

Fact Sheet

HIV in WHO Regional Office in Europe (EURO)

Regional context

- There were over 100,000 new cases of HIV reported in Europe in 2008 -- the highest annual increase to date for the Europe and Central Asia Region.
- According to the latest data from UNAIDS, the estimated number of adults and children living with HIV in Eastern Europe and Central Asia rose to 1.5 million [1.4 million–1.7 million] in 2008, a 66% increase from 900 000 [800 000–1.1 million] in 2001.
- The highest rates were in **Estonia, Latvia, Kazakhstan, Republic of Moldova, Portugal, Ukraine and United Kingdom**.¹ However, a number of countries (including the Russian Federation) did not input into this report.
- The rate of newly diagnosed HIV cases reported per million varied widely among the three geographical areas in Europe and Central Asia (East, Centre and West).^{2,3} The highest rate was reported in the East (179/million), more than twice which reported in the West (72/million) and more than ten times that in the Centre (15/million).⁴
- In Europe and Central Asia, the sharp increase in HIV infections over the past decades has strongly correlated with social exclusion processes. The population groups experiencing greatest exclusion—across economic, social, cultural and political dimensions—have been disproportionately vulnerable to HIV infection and have been facing considerable barriers in access to necessary prevention, treatment, care and support services.
- Upstream determinants of the HIV/AIDS epidemic in the Region include poverty and rising social inequities, limited employment and education opportunities, discrimination and stigmatization towards those most at risk and vulnerable.⁵
- The predominant mode of HIV transmission varies by country and geographical region, illustrating the diversity in the epidemiology of HIV.
- Injecting drug use is still the main mode of transmission in the East, while in the Centre the main mode of transmission is sex between men followed by heterosexual contact. In the West, the predominant mode is sex between men, followed by heterosexual contact, when cases originating from countries with generalized epidemics are excluded.⁶ Forty percent of cases acquired through heterosexual contact were diagnosed among peoples originating from countries with generalized epidemics.⁷

Eastern Europe

- HIV prevalence in the region is on the rise, with severe and growing epidemics in the **Ukraine** and the **Russian Federation**. With an adult HIV prevalence of 1.6% [1.1–2.0%] in 2007, Ukraine has the highest prevalence in all of Europe.
- Three countries in the region (Estonia, Russian Federation and Ukraine) have HIV prevalence that exceeds 1%.

¹ Ibid.

² Countries are grouped as follows: *East*: Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine, Uzbekistan. *Centre*: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Hungary, The former Yugoslav Republic of Macedonia, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia, Turkey. *West*: Andorra, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, Netherlands, Norway, Portugal, San Marino, Spain, Sweden, Switzerland, United Kingdom. These groupings do not consider Liechtenstein.

³ Data were not available (that is, not reported to WHO) from Austria, Denmark, Liechtenstein, Monaco, the Russian Federation or Turkey.

⁴ ECDC/WHO Regional Office for Europe. *HIV/AIDS Surveillance in Europe 2008*, op.cit.

⁵ ECDC/WHO Regional Office for Europe. *HIV/AIDS Surveillance in Europe 2008*. Stockholm, ECDC, 2009.

⁶ ECDC/WHO Regional Office for Europe. *HIV/AIDS Surveillance in Europe 2008*, op.cit.

⁷ Ibid.

- High HIV prevalence among injecting drug users has been reported in **Ukraine** (38.5–50.3%) and the **Russian Federation** (37%).
- Injecting drug use remains the primary mode of HIV transmission in the region. With increasing transmission among the sexual partners of drug users, many countries in the region are experiencing a transition from an epidemic concentrated among injecting drug users to one that is increasingly characterized by significant sexual transmission.
- Use of contaminated drug injecting equipment was the source of 57% of newly diagnosed HIV infections in Eastern Europe in 2007. An estimated 3.7 million people currently inject drugs in the region, and roughly one in four are believed to be HIV-infected.
- In Eastern Europe, heterosexual transmission was the source of 42% of newly diagnosed HIV infections in 2007.
- The common overlap between sex work and injecting drug use further facilitates the spread of HIV in the region. In the **Russian Federation**, studies indicate that more than 30% of sex workers have injected drugs. In **Ukraine**, HIV prevalence among sex workers ranges from 13.6% to 31.0%.
- Although HIV prevention coverage for injecting drug users remains low in the region, scattered progress has been reported in expanding harm reduction services. In **Estonia**, the number of sterile syringes distributed through harm reduction programmes per injecting drug users doubled, reaching 112.
- HIV transmission between men who have sex with men accounts for a small share of new infections in Eastern Europe and Central Asia. In 2007, sex between men accounted for only 0.4% of newly diagnosed HIV infections in Eastern Europe.
- However, HIV prevalence among men who have sex with men is 5.3% in **Georgia**, 6% in the **Russian Federation** and 10–23% in **Ukraine**.
- The infection rate is higher among prisoners than in the general populations in Europe; a high percentage of prisoners are injecting drug users. In Azerbaijan, one third of people living with HIV are in jail.

Responses

- **Prevention of mother-to-child transmission (PMTCT):** One of the biggest achievements in the AIDS response in the region has been the high coverage of services to prevent mother-to-child HIV transmission. In December 2008, the coverage of services to prevent mother-to-child transmission exceeded 90% in Eastern Europe and Central Asia.
- A critical component of success was the integration of PMTCT interventions into Maternal and Child Health services. The key challenge ahead is to ensure that the most vulnerable women (such as drug-using pregnant women and other at-risk women who are missed by services) are able to access them.
- **HIV treatment:** A number of countries has expanded access to antiretroviral therapy, although treatment coverage remains quite low. By December 2008, 22% of adults in need of treatment were receiving it—less than the global average for low- and middle-income countries (42%). Evidence suggests that injecting drug users, the population most at risk of HIV infection in Eastern Europe and Central Asia, are often the least likely to receive antiretroviral therapy.
- **Harm reduction:** All countries in the region have set up – and are scaling up – outreach programmes of “harm reduction” for injecting drug users, including counseling, needle and syringe exchange programmes, condom supply, etc.
- Several countries have included opioid substitution therapy in their programmes, making oral methadone or buprenorphine available to drug users to reduce drug injection and sharing of injecting equipment.
- In Ukraine, more than 100 opioid substitution therapy centres serve over 5,000 drug users. However, many of these programmes are of a small scale or at a pilot level, serving very small numbers of people.

- Given that an estimated 2.5 million people in the region are injecting drugs, these efforts are far from sufficient and need to be substantially scaled up if the HIV epidemic is to be controlled. Furthermore, currently many of the programmes serving most at risk populations are dependent on outside funding, mostly supported by the Global Fund to fight AIDS, TB and Malaria, which makes them particularly fragile. As has been seen recently in several countries, when such funding ends or is reduced, the programmes tend to close down and often discontinue their activities.
- An example of an innovative intervention to strengthen collaboration between national TB and HIV programmes is the project “Scaling up treatment and care for HIV/AIDS and TB and accelerating prevention within the health system in the Baltic States (Estonia, Latvia, Lithuania)”. With support from WHO, “TB/HIV/Health Systems Strengthening” working groups were established in each of the three countries to conduct detailed cost analyses and flow of funds assessments. These highlighted potential major savings from collaborative TB and HIV/AIDS interventions.

Example of Ukraine

- According to a recent report*, by the end of 2007, some 440,000 had been infected, representing roughly 1.6 per cent of the adult population. That year also saw 17,669 (38 per 100,000 population) officially reported new infections, the largest number to date.
- The proportion of new infections attributed to sexual contact continues to spread HIV beyond groups at highest risk, with the number of sexual partners of IDU estimated at 552,000.
- Ukraine has been a leader in HIV prevention, especially in the development of harm reduction services through which IDU exchange clean syringes for used ones, and receive other health and social services. In 2007, more than 124,000 IDU have been reached through 645 needle exchange points, the largest such network in Eastern Europe.
- Recent innovations have included providing pharmacy-based needle exchange, overdose prevention services, new programs targeting stimulant users, and improved case management services.
- A series of studies, conducted over seven years from 2004 to 2009 in Ukraine**, indicates that:
 - OST (opoid substitution therapy) was highly efficient in reducing illicit drug use and HIV risk behaviours (unsafe injecting practices) as well as improving general health status of patients;
 - OST leads to significant reduction of criminal behaviours and increased social integration;
 - OST of adequate quality is feasible in the country.
- With experiences made in Europe and North America, the integrated care (IC) model for HIV, tuberculosis (TB) and drug dependency seeks to improve access to care, health outcomes and patient satisfaction while reducing costs that result from duplication in the healthcare system and loss of patients who need care.
- First IC programs targeting IDU were created started in the mid-2000s by health policy officials, medical staff and social workers in the country with support from the international donor community. With support from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM), NGOs and government health professionals, Ukraine has made strides toward universal access to HIV care and treatment, which has improved on several indicators in recent years.
- Though no IC program in Ukraine has yet been able to completely fulfil the goal of truly bridging different parts of the healthcare system in order to improve the continuity of care and outcomes for patients, IC has huge potential to reshape Ukrainian medicine for the better. Recent evaluations have found that IC is contributing to improvements in access to care and treatment and increasing cooperation across medical disciplines.

Core services such as narcological assistance, HIV and TB diagnostics, and psycho-social consultation had consistently high uptake.

- Ukrainian IC programs face a number of obstacles to their development, including an inadequate cross-training between medical specialties, an overemphasis on diagnostics, insufficient access to women's health services, restrictive government quotas on OST treatment slots, lack of OST prescription, take-home allowances or pharmacy dispensing, burdensome OST reporting requirements, law enforcement interference and associated fear, funding shortages and often weak infrastructure, and an inefficient use of staff resources.
- With integrated care, much remains to be done, but Ukraine is largely on the right track. Several donors have made a commitment to IC, which must be extended and matched by the Government. Initial efforts to create a cadre of IC experts have yielded skilled staff and innovative programs in a number of cities. With regard to OST many patients' quality of life and willingness to participate in services, some regulatory changes, deeper training of a wider variety of medical personnel, and efforts to familiarize officials outside of medicine with OST could produce numerous improvements.

* Building Integrated Care Services for Injection Drug Users in Ukraine, WHO, Matt Curtis, November 2009 (in publication)

** Final Monitoring and Evaluation Report on Opioid Substitution Treatment in Ukraine, Ambros Uchtenhagen, Prof. MD PhD, and Michael Schaub, PhD, (8 June 2010) (in publication)