

## **BORDERNETWork project**

### **Work Package 6. Access to early HIV and STI diagnostics for vulnerable groups**

#### **Country profiles**

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The following people contributed to this report:

- Isabell Eibl (Austria)
- Kristi Rüütel (Estonia, Bulgaria)
- Alexander Leffers (Germany)
- Beata Milgrave (Latvia)
- Kristof Kulczycki (Poland)
- Galina Musat (Romania)
- Barbora Kucharova (Slovak Republic)
- Oleksandra Sluzhynska (Ukraine)

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## Abbreviations and acronyms

ACC	AIDS counselling center
AIDS	acquired immune deficiency syndrome
ART	antiretroviral treatment
ARV	antiretroviral
CD4	cluster of differentiation 4 ( <i>T-cell coreceptor</i> )
ECDC	European Center for Diseases Control and Prevention
EMCDDA	European Monitoring Center for Drugs and Drug Addiction
EU	European Union
EUR	euro
FCSW	female commercial sex worker
HAART	highly active antiretroviral treatment
HBV	hepatitis B virus
HCT	HIV counselling and testing
HCV	hepatitis C virus
HIV	human immunodeficiency virus
IDU	injecting drug user
MSM	men who have sex with men
MTCT	mother to child transmission
NGO	nongovernmental organization
OST	opioid substitution therapy
PCR	polymerase chain reaction
PLHIV	people living with HIV
PMTCT	prevention of mother to child transmission of HIV
SEP	syringe exchange program
STI	sexually transmitted infection
SW	sex worker
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
USD	United States dollar
VCT	voluntary counselling and testing
WHO	World Health Organization

## Background

Sexually transmitted infections (STI) and HIV remain an important public health issue in Europe. Even though in many European countries the rates of STIs have somewhat decreased in recent years, some vulnerable groups are still highly affected. For example in 2008 almost three quarters of syphilis cases were diagnosed among men and this may be influenced by the ongoing epidemic among men who have sex with men (MSM) (ECDC 2010a).

Since 2000, the rate of newly diagnosed HIV cases reported has more than doubled from 44 per million population in 2000 to 89 per million in 2008, based on the 43 countries that have consistently reported HIV surveillance data during this period. This is particularly due to increasing infection rates in the eastern part of the region. HIV epidemics in Europe are also largely concentrated among specific populations (ECDC 2010b).

BORDERNETwork is a EU funded (Public Health Programme) networking project with 13 participating organizations from 8 EU countries, and above 20 collaborating partners, 5 of them from non EU countries. The main goal of the project is to improve prevention, diagnostic and treatment of HIV/AIDS (including co-infections) and STIs through bridging gaps in practice, policies and cross-country cooperation and enhancing capacity in interdisciplinary response (medical, prevention, research).

The increase in the rates of newly diagnosed cases of HIV in some of the BORDERNETwork partner countries has been the highest in the world in last three to five years. Especially Estonia and Ukraine have witnessed massive outbreaks of HIV among injecting drug users. Figures 1 and 2 present the rates of newly diagnosed HIV infections in the eight BORDERNETwork partner countries. Data is not available for Austria.

Figure 1. The rates of newly diagnosed HIV infections per 100 000 population by country (Bulgaria, Germany, Poland, Romania, and Slovak Republic) and year of diagnosis (2000–2009) (ECDC 2010b)

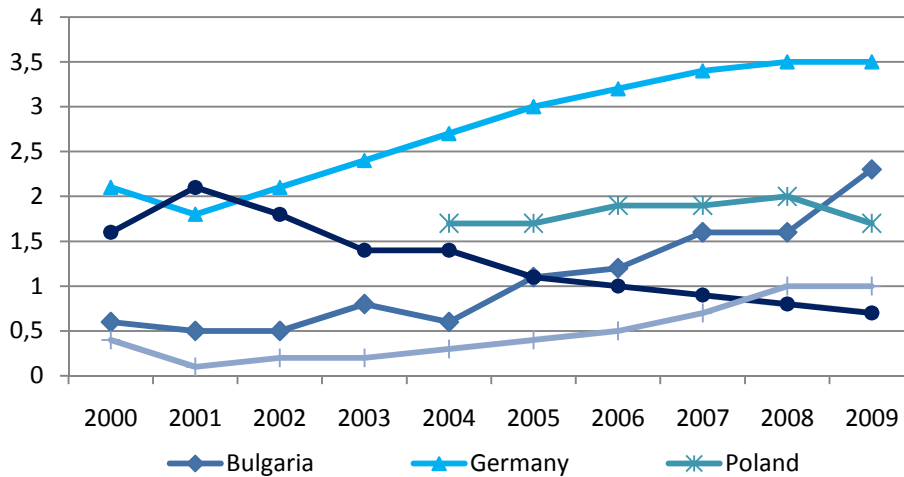
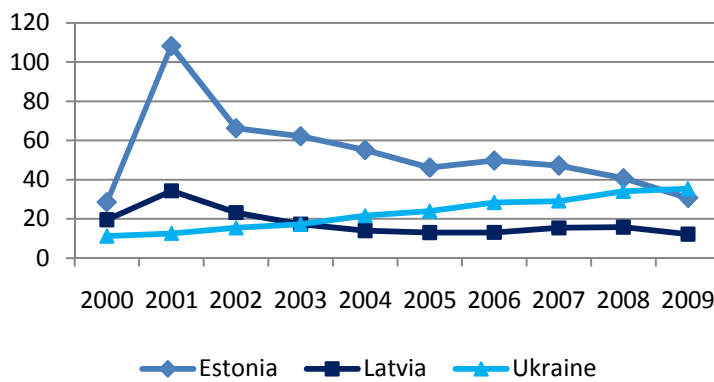


Figure 2. The rates of newly diagnosed HIV infections per 100 000 population by country (Estonia, Latvia, and Ukraine) and year of diagnosis (2000–2009) (ECDC 2010b)



In the face of such epidemics the need to scale up HIV and STI testing and other prevention services is a continuous need. BORDERNETwork project work package 6 focuses on early diagnostics and its main aim is to intensify efforts in early diagnosis of HIV and STIs for most at risk groups. For these purposes all partner organizations will design and pilot an intervention (a new model of service provision) to address the barriers to STI/HIV testing among vulnerable groups.

In order to identify the population groups most in need of these services, correctly address the gaps and barriers in the existing system and design appropriate intervention, all partners conducted a short literature review of the situation within their countries. The current report presents the results of these reviews – short country profiles containing background information on STI, HIV and co-infections epidemiological situation, vulnerable groups and HIV and co-infections related health services, including testing. The profiles do not aim to provide a comprehensive analysis but rather key points

important for understanding the situation and rationale for BORDERNETwork project activities.



## Austria

### *General overview of HIV situation*

The first HIV case in Austria was registered in 1983. There is no mandatory registration of HIV in Austria (by doctors), only for AIDS. The two main sources of epidemiological data are the Ministry of Health and the Austrian HIV Cohort Study. The Ministry of Health publishes AIDS relevant data as well as the number of new HIV infections reported by the testing laboratories. The Austrian HIV Cohort Study was founded in 2001 and was assigned by the Ministry of Health to provide epidemiological data on HIV. It collects data of HIV-positive patients in seven HIV clinics in Austria. Although not all HIV-positive patients are included in the Austrian HIV Cohort Study, it is considered representative for the situation of HIV in Austria.

There are two different estimations on HIV prevalence in Austria: The Ministry of Health estimates that about 6,200 to 9,000 people are living with HIV in Austria, and Aids Hilfe Wien estimates that this number is 12,000 to 15,000. Half of all HIV-positive people are living in Vienna, the capital of Austria. According to the Ministry of Health, in 2009 507 new cases were registered – this is the data of four certificated laboratories, meaning that double testing might be included. The Austrian Cohort Study shows lower numbers – only 197. The HIV incidence is more or less stable at around 500 new infections each year since 2007, implying that one to two people contract HIV daily. Women account for one third of all new infections. Whereas in the beginning of the epidemic the main mode of transmission was homosexual followed by injecting drug use, then nowadays 43% of all transmissions is due to heterosexual contacts, 40% due to homosexual transmission and 9% are accounted to IDU. Data of the Austrian cohort study shows that the average age of their patients is 43.7 years and very similar across all federal states. The proportion of late diagnosis was about 30% in 2009.

At the time of data evaluation 34 participants got infected with HIV due to vertical transmission, 20 of those were below the age of 18. In the years 2001 to 2005 no newborn got infected due to vertical transmission; from 2006 to 2009 seven newborns got HIV – at least two transmissions have been linked to counseling with HIV denialists.

About 30% of all HIV-positive people in the Austrian HIV Cohort Study originate from high prevalence countries. Having sex with a person originating from a high prevalence country accounts for another 15.5% of all those infected. From 2007 to 2009 11 to 13% of all new HIV diagnoses were among people who originate from Africa. HIV-positive people from high prevalence countries have a five times higher risk to get diagnosed at a late stage; this risk is similar for an advanced diagnosis.

By the end of July 2010, 1,268 people were living with AIDS. The trend to heterosexual transmission is also shown in the AIDS statistic – since 1999 more people who got infected due to heterosexual transmission were diagnosed with AIDS than due to other ways of transmission. It is significant that heterosexual men and women and people

origination from high prevalence countries are at higher risk to get tested HIV-positive in “late” or “advanced stage of HIV”.

Since the introduction of antiretroviral medication mortality due to HIV has decreased drastically. In the observation period 2002–2007 a total of 75 % of patients were still alive at six years after the initial diagnosis of AIDS. The causes of death are more diverse, but still 35% die due to AIDS defining events, followed by hepatitis B/C (11.5%) and non-AIDS-defining infections and non-AIDS-defining cancer (each 8.6%).

### *Other sexually transmitted and blood borne infectious diseases*

#### **Syphilis, gonorrhea, and chlamydia**

The incidence of sexually transmitted infections has increased since 2000, especially in the MSM community. In 2008 80% of the 551 syphilis cases registered were among men. The cohort study also shows the highest numbers of HIV-syphilis co-infection among MSM: out of 304 active syphilis cases 244 were MSM. About 800 cases of gonorrhea were registered in 2008.

The most prevalent STI among the general population is Chlamydia. It is estimated that around 20% of people in Austria get infected with Chlamydia at least once in their lifetime. Chlamydia is not a notifiable disease. It is estimated that at the point of time about 5% of all inhabitants of Austria are infected.

#### **Hepatitis B and C**

In 2009, 672 persons got infected with Hepatitis B, and 877 with Hepatitis C. Hepatitis is mainly a problem for IDUs and for people living with HIV. Among IDUs the prevalence of Hepatitis B is between 2 to 19% (depending on the facilities where the data is collected) whereas the prevalence of Hepatitis C antibodies is between 22 and 60% percent (once again depending on the facilities where the data was collected). Different facilities show a prevalence of chronic HCV among IDUs to be between 38 and 75%. All the data cannot be regarded as representative. The prevalence of chronic HCV among participants of the Austrian HIV cohort study is 15%, of chronic HBV it is 3%. Two thirds of the participants with a chronic HCV and three quarters of participants with HBV are male; 6% of all participants with chronic HCV and one third of the participants with chronic HBV are MSM.

### *Vulnerable groups*

Two main risk groups – men having sex with men and people originating from Sub-Saharan Africa – are covered in this section. Although Aids Hilfe is also working with IDUs, prisoners, and sex workers, those target groups are well served by other organizations.

#### **Men who have sex with men**

Assuming that 5% of all men in a society are MSM, in Austria there would be about 200,000 MSM. There is no data available on demographics since the sexual orientation is not part of the statistical census. Nevertheless, a representative study conducted in Austria in 2007 shows that 63% of MSM are living in bigger cities. About one quarter is living in places with less than 20,000 inhabitants. The internet is becoming more and more important – for gaining information as well as for looking for (sexual) partners. Only 4% have never searched for sexual partners on the internet. About 10% are regular visitors of dark rooms.

MSM are one of the best-informed population groups in Austria. More than two thirds of the study participants have tested for HIV at least once. 5.9% of the sample was HIV-positive; of whom one third tested positive within the two years prior to the study. In the past years incidences of syphilis, gonorrhoea, and chlamydia are increasing among MSM. 62% said that they use condoms to prevent HIV.

Still, a third of all HIV infections in Austria are due to homosexual contacts, varying from county to county (e.g. Vienna 45%, Upper Austria 20%). Almost 90% of these cases are Austrian.

- Gay Life and HIV/AIDS in Austria (Aids Hilfe Wien, Vienna, 2009)

854 men took part of this study undertaken by Aids Hilfe Wien, in cooperation with WZB-Wissenschaftszentrum Berlin. Almost half of the participants live in Vienna, 7.4% in Graz, 4.9% in Linz, 2.2% in Salzburg, and the rest 35% in places with less than 100,000 inhabitants. Most of the men were Austrians, followed by 5% of Germans. Only a small number of MSM originating from Non-EU-countries took part on the study. 54% identified themselves as gay, 30% as homosexual, 10% as bisexual, others did not want to call themselves any of those categories.

When asked how they would describe their sexual activity within the last twelve months prior to the survey, 87% indicated that they had had sex only with men, and 13% had also had sex with women (some more, some less). Analyzing the data from this point of view, it was shown that they use the same places for “recruiting” sexual partners, have about the same high level of knowledge, etc. Differences were in sexual practices: receptive oral sex is less frequent among men having also sex with women; they visit more often porn cinemas; the “gay side” in their lives is often not known by friends, their working environment, and female partners. Men who have also sex with women are more anxious about risks of infection: 12% think that saliva is infectious. They also tend to have higher risk behaviors.

### **Sub-Saharan Africans**

Little is known about Africans from Sub-Saharan countries living or seeking for asylum in Austria. According to a statistical report about 22,000 Africans (whole continent) with a legal status are living in Austria. The Austrian HIV Cohort study shows that 28% of the cohort participants originate from a high prevalence country in Sub-Saharan Africa.

Churches have a great influence on religious Africans which may cause denial of the HIV-status and affect adherence on treatment regimens, depending on the beliefs of the church.

## ***HIV and STI related health care services***

About 99% of the Austrian population is covered by statutory health insurance. Depending on the type of employment there are different kinds of mandatory health insurance.

### **HIV- and STI testing**

Austria has the highest per capita HIV-testing rate in Europe due to a compulsory testing of blood donations. Testing (partly – depending on the provider) and treatment are paid for by health insurance.

Testing of HIV and STI testing is available at different service providers in Austria: general practitioners, laboratories, hospitals, local AIDS institutions, etc.

Data privacy and costs are influenced by the service providers chosen for the test: At AIDS Hilfe institutions all tests offered (HIV-Ab-Test, HIV-PCR-Test, HIV rapid test, syphilis screening, HBV and HCV screening) are anonymous and the HIV-Antibody-Test is also free of charge. All other tests are available at cost price. The clients have to pay on their own. Tests at general practitioners and in hospitals are also free of charge but not anonymous since social insurance pays for it.

Tests can also be made in laboratories. Either a doctor refers the patient or the patient himself/herself goes to the laboratory to make a HIV-test. In the first case the test is free of charge but not anonymous; in the latter case the test is anonymous but not free of charge.

Testing in prisons is voluntary and free of charge for prisoners.

In general, testing in Austria has to be voluntary (there is no opt-out regulation). Pre- and post test counseling is mandatory but mainly done by AIDS Hilfe Institutions and other specialized providers and doctors.

Sex workers need to test for different STIs regularly (once a week) at the public health department in order to keep their working permission. If a sex worker is tested HIV-positive, she/he loses the work permission. Sex work is the only profession a person living with HIV is legally not allowed to work in.

### **Special services for vulnerable groups**

- ***General population, uninsured people.*** Aids Hilfe institutions in Austria offer several testing services anonymously and therefore insurance coverage is not necessary. In case a person tests positive in Aids Hilfe, they are referred to specialists. Aids Hilfe offers psychological support for concerned persons, their relatives, partners and friends. Additional social services and leisure activities are offered.
- ***Sex workers.*** There are two organizations (NGOs) in Vienna who offer social services and support for sex workers but do not offer any health services. Sex workers need to register and test for several STIs weekly at the local public health departments. The examination is free of charge.
- ***Men who have sex with men.*** There are no special health care services for MSM although there are some doctors (especially in Vienna) who are specialized in MSM health. Those doctors recommend HIV and STI testing as part of health examinations.

- **Sub-Saharan Africans.** There is an institution caring for asylum seekers but no special health services are available for Sub-Saharan Africans.
- **Prisoners.** In Austrian prisons HIV and STI testing is voluntary and free of charge for prisoners. The Federal Ministry for Justice is also paying for treatment if necessary.

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## **Bulgaria**

### *General overview of HIV situation*

Since 1986, when HIV case registration started in the country, to the end of 2009, a cumulative total of 1,109 HIV cases have been registered in Bulgaria. The annual number of newly registered HIV cases increased from 50 in 2004 to 171 in 2009. From the total number of registered cases in the period 1986–2009 with a known route of transmission, 66% are heterosexual, 21% are injecting drug users, and 10% are MSM. 17 cases (2% of all cases) were infected through transfusion of blood and blood products, last such cases were registered in 1996. Children infected by their mothers constitute only 1% of all cases. Since 2004, there has been an increase in the number of HIV cases among IDUs. In 2009 only, their number was 74 (43% of the total number of cases in 2009). The annual share of newly registered HIV cases among MSM has also risen to 19% of the total number of cases for 2009. The distribution of the newly registered HIV cases in 2009 by age groups indicates that half of the cases are among young people aged 15–29 years. The youngest person registered in 2009 is 16-year old, while the eldest is 66 year old. Geographical distribution of registered HIV cases indicates that the majority of them are concentrated mainly in large urban areas as Sofia, Plovdiv, Burgas, Varna and Pazardzhik.

### *Vulnerable groups*

#### **Injecting drug users**

Survey results for the period 2004–2008 indicate an increase in HIV prevalence among IDUs – from the baseline 0.6% in 2004 to 7% in 2008. In the end of 2008, the percentage of IDUs who report having an HIV test and knowing their results indicated more than 2.5 times increase (from the baseline 17% in 2004 to 48% in 2008).

There is a very strong negative influence on the outreach work with IDUs in Bulgaria related to the change in Penal Code in 2004 and the abolishment of the so-called “single dose” article, which decriminalized the simple possession of drugs for the IDUs. At the moment, every possession of non-medical drugs is criminalized, which has led to hiding of the target group, formation of “shooting galleries”, using in small hidden hard-to-reach groups, combining drug dealing with drug using, rapid increase of the population of IDUs in prisons and mixing of injecting drug users from different parts of the cities. All these factors in many other cities and countries have had contributed to an acceleration of the HIV epidemic among IDUs and similar epidemiological trend is observed in Bulgaria.

#### **Sex workers**

In the end of 2008, the percentage of SWs who reported having an HIV test and knowing their results was 58%, which indicates a tendency of significant increase compared to baseline data for this group in 2004 – 35%. This tendency could be explained by active provision of prevention services with the support of NGO implementing outreach



activities and VCT centres. Studies conducted during 2004–2008 indicate that the low HIV prevalence among SWs has been preserved significantly below the point of concentrated epidemic – 0.6% in 2008. At the same time syphilis prevalence among SWs has also stayed stable, being 10% in 2008.

### **Men who have sex with men**

The percentage of MSM who had received HIV test in the last 12 months and knew their result was 42% in 2008 which is a 1.5 times increased compared to 2006. This is the result of the active provision of free-of-charge anonymous HIV counselling and testing for most-at-risk groups. IBBS survey results for the period 2006–2008 indicated that HIV prevalence among MSM has increased but still remains below the point of concentrated epidemic – from 0% in 2006 to 3% in 2008.

### ***HIV and STI related health care services***

In Bulgaria ARV treatment and monitoring of the treatment is free of charge for all PLHIV. At the end of 2009, 327 PLHIV were receiving ARV treatment, out of them 223 men and 3 children under the age of 15 years of age. There are three NGOs which provide psychosocial support to PLHIV.

In the country there is a functioning network of 19 centres for voluntary VCT in 15 largest cities. They provide testing to all, including young people, unemployed and people with low socioeconomic status. The services are provided by medical professionals – doctors, laboratory assistants, nurses, and psychologists.

### **Barriers to HIV testing among Roma people**

In October 2010 in the Health-Social Center of HESED in the Roma neighborhood “Fakulteta” in Sofia a focus group was held involving nine young men aged 16–25 years with Roma origin. No one was an injecting drug user, all of them were MSM. They had low level of education and all were unemployed. Some of them had families with wife and children and at the same time they had frequent multiple sexual partnerships both with women and men. All of them offered sexual services (mostly paid) but some were ashamed of that and did not declare it openly.

Participants thought that they had good awareness of HIV and STI related issues. They received information from the Health-Social Center of HESED in the Roma neighborhood and also from other men who had been trained there; there were no other sources of information. Participants were interested in more information about condoms and the reliability of condoms to prevent infections because some people think that condoms did not prevent infections 100%. They generally considered themselves to be in danger of contracting HIV or any other STI, especially if drunk. Gays were considered especially risky partners, because they have sex with many people, women were not considered so risky, and steady partners were not considered risky at all.

All participants had tested for HIV or STIs and they knew where to get tested. They considered testing easy, because they knew where to go and because testing was free of

charge. Opportunities for treatment were considered to be adequate and participants knew where to go for treatment should they need it.

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## Estonia

### *General overview of HIV situation*

The first HIV-case in Estonia was registered in 1988. In 1988–1999, the cumulative number of registered HIV-cases in Estonia was 96. During the 2<sup>nd</sup> half of 2000, there was a substantial rise in the number of new HIV cases that also continued in 2001. Starting from 2002, the number of officially registered cases has decreased; in 2010, 372 new cases were registered (Health Board). All in all, by the end of 2010, 7,692 HIV-cases have been reported in Estonia.

In 1988–1999 HIV-infection spread in Estonia mainly through sex (both homo- and heterosexual). Since 2000, the infection has been mainly transmitted through the sharing of contaminated syringes. In past years there are some indications of possible increase in sexual transmission. For example according to the AIDS counseling centers (ACC) IDUs accounted for 90% of new HIV-cases in 2001, 66% in 2003 and 54% in 2007, and 48% in 2009 (6). At the same time the absolute numbers of diagnosed HIV-infections among clients who are not IDUs have not increased (and the increase of the proportion relates to the decrease of absolute numbers of IDUs diagnosed with HIV).

In 2000, the explosive spread of HIV-infection occurred in North-Eastern Estonia, in a county called Ida-Virumaa which is bordering Russian Federation. New HIV cases registered in this region accounted for 92% of all cases in 2000. In comparison with the year 2000 the proportion of HIV-cases diagnosed in North Estonia (capital Tallinn and surrounding area – a county called Harjumaa) increased considerably in 2001–2002. In 2009 46% of all new cases (n=189) were diagnosed in North-Eastern Estonia and 36% of all new cases (n=150) in capital city Tallinn. The number of new HIV-cases per 100,000 population was 110 in North-Eastern Estonia and 38 in Tallinn in 2009. The rate of new cases in other regions of the country is less than 10 per 100,000 population (Health Board, Statistics Estonia).

The majority of HIV cases have been men but the proportion of women has increased in recent years (due to the decrease in the number of men being infected). In 2000, women accounted for 20% of all new cases registered during that year, in 2007–2009, the proportion of women among new cases has been around 40%. The mean age of the newly diagnosed cases is increasing. Among new cases in 2001 92% but in 2009 only 56% were younger than 30 years of age.

HIV is quite common in Estonian prisons. The first new HIV-case in a prison was registered in May 2000. That year, 80 prisoners with HIV were detected (20% of all new HIV-cases registered that year). In the following years the proportion of prisoners among newly diagnosed HIV-cases increased (for example in 2003 32% of all new cases were diagnosed within prison system). Since 2004, the proportion of prisoners among new HIV-cases has decreased being 16% in 2009 (Health Board). Most prisoners have been infected before imprisonment (Ministry of Justice).

## *Other sexually transmitted and blood borne infectious diseases*

### **Sexually transmitted infections**

The incidence of sexually transmitted infections has declined in recent years. In 2008 79 cases of syphilis were diagnosed all across the country (6 cases per 100 000 population) – 11 out of them (14%) among people aged 15–24 (5 cases per 100 000 population) and 24 (30%) among people aged 25–34 (13 cases per 100 000 population). The most common STI is chlamydia. In 2008 2,182 cases were diagnosed (163 cases per 100 000 population) – 1,323 out of them (60%) among people aged 15–24 (650 cases per 100 000 population) and 621 (28%) among people aged 25–34 (327 cases per 100 000 population). The number of chlamydia cases among females in both age groups is several times higher than among males (Health Board).

### **Hepatitis B and C**

The dramatic increase in injecting drug use in the population aged 15–29 years in the early 1990s led to an increased incidence for both hepatitis B and C. Between 1992 and 1998, there was a marked increase in the rates of hepatitis B (6/100,000 in 1992 and 34/100,000 in 1998) and hepatitis C (0.4/100,000 in 1992 and 25/100,000 in 1998). Since 2002, the incidence of both hepatitis B and C has decreased, being (respectively) 3.3 and 2.7 cases per 100,000 inhabitants in 2007. From 1996 until today, IDU is the most frequent risk factor identified among youth, accounting for more than half of all new hepatitis C cases (Health Board).

## ***Vulnerable groups***

### **Injecting drug users**

Injecting drug use started to increase in 1990s. The first reports describing IDU outbreak and the size of IDU population in Estonia are based on field reports and expert opinions. They describe about 10,000–15,000 IDUs in Estonia (personal communication, N. Kalikova). In 2004 the estimated number of IDUs in Estonia is 13,800 and the adult injecting drug use prevalence rate 2.4% (Uusküla 2007). Injecting drug use problem is the severest in North-Eastern region of the country and in capital city Tallinn. HIV prevalence among IDUs recruited Tallinn in 2005 was 54% (Platt 2006). In 2007 HIV prevalence among 350 IDUs recruited in capital city Tallinn was 48% and in Kohtla-Järve 59% (a city in North-Eastern Estonia). Hepatitis C prevalence was even higher – 90% in Tallinn and 76% in Kohtla-Järve (Lõhmus 2008).

### **Sex workers**

Sex workers (SW) in Estonia work mainly in the capital city Tallinn. Many SWs are soliciting their clients through independent advertising on the Internet and in newspapers and tend to be organised in small groups in a rented flat. There is also prostitution in few big brothels, on the hotels/bars and on the street. The number of SWs has decreased last years due to recent economic recession and police efforts in closing down brothels. According to the estimations of the organisations offering services to SWs, the number of SWs could be around 1,500 (19). A study in Tallinn detected 7.6% HIV-prevalence

among a group of SWs (n=191) in 2006. As the proportion of people co-infected with both HIV and hepatitis C was low, there is a reason to assume that at least some of the HIV cases had been transmitted sexually (Uusküla 2008).

### *HIV and STI related health care services*

STI and HIV testing in Estonia are considered to be health care services and thus they can be provided only by health care institutions that have respective licenses and properly trained personnel.

The majority of health care services are financed by National Health Insurance Fund. There are some exceptions regarding HIV, STI and TB service funding which are described below. Private health insurance in Estonia is very limited.

All people who pay social tax, have national health insurance. Besides that all children up to age 18, all pregnant women, all retired people and some other small groups have national health insurance. Around 4% of the total population does not have national health insurance – mostly adult people with no legal job.

#### **HIV testing and treatment**

HIV testing in Estonia is de-centralised and can be provided by any GP or specialist doctor. In case the person has national health insurance then HIV testing is free of charge. Besides that there are special Anonymous AIDS Counseling Centers (ACC) in 8 bigger towns and this testing is free of charge for all people. ACCs provide testing to anybody (including foreigners and people who have no insurance) and they have special focus on risk-groups (for example they provide testing in syringe exchange programs).

ARV and specific health care services for people with HIV are centralised and provided by infectious diseases specialists who see patients in 5 bigger cities. These services are covered through Estonian Health Insurance Fund for those who meet the criteria for insurance and through the state budget for those who do not have insurance. Antiretroviral treatment is provided in the same locations and is free of charge for all in need of it.

#### **STI testing and treatment**

STI testing is also de-centralised. Outpatient clinics in practically all towns in Estonia provide STI services. These services are free of charge for all people who have national health insurance. These services are not anonymous. There are also some private clinics where people can go anonymously but usually they have to pay fully for these services. GPs can also test and treat people with STIs but this is not a very common practice.

#### **Special services for general population and vulnerable groups**

- **Sex workers.** There are two organizations in capital city Tallinn that provide free of charge and anonymous health care services related to STI and HIV testing for SWs.
- **Injecting drug users.** There are two organizations in North-Eastern Estonia that provide HIV testing and STI services for IDUs and their sexual partners (anonymously and free of charge). They provide testing of sexually transmitted

- infections and HIV, counselling on safe sex, STIs, contraception, and also outpatient treatment of some STIs (syphilis, trichomoniasis).
- **Youth aged up to 24 years.** There are 18 youth counselling centers in Estonia (at least one in every county) that provide HIV counselling and testing, STI counselling, diagnostics, and treatment, counselling on safe sex and family planning issues for young people up to 24 years of age. Services are free of charge for all clients. The work of youth counselling centers is coordinated by the Estonian Association of Sexual Health and financed through National Health Insurance Fund and National Institute for Health Development.
  - **Prisoners.** Estonian prison system has its own health care services, which are financed through the Ministry of Justice. HIV and STI testing and treatment are available in all prisons and are free of charge for all prisoners. HIV and STI testing are voluntary in prison system and prisoners can receive these services any time during the imprisonment.

### **Hepatitis testing and treatment**

In all the above-mentioned services also hepatitis B and C testing is offered. In case the screening test is positive then the person is usually referred to either infectious diseases specialist or gastroenterologist (the latter see patients in the bigger out-patient clinics all across the country) for further diagnosis and treatment. Treatment is free of charge only for those people who have national health insurance.

### **Barriers to HIV testing among IDUs**

Barriers to testing have been addressed in two projects. In HIV rapid testing piloting in 2008 participants in one syringe exchange program in capital city Tallinn (n=200) cited the following reasons for not having testing earlier: no time (21%), have not had an opportunity (14%); have not thought about it (13%); afraid that name will be reported (5%); afraid of the results (5%). Few people also mentioned other reasons (Rüütel et al 2008). From the different perspective – in a study among HIV-infected people who reported IDU (n=52) participants reported fear of social consequences (79%), fear to find out they may have a serious disease (73%), and not being aware of HIV risks (60%) as the main possible reasons why PLHIV do not get tested for HIV earlier. Only a few cited poor knowledge of testing places (10%) and nobody thought that financial constraints are reasons for not testing. These results revealed that HIV-infected IDUs consider the knowledge of testing sites to be high among their peers. The financial issues were also not considered as major barriers. Lack of testing was thought to be more related to personal barriers (low risk perception, fear of consequences) (Rüütel 2011).

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## Germany, Region of Brandenburg

The Federal State of Brandenburg is one of 16 Federal States in Germany. Brandenburg adjoins the Federal States of Mecklenburg-Western Pomerania, Saxony, Saxony-Anhalt and Lower Saxony. Since 1990, Brandenburg is a part of the Federal Republic of Germany. Before it was part of the German Democratic Republic and divided into three districts. An important fact is that Brandenburg encloses the capital of Germany Berlin, so the region Berlin-Brandenburg is an important metropolitan area with around 6 million inhabitants. In addition to that, Brandenburg is located on the Polish border and is a relevant transit lounge from Eastern to Western Europe.

### *General overview of HIV situation*

The first HIV case in Germany was registered in 1982 in Frankfurt/Main, in the Federal Republic of Germany. For Western Germany, the HIV/Aids surveillance started in 1982 (AIDS-case registry) and continued its efforts with the blood donation screening (1985) and the reporting obligation for HIV positive test results.

Reliable data for Brandenburg is available since 1993. This time before, there is no reliable data available. Physicians in the GDR diagnosed the first HIV case in 1985 and registered the first Aids death in 1986. In 1993 the Federal State of Brandenburg takes part in the surveillance activities of the Robert-Koch-Institute. From 1993 to 1997 the number HIV positive diagnosed people increased slowly (12 cases in 1993/ 21 cases in 1997) and regressed in 1999 (4 cases). But since the millennium, the number of diagnoses of HIV increases again. In 2009 47 new cases were registered, and in 2010 until the 1<sup>st</sup> December 46 cases. The Robert-Koch-Institute estimates 610 cases of HIV in Brandenburg. 418 cases are reported by the surveillance-system of the RKI. Because of the proximity to Berlin it is difficult to separate the reported cases in to the Federal State of Brandenburg and the Federal State of Berlin, so the estimated number of infected persons is eventually much higher. With 2.507.700 inhabitants the percentage of people living with HIV and Aids (418 reported/610 estimated cases) is 0,024%. There are 17 reported and 24 estimated HIV positive persons per 100.000 population.

Men are the largest group of people with HIV. 70–80% of HIV positive persons are male. The infections especially spread through homosexual intercourse. About 41, 6% of the HIV-cases in Brandenburg are related to the group of MSM, 18, 2% are related to heterosexual persons and 17, 7% to persons from high prevalence countries. An interesting point is the fact, that the most cases of HIV in the target group of persons from high prevalence countries are female (male: 27 persons/ female: 46 persons). The infection via intravenous drug use is insignificant (1, 9% of all diagnoses). The most HIV positive men are between 20 and 59 years old and the average age of men with HIV lies between 26 and 45. While HIV positive women are between 20 and 39 years old. The average age of new diagnosed women lies between 24 and 34 years.

Geographically the most cases were registered in the greater cities of Brandenburg (Potsdam, Cottbus, Brandenburg/Havel and Frankfurt (Oder)). With 56 positive diagnosed persons is Potsdam the city with the most people living with HIV/Aids.



### *Other sexually transmitted and blood borne infectious diseases*

#### **Syphilis**

The incidence of sexually transmitted infections in Brandenburg is relatively low. In 2009 were 28 cases (1.12 per 100.000) of syphilis diagnosed, in 2010 until the first of December 25 (1.0 per 100.000) cases. The target group of MSM is represented with 13 persons (0.5 per 100.000) in 2009 and 9 persons (0.36 per 100.000) in 2010.

#### **Hepatitis A, B and C**

Cases of Hepatitis are not stringently connected to the use of intravenous drugs, but rather to sexual contacts. Cases of Hepatitis A in 2009: 31 (1.24 per 100.000) and in 2010 until 15.12.2010: 18 persons (0.7 per 100.000). The number of cases of Hepatitis B in 2009 was 16 (0.6 per 100,000) and in 2010 (until 15.12.) 17 persons (0.7 per 100,000). Hepatitis C is the most prevalent type of Hepatitis, with 76 infections in 2009 (3 per 100,000) and 67 infections in 2010 (2.7 per 100,000 until 15.12.).

### *Vulnerable groups*

#### **MSM**

MSM are the most prevalent target group. About 40% (174 out of 418 PLHIV) of HIV positive persons are men, who have sex with other men. The majority of MSM lives in the bigger cities of Brandenburg and on the edge of Berlin. This group is very mobile and dynamic, in fact they get to know each other via chat rooms and hence they arrange sexual contacts. Especially the metropolitan area of Berlin becomes important for the search for sexual contacts. The number of HIV positive men continues to rise since 2001 (2001: 12; 2002: 10; 2003: 12; 2004: 11; 2005: 16; 2006: 14; 2007: 21; 2008: 17; 2009: 18; 2010: 21). In 2009 the DAH (Deutsche AIDS-Hilfe) conducted a special campaign on counseling and testing for MSM, called IWWIT ("Ich weiß was ich tu", means: I know what I'm doing), so it isn't really clear, if the increase of testing or the sexual behavior caused the higher number of registered infections.

#### **Persons from high prevalence countries**

The group of foreigners, especially from Africa and Eastern Europe, is the other important risk group. Often they infected themselves in their origin countries. With 3 persons in 2001 and 11 positive diagnosed people in 2010 the group of people, who are coming from high prevalence countries, is the most growing risk and target group. With the ratio of 2.6 percent of the whole population in Brandenburg, the group of foreigners is an overrepresented group in the field of HIV new infections (ca. 25% of all new registered cases of HIV in 2010).

### ***HIV and STI related health care services***

HIV and STI testing in Brandenburg and Germany were provided by regional health services. All health care services are financed by the national health care system – a health care insurance. STI testing is offered by dermatologists who bill their costs at the health care insurance. HIV testing is provided by regional Public Health Departments, doctors and regional NGOs.

#### **HIV testing and treatment**

HIV testing in Germany is offered by regional actors, the regional Public Health Departments, doctors and laboratories. The Public Health Departments are financed by the regional administration and are often connected to other health care services beside HIV counseling and testing. They offer also counseling of pregnant women etc. The HIV testing in the regional Public Health Departments takes place anonymously and voluntarily, it is free of charge. Doctor's offices and laboratories couldn't make the HIV testing anonymous, because of billing the health insurance agencies (the doctors get the health-ID with the name and the contacts of the patient). In the regional Public Health Departments the anonymisation of HIV testing operates via encoded data the patient offers. In Brandenburg there are 27 regional Public Health Departments, who are offering their services mostly twice a week.

**STI testing and treatment** is performed by dermatologists. The offers are financed by the national health care system. These services are free of charge, but not anonymous, because the dermatologist bills his costs at the health insurance of the patient.

#### **Migrants and illegal foreigners**

Migrants are included in the national health care system via the welfare agency and the German social welfare Law for asylum seekers. Everybody who is registered as asylum seeker is included.

Illegal foreigners are covered too. They have to report their presence to the administration of the local community and get the testing and treatment financed by the welfare agency, but only when serious symptoms are present.

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## Latvia

### *General overview of HIV situation*

In Latvia, data on the morbidity of HIV/AIDS is collected and analyzed by the Infectology Center of Latvia<sup>1</sup>.

HIV/AIDS cases in Latvia have been registered since 1987. First cases were related to men, who got the infection through homosexual contacts. First heterosexual HIV case was registered in 1990. In 1997 the situation changed when HIV infection penetrated and increased sharply among injecting drug users.

Latvia so far belongs to the countries in the EU where HIV infection rates are high. HIV infection rate in Latvia in 2008 was nearly three times higher as that in the EU: 157.6 per million populations as compared to 60.6 per million populations in the EU<sup>2</sup>. At the end of 2010 4,888 HIV cases had been registered in the country and 952 were AIDS cases<sup>3</sup>. In the end of 2010 data showed the lowest number (274) of newly registered HIV cases per year since 2001<sup>4</sup>.

HIV infection is distributed unevenly through the regions of Latvia. Riga, the capital and the largest city in Latvia (706,413 inhabitants at the 01.12.2010.) appeared to be a central scene of HIV spread and drug use. Riga and the region show the highest HIV prevalence figures (408 cases per 100,000 residents in 2009). At the end of 2010 3,630 HIV cases (as of December 31, 2010) had been registered in the capital Riga (514 cases per 100,000 residents<sup>5</sup>).

HIV infection by transmission route. The majority of people living with HIV is male IDUs who were infected through sharing of needles and syringes. IDUs clearly dominate in the current Latvia's epidemic and account for 58.3% of all registered cases, heterosexual transmission – 21.1%, homosexual transmission 4.4 %, mother-to-child transmission – 0.8%, and unidentified transmission 15.5%. Since 2001 the number of newly diagnosed HIV cases among IDUs and the proportion of IDUs among new cases have decreased gradually<sup>6</sup>.

In 2001 there were 665 cases registered as a result of IDU (82%), in 2005 – 114 cases (38%), in 2007 – 141 cases (40%), and in 2009 – 74 cases (27%). While in Latvia transmission through injecting drug use is the prevailing route for HIV spread, it has been declining, and heterosexual transmission increasing slightly. It seems likely that so far most of the heterosexual spread is affecting “bridging groups” – sex partners of IDUs, sex workers and clients – rather than the general population<sup>7</sup>.

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<sup>1</sup>Infectology Center of Latvia <http://www.lic.gov.lv>

<sup>2</sup> UNGASS 2010:4

<sup>3</sup> Infectology Center of Latvia <http://www.lic.gov.lv/docs/268/HIV/Kumulativi.pdf>

<sup>4</sup> UNGASS 2010:4

<sup>5</sup> Infectology Center of Latvia <http://www.lic.gov.lv/docs/268/HIV/IntensivoAbsolutotabula.pdf>

<sup>6</sup> UNGASS 2010:11

<sup>7</sup> UNGASS 2010:13

HIV infection by age and gender. At the outset of HIV epidemic during 2000–2001, males were more affected. However, over the course of recent years, infection is moving into female population, and in 2009 females contributed 60% of cases found among people 15–24 years (in 2001 there were only accounted for 24% of HIV positive cases). Similar trend is seen among people older than 25 years. Generally, since peak in 2001 the number of new HIV infections detected among men each year has declined, whereas the number of new infections detected among women each year has remained more or less static.

### *Other sexually transmitted and blood borne infectious diseases*

#### **Sexually transmitted infections**

Registered cases of syphilis and gonorrhea have decreased in last 4 years. In case of syphilis it has decreased from 19.2 cases per 100,000 populations in 2005 to 7.6 cases per 100,000 populations in 2009 and from 30.1 cases per 100,000 populations in 2005 to 19.1 cases per 100,000 populations in 2009 in case of gonorrhoea. At the same time cases of chlamydia infection have increased from 31.6 per 100,000 populations in 2005 to 49.8 per 100,000 populations in 2009.

In 2010 there were 1588 STI cases registered. Among them – 66% (1042 cases) – chlamydia infection; 22% (357 cases) – gonorrhea; 8% (134 cases) – syphilis; 4% (55 cases) – genital herpes<sup>8</sup>.

#### **Hepatitis B and C**

Since 2001, stabilization is observable in the morbidity of hepatitis B and C; however, an increase in the incidence of injecting drug users has been observable since 2005. For the moment this trend is difficult to explain unequivocally, as this is the first time such an increase has been observable since 2001. One explanation could be the fact that opportunities for testing for hepatitis B/C are increasing; and users, thanks to the operation of harm reduction programs and information available in the mass media are possibly undertaking testing for these infections more frequently<sup>9</sup>.

In Latvia in 2008, acute hepatitis B was registered for 140 persons (103 men and 37 women). Of the 140 persons, 31 persons (29 men and 2 women) were identified as drug users, comprising 22.1% of the total. The total number of persons infected with acute hepatitis B has slightly reduced in comparison with 2007; however, the number of drug users has increased by 10%. Acute hepatitis C was registered for 116 persons (64 men and 52 women). Of these, 21 persons (all men) were identified as drug users, comprising 18.1% of those infected. The incidence of acute hepatitis C in 2008 has increased by 13 cases as compared to 2007, while among drug users it has remained rather stable<sup>10</sup>.

There were registered 123 acute hepatitis B cases in 2009 (140 in 2008). 43 (35.0%) of infected were those of women and 80 (65.0%) – men. 33 (26.8%) were infected through

<sup>8</sup> Infectology Center of Latvia <http://www.lic.gov.lv/index.php?p=7793&pp=10844&lang=258#sti>

<sup>9</sup> The Centre of Health Economics Latvia 2009:48

<sup>10</sup> The Centre of Health Economics Latvia 2009:48–49

injecting drug use. Chronic hepatitis B was identified to 73 persons, from which 3 cases were related to use of common drug injecting equipment<sup>11</sup>.

There were 91 persons reported to be infected with acute hepatitis C in 2009 (116 in 2008). 23 (25.3%) among them were infected by using drugs. Chronic hepatitis C was identified to 1,271 persons, from which 112 (8.8%) were injecting drug users. There is high amount of cases where the mode of transmission is unidentified – 36.3% (n=33) in case of acute hepatitis C and 77.2% (n=981) in case of chronic hepatitis C<sup>12</sup>.

### ***Vulnerable groups***

#### **Injecting drug users**

It is estimated that there were 18,000 drug users in Latvia<sup>13</sup>. This estimate covers year 2008. Four source capture-recapture method was used and the number of heroin users in Riga capital city for 2008 was estimated to be 5,912 (95% CI 3,913–10,164). By taking into account national drug situation, e.g. the vast majority of problem drug users in Latvia are injecting drug users, a large proportion of users are amphetamine injectors, a proportion living outside Riga city, extrapolation of central estimate was carried out. The suggested number of problem opiate and/or amphetamine users in Latvia would be around 18,000, of which 12,000 are heroin users. Some other extrapolation from this figure suggested the number of “problem drug users” in Latvia might be in the range of 19,000–24,000.

In Latvia until now two general population surveys aimed specifically at assessing illegal drug use among 15–64-year-old population have been carried out. The first study was conducted in 2003, while the second one – in 2007. The sample sizes for the survey were 4,534 and 4,500, respectively. Both surveys followed similar methodology and sampling, thus the results are comparable. The national population survey carried out in 2007 (n=4,500) shows that 16% of population aged 15–64 have tried some illegal drugs in their lifetime. The level of the illegal drug use during last year or last month prior to the survey is considerably lower in comparison with usage ever in the lifetime – accordingly 6% and 2%. Compared to the national population survey of 2003, the part of drug-trying inhabitants has grown by 4% (from 12% to 16%). Men have tried illegal drugs twice more often than women.

Within the 2009 cohort study, problem drug use estimates by applying Police multiplier method were carried out. The multiplier used in the study was according to self-reports of being brought for drug testing among interviewed drug users, while the data source used was positive drug tests carried out at the Riga Addiction and Psychiatry Centre. According to the cohort data, the police had brought 25.2% of interviewed drug users to the drug tests at least once in the previous 12 months; while Riga Addiction and Psychiatry Centre data suggests 1,879 individuals were tested positive for heroin or other

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<sup>11</sup> The Centre of Health Economics Latvia 2010:31

<sup>12</sup> The Centre of Health Economics Latvia 2010:31

<sup>13</sup> Centre of Health Economics (CHE) (2010). 2010 National Report (2009 data) to the EMCDDA by the Reitox National Focal Point. Latvia: new developments, trends and in-depth information on selected issues. Riga: The Centre of Health Economics

opiates, cocaine and/or amphetamines. Thus according to the Police multiplier the estimated number of problem drug users in Riga and surrounding areas was 7456<sup>14</sup>.

HIV prevalence surveys took place since 2001 among IDUs in capital city Riga, using LTCs services for recruiting respondents. So, mainly LTCs clients were enrolled in the status samples. Respondent driven sampling (RDS) methodology was introduced in 2007. The prevalence rates estimated from special biological survey has increased and remained high and relatively stable (13.7% in 2001; 21% in 2002; 22% in 2003; 26% in 2005; 22.6% in 2007), notwithstanding, that newly diagnosed and reported HIV cases related to IDUs have substantially declined since 2002<sup>15</sup>.

### **Prisoners**

HIV and other infections (TB, STIs, and HCV, HBV) is significant problem in Latvian prisons.

There were about 7,000 people in 12 prisons in 2009<sup>16</sup>.

In 2008, a total of 628 HIV positive persons were registered in Latvia's places of incarceration, which is 58 inmates more than in 2007. 72 new cases of HIV infection were registered within prisons as compared with 70 incident cases in 2007. In 2002 and 2003 the HIV prevalence indicators were slightly higher, at 766 and 803 respectively. In 2008, there were 103 incarcerated persons in the AIDS phase – a slight increase as compared with 2007 when 97 in AIDS phases were serving their sentence. By comparison, there were only 23 inmates registered in the AIDS phase in 2002, but by 2003, the total had already risen to 59<sup>17</sup>.

1,155 cases or 25% of all newly diagnosed HIV cases (N=4,614) are being reported from prisons by December 31, 2009. This rate may be due to the large scale testing being performed for this population, since HIV test is routinely offered to all people entering the prison system. However, it is still unclear whether the HIV infection had been contracted before or during detention and imprisonment. HIV prevalence among all prisoners is about 6.6%.

Based on data from Ministry of Health for 2008–2009, it appears that there are a total of 400–450 PLWHA in prisons. Of these 85% are men and 15% are women. Almost all (95%) of people living with HIV in prisons have a history of injecting drug use<sup>18</sup>.

### **Men who have sex with men**

Two surveys on HIV prevalence among MSM were carried out in the 1990's. The survey implemented in 1997 recruited 207 MSM from one health centre and gay night clubs in Riga. The prevalence of infections was: HIV 2%; syphilis 8.3%, and hepatitis C 3.9%. Another survey was done in 1998 among 242 MSM in gay night clubs in Riga and Liepaja and found the HIV prevalence had increased to 5%<sup>19</sup>.

In 2008, an anonymous cross-sectional study was conducted in Riga. Using time and venue based sampling 252 MSM have been recruited and questioned. The proportion of

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<sup>14</sup> The Centre of Health Economics Latvia 2009:31

<sup>15</sup> UNGASS 2010:11

<sup>16</sup> UNGASS 2010:26

<sup>17</sup> The Centre of Health Economics Latvia 2009:47-8

<sup>18</sup> UNGASS 2010:27

<sup>19</sup> AIDS Prevention Center of Latvia data

participants older than 25 years was 48%. The proportion of participants tested for HIV before was 61.9%. Prevalence of HIV in the group was 4%<sup>20</sup>.

### **Sex Workers**

Several surveys on HIV prevalence among CSW were done in the past in Riga- the capital of Latvia. Data showed that there was 1 HIV positive case from total 196 respondents in 1998 (0.5%). Since then HIV prevalence has increased to 16.8% (17 respondents) in 2004 (total 109 respondents). The prevalence could be even higher in 2004 because of there was used self-report method to estimate HIV prevalence. The previous survey in 2002 showed that self-report prevalence is 3% less than data from saliva tests showed (13% vs. 16%). The main transmission way was common use of syringes<sup>21</sup>.

### **Ethnic minorities**

No special HIV/AIDS surveys for national minorities had been carried out in Latvia, however, in 2009 assessment of IDU scene in Ventspils, one of the biggest cities of Latvia (43 088 inhabitants in Ventspils) was performed (granted by UNODC project "HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania"; Project Number: XEEJ20). This included small bio-behavioural investigation. Unexpectedly among all respondents (n=195) 50% were Roma (n=97). 23% of all Roma participated in the survey were detected HIV positive notwithstanding, similar proportion was observed among Latvians (24%) and Russians (25%). It should be noted that education level among all respondents was extremely low – elementary and incomplete elementary education for 66.4% of respondents. Good knowledge about HIV/AIDS was declared only for 13.6% but insufficient for 86.4%.

### ***HIV and STI related health care services***

In Latvia, health care services are covered through Health Payment Center. In order to receive health care services free of charge, people have to register to a family doctor.

### **HIV testing**

Any medical institution in Latvia can provide HIV testing. Only persons with medical education can perform testing. HIV testing in Latvia is voluntary. VCT is now widely available at a range of health facilities. It is mandatory for health staff to offer HIV test to all TB patients, pregnant women, persons from high risk groups (IDUs, CSW), STI patients, and prisoners at entry to prison system<sup>22</sup>.

For vulnerable groups- IDUs, MSM and sex workers HIV testing (HIV test and related counselling) is free of charge only in Low threshold centers (LTCs) (4 sites in Riga and 15 sites in other cities). LTCs have no status of medical institution, but it is requirement to have a medical professional working there.

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<sup>20</sup> Dudareva, S., Karnīte, A. (2008) HIV/AIDS knowledge and sexual risk behaviour among MSM in Latvia

<sup>21</sup> AIDS Prevention Center of Latvia data

<sup>22</sup> UNGASS 2010:9

## **HIV and STI treatment**

One of the largest treatment institutions for infectious diseases is the Infectology Center of Latvia, which is subordinate to the Ministry of Health. The aim of the Centre is to provide informative support to state administration institutions and the public, and methodological and organizational support to the Ministry of Health in the formation implementation of infectology policy, and to provide highly qualified and high-quality specialized outpatient and inpatient secondary and tertiary level medicinal assistance to persons suffering from infectious diseases (including rare diseases, HIV/AIDS, sufferers from sexually transmitted or parasitic diseases), and to also undertake the specific prevention of, and research into infectious diseases<sup>23</sup>.

Till the end of 2009, treatment was available only in Infectology Center of Latvia. Since 2010 treatment is decentralized. HIV-positive patients can receive Highly Active Anti-Retroviral Treatment (HAART) even if they do not have family doctor. At the end of 2010 (31.12.2010.) 508 patients were on HAART (out of 4888 HIV/AIDS patients) 46 prisoners and 235 IDUs among them<sup>24</sup>.

Prophylactic antiretroviral (ARV) treatment for HIV infected women during the pregnancy as well as for their newborns is available free of charge (Regulation of the Cabinet of Ministers No 611, 07.25.2006).

## **Financing of services**

HIV testing in the general health care system in Latvia is free of charge; however patients should pay for pre- and post-test counseling. Patients` contribution in Latvia is 3.00 LVL (approx.4.2 EUR).

LTCs are financed partly by government and local authorities. Government pays for the medical equipment (syringes, needles, test kits etc.). Local authorities pay all administrative costs.

Latvian prison system has its own health care services, which are covered by the Ministry of Justice (except medicaments for treatment of TB and HIV/AIDS, which are paid from the State budget funds foreseen for health care).

Hepatitis C treatment is not free of charge. State compensation for the treatment needed medicine is 75 %.

## **STI screening**

Syphilis screening is available for donors. Pregnant women are tested on syphilis and Chlamydia. Screening for these groups is free of charge. STI treatment in Latvia is not free of charge, except of treatment in stationary in Infectology Center of Latvia.

## **Barriers related to accessing HIV/STI VCT services among high risk groups**

Injecting drug users. Although the majority of those living with HIV were infected through injecting drug use, less than a third of those receiving ART have a history of injecting drug use. Along with the official reason of low coverage of ART among IDUs – the insufficient adherence to treatment process, there is evidence of other significant barriers to IDUs in receiving ART both in the community and, particularly, in prisons.

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<sup>23</sup> The Centre of Health Economics Latvia 2009:62

<sup>24</sup> Infectology Center of Latvia [http://www.lic.gov.lv/docs/268/HIV/atsk3\\_Decembris\\_2010.pdf](http://www.lic.gov.lv/docs/268/HIV/atsk3_Decembris_2010.pdf)



These barriers include stigmatizing attitudes of health staff and very limited access to opioid substitution treatment (OST)<sup>25</sup>.

Prisoners. It is still unclear whether the HIV infection had been contracted before or during detention and imprisonment. In principle, prisoners are entitled to free HIV and TB treatment. However, they are requested to pay the full price for certain types of care and drugs, including treatment of opportunistic diseases. Although ART is available in prisons to those in need, it appears that very few (about 5% of PLHIV in prisons) receive this, in practice.

Reasons for relatively low uptake of ART in prisons are varied, including limited funds for ART and a lack of knowledge among HIV infected prisoners. There are also problems with availability of support services required to ART. Financial issues mean that, in 2009, HIV testing on entry into the prison system was suspended. Services for IDUs, such as the provision of methadone and/ or sterile injecting equipment, are not available in Latvian prisons. Moreover, prisoners face interruption in their methadone because of arrest and non-availability of methadone in the criminal justice system.

Money available for health care in prisons system in 2009 has been reduced from 2008 levels because of the financial crisis, and the prisons system will no longer have earmarked funds for health. As a result, HIV prevention activities in prisons are fragmentary but harm reduction activities (needle/ syringe exchange) are not available at all<sup>26</sup>.

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<sup>25</sup> UNGASS 2010:29-30

<sup>26</sup> UNGASS 2010:28

## Poland and the Podkarpackie Province

The Republic of Poland is a country located in Central Europe between the Baltic Sea in the north and the Carpathian and Sudeten Mountains in the south. From the east it borders with Ukraine and Belarus, north east of Lithuania and from the north and the Kaliningrad Russian Federal Republic, most of the northern boundary of the Polish Baltic Sea coast sets, with the Germans from the west and south of the Czech Republic and Slovakia. The total area of the country is 322,575 km<sup>2</sup>. Poland is the ninth largest country in Europe and 68<sup>th</sup> in the world. The population was 38.46 million people in 2010 (sixth largest in the EU and 34<sup>th</sup> in the world in terms of population). 61.8% of the population is urban and the population density is 124 per km<sup>2</sup>. Polish nationality was declared by 95.6% of the population (Census 2002).

The Podkarpackie Province is a region with an area of 17.8 thousand km<sup>2</sup> (5.7% of Polish territory). The population size is 2.1 million inhabitants and 41% of population in urban. Carpathian is the most advanced in the south-east region. In the east it borders Ukraine (Lviv circuit and the Transcarpathian region), and in the south Slovak Republic.

### *General overview of HIV situation*

In Poland, the first HIV case was diagnosed in 1985, and the first AIDS case in 1986. At that time, the problem affected only people addicted to intravenous drugs and homosexual men. The largest increases in incidence rates of HIV infections and AIDS cases occurred in Poland in 1989 to 1990. Then the observed rates increased several times. In subsequent years, declines were observed in recorded infections in absolute terms (for example, between 1990–1993 from 809 cases to 400 cases). These results caused that in Poland an extensive campaign of surveillance was started, including the promotion of early diagnosis of infections – including for people with high risk behaviors – by creating a nationwide network of counselling, free and anonymous testing. Due to the recognition of common infections in groups of drug addicts and homosexuals, this led to stigmatization of drug abuse and homosexuality. At first these were erroneously recognized as the only ways and risk factors associated with HIV and AIDS.

Since 1993, slight increases in the number of people infected were observed in comparison to previous years, maintained with various small fluctuations until now (virtually constant rate of 0.3–0.5 per 100 thousand residents). A significant change in the epidemic has been observed since 2000, through a gradual change in trends in risk behaviors since 2001, particularly increasing rates among people with risky sexual contacts, often closely linked with the consumption of drugs, including alcohol. Characteristic is also increased number of infections among people for whom it was not possible to identify a clear route of infection. In Poland, the implementation of the study since 1985 to 2010 found HIV infection in 13,926 Polish citizens, among whom there were at least 5,705 infected in connection with the use of drugs, which is approximately 41% of those infected. In the second half of the eighties, the percentage was about 85%. Now the infection via heterosexual contacts (and these are often associated with alcohol abuse and drugs) is becoming dominant. Up to 60% of newly diagnosed HIV infections



did not contain information about risk behaviors, which prevents accurate determination of what is now the dominant route of transmission. It is estimated that the number of people infected with HIV in Poland is 20,000–30,000 people. By the end of 2010 a total of 2,435 AIDS cases have been recorded out of which 1,052 patients have died. In Podkarpackie Province (about 2.1 million residents) a total of 217 serologically confirmed HIV cases have been diagnosed until December 2010 – 154 men, 52 women, 4 children up to age of 15, and 7 people with no data available.

In the Podkarpackie the main age group is 21–30 years, it represents around 60% of all cases. 100 people with HIV used or use drugs intravenously, among them were 21 women. Unfortunately, the number of people with HIV in the registry does not reflect the scope of the problem, because of the denial of the problem by the people engaging in risk behaviours, and low testing rates, even anonymous testing. So, the estimated number of PLHIV in Podkarpackie is 450–600 people. Since the beginning of registration 65 AIDS cases have been reported in Podkarpackie Province, including 26 deaths.

### *Other sexually transmitted and blood borne infectious diseases*

#### **Sexually transmitted infections**

In 2007 in Poland, 915 cases of all forms of syphilis were reported, this is 21 cases less than in 2006 (incidence rate for syphilis in 2007 – 2.39 and in 2006 – 2.45 per 1000 000 population). In 2007 694 cases were early syphilis, 3 less than the 2006 (incidence rate in 2007 was 1.82 while in 2006 – 1.56 per 100 000 population).

In 2007 488 cases of gonorrhea were reported, which is 79 cases more than in 2006 (the incidence rate was 1.28 per 100 000 population).

Genital warts – in 2007 – 862 cases, which is 94 cases less than in the previous year. Incidence rate was 2.26 per 100 000 population in 2007 and 2.51 in 2006.

Genital herpes was diagnosed in 193 people, which is 103 cases less than in 2006. The incidence rate was 0.51 per 100 000 population in 2007 and 0.78 in 2006.

In 2008 worsening of the epidemiological situation was observed. The increase in incidence was confined to gonorrhea. Since 2006 a significant increase in the incidence of acquired syphilis has occurred. In Poland children are still born with congenital syphilis and the number of performed serological tests for syphilis has decreased.

In 2009 the incidence of all infections increased. Thus the total number of syphilis cases was 707 in 2008 and 1,004 in 2009 (including 12 cases of congenital syphilis), the number of gonorrhea cases increased from 285 to 402 in the same period, and the number of herpes cases increased from 211 to 684.

The worst epidemic situation, many times exceeding the average national incidence rate, has been recorded in Mazowieckie, with Warsaw, inclusive. Podkarpackie belongs to the provinces with a relatively small number of cases, significantly lower than the average rate nationwide, but in part it may result from the lack of research.

#### **Hepatitis B and C**

Incidence of hepatitis B has decreased gradually since the 1990s, that is, from the start of wide introduction of vaccination against hepatitis B. In 2010, there were 1,634 cases, and the respective incidence rate was 4.28 per 100 thousand residents. For comparison, in

2009 1,513, in 2008 1,375, and in 2007 1,523 cases were reported. With the high coverage of mandatory vaccination against the viral hepatitis B for children and young people only rarely an acute hepatitis B is diagnosed in this population. Currently, it is assumed that the population under age of 25 is immune for HBV infection. In 2010, in Podkarpackie province recorded a slight increase in the number of reported cases from 45 in 2009 (incidence 2.14 per 100 thousand) to 67 cases (incidence 3.19 per 100 thousand population). The incidence is one of the lowest in Poland.

Hepatitis C trend has been on the same level for many years. In year 2010 there were 2,069 cases – the incidence rate was 5.42 per 100,000 population. For comparison, in 2009 1,932 cases, in 2008 2,393 cases, in 2007 2,811 cases and in 2006 3,025 cases were registered. In 2010, in Podkarpackie 41 cases of hepatitis C were registered, and the respective incidence rate per 100,000 was 1.95 (in 2009 the incidence rate was 1.81 per 100 thousand populations). Based on epidemiological estimates, it is believed, however, that the number of people infected with HCV in Poland is around 750,000. On the basis of epidemiological interviews it is assumed that approximately 80% of registered cases of HCV infection are associated with transmission in health care settings (no proper regime of sterilization instruments, disinfection of premises and equipment, procedures for operations affecting the continuity of the tissues).

### *Vulnerable groups*

#### **Drug users – addicts and people experimenting with drugs**

The results of the nationwide ESPAD study (European School Survey Project on Alcohol and Other Drugs) in 2007 indicated a stabilization or even decrease of the problem of drug use among school children. In 2007, 16% of surveyed youth (15–16 years) reported, although, contact with marijuana and hashish, and amphetamines (4%). Another study undertaken in 2011 will show whether these trends continue. Prevalence of drug use in Poland is lower than in other EU countries, excluding the use of tranquilizers and sleeping pills without a prescription (18%). For these measures, Poland is among the countries with the highest prevalence.

The results of studies conducted in 2008 indicated that the psychoactive substances most widely used by young people (for 'once in my life') were marijuana and hashish (30.5%), sedatives and sleeping pills without a doctor's recommendation (21.8%) and amphetamine (9%). Use of the so-called "boost" was admitted by 3.5% of the respondents, which is comparable to the hallucinogenic mushrooms (3.6%), anabolic steroids (3.4%) and cough medicines (3.2%). Moreover, prevalence of alcohol use in combination with marijuana and alcohol with tablets was respectively 17.3% and 12.2%.

Most recent data on drug abuse treatment patients on inpatient treatment is from 2007: the stationary units provided treatment to 12,582 persons, which is a decrease compared to 2006 (13,198 patients). At the same time in 2007, 5,690 people were admitted to inpatient treatment for 'the first time in my life', which also indicates a downward trend compared to previous year (6,480 persons in 2006). Poland is among the European Union countries with the lowest availability of substitution treatment – in 2010 this form of therapy benefited only 2,110 persons which means that treatment was available for 7% of opiate addicts.

National data reported to the Sanitary-Epidemiological Station of HIV infections and cases of AIDS, including on drug abuse, are derived from the National Institute of Public Health – National Institute of Hygiene. Number of reported new cases of HIV infection among drug users in recent years has maintained a decreasing trend.

In 2008 there were 809 cases of HIV infections in total, including 45 injecting drug users. In 2009, 689 new infections were reported (out of them 40 among injecting drug users). Overall, out of all HIV cases since 1985 (n=13,926) injecting drug use was reported by 41% (n=5,705). In interpreting these figures the fact that many reported cases of HIV infection do not indicate the source of infection should be taken into account. AIDS among injecting drug users showed a decreasing trend during 2003–2006. In 2007 183 AIDS cases were recorded (in 2006 – 130 cases), including 102 among IDUs (in 2006 – 65). In 2008, 161 cases of AIDS were recorded in total, including 66 among IDUs.

### **Sex workers**

It is estimated that in Poland sexual services for money are provided by 18 to 20 thousand people (although other sources estimate that that the number could be even as high as 150–160 thousand people, and that the number of escort agencies is around 15,000). In agencies providing sexual services besides Polish women (72%) women mainly from the Eastern Europe are working: Ukrainians (19%), Russians, Belarusians, Bulgarians, and Moldovans. The research conducted in 2002 showed that over 17% of respondents providing sexual services did it because of the possibility of earning a living and profit, while 14% desired to raise the standard of their own lives, but the majority (over 60% of women) worked as prostitutes because of the difficult economic situation. In addition, 2.8% of respondents declared that they were working as prostitutes as a result of coercion by others. Only 7% of respondents said that someone in the family knows or suspects that they work as prostitutes.

In December 2002 serological testing was performed among a group of 400 prostitutes from 13 major Polish cities, including Rzeszow, the capital of Podkarpackie. 9 were infected with HIV, and in 1,914 the presence of infection with syphilis, a sexually transmitted disease. It is noteworthy that from the nine HIV infected patients, six women came from Wroclaw, the capital of Lower Silesia.

### ***HIV and STI related health care services***

#### **Health care and financing of health services**

Health services for the treatment of HIV, STIs and hepatitis B and C are free of charge for insured persons, funded by the National Health Fund. According to the act on health care services financed from public funds uninsured persons having Polish citizenship and residence in the Polish territory, and who meet certain income criteria, are entitled to treatment under the same conditions as insured persons, after receiving the decision of the mayor after confirmation of entitlement to benefits. Then their treatment is paid from the state budget. Certain groups of people are entitled to free treatment regardless of the insurance or without having to request supporting documents. They include children (up to 18 years old) and women during pregnancy, childbirth and postpartum. The only requirement is the possession of Polish citizenship and residence in Poland. Free

treatment is also available for those sick or suspected of being affected with infectious diseases that pose a threat to public health, such as tuberculosis, syphilis, and HIV. People addicted to illegal drugs and alcohol are entitled to free rehabilitation, and people with mental disorders to free psychiatric treatment. Free medical care is also available for people who are deprived of their liberty (arrested and convicted).

### **HIV testing, STI and infections with hepatitis B and hepatitis C treatment**

In Poland, thanks to the activities of the National Centre for AIDS, 1,929 Consulting and Diagnostic (PKD) are working, at least one in each province. In these places people can perform free HIV test and get pre- and post-test counseling. In Rzeszow PKD people can also test for HBV and HCV infections, as well as selected STIs.

In any health care facility, laboratories can perform HIV testing if the patient pays. Free testing for HIV is available for pregnant woman, (the referral of a gynecologist-obstetrician). Treatment of patients with AIDS and ARV treatment is carried out in selected hospitals and outpatient centers in Poland.

STI screening can be done in Poland by primary care physicians (for syphilis) or dermatologist-venereologists for free. For this people can go to a specialist without a referral, specialist clinics are located in virtually all districts, hospital treatment is available in each province.

Referral for testing for HBsAg can be done by primary care physician. Other diagnostic tests for infections with HBV and HCV, including PCR, can be done by medical specialists of infectious diseases and gastroenterology. Examination is free of charge for people with no job and can be performed in any laboratory conducting the diagnostic serology and PCR. Outpatient treatment is carried out by specialist clinics and gastroenterological disease clinics. Hospital care is provided by specialized departments, except that the treatment of hepatitis C is carried out in selected locations, which have signed contracts with the National Health Fund. In the Podkarpackie province it can be done in two hospital wards and infectious Lancut Debica.

There are many non-governmental organizations in Poland working with the problems of HIV, STIs, hepatitis B and hepatitis C, and the addicts (alcohol, drugs) and sex workers, people with different sexual orientation, inmates and people leaving prisons as well as children and youth from dysfunctional families. Below are some examples:

- Society for Threatened People Excluded and Social Exclusion "Podwale Seven"
- ETOH Foundation for the Development of Prevention, Education and Therapy for Alcohol Problems
- Association for Health Promotion and Prevention of Social Risks TADA Szczecin
- Association for Solidarity "PLUS"
- Association for Children and Youth Program "STATION"
- Together for the Living with HIV / AIDS "The positive in the Rainbow"
- Pomeranian-Foundation "House of Hope"
- Center for Prevention and Social Education "Umbrella"
- Association of Volunteers "DA-DU"
- The Association of Volunteers Against AIDS "Be with Us"

- Association "POMOST" in Rzeszow

## Romania

### *General overview of HIV situation*

According to the Report of the Compartment for Monitoring and Evaluation of the HIV/AIDS Infection in Romania<sup>27</sup>, within the Institute for Infectious Diseases Matei Bals, at the end of June 2010, 16,433 cumulative HIV/AIDS cases were registered. Out of these, 5,626 persons had died and 562 were reported lost to follow-up. The number of registered PLHIV at mid 2010 was 10,245. UNAIDS<sup>28</sup> estimated that the number of PLHIV in Romania at the end of 2008 could have been between 12,000–16,000 people. The number of newly diagnosed cases in 2007–2009 has been stable (368, 436, and 428 cases respectively). The same report indicated that 8,734 PLHIV had access to specialized care and were monitored in one of the nine regional treatment centers (as of June 2010). Out of them, 7,306 were receiving antiretroviral treatment.

During 2007 to mid 2010 the percentage of cases attributable to IDU has increased from 0.8% to 2.0%, and the percentage of cases among MSM from 3.8% to 7.8%. The percentage of cases due to heterosexual transmission has remained the same – 75% out of all newly diagnosed cases.

The data obtained by the surveillance system are similar to the data from research conducted in 2009. Thus, the research shows that among IDUs, HIV prevalence rate does not exceed 1%, similar to the one among SWs. At the same time the prevalence rate among MSM is over 4.7%. Most of the young girls infected with HIV in childhood during 1986–1991, are now at the fertile age that might explain the raise in the weight of the vertical transmission. Thus almost all young women infected with HIV as children during 1986–1991 had been diagnosed, their access to specialized services to prevent the vertical transmission is unequal in the country. The sexual transmission (hetero and homo/bisexual) might be assigned to 4 out of 5 diagnosed cases and it had been registered especially to young people aged between 15 and 29 years, with a peak among those aged 20 to 24. The data corroborated with the results of the studies on seroprevalence show that the most probable the transmission is concentrated among MSM and less among other vulnerable groups as SWs, IDUs or detainees. New infections at high level are registered also among HIV contacts, for which, the results of the tests made during the last 2 years show percentages between 8 and 10% positive tests from the total number of tests.

The number of infected persons in active medical surveillance, meaning those who go at least once a year to one of the regional treatment centers, raised from 7,591 at the end of 2007 to 8,734 at mid 2010. The number of patients on ART was the highest at the end of 2008 and decreased slightly by mid-2010 (respectively 7,434 and 7,306 people).

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<sup>27</sup> Available on [www.cnlas.ro](http://www.cnlas.ro).

<sup>28</sup> <http://www.unaids.org/en/CountryResponses/Countries/romania.asp>



With the coverage of ART of about 50% from the estimated number of PLHIV (n=15,000), with 75% of the registered cases (n=10,245), and with 83% of the estimated number of people in need of treatment (n=8,900), Romania is a country with one of the highest treatment rates in Europe. In 2009 and mostly in 2010, many counties faced difficulties in financing and ensuring the need of medicines, that lead to interruption of treatment for a significant number of patients. In 2010, over a third of the patients have faced at least once this interruption, according to the estimation of the National Union of the Organization of People Affected by HIV/AIDS. Some counties had this problem in January 2010, over 15 counties in April and all the counties had problems in ensuring the continuity of the treatment for all the patients May, the same year. The interruptions were generally less than two weeks, with some exceptions: Neamt and Suceava counties. Many patients had to go weekly to the hospital to get the medicines, that had a negative influence to the adherence to treatment.

### *Vulnerable groups*

#### **Sex workers**

Sex work is a visible phenomenon in Romania, but its hidden part is, perhaps, at least as important in number. In 2003, WHO was estimated that between 23,000 and 47,000 women and men were practicing commercial sex in Romania<sup>29</sup>. During a 3 year period (2007–2010), The Romanian Association Against AIDS (ARAS), the unique service provider for this group worked with about 5,900 sex workers in 10 counties (Arad, Bacău, Braşov, Cluj, Constanţa, Dolj, Iaşi, Neamţ, Timiş şi Bucureşti-Ilfov). 2,856 of these persons had been approached in Bucharest.

The vulnerability of the persons involved in the commercial sex towards HIV infection is often increased by the background of disorganized families, abuse, institutionalization, but also because women, especially in the poor communities in Romania, continue to be considered inferior in comparison with men. Without the right for an opinion and free choice, women involved in commercial sex are often obedient to the men they live with and accept risk behaviors (unprotected sex, injecting drugs).

Another important factor of vulnerability is that in Romania, prostitution is illegal<sup>30</sup>: the crime character of practicing commercial sex leads to an erosion of capacities of these women to complain to the public authorities against the abuses and aggressions they experience with the clients or other persons involved in the commercial sex (pimps, combinator).

The main risks related to HIV transmission that the persons practicing the commercial sex are exposed to are related to the unprotected sex with the clients, but mainly with their partner. A study developed by ARAS in 2005 shows that the rate in condom use at the most recent sexual contact, with the client, but also with the „husband” is 36.2%,

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<sup>29</sup> Presidential Administration, The Presidential Committee for the Analysis of Social and Demographical Risks, Risks and Social Inequities in Romania (Administraţia Prezidenţială, Comisia Prezidenţială Pentru Analiza Riscurilor Sociale şi Demografice, Riscuri şi inechităţi sociale în România), 2009

<sup>30</sup> Penal Code, art. 328. – Prostitution, Law No 61/1991

while the rate of constant use of the condom with all the sex partners (clients and stabile partner) was only 20%.<sup>31</sup>

Another problem stressed in this study is the great incidence of injecting drug use among CSW (over 11% declared use of injecting heroine in 2004 or 2005). The data registered by the ARAS outreach teams between 2007 and 2010 show an increase of this phenomenon, so that out of 2,856 CSW (men and women) that have been beneficiaries during these three years in Bucharest, 1401 (49,01%) were also injecting drug users. According to the 2005 study, aproximately 40% of the CSW injecting drug users declared the share of injecting equipment, thus increasing the risks of infecting with diseases transmissible throught blood.

Other vulnerabilities of the CSWs have been widely described in the qualitative study developed by Romanian Angel Appeal Foundation (București, 2010)<sup>32</sup>.

Among these, it is important to be mentioned the lack of identity documents that means, especially for the vulnerable persons, a barier in accessing social and health services. According to a study, developed by the Faculty for Sociology and Social Assistance (University of Bucharest) with the support of UNICEF<sup>33</sup>, 36% of the persons that practice the commercial sex don't have identity papers (permanent or temporary) and 30% don't have even a birth certificate. More recent integrated studies (bio-behavioral) from 2009 and 2010 are going to be published.

### **Injecting drug users**

are a big group especially in Bucharest. In 2009, The National Anti Drug Agency (ANA) estimated a number of 17,767 injecting drug users (problematic use - asimilated aparently to the cuse of drugs by injection)<sup>34</sup>. According to the National Report regarding the HIV/AIDS situation in Romania, that mentions data colected by UNODC (United Nation Organization for Drug and Crime), at country level, in Romania, 7,334 users have accessed the Harm Reduction services (needle exchane programs), in 2009. Between 2007–2010 ARAS had approached, within the HIV prevention programms, 6,650 IDUs in Bucharest.

Vulnerability is still high because of the insufficient and lack of sustainable harm reduction services, lack of treatment for the opiate dependence, refusal of most of the pharmacies to sell syringies, stigmatization of the drug use in Romanian society, and the legal framework that according to which the possession of drugs is a crime (even if a person has a single doze, for own use she can be punished to jail).

15% of the IDUs have a high risk behavior (sharing of already used syringies). At the most recent sexual contact, only 17% of the IDUs declared the use of condom and 13%

<sup>31</sup> COMMERCIAL SEX, THE PERSPECTIVE OF PUBLIC AND SOCIAL HEALTH - ARAS, UNAIDS, with the support of UNAIDS and the Global Fund for AIDS, TB and Malaria (through the mean of the Ministry of Health) (SEXUL COMERCIAL, PERSPECTIVA DE SĂNĂTATE PUBLICĂ ȘI SOCIALĂ), 2005 – ARAS, UNAIDS, cu sprijinul UNAIDS si Fondului Global pentru SIDA, malarie si TB (prin intermediul MS), [www.hivnet.ro](http://www.hivnet.ro).

<sup>32</sup> Women Practicing Commercial Sex in Bucuresti: life stile and behavior with risk of transmission of HIV, Hepatitis B and C – qualitative formative research (Femei care practica sexul comercial in Bucuresti: stil de viata si comportamente cu risc de transmitere HIV, hepatita B si C – cercetare calitativa formativa), Romanian Angel Appeal, 2009: [www.fondulglobal.ro/rapoarte-si-studii](http://www.fondulglobal.ro/rapoarte-si-studii)

<sup>33</sup> Study Concerning Adolescents with High Risk of HIV/AIDS – Faculty of Sociology and Social Assistance, with the support of UNICEF, 2008 (Studiu privind adolescentii cu risc crescut de HIV/SIDA – Facultatea de Sociologie si Asistenta Sociala, cu sprijinul UNICEF, 2008)

<sup>34</sup> National Report on the situation of drug use (Raport National privind situatia consumului de droguri), 2009. ANA



of the IDUs had offered sexual services for money, drugs or other goods.<sup>35</sup> 4% of the IDUs that have participated in the serological and behavioral study had no kind of identity papers and 21% of them did not have valid IDs at that moment.

The study also revealed that the prevalence of HIV among IDUs is 1%, hepatitis B – 5%, and hepatitis C – 83%.

### **Homeless people**

According to the National Anti-Poorness Plan, in Romania, there are about 15,000 persons that don't have a home; about 5,000 are in Bucharest (Statistics of the MSF – Medicens Sans Frontieres). Homeless people, especially those that are a long time on the street, have a significant decrease of the self-esteem, of the interest for their own wellness and these contribute both to their vulnerability towards HIV and other diseases but also to remaining in the street (they don't do any efforts to change this situation).

### **Roma people**

According to the National Anti-Poorness Plan, in Romania, census in January 1992 registered 409,723 Romanian citizens that had identified themselves as roma/gipsies. The Roma organizations offered estimations between 2,500,000 and 3,000,000 people, but none of these figures have been justified by a concrete calculation methodology. In 1992, corroborating more methods, a research upon the socio-economic life conditions of the Roma population, its dimensions have been estimated to about 1 million people (E. Zamfir, C. Zamfir, coord., 1993, pp.59–64).

According to the same document, 3,1% of the persons of the Roma minority do not have any identity documents and 5,7 of those over 14 years do not have an identity card.

Lack of legal identity, with effect on exclusion from any social right, affects a great number of Roma. They are completely excluded from all other rights derived from the citizen status: social assistance, social insurance, political participation right, hiring on a legal job.

The Roma minority in Romania is confronting two specific risks – one of these affects the entire population, the other one only one segment. On one hand, all the Roma people are, directly or not, confronting discrimination. On the other hand, an important segment of the Roma population leaves at the border of contemporary society – especially from the point of view of participation in organizations, as pupil in childhood, student in youth or employee during the adult life.

There are no relevant statistics to prove the prevalence of risky behaviors, prevalence of HIV or STIs infection. There are no medical statistics disaggregated by ethnics, thus is not possible to reveal vulnerability or the impact of HIV/AIDS among Roma people, but there are recognised some vulnerability elements that appear within the traditional communities, especially: the tabu associated with sexuality (and contraception/condom), discrimination, rejection of the persons that use drugs or practice commercial sex, that are often rejected by families and community. But, in Bucharest, there are some areas where a kind of normalization occurred. Towards drug use (in a statistic manner), the attitudes are

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<sup>35</sup> Survey on serological and behavioral surveillance regarding HIV and viral Hepatitis B and C among injecting drug users in Bucharest and Ilfov county, (Ancheta de supraveghere serologica si comportamentala vizind HIV si hepatitele virale tip B si C in rindul consumatorilor de droguri injectabile din Bucuresti si Ilfov), Romania: [http://www.politiaromana.ro/BSS\\_report\\_studiu\\_HIV\\_ANA.pdf](http://www.politiaromana.ro/BSS_report_studiu_HIV_ANA.pdf)

replaced by despair and helplessness, felt by the families with drug using children that have no access to treatment and help.

### *HIV and STI related health care services*

The HIV diagnostics, health monitoring and treatment is ensured in Romania through 41 Infectious Diseases Hospitals from 41 counties, day clinics, and the University Clinics in the nine Reference Centers of HIV/AIDS, under the coordination of the National Institute for Infectious Diseases “Matei Bals” from Bucharest (leader of the National AIDS Commission of the MoH). The ARV treatment costs for the PLHIV are covered from the National Program funds, and are being provided free of charge. Starting from 2001 Romania developed a Plan for Universal access to Treatment and Care Romanian authorities maintained the focus and commitment to provide universal access to treatment, care and social support for people living with HIV/AIDS.

The number of PLHIV receiving ARV treatment grows each year, universal free access continuing to be ensured through national budget fund allocation (37,263,289 euro/2008 and 39,334,177 euro in 2009)<sup>36</sup>. All the people in need for ARV treatment have access to it, with the condition of having identification papers.

Testing for HIV services should be available for free in every district of Romania (MoH centres in each district capital). The National Program for communicable diseases covers the funding for the VCT and PMTCT programs. The total number of HIV tests performed in the general population in the framework of the national HIV/AIDS program<sup>37</sup> ("on demand", at the VCT centers) were in 2009 – 118,981 HIV tests (out of which 893 were positive), and in 2010 – 116,427 tests (out of which 918 were positive). The tests performed among specific target population varied as follows:

- pregnant women (2010 – 110,920; 2009 – 99,767);
- IDU (2010 – 96; 2009 – 277)
- SW (2010 – 89; 2009 – 47)
- MSM (2010 – 47; 2009 – 24)
- Inmates (2010 – 58; 2009 – 199)

According with the law, the HIV testing should be accompanied by pre- and post-test counseling, yet the availability and quality of the counseling is variable around the public services developed at county level in the country, in the national HIV/AIDS program, as the trained human resource is more and more missing ( a program developed by civil society organization Romanian Angel Appeal, which created 18 VCT centers in 18 counties, unfortunately could not be properly continued by public health authorities).

Access to HIV testing and pre/post test counseling is free of charge for all the people who have identification paper. Access is limited in the counties in which there are not outreach services or other services targeting the vulnerable people, which may connect them to the VCT centers (outreach services are available only in 9 districts and

<sup>36</sup> [http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/](http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/romania_2010_country)

2010progressreportsubmittedbycountries/romania\_2010\_country

<sup>37</sup>The national AIDS Commission, Ministry of Health, [http://www.cnlas.ro/images/doc/date\\_romania\\_31dec2009.pdf](http://www.cnlas.ro/images/doc/date_romania_31dec2009.pdf), [http://www.cnlas.ro/images/doc/romania\\_31dec\\_2010.pdf](http://www.cnlas.ro/images/doc/romania_31dec_2010.pdf)

Bucharest, from 41 counties). Commercial sex workers may have difficulties in accessing VCT as the program or location of the VCT may be inadequate (for example the VCT center in one of the big counties is open 8–10 am).

Testing for HIV and counseling may be also provided by authorized private service providers. The service providers must be accredited for performing tests by the local direction for public health. If performed by a private service provider, the test must be paid for (pre/post test counseling availability is variable, depending on the service provider).

Unfortunately, HIV rapid testing kits were launched to be sold on the pharmacies in 2010 (ARAS was public against this, as the test was not accompanied by counseling pre/post test). The product success on the market was very low.

Rapid testing for HIV as well the pre/post test counseling were available within the projects funded by the Global Fund program (2007–2010) for sex workers, injecting drug users, people who live in the street, Roma people from disadvantaged communities, inmates. In the framework of the mentioned GFATM program in Romania, ARAS provided pre/post test counseling for sex workers, IDUs, people who live in the street and roma from disadvantaged communities, in outreach activities (in 9 counties and Bucharest) and through drop-in centers in Bucharest. The BORDERNET*work* project also provided support for providing pre/post test counseling and testing for HIV, hepatitis B and C.

MoH registers only the number of HIV tests performed and the population based surveys did not included questions regarding HIV testing as far (last one was conducted in 2004/2006). HIV testing services are included at national level in the antenatal health services package (free of charge, recommended by general practitioners).<sup>38</sup>

### **Barriers to HIV testing among injecting drug users**

ARAS organized 3 focus groups where altogether 3 female and 12 male IDUs participated. All the participants identified themselves as being at risk of getting HIV because they had shared syringes while using drugs and they all knew that this is a possible way of getting infected with HIV. The majority of participants stated that they had enough information on HIV and STIs. They had received information, informative and preventive materials during their sessions with the NGO's staff. The information they felt most in need of were related to treatment and the other ways of transmission besides sharing syringes.

Access to health care services would be much easier if the doctors would be more accessible. For some participants it is very difficult because they have no job, no medical insurance, and no family doctor. There are also situations when people have no identity papers and they can get only temporary documents because they don't have a stable home.

All the participants answered that they know that they can get a free, confidential, anonyms rapid test for HIV, Hepatitis B&C, syphilis at ARAS centers. Most had also done these tests. Two men said they did not want to have a test. They didn't express the

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<sup>38</sup> [http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/romania\\_2010\\_country](http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/romania_2010_country)

reason for this clearly but they seemed to be afraid of finding out that something was wrong with them.

All participants knew that there is treatment for HIV and STIs but they did not know the procedures if they would need HIV treatment.

## Slovak Republic

### *General overview of HIV situation*

In the European Union Slovakia is among the countries with low prevalence of HIV infection, and it has the lowest prevalence in Central Europe. In 2006 a total of 27 (0.5 cases per one million population), and in 2009 a total of 53 new cases of HIV were registered (1.0 cases per one million population). Since the start of reporting, a total of 330 HIV cases have been diagnosed in Slovakia (ECDC/WHO 2010).

Around 125,000 to 150,000 HIV tests per year are done in the health care system. Overall, in 2006 197,368 tests were performed for anti-HIV antibodies, out of which 194 cases were referred to testing because of injecting drug use. In 2006, one case of infection by the intravenous drug use took place outside Slovakia (in Portugal) (NRC HIV/AIDS, 2007). It was the third case in country's history, the first two cases having been diagnosed in 1985 and 1986. The most common routes of transmission are homosexual and heterosexual contact (both accounting for approximately 40% of all cases).

Reasons for the low prevalence of HIV in Slovakia have been proposed by several experts: e.g. for a long period Slovakia was isolated from Western countries, like most countries of the former Soviet Union. After opening of the borders the prevalence is gradually increasing, but not as sharply as in other countries. Immediately after the first HIV case in 1986 a mandatory testing of blood donors was introduced, and later the semen, tissues, organs, and breast milk was started to screen. At the same time in Bratislava, Institute of Virology, Slovak Academy of Sciences created the first specialized department dedicated to the diagnosis of HIV/AIDS and the first National Programme for HIV/AIDS in Slovakia was established. National Reference Centre for the Prevention of HIV/AIDS was established in the Ministry of Health, Institute of Preventive and Clinical Medicine, in 1994 (Staneková 2007).

Relatively soon programs for prevention of HIV/AIDS were started by NGOs, especially those working in harm-reduction, and especially in Bratislava, which was at the highest risk because of being a capital city and having the highest prevalence of illegal drug use. Already in the beginning the organization had an opportunity to learn from their more experienced Western partners and directly benefit from more effective prevention mechanisms, which had been tested in other countries (Staneková 2007).

On the other hand, the apparently low prevalence may also be caused by low testing (approximately 100 000 HIV tests per year), as well as underestimating the overall problem. Most people do not realize the threat of infection, in order to protect themselves or test. Therefore, the currently known number of HIV-infected individuals may represent only the tip of the iceberg (Staneková 2007).

## *Other sexually transmitted and blood borne infectious diseases*

### **Other STIs**

Syphilis – since 1953 the number of cases in our country has fallen significantly. The last few cases occurred in Roma communities.

### **Hepatitis B and C**

Hepatitis B is problematic in the Roma communities in eastern Slovakia. Hepatitis C is mainly a problem among IDUs, more than 80% of IDU being infected.

## *Vulnerable groups*

### **Roma community**

It is estimated that the number of Roma people actually residing in Slovakia is in between 300,000 to 400,000) people. Marginalized Roma communities suffer from the increased incidence of infectious diseases and pulmonary diseases due to poor living conditions. This is a consequence of insufficient hygiene and the lack of health prevention, the poor living conditions of the population living in apartment buildings due to the disconnection of fundamental utilities (heating, water, gas, and electricity) and the unavailability of sources of drinking water in segregated and remote locations. The permanent health threats to the population arising from its polluted immediate environment (epidemics and sickness affecting a large section of the population, rats, waste) causes reduced life expectancy and increases in oncological illnesses. High birth rates and the young age of women giving birth in socially excluded communities along with the problem of sexual crime and prostitution is growing. The incidence of illegal drug abuse, especially in the case of children and teens is increasing in segregated locations.

### **Injecting drug users**

Injecting drug users constitute the next risk group. It is estimated that there are approximately 17,000 IDUs in Slovakia. Services for them are provided by five NGOs in six towns (Bratislava, Trnava, Sered', Nitra, Banská Bystrica, and Košice).

The services of the streetwork are the following:

- Information on: HIV, drugs, substitution therapy, social hostels, trafficking, health service, legislation and police, advocacy
- Distribution of condoms
- Outreach project in 2007 and 2008 on festivals (5,000–6,000 HIV, Hepatitis and Syphilis tests per year) for target groups youth, Roma, homeless people and drug users

Prima is also involved in a network of organizations who perform outreach testing.

## *HIV and STI related health care services*

### **HIV- and STI testing**

Testing of HIV and STI testing is anonymous and free of charge. Testing is provided by the National Reference Centre for HIV/AIDS and eight Regional Offices for Public Health. Testing in prisons is voluntary and free of charge for prisoners.

Only about 60 people receive ARV treatment at the moment.

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## Ukraine

### *General overview of HIV situation*

Since the identification of the first HIV case in Ukraine in 1987 until 2009, a total of 161,119 HIV-cases have been officially registered among Ukrainian citizens, including 31,241 AIDS cases and 17,791 deaths caused by AIDS-related diseases. In 2009, 19,840 new HIV infection cases were registered in the country (43.2 per 100,000 population). Although the number of newly diagnosed HIV cases has been growing annually since 1999, reduction in the growth rate has been observed during 2006–2009: 16.8%, 10.5%, 7.6%, and 5.7% respectively. It should be noted that the number of HIV tests in Ukraine has also increased by 136,000 (4.2%) in 2009 compared to 2008; among them, the number of tests financed by local budgets increased by almost 146,000 (13.0%).

At the same time, according to results of serum epidemiological monitoring of HIV-infected people in Ukraine, the HIV infection rate among Ukrainian citizens in 2009 decreased slightly compared to 2008, from 1.16% to 1.11%. All the above data indicates some stabilization of the HIV epidemic situation in the country. According to official data, every day in 2009 HIV infection was diagnosed in 54 people, AIDS was diagnosed in 12 people, and seven people died of AIDS-related diseases. Of all officially recorded HIV cases among Ukrainian citizens since the beginning of the epidemic, 101,182 people were under medical observation as of 1 January 2010 (220.9 per 100,000 population) including 11,827 diagnosed with AIDS (25.8 per 100,000 population).

It is universally recognized that official data do not reflect the real scale of the HIV epidemic in Ukraine, particularly the real number of HIV-infected people. The data only provide information on people who have been diagnosed with HIV and whose data were entered into the official national register of HIV infection cases. A considerably larger number of Ukrainians may be infected but are not aware of their status.

Updated HIV/AIDS estimates for Ukraine indicate that up to 360,000 HIV-infected people aged 15 and over are living in Ukraine (as of January 2010). This figure differs from official statistics on the number of PLHIV (161,119) and under medical observation in specialized health facilities (101,182) at the beginning of 2010. The difference between these indicators proves that only 28%, or every fourth person living with HIV in Ukraine, knows his or her HIV-positive status.

During the entire period of epidemiological HIV surveillance in Ukraine, the number of deaths caused by AIDS-related diseases increased. In 2009, for the first time compared with the previous year, the number of AIDS related deaths decreased from 2,710 to 2,591 (from 5.8 to 5.6 per 100,000 population, or by 2.6%), which is the first evidence of the positive impact of large-scale antiretroviral therapy implementation in Ukraine. However, the access to antiretroviral therapy in Ukraine still remains low. According to recent estimates, almost 23,000 patients needed ARV treatment in 2009 whereas 15,871 received it. The percentage of active injecting drug users on ARV remains limited (according to 2009 data, only 7.5% of the total number of those receiving ART were IDUs) because of insufficient availability of substitution treatment, and hence problems with adherence to ART.

The growth in recent years of the number of HIV-infected people identified due to clinical indications should also be taken into account. According to serum epidemiological monitoring results, almost 22% of all positive cases in 2009 were identified among people examined due to clinical indications. Of the 4,437 AIDS cases diagnosed in 2009, 49% (n=2,182) were late diagnoses.

In 2009, over 77% of HIV-infected Ukrainian citizens were in the reproductive and working age (15–49 years). However, the share of HIV cases in the 15–24 age group among all newly diagnosed HIV cases has decreased over recent years, being 16% in 2006, 15% in 2007, 13% in 2008, and 12% in 2009. This also indicates some overall stabilization of the HIV epidemiological situation owing to young people's shift to less risky behaviours.

There are considerable variations in HIV prevalence between different regions in Ukraine. The highest HIV prevalence rates have been observed in the southeast regions of Ukraine: Dnipropetrovsk, Donetsk, Mykolaiv, Odesa and Kherson oblasts, Kyiv and Sevastopol, and the AR of Crimea (512.7–223.7 cases per 100,000 population) where this indicator considerably exceeds the country average of 220.9 per 100,000 population (as of 1 January 2010).

Parenteral transmission, mainly by sharing injecting paraphernalia, was the main HIV transmission route in Ukraine from 1995 to 2007. In 2008, for the first time since 1995, a change occurred: the percentage of parenteral transmission fell below that of sexual transmission. In 2009, the share of people infected by sexual transmission continued to grow and reached almost 44%. Parenteral transmission accounted for 36%. However, the HIV epidemic still remains concentrated in most-at-risk groups (injecting drug users and their sexual partners).

At present, the HIV/AIDS epidemic situation in Ukraine continues to worsen. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), Ukraine is currently referred to as one of the countries demonstrating the highest HIV incidence rate in Europe and Central Asia.

### ***Vulnerable groups***

#### **Injecting drug users**

HIV prevalence among IDUs in 30 territorial regions in 2008 and 2009 was estimated to be 22.9% (c.i. 21.9%–23.9%). There are clear geographical differences in HIV prevalence rates among IDUs. The highest prevalence rates have been observed in Mykolaiv, Kryvyi Rih, and Odesa; the lowest in Luhansk, Vinnytsia, and Uzhhorod.

#### **Female commercial sex workers**

HIV prevalence among female CSWs in 25 territorial regions in 2008 and 2009 was estimated to be 13.2% (c.i. 12.0%–14.4%). HIV prevalence in individual cities show geographical differences in infection rates. In such cities as Dnipropetrovsk, Vinnytsia and Zhytomyr, HIV prevalence approaches Ukraine's average. The infection rate in Donetsk, Kyiv, Simferopol and Mykolaiv is higher than in other cities. The lowest HIV prevalence rate is found in Kharkiv, Chernihiv, Uzhhorod and Chernivtsi.

The highest probability of HIV infection among FCSWs is determined by injecting drug use. For example, HIV prevalence among FCSWs who may be described as IDUs according to their behaviours is 42.5% and among those who do not inject drugs – 8.5%.

### *HIV and STI related health care services*

In each region of Ukraine there is the AIDS Center, where everybody can be tested for HIV free of charge. In the small towns people are afraid of spreading information about their HIV status, and therefore avoid to perform HIV-testing.

Medical examination, treatment, and ART for HIV-positive people are also free of charge. Besides all PLHIV are provided with social services and social protection.

As a result of close cooperation between the Ministry of Health and its key partners (the International HIV/AIDS Alliance in Ukraine, the All-Ukrainian Network of People Living with HIV, UNAIDS), AIDS-related mortality is reduced. Better access to prevention, treatment and care, and higher quality and intensity of prophylactic interventions are provided.

## Conclusions

The current report presents the short country profiles of BORDERNETwork project partners containing background information on STI, HIV and co-infections epidemiological situation, vulnerable groups and HIV and co-infections related health services, including testing. One of the main aims of this review was to identify needs, including barriers to services, in order to assist in developing STI/HIV services for vulnerable groups in order to improve access and decrease late diagnoses.

In all countries the highest burdens of HIV and hepatitis can be found among vulnerable groups – like IDUs, MSM, Roma community, migrants, sex workers, and others. STIs are also common among general population, especially youth. HIV situation has stabilized in recent years, after outbreaks in 1990ies and early 2000s. In Eastern European countries (Estonia, Latvia, Ukraine) IDUs constitute the main risk group, in Central and Western European countries MSM and migrants are most at risk. Higher HIV and STI burden among sex workers can be found in all regions, with higher blood-borne infections prevalence among those sex workers who also inject drugs.

In general, in all countries there are special organizations and services for STIs, HIV and hepatitis in place targeting vulnerable groups. In most cases testing services are anonymous and free of charge for the clients. In many countries there are systems for providing and paying for services also for non-citizens. On the other hand, treatment is not anonymous. HIV treatment is free of charge, but this is not always the case with STI and hepatitis treatment, where patients oftentimes have to pay for drugs themselves or must have some form of health insurance.

In many cases services have been started in the framework of different projects (both national and international) which is a threat to the sustainability as well as a hindrance to the expansion and quality improvement.

Another issue is the fragmentation of services – HIV, STI, TB, and hepatitis services are oftentimes provided by different health professionals and organizations, and clients have to attend different locations in order to get help. Links do exist between testing and treatment services, special and general health services, but they are not always efficient, causing confusion in potential clients and delays in accessing services.

Systematic data on access and barriers to services among vulnerable groups is rather limited. In Bulgaria and Romania special focus groups were conducted among vulnerable groups (MSM in Roma neighborhood in Bulgaria and IDUs in Romania) and in some other countries (e.g. Estonia and Latvia) existing literature was summarized to describe the main barriers to HIV and STI services. Different issues were identified, which are in accordance with the evidence from across Europe:

- Sociocultural barriers (personal beliefs – fear of names being reported; fear of the negative attitudes of the health care staff; low risk perception);
- Socioeconomic barriers (lack of health insurance, no citizenship);

- Geographic barriers (distance from services);
- Organizational barriers (unconvenient opening hours, not knowing the procedures needed to access services).

Together with the findings from the assessment of the good practice level of HIV counseling and testing services using “Self-Assessment Checklist for Voluntary Counseling and Testing” this overview will provide a basis for BORDERNETwork partner organizations for designing an intervention to address the barriers to STI/HIV testing among vulnerable groups.

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