



HIV/AIDS HEALTH PROFILE

Europe and Eurasia Region

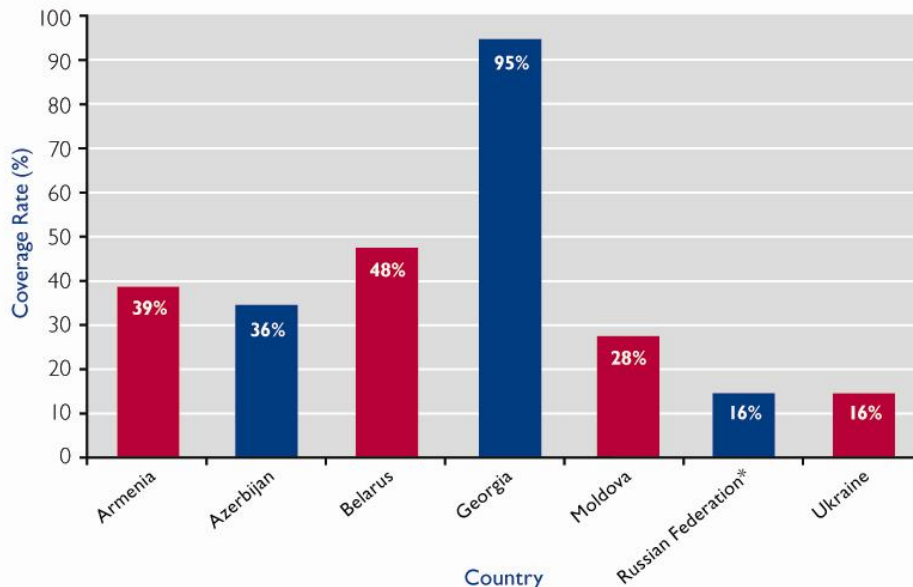


Overall HIV Trends

Eastern Europe and Central Asia is the only region where HIV prevalence clearly continues to increase, with an estimated 130,000 new infections in 2009 alone. In the same year, 1.4 million adults and children were living with HIV in Eastern Europe and Central Asia. From 2001 to 2008, there was a 66 percent increase in the total number of people living with HIV/AIDS (PLWHA); in comparison, prevalence in sub-Saharan Africa fell from 5.8 percent to 5.2 percent, and prevalence in Southeast Asia stabilized in the same period. Eastern Europe is also the only region where the annual number of HIV-related deaths continues to rise, increasing fourfold from 18,000 in 2001 to 76,000 in 2009.

In Eastern Europe, injecting drug use continues to be the primary form of transmission, accounting for 57 percent of new HIV infections in 2007, according to the Joint United Nations Program on HIV/AIDS (UNAIDS). However, heterosexual transmission accounted for 42 percent in the same year, and the proportion of new infections through sexual transmission has been growing as the epidemic moves from injecting drug users (IDUs) to their partners. Increases in prevalence among women are linked to the epidemic through IDUs. An estimated 35 percent of women living with HIV acquired the virus through injecting drugs, and 50 percent of HIV-positive women contracted the disease by having sex with IDUs. In **Ukraine**, the hardest hit country in the region, sexual transmission of HIV outpaced transmission via injecting drug use for the first time in 2008, although HIV prevalence still seems

HIV-Infected People Receiving Treatment in Europe and Eurasia, 2009



Source: WHO/UNAIDS/UNICEF *Towards Universal Access 2010* based on WHO 2006 guidelines
*Russian Federation data from WHO/UNAIDS/UNICEF *Towards Universal Access 2008*, data for end 2007

focused among IDUs and their partners. In the same year, a study in **Russia** found that having sex with an IDU increased the risk of acquiring HIV by 3.6 times compared to having sex with a non-IDU. With 66 percent of IDUs in Russia having had sex with noninjecting partners in the past year, there is a high risk of transmission to non-IDUs.

The severity of the HIV epidemic in the countries of Eastern Europe and Eurasia (E&E) varies widely, from concentrated epidemics in **Ukraine** and **Russia** to low-level epidemics in **Armenia** and **Georgia**. **Ukraine** has the highest HIV prevalence rate in the E&E region, with an estimated adult prevalence of 1.1 percent in 2009 and more than twice as many annual HIV diagnoses than in 2000. **Russia** and **Ukraine** together account for approximately 90 percent of all people newly reported to be living with HIV in the region, according to UNAIDS. Particularly high HIV prevalence has been found among drug users in both countries; studies in select regions and cities found prevalence between 39 and 50 percent in **Ukraine** and as high as 37 percent in **Russia**.

Sex workers are one most-at-risk population (MARP) in E&E, especially those who engage in transactional sex with IDUs. HIV prevalence rates among sex workers varied greatly between and within countries – as high as 20 percent in Irkutsk, **Russia**, in 2009, and from 14 to 31 percent in **Ukraine**. A 2006 study in St. Petersburg focusing on sex workers under 19 years of age found an HIV prevalence of 33 percent. Infection among IDUs and sex workers is often linked because these two high-risk populations overlap. Some sex workers inject drugs, while some IDUs do sex work to earn money for drugs. In **Russia**, at least 30 percent of sex workers were found to have injected drugs in the past, according to UNAIDS.

Men who have sex with men (MSM) comprise the third major MARP in the E&E region. Official estimates of HIV transmission and prevalence among MSM are thought to be grossly underestimated, according to UNAIDS. Moreover, the data that do exist for this population are limited because the stigmatization of MSM discourages men from accurately reporting their high-risk behaviors. In a 2009 study of 14

HIV Estimates in Europe and Eurasia Region*	
Armenia	
Total Population	3.0 million
Estimated Number of Adults and Children Living with HIV/AIDS	1,900
Adult HIV Prevalence	0.1%
Azerbaijan	
Total Population	8.3 million
Estimated Number of Adults and Children Living with HIV/AIDS	3,600
Adult HIV Prevalence	0.1%
HIV Prevalence Among IDUs (Baku, 2008)	10.3%
HIV Prevalence Among Female Sex Workers (Baku, 2008)	1.7%
HIV Prevalence Among MSM (Baku, 2008)	1.0%
Belarus	
Total Population	9.6 million
Estimated Number of Adults and Children Living with HIV/AIDS	17,000
Adult HIV Prevalence	0.3%
HIV Prevalence Among IDUs (Minsk, 2009)	13.7%
HIV Prevalence Among Female Sex Workers (Minsk, 2009)	6.4%
HIV Prevalence Among MSM (Minsk, 2009)	2.7%
Georgia	
Total Population	4.6 million
Estimated Number of Adults and Children Living with HIV/AIDS	3,500
Adult HIV Prevalence	0.1%
HIV Prevalence Among IDUs (Tbilisi, 2008)	2.2%
HIV Prevalence Among Female Sex Workers (Tbilisi, 2009)	2.0%
HIV Prevalence Among MSM (Tbilisi, 2007)	3.6%
Moldova	
Total Population	4.3 million
Estimated Number of Adults and Children Living with HIV/AIDS	12,000
Adult HIV Prevalence	0.4%
HIV Prevalence Among CSWs (2009)	6.1%
Russia	
Total Population	139.4 million
Estimated Number of Adults and Children Living with HIV/AIDS	980,000
Adult HIV Prevalence	1.0%
HIV Prevalence Among IDUs (National, 2009)	15.6%
HIV Prevalence Among IDUs (St. Petersburg, 2009)	61.2%
HIV Prevalence Among MSM (2009)	8.3%
HIV Prevalence Among Commercial Sex Workers (2009)	4.5%
Ukraine	
Total Population	45.4 million
Estimated Number of Adults and Children Living with HIV/AIDS	350,000
Adult HIV Prevalence	1.1%
HIV Prevalence Among IDUs (30 territories, 2008–2009)	22.9%
HIV Prevalence Among MSM (14 cities, 2009)	8.6%
HIV Prevalence Among Sex Workers (25 territories, 2008–2009)	13.2%

* HIV data are not available for Albania and Kosovo.

Total Population: U.S. Census Bureau

Number of PLWHA and HIV Prevalence: UNAIDS

HIV Prevalence among MARPS: UNAIDS, UNGASS *Country Progress* reports

cities in **Ukraine**, prevalence among MSM was as high as 8.6 percent, more than five times the prevalence in the general population.

Treatment coverage remains low in all E&E countries except Georgia, as illustrated in the graph on the first page. Access to antiretroviral therapy (ART) is expanding, however; from 2003 to 2007, the number of people receiving ART increased from 15,000 to 54,000. The concentration of HIV in MARPs and other hard-to-reach populations is a challenge in increasing ART coverage, as these populations often have limited access to health services. In 2009, the World Health Organization (WHO) issued revised recommendations about when adults, adolescents, and pregnant women should initiate ART. WHO now recommends ART be initiated when the CD4 white blood cell count reaches or drops below 350 cells/mm³, rather than the 2006 recommendation of 200 cells/mm³. This change immediately increased the number of PLWHA who are eligible for and in need of treatment, and WHO anticipates it will reduce HIV-related morbidity, mortality, and hospitalization in the long term.

Increases in the number of PLWHA receiving treatment are having profound effects on HIV-related mortality in many countries in the E&E region due to prolonged life and reduced annual deaths from HIV/AIDS. Prevention of mother-to-child transmission (PMTCT) coverage in the region was the highest in the world. In **Ukraine**, WHO estimates between 76 and 95 percent of HIV-positive pregnant women received antiretroviral drugs for PMTCT in 2009.

Ukraine has the highest estimated adult HIV prevalence in the E&E region, at 1.1 percent. In 2009, sexual transmission accounted for almost 44 percent of new infections. Despite this, the epidemic continues to be concentrated in IDUs and other MARPs. For example, transmission by injecting drug use accounted for 36 percent of new infections in 2009. In 2008 and 2009, HIV prevalence among IDUs in 30 territories averaged 22.9 percent, and prevalence as high as 55.2 percent was recorded among IDUs in the city of Mykolaiv. Limited knowledge of HIV fuels the spread of the virus: Fewer than half of men and women in the country have a comprehensive understanding of how to reduce the risk of infection, according to the 2007 Ukraine Demographic and Health Survey. Lack of opioid substitution therapy and limited needle exchange programs for IDUs, as well as stigma and discrimination against IDUs and PLWHA, fuel the continued spread of the virus in the IDU population.

With an estimated adult HIV prevalence of 1 percent, **Russia** has the second highest HIV prevalence in the region. By 2009, an estimated 980,000 people in Russia were living with HIV. The prevalence in the country remained low through 1996, when 1,515 new cases were reported in connection with an outbreak among IDUs, and started to increase dramatically after 2003. Transmission through injecting drug use accounted for 62 percent of new infections in 2009, but, as in Ukraine, the proportion of new HIV infections due to injection drug use has fallen, and sexual transmission is on the rise. In 2007, more than one-third of new cases were attributed to sexual transmission, although data suggest the epidemic is still concentrated among IDU populations and their partners.

Adult HIV prevalence in **Georgia** has slowly increased over the past decade to 0.1 percent in 2009; in the same year, the country was home to approximately 1,200 PLWHA. The epidemic continues to be driven by injecting drug use, which accounts for 60 percent of new infections, but heterosexual transmission has become more common in recent years (34 percent of new cases). The majority of PLWHA are men, with three HIV-positive men for every HIV-positive woman. Despite having a low overall prevalence, widespread injecting drug use puts the country at risk of a broader epidemic.

In **Armenia**, prevalence remains low; 823 cases of HIV were officially diagnosed as of December 2009, and UNAIDS estimates 1,900 people are currently living with HIV/AIDS. The number of new cases of HIV has been on the rise in recent years, with the highest number of cases (149) of any year diagnosed in 2009. While marked increases in the number of new infections reported may be skewed by increases in testing and scale-up of laboratory capacity, the increases are still a reason for concern. Heterosexual sex accounts for 50 percent of cases, and injection drug use accounted for an additional 41 percent; most infections among men are attributed to injecting drug use, while 98 percent of infections in women are through sexual transmission.

In 2009, **Belarus** had 1,500 new HIV infections, according to UNAIDS, and the annual rate of new infections has held steady since 2003. UNAIDS indicated the estimated adult HIV prevalence tripled, from 0.1 percent in 2001 to 0.3 percent in 2009. The epidemic is concentrated among IDUs; in the city of Zlobin, prevalence rates as high as 52 percent were reported among IDUs in 2006.

The number of newly diagnosed HIV infections in **Moldova** has increased almost fourfold since 2001, although the estimated adult prevalence has remained fixed at 0.4 percent over the past decade due to HIV-related mortality. While transmission through injecting drug use was the dominant cause of infection in the late 1990s and early 2000s, heterosexual sex has been the primary mode of transmission since 2004. Nearly all pregnant women are tested for HIV, and prevalence among this group was approximately 0.29 percent in 2009. Recent surveillance

data from 2009 found a prevalence of 6.1 percent among commercial sex workers (CSWs), markedly higher than among the general population.

Low HIV prevalence in some E&E countries, such as **Albania**, **Kosovo**, and **Azerbaijan**, must be considered with caution due to the risk of continued spread of the virus. **Albania** is a very low prevalence country, with more than 90 percent of new infections transmitted through sexual contact. The majority of PLWHA are in the capital city of Tirana. **Kosovo** is home to 43 known cases of HIV, and the majority of these cases are among males aged 30 to 39; however, the actual number is estimated to be much higher. Based on limited available data, the country is experiencing a low-level epidemic. **Azerbaijan** is another low-prevalence country, with an estimated 0.1 percent prevalence in the adult population, although the country experienced a 16.2-percent increase in the rate of newly diagnosed HIV infections from 2005 to 2006.

While the U.S. Agency for International Development's (USAID's) E&E Bureau no longer runs programs in the Baltics, HIV continues to be a major challenge in the area. The rate of new HIV diagnoses has declined since 2003, although the HIV incidence rate in Estonia – the highest in WHO's European region – is 504.2 to 626.3 per 1 million population; the country's estimated adult prevalence in 2007 (1.3 percent) was one of the highest in the E&E region. The history of HIV in Estonia is one of the most pointed examples of how the virus can spread quickly through use of shared injecting drug equipment. A limited number of cases had been detected in the country a decade ago, but within a few years the majority of IDUs surveyed (up to 72 percent in some surveys) were HIV positive, according to UNAIDS. By 2007, 62.5 percent of IDUs in the capital city of Tallinn were living with HIV.

HIV-tuberculosis (TB) co-infection complicates the care and treatment of both diseases. HIV weakens the body's ability to fight TB, the most common AIDS-associated disease in the region. Estimated TB incidence varies throughout the region, according to WHO. In **Russia**, estimated TB incidence was 106 new TB cases per 100,000 population in 2009; in **Ukraine**, incidence was 101 per 100,000 population. In **Russia**, 4 percent of people with TB are co-infected with HIV; in **Ukraine**, 11 percent of people with TB also have HIV, the highest co-infection rate in the region.

Economic and Social Impact of HIV/AIDS in Europe and Eurasia

The cost of addressing HIV can divert resources from investments critical to economic development on a national level, and from meeting day-to-day needs on a family level. HIV infection can drain a family's resources due to increased medical expenses. It can also leave a house with one or no income-earning adult. As has been demonstrated in other countries, the impact of the epidemic on families and communities influences the epidemic's future course. HIV-related morbidity and mortality can change a population's demographic and economic structure when younger, normally productive members of society are unable to work or die from complications related to HIV. Some parents who die from complications associated with HIV/AIDS leave behind young children who are also HIV positive. Such children often do not receive medical care and suffer social isolation and discrimination. Although the prevalence of HIV currently remains low in most countries of the region, the continued growth and spread of the epidemic will create ongoing challenges to development.

While the economic effects of HIV/AIDS remain limited in the E&E region, their impact is beginning to be felt in countries with larger epidemics, including **Russia** and **Ukraine**. In **Ukraine**, a 2006 World Bank study estimated a 1 to 6 percent reduction in gross domestic product (GDP) from 2004 to 2014 as a consequence of the growing HIV epidemic. The same World Bank study predicted a 1 to 2 percent reduction in the labor force due to the epidemic; it also estimated that the 20 to 34 age group would account for three-quarters of all new HIV infections by 2014, if HIV/AIDS programming continues at 2006 levels. In **Russia**, a separate non-intervention scenario from the World Bank estimated the country's GDP could decline by as much as 10.7 percent as a result of the epidemic. The costs of HIV/AIDS care and treatment also divert resources from other important health investments.

HIV prevention among mobile populations is becoming increasingly important to controlling the epidemic, as many migrant workers travel from Central Asia to **Russia** for work. When migrant workers are away from their families for extended periods of time, they tend to engage in risky behavior, which puts them and their respective partners at home at greater risk of contracting HIV. Immigrants often lack access to health services, including HIV prevention and treatment, compounding the risk of spreading the epidemic.

Stigma and discrimination toward PLWHA, especially toward those who belong to marginalized groups, can contribute to further spread of the virus when members of these groups are reluctant to access health services; MSM and IDUs living with HIV often face stigma both for their positive status and for belonging to stigmatized groups. Stigma against PLWHA encompasses a range of behaviors, including gossip and verbal abuse, violence and physical abuse, and discrimination when seeking employment.

When HIV-positive individuals are reticent about disclosing their HIV status, they cannot receive the proper care and treatment or be counseled on methods of preventing the spread of HIV. Negative attitudes and behaviors often deter PLWHA from seeking services at health facilities due to fear of stigmatization and discrimination by health workers. A small study by USAID reported discriminatory attitudes toward PLWHA hindered health workers' ability to provide high-quality care. A survey across three *oblasts* in **Ukraine** found that while most health workers received HIV/AIDS-related training, half thought it was insufficient, and nearly one-third thought HIV-positive patients should be treated in isolation in order to prevent the spread of infection to other patients and staff.

The United Nations Development Program found that the majority of people living in the E&E region fear the discrimination associated with being HIV positive more than they fear the actual health effects and complications of infection. PLWHA who disclose their status often have difficulty finding employment or face discrimination at work, relegating them to informal employment or low-skill, low-wage positions. For PLWHA who are also MSM, IDUs – or both – the chances of finding employment are reduced even further.

National/Regional Response

The transition away from communism throughout the former Soviet Bloc countries resulted in systemic restructuring throughout the E&E region. During the 1990s, budget shortfalls during the rebuilding process led to compromised public health systems in many countries, creating challenges in the early response to HIV. More recently, the Commonwealth of Independent States (CIS)¹ developed a Coordinating Council on HIV through which member states cooperate on scaling up access to ART under WHO's former "3 by 5" initiative and other AIDS-related initiatives. In 2006, the first Eastern European and Central Asian AIDS Conference was held in Moscow, with all countries in the region coming together to discuss urgent issues and examine strategies to overcome challenges. The participants emphasized evidence-based, nondiscriminatory care and the use of civil society groups, the private sector, and other stakeholders as partners in the implementation of a response. Despite this promising rhetoric, there continues to be many challenges to adequately address and combat the HIV epidemic throughout the E&E region.

Country responses to the epidemic vary throughout the region.

- **Ukraine** has actively worked to stop the spread of HIV since the early 1990s. In 2005, the national response was reinvigorated with the establishment of the National Coordination Council on HIV/AIDS. Additional policies and programs were developed to expand access to treatment, care, and family planning services for PLWHA. The country has also introduced opioid substitution therapy for IDUs and harm reduction programs to address the population most affected by the epidemic; many of these services are supported by grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Despite expanded programs, a UNAIDS evaluation found sex workers and MSM remain largely hidden and unreached populations.
- In **Russia**, the Government recognizes HIV infection as one of the major threats to national security and the health of the nation, with the disease spreading with increasing frequency from MARPs to the general population. Federal funding for the response to HIV has grown rapidly since 2005, and the Government has made a number of commitments to address the HIV/AIDS epidemic. Government programs focus primarily on treatment of AIDS rather than prevention, care, and support, although they have a widely implemented PMTCT program. In 2009, approximately 9,380 pregnant women received antiretroviral drugs for PMTCT, according to UNAIDS.
- **Georgia** has mainstreamed HIV prevention and control activities since 1994, prioritizing voluntary counseling and testing, reaching MARPs, providing free PMTCT services, building capacity, and raising local awareness through media campaigns. As of 2008, the Government also supported opioid substitution therapy as a response to the widespread use of injected heroin; a limited Government-sponsored detoxification program started in the same year.
- In 2003, **Albania** created a network of strategic partners to respond to HIV, and the current response to the epidemic is guided by the National Strategic Plan for 2008–2014. A new law passed in 2008 addresses the most critical legal aspects of HIV/AIDS, including discrimination, the right to keep one's job, informed consent, confidentiality, and the establishment of safe places for care and treatment.
- **Armenia** passed landmark human rights amendments to the law on HIV prevention in March 2009. The U.S. Government (USG) provides nearly 30 percent of the Global Fund's total contributions worldwide.

¹ The following countries make up the CIS: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan.

From 2003 to 2010, the Global Fund has approved grants to countries in Eastern Europe and Central Asia totaling nearly \$763 million (the majority of which are grants for activities in **Russia** and **Ukraine**). These grants have targeted high-risk groups, including IDUs, CSWs, youth, street children, prisoners, uniformed personnel, and migrants. Programs support a broad range of accessible services to reduce these groups' vulnerability to infection as well as referral to treatment and care services for people living with HIV. A number of grants are for integrated HIV-TB services. However, as grants come to an end across the region, it will be important to work with governments to ensure they are taking on the responsibility for these key programs and funding them.

USAID Regional Support

USAID's HIV/AIDS programs in the E&E region are implemented as part of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Launched in 2003, PEPFAR is the USG initiative to support partner nations around the world in responding to HIV/AIDS. Through PEPFAR, the USG has committed approximately \$32 billion to bilateral HIV/AIDS programs and the Global Fund through fiscal year 2010. PEPFAR is the cornerstone of the President's Global Health Initiative (GHI), which supports partner countries in improving and expanding access to health services. Building on the successes of PEPFAR, GHI supports partner countries in improving health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns, and children.

USAID programs in the region prioritize prevention activities to decrease HIV infections and help contain the epidemic in the E&E region. Currently, USAID provides both country and regional support for prevention, care, and support programs. The Agency also provides technical assistance to a range of countries to help them develop HIV/AIDS programming and obtain funding from the Global Fund. USAID programming focuses on reaching high-risk populations by providing assistance to local governments and organizations to improve access to effective and high-quality services. Programs include prevention of sexual and biomedical transmission; care for those affected and infected with HIV, including orphans and vulnerable children; improving access to treatment; support to create political will to combat the epidemic; and support of policies addressing stigma and discrimination of PLWHA.

HIV/AIDS activities in 2009 included the continuation of the regional medication-assisted therapy (MAT) policy project. The MAT project is intended to provide information and resources for 10 countries: **Albania, Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Russia, Tajikistan, Ukraine, and Uzbekistan**. The goal of the project is to create tools that will assist local advocates and policymakers in building public policy foundations that support the implementation and expansion of evidence-informed drug dependence services, particularly opioid substitution maintenance therapy.

Throughout the E&E region, country programs had significant achievements in 2009. In **Georgia**, for example, the USG is one of the few providers of HIV prevention services for MARPs and supports organizational capacity building throughout the country. In **Russia**, programs reached more than 86,000 individuals with HIV prevention activities in 2009; they also expanded coverage to 6,400 IDUs and approximately 12,000 CSWs and their partners in the same year. A partnership with a Russian organization, Transatlantic Partners Against AIDS, helped mobilize high-level official, business, and mass media partners to address the epidemic through policy research, information, analysis, and workplace initiatives. An additional partnership with the American International Health Alliance provided training in basic HIV skills and knowledge to more than 1,100 health care workers, teachers, and social workers as part of an effort to strengthen the HIV/AIDS treatment and care service delivery system.

In 2009, USAID technical support facilitated the preparation and adoption of 11 policy and regulatory documents on HIV issues by the Government of **Ukraine**. These issues included the National AIDS Law; voluntary counseling and testing for MARPs; methadone-based treatment for HIV-infected IDUs; HIV/AIDS drug and commodity procurement; and support for vulnerable children. In addition, training 75 civil society representatives in advocacy enabled PLWHA, nongovernmental HIV service organizations, and MARP representatives to work more efficiently with policymakers.

Important Links

USAID's HIV/AIDS Web site for Europe and Eurasia:

http://www.usaid.gov/locations/europe_eurasia/health/technical_elements/hivaids.html.

For more information, see USAID's HIV/AIDS Web site: http://www.usaid.gov/our_work/global_health/aids.