
 - Information, education and communication on healthy life styles and safe behavior targeting all young people, in-school and out of school, as well as young people in the armed forces.
 - Provisions of appropriate medical services and care for vulnerable groups and for care.
2. At the national level the project continue working with the Ministry of Health, in particular with Republican AIDS Center, which coordinates HIV/ AIDS prevention activities in the country.
3. In framework of the partnership and collaboration with governments Project has establish a good working relationship with Ministry of Justice, Ministry of Internal Affairs. Impact on HIV/AIDS prevention in penitentiary system was provided though extending pilot initiatives among incarcerated people in 8 regions of the Republic of Kazakhstan.
4. The representatives of the Ministry of Defence, also acted as counterparts in the project implementation.

As a result of the Pilot Project implementation a new coherent HIV prevention system established in the Armed Forces of Kazakhstan, based mainly on the activities targeted at reduction of HIV cases transmitted through unsafe behavior.

Recommendations and Proposed Action:

Public health policy-makers have to realize that the social transformations resulting from political change require changes in public health policies and there has been a shift from the curative medical approach to a preventive one focusing on the individual and promoting behavioural change. Also should be accepted that the response to the threat of HIV/AIDS has to be multi-sectoral, involving not only line ministries (health, justice, education, etc.) but also representatives from civil society, NGOs and the community at large.

An important role for Government is to clear the way so all sectors of society can contribute to the response. Political leadership of Government is essential to an effective response. Political leadership and action are clearly needed to set the direction for a national response and initiative the development of policies the determine the strategy for managing the epidemic therefore UNDP provides support to the Government of Kazakhstan in implementation of the "Programme on Counteracting the AIDS epidemic in the Republic of Kazakhstan for 2001-2005".

Project Performance – Implementation Issues

1. A national response based on strategic planning and multisectoral approaches is not a magic solution to all possible challenges. That is why it is very important to use non-traditional interventions such IEC strategies, promotion of wider use of condoms, supply of medication addressed to vulnerable group, particularly provision of STI treatment, condoms supply for commercial sex workers, provide disinfectants and condoms to the inmates

population in the penitentiary system of RK, inculcation of syringes and needles exchange programs for injecting drug users). Below are the geographical location of the pilot sites throughout of the country:

- ·For Injecting Drug Users in Almaty, Astana, Pavlodar, Petropavlovsk, Shymkent, Taraz, Ust-Kamenogorsk, Karaganda, Temirtau;
 - ·For commercial sex workers in Pavlodar, Shymkent;
 - ·For MSM in Almaty, karaganda
 - ·For prisoners in penitentiary institutions in 8 regions of RK (Almaty, Astana, Pavlodar, Petropavlovsk, Shymkent, Taraz, Ust-Kamenogorsk);
 - ·For people living with HIV/AIDS in Temirtau city of Karaganda oblast.
2. More and more, people living with HIV/AIDS are being seen in prevention and care. The GIPA principle (Greater Involvement of People living with HIV/ AIDS), as set out in the 1994 Paris Declaration, recognizes that people who live with the disease add immeasurable value and impetus to the response. They help personalize the epidemic and bring home the wider public; political and civil society institutions and policy-makers the realization that HIV is everyone's problem. That is why the Project provided support for establishment of 2 non-governmental organizations, working with people, living with HIV/AIDS, in Almaty and Pavlodar cities. At the present, the "Begin a New Life" NGO together with the Republican AIDS Center are giving training to volunteers of these NGOs on building capacity and mobilizing resources.

Technical assistance was provided to the national authorities in developing the Programmes on counteracting the HIV/AIDS of Ministry of Labor and Social Protection and Ministry of Culture, Informational and Public Concord.

XVIII: <http://www.undp.kz/projects/files/117-24635.htm>

For project: KAZ 13227 "Support to the Programme on Counteracting the AIDS Epidemic in the Republic of Kazakhstan for 2001-2005".

Period covered: December 2003-June 2004

Outcomes:

SRF Goal: Economic and social policies and strategies focused on the reduction of poverty
Institutional capacity built to plan and implement multi-sectoral strategies at both national and sub-national levels to limit the spread of HIV/AIDS and mitigate its social and economic impact on poor people and women.

Update on Outcomes: Under the current National Programme on Counteracting the AIDS Epidemic for 2001-2005, the Ministry of Health adopted Decree # 295 on March 29, 2004 regarding the friendly clinics on STI syndrome case management.

National protocol of anti-retroviral therapy of HIV/AIDS was developed and approved.

The government has revised its policies regarding compulsory testing and isolation of HIV-positive inmates. New policies aimed at extensive education, voluntary counseling and testing, integration of HIV-positive prisoners, and confidentiality regarding HIV status, are implemented. The Government has proclaimed anonymity and confidentiality of HIV testing, refusal from registration of people with HIV/ AIDS and provision of pre- and post-test counseling.

Progress Outputs:

SRF Sub Goal: Human and income poverty addressed in national policy frameworks

1. National legislation enacted and revised to eliminate discrimination and ensure guarantee of human rights and freedoms of all vulnerable groups, particularly PLWHA
2. Technical working groups strengthened and trained to provide technical assistance to the National Coordination Committee
3. National Protocols of antiretroviral HIV and palliative treatment developed

4. Sustainable mechanisms put in place for care and support of PLWHA
5. Harm reduction assistance provided to IDUs, CSWs, MSMs in major cities of Kazakhstan. Existing pilot sites consolidated and improved. Programme is extended to additional sites following rapid needs assessment
6. Two pilot centers established for methadone substitution therapy
7. Prevention programme on HIV/AIDS, STI and IDU for the Army and internal security troops established

Update on Outputs:

Strategic Area of Support: Comprehensive strategies to prevent the spread and mitigate the impact of HIV/AIDS

As a result of collaboration with the Republican AIDS Center, the order on “The establishment of friendly clinics for STI treatment” for the vulnerable groups of the population was issued. The order has been ratified by the Ministry of Health of Kazakhstan.

Amendments to the current law on AIDS were developed with the technical support from UNAIDS and UNDP. The amendments were discussed at the Parliament’s hearing in June 2004 in Astana. The major amendments were reflected in the new draft law on AIDS.

National protocol on anti-retroviral therapy for HIV/AIDS was developed and approved in accordance with WHO recommendations. The protocol was developed during the seminar, organized in collaboration with the Ministry of Health and the Republican AIDS Center in February 2004 with the technical support from UNDP and UNAIDS.

1. Medical specialists of 14 regional AIDS Centers were trained on principals of home-based and palliative care, treatment of opportunistic infections and antiretroviral therapy. During the workshop, 40 participants including representatives from Ministry of Health, Republican AIDS center, regional centers were trained. The workshop was organized jointly by the Ministry of Health, UNAIDS and UNDP.
2. In working with PLWHA, the project focused on the prevention aspects, i.e. 52 thousand condoms were distributed at Temirtau city/ Karaganda oblast among PLWH, sex-workers and injecting drug users. Within the regional programme on HIV/AIDS prevention, the administration of Temirtau provides trust points with syringes and needles for their further distribution among injecting drug users. Apart from this, the AIDS Center in Temirtau develops and publishes thematic informational and educational materials targeted at the vulnerable groups of the population.
3. Technical and organizational support was provided to a newly fledged non-governmental organization of PLWHA in Karaganda city, where the first outbreak of the epidemics took place.

I. Penitentiary institutions

Monitoring visits of representatives of the AIDS Foundation East-West, Ministry of Justice, AIDS centers were organized to prisons in the following regions:

- Astana;
- Pavlodar;
- Shymkent ;
- Taraz.

Survey was conducted during the monitoring visits and its findings and recommendations were presented to the Ministry of Health, Republican AIDS Center, and Ministry of Justice.

The project supplied the prisons with condoms and disinfectants. Thus, almost 450 thousand condoms were delivered to the inmates in 8 regions of Kazakhstan.

A study tour to the best practice site - Karaganda region – was conducted for specialists of penitentiary institutions and AIDS centers from 5 regions to replicate the project experience in 3 new regions of the country, namely Aktau, Atyrau, Uralsk

2. Commercial Sex Workers (CSW)

Given poor availability of medicines and limited access to diagnosis for this particular group, the Project provided medicines for syndromic care management in two regions of Kazakhstan (STI institution in Pavlodar city, NGO “Senim” in Shymkent city), as well as 2 thousand condoms for distribution among CSW’s in Karaganda city.

3. Men having sex with men (MSM)

In the environment where MSM are hard to identify and reach with prevention services, the Project provides support to the NGOs working with MSM community. Through the NGOs, more than 5 thousand condoms were distributed to MSM in Astana city, the same number in Karaganda city, and more than 21.5 thousand at Almaty city for distribution among MSM and CSW among MSM. Behavioural surveillance was conducted jointly with the State Medical University among MSM community, its findings were published in a book, and distributed among representatives of MSM, NGOs, medical staff, etc.

Two sites were identified for the pilot project on the methadone substitution therapy – Pavlodar and Karaganda. Premises for project activities were allocated in both regions. With financial support from UNDP Project, 10 medical specialists from both regions received training at the Republican Narcological Center in Bishkek Kyrgyzstan. However, methadone has not been registered in Kazakhstan yet. Correspondingly, there is no permission for importing the methadone. In June 2004, a meeting between representatives of the Ministry of Health and Committee against Drugs of the Ministry of Justice took place. A detailed strategy on overcoming the current situation was developed.

Sentinel and behavioural surveillance was been conducted among uniformed services as a joint effort of the Project and Kazakh National Medical University. The survey findings were used for the defence sub-project activities evaluation. An international consultant conducted the evaluation and prepared a report on its findings.

The evaluation report is to be presented to the Ministry of Defence in the upcoming workshop to ensure an improved harm reduction programme in that sector. Within the collaboration between the UNDP Project and the Ministry of Defence, the Project Management Team has been formed. The Programme of Counteraction to HIV/AIDS Epidemic in the Armed Forces for 2002-2005 was developed and approved. As a result of a series of trainings conducted among military personnel, representatives of military educational institutions, educational and medical officers were trained on the following issues:

- 32 participants were trained as would-be as trainers on HIV/AIDS prevention issues;
- 30 medical officers from different regions were trained on the STI Syndromic approach;
- 142 educational officers were trained on HIV/AIDS issues.

IEC materials on HIV/AIDS were developed, tested, produced and distributed among different categories of the Armed Forces.

Cooperation between the Army garrisons and regional AIDS centers were established on provision of VCT services to military personnel.

Reasons if Progress below Target:

In the Republic of Kazakhstan realization of the project on methadone substitution therapy is suspended because methadone has not been registered yet and it is not permitted for import.

Steps to be undertaken: Collaboration with the Ministry of Health for acceleration of the registration process of methadone in RK, and collaboration with the Committee against Drugs of the Ministry of Justice on issuing a permission for importing methadone into RK.

The level of trust between the vulnerable groups (PLWHA, CSW, MSM) on the one hand and AIDS Centers on the other hand is still low. **Steps to be undertaken:** The Project should take consistent efforts in establishing partnerships with and among target group NGOs and AIDS centers with the goal of developing an efficient network. Thus, a National Forum with participation of the NGOs representatives, AIDS centers, Government and international organizations is scheduled for September 2004.

There are no national experts on HIV/AIDS, in particular on issues related to PLWHA, IDU's, CSW's and MSM. As a result locally commissioned research and recommendations are not up to the mark. **Steps to be undertaken:** The staff of the National AIDS Center should be continuously involved in the missions of international consultants in order to learn the principles and methods of rapid assessment. Besides, representatives of the Republican and regional AIDS Centers are actively involved into seminars, conducted by the UNDP Project as well as other international organizations.

Update on Partnership Strategies:

At the national level, the project continues building partnerships with the Ministry of Health, in particular with Republican AIDS Center, which coordinates HIV/ AIDS prevention activities in the country.

In the framework of collaboration with the Government, the Project established good working relations with the Ministries of Justice and Internal Affairs. As the project outcome, the pilot initiatives among the prison inmates were extended to cover 11 regions of the country.

Partnership was established with the Ministry of Defence that acted as a counterpart in the project implementation. As a result of the Pilot Project implementation a new HIV prevention system was established in the Armed Forces of Kazakhstan, based mainly on the activities targeting the reduction of HIV cases transmitted through unsafe behavior.

Recommendations and Proposed Action:

A national response based on strategic planning and multisectoral approaches is not a magic solution to all possible challenges. That is the reason why it is very important to use non-traditional interventions such IEC strategies, promotion of condoms, supply of medication to vulnerable group, in particular for STI treatment, condoms supply for commercial sex workers, disinfectants and condoms to the inmates in the penitentiary system inculcation of syringes and needles exchange programs for injecting drug users. It is recommended that the local governments paid attention to the HIV/AIDS prevention among vulnerable groups in their respective regions, supported the outreach carried out by volunteers, provided technical and financial support to trust points for implementation of syringe exchange programmes, and supported the friendly clinics. It is recommended to ratify a decree on provision of support to non-governmental organization by the governments and law-enforcement bodies in each region to ensure a better access by the vulnerable groups to the harm reduction programmes.

The government's role is very important, since its political leaderships essential to set the direction for a national response and initiate the development of policies to cope with the epidemic.

Project Performance – Implementation Issues

1. In Kazakhstan the national policy on HIV/AIDS prevention has been formed. Under the umbrella of the National "Programme on Counteracting the AIDS epidemic in the Republic of Kazakhstan for 2001-2005" several ministries developed sectoral programmes of their own. A Coordination Committee on HIV/AIDS prevention was formed, consisting of representatives from different ministries and agencies, international organizations and the vulnerable groups of the population. It is necessary to conduct explanatory work with national counterparts, including the Ministries of Health and Justice. Thus, up to this date a practical decision on methadone substitution therapy projects in Pavlodar and Karaganda has not been made due to bureaucratic obstacles created by those Ministries.

2. Regional administration in different regions of Kazakhstan do not always support harm reduction programmes. The outreach carried out by volunteers from non-governmental organizations is often discredited by representatives of law-enforcement bodies. To create a mechanism for collaboration, it is necessary to establish teamwork by the regional administration, law-enforcement organs, AIDS centers and non-governmental organizations aimed at effective realization of HIV/AIDS prevention among the vulnerable groups of the population.

XIX: From: [http://www.unesco.kz/index.php?sector=®ion=&lang=&newsid=788&announce=Training course "Envisaging supportive legal and public environment to effective HIV/AIDS counteracting"](http://www.unesco.kz/index.php?sector=®ion=&lang=&newsid=788&announce=Training+course+\).

15 March 2004, Central Asia, Education.

Course is going in framework of activity: Raising awareness and promoting change in attitudes and behaviors, within the project called "Strengthening Technical Capacities of Policy Makers, Professionals and NGOs from Central Asian Countries to Implement key activities on HIV/AIDS Combat through series of workshops" and under UNAIDS PAF funds, UNESCO Almaty office in cooperation with UNAIDS regional office.

Objective: To build regional partnership and common understanding of the policies and practices aimed at defending human rights and decrease vulnerability as an essential tool to defeat the epidemic.

Key items of the agenda: How can legislation and regulations support or conflict with the goal of slowing down the HIV/AIDS epidemic

Participants: Delegations from 5 Central Asian countries consist of Representatives of governmental justice, Interior, Education and health sectors training institutions, journalists and local NGOs.

From: [http://www.unesco.kz/index.php?sector=®ion=&lang=&newsid=789&announce=bRegional ToT workshop "Review of regional experience in HIV/AIDS prevention among men having sex with men"](http://www.unesco.kz/index.php?sector=®ion=&lang=&newsid=789&announce=bRegional+ToT+workshop+\).

24 May 2004, Central Asia, Education.

Course is going in framework of activity: Raising awareness and promoting change in attitudes and behaviors, within the project called "Strengthening Technical Capacities of Policy Makers, Professionals and NGOs from Central Asian Countries to Implement key activities on HIV/AIDS Combat through series of workshops" and under UNAIDS PAF funds, UNESCO Almaty office in cooperation with UNAIDS regional office.

Objective: to achieve common understanding of the efficient policy of and regional partnership in implementing HIV prevention interventions among MSM

Key items of the agenda: Regional practices of implementing HIV/AIDS prevention among MSM, reasons for successes and shortcomings of the project.

Participants: Delegations from 5 Central Asian countries consist of representatives of governmental health authority body training institutions, project staff including NGOs from the projects' sites, journalists, and international expert to moderate discussions.

From: [http://www.unesco.kz/index.php?sector=®ion=&lang=&newsid=790&announce=Regional ToT workshop "Review of regional experience in HIV/AIDS prevention among injecting drug users" 9-11 July \(Bishkek, Kyrgyzstan\)](http://www.unesco.kz/index.php?sector=®ion=&lang=&newsid=790&announce=Regional+ToT+workshop+\).



9 July 2004, Central Asia, Education.

Within the project called “Strengthening Technical Capacities of Policy Makers, Professionals and NGOs from Central Asian Countries to Implement key activities in HIV/AIDS responses” UNESCO Almaty office in partnership with UNAIDS and with the collaboration of the Kyrgyz Narcological Centre and AFEW NGO is going to held a workshop on HIV/AIDS among IDUs.

The objective of the workshop is to build common understanding of the efficient policy and regional partnership in implementing HIV prevention interventions among IDUs.

Key Items of the agenda:

- Human rights issues relevant to the use of drugs;
- Regional practices of implementing harm reduction strategies among IDUs
- Access of the target groups to the package of services;
- Experience of substitution therapy among IDU;
- Provision of HAART to IDU living with HIV;
- IEC: Role of communication and counselling skills, peer education and production of the group targeted messages;
- Results of situation assessments, projects evaluation;
- Outcomes of sentinel behavioural and serological surveillance for HIV among IDU in the region;
- World best practice examples

Participants: Representatives of governmental health (AIDS and Narcologic centers), NGOs including project staff from the sites of piloting projects, journalists and one regional expert to conduct and moderate the discussion, around 35 people.

From: [http://www.unesco.kz/index.php?sector=®ion=&lang=&newsid=923&announce=Second training on HIV/AIDS Prevention in schools of Kazakhstan](http://www.unesco.kz/index.php?sector=®ion=&lang=&newsid=923&announce=Second%20training%20on%20HIV/AIDS%20Prevention%20in%20schools%20of%20Kazakhstan).

27 July 2004, Kazakhstan, Education.

Second training course is conducted from 27 to 30 July 2004 for oblasts in-service teacher training institutes, oblast education departments, methodologists and teachers. In all 30 persons raise their skills of using the manual for teachers on HIV/AIDS prevention in schools. The trainings are conducted in the framework of "Education and HIV/AIDS".

Venue: Republican In-Service Teacher Training Institute, Almaty.

From: [http://www.unesco.kz/index.php?sector=®ion=&lang=&newsid=787&announce=Regional Training of Trainers Workshop "HIV prevention among sex workers"](http://www.unesco.kz/index.php?sector=®ion=&lang=&newsid=787&announce=Regional%20Training%20of%20Trainers%20Workshop%20%20HIV%20prevention%20among%20sex%20workers).

23 August 2004, Central Asia, Education.

Within the project called “Strengthening Technical Capacities of Policy Makers, Professionals and NGOs from Central Asian Countries to Implement key activities in HIV/AIDS responses” UNESCO Almaty office in partnership with UNAIDS and with the collaboration of the Republican AIDS Center is going to held a workshop on HIV/AIDS among sex workers.

The Objective of the workshop is to build the capacity of a core group of trainers to train, sensitise and build a supportive environment for implementing an effective national response to HIV prevention among sex workers.

Output of the workshop

- Skills of a core group of regional trainers strengthened and enhanced in Central Asia to

provide technical assistance to ensure that the regions' proposals to the Global Fund are implemented and achieved

Outcomes of the workshop

- Core trainers identified, established and trained with a view to strengthening harm reduction programmes among sex workers in the region
- Sustainable mechanisms put in place for conducting regular ToT workshops

Key items of Agenda

- Outcomes of sentinel behavioural and serological surveillance for HIV among sex workers in the 4 regions of the Republic of Kazakhstan;
- Communication exercise to improve trainer's skills;
- Safe Sex. Who is at risk
- Regional practices of implementing HIV/AIDS prevention programme among sex workers

Participants: Representatives of governmental health (AIDS Centers, STI clinics) NGOs including project staff from the sites of piloting projects, journalists and one regional expert to conduct and moderate the discussion, around 30 people.

From: <http://www.unesco.kz/index.php?sector=®ion=&lang=&newsid=1038&announce=> Regional ToT workshop "Greater involvement of people living with HIV in counteracting HIV/AIDS epidemic", 18-20 October, 2004, Astana, Kazakhstan.

18 October 2004, Central Asia, Education.

17 Representatives of governmental health (AIDS Centers) NGOs including project staff from the sites of piloting projects, international organizations, would participate in Regional ToT workshop "Greater involvement of people living with HIV in counteracting HIV/AIDS epidemic". Within the project called "Strengthening Technical Capacities of Policy Makers, Professionals and NGOs from Central Asian Countries to Implement key activities in HIV/AIDS responses" UNESCO Almaty office in partnership with UNAIDS and with the collaboration of the Republican AIDS Center, NGO "Saktan" is going to conduct a workshop targeted to people, living with HIV/AIDS (PLWHA).

The Objective of the workshop is

- to get practical lessons on how to proper address the HIV/AIDS epidemic through the involvement of PLWHA.

Output of the workshop

- Skills of a core group of regional trainers strengthened and enhanced in Central Asia to provide technical assistance to ensure that the regions' proposals to the Global Fund are implemented and achieved

Outcomes of the workshop

- Core trainers identified, established and trained with a view to strengthening HIV/AIDS prevention programmes among vulnerable group of population including PLWHA.

Key items of Agenda

- Alleviating of the consequences of HIV/AIDS epidemic: studies of priority needs of PLWHA in the region;
- Overcoming of stigma and discrimination;

- Better access to treatment, including HAART, care and support;
- Insurance of essential human rights of PLWHA

From: <http://www.unesco.kz/index.php?sector=®ion=&lang=&newsid=1215&announce=>
 During the Youth Festival - 1 500 students of KIMEP, Kazakh National university, Medical Academy and others were gathering together. The Youth festival was organized within the framework of the World AIDS campaign on the World AIDS Day “Girls, Women and HIV/AIDS” The Youth festival was conducted in close collaboration with PSI/USAID project, National Healthy Life Style Center/ Republic of Kazakhstan and the number of universities. A game titled “Rules of Safety”, conducted by volunteers from PSI organization and National Healthy Life Style Center, during which they explained young people the difference between HIV and AIDS, HIV ways of transmission, safe behavior issues, etc., opened the youth festival.

Head of Cluster Office UNESCO, Almaty, Mrs. Anjum R. Haque, US Ambassador Mr. Ordway J., Rector of Kazak National al Farabi University Mr. Kozhamkulov T., Deputy Director of National Healthy Life Style Center Mrs. Slazhneva T. took part in the official opening ceremony.

During the Festival a film about the young women infected by HIV was showed, the film was prepared by the students of the Kazakh National University, and different competitions within the theme of World AIDS Day were organized among students. The winners of the best report, wallpaper, essay, poetry and film loop were presented with diplomas and prizes. There were a number of performances, shows; dancing, and much more demonstrated during the festival.

The festival resulted in adoption of a Manifest – 1 500 students stated in written that they are against stigma and discrimination of PLWHA, that they will provide support to PLWHA, will learn about HIV/AIDS, try to increase level of awareness in order to change behavior patterns, etc.

XX: From:

<http://www.worldbank.org.kz/WBSITE/EXTERNAL/COUNTRIES/ECAEXT/KAZAKHSTANEXTN/0,,contentMDK:20332951~menuPK:361875~pagePK:141137~piPK:141127~theSitePK:361869,00.html>

Central Asian Countries Negotiate First Regional Project to Fight HIV/AIDS

Contact: **Almaty - Elena Karaban (7-3272) 980-580**
 Email: ekaraban@worldbank.org

ALMATY, January 26, 2005—Today, four delegations representing the Central Asia Cooperation Organization (CACO), and representatives of **the World Bank** completed negotiations on the first regional Central Asia AIDS Control Project. Negotiations were held in Almaty on January 24-26, 2005 and followed series of regional meetings, in one of which the Memorandum of Understanding among all the parties was signed.

According to the World Bank “Central Asia AIDS Study”, countries of Central Asia are highly vulnerable to a serious HIV/AIDS crisis over the next 20 years. Without concerted action, one may expect to see the rapid development over 4-5 years of an HIV epidemic concentrated among injecting drug users, and achieving very high prevalence levels in this group, followed by a generalized epidemic developing over 15-30 years, with sexual transmission as the predominant mode. This would follow the epidemic’s pattern in other regional countries such as Russia, Ukraine and Moldova.

“No nation is immune to the epidemic, nor does it recognize national boundaries, so the fight against this terrible disease must be a regional one. The proposed regional project to prevent HIV/AIDS epidemic in Central Asia is an important step to control its spread and avoid the huge

costs an epidemic would bring”, said Dennis De Tray, World Bank Country Director for Central Asia.

The goal of the first regional AIDS Control Project is to minimize the potential negative human and economic impact of a generalized HIV/AIDS epidemic in Kazakhstan, Kyrgyz Republic, Tajikistan, and Uzbekistan. The project has three objectives: 1) reduce the growth rate of the HIV/AIDS epidemic in Central Asia in the period of 2005-2010; 2) establish the Regional AIDS fund – a mechanisms that will serve as a vehicle for financing HIV/AIDS prevention and control activities in the region beyond the end of the project; and 3) contribute to better regional cooperation in Central Asia, and effective inter-sectoral collaboration between public sector, non-governmental organizations, and private sector on HIV/AIDS control in the region.

The project would ensure the necessary regional coordination and harmonization of approaches to control HIV/AIDS in Central Asia, and would complement country-specific programs and projects financed by Governments, the Bank and other partner organizations such as DFID, UNAIDS, GFATM, and USAID among others. Funding from the World Bank will be provided in the form of the grant in the amount of 25 million US dollars. DFID will also provide a grant of about 2 million US dollars.

During negotiations, delegations of CACO and World Bank representatives discussed legal and operational issues. The results of the negotiations have to be endorsed by CACO. It is expected that the project will be considered by the World Bank Board of Executive Directors in March 2005.

XXI: From:

<http://www.britishembassy.gov.uk/servlet/Front?pagename=OpenMarket/Xcelerate/ShowPage&c=Page&cid=1017170901949>

DFID's regional programme of support for the prevention of HIV/AIDS in Central Asia will include Kazakhstan. Projects for Kazakhstan will be funded through DfID's £1 million trust fund with the World Bank.

XXII: From: <http://www.dfid.gov.uk/pubs/files/rapcascsm.pdf>

Central Asia, South Caucasus and Moldova. Regional Assistance Plan. 2004

Countering the spread of HIV/AIDS. We will mainstream HIV/AIDS prevention in all our interventions, and in Central Asia provide specific targeted support, together with other agencies, to assist in effective implementation of national programmes.

New Directions of **DFID** in Kazakhstan:

Develop national level component of regional initiative.

XXIII: From http://www.un.kz/script_site.php?id=42

*What is **UNAIDS**?*

A Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together the experience, efforts and resources of eight UN system organisations (UNICEF, UNDP, UNFPA, UNDCP, UNESCO, WHO, World Bank and ILO) to help the world prevent new HIV infections, care for those already infected, and mitigate the impact if the epidemic.

UNAIDS in Kazakhstan

UN assistance in the field of HIV/AIDS prevention has been provided to Kazakhstan starting 1994, initially under WHO Global Programme on AIDS and since January 1996-by UNAIDS. Jointly with the Co-sponsors (who work together in UN Theme Group on HIV/AIDS) UNAIDS provides practical assistance to partners from government and community groups in their response to the epidemics. UNAIDS office for Central Asia is based in Almaty, Kazakhstan and headed by the Country Coordinator.

Main Achievements

UNAIDS in Kazakhstan provided initiation, coordination and streamline of activities aimed to develop more strategic response to HIV/AIDS epidemic through advocacy, material, technical and consultative assistance to co-sponsors, government and NGOs.

One of the major outcomes of UNAIDS mission in the country is that Concept Document (2000) and then National Strategic Programme on HIV/AIDS Counteracting for 2001-2005 (2001) based on the principles of international best practices were developed and adopted by the Government. Other important outcome of UNAIDS activities is that the implementation of harm reduction interventions among vulnerable groups of population has become a national policy.

UNAIDS puts much efforts in tracking the epidemic by facilitating in building capacities of the government and NGOs to conduct both behavioral and serological surveillance for HIV, which helps to pinpoint emerging problems.

UNAIDS assists in building committed and supportive governments, donors and private companies, and to bring on board a wide range of partners including people living with HIV/AIDS.

HIV/AIDS issues are now included into all items of social policy of the strategic plan of Development of the Republic of Kazakhstan up to 2010 approved in 2001. HIV/AIDS is mainstreamed in the activities of education, health, interior, justice, mass media and military sectors. Each of them has developed strategic plans on HIV/AIDS combat with the assistance of UNAIDS.

The main issues of strategic and current interests of the country are the providence of adequate care and support to people living with HIV and expanding coverage of vulnerable groups of population by prevention interventions, which is delayed due to the lack of financial resources. In such situation UNAIDS provided to the country coordination mechanism consultative and technical assistance in the development of proposal to the Global Fund to Fight HIV/AIDS, TB and Malaria, Kazakhstan was successful in its application to the Global Fund and will receive **22 mill USD** to support the National Strategic Program.

XXVI: From: <http://www.theglobalfund.org/search/portfolio.aspx?countryID=KAZ>

The Global Fund

Kazakhstan:

PORTFOLIO OF GRANTS IN KAZAKHSTAN	
Country Coordinating Mechanism (CCM):	Dr. Isidora Erasilova General Director Republic Centre for AIDS Prevention and Control CCM Kazakhstan, Contact 1 Almaty 480008 84, Auezov Street 73272 438830 (phone) 73272 779713 (fax) rcaids@netmail.kaz rcaids@nursat.kz

Disease(s):	Round 2: The Republican Center for Prophylactics and Control of AIDS of the Government of the Republic of Kazakhstan
Total Funding Request:	\$22,360,000.00
2-year Approved Funding:	\$6,502,000.00
Total Funds Disbursed:	\$3,419,669.98

HIV/AIDS

Project Title:	Promotion of and support to safer behavior choices among target population groups (injecting drug users, commercial sex workers, youth); provision of care and support to people with HIV/AIDS
Country:	Kazakhstan
Round:	2
Principal Recipient:	The Republican Center for Prophylactics and Control of AIDS of the Government of the Republic of Kazakhstan
Local Fund Agent:	KPMG 105 Abylai Khan Ave. , Almaty , Kazakhstan 732 7250 8855 732 7250 8877 (fsz) Mr.Ward D.Jones Wjones@kpmg.kz Ms. Natalya Yemelyanova NYemelyanova@kpmg.kz
Portfolio Manager:	Chernyavskiy, Valery Valery.Chernyavskiy@TheGlobalFund.org
Grant Agreement Signed:	04-Aug-03
Total Funding Request:	\$22,360,000.00
2-year Approved Funding:	\$6,502,000.00
Total Funds Disbursed:	\$3,419,669.98

The main goals of the proposal are to prevent HIV infections among vulnerable groups: sex workers, MSM, injecting drug users, and to expand care of support of those living with HIV, including Antiretrovirals.

A separate proposal was submitted for joint HIV/Tuberculosis component.

2,522 HIV cases are registered and incidence is high, 87% of them injecting drug users. According to estimates from Kazakhstan, 3% of adult population injects drugs. Total population of the country is 16 million.

From: <http://www.usembassy-kazakhstan.freenet.kz/press-releases/pr-04-41-print-en.html>

CDC/CAR:

The U.S> Centers for Disease Control and Prevention, Central Asia Regional Program's (CDC/CAR) Activities in Kazakhstan focus on reducing the burden of infectious diseases, primarily HIV and tuberculosis (TB). CDC's strategy is twofold: to improve local capacity in surveillance and prevention, by strengthening laboratory and epidemiological systems, and to build on these capacities by building programs that positively impact the health of the people of Kazakhstan. CDC is recognized as a leading governmental agency for protecting the health and safety of people both within and U.S. and internationally.

From: <http://www.ilo.ru/aids/docs/dec02/cis/Kazakhstan-eng.pdf>

UNDP HIV/AIDS in Kazakhstan report

Response: International Initiatives

Currently, international institutions provide support to some HIV/AIDS control projects in Kazakhstan, e.g. the Coordinated Health Promotion Programme (since 1999) cosponsored by UNAIDS, UNDP, UNICER and UNESCO. This project helps the government with HIV/AIDS/STI/drug abuse control in both policy development and its nation-wide outreach work with risk groups.

Another pilot projects, Facilitating Multi-Sectoral Response to HIV/AIDS/SIT/Drug Abuse in Karaganda Oblast and Kazakhstan, was implemented in 1997-2000, primarily in Temirtau. This project was supported by UNDCP, UNDP, UNAIDS, and Ispat Steelworks. The project introduced untraditional outreach work in the city: drug user education; training; counseling; syringe and needle exchange; condom and disinfectant distribution and treatment for sexually transmitted infections. A large-scale health education campaign was launched to enhance community awareness of the HIV/AIDS threat and the prevention of it.

Worth noting is the syndrome-based treatment project for STIs involving family doctor implemented with the assistance of USAID in Zhezkazgan. Also, CDC has proposed a set of educational initiatives on improved HIV/STI-related epidemiological surveillance. Some information and educational projects on HIV/AIDS enjoy the support of UNESCO, with a package of educational materials already developed. The UNFPA project develops national treatment protocols for sexually transmitted infections for the reproductive health and family planning services.

In 2000, UNAIDS in Kazakhstan initiated a strategic planning exercise of the national response to the HIV/AIDS epidemic. One of the outcomes of this initiative was the approval in December 2000 of the National AIDS Control Policy Concept for Kazakhstan, and, in September 2001, the strategic National AIDS Control Programme for Kazakhstan for 2001-2005.

UNAIDS has identified new key partners in the government, non-governmental and private sectors for the continuous efforts in the control of the HIV epidemic. For mounting the national response to the HIV/AIDS epidemic, it has become possible to mobilize the resources of the Kazakhstan Strategic Planning Agency, which, although not previously involved in this area, became in 2000 one of the leading government partners. Apart from medical services, the educational and operations services of the ministries of defense the interior and transport were drawn into HIV prevention thanks to the large-scale educational work conducted among sector leaders by the UN Theme Group on HIV/AIDS.

The UN Theme Group and UNAIDS facilitated the incorporation and capacity building of NGOs doing outreach work with risk groups. These national and local NGOs currently operate in five cities in Kazakhstan.

Harm reduction programmes are underway in six regional centers (Karaganda, Kostanay, Kokshetau, Kyzylorda, Uralsk, Aktobe) enjoying the support of the Soros Foundation. Each project envisions the distribution of 160,000 syringes, 80,000 condoms and 400 kg of disinfectants. Respective outreach work is quite limited and covers less than 5 per cent of the estimated number of IDUs in Kazakhstan.

c. NGOs:

From: <http://www.ilo.ru/aids/docs/dec02/cis/Kazakhstan-eng.pdf>

Response: Non-governmental organizations

There are 115 non-governmental organizations on record currently, including 33 engages in preventive action regarding risk groups, namely: Nadezhnaya Opora (reliable support) and Senim in Shymkent; Alternative in Almaty; Zhemtchushina (pearl) in Karaganda; Mothers Against Drugs in Temirtau; and Help in Kostanay. In Temirtau, there also is Shapagay (string) non-governmental organization protecting the interests of people living with HIV. Although a dialogue in recent years between authorities and non-governmental organizations, it is still limited.

The non-governmental organization are unstable and their potential for epidemic control needs improvement. The reason for that is, probably, the single source of funding available for NGOs involved in HIV prevention and risk group support is grants provided by the international institutions making part of the UN network, and other donors. Moreover, most of these NGOs were specifically created for certain projects and international programmes. This is why the coverage by these NGOs of various community groups, their performance and potential (equipment, human and technical resources) should not be evaluated in isolation from respective international institutions, primarily the UN and the Soros Foundation.

d. CIVIL SOCIETY:

e. OTHERS:

From: <http://www.usembassy-kazakhstan.freenet.kz/press-releases/pr-04-41-print-en.html>

US Government donated \$80,000 USD of Laboratory Equipment to Kazakhstan

16 November 2004

On Tuesday Nov 16, a handover ceremony marked the donation of four sets of serological laboratory equipment from the U.S. Government to the Kazakhstan Ministry of Health.

The U.S. Centers for Disease Control and Prevention, Central Asia Regional Program (CDC/CAR), with the financial support of the U.S. Agency for International Development (USAID), has provided four laboratories, each with a complete set of laboratory equipment for effective blood testing. Each set includes an automated ELISA reader and washer, incubator, centrifuge, water purification system, refrigerator, computer, pipettes, and additional laboratory supplies used for a wide variety of tests. The cost of the laboratory equipment totals approximately US \$80,000.

The four sets of laboratory equipment will be distributed to four Oblast AIDS Centers, including Pavlodar, Shymkent, Uralsk and Almaty. Karaganda Oblast previously received a similar laboratory. The donation of these four laboratories is part of a comprehensive laboratory improvement and training program to reduce the spread of HIV/AIDS and other bloodborne diseases in Kazakhstan and Central Asia. This laboratory equipment will increase the accuracy of HIV and other test results, which can improve the country's response to HIV/AIDS and other infections. The information will shape educational campaigns, patients care, and community mobilization to reduce the risk of HIV/AIDS.

From: <http://www.ilo.ru/aids/docs/dec02/cis/Kazakhstan-eng.pdf>

Response: Private Sector Initiatives

So far, the HIV/AIDS epidemic has not seriously alarmed the industrial sector. However, there is an example of effective involvement of a major enterprise (Ispat Steelworks) in HIV/AIDS control in Temirtau. The contribution by this plant to the harm reduction programme in this city contributed a great deal to the slowdown of the advance of the epidemic. Also, Kazakhtelecom helped in installing and maintaining telephone hotlines for risk groups in three cities of Kazakhstan.

Yet, these contributions by employers to HIV/AIDS prevention among risk groups and their own personnel present an exception to the rule. Employers do not finance educational publications and programmes, condom supplies, treatment for STIs, or any benefits for their young employees and their families in case of HIV infection. Even the most prosperous oil producers do not assume the burden of antiretroviral therapy for their workers and their family members when they are infected.

III. CURRENT ASSESSMENTS ABOUT EPIDEMIC AND RESPONSE (same as II. Current response to HIV/AIDS epidemic in the country)

From: Fanning the Flames

How Human Rights Abuses are Fueling the AIDS Epidemic in Kazakhstan

Human Rights Watch

June 2003, Vol. 15, No. 4(D)

RECOMMENDATIONS: to the government of Kazakhstan

On HIV/AIDS:

- Implement fully and as soon as possible the decisions announced by the government in July 2002 to rescind the policy of mandatory testing of all persons in government detention. Review the proposed replacement policy on voluntary testing against the UN International Standards on HIV/AIDS and Human Rights, with particular attention to safeguarding the provision of voluntary and confidential HIV testing and minimizing the use of mandatory HIV testing by the state.
- Discontinue the registration of HIV-positive persons by government offices and any other practice that violates an individual's right to confidentiality about HIV status.
- Discontinue the practice of isolation of HIV-positive prisoners.
- Discontinue the practice of confiscating official identification papers of detainees, drug users and persons living with HIV/AIDS.
- Amend Article 14(2) of the Constitution of the Republic of Kazakhstan on non-discrimination or issue a policy or official edict to interpret the article to ensure that no person can be discriminated against based on HIV status or sexual orientation. Similarly, specify that all persons regardless of HIV status should enjoy equality before the law, as noted in Article 14(1).
- Ensure that prompt review of HIV/AIDS legislation and regulations being undertaken by the government and the use of international standards such as the UN International Guidelines on HIV/AIDS and Human Rights against which to judge the appropriateness of laws and policies.
- Establish humane treatment services for narcotics addiction in accordance with Kazakhstan's commitment as a state party to the Single Convention on Narcotics Drugs of 1961 and its additional protocol of 1972, the Convention of Psychotropic Substance of 1971, and the UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.
- At AIDS centers, skin and venereal disease hospitals and other health facilities, establish health services for persons at risk of and living with HIV/AIDS according to the

standards of the UN International Guidelines on HIV/AIDS and Human Rights, with particular attention to confidentiality of HIV testing and non-mandatory HIV testing with appropriate counseling. Eliminate all practices by government authorities at these centers and facilities that violate the right to confidentiality of HIV testing and to non-mandatory HIV testing.

- Government officials at all levels should use public events and contacts with the media to condemn persecution of police harassment of and human rights abuses against high-risk groups and HIV/AIDS workers and to reiterate the crucial importance of HIV/AIDS prevention services for person at high risk.

On Law Enforcement Conduct:

- Establish and maintain a program of training for police at all levels on HIV/AIDS, the importance of harm reduction services, and related human rights issues. All new officers should be trained, and there should be refresher training for veteran officers. Police and legal and judicial officers should also be trained on the provision of the 1997 Kazakh law repealing the prohibition of homosexuality and recent international agreements on the right to nondiscrimination based on sexual orientation.
- Abolish the use of arrest or detention quotes by police at all levels. Accused persons should be detained before trial only in cases where they are likely to flee or represent a threat to the community. Prosecute to the fullest extent of the law those law enforcement agents responsible for arbitrary arrest, extortion, mistreatment and abuse of office.
- Ensure that detainees have full and unimpeded access to counsel during all phases of investigation and trial, that the practice of mistreatment in pretrial detention be ceased, and that confessions coerced under duress cease to be admitted as evidence in Kazakhstan's courts. Ensure that individuals can, without intimidation, put cases of mistreatment to independent authorities for prompt and thorough investigation.
- Ensure that the office of the Ombudsman in Kazakhstan takes it upon itself to investigate violations committed by law enforcement officers.
- Strengthen constitutionally guaranteed legal assistance services and ensure the implementation of these services in a way that does not discriminate against socially marginalized groups such as drug users and sex workers.

RECOMMENDATIONS: to the National AIDS Program:

- Expand and increase the scope of existent harm reduction services, including in prisons, and provide appropriate and adequate training to harm reduction personnel. Ensure access to comprehensive information on HIV/AIDS, and voluntary and confidential HIV testing for all persons in state detention.
- Implement as soon as possible pilot methadone therapy programs scheduled for start-up in the first trimester of 2003
- Include in AIDS program work plans regular monitoring and follow-up of human rights abuses against individuals in high-risk groups, and define performance indicators showing specific compliance with human rights standards.
- Include persons living with AIDS on government policy-making bodies and coordination committees related to HIV/AIDS policies and programs.
- Take measures to ensure the collection of accurate statistics on HIV/AIDS incidence and prevalence and numbers in high-risk groups.
- Intensify and increase educational and training programs on HIV/AIDS for law enforcements officers and medical professionals.
- Ensure that IDUs are not discriminated against in access to antiretroviral medicines.
- Intensify information campaigns that explain the basic facts of HIV/AIDS to the general population, including to young people in schools and young men doing their obligatory military service. Such campaigns should stress the importance of not criminalizing or stigmatizing either persons living with HIV/AIDS or vulnerable individuals or groups and should include information on the legality of same-sex behavior.
- Increase information and outreach campaign to men who have sex with men and expand cooperation with NGOs representing men who have sex with men.

RECOMMENDATIONS: to UN Agencies and Other Multilateral and Bilateral Donors:

- Urge that Kazakhstan immediately accede to basic human rights treaties, including the International Covenant on Civil and Political Rights and its additional protocols and the International Covenant on Social, Economic and Cultural Rights.
- Target support for HIV/AIDS programs and policies in Kazakhstan to measures that help bring services in line with international standards and that reflect protection from stigma and discrimination for persons affected by HIV/AIDS and the right to voluntary and confidential testing and comprehensive treatment and care

IV. GAPS

VII: from http://www.kff.org/hivaids/upload/14225_1.pdf

Access to HIV prevention: Closing the Gap

*Eastern Europe and Central Asia: Emerging Epidemics and Countries in Transition
Status of the epidemic in Eastern Europe and Central Asia*

The epidemic is spreading fastest in Eastern Europe and Central Asia, with annual rate of increase above 25%. In 2002 alone, 250 000 people in the region became infected with HIV.

Injection drug use – abetted by the cheapness of heroin, the existence in the region of major drug trafficking networks, and social dislocation caused by rapid economic and political change – drives the epidemic in the region.

IDUs require sustained behavioral interventions to encourage them to adopt safer injecting behavior, reduce or eliminate drug use, and use condoms during sexual intercourse.

Young people: face the growing risk of sexual acquisition of HIV. Accompanying the rapid social and economic changes in the region has been a marked change in sexual behaviors. UNAIDS reports that young people in the former Soviet Union are now having sex at an earlier age and that social strictures against premarital sex are easing.

Youth-appropriate prevention programs, coupled with investment in basic sex education, are needed to prevent an escalation in sexual transmission among the region's young people.

Drug use is a source of great stigma in the region, encouraging governments to address HIV transmission among IDUs from a criminal justice standpoint rather than as a public health matter. Leading donors have also resisted funding needle and syringe programs.

IDU prevention gap: Only 11% of IDUs have access to harm reduction programs.

Behavioral intervention gap: 40% of in-school youth, and only 3% of out-of-school youth, are reached by behavior change programs. Targeted behavioral interventions reach only 4% of sex workers and their clients, and only 9% of MSM.

VCT gap: only 28% of people who want VCT have access.

Awareness gap: only 19% of people at risk are reached by mass media campaigns on HIV/AIDS.

Current Prevention Resources: in 2002, the working group estimates that only \$23 million was spent on HIV prevention measures in the region.

Estimates Need: To combat the spread of HIV in Eastern Europe and Central Asia, more than \$1.2 billion in prevention spending will be required by 2005. By 2007, prevention resource needs will increase to \$1.6 billion.

Prevention Resource Gap: \$1.18 billion additional annual spending needed by 2005.

In 1996, early evidence pointed to the presence of HIV in Karaganda Oblast, and administrative region of Kazakhstan. Joint efforts by the government of Kazakhstan and UN agencies, however, led to the swift establishment of a multi-faceted prevention initiative targeting drug use, including efforts to enhance access to sterile injection equipment, as well as awareness campaigns targeting IDUs, health professionals, the public and private sectors, and the general public. School-based prevention programs were initiated focusing on the HIV transmission risks of drug use, and legal reforms were implemented to reduce police harassment of people possessing needles and syringes. Results of this initiative have been impressive – the level of HIV infection among people injecting less than a year (i.e., “recent injectors”) declined from 15% in 1997 to roughly 5% in 1999.

HIV prevention among incarcerated population in Kazakhstan: In response to evidence indicating that incarcerated populations are at high risk of infection in the region, the national government’s Ministries of Internal Affairs and of Justice initiated various policy changes to promote effective management of the epidemic in correctional facilities. Free STD treatment was provided; condoms, disinfectant and educational materials were made available; peer educators were recruited and trained from among the inmate population; mandatory HIV testing was banned; and segregation of HIV-infected inmates was ended. After the policy had been in place for one year, inmates at four different correctional institutions were surveyed. Results indicated significant increases among inmates in their understanding and perception of personal risk, understanding of the proper methods for condom use and sterilization of injection equipment, and awareness of opportunities for recovery from substance abuse. Corresponding increases were also recorded in the knowledge and perception of correctional staff.

*From: Fanning the Flames
How Human Rights Abuses are Fueling the AIDS Epidemic in Kazakhstan
Human Rights Watch
June 2003, Vol. 15, No. 4(D)*

Human Rights Watch’s research suggests that police arrest injection drug users and sex workers not for specific illicit acts, but primarily because of their status as drug users and sex workers. The resulting marginalization increases their vulnerability to HIV/AIDS. The police forces, which is generally repressive and routinely violates the rights of detainees, is especially brutal with stigmatized persons. Needle exchange – a health program whereby injection drug users exchange used syringes for sterile ones – is available in Kazakhstan and is a proven means of reducing HIV transmission among IDUs. But the utilization and effectiveness of needle exchange services is severely limited in part because drug users are aware that police in the past targeted needle exchange sites to harass drug users and continue to do so today, though less so than in the past. Furthermore, drug users, sex workers, and others who are marginalized in society are deeply suspicious of turning to state authorities for services. This distrust is a major obstacle in any state effort to control the epidemic’s spread and effects.

Current government estimates put the number of persons living with AIDS in Kazakhstan at more than 35,000, in excess of the combined total from official estimates in the four other Central Asian republics. The epidemic in Kazakhstan has thus far been largely contained among IDUs; over 80% of HIV-positive persons are estimated to be drug users. IDU is a more efficient means than sex for transmitting HIV. Kazakh authorities reported that in 2001 alone the number of HIV infections rose by about 240 %. A high prevalence of STIs in the population also increases HIV transmission risk. Kazakhstan also bears the highest TB burden in Central Asia. TB, suicide, and narcotics drug overdose are the largest contributors to mortality of persons with AIDS, according to experts in the country.

People at risk of infection and people living with AIDS face a triple threat. The Kazakhstan police are corrupt, abusive, and seemingly impervious to any oversight. The police routinely target IDUs and CSWs – more for their inability to shield themselves from extortion and then lack of credibility when they file complaints for abuse – than for any legitimate law enforcement purpose. Once injection drug users and sex workers are in custody, they are often forced to bribe arresting officers regardless of whether the arrest itself was legitimate or, in the case of sex workers, provide sexual “services” for the police. Those who are unwilling or unable to comply are routinely beaten, framed, and /or falsely charged with a crime.

These abuses occur in context of extremely harsh laws governing drug possession. Under the penal code, a person can be detained for as little as 0.5 grams of opiates. In the face of enforcement of these draconian laws, set-ups by the police, and sentences tied to conviction for both drug charges and additional false charges, many drug users end up serving prison sentences.

But detention in a jail or prison is also risky. Ironically, in some cases, defendants are even given narcotic drugs by the police as a reward for confessing to a drug charge or another charge. Drugs are reportedly widely available in places of detention – but harm reduction services are limited or nonexistent in these facilities. As a result many injection drug users resort to unsafe injection practices behind bars. The practice of segregating HIV-positive inmates from other inmates fuels misinformation about HIV/AIDS and reinforces the stigma associated with being HIV-positive.

Finally, as a result of having been identified as an IDU or CSW, the very people who most need access to accurate information, testing, counseling, and other services are either denied access to services because of who they are or are subjected to abuse by the authorities. Information and services are not reaching the people most in need; abusive practices by a multitude of state actors breeds distrust of all state actors; and risky behaviors that could be changed continue unabated.

80 percent of injection drug users interviewed by Human Rights Watch stated that they had served a prison sentence at one time or another during the span of their addiction. Mistrust of state HIV/AIDS-related services is prevalent among drug users, whose most frequent interaction with the government, appears to be through the criminal justice system.

A discriminatory practice of isolating HIV-positive prisoners has in addition produced serious tensions in the prison population and between prisoners and prison personnel. The Government adopted new testing guidelines in July 2002 which discontinued this practice, but at the time of this writing many HIV-positive prisoners continued to be isolated. Discrimination in employment, health, and housing is evidence of further stigma faced by persons living with HIV/AIDS and those at risk.

Because government HIV/AIDS services are based on policies that violate the right to confidentiality, they have so far failed overall to gain the trust of high-risk groups. Single and venereal disease hospitals, which deal with detection and treatment of sexually transmitted infections, and narcological centers, mandated to deal with substance abuse, conduct compulsory testing and require patients to identify their sex partners to the authorities. These facilities register clients and their partners as injection drug users or STI carriers, information which becomes a part of clients’ permanent identification status on record with authorities.

According to UN, only 8 to 10% of high-risk persons in Kazakhstan have been covered so far by harm reduction services, and recent studies show that risky behavior is still widespread. The UN estimates that harm reduction programs have achieved a significant impact only when a minimum of 50% of IDUs are reached.

The criminalization of drug users coupled with severely limited access to effective narcotics addiction and rehabilitation and treatment – including methadone maintenance or other substitution therapy – meant that injection drug users are offered few genuine alternatives.

Treatment at rehabilitation and drug centers is often ineffective, in part due to under funding, and is in most cases applied in a repressive fashion. Deep-rooted stigma and discrimination along with the lack of effective rehabilitation and treatment have led to an overwhelming sense of hopelessness for IDUs.

The lack of combination antiretroviral (ARV) therapy in the country compounds the absence of effective treatment services for person living with AIDS. A very short course of ARVs is available to HIV-positive pregnant women in much of the country, but access to long-term ARVs for people with AIDS is either severely limited or non-existent. Perhaps in part due to a lack of information on the effects and benefits of ARVs, many health professionals and persons living with AIDS interviewed by Human Rights Watch hold the view that ARV treatment is either too difficult to follow or ineffective, and several drug users stated that they refused ARV treatment on these grounds. The head of the National AIDS program has nevertheless indicated that discussions have begun on the possibility of acquiring generic antiretroviral drugs for us in Kazakhstan.

The government of Kazakhstan has taken several positive steps in the past year. In July 2002 the government adopted measures to lift the long-standing national policy on mandatory HIV testing of a wide range of persons, including drug users and those in pretrial detention. The government has also announced an end to the discrimination policy of segregating HIV-positive prisoners. A revision of HIV/AIDS –relevant regulations and laws is currently underway with the view of bringing them into compliance with international standards on HIV/AIDS and human rights. Two pilot methadone substitution therapy programs were promised by the end of the first trimester of 2003, and the president of Kazakhstan has commissioned a study to consider the legalization of cannabis and hashish and reduced penalties for drug users as part of “humanizing” their treatment. In addition, in 2001 the government developed a five-year interministerial plan to combat HIV/AIDS, involving eight ministries and agencies.

p. 30: Problems with State-run AIDS-related services

The government-run AIDS centers espouse confidentiality and anonymity, but certain practices would appear to contradict this policy, and certainly among person at high risk of HIV the overall perception of lack of confidentiality prevails. For example, the National AIDS program allegedly retains a database with names of all registered HIV-persons in the country. Officially registered HIV-positive persons are required to register with the local AIDS Center if they change their place or permanent residence. In one province, the AIDS Center is said to require that blood samples submitted to them by venereal and skin disease hospitals be identified by name and address of the donor, creating a significant risk of breach of confidentiality. The AIDS Center has also been accused by some parties in the recent past of providing police with personal information on injection drug users who have come for anonymous testing, resulting in their arrest and conviction.

p. 31: Harm reduction services

Injection drug users and harm reduction workers told Human Rights Watch that in Temirtau, drug users in general continued to be reluctant to access the AIDS Center and harm reduction services due to fear and stigma despite the focus on human reduction efforts. In addition to the environment of stigma and discrimination in which they operate, AIDS experts in-country and recent studies attribute the trust points’ low coverage to the following factors: being located in hospitals or clinics where anonymity is at risk; harassment and surveillance by police of visitors to the trust points; that the trust points are too few and inaccessible; improperly or insufficiently trained staff; and an insufficient number of staff and volunteers.

AIDS center staff and harm reduction workers told Human Rights Watch that there was a need to make trust points more welcoming by rendering them less official – that is by staffing them with personable and approachable people and providing a comfortable atmosphere.

p.32: Police interference with harm reduction services

Many government health officials and harm reduction workers argued that a lack of understanding on the part of law enforcement officers, insufficient training and education on HIV/AIDS for police, and entrenched repressive attitudes result in harassment and discrimination by police against those providing harm reduction services.

In Pavlodar and in Almaty several persons said police conducted regular surveillance of drugstores in order to identify drug users who buy disinfection materials or syringes, sometimes stopping them for questioning or body searches as they exit from the drugstores. Some IDUs said they had had to resort to using dirty needles instead of exposing themselves to police monitoring.

In Shymkent, harm reduction workers claimed that when police conduct “raids” to fill in arrest quota, numbers of clients frequenting trust points fall significantly and the effectiveness of mobile trust points is also diminished in consequence. The police’s widespread targeting of trust points to identify, harass, and arrest IDUs, common in some locations up until one to two years ago, appears to have dropped in intensity thanks to increased understanding by the police of the role of the trust points and ongoing educational efforts with law enforcement agents. Nonetheless, problems remain. A 2002 IDU survey that covered nine cities in Kazakhstan found 43% of respondents pointed to fear of police as a factor limiting their access to disposable syringes available either at trust points or in pharmacies. In Karaganda, for example, police continued to trail a mobile trust point, and in Shymkent, a trust point was closed down in 2002 because of police interference, including harassment and arrests.

p.34: Narcotics treatment services

All injection drug users consulted by Human Rights Watch who had received treatment in narcology centers said they had returned to drug use almost immediately following the course of treatment. A common complaint was that although detoxification was initially successful, the lack of psychological and moral support, accompanied by an oppressive and restrictive atmosphere, has prevented an effective cure.

Witnesses said private drug treatment clinics often do not offer sufficient psychological or moral support. Interviewees also alleged that corruption plays a role in reducing the effectiveness of the treatment centers. An epidemiologist in Pavlodar stated that if a client could not pay the required fee, narcology center staff would deliberately prescribe reduced medication, thus ensuring a failed treatment. Another drug user alleged that during his stay in a narcology center in Pavlodar in 2001, drugs could be bought from center personnel.

p. 35: Lack of antiretroviral treatment

Many persons living with AIDS, possibly because they have been given incomplete or erroneous information by health professionals on the benefits of ARVs, believe that ARVs are unnecessary for persons who do not have serious symptoms of AIDS, or too much trouble to try, particularly if they are IDUs. The large majority of HIV-positive prisoners interviewed by Human Rights Watch has either not heard of ARVs or were unaware of their benefits, and the same was true for many other persons living with AIDS. One former drug user said he spoke for many when he asserted that general opinion holds that persons living with AIDS do not deserve costly antiretroviral treatment as they will die anyway.

From: Harm Reduction News

Newsletter Focus

Fall 2002 – Volume 3, Issue 3

p. 5 HIV Infection and Heroin Trafficking by Chris Beyrer

A review of the literature suggests three principal **problems** with the implementation of harm reduction. First, it is repeatedly seen as condoning or facilitating injection drug use, making it politically unpopular. Second, it has faced legal, security, and policy challenges since it requires “safe” domains of interaction with active IDUs, a special concern in trafficking zones where criminal control may be extensive. And third, in order to effectively reach the IDU population and stop the HIV epidemic, many more needle exchange programs must be available and used by IDUs.

KYRGYZSTAN:

I. HIV/AIDS SITUATION IN THE COUNTRY:

IX: From:

[http://wbln0018.worldbank.org/ECA/ECSHD.nsf/ECADocByUnid/540336358112962585256DEF00762D01/\\$FILE/1758-06R_Ch04.pdf](http://wbln0018.worldbank.org/ECA/ECSHD.nsf/ECADocByUnid/540336358112962585256DEF00762D01/$FILE/1758-06R_Ch04.pdf)

HIV/AIDS and TB in Central Asia: Kyrgyzstan Country Profile

Chapter 5: Country Profile: Kyrgyzstan (p. 39-50)

The Kyrgyz Republic is the smallest country in Central Asia in terms of both territorial size and population (about 5 million), and one of the poorest, with US \$270 per capita of annual income. More than 50% of the population is aged 15-49 years, and more than half live in poverty (less than US\$1.00 per day).

HIV/AIDS Epidemiological Profile

The Kyrgyz Republic still has a low level of HIV prevalence. However, the country is now experiencing a rapid increase in the number of newly registered HIV-infected persons, especially over the past two years. By May 2003, there were a total of 410 officially registered HIV cases, of which 309 were identified in 2001 and 2002. One hundred forty nine were identified in 2001, a trebling of the total number of cases that had been identified in the period 1987-2000. However, UNAIDS estimates that the real number of HIV cases was 500 in 2001 (UNAIDS 2002b). The prevalence of HIV infection is highest among males (74%), especially those aged 29 years and younger (64%). Approximately 56% of cases are found among prison inmates. The worst affected region is Osh, with more than 50% of the cases, but Bishkek and Chui are also heavily impacted. Osh is at a crossroads of drug routes from Afghanistan to Russia. In 2001, there were four living AIDS patients with seven reported previous AIDS deaths.

The HIV/AIDS problem is closely linked with increasing drug trafficking and the consequent increase in the number of IDUs. Approximately 83% of cases report IDU as the main risk factor. Astonishingly, various experts estimate that about three of every four IDU are already HIV-positive. In 2000, sentinel surveillance found an HIV prevalence of 12-19% among IDUs in Bishkek and 32-50% in Osh, which has led to MoH estimate the number of IDUs HIV-infected in Bishkek at about 6,500, and in Osh at about 2,050. Behavioral surveys carried out in 2000 found that 96% of drug users share syringes, 99% inject drugs with a syringe from a common container, 35% use on syringe more than 20 times; 42% share syringes; 64% cannot afford to buy syringes; and only 14 % use sterile syringes.

Kyrgyz has one of the largest population of IDUs in Central Asia (an estimated 55,000 of which 65% are below the age 35 years), and consequently the highest estimated population prevalence of drug users in the region (1,700-2,000/100,000). The average age of drug users is 14 to 15 years. This situation has created a market for drug dealers, not only in the south but now in the north of the country, especially in larger cities. In 2002, only about 5,000 drug users were officially registered as patients at Narcology Centers, and almost 70% of these were opium users. Rates of newly registered drug users increased from over 30/100,000 in 1992 to over 100/100,000 in 1999 and from 73/100,000 in Osh to 280/100,000 in Bishkek in 1999. A dose of heroin costs 50 cents in Osh, which makes it cheaper than a bottle of vodka or even beer, and \$2 in Bishkek. In a region where the average monthly salary remains below US\$50, drug production and dealing area a tempting source of income in this poverty-stricken former Soviet Republic. Many young Kyrgyz citizens are turning to drugs as an escape from economic hardship and lack of opportunities.

The prevalence of HIV among prisoners was 776/100,000, which is 130 times higher than among the adult population in the country. In 2001, the prevalence of syphilis among prisoners was also very high at 3,500/100,000, or 70% higher than among the country populations. About 70% of prisoners are drug users, and 80% of these are IDUs. As an anonymous survey found that 40-50% of prisoners use injection drugs, and given the high rates of syphilis in this population, it is clear that they are also engaged in high-risk sexual behavior.

While only 4% of HIV cases were due to heterosexual transmission in 2001, this percentage increased to 23% in 2002. The HIV epidemic was preceded by a STI epidemic. In 2002, UNICEF reported that Kyrgyz Republic had one of the highest burdens of STIs in the region (almost 300/100,000 population of new cases of syphilis and gonorrhea in 2000). According to official statistics, incidence of syphilis declined from 167/100,000 population in 1997 to 73.5 in 2000, although rates still varies from 225 in Karakol City to 41 in Djalal-Abadskaya Oblast. In addition, it is estimated that about 3,000 people are involved in sex work. Among CSWs that visited STI services in 2001, 37% had syphilis.

Strategies, Policies, and Legal Framework

The Kyrgyz Republic appears to be taking the threat of drugs and HIV/AIDS quite seriously, and stands out in the region as being particularly innovative in its response to the epidemics. Kyrgyz's willingness to respond to a potential HIV epidemic during the early years - when the first cases of the virus were – can be considered international best practice. Although seriously under-funded, the Government has actively taken measure to address the potential epidemic with assistance from national NGOS and international partner. The HIV/AIDS Coordinating Committee is headed by the First Vice Prime Minister of Emergency Preparedness.

AIDS and prevention of STIs are both included in the Health Reform Program “Manas” and in the State Program “Healthy Nation.” In 1996, when only four cases of HIV had been identified in the entire country, the Parliament adopted a Law on AIDS Prevention. The adoption of this Law undoubtedly intensified HIV prevention activities in the country, ensured the involvement of all state agencies, and facilitated securing funds for special program. The first National Program on HIV/AIDS Prevention was approved in 1997, and the “Strategic Plan of National Response to the Epidemic of HIV/AIDS in the Kyrgyz Republic” was approved in 2000. The general objective of the prevention program is to reduce the number of HIV infected people, reduce the scale of the spread of HIV, and reduce the incidence of STI incidence in the Kyrgyz Republic.

Five strategies and interventions have been identified:

- Development of a national policy on HIV/AIDS and STIs;
- Ensuring the safe provision of medical procedures, including prevention of HIV and other infections through blood transmission, invasive procedures, and unsafe injections;
- Prevention of the sexual transmission of HIV and STIs, through the fostering of safe sexual behavior, the provision of condoms, and the provision of medical care for STIs;
- Prevention of the prenatal transmission of HIV by providing the population group of fertile age with information on HIV/AIDS and STIs regarding family planning, and the provision of condoms; and
- Provision of medical and social care for HIV-positive patients, AIDS patients, and their family members.

The decriminalization of drug use is currently being discussed at several levels, and the Government is considering a revision of the Criminal Code.

Surveillance Needs and Additional Studies

Trust Points are available through several outlets, and HIV cases identified in these outlets are reported to a national database. Health behavioral surveys have also been conducted in the country, and the Government is eager to improve its overall health database. For example, The Government is currently working on the development of a birth registry, since infant and maternal mortality data are currently not a reliable source of information for health planning and

assessment. UNAIDS, together with UNDP, has carried out studies of seroprevalence and rapid response assessments. NGOs carry out sociological and behavioral surveys of highly vulnerable groups such as IDUs and CSWs. However, the Government officials consider that to get a clearer picture of health sector issues, data are also necessary in several other areas:

1. on adolescents aged 15 to 18 years
2. on IDUs regarding HIV/AIDS risk behavior
3. on risk behaviors and seroprevalence in prisons
4. on over-prescription of antibiotics by physicians
5. on training needs for the rational use of drugs
6. on resistance to antibiotics for STIs

With support from the USAID, CDC has initiated training of MoH staff on sentinel surveillance.

Vulnerable and Highly Vulnerable Groups

The Kyrgyz Republic is actively promoting needle-exchange programs, which according to evidence shown in other countries, significantly reduces the spread of infectious disease among IDUs. Currently, 1,400 IDUs have access to free syringes in Bishkek, Takmak, and Osh. On average, the programs register a 90% rate of needle return. Innovative approaches have been used to tackle the STI epidemic such as provision of information and care to CSWs, introduction of the WHO-recommended public health approach to STI prevention and treatment, including the syndromic approach to STI management, and monitoring STI antimicrobial resistance. Public services and many NGOs work with highly vulnerable groups, such as IDUs, CSWs, and MSM, but these groups are insufficiently covered. UN agencies, bilateral agencies and foundations such as Soros Foundation/OSI provide assistance to national agencies.

The Ministry of Health services involved in prevention and treatment of drug abuse, HIV/AIDS, and STIs, and in ensuring blood safety include the AIDS National Association, five oblast AIDS Prevention centers and 36 laboratories with a staff of about 200, the National Narcology Center, the National Dermatology and Venereal Dispensary, and the National Blood Transfusion Center. The Ministries of Education, Defense, Labor, and Internal Affairs as well as regional and local authorities are also involved in HIV/AIDS prevention. National authorities closely cooperate with numerous national NGOS that cover many areas of drug abuse and HIV/AIDS prevention.

UNICEF (2002) reports that 58% of young people aged 14-17 are aware of the use of condoms as a means of HIV prevention. Yet despite high levels of awareness, the message is not getting through clearly enough to young people. Teenagers are poorly covered by prevention efforts, and there is a strong need to reach out to those who dropped out or are likely to drop out of school. Peer education and an IEC campaign are needed for vulnerable young people – those who are not necessarily at risk now but who can be at risk in the future. Posters and printed materials need to be prepared with participation of representatives from those groups. Leaders of both the Muslim and the Christian Orthodox communities have been approached and have become supportive of condom use and needle-exchange programs, except in schools.

The Republican Center for Health Promotion advocates inter-sectoral policies on healthy lifestyles and educational programs in partnerships with NGOs, local communities, and schools. Together with the Ministry of Education and WHO, the Center works on health promotion in schools, having started four pilot projects in Sep 2002 and teaching health subjects in first and fifth grades. About 10% of the teachers involved in this program have already been trained. Furthermore, the Center works on raising awareness about HIV/AIDS, and on prevention of drug addiction with the Ministry of Interior. The Union of Educational Institutions of the Kyrgyz Republic is an association that provides consultations, information, coordination, and training on HIV/AIDS to students, parents, and teachers in the entire republic.

The NGO Bely Zhurav focuses on the youth in the army, and has been carrying out an IEC campaign for soldiers on prevention of HIV/AIDS and STIs, and providing legal and medical assistance to those who are HIV infected. According to this NGO, which works with assistance

from UNDP, all administrative levels of the Ministry of Defense have understood the importance of prevention work. The NGO will also carry out activities in the Ministry of Interior. There are about 10-12,000 soldiers in the Ministry of Defense and 20-36,000 in the Ministry of Interior. The NGO Biom is a youth ecological movement, which mainly provides education on household ecology, but also has training programs on healthy lifestyle (that partially cover HIV/AIDS and TB prevention) and primary prevention in schools.

Preventive, Diagnostic, and Treatment Issues

Under a new UNDP/UNAIDS program starting next year, methadone will be distributed free to female IDUs and HIV-positive IDUs. Taken orally under medical supervision, methadone reduces the risk of infection from needle sharing. Family doctors are involved in prevention and treatment activities. The Association of Groups of Family Doctors trains family doctors on appropriate treatments of TB, HIV/AIDS and STIs, assisted by the Soros Foundation/OSI and USAID. The Association carries out workshops on proper practices of HIV/AIDS prevention and diagnosis, which will be replicated throughout the Republic. The Association had been working with USAID on a pilot project in Chui, where there is a large number of drug users. No information is available on MTCT in the Kyrgyz Republic.

NGO and Partner Activities

The Kyrgyz Republic has a very strong presence of NGO activities in the country, with over 5,000 NGOs registered. A Council of Public Organizations, which is chaired by the President of the Kyrgyz Republic, includes representatives of NGOs. NGOs involved in the work with IDUs meet once a year.

Examples of the work of some of the active NGOs:

- Socium is an NGO that works with drug addicts covering Bishkek and Chui Oblast. It provides medical assistance for IDUs; offers behavioral and sociological support; trains outreach workers on harm reduction support; and works on prevention of HIV/AIDS among drug users. Socium is now covering about 4,000 IDUs, while funding is only available for 700 IDUs, and is increasingly covering women. This NGO is a member of the Central European Network on Harm Reduction, and receives part of the condoms distributed from the Republican AIDS Center. The NGO Sanitas Charity Fund deals with drug addiction amongst teenagers, providing treatment
- Tais Plus is supported by UNDP to work on HIV/AIDS and STIs prevention for CSWs. This NGO started in 1998 and is now covering more than 80% of the country, covering 90% of the CSWs in Bishkek, and CSWs in other cities, but only distributes 10% of the necessary condoms. The price per condom is about 5 som (12 cents), which many CSWs cannot afford. This NGO is also carrying out an IEC campaign, including training, workshops, information materials and condom promotion; provides free medical services at anonymous centers supported by WHO; and works with law enforcement bodies
- Oasis is an NGO that works with MSM by providing information on the prevention of HIV/AIDS and STIs and legal support for MSM. The NGO has about 5,000 MSM clients. Since homosexuality is usually concealed, it is difficult to reach this group and organize it. MSM are also a diverse social mix, including high-level officials, married men, and poorly educated people in rural areas. Oasis conducts workshops, develops information materials, and distributes condoms. Condom use among MSM increased from 5% in 1997 to 35% in 2001. However, more funding is necessary for condoms.

UN agencies, bilateral agencies, and the Soros Foundation/OSI have also been very active in drug use, HIV/AIDS, and STIs prevention in the country. However, it is estimated that only about 2 to 5% of drug users are covered by harm reduction programs, at a cost of \$30,000/year for 1,000 clients (only for syringes).

A Multi-Sectoral Committee on HIV/AIDS Prevention, supported by UNDP and Soros Foundation/OSI, provides peer education and needle exchange to highly vulnerable groups through a network of 25 NGOs spread throughout the country. The Committee has also prepared educational program on healthy lifestyles. **UNDP** has contributed **\$800,000** for HIV/AIDS prevention and treatment since 1997, having assisted the government to set up the National Program, and has now a **\$510,000** program for the next five years.

The **Soros Foundation/OSI** has been working since 1999 with UNDP on prevention programs, which are now partially funded by **\$110,000** from USAID. The first pilot projects for 700 drug users were implemented in Bishkek and Osh. In Bishkek drug users are more open (attend psychotherapy sessions on how to prevent overdose, how to prepare drugs in a safe way, etc.) Soros Foundation/OSI has also followed up on a needle exchange program for CSWs that was initially established by the AFEW. Although OSI works with the Ministry of Interior, some officials are against HR as they fear that it promotes use of drugs. A prison program includes education and distribution of bleach, but not needle exchange. **Soros Foundation/OSI** has also started a pilot methadone program for 50 clients, but which has been providing treatment to only 28 clients, of which eight are HIV positive. This program costs **\$3,000 per year for 100 people**. The Ministry of Justice is expected to allow the establishment of a methadone program in prisons. Soros Foundation/OSI also works with street children, using cartoons to educate children about drug abuse and HIV/AIDS, as suggested by Street Kids International. The Ministry of Education has not yet included education on drug abuse and HIV/AIDS in the school curriculum. Thus this program is only carried out through local NGOs.

UNICEF had been chairing the UN Theme Group, and has been carrying out a four-year program for 2000-2004 with **US\$4 million** that includes HIV/AIDS activities. UNICEF carried out a Knowledge, attitude and practice (KAP) baseline study in five oblasts (Narine, Osh, Chio, Issuk-Kul, Babken), assessing the knowledge of 15 to 18-years-old on sexual behavior, STIs, and HIV/AIDS. It works on a health promotion program with the Ministries of Health and Education, and five radio stations. The health promotion program focuses on HIV prevention and healthy life skills and attitudes; and involved peer education to strengthen youth organization, making sure services for youth are friendly and accessible (involve youth in design). The Youth Program is now being scaled up, aiming at having at least one hour per week of healthy life skills taught in schools. UNICEF is also assisting NGOs in working with street children to raise funding and establish shelters.

UNFPA works with the National AIDS Center addressing heterosexual transmission, which is estimated to be responsible for more than 20% of the HIV positive cases. STIs among university students are increasing rapidly (as many female students would be involved in occasional sex for money). UNFPA is also working with UNICEF in schools and training school teachers; and with the IPPF and Association for Reproductive Health (NGO), which carried out a study on awareness and knowledge about reproductive health. Condom availability is uneven, and UNFPA is unable to cover all the needs. In 2002, DFID and the Government of Netherlands covered 80% of the condom needs for highly vulnerable groups, and the **local government in Osh** allocated **\$24,000** for condom procurement. The religious community poses some obstacles to this work. Although the religious community has made commitments to reproductive health rights and no prevention of HIV/AIDS, it opposes discussions on safe sex and the distribution of condoms in schools. UNFPA organized a roundtable with religious leaders, and it was expecting their endorsement of the Law on Reproductive Rights.

The UNHCR focuses on reproductive health and HIV/AIDS among refugee youth, who mostly come from Tajikistan (but are ethnically Kyrgyz), but also include Chechens and Afghans. UNHCR supports NGO-based awareness campaigns among refugee youth, condoms distribution, and clinics for refugees. The IOM works on a public information campaign for labor migrants. Labor migrants usually lack access to health care and are more vulnerable to HIV/AIDS. Many women end up in forced sex labor or resort to CSW as a temporary way to earn income until they get regular jobs. In Kyrgyz, blood tests are required for official work, and

therefore, ethnic Kyrgyz returning from Tajikistan, Uzbekistan, and other countries, have to pass an HIV test to become citizens.

USIAD has been assisting HIV/AIDS prevention activities in Kyrgyz in the context of the implementation of its Central Asia Strategy, which includes **\$2 million** for prevention programs over the next two years. USAID has also been supporting US CDC activities, including training the Ministry of Health staff in sentinel surveillance. **DFID** allocated an initial **\$2 million** for HR programs, and is providing support to restructure the penal system. The **Swiss Cooperation Office** has provided **160,000 Swiss francs** to an information program on drug use in Osh, targeting students and training teachers. It opened the Rainbow Information Center, which provides support to the program in Jalal-Abad and Batken Oblasts.

Donors and NGOs have referred the need to scale up HR programs to cover 60% of highly vulnerable groups (IDUs, CSWs), and ensure that long-term sustainability of HIV/AIDS prevention and treatment activities in the Kyrgyz Republic; providing school drop outs with information and education on HIV/AIDS; dealing with the issue of stigma; decriminalizing drug use; reducing overcrowding in prisons; and supporting expanded methadone substitution treatment for IDUs.

Funding:

The Kyrgyz Republic allocated 1.8% of the GDP to the health sector in 2000 (12% of total public expenditures), which resulted in less than \$7 per capita on health. The Government stated that in 2001 it allocated about **\$1 million** for the implementation of the second HIV/AIDS program, but the first HIV/AIDS Program only obtained 18% of the planned funding, and thus disbursement for the second program is worth attention. The Joint Program with **UNDP and UNAIDS** had **\$250,000** funding. HR programs are supported by UN agencies, Soros Foundation/OSI, and the local government in Osh. **The GFATM** approved a **\$5 million** grant for HIV/AIDS out of a request of \$17 million that has been prepared with assistance from UNAIDS. This will complement expected **funding from public and other sources (of about \$5 million)** for 2003-2007.

XI: From: <http://hivinsite.ucsf.edu/global?page=cr03-kg-00>

HIV/AIDS in Kyrgyzstan	
Adults age 15-49 with HIV/AIDS, 2003	3,900
New HIV infections, 2004	nd
Adult HIV prevalence (%), 2003	0.1
Women age 15-49 with HIV/AIDS, 2003	<800
Children with HIV/AIDS, 2003	nd
AIDS orphans (ages 0-17), 2003	nd
AIDS deaths, 2003	<200
nd = No data	

Source: UNAIDS

XIII: From: <http://hivinsite.ucsf.edu/global?page=cr03-kg-00&post=19&cid=KG>

Kyrgyzstan: Comprehensive Indicator Report

General HIV/AIDS

(Source: UNAIDS, 2004: UNAIDS 2004 Report on the global AIDS epidemic
<http://www.unaids.org/bangkok2004/report.html>)

Indicator	Year	Kyrgyzstan	Eastern Europe & Central Asia	World	Source
Adults and children (ages 0-49) living with HIV/AIDS	2003	3,900	1,400,000	39,400,000	UNAIDS, 2004
Adults (ages 15-49) living with HIV/AIDS	2003	3,900	1,300,000	37,200,000	UNAIDS, 2004
Women (ages 15-49) living with HIV/AIDS	2003	<800	490,000	17,600,000	UNAIDS, 2004
Children (ages 0-14) living with HIV/AIDS	2003	nd	8,100	2,200,000	UNAIDS, 2004
AIDS orphans currently living (ages 0-17)	2003	nd	nd	15,000,000	UNAIDS, 2004
Adults and child AIDS deaths (ages 0-49)	2003	<200	60,000	3,100,000	UNAIDS, 2004
Adults and children newly infected with HIV	2004	nd	210,000	4,900,000	UNAIDS, 2004
nd = No data					

HIV Prevalence

(Source: UNAIDS, 2004: UNAIDS 2004 Report on the global AIDS epidemic
<http://www.unaids.org/bangkok2004/report.html>)

Indicator	Year	Kyrgyzstan	Eastern Europe & Central Asia	World	Source
Adult (ages 15-49) HIV prevalence (%)	2003	0.1	0.8	1.1	UNAIDS, 2004
HIV prevalence, sex workers, capital city (median %)	Various Years	nd	nd	nd	UNAIDS, 2004
HIV prevalence, injecting drug users, capital city (median %)	Various Years	nd	nd	nd	UNAIDS, 2004
nd = No data					

HIV Knowledge and Behavior

(Source: UNAIDS, 2004: UNAIDS 2004 Report on the global AIDS epidemic
<http://www.unaids.org/bangkok2004/report.html>)

Indicator	Year	Kyrgyzstan	Eastern Europe & Central Asia	World	Source
Know that a healthy-looking person can have HIV (female, ages 15-24) (%)	Various Years	nd	nd	nd	UNAIDS, 2004
Reported higher-risk sex (male, ages 15-24) in the last year (%)	Various Years	nd	nd	nd	UNAIDS, 2004
Reported higher-risk sex (female, ages 15-24) in the last year (%)	Various Years	nd	nd	nd	UNAIDS, 2004
Used a condom the last time they had higher-risk sex, of those who had high-risk sex in the last year (male, ages 15-24) (%)	Various Years	nd	nd	nd	UNAIDS, 2004

Used a condom the last time they had higher-risk sex, of those who had high-risk sex in the last year (female, ages 15-24) (%)	Various Years	32	nd	nd	UNAIDS, 2004
nd = No data					

Access to Care and Treatment

(Source: WHO Health Services Coverage, 2004:
http://www.who.int/tb/publications/global_report/en/)

Indicator	Year	Kyrgyzstan	Eastern Europe & Central Asia	World	Source
Percent of adults receiving VCT in last year	2003	nd	1.5	nd	WHO Health Services Coverage, 2004
Number of VCT clients per year	2003	nd	1,042,637	6,000,000	WHO Health Services Coverage, 2004
Number of VCT sites	2003	nd	1,136	nd	WHO Health Services Coverage, 2004
Percent of pregnant women offered PMTCT services	2003	nd	37	8	WHO Health Services Coverage, 2004
Percent of HIV+ pregnant women receiving ARV prophylaxis	2003	nd	6	3	WHO Health Services Coverage, 2004
Number of sites offering PMTCT services	2003	nd	969	37,513	WHO Health Services Coverage, 2004
Estimated coverage of antiretroviral therapy (est. %)	2003	nd	11	nd	WHO Health Services Coverage, 2004
Number of public sector patients receiving antiretroviral therapy	2003	nd	5,352	nd	WHO Health Services Coverage, 2004
Number of sites offering antiretroviral therapy services	2003	nd	27	nd	WHO Health Services Coverage, 2004
Coverage of cotrimoxazole prophylaxis for adults	2003	nd	4	nd	WHO Health

(est. %)					Services Coverage, 2004
Number of adults receiving cotrimoxazole prophylaxis	2003	nd	1,826	190,000	WHO Health Services Coverage, 2004
Coverage of cotrimoxazole prophylaxis for children (est. %)	2003	nd	32	nd	WHO Health Services Coverage, 2004
Number of children receiving cotrimoxazole prophylaxis	2003	nd	1,095	28,000	WHO Health Services Coverage, 2004
Coverage of isoniazid prophylaxis for adults (est. %)	2003	nd	1	nd	WHO Health Services Coverage, 2004
Number of adults receiving isoniazid prophylaxis	2003	nd	432	36,000	WHO Health Services Coverage, 2004
Percentage of population living in areas with DOTS coverage	2002	98	nd	nd	WHO TB Control Report, 2004
Number of TB cases registered for treatment under DOTS	2001	1,458	nd	nd	WHO TB Control Report, 2004
nd = No data					

Mortality

(Sources: World Population Data Sheet 2004 of the Population Reference Bureau: http://www.prb.org/pdf04/04WorldDataSheet_Eng.pdf

UNICEF: www.unicef.org, UNDP: www.undp.org, UNFPA: www.unfpa.org)

Indicator	Year	Kyrgyzstan	Eastern Europe & Central Asia	World	Source
Life expectancy at birth (years)	Various Years	68	68	67	PRB Data Sheet, 2004
Infant (Ages 0-1) mortality rate (per 1,000 live births)	2003	59	34	54	UNICEF, 2005
Under-five mortality rate (per 1,000 live births)	2003	68	41	80	UNICEF, 2005
Maternal mortality ratio (per 100,000 live births)	2000	110	nd	nd	UNFPA, 2004
Probability at birth of surviving to age 65, female (% of cohort)	2000-2005	77.2	80.6	72.9	UNDP, 2004

Probability at birth of surviving to age 65, male (% of cohort)	2000-2005	61.5	58.8	64.4	UNDP, 2004
nd = No data					

General Population

(Sources: World Population Data Sheet 2004 of the Population Reference Bureau: http://www.prb.org/pdf04/04WorldDataSheet_Eng.pdf)

Indicator	Year	Kyrgyzstan	Eastern Europe & Central Asia	World	Source
Total population (millions)	mid-2004	5.1	299	6,396	PRB Data Sheet, 2004
Total projected population - 2025 (millions)	2025	6.7	281	7,934	PRB Data Sheet, 2004
Total projected population - 2050 (millions)	2050	8.2	243	9,276	PRB Data Sheet, 2004
Rate of natural increase (%)	Various Years	1.4	-0.5	1.3	PRB Data Sheet, 2004
Percent urban		35	68	48	PRB Data Sheet, 2004
nd = No data					

Youth

(Sources: World Population Data Sheet 2004 of the Population Reference Bureau: http://www.prb.org/pdf04/04WorldDataSheet_Eng.pdf)

Indicator	Year	Kyrgyzstan	Eastern Europe & Central Asia	World	Source
Population ages 10-24 (millions)	2000	1.4	71	1663.0	PRB Youth Data Sheet, 2000
Percent of total population ages 10-24	2000	31	23	27	PRB Youth Data Sheet, 2000
Percent of total population under 15	mid-2004	35	16	30	PRB Data Sheet, 2004
nd = No data					

General Health

(Source: UNDP: www.undp.org, UNICEF: www.unicef.org; WHO: http://www.who.int/tb/publications/global_report/en/)

Indicator	Year	Kyrgyzstan	Eastern Europe & Central Asia	World	Source
Health expenditure, private and public (US\$ per capita)	2001	108	nd	nd	UNDP, 2004
Physicians per 100,000 people	1990-2003	272	nd	nd	UNDP, 2004
Births attended by skilled health staff (%)	1995-2002	98	97	58	UNDP, 2004

Malaria cases per 100,000 people	2000	nd	nd	nd	UNDP, 2004
Prevalence of child (ages 0-5) malnutrition (%)	1995-2003	11	6	27	UNICEF, 2005
TB treatment success rate, new smear-positive cases-DOTS (% of cases)	2001	81	nd	nd	WHO TB Control Report, 2004
nd = No data					

Fertility

(Sources: UNFPA: www.unfpa.org; World Population Data Sheet 2000 of the Population Reference Bureau:

<http://www.prb.org/Template.cfm?Section=PRB&template=/ContentManagement/ContentDisplay.cfm&ContentID=8500>)

Indicator	Year	Kyrgyzstan	Eastern Europe & Central Asia	World	Source
Total fertility rate (number of children)	2000-2005	2.64	nd	2.69	UNFPA, 2004
Births per 1,000 women (ages 15-19)		33	nd	50	UNFPA, 2004
Percent of TFR attributed to births by ages 15-19		6	14	12	PRB Youth Data Sheet, 2000
Percent giving birth by age 20		37	nd	31	PRB Youth Data Sheet, 2000
nd = No data					

Education

(Sources: UNICEF: www.unicef.org)

Indicator	Year	Kyrgyzstan	Eastern Europe & Central Asia	World	Source
Gross primary school enrollment ratio, male	1998-2002	102	101	104	UNICEF, 2005
Gross primary school enrollment ratio, female	1998-2002	99	98	97	UNICEF, 2005
Gross secondary school enrollment ratio, male	1998-2002	86	90	66	UNICEF, 2005
Gross secondary school enrollment ratio, female	1998-2002	87	85	61	UNICEF, 2005
nd = No data					

VII: *From: AIDS in Kyrgyzstan: Five Year Resistance, Bishkek 2003*

Book published by UNAIDS, UNDP, the government of the Kyrgyz Republic

p. 20: *HIV/AIDS in the Kyrgyz Republic, 2.1. History of the epidemic*

As of 1996 the WHO European Bureau regarded the Kyrgyz Republic as the last HIV-free country. The first HIV case among local residents was recorded in 1996 in Bishkek. HIV incidence tracking in the regions began in 1998. By February 1, 2001, fourteen HIV-positive persons were detected among the native population in total, including four in the regions.

However the situation drastically changed in 2001 when a rapid spread of HIV/AIDS was observed. Thus HIV incidence has increased in 2001 against 2000 by 10.6 times for the country overall, and has increased by 2.8 times since the epidemic began in 1987. This rise is related to the outburst of HIV-injection among injecting drug users (IDUs) who accounted for 82% of all officially registered number of people living with HIV/AIDS (PLWHA) and for 95.9% of all PLWHA recorded in 2001. As for the epidemic dynamics, the Osh oblast is the worst-affected region of the country: in 2001 the HIV incidence rate for the region increased 44-fold compared with the entire previous period since the onset of the epidemic, and drug users accounted for 98.8% of all HIV cases recorded there. The dynamic continued to be high in 2002 and was 7% higher than in the previous year. The number of newly recorded HIV infections in Kyrgyz citizens has approximated to the number of all cases having been registered for the whole previous period of the epidemic development (totaling 85.4% of the latter). Altogether a total of 362 HIV infections had been recorded in the Kyrgyz Republic by January 1, 2003.

Thirteen HIV-infected persons, including two women, have already died, and of those, eight who have died from AIDS (six in 2002). Four persons have died for other reasons: drug overdose (2), alcohol poisoning (1), suicide (1).

2.3. The epidemic background

STI incidence:

“...very high rates of sexually transmitted infections continue to be found in Eastern Europe and Central Asia pointing to widespread unsafe sex and increased odds of HIV infection...”
(AIDS Epidemic Update: Dec 2002 UNAIDS/WHO, Geneva, 2002, p. 18)

The HIV epidemic in the Kyrgyz Republic was preceded by an increase in the prevalence of syphilis, an indicator for STI epidemic trends. This epidemic of syphilis evidenced that conditions do exist in the country that favor sexual way of HIV transmission.

The last decade saw an increased syphilis incidence between 1990 and 1997, with a 77-fold increase for the country overall and 140-fold increase for Bishkek. Although a stable downward trend is being currently observed regarding syphilis, the morbidity rate remains high. Thus 2,988 syphilis cases were recorded in 2001 (61.1:100,000), which is over 30 time more than the number in 1990.

Furthermore the officially registered syphilis incidence does not reflect the actual rate. According to experts official data reflect a maximum of 60% of the actual number. This view is also substantiated by a high share of more hidden, latent forms of syphilis, which totaled, in 2000-2001, 80% of all registered cases, as well as by growing numbers of congenital syphilis.

Drug Use:

The Kyrgyz Republic lies on one of the main drug trafficking routes. At present drug traffickers use the route across the Osh Oblast: Afghanistan and Pakistan – Khorog (Tajikistan) – Osh (Kyrgyz Republic) – Bishkek – CIS – Eastern Europe. The extremely low living standards of the local population, in particular in the border areas; increasingly pushes women, children and adolescent girls to drug dealing as traffickers.

Before 1986-87 the country only saw rare cases of hashish and opium use. According to the State Commission on Drug Control, drug addictions have increased six-fold between 1991 to 2000. Also “the age of an average drug user has recently decreased to 14-15 years of age, and several instance of drug use at an even earlier age – 10 or 12 years old (!) – have been reported.” Almost half of all drug users are in their most reproductive years (21 to 30 years of age) whereas young people aged 16 to 20 years old account for 15% of drug users. As of Jan 1, 2002, 5,100 persons were officially registered as drug addicts at the National Narcology Center

of the Ministry of Health, of them approximately thirty persons were minors. As transits of opium and heroin have increased, and increase in injecting drug use has resulted and this now accounts for 96.8% of all drug addictions.

Real numbers of drug use are significantly higher than the official statistical data. The 2001 express situation assessment conducted by a UNODC Project in Bishkek showed that “real numbers of drug users are 15 times higher than those presented by official statistics of the narcology service” and thus total 80,000 to 100,000 persons. The Kyrgyz Republic’s prevalence rate of drug use is estimated as the highest amongst Central Asian countries, and it amounts to 1,644-2,054:100,000 (1,110-1,251 in Kazakhstan: 262-367 in Uzbekistan).

From: http://www.aids.undp.kg/en/aids/in_kg/

HIV Infection Spread in the Kyrgyz Republic

Background:

The first HIV case in the Kyrgyz Republic was registered in 1987. This was a citizen of Africa, who was a student of the pilot military school in Bishkek city. From 1987 till 1991 there were 15 cases registered among the foreign students of this school. Out of them 14 people were citizens of African countries, and one was from Asia. From 1992 till 1994 there was not a single HIV case registered in the country. But 1995 new HIV case appeared again among CIS citizens, who came to Kyrgyzstan for drug abuse treatment in the private medical clinic of Dr. Nazaraliev. Overall, since 1995 till November 1, 2001, there were 37 HIV infected registered, all of them foreign citizens; including 1 citizen of Africa, 24 citizens of Russian Federation, 4 citizens of Ukraine, 3 citizens of Kazakhstan, 3 citizens of Uzbekistan, and two of unknown origin. End of 2002, a total of 68 HIV cases were registered among foreigners.

Till 1996 Kyrgyzstan was the only country without local HIV cases, registered by WHO Europe Regional Bureau. First HIV-infected among local citizens was detected in 1996 in Bishkek city, capital of the Republic. Since 1998, HIV cases were registered in the regions of the country. Up until February 1, 2001 there were 14 local HIV cases, out of them 4 are from the regions of the country. Since that time and till the end of 2002, there were 146 HIV cases among local citizens officially registered, including 87 in Osh oblast, 208 cases in Chui oblast, and three cities in Jalal-Abad. This designates the beginning of HIV epidemic among injecting drug users in the Kyrgyz Republic. Registration of HIV infection among prisoners - total 25 cases - is of a special concern.

During the whole period of control over the AIDS epidemic, the Kyrgyz Republic has 350 HIV cases, out of them 282 are citizens of Kyrgyzstan, and 68 are foreigners. The number of HIV infection in 2002 has increased more than two-fold the number of cases, registered since the beginning of the epidemic (since 1997). At this, in the most suffered Osh oblast the number of HIV infection cases has increased in 44-fold comparing to the previous years of epidemic. Five Kyrgyz citizens have already died from AIDS.

Number of HIV infected by years:

1987-1991	1992-1994	1995	1996	1997	1998	1999	2000	2001	2002	Total:
15	0	2	2	2	6	10	16	149	160	362

HIV infection spreads mostly among men of reproductive age. Out of 350 HIV registered cases, men make 89%, women - 10,3%. HIV-infection spreads mostly among men of reproductive age.

Further development of HIV epidemic

At present, number of injecting drug users among HIV infected is increasing. If until 1990 HIV was transmitted only sexually; than in the years of 2000-02, the HIV contamination happened at drug abuse in all new 55 officially registered cases. Performed study of samples of blood residue in syringes showed that level of HIV-infection spread in the tested group is 15% in Bishkek city and 41% in Osh city. Estimated number of HIV-infected injecting drug users in Bishkek is approximately 6550 people and 2050 people - in Osh city.

The further development of the HIV epidemic in the Kyrgyz Republic will bring to the worsening of the economic situation and increase of the poverty level, as well as to the acute social and political situation in the country.

a. HIV PREVALENCE RATES (GENERAL):

VIII: From: http://www.unaids.ru/index_ru.php?id=aids_epidemic_update_eng-5&nm=4

UNAIDS: Key Materials: Eastern Europe and Central Asia

In Estonia and Latvia, it has been estimated that up to 1% of the adult population injects drugs, while, in Kyrgyzstan, that figure could approach 2%.

In Ukraine, 25% of those diagnosed with HIV are younger than 20, in Belarus 60% of them are aged 15 - 24, while in Kazakhstan and Kyrgyzstan upwards of 70% of HIV-positive persons are under 30 years of age.

These patterns highlight the need for a more vigorous and comprehensive response that diminishes the vulnerability of young people, and enables them to reduce drug injecting and risky sexual behaviour. That means greater access to information, as well as to prevention tools and services. Harm reduction forms a cornerstone of such a comprehensive response, and should be broadened quickly to address the needs of young drug injectors who face immediate and high risks of HIV infection. Special attention should be paid also to their predominantly female sexual partners, to men who have sex with men, and to the young women and men who engage in sex work. The prevention of mother-to-child transmission is a new and urgent priority. But the growing treatment and care needs of people living with HIV can no longer be overlooked.

The most recent HIV outbreaks in the region are to be found in Central Asia, where reported HIV infections have grown exponentially from 88 in 1995 to 5,458 in 2002. This is mainly due to the sharp rise in infections recorded in Kazakhstan, Kyrgyzstan and Uzbekistan. HIV has now spread to all regions of Kazakhstan, while the majority of cases reported in Kyrgyzstan are concentrated in the Osh region, which serves as a drug transit route for neighboring countries. Given that the five Central Asian republics straddle major drug trafficking routes into the Russia Federation and Europe, it is no surprise that the majority of infections currently are related to injecting drug use. Indeed, in some parts, heroin is now believed to be cheaper than alcohol. As elsewhere in the region, young people are the worst-affected, with those on the margins of the economy particularly vulnerable. In Kazakhstan, for example, three-quarters of people diagnosed with HIV were unemployed.

These epidemics are very recent and can be halted if prevention efforts are targeted at those who are currently most affected - injecting drug users and sex workers - and are supported by prevention work among young people generally. In some instances, even more elementary

prevention steps are required - such as screening blood donations for HIV. Tajikistan, for example, reportedly did not test 40% of those who donated blood in 2002.

II. From: www.rbec.undp.org/hiv/?english
HIV/AIDS in Central and Eastern Europe and the CIS

p. 22: HIV is only now beginning to register in the Kyrgyz Republic: only 364 HIV cases had been reported in there as of mid-2003. Most of these were attributable to **injecting drug** use as in the rest of Central Asia, and are geographically concentrated.

More than half of the people reported as living with HIV in the Kyrgyz Republic are located in one prison in the district of **Osh**.

The Kyrgyz Republic has introduced some elements of **second-generation surveillance** and that may help to more precisely assess risks in the future.

The **trafficking** of opiates from Afghanistan into and though the Kyrgyz Republic gives higher risks in terms of injecting drug use than would otherwise be the case. The country's relatively low per-capita GDP and human development indicators (the Kyrgyz Republic is one of the poorest countries in CIS) offer further grounds for concern. The fact that the Kyrgyz Republic in 2000 reported only \$145 in per-capita health expenditures (compared to \$415 for the Russian Federation) underscores the basic frailty of the public health infrastructure in the country.

b. HIV PREVALENCE RATES (WITHIN THE COUNTRY, BY REGIONS):

VII: From: *AIDS in Kyrgyzstan: Five Year Resistance, Bishkek 2003*

Book published by UNAIDS, UNDP, the government of the Kyrgyz Republic

p. 20: *HIV/AIDS in the Kyrgyz Republic, 2.1. History of the epidemic*

2.4. Epidemic Outlook

As estimated by UNAIDS, the actual number of HIV-infected people in the Kyrgyz Republic is ten times more, and amounts to over 3,000 persons. According to test findings for residual blood in syringes used by injecting drug users, which was conducted in 2000 within sentinel epidemiological surveillance, the HIV incidence in the group tested was 15% for **Bishkek** and 41% for **Osh**. Thus the number of HIV-infected IDUs was estimated at 6,550 in Bishkek and 2,050 in Osh. According to the Ministry of Health of the Kyrgyz Republic the number of person with HIV in Osh Oblast and Bishkek alone may exceed 9,000 by the end of 2003.

Behavioral studies performed in the Kyrgyz Republic point to the high sexual activity of injecting drug users. Moreover IDUs may be found among sex workers.

The general trend towards increased numbers of HIV-positive women is also alarming. Infections in women, in turn, may result in giving birth to HIV-infected newborns.

The high probability of HIV spread among MSM (men who have sex with men) is also present. The criminalization of homosexuality in Soviet times along with the still prevailing negative public attitudes towards MSM makes people in this group very closed. Several prevention programs are being currently carried out among MSM, but they do not cover the whole group. They lack adequate funding and fail to reach those MSM who still conceal their homosexual preferences.

HIV risk is also high in penal institutions. As of Jan 1, 2003, 166 PLWHA were kept in prison. Conditions in penal institutions limit the possibilities for the development of syringe-exchange programs and methadone substitute programs. By force of a traditional concealment of the problem, prison managers never openly discuss the need to prevent HIV transmission through sexual contacts between inmates (with most such contacts being of a forced nature).

Instances of using unscreened blood in life-threatening circumstances have been reported. This practice, as well as inadequate antibody-based methods for HIV diagnostics and the existing practices of paid blood donation, may lead to HIV transmission through a transfusion of infected blood.

I. From <http://www.eurasiahealth.org/resources/mdlIDoc/1467-e.pdf>
AIDS Epidemic Update: December 2004

Eastern Europe and Central Asia: p. 47 to 56

Kyrgyzstan's much smaller epidemic is being propelled mainly by injecting drug use and is concentrated largely still in **Osh** Oblast, two regions of **Chui** Oblast (Jaiyl and Yssykata) and **Bishkek** City. In a country where it is officially estimated that at least 2% of the adults population injects drugs, huge scope exists for rapid and extensive spread of HIV.

c. HIV PREVALENCE RATES (VULNERABLE GROUPS):

V: From UNIFEM Summary on Community Based Research
Community based research: Gender dimensions of HIV/AIDS in Kyrgyzstan

UNIFEM supported community based research was conducted to identify sexual behavioral factors and socio-cultural stereotypes leading to vulnerability of **women** with regard to HIV/AIDS.

The research also identified the problems of sexual upbringing of young people and the level of awareness of the rural population about HIV/AIDS.

Traditional practices and the population's attitude towards sex and sexuality

As a result of the research, a number of factors regarding women's vulnerability in the sexual sphere, including their vulnerability to HIV/AIDS, were identified. One of the most important factors are gender stereotypes in the sexual sphere:

- In rural families initiative and sexuality are displayed mainly by men (70-90% of families). This is considered to be a norm in family relations.
- Basic reasons for women's sexual passivity include the following: tiredness after house and fieldwork, sickness, absence of proper housing conditions; men's negative attitude to women's sexuality is also considered to be an important psychological factor (regarded as a sign of libertinism); and one more factor in some families - violence.
- A girl must be a virgin when she gets married. There are cases when a girl is sent back to her parent's home if she is not a virgin, even if all traditional ceremonies and rites have been observed, including the wedding. A man can have sexual experience before marriage. This is not condemned by the society. Recently, an increase in the number of polygamic marriages can be observed, especially in rural area.
- Cult of childbearing. If a family does not have children, this is always women's fault (women are stigmatized as being sterile). A man is above doubt even if he is sterile – it is not habitual to speak about it.

- Family planning issues, use of contraceptives, and safe sex are women's responsibility.

The research identified a number of problems in rural youth's sexual education:

- Taboo on discussions about sex and sexuality between parents and children;
- Lack of experience and the system of knowledge among parents, as well as positive terminology for adults and children to communicate on the issues related to sex and sexual relations;

The level of awareness of the rural population about HIV and its attitudes towards HIV positive people.

- The rural population knows that HIV/AIDS is a deadly and incurable disease. However, they can hardly realize that HIV/AIDS poses a real treat to their own health and the health of their family members. They have superficial knowledge about the ways of HIV transmission and prevention of the HIV/AIDS epidemic.
- In rural area people have different attitudes to HIV positive people: most tolerant and human attitude can be observed among young people (they receive training at school), while adults treat HIV infected people with anxiety and condemnation; some of them even display aggressiveness. Adults begin to display tolerance when they realize that HIV/AIDS can strike everyone, including themselves and their family members.

Factors of women's vulnerability to HIV/AIDS

The research demonstrated that the subordinated position of women in a family, their economic dependence, lack of knowledge on legal matters, coercive forms of marriages (abduction of a bride without her consent, marriages based on parental agreement) do not give them an opportunity to insist on safe sex.

Conclusions

Women's vulnerability in the sexual sphere, including vulnerability to HIV/AIDS is predetermined by the following factors:

- Gender stereotypes in the sexual sphere;
- Ignorance of the legislation ("legal illiteracy" of women);
- Low awareness of the ways of HIV/AIDS transmission and prevention;
- Low economic status of women;
- Low self-esteem of women and their passivity;

Main difficulties and problems in the sexual up-bringing of children in rural families are as follows:

- Psychological barriers between parents and children, between schoolchildren and teachers;
- Insufficient number of positive terms related to sexual relations.
- The rural population (adults) are poorly informed about the ways of transmission and prevention of HIV/AIDS

Points for action

1. It is necessary to carry out HIV/AIDS prevention activities at the national level taking into account gender aspects of the pandemic and to provide for the approach based on the legislation that recognizes gender equality, expansion of rights and opportunities for women;
2. Use CEDAW (Convention on the Elimination of all Forms of Discrimination against Women, <http://www.un.org/womenwatch/daw/cedaw/>) as a legal basis for observing women's rights, decreasing their vulnerability to HIV/AIDS by liquidation of all forms of violence, discrimination, and stigmatization of women and girls, including discriminating cultural traditions and stereotypes;

3. The state should carry out activities on implementing the CEDAW regulations related to free choice of a spouse. This will enable to fight against coercive marriages. Moreover, it is necessary to create conditions for free display of sexuality and for the exit from the situation of permanent sexual violence, which is considered to be a norm in many families.

d. MAJOR TRANSMISSION ROUTES :

VII: From: AIDS in Kyrgyzstan: Five Year Resistance, Bishkek 2003

Book published by UNAIDS, UNDP, the government of the Kyrgyz Republic

p. 20: HIV/AIDS in the Kyrgyz Republic, 2.1. History of the epidemic

2.2. HIV transmission routes

Only two routes of transmission were officially established: **heterosexual** (unprotected sexual contacts) and **parenteral** (injecting drug use with unclean injection equipment). In three HIV cases the route has not been identified.

Prior to 1991 only sexual transmission has been observed (all HIV-infected persons were from African and Asian countries). Starting in 1995 HIV infections were being detected in drug users. Thus all new cases officially registered in 2000 and 143 cases (out of 149 in total) detected in 2001 (95.9%) were in injecting drug users. As of January 1, 2003, 297 people had been infected through injecting drug use: 46 CIS residents out of 52 total cases and 251 local residents out of 294 infections (85.4%), of those, 157 cases (out of 178) were registered in Osh (or 88.2%).

The rise in HIV infections through sex (from 4.1% in 2001 to 21.2% in 2002) is alarming. This is recognized as indirect evidence of the end of a considerably long-lasting stage in the epidemic development among injecting drug users and indicates the beginning of the spread of the virus outward from drug-using circles into the general population.

HIV in the Kyrgyz Republic spread primary among men aged below 29 years (46.1% of all HIV-infected persons) and among those men who fall in the age group of 30 to 39 (34.3%). Of the 362 PLWHA on record as of Jan 1, 2003, 328 are males (90.6%). Women account for 26 cases (8.8%) in local residents and for 7 cases (10.3%) in foreigners.

At the initial epidemic stage, from 1987 to 1996, all HIV cases were in males only. Despite this prevalence of HIV infection among males, the first HIV cases among local residents were detected in 1996-1997 in women. The number of infections in females is growing, with one HIV case in 1996-1998, two in 1999, one in 2000, fourteen in 2001, and same number in 2002. Several instances of childbirth to HIV-positive women were recorded (one in 1997 and one in 2002). These women were on preventive treatment during pregnancy. As a result one child is currently healthy; and the other child was still under doctor's supervision until he reached 18 months.

In 1996 and in 1998 new cases among female showed only sexual transmission. Transmission through injecting drug use was first registered among women in 1997. Overall seventeen out of thirty-three infections in women have been acquired through injecting drug use, including five among CIS residents and twelve among local residents.

Of all PLWHA throughout the entire period of epidemic surveillance, 18 persons were under 19 years of age (18-19), with 170 (the majority – 46.9%) in the 20-29 age group, 132 (36.5%) in the 30-39 age group, and 34 (9.4%) in the 40-49 age group. Most HIV-infected women also fall in the most numerous age group of 20-29, including five out of the seven HIV-infected CIS residents and twelve out of twenty-six HIV-persons (15 out of 16) were in the age group of 20-29. Since 1995 HIV is being diagnosed in other age groups too. People in their best reproductive years prevail among the PLWHA diagnosed throughout the entire period of epidemic surveillance in the Kyrgyz Republic.

e. ACCESS TO TREATMENT:

IX: From <http://www.euro.who.int/document/mediacentre/fs0603e.pdf>
HIV/AIDS treatment: antiretroviral therapy
Fact Sheet EURO /06/03
WHO Europe
Copenhagen, 1 Dec 2003

Country	Estimated number of people who need ART	Estimated coverage (%)
Kazakhstan	100	55.0
Kyrgyzstan	10	0.0
Tajikistan	5	0.0
Turkmenistan	0	0.0
Uzbekistan	100	0.0

From: Harm Reduction News
Newsletter Focus
Fall 2002 – Volume 3, Issue 3
p. 9: Kyrgyzstan: Leading the Way on Methadone, by Tynchtykbek Asanov

The first time Kyrgyzstan's health care and law enforcement representatives discussed methadone substitution therapy in the summer of 2000, they were decidedly unenthusiastic. The new idea met with prejudice and stagnant thinking.

So how, only two years later, did Kyrgyzstan become the first country in Central Asia to introduce the practical use of methadone for substitution treatment of opiate addiction?

Unfortunately, this welcome policy change was helped by the revelation in the fall of 2000 of a sharp increase in the number of HIV cases in the Osh region. The increase was especially high among IDUs. For the first time people were forced to seriously consider HIV/AIDS prevention.

Kyrgyzstan also had favorable drug laws prior to the introduction of methadone treatment. There are no legal barriers to the use of narcotic drugs to treat drug addiction. Buprenorphine, for example, had been used under the name of *norphine* for many years for the detoxification of opiate addicts. Further, methadone was not included on the list of narcotics prohibited from use for medical and scientific purposes.

Implementing methadone therapy in Kyrgyzstan had distinct legal, technical, and practical stages.

During the legal stage, advocated for methadone treatment has to overcome opposition from the government ministries responsible for public order and control of narcotic drugs. There were three private working meetings with them dedicated to the methadone program. There were also three TV public discussions involving doctors, lawyers, and police. And a briefing for the mass media was held that provoked many newspapers to article in the months leading up to the launch of the methadone program.

By the summer of 2001 the Soros Foundation-Kyrgyzstan and the Republican Narcology Center has received all the necessary paper-work, clearing the way for an agreement that provided a grant to the center for a pilot methadone therapy project in Bishkek.

Once all the legal requirements were cleared, the technical stage began. Minor repairs to the center were made, essential equipment was bought, and an agreement for the delivery of methadone hydrochloride from Slovakia was signed.

In late January 2002, methadone arrived in Bishkek. Implementation of the third, practical stage started in April in Bishkek and Osh when the project saw their very first clients.

Implementation of the third, practical stage started in April in Bishkek and Osh when the projects saw their very first clients, who have heard about the project from the media. The majority of later clients came to the projects based on the recommendation of participants.

In a strategic compromise move to appease opponents concerned about the illegal circulation of methadone, the programs have a high threshold for accessibility. Methadone therapy can be provided only at state narcological institutions, and doctors from other agencies or with other specializations do not have the right to prescribe methadone to their patients. Anonymous participants in these programs is prohibited. The methadone solution is given out daily and there is periodic testing of clients for the presence of other narcotic drugs and psychotropic substances. If the consumption of illegal opiates is confirmed the participant can be excluded from the program. It is expected that such harsh conditions to be softened, if the pilot project prove to be successful.

Currently there are 72 participants in the two programs – 42 in Bishkek and 30 in Osh. It is informative to profile the Bishkek participants. They range from 20 to 51 years old. One-quarter of them are women. They have been using opiates for an average of 11 years and practically all of them have concomitant disorders such as anxiety and depression. A little more than half are infected with viral hepatitis. At the time they entered the program, almost all of the participants used heroine intravenously (one was shooting up in the muscle tissue as all accessible veins has atrophied or sclerosed). The average dose of heroine during the last month before entering the program was 1.2 grams a day in 2-3 daily injections. Two of the program participants are HIV positive. Nearly 60% have prior convictions.

Since the project started, three participants have left. One was convicted for a criminal offence, another was excluded from the program for an attempt to carry out methadone from the office, and the third stopped coming into the program of his own accord.

The somatic health of the participants has improved noticeably. The patients and their relatives report sleep stabilization, restoration, and “mood improvement.” Women also report restoration of their menstrual cycles.

While there have been no major changes in the social status of the participants since the projects started, one patient has gotten married, one has returned to his family, and two participants have started working. There has also been a significant improvement in personal relationships, especially with the clients’ families.

II. CURRENT RESPONSE TO HIV/AIDS EPIDEMIC IN THE COUNTRY

a. GOVERNMENT

X. From: http://www.youth-policy.com/Policies/Kyrgyzstan_AIDS_Law.cfm

LAW OF THE REPUBLIC OF KYRGYZSTAN ON AIDS PREVENTION

Adopted by Legislative Assembly
Zhogorku Kenesh of the Kyrgyz Republic

2 December 1996

AIDS is a particularly dangerous infectious disease which considering the absence of effective methods of its treatment and specific prevention causes death of an infected person. Control of AIDS is one of the priority issues of the Government's political agenda on public health.

The law determines the procedure for legal regulation of issues related to spread of this disease, provision of social protection against HIV infection to the population of Kyrgyz Republic in accordance with standards of International Law.

SECTION 1. GENERAL

Article 1. Main terms and definitions

The following terms and definitions are used in this Law:

HIV-infection - a disease caused by Human Immune-Deficiency Virus (HIV).

AIDS (Acquired Immune Deficiency Syndrome) - final stage of HIV-infection.

HIV-infected persons - those in whose bodies Human Immune-Deficiency Virus has been detected (HIV-carriers and people suffering from AIDS).

HIV - carriers are people with no clinical signs of AIDS.

AIDS patients are people with various pathological signs caused by deep affection of immune system by human immune-deficiency virus.

Article 2. National AIDS Control policy of the Kyrgyz Republic

National policy of the Republic of Kyrgyzstan on AIDS control is being realised through implementation of the present Law, other laws and legislative acts of the Republic of Kyrgyzstan.

Article 3. The state guarantees:

- regular informing of population, also through mass media, on available HIV preventive measures;
- epidemiological surveillance of HIV spread on the territory of Kyrgyz Republic; as well as control for safety of medical substances, biological fluids and tissues used for diagnostics, treatment and scientific purposes;
- accessibility of medical testing for HIV (further HIV-testing), including anonymous with pre- and post-test counselling, as well as ensuring safety of this procedure for both people undergoing testing and those performing it;
- free provision of comprehensive qualified and specialized medical care to HIV infected people, free supply of medicaments by out-patient and in-patient health establishments, as well as reimbursement of expenses incurred by their travel to and from the place of treatment within Kyrgyz Republic;
- development of scientific research on HIV;
- introduction of moral and sexual education into curriculum of educational institutions;
- provision of social and economic support, education, re-qualification and employment to HIV infected people;
- training of specialists for carrying out activities aimed at prevention of HIV spread;
- development of international cooperation and regular exchange of information within the frames of international HIV prevention programmes.

AIDS prevention measures are being realized by the Government of Kyrgyz Republic, local state administrations, local authorities.

Institutions, organizations, communities, including international, private persons, including foreign citizens, can participate in the implementation of AIDS control activities. The state guarantees support to juridical and physical persons in their activities aimed at implementation of these programmes.

Article 4. Financing of AIDS prevention activities

Financing of targeted programmes, activities of institutions, services and organizations involved in HIV prevention, treatment and social protection of HIV infected people is realized at the expenses of:

- republican budget, with special allocation of funds and local budgets of the Kyrgyz Republic;
 - special funds;
 - voluntary medical insurance funds;
 - other sources of financing not prohibited by the legislation of the Kyrgyz Republic.
- State financing of HIV preventive activities is considered a priority issue with a view of protecting personal and public security.

SECTION II. TESTING FOR HIV, CASE FOLLOW UP

Article 5. Right to AIDS prevention

Citizens of the Republic of Kyrgyzstan, aliens, and stateless persons residing or staying in the Republic of Kyrgyzstan have the right:

- to be tested for HIV with a view to detecting infection by the human immunodeficiency virus and have medical examination in specialised health care units regardless departmental subordination of these units;
- to be informed on the results of such tests and receive recommendations on prevention of further HIV transmission.

This right is ensured by qualified medical assistance, established network of services for AIDS prevention and care.

Persons undergoing HIV-testing are guaranteed safety of medical procedures and confidentiality.

Article 6. HIV testing

Test for HIV is performed in state, communal or private health care services on the basis of the license obtained by them in accordance with procedure established by the legislation of the Kyrgyz Republic.

Issue of HIV certificates to citizens of Kyrgyzstan, aliens, and stateless persons is performed only by state or communal services of public health system.

HIV test is performed on a voluntary basis, excluding the cases provided for in article 8 of the present law, when such tests are mandatory.

A person undergoing test for HIV has the right to the presence of his legal representative during the test.

HIV testing of children under 16 and of persons legally recognized as disabled can be performed at the request or with the consent of their legal representative, who have the right to be present during test.

Rules for medical testing with a view to detecting infection by the human immunodeficiency virus, registration, medical examination of HIV infected people and their follow up are developed and approved by the Government of Kyrgyz Republic.

Information concerning infection of persons by immunodeficiency virus or AIDS is considered an official secret protected by law.

Staff members of diplomatic and consular missions of foreign states enjoying diplomatic privileges and immunities on the territory of the Kyrgyz Republic can be tested for HIV through

their consent. Ministry of Health has to reach prior agreement with Ministry of Foreign Affairs of Kyrgyz Republic on proposals as to testing of such persons.

Article 7. Voluntary HIV testing

HIV testing is to be performed in state, communal or private establishments of public health system on a voluntary basis, at the request of the individual or with his/her consent, and in cases determined in article 6 of the present law - at the request or with consent of his/her legal representative.

Article 8. Mandatory HIV testing.

Donors of blood, biological fluids, tissues and organs are subject to mandatory HIV-testing. Persons who refused to undergo mandatory HIV testing cannot be donors of blood, biological fluids, organs and tissues.

Clinically suspected cases and those falling within epidemiological signs determined by the Government of Kyrgyz Republic (if reliable information on them as a possible source of infection is available) are also subject to mandatory confidential HIV testing.

Ministries, departments, institutions and organizations irrespective of their form of property have no right to demand HIV certificates from their staff members and citizens, if this is not contemplated in the rules for HIV testing.

Article 9. Case follow-up

Medical and preventive follow-up of HIV-infected (HIV carriers and AIDS patients) citizens of the Kyrgyz Republic, aliens, and stateless persons residing or staying on the territory of Kyrgyz Republic is to be performed by state, communal or private establishments of public health system.

Article 10. Deporting of HIV infected foreigners.

HIV infected aliens staying on the territory of Kyrgyz Republic are subject to deporting out of Kyrgyz Republic by epidemiological signs in accordance with procedure stated in the legislation of the Kyrgyz Republic.

SECTION III. RIGHTS AND SOCIAL PROTECTION OF PEOPLE WITH HIV/AIDS AND THEIR FAMILIES.

Article 11. Rights of HIV infected persons.

People with HIV/AIDS have the right to:

- human attitude from the community side, which excludes humiliation of their dignity;
- demand the information on their health status to be kept confidential;
- be recovered for losses associated with disclosure of information on their HIV status;
- have job they have chosen excluding jobs and posts specified in a special list;
- have a free supply of comprehensive qualified medical care and medicaments;

It is allowed to involve HIV-infected persons in trials of medicines and treatment methods, scientific researches or teaching process, take photos of them or make video films only through their consent.

It is not allowed to refuse access to health care establishments, urgent medical assistance, and infringe upon human rights on the ground of HIV/AIDS status or on the ground of being related to a person with HIV.

Article 12. Social protection of HIV infected people and their families.

Persons infected with HIV as a consequence of inappropriately performed medical procedures are granted pension allowances.

Parents or people taking care of children with HIV/AIDS have the right:

- to stay with their children (up to the age of 14) in hospitals and be relieved from work for this period with payment of temporary incapacity allowance;

- to temporarily incapacity allowance to one of the parents who has to leave the job in order to take care of the sick child under 16, on the condition that he/she resumes his/her duties when the child reaches the above mentioned age.

Mothers having children with HIV/AIDS under the age of 16 have the right to get their annual vacation in summer or any other time convenient for them. In case of absence of a mother this right is granted to a father or other person taking care of the child.

Children with HIV/AIDS under 16 are entitled to a state monthly allowance at the rate of two minimal salaries.

Persons taking care of such children are entitled to attendance allowance according to procedure determined by the legislation of Kyrgyz Republic.

State Department on Education, Science and Culture of the Kyrgyz Republic jointly with Ministry of Health will develop special programmes based on secondary school curriculum and organize teaching of children and adolescents with HIV/AIDS who are undergoing treatment in hospitals, rehabilitation centres or at their homes.

SECTION 5. SOCIAL PROTECTION OF PERSONS EXPOSED TO RISK OF HIV INFECTION WHILE PERFORMING THEIR DUTIES.

Article 13. AIDS as an occupational disease

HIV infection of medical and pharmaceutical personnel as well as other workers whilst performing their professional duties is classified as an occupational disease.

Article 14. State insurance of workers involved in provision of medical care to HIV infected people.

Personnel engaged in provision of medical care to population, laboratory and scientific researches on HIV and production of viral products as well as donors, personnel of social services, Ministry of Internal Affairs and other persons engaged in delivering assistance to people with HIV/AIDS are subject to compulsory state insurance for the case of HIV infection whilst performing their official duties and also for the case of disability and death resulting from HIV-infection. Procedure for compulsory state insurance of specified categories of personnel is determined by the Government of Kyrgyz Republic.

Administration of health services, which staff performs HIV tests, provides medical care to people with HIV/AIDS, have contacts with blood and other substances from HIV infected people is obliged to supply its workers with necessary protective means, ensure their regular testing for HIV.

Article 15. Benefits in labour sphere.

Workers engaged in provision of medical, social and other care to people with HIV/AIDS, involved in laboratory diagnostics of HIV, scientific research associated with use of infected substances, production of biological substances for diagnostics, treatment and prevention of AIDS have the right to supplementary indemnity, early retirement and additional annual leave in

accordance to List 1, which comprises professions, posts and indicators, approved by the Government of Kyrgyz Republic.

SECTION V. FINAL STATEMENTS

Article 16. Liability for breach of the present law

Breach of the present law entails administrative, criminal and civil liability in accordance with established legislation.

Article 17. Liability of HIV infected people.

Intentional HIV infection or exposure of another person (persons) to the risk of HIV infection by a person aware of his/her infection entail criminal liability established by legislation of Kyrgyz Republic.

The guilty person reimburses the expenses involved in provision of medical and social assistance to infected person.

Article 18. Procedure for appeal for unlawful acts committed by official persons.

Unlawful acts of official persons, violating the rights of people with HIV/AIDS and their relatives can be appealed through judicial institutions in accordance with the current legislation of Kyrgyz Republic.

Article 19. International collaboration of the Kyrgyz Republic.

Procedure for international collaboration of Kyrgyz Republic with other countries on AIDS prevention is determined by the legislation of Kyrgyz Republic.

In case of discrepancy between the rules of International treaties signed by Kyrgyzstan and rules stated in this Law, rules of International treaty come into force.

Article 20. On carrying the present law into effect.

1. To bring the law "On AIDS Prevention in Kyrgyz Republic" into effect since the moment of its issue.
2. The Government of Kyrgyz Republic is to bring its legislative acts in compliance with the present law.

President of the Kyrgyz Republic

A. Akayev

*VII: From: AIDS in Kyrgyzstan: Five Year Resistance, Bishkek 2003
Book published by UNAIDS, UNDP, the government of the Kyrgyz Republic
p. 27. Part II. Context. 3. National Policy*

3. National Policy

The National Program on the Prevention of HIV Infection and Sexually Transmitted diseases was approved in 1997 by Kyrgyz Government Resolution No.507, dated 1 Sep 1997, on AIDS and STD Prevention Measures in the Kyrgyz Republic. The same Resolution provided for the establishment of the National Multi-sectoral Coordinating Committee on AIDS and Sexually Transmitted Diseases under the Government of the Kyrgyz Republic. A year later, by Order

No.270 of the President of the Kyrgyz Republic, dated 8 Aug 1998, the functions of the National Committee were handed over to the Coordinating Commission on Healthcare Reform and Medical Insurance under the President's Administration. Between 1998 and 2001 the Commission was headed by the State Secretary of the Kyrgyz Republic.

By its resolution No. 785 (approved the regulations of the committee, determined its primary objectives, management, structure and functions) dated 13 Dec 2001, the Government approved a membership composition of the new Republican Multi-sectoral Coordinating Committee under the Government of the Kyrgyz Republic on Prevention of AIDS. The new structure includes representatives of AIDS-related non-governmental organizations and staff of the international Project on AIDS Prevention. Thus the newly formed Committee consists of 39 members.

The Committee was created for the purpose of facilitating the optimum interaction between all ministries, agencies, services, and non-governmental organizations in the prevention and anti-epidemiological efforts with regard to HIV/AIDS and infections of sexual and injecting transmission.

The National Program on Prevention of AIDS and Sexually Transmitted Diseases in the Kyrgyz Republic: was in effect between 1997 and 2001. The program was aimed at reducing risks and the magnitude of the HIV/AIDS epidemic and STI prevalence rates in the Kyrgyz Republic.

The program was divided into five strategic priority directions on the basis of the multi-sectoral approach.

Strategies:

1. To formulate a national policy on HIV/AIDS/STD
2. To provide with safe medical procedures
3. To prevent sexually transmission of HIV and STIs
4. To prevent pre-natal HIV transmission
5. To provide medical care for and social support to HIV-infected persons, people living with AIDS, and their family-members

The National Program has played a decisive role in formulating policies and organizing preventive programs. One the whole, it has managed to achieve its objectives. Still many problems are left unsolved. "This primarily relates to the policy of addressing vulnerable groups and the improvement of legislation and funding. The state sector's involvement remains limited in resolving problems relating to HIV/AIDS prevention. Activities of various ministries and agencies are poorly coordinated and no accord has been reached with regard to the methodology behind their interventions. Those intervention aspects that deal with the provision of safe medical procedures have not been fulfilled in full, particularly the supply of medical staff of medical instruments and means of protection, and the inadequate screening of donor blood for HIV (only 95.2% has been screened). No primary prevention issues of drug abuse have been addressed. The school program for promoting healthier behavior and lifestyles is still in its initial stages. Inadequate funding of health-care institutions makes drug-abuse treatment inefficient and inaccessible to most drug users. Some bylaws contradict existing laws and international norms and thus hamper the development of prevention program among vulnerable groups."

From:

<http://lnweb18.worldbank.org/ECA/ECSHD.nsf/ExtECADocByUnid/48480FC1CCDE1DCE85256C830060FDF4?Opendocument>

HIV/AIDS in the Kyrgyz Republic

- **Newly registered HIV-infections are rapidly increasing** although prevalence rates remain low. By November 2001, there were a total of 168 officially registered HIV cases, a staggering 115 of which were identified in 2001 alone.
- **Injecting drug use accounts for majority of infections** – about 90%. In a country where it is officially estimated that at least 2% of the adult population injects drugs, there is a serious risk of the rapid and extensive spread of HIV.
- **While many early cases were identified among foreigners, most HIV-infected persons are now Kyrgyz nationals.**

Kyrgyz Government's Response - International Best Practice

- **The Kyrgyz Republic's response during the early years – when the first cases of the virus were identified – can be considered international best practice.** Although seriously under-funded (only \$25,000 was allotted last year by the Government for prevention and awareness programs), the Government has taken active measures to address a potential epidemic.
- **The prevention of HIV/AIDS and sexually transmitted infections (STIs) is included in Health Reform Programs** - in 'Manas' and in the State Program 'Healthy Nation'.
- **The Parliament adopted a law on AIDS prevention in 1996**, when only 4 cases of HIV had been identified in the entire country. The adoption of this Law intensifies HIV prevention activities in the country, ensures the involvement of all state agencies, and facilitates the securing of funds for special programs.
- **The National Program on HIV/AIDS/STI prevention was passed in 1997.**

Government Strategies

Under the recent 'Strategic Plan of National Response to the Epidemic of HIV/AIDS in the Kyrgyz Republic', passed in 2000, five strategies and interventions are identified:

- **Developing a national policy on HIV/AIDS and STIs;**
- **Ensuring safe medical procedures**, including prevention of HIV and other infections through blood transmission, invasive procedures, and unsafe injection;
- **Preventing sexual transmission of HIV/AIDS and STIs** by fostering safe sexual behavior, providing condoms, and providing medical care for STIs;
- **Preventing prenatal transmission of HIV** by providing reproductive age groups with information on HIV/AIDS/STIs/family planning;
- **Providing medical and social care for HIV-positive patients, AIDS patients and their family members.**

From:
 HIV/AIDS
 Social and Economic Consequences in Countries of the Commonwealth Of Independent States
 Indicators for the World of Work
 Report of a Tripartite Seminar
 Moscow, 10-12 December, 2001

By Mr. Shamaral Maichiev

Starting in 1996, the number of registered HIV infections in Kyrgyzstan increased dramatically from less than two to 131. Ninety per cent of all infections are among IDUs, with needle sharing as the main route of infection; nine per cent of all infections are transmitted heterosexually. The number of registered drug users is still increasing and between 1996 and 2000, the number rose from 2,895 to 4,459. The trends from 1994 to 2000 indicate a dramatic change from oral drug use to injecting drug use.

Six per cent of those infected with HIV are younger than twenty years old, 54 per cent belong to the age group 20 to 29 years, 29 per cent to the age group 30 to 39 years, and 11 per cent are older than 40 years. The prevalence of syphilis peaked between 1996 to 1998, with 6,855 cases in 1998; from 1998 to date, the number of new registered cases went down to 2,496 (8 moths in the year 2000).

In response to the developing HIV/AIDS epidemic, the government has created a national policy based on principles advocated by UNAIDS and has promulgated laws respectively. That policy includes a national programme and a multi-sectoral committee addressing HIV/AIDS. A concerted multi-sectoral approach operates within the framework of the UN Theme Group on HIV/AIDS. Based on the principle of social support, targeted interventions are being carried out in groups with high behavioral risks, including men having sex with men, commercial sex workers, migrants, young people, and students. For drug users, harm reduction programmes are being implemented. Local and international NGOs have been encouraged to contribute to the HIV/AIDS prevention efforts of the government.

Workplace programmes were being developed for those occupational groups with the highest risk of HIV infection. For these groups, a national strategy for HIV/AIDS prevention in the workplace is being developed by creating sectoral policies (issuing orders, letters of instruction, etc.) Programmes are being implemented by identifying and designating responsible government officials and training them within the framework of vocational education and post-graduate internships. In addition, counseling at the workplace and instructions are being provided, seminars for specialists are being offered and required materials are being developed and published. All workplace programmes include a component of monitoring and evaluation. So far, specific programmes have been implemented with long-haul truck drivers, railway service personnel and army servicemen with encouraging results.

A number of activities are being planned: an information campaign in the media will be launched. Other future action includes an assessment of HIV/AIDS prevention programmes at the workplace, a workshop for heads of various departments and trade unions, and a review of sectoral instructions and policies on HIV/AIDS.

b. DONOR ORGANIZATIONS

XIV: From: www.unaids.org/Unaid/EN/Geographical+area/By+Country/kyrgyzstan.asp

The Kyrgyz Republic has become a model for other CIS countries and beyond in its methadone maintenance and syringe exchange programmes in Bishkek and Osh.

Country HIV and AIDS estimates, end 2003

Adult (15-49) HIV prevalence rate	0.1% (range: <0.2%)
Adults (15-49) living with HIV	3900 (range: 1500-8000)
Adults and children (0-49) living with HIV	3900 (range: 1500-8000)
Women (15-49) living with HIV	<800 (range: <1500)
AIDS deaths (adults and children) in 2003	<200 (range: <400)

Source: [2004 Report on the global AIDS epidemic](#)

Country Situation Analysis

Independent estimates put the overall number of HIV cases in Kyrgyzstan at nearly ten times the officially reported figure of 534. The leading mode of infection transmission remains intravenous, with the highest figures in the capital Bishkek and southern city of Osh. An estimated 60 000 people are injecting drug users, and in some cities the prevalence of HIV among them is over 20%. There is a trend toward an increasing number of people infected by the sexual mode of transmission—from 8% in 2001 to 16.5% in 2004—and a growing rate of HIV cases among women.

Responses to the growing threat of HIV have been in place in the Kyrgyz Republic for several years. The country has already mobilized a multisectoral response to HIV/AIDS. The State Programme on the Prevention of AIDS was adopted in December 2001, with emphasis on information, training, advocacy and prevention.

The state programme has managed to attain some success in HIV prevention. General population awareness of HIV prevention measures has grown, and is targeted to reach 90% among youth by 2008.

The Kyrgyz Republic has become a model for other CIS countries and beyond in its methadone maintenance and syringe exchange programmes in Bishkek and Osh. The latter needs urgent financial support, since the current financing by international donors ends in September 2004. Innovative work has been done with the media and youth organizations to create awareness and knowledge among young people. There is also considerable progress in joint work with the religious community. Influential Muslim leaders have become essential actors in a successful response to HIV/AIDS as they have legitimacy and durable presence in local communities, particularly those in the south of the country.

UNAIDS Support to the National Response

The UN Theme Group made a significant contribution to the preparation of the proposal to the Global Fund entitled «Prevention and Treatment of HIV/AIDS in the Kyrgyz Republic» and to setting up the local CCM. UNAIDS helped to initiate the work, mobilize high-level political support for the government, bring NGOs and people living with HIV into the process, gather information and proposals from stakeholders, prepare the zero draft and review the final proposal and its budget.

With UNAIDS and Theme Group assistance, the government has taken a decision to develop a universal system for monitoring the country response as an integral part of the State Programme on the Prevention of AIDS.

Expanded advocacy efforts have been undertaken by the Theme Group to advocate accelerated access to antiretroviral therapy and improvement of treatment infrastructure. Thirty people living with HIV need treatment and do not get it, while the number of people in need may sharply rise in the coming years.

Contacts

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XII: From: <http://www.theglobalfund.org/search/portfolio.aspx?countryID=KGZ>

The Global Fund

Kyrgyzstan:

PORTFOLIO OF GRANTS IN KYRGYZSTAN	
Country Coordinating Mechanism (CCM):	<p>Mr. K.E. Osmonov Honorable Vice Prime Minister Government House CCM Kyrgyzstan, Chairperson Bishkek 720003 205, Chuysky Prospekt 996312 225064 996312 666659 (fax) K.Osmonov@mail.gov.kg</p> <p>Dr. B.M. Shapiro Director General National AIDS Center CCM Kyrgyzstan, Contact 1 Bishkek 8, Logvinenko St., 5th floor 996312 227290 (996312) 227579 996312 227290 (fax) nac@elcat.kg</p> <p>Mrs. R.B. Ibraimova</p>

	National Red Crescent Society CCM Kyrgyzstan, Vice-chair Bishkek 720040 10, Erkindik Bulvard 916312 222414 (916312) 222411 916312 662181 redcross@elcat.kg
Disease(s):	Round 2: The National AIDS Center of the Government of the Republic of Kyrgyzstan
Total Funding Request:	\$19,844,388.00
2-year Approved Funding:	\$6,170,873.00
Total Funds Disbursed:	\$3,884,605.53

HIV/AIDS

Project Title:	Development of preventive programmes on HIV/AIDS, Tuberculosis and Malaria aimed at reduction of social and economic consequences of their spread
Country:	Kyrgyzstan
Round:	2
Principal Recipient:	The National AIDS Center of the Government of the Republic of Kyrgyzstan
Local Fund Agent:	PricewaterhouseCoopers Zhanbota.Bekonov@kz.pwc.com adilkhan.temirbekov@kz.pwc.com
Portfolio Manager:	Chernyavskiy, Valery Valery.Chernyavskiy@TheGlobalFund.org
Grant Agreement Signed:	04-Aug-03
Total Funding Request:	\$17,073,306.00
2-year Approved Funding:	\$4,958,038.00
Total Funds Disbursed:	\$3,288,377.53

This is a 5-year proposal for a comprehensive prevention and treatment programme of HIV/AIDS. Kyrgyzstan is a low prevalence (0.1 %), high incidence country which has a population of 4.7 million and a GDP of \$300 per capita. The country is poor and the government faces a huge budget deficit of 8% of GDP. Heroin is very cheap as Kyrgyzstan is on the drug route Afghanistan – Eastern Europe.

310 HIV cases have been identified with the estimated total number 10 – 20 times higher. IVDU has been recognised as the current driver of the epidemic and accounts for more than 85 % of prevalence and incidence.

The comprehensive, multi-sectoral proposal is targeting both high risk groups (drug users, commercial sex workers, MSM, prison inmates) and youth in general. The objective is to stabilize HIV prevalence at maximum 2%, provide drugs for treatment, offer social support, assure safe blood supply, and strengthen political and legal support for people living with HIV/AIDS.

VII: From: AIDS in Kyrgyzstan: Five Year Resistance, Bishkek 2003
Book published by UNAIDS, UNDP, the government of the Kyrgyz Republic
p. 39: Partnership. 4.1 The UN Theme Group on HIV/AIDS

4.1. The UN Theme Group on HIV/AIDS in Kyrgyz Republic:

It was formed in 1996 and from that time, until the beginning of 2002 it had been headed by the UNDP Resident Representative in the Kyrgyz Republic. The UN Theme Group consolidated all UN Agencies, represented in the Kyrgyz Republic and in the Central Asian region, includes governmental, non-governmental and other international organizations.

The UN Theme Group has played an essential role in the development of the coordinated national response to HIV/AIDS by supporting the efforts of the Government of the Kyrgyz Republic. TG members have consulted national policy-makers on drafting an AIDS prevention law in the Kyrgyz Republic. This approach has made it possible to draft and approve a law that meets international standards and requirements. Members of the UN Theme Group directly supported, and actively participated in, the drafting of the basic provision of the first National Program on HIV/AIDS prevention. The TG also coordinated the execution of the Situation Analysis and the National Response Review, the formulation of the National Strategic Plan, and the drafting of the second State Program of the Kyrgyz Republic on HIV/AIDS prevention. As a result the State Program reflected all strategic guidelines of UNAIDS and included recommendations of the UN Theme Group members in the Kyrgyz Republic. In 2002 the TG Chairmanship was transferred to the UNICEF Resident Representative.

The United National Development Programme (UNDP): with respect to HIV/AIDS related activities the UNDP is guided by its Corporate Strategy on HIV/AIDS. In the Kyrgyz Republic four main directions of focus by UNDP include:

- developing a multi-sectoral approach to the problem and building effective partnerships (between government agencies, non-governmental, including community-based, organizations, law-enforcement agencies, human rights organizations, research institutions, and other HIV/AIDS stakeholders) for increasing the efficiency of the response to development challenges posed by the epidemic;
- supporting initiatives aimed at community-based HIV prevention and care efforts;
- strengthening of a sound and enabling ethical, legal and human rights environment for HIV/AIDS prevention and care;
- integrating the response to the HIV/AIDS epidemic into broader national poverty alleviation strategies.

Since 1996 UNDP has been implementing HIV/AIDS prevention programs in the country through technical assistance. From 1997 onwards UNDP has been carrying out systematic interventions within program activities. A law on AIDS has been adopted and the first National HIV/AIDS Prevention Programme has been drafted and approved. At that time the country already has a substantial human capacity (trained national experts). All of the above mentioned factors have served a basis for providing financial support to the National Programme by UNDP (to the value of **USD 400,000**) and by UNAIDS (**USD 160,000**). The government of Kyrgyz Republic also supported the Joint Kyrgyz Government /UNDP/UNAIDS project KYR/97/004 –

Prevention of Sexually Transmitted Diseases and HIV/AIDS in the Kyrgyz Republic – and contributed **USD 100,000**.

Following the 2001 UNGASS Declaration of Commitment on HIV/AIDS UNDP has initiated a **Joint UN Agencies Programme on Expanded Response to HIV/AIDS in the Kyrgyz Republic**. This Programme is tasked with strengthening the national capacity to stem the HIV/AIDS epidemic by coordinating the efforts of international donors and eliminating any overlap and concentrating the limited financial resources available on the country's priorities.

Assistance is being rendered in the following main strategic directions:

- Strengthening Capacity for Multi-sectoral Responses to STIs and HIV/AIDS
- Building capacity for a legal and ethical environment in areas related to HIV and AIDS
- Mass media and HIV/AIDS awareness, prevention and behavior change
- Capacity-building for information, education and communication, peer education and counseling (IEC) strategies for behavior change
- CBOs/NGOs capacity-development to fight against the epidemic
- Improved capacity for HIV prevention among injecting drug users
- Improved capacity for HIV/AIDS prevention and care among migrants and refugees
- Condom provision and condom social marketing
- Improved capacity for STI/HIV/AIDS counseling and care

From: <http://www.aids.undp.kg/en/programme/uniformed/>

Joint Programme on Expanded Response to HIV/AIDS in the Kyrgyz Republic

Project objectives:

1. Development of a coordination mechanism within Uniformed Services on HIV/AIDS;
2. To improve the knowledge on HIV/AIDS among the uniformed services personnel and their families, especially new recruits so that they are able to protect themselves and continue the HIV/AIDS education activities in a sustainable manner
3. Ensure sustainable mechanisms are in place for implementation of the national programme.

Vulnerability of the target group:

Uniformed services personnel and first of all new recruits are especially vulnerable to HIV and STD due to the number of reasons:

1. Limited access to information related to the sexual health;
2. Young age and specific military culture which can support cult of risk and personal courage;
3. Remoteness from family due to the service in armed forces (for the soldiers);
4. High moral and psychological loads and stress (for instance, during emergencies and salvage operations) leading to the restricted control over the personal behavior.

Thus, the structure and organization of the uniformed services gives opportunity to realize large scale information and education campaigns among uniformed services at minimum costs.

The disassociation of the uniformed services in the Kyrgyz Republic needs a coordination of efforts towards prevention of HIV/AIDS.

Currently the uniformed services of the Kyrgyz Republic consist of several ministries and departments which are subordinate to the Government or the President of the country and are not interrelated:

- Ministry of Defense of KR;

- Border Management of KR;
- National Guards of the KR;
- Internal Troops under the Ministry of Interior of KR;
- Ministry for Ecology and Emergency of KR.

Despite the above mentioned there are some departments of military type like the Department for convoy of detained under the Ministry of Justice and Service for national security of the KR.

The country has accumulated the knowledge on developing peer education programmes for soldiers serving a fixed period; an HIV/AIDS diploma programme for officers of the Ministry of Interior bodies has been developed and included in the educational process. However, serious economic problems with high poverty rate and lack of adequate social infrastructure limit funding opportunities for HIV/AIDS prevention programmes. Therefore, current programmes are functioning separately; horizontal information exchange is lacking as well as joint activities on the development of HIV/AIDS prevention policies of the above mentioned ministries.

Methodological guidelines and training modules for recruits and officers have not been developed. Due to limited circulation of information materials, they do not reach the personnel of remote Uniformed Services dispositions. Therefore the project is like a resource center, which can coordinate activities and help uniformed services to develop training modules and implement their programmes.

The necessity to continue earlier started activities

During the last five years UNDP and UNAIDS and other international organizations regularly supported uniformed services in implementing activities on HIV/AIDS prevention. Thus, the prevention programmes were developed and some activities were implemented by each of the above-mentioned ministries and departments. The military personnel started regularly educating soldiers and officers in HIV/AIDS aspects.

However, there is no unique methodical approach to the education and information activities, there is no monitoring mechanisms to assess realized activities. The development of the methodic approaches and based on the best practices in the aspects of HIV/AIDS and its implementation to the uniformed services of the KR is the one of the significant objectives of the project.

Partners and target group:

The project has wide range of partners, which will be widened during the project implementation:

1. Ministries and departments:
 - Ministry of Defense of KR;
 - Border Management of KR;
 - National Guards of the KR;
 - Internal Troops under the Ministry of Interior of KR;
 - Ministry for Ecology and Emergency of KR.
 - Department for convoy of detained under the Ministry of Justice

Despite the above mentioned there are some departments and services, which will be the partners of the project. They are:

1. State drug control agency
 2. Service for national security of the KR
1. Civil state services:
 2. National AIDS Center;

3. Province AIDS Centers;
4. Narcological and venereal services of the KR.

1. Non-governmental organizations.
2. International and governmental organizations of other countries.

With the support of the project personnel and National AIDS Center the application to the American Embassy was developed. The embassy supported and with the help of the project the 6 sets of equipment were distributed for the implementation of HIV/AIDS prevention activities. The project and the Global Fund supported activities towards Worlds AIDS Day. Thus the funds were allocated by the Global Fund for each ministry and department.

Primary beneficiaries of the project will be the recruits of the Uniformed services and administrative departments, soldiers, cadets of special educational establishments, and young officers.

The secondary beneficiaries will be the family members of the uniformed services personnel, clients of the uniformed services, and through these groups the general population.

The Joint United National Programme on HIV/AIDS (UNAIDS)

As HIV infection continues to grow worldwide, in 1996 eight UN Agencies formed a Joint UN Programme on HIV/AIDS. UNAIDS assists the cosponsors, national programmes, and non-governmental organizations in the following three main areas:

- Advocacy
- Technical assistance for research, strategic planning and programme development, and
- Policy formulation, including coordination of strategies and activities by promoting partnerships and mobilizing resources

In the Kyrgyz Republic the programme has been functioning since 1996. The main objective of the UNAIDS is to “support the fulfillment of the national strategic plan by the development of multi-sectoral approach on HIV/AIDS prevention among vulnerable groups of population: youth, injecting drug users, commercial sex workers.”

Besides contributing to the Project KYR/97/004, UNAIDS has also provided additional funds for a situational analysis of the group of injecting drug users (IDUs). A project to organize interventions among IDUs has been prepared and the required resources have been provided by the Soros Foundation-Kyrgyzstan.

UNAIDS has allotted **USD 120,000** for improving information programmes within the World AIDS Campaign, training national experts to attract the resources of the Global Fund to Fight AIDS, Tuberculosis & Malaria, and supporting interventions among street children.

The World Health Organization (WHO):

This is the only international organization that provides for STI treatment of people in vulnerable groups (sex workers and MSM) to the extent necessary for effective prevention of HIV/AIDS.

The WHO has supplied diagnostic equipment for HIV testing, costing approximately **USD 5,000**. Over four years the WHO has been funding supplies of up-to-date medications for syphilis and other STIs.

The WHO European Bureau supported an HIV/AIDS/STI prevention project among sex workers (**USD 6,000**) and among MSM (**USD 7,000**). The WHO has also funded a regional workshop on

reaching MSM and international experts. The WHO supported the country in the second round of its application process to the Global Fund to Combat AIDS, Tuberculosis & Malaria.

The WHO's contribution into the attainment of the State HIV/AIDS Prevention Program is in the form of supporting and STI clinic for vulnerable groups. In addition the WHO has funded a reprint of a booklet for young people, *Friends, AIDS, and Drugs*, with 9,000 copies in Kyrgyz and Russian.

The WHO office in the Kyrgyz Republic is requesting additional funds from HQ to further develop their activities in the following main directions:

1. Continuing its existing project – the WHO clinic provides free and anonymous STI treatment for vulnerable groups (primarily, for sex workers) in Bishkek – **USD 10,000 (USD 20,000 for the two years)**
2. Expanding services offered by the Clinic, including services of an obstetrician for sex workers and of a psychologist for MSM. The planned amount for this component in 2003-2004 is **USD 30,000**. Additional funds will be also mobilized from other sources
3. Extending the pilot project (opening clinics in other cities of the country)
4. Providing access to the WHO information network on health issues (by providing technical support to the mass media).

The United Nations Population Fund (UNFPA) does not focus its projects exclusively on HIV/AIDS, but it does contribute to the prevention of HIV/AIDS within its other projects.

The UNFPA activities in the country include:

- Training of service providers in such areas as reproductive health issues, counseling on HIV/AIDS, good clinical practice, and referral for further evaluation and follow-up
- Information, Education and Communication (IEC) activities with respect to HIV/AIDS as a part of the population strategies and reproductive health IEC programs
- Condom supplies and distribution
- Sex education projects

UNFPA contributed **USD 350,000** to safe sex projects in Bishkek and in other regions of the country. In addition UNFPA provides condom supplies (in 1995 and in 1998-1999). Jointly with UNHCR, UNFPA has undertaken a situation analysis and implemented peer education projects for teenagers and young refugees.

UNFPA has contributed **USD 50,000** to the Joint United National Programme on HIV/AIDS for condom supplies and distribution. It has also invited an international expert on AIDS issues, financed by the Government of Sweden, to coordinate UNFPA activities in the HIV/AIDS area.

The United Nations International Children's Emergency Fund (UNICEF) within the framework of the Convention on the Rights of the Child, is especially concerned about:

- Human rights issues related to HIV/AIDS (both within the legal structure and communication/awareness raising)
- Improving young people's health; and
- Protection and prevention of mother-to-child transmission

In the Kyrgyz Republic UNICEF focuses on supporting the development and expansion of comprehensive health promoting programs for young people with an emphasis on vulnerable youth, including long-term prevention of HIV/AIDS.

UNICEF is already working in this direction within the Young People's Wellbeing Programme which is part of the overall country programme. UNICEF plans to allocate approximately **USD 60,000** for Adolescent Lifestyle Project with its sub-project – Life Skills and Peer Education – which is targeted at the specific needs of vulnerable youth (non-institutionalized, undereducated and unemployed youth), primarily in Bishkek and in Osh.

UNICEF also plans to support the creation of youth-friendly centers and clubs where educational and other types of HIV/AIDS prevention activities could take place, with an additional component of in-house confidential medical services.

This Project also includes the Young People and Socialization with Media sub-project within which UNICEF will continue their support to Radio Salam, the CNN student bureau in Bishkek and Osh, and five regional radio stations for developing medical programs, including information on HIV/AIDS. UNICEF also plans to support a Radio Hotline Program within one of the radio stations that are popular among young people (e.g. Europa Plus or Pyramid), where young volunteers could answer their peers' questions and tell them about health and development issues.

Other areas of support/activities within UNICEF's priorities include:

- HIV/AIDS and human rights. The human rights aspect could fall under the UNICEF's New Generation framework
- Ten facts about HIV/AIDS. UNICEF is operating with 10 main facts that young people have the right to know concerning HIV/AIDS. These 10 facts could be used as a framework in the further production of information materials for young people, as well as for health workers and teachers. UNICEF plans to produce pocket-sized pamphlets with ten facts about HIV/AIDS to be distributed about health workers.
- Mother-to-child transmission. UNICEF focuses on the prevention of mother-to-child HIV transmission through counseling within the UNICEF on-going projects under the Prenatal Care and Breastfeeding Program.

The United Nations Fund for Women's Development (UNIFEM) is supporting diverse strategies to make women's interests and contributions central to HIV/AIDS programs and strategies. A key component for addressing the gender and human rights dimensions is the Convention on the Elimination of All Forms of Discrimination against Women. Worldwide UNIFEM is piloting innovative community-based initiative, providing policy advice at the national level, and supporting advocacy for women's participation in global policy making related to HIV/AIDS.

UNIFEM is supporting women's organizations and NGOs working on HIV/AIDS prevention to expand their advocacy work and to include the gender dimensions in combating the epidemic. Partnerships between women's rights activities, HIV advocates and policy makers provide a basis for action and information to empower women to make informed decisions about the disease, to learn skills in assertiveness to be able to negotiated safe sex and to resist sexual violence.

To develop interventions in these directions **UNIFEM** has allotted **US\$50,000** on a parallel funding basis. In its involvement with the State Program, UNIFEM focuses on the gender and human rights dimension of HIV/AIDS prevention in the Kyrgyz Republic. Such involvement is being accomplished within a five-step approach:

- An orientation workshop on the gender dimension of HIV/AIDS;
- Community-based research of risky sexual behavior;
- A fellowship program for selected media representatives;
- A training program for women on assertiveness skills to negotiate safe sex and resists sexual violence; and
- An advocacy workshop for the convention of the Elimination of All Forms of Discrimination against Women and gender dimensions of the HIV/AIDS pandemic.

UN Office for Drug Control and Crime Prevention (currently, UNODC):

UNODC has participated in the Joint Project of the Kyrgyz Government and UNDP/UNAIDS KYR/97/004 through parallel funding and contributed **US\$75,000** to primary prevention of drug use and HIV infection among young people within this Project.

Harm reduction interventions have been performed within a UNODC Project based on an agreement with the UNDP Office in the Kyrgyz Republic. A Resource Center has been opened in Osh under the Regional Adolescent Center, and a similar resource center, already functioning in Bishkek, was supported. Training workshops were conducted for staff of adolescent centers, teachers, libraries, and students. Altogether nine workshops have been held where three hundred specialists from all regions of the country have been trained. Peer-education programs were introduced in Bishkek and in one of the country's rural districts. Information materials – six items totaling over 60,000 copies – have been designed and printed, including Prevention of Chemical Addictions, a guidebook for school psychologists and teachers, as well as methodological recommendations for prevention of drug use, in Kyrgyz and in Russian, which have been distributed to all schools in the country. Therefore, the capacity of national experts has been built and information assistance has been provided within the same project in order to facilitate the development or preventive programs among institutionalized youth in all schools in the country.

Within the regional project UNODC has performed as assessment of drug use prevalence in Central Asia countries (2001). Currently the findings of this assessment are used as basis in planning HIV/AIDS preventive programs for injecting drug users in the Kyrgyz Republic.

Within its regional project UNODC plan to invest up to US **\$100,000** in development of demand- and harm-reduction programs for injecting drug users in the Kyrgyz Republic.

UN Educational, Scientific and Cultural Organization (UNESCO):

In Central Asia UNESCO and UNAIDS collaborate in promoting HIV/AIDS awareness by means of the mass media, and train mass media representatives and health personnel on health promotion, on developing IEC programs, and on HIV/AIDS issues.

In the Kyrgyz Republic UNESCO has supported HIV/AIDS prevention programs through raising awareness about HIV/AIDS. In particular a series of training workshop has been conducted for doctors, teachers and journalists thanks to the assistance of this organization. UNESCP has also supported an intervention among long-distance truck drivers.

UN High Commissioner for Refugees (UNHCR): is presently providing basic health care to Tajik, Afghan and Chechen refugees in the Kyrgyz Republic through refugee medical clinics in Bishkek, Osh, Kara-Balta and Ivanovka, established by the Kyrgyz Red Crescent Society.

In 200 UNHCR, in cooperation with UNFPA, undertook a project, costing **US \$26,000** to increase refugee youth's awareness of reproductive and sexual health, including HIV/AIDS, issues. Twenty workshops have been held within this Project covering over 400 young Tajik refugees in the Chui oblast.

UN Volunteers (UNVs): have been active in HIV/AIDS prevention activities in the Kyrgyz Republic through the work of their national and international volunteers who have been distributing HIV/AIDS – related information through resource centers in the country's regions. A process of integrating HIV/AIDS prevention program with poverty alleviation program was launched within the Joint Program UN Agencies Program on Expanded Response to HIV/AIDS in the Kyrgyz Republic in 2002. In this connection two orientation and information workshops have been conducted for those UNVs working within poverty alleviation and decentralization program. As a result UNVs have actively participated in the World AIDS campaign. Thus, in 2002, campaign events, theatrical performances, marches, and other activities devoted to World AIDS Day were, for the first time, organized at the local level in 150 villages of the country. It is estimated that about 100,000 people participated in these events.

Further contribution of the UNVs in the area of HIV/AIDS will include expanding current activities of UNVs in HIV prevention locally through the networks of their partners and resource centers through social mobilization of local communities.

The World Bank: the World Bank's fundamental strategy for the health sector in the Kyrgyz Republic is to improve the capacity, effectiveness and efficiency of the health system and make it financially sustainable. For this reason the WB supports a comprehensive, integrated program that is capable of responding - through prevention and treatment – to a wide variety of infectious and non-communicable diseases.

Under the current WB-financed Second Health Sector Reform Project an assessment of the public health system (health promotion and the Sanitary Epidemiological Services) has been made to ascertain its preparedness to handle infectious diseases, including HIV/AIDS, in an effective and efficient way.

The Drug Quality Laboratory, established with the support of the WB, may be used to test the quality of drugs for people living with HIV/AIDS.

The project will be further addressing HIV/AIDS within the context of improving the capacity of the health care system to respond to HIV-related risks. The health promotion component will build the required institutional capacity. Specifically primary health care staff and schoolteachers will be provided with the ability to obtain and disseminate information on STIs, as well as on HIV/AIDS. The financial contribution to the reform of the Sanitary Epidemiological Services and the Health Promotion activities will be **US \$2,22 million**. The Bank will further support the introduction of family group practices all over the country as well as the training of family physicians and nurses. Those activities will provide a basis for strengthening the primary health care system and will improve prevention and treatment of infectious diseases, like HIV/AIDS. The training courses financed by the Bank will pay particular attention to HIV/AIDS issues. Allocations for support of primary health care and medical personnel training will total US \$1.7 million with a portion of this money to be allotted for training in HIV/AIDS issues.

International Organization for Migration (IOM) continues developing its information campaign on the prevention of people trading. IOM can also provide access to its information and publication network.

IV: From the document provided by Kyrgyzstan partner

1. Donor/UNAIDS Cosponsor: Soros Foundation Kyrgyzstan (Total: US\$ 443,829)

Program/activity title: Harm Reduction program "HIV prevention in CA" funded by USAID;

Drug Demand Reduction Program funded by USAID (US \$193,171, October 2003 – October 2004):

1. Projects on Treatment readiness; 2. Projects on Treatment and rehabilitation provide non-medical treatment and complex of rehabilitation services for drug addicts.

Brief description of activity, including 2004 results: Harm Reduction (US \$ 250,658, January – December 2004) program's main goal is – HIV prevention among IDUs. Support for 5 Needle exchange projects (NEP) in Osh, Bishkek, Tokmok, and in all prisons. Set up Methadone treatment program in Bishkek.

All NEPs were supported till November 2004. All projects had financial support from GFATM.

2. Donor/UNAIDS Cosponsor: DFID

Program/activity title: Regional HIV/AIDS Project

“Effective implementation of comprehensive national programmes, with a focus on harm reduction”

Brief description of activity, including 2004 results: End-2004 – Design Phase. For implementation early 2005 Tajikistan, Kyrgyzstan and Uzbekistan with Kazakhstan benefiting through the contribution to the World Bank regional fund

Estimated budget: Amount USD \$11Million over four years (of which \$2M goes directly to the WB regional fund)

Timeframe: 2005 - 2009

3. Donor/UNAIDS Cosponsor: KfW/Germany

Program/activity title: I – component Improvement of diagnosis;
II – component Social Marketing

Brief description of activity, including 2004 results: Tender of Consultant; Consulting contract

With GITEC; Beginning of activity January 2005

Estimated budget: Approximately 8,5 million

Timeframe: 2005-2009

4. Donor/UNAIDS Cosponsor: Swiss Agency for Development and Cooperation

Program/activity title: Prevention of HIV/AIDS/STIs and drug addiction among youth, Osh Kyrgyzstan (Covering of the youth of Osh, Batken and Jalal-Abad oblasts.

Brief description of activity, including 2004 results: I. To raise awareness of the youth about HIV/AIDS/STIs, drug addiction and to provide young people with safe behaviour skills;
II. To provide methodological support to secondary schoolteachers of “Healthy life style” course;
III. To guarantee the institutional development of Rainbow centre.

Estimated budget: 120,000

Timeframe: 01.07.2003 – 01.07.2006

5. Donor/UNAIDS Cosponsor: USAID

Program/activity title: HIV/Blood Safety/Laboratory Surveillance Implemented by CDC

Brief description of activity, including 2004 results: Increase the availability and use of high quality, reliable, and scientifically proven data for HIV case identification and surveillance by improving laboratory diagnostic data and implementing behavioral surveillance.

Improve HIV surveillance and use of surveillance data for public health decision-making by implementing second generation HIV surveillance, establishing integrated surveillance of parenterally transmitted diseases among high-risk groups, and enhancing the capacity of the Ministry of Health to use surveillance data in public health decision-making.

Improve the country’s response to the epidemic through development of a cost-effective means to determine the size of the populations at risk.

Reduce the risk of parenterally-transmitted infections from transfused blood and blood components by improving the process of blood donation and collection, laboratory testing, and blood product use.

Estimated budget: Approximately \$2.0 million over four years

Timeframe: 2002-2006

6. Donor/UNAIDS Cosponsor: USAID

Program/activity title: Drug Demand Reduction Program, Implemented by Open Society Institute / Soros Foundation lead Consortium

Brief description of activity, including 2004 results:

OBJECTIVE: To change attitudes towards drugs among vulnerable sectors of the Fergana Valley population

ACTIVITIES:

- **Soros** administers a grant program to support drug treatment, social rehab, and prevention education for health professionals.
- **AIDS Foundation East West (AFEW)** conducts prevention interventions with prisoners and commercial sex workers
- **Akkord (Street Kids International)** works with homeless youth
- **Population Services International (PSI)** conducts prevention education with high risk youth

Estimated budget: \$ 1.2 million over five years

Timeframe: 2002-2007

7. Donor/UNAIDS Cosponsor: UNDP

Program/activity title: 1. Assistance to the Republican Multisectoral Coordinating Committee on HIV/AIDS under the Government of the Kyrgyz Republic;

2. Awareness raising on HIV/AIDS among religious Muslim religious leaders through Partnership with the State Commission on Religious Affairs and Spiritual Management of Muslims of Kyrgyzstan;

3. Capacity building for a legal and ethical environment in areas related to HIV and AIDS;

4. CBO/NGO Capacity-Development to fight against the epidemic;

5. Strengthening capacity of HIV prevention among Injecting drugs users;

6. Strengthening capacity in consultations and assisting at STIs/HIV/AIDS;

7. Mass Media and HIV/AIDS Awareness, Prevention and Behavior Change;

8. UNDP/UNAIDS/Government joint project "Prevention of HIV/AIDS among the uniformed services".

Brief description of activity, including 2004 results: 3 meetings of the Committee were conducted; a new draft law "On HIV/AIDS in KR"; programme for Ministry of Educ. developed; Technical sector on epidemiology action plan; a Coordination and M&E Unit is established under PM Office; Seminars, pilot project and National Conference for religious leaders; academic course for Academy of Ministry of Internal Affairs and School of Police; Project of Legal clinic "Adilet"; project on information network and regional conference with Association of AIDS Service NGOs; Assistance to methadone therapy and syringe exchange programmes; Support to the development of Manual on psychosocial counseling, etc.

Estimated budget: USD 216,616

Timeframe: January – December 2004

8. Donor/UNAIDS Cosponsor: UNODC

Program/activity title: Diversification of HIV prevention and drug treatment services for injecting and other drug users;

In the framework of the revised project in addition to Bishkek and Osh three new localities, Tokmok, Jalalabad and Karasuu have been identified in consultation with the Drug Control Agency;

Implementation of pilot sub-project with the Republican Centre of Narcology and NGO Socium;

Implementation of pilot sub-project with the Osh Oblast Narcological Centre and NGO Musaada.

Brief description of activity, including 2004 results: A number of methodological materials and guidelines on improving the organisation and functioning of modern drug treatment and rehabilitation system has been elaborated and disseminated among the stakeholders;

Networking and information sharing;

38 experts trained in the following:

10-day course "Rehabilitation of drug users";

20-day course "Psychotherapy in drug treatment";

20-day course "Psychological counselling in drug treatment";

10-day course on "Narcological counselling";

15-day course on "Social work with drug users".

Estimated budget: 117,000

Timeframe: November 2003-December 2004

9. Donor/UNAIDS Cosponsor: WHO

Program/activity title: WHO HIV/AIDS treatment and care protocols;

WHO Mission on HIV/AIDS;

Technical consultancy to support National HIV/AIDS care plan and treatment protocols development;

Support for participation of one specialist at the WHO Technical meeting.

Brief description of activity, including 2004 results: Russian version of the clinical protocols on HIV/AIDS treatment and care adopted by the MoH;

Assessment of the country needs;

The first training was conducted to the local specialists on HIV/AIDS treatment;

Help to MoH to review existing services on management of congenital syphilis

Estimated budget: Technical assistance

Technical assistance

Technical assistance funded by WHO EURO/DFID and Abt Ass.

Timeframe: April 2004, May 2004, November 2004

10. Donor/UNAIDS Cosponsor: UNICEF, WHO, UNFPA

Program/activity title: 1. MAPM WS - Mapping Adolescent Programming and Measurement Framework WS for 15 key partners in LSBE, YFS and Peer to Peer Education.

Brief description of activity, including 2004 results: Measurement meeting of the UN Interagency Group on Young People's Health. Mapping Adolescent Programming and Measurement Framework (MAPM) to help *design and implement more effective programmes* and identify what to *measure to demonstrate* programme implementation and the impact of adolescent health and development programme¹.

Estimated budget: 10,000

Timeframe: 19-23 April 2004

11. Donor/UNAIDS Cosponsor: Funded by the UK National Committee of UNICEF via the Parthenon Fund.

Program/activity title: 2. "Distance Education on Air" project

Brief description of activity, including 2004 results: The Distance Education on Air project is a continuation of the Healthy Airwaves for Youth project.

- Radio Almaz Yug, Osh
- Radio Tatina, Karabalta
- Radio LW, Karakol
- Radio Tenir Too Naryn

Estimated budget: 58,000

Timeframe: 2004

12. Donor/UNAIDS Cosponsor: UNICEF UK National Committee through Parthenon Fund and Red Crescent

Program/activity title: "Young Football players of Kyrgyzstan against Drugs and HIV/AIDS"

Brief description of activity, including 2004 results: *The results achieved* were up to 7,000 football players of 12-14 years old have been equipped with knowledge on the dangers of HIV infection and drug use and sexual and reproductive health and encouraged to share this knowledge with their peers.

Estimated budget: 10,000

Timeframe: 2004

13. Donor/UNAIDS Cosponsor: UNICEF Core Funds

Program/activity title: "Children's Media Center"s project

Brief description of activity, including 2004 results: With UNICEF support two Children Media Centers have strengthened their capacities and activities. *Results:* The loyal public reaches more than 100,000.

¹ Although this resource manual focuses on adolescents it can easily be adapted for other age-groups.

Estimated budget: 14,000

Timeframe: 2004

14. Donor/UNAIDS Cosponsor: UNICEF Core Funds

Program/activity title: "Advice among friends- HIV and drug use" prevention among especially vulnerable young people"

Brief description of activity, including 2004 results: HIV/AIDS, STIs and drug use prevention awareness, increasing their knowledge, skills and attitudes necessary to protect themselves among especially vulnerable groups of children has been raised through the project activities.

Estimated budget: 16,000

Timeframe: 2004

15. Donor/UNAIDS Cosponsor: UK National Committee

Program/activity title: "Healthy Airwaves for Youth" sub-project

Brief description of activity, including 2004 results: The workshop was part of a process of the project and aimed to build the programming capacity of radio and media project offices in the area of young people's health, development and protection - with a focus on HIV/AIDS prevention: to develop skills in Training "HAFY" project personnel.

Estimated budget: 2,200

Timeframe: Sept.2004

16. Donor/UNAIDS Cosponsor: UNICEF Core Funds

Program/activity title: "Support Youth Development project in migrant areas of Bishkek"

Brief description of activity, including 2004 results: UNICEF-supported youth center mainly dealt with migrant children from rural areas. Approximately 600 adolescents participated.

Results: Approximately 600 adolescents have been actively involved in different educational activities provided by the center.

Estimated budget: 7,000

Timeframe: 2004

17. Donor/UNAIDS Cosponsor: UNIFEM project "Building capacity for addressing gender dimensions of HIV/AIDS in Kyrgyz Republic"

Program/activity title:

1. Educational, training and information (ETI) materials of the partners' organizations dealing with HIV/AIDS are gender sensitive
2. The governmental bodies, international organizations and other parties are equipped with technical skills and capacities to work collectively in responding to HIV/AIDS epidemic
3. Wide public became more tolerant and better aware of gender dimensions of HIV/AIDS epidemic

Brief description of activity, including 2004 results:

1. Network of trainers from Republican Health Promotion Center under the Ministry of Healthcare on "Gender dimensions of HIV/AIDS" was trained on TOT with following trainings on the fields.

2. Teachers from 20 pilot vocational schools of Kyrgyzstan under the Vocational Education Department of MLSP were equipped with skills and knowledge on the TOT "Gender dimensions of HIV/AIDS" with further development and probation of Model Curricula on "Gender and AIDS" in 20 pilot vocational schools all over the country.

UNIFEM trainers conducted TOT sessions on "Gender and HIV/AIDS" for Kazakhstan UNV during Summer Youth School "Volunteerism in prevention of HIV/AIDS and drugs" in Almaty, Kazakhstan, where the gender dimensions of HIV/AIDS had been introduced at Central Asian extend. Trainers and volunteers from Kazakhstan, Tajikistan and Russia acquired a set of skills and knowledge to address gender dimensions of HIV/AIDS at their respective strands and expressed their willingness and interest to collaborate in this field with Kyrgyz partners.

3. Joint participation and contribution to conduct a National Forum on "Improving the state machinery on elimination of violence against women (EVAW)", where UNIFEM session was to give understanding of VAW as one of the main reasons of HIV/AIDS spread and give the idea of

2004 year 16-day campaign on EVAW, which sounded as “*For a health of women, for a health of the world: Stop Violence!*”.

Media Youth Action “Yes for gender equality, No for HIV/AIDS!” to December 1st 2004 developed and conducted in close cooperation with network of trainers within VED system, trained by UNIFEM project, involving network of vocational schools of Bishkek city. Idea of this Action is to draw especial attention of wide public, particularly, youth to issues of gender equality and women’s empowerment as fundamental elements of reducing women’s and girls vulnerability to HIV/AIDS epidemic.

Creeping line on National TV “Women, girls and HIV/AIDS” tied to the World AIDS Campaign with holding a helpline at AIDS-service NGO “Koz-Karash” to give competent consultations to TV viewers on raised issues, such as higher women’s and girls vulnerability to AIDS infection, general information on AIDS spread and other relevant information.

Publication and distribution of UNIFEM research “Gender dimensions of HIV/AIDS” and other info-kits (brochures, posters, leaflets) on two languages (Russian and Kyrgyz)

Estimated budget:

Soros Foundation – 6,000
UNIFEM – handouts, info-kits, trainers
UNIFEM – 4,500
UNIFEM – 700
UNIFEM – 2,000 info-kits and handouts
UNIFEM – 1,000
UNIFEM – 4,274 KG SOM
UNIFEM – 6,000

Timeframe:

June 28th-July 3rd 2004
September 9th-14th 2004
26th May- 3rd June 2004
November 23rd-25th 2004
December 7th 2004
December 17th-30th 2004
December 2003 – January 2004

18. Donor/UNAIDS Cosponsor: UNFPA

Program/activity title: “Project KYR/00/P06 “Development and Dissemination of IEC on RH/FP”

Brief description of activity, including 2004 results: The main purpose of sub-programme is to have contributed strengthening RH service delivery and to increase utilisation of integrated and quality reproductive health services and information. And, particularly within this output – establishment of core expertise for RH/FP communication strategies planning and development, production and dissemination of IEC and materials for the mass media – several strategies were touched upon through implementing project activities:

(1) *Male involvement*

UNFPA initiated seminars and meetings for community and religious leaders on “Family Planning in Islam Legacy” and religious school teachers; a working group was initiated for adoption of the book by Abdel Rahim Omran, world known authority on population and demographic studies, “Family Planning in the legacy of Islam” for local use by the group of national experts and discussed at the Council of Ulems (senior religious leaders)

(2) *Development of communication and counseling skills*

Conduct of training for health service providers, peer educators and NGO representatives on behaviour change and gaining life skills on HIV/RH/FP issues; A baseline study was conducted on risky behavior change and gaining the healthy life skills in the northern regions of the country

(3) Adolescent RH and peer education

A number of trainings took place – for vocational school teachers on adolescent RH and sexual education, training for NGOs on RH/FP/HIV peer education. Due to the high level of STIs and newly registered HIV/AIDS cases, a number of activities planned in the project were aimed at increasing awareness among different population groups about sexually transmitted infections, including HIV/AIDS. As most of the reported HIV cases were registered among the younger population groups (number), the youth drama activity, which was started in 2003, was continued with performing a drama at province level.

(4) Health promotion activities and HIV prevention

A grant was given to NGO for implementing community based IEC activities in remote district of Issyk-Kul region; a number of IEC materials were reprinted; a grant was given to NGO “El-Kuru” for development of IEC materials and address delivery for targeting people in uniforms; a grant was given to NGO KFA for reaching refugees in Jalal-Abad remote areas aimed at increase of their knowledge of HIV/RH issues; a number of activities have been initiated devoted to AIDS Prevention Day.

Estimated budget: 84,333

Timeframe: 2004

19. Donor/UNAIDS Cosponsor: UNFPA

Program/activity title: Project KYR/00/P01 “Contraceptive Logistics and RH-LMIS”

Brief description of activity, including 2004 results: Procurement of condoms

Estimated budget: 20,000

Timeframe: 2004

20. Donor/UNAIDS Cosponsor: UNFPA

Program/activity title: Project KYR/03/P08 “Strengthening of RH services in northern regions of Kyrgyzstan”

Brief description of activity, including 2004 results: Procurement of condoms, publications, seminars for health service providers

Estimated budget: 37,000

Timeframe: 2004

VI: From: <http://www.dfid.gov.uk/pubs/files/rapcascm.pdf>

Central Asia, South Caucasus and Moldova. Regional Assistance Plan. 2004

New Directions of **DFID** in Kyrgyzstan:

Support to the National Programme – focus on harm reduction.

III. From UNIFEM/Building Local Knowledge to Halt HIV/AIDS brochure

In response to HIV/AIDS situation in Kyrgyzstan the Joint UN Agencies Programme on HIV/AIDS was developed in order to strengthen the national, regional and community levels capacities to address the social, political, economic and health determinants of HIV/AIDS spread and to build an enabling environment for behavioral change and support.

Responses to the epidemic must build on an understanding of gender-related expectations and needs, and may need challenge adverse norms because:

- It is women who, in major way, bear the brunt of the infection and the social attitude the impact on their daily lives as care givers, workers and mothers;
- Women are biologically more vulnerable than men, but this vulnerability is often reinforced by socially constructed constraints on women’s ability to protect themselves, cultural pressures and by gender inequalities in income and wealth;

- For women, risk-taking and vulnerability to infection are increased by traditional norms that make it inappropriate for women to be knowledgeable about sexuality or to be able to negotiate safe sex;
- In culture where HIV is a sign of sexual promiscuity, gender norms shape the way men and women infected with HIV are perceived, in that HIV-positive women face greater stigmatization and rejection than man.

UNIFEM input into the **Joint UN Programme on HIV/AIDS prevention** is focused on gender and human rights dimension of HIV/AIDS prevention in Kyrgyz Republic.

Guided by a human right approach, **UNIFEM Project Building Capacity for Addressing the Gender Dimension of HIV/AIDS in Kyrgyzstan** is supporting diverse strategies to make women's interests and contribution central to HIV/AIDS programmes and strategies. A key component for addressing gender and human rights dimensions is CEDAW (International Convention on the Elimination of All Forms of Discrimination Against Women).

The project strategy:

- Improvement assertiveness skills of women to negotiate safe sex and to resist sexual violence;
- Raising awareness of women and public in general on gender dimension of HIV/AIDS;
- Creating enabling environment for behavioral changes;
- Mobilizing NGOs, CBOs, Government representatives to work collectively under the gender dimension of HIV/AIDS;

The project activities focus on:

- An Orientation Workshop on the Gender Dimension of HIV/AIDS in Kyrgyzstan with participation of a wide range stakeholders;
- A Community based research on gender and sexual behavioural factors, including discrimination against women and girls, which contribute their vulnerability to HIV/AIDS
- A Competition Fellowship Programme for selected journalists on producing and publishing a series of articles and TV/Radio messages to raise the issue of human rights and the impact of the HIV/AIDS on women and youth;
- Preparing and publishing of IEC material (posters, booklets, books, manual, leaflets, stickers etc.) on gender issues and HIV/AIDS prevention;
- A Training Programme for rural women, NGO's, CBO's and trainers on assertiveness skills to negotiate safe sex and resist sexual violence;
- An Advocacy Workshop on CEDAW and gender dimensions of the HIV/AIDS epidemic.

AIDS/HIV epidemic looks set to grow considerably in Central Asia as a result of the large number of injection drug users, increasing rates of STDs, the growing commercial sex industry and socioeconomic transitions. The Project seeks to replicate the Kyrgyz model in other Central Asian countries with expanded community training and media incentives to report more fully on the problem.

Facts:

Of the 38.6 million adults living with HIV/AIDS, 50% – OR 19.2 million – are women.

Of the 4.2 million adults newly infected with HIV in 2002 – 2 million are women.

55 % of 16,000 new infections occurring daily are women.

52% (1.2 million) of all AIDS death in 2002 were women.

HIV incidence in Eastern Europe and Central Asia is rising faster than anywhere else in the world. There were an estimated 250,000 new infections in 2002, raising to 1,2 million the number of people living with HIV.

HIV spread in Kyrgyzstan was preceded by syphilis epidemic, which shows that a real threat of HIV infection does exist in the country.

For the last five years average number of injecting drug users in Kyrgyzstan grew 5,9-fold. This creates a serious danger of HIV/AIDS spread.

Total amount of commercial sex workers (CSW) is great in Kyrgyzstan with the tendency to increase by recruiting the young women coming to cities from rural areas. CSW practice HIV-risky behavior including unsafe sex and intravenous drug using.

c. NGOs

VII: From: AIDS in Kyrgyzstan: Five Year Resistance, Bishkek 2003

Book published by UNAIDS, UNDP, the government of the Kyrgyz Republic

p. 48: National NGOs

National non-governmental organizations: serve as local operators of some prevention program protecting the interests of vulnerable groups. Over 20 national NGOs have participated in various preventive campaigns and activities

Promising NGOs:

The Socium NGO:

The prevention of HIV/AIDS in IDUs has been the main activity of the NGO since 1998. Syringe/needle exchange program are being successfully developed. The NGO is experienced at implementing peer-based interventions, publishing and in the interaction with state health-care institutions. Socium also includes an initiative group that, in 1997, conducted a survey of, and implemented interventions among the refugees residing in the Osh and Chui Oblasts. In 1998 this initiative group conducted a similar survey of, and implemented similar interventions among, the refugees residing in the Bishkek Migration Circle. The NGO also carries out preventive activities in Bishkek markets.

The Oasis Public Foundation: for the protection of and assistance to young people, was founded in 1995, and it was officially registered in 1997. The Fund serves MSM. The organization mainly includes members of the target group: businessmen, doctors, services providers and students. The main activities of the Foundation include STD/HIV/AIDS prevention and organizing leisure activities to serve the interests of MSM.

Oasis owns a youth center and a semi-open club. The NGO has recruited fifteen regular volunteers (outreach workers) who have been specially trained. As estimated by the NGO leadership they manage to reach 60% of the target group (there are approximately 3,000 MSM in Bishkek). The NGO has an extensive experience with peer-based interventions.

The Tais Plus NGO: Tais Plus has been functioning since Nov 1999. It is tasked with developing prevention programs for sex workers, including this providing of legal, social and medical assistance to sex workers. The NGO is composed of sex workers (both existing and former), pimps, telephone operator, doctors, academics, psychologists, lawyers, students.

The NGO has twenty trained volunteers (outreach workers), including eight regular volunteers, from the beneficiary group, who carry out peer-based interventions. To date that NGO reaches approximately 90% of all sex workers in Bishkek (1,500 persons) and about 50% of all sex workers in Jalal-Abad (over 130 persons). Tais Plus has a unique experience or organizing

behavioral studies within the group. It has an extensive experience of peer-based interventions and or producing information materials.

The Sanitas International Charity Fund: works in the area of information, education and communication aimed at the prevention of HIV/AIDS/STIs, along with sex education and the prevention of drug use among the adolescents characterized by their high-risk behavior. The target group includes both school and university students, as well as specialists working with children (teachers, community-based educators, juvenile officers).

The NGO works mainly by way of lectures, workshops and one-time activities. Sanitas has a resource center. The NGO is experienced at developing peer-based interventions and in publishing.

NGOs experienced in the development prevention programs

The Union of Educational Institutions (UEI) is experienced in developing valueology programs, including peer education programs for adolescents, out-of-school education and the training of teachers and parents.

The Nadezhda (Hope) NGO main activities include working with youth and school leaders, as well as those who are members of informal associations and groups of young people. The NGO includes a working group, which is experienced in developing a healthy-lifestyle promoting program, at organizing activities for youth and at producing innovative information and promotion materials with the involvement of some members of the target group.

The Drevo Zhizhi NGO in 1997-98 the NGO served as an umbrella association for working groups that were developing prevention program for sex workers, for MSM, and for refugees and migrants. Later these enterprising groups joined other NGOs (in particular, the Socium NGO) or have founded their own NGOs (such as Tais Plus)

The Parents against Drug NGO main activity is the prevention of drug abuse among adolescents. In 1998-99 it implemented a small-scale pilot program in one Bishkek school and one suburban school. The findings of this study have been used to develop a method for discouraging the motivation to use psychoactive substance within the environment of young people. This is a completely innovative method of motivational training for school students and teachers in the prevention of drug-taking behavior. This method was used to conduct training workshops for teachers and school students. The NGO published methodological recommendations and a manual for school psychologists and teachers, *Prevention of Chemical Addictions*. 10,000 copies of the book were published in the Kyrgyz and Russian languages, and they were distributed throughout all the schools and libraries in the country.

d. CIVIL SOCIETY

VII: From: AIDS in Kyrgyzstan: Five Year Resistance, Bishkek 2003

Book published by UNAIDS, UNDP, the government of the Kyrgyz Republic

p. 47: Partnership. International NGOs

International Non-governmental Organizations (that are assisting the Kyrgyz Republic in the implementation of specific HIV/AIDS prevention programs in close cooperation with the UN Theme Group. This collaboration has enabled all priority groups in key regions of the country to be covered by HIV/AIDS interventions):

The Soros Foundation Kyrgyzstan: Soros has extended support to pilot schools within the Culture of Health Program. It finances interventions among injecting drug users through syringe-

exchange program in Bishkek, Tokmok and Osh, and though a methadone substitute program in Bishkek. The Foundation is also supporting HIV/AIDS prevention program among prisoners through a syringe-exchange program in particular. Other HIV-related efforts include publishing activities and various training programs, including for specialists and decision-makers. The Soros Foundation intends to develop interventions among sex workers and to undertake programs on legal aspects of HIV/AIDS with regard to vulnerable groups. The Foundation has a network of cooperating NGOs and state structures. It funds int'l experts to support on-going HIV/AIDS prevention programs

British Council:

The regional Representative Office of the British Council (located in Almaty) has supported training, conducted by an international expert, for sex workers and for persons who organize interventions in this group. A book of comics for sex workers' clients has been published. A video film about HIV/AIDS prevention program for sex workers has been produced.

USAID:

The **Zdravreform** Organization, Almaty, financed by USAID, has provided fund of **US \$8,982** to support prevention measures in the resort area of Issyk-Kul Lake. Booklets and posters have been published in Kyrgyz and Russian (four titles altogether), and a special workshop has been conducted for health-resort personnel and for family physicians. USAID provides financial support to program implemented by the Soros Foundation – Kyrgyzstan and to the Centers for Disease Control and Prevention (CDC, Atlanta). CDC supports the introduction of the second generation of the observational epidemiological surveillance. The personnel involved are being trained locally, at regional events and in the US. Condom social marketing programs will be introduced in Osh. Publishing activities are being carried out.

Save the Children Fund (United Kingdom): The Fund has organized and supported participation of national experts in HIV/AIDS prevention seminars for the South-Asian region, Kathmandu, Nepal.

Medicins sans Frontieres, French NGO (MSF): This int'l NGO was operating in Osh between 1996 and 2001. Systematic prevention works were initiated by this Organization in Oct 1998. MSF has provided support to the introduction of modern STI treatment methods, the supply of medicines and condoms and the training of doctors from the Osh Oblast in STI treatment. As a result of MSF's activities, two local NGOs – Podruga (Girlfriend) and Rainbow Center – have been formed in Osh. Staff from these NGOs were trained in HIV/AIDS prevention issues. Required funds have been obtained to sustain the further functioning of these NGOs: office space has been acquired, equipment has been provided, medicines have been supplied and additional sources of funding have been found. The Podruga NGO undertakes preventive program for sex workers. It is also currently implementing, with the support of the Soros Foundation-Kyrgyzstan, a syringe-exchange program for sex workers who inject drugs. With the support of the Swiss Coordination Office the Rainbow-Center NGO is developing valedological programs, along with peer-education programs, for young people and school students. Both those NGOs undertake publishing activities and participate in all actions and events organized by Osh and the region. They are also represented on board of the Regional Multi-sectoral Committee.

The Swiss Coordination Office has equipped the Immune Blot Laboratory at the National AIDS Center to perform HIV confirmation tests. This Organization also supports the Rainbow-Center NGO in their educational programs for young people and school students.

The German Development Bank (KfW) and the Department for International Development (UK) plan to extend substantial assistance to the country. The funds will be allocated to supporting the State Program on HIV/AIDS Prevention.

III. CURRENT ASSESSMENTS ABOUT EPIDEMIC AND RESPONSE (same as II. Current response to HIV/AIDS epidemic in the country)

VII: From: AIDS in Kyrgyzstan: Five Year Resistance, Bishkek 2003

Book published by UNAIDS, UNDP, the government of the Kyrgyz Republic

p. 190: Lessons of the Project

Positive Lessons Learned from Implementing Prevention Programs in the Kyrgyz Republic:

- Prevention program become more efficient when there is a political support for HIV/AIDS prevention and mutual understanding between political leaders to this effect
- Interventions among vulnerable groups are only possible with the involvement of non-governmental and community-based organizations
- The training of specialists in HIV/AIDS at the initial stage of the development of prevention programs is of critical significance to success in the further implementation of such programs
- Information materials on HIV/AIDS prevention will be successful if they are developed based on the needs of a target group and with the involvement of members of such group, provided that such materials are further tested within the target group
- The sustainability of prevention programs is of importance. The introduction of peer education strategies with the involvement of outreach workers and volunteers from within target groups is an indispensable condition of the programs' sustainability
- Prevention programs for vulnerable groups will be effective if they are developed based on the actual needs of members of such groups – STI treatment and condom supplies for sex workers; substitution therapy and the provision of clean injection equipment for IDUs; performances, shows, and discos for young people.

VII: From: AIDS in Kyrgyzstan: Five Year Resistance, Bishkek 2003

Book published by UNAIDS, UNDP, the government of the Kyrgyz Republic

p. 34: National Policy

Factors Determining the Spread of HIV Infection in the Kyrgyz Republic (was developed by the working group as a result of the situation analysis):

Political Factors:

- Policy on preventive programs
- Legislation;
- Legal practices

Economic Factors:

- Funding of preventive programs

Socio-cultural Factors:

- Accessibility of information
- Accessibility of medical services
- Public attitude towards vulnerable groups
- Migration processes
- Consumption of psychoactive substances and their availability and accessibility

- Availability of social support programs

The Most Promising Opportunities for Expanding Prevention Programs:

- A national policy in the area of HIV/AIDS/STI prevention in the Kyrgyz Republic has been set
- State government bodies at all levels provide political support to programs targeted at prevention of the spread of sexually transmitted diseases and HIV/AIDS
- Sectoral and institutional HIV/AIDS/STI prevention programs have been developed and are being implemented
- State structures (primarily the Ministry of Health, the Ministry of Education and Culture, the Ministry of Labor and Social Protection, the Ministry of Internal Affairs, and state mass media) have a capacity (both resources and personnel) that can be re-oriented towards providing support to preventive programs
- Efforts of non-governmental AIDS service organizations, community-based organizations, independent experts on preventive programs, and independent mass media have been mobilized
- An educational curriculum has been developed for young people and school students on fostering healthier behavior and lifestyles; the Teacher's Guidebook in the Healthy Lifestyle Course has been published in the three main languages of the people of the Kyrgyz Republic
- An opportunity exists for obtaining targeted financial assistance from international organizations for the development of preventive programs
- There is a positive experience in developing preventive programs in the Kyrgyz Republic

VII: From: AIDS in Kyrgyzstan: Five Year Resistance, Bishkek 2003

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p. 35: National Policy

Necessary Steps of the National Response to the HIV/AIDS epidemic to assure the effectiveness were as determined:

- To harmonize Kyrgyz legislation regulating activities and attitudes of state structures towards vulnerable groups with international legal standards
- To formulate the concept and strategic plan for STI/HIV/AIDS prevention by state institutions with the involvement of healthcare and education systems and law-enforcement agencies, which will be based on situation and response analyses, including monitoring the efficiency of prevention programs
- To create a single informational network for HIV/AIDS/STI-related services
- To expand horizontal links among law-enforcement agencies, healthcare and education systems and NGOs experienced in prevention programs, and to support the preventive activities of such NGOs by state institutions and agencies
- To develop a strategy with regard to interaction with NGOs and the mass media in the area of support to prevention programs
- To mobilize resources and procure raise funds for prevention programs

Assessment of the National Response to the HIV/AIDS Epidemic in the Kyrgyz Republic

Efficient and should be preserved:

- Research activities
- Efforts in formulating national policy in the area of STI/HIV/AIDS prevention

- Programs fostering healthy lifestyle among organized youth and the general population
- Publication on adequate targeted informational materials
- Efforts in preventing chemical substance abuse
- One-time prevention actions

Efficient and should be expanded:

- Training personnel in diagnosing HIV/AIDS/STI, treating STI, psychosocial counseling, political attitudes towards vulnerable groups, and public relationships on the issues of the development of prevention programs
- Interventions among vulnerable populations by using the peer-education methods
- Distributions of personal protection tools (condoms, syringes) within targeted groups
- Prevention programs among informally organized and non-organized young people and socially unadapted populations highly exposed to HIV infection (homeless, unemployed persons)
- Provisions of vulnerable groups with accessible and quality service for STI treatment (with obligatory involvement of state medical institutions)
- Program on social condom marketing
- Program on public relations by using the capacity of the mass media
- Training programs for those state institutions that deal with vulnerable groups

Ineffective and should be curtailed:

- Programs involving involuntary testing for STI and HIV/AIDS
- Program involving any persecutions of people from vulnerable groups, primarily joint medical and police raids and joint program of medical institutions with law-enforcement agencies and the mass media involving stigmatization of vulnerable groups (sex workers, drug users)
- Distribution of condoms through family-planning services

Efficient but are not implemented and should be introduced:

- Revising the current legislation and bylaws to ensure that they do not permit any persecution of vulnerable groups
- Creating opportunities for vulnerable groups to obtain free and urgent legal services
- Revising the reporting system of state structures through introducing monitoring and evaluation mechanisms to evaluate the efficiency of preventive efforts (including interaction with NGOs representing the interests of vulnerable groups)
- Introducing systems of condom distribution through AIDS-related, STD, and narcologic services
- Expanding pre- and post-test counseling for HIV testing
- Developing monitoring and evaluation mechanisms with regards to the efficiency of preventive efforts at the national and regional (provincial) levels, including evaluation of efficiency of the use of available financial, human, and material resources
- Creating and developing a national information network supported by the methodological center and a database on specialists to ensure a methodological unification of interventions by different entities and a horizontal information exchange among them

Strategic Plan for the National Response to the HIV/AIDS epidemic and the New 2001-2005 State Program on Prevention of AIDS in the Kyrgyz Republic

The following interventions have been identified as priorities:

1. to reduce the vulnerability of young people
2. to reduce the vulnerability of sex workers
3. to reduce the vulnerability of injecting drug users

Key strategies of the 2001-2005 State Program on Prevention of HIV/AIDS and Infections Transmitted Sexually and Through Injecting Way in the Kyrgyz Republic

Strategy 1: to improve national policy in the area of HIV/AIDS/STI

Strategy 2: to ensure safe medical procedures

Strategy 3: to reduce the vulnerability of young people

Strategy 4: to reduce the vulnerability of injecting drug users

Strategy 5: to reduce the vulnerability of sex workers

Strategy 6: to develop information and education programs for HIV/AIDS prevention

Strategy 7: to provide medical aid and care for STI patients

Strategy 8: to prevent prenatal HIV transmission

Strategy 9: to provide medical aid and social support to HIV-infected persons, people living with AIDS, and people affected by HIV/AIDS

Informational Support to Decision-Makers:

Besides regional workshops and conferences funded by international organizations (primarily by Soros Foundation-Kyrgyzstan, the Open Society Institute, and UNAIDS) measures were undertaken to provide national specialists with the necessary information on HIV infection and possible solutions by publishing a quarterly information bulletin Pulse. The review *AIDS. Global Challenges – Kyrgyzstan Response* was prepared, as well as a research book with a comparative analysis (AIDS: people and countries), and many more.

More than 40 workshops altogether have been conducted between 1997 and 2002 for representatives of government structures and of non-governmental organizations – thus covering over 2,000 persons, including upwards of 350 decision-makers.

IV. GAPS

VII: From: AIDS in Kyrgyzstan: Five Year Resistance, Bishkek 2003

Book published by UNAIDS, UNDP, the government of the Kyrgyz Republic

p. 50: Partnership. Provincial NGOs:

Provincial NGOs:

Six provincial NGOs participate in the implementation of prevention programs. The cooperation with the **Uigu NGO** (the village of Kerben, Aksy Rayon, Jalal-Abad Oblast) and with the **Tandesh NGO** (Naryn Oblast) was the most successful. They collaborated with local state administrations, healthcare providers, educational establishments and use activities such as community meetings, workshops, and training programs.

The Women's Support Center, Naryn, conducts training for students of preventive interventions among young people and other inhabitants of the city of Naryn and the Naryn Oblast. **Parents against Drugs**, an Osh-based NGO, was the first to launch syringe exchange program in Osh and currently serves five hundred IDUs daily.

GAPS: still NGOs remain dependent of external sources of funding. As on the day of the evaluation the Oasis Public Foundation was the only non-governmental AIDS-service organization capable of developing small-scale prevention programs at its own expense. Interaction between NGOs and official bodies remains extremely problematic. Most NGOs have failed to establish productive contacts with law-enforcement agencies and have not attained success in the legal protection required to serve the needs of the prevention program they developed. Provincial NGOs participate in prevention programs to the extent their opportunities and capacities permit, and not to the extent of meeting the needs of their respective regions. In particular it is obvious that local NGOs in the Jalal-Abad Oblast are not adequately active. No

NGO develops any HIV/AIDS prevention programs in the Chui, Talas, and Batken Oblasts, which, due to their geographic locations, and potentially problematic with regard to the spread of HIV/AIDS.

p. 190: Lessons of the Project

Negative Lessons Learned from Implementing Prevention Programs in the Kyrgyz Republic:

- Achieving sustainability of prevention programs is a matter of time. This is mostly true of decisions concerning policy changes. Thus support is still required to change the prevailing approaches to treatment of STIs, especially at the regional level.
- Preventive activities are more efficient in the capital and in larger cities and towns than in villages. This related to the lack of local non-governmental AIDS service organizations – sustainable, well trained and motivated.
- The lack of professional interest on the part of some public officials who require extra remuneration for activities that are within the scope of their duties is a serious obstacle to prevention programs
- The lack of required materials and irregular supplies may completely discredit a program or may significantly reduce its effectiveness. Thus limited and irregular condom supplies jeopardize any program for promoting safer behavior among sex workers. The supply of low-quality injection equipment leads to the refusal of drug users to participate in needle exchange programs
- Due to limited funding prevention programs (such as needle exchange, substitution therapy, or free STI testing and treatment) may not expand and will fail to reach greater number of people in vulnerable groups who actually need help and want to participate in such programs
- The pilot character of intervention fails to ensure the sustainable development of preventive initiatives
- Sometimes state partners do not regard the involvement of international organizations as assistance. Rather they consider that international organization implement prevention program in their own interest. As a result state partners thus avoid their responsibility for their inaction or failure to act in the implementation of the national response to the HIV/AIDS epidemic

p. 191: Conclusion:

Attitudes of target groups towards prevention programs:

Members of vulnerable groups are positive about the development of prevention programs. They appreciate the efforts and actively participate in preventive activities. Injecting drug users fear that the needle exchange program, currently in force may be closed down. Sex workers are ready to expand their activities to areas related to human rights. Schools report their need for extra educational materials and for additional academic hours to cover HIV-related subjects.

TAJIKISTAN:

I. HIV/AIDS SITUATION IN THE COUNTRY:

XVII: From:

[http://wbln0018.worldbank.org/ECA/ECSHD.nsf/ECADocByUnid/540336358112962585256DEF00762D01/\\$FILE/1758-06R_Ch04.pdf](http://wbln0018.worldbank.org/ECA/ECSHD.nsf/ECADocByUnid/540336358112962585256DEF00762D01/$FILE/1758-06R_Ch04.pdf)

Joana Godinho, Thomas Novotny, Hiwote Tadesse, Anatoly Vinokur. World Bank, November 2003.

HIV/AIDS and TB in Central Asia: Tajikistan Country Profile

Chapter 6: Country Profile: Tajikistan (p. 51-59)

Tajikistan is the poorest ECA country, with an annual per capita income of \$170. According to the official data, 80% of the population live in poverty, and according to Bank estimates, 30% may be unemployed. As reported by Central Asia News, between 30 to 50% of Tajikistan's economic activity is linked to narcotics trafficking, and the number of Tajiks using hard drugs such as opium and heroin, has been steeply increasing. Tajikistan's economic dependency on drug trafficking creates many barriers against containing the pending drug-related epidemic of HIV/AIDS. Some foreign experts in Tajikistan assert that the elimination of trafficking-related economic activity would have a serious impact on living standards in an already very poor country.

HIV/AIDS Epidemiological Profile

According to the official statistics, Tajikistan had only 92 HIV-infected persons and 1 person with AIDS in April 2003, but two thirds of the cases were reported in 2001 and 2002. Among those infected, 65% are IDUs, but 19% are of unknown cause. According to survey data reported by national and UNAIDS experts, the actual number of HIV infected may be 10 times higher. In some regions, this figure could be 20 times higher or more, but limited laboratory services do not allow collection of sentinel surveillance data from vulnerable groups. As in other Central Asian countries, the growth of the epidemic since first established in 1995 has been significant and it is mainly concentrated on male (56%) IDUs.

Intravenous drug use with needle sharing is the predominant mode of transmission. Over 6,000 drug addicts are officially registered, but the Government estimates that the number of IDUs is 30,000, and UNODCCP estimates that the real number of drug users is closer to 100,000. About 4,500 drug users were registered in Dushanbe alone, and many of these (93%) report sharing needles and syringes; therefore the AIDS Center expects the number of cases of HIV infected IDUs to rise steeply in the capital in the near future. A substantial part of Tajikistan's economic activity is unofficially linked to drug trafficking. In 2001, law enforcement officials intercepted 8.8 tons of drugs, including 4.2 tons of heroin, a 26% increase over 2000. The quantities of raw poppy seeds seized indicate also that heroin production laboratories now exist in the country.

There are an estimated 5,000 of CSWs, 500 of whom are based in Dushanbe. The average age of CSWs is 20-25 years, but very young girls, 12-13 year-olds, are also involved in CSW. An official assessment showed that 20% of CSW inject drugs and provide sexual services in exchange for money to buy the drugs. CSWs do not have adequate access to condoms, and clients of low-paid CSWs usually do not use condoms. Therefore, it is not surprising that, since 1993, the number of STIs has been increasing, especially in this vulnerable group.

Strategies, Policies, and Legal Framework

With assistance from the UNAIDS Theme Group, the Government of Tajikistan prepared a Strategic Plan for the period 2002-2005 to control HIV/AIDS in the country. Despite the low level of HIV infection (according to official statistics), and the enormous pressure places on a crumbling health care system by transition and civil war, the political leadership has demonstrated strong commitment to HIV/AIDS prevention. The first cases of HIV were detected in 1991. In 1991, the Center on HIV/AIDS Control was established and branches set up in the oblasts. In 1993, a Law was adopted on HIV/AIDS Control and a new version of that law is currently being drafted. A Government Resolution in 1997 established the National Coordination Committee for HIV/AIDS Prevention, which is headed by the Deputy Prime Minister of the Republic of Tajikistan. The 1st National Program was adopted in 1997 and a 2nd National Program up to 2007 was adopted on Dec 30, 2000. These actions highlight the country's proactive approach in securing an expanded response to the HIV/AIDS threat.

The National Program outlines the key policy directions, strategies, and priority interventions for HIV/AIDS and STIs. The National Program policy is founded on the following elements:

- HIV/AIDS and STIs are problems that affect the whole society and call for political and financial support from the Government;
- There is a need for a multi-sectoral approach that involves ministries, NGOs, and donor agencies
- Information about HIV/AIDS status should be kept confidential and disclosed only to the persons tested and those referred to in the Law on AIDS Prevention
- It is essential to integrate the prevention and care dimensions into the programs and actions on HIV/AIDS and STI prevention and control, blood transfusion, family planning, and mother to child health programs
- The National coordinating mechanism for the National Program implementation was established in 1997 and extended in 2002
- Care for and protection of HIV-infected people should be secured
- Issues of condom promotion and distribution, as well as provision of medicines for HIV/AIDS and STI patients should be addressed
- Wide dissemination of information about HIV/AIDS and STIs among the population, particularly among youth and risk groups, is essential.

Surveillance Needs and Additional Studies

No sentinel surveillance has been conducted among highly vulnerable groups, and screening to assure blood safety is deficient. The AIDS Center has carried out studies twice amongst ISUs and only 1 to 2 HIV cases have been found. This is probably because of the low quality of tests and the fact that testing was done on a voluntary basis. However, CDC has recently initiated activities in the country, and under the GFATM grant, investments on upgrading the lab network were planned.

Vulnerable and Highly Vulnerable Groups

AIDS Centers have been established in Dushanbe and all regional centers. These Centers coordinate HIV/AIDS prevention activities of dispensaries for STIs and TB, narcology centers, and blood transfusion units. AIDS Centers promote the work of NGOs with vulnerable groups. With the support of UNAIDS, international NGOs (Soros Foundation/OSI, USAID), and local municipalities, 15 Trust Points for IDUs and one pilot project for CSWs were established to work with vulnerable and highly vulnerable groups. Specialists working in these settings (a drug abuse specialist, a psychotherapist, a STI physician) render consultations, exchange used syringes and needles, provide condoms, and disseminate educational materials. Former drug users work as volunteers. However, the AIDS Center estimates that only about 5% of IDUs in the country, and 10% of IDUs in Dushanbe, are being covered by preventive activities. Under the GFATM grant, the CCM plans to open 13 additional Trust Points to cover 40% of IDUs in the

country. Prevention of HIV/AIDS among drug addicts is not considered by law enforcement agencies as a priority. No services for drug addicts exist in the country.

Condom availability in the country is poor, and the majority of IDUs and CSWs cannot afford to buy condoms. All condoms available in the market are sold through drug stores. Storage rules are not observed, and vendors do not possess information about the specification, date of production, and expiration date of condoms.

The UNAIDS rapid assessment showed that 60% of the population are not aware of HIV/AIDS infection routes and prevention measures, especially in rural areas, where 70% of the population lives. According to UNICEF (2000), only 24% of young people aged 14-17 are aware of the need to use condoms as a means of preventing HIV infection, the lowest rate in the region. Among women aged 30-49, approximately 10% are aware of the need to use condoms to prevent infection, while only 7% of the younger group of women (aged 15-29 years) is aware of this prevention measure. The HIV/AIDS Program include an educational campaign for youth and adults, and it has published textbooks about HIV/AIDS infection for use in schools.

Prevention, Diagnostic, and Treatment Issues

Only STI dispensaries and a private center (“Zoukhra”, in Dushanbe) have the legal right to diagnose and treat STIs. Officially, diagnosis and treatment are free of charge. In reality, the patient must pay for most of these medical services, and he or she has to cover the cost of pharmaceuticals. Patients can also receive free hospital treatment, but in that case their personal data would be reported, which makes treatment undesirable for vulnerable group members who fear being exposed.

NGO and Partner Activities

The UN Theme Group is very active and well organized in Tajikistan, including cosponsors of UNAIDS, international NGOs, and bilateral agencies. It operates in close collaboration with national experts and local NGOs. Although the main focus of the work is on youth, it has been contentious to address HIV/AIDS and STIs prevention in school programs. A manual for trainers on how to teach and explain HIV/AIDS and a new textbook on “Healthy Lifestyles” for teaches of the secondary schools were developed. These cover various issues such as drug use, reproductive health, HIV/AIDS, STIs, and tobacco. The Ministry of Education selected 60 pilot schools where trained teachers will start educating students on healthy lifestyles.

Funding

While the goals of the HIV, AIDS, and STIs control program are well articulated, the Government faces serious constraints in funding health care in general. The Government provides some funding for the HIV/AIDS National Program from the national budget, mainly for infrastructure and labs, but most of the assistance has been provided by member organizations of the UN Theme Group on AIDS, including UNFPA, UNDP, UNICEF, Soros Foundation/OSI, and other organizations. The Ministry of Health provided a more accessible facility to house the AIDS Center, which still needs rehabilitation. **The GFATM** awarded a grant of **\$600,000** for HIV/AIDS prevention for the period 2003 to 2004, and **the Bank may award an IDA credit on HIV/AIDS in 2005**. **UNICEF** has been implementing a four year program (2000-2004) of **\$6 million** that includes HIV/AIDS prevention activities with youth. However, additional funding is necessary to improve the health infrastructure, labs, blood safety, and work with other vulnerable groups.

XVII: From: <http://hivinsite.ucsf.edu/global?page=cr03-ti-00>

HIV/AIDS in Tajikistan	
Adults age 15-49 with HIV/AIDS, 2003	<200
New HIV infections, 2004	nd
Adult HIV prevalence (%), 2003	<0.1
Women age 15-49 with HIV/AIDS, 2003	nd
Children with HIV/AIDS, 2003	nd
AIDS orphans (ages 0-17), 2003	nd
AIDS deaths, 2003	nd
nd = No data	

Source: UNAIDS

XIII: *Tajikistan: Comprehensive Indicator Report*

General HIV/AIDS

(Source: UNAIDS, 2004: *UNAIDS 2004 Report on the global AIDS epidemic*
<http://www.unaids.org/bangkok2004/report.html>)

Indicator	Year	Tajikistan	Eastern Europe & Central Asia	World	Source
Adults and children (ages 0-49) living with HIV/AIDS	2003	<200	1,400,000	39,400,000	UNAIDS, 2004
Adults (ages 15-49) living with HIV/AIDS	2003	<200	1,300,000	37,200,000	UNAIDS, 2004
Women (ages 15-49) living with HIV/AIDS	2003	nd	490,000	17,600,000	UNAIDS, 2004
Children (ages 0-14) living with HIV/AIDS	2003	nd	8,100	2,200,000	UNAIDS, 2004
AIDS orphans currently living (ages 0-17)	2003	nd	nd	15,000,000	UNAIDS, 2004
Adults and child AIDS deaths (ages 0-49)	2003	nd	60,000	3,100,000	UNAIDS, 2004
Adults and children newly infected with HIV	2004	nd	210,000	4,900,000	UNAIDS, 2004
nd = No data					

HIV Prevalence

(Source: UNAIDS, 2004: *UNAIDS 2004 Report on the global AIDS epidemic*
<http://www.unaids.org/bangkok2004/report.html>)

Indicator	Year	Tajikistan	Eastern Europe & Central Asia	World	Source
Adult (ages 15-49) HIV prevalence (%)	2003	<0.1	0.8	1.1	UNAIDS, 2004
HIV prevalence, sex workers, capital city (median %)	Various Years	nd	nd	nd	UNAIDS, 2004
HIV prevalence, injecting drug users, capital city (median %)	Various Years	nd	nd	nd	UNAIDS, 2004
nd = No data					

HIV Knowledge and Behavior

(Source: UNAIDS, 2004: UNAIDS 2004 Report on the global AIDS epidemic
<http://www.unaids.org/bangkok2004/report.html>)

Indicator	Year	Tajikistan	Eastern Europe & Central Asia	World	Source
Know that a healthy-looking person can have HIV (female, ages 15-24) (%)	Various Years	8	nd	nd	UNAIDS, 2004
Reported higher-risk sex (male, ages 15-24) in the last year (%)	Various Years	nd	nd	nd	UNAIDS, 2004
Reported higher-risk sex (female, ages 15-24) in the last year (%)	Various Years	nd	nd	nd	UNAIDS, 2004
Used a condom the last time they had higher-risk sex, of those who had high-risk sex in the last year (male, ages 15-24) (%)	Various Years	nd	nd	nd	UNAIDS, 2004
Used a condom the last time they had higher-risk sex, of those who had high-risk sex in the last year (female, ages 15-24) (%)	Various Years	nd	nd	nd	UNAIDS, 2004

nd = No data

Access to Care and Treatment

(Source: WHO Health Services Coverage, 2004:
http://www.who.int/tb/publications/global_report/en/)

Indicator	Year	Tajikistan	Eastern Europe & Central Asia	World	Source
Percent of adults receiving VCT in last year	2003	nd	1.5	nd	WHO Health Services Coverage, 2004
Number of VCT clients per year	2003	nd	1,042,637	6,000,000	WHO Health Services Coverage, 2004
Number of VCT sites	2003	nd	1,136	nd	WHO Health Services Coverage, 2004
Percent of pregnant women offered PMTCT services	2003	nd	37	8	WHO Health Services Coverage, 2004
Percent of HIV+ pregnant women receiving ARV prophylaxis	2003	nd	6	3	WHO Health Services Coverage, 2004
Number of sites offering	2003	nd	969	37,513	WHO

PMTCT services					Health Services Coverage, 2004
Estimated coverage of antiretroviral therapy (est. %)	2003	nd	11	nd	WHO Health Services Coverage, 2004
Number of public sector patients receiving antiretroviral therapy	2003	nd	5,352	nd	WHO Health Services Coverage, 2004
Number of sites offering antiretroviral therapy services	2003	nd	27	nd	WHO Health Services Coverage, 2004
Coverage of cotrimoxazole prophylaxis for adults (est. %)	2003	nd	4	nd	WHO Health Services Coverage, 2004
Number of adults receiving cotrimoxazole prophylaxis	2003	nd	1,826	190,000	WHO Health Services Coverage, 2004
Coverage of cotrimoxazole prophylaxis for children (est. %)	2003	nd	32	nd	WHO Health Services Coverage, 2004
Number of children receiving cotrimoxazole prophylaxis	2003	nd	1,095	28,000	WHO Health Services Coverage, 2004
Coverage of isoniazid prophylaxis for adults (est. %)	2003	nd	1	nd	WHO Health Services Coverage, 2004
Number of adults receiving isoniazid prophylaxis	2003	nd	432	36,000	WHO Health Services Coverage, 2004
Percentage of population living in areas with DOTS coverage	2002	13	nd	nd	WHO TB Control Report, 2004
Number of TB cases registered for treatment under DOTS	2001	0	nd	nd	WHO TB Control Report, 2004
nd = No data					

Mortality

(Sources: World Population Data Sheet 2004 of the Population Reference Bureau:
http://www.prb.org/pdf04/04WorldDataSheet_Eng.pdf

UNICEF: www.unicef.org, UNDP: www.undp.org, UNFPA: www.unfpa.org)

Indicator	Year	Tajikistan	Eastern Europe & Central Asia	World	Source
Life expectancy at birth (years)	Various Years	68	68	67	PRB Data Sheet, 2004
Infant (Ages 0-1) mortality rate (per 1,000 live births)	2003	92	34	54	UNICEF, 2005
Under-five mortality rate (per 1,000 live births)	2003	118	41	80	UNICEF, 2005
Maternal mortality ratio (per 100,000 live births)	2000	100	nd	nd	UNFPA, 2004
Probability at birth of surviving to age 65, female (% of cohort)	2000-2005	75.4	80.6	72.9	UNDP, 2004
Probability at birth of surviving to age 65, male (% of cohort)	2000-2005	66.2	58.8	64.4	UNDP, 2004
nd = No data					

General Population

(Sources: World Population Data Sheet 2004 of the Population Reference Bureau:
http://www.prb.org/pdf04/04WorldDataSheet_Eng.pdf)

Indicator	Year	Tajikistan	Eastern Europe & Central Asia	World	Source
Total population (millions)	mid-2004	6.6	299	6,396	PRB Data Sheet, 2004
Total projected population - 2025 (millions)	2025	8.6	281	7,934	PRB Data Sheet, 2004
Total projected population - 2050 (millions)	2050	10.0	243	9,276	PRB Data Sheet, 2004
Rate of natural increase (%)	Various Years	1.9	-0.5	1.3	PRB Data Sheet, 2004
Percent urban		27	68	48	PRB Data Sheet, 2004
nd = No data					

Youth

(Sources: World Population Data Sheet 2004 of the Population Reference Bureau:
http://www.prb.org/pdf04/04WorldDataSheet_Eng.pdf)

Indicator	Year	Tajikistan	Eastern Europe & Central Asia	World	Source
Population ages 10-24 (millions)	2000	2.0	71	1663.0	PRB Youth Data Sheet, 2000
Percent of total population ages 10-	2000	33	23	27	PRB Youth

24					Data Sheet, 2000
Percent of total population under 15	mid-2004	42	16	30	PRB Data Sheet, 2004
nd = No data					

General Health

(Source: UNDP: www.undp.org, UNICEF: www.unicef.org; WHO: http://www.who.int/tb/publications/global_report/en/)

Indicator	Year	Tajikistan	Eastern Europe & Central Asia	World	Source
Health expenditure, private and public (US\$ per capita)	2001	43	nd	nd	UNDP, 2004
Physicians per 100,000 people	1990-2003	212	nd	nd	UNDP, 2004
Births attended by skilled health staff (%)	1995-2002	71	97	58	UNDP, 2004
Malaria cases per 100,000 people	2000	303	nd	nd	UNDP, 2004
Prevalence of child (ages 0-5) malnutrition (%)	1995-2003	nd	6	27	UNICEF, 2005
TB treatment success rate, new smear-positive cases-DOTS (% of cases)	2001	nd	nd	nd	WHO TB Control Report, 2004
nd = No data					

Fertility

(Sources: UNFPA: www.unfpa.org; World Population Data Sheet 2000 of the Population Reference Bureau: <http://www.prb.org/Template.cfm?Section=PRB&template=/ContentManagement/ContentDisplay.cfm&ContentID=8500>)

Indicator	Year	Tajikistan	Eastern Europe & Central Asia	World	Source
Total fertility rate (number of children)	2000-2005	3.06	nd	2.69	UNFPA, 2004
Births per 1,000 women (ages 15-19)		25	nd	50	UNFPA, 2004
Percent of TFR attributed to births by ages 15-19		4	14	12	PRB Youth Data Sheet, 2000
Percent giving birth by age 20		nd	nd	31	PRB Youth Data Sheet, 2000
nd = No data					

Education

(Sources: UNICEF: www.unicef.org)

Indicator	Year	Tajikistan	Eastern Europe & Central Asia	World	Source
Gross primary school enrollment	1998-	109	101	104	UNICEF,

ratio, male	2002				2005
Gross primary school enrollment ratio, female	1998-2002	104	98	97	UNICEF, 2005
Gross secondary school enrollment ratio, male	1998-2002	90	90	66	UNICEF, 2005
Gross secondary school enrollment ratio, female	1998-2002	74	85	61	UNICEF, 2005
nd = No data					

XIV: From: <http://www.unaids.org/Unaids/EN/Geographical+area/By+Country/tajikistan.asp>
The Republic of Tajikistan has the lowest Gross Domestic Product per capita of the CIS countries (US\$290); according to official data, 80% of the population is living below the poverty line.

Country HIV and AIDS estimates, end 2003*

Adult (15-49) HIV prevalence rate	<0.1% (range: <0.2%)
Adults (15-49) living with HIV	<200 (range: <400)
Adults and children (0-49) living with HIV	<200 (range: <400)
Women (15-49) living with HIV	...
AIDS deaths (adults and children) in 2003	...

Source: [2004 Report on the global AIDS epidemic](#)

* No estimates have been made where sufficient data for the last six years was not available.

Country Situation Analysis

The Republic of Tajikistan is currently viewed as a country with low prevalence of HIV infection. As of March 2004, 170 cases of HIV infection have been registered in the republic, or 0.28 cases per 100,000 of the population. Of the total number of cases, 81% are men and 19% women, but since 2000 there has been a growing trend of infection among women. In 71% of cases, infection was transmitted through injecting drug use, in 9% through sexual contacts, in 4% through blood transfusion, and in 16% the mode of transmission is not identified.

The official data, however, do not reflect the real situation. Due to economic instability in the last decade, Tajikistan could not afford full testing in the country. Improved laboratory diagnostics for HIV began only in 2003 with support from the Global Fund to fight AIDS, Tuberculosis and Malaria.

In just two months in 2004, 51 new cases were registered. UNAIDS experts estimate that, taking into account the factors conducive to the spread of HIV infection (an increasing number of injecting drug users, sex work, unemployment, poverty and migration), the real number of HIV-infected people in the country is 10–20 times higher than the official data.

Tajikistan has already mobilized an effective multisectoral response to HIV/AIDS. The National Coordination Committee on HIV Prevention was established in 1997. In 2000, the government approved a second national programme for the period up to 2007. In 2002 the National Strategic Plan (NSP) for the response to the HIV/AIDS epidemic in the country for the period 2002–2005 was adopted by the government. The plan places great emphasis on preventive activities among injecting drug users, sex workers, and youth, as well as on donor blood safety.

UNAIDS Support to the National Response

The UN and partners assisted the government with the development and dissemination of the National Strategic Plan (NSP) (2002–2005), preparation of sectoral programmes in health and education, and preparation of the national report on the implementation of the UN Declaration of Commitment on HIV/AIDS in 2003.

Additional support was provided to facilitate the functioning of the HIV/AIDS-related CCMs. UNAIDS capacities were used to mobilize technical and financial resources to assist the government with the costing and budgeting of the NSP and the submission of the first and third round Global Fund proposals.

UNAIDS provided technical and financial support to conduct an assessment of the HIV situation among injecting drug users and sex workers, and rapid assessment and response among especially vulnerable groups of youth.

UNAIDS is assisting the establishment of the M&E system at the country level. UNAIDS and the Theme Group are assisting national capacity-building on HIV. With technical, advocacy and financial support from UNAIDS, new programmes were opened in 2003–2004, and more vulnerable groups were covered:

- the first NGO for men who have sex with men was supported;
- the first NGO for people living with HIV was established; and
- a prevention programme in the uniformed services was launched.

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a. HIV PREVALENCE RATES (GENERAL):

From: Harm Reduction News

Newsletter Focus

Fall 2002 – Volume 3, Issue 3

p. 11: Struck by Drugs, HIV, and a Will to Respond

by Muratboki Bekhazarov

In the last year and a half the number of people infected with HIV in Tajikistan increased eight times more than it did in the last decade. Seventy-three percent are injection drug users. As stunning as these figures are, they do not come close to the reality of the HIV epidemic. As in other Central Asia countries, the lack of tests and diagnostic equipment makes epidemiological surveillance of the vulnerable populations almost impossible.

It is known, however, from a joint government-UNAIDS rapid situation assessment of drug use in Dushanbe in 1999, that the spread of HIV is related to injection drug use. An estimated 15-18

thousand people were found to be users of drugs, mainly heroin, of which 4-5 thousand injected. Almost no drug users used condoms.

The assessment also determined that the violent increase in the number of IDUs in the previous few years among 20-35 year olds was related to the economical high from injecting rather than inhaling heroin. Sharing syringes in a group was typical among 93% of the IDUs and few drug users disinfected their apparatus.

The rise in drug use can be squarely blamed on the appearance of heroin in the country. Before 1996-1997 there were practically no IDUs. Bordering Afghanistan, China, Uzbekistan, and Kyrgyzstan, Tajikistan has the misfortune of being located on a drug trafficking route. Both the fall of the Soviet Union in 1992 and the civil war in 1993-1994 made it difficult to control the flow of drugs. Further, in the four years after the end of Soviet rule, unemployment increased seven times. Many people looked to drug smuggling and dealing to earn money.

Recognizing the growing HIV problem, the Republican AIDS Center opened two stations for IDUs in Tajikistan's capital, Dushanbe, in 1999. With support from UNAIDS, the Ministry of Health, and the city government, the Center provided counseling, disseminated information, distributed condoms, and exchanged needles. The program was well run and only specially trained consultants (a narcologist, a dermatologist-venereologist, and a psychotherapist), social workers, and volunteers worked in the stations. Everything was anonymous and confidential. Yet during the first six months the Center reached only 60-70 people.

To attract more clients to the projects, the Republican AIDS Center working with trained volunteers to do outreach and peer education among drug users. It was also necessary to create a more favorable environment for the harm reduction program and stimulate public debate. Seminars, round table discussions, and press conferences were held for politicians, law enforcement officials, the mass media, and the general population on HIV prevention among IDUs.

Six new stations were opened in 2000 with financial support from the OSI in New York. The worsening HIV situation prompted the creation of several more locally funded programs across the country. All told, 15 stations now serve an average of 1,500 drug users daily, approximately 5% of the estimated number of IDU in the country.

Key ministries and departments have already approved a national strategic plan to respond to HIV/AIDS. The plan, developed by the government, NGOs and international experts, highlights HIV prevention among IDUs. The problem is recognized at the highest government levels, including by Tajikistan's vice-prime minister who spoke out about HIV prevention among IDUs at the Int'l AIDS Conference in Barcelona in July. Recognition has been translated into financial support – the government funds eight projects – but the need is far greater than the state's ability to meet it.

b. HIV PREVALENCE RATES (WITHIN THE COUNTRY, BY REGIONS):

c. HIV PREVALENCE RATES (VULNERABLE GROUPS):

XVI: From: http://www.unaids.ru/index_ru.php?id=aids_epidemic_update_eng-5&nm=4
UNAIDS: Key Materials: Eastern Europe and Central Asia

These epidemics are very recent and can be halted if prevention efforts are targeted at those who are currently most affected - **injecting drug users and sex workers** - and are supported by prevention work among young people generally. In some instances, even more elementary prevention steps are required - such as screening blood donations for HIV. Tajikistan, for example, reportedly did not test 40% of those who donated blood in 2002.

HIV/AIDS

Social and Economic Consequences in Countries of the Commonwealth Of Independent States
Indicators for the World of Work
Report of a Tripartite Seminar
Moscow, 10-12 December, 2001

The increase in injecting drug use and sexually transmitted infections (the Tajik experience)
By Ms. Margarita Khagai

In November, 2001, there were 45 registered cases of HIV. The current estimates of infection are thought to be much higher with approximately 600-700 people with HIV. About 73 per cent of HIV-infected persons are injecting drug users, while 16 per cent of the infections resulted from unprotected sexual intercourse.

Injecting Drug Use:

By the end of 2000, there were 4,604 registered drug users in Tajikistan. National and international experts believe that the real number of drug users is more than 20 times higher. Many factors contributing to increasing drug use and HIV vulnerability in the country:

- the high level of unemployment among young people: most drug users are aged 25-35;
- high availability of drugs in the country: Tajikistan is located along one of the main drug-trafficking routes;
- the low price of drugs: the price for a dose of narcotics varies from \$1.50-2.00 to \$5-7 per dose, depending on the quality;
- injecting drug use is on the rise and is preferred by drug users for economic reasons – it is more cost-effective than other forms of drug use;
- social, economic and legal problems related to drug use make it difficult for drug users to participate in needs and syringe exchange programs. Such programs are currently being implemented by UNAIDS, the National AIDS Center, and the Soros Foundation;
- insufficient interventions from public health services, communities and local NGOs to prevent drug use;
- and the limited number of clinics for treatment and rehabilitation of drug users.

Sexual Transmission:

The incidence of sexually transmitted infections (STIs) provides some insight into the sexual behavior of the population and the potential risk of HIV infection. According to official statistics, the prevalence of STIs shows a decrease over recent years in Tajikistan. These official statistics are based upon registered cases and may not reflect the real situation. For example, according to official statistics there were 24.6 cases of syphilis and just 8 cases of gonorrhoea per 100,000 women in the age group of 15-49 years in the country in 1999. Experience shows, however, that gonorrhoea is usually more prevalent than syphilis. Patients with gonorrhoea often prefer either self-treatment or to visit a doctor illegally.

A survey of 1,034 women in Khatlon Province in 1999 indicated a high prevalence of STIs. Out of 400 women selected for a pelvic examination, an STI was discovered in 75 per cent of all cases. Syphilis and gonorrhoea were found in about 16 per cent and 5 per cent of all cases respectively, and non-specific vaginal infections in another 6 per cent.

The highest incidence of STIs was found among women between 21 and 39 years old. Ninety per cent of those infected women were married. Although women in Tajikistan are not considered a high-risk group for HIV infection, these data indicate a high incidence of unprotected sexual contacts, and as a consequence, a considerable risk for HIV infection.

These are a number of social and economic reasons for the high incidence of STIs and the potential threat of an HIV epidemic.

- Lack of information about HIV and other STIs in communities;
- Lack of quality condoms at affordable prices;

- Increasing polygamy;
- Increasing long-term labor migration among young, sexually-active men;
- Lack of women's right to refuse unsafe sex;
- Increasing sex work;
- And barriers to the treatment of STIs among sex workers

Future Outlook:

Predictions from national experts:

- HIV will spread rapidly in Tajikistan among people in aged 18-35 years old
- During the first stage, HIV will spread among IDUs
- During the next stage, HIV will spread through sexual contacts
- Approximately 2,500 HIV infections are expected in Dushanbe, where there were 5 registered cases by Nov 2001
- And, taking into account the high level of migration, HIV will spread rapidly to the other provinces of the country.

d. MAJOR TRANSMISSION ROUTES:

I. From: www.rbec.undp.org/hiv/?english

HIV/AIDS in Central and Eastern Europe and the CIS

p.22: 92 HIV cases were reported in Tajikistan as of mid-2003.

In Tajikistan, inadequate public health resources have caused fluctuating HIV testing patterns over time, which create further difficulties in interpreting case-reporting results.

The **trafficking** of opiates from Afghanistan into and though Tajikistan gives higher risks in terms of injecting drug use than would otherwise be the case. The country's relatively low per-capita GDP and human development indicators (Tajikistan is a poorest country among other CIS countries) offer further grounds for concern. The fact that Tajikistan in 2000 reported only \$29 in per-capita health expenditures (compared to \$415 for the Russian Federation) underscores the basic frailty of the public health infrastructure in the country.

e. ACCESS TO TREATMENT:

IX: From <http://www.euro.who.int/document/mediacentre/fs0603e.pdf>

HIV/AIDS treatment: antiretroviral therapy

Fact Sheet EURO /06/03

WHO Europe

Copenhagen, 1 Dec 2003

Country	Estimated number of people who need ART	Estimated coverage (%)
Kazakhstan	100	55.0
Kyrgyzstan	10	0.0
Tajikistan	5	0.0
Turkmenistan	0	0.0
Uzbekistan	100	0.0

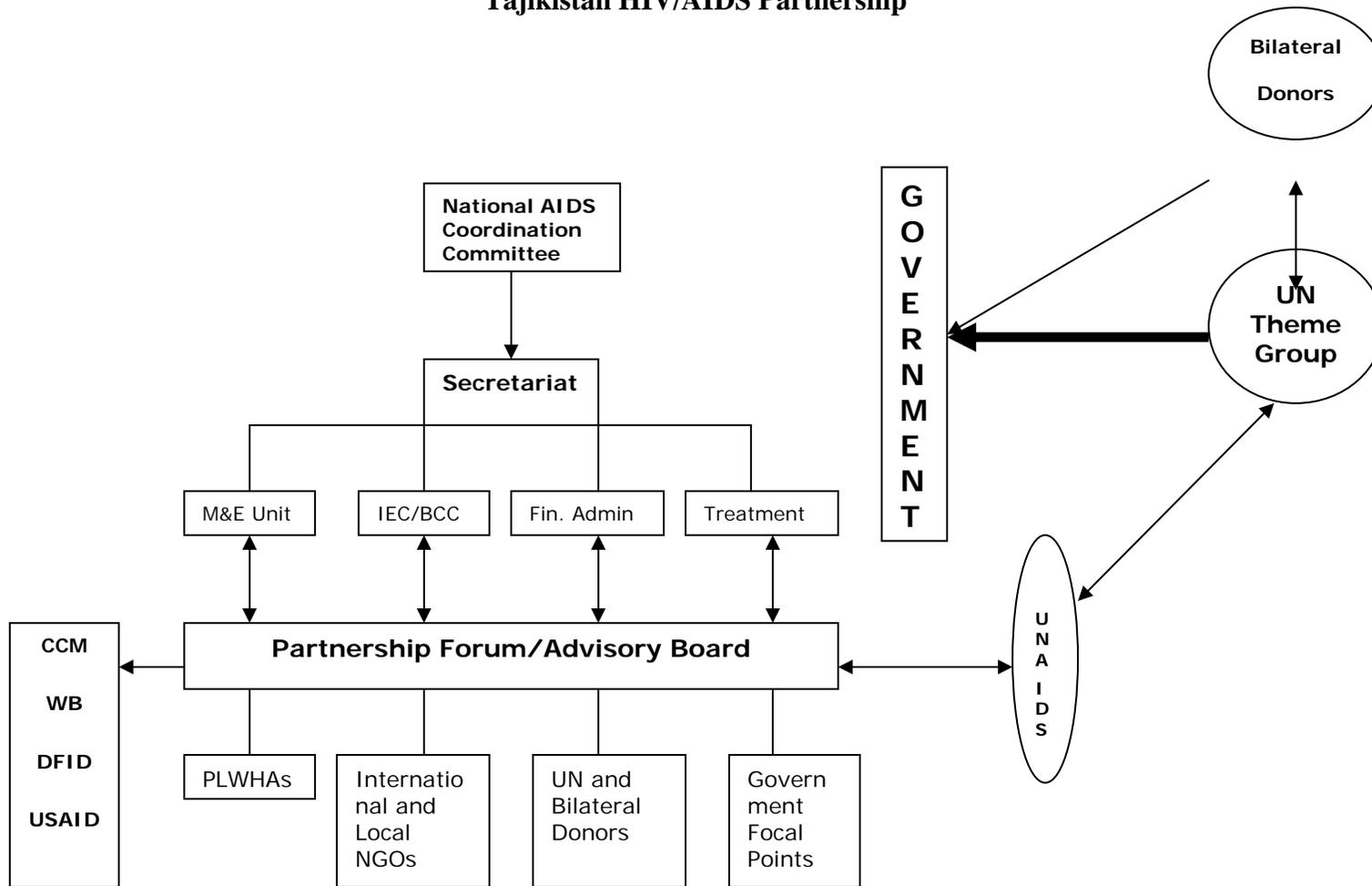
II. CURRENT RESPONSE TO HIV/AIDS EPIDEMIC IN THE COUNTRY

a. GOVERNMENT

III. From: the information sent to us by Tajikistan partner

The constituencies of the **Partnership** will include the Ministries of Government, United Nations (UN) and Bilaterals, People Living with HIV/AIDS (PWHA) organizations, National NGOs, International NGOs, Faith Based Organizations and Research, Academia and Science. These institutions will share information, plan and coordinate issues within their constituencies. All eight will be elected a representative to participate in the HIV/AIDS Partnership Committee (PC), which will meet with the members of the Partnership Forum once every three months. The ministries of Health and Finance, education, Labour and Social Protection, UNAIDS and NACC Secretariat, each will have a permanent seat on the Committee. The National AIDS Coordination Committee will chair the Partnership committee. The PC sets the agenda for the update, implementation and monitoring of the National Strategic Plan on HIV/AIDS (NSP) and facilitates and harmonizes HIV/AIDS policies, programmes, plans and spearheads resource mobilization. An annual HIV/AIDS Partnership Forum bringing together all members of the partnership reviews progress and sets priorities for the next year.

Tajikistan HIV/AIDS Partnership



From: <http://lnweb18.worldbank.org/ECA/ECSHD.nsf/ExtECADocByUnid/814FDCE14FDAF46585256C83006D9373?Opendocument>

HIV/AIDS in Tajikistan

- **Although Tajikistan has few reported HIV/AIDS infections, the country is gripped by a serious drug crisis.** There is ample evidence from other regions that drug trafficking, injecting drug use, and HIV infection are closely woven together. Of the 45 HIV-infected persons by end 2001, 33 were intravenous drug users, according to official statistics.
- **Poverty is fueling the drug trade in Tajikistan, one of the poorest countries in the region.** Some foreign experts assert that the elimination of trafficking-related economic activity would have a serious impact on living standards in the already impoverished country.
- **Some reports estimate that between 30 to 50 percent of Tajikistan's economic activity is linked to narcotics trafficking.** One report found that 30 percent of the population is economically dependent on the illicit drug business. This compounds the difficulties for officials and NGOs.
- **The number of Tajiks using hard drugs, such as opium and heroin, appears to be increasing very rapidly.** Over five thousand drug addicts are officially registered. However, UNODCCP estimates that the real number is some 100,000.

Government Response

The political leadership has demonstrated strong commitment to HIV/AIDS prevention, in spite of the very low rates of HIV infection (according to official statistics) and the enormous pressure placed on a crumbling health care system by transition and civil war.

A Presidential decree in 1997 approved the 1st National Program on HIV/AIDS and established the National Coordination Committee for HIV/AIDS Prevention.

However, while the goals of the programs are well-articulated, the Government faces serious constraints in funding.

Government Policy Directions

The National Program outlines the key policy directions, strategies and priority interventions for HIV/AIDS and STIs. It is based on the following elements:

- **HIV/AIDS and STIs are problems that affect the whole society** and call for political and financial support from the Government;
- **A multi-sectoral approach is needed** that involves ministries, NGOs, and donor agencies ;

- **Information about a person's HIV/AIDS status should be kept confidential** and disclosed only to the person tested and those referred to in the law 'On AIDS Prevention';
- **It is essential to integrate prevention and care into programs** and actions on prevention and control of HIV/AIDS and STIs, blood transfusion, family planning, and mother and child health programs;
- **A coordination mechanism for implementation of the National Program** needs to be established;
- **Care for and protection of HIV -infected people should be ensured;**
- **Issues of condom promotion and distribution, as well as provision of medicines** for HIV/AIDS and STI patients should be addressed;
- **Wide dissemination of information about HIV/AIDS/STIs** among the population, particularly among youth and risk groups, is essential.

b. DONOR ORGANIZATIONS

XII: From: <http://www.theglobalfund.org/search/portfolio.aspx?countryID=TAJ>

The Global Fund

Tajikistan:

PORTFOLIO OF GRANTS IN TAJIKISTAN	
Country Coordinating Mechanism (CCM):	<p>Khairinissa Mavlonova Honorable Vice Prime Minister 80 Rudaki Str. CCM Tajikistan, Chairperson Dushanbe 992372 213774 992372 215110 tasus@yandex.ru</p> <p>Nazira Artikova Liaison Officer CCM Tajikistan, Contact 1 (Round 3) Dushanbe 106, Druzhbi Narodov 992372 214871 (992372) 219676 992372 992372214 artykova.who@tajnet.com</p> <p>Nusratullo Fayzulloev</p>

	<p>Minister of Health Care CCM Tajikistan, Vice-Chair Dushanbe 61, Shotemur Street 992372 211835 992372 214871 vazir@tojikiston.com</p> <p>Massoudbek M. Narzibekov DEX Programme Analyst UNDP CCM Tajikistan, Contact 1 (Round 1) Dushanbe 734024 39, Aini Street 992372 210670 992372 510021 massoudbek.narzibekov@undp.org</p>
Disease(s):	<p>Round 1: The United Nations Development Programme Round 4: The United Nations Development Programme</p>
Total Funding Request:	\$13,108,367.00
2-year Approved Funding:	\$5,284,725.00
Total Funds Disbursed:	\$3,534,233.00

HIV/AIDS

Project Title:	Support to the Strategic Plan of the National Response to the HIV/AIDS epidemics in prevention activities among IDU, SW and youth and envisaging blood safety in Tajikistan
Country:	Tajikistan
Round:	1
Principal Recipient:	The United Nations Development Programme william.paton@undp.org
Local Fund Agent:	PricewaterhouseCoopers

	finconsult.tajik@runbox.com finconsult.tajik@runbox.com
Portfolio Manager:	Chernyavskiy, Valery Valery.Chernyavskiy@TheGlobalFund.org
Grant Agreement Signed:	30-Mar-03
Total Funding Request:	\$2,425,245.00
2-year Approved Funding:	\$1,474,520.00
Total Funds Disbursed:	\$1,474,520.00

Summary:

The Programme provides support to the implementation of the Strategic Plan of Overcoming Propagation of HIV/AIDS epidemic in Tajikistan for the period of 2003-2005. The strategic Plan envisages preventive activities among intravenous drug users, commercial sex workers and their clients and youth, including building a system for blood safety control. The programme creates opportunities for decentralization of preventive activities and expansion of intervention among vulnerable groups. The programme is aimed at reducing vulnerability of intravenous drug users (IDUs), commercial sex workers (CSW) and youth, ensuring their rights through the strengthening of capacities of the government and civil society and the insurance of supply with necessary supplies. The programme also includes building capacities to provide stronger leadership of the government on HIV/AIDS prevention, better cross-sectoral coordination, and continued dialogue between the government and NGOs on central and local levels.

Principal Recipient:

UNDP was requested to act as the Principal Recipient in a meeting of the Country Coordinating Mechanism on 25 October of 2002 after which the Vice-Premier of Tajikistan, Ms. Nigina Sharopova, issued a confirmation letter to the UNDP Resident Representative. The Office of the United Nations Development Programme in Tajikistan was established in 1994. Its first years were dominated by its contributions to the United Nations efforts to secure a durable peace. Since the signing of the Peace Agreement in 1997, UNDP has played an active role in social and economic recovery, confidence building at the community level and stabilizing the post-conflict environment.

Presently, the UNDP in Tajikistan has three areas of intervention: good governance and capacity building at the national level; rehabilitation, reconstruction and development; and protection and sustainable management of natural resources. UNDP is in possession of extensive experience in implementation of projects under different modalities.

Project execution will be performed according to UNDP rules and regulations for nationally executed projects. Country Coordinating Mechanism will fulfil the functions of Coordination Committee of the project. UNDP will hire a Project manager, consulting the Government on the selection of candidates.

UNDP assumes the Principal Recipient's role to oversee the implementation of the Program in accordance with its regulations, rules and procedures. The Principal Recipient will be responsible and accountable to the Global Fund for all resources it receives under the Program and for the results that are to be accomplished.

Programme Objectives:

The programme consists of four inter-connected components:

- 1) HIV prevention among IDUs, CSWs and youth through improved access to Educational Information and Communication materials (EIC),
- 2) Voluntary conscious testing (VTC),
- 3) improved means and awareness of individual protection (condoms as well as syringes and disinfectants for IDU)
- 4) treatment of sexually transmitted infections (STI). Improvement of laboratory facilities will ensure blood safety and facilitate monitoring and evaluation of impact of prevention activities.

Intended Programme Results:

- Level awareness of IDU in safe injecting and sexual behaviors: By the end of the Programme, 30% of IDUs are aware of safer injecting and sexual practices
- Coverage of the needs of IDU in disposable syringes, needles, disinfectants, condoms: Amount of distributed goods meets not less than 90 per cent actual needs of the covered group.
- Level awareness of CSW in safe sexual behaviors: At least 50% of CSWs are completely aware of safer sexual practices
- Number of teachers trained to conduct lessons on HIV/AIDS, STI and drug abuse prevention: Not less than 2840 teachers trained to envisage the starting of the program in each secondary school.
- HIV/AIDS awareness level of students aged between 15 and 18: At least 65 % of students all over the country aged 15-18 are aware of HIV/AIDS and of how to protect oneself from infection
- The equipment and test kits are procured: Equipment to envisage routine testing of 100,000 samples annually is procured and installed in 13 laboratories. Equipment to provide verification of results installed in one laboratory. Appropriate number of test kits purchased and distributed.

Beneficiaries:

- injecting drug users
- commercial sex workers
- youth
- other groups considered high risk due to unsafe behavior and inappropriate social environment.

The programme is aiming to strengthen the capacities of the following groups to counteract HIV/AIDS through increased awareness and improved skills:

- Government officials on the central and local level;
- Professionals in health, education and mass media;
- Staff of Law enforcement;
- NGOs as services providers.

Initial Country Coordinating Mechanism Members:

The composition of the Country Coordinating Mechanism may change from time to time. At the time of signing of this Agreement, the Country Coordinating Mechanism consists of members of the Government of Tajikistan, representatives of UN agencies, representatives of international organizations, religious organizations, domestic and international non-governmental organizations. The total number of the CCM members is 32 people. The CCM is chaired by the Vice-Premier of the Republic of Tajikistan.

XV: From: <http://www.dfid.gov.uk/pubs/files/rapcascsm.pdf>

Central Asia, South Caucasus and Moldova. Regional Assistance Plan. 2004

New Directions of **DFID** in Tajikistan:

Support to the National Programme – focus on harm reduction.

XIV: from the Minutes from the meeting of the **UN Focal Points (FP)** on HIV in Tajikistan

Three Ones Initiative: It was agreed that this initiative is very important for Tajikistan. Specifically it is important now for the country, where financial resources dramatically increased for the period 2005-2010: GFATM will provide about US\$ 10mln, the WB is planning to contribute about US\$ 25 mln, the DFID Regional project and USAID “CAPACITY” will be launched, also contribution from UN system and other donors will be increased (only in 2004 UN system allocated about US\$600,000 to fight AIDS in Tajikistan).

Only several key activities were included into the implementation of the NSP (National Strategic Plan adopted in 2002 for the period until 2005): indicators for the NSP were not included in the actual plan. It was suggested to further elaborate on the identified indicators, since the situation on HIV in Tajikistan is rapidly worsening and the goals of strategy should be targeted not only on the prevention but on treatment care and support.

It was suggested to expand the targeted audience for service provision to: migrants, prisoners, street children, military, and therefore, earlier identified indicators need to be developed, and budget for implementation of NSP need to be revised according to new goals and growth of the epidemic.

The revision of the NSP needs to be done in 2005, and UNAIDS now is looking for funds to do so.

It was also suggested to establish the M&E system in the country.

The Government has already agreed to establish the system under the responsibility of the National Coordination Committee, the letter on the establishment of Intra ministry Working Group on the M&E is already signed. The group will consist of 15 representatives from different Ministries and NGOs working with vulnerable group of population. Representatives from international community will be invited as advisers of the WG. When the WG will be officially established (February, 2005), the one day briefing will be conducted by UNAIDS, after that the National indicators will be developed, adopted and included in the Country Response Information System. The data base will be established. Unified system of indicators will be included in the evaluation of all projects. The representatives from the donor's organizations will be invited to the briefing.

At the meeting participants also discussed (initiated by UNFPA) the issues related to the delivery of services, especially on the provision and distribution of condoms. The problem is that UNFPA is one of the main providers of condoms at the country level has not receive full report on the distribution of the condoms, and the question is how to improve the report system in the delivery area. One of the options suggested is the improvement of the registration and M&E system. The results of the utilization of the condoms will be identified during special assessment on the behavior change. The questions on the improving of monitoring on the delivery of commodities provided by the project/donors also need to be included in the developing of the National indicators.

OSI–Tajikistan informed participants that the Regional meeting on the signature agreement between Governments of Uzbekistan, Tajikistan and Kyrgyzstan and DFID on the Regional project financed by DFID will be held on 3-4- February 2005 in Bishkek, Kyrgyzstan.

II. From: DDRP website

Drug Demand Reduction and Health Promotion Among Sex Workers Tajikistan

PROJECT DURATION: October 2002 through September 2007

DONOR(S): United States Agency for International Development (USAID; www.usaid.gov)

The Drug Demand Reduction Programme (DDRP) is a five-year USAID-funded initiative in Central Asia designed to respond to the dramatic increase in drug use among vulnerable populations in two key countries of a region in which HIV/AIDS is spreading rapidly and primarily through injecting drug use.

Throughout the five-year Programme, Drug Demand Reduction interventions will be implemented in select oblasts of Tajikistan, Uzbekistan, and the Ferghana Valley region of Kyrgyzstan with the short term goal of **'increased knowledge and skills with respect to the prevention of drug use in select populations'**. This is stated as a step toward the long-term goal of a 'decrease in drug use among these select populations'.

PARTNER(S): The Open Society Institute - Kazakhstan, The Open Society Institute - Tajikistan, Internews, Population Services International (PSI); Accord - an affiliate of Street Kids International; The Ministry of Health of Tajikistan, The Ministry of Internal Affairs of Tajikistan

REGION: Tajikistan

BACKGROUND:

The number of women working in the sex industry has rapidly increased in the Central Asian Republics during the last decade. This growing phenomenon is the result of a multitude of factors including the significant and far-reaching socio-economic and political changes which have continued to sweep the region since gaining independence in the early 1990s.

Many women from this region continue to struggle with high levels of unemployment and ultimately, the feminisation of poverty. Sex work is often one of the few income-generating options available to support themselves and their families. As such, tendencies such as high migration patterns from rural to urban regions, and frequent movement across borders into neighbouring countries, have been noted among women and young girls.

Drug use and sex work are strongly interlinked. Drug users often sell or trade sex for narcotics and sex workers often use drugs as a coping mechanism. As of 1 April 2003, the Republican AIDS Centre reported 92 registered cases of HIV/AIDS for Tajikistan. Among these cases, 60% are attributed to injecting drug use where the route of transmission is known. An additional 20% of registered cases have been attributed to heterosexual contact.

OVERALL OBJECTIVE:

To contribute to the implementation of a comprehensive and sustained, country-wide drug demand reduction policy through the development of a pilot programme on drug demand reduction and health promotion among sex workers in Tajikistan

SPECIFIC OBJECTIVES:

1. To develop within the Tajik government and NGOs the appropriate tools and structures for drug demand reduction and health promotion among sex workers and to promote the transfer of knowledge and skills among all counterparts involved
2. To strengthen the personal decision-making skills of sex workers related to drug demand reduction via drug counselling services, peer support, and the distribution of appropriate information materials
3. To reduce the relative isolation of Tajik sex workers by promoting and facilitating the establishment of peer-led self-help groups, strengthening survival skills, increasing access to alternative employment training, and by stimulating co-operation with the respective municipal health institutions and NGOs

4. To stimulate the replication of developed structures in Tajikistan in close co-operation with the Ministry of Health, municipal health authorities, and NGOs

TARGET AUDIENCE(S):

- Sex workers
- Selected governmental and non-governmental organizations
- Law enforcement agencies
- Health professionals working within drug treatment establishments, sexually transmitted infection clinics, and AIDS centers
- Local and national health authorities

PROGRAMME ACTIVITIES:

The following activities may be developed, implemented, evaluated and handed over to local agencies during the **five-year programme**:

- Conduct an extensive rolling needs assessment in Tajikistan among **sex workers**
- Development and dissemination of practical training guidelines for local partner organizations and agencies on themes related to **drug demand reduction** and **health promotion** among sex workers
- Conduct capacity building seminars on themes related to drug demand reduction and health promotion for local project partners and target audiences
- Regular consultancy site visits by AFEW technical advisors to project sites
- Development, production and dissemination of a wide range of printed materials on issues related to drug demand reduction and health promotion for all programme target audiences (i.e., **sex workers, NGO personnel, medical professionals, law enforcement officials, health authorities and policy makers**)
- Promotion of and support for the establishment of local peer-led initiatives such as self-help groups to assist in building self-esteem, confidence, and to provide education and support to other sex workers
- Development of links to existing alternative employment training programmes and potential partnerships with micro-credit initiatives to support opportunities for women seeking to leave the sex industry
- Development of a training programme and information resources on drug demand reduction for Tajik law enforcement agencies and medical establishments
- Participation in a regional drug demand reduction conference during the third and fifth years of programme activities

(EXPECTED) RESULTS:

- A comprehensive, multi-sectoral results-based programme will be developed and implemented on drug demand reduction and health promotion as a direct outcome of the extensive needs assessment among sex workers
- A continuum of **10 to 12 capacity building training seminars** will have been implemented among NGO personnel, police and health authorities, and medical professionals from several regions of Tajikistan
- A series of best practice training guidelines for partner organizations on drug demand reduction and health promotion among sex work populations will be developed and widely disseminated across all regions of Tajikistan

- Response-based targeted materials on drug demand reduction and health promotion will be developed and disseminated in collaboration with sex work populations in Tajikistan
- Political commitment and involvement from local and national health authorities will facilitate the development and dissemination of materials and will support the sustainability of programme operations through a controlled hand-over process to local structures

(EXPECTED) MATERIALS PRODUCTION:

Throughout the duration of the five-year programme, a comprehensive series of quality printed materials and best practice resources will be developed and disseminated among sex workers, medical professionals, NGO personnel, law enforcement officials, and policy makers in Tajikistan, including the following:

- As many as four **(4) best practice manuals on drug demand reduction**, and health promotion materials will be developed and disseminated among the project target audiences
- **50 000 copies of health promotion printed materials** will be disseminated among **sex work populations in Tajikistan**
- **8 000 copies of best practice resources and guidelines** will be developed and disseminated **among NGOs, health professionals, and health authorities in Tajikistan**
- **10 000 copies of guidelines on health promotion and drug demand reduction materials** will be developed and disseminated among **Tajik law enforcement officials**

RESEARCH COMPLETED AND PLANNED BY AFEW:

- In December 2002 to January 2003, *AFEW* completed a baseline needs assessment among NGO counterparts.
- In June 2003, *AFEW* completed a Rapid Assessment and Response on psychoactive substance use and sexual risk behaviour (SEX-RAR) among sex workers.
- In June 2003, *AFEW* completed a baseline KAPB survey among sex workers.

FOR FURTHER INFORMATION, PLEASE CONTACT:

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AFEW
P. O. Box 75752
1070 AT Amsterdam
The Netherlands

Some additional information on/the initiative:

Drug Demand Reduction Program in Tajikistan (DDRP)

Summary: The aim of the programme is to raise drug use (heroin/opiate) awareness of a selected population, availability of treatment, rehabilitation, social services and increase of the availability of drug demand reduction - services at universal, selective and indicated levels. Also, to improve regulatory and policy environment related to drug demand reduction.

DDRP consortium: OSI-Tajikistan, PSI, AFEW, Accord, Internews Tajikistan

Primary Funding Organization: USAID

Geographical Focus: Nation-wide

Indicators:

- number of IEC materials developed and distributed
- % of Youth, prisoners, SWs trained on drug demand reduction
- % of Families supported
- % of families and drug addicts received legal assistance, DDR information

- number of rehabilitation and drop in centers established, their use and services provided to drug addicts and their families
- referral mechanism established for legal, psych-social and medical services
- number of media campaigns and percent of population covered
- number of Peer educators trained
- number of Youth centers established and its use

Target population: Youth, general public, IDU and their families

Age group: 14-49

Starting date: 2003

Ending date: 2007

XII: From: the information sent to us by Tajikistan partner

Aga Khan Foundation

Project title: AKF Health Programme

Summary:

The project is aimed at improving the regional coordination of HIV activities, strengthening national capacity on the HIV prevention, testing and counseling and improving the public awareness through IEC campaign.

Primary Funding organization: AKF

Geographical Focus: GBAO

Indicators:

- Number of Training course for epidemiologists on surveillance and prevention work with risk group,
- Number of IEC materials developed and distributed
- Number of Training course on HIV counseling and testing and counseling
- Number of trained VCT counselors
- Number of training seminars conducted for health workers on HIV/AIDS prevention issues for HWs
- Number of HIV tests rapid provided to SES labs of the seven districts of GBAO

Target population:

Youth, general public and Health workers

Age group: 14-49

Starting date: 01/01/2004

Ending date: 31/12/2004

XIII: From: the information sent to us by Tajikistan partner

PSI activities

Summary:

In the framework of DDRP in Tajikistan conducts youth center activities including human resources, financial support for classes and school activities; peer education; mass media education, awareness campaigns and Social Marketing of condoms.

Indicators:

- Number of condoms purchased and sold per year
- % of youth trained.

Primary funding organization: USAID

Geographic focus: Dushanbe, Khudjand

Target population: Youth

Age group: 14-49

Starting date: 2003

Ending date: 2007

IV: From: the information sent to us by Tajikistan partner

UNDP

Project Title: Straight Talk

Summary: Straight Talk Project is a collaborative endeavor designed to challenge the potential serious problems facing Tajikistan with regard to the spread of HIV/AIDS. The project's aims are in accordance with internationally defined and accepted strategies regarding HIV/AIDS prevention. The UNDP focus will be to take advantage of the current low prevalence of the disease through Straight Talk — intensive advocacy efforts that will enhance behavioral change amongst targeted groups, increase public & human rights awareness and understanding of risk and vulnerability, mobilize civil society and encourage commitment from leading public figures — leading to more vocal and visible acknowledgement of HIV/AIDS and the actions required to implement reduction and prevention policies.

Indicators:

- Number and types of IEC materials developed and distributed
- Number of Radio spots and TV programmes aired to the public
- Number of newspaper articles published in different newspapers
- Number of training for Journalist, Jomoat, and low enforcement institutes realized
- Number of PLWHAs mobilized and provided trainings, care and support
- Number of interministerial working groups establish
- % of the government budget allocated to HIV/AIDS interventions
- Established Secretariat function within the National AIDS Coordination Committee

Primary funding organization: UNDP/UNAIDS

Geographical Focus: Central level, Khudjand, GBAO, Khatlon and DRD

Target population: Youth, general public, political and opinion leaders

Age group: 14-49

Starting date: 01/01/2005

Ending date: 31/12/2005

V: From: the information sent to us by Tajikistan partner

UNFPA**Summary/project description:**

The following activities are envisaged in the framework of the RH annual work plan in 2005 (a) training and sensitization of health sector managers on ICPD, gender, including adolescent reproductive health; (b) technical training and sensitization of service providers on ICPD; (c) revision of necessary guidelines and protocols and adaptation of them; (d) provision of essential supplies/equipment to reproductive health facilities, including condoms, (c) improvement of LMIS; (d) development and distribution of IEC materials and approaches for contraceptives, including condoms, gender-based violence, safe motherhood, adolescent reproductive health, STIs and HIV and cervical cancer.

Project Indicators:

- Number of primary health-care facilities providing relevant information and counselling on reproductive health issues, including HIV/AIDS
- Number of primary health care facilities providing at least three types of contraceptives, including condoms

Primary Funding Organization: UNFPA

Target population: Female and male population of reproductive age
Geographical Focus: *Oblast/s:* Sogd; Khatlon; Direct Rule Districts; Rasht valley
Age group: Population of reproductive age with a focus on adolescents.

Starting date: 01/01/05
Ending date: 31/12/05

VI: From: the information sent to us by Tajikistan partner

UNICEF

Project title: Young People's Healthy development and HIV/AIDS, UNICEF

Summary/project description: According to Country Program Cooperation with government of Republic of Tajikistan UNICEF supports the efforts of Government, NGOs, civil society with a strong advocacy tool to promote healthy development, protection of young people and ensure their participation in decision making process.

The Programme emphasizes the rights of young people in accordance with the Convention on the Rights of the Child. It covers a wide array of activities related to the development of national and cross sectoral approaches for addressing HIV/AIDS, STDs and IDU and other forms of substance abuse with involving young people themselves in that. The programme supports youth participation programmes through peer to peer education, thus enable young people in participation in decision making process. The programme also assists projects that monitor the situation of young people, promote youth behavior development, communication campaigns and services to ensure that young people have access to services that respect confidentiality and provides care and appropriate response to the needs of young people

Primary Funding Organization: UNICEF

Geographical Focus: *Oblast/s:* 15 priority districts in Sughd oblast and GBAO

Rayon/s; Town/S: Dushanbe, Khudjand, Chkalovsk, Kairakum, Kanibadam, Khorog,, Shugnan, Bobodjon Gafurov, Djabor Rasulov, Isphara, Istarvshan.

Project Indicators:

- % of young people who are raised their knowledge and skills how to protect one's from unwanted sex, STIs and HIV/AIDS
- % of YP who are informed about the drug use consequences
- % of EVYP who are not sharing with needles and use condoms
- No of EVYP are involved in PE programmes
- % of YP has an access to information and YFHS.
- No of YP involved in peer education

- No of YP certified as Master Trainer on Peer to peer education
- % of teachers who are able to deliver LSBHE in schools
- % of service providers who are able to conduct VCCT
- % of services introduced the “Code of conduct”.

Target population

Direct: Young people,

Indirect: Duty berries, service providers and community.

Age group: 10-25 aged young people

Start Date: 1/01/05

End Date: 31/12/09

VII: From: the information sent to us by Tajikistan partner

UNODC

Project title: AD/RER/03/F75 – Diversification of HIV prevention and drug treatment services for injecting and other drug users in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan

Summary:

The project addresses the needs to improve and further develop range of HIV prevention and drug treatment services for injecting drug users in selected localities in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. This includes outreach and low-threshold services including HIV/AIDS prevention education, access to condoms and clean injecting equipment and counselling as well as outpatient and inpatient detoxification, treatment and rehabilitation. Emphasis is placed on the replication of existing successful initiatives in the region, in-service training through exchanges among organisations in the region and training seminars organised at the regional and national levels. Emphasis is also be placed on the development of linkages to other services to meet other health and social needs of the drug users

Project Indicators:

- increased accessibility and availability of diversified services for drug users;
- increased coverage of drug users with effective HIV prevention and drug treatment services
- service utilization (clients) and delivery (services) data, referral data, data on behavioural change of clients
- number of trained professionals and other staff involved in service delivery
- evaluation of workshops and training activities
- service delivery standards and protocols developed and introduced
- reduction of drug abuse and HIV/other blood-borne infections prevalence rate among IDUs

- number of policy and legal documents, service organisation guidelines adopted

Primary Funding Organisation: UNODC

Target population: Injecting drug users

Geographical Focus: Dushanbe city, Sogd & Khatlon oblasts, GBAO

Age group: Any

Start Date: 01/03/03

End Date: 28/02/06/

VII: From: the information sent to us by Tajikistan partner

IOM (Int'l Organization for Migration)

Project Title: Combating human trafficking

Summary:

IOM provides Raising HIV/AIDS awareness among potential labor migrants within its programmes "Combating human trafficking", through the Resource Center for labor migrants.

Primary Funding Organization: USAID, SIDA, Global Fund and SDC

Indicators:

- Number of IEC materials produced and distributed
- Number of Community drama realized
- Number of Labor migrants provided information and medical services

Geographical Focus: Sughd, Khatlon

Target population: Labor migrant and their spouses

Age group: 16-45

Start Date: May 20 04

End Date: April 2005

VIII: From: the information sent to us by Tajikistan partner

World Health Organization (WHO)

Project title: WHO technical assistance on ARV treatment standard protocols

Summary project description:

Technical assistance on developing action plan and national treatment protocols on ARV treatment for adults and children

Project Indicators:

- Number of patients got access to ARV treatment
- Number of facilities could provide the treatment
- Number of trained on ARV staff

Geographical Focus: *Oblast/s Central level*

Primary implementing Organization/s: MoH and NGOs

Target population: People with HIV and their children

Age group: All ages

Start Date: 07/07/04

End Date: 30/09/04

VII: From: the information sent to us by Tajikistan partner

Global Fund to fight AIDS, tuberculosis and malaria Project**Summary:**

Support to the National HIV/AIDS Strategic Plan to Response to the HIV/AIDS epidemics through prevention activities among IDU, SW, youth and blood safety

Indicators:

- 35% of estimated number of IDU reached by prevention services
- 35% of IDU targeted by GFATM program following safe injecting and sexual practices
- 100 service deliverers trained to implement prevention activities among IDUs
- 100 IDUs reached by STI comprehensive case management

- 35% of estimated number of SW reached by prevention services
- 35% of SW targeted by GFATM program following safe injecting and sexual practices
- 100 service deliverers trained to implement prevention activities among SW
- 200 SW reached by STI comprehensive case management
- 60% of young people aged 15-18 exposed to HIV/AIDS education in school settings
- 70% of secondary schools providing life-skills based HIV/AIDS education
- 1250 teachers trained to deliver education on HIV/AIDS
- 500 street children exposed to HIV/AIDS peer education out of school settings
- Needs of laboratories for HIV test-systems are met by 100 %.
- 120 peer educators trained to provide HIV/AIDS education to migrants and street children
- 150000 migrants and street children provided with HIV/AIDS IEC materials
- 30000 people have access to volunteer counseling and testing (VCT)
- 40 VCT counselors trained
- 20000 patients receive STI treatment
- 40 health workers trained in STI comprehensive case management
- 15 friendly cabinets provide STI comprehensive case management
- 18 prisons involved in annual HIV/AIDS campaigns
- 1140 trainers and peer educators trained to provide education on HIV/AIDS prevention in prisons
- 15200 IEC materials developed and disseminated among peer educators and prisoners.
- 10000 prisoners exposed to HIV/AIDS prevention programmes
- 800 prisoners with STI receive treatment
- 50 people with advanced HIV infection receiving antiretroviral combination therapy (ARVT)
- 35 people treated for opportunistic infections
- 110 service deliverers trained to provide treatment and care for PLWHA
- 100% of pregnant HIV-positive women have access to ARVT and PMTCT
- 60 NGO/CBO staff trained to support the adherence of PLWHA to treatment
- Capacities for conducting M&E by National and regional centers for HIV/AIDS prevention improved
- National guidance on M&E of HIV/AIDS prevention activities developed

Primary funding organization: GFATM

Geographical Focus:

Trust points

K-Tube, Kulab, Moscovski, Nurek, Hodjent, Kanibadam, Isfara, Istravshan, Horog, Vahdat, T-zade

Friendly clinics

K-Tube, Kulab, Hodjent, Kanibadam, Isfara, Istravshan, T-Zade, (Dushanbe under consideration)

Target population: Migrants, Youth, SWs, IDUs, HWs, Street children and MSM

Age group: 14-49

Starting date: May 2002

Ending date: April 2009

VIII: From: the information sent to us by Tajikistan partner

CARE International

Project Title: Food and Agriculture Consortium for Tajikistan (FACT) project

Summary:

Aims to improve mother and child health and nutrition, including training for medical staff and members of CBOs to promote the information on maternal and child nutrition, hygiene, and HIV/AIDS.

Intervention related to HIV/AIDS:

Increase awareness among women with children under five about reproductive physiology, contraception and STIs/HIV/AIDS.

Indicators:

- % of women with children under 5 who know at least two types of STIs
- % of women with children under 5 who know at least two ways to prevent STIs/HIV/AIDS
- % of women who know at least two ways of HIV/AIDS transmission

Funding Organization: USAID

Geographical Focus: Yovon; Vakhdat

Target population: Women with children under 5 and their family members

Age Group: 15-49

Start Date: 02/01/05

End Date: 01/31/06

IX: From: the information sent to us by Tajikistan partner

OSI/Soros Foundation

Summary/project description:

Prevention of HIV/AIDS, sexually transmitted diseases and virus hepatitis among injections drug users (IDU), commercial sex workers (CSW) and prisoners through exchange of needles, distribution of condoms and conduction of educational events

Project Indicators:

HIV/AIDS prevention and prophylaxes (among injection drug users, commercial sex workers, prisoners)

- support of HIV/AIDS prevention projects
- exchange syringes and needles points
- distribution of condoms
- advocacy and communication

HIV/AIDS education (among injection drug users, commercial sex workers, prisoners)

- arrangement of educational practice of the project stuff
- seminars and training
- distribution of the HIV/AIDS informational brochures
- establish and scaling up HIV/AIDS project

Primary Funding Organization: Open Society Institute-Assistance Foundation Tajikistan, USAID , DFID

Target population

1. Injection drug users,
2. Commercial sex workers,
3. Prisoners

Geographical Focus: *Oblast/s:* Khatlon, Sughd , GBAO,

Town/S: Dushanbe, Kulyab, Kurgan-tube, Penjikent, Khujand, Qairoqum, Chkalovsk, Khorog

Age group: Any

Start Date: 2005

End Date: 2009

X: From: the information sent to us by Tajikistan partner

Project SINO

Project Title: Tajik-Swiss Health Sector Reform and Family Medicine Support Project (SINO)

Summary:

To improve access to high quality PHC services through training of Health Workers on HIV/AIDS related issues including blood safety and implementing health lifestyle approach in pilot districts

Primary funding Organisation: SDC

Geographical focus: Dangara and Varzob

Indicators:

- At least 30% increase in knowledge about HIV/AIDS among population of Dangara and Varzob

Target population:?

Age group: 14-49

Starting date: 2003

Ending date: 2006

XI: From: the information sent to us by Tajikistan partner

IFRC and National RCS (The International Federation of Red Cross and Crescent Societies)

Summary:

Community mobilization and scaling up of HIV/AIDS/STI and TB awareness and fight against stigma and discrimination. The activity will cover 24,000 of youth, and 20 PLWA through regional workshops for 100 volunteers on HIV/AIDS/STIs

Primary Funding Organization: IFRC and National RCS

Geographical focus: ?

Indicators:

- Number of condoms procured and distributed
- Number of Out of School youth trained on HIV/AIDS

- Number of IEC material developed and distributed

Target population: ?

Age group: ?

Starting date: 01/01/2004

Ending date: 31/12/2004

c. NGOs

d. CIVIL SOCIETY

III. CURRENT ASSESSMENTS ABOUT EPIDEMIC AND RESPONSE (same as II. Current response to HIV/AIDS epidemic in the country)

IV. GAPS

TURKMENISTAN:

I. HIV/AIDS SITUATION IN THE COUNTRY:

II: From:

[http://wbln0018.worldbank.org/ECA/ECSHD.nsf/ECADocByUnid/540336358112962585256DEF00762D01/\\$FILE/1758-06R_Ch04.pdf](http://wbln0018.worldbank.org/ECA/ECSHD.nsf/ECADocByUnid/540336358112962585256DEF00762D01/$FILE/1758-06R_Ch04.pdf)

HIV/AIDS and TB in Central Asia: Turkmenistan Country Profile

Chapter 7: Country Profile: Turkmenistan (p. 61-68)

Joana Godinho, Thomas Novotny, Hiwote Tadesse, Anatoly Vinokur. World Bank, November 2003.

Turkmenistan has a population of approximately 5 million people, with about 46% in the age group 16-45 years. The country is rich in oil and natural gas, and it has great potential for economic and social development. No reliable information is available on poverty. Physical infrastructure and social services are extremely underdeveloped, and the country suffers from a chronic water shortage.

HIV/AIDS Epidemiological Profile

Little data is available on HIV/AIDS in Turkmenistan. Officially, there have been only two reported cases of HIV/AIDS, both of whom are foreigners (one from Ukraine and the other from Africa), and one of whom would have died.

According to available official statistics, the number of drug users in Turkmenistan increased 400% in 1995 to 1997 alone. Turkmenistan currently has about 6,000 registered drug users, 95% of whom are male, but UNODCCP estimates that the real number is more than 50,000, of which 15% are IDUs. In addition, approximately 50% of the prisoners in Turkmenistan are thought to be IDUs. The risk of HIV transmission among these risk group members is evidently high, as limited surveillance data reported by UNAIDS show that as many as 80% of IDUs have Hepatitis B antigen, suggesting widespread needle and syringe sharing.

According to UNICEF (2002), the incidence of STIs nationwide was of 80/100,000 in 2000. Furthermore, syphilis incidence increased seven-fold over the period 1992 to 1998, and the Ministry of Health suggests that only 30% of syphilis and gonorrhea cases are reported through official surveillance systems. It is likely that most STI cases are treated outside the government health system for reasons of confidentiality, access, and anonymity, and it is not clear how many of these high-risk persons are screened for HIV, if at all. Given the risks of HIV transmission through evidently widespread risky sexual behavior, the lack of contact tracing and screening for STIs, and the added risk of HIV transmission through ulcerative STIs, the number of HIV cases is likely already higher than two in this country. Incidence would be expected to increase exponentially in the near future as in other Central Asian republics.

High average drug prices (one gram of heroin costs \$70) may have contributed to relatively low demand and low IDU usage in the past. In addition, local researchers believe that the predominant form of drug use (heroin and opium) is through smoking instead of injection. Thus, there may be relatively lower risk for many drug-addicted persons in Turkmenistan, but the high rates of Hepatitis B antigen in some populations of drug users suggests that significant needle sharing does occur. Clearly, more research on behavior patterns among the highly vulnerable IDU population is needed in order to accurately characterize the status of the HIV/AIDS epidemic in Turkmenistan. To date, political and social influences appear to have inhibited the epidemiological investigations needed for this characterization.

Strategies, Policies and Legal Framework

Turkmenistan has an extensive border with Afghanistan (the source of most heroin and opium), but the Government claims a successful border strategy involving border troops and Ministry of Interior agents. Clearly, this interdiction strategy is not completely successful in deterring drug use; economic forces, both on the supply side as well as on the demand side, where poverty and destitution facilitate drug use, can overwhelm such a strategy.

Although the President signed a Law on Prevention of HIV/AIDS in 1991, this law has been revised and is under consideration by the Parliament. The Government had adopted a National Program for HIV/AIDS for 1999-2003. The main goals of the program are to prevent the spread of HIV/AIDS through blood product transfusion and unsafe sex. Program coordination is the responsibility of an Inter-Ministerial Task Force led by the Ministry of Health, National AIDS Center, and the STIs Dispensary. In addition to the line ministries, the committee includes representatives from the Democratic Party of Turkmenistan, Women's Union, Youth Union, National Center of Trade Unions, and the National Society of Red Crescent. The plan is implemented by all involved parties with active assistance from the UNAIDS TG, but no monitoring and evaluation data on program results are available.

The National HIV/AIDS Program includes five main areas:

- Definition of AIDS/STI policies, including revision of current legislation and a multi-sectoral approach;
- Early prevention of HIV/AIDS;
- Prevention of blood born transmission, including prevention of IDU;
- Prevention of sexual transmission, through safer sexual behavior, provision of condoms, and availability of STIs information, counseling, and treatment;
- Prevention of mother-to-child transmission through provision of information and increased use of condoms; and
- Support to people living with HIV/AIDS

The Ministry of Health has also developed a National Reproductive Health Strategy in which HIV prevention is addressed, and within this strategy, it plans to adopt the syndromic approach for STIs as recommended by the WHO. The AIDS National Program also seeks revision of drug use legislation. Drug users caught consuming drugs are referred for medical treatment of their drug addiction. Prostitution is illegal in Turkmenistan, and the first time a CSW is attested, he/she is fined; if arrested a second time within the same year, he/she is imprisoned. The extent to which the CSW and IDU risk groups overlap is unknown. Given the social disruption and economic pressures on these risk groups, it is clear that more data are needed on their behaviors and potential to spread blood born infections such as HIV through the general population.

Surveillance Needs and Additional Studies

UNODCCP carried out a HIV/AIDS Rapid Assessment in Turkmenistan, but officially sanctioned data are not yet available from this study. UNICEF is also carrying out a baseline assessment of knowledge, attitudes, and behavior among youth. The National AIDS program plans to develop sentinel surveillance among high risk groups such as IDUs and CSWs, and UNAIDS has supported the introduction of information technology for monitoring HIV/AIDS and STIs. However, few technological resources are available at the regional (Velayat) level. In addition to establishing sentinel surveillance, UNAIDS TG partner recommend evaluation studies on the impact of IEC measures implemented through Ministry of Health, hospitals, outpatient center, and schools regarding HIV/AIDS and reproductive health. In Turkmenistan, there seems to be a significant lack of information about the extent of the HIV/AIDS epidemic and its antecedent risk

conditions. Part of this appears to be a function of Government secrecy, but technical resources and lack of training appear to impede progress in this area.

Vulnerable and Highly Vulnerable Groups

The UNAIDS TG has provided active support to the implementation of the AIDS National Program, including training of government staff and NGOs and education of young people. Support has been provided to young vulnerable women who engage in casual and commercial sex work, through peer education, condom promotion, and access to appropriate health care. A competitive grant mechanism to support NGOs that carry out training and outreach activities had been established.

Various groups have provided syringes and bleach in Dashoguz, and syringes in three prisons (in Ahal Region), which is justifies in the context of hepatitis prevention and not HIV/AIDS. UNFPA has been distributing more than one million condoms per year, and in 2002, it also supplied 5,000 women with condoms. The management of condom distribution has changed. Previously, they were distributed through the National Mother and Child Center, but now condoms are distributed through the National Reproductive Health Centers and the National Aids Centers. UNFPA has also started working with the Army, having organized trainings with soldiers to discuss reproductive health issues, contraception, STIs, and urological diseases.

The Ministry of Health carries out HIV/AIDS education activities, but these have not been evaluated. The Youth Union has a TV Channel (Yaslik), which can be used to health promotion and education programs. In 1998, when the UNAIDS started activities in Turkmenistan, discussion of HIV/AIDS in the media was prohibited, but since then an extensive media awareness campaign had been implemented. UNAIDS and UNICEF have been assisting the development of public awareness regarding HIV/AIDS and condom promotion, especially among youth. UNICEF works with youth and has a program known as Adolescent Lifestyle, which addresses issues of lifestyle, risk behavior, STI, HIV/AIDS, and substance abuse by advocating access to information; this program provides life skills training in schools and to out-of-school youth through various youth clubs.

Preventive, Diagnostic, and Treatment Issues

Turkmenistan has six AIDS centers (one national and five regional in each Velayat). Anonymous testing centers with hot lines have been established, and the country has 27 diagnostic laboratories that may perform HIV serologic testing. STIs services are provided at six STI hospitals and a few general hospital departments, and venereologists work in health polyclinics at the rural level. The Ministry of Health and established three STI Centers which provide condoms free of charge. The Center for Dermatology and Venereal Diseases opened a special center for reproductive health, which deals with all sexually transmitted infections, including HIV/AIDS/ There is also a Reproductive Health Center for Men, since a large number of them have STIs and infertility, which also provides information on HIV/AIDS. The Ministry of Health is planning to adopt the syndromic approach for STIs, although it is considered very expensive. There are also 3,000 family group practices, which the Ministry of Health considers could become engaged on HIV/AIDS prevention activities. No information is available on anti-retroviral treatment or on MTCT prevention.

NGO and Partner Activities

In Turkmenistan, the local NGOs are called Community Based Organizations (CBOs). There are officially five CBOs, with other CBOs operating under the umbrella of those five. The UNAIDS TG includes UNAIDS, UNFPA, UNICEF, UNDP, and USAID. The TG activities include:

- Ensuring political commitment through the adoption of a National Strategy (up to 2010);
- Supporting the National HIV/AIDS Program;

- Implementing an IEC Campaign for children, youth, and women;
- Promoting healthy lifestyles;
- Reducing the risk of vulnerable groups: IDUs, CSWs, and MSM through outreach work.

Partner organizations report that constant changes in Government poses special challenges to the continuity of HIV/AIDS prevention work in Turkmenistan. It has been difficult to implement activities through the educational system, and work in prisons has faced constant changes in system leadership. Therefore, UNAIDS TG partners consider it essential to engage in a public communication campaigns to increase Government political commitment and public awareness in general about HIV/AIDS.

Funding

No official information on public expenditures on HIV/AIDS and STI program is available in Turkmenistan. However, the AIDS National Program estimates that the cost of implementing the work plan in 1999-2003 was \$2.75 million, of which \$1.7 million was for prevention of HIV transmission in blood products and unsafe sex (condom distribution), and \$1 million for support to PLWHA. Last year, the Ministry of Health submitted to donors a \$600,000 proposal on HIV/AIDS. The proposal would include establishing an electronic network for disease surveillance (including HIV sentinel surveillance), building the capacity of CBOs, and a public communications campaign.

USAID provided **\$51,000** for HIV/AIDS prevention work in Turkmenistan in 2000, and it had allocated **\$200,000** for these activities in **2002-2003**. The Asian Development Bank had been assisting the activity of the UNAIDS TG on IEC and training family doctors and nurses on counseling regarding HIV/AIDS. **UNICEF** has been implementing a four-year, **US\$4.3million** program (200-2004) that includes HIV/AIDS prevention activities among youth.

III: From: <http://hivinsite.ucsf.edu/global?page=cr03-tx-00>

HIV/AIDS in Turkmenistan	
Adults age 15-49 with HIV/AIDS, 2003	<200
New HIV infections, 2004	nd
Adult HIV prevalence (%), 2003	<0.1
Women age 15-49 with HIV/AIDS, 2003	nd
Children with HIV/AIDS, 2003	nd
AIDS orphans (ages 0-17), 2003	nd
AIDS deaths, 2003	nd
nd = No data	

Source: **UNAIDS**

IV: From: <http://www.unaids.org/Unaid/EN/Geographical+area/By+Country/turkmenistan.asp>

Country HIV and AIDS estimates, end 2003*

Adult (15-49) HIV prevalence rate	<0.1% (range: <0.2%)
Adults (15-49) living with HIV	<200 (range: <400)
Adults and children (0-49) living with HIV	<200 (range: <400)
Women (15-49) living with HIV	...
AIDS deaths (adults and children) in 2003	...

Source: [2004 Report on the global AIDS epidemic](#)

* No estimates have been made where sufficient data for the last six years was not available.

From:

<http://inweb18.worldbank.org/ECA/ECSHD.nsf/ExtECADocByUnid/F425FCD98748DD9185256C83007144C4?Opendocument>

- **Information about the status of HIV in Turkmenistan is very limited.** However, as Turkmenistan has about 6,000 registered drug users* and STIs have been increasing rapidly, (a 7-fold increase in syphilis in 1992-98) the number of HIV cases is also expected to rise.
- **While it is believed that Turkmenistan does have low incidence of infection, HIV/AIDS is a priority of the State Health Program.**
- **The National Program on HIV/AIDS and STIs Prevention for 1998-2002 was approved in 1999.**
- **Program coordination is the responsibility of an Inter-Ministerial Task Force led by the Ministry of Health, National AIDS Center and the STIs Dispensary.** In addition to the line ministries, the committee includes representatives from the Democratic Party of Turkmenistan, Women's Union, Youth Union, National Centre of Trade Unions, and the National Society of Red Crescent.

* UN agencies estimate the number of drug users to be over 50,000.

a. HIV PREVALENCE RATES (GENERAL):

I. From: www.rbec.undp.org/hiv/?english

HIV/AIDS in Central and Eastern Europe and the CIS

Turkmenistan has reported only **two HIV** cases so far, and almost no other national data are available. At risk populations are nonetheless present, and not only because of the country's proximity to Afghanistan and the opiates that are transported through Central Asia.

V: *Turkmenistan: Comprehensive Indicator Report*

General HIV/AIDS

(Source: UNAIDS, 2004: UNAIDS 2004 Report on the global AIDS epidemic
<http://www.unaids.org/bangkok2004/report.html>)

Indicator	Year	Turkmenistan	Eastern Europe & Central Asia	World	Source
Adults and children (ages 0-49) living with HIV/AIDS	2003	<200	1,400,000	39,400,000	UNAIDS, 2004
Adults (ages 15-49) living with HIV/AIDS	2003	<200	1,300,000	37,200,000	UNAIDS, 2004
Women (ages 15-49) living with HIV/AIDS	2003	nd	490,000	17,600,000	UNAIDS, 2004
Children (ages 0-14) living with HIV/AIDS	2003	nd	8,100	2,200,000	UNAIDS, 2004
AIDS orphans currently living (ages 0-17)	2003	nd	nd	15,000,000	UNAIDS, 2004
Adults and child AIDS deaths (ages 0-49)	2003	nd	60,000	3,100,000	UNAIDS, 2004
Adults and children newly infected with HIV	2004	nd	210,000	4,900,000	UNAIDS, 2004
nd = No data					

HIV Prevalence

(Source: UNAIDS, 2004: UNAIDS 2004 Report on the global AIDS epidemic
<http://www.unaids.org/bangkok2004/report.html>)

Indicator	Year	Turkmenistan	Eastern Europe & Central Asia	World	Source
Adult (ages 15-49) HIV prevalence (%)	2003	<0.1	0.8	1.1	UNAIDS, 2004
HIV prevalence, sex workers, capital city (median %)	Various Years	nd	nd	nd	UNAIDS, 2004
HIV prevalence, injecting drug users, capital city (median %)	Various Years	nd	nd	nd	UNAIDS, 2004
nd = No data					

HIV Knowledge and Behavior

(Source: UNAIDS, 2004: UNAIDS 2004 Report on the global AIDS epidemic
<http://www.unaids.org/bangkok2004/report.html>)

Indicator	Year	Turkmenistan	Eastern Europe & Central Asia	World	Source
Know that a healthy-looking person can have HIV (female, ages 15-24) (%)	Various Years	42	nd	nd	UNAIDS, 2004
Reported higher-risk sex (male, ages 15-24) in the last year (%)	Various Years	nd	nd	nd	UNAIDS, 2004
Reported higher-risk sex (female, ages 15-24) in the last year (%)	Various Years	nd	nd	nd	UNAIDS, 2004
Used a condom the last time they had higher-risk sex, of those who had high-risk sex in the last year (male, ages 15-24) (%)	Various Years	nd	nd	nd	UNAIDS, 2004
Used a condom the last time they had higher-risk sex, of those who had high-risk sex in	Various Years	nd	nd	nd	UNAIDS, 2004

the last year (female, ages 15-24) (%)					
nd = No data					

Access to Care and Treatment

(Source: WHO Health Services Coverage, 2004:
http://www.who.int/tb/publications/global_report/en/)

Indicator	Year	Turkmenistan	Eastern Europe & Central Asia	World	Source
Percent of adults receiving VCT in last year	2003	nd	1.5	nd	WHO Health Services Coverage, 2004
Number of VCT clients per year	2003	nd	1,042,637	6,000,000	WHO Health Services Coverage, 2004
Number of VCT sites	2003	nd	1,136	nd	WHO Health Services Coverage, 2004
Percent of pregnant women offered PMTCT services	2003	nd	37	8	WHO Health Services Coverage, 2004
Percent of HIV+ pregnant women receiving ARV prophylaxis	2003	nd	6	3	WHO Health Services Coverage, 2004
Number of sites offering PMTCT services	2003	nd	969	37,513	WHO Health Services Coverage, 2004
Estimated coverage of antiretroviral therapy (est. %)	2003	nd	11	nd	WHO Health Services Coverage, 2004
Number of public sector patients receiving antiretroviral therapy	2003	nd	5,352	nd	WHO Health Services Coverage, 2004
Number of sites offering antiretroviral therapy services	2003	nd	27	nd	WHO Health Services Coverage, 2004
Coverage of cotrimoxazole prophylaxis for adults (est. %)	2003	nd	4	nd	WHO Health Services Coverage, 2004

Number of adults receiving cotrimoxazole prophylaxis	2003	nd	1,826	190,000	WHO Health Services Coverage, 2004
Coverage of cotrimoxazole prophylaxis for children (est. %)	2003	nd	32	nd	WHO Health Services Coverage, 2004
Number of children receiving cotrimoxazole prophylaxis	2003	nd	1,095	28,000	WHO Health Services Coverage, 2004
Coverage of isoniazid prophylaxis for adults (est. %)	2003	nd	1	nd	WHO Health Services Coverage, 2004
Number of adults receiving isoniazid prophylaxis	2003	nd	432	36,000	WHO Health Services Coverage, 2004
Percentage of population living in areas with DOTS coverage	2002	35	nd	nd	WHO TB Control Report, 2004
Number of TB cases registered for treatment under DOTS	2001	658	nd	nd	WHO TB Control Report, 2004
nd = No data					

Mortality

(Sources: World Population Data Sheet 2004 of the Population Reference Bureau: http://www.prb.org/pdf04/04WorldDataSheet_Eng.pdf

UNICEF: www.unicef.org, UNDP: www.undp.org, UNFPA: www.unfpa.org)

Indicator	Year	Turkmenistan	Eastern Europe & Central Asia	World	Source
Life expectancy at birth (years)	Various Years	67	68	67	PRB Data Sheet, 2004
Infant (Ages 0-1) mortality rate (per 1,000 live births)	2003	79	34	54	UNICEF, 2005
Under-five mortality rate (per 1,000 live births)	2003	102	41	80	UNICEF, 2005
Maternal mortality ratio (per 100,000 live births)	2000	31	nd	nd	UNFPA, 2004
Probability at birth of surviving to age 65, female (% of cohort)	2000-2005	74.2	80.6	72.9	UNDP, 2004
Probability at birth of surviving to age 65, male (% of cohort)	2000-2005	60.6	58.8	64.4	UNDP, 2004

nd = No data

General Population

(Sources: World Population Data Sheet 2004 of the Population Reference Bureau:
http://www.prb.org/pdf04/04WorldDataSheet_Eng.pdf)

Indicator	Year	Turkmenistan	Eastern Europe & Central Asia	World	Source
Total population (millions)	mid-2004	5.7	299	6,396	PRB Data Sheet, 2004
Total projected population - 2025 (millions)	2025	7.6	281	7,934	PRB Data Sheet, 2004
Total projected population - 2050 (millions)	2050	8.7	243	9,276	PRB Data Sheet, 2004
Rate of natural increase (%)	Various Years	1.6	-0.5	1.3	PRB Data Sheet, 2004
Percent urban		47	68	48	PRB Data Sheet, 2004
nd = No data					

Youth

(Sources: World Population Data Sheet 2004 of the Population Reference Bureau:
http://www.prb.org/pdf04/04WorldDataSheet_Eng.pdf)

Indicator	Year	Turkmenistan	Eastern Europe & Central Asia	World	Source
Population ages 10-24 (millions)	2000	1.4	71	1663.0	PRB Youth Data Sheet, 2000
Percent of total population ages 10-24	2000	32	23	27	PRB Youth Data Sheet, 2000
Percent of total population under 15	mid-2004	38	16	30	PRB Data Sheet, 2004
nd = No data					

General Health

(Source: UNDP: www.undp.org, UNICEF: www.unicef.org; WHO:
http://www.who.int/tb/publications/global_report/en/)

Indicator	Year	Turkmenistan	Eastern Europe & Central Asia	World	Source
Health expenditure, private and public (US\$ per capita)	2001	245	nd	nd	UNDP, 2004
Physicians per 100,000 people	1990-2003	300	nd	nd	UNDP, 2004
Births attended by skilled health staff (%)	1995-2002	97	97	58	UNDP, 2004
Malaria cases per 100,000 people	2000	1	nd	nd	UNDP, 2004
Prevalence of child (ages 0-5) malnutrition (%)	1995-2003	12	6	27	UNICEF, 2005

TB treatment success rate, new smear-positive cases-DOTS (% of cases)	2001	75	nd	nd	WHO TB Control Report, 2004
nd = No data					

Fertility

(Sources: UNFPA: www.unfpa.org; World Population Data Sheet 2000 of the Population Reference Bureau:

<http://www.prb.org/Template.cfm?Section=PRB&template=/ContentManagement/ContentDisplay.cfm&ContentID=8500>)

Indicator	Year	Turkmenistan	Eastern Europe & Central Asia	World	Source
Total fertility rate (number of children)	2000-2005	2.70	nd	2.69	UNFPA, 2004
Births per 1,000 women (ages 15-19)		17	nd	50	UNFPA, 2004
Percent of TFR attributed to births by ages 15-19		3	14	12	PRB Youth Data Sheet, 2000
Percent giving birth by age 20		nd	nd	31	PRB Youth Data Sheet, 2000
nd = No data					

Education

(Sources: UNICEF: www.unicef.org)

Indicator	Year	Turkmenistan	Eastern Europe & Central Asia	World	Source
Gross primary school enrollment ratio, male	1998-2002	nd	101	104	UNICEF, 2005
Gross primary school enrollment ratio, female	1998-2002	nd	98	97	UNICEF, 2005
Gross secondary school enrollment ratio, male	1998-2002	nd	90	66	UNICEF, 2005
Gross secondary school enrollment ratio, female	1998-2002	nd	85	61	UNICEF, 2005
nd = No data					

b. HIV PREVALENCE RATES (WITHIN THE COUNTRY, BY REGIONS):

c. HIV PREVALENCE RATES (VULNERABLE GROUPS):

From: Harm Reduction News
 Newsletter Focus
 Fall 2002 – Volume 3, Issue 3
 p.17: Preventing HIV Before it Starts
 By Nurnabat Aimammedova

In a striking example of foresight, Turkmenistan has started an HIV prevention program in prisons. Official data indicate no cases of HIV in the prison system and HIV prevalence in the

country is though to be low. Yet the potential for a large epidemic is reflected in the high rates of drug use and sexually transmitted diseases.

The HIV/AIDS/Drug Abuse Prevention in Prisons project, run by the NGO Force for Change has reached over 2,000 inmates since 2000. The project prisoners how to protect themselves from HIV and practice safer sex by motivating clients to change unsafe behavior.

Collaborating with National AIDS Center and the Ministry of Internal Affairs, Force for Change identifies leaders among the inmates and works with prison personnel to gain their cooperation. The leaders are trained to carry out peer support education. Special information materials for the project have been developed, tested, and produced. Such information and counseling have proven particularly successful in gaining clients' trust. Methadone replacement therapy is illegal and possibilities for needle and syringe exchange are being studied by Force for Change. Yet some harm reduction practices such as disinfectants in prison dormitories and condom distribution are used in the project.

Force for Change chose to start the project, which is supported by IHRD, in the Akhalsky prison system since its three penitentiaries are located within one city. The project is planned to the expansion in other prisons in the country.

d. HIV PREVALENCE RATES (VULNERABLE GROUPS):

e. ACCESS TO TREATMENT:

*IX: From <http://www.euro.who.int/document/mediacentre/fs0603e.pdf>
HIV/AIDS treatment: antiretroviral therapy
Fact Sheet EURO /06/03
WHO Europe
Copenhagen, 1 Dec 2003*

Country	Estimated number of people who need ART	Estimated coverage (%)
Kazakhstan	100	55.0
Kyrgyzstan	10	0.0
Tajikistan	5	0.0
Turkmenistan	0	0.0
Uzbekistan	100	0.0

II. CURRENT RESPONSE TO HIV/AIDS EPIDEMIC IN THE COUNTRY

a. GOVERNMENT

b. DONOR ORGANIZATIONS

c. NGOs

d. CIVIL SOCIETY

III. CURRENT ASSESSMENTS ABOUT EPIDEMIC AND RESPONSE (same as II. Current response to HIV/AIDS epidemic in the country)

IV. GAPS

UZBEKISTAN:

I. HIV/AIDS SITUATION IN THE COUNTRY:

X: From: [http://wbln0018.worldbank.org/ECA/ECSHD.nsf/ECADocByUnid/540336358112962585256DEF00762D01/\\$FILE/1758-06R_Ch04.pdf](http://wbln0018.worldbank.org/ECA/ECSHD.nsf/ECADocByUnid/540336358112962585256DEF00762D01/$FILE/1758-06R_Ch04.pdf)

HIV/AIDS and TB in Central Asia: Uzbekistan Country Profile

Chapter 8: Country Profile: Uzbekistan (p. 69-79)

Uzbekistan is the most populous country in Central Asia, with 25 million persons. More than 25% of the population is between 15-29 years of age. The country has a GDP per capita of almost \$3,000, but over 60% of the population lives below the official level of poverty (\$4/day).

HIV/AIDS Epidemiological Profile:

The HIV epidemic in Uzbekistan is still in a nascent stage, but Uzbekistan had all the conditions for rapid spread of HIV infection. While only 51 cases had been identified in the first ten years of the epidemic (1989-1998), almost 800 cases were registered by the end of 2001, and 2,209 cases by end of April 2003; of these cases 84 died. However, according to the official definitions, HIV-positive patients with TB are not diagnosed as having AIDS, thus contributing to an underreporting of HIV/AIDS. About 55% of cases of HIV/AIDS are reported among people under age 30 years.

According to the Ministry of Health, injection drug use accounts for the majority (63%) of HIV infections, as in other countries in the region, but the proportion of cases of heterosexual transmission is growing. Of concern is the high number of cases of unknown origin (about 25%). About 84% of HIV cases are among men, and two-thirds are among young people aged 15-34. More than 50% of cases are among prisoners. The highest number of cases has been identified in Tashkent. In April 2002, there were about 350-360 infected people in Tashkent City, another 350-360 in Tashkent Oblast, and about 40 each in Ferghana and Surkhan-Darya regions. An outbreak of HIV was registered in Yangiyul (near Tashkent) with over 200 HIV cases, of which 90% were IDUs. It is an industrial zone and, due to economic reforms, many plants have closed, leaving many young people unemployed.

The number of registered drug users is around 25,000, but the UN estimates that the country has at least 60,000 drug users, 60-70% of whom would be injecting drug users. In the 1980s, there were 2,000 registered drug users; in 1995, there were 6,000 registered drug users, but today there are 18,000 registered outside prison and 7,000 identified in prisons. According to surveys conducted by UNAIDS, there are about 12,000 IDUs in Tashkent City alone; 1,800-2,000 in Yangiyul City; 10,000-10,500 in Samarkand City; and 1,300 in Jizzak City.

These areas are on the crossroads of drug traffic routes from Tajikistan and Afghanistan, where opium and heroin are produced. Since Sep 11, 2001, the frontiers with Afghanistan have been opened. The drugs coming from Afghanistan go through Uzbekistan to Russia by railroad. While older

generations commonly smoked hashish, younger generations have shifted to injecting heroin. One region that does not have any HIV cases is Karakalpakstan, which is attributed to the fact that drug users from this region still mainly smoke drugs instead of injecting them. As a result, HIV/AIDS is regarded as a problem of injecting drug users, which significantly stigmatizes this vulnerable group.

The proportion of IDU-related cases appears to be declining, however, while the rate of infection through heterosexual contact appears to be rapidly increasing, representing currently over 12% of infected cases. Migration to Tashkent has increased, accompanied by increasing prostitution; many of these women also become drug users. An assessment of men who have sex with men carried out in 1998 mentions that homosexual behavior is a common practice in Uzbekistan (Oostvogels and Mikkelsen 1998). Alarmingly, there have also been unconfirmed reports that some poorly equipped hospitals are part of the HIV transmission process through nosocomial transmission. This is compounded by claims that the blood supply in places is not adequately screened for organisms found in HIV, Hepatitis B, and Hepatitis C.

According to the official statistics, 1.2% of IDUs (over 18,000 tested), 0.01% of CWS (over 15,000 tested), and 0.4 % of prisoners (over 65,000 tested) were HIV positive in 2001. However, sentinel surveillance in Tashkent indicates a 46% prevalence rate among IDUs in Tashkent City. Isolated cases of HIV infection have also been reported in MSM, blood donors, patients with STIs, pregnant women, and newborns (3 cases in 2000-2001). According to the AIDS center, of 360 people tested in 3 Trust Points, 45% were HIV positive, while results from a second study showed that only 20% were infected. A rapid assessment of IDUs carried out in Tashkent in 1998 showed that over 90% were male and that the majority were young people aged 18-30 years (Busel et al. 1998). Almost 70% of IDUs were unemployed. Another rapid assessment carried out in Samarkand in 2001 showed that, among those who tested positive for HIV, almost 90% were male, 60% were young people under the age 30, and the majority were unemployed (Zaripova et al. 2001).

Unsafe sexual behavior has increased, attested to by a high prevalence of STIs, compounding the risks for HIV spread. In 2001, Uzbekistan had 221 syphilis cases per 100,000 pregnant women, not usually considered a vulnerable group. However, this is 10 times the reported prevalence in the general population. One out of six CSWs who visited STIs services has syphilis. Rapid assessments of CSWs were carried out in Tashkent in 1997 (Thomas) and 2001 (Oostvogels). In 1997, the assessments estimated that there were 5,000 sex workers and 250,000 clients in the capital city. CSWs try to hide from authorities as indicated by the fact that only 180 sex workers were registered in Tashkent. This is despite the fact that 3,870 CSWs were tested for STIs in 1996, and over 15,000 were tested for HIV/AIDS by the AIDS Center in 2002.

Condoms are readily available from kiosks and are affordable for some CSWs at about 50 cents each. However, the majority of the CSWs, with ages varying from 13-30 years, do not use condoms, and 30% are IDUs. The majority of clients refuse to use condoms, particularly Uzbeks who are reportedly even more reluctant than foreigners to use condoms. However, other CSWs would be spending about 10% of what they earn from a client on a condom. The Uzbek Health Examination Survey indicated that only 2% of married women reported using condoms, but this percentage increased to 27% among unmarried women; only 1% of married men reported using condoms, while 39% of unmarried men reported condom use (Ministry of Health 2003).

A survey of 3,600 young people (15-24 years) throughout Uzbekistan has indicated that 44% of young males have sexual activity but only 33% use any form of contraception (Uzbek Association on Reproductive Health/IPPR 2001). This survey also indicated that they are learning little or nothing

about how HIV infection is transmitted and prevented through school educational program designed to provide this information. According to the survey, 50% are not even aware of this risk. UNICEF (2002) reports that 43% of young people aged 14-17 are aware of condom use as a means for HIV prevention. However, among women aged 30-49, the proportion decreases to 35%, and among young women aged 15-29, the proportion further decreases to 26%. The (UHES) reports that 90% of female respondents and 95% of male respondents have heard of AIDS, but only about 60% of women and 80% of men believe that there is a way to avoid AIDS.

Strategies, Policies, and Legal Framework

Commitment to prevent further spread of HIV/AIDS is shown by the following: the approval of an AIDS Law and of the HIV/AIDS National Program; the Government approval of an appropriate Strategy (Interdepartmental Working Groups on HIV/AIDS. Strategic Program on Counteraction to HIV/AIDS epidemic expansion in the Republic of Uzbekistan) prepared with assistance from UNAIDS; a functioning UN Theme Group; the establishment of more than 200 Trust Points throughout the country; and requests for grants from the GFATM and IDA to contribute to assist in addressing the burgeoning epidemic.

The Government is also committed to the fight against IDU, and it has signed all international conventions against drug trafficking. A Special State Committee headed by the Prime Minister has been set up to tackle the struggle against drug trafficking, with special units in the Ministry of Health and Ministry of Internal Affairs. The Inter-ministerial Committee on Drug Abuse includes the Ministries of Interior, Defense, education, Health, Social Protection, and Labor.

Strategic planning on HIV/AIDS was initiated by the UN-AIDS Theme Group, which is currently chaired by the World Bank, and it has been supported by the Government. In addition, the Ministry of Health has been cooperating with UN agencies and donors on implementation of HIV/AIDS activities. The Ministry of Internal Affairs has also been cooperating with the Soros Foundation/OSI on the implementation of HIV/AIDS activities in prisons. The recently approved HIV/AIDS Strategy aims to:

- Encourage a multi-sectoral approach in the implementation of the HIV/AIDS Strategy with the involvement of relevant line ministries such as Ministries of Health, Internal Affairs, Education, and Finance, and UN agencies and NGOs.
- Strengthen targeted interventions for high-risk populations, which are critical to reversing the HIV/AIDS epidemic in Uzbekistan;
- Strengthen the management structure and implementation capacity to ensure the sustainability of the National Program on HIV/AIDS and STIs.

The Strategy considers the following as factors conducive to the spread of HIV infection in Uzbekistan:

1. Insufficient government to fight the epidemic
2. Weak multi-sectoral coordination
3. High susceptibility of groups of the population in which the infection is concentrated
4. Incomplete observance of human rights and freedoms related to HIV/AIDS, and
5. Insufficient focus on prevention activities, care and treatment, and support to PLWHA.

In reality, there is poor inter-ministerial coordination, and the Government was reluctant to approve the HIV/AIDS Strategy and proposals for funding to the GFATM out of religious and cultural concerns.

Illegal purchase and storage of drugs is prosecuted as a criminal offense, and drug replacement therapy is not yet legal in Uzbekistan. CSWs are prosecuted by law, and MSM are also subject to criminal prosecution. The Law on AIDS further contributes to stigmatization of HIV infected people, which provides an additional incentive for highly vulnerable groups to avoid testing.

Surveillance Needs and Additional Studies:

Uzbekistan has 14 AIDS centers and 90 laboratories for HIV diagnosis. The AIDS Center published quarterly reports on HIV/AIDS. UNAIDS has carried several rapid situation assessments in Tashkent since 1998. ODCCP is carrying out a survey on drug abuse in Uzbekistan. CDC is carrying out a HIV prevalence survey in Tashkent, and the results should be available in 2003. USAID in cooperation with CDC is providing equipment for the AIDS laboratories and training in sentinel surveillance.

The National AIDS Center laboratory has identified thousands of HIV positive cases by ELISA, which need to be confirmed by Western Blot. Rapid assessments were carried out on IDUs in five regions (Tashkent City, Sukhandaria, Samarkhand, Gizak, Tashkent), and the blood in syringes from three Trust Points was tested.

Vulnerable and Highly Vulnerable Groups:

Since the Uzbek Parliament passed a law on prevention of HIV/AIDS in 2000, Trust Points have been opened throughout Uzbekistan. These points are expected to provide counseling, testing, and free syringes, condoms, and information brochures. After the successful establishment of pilot Trust Points, the Minister of Health decreed that each oblast AIDS Center should set up at least one Trust Point providing anonymous and confidential testing and counseling for IDUs. Recognizing this initiative as best practice, UNAIDS reports that this is the first initiative by national authorities to implement trust points nationwide in Central Asia. The Ministry of Health has reported that the number of registered HIV cases actually decreased by 38% in areas where Trust Points are active.

The Government supports the harm reduction approach, and it has decided to increase the number of Trust points from 50 to 230. Currently, about 200 Trust Points are functioning throughout the country, up from 3 that were opened in 2000. In Tashkent City, there are 10 Trust Points, which distribute 800 to 1,000 needles daily the same number that is distributed in all other oblasts. Volunteers work with the drug users who come to the trust points and speak with them confidentially. Fees for volunteers, syringes, and other supplies are paid by the Government or are provided by the Soros Foundation/OSI. However, the Trust Points are frequently out of condoms, and health care workers work in cooperation with law enforcement bodies, which exercise repressive practices over groups at risk.

There is a prison pilot project on HIV/AIDS prevention in the Chirchik prison. Prisons usually isolate HIV positive prisoners, which has led to revolts in some prisons due to isolation. The Government has arranged a study tour to Karaganda, to observe HIV/AIDS prevention work in prisons in Kazakhstan. HIV/AIDS prevention work is also taking place in the army and information materials geared towards soldiers have been prepared.

The Government's current HIV prevention campaign, aimed almost exclusively at the IDU community, is considered a major barrier to preventing a broader epidemic. This approach is leading young people to think that the HIV/AIDS phenomenon does not affect them, but rather only marginalized people such as IDUs. Although an educational program had been developed for schools, it had not yet been integrated in the compulsory curricula. IEC for out-of-school young people and a public awareness campaign through the mass media have not yet been developed.

UN agencies and USAID/CAR have been training mass media and raising public awareness on drug related issues. UNICEF has also been conducting an IEC strategy to raise awareness regarding drug abuse, safe sexual behavior, and HIV/AIDS and STIs for 40,000 people aged 13-20 years. PSI, with funding from USAID, has been implementing a condom social marketing campaign, in which condoms are distributed at a low price.

Preventive, Diagnostic, and Treatment Issues

The UN Office for Drug Control and Crime Prevention (UNODCCP) and the Government of Switzerland have assisted in the establishment of a network of narcological health centers for treatment of drug abuse. Soros Foundation/OSI and the International Harm Reduction Network (IHRD) support a policy for replacement therapy for treatment of drug abuse. Methadone is on the list of drugs not allowed into the country, but there are attempts to develop a pilot project on replacement therapy with methadone. Recently seven specialists spent a month in the US studying the implementation of substitution therapy.

No information is available on treatment of opportunistic infections, and as a rule, HIC infected people do not have access to antiretroviral treatment.

NGO and Partner Activities

There are numerous NGOS working on HIV/AIDS in Uzbekistan: Kamalot works with youth; Sabokh and Tiklal Avlot work with CSWs (2 projects); Anti-AIDS works with MSMs; and Mahala works with IDUs (2 projects). NGOs are mainly funded by international and bilateral agencies.

The UN Theme Group includes the Ministries of Health, Defense, and Interior, and World Bank, USAID, Soros Foundation/OSI, UNAIDS, UNDP, UNFP, UNICEF, UNDCP, WHO and NGOs. The TG has an integrated working plan, which includes a list of 29 NGOs involved in HIV/AIDS work in the country. USAID had been providing technical and financial support to HIV/AIDS prevention in Uzbekistan, including upgrades in surveillance and in the lab system, prevention of mother to child transmission and blood safety. The Soros Foundation/OSI has been supporting the establishment of Trust Points in cooperation with the AIDS Center. The International Harm Reduction Program (IHRP) is also involved in harm reduction and prevention of HIV/AIDS with financial support of USAID.

Funding:

In 2001, 3.4% of total public expenditure was on health, which gives a spending per capita of less than \$10. **The Government** has indicated a budget for the **HIV/AIDS Program of \$704,000** in 2003, and in addition **\$610,000 from donors**. For the period of 2001-2003, **UN agencies, USAID, and Soros Foundation/OSI** have been providing over **\$1.5 million**, and **KfW** has been providing **DM5 million** for family planning, including contraceptives and condoms. Although the Government supports the establishment of the Trust Points throughout the country, funding is insufficient to cover the needs, which have been estimated at about \$40 million for four years. Therefore, the Government has applied to IDA, GFATM, and bilateral agencies for financial and technical support.

Recently, the Government started preparation for an AIDS component of a World Bank – financed project, which would be included in Health Project II. The AIDS Component would be financed by an **IDA** grant of about **\$2 million**. The Ministry of Health and project team have agreed that the component would support the approval and implementation of the HIV/AIDS Strategy that the Ministry of Health prepared with assistance from UNAIDS and has been recently approved. The component would also complement activities that have been launched with support from the Government and donors.

The Ministry of Health has also submitted, with assistance from the UN Theme Group, a grant proposal to **the GFATM** in the amount of \$24million, of which was granted **\$5million**. An Interministerial Committee, with participation of UN agencies and NGOs, would street the implementation of the HIV/AIDS Strategy and the use of the funds available from the Government, IDA, GFATM, UN agencies, USAID, Soros Foundation/OSI, and other NGOs. The grant from the GFATM would cover other unfounded activities such as scaling up target prevention interventions throughout the country, treatment of opportunistic infections and AIDS, and palliative care.

XIV: From: <http://www.unaids.org/Unaid/EN/Geographical+area/By+Country/uzbekistan.asp>

Country HIV and AIDS estimates, end 2003

Adult (15-49) HIV prevalence rate	0.1% (range: 0.0%-0.2%)
Adults (15-49) living with HIV	11 000 (range: 4900-29 000)
Adults and children (0-49) living with HIV	11 000 (range: 4900-29 000)
Women (15-49) living with HIV	3700 (range: 1700-9900)
AIDS deaths (adults and children)	<500 (range: <1000)

in 2003

Source: [2004 Report on the global AIDS epidemic](#)

XIII: From: <http://hivinsite.ucsf.edu/global?page=cr03-kz-00&post=19&cid=KZ#Youth>

Uzbekistan: Comprehensive Indicator Report

General HIV/AIDS

(Source: UNAIDS, 2004: UNAIDS 2004 Report on the global AIDS epidemic <http://www.unaids.org/bangkok2004/report.html>)

Indicator	Year	Uzbekistan	Eastern Europe & Central Asia	World	Source
Adults and children (ages 0-49) living with HIV/AIDS	2003	11,000	1,400,000	39,400,000	UNAIDS, 2004
Adults (ages 15-49) living with HIV/AIDS	2003	11,000	1,300,000	37,200,000	UNAIDS, 2004
Women (ages 15-49) living with HIV/AIDS	2003	3,700	490,000	17,600,000	UNAIDS, 2004
Children (ages 0-14) living with HIV/AIDS	2003	nd	8,100	2,200,000	UNAIDS, 2004
AIDS orphans currently living (ages 0-17)	2003	nd	nd	15,000,000	UNAIDS, 2004
Adults and child AIDS deaths (ages 0-49)	2003	<500	60,000	3,100,000	UNAIDS, 2004
Adults and children newly infected with HIV	2004	nd	210,000	4,900,000	UNAIDS, 2004
nd = No data					

HIV Prevalence

(Source: UNAIDS, 2004: UNAIDS 2004 Report on the global AIDS epidemic <http://www.unaids.org/bangkok2004/report.html>)

Indicator	Year	Uzbekistan	Eastern Europe &	World	Source
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			Central Asia		
Adult (ages 15-49) HIV prevalence (%)	2003	0.1	0.8	1.1	UNAIDS, 2004
HIV prevalence, sex workers, capital city (median %)	Various Years	nd	nd	nd	UNAIDS, 2004
HIV prevalence, injecting drug users, capital city (median %)	Various Years	nd	nd	nd	UNAIDS, 2004
nd = No data					

HIV Knowledge and Behavior

(Source: UNAIDS, 2004: UNAIDS 2004 Report on the global AIDS epidemic <http://www.unaids.org/bangkok2004/report.html>)

Indicator	Year	Uzbekistan	Eastern Europe & Central Asia	World	Source
Know that a healthy-looking person can have HIV (female, ages 15-24) (%)	Various Years	41	nd	nd	UNAIDS, 2004
Reported higher-risk sex (male, ages 15-24) in the last year (%)	Various Years	nd	nd	nd	UNAIDS, 2004
Reported higher-risk sex (female, ages 15-24) in the last year (%)	Various Years	nd	nd	nd	UNAIDS, 2004
Used a condom the last time they had higher-risk sex, of those who had high-risk sex in the last year (male, ages 15-24) (%)	Various Years	nd	nd	nd	UNAIDS, 2004
Used a condom the last time they had higher-risk sex, of those who had high-risk sex in the last year (female, ages 15-24) (%)	Various Years	nd	nd	nd	UNAIDS, 2004
nd = No data					

Access to Care and Treatment

(Source: WHO Health Services Coverage, 2004: http://www.who.int/tb/publications/global_report/en/)

Indicator	Year	Uzbekistan	Eastern Europe & Central Asia	World	Source
Percent of adults receiving VCT in last year	2003	0.1	1.5	nd	WHO Health Services Coverage, 2004
Number of VCT clients per year	2003	8,210	1,042,637	6,000,000	WHO Health Services Coverage, 2004
Number of VCT sites	2003	253	1,136	nd	WHO Health Services Coverage, 2004
Percent of pregnant women offered PMTCT services	2003	6	37	8	WHO Health Services Coverage, 2004
Percent of HIV+ pregnant women receiving ARV prophylaxis	2003	nd	6	3	WHO Health Services Coverage, 2004
Number of sites offering PMTCT services	2003	nd	969	37,513	WHO Health Services Coverage, 2004
Estimated coverage of antiretroviral therapy (est. %)	2003	nd	11	nd	WHO Health Services Coverage, 2004

Number of public sector patients receiving antiretroviral therapy	2003	nd	5,352	nd	WHO Health Services Coverage, 2004
Number of sites offering antiretroviral therapy services	2003	nd	27	nd	WHO Health Services Coverage, 2004
Coverage of cotrimoxazole prophylaxis for adults (est. %)	2003	3	4	nd	WHO Health Services Coverage, 2004
Number of adults receiving cotrimoxazole prophylaxis	2003	20	1,826	190,000	WHO Health Services Coverage, 2004
Coverage of cotrimoxazole prophylaxis for children (est. %)	2003	0	32	nd	WHO Health Services Coverage, 2004
Number of children receiving cotrimoxazole prophylaxis	2003	nd	1,095	28,000	WHO Health Services Coverage, 2004
Coverage of isoniazid prophylaxis for adults (est. %)	2003	1	1	nd	WHO Health Services Coverage, 2004
Number of adults receiving isoniazid prophylaxis	2003	8	432	36,000	WHO Health Services Coverage, 2004

					2004
Percentage of population living in areas with DOTS coverage	2002	41	nd	nd	WHO TB Control Report, 2004
Number of TB cases registered for treatment under DOTS	2001	854	nd	nd	WHO TB Control Report, 2004
nd = No data					

Mortality

(Sources: World Population Data Sheet 2004 of the Population Reference Bureau: http://www.prb.org/pdf04/04WorldDataSheet_Eng.pdf

UNICEF: www.unicef.org, UNDP: www.undp.org, UNFPA: www.unfpa.org)

Indicator	Year	Uzbekistan	Eastern Europe & Central Asia	World	Source
Life expectancy at birth (years)	Various Years	70	68	67	PRB Data Sheet, 2004
Infant (Ages 0-1) mortality rate (per 1,000 live births)	2003	57	34	54	UNICEF, 2005
Under-five mortality rate (per 1,000 live births)	2003	69	41	80	UNICEF, 2005
Maternal mortality ratio (per 100,000 live births)	2000	24	nd	nd	UNFPA, 2004
Probability at birth of surviving to age 65, female (% of cohort)	2000-2005	76.9	80.6	72.9	UNDP, 2004
Probability at birth of surviving to age 65, male (% of cohort)	2000-2005	65.7	58.8	64.4	UNDP, 2004
nd = No data					

General Population

(Sources: World Population Data Sheet 2004 of the Population Reference Bureau: http://www.prb.org/pdf04/04WorldDataSheet_Eng.pdf)

Indicator	Year	Uzbekistan	Eastern Europe & Central Asia	World	Source
Total population (millions)	mid-2004	26.4	299	6,396	PRB Data Sheet, 2004
Total projected population - 2025 (millions)	2025	36.9	281	7,934	PRB Data Sheet, 2004
Total projected population - 2050 (millions)	2050	48.5	243	9,276	PRB Data Sheet, 2004
Rate of natural increase (%)	Various Years	1.6	-0.5	1.3	PRB Data Sheet, 2004
Percent urban		37	68	48	PRB Data Sheet, 2004
nd = No data					

Youth

(Sources: World Population Data Sheet 2004 of the Population Reference Bureau: http://www.prb.org/pdf04/04WorldDataSheet_Eng.pdf)

Indicator	Year	Uzbekistan	Eastern Europe & Central Asia	World	Source
Population ages 10-24 (millions)	2000	7.8	71	1663.0	PRB Youth Data Sheet, 2000
Percent of total population ages 10-24	2000	32	23	27	PRB Youth Data Sheet, 2000
Percent of total population under 15	mid-2004	38	16	30	PRB Data Sheet, 2004
nd = No data					

General Health

(Source: UNDP: www.undp.org, UNICEF: www.unicef.org; WHO: http://www.who.int/tb/publications/global_report/en/)

Indicator	Year	Uzbekistan	Eastern Europe & Central Asia	World	Source
Health expenditure, private and public (US\$ per capita)	2001	91	nd	nd	UNDP, 2004
Physicians per 100,000 people	1990-2003	293	nd	nd	UNDP, 2004
Births attended by skilled health staff (%)	1995-2002	96	97	58	UNDP, 2004
Malaria cases per 100,000 people	2000	1	nd	nd	UNDP, 2004
Prevalence of child (ages 0-5) malnutrition (%)	1995-2003	8	6	27	UNICEF, 2005
TB treatment success rate, new smear-positive cases-DOTS (% of cases)	2001	76	nd	nd	WHO TB Control Report, 2004
nd = No data					

Fertility

(Sources: UNFPA: www.unfpa.org; World Population Data Sheet 2000 of the Population Reference Bureau: <http://www.prb.org/Template.cfm?Section=PRB&template=/ContentManagement/ContentDisplay.cfm&ContentID=8500>)

Indicator	Year	Uzbekistan	Eastern Europe & Central Asia	World	Source
Total fertility rate (number of children)	2000-2005	2.44	nd	2.69	UNFPA, 2004
Births per 1,000 women (ages 15-19)		54	nd	50	UNFPA, 2004
Percent of TFR attributed to births by ages 15-19		5	14	12	PRB Youth Data Sheet, 2000

Percent giving birth by age 20		25	nd	31	PRB Youth Data Sheet, 2000
nd = No data					

Education

(Sources: UNICEF: www.unicef.org)

Indicator	Year	Uzbekistan	Eastern Europe & Central Asia	World	Source
Gross primary school enrollment ratio, male	1998-2002	103	101	104	UNICEF, 2005
Gross primary school enrollment ratio, female	1998-2002	102	98	97	UNICEF, 2005
Gross secondary school enrollment ratio, male	1998-2002	100	90	66	UNICEF, 2005
Gross secondary school enrollment ratio, female	1998-2002	97	85	61	UNICEF, 2005
nd = No data					

XI: From: <http://hivinsite.ucsf.edu/global?page=cr03-uz-00>

HIV/AIDS in Uzbekistan	
Adults age 15-49 with HIV/AIDS, 2003	11,000
New HIV infections, 2004	nd
Adult HIV prevalence (%), 2003	0.1
Women age 15-49 with HIV/AIDS, 2003	3,700
Children with HIV/AIDS, 2003	nd
AIDS orphans (ages 0-17), 2003	nd
AIDS deaths, 2003	<500
nd = No data	

Source: **UNAIDS**

a. HIV PREVALENCE RATES (GENERAL):

XV: From: <http://www.afew.org/english/statistics/HIVdata-Uzb-2003-31Dec-Eng.htm>

Officially Registered HIV Cases in the Republic of Uzbekistan 1 January 1987 through 31 December 2003 (based on data from the Republican AIDS Centre)

Year	New Registered Cases	Cumulative Registered Cases ⁽¹⁾	Prevalence per 100 000 ⁽²⁾	Annual Incidence per 100 000 ⁽³⁾	Prevalence Increase Index	Annual Incidence Increase Index	% of Total Infections
1987 to 1993	8	8	0,0	-	-	-	-
1994	0	8	0,0	0,0	1,0	-	-
1995	1	9	0,0	0,0	1,1	-	0,3 ⁽⁴⁾
1996	3	12	0,1	0,0	1,3	-	0,1
1997	7	19	0,1	0,0	1,6	2,3	0,2
1998	5	24	0,1	0,0	1,3	0,7	0,1
1999	20	44	0,2	0,1	1,8	3,9	0,6
2000	153	197	0,8	0,6	4,5	7,5	4,3
2001	540	737	2,9	2,2	3,7	3,5	15,3
2002	967	1 704	6,7	3,8	2,3	1,7	27,3
2003	1832	3 536	13,8	7,0	2,1	1,9	51,8

100,0%

Report Date	New Cases as of Report Date ⁽⁵⁾	Cumulative Cases as of Report Date
1 Jan 2003	-	1 704
31 Dec 2003	1 832	3 536

IX: From: http://www.unaids.ru/index_ru.php?id=aids_epidemic_update_eng-5&nm=4
UNAIDS: Key Materials: Eastern Europe and Central Asia

The most recent HIV outbreaks in the region are to be found in Central Asia, where reported HIV infections have grown exponentially from 88 in 1995 to 5,458 in 2002. This is mainly due to the sharp rise in infections recorded in Kazakhstan, Kyrgyzstan and Uzbekistan. HIV has now spread to all regions of Kazakhstan, while the majority of cases reported in Kyrgyzstan are concentrated in the Osh region, which serves as a drug transit route for neighbouring countries. Given that the five Central Asian republics straddle major drug trafficking routes into the Russia Federation and Europe, it is no surprise that the majority of infections currently are related to injecting drug use. Indeed, in some parts, heroin is now believed to be cheaper than alcohol. As elsewhere in the region, young people are the worst-affected, with those on the margins of the economy particularly vulnerable. In Kazakhstan, for example, three-quarters of people diagnosed with HIV were unemployed.

These epidemics are very recent and can be halted if prevention efforts are targeted at those who are currently most affected - injecting drug users and sex workers - and are supported by prevention work among young people generally. In some instances, even more elementary prevention steps are required - such as screening blood donations for HIV. Tajikistan, for example, reportedly did not test 40% of those who donated blood in 2002.

b. HIV PREVALENCE RATES (WITHIN THE COUNTRY, BY REGIONS):

From: <http://www.drugpolicy.org/docUploads/UZBEKISTAN.pdf>

Drug Policy and Health in Uzbekistan
A profile prepared by the Drug Law and Health Policy resource network
Revised: 12 Feb 2002

p. 7 Regional Distribution:

The majority of HIV/AIDS cases have occurred in the capital city of Tashkent and the city of Yangiyol. According to Intercountry programme advisor for UNADIS Rudick Adamian, there is an eighty percent prevalence of HIV among IDUs.

c. HIV PREVALENCE RATES (VULNERABLE GROUPS):

I. From <http://www.eurasiahealth.org/resources/mdlDoc/1467-e.pdf>
AIDS Epidemic Update: December 2004

Eastern Europe and Central Asia: p. 47 to 56

In Uzbekistan, which hosts one of the youngest epidemics in the world, almost 91% of all reported infections were diagnosed between 2001 and mid-2003, bringing to more than 2500 the total number of reported HIV cases.

Uzbekistan's epidemic is now developing swiftly. Already, **commercial sex** appears to be playing a large role. The proportion of women among people living with the virus has grown annually from just over 12% in 2001 to almost 18% in 2003. HIV infections have been recorded in all regions of the country, though the epidemic is most heavily concentrated in the capital Tashkent (48% of all registered HIV cases) and surrounding areas (20%).

From: Harm Reduction News

Newsletter Focus

Fall 2002 – Volume 3, Issue 3

p. 14: A Brighter Future for Sex Workers

by Tadjikhon Saidikramova

Some commercial sex workers in Uzbekistan are as young as 17 years old, although most are in their early 20s, and stay in the profession for an average of two years. Few are married and 20% have a child. Thirty percent inject drugs. But their biggest risk of HIV is from unprotected sex; at the client's request, every third CSW does not use a condom.

As of July 2002, 1,303 HIV cases were officially registered in the country – 1,230 men and 169 women. Over 80% of the infected are injection drug users. Sexual transmission is not prevalent but government and UN experts predict that the number of cases will increase in the coming years. This trend is accompanied by the increasing involvement of drug users in CSW.

The center Sabo opened in Tashkent for years ago to help socially vulnerable women create a brighter future for themselves. In ancient Uzbek, *sabo* means "morning freshness" and calls to mind a bright future. At first staff (doctors and teachers experienced in social and educational work) worked with students, housewives, girls, and those entering marriage. Soon the center's HIV/AIDS program began to focus on female CSWs because they are among the most at-risk and marginalized groups in Uzbek society.

Uzbek laws do not define prostitution, and liability for engaging in commercial sex work is not clearly established. But public opinion is clearly established, condemning women for frivolity with men and blaming them for prostitution. Their stigmatization forces them into secrecy making them difficult to reach and mistrustful even of the people who try to help them.

The negative public attitude makes CSWs wary of openly discussing their problems. But many of them are unhappy and need support. They need medical, psychological, and legal aid. Sabo accepts CSWs for who they are. The organization's goal is solely to lower the behavioral risks.

The project identified, after conducting a six-month needs assessment project, the need for confidential services from gynecologist, dermatologist-venerologist, psychologist, lawyer, and immunologist, which the center now provide for free. The center also runs a hotline and distribute information

materials, syringes, and condoms. Some CSWs train to become volunteers themselves. And the center provides over 90 CSWs with information about safety and legal rights.

The CSWs that come to Sano know about safer sex, contraceptives, and the prevention of HIV and STIs. In four years Sabo has grown into a busy center with a professional staff and 25 volunteers.

From: <http://www.drugpolicy.org/docUploads/UZBEKISTAN.pdf>

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Revised: 12 Feb 2002

p. 7: Risk Behavior

According to International Harm Reduction Development Programme (IHRD), ignorance of the risks of HIV and other STIs is relatively high in Uzbekistan. Those at greatest risk – commercial sex workers - are not necessarily better informed than the general public. Many commercial sex workers engage in high-risk behavior, such as drug use and having unprotected sex.

From: <http://www.drugpolicy.org/docUploads/UZBEKISTAN.pdf>

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Revised: 12 Feb 2002

p. 9: Summary of the Situation.

Drug abuse and addiction is increasing. There is a dramatic increase in the use of heroin, opium and hashish. Explosive growth of heroin and opium production in Afghanistan has led to a dramatic increase in the amount of heroin and opium available in the country. Most experts say there are approximately 20,000 people addicted to drugs in Uzbekistan. In 1998 the government, with UNDCP assistance, commissioned a study to get a more precise picture of demand in the country. Despite awareness of the problem, however, the government has instituted no demand reduction programs. The 15,000 registered addicts are, however, subject to compulsory treatment. Some experts believe that the actual number of addicts could be 44,000.

d. MAJOR TRANSMISSION ROUTES:

II. From: www.rbec.undp.org/hiv/?english

HIV/AIDS in Central and Eastern Europe and the CIS

p. 21: Uzbekistan reported sharp annual increases in newly registered HIV cases during 1999-2002. By July 2003, UZ reported a total of 2,534 new HIV infections, and 6 AIDS cases. As in most other CIS countries, the vast majority of the people living with HIV in UZ are men (84%) in young age cohorts (56% are under 30). Some 84% reportedly contracted HIV through **injecting drug use** and 15% through **heterosexual contact**. Only 1% was attributed to **male-to-male sex**. Some 75% of all cases were registered in the Tashkent area. Other regions each reported less than 4% of all HIV cases.

From: <http://www.drugpolicy.org/docUploads/UZBEKISTAN.pdf>

Drug Policy and Health in Uzbekistan

A profile prepared by the Drug Law and Health Policy resource network

Revised: 12 Feb 2002

p. 3: III. IDU

Drug Use: Drug use and addiction are increasing, thanks to increased opium production in Afghanistan. During 2000, new epidemics in drug injectors emerged in Uzbekistan. Most experts say there are about 20,000 drug-dependent people in Uzbekistan. However, some sources place that number as high as 44,000.

Risk Behavior: There are particularly problems in the prison and sex workers population. Drugs are available in prison and reuse of contaminated injection equipment is common.

From: <http://www.drugpolicy.org/docUploads/UZBEKISTAN.pdf>

Drug Policy and Health in Uzbekistan

A profile prepared by the Drug Law and Health Policy resource network

Revised: 12 Feb 2002

p. 9: Drug Traffic:

Effective government eradication programs have eliminated nearly all illicit production of opium poppies in Uzbekistan. However, the amount of drugs crossing Uzbekistan is growing, because of its location on a major drug route and because Uzbekistan's roads and air service are in relatively good shape. Opium and cannabis products originating in southwest Asia and bound for Russia and Europe take several routes across Uzbek territory. The only Afghan-Uzbek border crossing is closed, so most drugs come into Uzbekistan via Tajikistan. One major route – view the Gorno-Badakstan region of Tajikistan, through Osh in Kyrgyzstan, and into Uzbekistan's Ferghana Valley – has been seeing less traffic. Instead, smugglers are crossing the Tajik-Uzbek border near Khojand into the Syrdarya Oblast, and further south into the Surkhandarya Oblast. Drug smugglers are regularly caught on the Dushanbe-Moscow train. Some cannabis and opium poppies are cultivated in the mountainous areas of Uzbekistan, particularly in the regions of Samarkand and Syrhandarya. However, the amount growing there has been decreasing, due to Uzbek eradication efforts.

e. ACCESS TO TREATMENT:

II. CURRENT RESPONSE TO HIV/AIDS EPIDEMIC IN THE COUNTRY

a. GOVERNMENT

From: <http://lnweb18.worldbank.org/ECA/ECSHD.nsf/ExtECADocByUnid/6E5753F05D5CEE7C85256C830072900E?Opendocument>

HIV/AIDS in Uzbekistan

- **HIV is spreading rapidly in Uzbekistan.** Uzbekistan hosts one of the youngest epidemics in the world. Almost 91% of all reported infections were diagnosed between 2001 and mid-2003, bringing to more than 2500 the total number of reported HIV cases (UNAIDS).
- **Men account for most of the infections** -more than 85% .
- **Young people, between 15-34 years of age, account for two-thirds of the cases.**
- **Tashkent has the highest number of infected persons.**
- **Injecting drug use was the cause of the majority of infections** – about 90% - as in other countries of the region.
- **There are around 25,000 registered drug users, though the UN estimates the number to be at least 60,000.**

Government Response

The Uzbek Parliament passed a law in 2000 on the prevention of diseases caused by HIV. Since then, HIV counseling stations have been opened in

the regional centers of Uzbekistan and in Tashkent. People applying to these counseling centers can get advice from specialists, have themselves tested, and receive free syringes, condoms, and information.

Establishment of 'Trust Points' - An International Best Practice

After the successful establishment of pilot 'trust points', the Minister of Health decreed that the AIDS Center in each oblast should set up a 'trust point' providing anonymous and confidential testing and counseling for IDUs.

UNAIDS reports that this initiative is the first initiative in Central Asia by national authorities to implement trust points nation-wide, and is an international best practice.

From: <http://www.drugpolicy.org/docUploads/UZBEKISTAN.pdf>

Drug Policy and Health in Uzbekistan

A profile prepared by the Drug Law and Health Policy resource network

Revised: 12 Feb 2002

p. 4: Public Health Interventions

The government of Uzbekistan has recognized that narcotics are important security concern. However, the government's efforts are focused on sopping the narcotics trade, not on harm reduction. The Ministry of Health has set up seven substance abuse rehabilitation clinics in the country. Also, the Open Society Institute funds one harm reduction program, the Tashkent City Women's and Children's Center, which works primarily with commercial sex users. It works to reduce drug use among this group. It also distributes condoms and is setting up a hotline.

Drug Treatment: registered addicts are subject to compulsory treatment. Syringe exchange programs are not illegal. However, possession of syringes may expose a person to the policy by indicating drug possession. The authors of the reports were not able to determine the legality of opium substitution therapy.

From: <http://www.drugpolicy.org/docUploads/UZBEKISTAN.pdf>

Drug Policy and Health in Uzbekistan

A profile prepared by the Drug Law and Health Policy resource network

Revised: 12 Feb 2002

p. 9: Laws and Law Enforcement practices:

a. Drug Use Related – Law

Syringe Access/Needle Exchange – Law: No law prohibits syringe purchase or possession, or the operation of syringe or syringe exchange programs

Syringe Access/Needle Exchange – Practice: Possession of a syringe exposes an IDU to potential police intervention by indicating drug possession. This practice is likely to discourage drug users from carrying or possessing sterile injection equipment

Drug Possession – Law: according to the U.S. State Department, Uzbekistan has enacted a new comprehensive drug control law:

The law sets out a legal framework for the regulation of production, use and transport of narcotics and precursors. Licensing is now required for all legitimate activities, including medical use, of these substances. In addition, import and export activities require explicit permission of the State Commission on Drug Control. The law also contains a section on combating illegal trafficking in narcotics, directing the State Commission on Drug Control to coordinate counternarcotics efforts and authorizing law enforcement agencies to take such measures as conducting searches, confiscating contraband and compelling blood testing for suspected criminal drug use. The law's final section guarantees medical treatment for addicts. Although the law's scope is comprehensive, it is not detailed. Officials are currently drafting the regulations necessary to implement the law.

Drug Possession – Practices: As reported by Eurasianet, anti-drug efforts are believed by human rights groups to target particular ethnic and religious groups. Also, many official force people to pay enormous bribes, under the pretext of stopping narcotics trafficking. As a rice trader from Batken put it, "the Uzbek police start searching us...they say they are looking for drugs...I know several Kyrgyz businessmen who have been relieved of their goods as well as large sums of money. Of course they didn't try to complain because everyone knows that if you end up in an Uzbek prison, you'll probably never get out." Uzbekistan's main counter-narcotic efforts centers around destroying the illicit crop cultivation. The efforts are sponsored by the UN's Office for Drug Control and Crime Prevention (UN ODCCP). The UN ODCCP is supporting research at Uzbekistan's Institute of Genetics on the development of a fungus capable of destroying the opium crop at its root. The fungus was first discovered at a former Soviet biological warfare plant in Uzbekistan, originally designed to destroy NATO's food supplies.

Compulsory Treatment Practices: registered addicts are subject to compulsory treatment

Drug trafficking – Practices: criminal penalties for dealing drugs are quite sever. In 1995, a new criminal code was implemented. It includes the possibility of the death penalty for drug dealers and tougher penalties for drug-related crimes all around.

Drug treatment – Regulations: the legality of opium substitution therapy, such as methadone and Buprenorphine, is unknown.

b. Right to Health Care/HIV treatment – Law: People with HIV have a right to treatment and social assistance. They are given free travel to the place of treatment and free medicines

HIV Testing Provision – Law and Practice: Anyone arrested or under criminal investigation is tested for HIV. Prison inmates are tested regularly. Prisoners with HIV are reportedly segregated.

Anti-discrimination – Law and Practices: People with HIV may not be fired from work or have restrictions places on their job or their schooling. Anyone who does not respect the rights of those with HIV is subject to liability.

Privacy generally and HIV in particular – Law: under a 1991 law, medical worker may face criminal charges is they violate medical confidentiality.

Criminal Penalties for Exposing/Transmitting HIV law and practices: A person is held criminally liable for infecting another person of if they are aware of the possibility that they may pass this condition.

c. Interventions to reduce disease and other injuries associated with drug use

Summary of government position and activities: Uzbekistan considers the trafficking of narcotics to be an important security concern. Uzbek authorities have mainly focused on sopping the narcotic trade rather than on harm reduction. Many Uzbek's don't trust the government's operations aimed against narcotics.

IHRD supports one harm reduction program, the Tashkent City Women's and Children's Center (SABO). The project is increasing AIDS education efforts, in particular among sex workers who use drugs, with the help of new volunteers and specialized prevention information. It is setting up hotline and new condom-distribution centers throughout the city.

d. Drug treatment programs/availability:

The Ministry of Health has recognized that Uzbekistan has a serious drug problem. There are seven substance abuse rehabilitations clinics in Uzbekistan. They treat both drug and alcohol abuse.

Substitution Therapies: Substitution therapies are generally not available.

e. Public Health Measures to prevent HIV and other significant diseases

Government Efforts/Attitudes: In Uzbekistan, IDU was linked to 80 percent of new HIV cases. Awareness and prevention programs, if implemented quickly, could significantly reduce the chances of an AIDS epidemic in the region, experts say. Sub the implementation of effective awareness and prevention program is hampered by a severe lack of government resources. Also, many religious leaders remain sensitive over HIV/AIDS harm reduction projects. Most ordinary citizens share their sentiments. Many media campaigns have met significant resistance from the public, especially those with explicit references to sex.

b. DONOR ORGANIZATIONS

XII: From: <http://www.theglobalfund.org/search/ccmMembership.aspx?countryID=UZB>

The Global Fund

Uzbekistan:

PORTFOLIO OF GRANTS IN KAZAKHSTAN	
Country Coordinating Mechanism (CCM):	<p>Mr. Khairulla Karamatov Deputy Prime Minister House of Government CCM Uzbekistan, Chairperson Tashkent 700000 Mustakilik Square 99871 1398288 99871 1398601 Nmannapbekov@cm.uzpak.uz</p> <p>Dr. Feruz Nazirov Honorable Minister of Health Ministry of Health CCM Uzbekistan, Vice-Chair Tashkent 700011 12 Nanoi Street 99871 2411680 99871 2441033 serka@bcc.comm.uz</p> <p>Dr. Mumtoz Khakimov Director Republican AIDS Centre CCM Uzbekistan, Contact 1 Tashkent 700135 12, Farkhadskaya Street, Quarter Chilanzar 99871 762608 99871 763776 uzbekspid@yandex.ru</p>
Disease(s):	Round 3: The National AIDS Center of the Ministry of Health of the Government of the Republic of Uzbekistan
Total Funding Request:	\$40,778,168.00
2-year Approved Funding:	\$12,160,743.00
Total Funds Disbursed:	\$407,181.00

HIV/AIDS

Project Title:	Scaling up the Response to HIV/AIDS: A Focus on Vulnerable Populations
Country:	Uzbekistan
Round:	3
Principal Recipient:	The National AIDS Center of the Ministry of Health of the Government of the Republic of Uzbekistan Ms.Gusal Guyassova uzbekspid@yandex.ru
Local Fund Agent:	PricewaterhouseCoopers altaf.tapia@uz.pwc.com otabek.muhammadiyev@uz.pwc.com
Portfolio Manager:	Chernyavskiy, Valery Valery.Chernyavskiy@TheGlobalFund.org
Grant Agreement Signed:	28-Sep-04
Total Funding Request:	\$24,497,920.00
2-year Approved Funding:	\$4,760,755.00
Total Funds Disbursed:	\$407,181.00

Summary HIV/AIDS: The goal of the HIV/AIDS component is to prevent the spread of HIV/AIDS into the general population by reducing its impact on the most vulnerable populations, including injecting drug users (IDUs), prisoners, sex workers (SWs) and men who have sex with men (MSMs). Uzbekistan has an emerging infrastructure of NGOs and government organizations that will manage a range of essential activities required to address the component's three objectives: 1) effective prevention programs focused on the needs of vulnerable populations, 2) access to care, support and treatment for people living with HIV/AIDS, and 3) an enabling environment that supports work with vulnerable populations. During the five-year lifespan of this initiative, the expectation is that prevalence rates among key vulnerable populations will decline and that the prevalence rate among pregnant women, which serves as a marker for the general population, will remain below 1%.

Target groups/Beneficiaries:

Uzbekistan's epidemic is spreading most rapidly among the country's 100,000+ IDUs. Other highly vulnerable groups, including prisoners (100,000+), sex workers (20,000+) and MSMs (15,000+), are increasingly at-risk of contracting HIV. Consequently, these populations will be the primary beneficiaries of the HIV/AIDS component. The secondary beneficiaries are PLWHAs in Uzbekistan (estimated at between 2,000 - 6,000), who will

have increased access to treatment, care and support services. A third beneficiary is the growing population of young people (approximately six million and rising), who will benefit from activities that help them understand and avoid the risk behaviours associated with HIV/AIDS. For both the highly vulnerable populations and the youth population, the core benefit is access to information and services that will help prevent them from contracting HIV. For PLWHAs, the core benefit is access to ongoing treatment, care and support services, which will improve their quality of life.

Planned Activities:

Technically, most activities are a significant scaling-up of existing projects in Uzbekistan. However, given the many challenges of such a sizeable scaling-up process, much of this work will, in effect, be new activities. For example, international best practice indicates that NGOs must play a critical role in interventions for vulnerable people. Despite the fact that there are local NGOs in Uzbekistan currently working with vulnerable populations, fully implementing this approach will require wide-ranging and groundbreaking work with the country's NGO/CBO sector.

Several activities, including broad access to ARV therapies, MCTC and substitution treatment for IDUs, are new to Uzbekistan. Every new activity has been modelled after international best practices and, as these activities are put in place, the implementing agencies will draw on lessons learned in similar situations.

In general, the broad-based approach to harm reduction puts Uzbekistan on the leading edge. Given the critical link between IDUs and HIV/AIDS in Central Asia, it is necessary to take a progressive approach to reduce the vulnerability of IDUs and prevent the spread of HIV into the general population. Launching comprehensive and integrated HIV/TB activities among prisoners is also on the leading edge.

Each objective will be achieved through an integrated set of activities; there will also be activities that address issues relevant to multiple activities. Activities for the first objective - effective prevention programs focused on the needs of vulnerable populations - include: harm reduction initiatives for IDUs (i.e., needle exchange, condom distribution, IEC campaigns and substitution treatment), outreach and peer education programs with sex workers and MSMs, IEC and condom distribution programs in prisons, school and community-based IEC/BCC programs for young people and improvements in STI services. Activities for the second objective - access to treatment for people living with HIV/AIDS - include: broad-based care and treatment services (e.g., ARVs, treatment for opportunistic infection, psycho-social support and palliative care) and MCTC. Activities for the third objective - development and implementation of policies to ensure that the enabling environment required to work with vulnerable populations exists in the country - include: education and advocacy campaigns targeting policy makers and opinion leaders in Uzbekistan, training for journalists on HIV/AIDS and improvements in surveillance policy and practice. Different government and NGO/CBO/FBO partners, each of which will be required to have relevant knowledge and skills, will implement activities across all the objectives. Where required, the implementing partners will have access to domestic and international technical assistance to ensure that the interventions are effective. For example, CDC will provide technical assistance on the improvements in the surveillance systems.

Expected Results:

Key results from the various activities include:

- Reduction in the percentage of IDUs reporting sharing injecting equipment and solutions;
- Increase in the percentage of sex workers reporting condom use with their most recent partner;
- Providing effective STI treatment to 75% vulnerable populations;
- 70% of PLWHAs are enrolled in ARV treatment programs; and
- Stigma and discrimination for vulnerable populations, including PLWHAs, is reduced because of new legislation.

III: From: <http://www.dfid.gov.uk/pubs/files/rapcascm.pdf>

Central Asia, South Caucasus and Moldova. Regional Assistance Plan. 2004

New Directions of **DFID** in Uzbekistan:

Support to the National Programme – focus on harm reduction

II: From: *DDRP website*

*Drug Demand Reduction and Health Promotion Among Sex Workers
Uzbekistan*

PROJECT DURATION: October 2002 through September 2007

DONOR(S): United States Agency for International Development (USAID; www.usaid.gov)

The Drug Demand Reduction Programme (DDRP) is a five-year USAID-funded initiative in Central Asia designed to respond to the dramatic increase in drug use among vulnerable populations in two key countries of a region in which HIV/AIDS is spreading rapidly and primarily through injecting drug use.

Throughout the five-year Programme, Drug Demand Reduction interventions will be implemented in select oblasts of Tajikistan, Uzbekistan, and the Ferghana Valley region of Kyrgyzstan with the short term goal of 'increased knowledge and skills with respect to the prevention of drug use in select populations'. This is stated as a step toward the long-term goal of a 'decrease in drug use among these select populations'.

PARTNER(S): The Open Society Institute - Kazakhstan, The Open Society Institute - Uzbekistan, Internews, Population Services International (PSI); Accord - an affiliate of Street Kids International; The Ministry of Health of Uzbekistan, The Ministry of Internal Affairs of Uzbekistan

REGION: Uzbekistan

BACKGROUND:

The number of women working in the sex industry has rapidly increased in the Central Asian Republics during the last decade. This growing phenomenon is the result of a multitude of factors including the significant and far-reaching socio-economic and political changes which have continued to sweep the region since gaining independence in the early 1990s.

Many women from this region continue to struggle with high levels of unemployment and, ultimately, the feminisation of poverty. Sex work is often one of the few income-generating options available to support themselves and their families. As such, tendencies such as high migration patterns from rural to urban regions, and frequent movement across borders into neighbouring countries, have been noted among women and young girls.

Drug use and sex work are strongly interlinked. Drug users often sell or trade sex for narcotics and sex workers often use drugs as a coping mechanism. As of 1 July 2003, and according to the Republican AIDS Centre of Uzbekistan, Ministry of Health of the Republic of Uzbekistan, 2 534 cases of HIV/AIDS have been officially registered in the country. Among these, 98 individuals have died from AIDS-related causes. Among all cases where the route of transmission is known, 60.5% are attributed to injecting drug use, and 11.5% are attributed to heterosexual contact. Women living with HIV/AIDS account for 17.2% of all registered cases.

OVERALL OBJECTIVE:

To contribute to the implementation of a comprehensive and sustained country-wide drug demand reduction policy through the development of a pilot programme on drug demand reduction and health promotion among sex workers in Uzbekistan

SPECIFIC OBJECTIVES:

1. To develop within the Uzbek government and non-governmental organisations the appropriate tools and structures related to drug demand reduction and health promotion among sex workers and to promote the transfer of knowledge and skills among all counterparts involved in programme activities
2. To strengthen the personal decision-making skills of sex workers with regards to drug demand reduction via drug counselling services, peer support, and the distribution of the appropriate information materials
3. To reduce the relative isolation of Uzbek sex workers by promoting and facilitating the establishment of peer-led self-help groups, strengthening survival skills, increasing access to alternative employment training, and by stimulating co-operation with the respective municipal health institutions and NGOs
4. To stimulate the replication of developed structures in Uzbekistan in close co-operation with the Ministry of Health, municipal health authorities, and NGOs

TARGET AUDIENCE(S):

- Sex workers
- Selected governmental and non-governmental organisations
- Law enforcement agencies

- Health professionals working within drug treatment establishments, sexually transmitted infection clinics, and AIDS centres
- Local and national health authorities

PROGRAMME ACTIVITIES:

The following activities may be developed, implemented, evaluated and handed over to local agencies during the course of the five-year programme:

- Conduct an extensive rolling needs assessment in Uzbekistan among sex workers
- Development and dissemination of practical training guidelines for local partner organisations and agencies related to drug demand reduction and health promotion among sex workers
- Conduct capacity building seminars related to drug demand reduction and health promotion for local project partners and target audiences
- Regular consultancy site visits by AFEW technical advisors to project sites
- Development, production and dissemination of a wide range of printed materials on issues related to drug demand reduction and health promotion for all programme target audiences (i.e., sex workers, NGO personnel, medical professionals, law enforcement officials, health authorities and policy makers)
- Promotion and support for the establishment of local peer-led initiatives such as, sex worker self-help groups to assist in building self-esteem, confidence, and to provide education and support to other sex workers
- Development of links to existing alternative employment training programmes and potential partnerships with micro-credit initiatives to support opportunities for women seeking to leave the sex industry
- Development of a training programme and information resources related to drug demand reduction for Uzbek law enforcement agencies and medical establishments
- Participation in a regional conference during the third and fifth years of programme activities

(EXPECTED) RESULTS:

- A comprehensive, multi-sectoral results-based programme will be developed and implemented on drug demand reduction and health promotion as a direct outcome of the extensive needs assessment carried out among sex workers
- A continuum of 10 to 12 capacity building training seminars will be implemented among NGO personnel, police and health authorities, and medical professionals from several regions of Uzbekistan
- A series of best practice training guidelines for partner organisations on issues related to drug demand reduction and health promotion among sex work populations will be developed and widely disseminated across all regions of Uzbekistan
- Response-based targeted materials on themes related to drug demand reduction and health promotion will be developed and disseminated in collaboration with sex work populations in Uzbekistan
- Political commitment and involvement from local and national health authorities will facilitate the development and dissemination of materials and will support the sustainability of programme activities through a controlled hand-over process to local structures

(EXPECTED) MATERIALS PRODUCTION:

Throughout the duration of the five-year programme, a comprehensive series of quality printed materials and best practice resources will be developed and disseminated among sex workers, medical professionals, NGO personnel, law enforcement officials, and policy makers in Uzbekistan,

including the following:

- As many as four (4) best practice manuals on drug demand reduction, and health promotion materials will be developed and disseminated among project target audiences
- 50 000 copies of health promotion printed materials will be disseminated among sex work populations in Uzbekistan
- 8 000 copies of best practice resources and guidelines will be developed and disseminated among NGOs, health professionals, and health authorities in Uzbekistan
- 10 000 copies of guidelines on health promotion and drug demand reduction materials will be developed and disseminated among Uzbek law enforcement officials

RESEARCH COMPLETED AND PLANNED BY AFEW:

- A comprehensive literature review on sex work in the Central Asian Republics was completed by *AFEW* in June 2003.
- Rapid Assessment and Response (RAR) research, including a KAPB survey is currently pending.

FOR FURTHER INFORMATION, PLEASE CONTACT:

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c. NGOs
d. CIVIL SOCIETY

III. CURRENT ASSESSMENTS ABOUT EPIDEMIC AND RESPONSE (same as II. Current response to HIV/AIDS epidemic in the country)

IV. GAPS

From: <http://www.drugpolicy.org/docUploads/UZBEKISTAN.pdf>

Drug Policy and Health in Uzbekistan
A profile prepared by the Drug Law and Health Policy resource network
Revised: 12 Feb 2002

p. 7: Stigma and Social Attitudes toward HIV/AIDS and Risk Behavior:

These appears to be considerable reluctance throughout the society to deal with the threat of HIV. Surveys indicate that few of the estimated 5,000 sex workers in Tashkent have ever had an HIV test even after other STIs have been confirmed.

Also, many religious leaders remain sensitive over HIV/AIDS harm reduction projects. Most ordinary citizens share their sentiments. Many media campaigns have met significant resistance from the public, especially those with explicit reference to sex. "in most towns of the Ferghana Valley, sensitivity about practices connected with sex is traditionally high," said Yusyp Tavakilov, a journalist based in the Uzbek city of Andijan.

It is especially hard to reach the homosexual population. "I constantly am very afraid for my life because my community hates homosexuals, and police persecution is very brutal here," said Tolibjon, a homosexual who lives in Margelan, a small town in the Uzbek sector of the Ferghana Valley.

HIV/AIDS

Social and Economic Consequences in Countries of the Commonwealth Of Independent States

Indicators for the World of Work

Report of a Tripartite Seminar

Moscow, 10-12 December, 2001

Poverty and HIV/AIDS in the Republic of Uzbekistan

Mr. Arustan Zholdasov

p. 22: It is widely assumed there is a complex relationship between the prevalence of HIV/AIDS and the extent of poverty in a country. In the case of Uzbekistan this relationship cannot yet be clearly described due to the lack of reliable and valid data on the dynamics, level and character of poverty, as well as data on HIV/AIDS. AS a consequence, to discuss HIV/AIDS and poverty in Uzbekistan, indirect data derived from official statistics have to be used to allow for preliminary judgments on the scope and tendency of poverty and its relationship to HIV/AIDS.

The demographic situation in Uzbekistan is closely related to poverty. High birth rates contribute significantly to poverty in the country. In the 20th century the population of Uzbekistan has increased more than 5 times – from 4.6 million people in 1926 to 23.8 million in 1999. the age structure of the population is young: in 1999, the share of children in the age group below 16 years was 41 per cent of the total population; the working age population (16-60 years) constituted 51 per cent, and for those beyond working age the percentage was 7.5 per cent. Although measures were taken to decrease the birth rate, the current level will remain unchanged for the coming 5-10 years due to the arrival of young cohorts at the age of sexual activity.

The economy of the country is based on agriculture and irrigated farming. The area of the irrigated soil in 2002 decreased to 1800 square meters per person due to the increase of the population and the limited quantity irrigated soil (4.28 million hectares).

Poverty and the search for income has caused increased internal and external migration during the period from 1989 to 1998: approximately 4 million persons left their permanent address and 2,768,000 persons registered at a new address, most of them in country of the CIS. But there has also been a large influx of migrants from CIS countries: in the same period, approximately 2.6 million persons moved to Uzbekistan. About 1.9 million persons moved to other parts of Uzbekistan. These data indicate a high degree of mobility in the population which can have serious implication for the spread of HIV.

During the period of 1990-1999 the percentage of wages in the income of the population was decreasing as well as the purchasing power of the average wage. In 1997 the average wage started to increase, but the level is still far behind the levels of the early 90s.

Mr. Zholdasov called attention to other health indicators like tuberculosis. Annually, 14,000 to 15,000 new cases of TB are registered in the country. Almost 20 per cent of all infected persons are children, and 75 per cent are persons of working age. The numbers of untreated cases has increased from about 37 per cent in 1991 to 42 per cent in 1999. IN 1991 46.1 cases of TB per 100,000 were registered and that figure had increased to 62.1 by the end of 1999.

Data on social problems is extremely scarce in Uzbekistan and is often outdated. Still, the available information may indicate trends. For example, the number of registered rape cases increased from 1.9 per 10,000 women in 1992 to 2.6 cases per 10,000 in 1996. The number of registered drug users increased in specific regions of the country, however, details are not available at this stage. Similarly, there are no estimates on the number of sex workers and men having sex with men.

One the assumption that 75 per cent of the population is able to work, this percentage would have yielded in 1997 a labor force of approximately 8.7 million people, and this figure increased by the year 2001 to about 9.5 million. The excess of manpower creates strong pressure on the labor market and forces millions of people out of the governmental sector of the economy into the private sector. This has led to a sharp decrease in wages and to reduced social security. According to the available labor statistics, in the beginning of 2001, 4.3 million people were registered as wage laborers. This indicates that some 5 million people made their living in the informal sector with no social insurance coverage or any type of legal contract. The number of registered unemployed persons rose by approximately 37 per cent between 1993 and 1997.

It was concluded that if, as widely assumed, there is a relationship between poverty and HIV/AIDS, the available evidence in Uzbekistan indicates that the country is very vulnerable to the epidemic. This seems true even if the evidence is scarce, unreliable and outdated. To avoid a serious epidemic would require, *inter alia*, a poverty reduction strategy specifically addressing poverty issues as related to HIV/AIDS. At this stage, however, policy makers and stakeholders from the private sector have little understanding of the nature of the relationship between poverty and HIV/AIDS and, as a consequence, there is as yet no effective strategy.

The CAPACITY Project
Central Asian Program on AIDS Control and Intervention Targeting Youth and High-Risk Groups
Abt Associates Quarterly Technical Report
1 January – 31 March 2005

ABT ASSOCIATES (ZDRAV-PLUS HEALTH REFORM PROJECT)
Quarterly Technical Report: 1 January – 31 March 2005

I. General Scope of Work/Deliverables Description

Abt Associates is providing technical assistance on policy and financing issues, linking the CAPACITY Project and HIV/AIDS efforts to overall health reform efforts led by Ministries of Health in each country.

II. Current Quarter's Activities / Implementation

Abt participated in the Uzbekistan country assessment as a member of the Country Assessment Team and contributed to the following specific tasks:

- Adapt and finalize the assessment protocols (questionnaires) for Uzbekistan, by organizing pre-testing and revisions based on pre-test feedback;
- Explain the assessment protocols to the members of the Uzbekistan Country Assessment Team;
- Assist with all aspects of preparation for the Country Assessment Meeting;
- Assist the facilitation process of the small group sessions during the Country Assessment Meetings in clarifying the protocols and getting them appropriately filled in;
- Identify gaps in the completed assessment protocols and suggest needed follow-up actions to address any gaps or unclear issues; and
- Assist with writing, editing, and finalization of the assessment report.

In addition to supporting the assessment process in Uzbekistan, Abt provided technical support to CAPACITY's Country Manager in Uzbekistan on an ongoing basis, as and when requested.

III. Next Quarter's Anticipated Activities / Implementation

Abt is specifically responsible for compiling and analyzing the responses of the international agencies/programs in Uzbekistan and taking the lead on writing the report on this, as well as developing a detailed Country Database of the International Agencies/Programs for Uzbekistan, with descriptions of their specific activities/projects on HIV/AIDS. This work will take place in April.

Abt also will participate in the SPMs planned for the weeks of May 2 and May 9 in Almaty.

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Boston University Quarterly Technical Report
1 January – 31 March 2005

BOSTON UNIVERSITY PHARMACEUTICAL ADVISOR
Quarterly Technical Report: 1 January – 31 March 2005

I. General Scope of Work / Deliverables

Technical assistance for activities related to pharmaceuticals in the treatment of HIV/AIDS and AIDS-related illnesses. Technical assistance will be provided, as needed, for a wide range of implementation activities including: policy evaluation for medicines used to treat HIV/AIDS; ARV procurement, financing, product selection, quantification, intellectual property considerations, quality assurance, distribution, and use; coordination of pharmaceutical activities between HIV/AIDS and TB programs; coordination of pharmaceutical activities in HIV/AIDS program and overall health reform projects; creation and/or delivery of necessary training programs; monitoring and evaluation of pharmaceutical activities in HIV/AIDS programs. Deliverables for this quarter include a presentation given at the partner's meeting in January and a baseline assessment tool to evaluate the distribution and use of ARVs in the region.

II. Current Quarter's Activities / Implementation

This quarter's activities included preparation for and attendance at the partner's meeting in January. Other activities include the development of an assessment tool to evaluate the existing system of purchasing, delivering, storing, prescribing, and dispensing ARVs in national HIV/AIDS programs.

III. Next Quarter's Anticipated Activities / Implementation

Next quarter's activities include a trip to the region in May. The purpose of the trip is to attend the partner's meeting in Almaty and provide technical assistance related to ARVs and other medicines used to treat HIV/AIDS and related illnesses. It is expected that the baseline assessments already conducted, combined with visits to the AIDS centers to conduct brief needs assessments, and meetings with government officials will provide sufficient information to draft initial recommendations on specific implementation issues related to ARVs, including drug selection, procurement, quantification, and quality assurance.

The CAPACITY Project
Central Asian Program on AIDS Control and Intervention Targeting Youth and High-Risk Groups
International HIV/AIDS Alliance Quarterly Technical Report
1 January – 31 March 2005

INTERNATIONAL HIV/AIDS ALLIANCE
Quarterly Technical Report: 1 January – 31 March 2005

I. General Scope of Work/Deliverables Description

The International HIV/AIDS Alliance (the Alliance)'s role within the CAPACITY project focuses on strengthening the capacity of local non-governmental organizations (NGO) in Central Asia through:

- Supporting the development of a local NGO support mechanism to be based in one of the Central Asian countries with the aim to strengthen sustainable local capacity for ongoing NGO support provision and programming;
- Working with local partners and stakeholders to identify gaps, needs and priorities in existing and planned technical support provision, and the development of a coordinated plan of targeted support provision to meet those needs regionally;
- Supporting the mobilization of civil society in order to promote more active and united engagement and meaningful representation of the sector in the design and implementation of national and regional responses to the HIV/AIDS epidemic.

II. Current Quarter's Activities / Implementation: 1 January – 31 March 2005

During the start-up phase of project activities, the Alliance put considerable efforts into building and strengthening new and existing partnerships with civil society organizations in Central Asia (CA). As a result, we have been able to engage local civil society in project planning and development from the outset, and have worked in close collaboration with a team of regional experts through the assessment phase of the project start-up.

Recruitment

The recruitment process for the two dedicated Alliance staff members within CAPACITY was initiated in December 2004. The two positions are (1) 'NGO Capacity Building Advisor' - to be based in the CAPACITY regional office in Almaty, and (2) 'In-country NGO Support Coordinator' - to be based at the NGO support mechanism. Following local and international advertising, telephone interviews were conducted with short-listed candidates, followed by face-to-face interviews with Alliance staff in Bishkek in February 2005.

In March 2005, following interviews with Alliance and CAPACITY project representatives, the Alliance was very pleased to make an offer for the position of 'NGO Capacity Building Advisor' to a particularly strong candidate from Uzbekistan – Viktoriya Ashirova. Viktoriya has extensive experience in the field of HIV/AIDS, both as the director of a national Uzbek NGO, and as the programme manager for an international HIV/AIDS programme in Uzbekistan, with extensive experience in the areas of NGO development, focused HIV prevention work with vulnerable communities, direct service provision, training and research. Victoria will be joining the CAPACITY team for the Strategic Planning Meetings in Almaty at the beginning of May, and then in her full-time capacity as NGO Capacity Building Advisor from the beginning of June.

With regard to the position of In-country NGO Support Coordinator, we have not yet been unable to identify an appropriate candidate for this position but will be re-advertising the post following the strategic planning meetings in May.

Capacity Assessment of Central Asian NGOs

The CAPACITY Project
Central Asian Program on AIDS Control and Intervention Targeting Youth and High-Risk Groups
International HIV/AIDS Alliance Quarterly Technical Report
1 January – 31 March 2005

Within the framework of the CAPACITY Project Initial Assessment (Assessment Area II.2. NGO Capacity Building), the Alliance worked together with the Kyrgyz-based Association 'Anti-AIDS' and a group of regional experts from each of the five Central Asian countries, along with project partners JSI and PSI, to develop assessment tools and methodology aimed at assessing the capacity building needs of Central Asian NGOs in key areas fundamental to effective HIV/AIDS work.

This area of assessment (II.2) was carried out as a process separate from the wider country assessment meetings, with the acknowledgement that such an approach would allow for broader coverage of existing organizations, and input from a wider range of AIDS-service civil society organizations, including formally registered NGOs, community-based organizations, and emerging initiative groups formed by key populations vulnerable to the epidemic.

Assessment Process

Given the aim of the assessment, and the particular focus on the potential for meaningful, united engagement of NGOs in the response to the HIV/AIDS epidemic, the Alliance worked with a team of local consultants from Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. All consultants were from AIDS service non-governmental organizations and representatives of communities affected by HIV/AIDS.

The assessment process was constructed in the following manner:

January – February: development of assessment tools, including electronic questionnaires and interview scripts developed in partnership with local experts from the NGO sector and CAPACITY partners, JSI and PSI.

7 - 8 February, Regional Assessment Meeting, Bishkek

Participants: Alliance facilitators, PSI representative and nine regional experts. Andreas Tamberg (CAPACITY CTO, USAID also attended the meeting for several hours.)

Key meeting outcomes:

- Pre-testing and amendment of the assessment tools and methodology with regional experts;
- Agreed understanding of the assessment process (including sampling, survey and interview stages, processing and analysis of data, reporting, key principles and possible challenges);
- Skills-building among the participants on research techniques such as data analysis processes (working with the questionnaires, data entry and data analysis) and interview techniques, through role-play and discussion;
- Clarification of roles within the country teams.

March

Dissemination of the questionnaire to identified civil society organizations working directly on HIV/AIDS issues in five countries. Over 100 questionnaires were completed and returned to the research team:

Country	Disseminated	Received
Kazakhstan	45	24
Kyrgyzstan	58	49
Tajikistan	23	7
Turkmenistan	10	9
Uzbekistan	45	25

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There were some difficulties experienced by local NGOs in terms of completion of the questionnaire - these included the file size of the electronic questionnaire and the need, in some cases, for further clarification regarding specific terminology being encountered for the first time. However, regional consultants were on-hand to support local partners during the process.

It should also be noted that the assessment tools were, in themselves, designed as capacity building instruments and as a process to help NGOs identify both their areas of need in terms of capacity building, and also their existing strengths. This was an approach that was strongly supported by the team of regional consultants.

III. Next Quarter's Anticipated Activities / Implementation: 1 April – 30 June 2005

Recruitment

- Alliance interim staffing: given the slightly delayed appointment of the NGO Capacity Building Advisor and the practical challenges of representation and coordination between the UK-based Alliance team and the CAPACITY team on the ground in Central Asia, an interim staffing proposal was agreed between JSI and the Alliance. Julie Banks, Programme Officer: Eastern Europe and Central Asia (the Alliance) is to join the CAPACITY team in Almaty for a period of 1.5 – 2 months in April/ May as the Alliance's representative within the team;
- May: re-advertisement of In-country Support Coordinator position;
- June: Viktoriya Ashirova, NGO Support Advisor, to join the CAPACITY regional office in Almaty.

Capacity Assessment of Central Asian NGOs

- Analysis of questionnaire data;
- Follow up face-to-face and telephone interviews with a selected sample of NGOs in each country, with the aim to explore more complex areas such as networking and partnerships, advocacy, community representation and mobilisation in more depth;
- Analysis of assessment data and preparation of country reports;

The results of the assessment will be used to:

- Feed into the CAPACITY project strategic planning process;
- Better identify the capacity building needs of local NGOs and to better coordinate the activities of the various organisations providing financial and technical support to local organisations working on HIV/AIDS in Central Asia;
- Identify gaps in current and planned technical support provision and develop a detailed work plan for the provision of support necessary to fill those gaps;
- Develop a well-coordinated plan of activities that should increase NGO networking potential and lead to more united and active engagement of the civil society in the design and implementation of responses to HIV epidemic at various levels.

Assessment of an NGO Support Mechanism

Process and criteria for short-listing an NGO Support Mechanism

The main aim of the short-listing process is to identify one NGO who can potentially take on the role of an NGO Support Mechanism (NSM). The Alliance recognizes that certain contextual issues need to be taken into consideration when formulating the exact nature of the NSM. Therefore, the Alliance will work together with the selected NGO to identify the technical support and required funding necessary to perform the NGO support functions, and to ensure that these functions are appropriate to the local NGO and donor environment and context.

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- Initial short-listing will be undertaken in April through a desk review of compiled information about existing NGOs, set against developed criteria;
- Short-listed NGOs will be sent a brief electronic survey containing background information about the assessment process, the CAPACITY project and the intermediary support model, in addition to an expression of interest and a series of assessment questions;
- NGO responses will be verified through references obtained from international organizations and donors active in the HIV/AIDS field in the region;
- Final short-listed candidates will be contacted in May;
- Once an NGO is selected, the Alliance will work together with this NGO to:
 - (a) Identify the most appropriate structure and functions taking into consideration context, needs, and budget parameters;
 - (b) Identify the technical support needs of the NSM;
 - (c) Provide support to the NSM to engage with donors and international NGOs to make use of this emerging mechanism as a local intermediary in their capacity building and HIV/AIDS prevention programs.

Regional Initiatives

The Alliance has been approached by a number of partners in the region with regard to taking supporting and forward certain regional NGO initiatives:

- Supporting the mobilization of civil society in order to promote more active and united engagement and meaningful representation of the sector in the design and implementation of national and regional responses to the HIV/AIDS epidemic;
- Provision of technical support to local civil society in exploring funding opportunities and the development of national and regional proposals to bridge current funding gaps;
- Strengthening partnership, collaboration and understanding between civil society and the governmental sector in national and regional responses to the HIV/AIDS epidemic.

The CAPACITY Project
Central Asian Program on AIDS Control and Intervention Targeting Youth and High-Risk Groups
Population Services International Quarterly Technical Report

POPULATION SERVICES INTERNATIONAL (PSI)
Quarterly Technical Report: 1 January – 31 March 2005

I. Quarterly Report – Sales

Total Distribution/Country	Kazakhstan	Kyrgyzstan	Uzbekistan	Tajikistan
Distribution by Sales				
Traditional Outlets/FMCGs	66 900	9 000	6 000	12 450
HRZ Sales- NTO	12 066	37 227	0	14 535
Sales Total	78 966	46 227	6 000	26 985
Free Distribution	2 418	240	390	165
Grand Total for the Month	81 384	46 467	6 390	27 150

Total Central Asian condom sales for the month: **161,391** (including free distribution).

II. Quarterly Report – Target Populations Reached

Regional:

- Capacity is official in assessment phase while PSI is implementing on a limited basis (peer education, outreach, and sales).

Kazakhstan:

- Capacity- Peer Education and Outreach staff reached 1,533 Youth in 118 trainings and 36 IDUs in 4 trainings. 891 Sex Workers were reached in 32 Field Visits with 122 mini-sessions and 51 in 8 trainings.

Tajikistan:

- Capacity- Peer Education and Outreach staff reached 1,241 Youth in 310 sessions and 466 youth participated in 12 special events. 21 IDUs and 95 SWs were also trained.
- Some employee turnover for multiple reasons (relocation, illness, dismissal, better position with another NGO).

Uzbekistan:

- Capacity-Peer Education and Outreach staff conducted 74 education sessions for 240 youth and held one edutainment event for 1,500 youth. 150 SWs were reached in field visits, 2 TOTs for 47 SWs, and 69 apartment mini-sessions were held for 112 sex workers.

Kyrgyzstan:

- Capacity- 14 PSI peer educators conducted 224 PE sessions targeting 670 youth, providing 2760 session hours of education. 1 TOT was conducted for 19 youth.
- At the end of March, former subcontractor Tais Plus requested that PSI finance the continuation of the previous project supported by PSI for PSI's Kyrgyz SW portfolio of Capacity.
- Political demonstrations in March throughout the country have led to clashes between pro-government and opposition forces. Things have since settled somewhat and operations reopened in April.
- 2 new sales reps are being trained.