



# HIV/AIDS HEALTH PROFILE

## Europe and Eurasia



### Overall HIV Trends

USAID works in 15 countries in Europe and Eurasia (E&E)<sup>a</sup> where it provides both country and regional support for HIV/AIDS programs. Eastern Europe and Central Asia, more broadly, is the only region in the world where HIV prevalence clearly continues to increase, with an estimated 160,000 new infections in 2010 alone, an increase from 130,000 new infections in 2008<sup>1</sup>. From 2001 to 2010, there was a 250 percent increase in the total number of people living with HIV/AIDS (PLWHA) from an estimated 410,000 adults and children in 2001 to 1.5 million in 2010<sup>1</sup>. By comparison, prevalence in sub-Saharan Africa fell from 5.9 percent to 5.0 percent, and prevalence in Southeast Asia stabilized in the same period<sup>2</sup>. Eastern Europe and Central Asia is also the only region where the annual number of HIV-related deaths continues to rise, increasing nearly 12 times from 7,800 in 2001 to 90,000 in 2010<sup>3</sup>.

The severity of the HIV epidemic in E&E countries 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 2001<sup>4</sup>. **Russia** and **Ukraine** together account for approximately 90 percent of all people newly diagnosed with HIV in the region<sup>2</sup>.

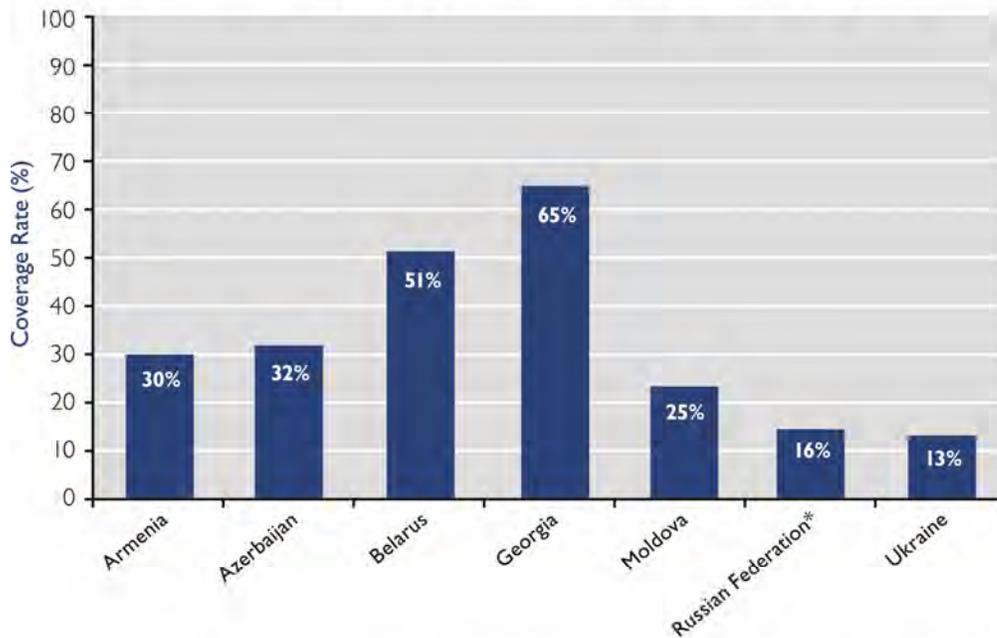
**Most-at-Risk-Populations.** The epidemic has been spreading rapidly since the late 1990s, first among injecting drug users (IDUs) and later among their sexual partners. Increases in prevalence among women are linked to the epidemic through IDUs<sup>3</sup>. An estimated 35 percent of women living with HIV acquired the virus by injecting drugs, and 50 percent of HIV-positive women contracted the disease by having sex with IDUs<sup>2</sup>. 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 injecting drug use is still a significant source of transmission<sup>5</sup>. St. Petersburg, **Russia**, has seen HIV prevalence double in the last 5 years, with a 59.1 prevalence among IDUs<sup>6</sup>.

Sex workers are another most-at-risk population (MARP) in E&E, especially those who engage in transactional sex with IDUs or who inject drugs themselves. In **Russia**, one-third of sex workers are believed to inject drugs. In **Ukraine**, HIV prevalence among sex workers who inject drugs was as high as 43.0 percent compared with 8.5 percent among those who did not inject<sup>2</sup>.

Official estimates of HIV transmission and prevalence among men who have sex with men (MSM) are thought to underplay the actual extent of the problem. Moreover, the data that do exist for this population are limited because the stigmatization of MSM discourages them from accurately reporting their high-risk behaviors. Studies of MSM in the region have shown HIV prevalence rates of up to 8.3 percent in Moscow, **Russia**<sup>7</sup>; 6.4 percent in **Ukraine**<sup>8</sup>; and 7.0 percent in Tbilisi, **Georgia**<sup>9</sup>.

<sup>a</sup> Europe and Eurasia (E&E) region includes: Albania, Armenia, Azerbaijan, Belarus, Bosnia-Herzegovina, Cyprus, Georgia, Ireland/Northern Ireland, Kosovo, Macedonia, Moldova, Montenegro, Russia, Serbia, and Ukraine.

### HIV-Infected People Receiving Treatment in Europe and Eurasia, 2010



Source: WHO/UNAIDS/UNICEF Global HIV/AIDS Response 2011. Coverage estimates are based on 2010 WHO guidelines.  
\*Russian Federation data from WHO/UNAIDS/UNICEF Towards Universal Access 2008, data for end 2007

**Antiretroviral Therapy.** Antiretroviral therapy (ART) coverage remains low in all E&E countries except **Georgia** and **Belarus**, as illustrated in the graph above. Access to ART is expanding; however, coverage in this region was only at 22 percent in 2010, which is the lowest coverage in the world. The average ART coverage for low- and middle-income countries is 47 percent. 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<sup>2</sup>.

**Prevention of Mother-to-Child Transmission.** In the region, prevention of mother-to-child transmission (PMTCT) coverage (89 percent) was the highest in the world in 2010. A study in **Ukraine** showed the percentage of HIV cases due to mother-to-child transmission decreased from 27.8 percent in 2001 to 4.7 percent in 2009<sup>8</sup>. The same study showed that 76 percent of women received antiretroviral drugs for PMTCT in 2009. By 2010, there was universal access for PMTCT in **Ukraine**.

**Country-Specific Epidemics.** **Ukraine** has the highest estimated adult HIV prevalence in the E&E region at 1.1 percent<sup>4</sup>. Sexual transmission of HIV increased from 44 percent to 49 percent between 2009 and 2011, while the proportion of new infections through injecting drug use decreased from 36 percent to 31 percent. The introduction of more needle exchange programs has helped to counter some of the spread of the infection, but there is still ongoing stigma and discrimination toward IDUs and PLWHA<sup>8</sup>. At this juncture, a growing concern is the shift toward HIV transmission through sex, particularly from IDUs to their sexual partners, with women in **Ukraine** representing 37 percent of people living with HIV in 1999 and 45 percent in 2009<sup>3</sup>.

With an estimated adult HIV prevalence of 1.0 percent, **Russia** has the second highest HIV prevalence in the region. By 2009, an estimated 980,000 people in Russia were living with HIV<sup>4</sup>. The majority of HIV infections (82 percent) are among the most economically active segment of the population, those aged 20 to 40 years. Within that group, the proportion of HIV infections in the 15 to 20 year age group is declining, while the proportion in the 20 to 30 year age group is rising rapidly. The MARPs are IDUs, sex workers, MSM, and prisoners. HIV prevalence varies by region, with 36 *oblasts* reporting prevalence of less than 1 percent, while 0.5 percent to 1.2 percent prevalence is reported in the most affected regions<sup>7</sup>.

Adult HIV prevalence in **Georgia** has slowly increased over the past decade, reaching 0.1 percent in 2011 when the country was home to approximately 3,500 PLWHA<sup>4</sup>. The driving force of the epidemic has shifted from injecting drug use to heterosexual sex, accounting for 46.7 percent and 43.3 percent, respectively, in 2010 to 44.6 percent and 47.4 percent, respectively, in 2011. The majority of those infected are still men. However, while in previous years the proportion was 75 percent male and 25 percent female, in 2011 the ratio shifted to 70 percent male and 30 percent female<sup>9</sup>.

In **Armenia**, adult prevalence remains low at 0.1 percent; however, 2011 brought the highest number of newly registered cases (182), and the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates 1,900 people are currently living with HIV/AIDS<sup>4</sup>. 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<sup>11</sup>. In 2011, heterosexual sex accounted for 54 percent of cases, an increase since 2005, and injection drug use accounted for an additional 37 percent. All infections via injecting drugs were reportedly among men, while over 98 percent of infections in women were through sexual transmission. In the same year, 70 percent of those infected were men, and 30 percent were women<sup>11</sup>.

In 2009, **Belarus** had an estimated 17,000 PLWHA. The estimated adult HIV prevalence tripled from 0.1 percent in 2001 to 0.3 percent in 2009<sup>4</sup>. The majority of reported cases (62 percent) are among young people aged 15 to 29. Among cumulative AIDS cases, injecting drug use is a major form of transmission, accounting for 47 percent of infections since 1987<sup>13</sup>.

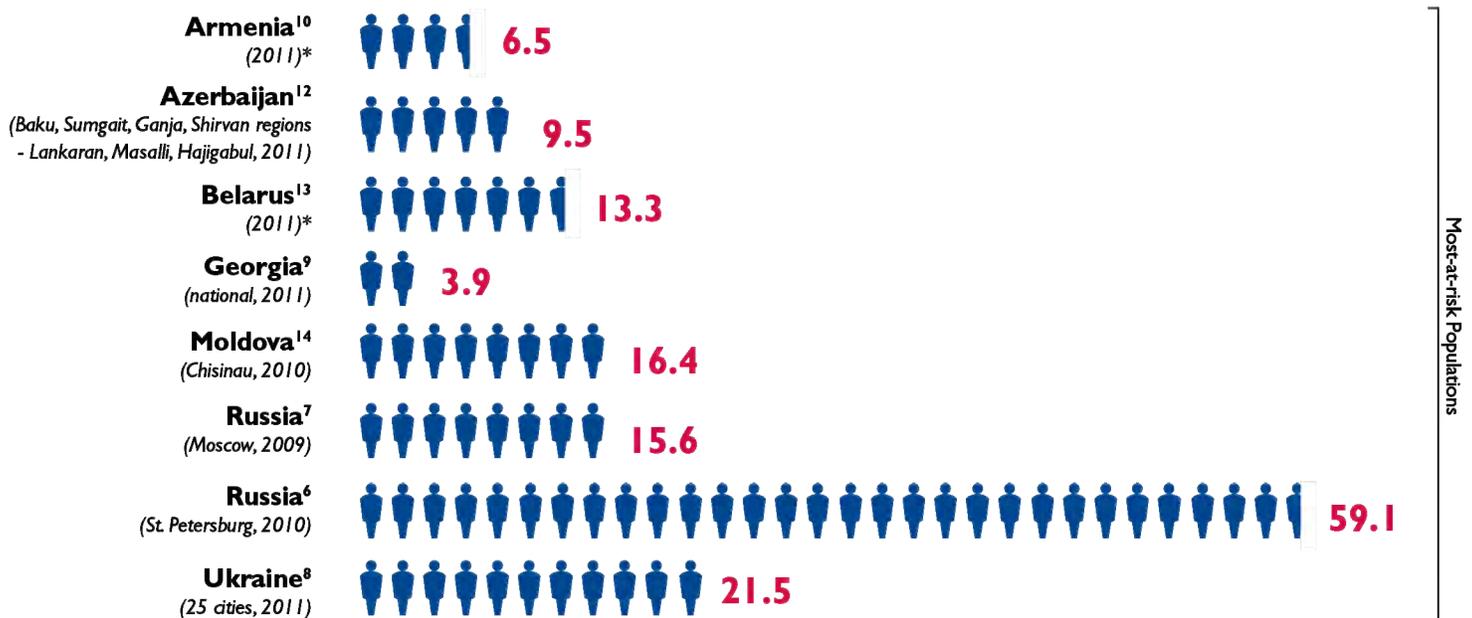
In **Moldova**, the epidemic is concentrated among IDUs, though the number of newly diagnosed patients among IDUs has been decreasing in the past 3 years. The main form of transmission has shifted toward heterosexual sex<sup>14,15</sup>. There was a decrease in the proportion of new infections among women from 52 percent in 2010 to 48 percent in 2011. Since 2007, nearly all pregnant women have been tested for HIV, and, in 2011, of the 80 new cases of HIV in pregnant women, 76 percent underwent voluntary counseling and testing (VCT)<sup>14</sup>. Among commercial sex workers (CSWs), recent surveillance data from 2010 found a prevalence of 6.1 percent in the capital, Chisinau, and a high rate in Balti of 23.5 percent, both markedly higher than among the general population<sup>14</sup>.

HIV Estimates in Europe and Eurasia Region*	
<b>Armenia</b>	
Total Population <sup>10</sup>	3.0 million
Estimated Number of Adults and Children Living with HIV/AIDS <sup>4</sup>	1,900
Adult HIV Prevalence <sup>4</sup>	0.1%
HIV Prevalence Among Injecting Drug Users <sup>11</sup> (2011)	6.5%
HIV Prevalence among Men Who Have Sex with Men <sup>11</sup> (2011)	3.4%
HIV Prevalence among Commercial Sex Workers <sup>11</sup> (2011)	<0.1%
<b>Azerbaijan</b>	
Total Population <sup>10</sup>	9.5 million
Estimated Number of Adults and Children Living with HIV/AIDS <sup>4</sup>	3,600
Adult HIV Prevalence <sup>4</sup>	0.1%
HIV Prevalence among Injecting Drug Users <sup>12</sup> (2011)	9.5%
HIV Prevalence among Men Who Have Sex with Men <sup>12</sup> (2011)	2.0%
HIV Prevalence among Female Sex Workers <sup>12</sup> (2011)	0.7%
<b>Belarus</b>	
Total Population <sup>10</sup>	9.5 million
Estimated Number of Adults and Children Living with HIV/AIDS <sup>4</sup>	17,000
Adult HIV Prevalence <sup>4</sup>	0.3%
HIV Prevalence among Injecting Drug Users <sup>13</sup> (2011)	13.3%
HIV Prevalence among Men Who Have Sex with Men <sup>13</sup> (2011)	2.8%
HIV Prevalence among Female Sex Workers <sup>13</sup> (2011)	2.4%
<b>Georgia</b>	
Total Population <sup>10</sup>	4.6 million
Estimated Number of Adults and Children Living with HIV/AIDS <sup>4</sup>	3,500
Adult HIV Prevalence <sup>4</sup>	0.1%
HIV Prevalence among Injecting Drug Users <sup>9</sup> (2011)	3.9%
HIV Prevalence among Men Who Have Sex with Men <sup>9</sup> (Tbilisi, 2010)	7.0%
HIV Prevalence among Female Sex Workers <sup>9</sup> (Tbilisi, 2008)	2.0%
<b>Moldova</b>	
Total Population <sup>10</sup>	3.7 million
Estimated Number of Adults and Children Living with HIV/AIDS <sup>4</sup>	12,000
Adult HIV Prevalence <sup>4</sup>	0.4%
HIV Prevalence among Injecting Drug Users <sup>14</sup> (Chisinau, 2010)	16.4%
HIV Prevalence among Men Who Have Sex with MSM <sup>14</sup> (Chisinau, 2010)	1.7%
HIV Prevalence among Commercial Sex Workers <sup>14</sup> (Chisinau, 2010)	6.1%
<b>Russia</b>	
Total Population <sup>10</sup>	138.7 million
Estimated Number of Adults and Children Living with HIV/AIDS <sup>4</sup>	980,000
Adult HIV Prevalence <sup>4</sup>	1.0%
HIV Prevalence among Injecting Drug Users <sup>7</sup> (Moscow, 2009)	15.6%
HIV Prevalence among Injecting Drug Users <sup>6</sup> (St. Petersburg, 2010)	59.1%
HIV Prevalence among Men Who Have Sex with Men <sup>7</sup> (Moscow, 2009)	8.3%
HIV Prevalence among Female Sex Workers <sup>7</sup> (Moscow, 2009)	4.5%
<b>Ukraine</b>	
Total Population <sup>10</sup>	45.1 million
Estimated Number of Adults and Children Living with HIV/AIDS <sup>4</sup>	350,000
Adult HIV Prevalence <sup>4</sup>	1.1%
HIV Prevalence among Injecting Drug Users <sup>8</sup> (2011)	21.5%
HIV Prevalence among Men Who Have Sex with Men <sup>8</sup> (2011)	6.4%
HIV Prevalence among Sex Workers <sup>8</sup> (2011)	9.0%

\* HIV data are not available for Albania and Kosovo.

## HIV Prevalence among Injecting Drug Users in the Europe & Eurasia Region

1 person = 2 percentage points



\*HIV prevalence based on pooled estimates from various studies and is not nationally representative.

Low HIV prevalence in some E&E countries, such as **Albania** 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 over 90 percent of new infections transmitted through sexual contact (82 percent heterosexual, 10 percent homo/bisexual)<sup>16</sup>. **Azerbaijan** is another low-prevalence country, with an estimated 0.1 percent prevalence in the adult population<sup>4</sup>; however, 2011 saw an increase in newly reported cases between 2010 and 2011 from 459 to 548, respectively. This followed a relatively stable period between 2007 and 2010<sup>12</sup>.

**Tuberculosis and HIV Co-infection.** 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. In **Russia**, estimated TB incidence was 106 new TB cases per 100,000 population in 2010; in **Ukraine**, incidence was 101 cases per 100,000 population. In **Russia**, 5.3 percent of new TB cases are co-infected with HIV; in **Ukraine**, 13 percent of newly diagnosed TB patients also have HIV, the highest co-infection rate in the region<sup>17</sup>.

### Economic and Social Impacts 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 in the region, the continued growth and spread of the epidemic will create ongoing challenges to development<sup>18</sup>.

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 from 2004 to 2014 as a consequence of the growing HIV epidemic. The same 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 about 75 percent of all new HIV infections by 2014, if HIV/AIDS programming continues at 2006 levels<sup>19</sup>.

HIV prevention among mobile populations is becoming increasingly important in controlling the epidemic, as many migrant workers travel from country to country 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. Interviews conducted with HIV/AIDS carriers in **Armenia** revealed that the majority were migrant workers who were infected while they were temporary residents in either **Russia** or **Ukraine**. The majority of the men were infected through injecting drug use, while the women were infected through sexual contact<sup>20</sup>. Immigrants often lack access to health services, including HIV prevention and treatment, compounding the risk of spreading the epidemic.

**Stigma and Discrimination.** Stigma and discrimination toward PLWHA, especially toward those who belong to marginalized groups, can contribute to the further spread of the virus when members of these groups are reluctant to access health services or seek treatment; studies in Eastern Europe and Central Asia show that not only do IDUs avoid services due to fear of ostracism, but they also fear their health providers will report them to law enforcement<sup>1,21</sup>. Stigma against PLWHA encompasses a range of behaviors, including gossip and verbal abuse, violence and physical abuse, discrimination when seeking employment, and restrictions in congregating in public spaces. At least six countries in Eastern Europe have banned public events for the lesbian, gay and bisexual community in the past decade<sup>22</sup>.

When HIV-positive individuals are reticent about disclosing their HIV status, they cannot receive the proper care and treatment or be counseled on HIV prevention methods. 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 the U.S. Agency for International Development (USAID) reported that 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<sup>23</sup>.

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 and/or IDUs, the chances of finding employment are reduced even further<sup>24</sup>.

## National/Regional Responses

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)<sup>b</sup> developed a Coordinating Council on HIV through which member states cooperate on scaling up access to ART under the World Health Organization'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<sup>8</sup>. A law was enacted in January 2011 on HIV prevention and the rights of PLWHA to harmonize relations between human rights requirements and public health needs, including harm reduction strategies and public-private partnerships. In the same year, the country introduced the State Service on Combatting HIV-infection/AIDS and Other Socially Hazardous Diseases to lead policy developments, national programs, and surveillance efforts. The Global Fund to Fight AIDS, Tuberculosis and Malaria has provided support for ART since 2006, reaching 27 regions as of 2008. As of 2012, 17 percent of ART coverage is supported by the Global Fund and 83 percent by the Ukrainian Government<sup>8</sup>.

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<sup>b</sup> The following countries make up the CIS: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan.

- 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 spent close to US\$800 million. Despite this level of investment, HIV infections are increasing, as little of the invested total goes toward harm-reduction programs for people who inject drugs, MSM, or sex workers. In 2008, although US\$181 million was spent on prevention programs, only US\$8 million was invested in these populations. In order to substantially reduce HIV infections, it may be necessary to reprioritize existing resources.
- **Georgia** has mainstreamed HIV prevention and control activities since 1994, prioritizing VCT, reaching MARPs, providing free PMTCT services, building capacity, and raising local awareness through media campaigns. The new National Strategic Plan of Action 2011–2016 is focused on MARPs and improving health outcomes for PLWHA. Strong collaboration and alignment exist between HIV and TB services. Currently, all patients with dual HIV-TB infection receive free care, including treatment for both diseases.
- 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 HIV/AIDS Strategic Plan for 2010–2015 and focuses on prevention, including education and behavior change<sup>16</sup>. The political support was crucial in the formulation of the country's future roadmap, identifying priorities within the national consultation process on universal access. In addition to the Strategic Plan, significant policy and legislation include the approval of the new AIDS law (2008) and the Anti-Discrimination Law (2010).
- **Armenia's** strategies for responding to AIDS are presented in the National Program on the Response to the HIV Epidemic in the Republic of Armenia for 2007–2011. The new National Strategic Plan on the Response to HIV Epidemic in the Republic of Armenia for 2012–2016, which is the multisectoral strategy/action framework, is under development and has been discussed with the participation of the interested national stakeholders. In 2009, Armenia had passed landmark human rights amendments to the law on HIV prevention. ART is provided free of charge to ensure universal access to HIV treatment, care, and support. The government provided 37 percent of total AIDS spending in 2011.

**Global Fund Investment in the Europe and Eurasia Region.** The U.S. Government provides nearly 30 percent of the Global Fund's total contributions worldwide<sup>25</sup>. From 2003 to 2012, the Global Fund disbursed grants to countries in Eastern Europe and Central Asia totaling nearly US\$981.3 million (the majority of which are grants for activities in **Russia** and **Ukraine**)<sup>26</sup>. 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 PLWHA. A number of grants are for integrated HIV-TB services. As grants come to an end across the region, it will be important for the national governments to sustain these key programs.

### USAID Regional and Bilateral 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 U.S. Government initiative to support partner nations around the world in responding to HIV/AIDS. PEPFAR, a cornerstone of President Obama's Global Health Initiative (GHI), supports partner countries in improving and expanding access to health services. The U.S. Government through PEPFAR and USAID is committed to strengthening health systems, with a particular focus on improving the health of women, newborns, and children.

USAID programs in the E&E region prioritize prevention activities to decrease HIV infections and help contain the epidemic. Currently, USAID provides both country and regional support for prevention, care, treatment, 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. Last year, USAID supported five activities through the E&E regional program: 1) a toolkit to analyze and advocate for effective IDU health policy and programs; 2) translations of key HIV/AIDS documents and tools into Russian; 3) an assessment of existing MSM surveillance data, approaches to HIV prevention and care for MSM, and best MSM practices; 4) an impact evaluation of IDU prevention programs in **Russia**; and 5) a costing study for HIV prevention programs for IDUs in **Georgia**.

HIV/AIDS activities in 2011 included the continuation of the regional medication-assisted therapy (MAT) policy project. The MAT project is intended to provide information and resources for eight countries: **Albania, Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan**. In 2011, USAID developed a costing tool for MAT. This costing tool will be used to build a public policy foundation that supports the implementation and scale-up of evidence-informed drug dependence treatment services, particularly opioid substitution maintenance therapy<sup>27</sup>. By partnering with a local non-governmental organization (NGO) in **Georgia**, the tool helped to assess the costs of implementing prevention programs for IDUs and project the changes in demand over time as drug user interventions expand more broadly in the country.

In addition to the MAT policy project, USAID focused on decreasing MSM stigmatization by conducting an assessment of data, surveillance, programming, and context for MSM in seven Eurasian countries: **Armenia, Azerbaijan, Belarus, Georgia, Moldova, Russia, and Ukraine**. The assessment helped fill the gap in information regarding this at-risk group. There was a regional meeting in **Armenia** to discuss the findings and develop recommendations to improve HIV prevention, care, and treatment services for MSM.

Throughout the E&E region, country programs had significant achievements in 2011. In **Georgia**, for example, USAID is supporting the country's efforts in HIV prevention among high-risk groups as well as providing anonymous HIV counseling and testing to more than 3,000 people who also received their results. In conjunction with the Ministry of Education and Science of Georgia, USAID supported a successful pilot test of a Healthy Lifestyles curriculum in 21 schools in Tbilisi and Telavi as part of an effort to reach the youth population.

In **Russia**, USAID focused on expanding services to IDUs and other high-risk groups. To build capacity, USAID assisted the Civic Chamber to organize a round table on issues of medical education and quality of HIV/AIDS services. Through a public-private partnership supported by USAID, 24 Russian clinical leaders from 21 regions have been trained in effective HIV treatment and care practices. In 2011, USAID reached 6,000 IDUs with HIV prevention services, and 95,000 PLWHA and their families were provided with a minimum of one care service. In collaboration with UNAIDS, USAID created technical working groups made up of three of the largest networks of NGOs to advocate jointly for the participation of civil society in HIV/AIDS policy development in Russia.

In 2011, USAID supported the development and implementation of policies and coordination mechanisms to support prevention programming for MARPs in the **Ukraine**. This included building the capacity of the public sector and NGO community to provide integrated, comprehensive HIV services to MARPs. In 2010, 43,300 individuals received counseling and testing for HIV/AIDS and 13,900 HIV-positive individuals received care and support services.

## Important Links

USAID's HIV/AIDS website for Europe and Eurasia:

[http://www.usaid.gov/locations/europe\\_eurasia/health/technical\\_elements/hivaids.html](http://www.usaid.gov/locations/europe_eurasia/health/technical_elements/hivaids.html)

For more information, see USAID's HIV/AIDS website: [http://www.usaid.gov/our\\_work/global\\_health/aids](http://www.usaid.gov/our_work/global_health/aids).

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