

Eastern Europe and central Asia

2025 DATA

17% increase in number of new HIV infections since 2010

11% increase in number of AIDS-related deaths since 2010

People living with HIV: 2.0 million [1.8 million–2.2 million]

New HIV infections: 120 000 [100 000–140 000]

AIDS-related deaths: 43 000 [34 000–54 000]

Testing and treatment cascade (all ages):

People living with HIV who know their HIV status: 83% [66–95%]

People living with HIV who are on treatment: 56% [44–63%]

People living with HIV who have a suppressed viral load: 48% [43–52%]

Elimination of vertical transmission:

Antiretroviral therapy coverage among pregnant women living with HIV: 92% [82–>98%]

Vertical transmission rate: 6% [5–7%]

Financing of the HIV response:

Resource availability for HIV: US$ 585 million

Despite progress, numbers of new HIV infections continue to rise

The HIV response in eastern Europe and central Asia continues to face challenges, with the annual number of new HIV infections rising to 120 000 [100 000–140 000] in 2025, a 17% increase from 100 000 [88 000–120 000] in 2010. In 2025, the region accounted for 10% of new HIV infections globally and is off track to achieve the targets for ending AIDS as a public health threat by 2030. Numbers of AIDS-related deaths are estimated to still be rising, reaching 43 000 [34 000–54 000] in 2025 (Figure 12.1), but with wide uncertainty in some countries with data or reporting limitations.

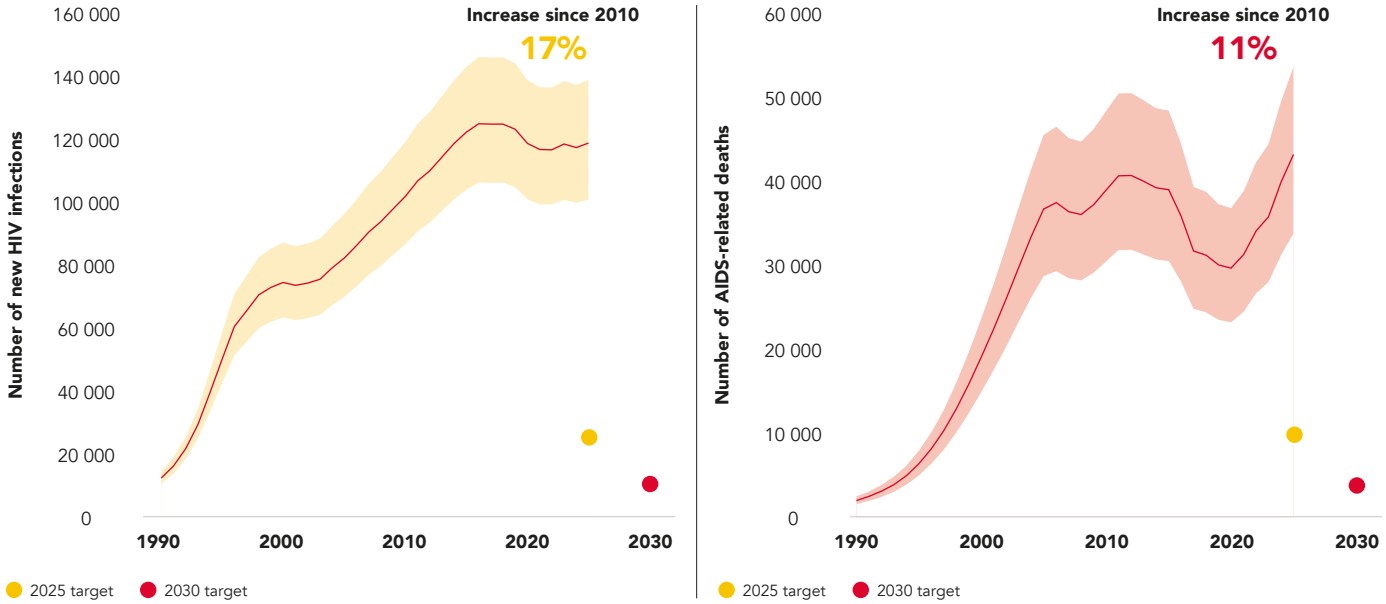
Numbers and trends of new HIV infections varied across countries. Between 2010 and 2025, there were substantial declines in Azerbaijan, Georgia and Tajikistan, but particularly pronounced increases in Armenia, Kyrgyzstan and Montenegro (Figure 12.2).

HIV remains concentrated among key populations in eastern Europe and central Asia, in terms of both the burden of prevalence and the number of new infections. Among countries reporting survey data, the median HIV prevalence was disproportionately high among people who inject drugs (6.7%), gay men and other men who have sex with men (5.1%) and sex workers (3.0%), compared with adults aged 15–49 years in the general population (1.1% [1.0–1.2%]) (Figure 12.2). These disparities highlight persistent gaps in access to HIV prevention, testing and treatment services.

UNAIDS estimated a high proportion of new adult infections in all countries in the region among people who inject drugs and sex workers and their clients and partners, and gay men and other men who have sex with men. These proportions notably increased between 2010 and 2024 for gay men and other men who have sex with men.

Numbers of new HIV infections and AIDS-related deaths continue to increase

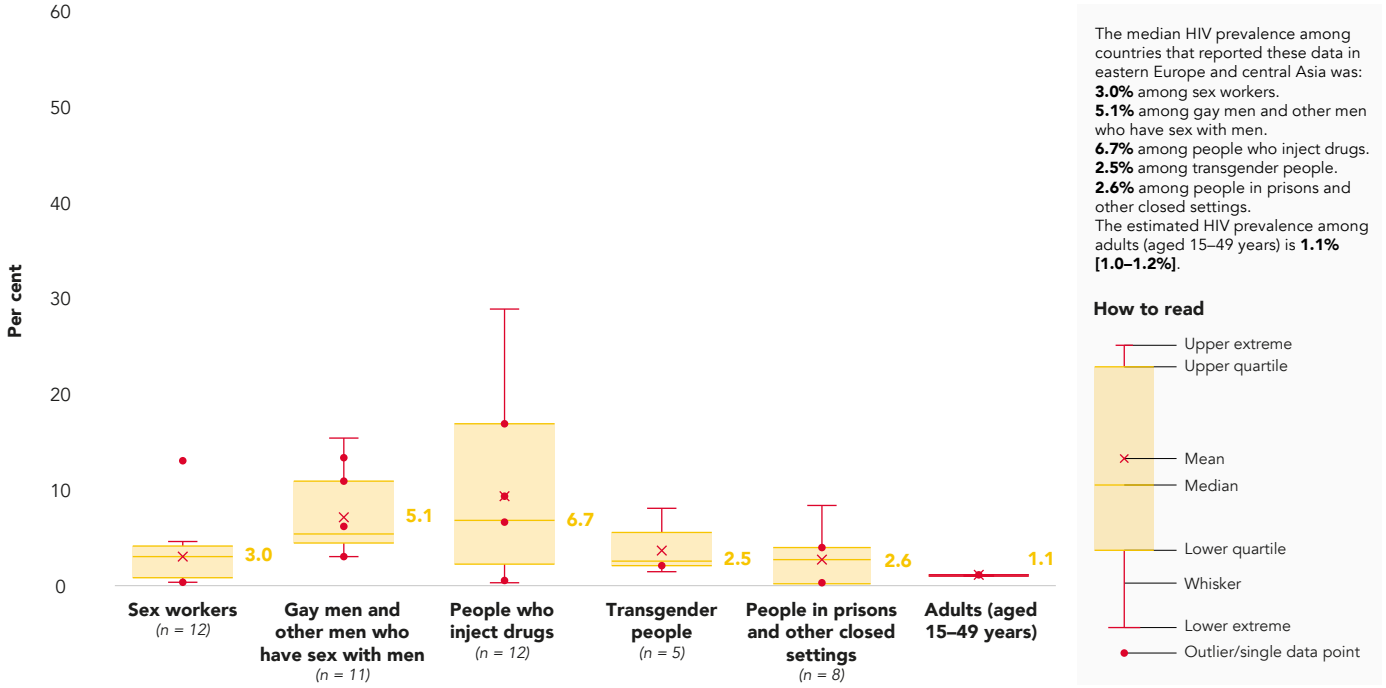
Figure 12.1. Numbers of new HIV infections and AIDS-related deaths, eastern Europe and central Asia, 2000–2025



Source: UNAIDS epidemiological estimates 2026 (https://aidsinfo.unaids.org/).

HIV prevalence remains markedly higher among key populations in eastern Europe and central Asia

Figure 12.2. HIV prevalence among people from key populations compared with adults (aged 15–49 years), reporting countries in eastern Europe and central Asia, 2021–2025



Source: UNAIDS Global AIDS Monitoring, 2022–2026; UNAIDS epidemiological estimates, 2026 (https://aidsinfo.unaids.org/).
Notes: n = number of countries. Total number of reporting countries = 16. The adult prevalence uncertainty bounds define the range within which the true value lies (if it can be measured). Narrow bounds indicate that countries reported similar prevalence, while wide bounds indicate greater disparity in the reported prevalence.

Coverage of HIV prevention and harm reduction services remains insufficient, particularly for populations most affected by HIV

Prevention coverage remains insufficient to curb the growing HIV epidemic in eastern Europe and central Asia. Uptake of pre-exposure prophylaxis (PrEP) increased by 16% between 2024 and 2025 but remained below the needed level, with only 38 000 people across 10 reporting countries receiving PrEP in 2025. Harm reduction services remain limited: median coverage of opioid agonist therapy was only 8% across eight reporting countries (far below the recommended 50%), and needle–syringe programmes distributed a median of 67 needles and syringes per person who injects drugs per year across eight reporting countries (below the recommended 300). As sexual transmissions continue to increase and people who inject drugs bear the highest HIV prevalence, scaling up evidence-based combination prevention is critical, including expanding access to PrEP, post-exposure prophylaxis, harm reduction, community-led outreach and people-centred service delivery. Achieving greater prevention impact will also require addressing punitive laws, stigma and discrimination that limit access to services, while ensuring sustainable financing for prevention programmes and community-led responses.

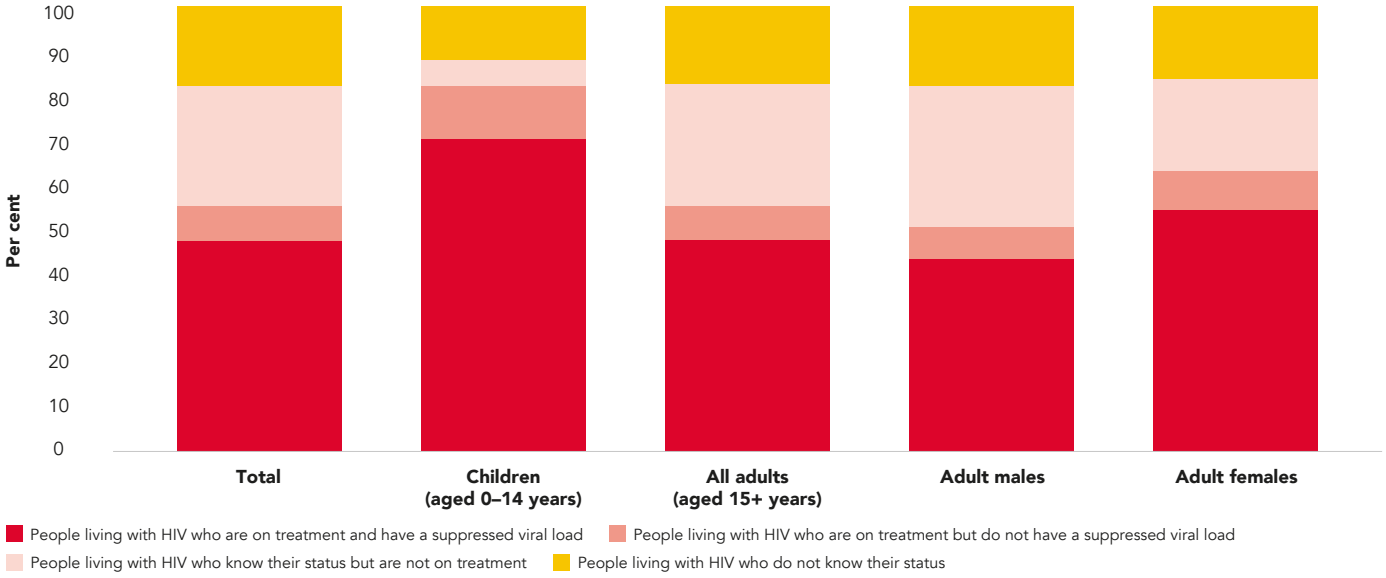
Reversing the epidemic will require accelerated action on the priorities of the 2026–2031 Global AIDS Strategy, particularly sustainable financing, combination prevention, integrated stigma-free services, legal reform and the protection of civic space to ensure equitable access to HIV services for people from key populations.

The region has achieved important gains in HIV status awareness, with 83% [66–95%] of people living with HIV knowing their HIV-positive status as of 2025. Substantial gaps remain in the HIV care cascade. In 2025, an estimated 560 000 people who knew their HIV-positive status were not receiving treatment, and more than 160 000 people on treatment did not have a suppressed viral load. Unlike in other regions, these outcomes were better among children than adults. As in most regions, women had higher treatment coverage and viral suppression levels than men (Figure 12.3).

Across countries that reported the treatment cascade for specific key populations, median antiretroviral therapy coverage was 52% among sex workers (four reporting countries), 85% among gay men and other men who have sex with men (seven reporting countries), 76% among people who inject drugs (six countries), and 99% among people in prisons and other closed settings (five reporting countries).

In addition to limited treatment coverage, late diagnosis, poor retention in care, inadequate treatment adherence and structural barriers play significant roles in contributing to ongoing HIV transmission, poor treatment outcomes and preventable AIDS-related deaths. People from key populations are often trapped in a cycle of discrimination, legal barriers and stigma that deny them access to basic health care, lifesaving treatment and dignity.

Figure 12.3. HIV testing and treatment cascade, by age and sex, eastern Europe and central Asia, 2025



Source: UNAIDS epidemiological estimates 2026 (https://aidsinfo.unaids.org/).

Punitive laws, stigma and shrinking civic space continue to undermine the HIV response

Progress towards reaching the 10–10–10 societal enabler targets[1] in eastern Europe and central Asia remains slow. All 16 countries in the region criminalize sex work; 15 countries criminalize nondisclosure, exposure or transmission of HIV, either explicitly or through general disease laws; and at least seven countries criminalize possession of small amounts of drugs for personal use. These laws, along with aggressive policing and stigma and discrimination, prevent all people, especially those from key populations, from seeking HIV and other health services.

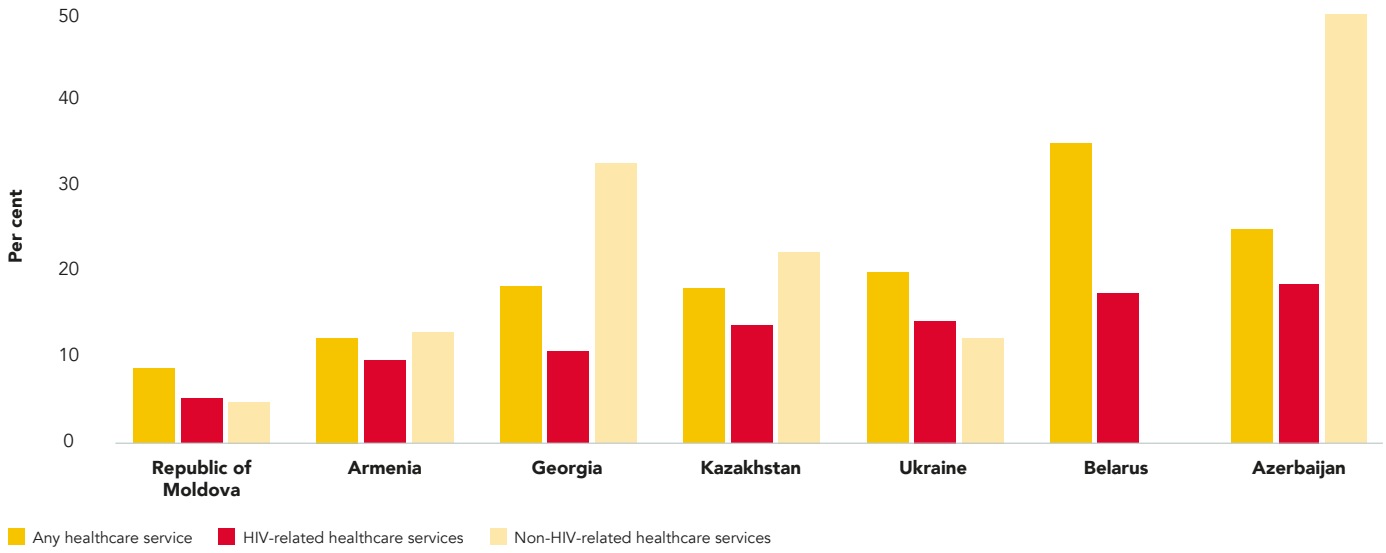
Stigma and discrimination towards people living with HIV persist in the region, including in health-care settings (Figure 12.4). Data from reporting countries highlight the pervasive impact of stigma and discrimination on people from key populations. A median of 47% of transgender people (four reporting countries), 29% of sex workers (four reporting countries), 26% of people who inject drugs (six reporting countries) and 16% of gay men and other men who have sex with men (seven reporting countries) reported experiencing stigma and discrimination in the past six months. A median of 41% of transgender people (three reporting countries), 23% of people who inject drugs (five reporting countries), 16% of sex workers (six reporting countries) and 14% of gay men and other men who have sex with men (five reporting countries) reported avoiding health care due to stigma and discrimination.

1 The 10–10–10 targets include that by 2030, less than 10% of people living with, at risk of or affected by HIV experience stigma and discrimination; less than 10% of women, girls, people living with, at risk of or affected by HIV experience gender inequality and violence; and, less than 10% of countries have restrictive legal and policy frameworks that lead to the denial or limitation of access to services.

Survey data indicate a high prevalence of sexual or physical violence against people from key populations in the region. A median of 22% of transgender people (five reporting countries), 21% of sex workers (nine reporting countries), 16% of people who inject drugs (seven reporting countries) and 10% of gay men and other men who have sex with men (nine reporting countries) reported experiencing physical or sexual violence in the past 12 months. Across the region, restrictive laws such as "foreign agent" and anti-LGBTQIA+ legislation have been introduced or reinforced, further shrinking civic space and hindering community-led HIV responses. The Rise and Decriminalize movement led by five regional community-led networks has emerged to enhance high-level dialogues at international forums to advance health and human rights, emphasize the need to decriminalize key populations, and ensure sustainable community-led HIV responses.[2]

The HIV response is occurring within the context of war in Ukraine, armed conflicts and political unrest in other countries, and shifts towards repressive governance and shrinking civic space. The region is increasingly connected with neighbouring regions through migration, trade, labour flows and social ties. These dynamics have direct implications for health-care systems, HIV transmission patterns, and the burden on public health infrastructure across Europe and central Asia.[3]

Figure 12.4. Percentage of people living with HIV who experienced stigma and discrimination in health-care settings in the past 12 months, countries with available data, eastern Europe and central Asia, 2022–2024



Source: People Living with HIV Stigma Index 2.0 studies, 2021–2024.
Note: experiences of stigma and discrimination in health-care settings are measured as having experienced at least one of the following because of HIV status in the previous 12 months: denial of care, advised not to have sex, being the subject of gossip or negative talk, verbal abuse, physical abuse, avoidance of physical contact, sharing of HIV status without consent.

2 Rise and Decriminalize movement to protect communities' rights in EECA region. Amsterdam: Robert Carr Fund for Civil Society Networks (https://robertcarrfund.org/article/rise-decriminalize-movement-to-protect-communities-rights-in-eeca-region/).

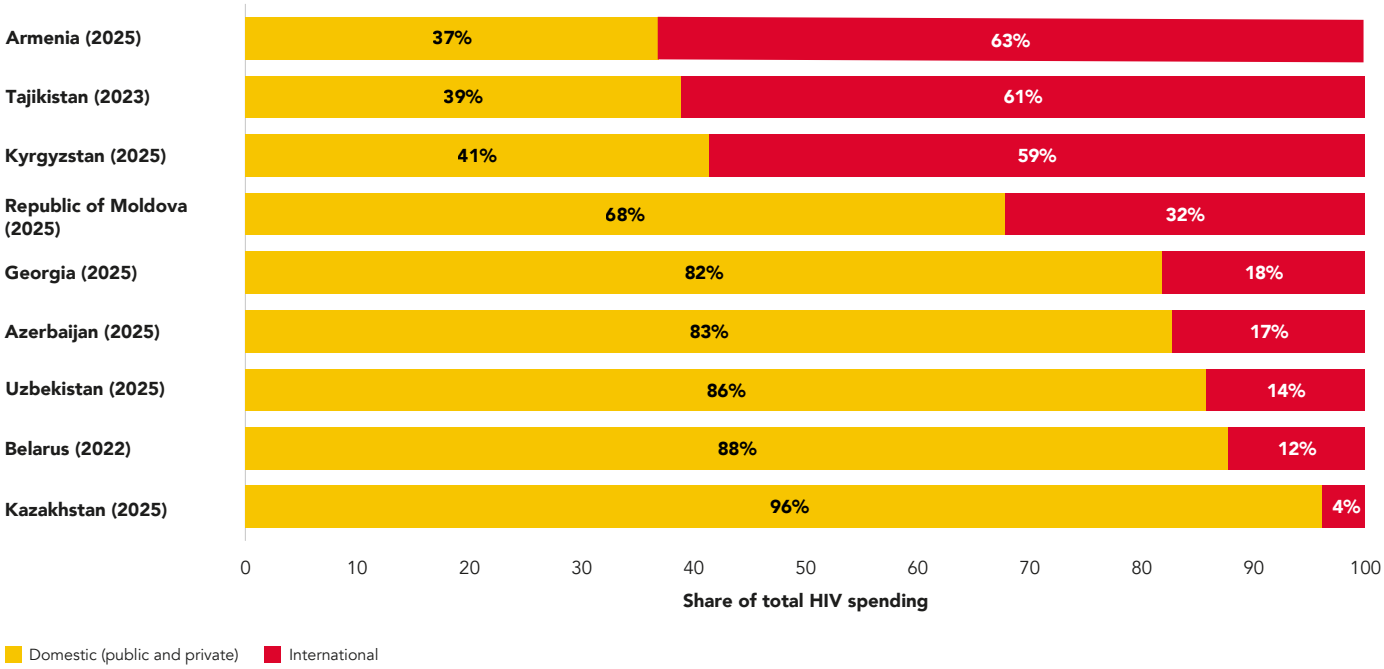
3 Parczewski M, Gökengin D, Sullivan A, de Amod J, Cairnse G,·Bivol S, et al. Control of HIV across the WHO European region: progress and remaining challenges. Lancet Reg Health Eur. 2025;52:101243 (https://doi.org/10.1016/j.lanepe.2025.101243).

Insufficient and unsustainable HIV financing threatens progress in the region

In 2025, resources available for the HIV response among low- and middle-income countries in eastern Europe and central Asia were estimated at US$ 585 million, against estimated resource needs of approximately US$ 670 million, leaving a financing gap of around US$ 85 million, or 13% of estimated need (Figure 12.6). Domestic resources accounted for US$ 389 million, or 66% of available resources. International financing contributed US$ 196 million (34%), including US$ 93 million from United States Government bilateral support, US$ 64 million from the Global Fund to Fight AIDS, Tuberculosis and Malaria, and US$ 39 million from other international sources.

The financing architecture has changed significantly in 2025. Domestic resources increased from US$ 365 million in 2024 to US$ 389 million in 2025, while international resources fell from US$ 264 million to US$ 196 million, a decline of 26% in a single year. The reliance on international financing remains substantial in several countries, accounting for 63% of HIV resources in Armenia, 61% in Tajikistan and 59% in Kyrgyzstan, compared with much lower shares in Kazakhstan (4%), Belarus (12%), Uzbekistan (14%) and Azerbaijan (17%) (Figure 12.5).

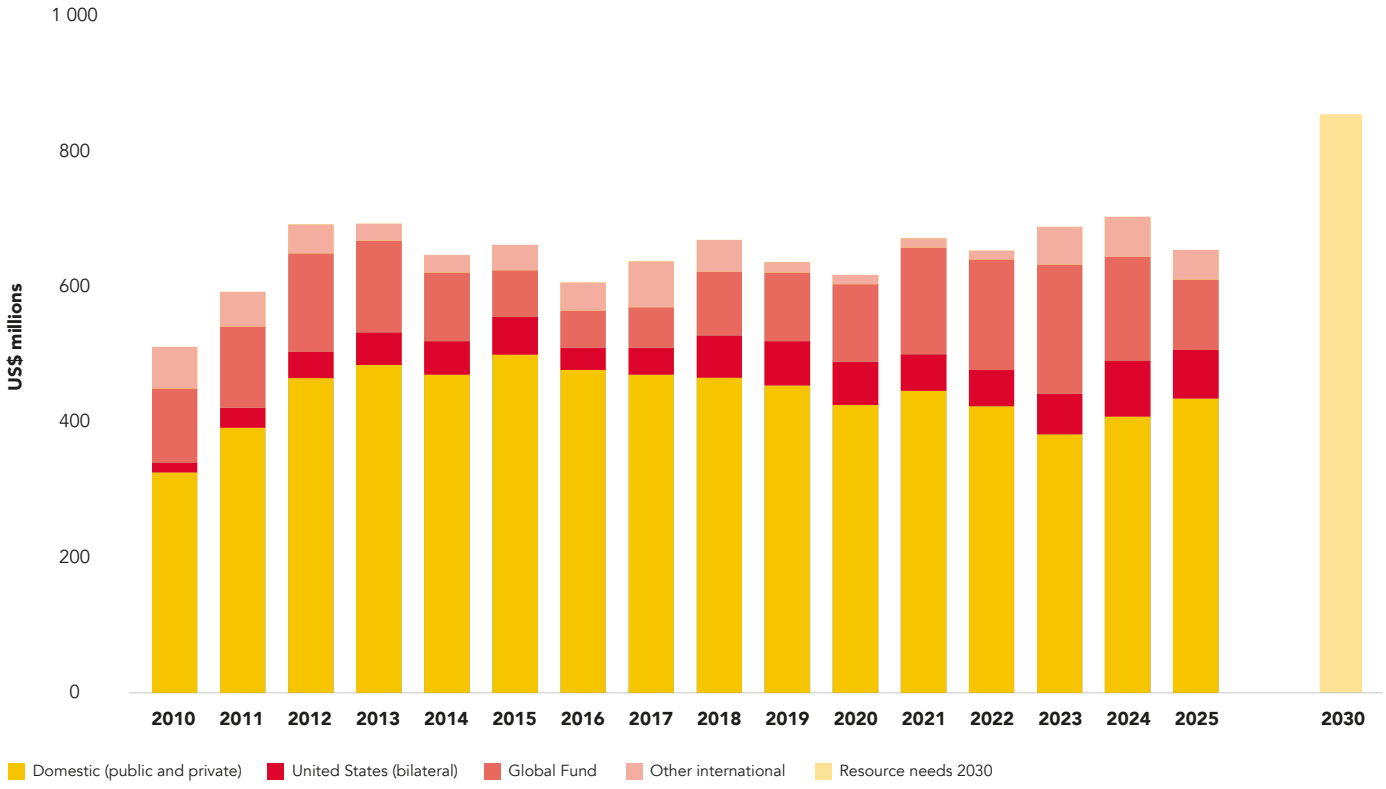
Figure 12.5. Domestic versus international share of total HIV spending, eastern Europe and central Asia, 2022–2025



Source: Global AIDS Monitoring, National AIDS spending assessments.

The increase in domestic resources between 2024 and 2025 demonstrates growing domestic financing, but it was not sufficient to compensate for the decline in international support, especially in programmes that were supported by international resources. Closing the gap will therefore require a combination of sustained domestic financing, protection of critical international support, and greater efficiency in the use of available resources. The estimated resource need already assumes important efficiencies, including substantially lower antiretroviral medicine prices, lower commodity costs for opioid agonist maintenance therapy (including methadone and buprenorphine), and more optimal allocation of prevention resources. Achieving the HIV targets within this resource envelope will therefore depend not only on mobilizing sufficient resources but also on realizing these efficiencies in practice.[4, 5]

Figure 12.6. Resource availability by funding source (2010–2025), and 2030 needs, eastern Europe and central Asia



Source: UNAIDS financial estimates.

4 Allocation of HIV resources towards maximizing the impact of funding in selected eastern European and central Asian countries. Melbourne: Burnet Institute; 2023 (https://optimamodel.com/pubs/Regional_HIV_EECA_2023.pdf).

5 Ten Brink DC, Bowring AL, Martin-Hughes R, Wulan N, Xiao Y, Burke K, et al. Optimising HIV spending in 12 eastern European and central Asian countries: a modelling study. Lancet HIV. 2024;11(10):e690–e699 (https://doi.org/10.1016/S2352-3018(24)00188-7).

An important priority in the region is to reduce the high procurement prices for HIV-related health products in some parts of the region. Large differences in the costs of antiretroviral therapy illustrate the potential efficiency needs. Annual antiretroviral medicine prices have been reported up to US$ 382 per person year in Kazakhstan compared with US$ 46 in Armenia. Protease inhibitor-based treatment needs to be monitored closely because the annual reported procurement price for protease inhibitor-based regimens were up to US$ 1891 per person year in Kazakhstan compared with US$ 172 in Uzbekistan. Improving procurement efficiency, alongside more efficient allocation of available resources, could generate fiscal space to expand treatment and prevention coverage without requiring a commensurate increase in overall resources.

At the same time, how resources are allocated remains as important as the overall financing envelope. Prevention programmes, community-led services and interventions for key populations remain particularly vulnerable where they depend heavily on external financing. Reported expenditure data from 11 countries between 2018 and 2024 indicate that a regional median of 59% of HIV prevention programme expenditure was donor-funded. As external financing becomes less predictable, countries will need to increase domestic financing for priority prevention programmes, while ensuring available prevention resources are directed towards the populations, interventions and locations where they can achieve the greatest impact.