

KAZAKHSTAN

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Fanning The Flames

How Human Rights Abuses are Fueling
the AIDS Epidemic in Kazakhstan

HUMAN
RIGHTS
WATCH



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I. SUMMARY

The government of Kazakhstan has a rare and limited-duration opportunity to contain a rapidly growing HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome) epidemic. So far the disease is largely confined to specific populations, in particular injection drug users and sex workers. But the severe human rights abuses these persons face impede their access to prevention and treatment programs, fueling the epidemic.

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 force, which is generally repressive and routinely violates the rights of detainees, is especially brutal with these 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 injection drug users. But the utilisation 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. It is crucial that the government take immediate steps to curb abuses such as those detailed in this report and to expand preventive and treatment services to avoid a major AIDS epidemic.

Throughout the history of the HIV/AIDS epidemic, human rights abuses have both fueled the spread of HIV and been suffered disproportionately by people living with HIV/AIDS. The late Jonathan Mann, who headed the first major United Nations program on HIV/AIDS, was among those who recognized early in the epidemic the importance of protecting the human rights both of persons vulnerable to HIV infection—including sex workers, men who have sex with men, and injection drug users who were stigmatized even before AIDS came onto the scene—and of persons already infected.¹ Due largely to his influence, early policy statements on AIDS from U.N. agencies underlined the importance of a two pronged strategy to combat the epidemic. First, governments must eliminate all forms of discrimination in laws, policies, and practice. This includes discrimination based on gender, sexual orientation, ethnicity, race, social status, and disability. By ending discrimination, governments take a significant step toward ensuring that all people have access to the information that allows them to reduce their risk of exposure to the virus and to have some control over situations that might lead to exposure. Secondly, as a corollary, governments must ensure that HIV-infected persons are also protected from discrimination.

As the epidemic grew, national policies in the industrialized world came increasingly to include explicit provisions against discrimination based on HIV status, protections for vulnerable persons including confidentiality of HIV testing, and prohibitions of the use of mandatory testing by the state. Few such provisions are present in the law and policy of former Soviet states, however, which currently are home to the fastest growing AIDS epidemic in the world. Antiretroviral medicines, which in wealthy countries have been crucial to the containment of HIV/AIDS as well as of stigma associated with the disease, remain largely unavailable in Kazakhstan and other former Soviet states.

Current government estimates put the number of persons living with AIDS in Kazakhstan at more than 25,000, 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 injection drug users; over 80 percent of HIV-positive persons are estimated to be drug users. Injecting drug use 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 percent. A high prevalence of sexually transmitted infections (STIs) in the population also increases HIV transmission risk. Kazakhstan also bears the highest tuberculosis burden in Central Asia.

¹ Jonathan M. Mann, "Human rights and AIDS: The future of the pandemic," in Jonathan M. Mann, Sofia Gruskin, Michael A. Grodin and George J. Annas, eds., *Health and human rights: A reader* (New York and London: Routledge, 1999), p. 217.

Tuberculosis, 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 injecting drug users and sex workers—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. This report shows that 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.² 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 injection drug user or a sex worker, 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. This is a recipe for disaster. 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.

This report documents how officials routinely harass and discriminate against injection drug users and sex workers, compounding their already marginalized status and reinforcing their reluctance to use AIDS-related health services, including needle exchange. While on the one hand, some state health facilities have attempted to reach out to drug users and other high-risk groups by offering prevention and care services, other state actors, in particular law enforcement agents, dissuade persons at risk from taking advantage of these services through repressive practices. Other vulnerable persons, including men who have sex with men, and those already living with AIDS, are similarly deeply stigmatized and marginalized.

Eighty 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, as this report demonstrates, appears to be through the criminal justice system.

Sex workers, whose numbers have substantially increased in Kazakhstan since the fall of the Soviet Union, provide a crucial bridge to the general population in the spread of HIV. Members of this group overlap significantly with drug users as the latter sometimes turn to sex work to support their habit. Sex workers are also systematically detained and extorted by police because they frequently lack official registration documents which are required to obtain legal residence and city services. Police also rape and demand free and sometimes unprotected sex from sex workers in lieu of detention or money.

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

² This tiny amount, less than one fiftieth of an ounce, is plainly only enough for very limited personal use.

new testing guidelines in July 2002 which discontinue 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. Skin and venereal disease hospitals, which deal with detection and treatment of sexually transmitted infections (STIs), 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.

Harm reduction³ services, including needle exchange, condom distribution, and voluntary HIV and STI screening, are available throughout the country, but they are reaching target populations at a much lower level than is needed to counter the epidemic. According to the U.N., only 8 to 10 percent 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 U.N. estimates that harm reduction programs have achieved a significant impact only when a minimum of 50 percent of injection drug users 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—means that injection drug users are offered few genuine alternatives. Treatment at rehabilitation and drug centers is often ineffective, in part due to underfunding, 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 injection drug users. Hope is a key ingredient to inspire drug users to take part in prevention and treatment programs.

The lack of combination antiretroviral (ARV) therapy in the country compounds the absence of effective treatment services for persons 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 Program⁴ has nevertheless indicated that discussions have begun on the possibility of acquiring generic antiretroviral drugs for use 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 of 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 discriminatory 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.

³ Harm reduction refers to programs and policies designed to diminish the individual and social harms associated with drug use, including the risk of HIV infection, without requiring the cessation of drug use. In practice, harm reduction programs include needle exchange, replacement therapy, health and drug education, HIV and sexually transmitted disease (STD) screening, psychological counseling, and medical referrals. For more information on harm reduction, see the website of the International Harm Reduction Development (IHRD) program of the Open Society Institute (OSI), www.soros.org/harm-reduction.

⁴ For the purposes of this report, the Republican AIDS Prevention and Control Center, as it is known in Kazakhstan, will be referred to as the National AIDS Program.

It is furthermore encouraging that senior Kazakh officials have in the recent past begun to make public comments which could elevate discussion about the epidemic to a more prominent level of national policy debate and even introduce a rights-based approach. Top-ranking health officials have in recent months warned of potential social and economic crises should the disease not be kept in check. In November 2002, the head of the National AIDS Program, Dr. Isidora Erasilova, announced that persecution of drug users discourages them from gaining access to prevention programs and makes them particularly vulnerable to contracting HIV.

II. RECOMMENDATIONS

To the government of Kazakhstan:

ON HIV/AIDS:

- Implement fully and as soon as possible the decision 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 United Nations International Guidelines 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 the prompt review of HIV/AIDS legislation and regulations being undertaken by the government and the use of international standards such as the U.N. 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 Narcotic Drugs of 1961 and its additional protocol of 1972, the Convention on Psychotropic Substances of 1971, and the U.N. 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 U.N. 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 persons at high risk.

ON INTERNATIONAL HUMAN RIGHTS CONVENTIONS:

- Ratify the International Covenant on Civil and Political Rights and its additional protocols.
- Ratify the International Covenant on Social, Economic and Cultural Rights.

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 provisions 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 quotas 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.

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 enforcement officers and medical professionals.
- Ensure that injection drug users 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 campaigns to men who have sex with men and expand cooperation with NGOs representing men who have sex with men.

TO U.N. 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.

TO THE EUROPEAN UNION AND MEMBER STATES:

- Use the periodic reviews of the Partnership and Cooperation Agreement (PCA) to urge the government of Kazakhstan to bring its laws and practices with regard to due process guarantees and freedom of expression into compliance with bilateral agreements and international standards, with particular attention to the violations documented in this report. The parliament should request that the EU-Kazakhstan Cooperation Council issue a public report regarding the state of Kazakhstan's compliance with these international standards, and should make clear that continuation of the PCA is contingent on specific and measurable progress in observation of these standards.

TO THE UNITED STATES:

- Continue to urge the government of Kazakhstan at the highest levels to bring its laws and practices with regard to due process guarantees and freedom of expression into compliance with bilateral agreements and international standards, with particular attention to the violations documented in this report, and with specific regard to resolutions such as the Joint Resolution Expressing the Sense of the Congress with Respect to Human Rights in Central Asia, S.J. Res. 3 of January 14, 2003.

TO THE EUROPEAN BANK FOR RECONSTRUCTION AND DEVELOPMENT:

- Article 1 of the Agreement Establishing the European Bank on Reconstruction and Development states that its purpose is to promote development in “Central and Eastern Europe countries committed to and applying the principles of multiparty democracy, pluralism and market economics.” In light of this statutory commitment, the Bank should consider the findings contained in this report in the context of its annual country assessment for Kazakhstan and signal that the nature and level of future assistance will be contingent on substantial progress in implementation of the recommendations listed above.

III. METHODS

Human Rights Watch conducted research for this report in Kazakhstan in August and September 2002 and subsequently by telephone and electronic mail from New York and Moscow. In Kazakhstan, Human Rights Watch researchers interviewed approximately eighty injection drug users, sex workers, and persons living with AIDS in Almaty, Shymkent, Karaganda, Temirtau, and Pavlodar.⁵ Interviews were also conducted throughout the country with thirty-one government officials in AIDS centers, narcological centers, skin and venereal hospitals, prisons and prison hospitals; one senior police officer and two lawyers; and staff of seventeen local NGOs. Human Rights Watch met with staff of three international organizations in Almaty, among them UNAIDS (Joint United Nations Programme on HIV/AIDS), and seven international NGOs in Almaty, Shymkent and Pavlodar, all of whom were working on HIV/AIDS. Interviews were generally open-ended and covered many topics.

Human Rights Watch in addition attended various fora in Kazakhstan including a press conference on HIV/AIDS in Almaty and staff meetings of a harm reduction NGO in Pavlodar and of medical personnel at a prison tuberculosis hospital in Karaganda province.

Interviews with thirty-eight injection drug users, thirty-three sex workers, twenty-one persons living with AIDS and seven relatives of these were conducted in public sites (including on the street), private residences, government-run AIDS centers, prisons, prison hospitals, and narcological centers. The identities of some interviewees have been withheld for their protection and at their request. Almost all interviews were carried out on an individual basis with only a few group interviews.

The majority of interviews were conducted in Russian; a few were in English. One or two Human Rights Watch staff members conducted the interviews. Human Rights Watch also gathered in Kazakhstan unpublished and published local government and non-governmental documents on HIV/AIDS, and other published and World Wide Web-posted information from a wide range of sources.

⁵ Despite repeated attempts, Human Rights Watch was unsuccessful in gaining interviews with men who have sex with men, aside from two leaders of NGOs working with this population. Other men who have sex with men we located declined interviews for fear of reprisal or disclosure.

IV. BACKGROUND

HIV/AIDS in the former Soviet Union

Until the mid-1990s, it was widely thought that the former Soviet Union had been spared a significant HIV/AIDS epidemic. In stark contrast, the United Nations system's annual reports on the state of the global HIV/AIDS epidemic in both 2001 and 2002 estimated that Eastern Europe and Central Asia—the United Nations region that includes the former Soviet Union (FSU)—has the fastest growing epidemic in the world.⁶ Official U.N. estimates put the number of persons living with AIDS in this region in late 2002 at 1.2 million, but it is widely recognized, including by U.N. officials, that these figures are a gross underestimate.⁷ The U.N. figure of 250,000 new infections in 2002, although it represents a 25 percent annual rate of increase, probably is a significant undercount.

The epidemic is growing so fast in the former Soviet Union at least partly because injecting drug use, the most prevalent means of HIV transmission in the region, is much more efficient than sexual transmission. In addition, experts have noted that especially risky injecting practices, including sharing of needles and other drug paraphernalia and use of blood in preparation of injected drugs, are widespread.⁸ The United Nations estimates that about one out of 100 persons in Eastern Europe and Central Asia is an active injection drug user,⁹ a very high percentage by global standards. Many analysts have traced the meteoric rise in use of injected heroin since the fall of the Soviet Union to economic collapse and attendant rises in unemployment, poverty and desperation, and to increased availability of cheap heroin trafficked through Central Asia and across the FSU.¹⁰ Some experts have suggested that the aftermath of the events of September 11, 2001 in Afghanistan and Central Asia has done nothing to stem the flow of heroin through the region and may even exacerbate it in the long run.¹¹ There is no indication that the epidemic of injecting drug use in the region is abating.

In the countries of Central Asia, Russia, Moldova, Belarus, Ukraine and the Baltic states, at least 60 percent of registered HIV/AIDS cases are injection drug users.¹² In Russia the figure is 93 percent. In Ukraine, which has the worst HIV/AIDS epidemic in the region in terms of HIV prevalence in the adult population—about 1 percent—the percentage of IDUs among new HIV cases has declined from over 80 percent in 1997 to about 60 percent in 2001 as the growing epidemic is increasingly spread through sexual transmission in the general population.¹³

The HIV/AIDS epidemic in Russia was highlighted in the widely cited 2002 report of the U.S. National Intelligence Council, an affiliate of the U.S. Central Intelligence Agency, on the “next wave” of global AIDS. The Council's analysis suggested that there could be as many as 8 million persons living with HIV/AIDS in Russia alone by 2010,¹⁴ a figure well in excess of extrapolations from current U.N. estimates. This report suggests that with injecting drug use “rampant and rising,” a deteriorated health system, and the

⁶ UNAIDS/WHO, AIDS Epidemic Update (UNAIDS/02.58E), December 2002, p.12, and UNAIDS/WHO, AIDS Epidemic Update (UNAIDS/01.74E), December 2001, p. 6.

⁷ AIDS Epidemic Update, December 2002, p. 12.

⁸ “Central Asia Faces ‘Explosive Growth’ of HIV/AIDS Cases,” *Eurasia Recaps*, January 1, 2001, [online],

<http://www.eurasianet.org/departments/recaps/articles/eav011201.shtml> (retrieved January 25, 2003); .

Jean-Paul Grund, UNAIDS, presentation at “Health Security in Central Asia: Drug Use, HIV and AIDS” conference, Dushanbe, October 14, 2002.

⁹ Report on the Global AIDS Epidemic, June 2002, p. 34.

¹⁰ See, e.g., Karl L. Dehne, Jean-Paul C. Grund, Lev Khodakevich, and Yuri Kobyshecha, The HIV/AIDS Epidemic among Drug Injectors in Eastern Europe: Patterns, Trends and Determinants, *Journal of Drug Issues* 29 (4), 1999; Julie Stachowiak and Chris Beyrer, John Hopkins Bloomberg School of Public Health, “HIV Follows Heroin Trafficking Routes,” October 14, 2002 [online] http://www.eurasianet.org/health.security/presentations/hiv_trafficking.shtml (retrieved January 25, 2003).

¹¹ Nancy Lubin, Alex Klaitis and Igor Barsegian, “Narcotics interdiction in Afghanistan and Central Asia: Challenges for international assistance” (A report to the Open Society Institute), 2002.

¹² Central and Eastern European Harm Reduction Network (CEEHRN), “Injecting Drug Users, HIV/AIDS Treatment and Primary Care in Central and Eastern Europe and the Former Soviet Union” (report of a survey), July 2002, p. 6.

¹³ AIDS Epidemic Update, December 2002, p. 13.

¹⁴ National Intelligence Council, “The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India and China,” September 2002.

government's "limited capability to respond" to the epidemic, the adult HIV prevalence rate by 2010 could be as high as 11 percent, a disastrous situation.¹⁵

Although the absolute numbers of persons living with the disease in Central Asia are small in comparison with those of Russia, HIV/AIDS in the five Central Asian countries has the potential to be a major calamity. The most recent U.N. report on the epidemic characterizes the growth of HIV/AIDS in Uzbekistan, for example, as "explosive," noting that there were as many new HIV infections in the first half of 2002 as in the previous ten years.¹⁶ UNAIDS also highlights Tajikistan as being on the brink of a major epidemic in view of recent increases in heroin use.

In any AIDS epidemic where injecting drug use is so central in driving the spread of the disease, societal, legal and judicial attitudes and practices toward drug users are important determinants of the capacity of a country to mount an effective response to HIV/AIDS. Unfortunately, with few exceptions, drug users in the FSU are socially marginalized and stigmatized, drug laws are draconian, and abuses of due process in handling of narcotics offenses abound. In addition, by global standards, a very high percentage of drug users in the FSU find themselves in prison or in state detention at some time in their lives. Prisoners throughout the region are at high risk of contracting HIV/AIDS in prison because harm reduction services and access to condoms in prisons are so limited. The HIV prevalence in prisons in Russia, for example, is estimated to be much higher than that of the general population,¹⁷ and Russia is probably not alone in this regard.

Beginning in about 1987, countries throughout the Soviet Union, including those in Central Asia, began establishing AIDS centers. Unfortunately, the mission of these centers does not seem to have been to provide information and preventive services to the population but rather to carry out a massive program of mandatory testing and official registration of persons with AIDS.¹⁸ Recommendations from international public health bodies generally condemn mandatory HIV testing, instead encouraging voluntary testing with counseling to help HIV-positive persons minimize further spread of the disease and HIV-negative persons to remain that way (though widespread anonymous HIV testing for surveillance of the epidemic has been conducted in many countries.)¹⁹ Widespread testing in Russia was neither voluntary nor apparently for epidemic surveillance. It is estimated that from 1987 to 1993 the Russian government conducted over 120 million HIV tests, largely on an involuntary basis, of "high-risk" persons, including drug users, gay and bisexual men, persons diagnosed with other sexually transmitted diseases, persons who had traveled abroad, and the sex partners of persons in these categories.²⁰ Virtually none of these persons received counseling about HIV testing or HIV/AIDS.

Similar practices were carried out throughout the Soviet Union and lingered past its demise. Mandatory testing of anyone arrested by the police on any charge was also established in most countries and exists to this day, and those who test positive are still isolated from other prisoners or detainees in much of the FSU.²¹ There is no tradition of respecting the confidentiality of any medical testing in or outside of prisons.

¹⁵ Ibid., pp. 10-12.

¹⁶ AIDS Epidemic Update, December 2002, p. 13. Some 620 new cases were officially registered in the first six months of 2002.

¹⁷ Mark Schoofs, "Jailed Drug Users Are at Epicenter Of Russia's Growing AIDS Scourge," *Wall Street Journal*, June 25, 2002 at A1. This article reports that in 2002, at Kresty prison in St. Petersburg, for example, about 1000 of 7800 inmates are HIV-positive.

¹⁸ Julie Stachowiak, "Systematic—forced—testing in Russia," *Women Alive*, Summer 1996. Available at <http://www.thebody.com/wa/summer96/russian.html>, (retrieved December 10, 2002).

¹⁹ See, e.g., Joint United Nations Programme on HIV/AIDS and United Nations Office of the High Commissioner on Human Rights, *HIV/AIDS and Human Rights: International Guidelines (HR/PUB/98/1)*, 1998, paragraphs 28(b) and 30(c).

²⁰ Kevin J. Gardner (AESOP Center), "HIV Testing and the Law in Russia," 1995-96, [online], <http://www.openweb.ru/aesop/eng/hiv-hr/hiv.html>, (retrieved January 25, 2003); Stachowiak, "Systematic-Forced-HIV Testing in Russia." By 1996, official statistics held that there were only 1150 HIV/AIDS cases.

²¹ Joana Godinho, Hiwote Tadesse, Anatoly Vinokur, Mattias Lundberg, Eluned Roberts-Schweitzer, Saodat Bazarova, Natalya Beisenova, Dinara Djodosheva, Dilnara Isamiddinova and Guljahan Kurbanova, "Study Concept Note: Central Asia HIV/AIDS, STIs and TB," The World Bank (ECSHD/ECC08), June 2002, p. 7. The testing of detainees in the former Soviet Union, conducted generally without consent of the person tested and without provision of counseling, is in violation of international norms as stated, for instance, in the U.N. "HIV/AIDS and Human Rights: International Guidelines," which notes that the seriousness of HIV testing demands that counseling be provided (paragraph 28.c). In addition, disclosing an individual's HIV status to others but not to the individual is clearly in violation of both public health and right to privacy norms.

There have been a few signs of change in recent years. In 1998, Ukraine adopted a law abolishing the practice of mandatory testing of detainees and isolation of HIV-positive prisoners.²² Thanks to the work of a number of pioneering organizations, including the Open Society Institute, some needle exchange services are available in virtually all countries of the FSU though in most countries they reach a very small percentage of those who need them.²³ Substitution therapy such as methadone maintenance therapy, which has been widely credited with controlling HIV transmission among injection drug users in Western Europe and North America, is available in a few countries but was illegal in nine countries of Central and Eastern Europe and the FSU as of mid-2002.²⁴ The Central and Eastern Europe Harm Reduction Network reported that more than 80 percent of all HIV-positive injection drug users lived in these nine countries.²⁵ Throughout the FSU, drug rehabilitation and detoxification programs are unavailable to the vast majority of users and when available are usually highly punitive.²⁶

Commercial sex work in the region has become much more widespread since the fall of the Soviet Union. As in many parts of the world, in the FSU the exchange of sex for drugs and the use of sex work to support drug habits provide important links between injection drug use and commercial sex.²⁷ Sex workers obviously represent an important population in the course of the epidemic because of their sexual interaction with the general population. Figures on condom use among sex workers are difficult to come by, but surveys show that rates of condom use in the general population are low in the region. For example, a recent study of condom use in Ukraine showed that among sexually active young men 28 percent said they always use a condom, 27 percent said they use condoms often, 34 percent reported rare use, and 11 percent said they never use condoms. For young women reporting on condom use of their sex partners, the corresponding figures were 17 percent, 23 percent, 41 percent and 19 percent.²⁸ Surveys reveal a worrying deficit of detailed knowledge of the epidemic in the region among both young people and adults. While in Ukraine virtually all girls and young women aged fifteen to nineteen surveyed in recent studies had heard of HIV/AIDS, only 10 percent of the same population knew three ways of avoiding infection.²⁹ In Uzbekistan, less than 60 percent of this age group had even heard of HIV/AIDS, and less than 10 percent knew how to protect themselves.³⁰ In Tajikistan, only about 10 percent of girls had heard of HIV/AIDS.

There is very little access to antiretroviral treatment for persons with HIV/AIDS in the FSU, and there is even more limited access for injection drug users than for the rest of the population.³¹ In Ukraine in 2002, for example, although 70 percent of persons with HIV/AIDS were estimated to be drug users, only 20 percent of persons getting antiretroviral therapy were drug users.³² In Russia, where about 90 percent of persons with HIV/AIDS were estimated to be drug users, about 50 percent of ARV treatment was among IDUs.

The rapid spread of HIV/AIDS in the region is facilitated by a catastrophic explosion in levels of other STIs since the fall of the Soviet Union, and AIDS mortality is facilitated by an underlying tuberculosis epidemic that has not received adequate attention.³³ Kazakhstan, for example, had a syphilis incidence of

²² United Nations Office on Drug Control and Crime Prevention, *Drug Abuse and HIV/AIDS: Lessons Learned* (E/01/XI/15), p. 90. Also available at http://www.undcp.org/odccp/report_2001-08-31_1.html.

²³ See, e.g., Open Society Institute, "Drugs, AIDS and Harm Reduction: How to Slow the HIV Epidemic in Eastern Europe and the Former Soviet Union," 2001.

²⁴ CEEHRN, p. 24.

²⁵ *Ibid.* This calculation includes Kazakhstan, which, as noted below, has announced plans for two pilot methadone programs.

²⁶ Henning Mikkelsen (UNAIDS-Geneva), "Building expanded responses to HIV/AIDS and injecting drug use in Central Asia," *Eurasia Policy Forum*, March 1, 2001 [online], http://www.eurasianet.org/policy_forum/mikkelsen030101.shtml, (retrieved January 25, 2003).

²⁷ Godinho et al., p. 3.

²⁸ British Council EC-US HIV/AIDS Prevention and Awareness Programme for Ukraine, *Condom Use and Availability* (consultant report), 2002, [online], http://www.britishcouncil.org.ua/english/governance/hiv01_02.htm, (retrieved January 25, 2003).

²⁹ John Novak (USAID), "The HIV/AIDS Epidemic in Eastern Europe and Eurasia and USAID's Response," presentation to the HIV/AIDS Committee, American Bar Association, November 1, 2002, Washington, DC

³⁰ *Ibid.*

³¹ CEEHRN, p.3.

³² *Ibid.*, p. 13.

³³ It is well demonstrated clinically that having other STIs, including syphilis, increases an individual's risk of HIV transmission. See, e.g., United States Centers for Disease Control and Prevention, *Fact Sheet: Prevention and Treatment of Sexually Transmitted Diseases as an HIV Prevention Strategy* [online], <http://www.cdc.gov/hiv/pubs/facts/hivstd.htm> (retrieved March 14, 2003).

640 cases per 100,000 population in 2000, a 500-fold increase from the early 1990s.³⁴ The STI treatment strategy in much of the former Soviet Union has been to hospitalize patients for diseases that are treated in most countries of the world on an outpatient basis and to require patients to identify their sexual partners and to be registered as STI carriers.³⁵ Drug users and sex workers are understandably not eager to seek treatment under these conditions.

Tuberculosis is a long-standing problem of epidemic proportion in the region. In 2000, the countries of Western Europe had thirteen cases of tuberculosis per 100,000 population while the fifteen countries of the FSU had ninety-two per 100,000.³⁶ With the deterioration of health services in the region in the 1990s, mortality due to tuberculosis grew to forty-seven deaths per 100,000 population in 1998 from fourteen in 1991.³⁷ The growing use of directly observed treatment of tuberculosis—where patients take their medicines in the presence of health workers—seems to have slowed mortality in some countries.³⁸ Prisons remain heavily affected by tuberculosis because of overcrowding and poor hygiene and nutrition.

HIV/AIDS in Kazakhstan

In 2002, the government of Kazakhstan estimated that some 25,000 persons were living with HIV/AIDS in the country (population 16 million), though the number of “registered” cases is much smaller.³⁹ Kazakhstan is estimated to have more than double the number of persons with HIV/AIDS of the other four Central Asian countries combined. The first cases of HIV emerged in the one-company town of Temirtau near the city of Karaganda where the closing of the town’s smelting plant in the early 1990s threw much of the population into unemployment and poverty. By the late 1990s, the United Nations estimated that about 2000 of the 32,000 persons aged fifteen to twenty-nine in Temirtau were injection drug users.

The first HIV-positive persons were registered in Temirtau in 1996,⁴⁰ and the town was estimated in early 2002 to be home to over half of the registered cases in Kazakhstan.⁴¹ More recently the government has said that no region of the country is without some persons with AIDS.⁴² Nationwide, about 85 percent of HIV transmission is estimated to be due to injecting drug use.⁴³ In late 2001, a high-level government official noted that of the 3,000 drug users registered in the preceding eighteen months, 87 percent were HIV-positive, indicating a frighteningly widespread problem among injection drug users.⁴⁴ The second most highly affected group, as in Russia and Ukraine, is probably sex workers, though numbers are difficult to come by. Sex workers, as elsewhere in the FSU, provide a crucial bridge to the general population in the spread of HIV. Men who have sex with men, normally also highly vulnerable to HIV infection, are marginalized and hidden except in the biggest cities, and the degree to which they have been affected by the epidemic is unknown.

As the Temirtau case illustrates, the rapid spread of HIV/AIDS in Kazakhstan has come hand in hand with increased poverty and unemployment since the fall of the Soviet Union. Although the Kazakh economy enjoyed 13.5 percent growth in 2001 due mostly to higher oil prices and increased oil and gas production in the country, the 1990s was a period of steep economic decline.⁴⁵ The Asian Development Bank estimated that the real unemployment rate in 2001 was 10.4 percent, an improvement over the levels

³⁴Ali Buzurukov, “HIV/AIDS epidemic: Time is running out for Central Asia,” *Central Asia/Caucasus Analyst*, April 10, 2002 [online], http://www.cacianalyst.org/2002-04-10/20020410_HIV-AIDS_CENTRAL_ASIA.htm (retrieved January 25, 2003).

³⁵ Ibid.

³⁶ Godinho et al., p.3.

³⁷ Ibid.

³⁸ Kazakhstan is cited by some donors as having enjoyed some success in DOTS implementation. See USAID, “Central Asian Republics (Europe and Eurasia): Tuberculosis Control” at http://www.usaid.gov/regions/europe_eurasia/car/briefers/tb_control.html. Retrieved December 27, 2002.

³⁹ “Number of HIV-positive people exceeds 25,000 in Kazakhstan—expert,” Interfax-Kazakhstan news agency, November 28, 2002.

⁴⁰ Douglas Frantz, “Drug Use Begetting AIDS in Central Asia,” *New York Times*, August 5, 2001, p. A8.

⁴¹ Buzukurov, “HIV/AIDS epidemic: Time is running out for Central Asia.”

⁴² “Kazakh Official Number of HIV Sufferers 2,780,” Interfax-Kazakhstan news agency, May 21, 2002.

⁴³ UNAIDS, National Response Brief—Kazakhstan. Available at <http://www.unaids.org/nationalresponse/result.asp> (retrieved December 4, 2002).

⁴⁴ “Kazakh deputy health minister sounds alarm over rise in HIV cases in country,” Interfax-Kazakhstan, November 27, 2001.

⁴⁵ Asian Development Bank, Kazakhstan Country Report 2001 [online] at http://www.adb.org/Documents/Reports/Annual_Report/2001/KAZ.asp (retrieved December 11, 2002).

of the previous several years,⁴⁶ but the U.S. Agency for International Development (USAID) estimated in 2002 that the real unemployment rate might be as high as 30 percent.⁴⁷ Though certain sectors are experiencing economic growth, “the economy remains dominated by oligarchic interests,”⁴⁸ and the economic decline of the 1990s left over 30 percent of the population living in poverty by late in the decade.⁴⁹ Educational opportunities for young people are much more limited than during the Soviet period. The U.N. Children’s Fund (UNICEF) reported in 2002, for example, that in Almaty only 10 percent of secondary school graduates were able to benefit from higher education, and about 7 percent joined the army (following their obligatory military service), but the vast majority were without further training and were very unlikely to get decent jobs.⁵⁰

Economic decline and the serious deterioration of social services experienced across the former Soviet Union have in Kazakhstan as elsewhere gone hand in hand with an explosion in injecting drug use. At first serving as a transit area for the trafficking of opiates from Afghanistan, Kazakhstan became a market for heroin in the 1990s. In some parts of the country, the price of a dose of heroin is not much greater than that of a small bottle of vodka.⁵¹ UNICEF’s recent report on the situation of young people in Kazakhstan said there was a fourfold increase in the young people registered as narcotics drug users by the government from 1999 to 2002,⁵² and those registered very likely represent a small percentage of the actual population. Some 19 percent of children aged twelve to fourteen years and 40 percent of children fifteen to eighteen years old reported in 2002 that they had consumed alcohol.⁵³

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 percent believed HIV was transmitted by sharing dishes or spoons, by insects, by kissing or by casual contact, and 20 percent thought “repressive and punitive actions” against persons with AIDS were necessary to contain the epidemic.⁵⁴ Only 15 percent of the children said they had received information on safer sex in school.⁵⁵ The need to conduct broader campaigns among young people is vividly clear: in Pavlodar alone, about 80 percent 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.⁵⁶

Young people’s expression of the need for repressive measures against persons with AIDS reflects both wider social opinion and government policy. Persons living with HIV/AIDS in Kazakhstan face deep stigma, social ostracization, and sometimes abandonment by their families. This stigma reflects the strong association in the public mind between HIV/AIDS and injecting drug use; injection drug users are deeply stigmatized. One U.N. official said this stigma is sometimes reinforced by government campaigns that “blur the difference between drug addiction and drug trafficking.”⁵⁷ Mandatory HIV testing of a wide range of persons considered to be at risk, including drug users and all persons in pre-trial detention, was national policy up until July 2002, and those who were convicted of a crime and who test positive for HIV are isolated in a special prison colony for persons with HIV/AIDS. In August 2002, the director of the National

⁴⁶ Ibid.

⁴⁷ United States Agency for International Development (USAID), Kazakhstan country summary from the Fiscal Year 2003 Congressional Budget Justification of USAID [online] <http://www.usaid.gov/country/ee/kz/> (retrieved December 13, 2002).

⁴⁸ Ibid.

⁴⁹ Asian Development Bank, Kazakhstan Country Report, 2001.

⁵⁰ United Nations Children’s Fund (UNICEF)-Almaty, United Nations Educational, Scientific and Cultural Organization (UNESCO), “Young People of Kazakhstan: Along the Path to a Health Lifestyle,” p. 11.

⁵¹ See Godinho et al., p.6.

⁵² UNICEF and UNESCO., p. 9.

⁵³ Ibid.

⁵⁴ Ibid., pp. 87 and 88.

⁵⁵ Ibid, p. 85.

⁵⁶ “Most of HIV Sufferers in Northern Kazakh Region Aged Between 15 and 29,” Kazakhstan Today news agency web site, Almaty, in Russian 0435 gmt 29 Nov 02, reprinted in BBC Monitoring.

⁵⁷ Mikkelsen, “Building Expanded Responses to HIV/AIDS.”

AIDS Program in Almaty announced that this practice would be discontinued, but the implementation of this policy was incomplete as of this writing.⁵⁸

The government has permitted the establishment of needle exchange programs—services where injection drug users can exchange their used syringes for sterile ones, reducing the HIV transmission risk associated with reuse or sharing of syringes. Many such services exist at health facilities and in mobile units under both public and private auspices in the country. Substitution therapy⁵⁹ has so far been illegal, but the government recently said it would authorize two pilot projects using methadone.⁶⁰ Detoxification therapy—where toxic levels of an addictive drug are eliminated from an addict’s body, usually gradually—is unavailable to the vast majority of drug users. The president of Kazakhstan recently commissioned a study to consider the legalization of cannabis and hashish and reduced penalties for drug users as part of an effort to “humanize” their treatment.⁶¹

There are government AIDS centers, health facilities charged with HIV prevention and AIDS care, in all fourteen provinces of the country. They offer HIV tests and register HIV-positive persons. As in much of the rest of the former Soviet Union, they are not integrated with tuberculosis, STI, or narcology centers. The AIDS centers in Karaganda, Temirtau, and Almaty have offered combination antiretroviral therapy to a small number of persons living with the disease, but drug users in Karaganda have been excluded unless they show themselves to be drug-free for at least six months.⁶² As one AIDS activist noted, both drug users and former drug users are deeply suspicious of government health services. Some former drug users have refused antiretroviral treatment because they do not trust the government services and believe that the medicines may be toxic.⁶³ Antiretroviral treatment in other parts of the country appears to be severely limited.

Kazakhstan established a five-year interministerial plan to combat HIV/AIDS for 2001-2005 focusing largely on prevention and epidemiologic surveillance. Implementation of the plan is estimated to cost about U.S.\$150 million, of which the government is seeking about U.S.\$147 million from outside sources.⁶⁴ A proposal was recently made to the Global Fund for HIV/AIDS, Tuberculosis and Malaria toward this end. The plan includes “social protection” of groups vulnerable to HIV infection, lowering “risky conduct,” “upgrading the state policy on attracting the social organizations to solve HIV/AIDS problem,” information and education programs on “a healthy way of life,” upgrading medical services related to HIV prevention, and improving the coordination of prevention programs.⁶⁵

AIDS mortality in Kazakhstan is fueled by a severe tuberculosis problem, and HIV transmission in Kazakhstan is facilitated by high rates of STIs in the population. Kazakhstan has the highest tuberculosis burden in Central Asia.⁶⁶ Although the introduction of “directly observed” treatment, including in some

⁵⁸ Human Rights Watch attended the government press conference announcing the rescinding of the mandatory testing policy in Almaty on August 15, 2002. As of publication date, several officials from multilateral and bilateral organizations as well as government health practitioners on the ground confirmed that the long-standing practice of HIV testing of all persons in pretrial detention has not been fully discontinued. See also “Health Services” section below.

⁵⁹ Substitution or maintenance therapies provide narcotics drug users with access to legal drugs that can substitute for drugs that are illegal or are obtained through illegal means. As the Drug Policy Alliance notes, these programs seek to assist drug users in switching from illicit drugs of unknown quality, purity and potency to legal drugs obtained from health services or other legal channels, thus reducing the risk of overdose and other medical complications, as well as the need to commit crimes to obtain drugs. For heroin addiction, methadone is a “substitution” drug of proven effectiveness. See Drug Policy Alliance, “Reducing Harm: Treatment and Beyond” [online], <http://www.drugpolicy.org/reducingharm/maintenancet/> (retrieved March 6, 2003).

⁶⁰ The methadone programs were originally scheduled to start up in October-November 2002. Human Rights Watch interview with Dr. Sagat A. Altynbekov, director, Republic Scientific-Practical Center of Medico-Social Problems of Addiction, Pavlodar, August 29, 2002.

⁶¹ Zamira Eshanova, “Kazakhstan: President Orders Study On Effects Of Decriminalizing ‘Soft’ Drugs”, Radio Free Europe/Radio Liberty, October 7, 2002, [online], <http://www.rferl.org/nca/features/2002/10/07102002153530.asp>, (retrieved January 20, 2003).

⁶² Human Rights Watch interview with Dr. Nikolai P. Kuznetsov, director, Karaganda AIDS Center, August 17, 2002, Karaganda.

⁶³ Human Rights Watch interview with Nurali Amanzholov, president, Shapagat (NGO supporting HIV/AIDS-affected persons), August 18, 2002, Temirtau.

⁶⁴ UNAIDS National Response Brief.

⁶⁵ Government of Kazakhstan, Programme on Counteracting the AIDS Epidemic in the Republic of Kazakhstan for 2001-2005, Almaty, 2001, pp. 118-119.

⁶⁶ Godinho et al. See also USAID, “Central Asian Republics (Europe and Eurasia): Tuberculosis Control.”

prisons with the support of the international organization Prison Reform International, has reduced tuberculosis mortality in recent years,⁶⁷ thousands remain untreated. Tuberculosis contributes greatly to AIDS mortality in Kazakhstan, as in other countries where there is a great deal of untreated tuberculosis. Kazakhstan is estimated to have the highest incidence of syphilis of all countries in the Europe region of the World Health Organization.⁶⁸ Alarming, while national surveys have shown that adults are aware of HIV/AIDS as a sexually transmitted infection, 36 percent of women and 16 percent of men in 1999 had not heard of STIs other than HIV/AIDS.⁶⁹ At the same time, 22 percent of unmarried men reported having multiple sex partners, and condom use was reportedly very low.⁷⁰ A 1999 survey of university students in Almaty indicated that up to 30 percent had at some point contracted a sexually transmitted infection.⁷¹

It is difficult to judge the success of government efforts to address the epidemic so far. The government's AIDS program is extremely underfunded. Planning and targeting of activities are handicapped by the lack of reliable figures on new and existing cases. The long tradition of using health facilities for mandatory testing for HIV and other infections and the lack of confidentiality of testing and other services make user-friendly services for drug users, sex workers, and people with AIDS the exception rather than the rule. The incomplete implementation of the decision to eliminate mandatory testing of persons in state detention may contribute to a lack of confidence on the part of drug users and others in government AIDS services.

The government has taken the progressive step of ordering a full review of existing laws and regulations with respect to international standards on HIV/AIDS and human rights. The Ministries of Justice, Health and the Interior as well as United Nations agencies are involved in this effort, and at least one human rights NGO has been invited to participate. Dr. Isidora Erasilova, the new director of the National AIDS Program, recently publicly recognized the degree to which stigmatization of drug users has impeded an effective AIDS response, noting that "lack of understanding of the problem [of AIDS] and persecution of drug-takers discourage them from taking part in prevention programs and make them especially vulnerable to contracting HIV."⁷²

⁶⁷ USAID, "Tuberculosis Control".

⁶⁸ Godinho et al., p.6. The prevalence of STIs among sex workers is also reported to be high. A study of selected sex workers conducted in the past two years showed that 60 to 70 percent suffer from STIs at any one time. And in Almaty, an AIDS Center doctor told Human Rights Watch that of female sex workers tested for HIV/AIDS and STIs, there was up to 60 percent syphilis prevalence and up to 80 percent chlamydia prevalence. U.N., "Support to National Strategic Plan Against HIV/AIDS, STIs and Injecting Drug Use," Almaty, June 12, 2002, p. 2; Human Rights Watch interview with doctor on duty at Almaty AIDS Center mobile trust point, Almaty, September 11, 2002.

⁶⁹ Academy of Preventive Medicine of Kazakhstan, *Demographic and Health Survey 1999* (Calverton, MD: Macro International, 2000).

⁷⁰ Ibid.

⁷¹ Baurzhan Zhusupov, "HIV/AIDS in Kazakhstan," December 2001, [online], <http://www.ilo.ru/aids/docs/dec02/cis/Kazakhstan-eng.pdf>, (retrieved January 23, 2003).

⁷² Dr. Isidora Erasilova quoted in "Number of HIV-positive people..." Interfax, November 28, 2002.

V. ABUSES AGAINST INJECTION DRUG USERS AND SEX WORKERS

Persons at high risk of HIV infection in Kazakhstan, especially injection drug users and sex workers, face systemic harassment and abuse from police. Police in Kazakhstan are notorious for torturing and otherwise mistreating detainees, which has led to growing public mistrust of law enforcement agencies.⁷³ But they routinely target injecting drug users and sex workers because their marginalized status makes them both easy targets for extortion and unlikely to file official complaints of abuse. Testimony gathered for this report describes cases of arbitrary arrest, verbal and physical mistreatment including beating with a baton or fists, physical abuse in some cases constituting torture, extortion, the planting of evidence on an IDU's or sex worker's person, forced sex (including unprotected sex), and coerced confessions. When police commit these abuses against injection drug users and sex workers, they effectively facilitate the spread of HIV AIDS.

These abuses are a recipe for disaster with respect to HIV/AIDS. They fuel the fears and mistrust sex workers and IDUs have of police, and by extension of other authorities, including government AIDS services. For example, a 2002 study among drug users in nine cities of Kazakhstan revealed that IDUs in Almaty and Shymkent in particular practiced high-risk injecting behavior in part due to police persecution;⁷⁴ another 2002 study showed that one group of drug users in Shymkent who had begun to inject six to eleven months earlier had 72 percent HIV prevalence.⁷⁵ Their well-founded fears of official abuse, in turn, discourage these vulnerable persons from seeking information on and treatment for HIV/AIDS. Risky behaviors that could be changed continue unabated.

The abuses are indefensible and cannot be justified as necessary to provide reasonable enforcement of laws related to narcotics use and sex work in Kazakhstan. As a result of having been identified as injection drug users or sex workers, the very people who most need access to accurate information on HIV/AIDS, testing, counseling and other services are either denied access to services because of who they are or subjected to abuse by the authorities. The abuses detailed below thus deepen the social stigma and isolation of marginalized persons, and also make it unlikely that HIV/AIDS prevention or care services will be sought by them or offered respectfully to them.

Police abuse of injection drug users

Our people and society think like this—a drug user is washed up. He's looked upon like a prostitute, like an outcast from society.

Baljan K. twenty-seven-year-old drug user, Pavlodar, September 2, 2002

Injection drug users are easy arrest targets, not only because of their marginalized status in society but because they can be arrested and convicted for very small amounts of drugs, sometimes as small as one dose of heroin.⁷⁶ In Kazakhstan, which is home to the third highest per capita prison population in the

⁷³ Research conducted in 2001 indicated that police in Kazakhstan conduct psychological and physical abuse on up to 65 percent of detainees during the first twenty-four hours of pretrial detention, mainly to extract confessions. The abuse includes beating, thrashing of kidneys, and choking. Forty-one percent of detainees claimed that they had retained traces on their bodies of the mistreatment. Monitoring Committee of Penal Reform and Human Rights, "Sobludenie prav cheloveka politsei pri zaderzhanii po podozrenii v sovershenii presuplenia v techenie pervikh 24 chasov" [The Observance of Human Rights By Police During the First Twenty-Four Hours of Detention], Pavlodar, 2001. Officials have admitted that up to a third of all detentions are illegal. U.S. Department of State, *Country Reports on Human Rights Practices for 2001: Kazakhstan* (Bureau of Democracy, Human Rights and Labor: March 4, 2002) [online], <http://www.state.gov/g/drl/rls/hrrpt/2001/eur/8275pf.htm> (retrieved January 14, 2003).

⁷⁴ Public Opinion Research Centre, "Behavioral Surveillance Among Injecting Drug Users in Nine Cities of Kazakhstan..." p. 27. After Temirtau, Shymkent is said to show the highest prevalence of HIV-positive persons among IDUs. Kossukhin, "HIV/AIDS in Central Asia."

⁷⁵ Center of AIDS Prevention and Control, Ministry of Health of the Republic of Kazakhstan, "Report on Sentinel Epidemiological Surveillance for HIV in the Republic of Kazakhstan in 2002," Almaty, 2002, p. 6.

⁷⁶ Article 259 of the Criminal Code of Kazakhstan imposes penalties for the "illegal production, purchase, storage, transport, transfer or sale of narcotic drugs or psychotropic substances. Large and particularly large amounts of narcotic drugs or psychotropic substances are defined in the Aggregated Table on Determination of the Small, Large and Extra-Large Amounts of Narcotic Drugs and Psychotropic Substances, which is attached to the Law on Narcotic Drugs or Psychotropic Substances Subject to Control in the Republic of Kazakhstan, No. 279-1, July 10, 1998. Some large amounts are 50-1000 grams of dry marijuana, 200-

world at 65,000, one-third of prisoners are reported to be serving sentences based on drug-related convictions.⁷⁷ Injection drug users, government officials, lawyers, and harm reduction workers all repeatedly told Human Rights Watch that police as a rule do not arrest drug dealers, even when they know where the dealers are located, but prefer the more marginalized and impoverished users.⁷⁸ Police must also reportedly fill arrest quotas, a holdover practice from the Soviet era,⁷⁹ and they naturally seek easy targets for arrest.

Regional specialists report that underfunding of police forces, widespread corruption and notorious unprofessionalism has resulted in the direct involvement of police in organized criminal activities throughout Central Asia.⁸⁰ Kazakhstan is no exception. During the course of research for this report, Human Rights Watch collected repeated and consistent testimony from injection drug users, sex workers, government health officials, and harm reduction workers on law enforcement officials who themselves work as agents in and earn profits from the drug and sex trades.⁸¹ Reports of the involvement of law enforcement agents in the drug trade in Tajikistan have been common enough in the past,⁸² and such reports are becoming more common in Kazakhstan. In July 2002, for example, a high-level officer in the Shymkent regional Ministry of Internal Affairs admitted that, in addition to extortion and abuse of office, drug trafficking was an increasingly frequent charge laid formally against police officers in the south of the country.⁸³ Local human rights organizations recognize that injection drug users are systematically subjected to wide-ranging police abuse and numerous due process violations but to date have not conducted extensive monitoring or reporting of the issue.⁸⁴

Numerous injection drug users and other persons interviewed by Human Rights Watch indicated that arrests often take place close to drug dealing points, either as users make their way there or as they return with the purchased drugs.⁸⁵ Moreover, these informants said that although police conduct close and constant surveillance of these locations and detain users, drug dealers themselves are rarely detained. Once apprehended, according to witness accounts, a detainee can be subjected to extortion as an alternative to arrest, can have drugs planted on him or her in order to justify the grounds for the arrest, or can be subjected to threats and physical ill-treatment such as beating with fists or feet. For example, when forty-one-year-old Abdelkasim Begzhanov approached a drug dealing point in Shymkent in March 2000, he claimed that local police at the moment of his arrest planted drugs on his person and beat him. Begzhanov also pointed to reticence on the part of police to apprehend drug dealers:

5000 grams of not dried marijuana, 5-200 grams of hashish, and 0.01-100 grams of opiates (0.01-1.0 grams of heroin). Human Rights Watch interview with Vadim Altyzbekov, deputy director, Anti-Drug Enforcement Unit, Karaganda City Ministry of Internal Affairs, Karaganda, August 19, 2002. IDUs told Human Rights Watch that one dose of heroin, depending on quality, ranges from 0.25 to 0.5 grams.

⁷⁷ After the United States and Russia. 19,000 prison personnel work in Kazakhstan's prison system to administer the large number of detainees. Human Rights Watch interview with Pyotr N. Posmakov, president, Ministry of Justice of the Republic of Kazakhstan Committee of Criminal-Executive System, Astana, September 4, 2002.

⁷⁸ Human Rights Watch interviews in Almaty, Temirtau, Karaganda, Pavlodar and Shymkent, August-September 2002.

⁷⁹ Human Rights Watch did not obtain documentation of a policy requiring police to fill an arrest quota for drug users, however, repeated and consistent allegations of such a policy from the IDUs, sex workers, legal and health professionals, and human rights monitors interviewed appeared credible, particularly in light of similar contemporary practices in the region. Sources also reported that policemen sometimes unreservedly explain to IDUs at the moment of detention that they are under pressure to satisfy a quota. See, in addition, information on police quotas in the Russian Federation, in Human Rights Watch, *Confessions at Any Cost: Police Torture in Russia* (New York: Human Rights Watch, November, 1999), pp. 122-3, and in Uzbekistan, in Human Rights Watch, "And it was Hell all over Again...": Torture in Uzbekistan," *A Human Rights Watch Report*, vol. 12, no. 12 (D), December 2000, p. 5; also International Crisis Group (ICG), *Central Asia: The Politics of Police Reform* (Osh/Brussels: ICG, December 10, 2002), pp. 16, 24.

⁸⁰ ICG, *Central Asia: The Politics of Police Reform*, pp. i, ii.

⁸¹ This testimony coincides with the recently-published findings of ICG, in *Central Asia: The Politics of Police Reform*. The report points to the involvement in drug trafficking, organized crime, and contraband of police and other law enforcement officials in Kyrgyzstan, Tajikistan and Uzbekistan, pp. 9, 17, 25.

⁸² In August 2002, for example, Nikolai Kim, former deputy defense minister of Tajikistan, was sentenced to thirteen years on charges including drug trafficking. *RFE/RL Newswire*, August 12, 2002.

⁸³ Daur Dosybiev, "Kazakhstan: Police Corruption Worsens," Institute for War and Peace Reporting (IWPR), RCA No. 128, July 5, 2002.

⁸⁴ Human Rights Watch interviews with Zhemis Turmagambetov, deputy director, Kazakhstan International Bureau of Human Rights and the Rule of Law (KIBHR), Almaty, August 14, 2002; Anara Irbaeva, head, Astana section of KIBHR, Astana, September 4, 2002; Konstantin Kovtunets, secretary, Monitoring Committee of Penal Reform and Human Rights, Pavlodar, September 1, 2002; and Svetlana Kovliagina, lawyer, Pavlodar, September 2, 2002.

⁸⁵ Interviewees were unable or unwilling out of fear of retaliation to name police agents responsible for abuse.

I was walking there, where they sell [the drugs], they [the police] saw me, took my money, pushed it [the drugs] into my pocket, and beat and beat me . . . there were four to five of them, and I was alone . . . they spread my legs apart and started to beat them [with a club], also on my knees, and then when I was put away they started to beat me on the soles of my feet. . . . you think they [the police] don't know where drugs are sold, who makes them available, but they know perfectly well. They hang out exactly there where the drugs are sold, but they don't catch them, the dealers, you see, they give money [to the police].⁸⁶

Lena Khopoleva, thirty-seven, from Temirtau, told how in 2002 she had been beaten by police in Temirtau while departing a drug dealing point. She said that law enforcement agents' attitude towards HIV-positive persons reinforces their hostility:

I was beaten not long ago; it was near the "Afghan" store. . . . there were two policemen, it was daytime, they led me into a nearby building in ruins and started to beat me. . . . if they find out that you're HIV-positive, then they say, 'Oh, you're the ones, it's because of you, you should all be killed altogether, you aren't human beings'. . . . I was beaten in the head, and on my body, with their fists, I didn't fall down, but then they let me go.⁸⁷

Sometimes police mistreat injection drug users unable or unwilling to comply with extortion demands. They may try to ensure future cooperation or the guarantee that the victim will not report the abuse by presenting him or her with free drugs.⁸⁸ Gavkhar S., the mother of an IDU in Pavlodar, stated that in 2001 her son had been severely beaten when detained by police, accused of drug possession, and unable to make the payment proposed in lieu of detention. Police supplied him with drugs to ease the pain that resulted from the beating:

When he was working and able to pay off the police, he did. But during last year . . . he didn't have any money, and they took him to the outskirts of the city, beat him [with a baton], he was bruised all over. Then they said 'you're going to be in pain,' put a couple of doses in his pocket, and then, when he came home of course he was hurting, and he went to the bathroom and shot up to get rid of the pain. . . . He didn't make a complaint.⁸⁹

Police can also extort or harass relatives of injection drug users to maintain psychological pressure regarding a potential arrest. Another mother of a drug user in Pavlodar told Human Rights Watch that when her son was detained for drug possession in 1997, the responsible policeman had offered her son's release in exchange for free sexual services. The mother agreed to meet with the policeman at a later date, following the release of her son; she explained that she had done so to prevent her son's future arrest.⁹⁰ Injection drug users and their relatives also recounted that relatives will provide money to police to prevent arrests.⁹¹ In Almaty, twenty-one-year-old Viktor T. explained that in 2000 he had both avoided an arrest and received drugs confiscated by the police when his parents paid an extortion fee: "When I started using heroin, in 2000, I was caught by the police...my parents helped me come up with U.S.\$150 to pay them off. When I delivered the money, they [the police] returned the narcotics to me."⁹²

Women injection drug users said police sometimes resort to conducting body cavity searches close to drug-dealing points, suspecting that women hide drugs inside their bodies. These witnesses said some of

⁸⁶ Human Rights Watch interview with Abdelkasim Begzhanov, Southern Kazakhstan Regional Drug Center, Shymkent, August 23, 2002.

⁸⁷ Human Rights Watch interview with Lena Khopoleva, Karaganda AIDS Center, August 19, 2002.

⁸⁸ Future cooperation can also include, for example, the identification of other IDUs.

⁸⁹ Human Rights Watch interview with Gavkhar S., Pavlodar, August 30, 2002.

⁹⁰ Human Rights Watch interview with Leila M., Pavlodar, August 30, 2002.

⁹¹ Ibid.; Human Rights Watch interviews with Valentina Skriabina, director, Reliable Support, Shymkent, August 23, 2002; Baljan N., Pavlodar, September 2, 2002; and Valentina Kniazova, Mothers Against Drugs (Temirtau), Almaty, August 14, 2002.

The following citation, from an interview with a former IDU in Almaty and typical of general testimony on the conduct of police in Kazakhstan, shows the close link between law enforcement agents' low salaries and their extortion practices: "Some policemen say it like this, 'I have a family, I have three children, I have to feed and educate them. How much money do you have?'" Human Rights Watch interview with Vitaly Bumakov, Almaty, September 11, 2002.

⁹² Human Rights Watch interview with Viktor T., Almaty, September 11, 2002.

these body searches led to sex in exchange for the return of seized drugs. Thirty-seven-year-old Lena Khopoleva told Human Rights Watch that in 2001 in Termirtau while departing a drug dealing site she was undressed by local police during a body cavity search and insulted.

It was about a year and a half ago . . . I was coming back from the *yama*⁹³ . . . they lead me into a run-down building nearby, but couldn't find anything on me, so they undressed me, and, frisking me, said, 'Now we'll call the gynecologist, we've got our own in the office, he'll have a look inside' . . . or they've said to me in the past, 'Come on, work it off, and we'll give you back the drugs.'⁹⁴

Under the current repressive drug laws, large numbers of injection drug users serve a prison term at one time or another during the period of their addiction.⁹⁵ Eighty percent of injection drug users interviewed by Human Rights Watch stated that they had received a prison sentence, while official statistics and legal research show that few drug dealers, as opposed to users, are sentenced to prison.⁹⁶ In partial testimony to the strict application of the law, many convicted IDUs interviewed by Human Rights Watch were serving their fourth or fifth sentences on charges of, generally, drug possession or robbery.⁹⁷

Procedural safeguards are also either widely abused or absent during pretrial detention, criminal investigations, and trials.⁹⁸ Among those we interviewed, many injection drug users either could not afford a lawyer, were represented by state-appointed lawyers who provided only a nominal defense, or refused the services of the latter because they lacked faith in state lawyers' willingness to vigorously defend their case.⁹⁹ Law enforcement officials coerce IDUs through physical mistreatment and psychological pressure to deliver confessions or accept false charges, which enable police to meet alleged criminal case quotas.¹⁰⁰ Olga F., a twenty-five-year-old sex worker in Pavlodar, explained that the reason for her two-day detention in 2002 was the need for police to close a robbery case:

I was held at the police station at 5, Lenin Street . . . it was in April, or the beginning of May . . . They wanted to close up a case . . . a robbery case. . . what they really want is for us to give them a free *subbotnik*¹⁰¹. . . if they can't close the case, then they scream, 'prostitute!' and slam the door, pressure her, she ends up admitting to the charges.¹⁰²

Olga F. did not succumb to pressure, but thirty-two-year-old Nurali Amanzholov, from Temirtau, did. He recounted that he had been detained while in possession of drugs and had been coerced to confess to false

⁹³ Literally, "hole." A *yama* is known as a drug dealing point.

⁹⁴ Human Rights Watch interview with Lena Khopoleva, Karaganda AIDS Center, August 19, 2002.

⁹⁵ IDUs constitute up to one third of the prison population. In 2000, 21,000 drug-related crimes were registered; there are approximately 65,000 prisoners in Kazakhstan. Human Rights Watch interview with Pyotr N. Posmakov, Astana, September 4, 2002.

⁹⁶ Ibid. Of the 21,000 drug-related crimes, about 1,000 were linked to drug trafficking. Human rights monitors and lawyers who have conducted recent research into pretrial detention conditions also confirmed that they encountered in the course of their research only detained drug users, not drug traffickers. Human Rights Watch interviews with Konstantin Kovtunets, September 1, 2002, and Svetlana Kovliagina September 2, 2002, Pavlodar.

⁹⁷ Human Rights Watch interviews with IDUs in prison colonies in Pavlodar and Karaganda provinces.

⁹⁸ A lawyer in Pavlodar estimated that up to fifty percent of prisoners had been unfairly convicted as a result of due process violations, with at least half of those violations being committed during criminal searches or due to the failure of officials to present an arrest warrant. Human Rights Watch interview with Svetlana Kovliagina, Pavlodar, September 2, 2002.

⁹⁹ Testifying to the general ineffectiveness of state lawyers, many IDUs stated that they had refused their representation in the belief that they could provide a better defense on their own. Legal research in Kazakhstan indicates that heavy workloads and poor salaries contribute to state lawyers' lack of motivation. Monitoring Committee of Penal Reform and Human Rights Meeting, Pavlodar, May 11, 2001, p. 8; Human Rights Watch interview with Andrei V. Andreev, director, Legal Initiative, Almaty, August 21, 2002.

¹⁰⁰ Monitoring Committee of Penal Reform and Human Rights, "Sobludenie prav cheloveka politsiei pri zaderzhanii po podozreniiu v sovershenii presuplenia v techenie pervikh 24 chasov" [The Observance of Human Rights By Police During the First Twenty-Four Hours of Detention], Pavlodar, 2001.

According to lawyer Svetlana Kovliagina, "The police have to meet their quota—one of the lawyers in our firm previously worked for the police, so he knows all about it—and it's much easier to plant charges on drug users." Human Rights Watch interview, Pavlodar, September 2, 2002.

¹⁰¹ During the Soviet period, a *subbotnik*, from *subбота* (Saturday), was unpaid community service work. For sex work, it means free sex.

¹⁰² Human Rights Watch interview with Olga F., Pavlodar, August 31, 2002.

robbery charges while in pretrial detention. “The police had had a complaint about a robbery, and they needed to find a thief to accuse. So they pinned it on me. I was lucky because I was released after about thirteen months for lack of evidence [on the robbery charge],” he said.¹⁰³

Physical abuse is also employed to extract confessions during the criminal investigation process. Amanzholov continued,

If the drug user is beaten and confesses, he is offered a certain charge. If he accepts the charge, for example, if he already committed a robbery and did a sentence, he is told, “Accept this [other] crime [too].” At trial, he’ll be prepared to accept more because he will have been beaten solid for two days. One year more or less [in prison] is not going to make much difference to him.¹⁰⁴

Drug users interviewed by Human Rights Watch also stated that while in detention many succumb to pressure from law enforcement agents to admit to false charges when supplied by the latter with drugs or temper their complaints about physical abuse when supplied with drugs. Forty-one-year-old Abdelkasim Begzhanov, for example, told Human Rights Watch in Shymkent that he ceased complaints to the prosecutor about torture when pretrial detention center personnel began to supply him with heroin: “. . . [They beat me] with a wooden club. They spread my legs wide apart like this. I had bruises, and I wanted to lodge a complaint with the prosecutor, but they told me, ‘you won’t get anywhere anyway.’ And they began to bring me heroin, so that I wouldn’t complain, so that I wouldn’t have pain, so that I wouldn’t go cold turkey. I shut up.”¹⁰⁵ Other injection drug users and former users said many detainees held in pretrial detention in previous years had confessed to false charges in response to coercive confession techniques applied by officials, and that detention officials had offered drugs to detainees in exchange for confessing to false charges.¹⁰⁶ As Vika S., thirty-four, from Temirtau noted, when drug users are arrested:

. . . those who have money just pay off the police. But those that don’t have money sometimes have false charges “hung” on them. For a dose he or she will accept robbery charges, for example . . . the police give it to them in the pretrial detention center so that they can shoot up. . . . Some detainees take the drugs because they’re really in pain. . . . If he or she has already been convicted for robbery once, then it doesn’t make a difference to them, he or she will take even up to five robbery charges. So they [the police] have a robbery solved, for their crime-solving records, and the drug user gets drugs.¹⁰⁷

A detainee with drugs has power among other inmates, not least because he or she can share the drugs if so inclined.¹⁰⁸

Fifty-two-year-old Sergei T. from Temirtau related that law enforcement officials tampered with material evidence during their criminal investigation to back up the charge against him of possession of an illegal amount of drugs:

I was arrested in 2000, here in Kazakhstan we’re put away for 0.5 grams of drugs. It’s [0.5 grams] considered a *palka* [dose]. I had a half *palka* on me, though . . . when I was arrested [leaving the drug dealing site], I had the drugs in my matchbox, and I tossed the matchbox away from me. Two policemen pounced on me, and started to beat me. I said, “It’s not mine.” At the trial, I stated that I had bought only a half *palka*, which doesn’t even weigh 0.5 grams, and now you’re telling me that I had 0.55 grams. But where in Temirtau can you buy

¹⁰³ Human Rights Watch interview with Nurali Amanzholov, director, Shapagat, Temirtau, August 18, 2002.

¹⁰⁴ Ibid.

¹⁰⁵ Human Rights Watch interview with Abdelkasim Begzhanov, Southern Kazakhstan Regional Drug Center, Shymkent, August 23, 2002.

¹⁰⁶ Human Rights Watch interview with Nurali Amanzholov, Temirtau, August 18, 2002; Alexander Kniazikov, HIV ward, Colony 159/18, Karaganda province, September 7, 2002; and Baljan N., Pavlodar, September 2, 2002.

¹⁰⁷ Human Rights Watch interview with Vika S., Temirtau, August 18, 2002.

¹⁰⁸ Human Rights Watch interview with Nurali Amanzholov, Temirtau, August 18, 2002.

a *palka* that weighs 0.55 grams? I had 0.2 grams on me at the most. This means that they increased the amount when they did the expertise of the material evidence. . . . I've served eight sentences, thirty years altogether, my whole live I've been put away on drug charges.¹⁰⁹

Some witnesses said detainees can often negotiate fees to obtain release from pretrial detention. Kairat D., a twenty-three-year-old former drug user in Termirtau, related that an acquaintance, a casual drug user, had recently bartered his release from detention for U.S.\$50. Kairat stated, "Not long ago I ran into my friend, a drug user who injects drugs from time to time. He got caught with a small amount of drugs, they detained him, and he had to give over [U.S.]\$50. . . . It was in Temirtau, they asked for [U.S.]\$100, but then said, 'Well, if you can just come up with \$50.' He did that, and got released."¹¹⁰

Law enforcement officials are also reported to extort money from detainees and detainees' relatives in exchange for reducing the length of sentences.¹¹¹ Several relatives of injection drug users in Pavlodar, for example, alleged that U.S.\$1000 could buy one year off a prison sentence.¹¹² The mother of an injection drug user in Pavlodar convicted on a robbery charge recounted that a state-appointed lawyer offered to reduce her son's sentence for U.S.\$1000:

A government lawyer named a fixed price—U.S.\$1000. They were going to sentence him anyways, but he said the sentence could be reduced to a minimum of three years general regime. When he offered to meet in his car, I sensed that it wasn't a totally clean deal. . . . I said, 'I'll come with my husband.'—'No need for two people to come along.' So then I got in the car, and he said, 'I can get it down to three years general regime, but you'll have to pay U.S.\$1000.' First of all, I don't work, on one salary it's tough, secondly—what for? I said, 'Where will I get this money?'—'Borrow it.'—'And to pay it back?'—'That's your problem, aren't you concerned for your son?' He was pressuring me psychologically. I spoke with my relatives, we agreed to a smaller sum, and he lowered his price, too. Our bargaining led to [U.S.]\$700.¹¹³

Elena T., forty-four, also a relative of an injection drug user from Pavlodar, told Human Rights Watch that she managed to get the U.S.\$1000 fee demanded by the state-appointed lawyer down to U.S.\$200. She stated,

When my relative was taken in with two grams of heroin, I said, 'Let him go, he needs treatment.' And he [the lawyer] said, 'One thousand dollars.'—'Do you really think I have that sum?'—'A thousand.'—'I don't have it.' Then he said, 'Well, how much can you give?' and we agreed to U.S.\$200 . . . but I didn't give it to him, I made sure I wasn't at home the next day. . . . A year off a sentence costs [U.S.]\$1000. To get a three-year sentence lifted, you just pay \$3000.¹¹⁴

One witness reported that she received a harsher sentence for her infraction because she was HIV-positive. Lena Khopoleva, thirty-seven, asserted that the judge presiding in her trial in 2000 modified her sentence, which would most likely have been a suspended sentence or corrective labor, once her HIV status became known to him:

¹⁰⁹ Human Rights Watch interview, Temirtau, August 18, 2002.

¹¹⁰ Human Rights Watch interview with Kairat D., Temirtau, August 18, 2002.

¹¹¹ A police colonel interviewed by Human Rights Watch denied that incidents of extortion occurred, but remarked that many IDUs are mysteriously released from pretrial detention before trials are completed. He said, "We're responsible for detaining people in possession of drugs. I don't want to say anything negative about our judicial system, but for some reason, often after two or three months, these people are free." He also said relatives of drug users sometimes offer money to police to obtain the release of drug users from detention. Human Rights Watch interview with Vadim Deresinovich Altynbekov, deputy director, Anti-Drug Enforcement Unit, Karaganda City Ministry of Internal Affairs, Karaganda, August 19, 2002.

¹¹² Human Rights Watch interviews with Sultana V., Pavlodar, September 2, 2002; and Elena T. and Lisa M., Pavlodar, August 30, 2002.

¹¹³ Human Rights Watch interview with Sultana V., Pavlodar, September 2, 2002.

¹¹⁴ Human Rights Watch interview with Elena T., Pavlodar, August 30, 2002.

I had been charged with drugs possession I had only a very small amount on me. . . they [the prosecutor] requested a year-and-a-half, then they withdrew for a consultation, afterwards they came out and the judge read my sentence. He gave me a year in prison because I'm HIV-positive . . . [he said], 'you're HIV-positive and you need to be isolated from society.'¹¹⁵

Police corruption and involvement in the drug trade

As demonstrated above, witnesses report that police persecution of injection drug users is advantageous to the police for both extortion income and filling arrest quotas. Those involved in HIV/AIDS-related activities warn that HIV/AIDS and harm reduction workers will continue to fight an uphill battle as long as these practices continue and as long as police continue to be actively involved in the drug trade.¹¹⁶ Law enforcement officers are alleged to provide protection for drug dealers in exchange for cash payments, and, as indicated above, sometimes provide IDUs with drugs either to ensure silence for abuses or to pressure them to accept false charges. There are allegations that individual police officers are directly engaged in drug dealing.¹¹⁷

Injection drug users and sex workers in every city visited by Human Rights Watch asserted that they had either bought drugs from police officers or knew firsthand of such cases, or had been provided with drugs by law enforcement officers. According to Madina L., a twenty-six-year-old drug user from Karaganda, "We were walking through our neighborhood and saw a local policeman, we had come into contact with him several times, he knew us, and we knew him. He approached us, and said, 'Look, I know where you're going, I have six doses, buy them from me.' . . . He had seized them from someone, and then he sold them to us."¹¹⁸ A harm reduction volunteer and former IDU in Almaty pointed out the role of anti-drug enforcement units: "Not long ago an acquaintance of mine was taken in with heroin, he had a few grams, not just a dose, but a few grams. By the way, he bought them from the anti-drug enforcement unit. He gave them [the police] U.S.\$500 and they let him go."¹¹⁹

Human Rights Watch also heard repeated and consistent testimony in all regions visited on the availability of drugs in pretrial detention centers and prisons, where detention personnel are reported to engage in the sale of drugs to prisoners. When asked about the availability of drug in detention centers, twenty-three-year-old Dimitri V. in Temirtau said that it came down to money and connections. He explained,

It's pretty easy if you've got the right amount of money, or connections with the police or prison guards I myself was in the KPZ [*kamera predvaritel'nogo zaklucheniia*, or temporary holding cell at a police station] in Temirtau, and when I went into one of the cells, I got offered hashish right away. I was surprised, but they said, 'Come on, it's so easy, like picking apples off a tree!' I went into another cell, a guy there had just swallowed drugs, because he couldn't boil and inject, there weren't any syringes or the other instruments. He just ate it, swallowed it. It's not a problem, if you've got money you'll get hashish, or heroin, tea, cigarettes, even prostitutes.¹²⁰

¹¹⁵ Human Rights Watch interview with Lena Khopoleva, Karaganda AIDS Center, August 19, 2002.

¹¹⁶ Human Rights Watch did not receive testimony from police confirming their direct participation in the drug trade, however, repeated and consistent testimony from IDUs, government health officials, international organization representatives, harm reduction workers and lawyers lend credibility to this allegation. Further, medical professionals and harm reduction service providers claimed that anti-drug enforcement officers themselves deal drugs.

¹¹⁷ Representatives of an international NGO in Almaty who requested anonymity, and who have been in the forefront of HIV/AIDS prevention activities for several years, told Human Rights Watch that they believed that prominent drug dealers are members of police drug enforcement units and regulate drug market prices. Human Rights Watch interview, Almaty, August 15, 2002. Vadim Deresinovich Altynbekov at the Anti-Drug Enforcement Unit in Karaganda admitted to some cases of police misconduct in the past three to four years, but neglected to indicate whether they were linked to drug trafficking. Human Rights Watch interview, Karaganda, August 19, 2002. For further information on alleged police involvement in drug trafficking see Dosybiev, "Kazakhstan: Police Corruption Worsens."

¹¹⁸ Human Rights Watch interview with Madina L., Karaganda AIDS Center, August 19, 2002.

¹¹⁹ Human Rights Watch interview with Vitaly Bumakov, Almaty, September 11, 2002.

¹²⁰ Human Rights Watch interview with Dimitri V., Temirtau, August 18, 2002.

Several injection drug users told Human Rights Watch that they had first become exposed to and started to take drugs in prison, while others explained that they had initiated drug use directly following their release, citing as reasons desperation in the face of unemployment and lack of family and moral support. According to the United Nations Joint Programme on HIV/AIDS (UNAIDS), a survey of prisoners conducted in 2002 revealed that drugs were widely accessible in detention facilities, that up to 40 percent of prisoners injected drugs in prison, often with dirty needles, and that up to 20 percent engaged in same-sex activity.¹²¹

Police abuse of sex workers

If you're a prostitute, they [the police] think, well, that's the way it is, you're not human.
Luiza P., twenty-six-year-old sex worker, Shymkent August 24, 2002

I've only been working a short time, five months, not like the other women here who've been working for five or eight years. But I've already been through a lot: I've come home with beaten and with bruises, and I've been on subbotniks, and I've had money taken from me, real chaos – what haven't I been through?!

Elena M., thirty-two-year-old sex worker, Pavlodar, August 31, 2002

Organized, not individual, sex work is subject to prosecution under the law in Kazakhstan.¹²² Many sex workers in Kazakhstan's cities are migrants from rural areas and lack official registration documents required to obtain legal residence and city services. Others, for various reasons, including confiscation by law enforcement agents, are missing passports and other personal identification documents.¹²³ This vulnerable status makes them, as with injection drug users, easy and systematic targets for detention and extortion, and leads to further and similar systemic abuses, including verbal and physical mistreatment and rape, often unprotected.

Kazakhstan has seen a dramatic rise in the number of sex workers since the dissolution of the Soviet Union, particularly women and girls, and mostly due to unemployment, falling standards of education, and general desperation. UNAIDS estimates there are 20,000 sex workers in Kazakhstan's main cities.¹²⁴ Although many female sex workers in cities are migrants from rural areas, Human Rights Watch met with several university-educated women who explained that they had turned to sex work because they could not find other employment or because they were lacking personal identification documents necessary to obtain employment. Several university students indicated that they had entered the sex sector on a part-time basis to pay for their studies.¹²⁵ Particularly alarming are increasing reports of child sex workers in the south of the country some as young as eight years old, many of whom are alleged to be children of drug- or alcohol-dependent sex worker parents.¹²⁶

¹²¹ Alexander Kossukhin, UNAIDS, "HIV/AIDS in Central Asia" presentation at "Health Security in Central Asia: Drug Use, HIV and AIDS" conference, Dushanbe, October 16, 2002.

¹²² Uglovny kodeks respubliky Kazakhstan [Criminal Code of the Republic of Kazakhstan], No. 167-1, July 16, 1997, article 128 [online], <http://www.pavlodar.com/zakon/index.html?dok=00087&uro=08270> (retrieved January 26, 2003).

¹²³ As throughout most of the former Soviet Union, although citizens are allowed to move and reside freely throughout the country, they must register with municipal authorities in order to obtain legal residence and city services. This practice results in the detention by police for identity or registration checks of citizens on the grounds of suspicion of criminal or administrative offense. Homeless persons can also be detained on the grounds of missing personal documents for up to one month. Ukaz presidenta 2707 "Ob organakh vnutrennikh del respubliky Kazakhstan" [Presidential Decree No. 2707 "On Ministry of the Interior Bodies of the Republic of Kazakhstan"], December 21, 1995, article 11(2,12), [online], <http://www.pavlodar.com/zakon/index.html?dok=00153&uro=08015> (retrieved January 26, 2003); U.S. Department of State, *Country Reports on Human Rights Practices*.

¹²⁴ Kossukhin, "HIV/AIDS in Central Asia."

¹²⁵ Human Rights Watch interviews with Lyuda F., Pavlodar, August 31, 2002; Dina N., Karaganda, August 20, 2002; Ira S., Shymkent, August 24, 2002; and others, including health professionals.

¹²⁶ Human Rights Watch interviews with Evgenia V. and Zhanna S., Senim, Shymkent, August 22, 2002 and Zhan Berdibaev, director, Alternative, Almaty, August 16, 2002.

Sex workers in Kazakhstan provide a crucial bridge to the population in the spread of HIV/AIDS as drug users sometimes turn to sex work to support their habit.¹²⁷ A 2002 study of injection drug users in nine cities of Kazakhstan revealed that 40.3 percent of female IDUs had sold sex to finance their drug habit during the last six months; the study also showed that just 32.2 percent of those surveyed used a condom at the last sexual contact.¹²⁸ Human Rights Watch also met with and heard of HIV-positive sex workers in each of the five cities visited in Kazakhstan. In Shymkent, the director of an NGO working to support and defend the rights of injection drug users indicated that her organization knew of at least thirty-four HIV-positive sex workers working in that city alone.¹²⁹

Women sex workers face the stigma associated with their profession and the subordination suffered more generally by Kazakh women. Domestic violence in the country is widespread; in one 1999 study conducted by staff at the Shymkent Venereal Hospital, up to 60 percent of women surveyed indicated that they had experienced sexual violence at some point in their lives.¹³⁰ Despite the statistics, violence against women is still largely a taboo topic. The following anecdote is illustrative. Psychologists in the Shymkent Venereal Hospital recounted:

We were at a meeting organized by the commission on family and women's affairs at the district administration, and the district Ministry of Interior representative was in attendance. The secretary of the commission said to him, 'Your boss needs a forty-minute report on violence against women.' Surprised, he looked at the secretary, and answered, 'What's he going to talk about for forty minutes? There's no violence against women here.'¹³¹

Police units tasked with addressing rape and violence against women cases are said to be mostly ineffective, and, in many accounts, distort the information so that the blame is laid on the victim, not on the perpetrator.¹³² Yulia N., a thirty-three-year-old sex worker in Pavlodar, recounted her futile attempt to seek redress from police after having been robbed by a client at gunpoint. The head of the police station in question responded, "You don't have the right to make a complaint! You stand on the road, you get hit on daily, what are you going to do, lodge a complaint every day?"¹³³

Sex workers interviewed by Human Rights Watch said detentions were most frequently linked to a lack of official registration and personal identity documents. Detentions ranged in length from a few hours to a maximum of a month in custody, and were often accompanied by verbal and physical abuse, including beating with fists, feet, and batons. Larisa B., a forty-year-old sex worker in Pavlodar, explained that some weeks earlier local police detained her on suspicion of criminal activities, held her for several hours, and kicked her in the face, leaving severe bruises.¹³⁴ Fellow sex workers Natalya M., twenty-two, and Evgenia S.,

¹²⁷ Human Rights Watch's 2002 research indicated that at least 35 percent of populations of female sex workers encountered across the country were IDUs.

¹²⁸ Public Opinion Research Centre, "Behavioral Surveillance Among Injecting Drug Users in Nine Cities of Kazakhstan (Almaty, Pavlodar, Shymkent, Karaganda, Temirtau, Astana, Petropavlovsk, Uralsk, Ust-Kamenogorsk) Within the Framework of HIV Epidemiological Surveillance," Almaty, 2002, pp. 17-18.

¹²⁹ Human Rights Watch interview with Valentina Skriabina, Shymkent, August 23, 2002.

¹³⁰ Only 20 percent had sought redress. The survey respondents explained their reluctance to seek legal redress for the following three reasons: lack of faith in the ability of law enforcement agencies to provide an effective solution; fear of the attacker; and fear of disclosure. Human Rights Watch interview with staff at the Shymkent Venereal Hospital, August 22, 2002. Other local studies on and groups devoted to fighting violence against women in Kazakhstan also argue that beating of women in the family is prevalent, that women hold the view that violence in the family is a normal form of behavior, and that women are afraid to pursue legal remedies against abusers. See profiles of the work of several local nongovernmental organizations devoted to violence against women on the website of the Open Society Institute (OSI), [online], <http://www.osi.hu/vaw/2002propcount.php> (retrieved January 13, 2003).

¹³¹ Human Rights Watch interview with Ravshan Bigimetbetova, psychologist, Shymkent Venereal Hospital, Shymkent, August 22, 2002.

¹³² Staff of the hospital also claimed that in the majority of cases police attempted to place the blame on the victim. Human Rights Watch interviews with Dr. Tatiana Rodina, head doctor, and Ravshan Bigimetbetova, psychologist, Shymkent Venereal Hospital, Shymkent, August 22, 2002, and with sex workers in Pavlodar and Shymkent, August-September 2002. Also U.S. Department of State, *Country Reports on Human Rights Practices*.

¹³³ Human Rights Watch interview with Yulia N., Pavlodar, August 31, 2002.

¹³⁴ Human Rights Watch interview with Larisa B., Pavlodar, August 31, 2002.

twenty-eight, explained that they too were arbitrarily detained at the same time as Larisa B.: “This is how it was, one woman [Larisa B.] was detained for criminal activities, and we got hauled in too. They weren’t right [in doing it], but we were held until four o’clock in the morning. When she [Larisa B.] began to talk, he [a police officer] came up, and kicked her on the chin, then hit her on the cheek, then on the head. That’s what happened.”¹³⁵ Sex workers are subjected to extortion demands or forced to confess to false charges and can remain in custody for up to a month if they are unable to comply with extortion demands and if they lack identity documents. Nazim F., forty, told of two occasions on which she was detained, and paying the “required” sum hastened her release. She told Human Rights Watch, “I was held in the summer [of 2002] . . . it was a “raid,” they take us in and demand money from us . . . 1000 *tenge*¹³⁶ [U.S.\$6.67]. . . I was beaten, with fists, pretty hard. . . . I gave the money and got out . . . A year ago I was detained for a month, didn’t have any money, now I pay the money and get out fast.”¹³⁷

The harsh treatment by police of female sex workers was evident in Shymkent. There, on several occasions, Human Rights Watch at night observed club-swinging uniformed police officers and plainclothes police officers, only a few meters away from sex workers, delivering insults and provocatively hitting the sex workers lightly with clubs. Police pick-up trucks were parked nearby on the street, ready to deliver those detained to the police station.¹³⁸

Police were also reported to attempt to coerce sex workers into admitting to drug possession charges.¹³⁹ For example, Ira S., a thirty-seven-year-old HIV-positive sex worker from Shymkent said she had been pressured to accept drug possession charges and beaten with a water-filled container. She said, “I was held for three days . . . I was beaten, like a man . . . with [their] fists, with a plastic bottle filled with water They wanted me to confess to possession of drugs, but they weren’t mine, I didn’t sign the paper.”¹⁴⁰ But, she added, police also regularly demand free sexual services in lieu of detention or should the detained sex worker not be willing to comply with extortion demands. “They don’t request our services, they forcibly drag us, like in a fight, the car doors open, they pull someone in, take them to a park If they’ve been able to seize one woman, and there are four of them, then they’ll all have sex with her, as things go. That’s a *subbotnik*.”¹⁴¹

Although sex workers said they often find it difficult to negotiate condom use by clients, when their clients are police officers, the women reported feeling powerless to negotiate any of the terms of the sexual transaction, including condom use.

Natalya M., a twenty-two-year-old sex worker from Pavlodar, stated that she had participated in *subbotniks* with police three or four times in order to avoid detention or further harassment, and that she had on those occasions been raped (without condoms) by them under threat of physical abuse.¹⁴² A sex worker from Shymkent, Ella D., twenty-two, reported that she had on several occasions consented to a *subbotnik* instead of risking violence at the hands of police. She claimed,

I get detained because I don’t have a passport. . . they photograph you, ask for money, if you don’t give it they demand a *subbotnik* [in this case, unprotected and unpaid sex] . . . it’s like that for me every time, and if I don’t agree, then I get beaten, with fists, and they’re vulgar with me once they took me by the hair and pushed me into their car, saying ‘if you tell anyone, we’ll plant drugs on you.’¹⁴³

¹³⁵ Human Rights Watch interviews with Natalya M. and Evgenia S., Pavlodar, August 31, 2002.

¹³⁶ In August-September 2002 one U.S. dollar was approximately 150 *tenge*.

¹³⁷ Human Rights Watch interview with Nazim F., Shymkent, August 23, 2002.

¹³⁸ Human Rights Watch observations during interviews with female sex workers on the streets of Shymkent, August 22-24, 2002.

¹³⁹ Many sex workers also claimed that police target them as IDUs, or simply exploit their vulnerable status as individuals without proper identity documents, in an attempt to fulfill arrest quotas.

¹⁴⁰ Human Rights Watch interview with Ira S., Shymkent, August 24, 2002.

¹⁴¹ *Ibid.*

¹⁴² Human Rights Watch interview with Natalya M., Pavlodar, August 31, 2002.

¹⁴³ Human Rights Watch interview with Ella D., Shymkent, August 24, 2002.

Dina N., twenty-one, a sex worker was “managed” by a pimp whose operation was protected by the police in exchange for services that include free and often unprotected sex. In these circumstances, she explained, the sex workers have no choice but to provide whatever sexual services the police demand. As she said of one such occasion, “. . . it was a month ago . . . there were three of us, and they [the police] were about fifteen. We had unprotected sex. They summoned us to an apartment . . . they didn’t pay us anything.”¹⁴⁴

Some witnesses said the low salaries of police led them to treat sex workers and injection drug users harshly, including demands ranging from blatant extortion to requests for help with daily expenses including gasoline and food. Valentina S., twenty-seven, a sex worker in Pavlodar explained, “Sometimes they put you in the [police] car and say, ‘Give me money for gas or I’ll bring you to the station.’”¹⁴⁵

Health professionals, harm reduction service providers, and sex workers themselves claimed that many sex workers practice unprotected sex.¹⁴⁶ Sex workers’ desperate poverty, lack of information, and demands from clients are among the factors that prevent them from resisting unsafe sex or negotiating condom use.¹⁴⁷ Dr. Natalia Rodina, head of the skin and venereal hospital in Shymkent, said that the work of women in prostitution is

. . . difficult and risky . . . sometimes they even disappear, or land in the hospital with injuries resulting from beatings [from clients]. . . . Violence against women [in Kazakhstan] is really part of the picture, because a woman, even if she’s a prostitute, is still a woman, and she’s still subjected to violence here . . . and because of this she goes and has unprotected sex for a miserable 200 *tenge* [about U.S.\$1.33].¹⁴⁸

Muborak K., a nineteen-year-old Tajik migrant working in southern Shymkent, related that a lack of money leading to an inadequate supply of condoms as well as clients’ demands, had kept her from using condoms for periods ranging up to one month. “I don’t have enough condoms . . . I haven’t used one in a month the clients want sex without a condom. They say: ‘If you use a condom, I won’t pay you. That’s why.’”¹⁴⁹ In Pavlodar, thirty-two-year-old Valia F. described a practice, reported in other parts of the country, of opting for unprotected sex for more money: “. . . of course there are times when clients demand unprotected sex. I have clients who don’t use condoms with me, they like it, and then they come back and look for me They’re not sick, we have a good relationship Two or three times a day I get these kinds of clients, and they pay me more.”¹⁵⁰

Human Rights Watch accompanied harm reduction workers on outreach visits to sex workers in Pavlodar, Almaty, and Shymkent. In all these cities, the large majority of sex workers, claiming that their supply was inadequate, requested a greater quantity of condoms than were available for distribution from the harm reduction workers. Many also requested that the harm reduction workers visit them more frequently. Some sex workers complained of short hours and inadequate access to trust points where condoms are distributed.¹⁵¹ In Shymkent, twenty-eight-year-old Sauli A. alleged that closures of trust points on Saturdays or Sundays made it more difficult to obtain condoms when needed and caused an additional financial burden. She said,

If the client says, ‘Sorry, I haven’t got any,’ then we have to buy them ourselves. Not long ago I had taken too few condoms [from the trust point] and it was Saturday and Sunday, and

¹⁴⁴ Human Rights Watch interview with Dina N., Karaganda, August 20, 2002.

¹⁴⁵ Human Rights Watch interview with Valentina S., Pavlodar, August 31, 2002.

¹⁴⁶ Human Rights Watch interviews August-September 2002.

¹⁴⁷ Health professionals and harm reduction workers claimed that the level of knowledge of basic reproductive behavior, STIs and HIV/AIDS was significantly lower among sex workers who migrate from the countryside to Kazakhstan’s larger cities as compared to those from cities.

¹⁴⁸ Human Rights Watch interview with Dr. Tatiana Rodina, Shymkent, August 22, 2002.

¹⁴⁹ Human Rights Watch interview with Muborak K., Shymkent, August 24, 2002.

¹⁵⁰ Human Rights Watch interview with Valia F., Pavlodar, August 31, 2002.

¹⁵¹ A trust point is a confidential and user-friendly harm reduction service site offering some or all of the following: needle exchange, information on safe injection techniques, condom distribution, voluntary HIV and STD screening, HIV/AIDS and drug education literature, psychological counseling, and medical referrals. In Kazakhstan, trust points are mostly located in a range of public health settings including AIDS centers, hospitals, and medical clinics, but some are in unaffiliated office spaces.

then I had to buy more myself . . . that woman who's at the trust point now, she never has time, or she has something else, she says 'Come back another time,' and it makes you think twice about going there.¹⁵²

Police corruption and involvement in sex work

Police corruption in Kazakhstan is also alleged by some witnesses to extend to organized sex work.¹⁵³ Police were reported by witnesses to offer protection to pimps from criminal prosecution in exchange for monetary payments and free sexual services.¹⁵⁴ According to one pimp, the police also balance competing interests between prostitution rings. For example, if one pimp wants to get rid of another because the other's prostitution ring is making more money than his or the other's ring is luring his "girls" away, the pimp may "place an order" with police to arrest and convict his rival for an agreed sum.¹⁵⁵ Volodya M. delivered the following explanation:

I place an order. I promise that I'll pay money or provide girls, and tell them, 'this prostitution ring is interfering with my work.' I know what's going on in the market, in the high-class hotels, for example. In the springtime one of the more expensive hotels was mine, only I was working there. Then there was a reshuffling, and I lost it. Now I'm going through a hard time, always fighting with other firms. Not long ago a few other pimps tried to take my girls—I got rid of them with the help of the police . . . they instigated a criminal case on order, the last criminal case [against pimps] was at my behest. In the middle of August those other pimps got suspended sentences, one two years, another three, and another four.¹⁵⁶

Citing the lack of state protection from abuse, some sex workers asserted that they were shielded from police violence and other harassment if they worked under the management of a pimp.¹⁵⁷ A senior government official in Almaty claimed that police there were reluctant to take criminal action against the management of at least one brothel in Almaty because they themselves were profiting from the brothel.¹⁵⁸

¹⁵² Human Rights Watch interview with Sauli A., Shymkent, August 24, 2002. The trust point in the Pavlodar AIDS Center was closed when Human Rights Watch visited on Sunday, September 1, 2002.

¹⁵³ Human Rights Watch interviews with Sasha M., pimp, Dina N., Ella S., Anara V., and Victoria M., Karaganda, August 20, 2002; and Madina S. and Natasha R., Shymkent, August 22, 2002; and with government health officials and harm reduction workers in Shymkent who requested anonymity, August 22-24, 2002.

¹⁵⁴ Human Rights Watch interviews with Sasha M., pimp, Karaganda, August 20, 2002, and with Madina S. and Natasha R., Shymkent, August 22, 2002.

¹⁵⁵ Human Rights Watch interview with Sasha M. pimp, Karaganda, August 20, 2002. Sasha M. estimated eighteen to twenty-four prostitution rings in Karaganda alone. Also Human Rights Watch interviews with government health officials who requested anonymity, Shymkent, August 22, 2002.

¹⁵⁶ Human Rights Watch interview with Sasha M., Karaganda, August 20, 2002.

¹⁵⁷ *Ibid.*; and Human Rights Watch interviews with Dina N., Ella S., Anara V.F., and Victoria M., Karaganda, August 20, 2002.

¹⁵⁸ Human Rights Watch interview with Dr. Isidora Erasilova, director, National AIDS Program, Almaty, September 9, 2002.

VI. PROBLEMS WITH STATE-RUN AIDS-RELATED SERVICES

Government health services related to the fight against HIV/AIDS continue to a troubling degree to embody the Soviet legacy of controlling and repressive policies. Relevant services are divided among AIDS centers, narcotics rehabilitation and addiction centers, and skin and venereal hospitals (charged with detection and treatment of sexually transmitted infections). Human Rights Watch's observations indicated that some of the AIDS centers are beginning to overcome this legacy by emphasizing voluntary counseling and testing and by offering a range of services under one roof. Persons in high-risk groups are nonetheless fearful that their status as HIV-positive or STI-infected persons, or their being labeled injection drug users, sex workers, or men who have sex with men will become known and used against them if they use government facilities. In addition, many health professionals seemed to have little appreciation for the link between stigma and abuse of persons affected by or at high risk of HIV on the one hand and the spread of the AIDS epidemic on the other. It is thus not surprising that many observers said services at all these institutions are underutilized. In Shymkent, the director of the Shymkent skin and venereal hospital indicated that during the course of the past year just 250-300 clients had come for STI screening, and that of those only 20 percent sought HIV tests.¹⁵⁹ The mistrust of government health services among injection drug users is of particular concern given that HIV prevalence among them is the highest in the high-risk groups. Their most frequent interaction with the government is often through the criminal justice system, as demonstrated by the research in this report.

Officials nonetheless assert positive results of the AIDS centers' prevention efforts in Karaganda and Pavlodar provinces. According to the director of the Karaganda AIDS Center, Dr. Nikolai Kuznetsov, the use of prevention services has resulted in a steady decline of the rate of new HIV infections in Karaganda province since 1998.¹⁶⁰ UNAIDS indicated that two thirds of injection drug users in Temirtau were covered by prevention services.¹⁶¹ In Pavlodar, the head of the AIDS Center, Dr. Fedor F. Fesenko, said 30 to 35 percent of injection drug users in Pavlodar province have access to trust points, and that the HIV infection rate has in 2002 leveled off due to prevention programs.¹⁶² Notably, IDUs and sex workers encountered in Karaganda and Pavlodar indicated to Human Rights Watch that people with AIDS were treated humanely and helped with their clinical problems at the AIDS centers in those two cities, and the center staff reached out particularly to sex workers and drug users in respectful ways, perhaps providing some explanation of reports of the success of preventive efforts.

The government-run AIDS centers espouse confidentiality and anonymity, but certain practices would appear to contradict this policy, and certainly among persons 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.¹⁶³ Officially registered HIV-positive persons are required to register with the local AIDS Center if they change their place of 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.¹⁶⁴

¹⁵⁹ Human Rights Watch interview with Dr. Tatiana Rodina, Shymkent, August 22, 2002. The STI hospital estimates that there are close to 1,000 sex workers in Shymkent, while the Public Opinion Research Centre's 2002 survey on IDUs shows that 40 percent of IDUs turned to selling sex in the previous six months to finance their habit. Public Opinion Research Center, "Behavioral Surveillance Among Injecting Drug Users...", p. 17.

¹⁶⁰ Human Rights Watch interview with Dr. Nikolai P. Kuznetsov, head doctor, Karaganda AIDS Center, August 17, 2002.

¹⁶¹ Ibid.; and Human Rights Watch interview Alexander Kossukhin, UNAIDS, Almaty, August 15, 2002.

¹⁶² There are an estimated 10,000-14,000 IDUs in Pavlodar province, according to the Pavlodar AIDS Center. Human Rights Watch interview with Fedor F. Fesenko, head doctor, Pavlodar AIDS Center, August 29, 2002.

¹⁶³ Human Rights Watch interview with Alexander Kossukhin, UNAIDS, Almaty, August 15, 2002.

¹⁶⁴ To satisfy this requirement, doctors and nurses explain that they have to date supplied false names and addresses. Human Rights Watch interview with doctors and nurses and harm reduction NGO representatives, identities and location withheld, August 2002.

Harm reduction services

Harm reduction services in Kazakhstan include needle exchange, information on safe injection techniques, condom distribution, voluntary HIV and STI screening, provision of written information on HIV/AIDS and drug addiction, psychological counseling and medical referrals. Around the country, fixed and mobile “trust points”—meant to provide confidential and user-friendly services—offer some or all of these services. Needle exchange has a long track record around the world as a highly effective tool for limiting HIV transmission among injection drug users.¹⁶⁵ The U.N. estimates, however, that harm reduction programs can have a significant impact only when at least half of injection drug users in a given community are reached. To date, these services reach only an estimated 8 to 10 percent of high-risk populations in Kazakhstan, and recent studies show that risky behavior is still widespread.¹⁶⁶ In Almaty, the deputy director of the city’s AIDS Center admitted that the center had reached only one to two percent of IDUs in the city.¹⁶⁷ 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.¹⁶⁸ 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.

Drug users recounted that although trust points were a welcome and necessary prevention service, generalized fear, discrimination, and an atmosphere of criminalization continues to prevent their widespread use. Twenty-seven-year-old Baljan K. in Pavlodar stated that fear outweighed the incentive of receiving free syringes:

The trust points are really convenient because you can go and exchange needles at any time of day or night, and get new ones for free. But drug users still aren’t used to being able to come and get free needles. They think that they’re going to be followed, or that something bad will be said about them. It’s better for them to buy syringes for five to ten *tenge* [about U.S.\$0.03-\$0.06] in the drugstore, like they’ve always done.¹⁶⁹

The fear of being identified as an injection drug user and the accompanying stigma are also prevalent, according to twenty-one-year-old Vitaly Bumakov in Almaty: “. . . In any case, drug users are scared, and not only scared, they just don’t state that they use drugs. They hide this, and don’t go to the needle exchange point, rather, they buy needles in the drugstore. They have money for drugs, so they’ll find money for the syringe.”¹⁷⁰ Parents of injection drug users recounted that their children were reluctant to approach needle exchange services due to the stigma surrounding drug use. “Our children don’t go to

¹⁶⁵ A review of research on needle exchange even by a traditionally very skeptical U.S. government confirmed the effectiveness of this intervention with respect to HIV transmission. See, e.g. the U.S. Department of Health and Human Services public statement on this subject of April 20, 1998 [online] at <http://www.hhs.gov/news/press/1998pres/980420b.html> (retrieved March 5, 2003).

¹⁶⁶ U.N., “Support to National Strategic Plan Against HIV/AIDS, STIs and Injecting Drug Use,” p. 3; Public Opinion Research Centre, “Behavioral Surveillance Among Injecting Drug Users in Nine Cities of Kazakhstan...” The government’s national strategic plan to combat HIV/AIDS aims by 2005 to reduce needle and syringe sharing to under 5 percent of IDUs and to have prevention programs cover at least 50 percent of sex workers. U.N., “Support to National Strategic Plan Against HIV/AIDS, STIs and Injecting Drug Use,” p. 3.

¹⁶⁷ Almaty has a population of approximately 1.3 million. Dr. Gulsara Suleimanova estimates the numbers of IDUs in Almaty at 20-25,000. Human Rights Watch interview with Dr. Gulsara R. Suleimanova, deputy director, Almaty AIDS Center, September 12, 2002.

¹⁶⁸ Human Rights Watch interviews with Nurali Amanzholov, Vika S., Alex Pasko, and others, Temirtau, August 18, 2002; and Valentina Kniazova, Almaty, August 14, 2002. In addition, high-risk practices among IDUs in 2002 were still common and overall not significantly different from those in other cities. “Behavioral Surveillance Among Injecting Drug Users in Nine Cities of Kazakhstan...,” p. 15.

¹⁶⁹ Human Rights Watch interview with Baldjan K., Pavlodar, September 2, 2002.

¹⁷⁰ Human Rights Watch interview with Vitaly Bumakov, Almaty, September 11, 2002.

the needle exchange points because they're either afraid, or ashamed, or simply because it's easier to buy in the drugstore."¹⁷¹

'Injection drug users' generally low level of confidence in trust points can be attributed in part to their perception that they will be met with an insensitive reception. 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. Vasily S., a harm reduction volunteer in Pavlodar, related: "If we could create a homelike atmosphere in our trust points . . . they [the IDUs] are always hungry. You need to sit down with a person, chat, offer a cup of tea, some bread, not just 'Here's a needle, okay, need anything else?' . . . They don't need a lot. . . . In short, a person will be more inclined to come [if it's like this]."¹⁷² The approach of some harm reduction workers, however, betrays a lack of appropriate training and propels stigma. As an example, Vitaly Bumakov explained that a recent visit to a trust point located in an Almaty polyclinic had put him on the defensive and made him reluctant to return. Unable at first to locate the needle exchange point, he had asked for directions at the reception area. The receptionist asked why he needed to go there:

'Why would you like to go there?' she asked. I said, 'I'd like to get some syringes.' She responded, in a condescending tone, 'You are aware that they are for drug users only?' She right away made a [negative] judgment about me being a drug user . . . and you know, often the initial reaction, when a person goes for an HIV test, just to get checked, not because he needs the result for a certificate or for the MVD [the Ministry of the Interior], then everybody around him, including the medical personnel, thinks, oh, he's just left his wife, or he's sleeping around.¹⁷³

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 one case in Almaty in 2002, a harm reduction volunteer was arbitrarily detained by police when a booklet on safe injecting practice for drug users was found on his person. His volunteer colleague related:

He took the booklet, "Advice for injecting drug users" . . . then went home, and disappeared for three days. Then he reappeared, and told me that when he had been traveling home in his car he had been stopped for a document check, and when he showed his documents, they saw the booklet. They got interested right away: 'Oh, you're a drug user? Okay, let's check you out,' and they planted drugs on him. He bought them off for \$250 . . . they didn't take in his companion who was in the car too, just him. . . . Now I myself am scared to distribute this literature at the trust point, because they [the police] could find this booklet on people, and get into trouble.¹⁷⁴

The head of the AIDS Center in Pavlodar, Dr. Fesenko, also said police interference with trust points was a continuing problem: "The police can pounce on [IDUs] at the trust and needle exchange points, and put them under surveillance. . . . just recently one of my volunteers, Mikhail Nizhnik, was detained while carrying two boxes of empty syringes. When I found out I called up the police station and only that way got him out."¹⁷⁵ Twenty-year-old Sasha O. and twenty-two-year-old Sagat A., both inmates in Colony 162/2¹⁷⁶ in Pavlodar, told of the case of a fellow prisoner arrested and convicted on drug possession grounds at a drug

¹⁷¹ Human Rights Watch interviews with Vera T. and Lola N., August 30, 2002.

¹⁷² Human Rights Watch interview with Vasily S., Turan, Pavlodar, August 31, 2002.

¹⁷³ Human Rights Watch interview with Vitaly Bumakov, Almaty, September 11, 2002.

¹⁷⁴ Ibid.

¹⁷⁵ Human Rights Watch interview with Fedor F. Fesenko, August 29, 2002.

¹⁷⁶ "Colony" means prison in Russian. Inmates serve labor sentences in colonies, that is, work, while inmates in prisons do not serve labor sentences.

dealing location while carrying on his person an anonymous treatment card from the Pavlodar AIDS Center.¹⁷⁷ They asserted that he was kept in the prison for four months until a judicial review of his case concluded that the arrest was unfounded.¹⁷⁸

The testimony of injection drug users accessing trust points did not suggest regular police surveillance of these sites. But in Pavlodar and Almaty several persons said police conducted regular surveillance of drugstores in order to identify drug users who buy disinfection material 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, as Vitaly Bumakov in Almaty:

. . . It's scary to go to the drugstore because of the police, they stand close to the drugstore and watch, who's buying [syringes]. A person goes in, buys water for injecting, a syringe, which means he shoots up—and the police take him in. . . . Sometimes I injected three or four times with the same needle . . . or used dirty needles . . . when I didn't have enough money on me for new needles, and because of the police it was too frightening to go to the drugstore.¹⁷⁹

General fear of police in practical terms also obstructs harm reduction activity. In Shymkent, for example, harm reduction workers claimed that when police conduct “raids” to fill an arrest quota, numbers of clients frequenting trust points fall significantly and the effectiveness of mobile trust points is also diminished in consequence.¹⁸⁰ The police's widespread targeting of trust points to identify, harass, and arrest injection drug users, 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.¹⁸¹ Nonetheless, problems remain. A 2002 injection drug user survey that covered nine cities in Kazakhstan found 43 percent of respondents pointed to fear of police as a factor limiting their access to disposable syringes available either at trust points or in pharmacies.¹⁸² 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.¹⁸³ Evgenia V., a thirty-four-year-old harm reduction volunteer in Shymkent, stated that police often without explanation seize condoms from peer educators.¹⁸⁴ “Quite often the police grab condoms from the volunteers, when they're conducting raids . . . they need them for themselves, they just take them, no explanation given.”¹⁸⁵ In Almaty, workers who offer harm reduction services to sex workers in a mobile trust point told Human Rights Watch that police who regularly harass sex workers absent themselves on the evenings when the mobile trust point makes its rounds but reappear when it has gone.¹⁸⁶

A high turnover rate in the police force means that constant HIV/AIDS and harm reduction training must be conducted to help prevent police harassment at trust points, but several officials claimed that under funding of governmental HIV/AIDS programs prevents this.¹⁸⁷ Government officials, harm reduction

¹⁷⁷ Many AIDS centers provide clients with anonymous treatment cards, ensuring confidential treatment at AIDS centers, venereal hospitals, and for dermatological and gynecological care.

¹⁷⁸ Human Rights Watch interviews with Sasha O. and Sagat A., Colony 162/2, Pavlodar, September 2, 2002.

¹⁷⁹ Human Rights Watch interview with Vitaly Bukanov, Almaty, September 11, 2002.

¹⁸⁰ Human Rights Watch interview with Valentina Skriabina, and other harm reduction workers, Shymkent, August 23, 2002.

¹⁸¹ Specialists throughout the country told of widespread problems with the police when the trust points first began to function. Police harassed and arrested IDUs directly at the trust points.

¹⁸² Public Opinion Research Centre, “Behavioral Surveillance Among Injecting Drug Users in Nine Cities of Kazakhstan...” p. 20.

¹⁸³ Human Rights Watch interviews with Dr. Nikolai P. Kuznetsov, head doctor, Karaganda AIDS Center; Dr. Nadezhda V.

Kozachenko, State Medical Academy, Dr. Vagif Aliiev, United Nations Development Programme (UNDP) and Andrey Schmidt, director, Zhemchuzhina (Pearl), all in Karaganda, August 17, 2002; and Dr. Tatiana Rodina, Shymkent, August 22, 2002.

The director of the Shymkent AIDS Center, Dr. Ryskulbek S. Baikharashev, also confirmed that drug users continue to be arrested at trust points in Shymkent. Human Rights Watch interview, Shymkent, August 23, 2002.

¹⁸⁴ In the HIV/AIDS and harm reduction spheres, peer educators are drug users working with drug users, sex workers working with sex workers, or men who have sex with men working with other men who have sex with men, for example.

¹⁸⁵ Human Rights Watch interviews with Evgenia V. and Zhanna S., Senim, Shymkent, August 22, 2002.

¹⁸⁶ Human Rights Watch interviews with driver and doctor of Almaty AIDS Center mobile trust point, Almaty, September 11, 2002.

¹⁸⁷ Human Rights Watch interviews with Dr. Ryskulbek S. Baikharashev, director, and Dr. Dauletbek D. Dzhumagaliev, deputy director, Shymkent AIDS Center, Shymkent, August 23, 2002; and Fedor F. Fesenko, August 29, 2002.

personnel, and health workers interviewed by Human Rights Watch in Kazakhstan indicated that police training and sensitization were among the top priorities for making harm reduction and HIV prevention services more effective.

Narcotics treatment services

We have this saying, 'Whoever tries the tears of opium once will weep the rest of their life.'

Inna Zvereva, twenty-nine-year-old sex worker and IDU, Temirtau, August 18, 2002

Helping injection drug users get to the point where they no longer depend on injected drugs is a singularly important HIV prevention strategy. In Kazakhstan, the criminalization of drug users coupled with severely limited access to effective rehabilitation and narcotics addiction treatment means that IDUs are not offered genuine alternatives. Treatment in rehabilitation and narcotics addiction (narcology) centers is often limited and ineffective, in part due to underfunding. Furthermore, rehabilitation programs are often harsh and repressive. Police are frequently present inside the narcology centers, leading to their description as “prison-like,” and some witnesses alleged that police conduct surveillance of outpatients, as in the narcology center in Almaty.¹⁸⁸ Thirty-four-year-old Vika S. from Temirtau told Human Rights Watch:

[In the drug hospital] there was no medication. It was totally closed, like in prison. We had an hour a day to ourselves, and the rest of the day there were police and medical personnel at our doors I was given an injection of two doses of Seduksan, it's like a soporific or sedative. And that's it, I didn't get anything else. I did total cold turkey, just like that . . . I didn't sleep for twenty-five days . . . it all affected my nerves . . . and I think I went back on drugs because it was all too hard on my nerves. If it had been a more gentle treatment, I think I wouldn't have gone back on drugs.¹⁸⁹

All injection drug users consulted by Human Rights Watch who had received treatment in narcology centers said they too 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, had prevented an effective cure. Thirty-year-old Alexander Kniazikov's experience in Pavlodar mirrored that of Vika S. in Temirtau: “Rostovskaya 50' – that's a prison-like regime, it's just not effective. They throw people in cells, they waste away there without any medication, without any moral support, they simply suffer through the physical break. . . . it's really hard . . . I went back on drugs soon afterwards.”¹⁹⁰

Witnesses said private drug treatment clinics often do not offer sufficient psychological or moral support. Baljan N., twenty-seven years old, underwent unsuccessful treatment in a private drug treatment clinic in Pavlodar: “I had paid treatment, I paid U.S.\$100, and the medication cured my addiction. But after the physical dependency was eliminated, I didn't get any moral support. There, you just get treatment so that you're not in pain. After some time I fell back into drug use, it just wasn't effective.”¹⁹¹

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.¹⁹² Another drug user alleged that during his stay in a narcology center in Pavlodar in 2001, drugs could be bought from center personnel.¹⁹³ These claims ring true in light of the comments of a U.N. official in Kazakhstan, who said some staff of narcology centers make extra income for themselves by under-the-table sales of medicines

¹⁸⁸ Human Rights Watch interview with Valeria Gourevich, director, International Harm Reduction, Soros Foundation Kazakhstan, Almaty, August 15, 2002.

¹⁸⁹ Human Rights Watch interview with Vika S., Temirtau, August 18, 2002.

¹⁹⁰ “Rostovskaya 50” is a narcology center in Pavlodar. Human Rights Watch interview with Alexander Kniazikov, HIV ward, Colony 159/18, Karaganda province, September 7, 2002.

¹⁹¹ Human Rights Watch interview with Baljan N., Pavlodar, September 2, 2002.

¹⁹² Human Rights Watch interview with Natalia Babina, epidemiologist, Pavlodar AIDS Center, Pavlodar, September 2, 2002.

¹⁹³ Human Rights Watch interview with Alexander Kniazikov, HIV ward, Colony 159/18, Karaganda province, September 7, 2002.

they take from the centers.¹⁹⁴ An exception to the rule of underfunded narcology centers is the new ultra-modern National Scientific-Practical Center of Medico-Social Problems of Addiction in Pavlodar, the national narcology center. It includes a research and experimental drug rehabilitation center which offers a U.S.\$750 two-month program for a maximum of 100 patients.¹⁹⁵

Methadone substitution therapy for approximately eighty persons in Karaganda and Pavlodar is due to be offered in the first trimester of 2003.¹⁹⁶ Implementation of these projects has been delayed because of strong resistance from narcology center personnel, a number of whom support only those treatment strategies that do not rely on any chemical dependency,¹⁹⁷ while others reportedly fear that illegal revenues gained from providing under-the-table detoxification treatment will be lost should substitution methadone therapy be legalized.¹⁹⁸ The director of the National AIDS Program, Dr. Isidora Erasilova, has nonetheless supported the methadone pilots and also proposed the introduction of substitution methadone therapy in prisons.¹⁹⁹

Lack of access to effective treatment and substitution therapies for drug users, coupled with long-standing stigma and discrimination policies, has led to an overwhelming sense of hopelessness among injection drug users. As twenty-four-year-old Beksod S. from Pavlodar stated, "Here we say, 'The road for drug users leads either to prison or the cemetery.'"²⁰⁰ Experience from other settings shows that hope is a central ingredient to inspire injection drug users to take an active part in the fight against HIV/AIDS.

Lack of antiretroviral treatment

Several AIDS centers have offered combination antiretroviral (ARV) therapy to a small number of persons living with AIDS, but antiretroviral treatment is severely limited in most parts of the country.²⁰¹ All AIDS centers visited by Human Rights Watch offered standard short-course antiretrovirals for pregnant women to prevent HIV transmission to newborns but little or nothing in the way of long-term ARV 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 injection drug users. The large majority of HIV-positive prisoners interviewed by Human Rights Watch had either not heard of ARVs or were unaware of their benefits, and the same was true for many other persons living with AIDS.²⁰² 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.²⁰³

Medical personnel throughout the country attribute the lack of ARV medicine to grossly insufficient state funds. Kazakhstan's five-year interministerial plan to combat HIV/AIDS from 2001-2005 does not make the provision of antiretroviral treatment a high priority, and only recently have national officials begun to note the lack of ARVs and consequent lack of access for persons living with AIDS to essential

¹⁹⁴ Human Rights Watch electronic mail communication with U.N. official in Almaty, January 17, 2003.

¹⁹⁵ At the time of Human Rights Watch's visit to the Center in August 2002, sixty-five patients were undergoing treatment. The detoxification regime is seen by many to be strict, with clients required to sign a contract that forbids even the smoking of cigarettes, however, there are significant psychological, educational and physical training facilities.

¹⁹⁶ The methadone programs were originally scheduled to start up in October-November 2002. Human Rights Watch interview with Dr. Sagat A. Altynbekov, director, Republic Scientific-Practical Center of Medico-Social Problems of Addiction, Pavlodar, August 29, 2002.

¹⁹⁷ Human Rights Watch electronic mail communication with U.N. official in Almaty, January 17, 2003.

¹⁹⁸ *Ibid.*

¹⁹⁹ Human Rights Watch interview with Dr. Isidora Erasilova, Almaty, September 9, 2002.

²⁰⁰ Human Rights Watch interview with Beksod S., Republic Scientific-Practical Center of Medico-Social Problems of Addiction, Pavlodar, August 29, 2002.

²⁰¹ Among the AIDS centers which offer this treatment are Karaganda, Temirtau, and Almaty.

²⁰² Human Rights Watch interviews with persons living with AIDS at Colony 159/17, Karaganda province, September 6, 2002.

²⁰³ Human Rights Watch interview with Nurali Amanzholov, Temirtau, August 18, 2002. A 2002 study of IDUs by the Central and Eastern European Harm Reduction Network (CEEHRN) in the former Soviet bloc region also found the view among survey respondents that as IDUs do not respect life they do not deserve live-saving medication. CEEHRN, p. 12.

treatment.²⁰⁴ The head of the National AIDS Program indicated that discussions have begun on the possibility of acquiring generic antiretroviral drugs for use in Kazakhstan.²⁰⁵

Many medical practitioners apparently hold the view that the treatment is too difficult for injection drug users to follow. In Karaganda, for example, AIDS Center staff required IDUs to demonstrate that they have stopped taking narcotic drugs for at least six months before they “merit” ARV therapy.²⁰⁶ The majority of medical staff interviewed at a male penal colony housing persons living with AIDS in Karaganda province were also of the view that ARVs are in general too difficult to administer.²⁰⁷ In an AIDS epidemic where over 80 percent of those infected are injection drug users, discrimination appears to be shutting out from treatment the population that needs it most. It is possible that part of the overall lack of confidence in AIDS centers and harm reduction programs is due to the perception among persons living with AIDS and other high-risk groups that these institutions do not offer effective clinical care that will significantly contribute to saving their lives.²⁰⁸ There is no shortage of desperation among injection drug users affected by AIDS. Drug users, medical personnel, and AIDS experts told Human Rights Watch that drug overdose and suicide, followed by tuberculosis, were leading causes of death of persons living with AIDS in Kazakhstan.

²⁰⁴ Dr. Isadora Erasilova, the head of the National Aids Program, noted in November 2002 that persons living with AIDS do not have access to ARVs and must wait for symptoms of HIV/AIDS to develop. Interfax, November 28, 2002.

²⁰⁵ Human Rights Watch interview with Dr. Isidora Erasilova, Almaty, September 9, 2002, and remarks, “Health Security in Central Asia: Drug Use, HIV and AIDS” conference, Dushanbe, October 15, 2002.

²⁰⁶ Interview with Dr. Nikolai P. Kuznetsov, Karaganda, August 17, 2002.

²⁰⁷ Human Rights Watch interviews with prison medical staff and at Colony 159/17, Karaganda province, September 6, 2002.

²⁰⁸ Public health experts, among them over 100 Harvard University professors who work on HIV/AIDS, have argued that HIV/AIDS preventive efforts will fail if treatment access is not expanded. Gregor Adams et al., *Consensus Statement on Antiretroviral Treatment for AIDS in Poor Countries*, March 2001, [online], http://www.aids.harvard.edu/conferences_events/2001/consensus_aids_therapy.pdf. (retrieved January 15, 2003).

VII. STIGMA AND DISCRIMINATION

General stigma related to HIV status

Why don't people have a bad attitude towards people with hepatitis, or cancer, why do they only destroy HIV-positive people, their attitude towards us is purely moral, not related to physical appearance, simply moral, and that's a lot worse.

Lena M., twenty-six-year-old HIV-positive sex worker, Pavlodar, August 31, 2002

Persons living with HIV/AIDS in Kazakhstan face severe stigma and social ostracization, as evidenced by social opinion and government policy. Public opinion is fed by misinformation about HIV/AIDS in society at large, including the fear that HIV is contagious through casual contact.²⁰⁹ Some experts and informed observers feel that information campaigns have tended to link HIV/AIDS to “evil” behavior and nourished a “we-they” attitude—that is, clean, moral people versus dirty, evil drug users, and sex workers.²¹⁰ Discriminatory government policy, including mandatory HIV testing and the segregation of HIV-positive prisoners, serves to reinforce this stigma, which is sometimes so strong that HIV-positive persons are rejected by their families. Testimony from witnesses demonstrated that HIV-positive persons are also subjected to severe discrimination in health care, and many persons told of discrimination against persons living with AIDS in employment and housing.

Some persons living with AIDS told of encountering violent attitudes, including among relatives, marked by fear and a lack of information. Alex Pasko, an HIV-positive twenty-three-year-old in Temirtau, described his sister's fear of his disease:

*It's a problem for the entire society, but society doesn't understand this. They think it's only HIV-positive persons' problem, and those close to HIV-positive persons, and the whole society hits on these people. My sister said to me, 'If I had my way, I would gather all of you together and cremate you, or put you behind a barbed-wire fence.' My own sister, whom I love so much and would be ready to give my life for, said this to me.*²¹¹

Another source cited the case of an HIV-positive mother in Pavlodar who was sentenced to a prison term and was unable to hire paid help to look after her children due to disdain and fear among those approached.²¹²

Kazakh media to date have overall reinforced discrimination against drug users and sex workers and shown an alarming lack of knowledge on HIV/AIDS.²¹³ At an August 2002 press conference organized by the National AIDS Program, for instance, questions asked by journalists indicated that they thought segregation of HIV-positive prisoners from other inmates and widespread mandatory HIV testing were sound public health policies.²¹⁴ Additionally, some experts consider that HIV/AIDS informational campaigns and the media have tended to focus almost exclusively on sex workers and drug users, leading the general public to associate HIV/AIDS transmission and infection with these groups only.²¹⁵

²⁰⁹ United Nations Children's Fund (UNICEF), “Young People of Kazakhstan: Along the Path to a Health Lifestyle,” pp. 87-88, and International Planned Parenthood Federation European Network, “Peer-Led Sexuality Education: Results of the Knowledge, Attitudes, Practices and Behaviour (KAPB) Survey,” 2001, p. 21.

²¹⁰ Human Rights Watch interviews with Nina Wessel, Junior Professional Officer, UNAIDS, Almaty, August 13, 2002; Valentina Kniazova, Mothers Against Drugs, Almaty, August 14, 2002; and Leo Jacobs, general director, Decenta, Pavlodar, August 29, 2002.

²¹¹ Human Rights Watch interview with Alex Pasko, Temirtau, August 18, 2002.

²¹² Zhusupov, “Women, Youth and HIV/AIDS in Kazakhstan,” paper presented at Expert Group Meeting “The HIV/AIDS Pandemic and its Gender Implications,” November 13-17, 2000, Windhoek, Namibia [online], <http://www.un.org/womenwatch/daw/csw/hiv aids/Zhusupov.html> (retrieved January 15, 2003).

²¹³ Human Rights Watch interview with Alexander Kossukhin, UNAIDS, Almaty, August 15, 2002; and Dr. Isidora Erasilova, Almaty, September 9, 2002.

²¹⁴ Press conference organized by the National AIDS Program, Almaty, August 15, 2002.

²¹⁵ Human Rights Watch interview with Nina Wessel, Junior Professional Officer, UNAIDS, Almaty, August 13, 2002; and Lena Bondareva, director, Stentor, August 31, 2002.

Discrimination against and marginalization of injection drug users and persons living with AIDS have contributed to recognition of them by charitable organizations as impoverished and underprivileged groups. Organizations such as the National Red Cross in Shymkent, for example, have included persons living with AIDS and injection drug users in its underprivileged groups' clothes and food distributions.²¹⁶ A charitable organization managed by doctors and private interests in Karaganda provides material support including food to HIV-positive mothers and their children.²¹⁷

In large part due to fear and relentless stigma, attempts of persons living with AIDS to unite and organize have so far been extremely limited. Not one person living with AIDS has broadly publicized his or her HIV status, and even NGO workers who have been involved in high-profile harm reduction efforts are reluctant to reveal their HIV status. The one NGO in the country supporting the needs of persons living with AIDS, Shapagat in Temirtau, works to defend the rights of persons living with AIDS by providing them with information on HIV/AIDS, and support in seeking medical care, housing and employment. The organization also aims, among other things, to provide persons living with AIDS with assistance in obtaining the official papers each person needs and finding employment, and is hoping to establish a rehabilitation center to include living quarters, professional training programs, family liaison and document provision support.²¹⁸

Health services

Human Rights Watch's research revealed discrimination in access to health services for persons living with AIDS and persons at high risk of contracting HIV. To be sure, government AIDS centres have made important inroads in ensuring medical treatment for some opportunistic infections of persons living with AIDS,²¹⁹ but fear and prejudice among the medical community continue to obstruct HIV-positive persons' access to basic medical services. Staff at each AIDS center visited by Human Rights Watch said there were doctors in their districts who refused or were reluctant to provide care to persons living with AIDS due to fear or ignorance.²²⁰

The case of Svetlana S. in Temirtau illustrates an incident when medical professionals not only denied a person living with AIDS access to medical services but also violated confidentiality about her HIV status. In July 2002, Svetlana S. summoned an ambulance when an abscess on her leg burst, leading to severe bleeding. When the ambulance arrived at her home, she revealed her HIV status to the ambulance doctor, who thereupon refused to transport her to the hospital. Instead, the doctor immediately placed a telephone call to Hospital No. 3 from the neighbors' apartment; during the course of the conversation Svetlana S.'s HIV status became known to the neighbors. Svetlana S. was ultimately hospitalized and treated in Hospital No. 3, but in the hospital she was subjected by staff to further offensive verbal treatment related to her HIV status. In December 2002, when Svetlana S. lodged an official complaint against the ambulance staff and Hospital No. 3 personnel on the offensive treatment and violation of confidentiality

²¹⁶ Human Rights Watch interview with Malika Jusupova, head, Red Cross National Society, Shymkent Branch, Shymkent, August 23, 2002.

²¹⁷ Human Rights Watch interview with Stop Hunger Now representatives, Karaganda, August 20, 2002.

²¹⁸ Human Rights Watch interviews with Nurali Amanzholov, August 18, 2002, and Dushanbe, October 16, 2002.

²¹⁹ As was the case when harm reduction services were first established, instances of health service discrimination against persons living with AIDS in the earliest years of the epidemic were reportedly widespread. Staff in most of the AIDS centers visited reported that both a growing knowledge about HIV/AIDS and their frequent interventions in cases of discrimination have helped to reduce the number of such cases.

²²⁰ A U.N. official in Almaty as well stated that persons living with AIDS persons are regularly refused dental care and surgery. Human Rights Watch interview, August 13, 2002.

According to the Public Opinion Research Centre's 2002 research on IDUs, only 23 percent of respondents indicated that they had utilized medical services – likely due to stigma and discrimination – during the previous six months. "Behavioral Surveillance Among Injecting Drug Users in Nine Cities of Kazakhstan..." p. 21. A 2002 CEEHRN study shows that on average 73 percent of IDUs in the former Soviet Union have no access to primary care from any source. Emilis Subata, "Injecting Drug Users, HIV/AIDS Treatment and primary care in CEE/FSU: Results of a Region-Wide Survey," presentation at "Health Security in Central Asia: Drug Use, HIV and AIDS" conference, Dushanbe, October 15, 2002.

about her HIV status, the head ambulance doctor claimed that there had been insufficient grounds for her hospitalization, and hospital staff denied altogether the allegations in the complaint.²²¹

Bureaucratic procedures have sometimes resulted in dangerous delays or forced persons living with AIDS to conceal their HIV status in order to get treatment. Alex Pasko recounted how he had resorted to hiding his HIV status in order to gain urgent treatment:

A year ago, I had a tooth pulled, some of the root remained, and there were complications. I went to see a doctor, and he told me that I had three to four days until it blew up, that I had to go for an urgent operation in the provincial hospital in Karaganda. I had to go through the Karaganda AIDS Center to get a recommendation for the operation . . . but I couldn't get the paper. I waited, and waited . . . they told me, 'Run around the Ministry of Health offices, go to see the minister himself.' I said, 'I don't have time for that.' . . . My jaw had seized up, I couldn't talk, and I hadn't been able to chew for a week. The swelling had spread up to my head, from my ear to my temple. . . . I was forced to take other action, I hid my status, and got the operation done.²²²

Other persons with AIDS simply avoid approaching government medical institutions out of fear of refusal of treatment or discriminatory attitudes. Thirty-five-year-old Ira Sakharova, a person living with AIDS and an injection drug user in Temirtau, had been hospitalized previously at a general government hospital. Human Rights Watch encountered her as an inpatient at the Karaganda AIDS Center, where she said:

. . . [In the regular hospital] the attitude is awful. You can see from a person's intonation, from his behavior . . . it's a good thing that they established this hospital, so that we can undergo a cure in peace. If you go to a normal hospital, they can put you in a separate room, and people stare at you as though you were in an animal hospital, everybody comes around and gapes."²²³

Vika S., a thirty-four-year-old injection drug user and person living with AIDS, told Human Rights Watch that consistent reports of insensitive treatment at government health institutions led her to avoid them altogether:

. . . in the hospital the attitude of the doctors and nurses towards [persons living with AIDS] that have been hospitalized from here, well, they're just horrible. They stop speaking [to the patient] as soon as they find out that they're HIV-positive . . . I myself don't go to the hospital, because I know about these attitudes, I try and take care of myself by myself.²²⁴

Shapagat director Nurali Amanzholov told of the refusal of doctors in Temirtau to treat infections caused by, for example, the use of dirty needles, stating that the injection drug users might be HIV-positive. On some occasions when the NGO Shapagat has sought to follow up on cases of the refusal of medical assistance to persons living with AIDS, the doctors in question have either refused to identify themselves or attempted to dissociate themselves from the case.²²⁵

Lack of information about and fear of HIV/AIDS continue to mark the medical establishment, compounding institutional discrimination against high-risk groups. The following event underscores the urgent necessity to intensify training of medical personnel on HIV/AIDS. In August 2002, a group of just over 250 doctors, nurses and other medical personnel sent a letter to President Nazarbaev protesting new

²²¹ "Minutes of a meeting concerning the appeal of S.V. S...va to the deputy akim [mayor]," Temirtau, December 18, 2002, and Human Rights Watch electronic mail correspondence with Nurali Amanzholov, January 8, 2003.

²²² Human Rights Watch interview with Alex Pasko, Temirtau, August 18, 2002.

²²³ Human Rights Watch interview with Ira Sakharova, Karaganda AIDS Center, Karaganda, August 19, 2002.

²²⁴ Human Rights Watch interview with Vika S., Temirtau, August 18, 2002.

²²⁵ Human Rights Watch interview with Nurali Amanzholov, Temirtau, August 18, 2002.

HIV testing guidelines²²⁶ which lift the long-standing national policy of mandatory HIV testing of drug users and those in pretrial detention. In particular, the letter's signatories argued that high-risk groups would not come forward for voluntary HIV testing if there was a fee for testing, and that compulsory testing was necessary so that medical personnel would both be informed of patients' HIV status and be in a position to assume measures necessary to protect themselves against infection and to determine the required treatment.²²⁷ In an encouraging move, the Almaty-based National AIDS Programme responded with a press conference to explain the need for the new testing guidelines,²²⁸ and a vigorous defense of them was published by the National AIDS Program the following day in a leading Almaty daily.²²⁹

The new guidelines are also controversial for health professionals in the southern city of Shymkent, who argued that injection drug users and sex workers should for the time being be mandatorily tested because people in the south of the country are far from being ready to come forward for voluntary testing. The officials also said that the new guidelines should include a directive allowing for the broadening of circumstances requiring compulsory testing including, for example, the capacity to require tests of housewives who are largely confined to the home, or mandatory testing of Kazakh citizens who have spent at least three months abroad.²³⁰ AIDS and harm reduction professionals in Almaty suggested that implementation of the new guidelines would be difficult in institutions which maintain particularly repressive practices; the Almaty narcology center, they pointed out, maintains police to guard patients, and the city hospital charged with sexually transmitted infections refuses treatment to HIV-positive patients.²³¹ In Karaganda province, medical staff in the tuberculosis hospital of Colony 159/17 expressed fear and skepticism when a Ministry of Justice official informed them of the new voluntary testing guidelines. The staff told the official that if all prisoners were held together then HIV/AIDS would spread faster. Seeming not to distinguish the high contagion of tuberculosis from the low level of contagion of HIV, they also asked why, then, tuberculosis-infected prisoners were not held together with those not infected.²³²

Employment and housing

Injection drug users risk dismissal from work once their status as drug users becomes known to employers. Relatives of injection drug users and persons living with AIDS are also subject to firing and professional discrimination if these relations are revealed. Twenty-four-year-old Leila V. said that she had been dismissed from work in 2001 when “. . . an acquaintance told them [my employers] that I was using

²²⁶ Ministry of Justice and Ministry of Health of the Republic of Kazakhstan, Decree No. 575, “Ob utverzhdenii Pravil meditsinskovo osvidetel'stvovaniya na viavlennie zarazheniya virusom immunodefitsita cheloveka” (On the Approval of Medical Rules on Testing for the Human Immunodeficiency Virus), June 11, 2002. The new testing guidelines, nonetheless, still allow for a wide scope for mandatory testing.

²²⁷ Letter to President Nursultan Nazarbaev, signed by 251 medical personnel, Almaty, July 23, 2002. The protective measures the doctors allude to in their letter include a short course of a combination of ARV drugs, sometimes called post-exposure prophylaxis, that has been shown to reduce the risk of HIV transmission among health practitioners who are stuck with an infected needle or have other potentially infective exposures. See, e.g., U.S. Centers for Disease Control and Prevention, Exposure to Blood: What Health Care Workers Need to Know [online], http://www.cdc.gov/ncidod/hip/blood/Exp_to_Blood.pdf (retrieved March 14, 2003).

²²⁸ The press conference was held in Almaty on August 15, 2002.

²²⁹ A letter written by the deputy director of the National AIDS Program responding to concerns raised by the approximately 250 medical personnel was published in *Novoe Pokolenie* (The New Generation) [Almaty], No. 33 (221), August 16, 2002, p. 8. Some health professionals attributed the letter to consternation about a drop in income from mandatory HIV testing; up until that time, it was alleged, a laboratory linked to the National AIDS Program was making a substantial profit off the tests. Human Rights Watch interviews with government and international organization AIDS officials in Almaty, August 15 and September 9, 2002.

²³⁰ Human Rights Watch interview with Dr. Ryskulbek S. Baikharashev, and Dr. Dauletbek D. Dzhumagaliev, Shymkent, August 23, 2002. The need for compulsory testing in the south is a also view shared by some harm reduction workers, who also make the case that southern society is “not ready” for voluntary testing.

²³¹ Human Rights Watch interviews with Valeria Gourevich, Almaty, August 15, 2002, and Dr. Gulsara R. Suleimanova, September 12, 2002.

²³² Tuberculosis, unlike HIV, is airborne and highly contagious. Human Rights Watch attendance at meeting between Nurtai E. Abulmazhinov, deputy director of the medical department of the penitentiary committee of the Ministry of Justice, and medical staff of Colony 159/17 tuberculosis hospital, Karaganda province, September 6, 2002.

Misguided perceptions in the medical community about the transmission of HIV/AIDS and prevention approaches have produced even more radical suggestions from AIDS center professionals in the recent past. When a legal aid group conducted a study of HIV/AIDS-related legislation in the spring of 2001, for example, the head of one AIDS Center was at that time contemplating the possibility of isolating persons living with AIDS in the general population. Human Rights Watch interview with Andrei V. Andreev, director, Legal Initiative, Almaty, August 21, 2002.

drugs, and then my boss asked me to leave.”²³³ Marat S., twenty-nine, described the stigma that feeds such actions:

Society tries to shield itself from interaction with drug users. In any government office or in a private commercial enterprise, if the management finds out that one of their employees is a drug user, they try to fire him by any means. If my management knew that I’m a drug user, I would lose my job right away.²³⁴

Several persons living with AIDS also confided to Human Rights Watch that a fear of professional reprisal against their relatives fed their reluctance to reveal publicly their HIV status.

Lack of personal identity documents required by the government and employers is also a central impediment to landing work. Many injection drug users, sex workers, and HIV-positive persons lack these either because they have not had them returned upon release from prison, or, for example, they have handed them over as collateral when purchasing drugs.²³⁵ Replacing or obtaining the documents is usually burdensome and involves lengthy bureaucratic procedures, obstacles which can be bypassed by paying additional informal fees to officials. However, many injection drug users, sex workers, and persons living with AIDS lack the money to do so.²³⁶ Several sex workers told Human Rights Watch that if they had possessed identity documents and had not faced the difficulties posed in obtaining them, they would not have turned to sex work. The predicament of twenty-seven-year-old sex worker Valentina S. in Pavlodar is an example:

If you don’t have documents you get locked up in a homeless persons’ detention center, and there, they’re supposed to help you get documents, but for some reason they don’t do it. You have to pay them 300 tenge [U.S.\$2], but where am I supposed to get 300 *tenge*? You need to go back to the street to get the 300 *tenge* for a temporary registration certificate. . . . If I had documents I would have got a job a long time ago.²³⁷

Members of high-risk groups also encounter problems in obtaining housing, either due to a lack of official documents, lack of financial resources, or discriminatory attitudes from landlords. Lack of official documents also prevents persons living AIDS from obtaining government-subsidized housing.²³⁸ In Shymkent, the director of the NGO Reliable Support, Valentina Skriabina, described the case of Farida M., an HIV-positive drug user who in 2002 had been detained by police in Shymkent and filmed on videocassette in pretrial detention. After the videocassette was aired on local television, landlords objected to Farida M.’s HIV status and ejected her and her brother from their apartment. At the time of Human Rights Watch’s visit to Shymkent in August 2002, Farida M. had just recently, once again, undergone brief detention by the police. Police did not return her documents to her upon release from detention.²³⁹

Men who have sex with men

Men who have sex with men in Kazakhstan experience such severe stigma and discrimination that outreach to them has been extremely limited, resulting in little reliable statistical or even anecdotal information about the impact of HIV/AIDS on them.²⁴⁰ Government-run AIDS centers and harm

²³³ Human Rights Watch interview with Leila V., Republic Scientific-Practical Center of Medico-Social Problems of Addiction, Pavlodar, August 29, 2002.

²³⁴ Human Rights Watch interview with Marat S. Pavlodar, September 2, 2002.

²³⁵ Human Rights Watch interviews with Sauli A., Shymkent, August 24, 2002; Inna Zvereva, Temirtau, August 18, 2002; Nurali Amanzholov, Temirtau, August 18, 2002; and many others.

²³⁶ *Ibid.*

²³⁷ Human Rights Watch interview with Valentina S., Pavlodar, August 31, 2002.

²³⁸ Human Rights Watch interviews with Nurali Amanzholov, Temirtau, August 18, 2002, and Dushanbe, October 16, 2002.

²³⁹ Human Rights Watch interview with Valentina Skriabina, Shymkent, August 23, 2002.

²⁴⁰ UNAIDS reports that MSM are in practice inaccessible, and that they do not use AIDS services for reasons associated with stigma and coercive preventive practices. A number of HIV cases have nonetheless been documented among this group, including clinical AIDS cases. Kossukhin, “HIV/AIDS in Central Asia,” October 16, 2002. Also U.N., “Support to National Strategic Plan Against HIV/AIDS, STIs and Injecting Drug Use,” p. 3.

reduction workers in general have only miniscule contact with this group²⁴¹ and readily acknowledge that there is little willingness among men who have sex with men to come forward for testing or preventive services. One small-scale 2001 study shows that the prevalence of sexually transmitted infections (STIs) among these men was very high, with over 50 percent of respondents indicating that they had contracted an STI in the preceding year; about 35 percent of those surveyed indicated that they consumed drugs, 9 percent of those via injection.²⁴² Only 35 percent considered it necessary to use condoms to prevent transmission of HIV.²⁴³

Citing further evidence of the menace of rapid HIV transmission via sexual contact among this group's members, UNAIDS stated that rising levels of HIV/AIDS awareness have not had a positive impact on sexual behavior among men who have sex with men in prisons.²⁴⁴ Andrey Schmidt, the head of an NGO for gays, lesbians, and bisexuals in Karaganda, emphasized the severe stigma experienced by sexual minorities in Kazakhstan when he stated that HIV/AIDS prevention was a secondary preoccupation for his organization in relation to reducing homophobic attitudes in society at large. He added that in his estimation only 15 percent of members of the gay and bisexual community in Karaganda practice safer sex.²⁴⁵ The deep fear among members of this community prevented Human Rights Watch from conducting other interviews about this high-risk population. Some men who have sex with men declined interviews for fear of reprisal or disclosure.

²⁴¹ The AIDS Center in Karaganda, exceptionally, maintains constant and collaborative contact with an NGO for gays, lesbians and bisexuals, Zhemchuzhina (Pearl); and the Almaty AIDS Center has also done more outreach work with men who have sex with men.

²⁴² UNAIDS, "Study of HIV/STI Behaviour Risks of MSM (men having sex with men) and Their Awareness Level of on [sic] Ways of Transmission and Prevention," 2001, p. 6.

²⁴³ Ibid, pp. 2, 11.

²⁴⁴ Kossukhin, "HIV/AIDS in Central Asia," October 16, 2002.

²⁴⁵ Human Rights Watch interview with Andrei Schmidt, director, Zhemchuzhina (Pearl), Karaganda, August 17, 2002.

VIII. THE PENAL SYSTEM AND ISOLATION OF HIV-POSITIVE PRISONERS

Prisoners in Kazakhstan are at particular risk of contracting HIV/AIDS given generally overcrowded conditions, limited access to prevention services, unprotected sex and sexual abuse, and needle sharing in prison.²⁴⁶ Up until July 2002 it was national policy to conduct mandatory HIV testing of all persons in pretrial detention facilities. Those who tested positive and were convicted were isolated in separate wards in prison colonies in Karaganda province; HIV-positive prisoners with tuberculosis were further segregated in a separate ward.²⁴⁷ New HIV testing guidelines adopted by the Ministry of Health in June 2002 and subsequently adopted by the National AIDS Program have lifted the compulsory testing requirement of those in pretrial detention, and the government has announced that the segregation of HIV-positive prisoners will cease.²⁴⁸ As of this writing, however, the Ministry of the Interior, which oversees pretrial detention centers, had still not fully adopted the new policy, and many HIV-positive prisoners continued to be kept in isolation.²⁴⁹

In addition to the flagrant discrimination inherent in a policy that singles out HIV status, the isolation policy has created significant tensions among HIV-positive prisoners and prison personnel.²⁵⁰ The perception by HIV-positive prisoners of a contradiction between the policy to isolate them for medical reasons but not provide treatment has led to anger and frustration among them. Oleg Akhmetov expressed frustration on behalf of the prisoners: "At first they said we had to be isolated [because we were sick], now they say we're not sick, we're normal...they're demanding the impossible from us!"²⁵¹ The prisoners' demands for treatment have in turn created a hostile attitude among prison personnel, who view and treat HIV-positive prisoners as a prison elite who are physically and psychologically aggressive, prone to exaggeration, and unreasonably demanding.²⁵² Comments typical of those made to Human Rights Watch by officials who work with HIV-positive prisoners came from Tolgat Kiniskhanovich at the infectious diseases hospital of the prison system in Karaganda province: "We're all suffering from the isolation policy because the prisoners themselves are angry at being segregated . . . and they're aggressive, angry, and lie."²⁵³

²⁴⁶ UNAIDS/IPU, *Handbook for Legislators on HIV/AIDS, Law and Human Rights: Action to Combat HIV/AIDS in View of its Devastating Human, Economic and Social Impact* (Geneva: UNAIDS, 1999), p. 61; U.N., Support to National Strategic Plan Against HIV/AIDS, STIs and Injecting Drug Use, p. 2; and U.S. Department of State, *Country Reports on Human Rights Practices*.

²⁴⁷ These prisoners are Colony 159/18, Colony 159/17 and 159/9. In September 2002, there were approximately 500 HIV-positive prisoners held in isolation in these colonies and approximately fifty in pre-trial detention in Karaganda province. This number varies frequently due to releases and new convictions. As of publication date, HIV-positive prisoners with tuberculosis continued to be isolated from HIV-negative prisoners. Human Rights Watch interviews with Pyotr N. Posmakov, Astana, September 4, 2002; Dr. Vagif Aliiev, Karaganda, August 17, 2002; and Marat Akhmetov, head, Medical Department, Criminal-Executive System, Ministry of Justice, Almaty, August 16, 2002.

Juvenile HIV-positive prisoners were also isolated in a colony for minors in Almaty, and in September 2002, according to Pyotr N. Posmakov, there were eight juvenile HIV-positive prisoners detained there. Human Rights Watch interviews with Pyotr N. Posmakov, Astana, September 4, 2002, and Zhemis Turmagambetov, Almaty, August 14, 2002.

²⁴⁸ Dr. Isidora Erasilova, remarks, press conference organized by the National AIDS Program, Almaty, August 15, 2002; and Human Rights Watch interview with Pyotr N. Posmakov, Astana, September 4, 2002.

²⁴⁹ The Ministry of Justice assumed control of the country's prisons in January 2002, while pre-trial detention centers and police stations remained under the control of the Ministry of the Interior. Notably, numerous and widespread due process violations occur during the first twenty-four hours of detention, making the imperative for the transfer of pretrial detention centers to the Ministry of Justice even stronger. Penal Reform International, informal report received by Human Rights Watch in August 2001; "Sobludenie prav cheloveka politsiei pri zaderzhanii po podozreniu..." p. 49.

²⁵⁰ A guidebook for those working with HIV/AIDS law co-authored by UNAIDS and the Inter-Parliamentary Union points out several negative effects that can result from a policy to segregate HIV-positive prisoners: "...Segregation *per se* reveals HIV status to other prisoners and warders, providing an excuse for abuse and threats, which can enhance stigma and isolation even after release to the community. Mandatory testing and unauthorized disclosure of HIV status in prisons should be prohibited. Both mandatory testing and segregation lead to a false sense of security. Segregation is stigmatizing and implies that casual contact with people living with HIV is unsafe, as well as having no impact on violent or dangerous behaviour which is unrelated to HIV status." UNAIDS/IPU, *Handbook for Legislators on HIV/AIDS, Law and Human Rights*, p. 62.

²⁵¹ Human Rights Watch interview with Oleg Akhmetov, HIV ward, Colony 159/17, Karaganda province, September 6, 2002.

²⁵² Human Rights Watch interviews with Dr. Vagif Aliiev, Karaganda, September 5, 2002; doctors and nurses, HIV ward, Colony 159/17, Karaganda province, September 6, 2002; Tolgat Kiniskhanovich, head, Infectious Diseases Hospital, Criminal-Executive System, Karaganda province, September 7, 2002; Svetlana Turevna, head, Medical Department, Colony 159/18, Karaganda province, September 7, 2002; and Nurtai Abilmazhanov, deputy head, medical department, Ministry of Justice of the Republic of Kazakhstan Committee of Criminal-Executive System, Karaganda, September 5, 2002.

²⁵³ Human Rights Watch interview with Tolgat Kiniskhanovich, Karaganda province, September 7, 2002.

Lyuba N., a nurse at Colony 159/17, described the excessive amount of energy required for staff working in the HIV wards when she declared, “They consider themselves elitist and special, and they have no regard for the other prisoners, plus, they’re sucking the blood out of us!”²⁵⁴ Tensions have at times reached such a point that HIV-positive prisoners have reportedly smeared doorknobs with their blood, threatened to prick prison staff with syringes covered with their blood, and conducted hunger strikes to protest the inadequacy of their detention conditions.²⁵⁵ Furthermore, the isolation policy does not appear to have contributed to a reduction in risky behavior among those segregated.²⁵⁶

Tensions and misinformation created by the isolation policy also pose challenges for the transition to the integration with the regular prisoner population that would take place under the new policy. HIV-positive prisoners interviewed were overall hostile to the idea of integration in the regular prisoner population, as they felt that their already publicized status would only make them more vulnerable to discrimination and harassment. Some prisoners were also fearful that any new cases of HIV after integration would be blamed on them. HIV-negative prisoners were fearful of and opposed to the idea of integration, asserting that knowledge among prisoners of methods of HIV transmission was still insufficient and that overall poor state of detention conditions would only increase the possibility of contracting the virus.²⁵⁷ Prison staff are fearful of the new policy due to misinformation and a sufficient lack of understanding of HIV transmission,²⁵⁸ but officials are hopeful that integration with the regular prisoner population over time and increased information campaigns will overcome these obstacles.²⁵⁹

Conditions for HIV-positive prisoners in the segregated HIV-positive prisoners’ wards viewed by Human Rights Watch did not appear to differ significantly from those for HIV-negative prisoners. HIV-positive prisoners interviewed indicated they received an adequate diet, including almost daily meat or fish, butter, oil, milk, bread, and dried fruits, approximately the same as for HIV-negative prisoners. HIV-positive prisoners are not fed a special diet unless they become sick with opportunistic infections,²⁶⁰ and they do not carry out demanding physical labor.²⁶¹ Prisoners in the HIV wards were, in the presence of prison staff, physically at ease and unrestrained in their conversations with a Human Rights Watch representative.

Kazakhstan’s prisons are reported to suffer regular shortages of basic medicines and medical equipment, including rubber gloves and facial masks, concerns confirmed by HIV-positive prisoners and prison medical personnel interviewed by Human Rights Watch.²⁶² This situation raises particular concerns for persons living with AIDS, who require specialized medical care and treatment. Medical prescriptions for HIV-positive prisoners are written in close collaboration with the Karaganda AIDS Center.²⁶³ Officials and representatives of international NGOs working in Kazakhstan’s prisons indicated an overall shortage of

²⁵⁴ Human Rights Watch interview with Lyuba N., nurse, HIV ward, Colony 159/17, September 6, 2002. Prison personnel only at Human Rights Watch’s repeated insistence allowed a representative to view part of the HIV ward in Colony 159/18, stating that it was too dangerous due to the “tense and difficult situation between HIV-positive and regular prisoners.” Human Rights Watch interview with Svetlana Turevna, Colony 159/18, Karaganda province, September 7, 2002.

²⁵⁵ Marat Kairbekov, “Turma vnutri turmi,” (“A Prison Within a Prison”) *Yuridicheskaya gazeta* (The Jurisprudence Newspaper), April 17, 2002; Human Rights Watch interviews with Volodya S., Karaganda AIDS Center, August 19, 2002; Nurtai Abilmazhanov, Karaganda, September 6, 2002; and Sergei Znaiko, HIV ward, Colony 159/18, September 7, 2002.

²⁵⁶ Kossukhin, “HIV/AIDS in Central Asia.” HIV-positive persons are at risk of reinfection with HIV, which can speed the progression of AIDS disease.

²⁵⁷ Human Rights Watch interviews with HIV-positive and HIV-negative prisoners, Colony 159/18, Karaganda Province, September 7, 2002.

²⁵⁸ Human Rights Watch interviews with Marat Akhmetov, Almaty, August 16, 2002; prison doctors and nurses at Colony 159/17 tuberculosis hospital and Colony 159/17, Karaganda province, September 6, 2002; and Dr. Vagif Aliev, Karaganda, September 5, 2002.

²⁵⁹ Human Rights Watch interviews with Dr. Vagif Aliev, Karaganda, September 5, 2002; Nurtai Abilmazhanov, Karaganda, September 6, 2002; and with Pyotr N. Posmakov, Astana, September 4, 2002.

²⁶⁰ Human Rights Watch interview with Marat Akhmetov, Almaty, August 16, 2002.

²⁶¹ Human Rights Watch interview with Tolgat Kiniskhanovich, Karaganda province, September 7, 2002.

²⁶² Ibid.; Human Rights Watch interviews with Nurtai Abilmazhanov, Karaganda, September 6, 2002; nurses, doctors and HIV-positive prisoners at Colony 159/17, Karaganda province, September 6, 2002; with HIV-positive prisoners, Colony 159/18; and persons living with AIDS at the Karaganda AIDS Center, August 19, 2002.

²⁶³ Human Rights Watch interviews with nurse and doctors, Colony 159/17, Karaganda province, September 6, 2002.

medication to treat opportunistic infections.²⁶⁴ In particular, a shortage of drugs for treatment of tuberculosis, which leads the list of diseases contributing to AIDS mortality in Kazakhstan, highlights problems of insufficient medication for HIV-positive prisoners.²⁶⁵

Of additional concern is the view encountered among many medical prison personnel that it was not useful to offer HIV-positive prisoners antiretroviral treatment. Medical staff at colonies with HIV-positive prisoners, for example, said they knew cases of HIV-positive patients at the Karaganda AIDS Center who had refused treatment in the belief that it was too difficult to follow or simply ineffective.²⁶⁶ Some medical staff simply that the lack of antiretroviral medicines was the main impediment to offering them in prison.²⁶⁷ Not surprisingly, many HIV-positive prisoners exhibited a general lack of knowledge about the use and effects of antiretroviral treatment.²⁶⁸

A UNDP-sponsored pilot harm reduction project in prisons which includes provision of condoms, sterilization equipment, information on HIV/AIDS and sexual and drug injecting practices currently covers prisons in Karaganda province, Almaty, Astana and Pavlodar. Attempts by the Ministry of Justice to establish harm reduction services in prisons not included in the UNDP-sponsored project program are currently underway.²⁶⁹ Limited supplies of condoms and disinfectant materials were available in the HIV-positive persons' wards as well as in a regular prison colony visited by Human Rights Watch in September 2002 in Karaganda and Pavlodar provinces, while posters and information about HIV transmission were in prominent view.²⁷⁰ A psychological service was ostensibly available to incarcerated HIV-positive persons, although HIV-positive prisoners in Colony 159/18 complained that the service was ineffective or unavailable.²⁷¹

HIV-positive prisoners are released on humanitarian grounds if their medical condition reaches a critical stage.²⁷² According to prison medical staff at Colony 159/17, four HIV-positive prisoners with tuberculosis had been released from the colony since the beginning of 2002.²⁷³ They were unaware of what eventually became of these persons.

²⁶⁴ Human Rights Watch interviews with Dr. Vagif Aliev, Karaganda, August 17, 2002; Svetlana Pak, Penal Reform International (PRI), Almaty, August 16, 2002; Project Hope officials, Karaganda, September 6, 2002; and Nurtai Abilmazhanov, Karaganda province, September 6, 2002.

²⁶⁵ Project Hope, "Kazakhstan: Tuberculosis Management," [online] <http://www.projecthope.org/kazakhstanbt.htm> (retrieved January 15, 2003); Jay Dobkin, "Assessing and Responding to the AIDS Threat in Central Asia," *Eurasia Insight*, March 1, 2001, [online], http://www.eurasianet.org/policy_forum/dobkin030101.shtml (retrieved January 15, 2003).

²⁶⁶ Human Rights Watch interviews with nurses and doctors, HIV ward, Colony 159/17, Karaganda province, September 6, 2002.

²⁶⁷ *Ibid.*

²⁶⁸ Human Rights Watch interviews with HIV-positive prisoners at Colonies 159/17 and 159/18, September 6 and 7, respectively.

²⁶⁹ Human Rights Watch interviews with Dr. Vagif Aliev, Karaganda, August 17, 2002; and with Marat Akhmetov, Almaty, August 16, 2002. A U.N.-sponsored harm reduction project started up in Temirtau, Karaganda province, in 1997.

²⁷⁰ The prison visited in Pavlodar province was Colony 162/2.

²⁷¹ Human Rights Watch interviews with Denis Monatyrov, Dyma Kosov and Albert Zhitbaev, HIV ward, Colony 159/18, Karaganda province, September 7, 2002.

²⁷² Human Rights Watch interviews with Marat Akhmetov, Almaty, August 16, 2002, and with Pyotr N. Posmakov, Astana, September 4, 2002. A prison medical commission with representation from the Karaganda AIDS Center is responsible for determination of humanitarian release. Human Rights Watch interview with Svetlana Nikolaevna, doctor, Colony 159/17, Karaganda province, September 6, 2002. Dr. Gulsara R. Suleimanova at the Almaty AIDS Center also reported that juvenile HIV-positive prisoners are released on humanitarian grounds if their medical condition reaches a critical stage. Human Rights Watch interview, Almaty, September 12, 2002.

²⁷³ Human Rights Watch interview with Svetlana Nikolaevna, doctor, Colony 159/17, Karaganda province, September 6, 2002.

IX. LEGAL STANDARDS

International law

Kazakhstan is not a party to the International Covenant on Civil and Political Rights (ICCPR) nor to its Optional Protocols, but the former Soviet Union was. A 1994 U.N. Human Rights Committee report to the General Assembly reiterated the view that the inhabitants of Kazakhstan and other former Soviet states remain bound by the guarantees of the ICCPR and that the government was bound under its obligations as of the date of independence, including the obligation to submit reports on human rights conditions to the Human Rights Committee.²⁷⁴ As a member state of the Organization for Security and Cooperation in Europe (OSCE) and U.N., it has made a commitment to abide by OSCE standards, among them the Document of the Copenhagen Meeting of the Conference on the Human Dimension of the CSCE, signed in Copenhagen on June 29, 1990 (hereafter the OSCE Copenhagen Document), as well as the principles of the Universal Declaration of Human Rights (UDHR) proclaimed by the U.N. General Assembly in 1948.

Kazakhstan is also a party to the Single Convention on Narcotics Drugs of 1961 and its additional protocol of 1972, the Convention on Psychotropic Substances of 1971, and the U.N. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988. These conventions, among other things, oblige states to provide rehabilitation services for drug users and take measures to halt drug trafficking.

DUE PROCESS GUARANTEES

Article 9 of the ICCPR stipulates that “no one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law.”²⁷⁵ This principle is echoed in section 1.5(5.15) of the OSCE Copenhagen Document, which also guarantees *habeas corpus*: “[A]ny person arrested or detained on a criminal charge will have the right, so that the lawfulness of his arrest or detention can be decided, to be brought promptly before a judge or other officer authorized by law to exercise this function.”²⁷⁶ The UDHR enshrines the principle of protection from arbitrary arrest, detention or exile in its article 9.²⁷⁷

Articles 14 and 15 of the ICCPR ensure the right to a fair and impartial trial. Among the provisions in article 15 is protection from conviction for a crime not committed, that is, “No one shall be held guilty of any criminal offence on account of any act or omission which did not constitute a criminal offence, under national or international law, at the time when it was committed.”²⁷⁸ The OSCE Copenhagen Document ensures these rights under article 1.5, notably, “[I]n the determination of any criminal charge against him, or of his rights and obligations in a suit at law, everyone will be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law.”²⁷⁹

Both the ICCPR and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment prohibit torture and cruel, inhuman or degrading treatment or punishment,

²⁷⁴ Article 49 of the Human Rights Committee Annual Report to the U.N. General Assembly, U.N. Doc. A/49/40 vol. 1 (1994) [online], <http://www1.umn.edu/humanrts/hrcommittee/hrc-annual94.htm>. (retrieved January 14, 2002).

²⁷⁵ International Covenant on Civil and Political Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force Mar. 23, 1976, article 9(1).

²⁷⁶ The Document of the Copenhagen Meeting of the Conference on the Human Dimension of the CSCE, signed in Copenhagen on June 29, 1990, article 1.5(5.15). *Habeas corpus* is also guaranteed under article 9(3-4) of the ICCPR.

²⁷⁷ Universal Declaration of Human Rights, adopted and proclaimed by United Nations General Assembly resolution 217 A (III) on 10 December 1948.

²⁷⁸ ICCPR, article 15(1).

²⁷⁹ Article 1.5(5.16). Further provisions of article 1.5 guarantee that “[A]ny person prosecuted will have the right to defend himself in person or through prompt legal assistance of his own choosing or, if he does not have sufficient means to pay for legal assistance, to be given it free when the interests of justice so require,” and “no one will be charged with, tried for or convicted of any criminal offence unless the offence is provided for by a law which defines the elements of the offence with clarity and precision.” Article 1.5(5.17-5.18).

without exception or derogation.²⁸⁰ The OSCE Copenhagen Document requires participating states to “reaffirm their commitment to prohibit torture and other cruel, inhuman or degrading treatment or punishment, to take effective legislative, administrative, judicial and other measures to prevent and punish such practices, to protect individuals from any psychiatric or other medical practices that violate human rights and fundamental freedoms and to take effective measures to prevent and punish such practices.”²⁸¹

Other nonbinding declarations adopted by the General Assembly of the U.N., such as the U.N. Code of Conduct for Law Enforcement Officials,²⁸² the U.N. Body of Principles for the Protection of All Persons Under any Form of Detention and Imprisonment²⁸³ and the U.N. Standard Minimum Rules for the Treatment of Prisoners (and Procedures for Effective Implementation of the Rules),²⁸⁴ have also become universal norms by which police behavior is evaluated. Kazakhstan committed itself to bringing detention conditions into conformity with the two former declarations in March 2002.²⁸⁵

FREEDOM OF EXPRESSION

The right to receive and impart information without interference is embodied in article 19 of the ICCPR, which states that all persons shall have the right “to seek, receive and impart information and ideas of all kinds, regards of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.”²⁸⁶ Article 9.1 of the OSCE Copenhagen Document clearly sets out that the right to freedom of expression “will include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers.”²⁸⁷

HEALTH

Article 2 of the ICCPR protects all person from discrimination on the basis of “race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status” for the rights recognized in the Covenant.²⁸⁸ This article has been widely interpreted by the U.N. Commission on Human Rights and other U.N. bodies to include both sexual orientation and HIV status as factors on the basis of which discrimination is prohibited.²⁸⁹ The UDHR states that all persons have the right to “a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services.”²⁹⁰ The right to the highest possible standard of health is more explicitly set out in the International Covenant on Economic, Social and Cultural Rights (ICESCR), which stipulates that state parties recognize “the right of everyone to enjoyment of the highest attainable standard of physical and mental health.”²⁹¹ Kazakhstan has not acceded to the ICESCR, another basic and widely ratified treaty to which the former Soviet Union was party.

The Single Convention on Narcotics Drugs of 1961 and its additional protocol of 1972 and the Convention on Psychotropic Substances of 1971, to which Kazakhstan is a party, oblige states in articles 38 and 20, respectively, to establish rehabilitation and social reintegration services for drug users.²⁹² The U.N.

²⁸⁰ ICCPR, article 7, and Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, article 1.

²⁸¹ The OSCE Copenhagen Document, article 16(16.1).

²⁸² General Assembly of the United Nations, Resolution 34/169, December 17, 1979.

²⁸³ General Assembly of the United Nations, Resolution 43/173, December 9, 1988.

²⁸⁴ Economic and Social Council of the United Nations, Resolution 663 C(XXIV) of July 31, 1957 and 2076(LXII), May 13, 1977.

²⁸⁵ Statement by H.E. Mr. Kassymzhomart Takayev, Secretary of State-Minister of Foreign Affairs of the Republic of Kazakhstan at the 58th Session of the UN Commission on Human Rights (March 19, 2002, Geneva), [online], http://www.mfa.kz/english/st_190302.htm (retrieved January 18, 2003).

²⁸⁶ ICCPR, article 19(2).

²⁸⁷ The OSCE Copenhagen Document, article 9(1).

²⁸⁸ ICCPR, article 2(1).

²⁸⁹ See Commission on Human Rights, “The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)” (Resolution 1995/44, adopted without a vote, March 3, 1995).

²⁹⁰ UDHR, article 25(1).

²⁹¹ International Covenant on Economic, Social and Cultural Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force Jan. 3, 1976, article 12.

²⁹² Single Convention on Narcotics Drugs of 1961, as last amended by Protocol of March 25 1972 at Geneva Trb. 1980,184, and the Convention on Psychotropic Substances of 1971, G.A. Assembly res. 366 (IV) of 3 December 1949.

Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988 obliges Kazakhstan in article 14 to “adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, with a view to reducing human suffering and eliminating financial incentives for illicit traffic.”²⁹³

Although they do not have the force of international law, the United Nations Guidelines on HIV/AIDS and Human Rights are frequently used as a guide to policy and law related to HIV/AIDS. Measures to be taken with respect to prisoners are set out in paragraph 29:

Prison authorities should take all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion. Prison authorities should also provide prisoners (and prison staff, as appropriate), with access to HIV-related prevention information, education, voluntary testing and counseling, means of prevention (condoms, bleach and clean injection equipment), treatment and care and voluntary participation in HIV-related clinical trials, as well as ensure confidentiality, and should prohibit mandatory testing, segregation and denial of access to prison facilities, privileges and release programmes for HIV-positive prisoners. Compassionate early release of prisoners living with AIDS should be considered.²⁹⁴

The U.N. Guidelines recommend the protection of the right to confidentiality through the enactment of general confidentiality and privacy laws, and state that “HIV-related information on individuals should be included within definitions of personal/medical data subject to protection and should prohibit the unauthorized use and/or publication of HIV-related information on individuals.”²⁹⁵ Further, public health, criminal and anti-discrimination legislation “should prohibit mandatory HIV-testing of targeted groups, including vulnerable groups.”²⁹⁶

On HIV-related human rights abuses, the U.N. Guidelines suggest that states should establish HIV/AIDS focal points in relevant government branches, including national AIDS programmes, police and correctional departments, the judiciary, government health and social service providers and the military, for monitoring HIV-related human rights abuses and facilitating access to these branches for disadvantaged and vulnerable groups.²⁹⁷

Further, criminal law should be reviewed in order that it not be “an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug users.”²⁹⁸

National law

Kazakhstan’s constitution sets out guarantees against discrimination in article 14, which reads, “No one shall be subject to any discrimination for reasons of origin, social status, property status, occupation, sex, race, nationality, language, attitude towards religion, convictions, place of residence or any other status.”²⁹⁹ The constitution enshrines the right to due process in article 16, which states that “Arrest and detention shall be allowed only in cases stipulated by law and only with the sanction of a court or prosecutor of law. The detained person shall be provided with the right to appeal. Without the sanction of a procurator, a

²⁹³ U.N. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988, G.A. res. 39/141 of 14 December 1984, article 14.

²⁹⁴ Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, “HIV/AIDS and Human Rights International Guidelines” (from the second international consultation on HIV/AIDS and human rights, 23–25 September 1996, Geneva), U.N. Doc. HR/PUB/98/1, Geneva, 1998, par. 29(e).

²⁹⁵ *Ibid.*, article 30(c).

²⁹⁶ *Ibid.*, article 30(j).

²⁹⁷ *Ibid.*, article 44(b).

²⁹⁸ *Ibid.*, article 29(d).

²⁹⁹ Konstitutsia Respubliki Kazakhstan [The Constitution of the Republic of Kazakhstan], August 30, 1995, article 14(2), [online], <http://www.pavlodar.com/zakon/index.html?dok=00004&uro=08014> (retrieved January 23, 2003).

person may be detained for a period no more than seventy-two hours.”³⁰⁰ Further, all persons are entitled to legal defense: “Every person detained, arrested and accused of committing a crime shall have the right to the assistance of a defense lawyer (defender) from the moment of detention, arrest or accusation.”³⁰¹

Article 17 protects citizens from torture, asserting that “[n]o one must be subject to torture, violence or other treatment and punishment that is cruel or humiliating to human dignity.”³⁰² Rights to freedom of expression are enshrined in article 20, which guarantees that citizens shall “have the right to freely receive and disseminate information by any means not prohibited by law.”³⁰³ The Criminal Procedure Code of Kazakhstan also provides safeguards against physical mistreatment. Article 15 states that:

In the case of well-founded grounds demonstrating that a victim, witness, family members or other close relatives participating in a criminal case suffer a threat to their life, are subjected to violence, suffer damage to personal property, or other illegal actions, parties conducting the criminal case are required within their sphere of competence to take measures required by the law to protect the life, health, honor and dignity of those individuals.³⁰⁴

³⁰⁰ Ibid., article 16(2).

³⁰¹ Ibid., article 16(3).

³⁰² Ibid., article 17(2).

³⁰³ Ibid., article 20(2).

³⁰⁴ Ugolovno-protsessual’ny kodeks respubliky Kazakhstan [Criminal Procedure Code of the Republic of Kazakhstan], December 13, 1997, No. 206-1, article 15(3), [online], <http://pavlodar.com/zakon/index.html?dok=00147&uro=08015> (retrieved January 23, 2002).

X. CONCLUSION

“Kazakhstan 2030,” a ubiquitous logo on display on buildings and billboards across the country, is the president’s strategic plan for development through the year 2030. The overarching goal of the plan is ostensibly to improve the health, education, and well-being of all citizens. “Kazakhstan 2030” also aims to ensure that,

[c]itizens living in the year 2030 would be sure that the state would protect their rights and uphold their interests. More than that: they would know that the state would take care of the few who—by virtue of some unfavourable circumstances—failed to win a proper place in the sun and had to appeal to the state for social aid.³⁰⁵

A central element of the plan is to increase the current population of close to 15 million to 25 million by 2030.

The government of Kazakhstan has taken many positive steps in the fight against HIV/AIDS, among them the decision to rescind the policy of mandatory HIV testing, the initiation of a discussion on the “humanization” of drug laws, and pledging the establishment of pilot methadone substitution therapy programs. If the measures promised by these first steps are implemented with urgency, the government will greatly increase its chances of halting the AIDS epidemic in its borders. But these positive steps are marred by a wide range of human rights abuses against persons vulnerable to and those already living with AIDS, abuses which discourage and sometimes prevent these persons from gaining access to life-saving treatment. These abuses only serve to fuel the epidemic.

So far, in the course of this epidemic, there has been a tendency to single out and blame the vulnerable—those who remain in the shadows, outside of the reach of the Kazakh sun. More often than not, persons living with and vulnerable to AIDS experience abuse and discrimination at the hands of the state, rather than being able to enjoy their right to protect themselves from a lethal disease and lead lives of dignity. Were Kazakhstan to restore dignity and the protection of human rights to those affected by the disease, it could indeed provide other countries in the former Soviet Union and beyond with a model for fighting HIV/AIDS.

³⁰⁵ “Message of the President of the Country to the People of Kazakhstan, Kazakhstan—2030,” [online], <http://www.president.kz/main/mainframe.asp?lng=en> (retrieved January 27, 2003).

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A Kazakh "stop AIDS" awareness poster that emphasizes the close link in the public mind between heroin, the white cargo in the railroad car, and the HIV (two cars behind) that is brought along with it.

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Fanning The Flames

How Human Rights Abuses are Fueling the AIDS Epidemic in Kazakhstan

Abuse of the rights of injection drug users and sex workers is fueling one of the fastest growing AIDS epidemics in the world in Kazakhstan. Injection drug users, already subjected to social scorn, regularly face police brutality, lack of due process, false criminal charges that are easy to pin on them, and the absence of humane treatment options for their addiction. The fear and stigma with which they live often make them reluctant to use needle exchange services that could save their lives. Sex workers

in Kazakhstan regularly face rape, other violence and extortion by police. People living with HIV/AIDS face social abandonment as well as discrimination in jobs, housing and government services. Kazakhstan typifies the situation across the former Soviet Union where the flames of rapidly spreading AIDS epidemics are fanned by human rights violations that must be curbed if the epidemic is to be vanquished.



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