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# The Epidemic of the Young: An Overview of the HIV/AIDS Situation and Current Preventive Activities in Uzbekistan

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**The Epidemic of the Young:  
An Overview of the HIV/AIDS Situation and Current  
Preventive Activities in Uzbekistan**

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## ***Abstract***

During its more than twenty-year history, HIV/AIDS has taken away millions of lives worldwide. Although at nascent stage, the epidemic is rapidly increasing in Central Asian region. In Uzbekistan it is mainly driven by injecting drug users. Research shows that the epidemic has already found its way from the concentrated groups to the general population through heterosexual transmission, with more than fifty percent of the infections found among young people. This desk research is focused on the extent of the HIV/AIDS epidemic in Uzbekistan, and prevention activities taking place to address the epidemic spread among young people.

Chapters 1 and 2 focused on the global picture of the epidemic, factors that exacerbate the spread of HIV, the impact of the epidemic on development and education sector. Also, it looked at youth as a vulnerable group to the epidemic, and provided justification for the need to focus prevention programs on young people.

Chapter 3 linked theoretical background with practical application. Thus, interventions recognized by the international community as best practices in addressing the issues of youth in the context of HIV/AIDS, were discussed.

Chapter 4 focused specifically on the epidemic in the context of Uzbekistan, explored the activities and programs taking place in the country to halt the epidemic by the government, local and international organizations. The overview showed that there is not much emphasis on providing the population with information and skills to protect them from the epidemic. Very few initiatives are targeted at youth, who are in the context of Uzbekistan, its economic instability, cultural and religious beliefs, are particularly vulnerable to HIV/AIDS. Concluding thoughts provide some suggestions for opening the dialogue between various stakeholders on designing and implementing programs for young people.

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## ***Acronyms***

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>CIA</b>	Central Intelligence Agency
<b>CIS</b>	Commonwealth of Independent States
<b>CSW</b>	Commercial Sex Workers
<b>EIU</b>	Economist Intelligence Unit
<b>FHI</b>	Family Health International
<b>GDP</b>	Gross Domestic Product
<b>HIV</b>	Human Immunodeficiency Virus
<b>IBE</b>	International Bureau of Education
<b>IDU</b>	Injecting Drug Use
<b>IHRP</b>	International Harm Reduction Program
<b>IIEP</b>	International Institute for Educational Planning
<b>IPPF</b>	International Planned Parenthood Federation
<b>MSM</b>	Men who have Sex with Men
<b>NGO</b>	Non-governmental Organization
<b>OSCE</b>	Organization for Security and Co-operation in Europe
<b>OSI</b>	Open Society Institute
<b>STD</b>	Sexually Transmitted Disease
<b>UNAIDS</b>	Joint United Nations Program on HIV/AIDS
<b>UNESCO</b>	United Nations Educational, Scientific and Cultural Organization
<b>WHO</b>	World Health Organization
<b>UN</b>	United Nations
<b>UNDP</b>	United Nations Development Programme
<b>UNICEF</b>	United Nations Children's Fund
<b>UNFPA</b>	United Nations Population Fund
<b>UNODC</b>	United Nations Office on Drugs and Crime

## ***Introduction***

HIV/AIDS is the most deadly disease the world has faced so far. According to UNAIDS (2004), 39.4 million adults and children are estimated to be living with HIV/AIDS and 31 million people have died from AIDS globally. The epidemic is spreading rapidly, expanding to new regions in all the parts of the world with the fastest increases in East Asia, and in Eastern Europe and Central Asia.

It is in the nascent stage when the epidemic should be tackled through prevention programs. According to the World Bank (2002a), there are two windows of hope. First, children 5 to 14 years old represent one window of opportunity because they are “the least likely to be infected with HIV” (box 2.2, p. 15). Second, youth 15 to 24 years old, a high-risk group accounting for about 60 percent of all new HIV infections in many countries, is the group where the ignorance rate about the epidemic and prevention is high.

Substantial research showed education protects against HIV, which have the advantage of reaching children and youth early, while few are infected and before they engage in high-risk behaviors. However, education is not the only way to address the problem. Also, there are a number of interventions that contribute to the campaign to halt the epidemic.

While there are some preventive activities conducted in Central Asian region, where the epidemic is at nascent stage, more action is needed to combat the epidemic. The epidemic in Uzbekistan is driven by young injecting drug users; however, very little is being done to address HIV/AIDS among youth.

The purpose of this paper is to explore responses to the epidemic spread in various countries to identify the possible ways to incorporate the HIV/AIDS prevention education programs for young people in Uzbekistan and to ensure their effectiveness and acceptance.

## Chapter 1

### HIV/AIDS: Nature and Features, Global Extent

#### *Nature and Features of HIV/AIDS*

About two decades after the first cases were reported, AIDS has become the most devastating disease that the world has ever faced (International Institute for Educational Planning [IIEP]/United Nations Educational, Scientific and Cultural Organization [UNESCO], May 2003). What is AIDS and how is it spread? According to the Joint United Nations Programme on HIV/AIDS (UNAIDS)/World Health Organization (WHO), HIV (*human immunodeficiency virus*) is a retrovirus, which infects the cells of the immune system, and destroys and impairs their function. World Bank (1997) refers to HIV as a fatal, sexually transmitted disease (STD).

HIV belongs to the class of slow viruses, and thus the asymptomatic period and the deterioration of the human system is long and slow. When it reaches a certain degree, the person begins frequently experiencing various illnesses, with which an uninfected body would normally cope with (Kelly, 2000). Eventually, the body loses the ability to fight common infections and diseases. An individual, who has the level of immunodeficiency when these infections occur, is said to have AIDS, *the acquired immunodeficiency syndrome* (Kelly, 2000). Thus, AIDS is caused by HIV.

Individuals who have been infected with HIV are infected for life, because there is no known cure. High costly treatments such as antiretroviral therapies are available, but they cannot cure HIV; they just slow down its progression towards AIDS. In the developing world, where 95% of people with HIV live, only 7% of those who needed life-saving treatment could obtain it in 2003 (UNAIDS, n.d.).



From the time of being infected, the virus can be transmitted through body fluids from the infected person to others. This occurs in four principal ways (Kelly, 2000, p. 17):

- Through unprotected sexual contact with an infected person;
- Through transfusion of contaminated blood;
- Through shared use of sharp instruments that may carry contaminated blood;
- Through mother-to-child transmission during pregnancy, when giving birth, and through breastfeeding.

About three-quarters of HIV transmission worldwide is through sex and three-quarters of these account for heterosexual intercourse, while one-quarter involve sexual relations between men (World Bank, 1997).

Statistics shows that certain age groups are observed to have more infections than others. Thus, Kelly (2000) notes that the majority of AIDS cases are found in adults between the ages 20 and 50, while the peak ages for women with AIDS cases being 20-29, and 30-39 for men. However, in 2004 more than 50% of all the cases were found among young people under 24 (UNAIDS/WHO, 2004).

### ***Global Extent of the Epidemic***

The research and the statistics show terrifying numbers. The total number of people living with HIV rose in 2004 to reach its highest level ever: an estimated 39.4 million, including 3.4 million who acquired HIV in 2004 (UNAIDS/WHO, 2004).

The epidemic's "grip" on African countries has been so far the worst; however, "no part of the world is immune" (World Bank, 2002a, p. 2), because AIDS spreads rapidly within countries and across their borders, affecting people regardless of gender, status, geography or sexual orientation (United Nations Children's Fund [UNICEF]/

UNAIDS/WHO, 2002). According to the World Bank data (2002a), Sub-Saharan Africa remained the epicenter of the epidemic with average life expectancy of 47 and highest prevalence rates ranging from 10 percent in some countries to 44 percent among some population groups, for example pregnant women in Botswana. The statistics provided by UNAIDS/WHO in the annual publication *AIDS Epidemic Update 2004* shows that the epidemic in the region is stabilizing with the HIV prevalence rates at around 7.4 percent. However, UNAIDS/WHO (2004) argues that this data hides important aspects because (1) “roughly stable HIV prevalence means more or less equal numbers of people are being newly infected with HIV and are dying of AIDS” (pp. 2, 4); (2) the epidemic in the Sub-Saharan Africa varies from country to country, from one group to another both in terms of the scale and the pace at which it is spreading.

AIDS has become the leading cause of death of adults aged 15-44 in the Caribbean, where the HIV prevalence is the second-highest in the world (UNAIDS/WHO, 2004). Likewise, according to the same publication, the number of HIV infected people doubled between 2002 and 2004, an increase due largely to China’s increase in the epidemic.

### ***HIV/AIDS in Eastern Europe and Central Asia***

Evidence shows that the epidemic is on the rise, with the fastest increases in Eastern Europe. Infections in Russia seem to be almost “doubling annually since 1998” (World Bank, 2002a, p. 2). According to UNAIDS/WHO estimates (2004), in Eastern Europe and Central Asia there were 40% more people living with HIV in 2004 than in 2002 and more than nine-fold increase in less than ten years, reaching an estimated 1.4

million at the end of 2004. Much of this trend accounts for increasing number of infected people in the Ukraine and Russian Federation, which is the home for the largest epidemic in the region. In the Baltic states, HIV is spreading fast, and injecting drug use (IDU) accounts for the largest proportion of new infections, however, sexually transmitted cases are steadily growing in number (UNAIDS/WHO, 2004).

Central Asian and Caucasian countries are experiencing an early stage of the epidemic and HIV prevalence remains very low in the region, although the number of newly infected cases continues to rise rapidly, in particular in Uzbekistan, which according to UNAIDS/WHO (2004) “hosts the youngest epidemic in the world” (p. 54).

Although the epidemic is considered to be at nascent stage in some regions and concentrated in others, serious causes for concern are drug trafficking routes which pass through Central Asia. World Bank (2002b) estimated there were almost 0.5 million drug users, and outbreaks of HIV-related injecting drug use were reported in Central Asian countries.

The epidemic in Central Asia is currently concentrated among vulnerable groups: injecting drug users, sex workers, and prisoners. However, research statistics show the epidemic is steadily spreading to general population groups. There are several factors that make this process fast and certain: drug trafficking throughout the Central Asia region, poverty, and high unemployment, which in turn stimulates the growth of commercial sex and engagement of people into high-risk behaviors.

With commercial sex playing a large role in transmitting the infection, and the epidemic mostly concentrated in the capital of Uzbekistan, Tashkent, and the surrounding

regions, Uzbekistan is experiencing a swiftly developing epidemic with HIV infections recorded in all the regions of the country.

The epidemic in Kazakhstan is growing “at a fearsome pace” (UNAIDS/WHO, 2004, p. 54), and is mostly concentrated among young people who inject drugs and are in the sex business. The surveillance conducted in 2003 showed the prevalence levels of 3.8 percent in injecting drug users and 4.6 percent in sex workers (UNAIDS/WHO, 2004).

Although Kazakhstan ranks to have relatively low HIV prevalence, rates of epidemic expansion are one of the highest in the world. According to official government statistics, in 2001 the indicator of newly reported HIV cases in Kazakhstan was 11 per 10,000 tested, which is 3.5 fold higher than in 2000 (Strategic Program, 2002). Over 50% of reported HIV cases fall on young people aged between 15 and 29. Inquiries conducted among the persons in this age group showed that youth in general have insufficient knowledge on the modes of HIV transmission.

Kazakhstan’s geographical location on the route of illegal transportation of heroin from Afghanistan to Russia conditions high involvement of the population into drug trafficking and the use of injecting drugs, as well as the sphere of providing sexual services, thus, into the activities related to HIV transmission (The Program Counteracting the AIDS, 2001). According to Joanna Godinho et al (2003), 83 percent of HIV infection cases in Kazakhstan are associated with for injecting drug use transmission, while sexual transmission accounts for 9 percent of the cases.

Likewise, in Kyrgyzstan the epidemic is being driven by injecting drug use and is largely concentrated in Osh Oblast (Ferghana Valley), two regions in Chui Oblast and the capital city Bishkek (UNAIDS/WHO, 2004). Kyrgyzstan, the smallest country in Central

Asia with the smallest population, continues to have a low HIV prevalence rate, however now is experiencing a rapid increase in the number of newly HIV infected.

Tajikistan, with the lowest annual per capita income of US\$ 290 of the CIS countries and 80% of the population below the poverty line (UNAIDS, 2004), is currently considered a country with low HIV prevalence. Most reported cases are found among people under 29 years old and a total of 170 cases of HIV infection have been reported as of March 2004 (UNAIDS, 2004). However, UNAIDS estimates that taking into account the factors conducive to the spread of HIV infection- increasing number of injected drug users and sex workers, unemployment, poverty and migration- the real number of HIV infected people is probably 10-20 times higher than the official data (UNAIDS, 2004).

Information about the epidemic in Turkmenistan is limited and mostly not available. The Turkmen State News Service reported that “AIDS is not a problem in Turkmenistan due to the success of the governmental anti-AIDS measures” (as cited by World Bank, 2002b, p. 7).

UNAIDS/WHO (2004) distinguish *four common features* to the epidemic in the Eastern Europe and Central Asia region. In general, most of the infections are still in the early stage, which means that timely interventions can halt and reverse the spread of the epidemic. Secondly, the majority of the people in the region are young; and more than 80% of the reported infections occur among the people under 30. Thirdly, sexual transmission of HIV is increasing, thus indicating that “the epidemic has gained a foothold in the wider population” (UNAIDS/WHO, 2004, p. 47). Fourthly, the number of injecting drug users increases in the context of social and economic transitions. These commonalities will be discussed in more detail in context of Uzbekistan in Chapter 4.

Overall in Eastern Europe and Central Asia, the statistics reflecting the numbers of HIV infected and the prevalence rates is very unreliable largely because the epidemic in the region is very young and an effective surveillance system has not been established yet. Thus, the knowledge on the real extent of the epidemic is very limited.

### ***The Impact of HIV/AIDS on Development***

The international community recognizes that HIV/AIDS is not solely a health sector problem. As Kelly (2000) defines, HIV/AIDS is “a development crisis of unprecedented proportions” (p. 27). Although impacts of the epidemic on the health sector are threatening, there are other reasons why HIV/AIDS is a concern for development. Thus, Kelly (2000) in his work *Planning for Education in the Context of HIV/AIDS* explicitly states that the epidemic “reduces life expectancy; increases child mortality; leaves large numbers of children without adult care; places intolerable strains on health care systems; undermines economic development through increased labor costs and the decreased availability of skilled human resources; and impoverishes households” (p. 27).

Of special concern to the international community are the poverty and gender dimensions in the context of HIV/AIDS. According to the World Bank (1997), there are several factors that exacerbate the spread of the epidemic: widespread poverty and unequal income distribution; increased migration and rapid urbanization; and AIDS-related deaths which aggravate poverty and social inequality.

Indeed, poverty makes people more vulnerable to HIV infection, and Kelly (2000) identifies a number of factors which make people vulnerable to HIV/AIDS:

- the lower nutritional status of poor people;
- poorer state of general health and lack of access to adequate health services;
- lack of access to information and the means of protecting themselves from being infected;
- the overcrowded conditions in which the poor live;
- the survival needs which cause women and girls to practice high-risk sexual behaviors by entering commercial sex;
- the economic needs which make the poor men migrate from one high-risk locale to another in search of work;
- the absence of pleasurable experiences, other than sex, available to poor people (pp. 28-29).

Also, poor families in severely affected countries that experience significant impacts on their health sectors will also be impacted by the epidemic. As a consequence of the increased prices and reduced availability of health care to everyone due to the impacts on the health sector, the poor will be the groups hurt the most (World Bank, 1997). Consequently, the poor households hit by the epidemic will be less able to cope with the medical expenses. Thus, by taking away the wage-earners and deflecting resources for medical care, HIV/AIDS worsens poverty and increases inequality.

One important way in which AIDS does this, according to the World Bank (1997), is through the increased number of children who lose one or both parents to AIDS. In addition to immeasurable grief experienced by these children, they experience lower nutritional status and reductions in schooling, which in turn reduces their ability to acquire skills and knowledge, and thus escape poverty (World Bank, 1997).

Another factor which makes society more vulnerable to HIV/AIDS is gender inequality. Based on research conducted in 72 countries, the World Bank (1997) discusses two measures related to gender inequality and associated with higher infection rates. First is the ratio of males to females in urban centers. Research findings showed that the cities in which men ages 20-39 greatly outnumber women do have significantly

higher infection rates. This is perhaps largely due to men's using commercial sex services more increasingly, thus engaging in often unprotected sex with multiple partners. Thus, the World Bank (1997) argues that, for an average country, increasing the job opportunities for young women so that the ratio of males and females in urban areas decreases would bring down the HIV infection rates by 4 percentage points.

The second factor related to gender inequality is the gap between adult male and female literacy rates. When women are much less literate than men, they often lack complete control over their lives, thus putting themselves at greater risk in sexual encounters (World Bank, 1997). Indeed, in most societies women are brought up to be submissive to men. As a result, lack of self-assertiveness makes it difficult for most women from these societies to refuse sex, take measures to protect themselves from becoming infected with HIV, insist on using condoms, or claim that the partner abstains from sex with other partners. Furthermore, illiterate women will have difficulty finding jobs, thus depending more on sexual relationships for economic survival, which again creates situations of vulnerability for them (World Bank, 1997).

Additionally, social norms impose lack of knowledge on girls and young women, who are often ignorant about sex and sexuality. This lack of knowledge also increases vulnerability to HIV. According to *Demographic and Health Survey* conducted by UNICEF, in many countries most young women don't know how to protect themselves against the infection. Thus, in Cameroon, Lesotho, Mali, Senegal, and Vietnam, two thirds of young women aged 15-24 did not know three HIV prevention methods. In Moldova, Ukraine, and Uzbekistan, more than 80 percent of young women surveyed lacked this knowledge (Figure 3, as cited by UNAIDS/WHO, 2004).



A further discussion around gender dimension focuses on the biological reason why women are more vulnerable to being infected with HIV at an earlier age than men. For anatomical reasons, women who have unprotected sex with men are about four times more vulnerable to STD, including HIV, and younger women are even more vulnerable (Kelly, 2000). Kelly further explains this as follows:

The physiological immaturity of a young woman's reproductive system which provides less of a barrier to HIV infection, and partly because of the larger surface area exposed to contact (pp. 27-28).

Another cause of concern is that young girls are being targeted by older men because they believe that having sex with a virgin will cure them from AIDS (Kelly, 2000). Thus, due to social relations and economic realities in many societies, women face a range of HIV- related risk factors and vulnerabilities which are in turn conducive to the spread of HIV/AIDS.

In conclusion, the scale of the HIV/AIDS epidemic is enormous, and its spread has not been halted over the 20 years. On the contrary, the epidemic is expanding, spreading to new regions. The research and the literature showed that it particularly hits young adults in their most productive years. "It strikes hardest where lack of education, illness, malnutrition, violence, armed conflicts and discrimination are already well entrenched" (UNESCO, 2004, p. 7).

Given that there is no cure and vaccine to treat the infection, the countries have to mobilize their efforts and resources to combat the spread of the epidemic. The international community has promoted education as a crucial way of preventing HIV/AIDS and youth as a key to defeating the epidemic (UNAIDS, 2002).

The next chapter will discuss the role of education in HIV prevention and youth as the greatest hope in the struggle against the disease It will also cover the impacts of HIV/AIDS on education.

## **Chapter 2**

### **HIV/AIDS and Education**

#### ***The Impact of HIV/AIDS on Education***

The reviewed statistics in Chapter 1 show that, throughout the world, HIV/AIDS is having dramatic effects on the lives of individuals and communities. Taking into account all the adverse destruction the epidemic has done on the quality of life of many nations, experts estimate that “the full impact of the epidemic is yet to come” (UNESCO, 2003, p. 22). Thus, UNESCO (2004) states that HIV/AIDS epidemic will have “a greater impact on the size of the population of several developing countries than the Second War had on any society” (p. 28). The impact of the pandemic on all the sectors of society is expressed in the following statement:

With infection rates reaching a third of the population- and as many as half of the young in some countries- no institution will remain untouched: health services, educational institutions, public administration- all will be undermined and may become demoralized (UNESCO, 2004, p. 28)

The impact of the epidemic on the education sector in the countries with high prevalence rates can be more than dramatic. The World Bank (2002a) has clearly identified consequences of inaction, which put education and HIV/AIDS into a “vicious circle” reproduced in Figure 4. Thus, worsened HIV epidemic affects teacher supply, declines teaching quality, and increases out of school children. As a result, illiteracy rates increase and human capital deteriorates, which consequently affect the entire infrastructure of the country and its economic growth. In the end, health and education sector lack capacity and resources to effectively address the problems of HIV/AIDS.

Thus, within the education sector, the epidemic has a pronounced impact on the supply, demand, and quality of education (World Bank, 2000a; UNESCO/UNAIDS,

n.d.). Due to AIDS, the education sector will experience a loss of human resources- teachers, school administrators, and other staff. Available evidence shows teacher mortality rates increase in the presence of HIV/AIDS (World Bank, 2002a). Based on experience of African countries, the World Bank (2002a, p. 12) summarizes teacher supply in the context of the epidemic:

- In Central African Republic 85 percent of teachers who died between 1996 and 1998 were HIV-positive;
- In Kenya teacher deaths rose from 450 in 1995 to 1500 in 1999, while in one of Kenya's eight provinces 20 to 30 teachers die each month from AIDS;
- HIV-positive teachers account for more than 30 percent in parts of Malawi and Uganda, 20 percent in Zambia and 12 percent in South Africa.

In addition, HIV/AIDS greatly contributes to teacher and staff absenteeism from school which affects teaching time and class schedules, thus reducing the quality and quantity of education (World Bank, 2002a). Increased absenteeism and loss of teachers to death and disease disrupts the educational process (UNESCO, 2004). Thus, it is vitally important to timely plan for teacher replacement, training of new teachers and personnel, and development of new policies in the context of HIV/AIDS.

The specific costs attributed to the HIV/AIDS in the education sector will rise largely due to the serious burden of extra costs for replacement of absent teachers, as well as providing sick leave benefits to the teachers. Thus, budgets will have to accommodate hiring and training of new education sector personnel and substitute teachers, and full salary payment to absent sick teachers if the absences are recognized as official according to country policies (World Bank, 2002a).

The impact of HIV/AIDS on the demand for education is also severe. In the presence of AIDS, the school age number of children will be smaller than in the absence of the epidemic due to reduced number of adults of childbearing age and lower fertility

rates (World Bank, 2002a). However, at the same time the World Bank (2002a) argues that the school-age population will continue to grow. Estimates by the U.S. Census Bureau suggest that only 6 of the 26 countries worst affected by HIV/AIDS will experience reduction in the numbers of school-age population by 2015 (as cited by World Bank, 2002a). The reason for this is that AIDS does not have a primary effect on school-age children:

The majority of children dying of AIDS are young children who have contracted the disease from mother-child transmission. An estimated 3.8 million children have been infected with HIV since the epidemic began, and more than two-thirds have died (World Bank, 2002a, p. 14).

Thus, from the children who contracted the infection through mother-to-child transmission, fewer than half survive before going to school. Children born uninfected are unlikely to become infected before they reach adolescence and become sexually active (World Bank, 2002a). Thus, children in the age group 5-14 are least likely to be infected with HIV/AIDS and for this reason are considered “a window of hope” in the international community. Therefore, in most countries, “increases in the school-age children are expected” (World Bank, 2002a, p. 16).

However, if the infection touches the household, children will have to miss school to stay home and care for the affected siblings. Thus, although not being a primary effect on the school-age children, HIV/AIDS has an important impact on the enrollment rates (World Bank, 2002a). Also, due to increased expenses on medications for the infected, the families will not be able to cover school expenses for their children.

Another impact of the epidemic is the increased number of orphans. “Estimated at 2 percent for Africa prior to epidemic, the proportion of orphans to all children has now risen to as high as 15 to 20 percent in some African countries” (World Bank, 2002a, p.

16). Projections indicate that by 2010 the number of maternal and double (those who lose both parents to the epidemic) AIDS orphans will account for 35 million (World Bank, 2002a).

From what is known and the experiences of the worst affected countries, it is obvious that nations which do not bring the epidemic under control while the prevalence rates are still low will face a big challenge in the future (UNESCO/UNAIDS, n.d.). When the epidemic becomes widespread, it spreads much faster because more groups are infected, and if the problem is not being addressed, its impact may become very severe and affect every individual directly or indirectly.

### ***The Role of Education in HIV Prevention***

Among the 40 million people infected with HIV/AIDS, there is a large number of those who have undergone no test, and thus do not know they are infected (UNESCO, 2004). As UNESCO (2004) explains, this is mainly due to the absence of appropriate medical services, and often because the attitude towards taking tests is associated with social stigma and discrimination of those infected. Thus, the disease is associated with fear of being excluded from the community, workplace, or school for being infected, because of the widespread belief that the latter “deserve” that attitude for their “promiscuous” sexual behavior and drug abuse (Kelly, 2000, p. 29).

These fears develop social silence about the disease. Further, “the silence reinforces the sense of shame at both personal and institutional levels, and this in turn leads to further stigma and discrimination” (Kelly, 2000, p. 30), thus creating a circle which in the end reinforces silence and shame. As a result, people are reluctant to take

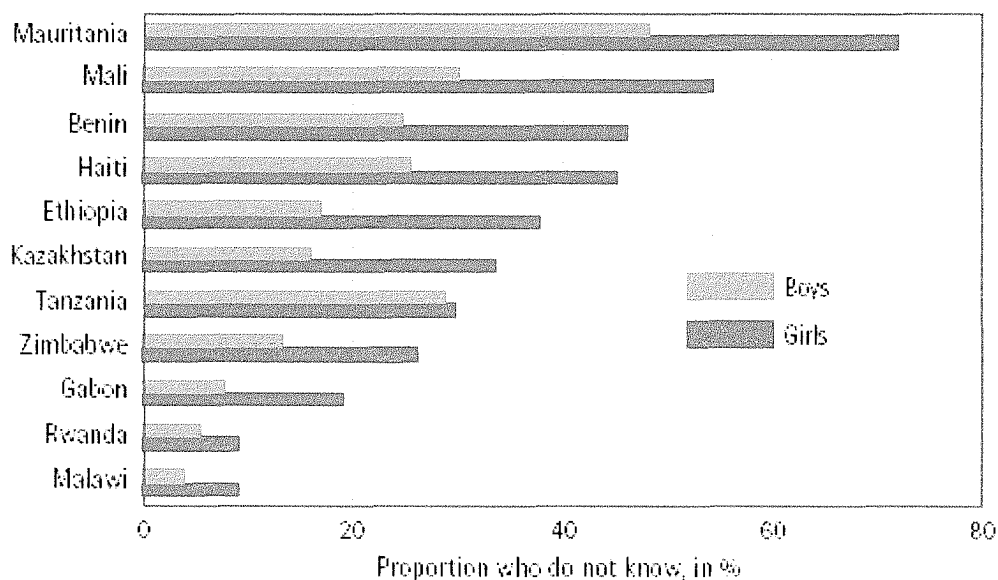
the tests and find out about their HIV status. This further increases the spread of the epidemic: not only do the infected not know about their being infected, but also their partners don't, because the disease has a long incubation period and it can take several years for the first signs of it to show (UNESCO, 2004).

Also, most people do not understand the nature of the disease and its transmission modes, thus as noted by UNESCO (2004), they lack adequate knowledge of how to protect themselves from being infected:

Even in the most advanced education systems children learn little about viruses and understand little about infections during their first five years of schooling. General knowledge is important at the age of five, while the next 5 years are critical for more specific knowledge about HIV/AIDS (p.12).

Thus, having inadequate knowledge about the infection at the time of reaching puberty and starting sexual relations, adolescents become vulnerable to being infected. Figure 1 below demonstrates the percentage of girls and boys in selected countries who do not know the ways of protecting themselves from HIV.

**Figure 1.** Large numbers of girls and boys do not know how to protect themselves.



Source: DHS, 1998- 2002 as cited by UNESCO, 2004, p. 12

In summary, the consequences of social silence and inadequate knowledge are contributing to the spread of the infection at a fast pace and practice of high-risk behavior. Also, lack of knowledge also leads to stigmatization and discrimination of the infected. Therefore, in *UNESCO's Strategy for HIV/AIDS Prevention Education* ignorance is defined as “a major reason why the epidemic is out of control” (p. 14).

Thus, education is the best tool to eliminate ignorance. Prevention education can reach out to many groups of people and make them aware that they are at risk and how they can avoid it. It has the advantage of reaching out to children and young people early, before they engage in high-risk behavior.

Research showed that there is a strong link between the level of education and HIV infection. The World Bank statistics (2002a) showed that in the late 1980s and early 1990s, when the epidemic was still young, there was a positive correlation between the rates of infection and the education level. In the same document the World Bank explains this as follows:

This was perhaps because the higher socioeconomic status and greater mobility of better educated people enabled encounters with a greater number and range of sexual partners, but also because at that time education seldom included HIV/AIDS prevention or behavioral change programs, and the level of knowledge about the disease was generally low (p.5).

However, later studies showed a reversal trend that educated people were more likely to adopt risk-free behaviors when the HIV/AIDS issues were incorporated into education, and thus, better educated people were having lower infection rates; this was particularly true about young people (Gregson, Waddell, & Chandiwana, 2001, as cited by World Bank 2002a).



Kelly (2000) states that education plays a key role to prevent the epidemic; the principle ways in which it makes the transmission less likely are:

- contributing to the promotion of national economic growth and personal poverty reduction;
- increasing access to the health services , understanding and acting on public health messages;
- better nutritional knowledge and practice;
- reducing gender inequality;
- empowering people to defend their rights and overcome discrimination, stigma and shame;
- promoting lifeskills (p.38).

At the same time, the international community has agreed that education is not the only long-term answer to the problem of the HIV epidemic and cannot alone promote behavior change (Kelly, 2000; UNESCO, 2004). Still, education is considered “a critical element in the long-term struggle against HIV transmission” (Kelly, 2000, p. 38) and a necessary component for changing behaviors, providing protection against vulnerability, promoting understanding and avoiding risk (UNESCO, 2004).

As World Bank (2002a) points out, the impact of education on behavior change is strongest among young people, and programs are relatively more effective in ensuring adoption of safe behavior among youth than changing established risk-behaviors in adults. Thus, targeting youth and providing them with effective skills to protect themselves against the epidemic is vital for the present education system. Moreover, preventive education is important for eliminating silence, discrimination, and stigma towards the infected.

### ***Youth as the Greatest Hope in the Fight against HIV/AIDS***

It is important to know which groups are addressed as “youth” and “adolescents”, as well as to know the basics of developmental issues young people of these groups face. Thus, WHO defines “adolescence” as “the period between 10 and 19 years of age” (WHO, as cited by UNESCO, 1998a, p. 1). United Nations (UN) has defined “youth” as a group of people in the age range 15-24 inclusive (UN, para. 3), thus partly overlapping the WHO definition of the adolescence.

Adolescence is a time for young people when not only physical changes in the body occur, but also the time when mental and psychological development takes place. The time of behavioral change when the reproductive system of young people develops is called puberty. Most adolescents go through these changes without any significant problems; however, all young people need support and care during this transitional period between childhood and adulthood (WHO, 2000a). They need to be provided with necessary information, lifeskills, health services, and support to go through sexual development and be able to make responsible decisions throughout their lives.

Nonetheless, for many years the needs of adolescents have been neglected both in population and reproductive health programs (UNESCO, 1998b). According to UNESCO, this is largely due to:

- extreme sensitivity of issues related to adolescent sexuality and reproductive health;
- lack of training and awareness among health professionals and educators;
- unpreparedness of parents to discuss sexuality with their adolescent children (p. 1).

As a result, lack of adequate information about reproductive health, family planning, and STD risks are widespread among youth:

Most teenagers get their information about sexuality and family planning from their peers, whose views are often inaccurate, based on rumors, and riddled by

misconceptions; as well as from the mass media which very often present sensationalized and mixed messages resulting in anxieties and confusion among adolescents who fall prey to prevailing myths and misconceptions (National Education Population Project, as cited by UNESCO, 1998a, p. 1).

Consequently, considering the fact that adolescence is the period for youth to experiment with sex, drugs, and alcohol (UNICEF/UNAIDS/WHO, 2002; UNESCO/UNAIDS, n.d.), it is obvious that young people become extremely vulnerable to the global HIV/AIDS epidemic.

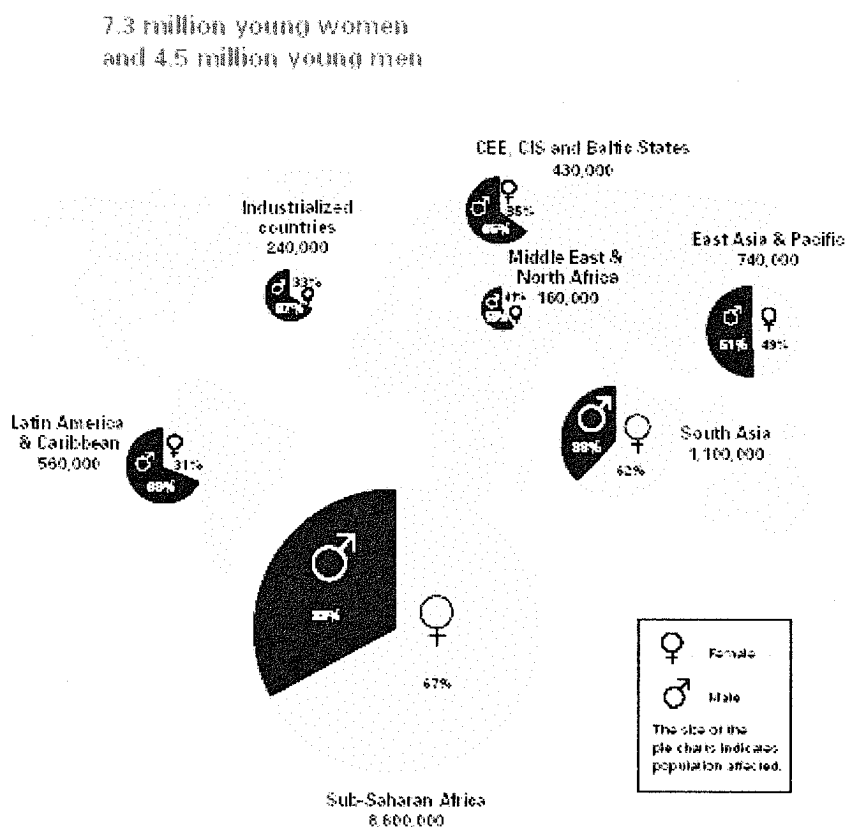
Unfortunately, adults and most parents tend to ignore the fact that many young boys and girls become sexually active before the age of 15. As a result, many issues related to reproductive health are being overlooked. Thus, lacking knowledge, younger adolescents are less likely to protect themselves. That's why it is very important for educators, parents, and policymakers to accept and address these issues. Otherwise, the statistical numbers are going to grow and the world is in danger of facing the irreversible pandemic.

According to United Nations statistics, the number of youth accounted for approximately one billion in 2001. Out of this number, an estimated 11.8 million young people were living with HIV/AIDS (UNESCO/UNAIDS/WHO, 2002). Moreover, statistics shows that each day nearly 6000 young people become infected with HIV/AIDS, thus bringing the number of infections among youth to more than 50 percent of all the new infections globally (UNICEF/UNAIDS/WHO, 2002; World Bank, 2002a).

These numbers bring youth into the center of the epidemic as the most vulnerable group. At the same time, they are the world's greatest hope in the fight against the epidemic. In its document *Education and HIV/AIDS: A Window of Hope*, the World Bank identifies youth as "a window of hope" (p. 5), dividing them into two groups. The first

group includes children 5-14 years of age who are least likely to be infected with HIV for the reasons discussed above in the *Impact on Education* section. Education is believed to be able to reach them before they enter puberty and engage in sexual relations. The other group, according to the World Bank (2002a), is the youth ages 15-24. This is a high-risk group, where the ignorance rate is dangerously high and where “education efforts can yield maximum results” (p.5).

**Figure 2. Young people living with HIV/AIDS**



Source: UNICEF/UNAIDS, 2001 as cited by UNICEF/UNAIDS/WHO, 2002, p. 4

Studies have shown that well-designed and successfully implemented HIV/AIDS prevention programs delay the age of first sex, reduce the number of sexual partners,

increase condom use, promote access to testing and timely treatment of STD, and reduce *injecting drug use* (UNESCO, n.d.; UNICEF/UNAIDS/WHO, 2002), therefore greatly reducing the high risks among young people. Likewise, teaching young people negotiation, conflict resolution, critical thinking, decision-making and communication skills improves their self-confidence and ability to make informed choices (UNICEF/UNESCO/WHO, 2002). A number of such programs will be discussed in the next chapter to provide examples of successful interventions.

Evidence shows that in the regions where HIV/AIDS is declining, it is primarily because the young people were provided with tools to protect themselves against being infected and the incentives to adopt and practice safe behaviors.

In summary, this chapter focused on the impacts of HIV/AIDS on the institutional capacity within the education sector. When the epidemic becomes particularly severe, it adversely affects the educational system by impacting its supply, demand, and quality. It affects supply by reducing the number in the teaching force and by contributing to teacher and personnel absenteeism, thus reducing the quality of education. It impacts the demand by reducing enrollment through affecting families and increasing poverty. It increases the number of orphans who are consequently withdrawn from school due to economic constraints.

Thus, the role of today's educational system is to provide adequate prevention programs to combat the impact and stop the spread of the epidemic. It is crucial for countries where the epidemic is still at the nascent stage to take early measures on educating the population and providing them with tools and skills to protect themselves against the epidemic and with incentives to practice safe behavior.

Research shows that it is more likely to get effective results by educating young people to help them adopt safe behaviors than changing the high-risk behaviors already established by adults. Education can reach out early to large masses of youth and adolescents, the two groups that are considered windows of hope in halting the spread of the epidemic, because they are extremely vulnerable to the epidemic and because the educational system has all the tools to provide them with the necessary information and skills. Thus, educational preventive programs should be designed and implemented for youth both in and out of school.

The next chapter will focus on measures to mitigate the impacts and to prevent the spread of the epidemic that need to be addressed at the national level within the education sector. It will also provide some alternative educational methods to address the issues of HIV/AIDS among youth.

## Chapter 3

### Prevention Programs for Youth

#### *The Role of Governments in Combating the Epidemic*

The discussion of education and its role in the prevention of HIV/AIDS led to the conclusion that helping people, particularly youth, adopt safe behaviors is vital for preventing them from contracting and spreading HIV. Many international organizations argue that governments play an important role in combating the spread of HIV/AIDS by investing in cost-effective programs. Thus, UNICEF/UNAIDS/WHO (2002) emphasize:

Governments can contain the epidemic at relatively low cost by investing in prevention before HIV/AIDS becomes a significant health issue and by providing young people at especially high risk of contracting HIV with the information and support they need to prevent infection (p. 24).

Likewise, the World Bank (1997), states that “active government involvement is crucial if AIDS is to be overcome” (Chapter 6, The Role of Government, para. 1). In the same publication, the World Bank provides the following advocacy for the role of the government in confronting HIV/AIDS:

Only governments have the means and mandate to finance the public goods necessary for the monitoring and control of the disease- epidemiological surveillance, basic research on sexual behavior, information collection for identifying high-risk groups, and evaluation of the costs and effectiveness of interventions... Governments also have a unique responsibility to intervene to reduce the negative externalities of high-risk behavior, while preventing discrimination that would inhibit behavioral change. Without these government efforts, those at high risk of contracting and spreading HIV are unlikely to reduce risky behaviors enough from the perspective of the rest of society (Chapter 6, The Role of Government, para. 1).

Prevention programs are vital for combating HIV/AIDS across nations (World Bank, 2002a). Thus, government responses could make a huge difference for about 2.3

billion people living in the areas where the epidemic is still at the nascent stage (World Bank, 1997) by providing prevention education for youth and groups most at risk. For countries with concentrated and generalized epidemics, “additional efforts to bolster the supply of teachers in the short term and address the orphan situation have been essential” (World Bank, 2002a, p. 27).

### ***Education Sector and Beyond: What Works?***

In the attempts to confront the AIDS epidemic, education ministries face a number of issues, which according to the World Bank (2002a) include the following:

- ensuring that school-age children remain uninfected as they grow up;
- maximizing prevention efforts for the young people at most risk of contracting HIV, which include males having sex with males, street children, refugee children, those orphaned by AIDS, child soldiers, young drug users, those who are sexually exploited (UNICEF/UNAIDS/WHO, 2002);
- protecting quality and quantity of education from the adverse impacts of the epidemic;
- addressing the problem of orphans withdrawn from schools;
- finding cost-effective ways and culturally appropriate approaches to address the above mentioned issues (p. 27).

Thus, one of the core tasks of the Ministry of Education is to provide the school age population with effectively designed and implemented prevention education programs. Basic education of good quality for all, providing sound knowledge about sexuality and HIV, is therefore essential because it can reach adolescents before they become sexually active. Experiences have shown that “better educated young people are more likely to acquire knowledge, confidence and social skills to protect themselves from the virus” (UNICEF/UNAIDS/WHO, 2002, p. 26). For instance, in Zambia with more than 20 percent of HIV-positive adults, adolescents who went through more years of schooling and thus were engaged in health HIV education classes were more likely to use



condoms and have less casual partners than those with fewer years of schooling, and therefore without health education, due to early dropout (UNICEF/UNAIDS/WHO, 2002).

Increasing knowledge through the school curriculum can be effective, but it will not reach every young person. According to WHO adolescent statistics (2000b), between 300 and 500 million adolescents do not attend school, thus bringing the number of secondary school enrollment down to 60 percent. Therefore, in this context a large share of the responsibility to reach young people falls to out-of school prevention activities, thus increasing the role of the communities and parents in HIV/AIDS prevention.

It is very important that parents, community and religious leaders recognize their roles in providing information and skills (UNICEF/UNAIDS/WHO, 2002). Further in the above mentioned document, several experiences are shown where parents, community and religious leaders have undertaken their responsibilities for delivering information and teaching the young people essential skills:

In Masaka, Uganda, health workers have taken on the role of traditional *sengas* (usually paternal aunts) who give guidance to adolescent girls. In rural Zambia, birth attendants and traditional chiefs travel in teams to deliver the facts about HIV and lift taboo on providing sex education to young adolescents. In an AIDS prevention program in India, *mahila mandals* or women's village councils reach out to young women.

In Adjumali district, northern Uganda, meetings were set up with small groups of parents to give them the knowledge and confidence to talk to their children about reproductive health. After a year, half had begun talking to their children, although 10 per cent still preferred aunts or close relatives to provide the information and another 10 per cent preferred community health workers to do it.

In Kenya, religious leaders are delivering messages about HIV and AIDS to their communities. A guide was designed to improve communication between parents and children, and 5000 copies were distributed through churches. The clergy have also used the guide to help advise parents (UNICEF/UNAIDS/WHO, 2002, p. 27).

In addition to out-of-school programs, mass media can be another “powerful weapon” (UNICEF/UNAIDS/WHO, 2002, p. 29) against HIV/AIDS. It can spread the information among youth, tackle sensitive issues, and counter misconceptions about young people and HIV/AIDS. An example of a successful program in South Africa is provided by UNICEF/UNAIDS/WHO (2002):

In South Africa, Soul Buddyz, a weekly television drama, runs in tandem with a radio series, both of them focusing on issues that range from adolescent sexuality, HIV/AIDS and children’s rights, to road safety, gun safety and bullying. By presenting fictional characters who make informed choices, the programmes provide positive role models for adolescents (p. 29).

In addition to mass media, different types of theaters and performances are used to break the silence about HIV/AIDS and deliver the information to people. For example, a circus of Guatemalan clowns travels from one community to another to promote risk-free sexual behavior and provide information about HIV/AIDS, using a street theater (Healthlink Worldwide, n.d.; Personal Communication)

Preventive education programs are only a partial response to the problem. Other core tasks identified by UNESCO (2004) in addition to expanding the knowledge about HIV/AIDS and prevention are:

- providing HIV/AIDS advocacy
- reducing risk and vulnerability;
- customizing the message and choosing the right messenger;
- ensuring rights and care for the infected and affected (p. 22).

The critical factor for HIV/AIDS prevention education is “the massive, consistent and unrelenting advocacy and support of political authorities at the highest national level” (UNESCO, 2004, p. 22). Indeed, high level leadership in breaking the silence, ending the discrimination against HIV infected and affected, and eliminating the shame is crucially

important for promoting openness about the issues and increasing knowledge and skills on preventing HIV/AIDS.

Uganda, one of the countries worst affected by HIV/AIDS, is a good example when the HIV epidemic was recognized early. The government and its institutions were determined “to deal with the issues openly and directly” and this initiative “placed Uganda in the forefront of the fight against HIV/AIDS” (UNAIDS, 1998, p. 5). Currently Uganda has one of “the most vigorous and wide-ranging program to combat HIV/AIDS” (UNAIDS, 1998, p. 5), and as a result, the country has been able to show consistent declines in HIV prevalence (UNAIDS, 2004).

Observations and experiences have shown that the messenger is equally important as the message (UNESCO, 2004). The knowledge needs to be delivered “in culturally appropriate ways and communicated by appropriate people: community and religious leaders, role models, peers and those infected” (UNESCO, 2004, p. 22). In the same publication, UNESCO considers the importance of support from the community and religious leaders:

Obtaining if not the cooperation, then at least neutrality, of community and religious leaders is important. All institutions must be mobilized to become media for renewed efforts in prevention education: ministries, schools, businesses, trade unions, newspapers. Campaigns that are only negative can lead to stigmatization and discrimination- even to increased hazard (p. 23).

Thus, advocacy for HIV/AIDS, customizing the message, and getting the support of community and religious leaders is vital for effective prevention programs.

Trustworthiness and validity of the sources of the information delivered are very important; however, how and what is comprehended and absorbed heavily depends on such factors as gender, educational level, economic status, and religious beliefs

(UNESCO, 2004). This means that “the message must be developed with and for the recipients, and it must be culturally appropriate to the kind of understanding they already possess and the physical context and social environment in which they live” (UNESCO, 2004, p. 24).

Therefore, when designing prevention programs for youth, it is important to involve young people into prevention efforts and promote their participation. This will not only educate them about HIV/AIDS and related issues, but can also make them very effective messengers for their peers (UNICEF/UNAIDS/WHO, 2002). Because peers are the major source of information on sexual issues for many young people, “properly trained peer educators can dispel misconceptions, shatter myths and present information on preventing HIV in a way that other young people will find pertinent” (UNICEF/UNAIDS/WHO, 2002, p. 33). Also, involving young people into the design process of the programs will ensure that the messages are going through right channels and will be understood properly.

In a number of countries, young people are already taking the lead in prevention activities. In Poland, young people were trained as “field counselors” to educate their peers on risks associated with HIV/AIDS, STI, and drug abuse in cafes, discos, youth clubs, etc. (UNICEF/UNAIDS/WHO, 2002). In Namibia, the project “My Future is My Choice” delivers messages about HIV/AIDS and reproductive health for youth through peer facilitators. This program aims at providing youth with sexual education and life skills to protect themselves from contracting HIV/AIDS and avoid high-risk behaviors (UNICEF, n.d.). UNICEF (n.d.) mentions that the evaluation of the project identified that

the program participants delayed the age of the first sex and increased condom use once they started sexual life.

There are a number of programs and activities where young people are involved in delivering information and providing skills for their peers on HIV/AIDS and related issues. Involvement of young people living with HIV/AIDS can be effective for conveying the message that the virus can affect anyone and that individuals should protect themselves from HIV/AIDS (UNICEF/UNAIDS/WHO, 2002). At the same time, this can become impossible where there is strong stigma and discrimination, as a result of which these young people “can suffer grievous harm from revealing their HIV status” (UNICEF/UNAIDS/WHO, 2002, p. 34). Thus, those young people infected with HIV who choose to “go public” (p. 34) should receive support and legal protection against various kinds of abuse due to their HIV status.

Another important aspect of education prevention campaigns is creating a safe and supportive environment for young people. This includes ensuring that young people feel safe and supported in schools, at home, and in the community; providing youth-friendly health services (clinics or facilities that provide various services and information to young people and are welcoming, accessible and confidential); and promoting voluntary and confidential HIV counseling and testing (UNICEF/UNAIDS/WHO, 2002) to encourage young people to get tested and find out their HIV status.

Thus, the design of effective education programs, which involve all the above discussed measures, will contribute to reducing individual risk and vulnerability by providing vital information and life skills to young people.

In conclusion, this chapter discussed the role of the government in addressing the issues of HIV/AIDS and youth, and provided examples of activities introduced by the education sector in various countries. Also, it highlighted the issues that need to be addressed beyond formal education programs. Country experiences and initiatives worldwide provide credible information that the interventions give successful results. For those countries where the epidemic is still at nascent stage, these provide promising directions for combating the epidemic.

## **Chapter 4**

### **Youth and HIV/AIDS in Uzbekistan**

#### ***Country Background***

Uzbekistan is the most densely populated country in Central Asia with a population of 26.4 million and population growth of 1.65% (Central Intelligence Agency [CIA], July 2004). With GDP growth of 4.4% and gross national income per person of \$420 in 2003, Uzbekistan is among the poorest countries in Commonwealth of Independent States [CIS] (World Bank, 2004a).

After becoming independent, Uzbekistan chose to pursue democracy and free market economy. However, the president and the state government have “strict control over the political and religious freedom” (European Observatory, 2001, p. 1). Government interference in the economy is extensive, business climate is unattractive for foreign investment, and economic growth is estimated to be below its potential (World Bank, 2004a). The country has significant resources in gold, silver, natural gas, and oil, and ranks third in the world for its cotton production.

A difficult transition from the communist style of governance to democracy and free market has resulted in deterioration of living standards and all the sectors of society. Thus, unemployment remains high and, according to United Nations Development Programme [UNDP], estimates could be as high as 26.5% (as cited by Economist Intelligence Unit [EIU], 2003). Around 18% of the population earns less than \$1 a day (UNICEF, 2003) and some 28% are not able “to meet their basic consumption needs” (World Bank, 2004a, para. 10). Godinho et al (2003) report that over 60% of the population lives below the official poverty line (\$4 per day).

The population of the country is young, with 41.4% aged under 16, and rural, with 62.4% of the total living in rural areas (EIU, 2001). European Observatory on Health Care Systems (2001) reports the following demographic situation in 1995: 46% of the population is younger than 18 years old and only 4.2% older than 65. The average life expectancy is estimated to be 67 years old.

Three-fourths of the population are Uzbeks, while the rest include Russian, Tatar, Kyrgyz, Kazakh, and other ethnic groups. According to official statistics, the adult literacy level is 99.3%. However, this is largely attributed to the universal education system during the Soviet Union period.

For Uzbekistan, the transition period from soviet style to democratic governance was accompanied by deterioration in education quality and health care. Since independence, Uzbekistan undertook a number of reforms in the education sector to meet the requirements of a market economy. The education reform called The National Program for Personnel Training System aimed “to improve the quality, efficiency and effectiveness of the education system, in particular the training of specialists to make it more responsive to the socio-economic development needs of a market economy” (International Bureau of Education [IBE], 2003, para. 9). Initiatives and programs included renovation of curricula, teacher training, improving infrastructure, introduction of new information technologies, establishment of a quality control system, and reorganization of the education management system (IBE, 2003).

However, public expenditures on education declined from 11.6% of GDP in 1992 to 7% in 2000 (IBE, 2003). As a result, the quality of the education system went down,



which was reflected in ineffective teacher training, shortage of skilled teachers, and lack of high quality text books, methodological manuals, and other resources.

Similarly, the health sector suffered from a reduced health budget. Thus, in 2001 government spending on health care was 3.6% of GDP, compared to 4.2% in 1997 (WHO, 2004). Besides lower funding and inefficiencies, the quality of health care and access to it was affected when the Russian speaking medical workers emigrated from the country after the collapse of the Soviet Union (EIU, 2003).

Health indicators such as infant and maternity mortality rates were lower in 1998 than in 1989, however are still high. Thus, Uzbekistan had 22.3 infant deaths per 1000 of newborns in 1998, which is the highest among the CIS countries (European Observatory, 2001). The EIU (2003) reports a drop of maternity rates from 30.1 per 100,000 live births in 1992 to 14.6 in 1999. The European Observatory on Health Care Systems (2001) attributes these decreases to the “increased awareness among women about the importance of the family planning and popularization of contraception” (p. 8).

Social changes after the collapse of the Soviet Union, high unemployment rates, and economic instability negatively influenced lives of the people in the country. These factors, combined with lack of sexual education which was a taboo during the communist regime, make people in the region, youth in particular, vulnerable to high-risk behaviors. This vulnerability is discussed by Zahorka (2002):

Widespread poverty, migration, declining health and education services have led to a massive increase in individual high-risk behaviour, like unprotected sex and drug abuse... The general lack of sex education together with the ever earlier onset of sexual activities leads to a rapid increase of sexually transmitted infections especially among those under 25 years of age (p.6)

Thus, with these preconditions for the epidemic to get out of control, Uzbekistan faces a devastating future, if the issues of HIV/AIDS are not addressed properly.

### ***The Extent of HIV/AIDS: Overview***

Although currently Uzbekistan has a relatively low HIV prevalence (less than 0.2% [UNAIDS, 2004]), the epidemic is developing and growing steadily. Since the first HIV cases in Uzbekistan were registered in 1987 among foreigners (UNAIDS, 2004), only 51 cases were reported by the end of 1998 (World Bank, 2002b). The opening of borders early in the 1990s and increased mobility of the population facilitated the increase of the HIV cases in the region.

The official statistics are believed to greatly underreport the extent of the epidemic (Organization for Security and Co-operation in Europe [OSCE], 2001), reporting only about 5500 of HIV-infected in 2004 (Uzbekistan AIDS Centre, as cited by AIDS Foundation East-West, 2004). However, research conducted by international organizations reveals much more disturbing figures. Thus, the World Bank (2004b) states that during the last four years the number of reported cases dramatically increased from about 500 in 2000 to over 8000 in 2004 (para 2). The studies conducted by the international community emphasize that “although a nascent epidemic, HIV poses an immediate and serious threat to public health in Uzbekistan” (OCSE, 2001, para. 4).

The epicenter of the epidemic was initially the capital city Tashkent and the Tashkent province. Thus, 48% of all registered cases have been identified in Tashkent and around 20% (UNAIDS, 2004) in Tashkent oblast (region) and Yangiyul (area near Tashkent). Although Tashkent region continues to report the highest numbers of HIV-

infected, other major towns and provinces are reporting an increasing epidemic (OSCE, 2001).

The spread of the epidemic is largely driven by expanding intravenous drug use, which accounts for 63.4% of all infections (UNAIDS, 2004). Estimates by UNAIDS (2004) report that 11.3% of transmission can be attributed to heterosexual contacts and less than 1% relates to sexual contacts between men. The same source notes that an alarming 25% of cases have an unknown route of transmission. This could be attributed largely to the poor surveillance system and/or unwillingness of the infected to share information with testing centers employees.

UN estimates that there are around 60,000 drug users in the country, 60-70% of which are injecting drug users, many of whom share needles (Godinho et al, 2003). These numbers are not surprising, because the main drug trafficking routes go through Ferghana Valley in the north of Uzbekistan (IMPACT/Family Health International (FHI), January 2001). Low prices and easy access to drugs provide a favorable environment for increasing the number of drug users. While older people traditionally smoke opiates, “younger generations have shifted towards injecting heroin” (Godinho et al, 2003, p. 70). First starting with heroin smoking, the young drug users quickly switch to injecting heroin (IMPACT/FHI, January 2001). The same report notes that the average age for IDU is 22-30 years in the countries of Central Asia; however, illegal substance abuse starts at earlier and earlier ages.

Commercial sex workers (CSW) group, which very much overlaps with injecting drug users, is also in the center of the concentrated epidemic. Godinho et al (2003) note that, according to 1997 assessment estimates, “there were 5,000 sex workers and 250,000

clients in the capital city” (p.71). The assessment survey revealed that “the majority of the CSWs with ages varying from 13-30 years, do not use condoms, and 30% are IDUs” (Godinho et al, 2003, p. 72). Part of the reason, as Godinho et al (2003) report, is that most clients of the CSWs refuse to use condoms; a number of CSWs reported that “they face violence if they try to negotiate condom use with clients” (OCSE, 2001, para. 26). Nonetheless, as Godinho et al (2003) note, there are still a few CSWs who would protect themselves from contracting the virus.

These numbers show that the epidemic is still concentrated among IDUs and CSWs; however, “it can easily spread to so-called bridge populations” (para. 4), which include partners of injecting drug users and commercial sex workers (World Bank, 2005). This is the way for the epidemic to spread to the general heterosexual population. Already now this mode of transmission appears to be increasing at a fast rate (Godinho et al, 2003).

In addition to IDUs and CSWs, men who have sex with men (MSM) and prisoners are other marginalized groups who are particularly vulnerable to the HIV infection. In the same research paper, Godinho et al (2003) note the individual cases that have been reported among men who have sex with men, pregnant women, newborns, and blood donors. Also, Godinho et al mention the claims that in some poorly equipped hospitals “the blood supply...is not adequately screened for organisms found in HIV, Hepatitis B, and Hepatitis C” (p. 71).

The number of reported cases of sexually transmitted infections (STI) among the population, which are known as conducive to the spread of HIV, is increasing. Thus, in

Uzbekistan 221 cases of syphilis were identified per 100,000 pregnant women in 2001, who were not previously considered a vulnerable group (Godinho et al, 2003).

An alarming number - about 55% of all HIV/AIDS reported cases - are identified among young people under 30 (Godinho et al, 2003). This is especially disturbing, because young people are most likely to engage in sexual behaviors and have multiple partners. Despite the widespread belief that adolescents in Uzbekistan do not have sex before marriage, which assumes that they will have only one partner, some independent research findings contradict these assumptions. For example, a study conducted by the US Agency for International Development (USAID) in Central Asia revealed that “a significant percentage of young males reported their first sexual experience to have been at 13 or 14 years age” (as cited by OCSE, 2001, para. 25).

Changes in social norms, sexual behavior, and easy access to drugs contribute to the spread of the epidemic among youth who are already strongly affected, “as evidenced by the fact that the majority of IDUs and sex workers in the region are less than 30 years of age” (USAID, 2002, p. 11). Thus, the young population of Uzbekistan have all the conditions for the rapid increase of the number of HIV/AIDS cases within their group, enhancing the potential for a generalized heterosexual epidemic which is currently mainly driven by the IDU.

An uncontrolled epidemic could be devastating for the households in the country, as well as brutally affecting the country’s economic growth and the major sectors of society, as demonstrated by the countries’ experiences discussed in earlier chapters. Experiences worldwide demonstrate that the epidemic can be averted. However,

Uzbekistan needs to undertake immediate measures towards prevention of the catastrophe.

### ***Current Strategies for HIV Prevention***

The government of Uzbekistan is aware of the problem the country faces, and some steps were initiated early to avoid the spread of the epidemic. The Parliament approved the AIDS Law in 1999 on the prevention of diseases caused by HIV (Закон Республики Узбекистан о Профилактике Заболевания, Вызываемого Вирусом Иммунодефицита Человека, 1999), which states the right of every individual for voluntary confidential testing and the access of HIV-infected people to the free medical services. However, it is rather controversial whether the adoption of the Law was positive in the campaign against HIV/AIDS. Thus, Godinho et al (2003) argue that this Law “further contributes to stigmatization of HIV infected people” (p. 73).

At the same time, it is worth noting that since the adoption of the law, HIV counseling points were established in every regional center of the country. These provided testing, confidential counseling, information on HIV/AIDS and STIs, syringes, condoms, etc (World Bank, 2005).

After the ‘trust points’ were successfully piloted, the Ministry of Health opened centers in every city and the regions to provide confidential and anonymous HIV testing, counseling for IDUs, needle exchange, contraception, informational fliers and leaflets on HIV modes of transmission and prevention methods (OCSE, 2001). More than 200 ‘trust points’ are now functioning in the country (Godinho et al, 2003). Internationally the achievements of the centers are acknowledged to be positive and effective. Thus,

according to the World Bank (2005), this is “an international best practice” (HIV/AIDS in Uzbekistan, para. 4), because this is the first initiative in Central Asia undertaken by the local government to establish ‘trust points’ nationwide.

In many cities, these centers have indeed provided a unique opportunity for injecting drug users to get the necessary information on HIV/AIDS, exchange syringes, and get appropriate counseling (OCSE, 2001; Godinho et al, 2003). However, many of these centers lack syringes, condoms, information materials (OCSE, 2001), as well as adequately trained and qualified specialists to provide counseling to those tested HIV positive. In addition, the ‘trust points’ do not offer treatment for HIV or other STIs, which can be “a serious drawback in efforts to attract people at risk to come forward for testing and healthcare” (OCSE, 2001, para. 11). Unfortunately, there is very limited information providing the details on the effectiveness of the centers and the statistics on the extent of the services used by the population.

Also, the Uzbek government has started several national reproductive health programs. These include “Health Generation” and “Healthy Mother – Healthy Child” which “seek to promote safe motherhood and family planning” (International Planned Parenthood Federation [IPPF], n.d., para. 5). Partly due to these efforts, the use of contraceptives among married women increased from 28% in 1990 to 66.8% in 2003 (IPPF, n.d., para. 5). However, the same source notes that contraceptive use is “heavily biased towards intra uterine devices” (para. 5), which is the only free and “favoured” (para. 5) method by the public health care system. This means that condom use remains very low, thus setting conditions for the spread of STIs and HIV.

Another government campaign was the design in collaboration with UNAIDS of a national HIV/AIDS strategic prevention plan for years 2002-2005. The program encourages a multi-sectoral approach in the implementation of the strategy, strengthens interventions for high-risk population groups and the management structure (Godinho et al, 2003). The approved strategy considers the following factors to be “conducive to the spread of the HIV infection in Uzbekistan” (Godinho et al, 2003, p. 73):

- Insufficient governance;
- Lack of strong multi-sectoral coordination;
- Incomplete observance of human rights;
- Insufficient focus on prevention, care and treatment.

In the same research paper, Godinho et al note that in reality the government was “reluctant to approve the HIV/AIDS Strategy” out of “religious and cultural concerns” (p. 73), which means that the government is not yet willing to take the leadership on publicly addressing the problems of HIV/AIDS.

The multi-sectoral approach of the Strategy includes also an educational component on HIV/AIDS prevention. The educational programs have been developed for secondary school students; however, they have not been integrated into the compulsory curricula yet (Godinho et al, 2003). The IPPF (n.d.) reports that sexuality education was included into the national education curriculum for high school and college students. This is a 40-hour compulsory course on healthy lifestyle and family planning. There is very limited information on how this course is being taught and who is teaching it. However, an evaluation assessing the impact of the course on students revealed that the latter have neither sufficient knowledge nor skills to protect themselves from the epidemic (UNESCO Tashkent, 2004).



Also, there is information on the impact of the various regional educational programs on youth knowledge about the infection. A survey of 3600 young people ages 15-24 throughout Uzbekistan, conducted by Uzbek Association on Reproductive Health, indicated that 44% of young males are sexually active, however only 23% use contraception (Uzbek Association on Reproductive Health, as cited by Godinho et al, 2003). Another survey conducted by UNICEF in 2002 reports that:

Forty three percent of young people aged 14-17 are aware of condom use as a means of HIV prevention. However, among women aged 30-49, the proportion decreases to 35 percent, and among young women aged 15-29, the proportion further decreases to 26 percent (as cited by Godinho, 2003, p. 72).

A number of independent researchers indicate that the students learn very little or almost nothing about the HIV infection and the modes of transmission through school prevention programs (Godinho et al, 2003; IPPF, n.d.).

In addition to government measures, there is a number of Uzbek NGOs currently working with youth to provide prevention education. The Uzbek Association on Reproductive Health (UARH), founded in 2000, operates in nine regions through its regional branches (IPPF, n.d.). The activities run by the association include promotion of sexual and reproductive health for CSWs, establishment of a new hotline for CSW adolescents, peer education projects, and provision of SRH to migrant populations (IPPF, n.d.). One of the projects is described below by the IPPF (n.d.):

The project “Promotion of Sexual and Reproductive Health Among Commercial Sex Workers (CSW)” was in large part run by volunteer trained peer educators in UARH’s Samarkand and Navoiy branches, who disseminated information and contraceptives within this population through outreach in markets, main motorways and disco-bars. Training seminars for CSW peer educators were held to address themes of contraception, reproductive health and rights, drugs and STI/HIV prevention, and negotiating skills for condom use with clients. In addition to these educational activities, confidential one-on-one counselling was provided free of charge to individual CSW, many of them youth, on issues

ranging from condom use to sexual harassment. A confidential telephone hotline was also established for those CSW who may be cautious about appearing in person for services (para. 12).

Kamolot-Konun, the Ibn Sino Foundation, and the National Center for Healthy Lifestyles are the national Uzbek NGOs that are involved in the education campaigns with school-age youth to prevent drug use (OCSE, 2001). These NGOs are mainly funded by international and bilateral organizations; however they sometimes also receive in-kind contributions from local sources.

Although there is no information on the effectiveness of these measures, all of these activities and efforts demonstrate that first steps are being taken towards HIV/AIDS prevention. All of the initiatives, as well as the HIV/AIDS problem itself, are new for the region and its people. However, consistent efforts will provide positive results. It is enlightening to know that many young people are attracted as volunteers to the prevention efforts, which means that, although slowly, the efforts will change their targeted population of IDUs and CSWs to the more general population of youth.

Indeed, all of the activities in the country, including the national HIV/AIDS campaigns, are currently targeted at IDU and CSW groups. According to international experts, this “gives a misleading picture of the nature of the epidemic” (OCSE, 2001, para. 7) and provides “a major barrier to preventing a broader epidemic” (Godinho et al, 2003). This approach is leading young people and others to believe that the infection will not affect them (Godinho et al, 2003) because HIV/AIDS is solely a problem of people with “promiscuous” behavior. Also, OCSE (2001) argues that “this approach prescribes inadequate prevention campaigns, leaving hundreds of thousands of people at risk from infection without the necessary information to protect themselves” (para. 7).

### ***International Agencies' Strategies on HIV/AIDS Prevention***

International and bilateral agencies are becoming very active in programs related to HIV/AIDS in the country. The UN theme group, which includes the Ministry of Health, Defence, and Interior, and the World Bank, United States Agency for International Development (USAID), UNAIDS, UNDP, UNICEF, United Nations Office on Drugs and Crime (UNODC), WHO and several non-governmental organizations (NGO), has an integrated plan on the HIV/AIDS work in the country (Godinho et al, 2003). The Theme Group also included Soros Foundation/Open Society Institute (OSI) which in April 2004 was denied registration by the local authorities and therefore suspended all the activities in the country.

The Soros Foundation/OSI in collaboration with the International Harm Reduction Program (IHRP) supported methadone treatment and harm reduction projects at needle exchange sites (USAID, 2002). Other activities included support of the establishment of the 'trust points' in cooperation with the National AIDS Center (Godinho et al, 2003). The IHRP is now involved into harm reduction activities and HIV/AIDS prevention.

The USAID has been providing financial and technical support in establishing surveillance systems in the cities with the outbreaks of the epidemic, supporting peer and outreach education activities in the country, as well as the activities among high-risk groups (USAID, February 2005). In addition, USAID is promoting national drug prevention policies by supporting work with groups such as youth, CSWs, prisoners, migrants, and refugees.

These activities are also undertaken by the UNODC, which assists in establishment of the facilities and network for treatment of drug abuse, and raising public awareness on drug related issues (UNODC, April 2005).

The World Bank has proposed \$32.16 million for the Central Asia AIDS Control Project which would cover four countries, including Uzbekistan. Still under preparation, the project is aimed at minimizing “the potential negative human and economic impact of a generalized epidemic”, thus, it would “establish a legal environment that allows for prevention work with highly vulnerable groups” and “improve information and decision making based on good quality epidemiological data” (World Bank, 2005, para. 14). Also, World Bank Health II project in Uzbekistan, which has an HIV/AIDS component, was approved this year.

Such organizations as United Nations Population Fund (UNFPA) and UNESCO are publishing and disseminating the materials on HIV/AIDS and the epidemic prevention issues to high-risk groups at health clinic (OCSE, 2001). Moreover, UNFPA works on the provision of reproductive health care services, promotes the demand for the reproductive health in various parts of the country, which includes provision of contraceptives to the population (UNFPA, n.d.).

### ***Youth and HIV/AIDS***

Youth is a group that internationally has been identified as particularly vulnerable to HIV, in special need of adequate information about preventive measures and access to quality reproductive health and care. However, in Uzbekistan the problems and needs of

young people are being neglected, as they are in most population and reproductive health programs worldwide (UNESCO, 1998, p. 1).

The youth in Uzbekistan is currently in need of special attention. Limited future opportunities, frustration about joblessness, declining health care and educational services, and widespread poverty cause fast increases in high-risk behaviors like drug abuse and early and unprotected sex among young people in the country. Zahorka (2002) discusses the social norms and characterizes the situation in the following way:

While the rigid social control of the past has eroded, new common social norms and values are still flimsy. The lack of common social norms and values has led to relaxation of sexual norms including a trend towards increasing casualness of sexual relationships with an even increasing age at first intercourse. The general lack of sex education together with the ever earlier onset of sexual activities lead to a rapid increase of sexually transmitted infection (p. 6)

Thus, in the context of economic instability, and lack of social norms and values, young people who lack information about reproductive health, family planning, HIV and other STDs, are not able to protect themselves against the virus. Ignorance about the infection combined with widespread accessible injecting drug use, earlier age for first sexual encounter and thus multiple partners, little practice of contraception use in the region- this is the environment young people in Uzbekistan live in. These are the favorable conditions for the epidemic to thrive in the country.

Unfortunately, very few prevention activities in the country are targeted at youth, and even those that do are considered not having any positive impact on the knowledge of the young people about the infection. Thus, the research conducted by UNICEF/UNAIDS/WHO (2002), showed that, among young women aged 15-19 in Uzbekistan, around 50% have heard of AIDS and less than 15 percent knew the three main ways of protection against contracting the virus. The study conducted by Spectrum

Social Consulting Agency in 2004 among the young people aged 13-19 in the capital city revealed that 65.1% of surveyed young people knew about the existence of HIV/AIDS.

At the same time the study showed that young people in Tashkent area do not clearly understand what HIV/AIDS is. Thus, in the open question to define HIV/AIDS, the following responses were gained from the surveyed youth (translated from Russian):

“The person dies at the end of the disease” (13 year old);  
“Untreatable disease which leads to death” (16 years old);  
“AIDS is an untreatable disease transmitted through sexual contact” (18 years old);  
“It can be transmitted through sexual contact and through blood” (15 years old);  
“It is a disease which can be contracted easily, especially by drug users” (15 years old);  
“HIV is a viral disease which can be treated at an early stage of its development; AIDS is also a viral disease however untreatable” (16 years old) (World Vision, 2004, p.26).

Interestingly enough, the results of the same study showed that the primary resources about HIV/AIDS for the Tashkent youth are television programs (35.2%), teachers (14.8), and public events (14.1%). Utilizing these findings in designing programs and conveying them through sources identified by young people as primary methods of learning about HIV/AIDS, is an important key to the effectiveness of the programs.

It is obvious that the knowledge about HIV/AIDS is very limited among Tashkent youth, which due to living in the capital city has much wider access to the information, television, media, public events, etc. With the exception of several more cities, the majority of young people live in rural areas which neither have sufficient resources, nor qualified people to work with youth on raising HIV awareness, prevention, providing testing, counseling, and other services. This means that the majority of young people have even less information than their Tashkent peers.

Global experience has demonstrated that the prevalence rates among young people are rising, and this brings them into the center of the epidemic. Immediate action is needed while there is still time to reach out to Uzbek youth to help the country face the challenges of coping with the brutal epidemic consequences.

### ***Barriers to Effective Prevention Campaigns***

A number of activities and campaigns are conducted in the country to address the HIV/AIDS issues which will contribute to raising awareness among the population. However, there are also a number of barriers that will hold back the positive impact and hinder the effectiveness of the strategies (OCSE, 2001).

Focusing predominantly on the IDU groups, the national approaches leave the majority of the population without necessary information on the epidemic, its transmission modes, and the prevention methods, thus putting millions of people at risk of contracting the virus. Political will to address publicly the issues related to HIV/AIDS and leadership at higher levels of administration is vital for raising awareness among the people and providing them with tools to protect themselves. International experiences show that the countries where strong political leadership “has fostered openness about the issues and wide- ranging responses, the tide is turning and clear successes are being achieved” (UNICEF/UNAIDS/WHO, 2002, p. 25). For Uzbekistan to halt the epidemic, overcoming the challenges of public exposure to the extent and nature of the epidemic is critical.

Addressing the issues of other vulnerable groups is politically challenging in Uzbekistan. Godinho et al (2003) explicitly summarize the reasons for that:

Illegal purchase and storage of drugs is prosecuted as a criminal offense, and drug replacement therapy is not yet legal in Uzbekistan. CSWs are prosecuted by law, and MSM are also subject to criminal prosecution (p.73).

Thus, political silence not only keeps people uninformed about the extent of the epidemic, but also provides incentives for the vulnerable groups to avoid testing and, thus, lets the epidemic thrive without being identified.

It is true that addressing the HIV/AIDS issues among IDU is important, however, these efforts should come along with educating the general population and addressing the issues of sexual behavior through a “national high-visibility campaign including mass media” (OCSE, 2001). Further, OCSE (2001) argues:

This step will require an opening up of a public debate on culturally sensitive issues, but it will ultimately be the only way to ensure that the whole population receives the information it needs and prevent a generalized epidemic in Uzbekistan (para. 17)... It may be politically safer to talk about sectors of the population such as drug users that are already heavily stigmatized, but this approach is leading the general population to think that the HIV/AIDS phenomenon does not affect them (para. 22).

Strong political commitment to the goals of tackling the epidemic and political leadership and openness in addressing the issues related to HIV/AIDS also means opening up a dialogue about sexual behavior as a way for HIV to spread. Unwillingness of the government to address these issues “reflects some entrenched social attitudes in Uzbekistan that take a negative view of sex education and preventive measures such as contraception” (OCSE, 2001, para. 26). Research conducted by UNFPA in Tashkent identified that condom use “is only considered really necessary with very ‘dirty’ prostitutes and never in casual or permanent relationships with members of the same or opposite sex” (as cited by OCSE, 2001, para. 26). Contributing to this information, IPPF (n.d.) reported that “the general population as well as the medical community still uses



abortion as the main method of family planning” (para. 8). Thus, as it was noted previously in the chapter, condom use practice is very limited in Uzbekistan. The same assessment conducted by UNFPA revealed that CSWs “face violence if they try to negotiate condom use with clients” (OCSE, 2001, para. 26). This information does not provide too much hope about the use of condoms in the general population.

Stigma and discrimination toward the issues of HIV/AIDS and the infected is also a serious barrier in preventing the spread of the epidemic in Uzbekistan. There are clearly vivid examples of the attitude of the community towards infected people:

Confidential reports in Uzbekistan describe how social pressure from neighbors and the “mahalla” or local community organization, have driven families with an HIV-positive member to move to other cities to avoid constant stigma and discrimination (OCSE, 2001, para. 27).

The extent of the stigma and discrimination was identified in the research conducted by UNICEF/UNAIDS/WHO in 1999-2001. Thus, among the women who have heard about HIV/AIDS in Uzbekistan, 2% of those aged 15-24 and 3% aged 25-49 expressed a positive attitude towards people living with HIV/AIDS [The two questions asked were: 1. Should a teacher who is HIV positive but looks healthy be allowed to continue working? 2. Would you buy food from an HIV-positive shopkeeper?] (UNICEF/UNAIDS/WHO, 2002, p. 25)

These statistics point out to the ignorance level among the population about the virus which is to a big extent feeding social stigma and discrimination. Associated with “promiscuous” behavior, those infected face the reality of being excluded from society and the community. Consequently, fear of stigma, discrimination, and exclusion makes people “less likely to adopt preventive strategies, such as using condoms, seeking testing

for HIV and other STIs, adhering to treatment or disclosing their HIV status to sexual partners” (UNICEF/UNAIDS/WHO, 2002, p. 25).

Visibility of the AIDS centers (UNFPA, as cited by OCSE, 2001), especially in small towns, and lack of confidentiality of the services and testing facilities related to the way of life in communities in Uzbekistan contribute to the fear of stigma and discrimination, resulting in avoidance of the HIV testing and counseling facilities, as well as seeking information. The need to change this negativity towards the infected and affected was expressed by OCSE (2001):

Prevalent negative social attitudes toward the virus and its victims will require much re-education of the population in order to ensure a socially coherent campaign against the spread of HIV/AIDS and to care for those already affected by the disease (para. 27).

The stigma and discrimination are further exacerbated by the cultural and religious attitudes, which “underpin many of the negative social views toward open discussions about sexuality and sexually transmitted diseases” (OCSE, 2001, para. 28).

The same resource quotes an Uzbek journalist about the attitudes of religious people towards HIV/AIDS:

...HIV infections are seen by some as an indicator of the spreading decay of societal values...and return to a traditional lifestyle is advocated as the best way of containing the disease, according to some clerics (Khamidov, as cited by OCSE, 2001, para. 28).

Thus, promoting sex education is viewed by religious people as promotion of immoral behavior, and by advocating “to return to traditional values”, they want to go back to traditional islamic values. It would not be an exaggeration to say that many Uzbek people who express traditional religious concerns and hold these traditional views will oppose sex education and public exposure of HIV/AIDS issues. However, a dialogue between the

political and religious community leaders of the country could bring up important points to the agenda. Winning the understanding and support of religious leaders could also contribute to lessening the widespread stigma and discrimination towards the people with HIV/AIDS.

From the previous section, it is clear that most of the barriers exist mainly due to population unawareness about the infection and the issues related to it. In Chapter 2 the reviewed literature concluded that education is the best tool to eliminate ignorance. Combined with government commitment and openness in addressing the HIV/AIDS related issues, education can bring positive results in confronting the epidemic in Uzbekistan.

## ***Conclusion***

The twenty-year history of the epidemic and global experiences have shown that early action is vital in halting the spread of the epidemic. Thus, if Uzbekistan does not bring its resources together to address the issues of HIV/AIDS while the prevalence rates are still low, the country is facing a disastrous future. The deadly disease has already found its way to the general population through the heterosexual transmission, and thus, the window of hope has already started to close.

Statistics show that young people in Uzbekistan already account for 55% of all infections. Fueled by widespread injecting drug use and increasing commercial sex work, the epidemic is spreading at a fast rate among young people under 30. The key to halting the epidemic spread and defeating AIDS in Uzbekistan is effective prevention programs, culturally and socially adapted to the environment and circumstances of the region.

My concluding thoughts include the summary of the issues that need to be addressed to prevent HIV/AIDS epidemic among youth in Uzbekistan. These insights were adapted from the recommendation steps from UNICEF/UNAIDS/WHO (2002).

### *1. Provide young people with knowledge and information through formal and non-formal education programs and media*

Evidence shows that Uzbekistani people in general and young people in particular do not have basic knowledge about HIV/AIDS. However, to be able to effectively protect themselves from contracting the infection, they need to know facts about the epidemic before they become sexually active, and this knowledge should be delivered both through in- and out-of-school activities and programs and aim not only at providing knowledge

for youth, but also emphasizing reproductive health education and stimulating adoption of risk-free behaviors.

While school programs can reach the majority of students in the country, out-of-school programs can provide supplementary knowledge to the education and skills provided in schools and also educate out-of-school youth.

Media can be a powerful tool to raise awareness about HIV/AIDS through TV and radio broadcast programs. Although not every household has a TV set in Uzbekistan, radios are widespread among the Uzbekistani people. Thus, media is able to disseminate the information to large numbers of people.

## *2. Design programs for parents and community*

The role of parents and community is crucial in providing supporting and understanding environments for the young to learn and practice safe behaviors. These programs should also aim at educating parents and community members to provide them with skills to discuss sexual issues with their children.

## *3. Provide youth friendly health services*

Lack of appropriate youth-friendly facilities is an important hindrance for the effectiveness of educational programs and interventions. Thus, establishing reproductive health services that are open, friendly, confidential, welcoming, affordable, and easily accessible to young people of any age and background, and provide full range of services and information to them will help in preventing the spread of HIV.

## *4. Promote voluntary and confidential HIV counseling and testing*

Although it is true that ‘trust points’ are providing these services, they are mainly targeted at young injecting drug users and, thus, may not be attractive to most young

people for fear of stigma and discrimination. Thus, it is important that already established centers restructure their current work to be attractive and encourage young people to use the services. As argued by a number of international agencies, voluntary and confidential counseling and testing will allow adolescents to evaluate their current behavior and possible consequences, thus contributing to the prevention of HIV.

*5. Promote participation of young people*

Involving young people in the design and delivery of programs and activities containing HIV/AIDS messages is meaningful for ensuring that the messages are communicated effectively and correctly, and are relevant to youth lives. For example, peer education is an effective way for young people to participate in preventive programs.

*7. Effective monitoring and evaluation system*

Designing monitoring and evaluation programs for current and future interventions is crucial in identifying successes and/or failures of the prevention programs and assisting in further development and enhancing of those to achieve the best possible results.

Addressing these issues will not necessarily ensure the effectiveness of the prevention programs, and thus, stop the spread of the HIV. However, occurring hand-in-hand with public openness about the problem, efforts directed at addressing the barriers such as stigma and discrimination and cultural resistance to HIV/AIDS programs, these interventions will be an important contribution to combating the epidemic.

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