Editorial

Illicit drugs in Central Asia: What we know, what we don't know, and what we need to know

Introduction

In 2013, two special issues with focus on health and drugs in Central Asia were published in Drug and Alcohol Dependence and Central Asian Survey journals (El-Bassel, Stratthdee, & El Sadr, 2013; Latypov, 2013, 2014). In this third special issue published by the International Journal of Drug Policy, the authors of ten research papers and commentaries seek to provide additional knowledge on a range of issues related to illicit drugs in the region, including the epidemiology of drug use and drug-related infectious diseases and other consequences, drug treatment and harm reduction programmes, the Central Asian drug markets and actors, drug economies and the state-crime nexus.

What informs these most recent papers and what questions, critical for our understanding and interpretation of on-going challenges in Central Asia, do they raise? In this editorial we highlight eleven core aspects of the intensely disquieting public health situation in Central Asia, discussed in these papers. We also point at two further, less exposed aspects – tuberculosis and the region’s prison systems.

HIV, HCV, tuberculosis and sexually transmitted infections (STIs); injecting drug use, imprisonment, poverty and stigma; drug business, state corruption, criminalisation and extortion; impoverished health services and poorly educated and motivated health professionals, unable to cope with the rising tide. These are the interlocking biological and social ingredients of the region’s mounting syndemic (Singer & Clair, 2003). We finally draw together this amalgam of profiteering, corruption, addiction and disease, illustrating how its vicious synergy fosters disease and seriously jeopardises the well-intended efforts to modernise the region’s response to the disease burden discussed in this special issue.

Drug situation in Central Asia

The special issue offers a summary of the drug situation in four of the five post-Soviet Central Asian republics (Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan) using the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)-developed system of key indicators of drug epidemiology. In their paper, Zabransky, Mravcilk, Talu, and Jasaitis (2014) cover drug use in general population, problem drug use as defined in Central Asia, demand for drug treatment, drug-related infectious diseases and harm reduction services, drug-related mortality, drug markets, drug seizures and arrests, as well as drug policies adopted by Central Asian governments. While this article relies overwhelmingly on routine data, assessed and analysed within the framework of EU-funded and locally approved Central Asia Drug Action Programme “by extraction from the databases of national institutions in the field of public health and law enforcement, by formal requests for the provision of information to national authorities, and by the analysis of national grey literature and administrative working papers” (and as such might be limited to perspectives offered by these sources), it is arguably one of the few recent articles that describes the drug situation in post-Soviet Central Asia using a comprehensive and standardised approach, with some observations of trends over time. As the authors conclude, despite a need for substantial improvements in the drug situation monitoring systems in Central Asia, the evidence that the existing systems are capable of generating can be used already now for planning and developing effective national and regional policies and responses (Zabransky et al., 2014).

HIV and HCV prevalence among people who inject drugs (PWID)

One of the key trends reported by Zabransky et al. (2014) is the declining HIV and HCV prevalence among PWID in Tajikistan and Uzbekistan. According to the authors, this “represents an unprecedented development and still needs further explanation and research.” Data from Kazakhstan, on the other hand, suggest a relatively low and stable HIV prevalence against the backdrop of the highest HCV seroprevalence compared to other counties. Latypov, Otashvili, and Zule (2014) also discuss significant variations in HIV and HCV prevalence in two Tajik cities of Kulob and Khorgo over a short period of time and, after examining site-specific HIV prevalence throughout Tajikistan, conclude that these variations might arise from considerable problems in quality and reliability of integrated bio-behavioural surveys (IBBSs) conducted by national authorities. Indeed, when data from alternative to IBBS sources are available for some of the Central Asian sites, as presented, for example, by El-Bassel, Gilbert, et al. (2014) and elsewhere (El-Bassel, Gilbert, et al., 2013), HIV prevalence among PWID was found to be much higher. Arguably, this implies that serious caution might be warranted when interpreting the IBBS data from the region.
HIV counselling and testing

Globally, research shows that HIV testing and counselling is a central strategy to receiving care and treatment among HIV-infected individuals and therefore plays an important role in HIV prevention for both infected and uninfected persons. Knowing one’s HIV status can promote declines in sexual and drug-risk behaviours (Denison, O’Reilly, Schmid, Kennedy, & Sweat, 2008). Although HIV testing has been extensively encouraged and supported globally for PWID, many drug users in Central Asia face multiple barriers to such testing. According to official governmental reports in Central Asia for 2011, the number of PWID who had been tested in the past 12 months ranged from 29% in Uzbekistan to 65% in Kazakhstan (Terlikbayeva et al., 2013). In the Latypov et al. (2014) paper in this issue, access to HIV testing by PWID in the city of Kulob was also inadequate. A recent study on access to HIV counselling and testing in Central Asia delineated risk environments that prevent PWID from accessing HIV testing such as criminalisation of drug use and police harassment, discrimination by service providers in HIV care, location of clinics and lack of human resources (Terlikbayeva et al., 2013). In order to increase coverage of HIV testing, these barriers must be acknowledged and addressed through structural interventions.

Combination HIV prevention for PWID

There is no complete and reliable data on the coverage of antiretroviral therapy (ART) among HIV-infected PWID in Central Asian republics. Many PWID have been lost to follow-up and some have not been assessed for ART eligibility (McNairy, Deryabina, Hoos, & El-Sadr, 2013). In 2010, the overall coverage of ART in Eastern Europe and Central Asia is estimated to be 35%, which is well below the global level of 60% (Donoghoe & Stengaard, 2010). Although Kazakhstan (163 needles and syringes per estimated injecting drug user (IDU)), Kyrgyzstan (187.6 needles and syringes per estimated IDU) (Zabransky et al, 2014) and Tajikistan (199 needles and syringes per estimated IDU) (Latypov et al., 2014) distribute sterile needles and syringes to PWID in numbers close to the estimated level for effective HIV prevention in this population, combination prevention for PWID including opioid substitution therapy (OST), needle and syringe programme (NSP) and ART and other essential interventions, remains rare or non-existent in Central Asia (Vickerman et al., 2014; Degenhardt et al., 2010; WHO, UNODC, & UNAIDS, 2012).

In the Vickerman et al. paper in this special issue, the authors conducted a modelling analysis to examine the potential impact on HIV incidence and prevalence of OST, NSPs and ART in three illustrative epidemic scenarios: Russia (St. Petersburg), Estonia (Tallinn) and Tajikistan (Dushanbe). For each intervention, the models considered the coverage needed for each intervention separately and in combination. One of the major findings of this paper is the possibility for lower coverage of combination prevention of OST, NSP and ART for Dushanbe compared to the other two cities with higher prevalence of HIV among PWID. To either reduce HIV incidence to less than 1% or HIV prevalence to less than 10% over 20 years, coverage of 23–34% of each of these interventions would be sufficient for Dushanbe. However, very high coverage levels of 74–85% are generally required to achieve the same target in the higher prevalence settings, such as Tallinn and St. Petersburg (Vickerman et al., 2014), pointing to the need to take immediate action in Dushanbe (and other similar settings across Central Asia) before coverage levels become hard to achieve.

It is disturbing, however, that ART coverage for HIV-infected PWID remains low in Central Asia, despite data that demonstrate: (1) the power of combination prevention in reducing the incidence and prevalence of HIV (Degenhardt et al., 2010); (2) UNAIDS guidelines recommending that ART should be offered to PWID in combination with prevention and substance use treatment activities to maximise the potential of its success (UNAIDS, 2012); and (3) early ART treatment has been found to prevent sexual HIV transmission within serodiscordant couples in stable relationships (Cohen et al., 2011).

Advocating for OST in Central Asia

The Vickerman et al., 2014 paper also underscores the critical need for legal and policy changes to enable the development of proven-to-be-effective combination HIV prevention interventions and the importance of political will and governments’ support of scaling up these prevention approaches. In Central Asia, where the majority of PWID inject opiates, this is particularly critical for OST, as coverage is below 1% (Latypov et al., 2014; Zabransky et al., 2014). Furthermore, OST programmes remain exclusively funded by international donors and are only available in three out of the five countries (Latypov, 2010; Parsons, Burrows, & Bolothbaeva, 2014). As Parsons et al. (2014) emphasise in their analysis, there are substantial negative campaigns and political attacks on OST in the region, and organised advocacy efforts are much needed. As they examine a range of proactive and reactive OST advocacy efforts and the variety of target audiences that need to be reached, one of their key conclusions is the necessity to strengthen local advocacy groups (Parsons et al., 2014).

Mortality of drug users and drug overdoses

As four papers (Kan et al., 2014; Latypov et al., 2014; Mravcik et al., 2014; Zabransky et al., 2014) in this special issue emphasise, overdose mortality appears to be significantly underestimated in Central Asia. While official data point to a decrease in reported fatal overdoses across the region, these reports are unreliable for a number of cultural, religious, policy and other reasons (Zabransky et al., 2014; Ataiants, Latypov, & Ocheret, 2011). In their study of the mortality of drug users in Central Asia, which found excess mortality in drug users registered by narcological facilities in Kazakhstan and Uzbekistan, Mravcik et al. (2014) also provide evidence that indicates a substantial underreporting of deaths in Kyrgyzstan and Tajikistan. Against this backdrop, data reported by PWID from various Central Asia cities and presented in Kan et al. (2014) and Latypov et al. (2014) paint a picture that is in stark contrast to official reports. These data suggest that large proportions of PWID experience non-fatal and/or witness fatal and non-fatal overdoses. However, both policy and programmatic responses to overdose morbidity and mortality are inadequate in Central Asia. While the Kan et al. (2014) study on pharmacy- and community-based naloxone distribution approaches in Kyrgyzstan and Tajikistan demonstrates high usage and low wastage of this short-acting opioid antagonist that reverses the effects of overdose, the availability of naloxone is very limited in Central Asia and naloxone distribution programmes are operating only through funding from international donors, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Females who inject drugs and non-IDU female sex partners of men who inject drugs

In recent years, a steady rise has occurred in the incidence of sexual transmission of HIV among two key populations: females who inject drugs (FWID) and non-IDU female sex partners of men who inject drugs (MWID) (UNAIDS, 2012). Despite this emerging trend, the true number of FWID and non-IDU female sex partners of
MWID in Central Asia remains unknown and research about these two key affected populations in the region is limited (El-Bassel, Shaw, Dasgupta, & Strathdee, 2014a, 2014b).

A number of reports and studies show that FWID in Central Asia face the same risk vulnerabilities for HIV as FWID in other countries (Thorne, Ferencic, Malyuta, Mimica, & Niemiec, 2010; UNAIDS, 2012). FWID are stigmatised, have low social status, are often victimised by their male sex partners, family members, community, and the police, and are sometimes perceived as deserving of abuse because of their drug use practices (El-Bassel, Terlikbaeva, & Pinkham, 2010; El-Bassel et al., 2014a, 2014b; Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005; UNAIDS, 2012). A paper by Mravcik et al. (2014) in this special issue examines mortality data on individuals listed in the narcological registries in Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan. The authors found that female drug users have higher mortality rates than male drug users in both Kazakhstan and Uzbekistan, perhaps due to the many challenges facing women that compromise their health. Because of the vulnerabilities described above and, in particular, stigma and discrimination, FWID may access health services at later stages of deteriorating health. These issues are further complicated by the fact that FWID face greater challenges than MWID in obtaining sterile injection equipment and accessing harm reduction programmes (Des Jarlais, Feelemyer, Modi, Arasteh, & Hagan, 2012), due to a reliance on intimate partners to provide drug-using resources including needles (Lazuardi et al., 2012) and greater levels of discrimination experienced when seeking HIV and drug use treatment as well as a lack of female-specific services (El-Bassel et al., 2010, 2014a). Each of these factors may play a role in the gender disparities in mortality rates found in the Mravcik et al. (2014) study. In the paper by Latypov et al. (2014), drug scenes, drug usage, and adverse harms associated with drugs are examined drawing on literature review and focus groups. The authors report difficulties in recruiting FWID into the qualitative study since they were more hidden than MWID due to less direct contact with NSPs and avoiding disclosing their drug use for fear of discrimination from family, community members, and male partners.

While limited data exist on non-injecting female sex partners of MWID, this group is also vulnerable to HIV and is a key affected population. The paper by El-Bassel, Gilbert, et al. (2014) in this special issue addresses gaps in the literature. The paper presents findings from a study among women who participated in Project Renaissance - a couple-based HIV prevention study conducted in Kazakhstan, where one or both members of the dyad reported IDU (El-Bassel, Gilbert, et al., 2013). Understanding how non-IDU female partners of MWID engage in sexual and non-injection drug use risk behaviours with their primary sex partners and others is critical to stemming the recent increase in heterosexually acquired HIV cases in the region.

In the paper by El-Bassel, Gilbert, et al. (2014), a couple-based HIV prevention modality was introduced as one important approach that can play a pivotal role in reducing HIV transmission from MWID to their IDU and non-IDU female sex partners. Given that sexual and drug use behaviours occur in dyadic contexts, FWID and non-IDU female partners may gain from being jointly involved in couple-based treatment to reduce HIV transmission risk, which is vital to fighting an epidemic where no vaccine is available. This paper also calls for gender-specific harm reduction and HIV care that meet the explicit needs of FWID and women involved with MWID.

Drug offences and arrests of people who use drugs for possession of minor quantities

Another important aspect underscored in this special issue concerns drug-related criminal offences reported by Kazakh, Kyrgyz, Tajik and Uzbek law enforcement agencies. While only data from Kazakhstan point explicitly to drug users often being the main target for the police, who arrest them for possession of minor quantities for personal consumption (less than 1 g of heroin, as was the case in Kazakhstan) (Zabransky et al., 2014), this is a significant problem in the region. Thus, as 1128 persons were convicted for drug offences in Kyrgyzstan in 2010, 686 cases that were submitted to the courts for the same year were related to possession of drugs in quantities below 10 g (Central Asian Drug Policy Centre, 2011). In Uzbekistan, of the 8171 drug offences registered in 2011, 1698 (21%) were related to possession for personal purposes, whereas the majority of drug possession offences “with the purpose of trafficking” involved petty drug dealing (The National Centre of Drug Control under the Cabinet of Ministers of the Republic of Uzbekistan, 2012). Similarly, the proportion of offences related to possession of drugs for personal purposes in the total number of drug offences registered in Tajikistan in 2011 was as high as 24% (DCA, 2012), suggesting this punitive approach is taken across the region.

Police corruption and state-crime nexus

In Central Asia, policing drug users is heavily linked with high levels of corruption running through the ranks of law enforcement. In Tajikistan, police officers are often involved in directly facilitating the distribution and street-level sales of narcotic drugs, providing heroin to favoured dealers, arresting or blackmailing competing dealers and exploiting drug users in various ways for the sake of information, money or sexual favours, or in order to fulfil arrest quotas (Latypov, 2011a, 2011b). As far as the major drug business is concerned, according to the head of the Tajik Drug Control Agency, almost every organised drug trafficking ring they investigate enjoys the “protection of state law enforcement officials” (Asia-Plus, 2012). Similarly, in Kyrgyzstan, the involvement of the police in the drug trade is so endemic that there is widespread use of the term “red heroin” which refers to heroin sold or distributed by law enforcement officers and other representatives of the ‘state organs of power’ (Zelichenko, 2011). It is in this context that De Danieli, 2014 and Kupatadze, 2014 are moving away from a problematic and dominant drug-terror discourse to explore the state-crime nexus and strategic partnerships “that have formed between drug traffickers and state actors around the exploitation of drug rents” in Central Asia. For De Danieli, whose doctoral research was focused on analysing ‘Silk Road Mafias’ in post-Soviet Tajikistan (De Danieli, 2010), ruling Central Asian elites appear as patrons of drug mafias, thus explaining the symbiotic relationship between the upperworld and underworld elements (De Danieli, 2014). While De Danieli seeks to draw a regional picture, Kupatadze, 2014 examines Kyrgyzstan through the lens of available empirical evidence and numerous interviews with senior state officials and other actors, which he conducted in his capacity of a consultant to the Kyrgyz government. Based on his analysis and categorization of drug trafficking networks, Kupatadze argues that Kyrgyzstan came closest to being defined as a “narco-state” under the rule of President Bakiev, and suggests that high ranking state involvement in illicit trade is still a significant problem and that there might be “a vested corrupt interest in keeping the status-quo” (Kupatadze, 2014). The issue of corruption also emerges in Latypov et al. (2014) study in this issue, as one explanation for the reported differences in drug prices in Kulob and Khorgo, as well as in drug arrests and drug seizures in the Khatlon and Gorno-Badakhshan regions of Tajikistan.
“Hashish as cash” and the significance of drugs in an agricultural semi-stub-seconomy

As De Danieli and Kupatadze reveal, narcotic drugs in Central Asia serve primarily to enrich the deeply intertwined upperworld and underworld networks. However, the fascinating research by Botoeva (2014) seeks to shift away from the upperworld–underworld paradigm and to investigate the contexts and conditions, whereby narcotic drugs also function as a vital commodity incorporated in local economic and social transactions. Indeed, Botoeva describes how drugs serve as a symbolic form of cash in rural areas strapped of currencies and resources. Based on numerous interviews and ethnographic observations of the livelihoods of communities in Toolu village in Tyup region of Kyrgyzstan, Botoeva’s paper convincingly demonstrates that the boundaries between ‘licit’ and ‘illicit’ can often be blurred in Central Asia, with drug production being considered legitimate and culturally valued and acceptable, and with farmers refusing to consider themselves as ‘criminals’ and defying the ‘illegality’ label imposed by the government.

From emerging epidemics to syndemics

As pointed out by many papers in this special issue, Central Asia represents a global HIV “hotspot” (Thorne et al., 2010), facing “the perfect storm” of high risk drug use, various blood borne infectious diseases (El-Bassel, Strathdee, et al., 2013) and other drug related harms, such as fatal overdoses (Kan et al., 2014; Mravcik et al., 2014). Such events of “disease clustering” (Knox, 1989) or “syndemics” (Singer & Clair, 2003) are more than just biological occurrences, but part of a process of social exclusion (March, Oviedo-Joekes, & Romero, 2006), linking multiple disparities (e.g., in personal, social, and economic conditions), which compounds the negative effects of drug use and vulnerability to infectious diseases and other harms (e.g., TB, overdose, viral hepatitis, STIs). Further components or contingencies in this high risk environment (Rhodes, 2009) are discussed by De Danieli, 2014 and Kupatadze, 2014 in this issue, who highlight human rights abuses by agents of the state and the related widespread corruption among law enforcement officers.

Two important component of this syndemic – one of a biological nature and one of a social-political nature – remain relatively untouched in this special issue and their further exploration is certainly warranted. These blind spots are the region’s burgeoning rates of tuberculosis and its unhealthy and inhumane prison systems.

Tuberculosis and co-infection issues in Central Asia

Tuberculosis is widespread in Central Asia. TB rates are reportedly “extremely high,” with alarmingly high rates of multidrug-resistant tuberculosis (MDR-TB) (Cox et al., 2004; Schlüter et al., 2013). Co-occurring rising rates of HIV infection among people who inject drugs (PWID), their sex partners, men who have sex with men, female sex workers and migrant workers raise acute concerns over a “potentially devastating co-epidemic of TB/HIV and MDR-TB/HIV” (El-Bassel, Strathdee, et al., 2013; Schlüter et al., 2013). Exceptionally high prevalence of HCV among PWID (Beyrer et al., 2009), very often co-occurring with HIV (Walsh & Maher, 2012) further underlines the menace of a syndemic health emergency in Central Asia. In Kazakhstan, the prevalence of HIV and HCV among a sample of PWID and non-injecting female partners of MWID was 22.5% and 61.0% respectively; among those infected with HIV, 73.4% also had HCV infection (El-Bassel, Gilbert, et al., 2014). Similarly, in Tajikistan, HIV prevalence was 12% among a sample of PWID, HCV prevalence was 61%, and HIV/HCV co-infection was 98% (Beyrer et al., 2009). Despite high prevalence of co-infection there is woefully inadequate surveillance data monitoring co-infection. Evidence shows that a high prevalence of HIV and hepatitis C co-infection has important implications for treatment. The presence of HIV accelerates the natural course of chronic hepatitis C, including increasing the risk of liver cirrhosis, hepato-cellular carcinoma, and decompensated liver disease (Brau, 2003; De Luca et al., 2002; Vento et al., 1998; Verucchi, Calza, Manfredi, & Chiodo, 2004). Some studies associate ARV HIV treatment directly with the acceleration of chronic HCV progression, either initially or over time. Despite this, the consensus is that ARV treatment has favourable effects on the course of HCV in co-infected individuals, and is recommended despite an increased risk of hepatotoxicity (Rockstroh & Spengler, 2004; Weber et al., 2006). But in this syndemic, these biological components dovetail with important social contingencies, the antiquated systems of infectious disease control and the inadequate response.

While efforts to introduce modern molecular diagnostic technologies are underway, TB cases are commonly detected by clinical diagnosis, chest X-rays or sputum examinations. Likewise, protracted inpatient hospitalisation and isolation at TB hospitals remain the central approach to TB treatment. A remnant of the Soviet (highly centralised and vertical) health care model, drug treatment, HIV prevention services, antiretroviral therapy, TB and hepatitis services remain poorly integrated (El-Bassel, Gilbert, et al., 2013; Grund, Tilienbaeva, Tchitchinadze, Henry, & Usupova, 2012; Schlüter et al., 2013; Zabransky et al., 2014). In fact, each of these “pillar institutes” presents a separate medical power structure with separate hierarchies and communication lines. Although their number is growing, harm reduction services continue to reach only a minority of PWID (FWID in particular) and the other vulnerable populations (El-Bassel, Gilbert, et al., 2014) and, as previously noted, OST has been introduced only recently and remains grossly underutilised in this region (Grund, Latypov, & Harris, 2013; Latypov, Bidordinova, & Khachatrian, 2012; Latypov et al., 2014; Parsons et al., 2014; Zabransky et al., 2014). Several authors suggested that integration of TB services, HIV care, and drug treatment is needed urgently for an efficient and coordinated response (Beyrer et al., 2009; Cox et al., 2004; El-Bassel, Gilbert, et al., 2013; Schlüter et al., 2013) and efforts towards more integrated service provision are underway in Central Asia, supported by the WHO, ICRC, MSF, PSI and other international organisations (Cox et al., 2004; Grund et al., 2012).

Central Asian prison systems

The antiquated prison systems in Central Asia are a key vector in the spread of infectious diseases, development of MDR-TB and an important obstacle to developing patient-centred care approaches for the affected populations. Although the prison population has been reduced in almost all Central Asian countries over the last 20 years, the total number of prisoners is still high (in all five countries together approximately 127,000). The number of prisoners per 100,000 ranges from 121 (Tajikistan) to 290 (Kazakhstan), with high percentages of female prisoners (ranging from 1.6% in Tajikistan to 12.3% in Turkmenistan). Many of the premises are overcrowded and in a condition lacking basic hygienic requirements. The percentage of drug users is high in most of the facilities. Compulsory treatment for drug dependent prisoners continues in Kazakhstan (Yusopov et al., 2012), Uzbekistan (The National Centre of Drug Control under the Cabinet of Ministers of the Republic of Uzbekistan, 2012) and Tajikistan (Khasanov et al., 2012). With the exception of the Kyrgyz Republic, no alternatives to imprisonment exist in the five Central Asian countries.
The dominant responses to drug dependence and drug use in most countries of the region continue to rely primarily on measures that have no or insufficient evidence of their efficacy – inadequate detoxification procedures using anxioytics and vitamins and 12-step programmes (e.g., the Atlantis programme in the Kyrgyz prisons). Whereas 12-step programmes could provide a supportive environment for recovery, they are often mistaken for treatment, which they are not. In the absence of evidence based drug treatment, 12 steps and vitamins are unlikely to adequately impact drug dependence in general and likely to worsen the developing syndemic.

With the introduction of OST programmes in some facilities and NSPs in almost all Kyrgyz prisons, only the penitentiary system in the Kyrgyz Republic responded to the challenges of HIV, viral hepatitis, co-infections with TB, as well as a very high proportion of incarcerated drug users (according to official figures, approximately 18% of the entire prison population in Kyrgyzstan are injecting drug users) (Aidarov et al., 2013). With the assistance of external donors, Tajikistan has also launched a pilot NSF, albeit on a very limited scale.

According to UNODC and other international bodies (2012), successful HIV prevention and treatment measures in prisons consist of 15 key interventions and include, amongst others, the provision of HIV/AIDS education and information, condom programmes, HIV testing and counselling, HIV treatment, care and support, sterile needles and syringes, drug dependence treatment (including OST), prevention, diagnosis and treatment of TB, and vaccination, diagnosis and treatment of viral hepatitis.

Denying access to these measures puts people in prisons at increased risk of HIV, hepatitis and sexually transmitted infections. It also puts prisoners living with HIV and other infections at increased risk of declining health, co-infection with tuberculosis and hepatitis, and ultimately death. Eventually, they pass on these health risks to their families and loved ones, underlining the need for a “continuum of care” approach that connects prison health services with those outside the prison walls. Furthermore, addressing HIV in prisons cannot be separated from wider questions of human rights and reform of custodial settings.

Conditions in prisons, the way in which they are managed, criminal justice and national policy – these macro risk factors (Rhodes, 2009) all have an impact; they either mitigate or mitigate the developing responses to HIV, hepatitis and tuberculosis in prisons. Structural reforms in prison are urgently needed, in identifying alternatives to imprisonment and in reducing the excessive use of pre-trial detention in particular. Such reforms will also contribute to reducing overcrowding and violence. In the short term, many problems that need immediate addressing are of an environmental nature – inadequate natural lighting, ventilation and the lack of protection from extreme climatic conditions remain unfortunately common in closed settings in many Central Asian republics. When these conditions are combined with inadequate means for personal hygiene, insufficient nutrition, poor access to clean drinking water and derisory health services, the vulnerability of inmates to HIV infection and other infectious diseases multiples, resulting in increased morbidity and mortality (UNODC, ILO, UNDP, WHO, & UNAIDS, 2012). Thus, prison health, and its role as a driver of multiple morbidities, requires urgent attention and adequate action in Central Asia – both from national authorities and international bodies. If undressed, the dire prison health situation will transmute into a regional public health emergency, affecting the health, quality of life and economic stability of families throughout Central Asia.

The missing links

However, the interaction of the cocktail of infectious diseases and inadequate public health responses discussed above is only part of the syndemic equation. Indeed, the response of public health authorities – in and outside of the prison walls – is shaped by further social-political contingencies, and we will try to illustrate this with an example from Kyrgyzstan, where one of the authors of this editorial paper recently assessed the response to MDR-TB in the prison system (Grund et al., 2012).

The incidence of TB in the Kyrgyz prison system is about 40 times higher than in the general population. TB testing in Bishkek city suggests that almost a quarter of new smear positive cases and more than half of previously treated cases have MDR-TB (ICRC, 2012) and the combined infection of TB and HIV is a growing concern in the country. Anecdotal evidence suggests that the majority of TB patients in Kyrgyzstan either have a history of imprisonment or drug use or both and often continue using drugs while being treated for TB. In 2012, 11.5% of TB patients in TB “Treatment Colony No. 27” were HIV infected (ICRC, 2012). Some 16% of OST patients were diagnosed with TB in 2011 (Republican Narcology Centre, 2011), while diagnoses of active TB among clients of NGOs working with PWID and ex-inmates reportedly doubled in the last two years (Bivol, Smelyanskaya, Aleshkina, & Lezhentsev, 2011). Official statistics of TB lack systematic information on risk behaviours, such as drug injecting or imprisonment, but the available information strongly suggests that drug injecting or imprisonment are the most important drivers of TB, HIV, HCV, and other blood-borne infections.

Known prisoners with TB are sent to two TB treatment colonies (No. 27 and No. 31) in Kyrgyzstan where the International Committee of the Red Cross and Médecins Sans Frontières – Switzerland support the prison authorities with developing TB directly observed treatment, MDR-TB Treatment and patient-centred care approaches for the affected prisoners.

But these efforts have faced high rates of treatment defaulting and refusals. The poor treatment response is only partly explained by personal factors (e.g., obstructing treatment so one can stay longer in the TB colony, which has a much milder regime than the general prison colonies) or institutional challenges described (staff education, motivation, beliefs; or the lack of service integration). In these colonies, TB patients are housed in different sections by stage of treatment or infectivity, separated by walls and gates. These separation measures are, however, structurally ignored by both inmates and prison staff (ICRC, 2012; Grund et al., 2012). A recent assessment of drug use and treatment in TB treatment colonies No. 27 and No. 31 concluded that the primary driver for disregarding these separation measures was the heroin trade in the colony (Grund et al., 2012).

Heroin is easily available in these two colonies and an estimated 7 out of 10 inmates inject drugs while inside (ICRC, 2012; Grund et al., 2012). Inside the colonies heroin is distributed by the “Obshchak” or the ‘Black Structure’. The Obshchak is an informal prisoner association and criminal subculture that actually runs most day-to-day functions of the camps and maintains order through its internal prisoner hierarchy. It controls the flow of (contraband) commodities in the colonies (International Crisis Group, 2006; Latypov, Rhodes, & Reynolds, 2013; Reyes, 1997). The heroin trade has perhaps become its primary source of income. In these two colonies, (a paiki of) heroin is commonly used as unit of exchange; those cleaning the toilets or working in arts and craft ateliers are paid in heroin.

Heroin is used in all sections of the colonies and therefore the Obshchak dealers have important incentives to cross the gates when they wish to and the Obshchak has used treatment and labour strikes to enforce their right of way. Thus, not heroin use per se, but...
the distribution system of heroin resulted in structural breaches of the TB separation measures. But where the inner borders in these two colonies were clearly porous, the outer walls were not. Both colonies were surrounded by open land, monitored from the watchtowers, and visitors were thoroughly checked. In other words, it would be almost impossible to bring drugs into these facilities unnoticed – at least in amounts that seemed required to keep the inmates happy. Several key respondents in Grund’s assessment explicitly noted that prison staff (through the ranks and in any colony) were involved in or benefited from heroin trade (Grund et al., 2012) – a reflection that was also shared by numerous respondents in a recent study on drug trade in and outside prisons in Tajikistan (Latypov, 2011a, 2011b).

These observations suggest that the state corruption, explored by De Danieli, 2014 and Kupatadze, 2014, does not end at the prison wall. The porous prison wall represents yet another example of the symbiotic relationship between the “red” and the “black” power structures they described. The negative influence of this state-crime nexus on prison TB treatment or on public health and human rights in general becomes obvious.

Concluding remarks

This editorial and the ten research papers and commentaries in this special issue discuss several of the Known Knowns, Known Unknowns and Unknown Unknowns (Rumsfeld, 2002) of the syndemic emergency that is developing in Central Asia around the use of illicit drugs. The known knowns are clear: high rates of injecting opiate use and rapid diffusion of several blood-borne viruses are merging into a context of outdated health services, prohibition, unstable political economies and corruption. An important known unknown concerns the quality of the data on the epidemiology of drug use, drug overdoses and drug-related infectious diseases, or on the actual response – access to evidence-based interventions for opioid dependence, HIV, HCV, TB and other health problems in both community and prison settings – presented by official statistics. This complicates a full comprehension of the magnitude and dynamics of the evolving syndemic. A further known unknown is the future of funding for the already sub-optimal level harm reduction services for people who use drugs and other marginalised populations in the region. When available, evidence-based services, such as OST, NSP and naloxone distribution programmes, rely heavily on international donors. In most countries, there is no clear perspective on whether governments will continue to fund these services when international grants dry up and the international community loses much of its leverage.

To borrow from the author of the foreword to this special issue, “we know what works” (Kazatchkine, 2014). Yet, the negative campaigns and political attacks on OST in the region actively reinforce the myth that “OST has failed in the West and is now being dumped on our country” (Grund et al., 2012). Evidence-based information campaigns and organised advocacy efforts are competing with conventional wisdom (Galbraith, 1958), mythology and disinformation campaigns. Perhaps the key is indeed the strengthening of local advocacy groups, leadership and ownership. These initiatives should actively promote the interests of people who use drugs, their families and of public health within a wider human rights agenda.

The inadequate access to combination prevention of HIV for PWID is well known and not limited to this region (Mathers et al., 2010; Wolfe, Carrieri, & Shepard, 2010), but the risk environments that prevent PWID from accessing such services, even when at serious risk of death (Grund et al., 2013), remain less well understood at the level of policy makers in this region. Furthermore, the complex risk environments experienced by females who inject drugs or have partners that do, and the consequences they unevenly bare continue to be insufficiently translated into actual policies and female-specific services in this region.

Male or female, across the region people who use drugs have not only been legally persecuted and stigmatised, they have been commoditised and exploited. The case study that we presented above and the papers collected in this special issue highlight the importance of social, political and economic factors in the syndemic spread of infectious diseases (Singer & Clair, 2003). As several of these papers show, this overly punitive and exploitative approach thrives on widespread corruption in law enforcement, the prison system, politics and the economy, and blurred lines between the upperground and underground.

This sinister synergy revolves around heroin in Central Asia and is justified by global drug prohibition and fuelled by the economic incentive this provides. When left unaddressed, it may not only annul the potential gains of well-intended, evidence-based innovations in prevention and treatment, but indeed sustain a perfect storm, threatening both public health and democracy. This collection of papers contributes to our understanding of the interactions between some of the ingredients in this syndemic alchemy, moving these out of the domain of unknown unknowns. Time will tell whether policy makers take these lessons to heart or whether they are merely moved to the unknown knowns – things we know of but prefer not to acknowledge (Zizek, 2004). But the bottom line conclusion is that while there are a number of known and unknown unknowns, the known knowns are serious and catastrophic enough to act now by scaling up combination prevention and treatment for HIV, TB, viral hepatitis and STIs, in the community and in prisons.

Conflict of interest statement

None declared.

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References

El-Bassel, Denison, DeCox, Cohen, Central Bivol, Beyrer, 
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