Integration of OST, TB, ARV's, Treatment and Scale-up for IDUS
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ALEXANDRA VOLGINA: Well, as I think about that as head of such project in St. Petersburg is that it's very crucial thing to make a treatment for three diseases, actually; HIV, TB and also drug dependence.

So these programs are rather complicated and we meet a lot of challenges trying to work with such programs and that's why we are discussing approaches needed to face the challenges and to help our clients. Our first speaker Zhaksylyk Doskaliyev, the Minister of Health of Kazakhstan. And he will speak Russian so that you really will need the translation, those of us who speak English.

ZHAKSYLYK A. DOSKALIYEV: Dear panel, dear ladies and gentlemen. I would like to tell you that today the theme or the topic for discussion is a very topical question because we have to take into account three different things.

It's HIV, it's TB, it's drug users who have to find the cure and the therapy for them. It's a very topical issue and I would like to inform you about the situation in Kazakhstan, what we are going to do and what we're doing to combat those diseases.

We are really very hard trying to battle the HIV epidemic so we are now in a stage where we have many people who – we have about 10-percent of the whole population of the

country are going through testing for HIV and TB, and we understand the sources, the driving forces of this epidemic and, unfortunately, that's mostly the intravenal– IDUs and the main source of infections.

And unfortunately, the ways of transmission are not only homo, but also heterosexual ways of transmission and up to – from two – or one to two or five [inaudible], five-fold and now we have 35-percent of infected person within village of key groups. That spells about 120,000 people and the people who are really registered, of whom we know, it's about one-third or two-thirds are not being registered.

The IDUS is about one-percent of the population who are older than 15, yes. But then, the official certifical [misspelled?] data, the prevalence of HIV inside of IDUS is three-percent, so it's three-fold of the normal population.

Then the registration of – as of the 1st of January 2001, it's 13,000 more HIV infected amongst the IDU cohorts, and that's about 73 person per 1,000 of the population. HIV infections had a peak – the infection of HIV peaked in the – in the year 2000, and now the concentration is mostly in the cohort of the IDU population.

You can see it here from year to year. More people are living with HIV. In only 2005, it was 3,951 person and to the

end of '09, we had 9,212 end of last year, and I want to tell about half of them are IDUS.

Beginning from 2005, we have – we have very active ARV therapy. This is a triple brand drug therapy and more and more people are getting comport [misspelled?] of this program. But starting from '06, we had 58-percent and now we have 64-percent in last year, so this is rising. And by the end of last year and this year, think will reach 70-percent of that population in need of ORT.

We do have a national program that records the IDU people have an equal access to this therapy. In '06 it was for the three-percent; in '09 it was about 61-percent, so we are really trying to get through to all of them. TB, tuberculosis is one of the most important opportunistic diseases that goes hand in hand with the HIV infection because this is just the system that are the through paths, so HIV is 73-percent and of them, 43-percent inside the IDU group.

Since we can treat both of them in parallel: HIV and TB, we have this one-stop window so we can – people who are getting a therapy against TB and [inaudible] HIV positive, they also get access to the [inaudible] therapy. Those patients who are getting at the same time both therapies: anti TB and then the HIV, we have 10-percent a few years ago and now we have nearly 40-percent in this year.

We have a national program to fight HIV in the country. For this year we have a funding for the ROT [misspelled?] therapy with about 5.5 million USD. Out of this sum, 39-percent will be getting a grant from the Global Fund. The rest is coming from the state budget, but we've got more coming from the Global Fund for the ROT program, 250,000, and this year 460,000, and that's easier for us that we can have some sort of – reach back, lean back for new programs.

We do have a memorandum from the [inaudible] with the Minister of Health of Kazakhstan and UND [misspelled?] and programs with [inaudible] we have a pilot projec– we have a pilot project for OCT, or for OST, or for substitution therapy for who builds the products.

And this OST we get 60 people are getting treatment out of that. From the 60-percent of them are HIV-infected person. One-third of them are also getting access to ORT. How to keep those people on the [inaudible] it's about 75-percent, the people who stay in that therapy.

In Kazakhstan, we have legal framework allowing us to reach all the- thanks to the Global Fund funding– to more and more people of HIV users to switch to this OST and we hope that in 2015, we'll reach out to more than 2,000 people.

Of course, this is a question that raises a lot of antagonism because of this OST, but it's just we have to pick

from two very difficult problems, one that is less harmful and repressive measures leads to the situation that drug dependent people, HIV users, HIV infected are just dropping out of sight and then they are just transmitting the disease to more and more people without our knowledge, so that's why we think this substitution therapy will help us in the fight, not only with the HIV infections, but also with [inaudible] dependency.

The repressive steps don't lead to anything, there's no country in the world of my knowledge where HIV infections were curbed thanks to those repressive measures. And, therefore, in Kazakhstan, we have this doctrine and I think it took away from repressive methods. I think we're on the right way.

According to anti-retrovirus therapy, I think we have to broaden the access also for people infected by HIV or TB because we have to lower the mortality of HIV-infected people. In 2006, HIV – the people who died because of HI – in connection with HIV, 24,000 people living with HIV, but in '09, this number, it's only 14,000, so it dropped by 10,000 people who died of infections in connection with HIV.

So I think that this highly-stepped up therapy really brings – yields some positive results, and, thus, the use of an integrated method of different drugs raises the effectiveness of the treatment, and the quality of life of those people

living with HIV is better and they live a little bit longer. Thank you for your attention. [Applause].

ALEXANDRA VOLGINA: Thank you very much for your presentation. I wanted to say that's a rare thing to hear from the Minister of Health from our region which was about substitution treatment. It was really good for me to hear that because I'm from Russia where substitution treatment is forbidden. Our next speaker Maksym Demchenko, he is the Director of the charity association which helps HIV positive people, the Light of Hope, from Bagdalva [misspelled?] Ukraine.

MAKSYM DEMCHENKO: A very good day to all of you. I'll try to tell you about our experience of our organization. We try to help IDUS and, of course, the rest of the population. I won't dwell upon those problems because we are all specialists, experts who understand this issue.

I do not think that the positive situation in our country differs very much from other countries, but, unfortunately, we do not have the infrastructure [inaudible] and our organizations are not that strong; we can't answer – reach out to all our patients and to all our problems.

We're trying to help each other and we want to show that we have to address a lot of patients. If we ask how many pregnant women are also HIV infected, then we can say that, unfortunately, those women, the pregnant women who are going to

a gynecologist, they'll never get even asked about their status of sero-positivity or negativity, and they might not even know that they are infected.

We do not have any data that we can rely upon. And then, about the discrimination, of course, I wouldn't tell you much because – but there are, of course, cases that IDUs are now – users are now co-dependents. Once they know that this person is HIV-positive they just refuse to treat them. And we know about cases that women were going to give birth to [Missing Audio]. Then this ROT and then social services for syringe exchange programs and OST.

We do not allow- the official part of this program never would reach out to so many patients or clients as they do because we help them. We have to interact, we have to work with them together, and we understand, of course, that the transmission mostly is going through the channel of IDUS and this touches upon the social sphere and the medical sphere.

And we don't have to really– much information disseminated become in between the people most in need of them, so we try to help them with disseminated information about where they can get their services they needed.

And because this is all very divided, an IDU and drug user who has to get some new syringe, he has to go to one place; he has to go to some TB poly clinic and if he is also

HIV infected, he has to go to some other place where they treat this issue.

And sometimes, even geographically, he has to travel half a day to get from one place of service to the other. And the same thing is there is no real interaction between social and medical centers, but it's not only the problem of drug users, but for the whole population as such, because hospitals do not – do not like to treat them and if people do not really contribute and some would just pay for those services, they won't really get the– get the qualified help, because doctors are susceptible to getting money for their services, they wouldn't disclose any information.

If people wouldn't sort of bribe them to tell them where they can find help. No, drug users are not really motivated; they are not really concerned about the status of their health, because an ideal client should just use a half a day's time to get to old people where he can get helpful information and the drug users are not an ideal patient, an ideal client.

Clients, when they can, they get into those centers, but they are not informed about all programs in those centers. We don't have a big percentage of people getting through testing for HIV or TB that's testing. And the diagnosis is the same and therapies to less people.

Now all our organization, it's an NGO, we do find the left out points where we think we have to do something; TB, HIV and other issues. We send our clients to an organization, a service center, but we are not sure that they really would get the services they needed, and they even had those services. And that's our goal, that's our– the things we have to do once somebody turns to us, then we'll have to get their whole– the whole spectrum of those services: medical, therapeutical and we would like that our clients get the full range of services.

We would like to be a one-stop window. We didn't want, because as we know people are not really monitored through their therapist, through their diagnosis. We wanted not only to broaden the spectrum for our services, but also to hike up the quality of our services, and that's what we came up with.

Here you see in the center, it's all clients. So here's $20 for help. We have about 18 programs working, they are going through our organizations, and then we have a social worker, they're there for the different managers program – managers.

They can advise him where to go. Then we have a monitoring program for HIV infected, for TB infected. We have programs for [inaudible], rehabilitation programs, support programs, children support programs and legal focusing programs.

So we would like to be a universal provider of services and we touch upon hepatitis; we can get the consultants about the times when he can get– go to an official HIV center, so we try to get appointments for them and he gets from us in exactly the time and the address and, of course, if this is somebody with a small child, he can leave this child in our child [inaudible] service.

And this program is very effective, much better than the programs where they were working with before. And this is an experience where we thought that we could just spread this program also to official service centers. We have such an HIV center, we have such a monitoring center for people under ROT or hepatitis that you can get services. Syringes you can get therapy for hepatitis B, then you can get some advocacy on pregnancy and, of course, of family planning and of a healthy lifestyle.

We have something like a dispensary where we have a sign of OSCT. We can offer some testing. We have an integrated site for TB there; we have different special doctors, within them is psychiatrists, infectologists, and there we can– in this place, in this site, you also can get the different drugs [inaudible], self-help group.

We have rehabilitation, we have consultantcy [misspelled?] talks which is open for our clients. What else

that we could integrate this harm reduction program, spread the drug reduction programs in our dispensaries and we have services for positive people that registered so we know about them and each quarter of the year, doctors and nurses are visiting them trying to get them to continue their therapy.

They give them information brochures and new syringes, and what we plan for the future on the basis starting from this center, we have reached out to people with alcohol problems, drinking problems. So we'll have some anti-tox center for them there too, for them as a [inaudible]. We can run tests there, again, syringes and we have just surgeries of doctors.

What difficulties do we have with other organizations? It was very difficult to bring together different components like rehabilitation and OST, for instance, because people didn't understand; people working in different services, why should we do that in parallel? Why should we do that together?

But now, we've started a dialogue in between different services and organizations, departments of organizations, and we really want to have scientifically proofs with how we can– not only can, but also we have to have the HIV infected to not only find the HIV infection, but also find new ways if they are IDUS.

Then, of course, it's a staff question. We don't have enough people; we don't have enough money to pay them and, of

course, working together with different other services and organizations, we have a very good scheme [inaudible].

We should – we do have to have a common schedule to plan our way together because social workers have to be something like go-betweens and to really navigate people from where they were to the doctors and service centers where they have to go because sometimes a patient pops up and the doctor hasn't the slightest idea is this now an HIV person or is it a person with TB or something?

And of course, we have to work with administration of our [inaudible]. We have to have some intersect– interrelationship. There are medical services, there are other services and it's very important that we somehow find the sustainable basis to continue our work and even broaden the – to reach out better to our future clients.

A focused regional level is a very important component building block in the whole construction of our work and I think such management would just help us to economize resources and just to use them more efficiently.

And what else we need, we'll have somehow to find what will have to– if a monitoring of the efficacy– on the verification of the efficacy. We have different donors which just want to find out, but that comes with some conditions, so we want to find out how the overall picture is and where the

efficacy is better and what donor and what donor program is bad or not.

Now, about results of our work. You might see where [inaudible] it's a small town. It's only several dozen thousands of inhabitants, but quite a big percent of clients we could just retain them in our programs so the percent of– I can't see the numbers, I hope you see them– would harm reduction.

It's not our work, it's other programs that deal with them and 70-percent that's our work, that's our testing program. And now we have the possibility to reach out to different clients and they got access to different services.

And after one year of this work, we found out that we can have more out of our– more use of our money because we have only one place or we pay for only one place of services, we have everything in one place, so we save our money, we save the money of our donors. And this is very universal– and a very universal and very effective approach. Thank you. [Applause].

ALEXANDRA VOLGINA: Thank you, Maksym, and because Acti [misspelled?] is not here still because of the technical reasons, we can start asking questions, actually, now. So we can start asking questions for our first speakers and. Is anybody ready?

ELIZABETH WILLIAMS: Good morning. My name is Elizabeth Williams. I work as a volunteer for an international organization in the Republic of Kazakhstan, and I would like to ask the Minister of Health in Kazakhstan two questions. Firstly, I was working in the city of Semipalatinsk and I have contacted several HIV-positive people. When they did their analysis for CD4 and for viral load, they had to wait for the results for up to one year or more, which might be too late to initiate or to change antiretroviral therapy.

Secondly, I worked there as a volunteer for one year to obtain a visa to enter the Republic of Kazakhstan. I had to do an obligatory HIV test. So I would like to ask the Minister of Health of Kazakhstan if he is aware of these circumstances and what is his position to them? [Foreign word spoken].

ZHAKSYLYK A. DOSKALIYEV: Thank you for your question. What about this RD [misspelled?]? I told in my presentation, I might repeat it, this is something that has to be put on a sustainable basis.

Those are three drugs, a combination of three drugs. It's a very effective therapy and about the visa regiment and that you had to pass a test on HIV positivity, I didn't know about it; I heard it from you just now, and I don't know about visa regiment, I don't know. Is it the Ministry of Health that's responsible for them?

I think there's another authority and I think I'll pass your question to them. If there are such rules, then probably they're right. If they acted not on the basis of some laws or norms, then we'll have to deal with that.

ALEXANDRA VOLGINA: Any other questions?

ARETHA GILBERG: Good morning, good morning. Thank you very much for the presentations. My name is Aretha Gilberg from Unicef. I have a question to Mak, and I'm sure if it's an issue around the translation, but are harm reduction services included in the work of your NGO, because from the translation, I understood they were not. And if not, why not? And secondly, could you speak a little bit about the support you're providing to the children, which I find very innovative. Thank you.

MAKSYM DEMCHENKO: Yes, thank you for your question. Of course, I spoke in my presentation about children. We have many programs especially for children with responsible parentship and it's just helping to find out HIV positive children.

It's crisis intervention centers and the programs of support we have special centers for children where parents can leave their children up to three hours. We have even English lessons there and they're people playing with them and they're

even helping making their home exercises for them. Did I answer your question?

ALEXANDRA VOLGINA: Let, first of all this woman and then please introduce yourself, okay?

JEANETTE: I'm Jeanette. I'm working in drug prevention and criminality. I was born in Kazakhstan, but now I'm working and responsible for Kazakhstan. I'm very thankful for your very interesting presentation; I'm very glad to hear that OST reaches Kazakhstan and Kazakhstan is even ready to move in that respect to enlarge it and make it more accessible for other people.

I know about Kazakhstan, that Kazakhstan was– changed its legislation and this is a very good point, but I do have an issue. Places of detention is something that nobody speaks about and the shed. We know that in prison the healthcare problems are not the only problems. It's an over population, very bad sanitary conditions, malnutrition, bad ventilation, many conditions that in principle just a bad atmosphere that leads to tuberculosis, to HIV and transmission of those diseases.

And now, I would like to ask you, could you spread this OST or also to prisons, to places of detentions, and services of healthcare and medicine, could they be given under the auspices of the Minister of Health, because OST is growing very

quickly and HIV prophylactics, but not – it's not reaching places of detention.

ZHAKSYLYK A. DOSKALIYEV: Maybe let's start on the second question about the OST, yes? We do have a pilot project and it's going very well. It'll be enlarged – it'll be encompassing more than 200 people and – and 200 is, of course, very representative [inaudible] where you can always make some analysis and make some conclusions, at least primary.

But, of course, to really analyze them, we'll have to have more – more than 2,000 people and that will be into the year 2015, and I think then we'll have enough data and we can then get a really good scientific base, the data, because OST – we need the – we have three – several positions in this connection.

People in the shed, we don't know about them, they are not registered. We are speaking about drug users and you know the drugs they use are not of a very high quality and since they are just addicted, they are all really sick and they can't take everything they are craving.

Then B, I think that the OST will lower the criminality which is connected with getting money to buy drugs, and then I think that this substitution therapy will maybe even eradicate this waste of this IDU use of drugs. And although the reasons why – because understands that those three problems are

interconnected. They're connected with HIV, with drug dependencies, very important.

About the penitentiary system, yes, of course, you are right, unsanitary conditions, and where people live, they eat and they sleep, a very bad– and in some prisons it's terrible to say the truth. And the government, the Minister of Justice, not yet asked us to transfer all medical services to transfer to the Ministry of Health, but in connection with that, we'll have a lot of problems connected with legislation problems because many of our colleagues within penitentiary systems, those are military people.

They have their grades and they may lose their grades and they all maybe may lose some money, so that's difficult. So we are debating that issue. I can't tell you how this will be and whether there'll be such decisions to pass those issues and medical issues to us. But I think in the next five, six months, we'll have to regulate that problem. Thank you. [Applause].

ALEXANDRA VOLGINA: Thank you. And around the second microphone, a question.

FEMALE SPEAKER: Thank you very much the two speakers for the nice presentation. I'm [inaudible] from the World Health Organization in Switzerland. I was really happy to hear that TB services integrated an HIV program and a drug addiction

program, but I would like to have more details on that and ask you if you do offer as a preventive therapy to people living with HIV and IDUs. And my second question is for the one [inaudible] to be diagnosed with TB, do you do drug sensitivity testing to diagnose MDR/TB, OST, as your region is severely it by MDR/TB Thank you.

ALEXANDRA VOLGINA: It's a question for both? For both of you. Okay, who will start?

ZHAKSYLYK A. DOSKALIYEV: Since it's a question directed to us both, I'll start. Both prevention measures [inaudible] just mentioned the different screening programs – [inaudible] screening programs connected with IDUs who are drug users, that were the first ones who are HIV.

But now, as I told you, we have those screening programs [inaudible] HIV infected and also TB infected, and those preventative measures that are very important that should be included in the national programs in every country.

Now about HIV and TB infections? HIV infected people are also prone to get the TB virus because the immune system of people who are living with HIV is very low; and of course the TB virus is very active and in a very short spread of time. It affects the immune system, which was already HIV infected.

It goes to the pulmonary system, and so on. And we do have this principle once the window was a pour closing, losing

Kazakhstan, in the HIV-infected person who also got TB, he can get the therapy, [inaudible] in Kazakhstan is treated against HIV and TB. Of course, this is a system that is adapted to the needs of all countries, plus RT because the two therapies have made been compatible. You can't only fight TB and stop ART.

This is the wrong accesses. We think those patients will have to get a compatible therapy, and comparable so they can be on therapy for all of those disease.

Now the NGO; we have service exchange points, we organized several times of [inaudible] to places where I use lift and help them on the [inaudible]. And then at our office and different centers, try to get those people to [inaudible] to infection is to doctors, and we have some consultants. So we try. It's the safest HIV center and community center.

So, we have a program of [inaudible] and people this triple problem of HIV and drug users, and they are affected by TB.

ALEXANDRIA OLGINA: Our last question and we'll turn it over to our last presentation, okay?

ALEXANDER SERVISKIT: I am Alexander Serviskit [misspelled?], a Russian NPO for people who live with HIV in Russia. To Maksym, my issue about rehabilitation as far as I understood, this is a commercial center, where you send those people? Where did you get the money from? How's it funded?

How is the funding to have some agreements with them? And how many people can you send them?

MAKSYM DEMCHENKO: Thank you for your question. Yes, if I speak about publication, I don't speak only about our center, within our organization. But of course, we do have a [inaudible], and they are also funders and they try. Within this global fund of financing and they also help people of rehabilitation. If they turn to us– if clients turn to us, then we have a database, and we have information where there's still free places in such rehabilitation centers.

In our center, we have a max of 10 people per month. For inpatient, and inpatient wards and laboratories, and the four per month. We have special projects that is financed by the Ukrainian network, and a full patients we can place in that center and new clients, there we have resources from other foundations.

ALEXANDRIA OLGINA: I am very happy to introduce Ekta Mahat. She is a member of the network The Positive People of Nepal, network of drug users, and she'll tell you how it's going on in Nepal. Ekta?

EKTA MAHAT: Respected Chairs, and people, and all the speakers here in this room it is such a pleasure to speak about women drug users, and to get services for drug users, in such a remote part of the world.

We are from Southeast Asia. I'm from Nepal. We have very pathetic services and pathetic situations for drug users there. But it's very surprising that even here, I lost my presentation. I was so messed up because early in the morning, I was so sick then.

I was so tired because I didn't get my methadone, and I went all around the city to get my methadone dose, but I didn't get it. And I find some people over there, in the village, and I was like running all around the morning, in this conference hall for the methadone.

So, everything is very messed up, but I'll try to explain whatever I have learned, or whatever I have to say, being a woman drug user, and living with HIV and being in an OST program. So I have a very messy presentation, grammatical mistakes, but I'll try to sort and try to reel it out.

So, this is my friend, and me in between. We meet 200 people every day at the clinic. We are methadone users. I ask my women friends if they wanted to be in the photo. They said no, so I ask these two little people and they said okay, to be in the photo, for here, so I could get photos of my friends.

And this print head story— and I want to tell you that story because I want to tell the importance of integrated services for drug users.

My friend with the goal is there, is Bill. He had a problem with his eye. He cannot see; he is blind. Because he had some disease related to HIV for eyes, and he's in the methadone program.

Because the methadone program is not so systematic, people also inject. They take methadone in the morning, and they go for hunting, and they do inject in the evening. It's because they only wish to use methadone, and there's no comprehensive programs, or serial programs for the methadone users.

The other friend, he is a doctor himself, but he don't have his leg now. This photo is before two months, his legs were swollen at the time, but now he waiting to cut his leg. Maybe he did his surgery this week. So, it's very sad. And this happens because there's no services at one place. Because we need HIV and AID services all in one place. But there's not services at the same place, and where we get the methadone, so it happens.

We don't go – there's like 10 kilometers away, AID centers, 10 kilometers away and rehab somewhere else, so it's very difficult for us.

So, this is the story of my friend, Aswen [misspelled?], his name's Aswen. He's increasing his methadone every day because there's no doctor; there's no good doctor in

the methadone clinic, so he's increasing and increasing every day because he thinks that ARV cuts the trip off; the high. The trip off methadone, so he always increases the methadone. And there's no one saying stop increasing the methadone.

So, there's again a problem. And when he's increasing and increasing methadone, because he thinks the ARV cuts the effect off of the methadone, so he wants to get high, and he'll take more and more methadone, and we don't have proper counseling for that.

So, this is a rough estimation I found out from the Internet. The posting is of people and the problems among drug users, in Southeast Asia. It's very high, in India and some parts of Nepal. It's more than 80-percent. Like in the Capital of Nepal, Katmandu, it's more than 80-percent, and nationwide it's more than 45-percent. And in Indonesia, it's 42.5-percent are HIV positive in infected drug users.

And, another problem, Hep C. There's not any services or any thoughts going on about Hep C in our country or in our region. So, drug users do not have access to Hep C services, and it's sometimes very difficult for us to get into the AIT and to the methadone, or having Hep C. And there's no Hep C counseling in the methadone clinics. Not only in Nepal, I've talked with friends in India, they are studying now, and everywhere.

The service provider, they are running their organizations just because they get money for doing whatever they want to do. They are donor driven. Not the programs, not the need. They are not need based.

The tuberculosis also. The tuberculosis is also a main problem among drug users. The study shows that drug users have 10 to 30 times more changes of becoming infected with TB. Inpatients, the risk is even higher.

So why integration? We need integration because we want to make the contact point for the services. And the second thing is, it will cut down the resources, because we need lots of resources, to have a different service provider settings, rather than having all the services at one place.

And the third is, also to reduce the risk. It either has greater difficulties having treatment like enrollment, being diagnosed and prescriptions of ARD medications. If it is there, then it will be easier for us.

And the biggest problem is drug users are not trusted, so if they have one-stop services available, then it will be easier for us because we'll get the services at one place, and they don't have to readmit us for every single service, like [inaudible] injections, methadone, TB or ARD because you go to one place and you can convince them you're such a good drug user, and again you go to the next place, and again and

convince them that you are a good drug user. So, it's very difficult for us.

Advantages of self-integrated services. It's convenient, effective treatment; it also improves elapsed cases, better use of resources, increased possibilities of overall checkups and required medical services, the service provider will be more [inaudible], decreased duplication of services and improved health outcomes in this specific community.

[Inaudible] agrees that there has been a practical problem, from the ground level in implementing its policy because of lack of coordination, suppressive national policies and local environments. This is a supportive thing for us because we want to do the services at one place.

The need of working with the collaborative approach on TB, OST and HIV among IDUs is urgent. That's it. Thank you. [Applause]

ALEXANDRIA VOLGINA: Thank you very much. Thank you Ekta. Now we can ask more questions for three of our presenters. You don't have any questions now? Okay. I have several.

The first of my questions is for the Mr. Minister, I wanted to ask you about— do you have collaboration with the NGOs working in Kazakhstan? How does it work? Because Maxine

was saying a lot about the row of NGOs in providing such services. And, I wanted to ask about how it's going on in Kazakhstan over there?

ZHAKSYLYK A. DOSKALIYEV: Thank you. At first, I put it that way. It's very difficult to imagine such a way to be done, about HIV-infected person, but drug addiction, without the participation of NGOs. And I would tell you that we have a country called the nation of counselor of the global front, and about 70-percent of people working on that committee, is 70-percent NGOs, of different other countries.

International and older national NGOs, and they encompass, those other people who've got away from the drug addiction, and are now counseling other people, for instance. That's why, I personally, am of the opinion that HIV infections, Tuberculosis and everything around that. This is no longer purely a medical problem. It's a social issue, being a social challenge. We have to really work together and to work together with NGOs.

So let me add that we are in the process of adopting new governmental program for the S 2011 to 2015 and this program is an intersected corporation, which is not just about setting up the program, but implementing it.

And since this program is based on the– should formulate the politics that will help all of us. And core

office will also use NGOs, as we will have a unified policy, about medical and social diseases, it won't' only be infectious diseases, it will also be epidemics that may not be infectious, but still those are the challenges of our 21st Century and especially when we have to care for the health of our citizens; and therefore, we understand the role the NGOs have to play to be effective.

So cooperation is very important. The Ministry of Health and different NGOs, I do have about 100 of those, so I won't read them off. But their different ones and you might know some of them.

[inaudible] and then volunteers who are helping us to implement this program to fight drug addictions and so on and so forth.

ALEXANDRIA VOLGINA: Any other questions. Yes. You can't be heard, can you speak louder please? –

DAVID JACK: David Jack is my name, from WHO in Vietnam. The last speaker reminded me that there are many issues with doses of methadone, in the presence of HIVs and TB treatment.

I'd like to ask our first speaker, the Minister of Health in Kazakhstan, about the doses of methadone in the pilot program because I'm aware, from Vietnam, where their pilot program treated 1,500 people, over the first year. But the

doses of methadone were much higher than anticipated, and many of the patients were requiring doses of 100 mg. or more, and even over 300 or 350 mg.

So, I'm just wondering what is the situation in Kazakhstan, and how have they dealt with this rather difficult problem of methadone doses? And this represents probably one of the key issues for the integration of these three programs, so that you get effective methadone treatment, in the presence of TB and HIV treatment.

I wonder also, if this perhaps is the reason for the high drop-out rate, in Kazakhstan, where 25-percent of people just continue the treatments, which is much higher than the discontinuation rate in Viet Nam.

ZHAKSYLYK A. DOSKALIYEV: I thank you for your question. I'd like to say this substitution therapy, it's not a cure, it's not a treatment. Methadone is also a drug, but it's not heroine and the mechanism of working is the same affect on their body. It's a substitution, but not with a political aim.

Why Kazakhstan decided to open up to this substitution therapy because from year to year, IDUs the percentage of HIV infections is rising, from year to year. Those steps that we have in Kazakhstan, it a needle exchange, it's a syringe

exchange, it's other methods, but this did not lower the infection rate, of HIV infections, for people who wear an IDU.

That's why we decided to go for substitution therapy. Now, at the moment we have this pilot project. And the regions; it's 50 regions with 50 patients, there is 100 in one country. I don't know why you say there is 25-percent dropping out. It is continuing to go with the methadone substitution therapy.

I do not have those numbers. I would be very glad to hear from you, what are the sources of this information? Where did you get them? But I want to say that they brought 100 people in this pilot project. It's still an important part, how they get their methadone, but this is not the representative material for further study.

We cannot deduct anything out of 100 people on OSTs. You can't have any long range results and that's why we decided to double that number. There'll be 200 of them and they will be a little more represented, but less represented, and as we enlarge, we will take more people on board who'll get this access to OST.

And that's why I said, and you would have said that would be positive. Then we'll — after the year 2005, we'll put much more people on this substitution therapy. Up to nearly

3,000 people already. Why, and I explained to you already. Thank you.

ALEXANDRIA VOLGINA: Another question?

STEYA FREANCE: Yes, thank you very much. My name is Steya Freance [misspelled?]. I am the Regional Director for Eastern Europe and Central Asia, from UNFPA. Thank you Excellency and dear friend for your meaningful inputs for this debate.

The situation maybe in Central Asia, is even more complex, and also Eastern Europe because we are facing a lot of migration and immigration. And it has a huge impact on HIV, but also on the drug users and the treatment of drug users. Cause it's very difficult to locate people and where they are because millions of people are moving around and also drug users are moving around.

And maybe Minister, your Excellency, can add a little bit more. What kind of policies Kazakhstan has in place to address this kind of inter-regional, sub-regional policies? Thank you so much.

ZHAKSYLYK A. DOSKALIYEV: Thank you. Let me put it that way. As per today we do have economic restraints, financial crisis [inaudible] still and we, of course, experience all those crisis, but though, the impact was not as strong as our neighboring countries, like [inaudible], not

unlike Central Asia, we are still adrift with a new program we want to have the real development in our economics, technical and industrial.

We understand perfectly well that we'll need a greater workforce to further develop economics in the Austrian zone. We understand it. Well as I said, but we'll trace it once more. And so what we need more people, we need a workforce, but not migrant one. One that will really have a certain level of experience, of knowledge and could help us to implement those programs.

We do have a code, about the health of the population, and where we have patient's rights, we have the rights of those people who live in the territory of Kazakhstan, and those people who are there, who live there, we do have a State guarantee where they have medical services free of charge.

If I speak about people living in Kazakhstan, if there are people using drugs and they're caught, it's as I told you the therapy is just according to the laws we have. But, people who are not there for a permanent worker, migrants, as you said, people who are just there for a certain period of time, then we do have a code, and we do need some insurance.

This is obligatory and those companies, who are just employ seasonal workers or other workers they have to have some insurance backing because they have to insure those people.

They are responsible for their health for as long as they work there.

And another issue, the illegal and the unregular migrations, through and in Kazakhstan, they have [inaudible] rights that could be people addicted to or using drugs. And this is no longer a problem in Kazakhstan cause we know it's a global problem all over the world.

In Kazakhstan is not the possibility to deal with that problem alone. So, it's all over the world, so the rules criteria are applicable for every country in the world. We don't want those people to disappear somewhere in the virtual space.

And somewhere we can't see them, we can't reach out to them, of course, the liberalization of those lost will help them and they would get all syringes and they'll have those places where they can anomalously talk to doctors and so on. Thank you.

ALEXANDRIA VOLGINA: Any other questions? Waitng for you.

CHRISTINA BOOKER: Hello and thank you for this great discussion. My name is Christina Booker [misspelled?], from APT Associates, in the U.S. and I evaluate programs. I am here specifically for a project to provide HIV testing and Case Management for poor people, in jails. And a lot of these

clients also have, of course, substance abuse problems and mental health problems. My question for the speakers is what is the access to mental health services, for the people that you work with?

ALEXANDRIA VOLGINA: Who would like to start?

MAKSYM DEMCHENKO: Well, our organizations have some of the programs running in jails. It's access to therapy, for HIV positive. Then it's for female jails, male jails we want to get them to diagnostics and therapy, and appointments with specialists, in the penitentiary system.

We offer them recommendations for testing for HIV, TB and so on. But of course, this has to go through official channels. It does not as well through the State and not with all the tensions in the penitentiary systems.

We do have testing and of course it's not very good because last time we took cervical test in the female prison, out of 20 of the women seven from 600 people— out of 600 women's prisoners, there were 120 positive for HIV. But, director wasn't very glad to hear about it because they just can't cope with it. We don't have any medicine; they don't have access, so they don't like those programs.

Then we add money to programs, a company program, medication programs, where company people when they get out of prison, and now we try to offer another new service for those

colonies and detention centers, in the technical sense of view. So we diagnose. We want to open such cabinets, as we say, to offer technical help with testing and diagnosing.

And I would like to add to that. We're very active on the Regional and National level and focus at least the excess at least to detox those people. [inaudible] cells.

In Poltolvin, [misspelled?], the town I live in, this will be the Ukraine, in a place of isolation detention, we will have also a detoxification for those people who are inmates there. But then, when legislation will catch up and will allow us to do that, then we'll continue within other prisons.

EKTA MAHAT: Regarding services in jail? I think providing services in jail is very sexy, and they like to give money for that. But, the service is very, very limited and it because of existing laws, in Nepal. And I think, in even India, they have some services to be provided in the jail, for drug users.

But it's very, very limited, and also in Nepal it's very, very limited and as far as I know, in our part of the world, in Southeast Asia, it's very, very limited, but they just want to give money. But we don't have good programs; the good guidelines for the concept of working in jail.

The jail, in our part of the world, is the very, very worst. Thank you.

ALEXANDRIA VOLGINA: Minister?

ZHAKSYLYK DOSKALIYEV: Yes, deal colleagues what was said of the former speakers is everything's right, but you can't say jail and that is bad per say. But you know the different types of severity of detention that might be very liberal.

It might be a very, very stringent one, and here, of course, you have to differentiate. Differentiate because there are different degrees, so if there is a regimen of detention for the inmates. That depends on what they did and what they wear in jail.

And when they're speaking about inmates, but about patients, when in the jail if they've got— if they [inaudible] they've got a special part of detention. The people who are contagious their somewhere monitored. And those who got over the infection, there in something like a quarantine, and if this TB or when another were infected, then they're treated.

You know that they are resistant themselves and multi-resistant forms of Tuberculosis, they get the treatment they need in the place of detention, but are isolated.

About patients that are drug addicts, then they also get therapy and their preoperative therapy. We don't always have in the places of detention. After knowing positively that this always stays in jails, will really be effective. We'll

have to prove this theory; the effectiveness, the efficacy, in jails that then, of course would use this also there.

Then the part of HIV infections in the penitentiary system, we have priorities we think. We have to fight with discrimination with this stigmatization of those patients and I'll explain why today, when this medical service didn't want to render any help to HIV infected people, then I think in jails there shouldn't be that barrier, of discrimination and stigmatization of HIV infected people.

ALEXANDRIA VOLGINA: We're out of time.

MALE SPEAKER: [Inaudible] Max [inaudible] I'm from the organization of people infected with HIV. We would like understand, what's your stuff? Who can work with your organization? Or do you have to have some sort of education or specification or something.

MAKSYM DEMCHENKO: I'll answer. Each program, of course, there will be different criteria, like reputation, for instance. There'll be a different set of criteria to include the mental program as the members.

70-percent of our stuff, are people inflicted with HIV, people using drugs, 70-percent of all that stuff, but first and foremost you have to be professional because just using drugs, that's not professional, that if you come HIV positive. It would have to be something more.

We have many clients who want to stay with us. They want to be well, they want to stay there as a volunteer and we have one educational program, one training might enable them to work with us, or in other service organizations.

So this training [inaudible] let's use them first every week, three to four months after that preparation, then we can see genuinely, when a person useful to work in the program, whether he wants to. But we're not short of helpers, no.

We have many good people ready to work and they run through our courses, but we don't have any workplace for them. We try to find some place for others, who are our partners, NGOs and HIV centers and wherever they have someplace they can take people, to work, then we send them there. That is one reason why we are full of useful people for them.

ALEXANDRIA VOLGINA: Time to follow session. I was on my way out, and I wanted to thank our speakers for a very informative presentation, for the experience, for the emotional also presentations and I wanted to thank of course, all of you for the interest to this issue and for your questions. Thank you very much. [Applause]

[END RECORDING]