

Draft: Please note that the paper will be extended in two ways:

- 1. the Kazakh case (for which I have similar data) will be added.*
- 2. the use of 2002 Uzbek DHS data (which will be available in January of 2005) will be added*

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ABSTRACT

Since 1991, contraceptive use has increased dramatically in Uzbekistan and reliance on abortion has declined. Yet, in spite of improvements in reproductive health, UNAIDS reports identify Central Asia as the fastest growing region worldwide for HIV infection. Inadequate sexual education programs, heavy reliance on IUDs, social norms discouraging condom use, substantial premarital and non-marital sexual activity, and growing rates of intravenous drug use in Uzbekistan provide a welcoming environment for the spread of HIV. Integrating state health statistics and reports, two rounds of DHS data (1996 (UDHS) and 2002 (UHES)), and interviews with health care providers and young adults, I find little evidence that wide scale family planning campaigns in Uzbekistan improved sexual health knowledge among men and women, especially those under 25 years of age. Individuals lack basic knowledge concerning symptoms relating to sexual infections, and over one third of men and women report that HIV is unavoidable in the 2002 UHES. In this paper I trace the structural development of national and international efforts to improve Uzbek reproductive health in the 1990s, and highlight the structural and attitudinal orientations that disconnected these programs from sexual health issues. This disconnect has led to alarmingly low levels of sexual health knowledge, providing a context for accelerated spread of sexually transmitted disease in Uzbekistan. The paper concludes with an analysis of why, well into the global AIDS pandemic, reproductive health programs may fail to integrate sexual health issues into their agendas

The 1994 Cairo International Conference on Population and Development codifies the central importance of sexual health as part of any reproductive health program, reflecting an increased awareness in the policy community of the central importance of HIV/AIDS education and prevention. The ICPD pronouncement solidifies the earlier stance of the World Health Organization, including sexual health and HIV knowledge as key elements in reproductive health years earlier. (PAI 2004) Simultaneously, across the former Soviet Union newly independent states were initiating wide scale reproductive health campaigns, with the support and in many cases direction, of international agencies and individual donor states. In the Central Asian state of Uzbekistan, these campaigns are associated with a dramatic rise in reported contraceptive familiarity, increasing acceptance of fertility limitation, and widespread modern contraceptive use among married women. Yet, for most Uzbeks, misperceptions regarding basic issues of sexual health and knowledge of HIV/AIDS prevention and transmission persist, and STI infections rates are growing rapidly. This indicated that reproductive health efforts take in the 1990s appear not to have succeeded in improving sexual health.. At present, Uzbekistan is identified as a future high growth region for HIV. The dire predictions concerning HIV infection rates increase the importance of analyzing why sexual health did not improve along with other reproductive health indicators.

Reproductive health campaigns in Uzbekistan launch well into the global AIDS pandemic, and at the same time international consensus regarding the importance of sexual health within reproductive health is solidified. What explains the marked success of these programs in terms of increasing contraceptive use, and their poor performance in raising sexual health knowledge? In this paper I trace the structural development of national and international efforts to improve Uzbek reproductive health in the 1990s, and highlight the structural and attitudinal orientations that disconnected these programs from sexual health issues. Integrating state health statistics and reports, Demographic and Health Survey and UNICEF Cluster Survey data (1996/2002 and 2002), and interviews with health care providers and women in the region between 2000 and 2003, I find little evidence that wide scale family planning campaigns in Uzbekistan effectively improved sexual health knowledge among women or men. Many individuals lack basic knowledge concerning symptoms relating to sexual infections, and

over one third of men and women report that HIV is unavoidable in the 2002 (DHS, 2004). Analyzing why, well into the global AIDS pandemic, reproductive health programs may fail to integrate sexual health issues into their agendas affords unique insight into the lag between policy and programs, the difficulties associated with measuring reproductive health, and the central importance of education and empowerment in reproductive health.

As Seltzer points out, orientations towards and motivations for family planning programs have evolved over time. (2002) Over time, rationales for programs change from interventions focusing on elements of demographic planning and public health, to broad based approaches centering on issues of human rights, agency, and autonomy. Standard approaches to the study of reproductive health stress the importance of enabling informed choice and developing individual decision making capacity, especially for women (Dixon –Mueller 2001). The expansion of reproductive health to include an emphasis on sexual health is a logical continuation of concerns regarding decision making and human rights, especially at the current stage of the global pandemic. The inclusion of sexual health as a priority has been integrated into the policy realm, through statements of support by major funding organizations such as USAID and UNFPA (Seltzer 2002:104, UNFPA 2002). The shift is clearly justified as multiple studies point to the need for better integration of sexual health issues into overall program promoting reproductive health (Askew and Merger 2003). Yet concerns that such expansions will spread resources for reproductive health too thinly appear valid (Seltzer 2002), especially as dominant approaches towards the measurement of family planning program effectiveness do not take into account any indicators related to sexual health. (Ross and Stover 2001) The stability, resilience, and efficacy of the integration of sexual health concerns into reproductive health programs are unclear, in spite over official pronouncements. Investigating if recent reproductive health initiatives (funded by international agencies programmatically committed to viewing sexual health as a component of reproductive health) generate simultaneous improvements in sexual and reproductive health indicators can clarify how seriously the shift to include sexual health as a major component of reproductive health is, pointing out whether sexual and reproductive health remain disconnected. It can also highlight potential barriers to the integration from the side of donors or recipient nations.

The Uzbek Case: Unmet Contraceptive Need

During the Soviet period, Uzbek cultural norms prohibit discussing sexual matters prior to marriage, and discourage discussions of sex with women regardless of marital status (Tashbaeva 1997). Norms supporting rapid child bearing after marriage and large families, particularly for ethnic Uzbeks and Tajiks were widely held (resident in the western sections of the country). School curriculum excluded sexual education in the Soviet Union (albeit with some programs in the Baltics) and discussing topics relating to sexual and reproductive health seldom happened in the popular media in either Uzbek or Russian. Throughout the Soviet period, heavy reliance upon abortion compensates for very low levels of contraceptive prevalence (David 1999). Preferences for large families, heavy reliance upon agriculture, and perhaps the greater relative worth of child benefits in Uzbekistan helps support high fertility during the Soviet period, even among urban residents, women with relatively high levels of education, and working women (Tashbaeva 1997). In 1989, Uzbekistan's TFR stands at 4.2, third highest in the USSR. Abortion (registered and unregistered) served as the main means of fertility control (Westoff et.al 2002), with an estimated general abortion rate of nearly 40 (39.1) for 1991-1993. (UHES 2004) At the end of the Soviet period (1990), only 28% of married women resident in Uzbekistan report using any type of contraceptives to prevent pregnancy (U.S. Census 2003) and familiarity with modern contraceptive techniques rare.

With the collapse of the Soviet Union, Uzbekistan experienced extreme economic turmoil. With inflation rates as high as 1500% annually (1994), nearly half the population falls below the poverty line. Over 40% of children under three years of age suffering from severe or moderate anemia, the motivations for delaying births or opting for smaller overall families are clear (Buckley 2003, Ubaidullaeva 2000, Wolf 2003:14). Strained social safety nets motivate President Islam Karimov to call for decreasing the birth rate soon after independence. Focusing on the development of a healthy generation, Karimov encourages citizens to bear only those children they are able to feed and educate (Karimov 2000), a high standard to reach in the difficult years of the early 1990s. Norms towards early child bearing remain firm, but informal discussions with women in Tashkent and Bukhara Oblast emphasized that beliefs in large families are changing rapidly in the early 1990s. A lack of assured

maternity leave, child care options, family benefits, rising costs for education and medical care, and poverty motivations for limiting family size. Recalling an earlier time, one ethnic Uzbek woman in Tashkent, with three teenaged children, lamented in 2002.

“It is another world now. My mother had six children, but that is a fantasy now. I can barely feed the children I have, educating and clothing them is beyond my resources. We have no help with families, I had an abortions and finally got sterilized. I had no choice”

An official in the Ministry of Health, who preferred to remain unnamed, raised similar issues in an interview in 2003:

“It was horrifying really, the early years of independence. So-called leaders arguing for more children and a return to tradition, no one was paid, no education regarding family planning. What can you expect? Doctors did what they could, but with what? We knew there were better options for women than abortion, but had no way to obtain spirals (IUDs), the Chinese condoms we had were terrible, and pills non existent. People were in terrible situations”

Faced with such challenges, the population of Uzbekistan was not only ready, but waiting, for the efforts of the Uzbek government and international organizations encouraging the adoption of modern contraceptives. Across the region states facing mounting social service costs, fragile public health system, and desiring to show improvement to the international community concerning social welfare sought to replace abortion with contraception. (Westoff et.al. 2002)

Uzbekistan, as one of the most centralized and autocratic of the successor states, was in a unique position to mount a national program on reproductive health. Characterized by strong central control of social services, tight reins on non-governmental associations, and complete control of the media, the Uzbek government is well positioned to carry out social directives. Throughout the period, non-governmental organizations, particularly those focusing on women’s issues, operate under tight government restrictions and oversight (Tokhtakhodjaeva 1998, Wolff 2002). While religious organizations grew in popularity after independence, they too are closely monitored by the state, enjoying very limited autonomy. (Seivers 2003) Health care remains under central control, in spite of limited clinic privatization, providing an efficient channel for realizing governmental goals concerning maternal and child health. The primacy of the state and weakness of among the existing institutions of

civil society provided an enabling background for a national reproductive health programs, but little possibility for effective oversight, monitoring, or potential opposition.

After the collapse of the Soviet Union, international agencies and individual donor states become very active in Central Asia. The low level of infrastructural development, educated population, oil reserves, and strategic location make the region an attractive aid recipient. The historically high fertility rates of the region and low contraceptive use rates provide a logical target for reproductive health programs. More recently, the previous heavy reliance upon abortion as a means of fertility control also appealed to the political dispositions within the United States, as one USAID official visiting Tashkent commented in 2002:

“This is an ideal situation, {who} can complain about resources going towards family planning when you can argue that, in essence, it is also an attempt to decrease reliance upon abortion? The typical restrictions (referring to the gag order on US funded projects discussing abortion) do not apply, the government wants as many IUDs as it can get, and things can really improve for women”

In the 1990s, Uzbekistan, as other countries in Central Asia, represents a green field opportunity for international organizations working in the area of reproductive health. There was significant interest and unmet need on the part of the population and strong government interest in controlling population growth. Beginning national campaigns on reproductive health well into the spread of the HIV/AIDS pandemic, countries such as Uzbekistan should provide an excellent opportunity for the integration of sexual health into reproductive health programs. Uzbekistan had opened HIV testing sites in 1987, and as of 1989 established mandatory HIV testing for expectant mothers (ILO 2002), well before reproductive health campaigns begin.

Reproductive Health Campaigns in Uzbekistan

A concerted structural effort to increase contraceptive use among married women in Uzbekistan begins in early 1993 when the pro-contraceptive (anti-abortion) policy of the Uzbek government, supported by significant international assistance from various organizations in the United Nations and by USAID, blankets the country with slogans advocating contraception and broadcasts encouraging women to utilize clinics for both information and contraceptives. In 1993 USAID launches a multi-site Reproductive Health Service Expansion Program (RHSEP) in Uzbekistan, which

includes training and retraining of health care providers, educational efforts in the media, and improving medical training in obstetrics. Organizations also begin shipping contraceptives as a form of material assistance, but the aid-based contraceptive mix for Uzbekistan (as for much of Central Asia) focuses upon Depo Provera, Pills, and IUDs. Between 1993 and 2000, UNFPA shipped over three million IUDs to Uzbekistan, in contrast to 76,000 condoms in the same period. (UNFPA 2002) According to some USAID officials in Tashkent, the emphasis upon IUDs is in response to requests from the Uzbek government, who “simply want more and more IUDs delivered.”¹ Examining project overviews from various USAID subcontractors, it seems the main goal of the RHSEP centers on the replacement of abortion with contraceptives (JHPIEGO 2002, Thompson et. al. 1997). In almost all cases, workshops and training on HIV/AIDs received some mentioned in program planning, but main efforts were reserved for contraceptive access and training the trainers session in major cities.. Reports on and assessments of completed campaigns focus exclusively upon contraception adoption among married women, declining abortion rates and reflect strong reliance on IUDs. Structurally, international reproductive health programs tend to reinforce the government’s emphasis on working through local makhallas, neighborhood organizations, typically run by male elders in the community. (Buckley et.al. 2004)

In 1994, mass media approaches were introduced, including the use of radio dramas supported by UNESCO such as Viliki Sholkovoi Put (the Great Silk Road). This drama focused on a family coming to grips with modern social problems including unplanned pregnancy, but no discussion of STIs or drug use, both of which were rising during the period (UNFPA 2002). While UNAIDS did open offices in Tashkent, there are few cooperative programs funded between reproductive health programs and AIDS related NGOs. Rather than the close linkages the Cairo statement advocates, sexual and reproductive health issues appear distinct, rather than complementary.

The US supported Red Apple project in Uzbekistan begin in earnest in 1995. The web site reporting the most popular categories among overall questions fielded by Red Apple outpost rooms lists no questions on STDs or HIV/AIDs. Local women involved in the Red Apple campaign know

¹ Personal interview, Tashkent July 13, 2001,

that “the purpose of the Red Apple program was to promote healthy families, healthy mothers and healthy children by advocating birth-spacing and modern contraceptives as alternatives to frequent births and abortions” (Futures Group 1997). Only in the last year (2003) did the current sponsoring organization, Zdrav Plus, report that the hotlines established under these programs provide information concerning sexual health, however their reports indicate the questions tend to come from men alone. (Zdrav Plus 2003) The incorporation of condom use and information on transmission and prevention of HIV/AIDS does not appear as a central element of the “healthy family” orientation of these family planning efforts, especially in their initial stages. A second form of intervention by USAID in the mid 1990s entitle SOMARC, seeks to assist in the marketing of contraceptives including information on condoms (Gulkin-Silver 1998), but is discontinued in 1999, as the economic instability in Uzbekistan prevented the emergence of a market in contraceptives. Imported condoms are priced at nearly one dollar each, or one tenth the average monthly wage. (Kudryashov 2004)

In 1997, with the support of the government, the Uzbek Women’s Committee places the promotion of family planning services as their top priority in addressing women’s needs, but the following year the only pilot program for school based reproductive health education was discontinued. (Mee 2001:11, Tashbaeva 1998) In Uzbekistan sexual information generally is not readily available to adolescents through either public or private channels (see Vaslov et al. 2001). Following two earlier pilot attempts at introducing reproductive health issues in 1993 and 1997, a new course on health is slated for inclusion in school curriculum, over a decade after national and international programs on family planning began. (ZdravPlus 2004)

Simultaneously to, and some cases in conjunction with, international programs medical professionals in urban and rural areas of Uzbekistan report the state began issuing directives to clinics across the country concerning IUD insertion quotas in early 1993. Those clinics failing to reach quotas face budget cuts and jeopardized wages. In the words of one clinic director, interviewed in 2003 “What consultation can I give someone? I have a job to do and a percentage of women who must have a spiral inserted.” A young nurse in a Tashkent clinic, referring to an American science fiction movie available in Uzbekistan on bootlegged DVD remarked in 2002,

“Workshops, education (sarcastically), these projects don’t mean anything for most women, {it is} just like that movie...resistance is futile. That is all. If a woman comes in she will get an IUD inserted after the birth, regardless of what her mother in law thinks, her husband says, or what she wants.....I do not know (pause) but am told this is for the best”

Clinics failing to meet their insertion quotas are under threat of losing their funding from the state, and many women referred to being pressured by clinic staff to have an IUD inserted. The power hierarchy reflected in the nurses comments (mother in law, husband, medical personnel) appear at odds with empowerment and choice based approaches to family planning, and reflect an approach toward family planning focused on practice, with little concern for attitudes or practice.

Initial reproductive health campaigns in Uzbekistan benefit from significant international resources from international organizations and individual donor states. The centralized nature of the Uzbek state is on one hand an enabling factor, as control over public health clinics, the media, and education facilitated the programs described above, and on the other hand a powerful and controlling force capable of circumventing individual decision making processes concerning contraceptive adoption or selection of contraceptive method.

Program Results: A Contraceptive Success and Sexual Health Failure?

In spite of years of low levels of sexual education, extremely high fertility, and restricted contraceptive access, a large scale shift in the ability of women to control their fertility takes place by the mid 1990s. By 1996 the total fertility rate declines to 3.2., with reported contraceptive knowledge (measured by having heard of a method) higher among married women of all ethnic groups and regions. Based on data from the 1996 Uzbek Demographic and Health Survey, 56% of all married women are using a modern contraceptive method, and over 80% of all contraceptors are using intrauterine devices. In the mid 1990s, IUDs are relied upon across age cohorts, ethnic groups, and linguistic groups (Barrett and Buckley 2002). The number of abortions per 1000 women of reproductive age falls markedly, from 34.6 in 1991 to 18.4 in 1996. (GDS 1998: 23).

Table One about Here

In terms of contraceptive knowledge, as seen in Table One, nearly all married women in Uzbekistan have heard of at least one contraceptive method. In 1996 nearly 96% of all married women responded that they had heard of a specific method and by 2002 this number increases to nearly 99%. In both years, women across all statuses were familiar with IUDs, if they were familiar with any method at all, reflecting the narrow programmatic emphasis in the Uzbek reproductive health initiatives. In 1996 married women were much more likely than the unmarried (ever active or not) to have heard of a contraceptive method, but this gap narrow slightly by 2002. The most striking difference between 1996 and 2002 is in familiarity with condoms. In 1996, it is rather low (less than half), but rises to nearly 70% in 2002. While most measures relating to condoms under the category of contraceptive can be misleading (as they may be identified solely with disease prevention by some and therefore not reported as a *contraceptive* used), the measure reflected in Table One simply represents familiarity (have heard) of the method, and therefore should give a valid indication of awareness. Condoms are unfamiliar to those not yet married, with less than one in four women who have yet to be sexually active familiar with them. In 2002, nearly three quarters of non-married women who have ever had sex were familiar with condoms, far higher than married women at 57%. This differential in familiarity may be linked to the association of condoms with extramarital or premarital sex, and warrants further investigation.² Table One indicates that major strides in contraceptive familiarity (albeit measured generously) among women occurred during the period of reproductive health programs in Uzbekistan, however, knowledge levels offer room for improvement. In 1996, 37% of the women surveyed (n=4411) are not aware of any location where they could obtain contraceptives, although by 2002 it had fallen to 32%.

Attitudes towards contraception and family planning appear to have also improved during the 1990s in Uzbekistan. In the 1996 DHS survey, the overwhelming majority of women approved of family planning messages broadcast in mass media. Only 7.6% of the 4411 surveyed objected to messages on the radio, and only 5.1% objected to family planning advertisements on television. Yet

² In spite of repeated assurances from colleagues in the Ministry of Health and repeated assurances and recants from colleagues at DHS, I have yet to gain access to the data from the 2002 study to date. When the abstract was submitted in January, I was assured I would have the data set by February at the latest.

attitudes towards young adults and reproductive issues remain restrictive. National and familial cultural beliefs, often fortified by perceived traditional sexual norms, create a situation in which targeting young people, particularly before marriage, for sexual education is problematic (Azimova and Alimova 2000). Young women occupy a difficult role, with traditional Uzbek culture painting a picture of a young unmarried woman as very shy, quiet, and not needing knowledge about sexual matters or even reproduction. While the same may be true for young Uzbek men, the importance of modesty operates to a much lesser extent. These traditional attitudes are further complicated by the lack of sexual education opportunities for young adults at home or school. (Buckley, et.al. 2004)

Contraceptive practice patterns in Uzbekistan clearly indicate improvement in reproductive health. The percent of married women using modern contraceptive (excluding measure for LAM, female condom, and emergency contraceptives) has increased from a reported 28% at the end of the Soviet period, to 51% in 1996, and to 60% according to the 2002 UHES survey. According to the results of a UNICEF multiple Indicator Cluster Survey, 67% of married women practice modern contraception techniques when the definition is expanded to cover LAM, female condom, and emergency contraceptives, but differences in the sample technique in the study may also help explain the higher estimate (UNICEF 2002). Two central goals of the family planning programs initiated in the early 1990s; increasing modern contraceptive use among married women and decreasing the abortion rate, have both been accomplished. Based on self-reported abortion histories in the UHES, the estimated general abortion rate has fallen from 39.1 in 1991-1993, to 28.0 in 2000-2002, a thirty percent decline.

Figure One About Here

As seen in Figure One, the resulting shift to contraceptive use in the mid 1990s occurs primarily at ages 25 through 40, most likely among married women who are using contraceptives to either space or to stop child bearing. The vast majority of all women employing a modern contraceptive, use the IUD. Contraceptive use rates for the youngest ages are low, indicating that contraceptives are less likely to be used as a means to delay first births or to prevent premarital conception. The majority of women under age 25 are not using any form of contraceptive, and,

according to DHS data, over sixty percent between 15 and 25 years of age have not been to a reproductive health clinic in the past year.

Substantial and important strides in contraceptive knowledge and practice appear in the Uzbek case, but several of areas of concern remain. Improvements in deepening reproductive health knowledge through familiarity with a variety of contraceptives and expanding educational efforts to youth and the non-married are justified. Emphasizing education and individual decision making, rather than centralized mono-method directives would serve the larger objectives of reproductive health. Including men in reproductive health training and service programs would also represent a substantial improvement. Yet, even with these shortcomings, the national and international efforts in the sphere of reproductive health did serve to increase attention to issue of fertility control, expand access to modern forms of contraception, and extend health care access and options for married women. Mass media campaigns brought discussions of reproductive health issues to the public at large, and are linked to measurable improvements in some aspects of reproductive well being.

But how effective have Uzbek reproductive health campaigns been in addressing issues of sexual health? Are there discernable influences linked to these programs in terms of this aspect of reproductive well being? Results from both the 2000 UNICEF survey and the 2002 UHES indicate that nearly all women of reproductive age have heard of AIDS. In 2000, the multi indicator survey finds that of the nearly 7,800 women between 15 and 49 surveyed , 74% had heard of AIDS. The UHES in 2002 finds that 90% of women in the reproductive ages have heard of AIDS, and 95% of the male sub-sample. Both studies indicate that awareness of HIV/AIDS is related to educational level, urban or capital city residence, and age. For men and women, education and urban residence increases the likelihood of AIDS awareness, and those in their thirties are most likely to be aware of the disease. In the UHES, more respondents of both genders were aware of AIDS than other sexually transmitted infections, in spite of increasing rate of syphilis and gonorrhea throughout the 1990s (Buckey, et.al. 2004). While the majority of respondents have heard of both AIDS and one or more sexually transmitted infection, questions regarding prevention and transmission indicate widely shared misconceptions regarding issues of sexual health.

Focusing on a standard ABC approach (abstinence, being faithful, using a condom), the UNICEF study in 2000 finds that less than 3% of the women surveyed were both familiar with the three advocated prevention strategies *and* able to identify standard misconceptions regarding transmission (for example, transmission by sharing utensils), concluding that knowledge levels are unacceptably low. (UNICEF 2001:22) The UHES in 2002 finds that only 69% of women and 80% of men surveyed believe AIDS is preventable, and that never married sexually inactive youth are most likely to believe there is no way to protect themselves from HIV transmission. Initial inspection of the data indicate that similar social characteristics increase the likelihood of low contraceptive knowledge and misconceptions concerning sexual health, but in the aggregate, reported sexual health knowledge is lower than contraceptive familiarity across a number of indicators.

Table Two About Here

Table Two examines specific measure of sexual health knowledge for men and women by marital status and sexual activity. Overall, individuals not currently in a marital union (never married or divorced/widowed) who have had sex appear to be the best informed concerning sexual health. Both men and women in this category appear to be better informed than the married or the never-sexually active never married. Generally, men appear more informed than women, especially with regards to condom use. In comparison with Table One, more women report familiarity with condoms as a contraceptive type, than report that condom use is an effective strategy to prevent HIV transmission, across marital status. More married women are familiar with a contraceptive technique than have heard of HIV, a finding worthy of further exploration. The level of misconception is surprising, given that Uzbekistan has strongly encouraged HIV testing for all pregnant women, and in the 2000 UNICEF study 41% of all respondents reported having been tested for AIDS. (UNICEF 2001: 25)

In terms of public attitudes relating to HIV/AIDS, the picture is somewhat mixed. Among respondents with a partner, only 32% of women and 25% of men report ever discussing HIV/AIDS prevention issues with their partner. 33% of all women respondents and 23% of men in the survey responded that if a family member had HIV/AIDS it should be kept secret. In terms of education, less

than half of the women and approximately 60% of the men supported teaching adolescents (12 to 14) how to use a condom. While these attitudes imply a reluctance to approach issues relating to HIV privately or publicly, attitudes towards people with HIV are generally quite tolerant. In the 2000 UNICEF study, less than 6% of women surveyed challenged the right of an HIV infected person to teach in an elementary school or would refuse to buy food from them. The UHES found nearly universal support for HIV/AIDS public service announcements over radio and television from both men and women.

The improvements in women's reproductive health options in Uzbekistan in the early 1990s often overshadow a striking increase in registered sexually transmitted diseases during the same period. As with many of the countries of the former Soviet Union, the 1990s bring dramatic increases in syphilis and gonorrhea in Uzbekistan, with nearly 70% of the increase attributed to individuals under the age of 25 (Buzurukov 2002). Public health records indicate a marked rise in officially reported rates for syphilis and gonorrhea. In Tashkent in 2000, there were 140 registered cases of syphilis for every 100,000 population, more than seven times the rate observed in 1993. (Buckley et.al. 2004) While increased testing may contribute to elevations in the prevalence rate, these findings are noteworthy as these data represent officially published estimates that are likely to significantly underestimate the overall level of venereal disease in Uzbekistan. Due to reluctance to be tested, cases detected and treated are likely to be in advanced stages which increases the likelihood of transmission prior to diagnosis (IRIN Nov 2002). Official statistics on other types of sexually transmitted diseases are lacking, but perceived prevalence of various types and severities of urogenital infections among women is reported at 80% (although no clear original source is provided) (Central Asia 2002, Buzurukov 2002).

Figure Two About Here

The rise of sexually transmitted disease in Uzbekistan is troubling. First, it provides confirmation of unprotected sexual activity occurring, especially among those under 25. Secondly, the growing rates of infection raise questions regarding the appropriateness of high IUD reliance, discussed above. It also lends credibility to international concerns over the future trajectory of HIV in

Uzbekistan. Figure Two displays the growth in officially registered HIV cases in Uzbekistan. Based on data obtained from the Republic AIDS Center it clarifies the precipitous rise in the number of HIV positive individuals in Uzbekistan, occurring simultaneously.

In addition to growing, the transmission path of HIV has changed. Prior to 1999, most cases of HIV infection are linked to sexual transmission affecting those age 30 to 39 primarily. After 1999, infection is increasingly linked to intravenous drug use, with nearly 60% of the HIV cases so linked, many of them in young people. Ominously, current press reports cite a recent small-scale study finding that over 45.5% of used syringes found on Tashkent streets contained HIV positive blood (CDC 2003), but large scale detailed information on overall prevalence is scarce and often contradictory. The most recent estimate of 200,000 represents a high-end estimate, with most estimates centering on between 12,000 and 15,000 individuals as habitual IDUs. UNAIDS estimates that approximately 20% of all drug users are between ages 14 and 17 (Zharkova 2003). According to governmental sources, there are 30.2 registered drug addicts per 100,000 in Uzbekistan and 78 per 100,000 in Tashkent in 2000, but such numbers woefully underestimate the real size of the population (Min Zdrav 2000). Sex workers, primarily female, who work in major cities and tourist areas, make up a second potentially problematic population, and figures on the size of the sex worker population are remarkably difficult to assess.

While significant national and international resources were spent on health campaigns such as the Red Apple program, sexually transmitted diseases like syphilis and gonorrhea increased across the population, and registered HIV infections grew. In Table Three I summarize improvements in reproductive health along the left side of the timeline, and changes in sexual health along the right. While contraceptive use increases from 28% in 1990 to over 57% in 2000, the total fertility rate falls by nearly 27%, and millions of IUDs are shipped to Uzbekistan by international donors, in terms of sexual health, syphilis increases markedly, and HIV cases, although still relatively low in terms of national prevalence, increase exponentially. What accounts for the anomalous finding of improving reproductive health indicators and worsening indicators of sexual health?

Attitudinal and Structural Impediments

Recently UNFPA Director Obaid reiterated the critical importance of integrating issues relating to sexual health into reproductive health programs in order to stem the HIV/AIDS pandemic. (2004) A decade after the Cario, call for the inclusion of sexual health in reproductive health programs abound, but concrete assessments of how best to achieve integration are infrequent. In studying changes in reproductive health in Uzbekistan in 2002 and 2003, I conducted semi-structured interviews with 15 NGO workers, 10 medical personnel. 15 men and women of reproductive ages, and 6 researchers working on population related issues in and outside of the Ministry of Health touching on topics related to family planning programs and sexual health education and practices. I also participated in sessions focusing on contraceptive training, attended conference concerning maternal health, and conducted observations in gynecological clinics and birthing hospitals. While not the original focus of the investigation, the paradox of improving reproductive health and worsening sexual health emerged as a strong theme. Mining field notes for relevant insights on this topic yielded three major issues, shedding light on the specific barriers dividing elements of reproductive health in Uzbekistan.

Throughout discussion with NGO workers and temporary consultants, indications of professional resistance to change and organizational lag arose. As one workshop leader with extensive international experience commented in a taped interview:

It's Weberian really, isn't it? There is a division of labor. My priority is to distribute contraceptives to women who get them where they are wanted. It is what I am good at, and what I am evaluated on. You can make it work anywhere. Don't get me wrong, AIDS education is critical, but it isn't what I do, what I am prepared and trained to do.....Funding directive(s) determine the phrasing and yes, we are all interested in HIV/AIDS now, but it {program content} isn't going to change easily, and I need to *protect* the importance of what it is I do.....this isn't Africa, and HIV is not the most pressing problem.

These remarks highlight the difficulty faced by professionals when conceptualizations of reproductive health are expanded. In raising the question of evaluation, she targets an important issue, and one mentioned by several respondents in country. Overarching goals are useful and interesting, but until they are translated into measurements amenable to evaluation, reorientation of approaches and materials is difficult to justify. In several circumstance, respondents pointed out that while rhetorically

sexual health issues were extremely important, practically family planning experts lacked the time, resources, and in some cases desire to extend already overburden schedules.

In some cases, a “first things first” mentality appears, stressing the importance of completing familiar and established tasks first while saving expanded duties for an undetermined future period. As one Uzbek doctor shared: “Family planning has to come first, it is what the Government wants and what donors want. I see people with needs today which are most important.” Increasing the availability of contraceptives today is justifiably more immediately important to women in Uzbekistan, but with HIV cases growing exponentially the question of when exactly the time for prioritizing sexual health initiative will be takes on added importance.

Secondly, the integration of sexual health issues, for either men or women, can be block if reproductive health programs do not highlight the importance of autonomy, individual decision making, agency and widespread access. The Uzbeks case provides a clear example of a top down, focused program to increase the use of contraceptives by married women. Women seldom had anything positive to convey concerning state run gynecological clinics, and most maintained they went to private clinics, “where your questions would be answered” whenever finances allowed. Young women, especially those unmarried, typically laughed when asked about going to a state clinic, as reproductive health services were viewed as the unique domain of married women. The authoritarian nature of the Karimov regime has little interest in developing female autonomy or encouraging individual choice. As one recently married female respondent remarked, “Books and talk do not help at all, you go to the clinic, they tell you what to do, you do it, simply that.” There was little reason to try and understand her options, if she felt she had none. Narrow and directed family planning programs have little potential for the successful integration of sexual health issues, especially those targeting populations at relatively low risk for STIs.

Similarly, the integration of sexual health issues into reproductive health programs can not be achieved unless client education is a central programmatic focus. Educational components are typically the most time consuming and resource intensive elements of intervention programs, and in resource constrained environment may be difficult to justify. However, the programs launched in

Uzbekistan in the 1990s, emphasizing contraceptive (IUD) adoption and access for married women over broad based efforts to educate men and women about family planning options, severely restricting potential contributions to sexual health goals. To some extent this may reflect the preference of the women the programs sought to serve. As one workshop participant in Bukhara volunteered, “None of the women in my region have the time or the patience to listen to all this, they simply want to stop having kids”. But without a strong educational focus, bringing in discussions of sexual health concerns and information relevant to sexual decision making will be of limited value. Educational efforts can assist in de stigmatizing sensitive issues and open lines of communication within families and increasing perceptions of individual autonomy. Most importantly it can provide tools for continuous decision making.

Judith Seltzer points out that, “new combinations of reproductive health services, particularly those that address sexually transmitted diseases and HIV/AIDS, will require reconfiguring services as well as new expertise, training, and financial resources”. (2002: xx) Examining the simultaneous worsening of sexual health and improvements in contraceptive use in Uzbekistan during the 1990s, highlights the professional, governmental, and programmatic barriers that can preclude the effective inclusion of sexual health issues into family planning programs.

Table One.

Knowledge of Contraceptive Method, by Marital Status and Sexual Activity Status and Method, Uzbek Demographic and Health Surveys 1996 and 2002

	Number		Any		IUD		Condom		Traditional	
	1996	2002	1996	2002	1996	2002	1996	2002	1996	2002
Married	3302	3720	95,7%	98,8%	95,5%	98,0%	54,4%	67,6%	39,2%	58,0%
Not Married Ever Active	136	339	89,2%	97,4%	86,4%	97,0%	46,1%	75,4%	28,4%	61,3%
Not Married Never Active	977	1406	66,2%	68,6%	64,5%	65,8%	20,0%	24,3%	9,7%	9,9%
Total	4415	5463	88,8%	91,0%	87,4%	89,6%	48,8%	67,6%	32,4%	58,0%

Figure One. Percent of Contracepting Women by Age and Method, Uzbekistan 1996 DHS

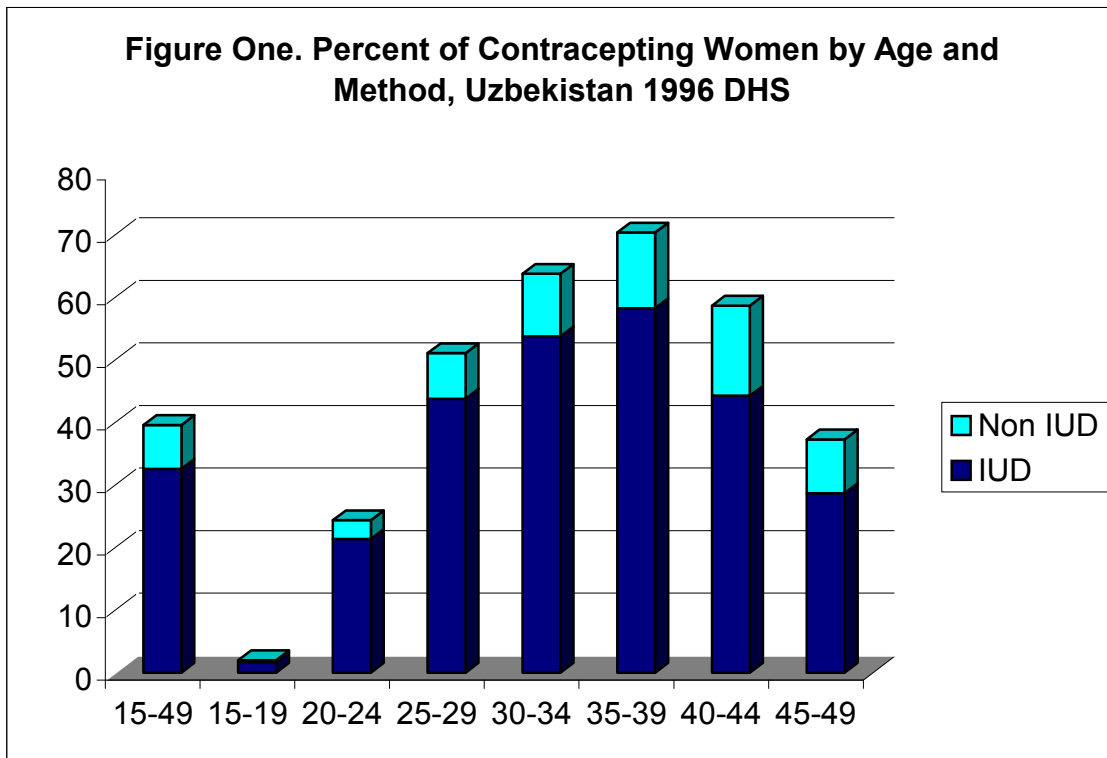


Table Two.

Knowledge of Sexual Health Issues by Marital Status and Sexual Activity Status and Method, Uzbek Health Evaluation Survey 2002

	Number		Heard of HIV		Can Prevent AIDS		Condoms Prevent AIDS		Healthy Person can have AIDS	
	F	M	F	M	F	M	F	M	F	M
Married	3720	1600	91,9%	95,5%	72,1%	84,5%	48,3%	70,6%	65,8%	74,8%
Not Currently Married Ever										
Active	339	172	92,5%	98,5%	76,2%	82,1%	65,0%	75,4%	72,0%	73,9%
Not Married Never										
Active	1404	560	85,6%	90,5%	59,0%	66,1%	23,5%	43,2%	51,7%	54,3%
Total	5463	2332								

Figure Two. Cumulative HIV Cases Registered, Uzbekistan 1994-2003

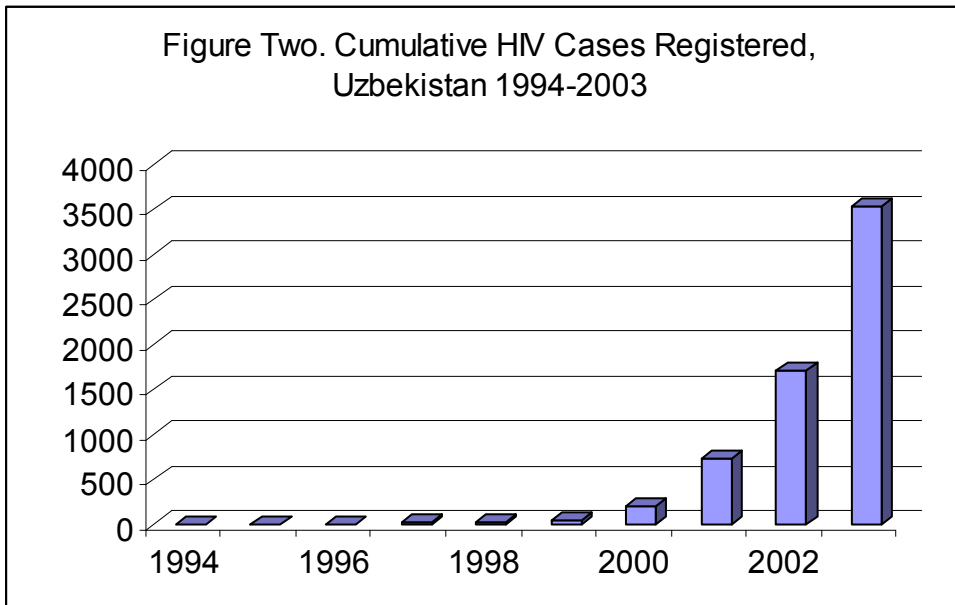


Table Three. Timeline: Reproductive and Sexual Health in Uzbekistan

<i>Reproductive Health</i>	Year	<i>STD/AIDS</i>
	1987	• HIV/AIDS testing sites opened, 71,500 people tested ¹
• Abortion rate reaches high of 60.7 per 1000 women ⁹	1988	
	1989	• Mandatory testing established ¹
• 28% of women using modern contraceptives ²	1990	• 21 registered AIDS cases ¹
• TFR 4.1 ²	1991	• Syphilis: 1.9 per 100,000; Gonorrhea: 19.2 per 100,000 ³
• Abortion rate drops to 23.0 per 1000 women ⁹	1992	
• USAID launches Reproductive Health Service Expansion Program	1993	
•	1994	
• Red Apple Starts, TFR 3.3 ²	1995	
• 56% of married women using modern contraceptives ³	1996	• HIV/AIDS testing assured “confidential” ¹
• Abortion rate drops to 11.8 per 1000 women ⁹		
• Red Apple Consumer Education Pilot Program begins ⁴	1997	
• Uzbek government identifies reproductive health and family planning as key goal in National Action Plan for the Improvement of the Status of Women ⁵		
• USAID’s Population Health and Nutrition Information Project sends 24,000 condoms to Uzbekistan ⁶	1998	• Syphilis: 44.9 per 100,000, Gonorrhea: 27.1 per 100,000 ³ • 12 testing HIV/AIDS labs operating, 980,400 tests administered. Of the 48 registered HIV cases, 27 are foreigners. ¹
• TFR 3.1 ²	1999	• New law pushes state to educate about HIV/AIDS ¹ • UNESCO implements radio drama addressing STDs, reproductive health ⁷
• 1993 - 2000, UNFPA sends almost 3 million IUDs, 76,000 condoms ¹⁰	2000	• 154 AIDS cases reported ¹
	2001	• 779 registered HIV cases ³ • Strategic plan for HIV established ¹
	2002	• 1748 registered HIV cases ³
• Zdrav+ Health Ed., TFR 3.0 ²	2003	Estimated 10,000 HIV cases ³ , 20,000 to 200,000 IDUs ⁸

¹ILO 2002, ²US Census 2003, ³Min. Zdrav. 2000b, ⁴Gokun-Silver 1998, ⁵Mee 2001, ⁶Population Health and Nutrition Information Project 2000, ⁷UNESCO Tashkent 2003, ⁸CDC 2002, ⁹Henshaw et al. 1999, ¹⁰UNFPA 2000

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