

HIV/AIDS in Russia

Commitment, Resources, Momentum, Challenges

A Report of the Task Force on HIV/AIDS
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HIV/AIDS in Russia

Commitment, Resources, Momentum, Challenges

*Judyth Twigg*¹

The only thing predictable about Russia's struggle with HIV has been its unpredictability. Over the last few years, the epidemic itself has taken unexpected and still poorly understood twists and turns. The country's declared political commitment to tackling the virus and its consequences is strong at the moment, but a history of denial and neglect call the sustainability of recently allocated policy attention and financial resources into question. Even in a resource-rich environment, Russia's capacity to spend money effectively and without unintended negative consequences remains uncertain. The international community has played a significant role in shaping the dynamic of Russia's response, and its continued involvement—including a strong bilateral U.S. presence—will remain an important determinant of Russia's success.

The Epidemic

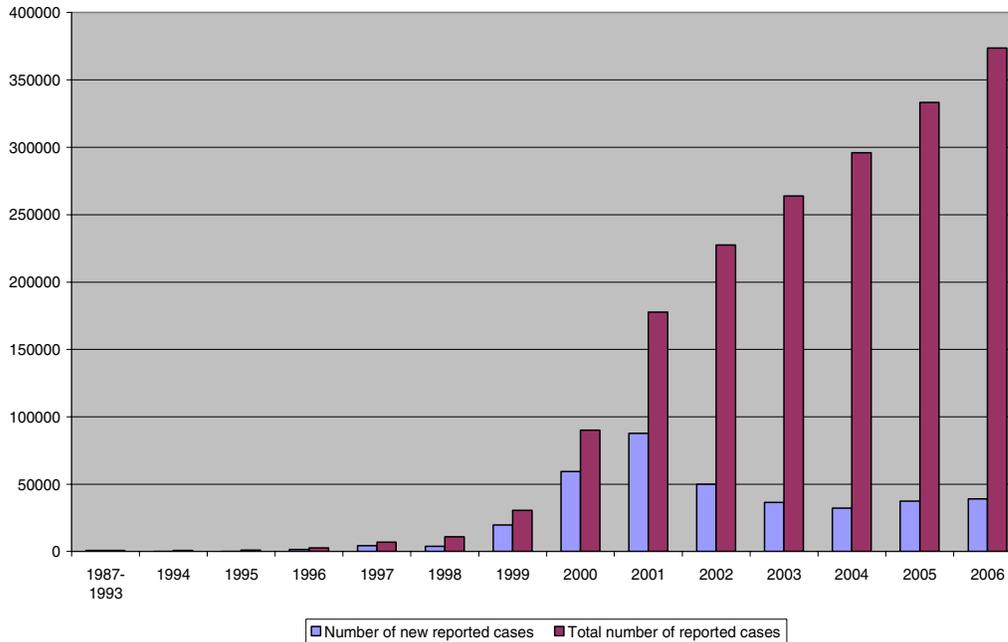
As of August 31, 2007, there were 390,365 officially registered cases of HIV in the Russian Federation.² In 2006, 0.5 percent of the population between the ages of 15 and 24 was registered as infected; in the 18 to 24 age group, the prevalence rate is over 1 percent. Young people ages 15 to 30 represent about 80 percent of Russia's cases. HIV first entered the Soviet Union in the mid-1980s, but an epidemic emerged only in 1996–1997, when the virus began to spread among injection drug users (IDUs). Russia in the late 1990s witnessed some of the most explosive increases in HIV incidence ever observed: from under 1,000 registered cases in 1995, to almost 250,000 in 2002. The peak incidence year was 2001, with over 87,000 new cases, declining to about 35,500 in 2005, but then rebounding to

¹ The author thanks the numerous U.S. and Russian government officials and representatives of Russian and international nongovernmental organizations who agreed to be interviewed, off the record, for this report.

² See the federal information portal Regions.Ru at www.regions.ru and the Information Agency of the Republic of Tatarstan at www.intertat.ru.

some 39,000 new cases in 2006. In the first half of 2007, almost 30,000 new infections were reported.³

HIV Incidence and Prevalence in Russia, 1987-2006



Just under 17,000 people in Russia have died of officially diagnosed AIDS or AIDS-related causes since the beginning of the country's epidemic. The cause of over half of recent AIDS deaths has been tuberculosis. The total number of deaths is most likely understated for a variety of reasons: physicians are not competent to diagnose AIDS-related deaths when they see them; and families of AIDS sufferers may bribe officials to list something other than HIV/AIDS as a cause of death in order to avoid the associated stigma.

Considerable uncertainty and controversy surround the difference between the number of officially registered cases and the "real" numbers. The formal count captures only those people who have been in direct contact with the country's HIV reporting system, and troubling disincentives to be tested haunt members of high-risk groups. It is also possible that there has been a "saturation" of HIV among IDUs in some regions, resulting in a smaller pool of drug users that has not yet been tested. The overall number of IDUs may be in decline as well, with the number of registered addicts growing by 21 to 24 percent annually in the 1990s but by only 0.05 percent per year from 2003 to 2005.⁴ HIV testing patterns have also changed, with 51 percent fewer IDUs and 30 percent fewer prisoners tested in 2004 than in 2000.⁵ Dr. Vadim Pokrovsky, the head of Russia's Federal AIDS

³ "HIV/AIDS Continuing to Spread in Russia," Interfax, May 15, 2007.

⁴ Itar-Tass, November 20, 2006.

⁵ Federal AIDS Center, "HIV Infection: Information Bulletin # 27," Ministry of Health and Social Development, 2005.

Center, reports evidence that there has been a significant real decline in HIV incidence among IDUs, based on data from routine testing of IDUs who had not been screened before or who had previously tested negative.⁶ The numbers reported by EuroHIV confirm this trend: 48,000 new cases reporting IDU as the transmission vector in 2001, compared to just over 10,000 in 2005.⁷ Similarly, the percentage of new cases linked to unsafe use of injection drugs has declined from more than 90 percent in 2000 to just under two-thirds in 2005. These data suggest that the spread of the epidemic due to sharing of nonsterile equipment among IDUs peaked in 2001, causing at least a temporary real decline in the rate of new infections.

A heated debate has emerged over the precise contours of the epidemic: not just its scale, but whether it remains concentrated primarily among IDUs or if it is generalizing through heterosexual transmission. Definitive answers are elusive. Russia has not yet adopted a system of sentinel surveillance of risk groups, instead continuing to rely on the Soviet-era approach of mass screening. Millions of annual tests of pregnant women and conscripts offer some insight: in 2005 and 2006, more than 40 percent of new cases were female, and in some regions in the southern part of the country more than half of new cases were female.⁸ The number of pregnant women detected with HIV rose from 300 cases in 1999 to 3,505 in 2005. As of February 2007, 44 percent of all Russians living with HIV were women.

But while an increasing number of women are testing positive, some studies indicate that these women are mostly IDUs or sexual partners of IDUs. The key questions about the sexual behaviors that would produce a generalized epidemic remain unanswered. Too few studies have focused, for example, on the sexual mixing patterns of IDUs and their partners, or on the risk behaviors of other bridge populations and nonrisk groups. The clients of harm-reduction programs tend to be surveyed over and over again, but they constitute a small minority of the total number of people engaging in risky behavior. Essentially, researchers are asking the same drug users and the same sex workers the same questions, over and over again. Too many of the studies being conducted lack methodological rigor and barely skim the surface of the epidemic's true depths.

For the last several years, UNAIDS has estimated the actual prevalence of HIV to be between 850,000 and 1 million; other sources recommend a multiplier of the official figures ranging from 1.5 to 5. Forecasts of the epidemic's future trajectory also vary widely. The U.S. National Intelligence Council has predicted 3 to 4 million cases by 2010⁹; more pessimistic observers foresee as many as 19 million HIV cases and 12 million AIDS deaths by 2050. Even the World Bank's

⁶ Cited in UNAIDS, *AIDS Epidemic Update: December 2006* (Geneva: UNAIDS, December 2006).

⁷ EuroHIV, *HIV/AIDS Surveillance in Europe: End-Year Report 2005*, No. 73 (Saint-Maurice: Institut de Veille Sanitaire, 2006).

⁸ Press-Obozreniye, August 9, 2006.

⁹ "The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India, and China," Intelligence Community Assessment (ICA) of the National Intelligence Council, ICA 2002-04D, September 2002.

most optimistic prognosis indicates that, by 2010, the economic impact of HIV will cost Russia a 4.15 percent slump in GDP and a 5.5 percent downturn in investment.¹⁰ Most of these scenarios were generated in the early part of this decade, and they were predicated on the assumption that the astronomical growth rates of that time period would be sustained. Even under best-case conditions, however, the epidemic's disproportionate impact on young Russians of reproductive age may exacerbate an already serious demographic decline. Minor perturbations in the size and health of the labor force can stifle productivity and economic growth rates, potentially strangling an already tight labor market and diverting resources away from care and treatment for affected people.

HIV is present throughout Russia, although a relatively small number of regions suffer disproportionately high official prevalence.¹¹

St. Petersburg City	33,604
Sverdlovsk	31,704
Moscow Region	30,333
Moscow City	28,581
Samara	28,316
Irkutsk	21,889
Chelyabinsk	16,819
Orenburg	16,104
Leningrad Region	11,412
Khanty-Mansi	10,665
Total	229,427 = about 60 percent of total prevalence

Risk Groups

Dr. Nataliya Ladnaya, a senior researcher at the Federal AIDS Center, estimates the size of Russia's main risk groups: 500,000 to 700,000 commercial sex workers; 0.5 to 3.5 million injection drug users; 1.3 to 2.5 million clients of commercial sex workers; 2.7 million men who have sex with men; and 9 million sex partners of IDUs.¹²

¹⁰ Christof Rühl, Vadim Pokrovsky, and Viatcheslav Vinogradov, "The Economic Consequences of HIV in Russia," World Bank, Moscow, 2002.

¹¹ Data as of May 31, 2007, from www.regions.ru.

¹² Cited in Victor Boguslavsky, "Situational Analysis of TB-HIV Co-Infection in Russia and Four QAP Project Regions: Samara, Saratov, Orenburg, and St. Petersburg," Quality Assurance Project Technical Report, USAID, July 2005.

IDUs. While Russia's first trickle of HIV cases in the late 1980s stemmed from sexual transmission, the explosive epidemic of the late 1990s was connected almost exclusively to injection drug use. Estimates of the number of IDUs in the country vary from 1 to 4 million, with only a small percentage officially registered. According to the Federal Drug Control Service, between 80,000 and 100,000 Russians die annually from overdoses and other problems related to the use of illegal substances, with the vast majority under the age of 30. Several studies have documented high rates of HIV infection among IDUs: between 1996 and 2001, 80 to 90 percent of registered new HIV infections were among IDUs, and explosive epidemics of HIV have been reported among IDUs in many parts of the country, with prevalence rates between 12 and 56 percent.¹³ The post-Soviet explosion in injection drug use has stemmed from an array of factors: the opening of borders, putting Russia along several widely used drug trafficking routes; high unemployment and other sources of social alienation and anomie among young people; a sharp decrease in financing of state health care and educational institutions; and the inexpensiveness and ready availability of drugs.

The head of the Federal Drug Control Service claims that heroin remains the most widely used drug in the country, although there is a growing problem with synthetic drugs, primarily among well-off youth in larger cities. More than 180,000 drug-related crimes were registered in Russia in 2006, an increase of 20 percent over the previous year. About 3,000 drug "dens" were put out of service in 2006 as a result of anti-drug-trafficking measures, resulting in what the Drug Control Service calls a "drug famine," particularly for heroin. Prices have risen considerably, and it has become more difficult to acquire the drug.¹⁴ Several moves by the State Drug Control Committee in 2005–2007 have created the impression that, after some indication that drug-use laws were beginning to set dealers rather than users in their sights, controls are retightening. Many in the harm-reduction community fear that this trend will have a chilling effect on HIV-prevention efforts, forcing addicts to steer clear of information and needle-exchange centers in order to avoid arrest. Even more worrisome are preliminary signs that Russia is entering a new phase of its "war on drugs" that could clamp down on existing harm-reduction sites and smother even the small hope that the prohibition of substitution therapy might be reversed. Several studies indicate significant willingness among IDUs to stop injecting drugs; two-thirds of IDUs studied in Moscow in 2002 tried to quit, but in over 60 percent of cases, their period of abstinence was less than six months. These findings highlight the wisdom of coupling drug control policies with accessible, affordable, humane programs to facilitate users' withdrawal efforts.

Sex workers. Sex workers form another key risk group. In some regions, nearly half of all sex workers are infected with HIV; the figures vary from 3 to 48 percent. Recent research has shown that as many as one-third of female IDUs report selling sex for money or drugs in St. Petersburg, where HIV prevalence

¹³ Robert F. Luo and Joseph Cofrancesco Jr., "Injection Drug Use and HIV Transmission in Russia," *AIDS* 20 (2006): 935–936.

¹⁴ Interfax, November 18, 2006.

among sex workers is 48 percent and the majority of sex workers also inject drugs.¹⁵ High HIV-prevalence levels have been detected among sex workers in other Russian cities, with the notable exception of Moscow: in the capital city, sex work is highly structured, injection drug use among CSWs is effectively discouraged, and HIV prevalence among sex workers is as low as 3 percent.¹⁶ While studies indicate that sex workers have relatively high awareness and knowledge of HIV and other infections, they do not apply this knowledge and understanding consistently, generally due to their inability to negotiate protected sex with their clients. Many sex workers report having as many nonpaying partners as paying clients, with a significantly lower level of condom use with nonpaying partners creating a significant risk for HIV transmission.¹⁷

Prisoners. Until the year 2000, the incarceration rate in Russia was the highest in the world. A major legal reform that year resulted in the release of 200,000 prisoners, leaving the country with a still-high imprisonment rate, but lower than that in the United States. A 2006 study found HIV prevalence in Russian prisons to range between 0.8 percent and 4.76 percent, with HIV prevalence among IDU prisoners as high as 46 percent in St. Petersburg.¹⁸ Syringe exchange in prisons remains illegal, and so harm reduction in the prison setting is generally limited to education and provision of disinfectants and condoms. Prisoners often refuse antiretroviral therapy, warned away by other inmates of the side effects of the drugs. Other inmates report that they would prefer to wait for their release from prison to be treated.¹⁹ The extent of HIV transmission in Russian prisons is not known; the only officially registered outbreak was in Tatarstan in 2001, when 260 prisoners became infected through IDU. A 2003 study funded by the World Bank showed that, of 3,000 inmates of two correctional facilities who were HIV negative on admission, only one had seroconverted in prison.²⁰ Other studies, however, have indicated that risk behaviors run rampant through the prison environment, with unprotected sex and nonsterile drug use and tattooing widespread. A recent survey of IDUs in Moscow, Volgograd, and Barnaul found that 55 percent of the men had a history of detention; they reported widespread availability of drugs in prison, but scarcity and therefore frequent sharing of injecting equipment, often in large groups. Inmates widely perceive that

¹⁵ A.P. Kozlov et al., "HIV Incidence and Other Factors Associated with HIV Acquisition among Injection Drug Users in St. Petersburg," *AIDS* 20 (2006): 901–906.

¹⁶ AIDS Infoshare, *HIV/STI/Hepatitis B Risk among Commercial Sex Workers: A Survey Report* (Moscow: AIDS Infoshare, 2005).

¹⁷ Population Services International, "Assessment of Key Health Behaviors, their Determinants, and Exposure to Preventive Interventions among Street-based Sex Workers in Samara and Saratov, Russian Federation," Moscow, December 2006.

¹⁸ Kate Dolan et al., "HIV in Prison in Low-Income and Middle-Income Countries," *Lancet Infectious Diseases* 7 (2007): 32–41.

¹⁹ Zosia Kmietowicz, "Tomsk—A Glimpse of One Russian Region's Experience with HIV/AIDS," *British Medical Journal* 332 (May 20, 2006): 1176.

²⁰ Alexey Bobrik et al., "Prison Health in Russia: The Larger Picture," *Journal of Public Health Policy* 26 (2006): 30–59.

equipment sharing is safe in the prison environment because all prisoners are tested for HIV upon entry, with those testing positive segregated.²¹

Men who have sex with men. Men who have sex with men (MSM) remain in the shadows of Russia's HIV epidemic. The reported HIV infection rate in this group remains relatively low (0.5 percent in 2004). Yet studies repeatedly show that unprotected sex among Russian MSM is common, consistent condom use is low, a large percentage of men exchange sex for money or other valuables, and many men in this group have sexual contact with both men and women. One study indicated that only 38.8 percent reported using a condom during their last anal sexual contact, and another found 64 percent of men reporting recent unprotected anal intercourse, half of those with multiple male partners.²² In a recent survey of sexually transmitted infection (STI) clinic patients, men with a lifetime history of having sex with men were more than twice as likely to have had multiple partners in the preceding three months, relative to men having no lifetime same-sex sexual contact.²³ A curious disconnect separates the reported risk behaviors of MSM in Russia and their absence from HIV surveillance data. This may be due to a failure to ask men about the gender of their sex partners at the time of HIV testing or, in general, to the still highly stigmatized and therefore hidden nature of same-sex sexual activity in Russia.

Military personnel. As of late 2006, a total of 2,200 military personnel were found to be HIV infected. Thousands of potential conscriptees are rejected from military service each year because they test positive; the chair of the Military Medical Commission claims that these numbers grew 25-fold from 2000 to 2005.

Coinfections

The prevalence of tuberculosis (TB) in Russia ranks it 12th among the 22 countries with the highest burden of disease. Russia also suffers one of the highest rates of treatment failure and mortality from TB in the world—a 2004 treatment failure rate of 13 percent and a mortality rate of 14 percent. Russian TB physicians cling to traditional methods of diagnosis and treatment. Although internationally recognized protocols are gradually being introduced through programs funded by the World Health Organization (WHO), the World Bank, and the U.S. Agency for International Development (USAID), implementation of the Directly Observed Therapy, short course (DOTS), strategy has not resulted in fundamental changes in TB control systems, with new cases still routinely hospitalized and lengthy, repeated hospitalizations the norm. Low cost-effectiveness of care is the inevitable result: treatment costs for TB in Russia are more than 15 times higher than the median cost in other high-burden countries,

²¹ A. Sarang et al., "Drug Injecting and Syringe Use in the HIV Risk Environment of Russian Penitentiary Institutions: Qualitative Study," *Addiction* 101, no. 12 (December 2006): 1787–1796.

²² Yuri A. Amirkhanian et al., "HIV Risk Behaviour Patterns, Predictors, and Sexually Transmitted Disease Prevalence in the Social Networks of Young Men Who Have Sex with Men in St. Petersburg, Russia," *International Journal of STD & AIDS* 17 (2006): 50–56.

²³ Eric G. Benotsch et al., "HIV Risk Behavior in Male and Female Russian Sexually Transmitted Disease Clinic Patients," *International Journal of Behavioral Medicine* 13, no. 1 (2006): 26–33.

with higher risk of nosocomial spread of TB to health care staff and possibly other patients.²⁴ Russia's rates of multi-drug-resistant (MDR) TB are the highest in the world, with over 10 percent of new cases and almost half of previously treated cases resistant to both isoniazid and rifampin; 14 percent of these MDR strains are extensively drug resistant.²⁵ Russia's prisons are its primary TB incubator, with 670 cases per 100,000 prisoners in 2006. Overcrowding, inadequate ventilation, and long periods of incarceration facilitate transmission, with drug resistance developing due to poor patient adherence to treatment during and after incarceration and poor follow-up after release from prison.²⁶

HIV coinfection with tuberculosis has not yet emerged as a serious problem, although most analysts view it as inevitable. A 2002–2003 study showed that HIV seroprevalence was rising among TB patients in St. Petersburg but that HIV was not yet driving the local TB epidemic.²⁷ In 2002, the Ministry of Health established a Federal TB Healthcare Delivery Center for HIV-Infected Patients, with a dedicated TB-HIV care coordinator responsible for care and record keeping for coinfecting patients. Still, health services for TB patients with HIV are not coordinated with AIDS centers and primary care institutions, particularly in outpatient settings.

HIV coinfection with hepatitis is also an emerging problem, with hepatitis-prevalence rates particularly high for IDUs infected with HIV. Of Russia's people living with HIV/AIDS (PLWHA), 80 percent are infected with hepatitis C, and 20 percent with hepatitis B, with a one-year course of treatment costing \$8,000 to \$40,000. In 2007, the health ministry is launching 20 regional pilot projects to offer hepatitis treatment for PLWHA. If the HIV epidemic is generalizing through heterosexual contact, then it is very likely that hepatitis is also being spread from IDUs to non-IDUs. One key study has shown that drug dependence and/or alcoholism, HIV, hepatitis, and tuberculosis frequently co-occur in St. Petersburg and the Leningrad region, with clear implications for the necessary integration of diagnostic, prevention, and treatment services. This study strongly recommends vaccination against hepatitis B of persons at high risk, and it suggests that assessment and treatment of alcohol dependency should become an important part of the equation. It is clear that substance use disorders and HIV, hepatitis B and C, and tuberculosis are parallel, overlapping epidemics.²⁸ Currently, separate

²⁴ Florian M. Marx et al., "Reform of Tuberculosis Control and DOTS within Russian Public Health Systems: An Ecological Study," *European Journal of Public Health* 17, no. 1 (2007): 98–103.

²⁵ M. Zignol et al., "Global Incidence of Multi-Drug Resistant Tuberculosis," *Journal of Infectious Diseases* 194 (2006): 479–485.

²⁶ Francis Drobniowski, "Drug-Resistant Tuberculosis, Clinical Virulence, and the Dominance of the Beijing Strain Family in Russia," *JAMA* 293, no. 22 (June 8, 2005).

²⁷ A. Van Rie et al., "TB and HIV in St. Petersburg, Russia: A Looming Catastrophe?" *International Journal of Tuberculosis and Lung Disease* 9, no. 7 (2005): 740–745.

²⁸ E.M. Krupitsky et al., "Co-morbidity of Infectious and Addictive Diseases in St. Petersburg and the Leningrad Region, Russia," *European Addiction Research* 12, no. 1 (2006): 12–19; M.F. Fleming et al., "Alcohol and Drug Use Disorders, HIV Status and Drug Resistance in a Sample of Russian TB Patients," *International Journal of Tuberculosis and Lung Disease* 10, no. 5 (2006): 565–570.

hospitals treat each of these conditions, with virtually no focus on treating multiple disorders simultaneously. The degree to which alcohol and drug use impact initial HIV infection and subsequent access to medical care is understudied, as is the impact of infectious disease on the recovery of persons with alcohol and drug dependence.

Russian Government Policy

Until very recently, the Russian government's response to the epidemic was one of awkward silence. Despite unassailable evidence that HIV represents a growing health, social, economic, and even national security challenge, officials at the highest levels of government sent an unmistakable signal—through their inaction—that HIV/AIDS was not a priority. This reluctance to respond most likely stemmed from a variety of sources: the conservative nature of Russian society, making it awkward to discuss topics like drug use and commercial sex; the fact that the country was facing (and continues to face) such a wide array of other health problems, most strikingly an epidemic of noncommunicable disease causing alarmingly high mortality rates among working-aged men, that HIV/AIDS seemed to be a lesser challenge; the formidable array of acute non-health-related crises that relegated longer-term issues to the back burner; and an instinctive retreat from a challenge whose magnitude seemed so overwhelming and for which available resources were so scarce.

There is no single landmark statement or event that marks the shift from a mute, inert Russian government response to its current relative openness and activism. Hints of change appeared in 2003, when President Vladimir Putin first mentioned HIV/AIDS publicly in his annual “state-of-the-nation” address to the Russian parliament. But significant steps forward emerged only in the fall of 2005, with Putin's announcement of dramatic increases in the federal budget allocation for the fight against the virus. Federal spending on HIV/AIDS programs had risen from about \$4 million per year in the early part of the decade to \$150 million in 2006 and to an estimated \$300 million in 2007. Institutional innovations have followed suit: the State Duma's health committee held hearings on HIV in February of 2006; the State Council considered a strategy on HIV/AIDS for the first time in April 2006; a month later, the first-ever Eastern Europe and Central Asia AIDS Conference was held in Moscow, with a second scheduled for spring 2008; a high-level, multisectoral Governmental Commission on AIDS was established in October 2006. This commission, consisting of representatives of 11 federal ministries and services (including the Federal Security Service, the State Drug Control Committee, the Ministry of International Affairs, the Ministry of Foreign Affairs, and the Ministries of Finance and Economic Development), members of the legislature, and civil society representatives, is to coordinate federal and regional authorities in the implementation of national policy; organize multisectoral participation in the national response to ensure scale-up of prevention, treatment, and care and support programs; and review legislative regulations related to HIV/AIDS. It met for the first time in January 2007, with its decisionmaking processes and

procedures still under development. After years of neglect and denial, high-level Russian government officials, as well as the mid- to lower-level functionaries who follow their lead, are matching words of commitment with actions and resources.

A confluence of factors explains this dramatic evolution in attitude. For years, international organizations, other governments, and a small but remarkably capable nongovernmental sector within Russia exercised both overt and subtle pressures on all levels of government, in many cases working productively to educate government officials about the need to respond to the epidemic. Government inaction prompted a consortium of five Russian nongovernmental organizations (NGOs) to make an ultimately successful application to the Global Fund's third round, a situation that clearly embarrassed the government and may have triggered attention to the epidemic. Perhaps most importantly, the natural resources-led economic recovery of the early and mid-1990s catalyzed a redefinition of Russia's role in the international system. A newly assertive Russia has been determined to reclaim its position as both regional hegemon and global power. To this end, Russia has been anxious to cast itself as part of the solution—rather than part of the problem—when it comes to key issues of global social and economic development. Russia has promised, for example, to reimburse the Global Fund for all \$270 million of its grant funding, and it has pledged tens of millions of dollars in contributions to the fund. Russia's 2006 presidency of the G-8 included a first-ever focus on global health and infectious disease; Putin could hardly ignore the situation within his own borders at the same time he was proposing grand schemes to tackle the same infections in Africa and Asia. A focus on health turns out to be good politics at home as well, with parliamentary and presidential elections approaching in late 2007 and 2008. HIV/AIDS spending in Russia is funneled through a National Health Project, one of four relatively new federal social programs (the others are housing, agriculture, and education) that are surely designed, in part, to guarantee a smooth presidential transition period in 2008.

Is the new policy attention likely to be sustained? The Ministry of Health has made it clear that HIV is but one of a significant array of health problems facing Russia, with important new efforts on tobacco control and noncommunicable disease emerging in 2007. Many observers wonder whether the national projects will continue beyond the coming election cycle, and in private conversations, the Ministry of Finance has indicated that current funding streams for HIV will not be sustained indefinitely, and so the Ministry of Health should work now to “solve the problem.” To the extent that Russia's reemergence as a world power provides incentives for it to portray itself as part of the global health solution, rather than part of the problem, it will want to be able to define the HIV problem as solved or, at minimum, contained. The recent several years' decline in incidence provides the possibility for this to take place.

Most of the millions of HIV/AIDS dollars now flowing through Russia are being spent on antiretroviral (ARV) therapy. In 2006, 3,000 to 4,000 people were on ARVs, with about 26,000 receiving treatment now and a goal of 50,000 set for the end of 2007. The latter target would cover about half of the Russians living

with HIV and AIDS who are in medical need. New Global Fund and government-financed resources for treatment have completely transformed the situation remarkably quickly. Just a year or two ago, very few PLWHA had access to ARVs. Now, in many cases, regional AIDS centers are desperately searching for patients to whom they can administer the drugs in their supply closets. In some cases, people with HIV are still unaware of the benefits to which they are entitled; in others, there are disincentives to report for treatment.

Russia is suffering many of the same growing pains as other countries being showered with Global Fund–financed ARVs for the first time: an imbalance between the quantity of medication now available and the availability of trained staff to deliver that medication; nonexistent or inadequate treatment guidelines (although the Ministry of Health is currently reviewing dozens of new protocols); and the challenge of institutional coordination between the regional AIDS centers, whose drugs are purchased by the government, and the many NGO-based service points supported by the Global Fund. Drug supplies were interrupted in late 2006, for instance, due to delays in tender procedures and unexpected difficulties with customs. As a result of these and other problems, about 1,200 patients who started treatment sometime in 2006 had stopped by the beginning of 2007. Treatment adherence remains a major concern, as does the potential for the spread of drug-resistant virus.

Given the extent to which Russia’s epidemic has been fueled by injection drug use, the question of ARV treatment for IDUs has become urgent and controversial. It is commonly assumed that drug users are unable or unwilling to adhere to treatment protocols and are less likely than non-IDUs to experience virologic and immunologic response. According to WHO protocols, there should be no categorical exclusion of IDUs from any level of care. Prior to 2006, because of lack of available medications and fears about poor adherence, virtually no active IDUs received antiretroviral therapy in Russia. Regional AIDS centers may now be putting current IDUs on treatment in order to achieve government-set targets for numbers of people receiving medications, without proper guidelines and systems in place to support treatment adherence. A mathematical model assessing the public health benefits and economic costs in Russia of an array of treatment strategies—treating only HIV-positive individuals who did not inject drugs versus treating both those who do and those who do not inject drugs—found that treating all HIV-positive persons, regardless of their drug-use status, would prevent a significantly larger number HIV infections over a 20-year period and would cost only \$300 more annually per life-year gained than treating only non-IDUs. This model includes the additional support costs required to ensure that drug users adhere to treatment regimens.²⁹ Representatives from Russia’s main harm-reduction NGO, the Open Health Institute, claim that of 2,000 people receiving treatment as part of a Global Fund–sponsored project, 60 percent are former IDUs, with a 90 percent retention and adherence rate.

²⁹ Elisa F. Long et al., “Effectiveness and Cost-Effectiveness of Strategies To Expand Antiretroviral Therapy in St. Petersburg, Russia,” *AIDS* 20 (2006): 2207–2215.

International experience has demonstrated that treatment and prevention must receive balanced and synergistic attention. In Russia, until this year, prevention has garnered a small minority of government funding, and those meager resources have been too often ill spent. Media campaigns and other efforts are implemented on a research basis that is flimsy at best. At present, the country enjoys no large-scale HIV-prevention programs at the federal or regional levels. Comprehensive school-based education on sex and illicit drugs is underdeveloped. This lack of information contributes to stigma and permits the dissemination of misinformation. A coherent strategy for prevention has not emerged, with key questions still not receiving the attention they deserve: should prevention messages be aimed at the general population or at key risk groups? How should groups be targeted? How does the unique Russian context shape the conditions for social marketing? The institutional structure of the Russian science, health, and education systems is in part to blame: hospitals are not linked to universities, which in turn are not linked to public health institutions, so that too-scarce competent research does not inform public health programming. The few Russian professionals with training and skills in social marketing are siphoned off into lucrative jobs in the private sector. In this environment, it is difficult to determine with certainty what prevention measures would prove most effective, let alone carry them to fruition.

Source of financing, 2006 (millions of rubles, \$1 = 27 rubles)	Total	Prevention	Treatment	Research	Construction
Federal Targeted Program	194.5	56.8	13.7	16.1	107.9
National Health Project	3,100.0	200.0	2,900.0	0	0
Regional budgets	393.7	380.9	12.78	0	0
World Bank project	13.6	13.6	0	0	0
GLOBUS project (Global Fund Round 3)	18.13	8.6	8.35	0	0
Global Fund Round 4	12.8	5.5	6.7	0.6	0
Total	4,890.2	1,385.6	3,333.0	32.3	107.9

As the government allocates more resources to prevention in 2007 and beyond, these issues assume even greater urgency. The bulk of prevention

funding in 2006 came from regional budgets, whose reliability is always uncertain.³⁰

Russia's total HIV/AIDS budget for 2007 more than doubles that for 2006, with the funds distributed along a significantly different pattern that highlights prevention; it remains unclear how these prevention resources are being distributed.

Source of financing, 2007 (millions of rubles, \$1 = 27 rubles)	Total	Prevention	Treatment	Research	Construction
Federal Targeted Program	350.2	13.7	81.5	25.6	229.4
National Health Project	7,800.0	4,600.0	3,200.0	0	0
Regional budgets	710.0	500.0	0	0	210.0
World Bank project	13.6	13.6	0	0	0
GLOBUS project (Global Fund Round 3)	16.43	8.96	6.32	0	0
Global Fund Round 4	21.3	5.0	15.4	0.9	0
Total	10,246.2	5,858.9	3,867.9	49.9	439.4

Russia's regions are far from homogeneous in their approach to the fight against HIV, with considerable differences in the stages of the epidemic, organizational arrangements, political environment, social attitudes, public financing, monitoring and clinical management of HIV/AIDS patients, civil society involvement, and the degree of multisectoral participation and integration.³¹ A significant amount of budgetary responsibility was transferred to the regions in mid-2004, but there were no accompanying standards or recommendations for action. While most regions remain stifled by the rigid legacies of the Soviet health care system and remain responsive only to incentives and edicts from Moscow, a few have managed to mobilize creative and progressive responses. For example, in Tatarstan, an autonomous republic with a history of action independent from the Kremlin, path-breaking innovations have emerged. The Simona Center in Kazan, the only one of its kind in the country, offers commercial sex workers support mechanisms including free diagnostics and medical services for HIV and STIs, free condoms, information on HIV

³⁰ Transatlantic Partners Against AIDS, "O finansirovani mer po profilaktike i bor'be v VICH/SPIDom v Rossii" [Financing the Prevention and Fight against HIV/AIDS in Russia], *Information Bulletin* 3, no. 7 (December 2006).

³¹ Rifat A. Atun et al., "Analysis of How the Health Systems Context Shapes Responses to the Control of Human Immunodeficiency Virus: Case-Studies from the Russian Federation," *Bulletin of the World Health Organization* 83, no. 10 (October 2005).

prevention, and referrals to treatment for those who test HIV-positive. The center, jointly run and financed by the city government and local NGOs, also conducts outreach programs, trying to persuade escort services to refer their sex workers for regular health checkups.³² A similarly progressive Kazan program, Project Renewal, also cofunded by the local government and international sources, provides needle and syringe exchange and associated harm-reduction services through 15 stationary outlets, one mobile unit, and three street outreach workers. Services include HIV and STI testing, individual counseling, and all associated counseling.³³

Harm reduction remains extremely controversial nationwide. A network of needle-exchange programs, largely supported by international donors, has persisted for more than a decade, but across the country these efforts endure local police harassment. Many street-level officers see all drug users as potential criminals who warrant a “preemptive” approach to crime prevention. Police officers loiter around pharmacies, as well as the few existing needle-exchange points, hoping to arrest drug users buying syringes in order to fulfill set “targets” for drug arrests and to extort money from drug users. The tension is not merely between public health and law enforcement; even some of the country’s senior health officials question the efficiency of needle-exchange programs in an environment where needles and syringes can be purchased cheaply and over the counter at any pharmacy, in many cases for less money than the subway ride to the needle-exchange point. The harm-reduction NGOs counter that their programs provide an important range of services beyond just needle exchange and that the lure of free, clean injecting equipment serves the important goal of attracting clients to those services. This dynamic grows more important as Russia’s drug culture changes, with a new generation of heroin users much less communal than the subculture of the 1990s. As a result, younger IDUs are even harder to reach.

A 2004 multisectoral cohort study in three Russian cities found a statistically significant difference in the rates of risky behavior, HIV prevalence, and HIV incidence between IDU harm-reduction participants and nonparticipants—and also between cities where harm reduction was present and where it was not. All new HIV infections, at the end of the one-year follow-up period, had occurred among nonparticipants in harm-reduction efforts. A 2002 cost-effectiveness study of 16 harm-reduction programs in Russia demonstrated that one HIV infection could be delayed for one year at a cost of \$564, a considerable savings over the annual cost of medical treatment for a single person infected with HIV.³⁴

Medically assisted therapy (MAT) for drug users cannot even be called controversial in Russia, so pervasive and explicit is the denial of its legality and legitimacy. While a very few supporters cite its proven effectiveness worldwide, its detractors—including the bulk of the medical establishment—proclaim that it

³² “Tatarstan Clinic Is Bold Exception in HIV Battle,” RFE/RL, August 10, 2006.

³³ Kevin Irwin et al., “Secondary Syringe Exchange as a Model for HIV Prevention Programs in the Russian Federation,” *Substance Use & Misuse* 41 (2006): 979–999.

³⁴ Studies cited in Ksenia Eroshina, “Harm Reduction Programs in the Civilian and Prison Sectors of the Russian Federation: Assessment of Best Practices,” Open Health Institute, Moscow, 2006.

simply substitutes one addiction for another, that it would be prohibitively expensive to implement, and that it risks illegal trade in diverted and surplus medicines. With no meaningful tradition of evidence-based medicine in Russia, the impact of international scientific evidence is not strong. The small number of physician proponents of MAT in Russia has been subject to tax investigation and detention by the authorities. Thus Russia remains one of the very few countries worldwide where MAT is prohibited. In April of this year, the head of the State Drug Control Agency's Information Office complained that foreign organizations had been "exerting pressure" on Russia to introduce methadone programs. He observed that methadone would not "pursue medical goals" in Russia, but rather "fulfill selfish interests" for Western pharmaceutical firms.³⁵ In fact, methadone is produced by many different companies at very low cost as a generic product.

The capacity of civil society to cope with HIV/AIDS is uneven. Russia hosts a small but remarkably competent and savvy group of NGOs that have fully integrated into the international AIDS community. Unfortunately, the talent in these NGOs is neither broad nor deep, and that shallow layer of very capable top leadership is experiencing burnout from travel to international conferences, from the frustrations of dealing with government bureaucracy, and from the challenge of working with difficult client populations. Too many of these important NGOs have little human resource management experience. They have not yet internalized the importance of hiring professional staff with specialized skills and of rotating capable individuals through stressful positions.

HIV/AIDS organizations have not yet appeared in the crosshairs of the government's recent policies toward internationally funded NGOs. Negative attention appears concentrated on organizations that focus on democracy and free media; the first wave of attacks consisted of auditors looking for institutions engaging in activity inconsistent with their charters. This is rarely an issue for HIV/AIDS agencies. Many of the HIV/AIDS NGOs assume that their "time will come," however, particularly if they are involved in controversial harm-reduction activities. But the more sophisticated NGOs have learned to involve government integrally into their efforts, often collaborating with working-level government personnel and offices in creative and productive ways.

In September 2005, the Russian Orthodox Church (ROC) emerged as a major figure on Russia's HIV/AIDS landscape, issuing a "Concept of the Contribution of the Russian Orthodox Church to Fighting against the Spread of HIV/AIDS and to Working with People Living with HIV/AIDS." The church concentrates its efforts on palliative care programs and rehabilitation centers for IDUs and PLWHA. These efforts, by and large, are not coordinated with the national government or with other players. The overarching concept is "hate the sin, but love the sinner," with promotion of behavior change focused on abstinence, faithfulness to a spouse, and drug demand reduction. The church's work on HIV remains controversial, however, with its head in 2006 having called Western-funded NGOs doing AIDS work "immoral." In April 2006, a ROC archbishop

³⁵ Interfax, April 5, 2007.

commented that prayer alone could cure HIV-infected people if they would commit to “a restoration of harmony between soul and body.”³⁶

Health care for people with HIV and AIDS takes place in Russia’s network of regional AIDS centers. Although staffing varies from region to region, most centers boast an infectious disease specialist; pediatrician; ear, nose, and throat specialist; ophthalmologist; neurologist; dentist; physiologist; social worker; nurses; and laboratory personnel—each of whom receives a significant salary supplement to work with HIV/AIDS patients. These clinics are isolated from the rest of the health care system. In general, the Russian system of health care is vertically oriented, with extreme specialization of personnel and facilities treating specific diseases or patient groups. This rigid system has kept information about HIV out of the hands of general practitioners, who do not see it as their responsibility. Prevention and detection is therefore virtually absent at most regular polyclinics. Doctors and nurses outside the confines of the AIDS centers remain ignorant of even the most basic facts about HIV. The lack of communication between different specialists lets patients coinfecting with HIV and TB, for example, or HIV and hepatitis, fall through the cracks. Narcology clinics would never think of distributing condoms or counseling their patients on safe sex practices—yet if HIV is to be stopped at bridge populations, improving the sexual health of IDUs should be a top priority. There is no comprehensive institutional mechanism on Russia’s horizon for breaking out of these silos. In a small number of regions, the problem has been recognized: in a select number of districts in St. Petersburg, for example, a project called PreventAIDS, funded by the city government and Population Services International (PSI), is establishing a network of medical, legal, and social services for HIV-infected people and members of risk groups. In some cases, in particular St. Petersburg and Tatarstan, there are experiments taking place where AIDS center physicians conduct initial patient intake and determine treatment protocols, but then local infectious disease doctors administer ARV medications. The Ministry of Health has adopted integration of HIV/AIDS care with primary care as a stated objective, but there is resistance. Primary care physicians, and even infectious disease doctors, are not interested in the increased work load. And many patients prefer the anonymity that goes along with travel to an AIDS center away from their home neighborhood for treatment.

The Russian government is allocating significant resources to the development of an HIV/AIDS vaccine. One of Russia’s pledges following the St. Petersburg G-8 summit was a \$40-million commitment to a regional center for developing HIV/AIDS vaccines and medications, pooling the talents of the country’s seven relevant research centers and institutes, including the Vector Research Center in Novosibirsk, the Institute of Immunology in Moscow, and St. Petersburg State University. The center is also envisioned as a base for monitoring the epidemic in Russia and Eurasia.

The private sector in Russia has engaged the epidemic to only a limited extent; several studies indicate that there is scant appetite for HIV as a workplace

³⁶ Cited in Reuters, April 21, 2006.

issue. The Russian business organization “Delovaya Rossiya,” or “Business Russia,” has held an annual spring conference since 2003 on AIDS and large business, attended recently by more than 100 Russian and international companies, including Alfabank and General Motors. Transatlantic Partners Against AIDS (TPAA) one of the primary sponsors of country-wide anti-AIDS media campaigns, funds its activities increasingly through Russian business rather than international sources.

Russia, the United States, and the World

The international community has mobilized impressively over the last five years to combat Russia’s HIV epidemic. The World Bank is implementing a \$286-million Tuberculosis and AIDS Control Project, funded by a \$150-million loan with a \$46.8-million HIV/AIDS component that covers all the country’s geographic regions. The project is developing large-scale interventions through updating strategies, guidelines, and protocols; conducting needs assessments; carrying out training to improve local capacities; supplying equipment and consumables for both diagnostics and treatment; and focusing in particular on the provision of drugs for TB treatment and the prevention of mother-to-child transmission of HIV. Implementation of the HIV parts of the project is lagging behind those for TB, mainly because of Ministry of Health delays in approving the required orders, guidelines, and protocols for prevention and treatment. It is suspected that these delays stem from the continued internal debate over the legitimacy and efficacy of harm-reduction programs.

The Global Fund has approved three grants to Russia, spanning rounds three, four, and five.

Recipient	Total Funding Requested	Approved Maximum	Total Disbursed as of July 2007	Project Dates
Round 3: Open Health Institute	\$88.7 million	\$88.7 million	\$57.2 million	2004–2009
Round 4: Russian Health Care Foundation	\$120.5 million	\$34.2 million	\$33.5 million	2005–2010
Round 5: Russian Harm Reduction Network	\$13.5 million	\$4.1 million	\$1.4 million	2006–2011

The round 3 grant process was one important element of the Russian government’s wake-up call on HIV/AIDS. Because the government could not coalesce sufficient strategy, organization, and commitment to form a viable country coordinating mechanism (CCM), and because stable decision procedures

were not in place for the production of a proposal, the Global Fund turned instead to a consortium of five NGOs that had been working successfully in the country for years: the Open Health Institute, Population Services International, AIDS Foundation East-West, AIDS-infoshare, and Focus-Media. A dramatic departure from the Global Fund's practice of allocating funds only to an established, multisectoral CCM, the round 3 grant supports these NGOs in the provision of sustainable prevention programs in both the mass media and with specific targeting of high-risk groups, in the provision of treatment, care, and social support services to PLWHA, and in their efforts to advocate for improvements in the HIV/AIDS policy environment. Round 3 activities take place in 10 of Russia's regions.

The round 4 grant funds the Russian government's efforts to identify PLWHA and refer them to appropriate treatment and care services. The program operates in 59 regions. In addition to the nation-wide scale-up of antiretroviral therapy (with a goal of 74,000 people on ARVs by 2009), the grant also strengthens national and regional surveillance and monitoring and evaluation systems and supports harm-reduction and outreach activities. Round 5 focuses on harm reduction, significantly increasing the number and coverage of services, including the provision of counseling, information, and treatment adherence support for IDUs. Its focus area includes 33 cities. It is expected that the number of IDUs accessing services will increase, as a result of grant activities, from 38,200 in the first year of the project to 167,800 in the fifth year.

The United States enjoys a long history of bilateral engagement with Russia on health. From 1993 through 2006, 32 health partnerships between U.S. and Russian health institutions in 24 regions of Russia and 24 U.S. states have linked more than 3,500 U.S. and Russian physicians, nurses, policymakers, health administrators, lab technicians, NGO representatives, educators, and social workers. These peer-to-peer relationships, administered by the American International Health Alliance (AIHA), have covered hospital care and administration, primary health care, reproductive health, women's health, neonatal resuscitation, emergency medical services, and child welfare.³⁷ With USAID funding, AIHA has also established an AIDS Training and Education Center (ATEC) in St. Petersburg, in partnership with the St. Petersburg Medical Academy for Post-Graduate Studies and several affiliated clinical sites. ATEC is providing targeted training for physicians, nurses, and social workers, as well as policymakers and allied health professionals, to develop the institutional and human resource capacity for a comprehensive, integrated approach to care for PLWHA.

President George W. Bush launched his President's Emergency Plan for AIDS Relief (PEPFAR) in January 2003, a \$15-billion, five-year initiative to combat the global HIV/AIDS epidemic through prevention, treatment, and care programs. Russia is not a focus country under PEPFAR, but in 2006 it became one of five "countries of interest" receiving additional bilateral funding under PEPFAR

³⁷ Embassy of the United States in Russia, "Bicentennial Partnerships: Health and Science," http://moscow.usembassy.gov/200th/anniversary.php?record_id=health.

auspices (the others are Cambodia, India, Malawi, and Zimbabwe). Each of these countries receives at least \$10 million in U.S. government funding for HIV/AIDS. A PEPFAR interagency team arrived in Moscow for the first time in July 2005, in preparation for the changeover of Russia to PEPFAR status. Since Russia became a PEPFAR country, assistance on HIV/AIDS in Russia has fallen under the aegis of the U.S. Global AIDS Coordinator, with interagency country teams working together.

The U.S. Agency for International Development has been the main player on bilateral health programs in Russia throughout the post-Soviet period. USAID's work on HIV in Russia dates back to 1998, but since 2006, every dollar spent on HIV in Russia has been PEPFAR funding channeled through various agencies. The PEPFAR umbrella provides a single framework for joint strategic planning among all U.S. government institutions working on HIV in the country. In the pre-PEPFAR period, USAID collaborated tightly on health issues in Russia with the Centers for Disease Control and Prevention (CDC), but its activities were less well integrated with those of other agencies. Still, before 2006, the U.S. embassy in Russia was one of the only embassies in the world to have an interagency task force on HIV, which greatly eased the transition to PEPFAR procedures. Now PEPFAR provides a vehicle for focus on outcomes across agencies. With the advent of the new arrangements, the U.S. Department of Defense has allocated more resources to efforts against HIV in Russia, and the National Institutes of Health (which have always sponsored research) have aligned their activities with the overall country strategy.

USAID's total budget for Russia has steadily declined from about \$106 million in FY 2004 to just under \$61 million in FY 2007. Throughout the current presidential administration, the U.S. government has been divided on assistance to Russia, rarely speaking with a single voice. In general, the Department of State has inclined toward increased engagement, with the Office of Management and Budget predictably leaning in the opposite direction, and the National Security Council sending mixed messages over time. As a result, Freedom Support Act (FSA) funding—by far the largest source of U.S. government funding for assistance to and partnership with Russia—is always rumored to be on the chopping block, with apprehension surrounding the annual appropriations process and then funding finally approved only at the 11th hour.

USAID's total health budget for FY 2006 was \$27.9 million, with 38 percent of that devoted to HIV/AIDS, 19 percent to tuberculosis and other infectious diseases, 13 percent to vulnerable children, 24 percent to reproductive health, and 6 percent to other public health threats. Overall FSA support for HIV/AIDS programming in Russia, with smaller continuing amounts through a Child Survival and Health Programs Fund (CSH), has tracked as follows.³⁸

³⁸ USAID, "USAID Budget: Russia," www.usaid.gov/policy/budget/cbj2007/ee/ru.html.

	FY 2004	FY 2005	FY 2006	FY 2007	Percent change, 2004–2007
CSH	\$3 million	\$3 million	\$2.97 million	\$2.97 million	-1.0 percent
FSA	\$7.078 million	\$10.9 million	\$8 million	\$5.321 million	-24.8 percent
Total	\$10.078 million	\$13.9 million	\$10.97 million	\$8.291 million	-17.7percent

The declared U.S. government HIV/AIDS strategy in Russia is to prevent the evolution of the epidemic from concentrated to generalized by engendering bold leadership within the Russian government, the Russian Orthodox Church, and the Russian armed forces; supporting UNAIDS and other multilateral donors; expanding and strengthening HIV/AIDS surveillance for decisionmakers as part of the UNAIDS “Three Ones” strategy; concentrating HIV-prevention efforts on the most vulnerable populations, including IDUs, commercial sex workers, soldiers, and prisoners; and engaging in dialogue with the medical community to provide integrated treatment and care services for the most at-risk populations. Rather than thinly spreading a limited pool of resources, the United States works primarily in two regions—Orenburg and St. Petersburg—to provide a broad spectrum of specific services at those sites: capacity building with local NGOs, the development of PLWHA support groups, strengthening treatment adherence, risk reduction, and outreach to sex workers and youth. The logic is that the Global Fund has the resources to provide medications, and so the United States can pursue other goals, including setting up pilots that establish best practices for the Global Fund and others.

The U.S. government clearly sees health and HIV as effective tools for engagement, particularly as Russia has become hostile toward programs related to democracy or open media. Yet the commitment to sustaining this engagement is weak. The current strategy is to phase out work on HIV in Russia in about five years, as there will be little chance to add value after that point: either Russia will have enhanced its domestic capacity and commitment to battle the epidemic, or it will have demonstrated that it is not genuinely interested in doing so. The counterargument is obvious: even if Russia’s political and financial commitment to HIV is sustained, it will take more than five years to develop the capacity to spend money effectively on treatment adherence, coinfections, and an array of other concerns.

U.S. strategy toward Russia has also developed a focus on joint opportunities to tackle global health problems, including vaccine development, rapid diagnostics for MDR-TB and other infections, effective and efficient clinical trials, and other challenges. In February 2005, Presidents Bush and Putin met at Bratislava, Slovakia, and committed to a number of initiatives, including greater joint efforts to counter the threat posed by the global spread of HIV/AIDS. The presidents committed to programs to raise public awareness, identify, train, and deploy health care professionals, and possibly work jointly to combat the

epidemic in third countries, at those countries' request. As a result of the Bratislava initiatives, U.S. and Russian laboratory specialists have worked together in Namibia and Ethiopia to train local specialists on HIV testing and diagnostics. Of course, there is a singular danger to this approach: the more the U.S.-Russia dialogue on HIV/AIDS centers on curbing the epidemic in the rest of the world, the more attention is diverted from the continuing challenges Russia faces at home.

PEPFAR and USAID have sponsored a number of HIV/AIDS initiatives in Russia worthy of special note:

- PEPFAR and AIHA sponsor “twinning” programs between Russian and U.S. institutions, where ongoing relationships are created between similar organizations. These partnerships focus on the creation of comprehensive, integrated model programs for providing prevention, treatment, care, and support services to PLWHA. The twinned pairs currently include the St. Petersburg City AIDS Center and Yale University School of Medicine; the Saratov AIDS Center and the Northern Rivers HIV/AIDS Consortium in Bemidji, Minnesota; the Orenburg AIDS Center and the Elmhurst Hospital Center in New York City; and the Samara Oblast Ministry of Health and Togliatti City Health Department with the National Perinatal Information Center in Providence, Rhode Island.
- The Healthy Russia 2020 project has trained Russian government and NGO personnel on models for evaluation of the cost effectiveness of various HIV/AIDS interventions. Lessons learned have been applied to regional and municipal HIV/AIDS budget planning in Irkutsk, Orenburg, and Ivanovo, with the results of the training having led to increases in regional budgets for HIV/AIDS in several cases.
- USAID funds Transatlantic Partners Against AIDS (TPAA). TPAA directs the Russian Media Partnership to Combat HIV/AIDS (RMP), a group of more than 30 television, print, radio, and Internet-based partners that creates public service announcements on all platforms and runs special radio and television programming and print publications. RMP launched Russia's first coordinated public education program, StopSPID (Stop AIDS), in December 2004 on World AIDS Day. TPAA also created the Health@Work program, designed to help private companies raise awareness among their employees, safeguard their health, and reduce economic losses due to HIV/AIDS. The program runs seminars for executives, workers, company-based medical staff, and human resource managers. Since 2004, the program has held seminars for Alfa-Bank, AvtoVAZ, Coca-Cola, DaimlerChrysler, BP, Unilever, Wimm-Bill-Dann, and others.
- The NIH has spent some \$10 million on HIV/AIDS research in Russia, out of a total NIH HIV/AIDS budget of about \$2.9 billion. The funding for Russia has decreased in recent years, with about \$2.4 million in FY 2004, \$1.5 million in FY 2005, and \$980,000 in FY 2006. The types of projects funded include assessments of risk behaviors among high-risk groups, risk reduction modeling, alcohol interventions, prevention of HIV among IDUs, drug law

and policy assessment, drug addiction treatment, and psychosocial treatment for IDUs and PLWHA.

- The U.S. Civilian Research and Development Foundation (CRDF) has expanded joint U.S.-Russian HIV/AIDS biomedical research and disease surveillance. Notably, in March 2007, CRDF sponsored a bioethics workshop, funded by PEPFAR, with a specific focus on ethical considerations during clinical trials for HIV medications. About 80 Russian scientists, health professionals, and NGO representatives completed this training.
- The CDC's ongoing HIV-related activities in Russia include:
 - 1999-present: Laboratory and integrated behavioral risk assessment on the prevalence of STIs, HIV, and illicit drug use among various population groups in Moscow and Saratov.
 - 2002-present: Technical assistance for implementation of a large-scale program to prevent mother-to-child transmission of HIV among high-risk women in St. Petersburg and the Leningrad region.
 - 2003-present: Technical assistance and joint work to develop protocols to collect specimens to screen for HIV and other STIs, along with the genotyping of agents, with the Russian Center of Molecular Diagnostics and Therapy in Moscow.
- The CDC also carries out a large number of research projects on tuberculosis in Russia, and with USAID funding it is partnering with Russian laboratory experts on a 2005–2007 project to build laboratory capacity in third countries. The goal is to gain shared experiences through joint consultations to implement a tiered, quality-assured laboratory system to support in-country PEPFAR initiatives. The collaboration also educates Russian health professionals with the goal of integrating them into the international public health community.
- The United States has also joined Russia in military-to-military contacts, with several joint conferences having taken place in Moscow to discuss diagnosis and treatment of HIV in the armed forces. This PEPFAR-funded, Department of Defense program trains Russian military leaders and physicians, shares treatment protocols, and may be working toward a comprehensive HIV-testing program for the Russian armed services. The program also has a burgeoning research component, with a knowledge, attitudes, and behavior survey in process among new recruits.

Recommendations

Clearly there are many avenues along which the U.S. government can and should continue to play a role in Russia's struggle with HIV/AIDS. The U.S.-sponsored research activity through the NIH and CRDF, for example, including collaborations, dialogue, and exchanges of personnel, has been perceived as enormously valuable in Russia. Evidence-based traditions are being nurtured by

researchers in Russian institutes and universities who have been part of these programs for over a decade.

More controversially, the United States can be a presence that delivers—sometimes by words, sometimes by example—strong, consistent messages on difficult issues. Unlike needle exchange, for instance, there is no U.S. government policy against substitution therapy, and therefore there would be no contradiction in USAID becoming more vocal about the indisputable body of international research on MAT's efficacy, cost effectiveness, and impact on reduction in crime and recidivism. The United States might successfully engage the Russian pharmaceutical industry in this effort, since it is clearly in that corporate interest to produce domestically and sell a product with such a potentially large market. The United States can also offer, through constructive and careful policy dialogue, the benefit of its own experience with intersectoral integration and cooperation in the health sector, faith-based programming that maintains a tone of compassion and inclusion, the crafting of effective incentives to lure marginalized groups of patients to health facilities for treatment, and other capacity issues on which Russia continues to struggle.

The United States is the only bilateral donor that remains committed to HIV/AIDS in Russia; the others have either pulled out or stated their intentions to do so in the very near future. On the surface, the argument may seem compelling: Russia has plenty of money now, and the needs seem far greater in other parts of the world. But the existence of plentiful resources does not guarantee the capacity to spend those resources effectively, nor does it guarantee the sustainability of the present Russian government commitment. It is not appropriate, of course, to be telling Russia what to do; a conversational, partnering tone is preferable to a “donor's” voice of arrogance. But USAID, working with other U.S. government agencies under the PEPFAR umbrella, can continue to highlight the need to focus on high-risk and marginalized groups; it can share its experience with research-based prevention efforts; it can demonstrate international best practices across a wide range of technical and programmatic issues; and it can sustain Russia's focus on HIV through productive U.S.-Russia programs to address HIV/AIDS and other health crises throughout the world. Significant challenges lie on the horizon, including coinfections with tuberculosis and hepatitis, treatment adherence, and overall capacity building. The Russian experience has much to offer to the rest of the world. The United States would be wise to remain engaged to help ensure that this experience remains on the positive track of momentum and commitment.

About the CSIS Task Force on HIV/AIDS

The CSIS Task Force on HIV/AIDS seeks to build bipartisan consensus on critical U.S. policy initiatives and to emphasize to senior U.S. policymakers, opinion leaders, and the corporate sector the centrality of U.S. leadership in strengthening country-level capacities to enhance prevention, care, and treatment of HIV/AIDS. J. Stephen Morrison, director of the CSIS Africa Program, manages the overall project, in cooperation with the CSIS Freeman Chair in China Studies, the CSIS Russia/Eurasia Program, and the CSIS South Asia Program.

The honorary cochairs of the task force are Senator Russell Feingold (D-Wis.) and Senator John E. Sununu (R-N.H.). Former senator William H. Frist remains an active partner of the task force. The CSIS Task Force on HIV/AIDS is funded principally by the Bill and Melinda Gates Foundation, with project support and input from the Henry J. Kaiser Family Foundation, the David and Lucile Packard Foundation, and Merck and Co. The task force outlines strategic choices that lie ahead for the United States in fighting the global HIV/AIDS pandemic and comprises a core network of experts drawn from Congress, the administration, public health groups, the corporate sector, activists, and others. This panel helps to shape the direction and scope of the task force and disseminate findings to a broader U.S. audience.

Now in its seventh year, the task force's principal focus is on two critical issues: first, raising the profile and improving the effectiveness of U.S. support to global prevention efforts and facilitating a bipartisan discussion of global HIV prevention policy; and second, examining how U.S. leadership can facilitate the sustainability of HIV/AIDS programs, both in terms of resource flows and in situating HIV/AIDS responses within a broader strategy to address gaps in gender equity, health infrastructure, human capacity, and international collaboration on global health. The task force continues to engage on the emerging dynamics of the epidemic in Russia, China, and India with recent delegation visits in mid-2007.