# HIV/AIDS in Eastern Europe and Central Asia

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## Summary and Keywords

Eastern Europe and Central Asia (EECA) is the only region in the world where annual HIV infection rates continue to grow. According to the Joint United Nations Program on HIV/AIDS (UNAIDS), in 2019 approximately 1.4 million people in the region were living with HIV. The main factors that have contributed to the spread of the epidemic over the past two decades include injecting drug use, the stigmatization and marginalization of vulnerable groups, the increasing spread of HIV into the general population, and the lack of evidence-based prevention and treatment programs necessary for controlling the epidemic. Limited access to life-saving antiretroviral treatment has intensified the impact of the epidemic in EECA and increased mortality rates among people living with HIV (PLWH).

In the post-Soviet space, Russia is experiencing by far the biggest HIV/AIDS epidemic. This can be attributed largely to the government's failure to introduce evidence-based prevention measures for vulnerable groups, e.g., harm reduction programs, which are recommended by international health organizations. Other countries in the region have been more pragmatic in their approach and introduced harm reductions programs on a broader scale. In Ukraine, the efforts to combat HIV, which led to an initial stabilization of the epidemic in 2012, have been endangered by the military conflict in the eastern part of the country and subsequent internal displacement, which has increased HIV vulnerability. In comparison with Russia and Ukraine, the countries of the South Caucasus and Central Asia are less affected by HIV. However, labor migration to Russia constitutes a persistent risk factor for HIV transmission from higher-prevalence Russia to lower-prevalence South Caucasus and Central Asia.

Although initially the HIV/AIDS epidemic has been mainly driven by injecting drug use, it is also clearly linked to lesbian, gay, bisexual, and transgender (LGBT) politics and policies in EECA. Because of widespread stigmatization and marginalization, the spread of HIV within LGBT communities remains underreported and is barely visible in official HIV statistics. This makes it difficult for prevention programs to reach out to vulnerable groups. In all countries in the region, prevention efforts among LGBT communities remain inadequate and largely depend on local civil society organizations (CSOs), which lack the capacities to provide nationwide information campaigns and other prevention programs for the LGBT community. In addition, the work of CSOs that advocate for HIV

prevention among LGBT groups is further undermined by repressive laws, e.g., the 2013 “gay propaganda law” in Russia, which has increased the stigmatization of LGBT people and has made prevention outreach more difficult. Research has contributed to our understanding of HIV vulnerability and its impact in EECA. Further research is needed, however, into the social and political factors that explain the persistent failure of regional decision-makers to adequately address the growing HIV epidemic.

Keywords: HIV/AIDS, Eastern Europe, Central Asia, Russia, Ukraine, South Caucasus, drug use, sex work, LGBT, MSM, LGBT politics

# Overview of HIV and AIDS in Eastern Europe and Central Asia

Worldwide, the spread of HIV and AIDS is on the decrease. According to the Joint United Nations Program on HIV/AIDS (UNAIDS), the international community has achieved remarkable results in the fight against the global epidemic. At the General Assembly High-Level Meeting on HIV/AIDS in June 2016, UN Secretary-General Ban Ki-Moon announced that the world has “made enormous progress” on halting and reversing the HIV and AIDS epidemic (UN Secretary-General, 2016). As part of its Sustainable Development Goals, the United Nations has set a new objective of “ending the epidemic by 2030” (Political Declaration on HIV and AIDS, 2016). Despite persistent difficulties and global inequalities regarding access to antiretroviral treatment, the global response to HIV and AIDS is thus on the right track.

The region of Eastern Europe and Central Asia (EECA) is an exception, however. It is the only region in the world where the epidemic is continuing to rise rapidly (UNAIDS, 2016). Between 2010 and 2015, the region—which includes all countries of the former Soviet Union except the three Baltic republics[1]—saw a 57% increase in annual new HIV infections (Aibekova et al., 2018; UNAIDS, 2016). In 2017, an estimated 1.4 million people were living with HIV in EECA, which equates to a regional prevalence rate of 0.8%. In absolute terms, the HIV and AIDS epidemic in EECA is smaller than in Southern Africa or Asia and accounts for only a fraction of the more than 36 million people living with HIV globally. However, steep growth rates in recent years indicate that the epidemic is far from being under control in EECA (see Figure 1). Within the region, Russia has been particularly affected by HIV and AIDS. In 2015, more than 80% of the region’s new infections occurred in Russia (UNAIDS, 2016).

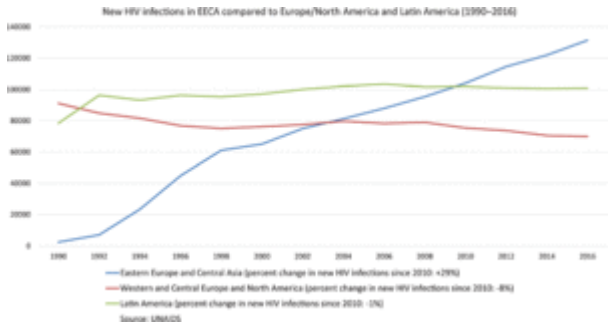


*Figure 1.* New HIV infections in EECA compared to Europe, North America, and Latin America (1990–2016).

(Source: UNAIDS)

The HIV and AIDS epidemic in EECA emerged in the context of post-Soviet transition. The dramatic political and socioeconomic changes experienced by the region following the collapse of the Soviet Union in 1991 had a profound impact on both the population's general health and the spread of infectious diseases in particular (Cook, 2013; Kainu, Kulmala, Nikula, & Kivinen, 2017; Rechel, Richardson & McKee, 2014). As a result, EECA can be characterized as a risk environment for HIV, a status that can be attributed to the breakdown of social cohesion at multiple sites. An important factor in the unfolding epidemic has been the rise of injecting drug use since the 1990s (Kramer, 2003, 2011; Luo & Cofrancesco, 2006; Vickerman et al., 2014). Following the collapse of the Soviet Union, injecting drug use spread rapidly among young people, especially young men. This was a result of the increased accessibility and affordability of illicit drugs, mainly opiates, traded from Afghanistan and Central Asia via the so-called "northern route" to Russia. Since the 1990s, EECA, and Russia in particular, has become an important transfer and target region in the global drug trade (Burki, 2012).

Worldwide, EECA is among the regions with the highest prevalence of injecting drug use (UNODC, 2017). Injecting drug users (IDUs) are at an increased risk of HIV infection resulting from unsafe injecting practices, e.g., the sharing of contaminated needles and syringes. Within the region, about 24% of IDUs have HIV, which is approximately twice the global average (UNODC, 2017). At the beginning of the 2000s, injecting drug use was by far the most dominant transmission route, accounting for 80% of annual HIV infections. In 2015, transmission via injecting drug use still accounted for more than half of infections in the region, although heterosexual transmission has been on the rise over recent years (Amirkhanian, 2012; UNAIDS, 2016).

In addition to IDUs, other specifically vulnerable groups include sex workers (SWs), prison inmates, and men who have sex with men (MSM). Studies have shown that commercial sex work and drug use are closely interconnected and are an important driver of the epidemic in the region (Aral, St. Lawrence, Dyatlov & Kozlov, 2005; Kerrigan, 2013; Platt et al., 2015; Schluger et al., 2013). The prison system, on the other hand, serves as a reservoir for the epidemic; HIV is spread within prisons via needles and syringes, which are more likely to be shared in the high-risk prison environment (Bobrik, Danishevski,

Eroshina, & Mckee, 2005). Finally, gay men and other MSM constitute another group at high risk of HIV infection in EECA. Although this trend remains invisible in many official HIV statistics, behavioral studies indicate that HIV prevalence among MSM is considerably higher than in the average population and can reach up to 22.8%, as shown in a 2017 study conducted by the Open Health Institute in seven Russian cities (Federal AIDS Center, 2018).

Social risk factors are reinforced by political decision-makers' failure to effectively confront the epidemic and adopt evidence-based prevention and treatment programs endorsed by international health organizations (Wood et al., 2010). Although national governments and international organizations have described the response to HIV/AIDS as a public health priority, the scale and scope of prevention efforts have thus far been inadequate.

This contribution provides an overview of the HIV/AIDS epidemic in EECA. It aims to understand why the region departs from global trends and has shown an increase in new HIV infections in recent years (see Table 1). The article approaches the topic of HIV/AIDS in EECA from a social science perspective and is inspired by the comparative study by Barnett and Whiteside (2006) on the global HIV/AIDS epidemic. Based on this approach, the contribution aims to investigate the social and political factors that have enabled the rapid spread of HIV in the EECA region. Special attention will be paid to the Russian Federation, which is the worst-affected country in the post-Soviet space and which accounted for an estimated 80% of the region's new infections in 2015 (UNAIDS, 2016).

The article is structured as follows. First, it provides an overview of the HIV epidemic in EECA on the basis of the HIV risk, vulnerability, and impact framework developed by Barnett and Whiteside (2006). This overview discusses the main micro- and macro-level factors that have enabled the spread of HIV in the region. Second, the article takes a closer look at four case studies that together provide an overview of the main trends in the diverse region. Each case study (Russia, Ukraine, the South Caucasus, and Central Asia) provides information on risk, vulnerability, and impact as well as state policies and responses from civil society. The case studies highlight the main political and social barriers to effective HIV prevention and treatment in the region, as well as opportunities for improving HIV policies. Third, the contribution will discuss the close link between the HIV epidemic and LGBT politics and policies in the region. The article will conclude with a summary and an outlook on policy and research on HIV/AIDS in EECA.

# Risk, Vulnerability, and Impact

A framework for understanding HIV risk, vulnerability, and impact was developed by Barnett and Whiteside in their publication *AIDS in the 21st Century* (2006). The authors argue that epidemics do not emerge randomly but unfold in social environments that, in various ways and to various degrees, facilitate or hamper the spread of infectious diseases. Epidemiologists use risk to describe the "relative risk or odds of infection associated with a specific behavior or other factors" (Barnett & Whiteside, 2006, p. 85). Conse-

quently, a risk group is defined as a “category of individuals with a characteristics associated with increased relative risk” (Barnett & Whiteside, 2006, p. 85). Risk is the result of a multitude of factors and should therefore be viewed as “characteristic of the environment rather than of the individuals or the particular practices” (Barnett & Whiteside, 2006, p. 86). In a risk environment, “individual, group and general social predisposition to virus transmission is increased” (Barnett & Whiteside, 2006, p. 89). HIV risk thus refers not only to individual behavior but also to all social and political factors that shape human interaction.

Vulnerability, on the other hand, refers to the adverse consequences of HIV/AIDS. Barnett and Whiteside argue that HIV vulnerability manifests itself at different levels, including the individual, group, community, and societal levels. An individual may suffer due to health limitations, societal marginalization, and stigma. Societies may become further vulnerable to HIV/AIDS as they face a decline in their workforce and an increase in public spending as a result of the epidemic. Poverty and social inequality facilitate the spread of HIV and in many cases hamper a society’s ability to respond to the epidemic. According to Barnett and Whiteside, each social setting constitutes a specific risk environment, which includes all factors that facilitate the transmission of HIV in a given context.

Barnet and Whiteside conclude that the origins and impact of epidemics are often linked at the root. The conditions that facilitate the spread of HIV/AIDS, such as poverty, social inequality, and marginalization, in many cases also hamper a society’s ability to respond to the epidemic and minimize its impact. As a result, HIV epidemics can create a vicious circle: the faster the epidemic develops, the more difficult it becomes to deal with the consequences. By comparing HIV/AIDS epidemics around the world, Barnett and Whiteside (2006) identify two main variables that determine how rapidly the infection will spread: (1) the overall level of wealth and (2) the degree of social cohesion in society. In general, prosperous countries are better prepared to confront HIV/AIDS due to the advanced capacities of their healthcare systems and the higher levels of individual assets and coping strategies within their borders. Even more decisive than a society’s economic wealth, however, is the extent of social cohesion. Societies with a low level of social cohesion are less able to deal with infectious diseases, since social exclusion and marginalization hamper efforts to confront epidemics.

With regard to the specific risk environment in EECA, three main factors explain the rapid spread of HIV over the past two decades. First, the epidemic in the region is closely related to injecting drug use, which has significantly increased throughout the region since the fall of the Soviet Union (Kramer 2003, 2011). IDUs represent the largest share of HIV cases in the region, and they face barriers to accessing HIV prevention and treatment, which further increases their vulnerability (Wolfe, 2007; Wolfe, Carrieri, & Shepard, 2010). Second, the spread of HIV is facilitated by marginalization and stigmatization, which affects people living with HIV (PLWH) and vulnerable groups, including IDUs, SWs, MSM, migrants, and prison inmates (Burki, 2015). HIV-related stigma forms an obstacle

to responding adequately to the epidemic, making outreach to vulnerable groups more difficult and creating a culture of neglect and avoidance.

A third factor that has enabled the spread of HIV in EECA is political in nature. Although the region was confronted by HIV considerably later than other parts of the world (the first case of HIV in the Soviet Union was only identified in 1987), decision-makers throughout the region have failed to make use of internationally available experience and to develop effective measures to combat the epidemic. The response to HIV has long been characterized by ignorance and neglect. Although there are important general trends in regional HIV epidemics, there are important differences between EECA countries with regard to policy responses. In the following, four case studies will be discussed in more detail in order to reveal similarities and differences with regard to epidemiological development and responses to HIV in the region.

## HIV and AIDS in Russia

Russia’s HIV and AIDS epidemic has developed dramatically over the past two decades. While there were hardly any HIV infections in Russia until the mid-1990s, the number of PLWH has grown rapidly over the past 20 years (see Figure 2). According to the Russian Federal AIDS Center, the cumulative number of HIV infections among Russian citizens amounted to 1,326,239 cases at the end of 2018 (Federal AIDS Center, 2019).[2]

In the post-Soviet space, Russia is thus the country with the highest HIV burden. At the end of 2018, the Federal AIDS Center reported a national prevalence of 686.2 per 100,000 population (Federal AIDS Center, 2019). This means that roughly 1% of the adult population in Russia is living with HIV. In some of Russia’s regions, HIV prevalence is significantly higher than the national average. In 2018, the Russian regions of Kemorovo, Irkutsk, and Sverdlovsk reported the highest prevalence rates in Russia, with more than 1,700 infections per 100,000 population, three times the national average (Federal AIDS Center, 2019). In these parts of Russia, HIV is firmly established in the general population, which is an indicator of a generalized epidemic (WHO, N.D.).

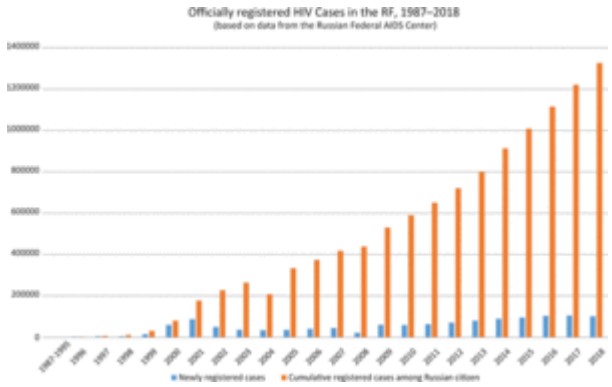


*Figure 2.* Officially registered HIV cases in the Russian Federation (1987–2017).

(Source: Based on data from the Russian Federal AIDS Center)

In recent years, the epidemiological situation in Russia has deteriorated significantly, with an annual growth rate of around 10% between 2011 and 2015 and 4.1% in 2016 (Federal AIDS Center, 2018). In 2017, an overall number of 104,402 new HIV infections were identified in Russia, which amounts to a national incidence rate of 71.1 per 100,000 population (Federal AIDS Center, 2018).

As Russia's HIV epidemic is closely linked to injecting drug use, the regional patterns follow the main routes of illicit drug trade from Central Asia and Afghanistan to the western parts of Russia. Throughout Russia, economically developed urban centers have been especially affected by HIV, as they are particularly targeted by illicit drug trade. Since 2008, Russia has seen a gradual generalization of the epidemic (Clark, 2016). HIV is no longer confined to most-at-risk groups and is increasingly extending to the general population. Whereas in the beginning of the 2000s nearly 90% of HIV transmissions were linked to injecting drug use, this percentage decreased to 43.6% in 2017 (Federal AIDS Center, 2018). Accordingly, the share of heterosexual transmissions is increasing and amounted to 53.5% in 2017 (Federal Aids Center, 2018). At present, there are two parallel epidemiological trends in Russia: the epidemic among IDUs is continuing, while at the same time HIV is actively spreading within the general population through heterosexual contact (Federal AIDS Center, 2018).

In recent years, the number of HIV transmissions linked to homosexual contact has grown, but it remains at a relatively low level of 1.9% of all transmissions in 2017 (Federal AIDS Center, 2018; Vashchenko, 2017). Experts agree that this low percentage can be partially attributed to underreporting. Due to the stigmatization of homosexuality in particular, patients are discouraged from revealing their sexual orientation in their communications with doctors and medical personnel.

Some groups are particularly affected by HIV. In Russia these key populations are IDUs, SWs, and MSM (Niccolai et al., 2012). The increased HIV risk arises particularly from behavioral factors, e.g., sharing needles and injection equipment and engaging in unprotected sexual contact, but it is reinforced through criminalization, marginalization, poverty,

and limited access to health services. Studies show that vulnerable groups are at a significantly higher risk of contracting HIV than the general population, as can be seen in a 2017 study among key populations conducted by the Open Health Institute, which covered a total of 3,744 respondents in seven Russian cities (Federal AIDS Center, 2018). The study showed that the prevalence among participating IDUs was as high as 57.2% in Ekaterinburg, 64.6% in Perm, and 75.2% in Kemerovo. Among SWs, HIV prevalence ranged from 2.3% in St. Petersburg to 15.0% in Perm. Within the group of MSM, HIV prevalence was 7.1% in Perm, 16.5% in Ekaterinburg, and 22.8% in St. Petersburg.

Vulnerable groups are virtually excluded from access to antiretroviral treatment. Limited access to treatment is one factor in the continuous spread of HIV in Russia. In 2017, around 350,000 PLWH received antiretroviral treatment in Russia, which equals 35.5% of the overall number and 47.8% of those enrolled in specialized medical institutions (Federal AIDS Center, 2018). According to Russian medical experts, this percentage is insufficient to slow down the spread of HIV in Russia (Federal AIDS Center, 2018). In recent years, HIV mortality has increased in Russia as well. In 2017, 31,898 PLWH died, which is 4.4% more than in 2016, with tuberculosis (TB) being the main cause of death among PLWH.

The continuous spread of HIV in Russia is the result of policy failure. In 2006, Russian president Putin addressed the problem of HIV/AIDS in a meeting of the State Security Council and declared that the fight against the epidemic was a priority for Russia (Putin, 2006). However, this announcement did not translate into a real commitment to introduce necessary prevention measures and treatment. To date, HIV policies in Russia are characterized by neglect and a failure to address the epidemic effectively in the populations that are most vulnerable (Clark, 2016).

The main shortcomings in the national response to HIV in Russia include a lack of primary prevention programs, insufficient coverage of prevention activities for vulnerable groups, and the treatment gap. First, Russia has no coherent strategy for providing information on HIV, especially to young people. International health organizations recommend the introduction of culturally sensitive education programs on HIV/AIDS in secondary schools, as these allow for outreach to the majority of adolescents. In the 1990s, Russian scientists advocated for the development of Russian sex education programs, including information on HIV (Kon, 1997). Their efforts failed, however, due to opposition from the Russian Orthodox Church and conservative groups (Kon, 1997). To date, Russian schools do not offer systematic sex education programs or comprehensive information on HIV, although these programs could provide a relatively inexpensive way to inform adolescents about health and sexually transmitted infections. General media and education campaigns on HIV are also limited in scope and coverage as they mainly depend on the funding and organization by the regional AIDS centers, which are poorly equipped and staffed. The general level of information on HIV within the Russian population therefore remains low.[3] Many Russians perceive HIV as a problem that solely affects marginalized population groups.

A second major shortcoming of state HIV policies in Russia is the lack of prevention programs for vulnerable populations, such as IDUs, SWs, and MSM. Harm reduction programs and other targeted prevention services are either not provided or only available at the local level. Overall, the coverage of harm reduction services is insufficient for slowing down the spread of HIV among IDUs. Furthermore, opioid substitution therapy (OST) remains illegal in Russia despite clear evidence of its effectiveness as a prevention strategy among IDUs (Clark, 2016; Colborne, 2016). With regard to HIV prevention among vulnerable groups, Russia scores worse than neighboring countries in the EECA region such as Ukraine, which opted for a more pragmatic approach and introduced targeted HIV prevention programs in the early 2000s. The underlying problem of the decline of evidence-based prevention is the politicization of the epidemic in Russia. Instead of being guided by medical evidence, Russian officials view the recommendations of international health organizations as harmful interference from the West (Colborne, 2016).

The third obstacle concerns limited access to antiretroviral treatment (the so-called treatment gap). Antiretroviral therapy (ART) can stop the progression of HIV infection, prolonging the life of individual patients and reducing the viral load within a population. UNAIDS recommends the so-called 90-90-90 strategy: 90% of all HIV-positive people should know their status, 90% of those diagnosed should have access to treatment, and 90% of those receiving antiretroviral therapy should have full viral suppression (UNAIDS, N.D.). In Russia, only about 30% of PLWH have access to ART, which is far too low to make it effective as a prevention measure. IDUs and other marginalized groups in particular find it difficult to secure a place in government treatment programs, even though Russian law guarantees free HIV treatment to all patients. In addition, there are frequent shortages in the supply of antiretroviral drugs at the regional AIDS centers responsible for providing HIV treatment. This has led to the privatization of HIV treatment: patients with appropriate financial means can buy their medication in Moscow or abroad; others must rely on the insufficient supply at the regional AIDS centers. Although the Russian government has identified the treatment gap as a major problem in the response to HIV, funding for government treatment programs has not increased, which will further widen the gap between need and capacity. Low access to treatment also increases mortality among PLWH. Together, lack of primary prevention, insufficient prevention coverage among vulnerable groups, and the treatment gap means that Russia’s HIV epidemic is continuing to grow.

Civil society has played an important role in confronting HIV in Russia (Brown, 2006; Pape, 2014; Stachowiak & Peryshkina, 2006). In many cities, CSOs were the first to set up prevention programs and to provide psychosocial assistance to those affected by the epidemic. CSOs fulfill important functions in service delivery, advocacy, community building, and empowerment (Spicer et al., 2011). Funding provided by the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFTAM) was crucial for the development of Russian AIDS service CSOs, including the GLOBUS project, which was organized by a consortium of five organizations in Moscow. Through collaboration with local CSOs in different regions, the GLOBUS project strengthened the capacities of the local level and demonstrated the effectiveness of HIV prevention among vulnerable groups, which was the main objective of the project. Despite promises from the Russian government, however, the pre-

vention efforts initiated by GLOBUS were not continued after the project ended, which contributed to the consistent gap in prevention coverage.

Overall, many HIV interventions developed by Russian CSOs have remained limited to the local and regional levels. Harm reduction programs are provided in some regions but do not cover Russia as a whole. Although CSOs fulfill important functions in implementing social services, they lack real influence at the political level (Pape, 2014). Through collaboration with international networks and medical experts in Russia, CSOs have raised awareness of the unfolding HIV epidemic (Spicer et al., 2011). However, due to the general weakness of civil society, the difficult policy environment, and the stigma of HIV, AIDS-service CSOs have found it difficult to build support among Russian citizens.

The 2012 “foreign agent law” has further hampered the work of AIDS-service CSOs in Russia. Since 2016, ten Russian AIDS-service organizations have fallen under the provisions of the law and are, thus, restricted in their efforts to provide services to vulnerable groups (Agency of Social Information, 2018). A few CSOs have even ceased their operation as a result of the “foreign agent law.” A new legal initiative of September 2018 stipulates that all foreign-funded HIV prevention programs proposed by Russian CSOs require an additional approval by the Russian Ministry of Justice (Agency of Social Information, 2018). This new trend will likely further increase state control of AIDS-service CSOs in Russia. Despite the difficulties, however, civil society continues to play an important role in the response to the epidemic. Over the past years, new AIDS-service CSOs have been established. The Moscow-based organization SPID-Center, for example, can rely on local members, volunteers, and donors and may be able to generate further societal support for the fight against HIV/AIDS in Russia.

Because of the lack of prevention programs for vulnerable groups, public experts believe that Russia’s HIV epidemic will continue to grow in the future (Vashchenko, 2017). In 2016, the Russian Prime Minister Medvedev approved Russia’s 2017–2020 HIV strategy (Clark, 2016; State Strategy, 2016). The strategy aims to reduce HIV transmission rates by focusing on prevention programs and by decreasing the number of HIV-related deaths. Although the rehabilitation, social adaptation, and social support of key affected populations is included in the document, no specific national programs are outlined, and, most importantly, no financing of the envisioned programs has been defined (State Strategy, 2016). The national HIV strategy thus largely remains a policy paper without much impact on reality. It is reasonable to conclude that Russia has thus far failed to confront HIV, as the government is not prepared to fully acknowledge the underlying causes of the epidemic or introduce necessary policies.

## HIV and AIDS in Ukraine

After Russia, Ukraine is the country with the highest HIV prevalence in the post-Soviet space. According to the Public Health Center of the Ukrainian Ministry of Health, 321,382 cases of HIV infection were officially registered in Ukraine between 1987 and 2018, including 46,024 deaths due to AIDS-related illnesses (Public Health Center of the

Ukrainian Ministry of Health, N.D.). In 2017, an estimated 240,000 people were living with HIV in Ukraine, which equals a prevalence rate of 0.9% of the adult population (Public Health Center of the Ukrainian Ministry of Health, N.D.). The key characteristics of Ukraine's HIV epidemic are similar to those in Russia. In Ukraine, too, HIV is closely linked to injecting drug use (Bojko, Dvoriak & Altice, 2013; Booth et al., 2009; Dutta et al., 2013; Lekhan et al., 2006; Zaller et al., 2015). In recent years, however, the epidemic has shifted from key populations to the general population. Since 2008, heterosexual transmission has been the main mode of transmission in Ukraine (WHO, 2014). With the gradual generalization of the epidemic, the proportion of women among PLWH is growing (Burruano & Kruglov, 2009). Adolescents are disproportionately represented among those at risk for HIV in Ukraine (Busza et al., 2011). Like Russia, the regional patterns of the epidemic originally followed the pathways of the illicit drug trade. In Ukraine, regions close to the river Dnieper, the southeastern part of the country, and urban centers such as the capital Kiev and the southern port city of Odessa have been most severely affected (Dutta et al., 2013; Zaller et al., 2015).

Despite the similarities between Ukraine and Russia when it comes to epidemiological development and vulnerability to HIV, there are also important differences in the policy response to the epidemic. In contrast to Russia, Ukrainian decision-makers have prioritized HIV prevention among vulnerable population groups. From 2002, Ukraine scaled up its harm reduction programs in order to control the spread of HIV among IDUs (WHO, 2014). In 2004, the country legalized OST, which is regarded as an important support measure for prevention efforts among IDUs (Twigg, 2015). Since then, the country has actively supported prevention programs for IDUs and other vulnerable groups. In 2010, the Ukrainian government changed its legislation on HIV/AIDS and introduced a stronger focus on human rights protection for people living with HIV, as well as access to harm reduction programs (Arkin, 2011; Vitek et al., 2014). Furthermore, the legal changes allowed AIDS-service CSOs to apply for state contracts (Arkin, 2011).

The introduction of OST in 2004 marked an important policy shift, as it showed that decision-makers acknowledged the need for targeted prevention programs to fight HIV in Ukraine. Local CSOs played an important role in bringing about this change. The International AIDS Alliance in Ukraine has played an important role in advocating for prevention among vulnerable groups and strengthening the capacities of community partners. The joint efforts of international health organizations and local civil society groups convinced Ukrainian decision-makers to focus on prevention among vulnerable population groups as a key strategy. Because of these prevention efforts, Ukraine has made progress in stabilizing the spread of HIV (see Figure 3). A 2014 epidemiological study found that Ukraine's HIV epidemic slowed down between 2005 and 2012 (Vitek et al., 2014). Since 2005, the number of new cases in Ukraine has decreased each year, with 2012 being the first year where the overall number of infections was lower than in the preceding year (Vitek et al., 2014). This progress in confronting the epidemic has been attributed to the scaling up of prevention programs among key populations (WHO, 2014). As a result, Ukraine has suc-

ceeded in expanding prevention coverage among those groups that are most at risk (Vitek et al., 2014).

Despite these positive developments, however, structural obstacles to confronting the epidemic among vulnerable groups in Ukraine persisted (Kiriazova, Postnov, Perehinets & Neduzhko, 2013). Several studies describe discrimination by healthcare providers, police harassment, and the interruption of HIV treatment in drug detention centers and prisons as important factors that restrict IDUs' access to treatment (Dutta et al., 2013; Mimiaga, Safren, Dvoryak & Reisner, 2010; Wolfe, Carrieri, & Shepard, 2010). In addition, prevention efforts in Ukraine lean heavily on the financial support of international donors. With very low levels of national funding and no coverage at all for prevention, GFTAM and the US Agency for International Development (USAID) have been the main donors to HIV prevention programs in Ukraine (WHO, 2014). With the support of these donor organizations, Ukraine has been able to provide harm reduction programs, which are implemented by the International HIV/AIDS Alliance in Ukraine. In 2013, there were 1,606 needle and syringe exchange points throughout the country. In 2013, WHO assumed that new infection rates would further drop in Ukraine if the country continued to provide necessary prevention programs for vulnerable groups (WHO, 2014).

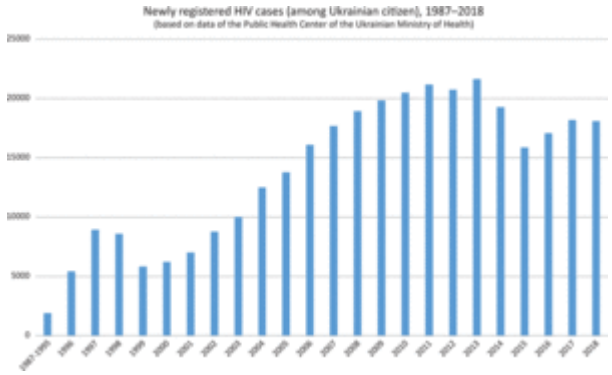


*Figure 3*. Newly registered HIV infections among Ukrainian citizens (1987–2017).

(Source: Based on data from the Public Health Center of the Ukrainian Ministry of Health)

From 2013 onward, however, the initial success of the Ukrainian response to the epidemic came under threat due to the severe financial strain on governmental resources caused by the political and military crisis in the country (Public Health Center of the Ukrainian Ministry of Health, N.D.). As a result, Ukraine's GDP dropped by 8%, while the inflation rate increased to 24.9%, which led to deep cuts in the funding of social programs, including the response to HIV/AIDS (Ukrainian Ministry of Health, 2015). The war in the eastern part of the country also meant that prevention and treatment programs were continuously disrupted in conflict zones (Filippovych, 2015; Vasylyeva et al., 2018). The Ukrainian Ministry of Health estimates that 24% of all new HIV infections in 2014 occurred in conflict-affected areas (Ukrainian Ministry of Health, 2015). In some areas, new infections have grown from 15 to 54% (Alliance for Public Health, N.D.). As the military conflict is taking place within the territories most affected by HIV (particularly in the eastern

part of the country), about 40% of PLWH under medical supervision have found themselves in areas not controlled by the government of Ukraine, which has led to difficulties in providing medical treatment (Ukrainian Ministry of Health, 2015). As a result, many HIV patients have fled the conflict zones and have relocated to central and western parts of Ukraine (Ukrainian Ministry of Health, N.D.). In the conflict areas, CSOs have continued their work under aggravated conditions (Owczarzak et al., 2015).

The situation in Crimea is of special concern. With the annexation by Russia in March 2014, OST was outlawed in the territory of the peninsula (Kazatchkine, 2014). As a result, patients who had previously been enrolled in these programs were forced to leave their homes and to look for treatment in other parts of Ukraine. In Crimea, new HIV infections have increased following the annexation. In 2017, Crimea ranked among the most severely affected regions in Russia (Federal AIDS Center, 2018).

The military conflict in eastern Ukraine has affected not only the conflict areas but the country as a whole. Since 2014, approximately 1.7 million people have been internally displaced in Ukraine. Forced displacement has a negative effect on public health, as it increases individual vulnerability and undermines social support structures. A 2017 epidemiological study found that the military conflict has increased HIV transmission from war-affected regions to other parts of Ukraine (Vasylyeva et al., 2018). It is still too early to fully assess the impact of the ongoing military conflict on Ukraine’s HIV epidemic. As forced displacement increases HIV vulnerabilities at different levels, however, it is feared that the conflict will undermine the country’s effort to combat HIV in the long term.

## HIV and AIDS in the South Caucasus

Compared to Russia and Ukraine, the countries of the South Caucasus—Armenia, Azerbaijan, and Georgia—have been less affected by HIV. In 2016, the number of PLWH amounted to 3,300 in a total population of 2.9 million in Armenia, 9,200 in a total population of 9.6 million in Azerbaijan, and 12,000 in a total population of 3.9 million in Georgia, which equates to a national prevalence rate of 0.2% in Armenia, 0.1% in Azerbaijan, and 0.5% in Georgia (UNAIDS, N.D.). All three countries can therefore be classified as low-prevalence countries. This is a remarkable fact, as the South Caucasus is a traditional drug trafficking corridor from Asia to Europe (Javakhishvili et al., 2015). The most vulnerable groups in the South Caucasus include IDUs, SWs, MSM, and prison inmates (UNAIDS, N.D.).

With the fall of the Soviet Union, injecting drug use increased in the South Caucasus. During the 1990s, heroin and homemade opium were the main drugs used in the region (Otiashvili et al., 2010). In the early 2000s, Georgia saw a sudden increase in the use of buprenorphine in the form of Subutex, which is manufactured as a treatment for heroin withdrawal but was used as a substitute for the more expensive opium or heroin (Otiashvili et al., 2010; Parfitt, 2006). Subutex was illegally imported in large quantities from EU countries and dominated the Georgian drug market between 2004 and 2008. Since 2008, a homemade stimulant called “krokodil,” prepared from cough medicines easily

available from pharmacies without prescription, has become the most widespread injected drug in Georgia (Javakhishvili et al., 2015; Otiashvili et al., 2016). Since the mid-2000s, Georgian drug policy has become more coercive, with widespread street drug testing and police harassment of drug users (Otiashvili et al., 2016). Critics emphasize that this repressive approach has increased vulnerability to HIV and other health risks by prompting drug users to switch to substances that are potentially more difficult to control and to polysubstance use (Otiashvili et al., 2016).

Although injecting drug use continues to be a problem in Georgia, the number of IDUs with HIV have remained roughly stable (Javakhishvili et al., 2015). In Armenia and Azerbaijan, injecting drug use is reportedly also on the increase, with about 30,000 IDUs in Azerbaijan. However, there has been no significant increase in HIV infections in the two countries. Overall, the HIV epidemic is relatively stable in all three countries of the South Caucasus. In Armenia, new infections peaked in 2001 and have since remained below the threshold of 500 new HIV infections per year (UNAIDS, N.D.). In Azerbaijan, new infections have grown since the 1990s, dropped in 2008, and have been stable since 2012, with an estimated fewer than 1,000 new infections per year (UNAIDS, N.D.). In Georgia, new infections increased until 2012 but have since remained stable, with approximately 1,100 new infections annually (UNAIDS, N.D.).

One reason for the difference between the South Caucasus, on the one hand, and Russia and Ukraine, on the other, when it comes to the spread of HIV is the fact that the three countries were quick to introduce harm reduction programs for IDUs. In Georgia, the harm reduction approach has been developing rapidly since 2002 due to support from the international donor community (Javakhishvili et al., 2015). Many CSOs that focus on harm reduction services have been established. In 2006, seven organizations formed the Georgian Harm Reduction Network (GHRN), which brought together 20 organizations in 2011 (Javakhishvili et al., 2015). In Armenia and Azerbaijan, harm reduction programs were also introduced in the 2000s.

A special concern in the South Caucasus is the prevention of HIV among labor migrants, who are particularly vulnerable to HIV and who constitute a bridge population for HIV transmission. In Armenia, for instance, migration played a role in about 80% of HIV transmission, either by occurring abroad or through partners who returned from abroad (Laga et al., 2015). International organizations such as the International Organization for Migration (IOM) have therefore introduced HIV prevention programs for migrant workers in the South Caucasus.

## HIV and AIDS in Central Asia

Central Asia is located between Russia in the North, China in the East, and Afghanistan in the South. The region consists of the former Soviet republics of Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan and altogether has a population of about 70 million people. Compared to Russia and Ukraine, Central Asian countries are less affected by HIV, with prevalence rates ranging from 0.2% in Kazakhstan and Kyrgyzstan to 0.3% in

Tajikistan (UNAIDS, N.D.). UNAIDS describes the HIV epidemics in Central Asia as limited, but observed a steep increase in infection rates since 2001 (DeHovitz, Uuskula, & El-Bassel, 2014).

The dynamic of the epidemics in Central Asia, however, points to a number of risk factors that have enabled the spread of HIV in the region. In Kazakhstan, new HIV infections have increased consistently over the past two decades, with around 2,900 new HIV infections in 2015 and 2016 (UNAIDS, N.D.). Since 2010, the HIV epidemic has grown particularly fast in this country, with new HIV infections increasing by 39% (UNAIDS, N.D.). In the other Central Asian republics, the growth dynamics have been less pronounced. In Kyrgyzstan, new HIV infections peaked in 2014 and have since been on the decrease, with an average of fewer than 1,000 new infections per year (UNAIDS, N.D.). In Tajikistan, new HIV infections peaked in 2007 and have since remained stable, with 1,300 new infections in 2016 (UNAIDS, N.D.). There are no epidemiological data available for Turkmenistan and Uzbekistan, which is linked to the closed character of the political regimes in those two countries (Ancker & Rechel, 2015).

The main risk factors for the spread of HIV in Central Asia include injecting drug use, sex work, and labor mobility between Russia and Central Asia (Ancker & Rechel, 2015; Gilbert et al., 2013). Official data on drug use in Central Asia are scarce; however, studies indicate that problem drug use is widespread in the region (Latypov et al., 2014; Zabransky, Mravcik, Talu, & Jasaitis, 2014). Heroin is the most commonly used drug among IDUs (Platt et al., 2015; Zabransky, Mravcik, Talu, & Jasaitis, 2014). HIV prevalence among IDUs is relatively high, with percentages ranging from 3.8% in Kazakhstan to 14.6% in Kyrgyzstan (Zabransky, Mravcik, Talu, & Jasaitis, 2014). Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan have introduced drug policies with the aim of controlling trade, strengthening prevention and rehabilitation, and mitigating the health risks of injecting drug use. Foreign donors and international health organizations have supported the countries of Central Asia in their efforts to control injecting drug use and related HIV transmission. Special attention has been paid to HIV/TB co-infections, which have the potential to become a serious public health concern (Schluger et al., 2013).

Next to drug use, sex work is an important risk factor for the spread of HIV in Central Asia (Baral et al., 2013). Again, it is difficult to estimate the extent of sex work in the region. A study from 2005 concluded that the sex industry had increased in all parts of the post-Soviet space, but particularly in the Central Asian republics, the poorest part of the former Soviet Union (CEEHRN, 2005). SWs have several risk factors for acquiring and transmitting HIV, including behavioral factors like having a high number of sexual partners and limited condom use (Baral et al., 2013). Social factors such as the criminalization of sex work, limited access to HIV prevention and other health services, poverty, inequality, and migration have increased HIV vulnerability among SWs (Baral et al., 2013). Another key population in Central Asia are MSM (Beyer et al., 2011). In a study from Kazakhstan, a local prevalence rate of 20.2% among MSM was observed (Berry et al.,

2012). Widespread discrimination and stigmatization continue to hamper prevention efforts within this target group.

Furthermore, labor migration between Central Asia and Russia has contributed to the risk environment for HIV in the region. Due to high unemployment and low wages in Central Asia, many people have sought work in Russia, either permanently or in the form of seasonal work. Labor migration is driven by the high demand for labor in Russia (Mukomel, 2013). In 2013, an estimated 3.5 million labor migrants worked in Russia, the majority of whom were from post-Soviet countries (Mukomel, 2013). The importance of labor migration for Central Asia can be seen in the percentage of remittances (i.e., payments by migrant workers to their families at home) in the national GDP of Central Asian republics. In Kyrgyzstan, for instance, remittances accounted for 30.4% of the national GDP in 2016, and in Tajikistan they accounted for 26.8% (World Bank, N.D.). This shows that the economies depend heavily on remittances from abroad (mostly Russia) and that significant parts of the population are involved in labor migration.

Due to family separation (Weine & Kashuba, 2012), precarious working and living conditions, abuse by employers and landlords (Round & Kuznetsova, 2016), sexual exploitation (Weine et al., 2013), social isolation, and lack of social support (Karpova & Vorona, 2014), migrant workers are particularly vulnerable to HIV and might thus form a bridge population for HIV transmission from high-prevalence Russia to low-prevalence Central Asia. There are few studies dedicated to the health situation of migrant workers in Russia. These studies indicate that low HIV knowledge, limited condom use, and multiple partnering contribute to HIV vulnerability among labor migrants (Amirkhanian et al., 2011). Overall, the specific prevention needs of labor migrants remain poorly understood and have yet to be adequately addressed. Although Central Asia has lower levels of HIV infection than Russia and Ukraine, the existing risk environment makes it vulnerable to the further spread of HIV in the future.

# HIV/AIDS and LGBT Politics and Policy in the Region

Although the HIV/AIDS epidemics in EECA are mainly driven by injecting drug use, the issue is also closely related to LGBT politics and policy in the region (Beyrer et al., 2011). Marginalization and discrimination against vulnerable population groups, including gay men and other MSM, is an important factor in the unfolding epidemic in EECA. A study on HIV stigma and discrimination in Russia found that false information and misconceptions (so-called “AIDS myths”) cause fear in society and lead to the social exclusion of those affected (Zvonovskii, 2008). Common AIDS myths include the belief that HIV is only transmitted via deviant behavior and does not affect those who lead a “normal” life in the eyes of the majority (Zvonovskii, 2008). In public discourses, HIV is often constructed as the disease of “the other”: of migrants (Round & Kuznetsova, 2016), IDUs (Burki, 2015), SWs, and MSM (Clark, 2014, Hylton et al., 2017). As HIV is commonly linked to behavior

that is deemed immoral, affected individuals are rejected by society and blamed for their situation (Balabanova, Coker, Atun, & Drobniewski, 2006; Zvonovskii, 2008).

Stigmatization hampers response to the epidemic in two ways. First, it makes it more difficult for prevention and treatment to reach the most vulnerable groups, who are reluctant to get tested, disclose their HIV status, take antiretroviral drugs, and access prevention services (UNAIDS, 2014). Second, stigmatization results in limited risk awareness among the general population, as people do not feel that they will be affected by HIV as long as they do not deviate from social norms or belong to one of the stereotypically stigmatized groups (Balabanova, Coker, Atun, & Drobniewski, 2006). It is important to note that HIV-related stigmatization and discrimination negatively affect not only interpersonal relations but also societal responses to the epidemic, as they create a culture of neglect and avoidance that makes it difficult to raise the issue of HIV and negotiate appropriate policies. Global experience has demonstrated that stigmatization and discrimination are major obstacles to responding adequately to the epidemic, as they keep millions of people from coming forward for testing and for prevention and treatment services (Sidibé & Goosby, 2013).

Gay men and other MSM often deal with double stigmatization resulting from the perceived threat of HIV transmission and the rejection associated with homosexuality. Homophobia is deeply engrained in the societies of EECA and threatens the fight against HIV in the region (Barnett-Vanes, 2014; Burki, 2015; Clark, 2014). A study on homophobia in Russia found that negative attitudes toward homosexuality can be traced back to the particular experience of revolution, political terror, and war endured by its people since 1917 (Healey, 2018). During Soviet times, homosexual relations between men were criminalized by law and often associated with repression in the Gulag prison system (Baer, 2009; Healey, 2001; Kon, 1993, 1997, 2010). The criminalization of homosexuality resulted in homosexuals being viewed by many as outsiders and in the linking of homosexuality with pedophilia (Healey, 2001). Homosexual relations between women were not criminalized in the Soviet Union; however, both women and men potentially faced enforced treatment in psychiatric hospitals (Buyantueva, 2018; Kon, 1993, 1997). Survey data from the end of the Soviet Union in 1991 indicate that “homosexuals [were] the most hated group in society” (Chaney, 2018; West & Green, 2002, p. 233). Consequently, the topic of same-sex relations was cloaked in silence, and networks could only exist underground (Baer, 2015; Buyantueva, 2018; Kon, 1993).

The fall of the Soviet Union marked a gradual relaxation of attitudes toward sexuality, including same-sex relations (Buyantueva, 2018). The opening of the borders and the new media culture played an important role in this process. In nearly all post-Soviet countries, the criminalization of homosexuality was abolished in the 1990s. It only remains a criminal offense in Turkmenistan and Uzbekistan (Wirtz et al., 2014). The first LGBT groups and communities emerged during perestroika in the 1980s. The fall of the Soviet Union brought with it the availability of information, which facilitated the establishment of small

LGBT movements in all parts of the former Soviet Union. Public attitudes toward homosexuality remained highly negative throughout EECA, however.

Public opinion polls show that levels of tolerance toward non-heterosexual orientations remain very low in Russia (Buyantueva, 2018; Levada Center, 2013) and Ukraine (Martsenyuk, 2012; Nash Mir Center, 2018). In Russian opinion polls, 43% of respondents indicate that they consider homosexuality to be "licentiousness and [a] bad habit," 32% view it as an "illness and mental disorder," and only 17% view it as a "sexual orientation with an equal right to exist" (Levada Center, 2013). In Ukraine, the 2010 telephone poll "Morals in Ukraine" found that 72% of Ukrainians have negative feelings toward sexual minorities (Martsenyuk, 2012). In the South Caucasus and Central Asia, prejudice against LGBT people is also a widespread phenomenon (CRRC, 2014; Hylton et al., 2017; Latypov, Rhodes & Reynolds, 2013). Although these surveys are not directly comparable and depend significantly on the context, it is evident that negative attitudes toward LGBT people are common in EECA overall.

The inherent homophobia characteristic of the first two decades following the collapse of the Soviet Union, originally established through societal experiences during Soviet times, has nonetheless caused LGBT communities to become more visible and to a certain degree more accepted in post-Soviet societies, particularly among the younger generation. Since the 1990s, LGBT lifestyles have found greater representation in popular culture and everyday life (Buyantueva, 2018). Furthermore, new LGBT movements that aim for the improvement of the LGBT situation and for greater tolerance have been established (Buyantueva, 2018). The emergence of the Internet and social media has facilitated the exchange of information and continues to offer further opportunities to meet like-minded people, even in smaller cities and towns (Buyantueva, 2018).

Since early 2010, however, policies toward LGBT communities in EECA have been regressing. This crystalized in the adoption of the so-called "gay propaganda law" in Russia in June 2013 (Buyantueva, 2018; Chaney, 2018). The law is nominally aimed at protecting children from information "aimed at forming non-traditional sexual attitudes among minors" (Federal Law 135 of the Russian Federation, June 29, 2013). From a broader perspective, however, the law needs to be understood as part of an increasing conservative political and public discourse in Russia that constructs same-sex relations as the result of a negative Western influence that threatens "traditional Russian values." The provisions of the law are intentionally vague, which makes it possible to ban LGBT organizations and events under the pretext of protecting minors (Buyantueva, 2018).

Researchers have shown that the anti-gay propaganda law cements the traditional values rhetoric and constructs the LGBT community as a threat to Russian national identity and as an example of negative cultural influence from the West. The law has led to a steep increase in public intolerance toward and harassment of LGBT people in Russia (Buyantueva, 2018). Since the early 2010s, negative attitudes toward same-sex relations have increased as the result of an increasingly repressive public discourse (Buyantueva, 2018). The law has been criticized by human rights organizations for legitimizing violence

against LGBT groups. In other EECA countries, LGBT communities are less threatened than in Russia. A similar anti-gay propaganda law was discussed in Ukraine but revoked in 2015 due to pressure from local CSOs and international human rights organizations (Krejcova, 2015). However, in Ukraine too, negative attitudes toward same-sex relations have increased since the beginning of the 2010s (Martsenyuk, 2012). A Russian-style anti-gay propaganda law was also proposed in Kyrgyzstan but failed to pass parliament in 2016.

This law threatens the fight against HIV/AIDS in Russia. Studies have shown that it has increased the stigmatization of LGBT groups in Russia and has led to negative health consequences, such as the increase of depression among MSM (Hylton et al., 2017). Furthermore, the law affects prevention work, as providing health information can be interpreted as a form of propaganda for same-sex relations (Clark, 2014). Organizations report that the legal changes have made HIV prevention among gay men and other MSM more difficult in Russia, as the law criminalizes the sharing of information on same-sex relations (Clark, 2014; Hylton et al., 2017). Furthermore, political discourses reinforce negative attitudes toward LGBT people in Russian society, which further increases stigmatization and hampers prevention outreach among MSM (Clark, 2014).

The work of LGBT organizations in Russia is further complicated by the 2012 so-called “foreign agent law,” which aims at restricting the activity of Russian CSOs that receive foreign funding and engage in “political activities,” deliberately defined vaguely, so that the law can be utilized against any organization (Skokova, Pape, & Krasnopolskaya, 2018). As of June 2018, the Russian Ministry of Justice has designated 158 Russian CSOs “foreign agents,” including several LGBT and AIDS-service organizations. Although the law is not aimed at LGBT groups or the response to HIV, it hampers the organizations’ prevention work targeted at gay men and other MSM in Russia, as reporting and financial accounting is much more cumbersome for organizations that are listed as “foreign agents.” Moreover, the law with its reference to the image of civil society actors as “traitors” and “spies” effectively delegitimizes CSOs in the eyes of the Russian population (Skokova, Pape, & Krasnopolskaya, 2018).

We can conclude that the HIV epidemic in EECA is closely connected to LGBT politics and policies. Gay men and other MSM are among the most vulnerable populations in the region. Although official reports on the spread of HIV within these groups are scarce, estimates indicate that prevalence rates are significantly higher than in the general population. Because of stigmatization, not much is known about HIV vulnerability among MSM in Russia or other parts of the region. Existing research suggests that specific risk factors include unprotected sex with non-steady partners, the lack of availability of condoms and the self-reported visiting of sex-related venues (Berg et al., 2017). The prevention needs of gay men and other MSM are not being met by current prevention services. The widespread stigmatization and legal repression of LGBT people, particularly in Russia, have increased their vulnerability and continue to hamper prevention efforts.

# Conclusions and Outlook

In contrast to other parts of the world, the post-Soviet region is currently experiencing further growth of the HIV and AIDS epidemic. The underlying causes of the spread of HIV in the region lie in the political and socioeconomic changes that arose following the collapse of the Soviet Union, which created a risk environment for HIV and AIDS. A common characteristic of all countries of the former Soviet Union is the fact that HIV epidemics have been mainly driven by injecting drug use. This sets the region apart from other parts of the world, where transmission via sexual contact has been dominant. The key problem in addressing HIV in the EECA region is lack of prevention for vulnerable population groups.

Despite the similarities with regard to vulnerability, there are important differences between the policy responses to the epidemic. The epicenter of the epidemic in the post-Soviet region is Russia, which is home to the biggest HIV epidemic in EECA by far. In Russia, one can observe a move away from evidence-based prevention programs endorsed by international organizations such as the United Nations Office on Drugs and Crime (UNODC), UNAIDS, and WHO. Harm reduction services are too limited in coverage to be able to combat the spread of HIV among IDUs in Russia. In addition, punitive drug laws, discrimination, and police harassment against drug users hamper prevention service outreach among vulnerable populations. Together with Turkmenistan, Russia is the only country in EECA that has a total ban on OST, which impedes rehabilitation and treatment access among IDUs. Rather than following international recommendations, the Russian government has focused on promoting traditional values, which includes the promotion of what it calls a “healthy lifestyle.” This is clearly inadequate for addressing HIV, as growing infection rates indicate.

In other countries in the EECA region, approaches to HIV prevention are more pragmatic but suffer from a lack of financial and organizational capacities. In Ukraine, which after Russia carries the highest burden of HIV in EECA, the scaling up of harm reduction and the introduction of OST led to the gradual stabilization of the epidemic from 2012. After 2014, however, military conflict and forced migration prompted a renewed deterioration of the epidemiological situation in Ukraine. In the South Caucasus and Central Asia, levels of HIV infection are significantly lower than in Russia and Ukraine, although risk factors remain prevalent. In all countries in the region, stigmatization and discrimination are important factors in the epidemic and also affect the LGBT community.

Research on HIV/AIDS in EECA is still limited. Although valuable studies have been conducted on different aspects of vulnerability and impact, many questions remain open, in particular with regard to the underlying social and political barriers that have prevented decision-makers from acknowledging the drivers of the epidemic and from introducing approaches that are most suitable for combating HIV in the region. Further research on how broad support for comprehensive prevention can be achieved and how policies can be improved is therefore needed. To date, the main problem in addressing HIV in the region is the lack of political will, particularly in Russia. The epidemic is spreading because

the governments in the region are failing to address the underlying causes of the epidemic. As long as governments are unable or unwilling to implement evidence-based prevention programs, the HIV epidemic will likely continue to grow.

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## Notes:

(1.) Geographical classifications of the region differ: UNAIDS includes the countries of the western Balkans in the EECA, whereas WHO, which divides the world into six regions, situates the EECA in the European Region, which encompasses the entire continent. This article focuses on the post-Soviet states (excluding the Baltic republics), as these countries share a common welfare tradition and face similar challenges in the fight against HIV/AIDS. The countries in the EECA region include Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan.

(2.) The cumulative number of HIV infections includes all registered cases in Russia since 1987, including 276,660 patients with HIV infection who died of different causes. As of the end of 2017, 943,999 Russian citizens had been living with HIV in Russia (Federal AIDS Center, 2018).

(3.) The responsibility for HIV treatment and prevention lies with the regions. All of Russia's 85 regions have their own regional AIDS centers, which are subordinated to the Federal AIDS Center in Moscow.

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