

COUNTRY PROFILE: UZBEKISTAN



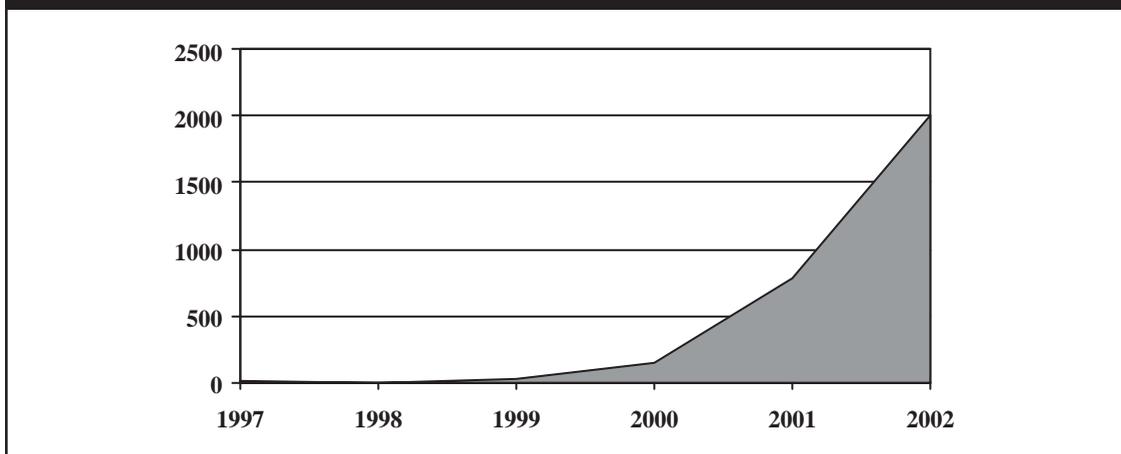
Uzbekistan is the most populous country in Central Asia, with 25 million persons. More than 25 percent of the population is between 15–29 years of age. The country has a GDP per capita of almost \$3,000, but over 60 percent of the population lives below the official level of poverty (\$4/day). Uzbekistan is an Islamic country, which has been ruled since the breakup of the Soviet Union by a President and a centralized Government.

HIV/AIDS Epidemiological Profile

The HIV epidemic in Uzbekistan is still in a nascent stage, but Uzbekistan has all the conditions for rapid spread of HIV infection. While only 51 cases had been identified in the first ten years of the epidemic (1989–1998), almost 800 cases were registered by the end of 2001, and 2,209 cases by end of April 2003; of these cases 84 died. However, according to official definitions, HIV positive patients with TB are not diagnosed as having AIDS, thus contributing to an underreporting of HIV/AIDS (TB is the most common opportunistic infection among HIV-infected persons.) About 55 percent of cases of HIV/AIDS are reported among people under age 30 years.

According to the Ministry of Health, injection drug use accounts for the majority (63 percent) of HIV infections, as in other countries in the region, but the proportion of cases of heterosexual transmission is growing. Of concern is the high number of cases of unknown origin (about 25 percent). About 84 percent of HIV cases are among men, and two-thirds are among young people aged 15–34. More than 50 percent of cases are among prisoners. The highest number of cases has been identified in Tashkent. In April 2002, there were about 350–360 infected people in Tashkent City, another 350–360 in Tashkent Oblast, and about 40 each in Ferghana and Surkhan-Darya regions. An outbreak of HIV was registered in Yangiyul (near Tashkent) with over 200 HIV cases, of which 90 percent were IDUs. It is an industrial zone and, due to economic reforms, many plants have closed, leaving many young people unemployed.

FIGURE 6. HIV: NEW CASES IN UZBEKISTAN



The number of registered drug users is around 25,000, but the UN estimates that the country has at least 60,000 drug users, 60–70 percent of whom would be injecting drug users. In the 1980s, there were 2,000 registered drug users; in 1995, there were 6,000 registered drug users, but today there are 18,000 registered outside prisons and 7,000 identified in prisons. According to surveys conducted by UNAIDS, there are about 12,000 IDUs in Tashkent City alone; 1,800–2,000 in Yangiyul City; 10,000–10,5000 in Samarkand City; and 1,300 in Jizzak City.

These areas are on the crossroads of drug traffic routes from Tajikistan and Afghanistan, where opium and heroin are produced. Since September 11, 2001, the frontiers with Afghanistan have been opened. The drugs coming from Afghanistan go through Uzbekistan to Russia by railroad. While older generations commonly smoked hashish, younger generations have shifted to injecting heroin. One region that does not have any HIV cases is Karakalpakstan, which is attributed to the fact that drug users from this region still mainly smoke drugs instead of injecting them. As a result, HIV/AIDS is regarded as a problem of injecting drug users, which significantly stigmatizes this vulnerable group.

The proportion of IDU-related cases appears to be declining, however, while the rate of infection through heterosexual contact appears to be rapidly increasing, representing currently over 12 percent of infected cases. Migration to Tashkent has increased, accompanied by increasing prostitution; many of these women also become drug users. An assessment of men who have sex with men carried out in 1998 mentions that homosexual behavior is a common practice in Uzbekistan (Oostvogels and Mikkelsen 1998). Alarming, there have also been unconfirmed reports that some poorly equipped hospitals are part of the HIV transmission process through nosocomial transmission. This is compounded by claims that the blood supply in places is not adequately screened for organisms found in HIV, Hepatitis B, and Hepatitis C.

According to official statistics, 1.2 percent of IDUs (over 18,000 tested), 0.01 percent of CSW (over 15,000 tested), and 0.4 percent of prisoners (over 65,000 tested) were HIV positive in 2001. However, sentinel surveillance in Tashkent indicates a 46 percent prevalence rate among IDUs in Tashkent City.¹⁰ Isolated cases of HIV infection have also been reported in MSM, blood donors, patients with STIs, pregnant women, and newborns (3 cases in 2000–2001). According to the AIDS Center, of 360 people tested in 3 Trust Points, 45 percent were HIV positive, while results from a second study showed that only 20 percent were infected. A rapid assessment of IDUs carried out in Tashkent in 1998 showed that over 90 percent were male and that the majority were young people aged 18–30 years (Busel et al. 1998). Almost 70 percent of IDUs were unemployed. Another rapid assessment carried out in Samarkand in 2001 showed that, among those who tested positive for HIV, almost 90 percent were male, 60 percent were young people under the age of 30, and the majority were unemployed (Zaripova et al. 2001).

Unsafe sexual behavior has increased, attested to by a high prevalence of STIs, compounding the risks for HIV spread. In 2001, Uzbekistan had 221 syphilis cases per 100,000 pregnant women, not usually considered a vulnerable group. However, this is 10 times the reported prevalence in the general population. One out of six CSWs who visited STIs services had syphilis. Rapid assessments of CSWs were carried out in Tashkent in 1997 (Thomas) and 2001 (Oostvogels). In 1997, the assessments estimated that there were 5,000 sex workers and 250,000 clients in the capital city. CSWs try to hide from authorities as indicated by the fact that only 180 sex workers were

TABLE 28. HIV/AIDS IN UZBEKISTAN

	1995	2000	2002
AIDS deaths			84
AIDS cases			25
HIV estimated cases			6,000
HIV registered cases	51		2,209*
HIV among IDUs (registered cases)			
Syphilis cases		73.5	
Registered drug users			25,000
Estimated # IDUS			100,000
Estimated # CSW			20,000
Estimated # MSM			15,000

Source: Ministry of Health. HIV cases refers to end of April 2003.

10. CCM (2003). GFATM grant proposal. Tashkent: Republican Emergency Anti-epidemic Commission for HIV/AIDS and TB.

registered in Tashkent. This is despite the fact that 3,870 CSWs were tested for STIs in 1996, and over 15,000 were tested for HIV/AIDS by the AIDS Center in 2002.

Condoms are readily available from kiosks and are affordable for some CSWs at about 50 cents each. However, the majority of the CSWs, with ages varying from 13–30 years, do not use condoms, and 30 percent are IDUs. The majority of clients refuse to use condoms, particularly Uzbeks who are reportedly even more reluctant than foreigners to use condoms. However, other CSWs would be spending about 10 percent of what they earn from a client on a condom. The Uzbek Health Examination Survey indicates that only 2 percent of married women reported using condoms, but this percentage increased to 27 percent among unmarried women; only 1 percent of married men reported using condoms, while 39 percent of unmarried men reported condom use (Ministry of Health 2003).

A survey of 3,600 young people (15–24 years) throughout Uzbekistan has indicated that 44 percent of young males have sexual activity but only 23 percent use any form of contraception (Uzbek Association on Reproductive Health/IPPR 2001). This survey also indicates that they are learning little or nothing about how HIV infection is transmitted and prevented through school educational programs designed to provide this information. According to the survey, 50 percent of young people consider that there is no risk of being infected by HIV and another 40 percent are not even aware of this risk. UNICEF (2002) reports that 43 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. The (UHES) reports that 90 percent of female respondents and 95 percent of male respondents have heard of AIDS, but only about 60 percent of women and 80 percent of men believe that there is a way to avoid AIDS.

Strategies, Policies, and Legal Framework

Commitment to prevent further spread of HIV/AIDS is shown by the following: the approval of an AIDS Law and of the HIV/AIDS National Program; the Government approval of an appropriate Strategy¹¹ prepared with assistance from UNAIDS; a functioning UN-Theme Group; the establishment of more than 200 Trust Points throughout the country; and requests for grants from the GFATM and IDA to contribute to assist in addressing the burgeoning epidemic.

The Government is also committed to the fight against IDU, and it has signed all international conventions against drug trafficking. A Special State Committee headed by the Prime Minister has been set up to tackle the struggle against drug trafficking, with special units in the Ministry of Health and Ministry of Internal Affairs. The Inter-ministerial Committee on Drug Abuse includes the Ministries of Interior, Defense, Education, Health, Social Protection, and Labor. In July 2002, the Government of Uzbekistan hosted the regional Conference on Drug Trafficking and Use.

Strategic planning on HIV/AIDS was initiated by the UN-AIDS Theme Group, which is currently chaired by the World Bank, and it has been supported by the Government. In addition, the Ministry of Health has been cooperating with UN agencies and donors on implementation of HIV/AIDS activities. The Ministry of Internal Affairs has also been cooperating with the Soros Foundation/OSI on the implementation of HIV/AIDS activities in prisons. The recently approved HIV/AIDS Strategy aims to:

- Encourage a multi-sectoral approach in the implementation of the HIV/AIDS Strategy with the involvement of relevant line ministries such as Ministries of Health, Internal Affairs, Education, and Finance, and UN agencies and NGOs.?

11. Interdepartmental Working Group on HIV/AIDS (2002). Strategic Program on Counteraction to HIV/AIDS epidemic expansion in the Republic of Uzbekistan. Tashkent: Government of Uzbekistan.

- Strengthen targeted interventions for high-risk populations, which are critical to reversing the HIV/AIDS epidemic in Uzbekistan.
- Strengthen the management structure and implementation capacity to ensure the sustainability of the National Program on HIV/AIDS and STIs.

The Strategy considers the following as factors conducive to the spread of HIV infection in Uzbekistan: 1) insufficient governance to fight the epidemic; 2) weak multi-sectoral coordination; 3) high susceptibility of groups of the population in which the infection is concentrated; 4) incomplete observance of human rights and freedoms related to HIV/AIDS; and 5) insufficient focus on prevention activities, care and treatment, and support to PLWHA. In reality, there is poor inter-ministerial coordination, and the Government was reluctant to approve the HIV/AIDS Strategy and proposals for funding to the GFATM out of religious and cultural concerns.

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. The Law on AIDS further contributes to stigmatization of HIV infected people, which provides an additional incentive for highly vulnerable groups to avoid testing.

Surveillance Needs and Additional Studies

Uzbekistan has 14 AIDS centers and 90 laboratories for HIV diagnosis. The AIDS Center publishes quarterly reports on HIV/AIDS. UNAIDS has carried several rapid situation assessments in Tashkent since 1998. ODCCP is carrying out a survey on drug abuse in Uzbekistan. CDC is carrying out a HIV prevalence survey in Tashkent, and the results should be available in 2003. USAID in cooperation with CDC is providing equipment for the AIDS laboratories and training in sentinel surveillance.

The National AIDS Center laboratory has identified thousands of HIV positive cases by ELISA, which need to be confirmed by Western Blot. Rapid assessments were carried out on IDUs in five regions (Tashkent City, Sukhandaria, Samarkhand, Gizak, Tashkent), and the blood in syringes from three Trust Points was tested.

Vulnerable and Highly Vulnerable Groups

Since the Uzbek Parliament passed a law on prevention of HIV/AIDS in 2000, Trust Points have been opened throughout Uzbekistan. These points are expected to provide counseling, testing, and free syringes, condoms, and information brochures. After the successful establishment of pilot Trust Points, the Minister of Health decreed that each oblast AIDS Center should set up at least one Trust Point providing anonymous and confidential testing and counseling for IDUs. Recognizing this initiative as best practice, UNAIDS reports that this is the first initiative by national authorities to implement trust points nationwide in Central Asia. The Ministry of Health has reported that the number of registered HIV cases actually decreased by 38 percent in areas where Trust Points are active.

The Government supports the harm reduction approach, and it has decided to increase the number of Trust points from 50 to 230. Currently, about 200 Trust Points are functioning throughout the country, up from 3 that were opened in 2000. In Tashkent City, there are 10 Trust Points, which distribute 800 to 1,000 needles daily, the same number that is distributed in all other oblasts. Volunteers work with the drug users who come to the trust points and speak with them confidentially. Fees for volunteers, syringes, and other supplies are paid by Government or are provided by the Soros Foundation/OSI. However, the Trust Points are frequently out of condoms, and health care workers work in cooperation with law enforcement bodies, which exercise repressive practices over groups at risk.

There is a prison pilot project on HIV/AIDS prevention in the Chirchik prison. Prisons usually isolate HIV positive prisoners, which has led to revolts in some prisons due to isolation. The Government has arranged a study tour to Karaganda, to observe HIV/AIDS prevention work in prisons

in Kazakhstan. HIV/AIDS prevention work is also taking place in the army and information materials geared towards soldiers have been prepared.

The Government's current HIV prevention campaign, aimed almost exclusively at the IDU community, is considered a major barrier to preventing a broader epidemic. This approach is leading young people to think that the HIV/AIDS phenomenon does not affect them, but rather only marginalized people such as IDUs. Although an educational program has been developed for schools, it has not yet been integrated in the compulsory curricula. IEC for out-of-school young people and a public awareness campaign through the mass media have not yet been developed.

UN agencies and USAID/CAR have been training mass media and raising public awareness on drug related issues. UNICEF has also been conducting an IEC strategy to raise awareness regarding drug abuse, safe sexual behavior, and HIV/AIDS and STIs for 40,000 people aged 13–20 years. PSI, with funding from USAID, has been implementing a condom social marketing campaign, in which condoms are distributed at a low price.

Preventive, Diagnostic, and Treatment Issues

The UN Office for Drug Control and Crime Prevention (UNODCCP) and the Government of Switzerland have assisted in the establishment of a network of narcological health centers for treatment of drug abuse. Soros Foundation/OSI and the International Harm Reduction Network (IHRD) support a policy for replacement therapy for treatment of drug abuse. Methadone is on the list of drugs not allowed into the country, but there are attempts to develop a pilot project on replacement therapy with methadone. Recently seven specialists spent a month in the United States studying the implementation of substitution therapy.

No information is available on treatment of opportunistic infections, and as a rule, HIV-infected people do not have access to antiretroviral treatment.

NGO and Partner Activities

There are numerous NGOs working on HIV/AIDS in Uzbekistan: Kamalot works with youth; Sabokh and Tiklal Avlot work with CSWs (2 projects); Anti-AIDS works with MSMs; and Mahala works with IDUs (2 projects). NGOs are mainly funded by international and bilateral agencies.

The UN Theme Group includes the Ministries of Health, Defense, and Interior, and World Bank, USAID, Soros Foundation/OSI, UNAIDS, UNDP, UNFP, UNICEF, UNDCP, WHO and NGOs. The TG has an integrated working plan, which includes a list of 29 NGOs involved in HIV/AIDS work in the country. USAID has been providing technical and financial support to HIV/AIDS prevention in Uzbekistan, including upgrades in surveillance and in the lab system, prevention of mother to child transmission and blood safety. The Soros Foundation/OSI has been supporting the establishment of Trust Points in cooperation with the AIDS Center. The International Harm Reduction Program (IHRP) is also involved in harm reduction and prevention of HIV/AIDS with financial support of USAID.

Funding

In 2001, 3.4 percent of total public expenditure was on health, which gives a spending per capita of less than \$10. The Government has indicated a budget for the HIV/AIDS Program of \$704,000 in 2003, and in addition \$610,000 from donors. For the period of 2001–2003, UN agencies, USAID, and Soros Foundation/OSI have been providing over \$1.5 million, and KfW has been providing DM5 million for family planning, including contraceptives and condoms. Although the Government supports the establishment of the Trust Points throughout the country, funding is insufficient to cover the needs, which have been estimated at about \$40 million for four years. Therefore, the Government has applied to IDA, GFATM, and bilateral agencies for financial and technical support.

Recently, the Government started preparation for an AIDS component of a World Bank-financed project, which would be included in Health Project II. The AIDS Component would be

financed by an IDA grant of about \$2 million. The Ministry of Health and project team have agreed that the component would support the approval and implementation of the HIV/AIDS Strategy that the Ministry of Health prepared with assistance from UNAIDS and has been recently approved. The component would also complement activities that have been launched with support from the Government and donors.

The Ministry of Health has also submitted, with assistance from the UN-Theme Group, a grant proposal to the GFATM in the amount of \$24 million, of which was granted \$5 million. An Interministerial Committee, with participation of UN agencies and NGOs, would steer the implementation of the HIV/AIDS Strategy and the use of the funds available from the Government, IDA, GFATM, UN agencies, USAID, Soros Foundation/OSI, and other NGOs. The grant from the GFATM would cover other unfunded activities such as scaling up target prevention interventions throughout the country, treatment of opportunistic infections and AIDS, and palliative care.

Tuberculosis Epidemiological Profile

Even with reported rates of TB significantly lower than in Kazakhstan and the Kyrgyz Republic, Uzbekistan has the largest number of TB cases in the region. A very low percentage of notified pulmonary smear positive cases (expected value should be over 50 percent) suggests that the true dimensions of the TB problem may be about twice as high as reported. The TB situation has been worsening in Uzbekistan (Table 29); notification of new TB cases increased by almost two thirds (65 percent) in the last 10 years, and the death rate increased by one third (30 percent) in the last five years. The highest TB notification rate in 2000 was in Karakalpakstan (128/100,000), which is twice as high as the national rate of 65. In 2001, the TB reported incidence rate was 72.4/100,000 for a total of 18,106 new TB cases, and the death rate was 12.5.

TABLE 29. TUBERCULOSIS DETECTION, CASES, INCIDENCE, AND MORTALITY IN UZBEKISTAN

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Cases notified	9,370	9,774	14,890	9,866	11,919	13,352	14,558	15,080	15,750	18,106
Notification rate	44	45	67	43	51	56	60	62	63	72.4
New cases ss+ pulmonary	NA	NA	7,487	2,735	3,350	3,388	3,504	3,977	3,825	4,664
Notification rate Ss+ cases pulmonary	NA	NA	34	12	14	14	15	16	15	NA
% pulmonary ss+ cases	NA	NA	50	28	28	25	24	26	24	NA
Notified death rate						9.6	11.1	10.7	11.5	12.5
Standardized death rate	12.57	14.59	14.57	16.25	17.94	18.08	19.45	NA	NA	NA

Source: WHO Global TB Control 2002; WHO HFA database 2002; CDC Central Asia Infectious Disease Network 2002

The TB problem in prisons is grave. The incidence of TB in prisons is estimated at over 3,000/100,000 population (2,000 patients have been annually diagnosed in a population of 64,000 prisoners). Up to half of all TB cases in the country may be in prisons. There are now about 30,000 prisoners with active TB in prisons, one out of each 10–12 inmates. Approximately 6,000 prisoners with active TB were released by an amnesty in 2001. Those who had completed TB treatment were released under the supervision of primary health care (PHC) services at the place of residence, and those who had not completed treatment were placed into hospitals until completing treatment.

Strategy, Policies, and Legal Framework

Government commitment to TB control is sufficient, but the Ministry of Health has limited resources to tackle the problem. The Government recognizes that a significant TB problem exists in the country, and has started working on the development of a strategic plan and revised national program for TB control. The Ministry of Health of Uzbekistan is supportive of the WHO TB control strategy DOTS. A coordination council for DOTS implementation in Uzbekistan has also been established. This Council is chaired by the first Deputy Minister of Health and includes representatives of relevant departments of the Ministry of Health, National TB Research Institute, regional TB facilities, and international and donor organizations. A national DOTS Center affiliated with the National TB Research Institute was established with assistance from Project HOPE. Pilot DOTS projects have started with support from WHO, KfW, USAID, Project HOPE, and MSF. The National Program aims to cover most of the country (except the Jizzak and Nawoi regions) by the end of the first quarter of 2003 with the DOTS approach. The Ministry of Health is searching for potential donors, and it has prepared a grant proposal to submit to the GFATM to extend the program to the two uncovered regions.

Surveillance Needs and Additional Studies

Currently, quarterly analysis of treatment results based on WHO definitions is limited to the DOTS pilot areas. The National TB Program envisages the establishment of a standardized reporting and recording system (assisted by CDC), allowing assessment of treatment results according to WHO guidelines. CDC has also been assisting the establishment of a quality assurance program for TB laboratories and laboratory training. CDC plans to develop and start implementation of the TB electronic surveillance case-based management program. Preliminary results from a drug susceptibility testing study conducted by MSF in Karakalpakstan and Khorezm suggest that rates of drug resistance, including multi-drug resistance, are among the highest in the world (Table 30).

TABLE 30. MULTIPLE DRUG RESISTANT TB (%) IN UZBEKISTAN

	Primary MDR New cases (%)	Secondary MDR Re-treatment cases (%)
Karakalpakstan	11	40

Source: MSF unpublished data, 2002

Preventive, Diagnostic, and Treatment Issues

The Ministry of Health intends to cover most of the country with DOTS by the end of 2003, but it needs to identify additional funding. The DOTS Strategy has been implemented in Uzbekistan since 1998, with support from WHO, MSF, USAID, Project Hope, CDC and KfW. However, the program has expanded slowly, and therefore it is unlikely to have a tangible impact on TB control. In 2000, only 7 percent of the population was covered with DOTS, and treatment success for patients registered in 1998 and 1999 was below the WHO target of 85 percent (Tables 31 and 32). A very high failure rate should be a cause for concern and the role of drug resistance and HIV infection needs to be investigated. MSF has provided support to the development of pilot projects in Karakalpakstan, and DOTS expansion accelerated with assistance from Project HOPE in 10 additional pilot districts. KfW has provided grant funding for TB drugs and lab equipment.

The National TB Program emphasizes abandoning MMR screening for TB and extensive utilization of inpatient treatments. The program gives priority to passive case finding (detection of TB among symptomatic patients self reporting to health services, using sputum smear microscopy) and limits active case finding to examination of household members of a sputum smear positive TB patient. The program specifies establishment of reference laboratories to ensure quality assurance for TB detection and diagnosis. Inpatient treatment at existing TB facilities is mandatory for all new TB cases during at least 2–3 months of the intensive treatment phase. Inpatient treatment can

be extended for patients who fail treatment and/or with low socio-economic status. The program plans involvement of primary health care at rayon level for provision of out-patient treatment for TB at the continuation phase.

TABLE 31. SUCCESS RATES FOR TB TREATMENT, KARAKALPAKSTAN DOTS PILOT AREA

Patient category	N	Treatment			
		success rate*	Death rate**	Failure rate***	Default rate****
New smear positive pulmonary	287	76	3.8	11.1	9.1
New smear negative pulmonary	397	93	1.5	2.3	2.3
Re-treatment smear positive pulmonary	330	60	13.9	15.2	10.6
Re-treatment smear negative pulmonary	388	86	3.6	2.8	7.5
Extra-pulmonary	107	92	0.9	0	7.5

Source: MSF (2002). Summary of tuberculosis treatment and outcomes for the Aral Sea Area TB program. Medecins Sans Frontieres – Holland, ASA Program.

* The success rate is the percentage of all patients who have the outcome of cured and have completed treatment.

** The death rate is the percentage of patients who die from any cause during treatment.

*** The failure rate is the percentage of patients who remain or become sputum smear positive at 5 months or more of treatment. A high failure rate can indicate a poor DOTS program with low adherence to treatment or a high rate of drug-resistant TB that is difficult to cure with first line TB drugs.

**** A patient is classified as a defaulter if their treatment was interrupted for at least two consecutive months.

Treatment of TB is based on WHO recommended standardized short course chemotherapy regimens. In DOTS pilot areas, TB treatment (including TB drugs) is free for patients. In non-DOTS areas, treatment is officially free, but in fact patients often have to buy the drugs.

There is capacity at the National TB Research Institute to expand DOTS, including the National DOTS Center staffed by trainers trained by Project HOPE, and the network of TB facilities (dispensaries, sanatoria, laboratories) throughout the country. Uzbekistan has 256 TB facilities, with over 15,000 beds, and 1,500 TB specialists. However, more health staff needs to be trained on DOTS to scale-up its implementation. There is a vast lack of funds to procure TB drugs, lab equipment and supplies, and to publish training and patient educational materials.

Prisons in Uzbekistan are under the management of the Ministry of Internal Affairs. No DOTS program has yet been implemented in Uzbek prisons due to a lack of funding. However, representatives of prison management expressed willingness to implement DOTS-based TB control. Prison authorities have developed a concept document on TB control in prisons, and they submitted an application to Soros Foundation/OSI for a DOTS pilot project in one of the colonies.

TABLE 32. TREATMENT OUTCOMES FOR NEW SMEAR-POSITIVE CASES TREATED UNDER DOTS IN UZBEKISTAN

Year	Registered for treatment	Cured %	Completed %	Died %	Failed %	Default %	Transfer %	Success*
	No. patients							
1998	135	73	6	7	7	7	1	79
1999	74	65	14	7	14	1		78

*Cured + Completed.

Source: WHO (1999–2002). Global TB Control.

NGO and Partner Activities

WHO, KfW, MSF and USAID through Project HOPE and CDC, have been active on TB control in Uzbekistan (Table 33). KfW has provided lab equipment and Project HOPE has been delivering 100 binocular microscopes, other lab equipment and reagents, and computers to 10 pilot districts and to the National Reference Laboratory at the TB Institute since 2002. KfW has pledged DM 1,115 million for procurement of first line TB drugs for prisons until 2005, but no funding has been received so far. With funding from USAID, Project HOPE trained a total of 45 clinical and laboratory trainers and 1,250 health providers, including 500 TB physicians, more than 500 primary care physicians, 45 nurses, and 100 laboratory specialists. Project HOPE held and sponsored conferences/workshops in Uzbekistan, and organized study tours and trips to international conferences for health care leaders of the country. Clinical and laboratory experts provided medical consultations, regular monitoring, and technical assistance in developing policy documents, including the National TB DOTS Program. In 2000–2001, Laboratory training and laboratory equipment were provided with technical assistance from CDC. In addition, TB drugs were provided for treatment of

TABLE 33. NGO AND PARTNER ACTIVITY ON TB IN UZBEKISTAN

Implementing agency	Funding Agency	Sites	Population Covered 2002	Area of activity
CDC	USAID	Nationwide	NA	Quality assurance of TB laboratories in pilots; Laboratory training Implementation of TB electronic surveillance case-based management program
HOPE	USAID KfW	Fergana Andijon Namangan Samarkand Urgut Syrdarya Yangiyer Tashkent	NA	DOTS training of health staff; Provision of TB drugs and lab equipment (1250 patients treated); Lab quality control; DOTS program monitoring
MSF	SIDA Holland KfW	Khorazm	2,211,675	DOTS training of health staff (2000 health staff trained); Provision of TB drugs and lab equipment (9641 patient treated and 22 laboratories upgraded); Managerial training for Ministry of Health staff; Lab quality control; DOTS program monitoring
KfW		Karakalpakstan Karakalpakstan Khorezm Tashkent Surkhondaryo Qashqadaryo Bukhara W. Namangan Andijan Fergana	NA	TB drugs for National DOTS Program; For Project HOPE and CDC, project manager
Red Cross		Khorezm Karakalpakstan		Food for TB patients

1,250 patients in 2000–2001. Also, 20,000 brochures and 8,000 DOTS posters were printed. This year, a new program to ensure the quality of TB drugs and appropriate drug management practices will be started in Uzbekistan with technical assistance from RPM Plus. The International Committee of the Red Cross provides food for TB patients in MSF-assisted DOTS pilot areas.

Funding

The Government reported a budget for the TB Program of about \$2 million in 2003, and donor assistance of over \$3 million, while annual needs would amount to about \$10 million. The Government, especially the Ministry of Health, is searching for external financial aid for TB control, and it has submitted a request of \$41.5 million to the Global Fund. The following needs have been identified:

- Prevalence surveys (TB disease and drug resistance).
- Communication campaign to remove stigma. Women may be more affected by stigma than men.
- Scaling up DOTS (particularly need funds for DOTS implementation in Nawoi and Jizzak Oblasts).
- Support to the national DOTS center in DOTS training.
- Publishing training materials, especially DOTS modules for GP.
- Procurement of laboratory equipment and TB drugs.
- Prisons need X-ray equipment, laboratory equipment, and TB drugs.
- Coordination of international agencies.

