

Harm Reduction  
Association of Kyrgyzstan  
“Partners’ network”

**Pointing the Way:  
Harm Reduction  
in Kyrgyz Republic**

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Interviewees included clients and staff of harm reduction and drug rehabilitation programs in Bishkek, Osh, Jalalabad, and Tokmok<sup>1</sup>, as well as representatives of international agencies and officials in the Ministry of Justice, Ministry of Internal Affairs, and the Drug Control Agency of the Kyrgyz Republic. Key respondents included:

- Raushan Abdildaeva, Department for Penitentiary System Reform, Ministry of Justice of the Kyrgyz Republic and Director, Interdemilge NGO (Bishkek)
- Talaai Abduraimov, Project Manager, Podruga NGO (Osh)
- Altynay Arstanbekova, Head of Licit Drug Control and Demand Reduction Service, Drug Control Agency of the Kyrgyz Republic
- Tynchtykbek Asanov, Chief Narcologist of the Ministry of Health, and Director, Republican Narcological Center (Bishkek)
- Larisa Bashmakova, Team Leader, DFID Central Asia Regional HIV/AIDS Programme
- Mamasobyr Burkhanov, Director, Osh Narcology Dispensary and Chief Narcologist, Osh
- Rano Burkhanova, Project Director, Parents Against Drugs (Osh)

- Batma Estebesova, Director, Sotsium NGO (Bishkek)
- Vladimir Chudaikin, Chief Narcologist Chui Oblast and Director, Ayan Delta NGO (Tokmok)
- Colonel Victor Donchenko, Chief, Penal Colony #3 (Bishkek)
- Mukhtarbek Madybaev, First Deputy Director, Drug Control Agency of the Kyrgyz Republic
- Elvira Muratalieva, Public Health Programs Coordinator, Soros Foundation Kyrgyzstan
- Vladimir Nosov, Head of Main Department of Penalty Execution, Ministry of Justice of Kyrgyz Republic
- Ainagul Osmonova, Deputy Director General, Kyrgyz National AIDS Center of Kyrgyz Republic
- Nurlan Shonkorov, Project Coordinator, Kozkarash NGO (Bishkek)
- Colonel Rasulberdy Raimberdiyev, First Deputy Minister, Ministry of Internal Affairs of Kyrgyz Republic
- Natalya Shumskaya, Director, Podruga NGO (Osh)
- Medet Tiulegenov, Executive Director, Soros Foundation Kyrgyzstan
- Boris Shapiro, Director General, National AIDS Center of Kyrgyz Republic and Principal Recipient, Global Fund

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## INTRODUCTION

Best practices are more complicated than they appear. Documents heralding strong approaches to HIV prevention often assume that time stands still, ignoring changes that transform yesterday's innovation into today's inadequacy. As late as 2004, for example, Thailand was being saluted for the 100% Condom Programme that had helped to lower HIV rates among sex workers in the mid-1990s. Meanwhile, the country was failing to introduce programs to address infections among drug users who made up a rapidly growing share of HIV cases in the new millennium.

The search for a “magic formula” suitable for export can also obscure important social and political contexts. In Brazil, rightly saluted for its commitment to providing free HIV treatment for all in need, the AIDS program owes as much to concepts of solidarity that emerged from political organizing against the military government in the 1980s as to a particular commitment to HIV prevention. Some Brazilian AIDS experts speak of the “Brazil experience” rather than the “Brazilian model,” reminding observers that replication may not be possible in countries with different political traditions, laws, or structures of civil society.

Nonetheless, identifying the process by which countries mount exceptional responses to the threat of HIV/AIDS is both important and instructive. Policies and practices that reduce drug-related harms, a relative rarity in the growing number of resource-poor countries facing HIV epidemics driven by injection drug use, are particularly important. Indeed, the overwhelming impact of injection drug use on HIV epidemics in Asia and the former Soviet Union since the mid-1990s suggests that policy on illicit drugs is

critical to the course of the global epidemic. By 2003, an estimated one in three new HIV infections outside of Africa came from a contaminated needle. Injectable drugs and HIV are among those “goods” moving with increasing rapidity across the newly opened borders and into the trade zones characteristic of post cold war economies. Yet in many countries of Asia and the former Soviet Union, the public health approaches proven to reduce HIV and other injection drug-related harms - including syringe exchange, methadone maintenance therapy, and overdose prevention - remain eclipsed by a law enforcement model that relies primarily on mass incarceration or institutionalization in coercive treatment settings. Many governments persist in treating drug users like drugs: as something to be controlled and contained. Paradoxically, HIV infections are often accelerated by this approach.

This paper considers an exemplary counterexample. Like all countries in the former Soviet Union, the Kyrgyz Republic experienced severe economic dislocation after the collapse of the Soviet Union. Like all countries in Central Asia, Kyrgyzstan became a transit point for heroin moving from Afghanistan to markets in Russia, Eastern Europe and the West. As in other former Soviet Republics, when drug trafficking began in Kyrgyzstan, injection drug use and HIV infection soon followed. Considered the last HIV free country by the World Health Organization in 1995, Kyrgyzstan saw the first cases of HIV diagnosed among Kyrgyz citizens in 1996 and a nearly tenfold increase in HIV cases between 2000 and 2001.<sup>2</sup> Then, as now, more than 80% of all cases were among injecting drug users (IDUs).

Unlike many countries in the former Soviet Union, Kyrgyzstan has responded with an aggressive plan to reduce HIV infections and other harms associated with drug use, including measures to protect the health of those unable or unwilling to stop injecting drugs.



- Since 1999, syringe exchange programs operate in the two largest cities in Kyrgyzstan, Bishkek and Osh. Sterile syringe programs also operate in Tokmok, some sixty kilometers outside of Bishkek, and in Jalalabad city. These programs were begun with the approval of government ministries, including the Ministry of Health and the Ministry of Internal Affairs, and with financial support by Soros Foundation Kyrgyzstan and the United Nations Development Programme (UNDP).
- In 2000, Kyrgyzstan became the only country in Central Asia, and the only country besides Moldova and Belarus in the Commonwealth of Independent States (CIS), to establish syringe exchange program in prisons. These programs were begun with the support of the Ministry of Justice and funding from Soros Foundation Kyrgyzstan, and are now being expanded to every prison colony in the country. The ministry has also committed to implementation of methadone maintenance in prison.
- In 2002, Kyrgyzstan became the only country in the CIS to offer ongoing methadone maintenance treatment (MMT) to opiate addicts. While Azerbaijan and Moldova now offer limited methadone maintenance, Kyrgyzstan's MMT programs—supported by funding from Soros Foundation Kyrgyzstan and UNDP, and scheduled for expansion through a grant from the Global Fund to Fight AIDS, TB and Malaria—continue to be the largest and most comprehensive in the CIS.
- In 2003, rehabilitation centers for drug users opened in Jalalabad, Osh, and Bishkek. While these are by

definition drug-free, they maintain strong ties to and share staff with harm reduction projects, allowing patients who relapse into drug use to remain engaged in ongoing HIV prevention efforts.

Efforts are too new, and too small, to yield definitive results in HIV incidence. Nor have harm reduction programs achieved anything approaching national scale or sufficient coverage. Syringe exchange programs reach only 6% of the estimated 54,000 injection drug users in the country.<sup>3</sup> Fewer than two hundred people receive methadone maintenance treatment in Kyrgyzstan, and rehabilitation centers have yet to conduct any kind of evaluation of their early efforts. As described in the pages that follow, however, preliminary research suggests that participants in syringe exchange programs experience sharply lower rates of needle sharing, overdose and other medical complications than other IDUs. Early evaluations of methadone are similarly encouraging, showing decreases in crime, increased success in finding employment, and reports of greatly enhanced family life.

Whether Kyrgyzstan's promising start can be broadened to anything approaching national scale is an open question. It is clear, however, that among the countries of the former Soviet Union, Kyrgyzstan remains uniquely positioned to stem an explosion of HIV. Indeed, in terms of political will and sustained support, Kyrgyzstan has already defined a "best process," one that has successfully included engagement of international organizations, involvement of national and local government, and collaboration between programs to provide integrated and cutting edge services to drug users. This paper seeks to offer some insights as to why and how.

## **BEST PRACTICES I: MOBILIZATION ACROSS THE GOVERNMENT SPECTRUM**

*What resistance did we face? One's own resistance can be very difficult to overcome. I was trained in the Soviet tradition of the sanitary system. In the Soviet approach, you focused on the individual primarily to maintain the health of society. You worked with old methods of epidemiology. You commanded that patients be tested, you demanded answers: "where have you been, with whom have you been, when?" With HIV, we understood other methods were needed. We asked for cooperation. "Could you help us to understand where you were? What were you doing?"*

**Boris Shapiro, Director General, National AIDS Center of Kyrgyz Republic**

*People say the international funders will help us for three years and we won't get anything after. I say, 'let it be three years and then let's see. Patients won't get hurt and there will be more people living in peace and safety.'*

**Altynay Arstanbekova, director of licit drug control, State Drug Control Agency of the Republic of Kyrgyzstan**

*"The problem of drug use is a national problem of national scale. Instead of asking if this is a government or non-governmental effort, why not do the work together for the benefit of the people?"*

**Colonel Rasulberdy Raimberdiev, First Deputy Minister, Ministry of Internal Affairs of Kyrgyz Republic**

Multisectoral response has become a standard of AIDS jargon, a phrase - like "capacity building" and "technical assistance"

- that has less and less meaning the more frequently it is repeated at conferences and in applications for international aid. In Kyrgyzstan, though, the number of government and non-governmental actors who claim a central role in the development of harm reduction suggests that support across the political spectrum is a reality rather than a platitude. Even police at the State Drug Control Agency and officials at the Ministry of Justice, while emphasizing eradication of drug use as a long-term goal, emphasize that drug users should be regarded as patients rather than criminals and use the language of harm reduction to assert that reduction of HIV and other ills associated with drugs must be a priority now.

While not specific to harm reduction, various theories have been advanced to explain why Kyrgyzstan's government has been generally receptive to international assistance, NGO participation, and local political expression than other Central Asian Republics. Sociologists suggest that the high percentage of Kyrgyzstan's population that was nomadic, rather than settled and agricultural, strengthened traditions of local authority. Unlike Kazakhstan, which also had a significant percentage of nomads, Kyrgyzstan was the last of the Central Asian Republics to be Sovietized, and never experienced pervasive institutionalization of a Russian bureaucratic elite. Kyrgyzstan is the only country among the Central Asian Republics whose president was not part of the Communist leadership in Soviet times. In contrast to a country like Uzbekistan, whose leader emphasizes a single national identity and political authority resting in the capital, political "self-concept" in Kyrgyzstan has tended toward pluralism and local control.

### **Acknowledgement of Need**

Government officials interviewed for this project, however, attribute their openness to a simpler cause: need. Economists

analyzing the rebound of Asian economies in the 1990s, and concurrent economic difficulties in Mexico and Nigeria, have noted the paradox that countries that are poorest in natural resources are those whose economies adapted most successfully to the global marketplace. The Kyrgyzstan case suggests that in HIV programs and policy, too, recognition of lack of resources has proved critical to effective response.

- The collapse of the Soviet economy depressed economic activity, with GDP in Kyrgyzstan sinking lower than in any Central Asian Republic except civil-war torn Tajikistan.<sup>4</sup>
- In 1996, GDP in Kyrgyzstan was only 54% what it had been before independence. By 1999, the year the first syringe exchange programs began, GDP was still at only 63% of its 1989 level.<sup>5</sup>

### **Active Solicitation of Foreign Assistance**

In many Newly Independent States, economic collapse was synonymous with abandonment of state support for social programs. While the amount the Kyrgyz government spent on social services plunged by nearly half between 1991 and 2000<sup>6</sup>, officials turned to foreign loan packages and assistance to help make up the difference.

- By the end of 1996, foreign assistance helped the Kyrgyz Republic devote a higher percentage of GDP on social programs than in all other Central Asian Republics except for far wealthier Uzbekistan.<sup>7</sup>
- In 1996, the Ministry of Health worked with local government and international experts to initiate a national health care reform strategy that included mandatory health insurance for all employees.<sup>8</sup>

- Foreign support for harm reduction efforts, from Soros Foundation Kyrgyzstan and UNAIDS/UNDP, began in 1998. Other donors, including the UK's Department for International Development (DFID), the UN Office of Drugs and Crime (UNODC), the US Agency for International Development (USAID), and Medicines Sans Frontières have provided additional support for drug demand reduction and HIV prevention among drug-using populations.

That harm reduction has been supported by international donors is not remarkable. Russia, for example, continues to rely almost entirely on foreign funding for HIV prevention, allocating only \$4 million of national funds to HIV programs of any kind, and almost none to harm reduction, in 2003. More extraordinary is that Kyrgyz officials from the Ministry of Internal Affairs, the State Drug Control Agency, and the Ministry of Justice routinely cite partnership with international experts as a goal to be aspired to rather than an inconvenience to be tolerated.

### **Study tours to ascertain new approaches**

Openness to international assistance has included consideration of new approaches to HIV prevention for injection drug users (IDUs). Government and NGO representatives alike cite study visits abroad, usually funded by international donors, as turning points in their understanding of harm reduction and the need to implement new interventions.

- Boris Shapiro director of Kyrgyzstan's National AIDS Center, traveled to Amsterdam with UNDP to see needle exchange, and helped begin syringe exchange in the Republican AIDS Centre in Osh oblast shortly thereafter.

- Rasulberdy Raimberdiyev, the former Police Chief of Osh and now the Deputy Minister of Internal Affairs, was part of a delegation of law enforcement officials that visited MONAR, a program offering methadone, needle exchange, and drug-free treatment in Poland. Impressed by drug user compliance with treatment models, he recognized that approaches other than incarceration were viable.
- Tynchtykbek Asanov, chief narcologist of the Republic of Kyrgyzstan, visited MONAR as part of a study group of narcologists [physicians specializing in the treatment of alcoholism and drug addiction], and returned to Central Asia willing to experiment with drug treatment models that allowed patients greater autonomy.
- Vladimir Nosov, Head of Main Department of Penalty Execution, Ministry of Justice of Kyrgyz Republic, visited English programs that provided methadone to prisoners: this service, though not yet available in Kyrgyzstan, is planned.

**Embrace of non-governmental organization (NGO) participation**

Kyrgyzstan established a national committee to coordinate international support and local government response to HIV and sexually transmitted diseases in 1997, the first year that HIV cases were found among Kyrgyz citizens.<sup>9</sup> While obstacles to NGO participation remain substantial—virtually no NGO in Kyrgyzstan is capable of funding HIV prevention programs without international support, and many lack ability to provide legal protections to their clients (see Section III, Syringe Exchange, and Section V, Methadone Maintenance) - NGOs are acknowledged as a critical and important part of the fight against HIV.

- Chaired by the vice Prime Minister, the multisectoral committee on HIV/AIDS expanded in 2001 to include NGOs and representatives of the international AIDS prevention program.
- NGO participants in HIV prevention efforts are not limited to the state-sponsored and state-controlled organizations (“pocket NGOs” or “quasigovernmental organizations”) familiar from many CIS countries. Rather, Kyrgyzstan’s NGO participants include independently funded organizations with strong ties to the communities they serve and a commitment to advocacy for government reform.

***Fluid movement of staff between government and non-governmental sectors.***

Movement of staff between organizations has literalized the notion of multisectoral collaboration. Shared histories and experiences appear to have made cooperation between sectors more likely, helping NGOs, government service providers and political officials understand how best to work with their partners.

- Batma Estebesova, the head of Sotsium, the largest NGO providing harm reduction services in Bishkek, was formerly the deputy of the city’s narcology centre.
- Larisa Bashmakova, former policy adviser to UNDP and a key player in the development of harm reduction programs in the Republic, was formerly the deputy of the Republican AIDS Centre, and is now team leader for DFID’s Central Asia Regional HIV/AIDS programme.
- The current head of the National AIDS Center, Boris Shapiro, was formerly deputy minister in the Ministry of Health.



- The governor of Osh oblast, Naken Kasiyev-who has allocated funds from his own budget for needle exchange, and has been a supporter of methadone maintenance-was formerly Minister of Health.

### **Revision of old models of narcology**

Under the Soviet System, narcologists were closely tied to the state security apparatus through association with the Ministry of Internal Affairs. Drug users were forcibly tested for drugs by police order, registered on lists that narcologists shared with police, forced into treatment and then required to report back to narcology clinics or subjected to regular home visits for evaluation. Treatment was synonymous with control. Kyrgyzstan's success in advancing harm reduction returns in part to government willingness to reconsider old models of narcology, including:

- **Passage of a 1998 law that recognized that drug users are patients, not criminals.** While possession of even small amount of drugs still carries unduly harsh criminal penalties, being a drug user per se is no longer illegal in Kyrgyzstan.<sup>10</sup>
- **Modification of protocols to sever ties between narcological doctors and police surveillance.** Although registration of drug users brought for treatment by the police is still mandatory, narcologists no longer routinely share names of voluntary patients with the police or participate in ongoing surveillance of drug users who pass through narcology centres for treatment.

### **Action in advance of complete agreement**

The fact that harm reduction has moved forward rapidly in Kyrgyzstan does not mean there is consensus about why the approach is valuable. Ministry of Internal Affairs officials

returned from Poland impressed with methadone's ability to exert social control over drug users, requiring them to make daily clinic visits and decreasing thefts and other crimes associated with illegal drug use. Narcologists visiting the same program were impressed by the fact that drug treatment providers regarded their patients as partners. Ministry of Justice commitment to methadone in prisons is still met with skepticism by some in the Ministry of Internal Affairs. Some harm reduction programs express discomfort with the idea of having active drug users mix with those seeking to abstain, while others conduct needle exchange and 12-step meetings at the same site and are committed to including active drug users among their volunteers.

The essential point, however, is that government officials, NGOs, and international donors have focused less on differences than on the common ground that has allowed them to proceed to program implementation.

- Pilot programs have become larger efforts without extended debate or delay.
- National and local government officials have advocated for support of harm reduction, facilitated delivery of goods and services to harm reduction programs, and made buildings available to them for free.
- Government officials have begun to contribute money to harm reduction. These grants, though small, are of great symbolic importance in a region where most governments leave harm reduction funding to foreign entities if they permit it at all.
  - o In 2003, Osh oblast contributed funds to harm reduction efforts.
  - o Bishkek city pledged funds toward to the purchase of syringes in 2004.



**Voices from the Front**

**Overcoming Government Opposition and Donor  
Discoordination**

Elvira Muralieva, Soros Foundation-Kyrgyzstan

**“It was the first time we had  
cooperated like this”**

*1998 was the year for the introduction of harm reduction in the country, for donor organizations and government officials. Kasia Malinowska, from Open Society Institute in New York, was here several times. The Ministry of Health was fine, the idea was acceptable, and everything seemed possible. The problem was with the Ministry of Internal affairs. There were no legal restrictions*

*against harm reduction, but at the same time it wasn't legal. If we worked with harm reduction without legal support, there would be some misunderstandings from the police side. When Malinowska visited the Ministry of Internal Affairs the first time, the deputy minister told her, "you can start harm reduction, but we will not give any official document that this is a recognized program, and my police will run after drug users and catch them. If they find them with a dose of drugs, even if it's only in the syringe, they will be caught." That was needle exchange. As for methadone, he said "It will never come into the country. If you, as Soros staff, start with the methadone, I will put you in prison." It was incredible, impossible for us in Kyrgyzstan, where we were fighting so hard against drugs, to allow methadone to come in.*

*We started first with the needle exchange project in cooperation with UNDP. There was not just a simple announcement of funding for this program, since it was new and difficult to understand for government organizations and for non-government organizations. We met with Batma Estebesova of the narcological center in Bishkek. She was the deputy of that program and at the same time she had been running Alcoholics Anonymous programs for four or five years. We approached the chief narcologist, Burkhanov, from Osh. We put them together to help write some terms, and integrated what they wrote into one big request for proposals funded by UNDP on one side and Soros on the other.*

*It was the first time we had cooperated like this. We didn't know how to do it. There was a suggestion from UNDP to make a cost sharing arrangement, and we gave our money to them. The difficulty was that we, as Soros Foundation, had rules that necessitated monitoring, financial and administrative, every three months. UNDP was surprised. "You will monitor us? It's impossible. We will do a report at the end of the project." But this was \$35,000. We couldn't go a year without monitoring. They said, "OK, we will do financial management every three months, but your staff will not oversee us." So we compromised.*

*It wasn't easy. We felt ourselves as a donor and UNDP as recipient organization. They felt themselves also as a donor that was giving money for the project. Their HIV Prevention director at that time said, "Hey, why do you buy so many needles and syringes? Let's reduce their number and buy some HIV tests." We said, "Sorry, that's not harm reduction. You can test, but with UNDP money." He said, "Perhaps we can reduce money for the publishing. We can make some copies on the copy machine, and it's enough." We said "No, it should be very attractive information, so we can attract clients."*

*From the UNDP side, they found our selection process too complicated. They do selection of grantees themselves, without publishing announcements to solicit proposals. For this project, we also required, for the first time, a Letter of Intent from potential grantees. Because even the idea of harm reduction wasn't clear for people. After that letter, we did a training-what is harm reduction, and what kinds of things you could do-to give potential grantees an opportunity to write a strong proposal. For UNDP, it was like "how much money are you going to spend for this announcement, for the training?" In the end we were all happy that we found exactly the right organizations. Later, when we started to work to expand the project beyond Bishkek and Osh, our first grantees disseminated their knowledge and experience to the new programs very openly.*

*That was the first year. At the same time, we needed to start working with the police. They were following our outreach workers going to the yamas (places where drugs are bought, sold, and sometimes used), catching the drug users, and making tests even of used syringes. If they found even a drop of heroin, they would throw them in prison. Our lawyers worked hard on the project, and we worked closely with Open Society Institute in New York, who had the idea of taking key persons from the Ministry of Internal Affairs and sending them to the same place in Poland where we had sent our project leaders for training. The Deputy Minister of Internal Affairs went, along with the head of Osh police, and high police officials from Bishkek. I think there were five. We'd made*

*presentations to them on harm reduction many times, but those were just words. When they saw with their own eyes how it worked, it was very useful. They were changed after that. Of course we didn't leave them alone-when they came back, we said, "So, let's do the training for policemen in the rural areas." They gave us one or two days, and gathered everyone by special order. And we saw the number of drug users being caught in the prison start to go down, and the police stopped following our outreach workers in the same way. The current Deputy Minister of Internal Affairs, when he was Police Chief in Osh, we asked him to come to the training and say hello to the policemen and tell them about what he had seen regarding harm reduction. When he said, "this is a good program, it's working well in Poland," for all the other policemen in the room his word was enough. Fifteen minutes of his words were more than when we were talking for two or three hours.*

*We still have work to do. But today, five years since we started, our projects have become models for others interested in methadone substitution therapy or needle exchange, including needle exchange in prisons. Our experience and trainings help not only local NGOs starting work in the field, but governmental and nongovernmental organizations from countries including Uzbekistan, Kazakhstan, Tajikistan and even China.*

## **BEST PRACTICES II: DONOR COORDINATION**

Funding for many harm reduction initiatives in Kyrgyzstan began as the result of a partnership between the Soros Foundation Kyrgyzstan and the United Nations Development Program. The joint effort, which involved reconfiguration of administrative requirements for both organizations, allowed for coordination of funding and administration, as well as for the articulation of new standards for applicants. Among them:

### **Grant process as community training**

The jointly funded harm reduction effort used more stringent criteria than either donor had used previously, making the grant application process serve as both education and community mobilization effort.

- Applicants initially produced letters of interest on the basis of the most promising of these, NGOs were trained in basics of harm reduction and program design in advance of their application for funding.
- Each stage of the process was highly competitive: Of 19 organizations applying, about a third progressed to the training stage, and fewer than half of these were funded in the initial round.

### **Ongoing planning to avoid duplication**

Soros and UNDP ended joint funding efforts in 2000, but not their collaborative approach.

- To start methadone pilot programs, UNDP focused funding on Osh, while Soros Foundation directed funding to Bishkek.
- Both organizations were active in the preparation of the application for funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria, which pledged Kyrgyzstan \$17 million over five years beginning in 2003.
- When delays in disbursement of Global Fund monies threatened disruption of HIV prevention for IDUs in early 2004, Soros Foundation Kyrgyzstan and UNDP again divided resources strategically to provide emergency coverage.



## **BEST PRACTICES III: SYRINGE AND NEEDLE EXCHANGE**

*People ask me, “how do you have the name Parents Against Drugs and participate in needle exchange” When I started working with the program, parents were asking me if I, as a doctor, could give their children pills to make them die peacefully. I didn’t know then what I know now, which is that drug users can get better.*

Rano Burkhanova, Parents Against Drugs NGO, Osh

*We chose honest outreach workers, social workers, but they weren’t connected to the people who needed them. We had some drug users, but they sold the syringes, so we had to say goodbye. We began to work with people who had what you might call social dependency-family members of drug users, relatives who had links to the people who most needed help, and that was successful.*

Vladimir Chudaikin, Ayan Delta NGO, Tokmok

Harm reduction efforts in Asia and the former Soviet Union often suffer one of two deaths: *death by pilot program*, where programs are kept small and on an experimental basis long after the approach has been shown effective; and *death by assimilation*, where governments incorporate harm reduction approaches but remove the flexibility and community responsiveness that make them work in the first place. Kyrgyzstan’s syringe exchange programs have avoided both fates, growing steadily yet changing their service models as the twin epidemics of HIV and drug use have themselves changed in the country.

In 1999, with funds from Soros Foundation Kyrgyzstan and UNDP/UNAIDS, syringe exchange programs opened in Bishkek and Osh. Program capacity in Bishkek was 300 for the first year,

though 618 clients were seeking services by year's end. In Osh, the program distributed more than 99,000 needles in the first nine months of 2001.

By 2004, more than 3,200 drug users in Kyrgyzstan were exchanging needles at locations as varied as the Osh Regional AIDS Prevention Center, the Oktobersky "sleeping region" in Bishkek, yamas in Jalalabad, a "trust point" in Tokmok as well as with outreach workers fanned out in neighborhoods where drug use was common. In addition to establishing "trust points" and mobile outreach for syringe exchange, harm reduction programs routinely included training to help drug users avoid overdose or prevent it from being fatal, information on sexual transmission and prevention of HIV, condom distribution, and referrals to doctors who would treat abscesses and other complications without reporting drug users to the police.

### **Local variation to meet local realities**

Syringe exchange programs in Kyrgyzstan do not not simply import models from outside, or function as jobs programs where workers with little stake in drug use issues repeat interventions, at the same times, each day. Rather, programs in Kyrgyzstan adapted international models to existing human and social resources.

- In Osh, where tightly knit communities make anonymous clinic visits difficult, outreach workers from Parents Against Drugs live in the communities in which they work, bringing syringes to people's homes or offering needle exchange and harm reduction education out of their own homes. When police followed outreach workers, confiscating their supplies, and rounding up anyone in possession of a syringe for forced drug testing, staff-including family members of drug users-engaged local law enforcement

and community leaders in trainings about harm reduction and its goals, and worked with local mass media. Harassment and arrests decreased.

- Podruga, an Osh NGO serving sex workers, draws some of its outreach workers from residents of the dormitory-style hostels built for the cotton factories. Though the factories are closed, female residents of the hostels remain, and many have turned to sex work for survival. Close to borders in Uzbekistan, China, and Tajikistan, Osh is also a commercial center for truckers who wait for weeks to deliver or acquire cargo. Recognizing that HIV prevention necessarily involved not only sex workers but the men who hired them, Podruga began outreach both with truck drivers and with taxi drivers who often take sex workers to the men who hire them.
- In Jalalabad, where the hospital routinely informed police when drug users arrived for treatment, friends and relatives allowed users to risk death rather than calling the ambulance after an overdose. Other times, since drug users could not pay extra, ambulances would simply refuse to come. The harm reduction trained drug users in overdose prevention techniques, and hired a former ambulance driver to work for them.
- In Bishkek, outreach workers use the bustle of the city as protection for their clients. Exchanges are possible both at the organization's fixed "trust points," and at satellite exchanges located within city clinics where drug users can slip in unnoticed with other patients. Because the organization covers an area that stretches for 150 KM, Sotsium divides the city into zones served by outreach workers, many of whom live in

the neighborhoods in which they work, and offers mobile exchange by car.

- In Tokmok, where family networks are tight and anonymity difficult, stationary needle exchange proved unable to reach drug users effectively. A mobile needle exchange has greatly improved the project's reach. Outreach workers include a veiled woman educated at a madraasah (religious school), and the relative of a Chechen mafia leader.

### **Combinations of services, in close proximity**

Syringe exchange, abstinence-based drug treatment, autonomous twelve-step networks, and methadone maintenance programs are often independent and mutually exclusive in the U.S. and Western Europe. In Kyrgyzstan, by contrast, programs are closely allied, offering drug users a range of choices no matter where they are in their drug using “careers.”

- Sotsium, a Bishkek NGO, runs twelve-step groups such as Alcoholics Anonymous, Drug Users Anonymous and Al-Anon (for family members) in the same compound of offices where it exchanges needles. Sotsium's office is only steps away from the city methadone dispensary, and several methadone clients work as needle exchange volunteers.
- Parents Against Drugs, the NGO serving the largest number of HIV-positive clients in Osh, includes an on-site clinic staffed by nurses, and works closely with the methadone dispensary to identify clients who might be eligible for methadone maintenance. Staff also maintain close ties with a new rehabilitation center offering drug-free treatment.

- The Osh NGO Podruga offers immediate treatment of sexually transmitted diseases outside of the forced-testing, forced treatment system imposed on sex workers by the police. Using WHO’s syndromic treatment model (treatment in the presence of symptoms when lab tests are not readily available), Podruga arranges for visits to venereologists and gynecologists who offer free services, without registering women’s names with the authorities.
- In Jalalabad, the harm reduction organization shares office space and staff with the drug-free rehabilitation center. The collaboration means that street outreach workers can help those who want to enter treatment to do so, but also that those who drop out or return to drug use are not lost to HIV prevention or ongoing support. The narcologist who works in the rehabilitation center also works downstairs in the city detoxification ward.

**Rolling assessment: changing with the needs of drug users**

Harm reduction urges that programs “meet drug users where they are.” Kyrgyzstan’s syringe exchange programs have done this literally-sending outreach workers into the streets-but also by conducting ongoing research to reshape their services as drug use patterns or political realities change. Many organizations conduct their own surveys or work with outside researchers to ascertain program effectiveness and changes in drug users’ needs that necessitate changes in service.

***Availability of different kinds of needles***

- At the start of 2000, 70-80% of IDUs in Bishkek used hanka, a homemade preparation of juice from opium

straw usually prepared in collective containers and shared. By the end of the year, only 26% of users reported hanka use, while 76% reported use of heroin. Noting the change, Sotsium began to distribute multiple varieties of needles and syringes: larger ones for hanka preparation and administration, and smaller gauges for heroin injection.

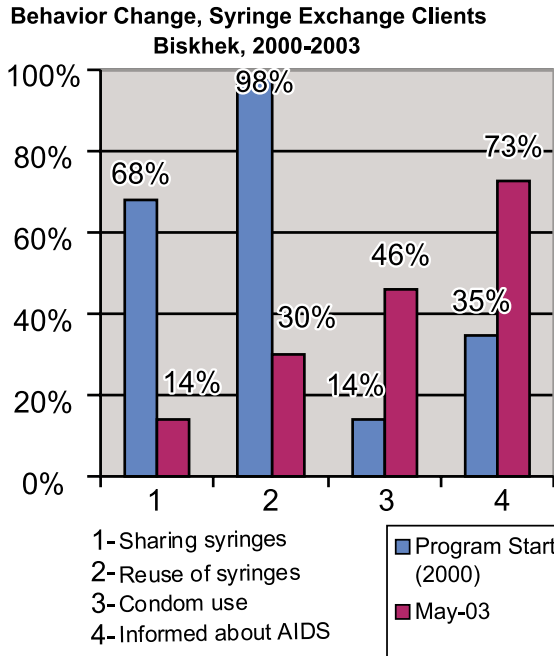
### *Variety of venues for syringe exchange*

- In Osh, drug-using sex workers bear a double stigma, hiding their heroin use even from other “working girls.” The NGO Podruga surveyed sex workers about where they would feel comfortable exchanging needles, and when responses indicated the need for exchange away from areas where they worked (at friend’s houses and in parks, for example), the organization began exchange in these locations.

### *Flexible hours*

Clinics that operate when it is convenient for the staff may miss the majority of drug users, whose use is not timed around usual working hours.

- Outreach workers for Parents Against Drugs in Osh frequently exchange needles from their homes. One resident of a mahalla (traditional neighborhood) maintains a box outside his house for middle of the night exchange, and has told clients that he is available at any hour.
- Sotsium operates a 24 hour hotline staffed by psychologists, narcologists, peer educators and social workers who volunteer time weekly to ensure complete coverage. Advice includes counseling on stopping drug use, what to do in the event of an overdose, and how concerned family members can help relatives who might be using drugs.



**Figure 1: Behavior Change, Syringe Exchange Clients, Bishkek 2000-2003**

**Source: Estebesova B (2003)**

***Program effectiveness: early indicators***

It is always difficult to measure HIV infections averted, and nearly impossible in an epidemic whose HIV epidemic is as new as Kyrgyzstan's. The effects of syringe exchange programs in reducing the behaviors that lead to HIV infection and other harms, however, are clear.

- In Bishkek, virtually all (98%) syringe exchange clients reported reusing injection equipment at the start of the project, many for twenty or more times. More than two of every three clients said they also shared needles with others. Three years later, a survey found

that fewer than one-third of clients reused syringes, and only one in seven reported needle sharing.<sup>11</sup>

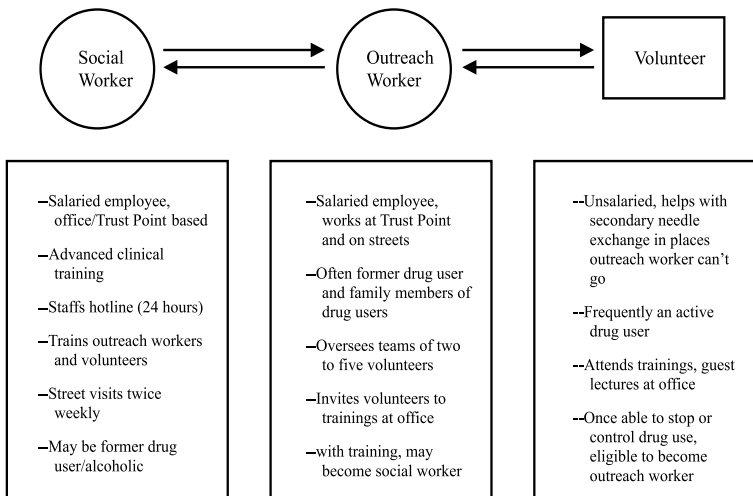
- In Chui oblast fourteen people died of overdoses in a three-month period in 2000, the first year syringe exchange program began operations there. In 2004, the oblast's reports no overdose deaths among 670 needle exchange clients.<sup>12</sup>
- In Osh, 90 percent of syringe exchange clients reported needle sharing at the start of 2001. By September 2001, reported needle sharing decreased to only 5 percent. Condom use among clients of syringe exchange had increased from 20 to 58 percent.<sup>13</sup>





***Left: Sotsium physician Evgeny Ten examines a client’s abscess. Sotsium takes medical advice out of the clinic and into the street, providing links to follow-up care when needed.***

### Increasing Options for Drug User Participation



***Figure 2 The Sotsium Model***

“Drug user” can refer to people who have a history of drug use but are no longer using, those who use drugs but are able to maintain regular work or other commitments, and those who cyclically or regularly are so dependent on drugs that it is difficult for them to do anything but pursue and inject them. Sotsium, the largest NGO serving drug users in Kyrgyzstan, uses a program model that has a place for all.

Even those drug users whose lives are chaotic or driven exclusively by drugs can be volunteers, performing needle exchange in drug dealing locations inaccessible to outreach workers, collecting used syringes to return to outreach workers, and advising of changes in the street scene, drug use patterns, or police activity.

*Outreach workers*, who include relatives of drug users and former drug users, receive a small salary for their HIV prevention work, manage teams of two to five volunteers of active drug users. Outreach workers often work in communities in which they live.

Each Tuesday, a different outreach worker and his or her volunteers come to Sotsium offices to attend staff meetings, submit weekly reports, and meet with social workers. While social workers do not have a specialized degree like those offered in Europe or the U.S., they have received counseling training, and conduct workshops and seminars for other employees. They also staff the organization’s 24-hour-hotline. Social workers, who may include former addicts or alcoholics or family members of drug users, also participate in street outreach twice a week.

With funding from UNODC, Sotsium began a drug free rehabilitation program in 2004. Providing food, shelter, and intensive individual and group counseling, and using non-verbal techniques such as holotropic breathwork, the program is the first in Bishkek to offer residential, peer-based rehabilitation.

Considered together, Sotsium’s spectrum of services ensures that drug users, both former and active, have a place in the organizational structure and access to a range of services. Those not ready to abstain, or those returning to drug use after a period of abstinence, are not regarded as “beyond reach” or as having no useful role in HIV prevention.



*Right to left: Raushan Abdildaeva, Director, Interdemilge NGO; Colonel Victor Donchenko, Chief of Penal Colony #3; and staff of the prison health clinic*

### Voices from the Front

#### From Penalizing to Humanizing: Harm Reduction in Prison

*Raushan Abdildaeva, Interdemilge NGO and Department of Penitentiary Reform, Ministry of Justice*

**“He said if I continued this work he would make sure I lost my job.”**

*In the Soviet Union, the government assigned you your job. As a narcologist, I was assigned to the medical center at Prison Colony 47, which was where convicted drug users were sent for treatment. In 1998, I went to a training in Almaty, Kazakhstan, where UNDP*

*was offering to fund education projects to reduce HIV in prison. The head of Colony 47, Mr. Nosov, he was receptive, so we started. It was hard—we had very little money, we had to work with the larger prison system, and officials were skeptical. This was when we were under the Ministry of Internal Affairs. We started with information and trainings, and saw that attitudes changed: no longer did people say “Oh, HIV positive people, we should put them to death.” We made trainings for the prison chiefs and their deputies and their medical staff, with a goal of reducing HIV and hepatitis. They didn’t have medicines to treat people, so they began to search for others ways of helping, and to regard drug users as patients rather than just criminals.*

*Only after we had figured out the steps, what worked, did we propose to expand. We put bleach dispensers in the bathrooms, so that people could clean their syringes and people would just think they were washing their hands. But when I proposed distribution of clean needles, the representative from the Ministry of Internal Affairs flatly refused. “You are proposing a harm program, not a harm reduction program,” he said. He told me I wanted to legalize drugs. And he said that if I continued with this direction of work, he would make sure that I lost my job.*

*In fact, it was his job that changed, since the prison colonies in 2000 were put under the Ministry of Justice. Mr. Nosov, the former head of Colony 47, went to work at the Ministry, and I came here too. We had one year to convince the administration, with roundtables, all available information, that syringe exchange would work. We invited people from the Ministry of Health, the AIDS Center, international experts. And they all said, ‘you have to have such programs.’ The Minister of Justice gave the okay, but for one colony only. That was the start. Because at the next roundtable, we could show that there had been no new HIV infections at the colony where we exchanged needles. From one colony we went to two. From two we went to six. Now it is twelve.*

## **BEST PRACTICES IV: HARM REDUCTION IN PRISONS**

*I worked sixteen years as a prison director, so I have seen it from the inside and the outside. We could say prisoners don't use drugs in prison, but it's not true. We don't have the means in Kyrgyzstan-not financially, not physically, not materially-to keep prisoners away from drugs. There may come a time when we can honestly say that people aren't using drugs. In the meanwhile, we can't close our eyes. If we can't stop drug use, at least we can exchange syringes to stop one prisoner from making another one sick.*

Vladimir Nosov, Head of Main Department of Penalty Execution, Ministry of Justice

In Soviet times, drug users convicted of criminal offences were sent for forced treatment in special narcological centers prior to incarceration with other convicts. Officials consequently insisted that prison was one of the few places where drug use did not occur. Long after the collapse of the Soviet system, and in spite of repeated studies and testimony showing widespread drug use behind bars, the system that requires forced treatment of prisoners and the myth that prisons are drug free continues in countries from Russia to Uzbekistan. Tattooing and sex between inmates, activities that also carry high risk for HIV and hepatitis C, are similarly wished away or left undiscussed.

Kyrgyzstan has taken a more realistic view. In 1998, with a UNAIDS/UNDP grant, the Ministry of Internal Affairs began staff education about how to reduce HIV infection. Support from Soros Foundation Kyrgyzstan allowed the installation of bleach dispensers for disinfection of syringes and tattooing equipment.

Distribution of needles, while favored by key staff within the system, remained impossible until 2000, when control of the prisons was transferred to the Ministry of Justice. Stunned by prison overcrowding, high rates of tuberculosis and the threat of HIV in the system, the Ministry sought help from AIDS experts, key ministry officials, and representatives of organizations such as the World Health Organization. The result, expressed in a special resolution, surprised even supportive funders. “It was incredible to read it,” recalls Elvira Muratalieva of Soros Foundation Kyrgyzstan. “It said, number one, ‘the Ministry of Justice will start needle exchange and methadone in prisons.’” We went to a roundtable after that with Ministry officials and they said, ‘Just decide. With which do you prefer to start?’”

A new non-governmental organization, Interdemilge, was established as a conduit for foreign assistance. Raushan Abdildaeva, its director, is the narcologist who introduced harm reduction into the penal system and now also works at the Ministry of Justice. Serving more HIV positive clients than any other NGO in the country, Interdemilge’s prison-based harm reduction programs may be among Kyrgyzstan’s most critical HIV prevention measures.

Though other CIS countries face overwhelmingly injection-driven HIV epidemics and high rates of incarceration of drug users, Kyrgyzstan is the only country in the region besides Moldova, and on a smaller scale Belarus, to offer syringe exchange behind bars. Among the best practices of the Kyrgyz syringe exchange program in prisons:

### **Rapid action**

- With evidence showing clear signs of HIV epidemics in prisons of other CIS countries, Kyrgyzstan began harm reduction trainings before there were any documented cases of HIV among inmates.

- Voluntary HIV testing in prison, introduced subsequently, has shown the importance of intervention. In 2004, 56% of registered HIV cases in Kyrgyzstan were among prisoners.

### **Steady scale up**

- The pilot syringe exchange program that began in 2002 in Colony 7, the prison whose narcological center was charged with treating convicted drug users, expanded to include four colonies in 2003.
- Twelve prisons in Kyrgyzstan adopted syringe exchange by the end of 2004.
- Plans call for expansion of the program to all colonies.

### **Services tailored to prisoners' needs**

#### ***Attention to confidentiality***

- All prison medical staff and officials are trained in the importance of safeguarding confidentiality for HIV positive prisoners, who may face violence and discrimination if their HIV status is known.

#### ***Secondary exchange***

- In addition to receiving alcohol pads, cotton, and sterile syringes for themselves, some volunteers take needles to perform secondary exchange for prisoners not willing or able to come to the exchange point.

#### ***Prisoner input into trainings and material development***

- At the start of the program, drug users were surveyed to find which kinds of needles were most useful. These were purchased for use.



- Staff and prisoners alike receive ongoing trainings on issues including overdose prevention, transmission of HIV and hepatitis, and safer sex education. Prisoners design HIV prevention materials themselves that are put through focus groups and produced for distribution throughout the prison system.

### **Integration with other health services**

#### ***Integration with prison health care***

- Though health care is severely limited in Kyrgyz prisons, syringe exchange is based at the health clinic, where nurses are trained in treatment of abscesses or other injection-related complications. Prisoners can visit and exchange syringes without revealing to other inmates that they use drugs.
- At colony #3, visited for this report, nurses report that abscess problems have sharply decreased since syringe exchange began.

#### ***Bridge to drug free treatment***

- Interdemilge, the NGO in charge of syringe exchange in the penal system, also has established Atlantis, a drug-free program that offers prisoners twelve-step meetings, peer support, and psychosocial counseling from former drug users and psychologists.

#### ***Links to harm reduction and HIV prevention upon release***

- While minimal, those released from prison receive some links to ongoing HIV prevention: an individual packet consisting of a disposable syringe, disinfectant, multi-vitamin, and a leaflet with the addresses of HIV prevention organizations.



**Voices from the Front**

**Focusing on the Possible: Moving Forward on Methadone**

Tynchtykbek Asanov, Chief Narcologist of the Republic of Kyrgyzstan

**“I could see that the old methods of treatment, of interaction, they were not effective.”**

*In 2000, in spring, Kasia Malinowska of the Open Society Institute came here and met with some people. She didn't meet me, but I heard that she left the country disappointed and thought that it was too early here in Kyrgyzstan to talk about substitution therapy. It was in spring when she came, and in autumn in our*

*country there was a large number of drug users infected with HIV and the number was increasing by two times or even more. In the Ministry of Health we gathered and began to discuss what should we do. We had all heard in other countries that HIV infection was increasing like a wave, and knew we should do something. And we made an agreement with the minister that he would support needle exchange, distribution of condoms. When we began discussing the question of substitution therapy the minister didn't know anything about this. Others like me who were responsible also knew very little about this. I had heard a little and read about it but never had seen it. They decided to send me to Poland and Slovakia in November of 2000 to see. The discussion with the minister was in September, and in November I was sent by the Soros Foundation. Of course the Soros Foundation was hinting that if I would begin the realization of this program they might be able to help provide some funding. I went with the aim to assess and implement.*

*When I came back, very quickly I wrote the project, because I saw there that this is a totally different approach. Our narcology took the position at the time that the doctor was higher, more clever and better, and the patients were stupid and bad. In Poland, patients and doctors were communicating at the same level, were discussing things together. And I saw that there were a lot of people who came to the clinic. We didn't have many patients at that time. For a long time I had been a clinician, doing treatment for patients and working in the Ministry of Justice as a doctor. And I could see that the old methods of treatment, the old methods of interaction, they were not effective. They yielded minimal results. I had been thinking about how to change this system earlier, and now in the Ministry of Health everyone was looking at me and asking how to make the system better. I saw that this was a potential direction, to treat the patients as partners. The patients were more open and honest, first of all. And secondly, they assumed a part of the responsibility themselves, so their internal resources are working actively.*

*When we began to negotiate the project with other ministries, there were some conflicts. The main resistance was from the Ministry of Internal Affairs, who said that methadone was not a treatment, that it was the substitution of one drug for one another, and that the government was legalizing it. An international consultant came, Emilis Subata, from Lithuania, who had a lot of experience, and together we met with high officials. And I had to run and get agreement for all these documents. Most important was that in our law, it was not prohibited to treat addiction with narcotics, and methadone was not included on the list of forbidden drugs. I had no relation to this law, it was written before me, but when our officials were composing the national list, years ago, they took the international model [from the World Health Organization], copied it, and signed. And methadone was not forbidden.*

*I focused on this: if it is not forbidden, then we as doctors can try it. And if the police are against it, it is not a police affair to interfere into treatment. Finally, after half a year, I got all the necessary signatures. And somewhere at a conference I met Kasia Malinowska. She was interested in how we were doing. And I told her, we have prepared all the documents: Now give me the money. Within three months we had signed the agreement, and I began to look for suppliers, to decide technical details.*

*Now when I see what is happening in other countries, I understand that a lot of our success with methadone was that a lot of people didn't know that they should resist. Today the issue is more political, and those who are engaged are beginning to debate and discuss these things, and are very interested in the results of the treatment we were making. But by this time, we have two years experience, two years results, and I can very easily invite them to come here, show them the improved relations with relatives, no more quarrels or stealing from the houses, how some patients found jobs or began to study, and how many of them renewed connections with their families. Everyone can see that even the appearance of the patients is changed.*

## BEST PRACTICES V: METHADONE MAINTENANCE

*“What would I say to a policeman in another country that was worried about methadone? At least it excludes infections you get through injection. This argument is enough for me.”*

Mukhtarbek Madybaev, First Deputy Director, Drug Control Agency of the Kyrgyz Republic

*“Soviet narcology was a part of the security system, very close to the Ministry of Internal Affairs. Patients were afraid of us. We were like police to them. But when harm reduction programs began, when the documents changed, when the protocols changed, our approach could also change.”*

Mamosoby Burhkanov, Chief Narcologist, Osh oblast

*“In terms of addiction, I am still dependent: as we say, horseradish doesn’t taste that different from radish. But when I used drugs, my wife used to tell me I was on the dark side: my body was mine, but she couldn’t reach me. My son couldn’t reach me. Now I can talk about Dostoevsky, God, feelings.”*

39-year-old client of methadone program, Bishkek

Discussions about drug treatment often start with the assumption that stopping of any form of dependence is the only gauge of success. Clinicians, patients, and family members in Kyrgyzstan’s methadone maintenance treatment (MMT) program tell a different story, suggesting that the definition of successful drug treatment should also consider improvements in quality of life for drug users, their families, and society at large. “When patients come at first to the methadone clinic, they can’t think

of anything but drugs” says Mamosobyr Burkhanov, narcologist for Osh oblast and head of the methadone dispensary. “With methadone treatment, their vision becomes wider. They begin to remember their children, that they used to work. They say, ‘doctor, I want to enter rehabilitation.’”

Methadone has effected a similar widening of vision among government officials in Kyrgyzstan, who have moved from opposition to cautious support of maintenance treatment for opiate dependent men and women. A total of nearly two hundred patients in Bishkek and Osh receive long-term methadone maintenance treatment in a program under the stewardship of Chief Narcologist of the Republic Tynchtykbek Asanov (see sidebar). Authorized to move forward in 2001, Asanov was required to obtain approval from the Ministry of Internal Affairs, National Security Service and State Drug Control. Pilot programs in Osh and Bishkek began for fifty patients in each city in 2002. With funding from UNDP for the Osh program and Soros Foundation funding for Bishkek, both have subsequently expanded.

Methadone remains an extremely controlled substance in Kyrgyzstan. Only the government narcology centers are permitted to buy and use methadone, and Dr. Asanov-as Chief narcologist-is required to report regularly to multiple government entities. Patients are approved for entry into through program by a special medical consulting commission. The only patients eligible to receive treatment are those who have been dependent on drug injection for years and who have attempted unsuccessfully to receive substance abuse treatment in medical institutions, or those suffering life-threatening or other serious complications from opiate injection and not younger than 18. Patients can receive methadone only at one of the two certified narcology dispensaries accredited by the Ministry of Health, and are subject to monthly urine tests for the presence of other opiates. “Take home” doses

are generally not permitted, restricting recipients to those patients able to make daily visits to the clinics. Anonymous treatment is not allowed, and family members and relatives are invited to attend counseling sessions and participate in surveys of program efficacy.

Nonetheless, Kyrgyzstan's methadone maintenance program-the first in any CIS country-is clearly breaking barriers. In Osh and Bishkek, methadone dispensaries have worked regularly with television, newspapers, and through roundtable meetings to overcome distrust and correct misunderstandings about MMT. The Governor of Osh oblast and the mayor of Osh city, as well as representatives of a wide range of city and state services, attended the opening of the Osh program. In the spring of 2003, with funding from UNODC, WHO, UNDP and Soros Foundation Kyrgyzstan, the government held an international conference on methadone and other methods of decreasing vulnerability of IDUs in Osh that included representatives of the Ministry of Internal Affairs, the State Drug Control Committee, and the Ministry of Justice. Dr. Asanov proposed there that MMT programs be implemented in all regions of Kyrgyzstan, starting in the south and in the large towns where drug use is most prevalent.

### **Free to clients, low cost to donors**

Unlike programs such as that in Lithuania, which require that patients pay a significant cost to cover the price of brand-name methadone, Kyrgyzstan's programs offer methadone and supportive services free to patients.

- Secured from a Slovak supplier, methadone for the first two years of operation of MMTP programs has cost US\$0.08 per patient/day, the same price as a Bishkek bus ticket.<sup>14</sup>

### **Links to other support services**

Methadone is seen as part of a continuum of care, rather than an end in itself.

- Patients have regular psychological counseling, including peer-based group support and cognitive behavior therapy. Family members are in regular contact with staff.
- All MMT patients have a medical consultation and tests upon intake including an electrocardiogram, hepatitis, and HIV tests. All have access to medical attention during daily clinic visits.
- MMT programs maintain close links to harm reduction and drug-free programs, enabling methadone patients to participate in twelve-step meetings or to volunteer as needle exchange workers. This ensures familiarity with services they would need if they returned to drug use or decided they would prefer to move from methadone to abstinence.

### **Dose adjustment and flexibility**

- Dosages, fixed for each client during an inpatient stay at the dispensary at the start of treatment, are adjusted regularly depending on clients' reports, side effects, etc.
- Use of heroin has not been synonymous with automatic expulsion from the program. Rather, narcologists use their best clinical judgment to assess progress and where appropriate, to attempt dose adjustment or other interventions. All expulsions for the program are approved by the medical consultation committee.



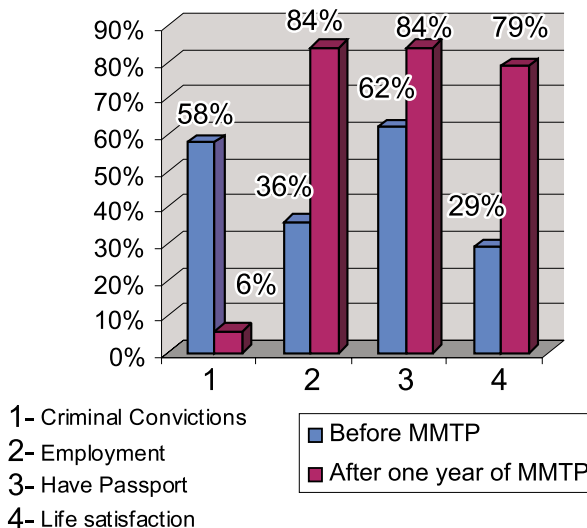
### **Ongoing evaluation**

Recognizing the importance of quantitative results in assessing program success and future possibilities, both Bishkek and Osh programs conduct evaluation of patients and seek feedback from family members

- MMT patients have experienced a sharp drop in criminal activity
  - Prior to enrollment in MMT, more than half of Bishkek clients had criminal convictions. In one year of treatment, only 3 of 50 patients had new criminal convictions.<sup>15</sup>
  - No Osh client was arrested in the first year of the program.<sup>16</sup>
- MMT patients report enhanced happiness and health, and sharp diminution of side effects over time.
  - In Osh, 80% of clients report improvement of physical and psychological health, including return of appetite, stable mood, weight gain and normalization of dreams.<sup>17</sup>
  - In Bishkek, 86% of clients report satisfaction with their health and financial situation. While only 29% reported life satisfaction upon entry, 79% did so one year later.
  - At the start of treatment in Bishkek, 36% of patients report nausea, and 18% vomiting. A year later, only 2% reported nausea and none were vomiting.<sup>18</sup>
- Urine tests show greatly reduced rates of opiate use over time.
  - In Osh, for example, one in four MMT patients used street opiates in addition to methadone in the first months of the project. Eleven months later, fewer than one in twenty did.<sup>19</sup>

- In Bishkek, the percent of patients using opiates in addition to methadone went from 44% in June of 2000 to 15% in April of 2003.<sup>20</sup>
- MMT patients and family members report increased financial stability.
  - Two-thirds of Bishkek patients were unemployed at the start of the program, but 84% had work after one year.<sup>21</sup>
  - In Osh, two thirds of families of patients reported improved financial situations in the first year of treatment, and more than half of MMT patients work.<sup>22</sup>
- Among MMT patients, only one HIV infection was reported in the first year of the program, in a patient who did not test positive for opiates at any time during his MMT treatment.<sup>23</sup>

## Changes in participants of Bishkek Methadone Maintenance Treatment Program, 2002-2003



**Figure 3: Changes in Patients of Bishkek Methadone Program, 2002-2003**

*Source: Parpieva A (2003)*

## VI. FUTURE CHALLENGES AND OPPORTUNITIES

*“We had a meeting this weekend in the mountains that gathered people with HIV from all around the country. Some of them had never expected any kind of help—even their parents did not want to help them.”*

Nurlan Shonkorov, NGO Kozkarash

*“Kyrgyzstan is a small country—we can reach a widespread epidemic of HIV/AIDS in a very short period of time. Now we are*

*on the cusp. If we work hard, we decrease infections and maybe Kyrgyzstan will be counted among the best practices in the world, especially in CIS countries. If we slacken, we fail, and the epidemic will generalize.”*

Larisa Bashmakova, Team Leader, DFID Central Asia Regional HIV/AIDS Programme.

### **Law Enforcement and Legal Reform**

Structural reform, particularly legal reform, may be as important to the course of harm reduction and HIV prevention in Kyrgyzstan as any individual intervention. As noted earlier, drug sentencing guidelines mandate incarceration for those who possess even a single dose of heroin. Other discriminatory laws increase stigma against sex workers, drug users and those with HIV, and make it more difficult to reach them with HIV prevention or health services, and increase their vulnerability to extortion or mistreatment by police.

- Carrying a syringe in Kyrgyzstan remains grounds for detention, search, or forced drug testing. Forced testing of suspected drug users by the police remains the most common way for police to identify drug users.<sup>24</sup>
- Regulations passed to address skyrocketing rates of sexually transmitted diseases in 1997 authorized “medico-police teams” to round up groups who “avoid” medical treatment,” or who are a public danger and forcibly test them for HIV and STDs. These have included sex workers and drug users.<sup>25</sup>
- As of September 2002, more than half (57%) of those known to have HIV in Osh oblast had been forcibly tested in temporary detention centers or through criminal investigations. All of those so detected had received little or no pre-test counseling.<sup>26</sup>

- Sex between an HIV-positive and HIV- negative person, even if consensual or with a condom, remains prosecutable as a criminal act.

For several years, a coalition of government officials and NGOs, including representatives of the State Drug Control Agency and those working with sex workers and drug users, have asked Parliament to reform such measures. Russia, whose law was the model for the Kyrgyz legislation, reformed its drug sentencing guidelines and criminalization of HIV transmission legislation in May 2004.

**Improvements in police practice** are also needed. While the Ministry of Internal Affairs and high-ranking officials may be supportive of harm reduction, frequent changes in mid- and lower-level staff, and the common police practice of extorting money from the public, have left drug users and harm reduction workers vulnerable to police abuses.

- Projects working with sex workers and drug users alike report periodic problems with law enforcement, including round ups and forced testing of their clients, and arrests from outreach sites and methadone clinics.
- During a visit to the Bishkek methadone clinic, researchers for this report observed plainclothes police arresting several clients from the Bishkek methadone dispensary, declining to reveal the charges or any explanation for the arrest to them or to the doctor on duty.
- Clients of harm reduction programs routinely report that police plant drugs on them and then demand money to prevent incarceration or public humiliation in the media.

- Government officials and NGOs alike cited the need for greater police training on harm reduction measures.

### **Scaling Up: The Global Fund and Additional Sources of International Assistance**

A major influx of international support for HIV programs is poised to flow into Kyrgyzstan. The Department for International Development (UK), the UN Office on Drugs and Crime (UNODC), the US Agency for International Development (USAID), German Development Bank (KfW), and the World Bank have begun, or will shortly begin, support of HIV programs. The Global Fund to Fight AIDS, Treatment, and Malaria has awarded Kyrgyzstan \$17 million USD for a five-year proposal that includes commitment to scale up both syringe exchange and methadone, including methadone in prisons.

Ironically, the influx of monies may represent a challenge as new forces angle for control. **Donor coordination and accountability of large grant recipients** will be particularly important. In interviews conducted for this project, the Global Fund grant represented one of the few points of tension cited by NGOs and government officials.

- Harm reduction programs in Osh, Jalalabad, and Bishkek all expressed disappointment that funding expected to flow from the Global Fund had not yet arrived and concern about lack of transparency for the process by which such decisions would be made.
- As of this writing, many programs remained unsure whether the Global Fund moneys would be used as promised. Failure by Global Fund representatives to fund syringe exchange had required emergency appeals to donors such as UNDP and Soros

Foundation, who had planned to redirect funding to services not supported by the Global Fund.

- In Osh and Jalalabad, syringe exchange programs reported that the funding lag had interrupted the supply of needles, a development that seriously undermines credibility of any harm reduction program and may have resulted in increased HIV infections.

### **HIV treatment**

The introduction of highly active antiretroviral therapy (ARV) into Kyrgyzstan will pose both an opportunity and a challenge. The Director of the National AIDS Center, which is the principal recipient of Kyrgyzstan's Global Fund grant, reports that treatment will be offered to all in need, including drug users. However:

- Clinical guidelines to offer injection drug users the support needed to achieve maximum benefit from ARV had not been formulated as of summer 2004. While clearer plans for provision of HIV treatment for drug users have since been articulated, implementation and accountability remain of concern.
- A protocol to provide ARV to patients on methadone maintenance had not yet been formed as of summer 2004.

Given data showing improved adherence to HIV medications for drug users who are offered appropriate supports, as well as recent studies showing high rates of adherence and treatment efficacy for those on opiate substitution therapies<sup>27</sup>, greater clarity on and commitment to the provision of treatment to drug users is needed. In a country where more than 80% of those with HIV have a history of injection drug use, these measures are essential, rather than secondary, to HIV treatment efforts.

## **Involvement of drug users and people with HIV/AIDS**

Efforts to increase participation of drug users and people with HIV/AIDS in policy and program development, an important part of successful responses to the epidemic elsewhere in the world, are in their earliest stages in Kyrgyzstan.

- A drug users' group, Ranar, has recently been formed, and is working with prison projects, NGOs, and members of the committee coordinating Global Fund activities to ensure responsiveness to drug user needs.
- A single advocate, Nurlan Shonkorov, has publicly identified himself in the media as HIV-positive, and formed an NGO, Kozkarash, to work on peer education, support, and advocacy for HIV treatment.
- In summer of 2004, Kozkarash held a retreat-attended by a physician from the National AIDS Center, harm reduction pioneer Larisa Bashmakova, and more than dozen people with HIV-to discuss how to move forward. It was the first such meeting in Kyrgyzstan's history.

All of these developments-legal reform, international aid, the advent of HIV treatment and activism by drug users and people with HIV-represent important challenges for Kyrgyzstan. So far, the country's commitment has made it a leader in the CIS in pioneering programs proven to stop the spread of HIV. The thousands of citizens likely to already be infected with HIV, and the millions who do not need to be, can only hope that Kyrgyzstan continues to demonstrate the necessary commitment, and point the way toward a future where the HIV epidemic has been successfully contained.



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<sup>1</sup> Sites visited include Podruga NGO, Parents Against Drugs NGO, Sotsium NGO, the methadone clinic of the Republican Narcological Center (Bishkek), the methadone clinic of the Osh narcological center, Musaada rehabilitation center (Osh), Pokoliene rehabilitation center (Jalalabad), Diaron NGO (Jalalabad), Sotsium rehabilitation center (Bishkek).

<sup>2</sup> L Bashmakova, G Kurmanova, and A Kashkarev, *AIDS in Kyrgyzstan: Five Years of Resistance* (Bishkek, 2003). 20.

<sup>3</sup> The UN Office on Drugs and Crime estimates that there are 80,000-100,000 drug users in Kyrgyzstan, with approximately 54,000 thought to inject drugs as of 2002. See TK Asanov, “Methadone Maintenance Treatment Programs in the Kyrgyz Republic,” in *Decreasing Vulnerability of Injection Drug Users in the Kyrgyz Republic: Conference Proceedings* (May 2003), ed. TK Asanov (Osh, 2003), 16.

- 4 Jane Falkingham, "Poverty, Affordability and Access to Health Care," in *Health Care in Central Asia*, ed. Martin McKee, Judith Healy, and Jane Falkingham (Buckingham; Philadelphia, 2002), 43.
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- 7 Pomfret, "Macroeconomic Pressures," 37.
- 8 WHO, *Health care systems in transition: Kyrgyzstan* (Copenhagen, 1996).
- 9 Bashmakova, Kurmanova, and Kashkarev, *AIDS in Kyrgyzstan: Five Years of Resistance*.
- 10 Possession of small amounts of drugs without intent to sell is technically not a criminal offence. However, since even a single dose of heroin is classified as "large," possession is effectively punishable by imprisonment. See Bashmakova, Kurmanova, and Kashkarev, *AIDS in Kyrgyzstan: Five Years of Resistance*. 121.
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- 25 Bashmakova, Kurmanova, and Kashkarev, *AIDS in Kyrgyzstan: Five Years of Resistance*. 54-55.
- 26 Bashmakova, Kurmanova, and Kashkarev, *AIDS in Kyrgyzstan: Five Years of Resistance*. 55.
- 27 For summaries of research on ARV for injection drug users in Russian and English, as well as data on ARV and substitution treatment, see [www.ceehrn.org/arv4idus](http://www.ceehrn.org/arv4idus).