



# Health-Related Issues in Russia and Eurasia: Context and Issues for Congress

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## Summary

After the collapse of the Soviet Union in 1991, all the newly independent Eurasian states faced economic dislocations, conflicts and population shifts, and more porous borders that contributed to rising communicable and non-communicable diseases such as HIV/AIDS and drug addiction. At the same time, the inherited healthcare systems were obsolete and unable to cope with existing health problems, let alone new challenges.

Even before the Soviet Union collapsed, the United States provided it with some health assistance to address urgent needs, including vaccines for children. Since then, Eurasian Health issues have received increased U.S. attention. As part of recent concerns, a December 2008 Intelligence Community Assessment highlighted global threats posed to U.S. citizens and interests by increasing infectious diseases and other health problems originating outside U.S. borders, including in Eurasia. The assessment and estimate warned that increased political, military, social, and economic disorder in the Eurasian states could be worsened by the spread of disease and declining health, thereby setting back their democratic and free market reforms, and that such instability might further complicate U.S. arms control cooperation, efforts to contain the proliferation of weapons of mass destruction, and trade relations. In addition, the assessment and estimate cautioned that Eurasian militaries and populations could face increased ill-health, harming the national security of the Eurasian states and diminishing the effectiveness of the militaries in international peacekeeping. Also, military forces and populations with significant health-related problems could become agents for the spread of diseases among U.S. forces involved in international exercises and training and to the U.S. homeland population.

After the terrorist attacks on the United States on September 11, 2001, the spread of anthrax by mail in the United States later in the year, and the rising global incidence of the West Nile virus, severe acute respiratory syndrome (SARS), the H5N1 (“bird flu”) virus and the H1N1 (“swine flu”) virus, there were heightened policy concerns about disease threats to the U.S. homeland. These concerns are increasingly shaping the debate over health policy and aid, including to Eurasia, where the major foci of U.S. policy long have been democratic and economic reforms and arms control, with health aid viewed as complementing reforms and as justified on humanitarian grounds.

Although U.S. health aid for Eurasia has long been overshadowed by other U.S. aid priorities, it increased as a percentage of all U.S. foreign assistance to Eurasia after FY2002. This report provides an overview of health conditions in the Eurasian states, U.S. aid efforts in recent years, and issues which Congress might consider in providing health assistance to the Eurasian states.

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## Introduction

The rulers of the former Soviet Union proclaimed the high quality of their socialized healthcare system. During this period, health information was closely guarded and some official health statistics were viewed by outside experts as highly suspect. Soviet data showed numbers of hospital beds and doctors per capita as among the highest in the world and life spans comparable to those in other developed countries. As became more apparent after the Soviet collapse at the end of 1991, such data were often incomplete or falsified and covered up substantial and growing health problems.

The newly independent Eurasian states of the former Soviet Union<sup>1</sup> faced problems sustaining the huge, expensive, and ineffective healthcare systems they inherited. Health conditions seemed to deteriorate during the 1990s, as measured by life expectancy at birth, infant and maternal mortality, drug addiction, rates of infectious disease, and other measures. Efforts to turn around this state of affairs accelerated in the 2000s, but in many respects these states still face some health challenges common to developing countries. These challenges, according to many observers, continue to hinder economic and democratic development in the states.<sup>2</sup>

The Eurasian states and international organizations are the sources of data used in this report. In some cases, international organizations have provided estimates when the data supplied by the Eurasian state have not complied with the data definitions of the World Health Organization.<sup>3</sup> Besides healthcare quality and access, factors affecting health touched on but not analyzed in detail in this report include poverty rates, conflict, living and working conditions, and the environment.

## Overview of U.S. Policy

U.S. health assistance to Eurasia began even before the collapse of the Soviet Union with a public-private medical aid program to distribute pharmaceuticals and medical supplies to the Soviet republics. Later, the George H.W. Bush and Clinton Administrations led international efforts to address needs in Eurasia, including health needs to some degree. The 1992 FREEDOM Support Act (P.L. 102-511), the major authorization for aid to Eurasia, included the provision of medicine and medical supplies and equipment and other aid to create quality healthcare and family planning services as among the priorities of U.S. assistance.<sup>4</sup>

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<sup>1</sup> The Eurasian states (also termed the Newly Independent States or NIS) are generally considered as including the Western Soviet successor states (Belarus, Moldova, Russia, and Ukraine), the South Caucasian states (Armenia, Azerbaijan, and Georgia), and the Central Asian states (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan).

<sup>2</sup> U.S. Agency for International Development (USAID). *Europe and Eurasia Health Vulnerability Analysis*, September 2007, p. 3; *The 2010 Europe and Eurasia Health Vulnerability Analysis*, March 2010, p. 9.

<sup>3</sup> Doctors Without Borders, a French non-governmental organization, has argued that health data reported to international organizations by Turkmenistan are highly suspect, and has warned that “international organizations risk being complicit in the entrenchment of problems by transmitting [Turkmen] government misinformation as fact and by failing to address openly and firmly the problems that they are witnessing in the health care system.” *Turkmenistan’s Opaque Health System*, April 2010.

<sup>4</sup> Silk Road Act language in P.L. 106-113, signed into law in November 1999, also authorized enhanced policy and aid to support humanitarian needs in the South Caucasus and Central Asia, including the provision of medicines and (continued...)

In the early 1990s, however, U.S. and Western donors lacked a clear picture of health conditions in the Eurasian states—largely because of the mostly sanguine picture painted by Soviet health officials—and some donors tended to assume that a short-term aid infusion would put Eurasian health systems “back on their feet” in a short time. It later became clear that the Eurasian states faced massive health problems that would be hard to ameliorate. As related by the U.S. Agency for International Development (USAID), “the assumption underlying USAID assistance programs to Europe and Eurasia at the beginning of the 1990s was that democratic reform and free-market economic growth would sustain and improve social sector conditions, including health.” However, the complexities and pre-existing inadequacies of healthcare in the region belied this assumption, according to USAID.<sup>5</sup>

## **U.S. Security and Health Assistance to Eurasia**

In recent years, U.S. policymakers have increasingly been concerned with global disease threats and other health problems. This increased attention began with a January 2000 unclassified National Intelligence Estimate (NIE) on the implications for U.S. national security of rising infectious disease outside U.S. borders. According to the NIE, infectious diseases could add to political, military, social, and economic disorder in the Eurasian states and otherwise set back democratic and free market reforms. Such instability might further complicate U.S. arms control cooperation and efforts to contain the proliferation of weapons of mass destruction. In addition, the NIE cautioned that Eurasian militaries and populations could face increased health problems, harming the national security of the Eurasian states and diminishing the effectiveness of the militaries in international peacekeeping. Also, military forces and populations with significant health problems could become agents for the spread of diseases among U.S. forces involved in international exercises and training and to the U.S. homeland population.<sup>6</sup>

However, the terrorist attacks on the United States on September 11, 2001, the spread of anthrax in the United States by mail later in the year, and the more recent foreign threats of new or lesser-known diseases such as the West Nile virus, severe acute respiratory syndrome (SARS), the H5N1 (“bird flu”) virus, and the H1N1 (“swine flu”) virus have heightened policy concerns about biological terrorism and international disease threats to the U.S. homeland and U.S. foreign interests. In September 2002, the National Intelligence Council (NIC) issued a follow-on report to its *Global Infectious Disease Threat* NIE which highlighted the threat of HIV/AIDS and other infectious diseases in countries of strategic importance to the United States, including Russia.<sup>7</sup> This new report warned that infectious diseases could “exacerbate social and political instability in key countries,” and threaten the United States, since it is a major hub of world travel with a large number of citizens residing overseas. The report stated that major means of combating the infectious disease threat, as well as biological terrorism, include the establishment of effective global surveillance and response systems, but that the lack of capacity, funds, and commitment in many Eurasian states stymie such efforts.

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(...continued)

medical equipment.

<sup>5</sup> USAID. *The 2010 Europe and Eurasia Health Vulnerability Analysis*, March 2010.

<sup>6</sup> CIA. National Intelligence Council. *The Global Infectious Disease Threat and Its Implications for the United States*, NIE 99-17D, January 2000.

<sup>7</sup> CIA. National Intelligence Council. *The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India, and China*, ICA 2002-04D, September 2002.

In response to a request from the Undersecretary of State for an update to the *Global Infectious Disease Threat NIE*, the National Intelligence Council issued *Strategic Implications of Global Health* in December 2008.<sup>8</sup> This Intelligence Community Assessment (ICA) expanded the concerns of the earlier NIE to include maternal mortality, malnutrition, chronic diseases, the availability of basic healthcare, and other non-infectious health issues that could affect the economies, governments, and armed forces of countries and regions of strategic interest to the United States. These health issues could impact the U.S. Homeland through diseases and declining economic and security cooperation with Eurasia. The report warned that continuing significant health problems in Russia could eventually set back its efforts to diversify its economy away from reliance on oil and gas exports and harm its military readiness. The report warned that U.S. joint missions with the armed forces of Russia could be compromised if Russian troops were not able to perform adequately because of poor health. Faltering healthcare and rising levels of infectious disease and non-infectious conditions could contribute to economic decline, increased authoritarianism, and regime instability in Eurasian and other developing countries. Former Director of National Intelligence Dennis Blair included the findings of the report in his 2009 and 2010 annual threat assessment testimony to Congress.<sup>9</sup>

In November 2009, the National Security Council released a *National Strategy for Countering Biological Threats* which warned that “in today’s interconnected world, an outbreak of highly communicable disease anywhere on the globe increases the risk to everyone....” The Strategy called for reducing such threats to the United States by “improving global access to the life sciences to combat infectious disease.... establishing and reinforcing norms against the misuse of the life sciences; and ... coordinat[ing] activities that collectively will help influence, identify, inhibit, and/or interdict those who seek to misuse the life sciences.” In meeting these goals, the Strategy called for “ensuring the global availability of ... capabilities such as disease surveillance and detection to mitigate the risks from natural, accidental, and deliberate outbreaks [and] ensuring that communities can quickly and effectively respond to large outbreaks of infectious disease.” By enhancing the ability of communities to respond to disease outbreaks, the Strategy avers, deliberate biological attacks are deterred or minimized if they do occur. The Strategy also calls for improving data reporting on infectious disease outbreaks and on the capacity of the global health community to “manage risks from naturally occurring and deliberately introduced infectious diseases.” Hailing a “strong track record” by the United States over the past few years in reducing the risks posed by “legacy biological weapons programs” in Eurasia, the Strategy details that these efforts have included redirecting the research of former weapons scientists, repurposing or decommissioning facilities and equipment, and enhancing safe and secure work with high-risk pathogens and toxins.”<sup>10</sup>

## **U.S. Agencies Involved In Healthcare Assistance to Eurasia**

U.S. policymaking on health issues in Eurasia involves the State Department’s Office of the Director of Foreign Assistance, the Bureau of European and Eurasian Affairs, the Bureau for

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<sup>8</sup> CIA. National Intelligence Council. *Strategic Implications of Global Health*, ICA 2008-10D, December 2008.

<sup>9</sup> U.S. Senate. Select Committee on Intelligence. Hearing on Threats to U.S. National Security. Dennis C. Blair, Director of National Intelligence. *Statement for the Record: Intelligence Community Annual Threat Assessment*, February 12, 2009; Hearing on Current And Projected Threats To The United States. Dennis C. Blair, Director of National Intelligence. *Statement for the Record: Intelligence Community Annual Threat Assessment*, February 2, 2010.

<sup>10</sup> President of the United States. National Security Council. *National Strategy for Countering Biological Threats*, November 23, 2009.



South and Central Asian Affairs, the Office of the Coordinator of U.S. Assistance to Europe and Eurasia, the Office of International Health Affairs, and USAID, and the Department of Health and Human Services (HHS) and other agencies.

The State Department's Coordinator of Assistance to Europe and Eurasia plays a major role in integrating policy and implementation goals and plays the leading role in allocating foreign aid appropriated by Congress for Eurasian countries. USAID receives the bulk of such aid and is the lead agency in implementing healthcare aid programs in the Eurasian states. Its Bureau of Global Health (GH) helps USAID country programs to improve access and quality of services for maternal and child health, nutrition, family planning and reproductive health; and to prevent and treat HIV/AIDS, malaria, tuberculosis, and other infectious diseases.

Working primarily through interagency agreements with USAID, HHS's Office of Global Health Affairs (OGHA) and HHS's Centers for Disease Control and Prevention (CDC) engage in health assistance across Eurasia. OGHA evaluates programs, provides guidance to field offices, and supports the U.S.-Russia Bilateral Presidential Commission's Health Working Group, which is chaired on the U.S. side by the HHS Secretary. CDC assumed greater prominence post-9/11 in helping to implement, often in cooperation with USAID, efforts to prevent and control infectious diseases in Eurasia, including biological agents.<sup>11</sup> Some critics argue that there is a need to improve the interagency coordination of healthcare policy and implementation, including that regarding Eurasia, in line with the *National Strategy for Countering Biological Threats*, other presidential directives, and the HHS's National Health Security Strategy.<sup>12</sup>

The CDC has emphasized that combating infectious diseases in Eurasia protects U.S. citizens at home and abroad, serves humanitarian and goodwill aims, and buttresses the world economy, democratization, and stability. It views aid for strengthening public health infrastructures and establishing strong infectious disease surveillance systems in the region as key to prevention, early warning, and early response to health threats there that could impact U.S. security. The CDC established a Global AIDS Program (GAP) Office in Russia in late 2006 to expand disease surveillance, develop pilot programs to prevent mother-to-child HIV transmission, improve guidelines for testing exposed infants, and provide support for other HIV programs carried out by the U.S. government and international agencies in Russia.<sup>13</sup> The CDC also has staffers at a Global Disease Detection and Emergency Response Branch (GDD) site in Kazakhstan and at International Emerging Infections Program (IEIP) sites in all the Central Asian states. CDC has a Field Epidemiology Training Program (FETP) advisor in Kazakhstan to provide expertise in training and outbreak investigations. There are USAID staffers in Russia and all the Central Asian countries to carry out HIV/AIDS and tuberculosis programs.

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<sup>11</sup> U.S. Department of State. *State Department Organization*, <http://www.state.gov>; The Department of Health and Human Services. *Office of Global Health Affairs*, at <http://www.globalhealth.gov>.

<sup>12</sup> U.S. Department of Health and Human Services. *National Health Security Strategy*, December 2009. For the debate over coordination, see CRS Report R40740, *U.S. Global Health Assistance: Background, Priorities, and Issues for the 111<sup>th</sup> Congress*, by (name redacted) and (name redacted). See also The Stimson Center and the Kaiser Family Foundation. *U.S. Global Health Policy Mapping: The United States Government Engagement In Global Public Health*, August 2009, pp. 116-122.

<sup>13</sup> CDC. Office of Global Health. *CDC Global Presence*, at <http://www.cdc.gov/globalhealth/presence.htm>.

## Congressional Response

Congress became increasingly concerned about the rising global threat of infectious diseases, including HIV/AIDS, TB, and malaria as early as 2005, and has authorized and appropriated funds reflecting that concern continuously since then (see the **Appendix** for a list of current health-related legislation being considered by the 111<sup>th</sup> Congress). The House Congressional Global Health Caucus was founded in 2005 to provide a bipartisan forum for discussions. Much attention in Congress has been focused on the threat infectious diseases pose in Africa, but attention has broadened to include health problems in Eurasia and other regions. Members of the House Banking Committee (H.Rept. 106-548), in reporting the Global AIDS and Tuberculosis Relief Act of 2000 (P.L. 106-264), cited the January 2000 NIE to the effect that increases in HIV/AIDS were threatening Eurasia and Asia as well as Africa. On the appropriations side, Foreign Operations Appropriations for FY2001 (P.L. 106-429) for the first time allocated a small amount (\$6 million) from the Child Survival and Disease Programs (CSD) fund to combat infectious diseases in Eurasia, and these amounts have since increased.

The HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (P.L. 108-25) established an Office of the Global AIDS Coordinator (OGAC) in the State Department to integrate and expand U.S. government global HIV/AIDS prevention, care, and treatment efforts. As re-authorized by the Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (P.L. 110-293), HIV/AIDS efforts were integrated into efforts to address global healthcare challenges. CSD was combined with the Global HIV/AIDS Initiative (GHAI) Account to form the Global Health and Child Survival (GHCS) Account. Assistance through the GHCS Account has been provided to all the Eurasian states except Belarus and Moldova. In 2008, the OGAC signed Partnership Framework agreements with Russia and Ukraine that set forth five-year plans for combating HIV/AIDS.

Congress generally has appeared to support health assistance that amounts to a few percent of the overall aid to Eurasia (see **Table 1** and **Table 2**). Total U.S. aid budgeted for FY1992-FY2010 for health programs in Eurasia was less than 5% of about \$35.3 billion of all aid for Eurasia (excluding the value of privately-donated cargoes).<sup>14</sup> Health aid has been dwarfed by that provided for democratization, economic reform, and arms control. However, after the terrorist attacks on the United States on September 11, 2001, and other events heightened U.S. concerns about U.S. vulnerabilities, including global health issues, a somewhat greater percentage of foreign assistance for Eurasia has consisted of health aid. The Obama Administration has boosted health aid as a percentage of assistance to Eurasia from 14% in FY2009 to 19% in FY2010 and 18% requested for FY2011.

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<sup>14</sup> The State Department's Office of the Coordinator for Assistance to Europe and Eurasia has compiled foreign assistance data to Eurasia from all agencies and authorities up through FY2008. Data for FY2009-FY2011 are available for the Assistance for Europe, Eurasia, and Central Asia (AEECA), Global Health and Child Survival (GHCS) accounts, Foreign Military Financing (FMF), International Military Education and Training (IMET), and Non-Proliferation, Anti-Terrorism, De-Mining, and Related (NADR) programs.



## Health in the Eurasian States: Context and Current Developments

As part of the legacy of the former Soviet Union, the Eurasian states inherited a large centralized and state-owned healthcare apparatus that provided good care for some medical conditions but relied on outdated practices to treat other illnesses. The health of Soviet citizens lagged behind that of U.S. and other Western populations in terms of access to many new medical procedures and medicines and even in terms of prosaic measures such as the number of hospitals with plumbing and heat. The healthcare system emphasized a large number of specialized medical facilities with large staffs and prolonged hospitalizations, rather than primary and preventive care, including regular check-ups. The healthcare system was isolated from changing world standards of treatment of diseases such as TB, it followed secretive practices that prevented the operation of a competent disease surveillance system, and it suffered from a lack of medical supplies and equipment outside of the major medical centers. The emphasis on specialized and hospital care meant that primary care and early diagnosis were starved of funds. After the Eurasian states gained independence, the new international borders separated many medical industries from their customers in other countries and required the re-negotiation of business relations that are still not wholly satisfactory.

Despite this shared legacy, the Eurasian states emerged from the Soviet collapse with varying health situations. Some of the Eurasian states had better healthcare facilities and healthier populations than others. Many observers have viewed Central Asia's population as having suffered the most from inadequate healthcare during the Soviet period. The Western Eurasian states had older populations than the Central Asian states at the time of the Soviet collapse, reflecting differences in fertility and mortality. Environmental catastrophe affected health in several regions, including the Chernobyl area (radiation fallout in Ukraine and Belarus), Chelyabinsk area (radiation contamination in Russia and Kazakhstan), Semipalatinsk (radiation from nuclear weapons testing in Kazakhstan) and the Aral Sea area (desertification in Kazakhstan and Uzbekistan). The Eurasian states also differed in their rates of economic decline during the 1990s. The extent to which decreases occurred in related areas varied as well, such as healthcare funding, the diets of the people, and living conditions, all of which affected morbidity and mortality. Conflicts in Eurasia also damaged health, leading to casualties, injuries, orphans, and displaced persons who suffered physically and psychologically.

In the post-Soviet era, demographers have been able to scrutinize previously suppressed health data and conduct analyses that suggest that some aspects of the health crisis in Russia and other Eurasian states can be traced back to the 1960s. A major indicator of overall health, life expectancy, peaked in the 1960s and began a downward trend in Russia and other republics of the former Soviet Union by the late 1960s. This downward trend has been linked by research to an increase in alcoholism, violence, tobacco use, and poor diets. Another peak occurred in the mid-1980s, mostly attributed to government restrictions on alcohol consumption.

Most observers agree that in the early years after the Soviet Union collapsed, there were major declines in health in virtually all Eurasian states in terms of such measures as infant mortality, alcoholism, and cardiovascular disease. The Central Asian states suffered the greatest declines in Eurasia in life expectancy, increased morbidity, deterioration of conditions in hospitals and other health facilities, and failures to control and prevent infectious diseases. In the late 2000s, health conditions have improved in some respects, but by many measures—including life expectancy,

under-5 and maternal mortality, TB rates, HIV/AIDS rates, and alcoholism (in the Western NIS), the Eurasian countries continue to lag behind most developed countries.

According to one USAID report that ranked Eastern European and Eurasian states in terms of various health factors, all the Eurasian states except Belarus ranked among the bottom one-half of the 28 countries considered. The most vulnerable countries were Kazakhstan, Kyrgyzstan, Russia, Tajikistan, and Turkmenistan. Such poor health conditions, USAID warned, “diminish society’s productive capacity, deteriorates the strength of civil society, and tarnishes people’s perceptions of the benefits of democracy and free-market economies. Poor health is, therefore, not only a threat in its own right; it is a threat to economic and democratic progress.”<sup>15</sup>

Health challenges in all the Eurasian states loom larger because of the very low percentages of gross domestic product (GDP) they have devoted to healthcare. **Table 3** shows GDP per capita in the Eurasian states and the percent going to health. Health spending levels are low in the Eurasian states in comparison to the 8.5% on average spent in the Organization for Economic Cooperation and Development countries (OECD; composed mostly of European countries and the United States), except for Georgia, where the percentage of spending virtually matches the OECD percentage.<sup>16</sup>

Soon after he came to power in Russia in 2000, then-President Putin began dedicating more budgetary resources to address health problems. A National Health Project, one of four National Priority Projects, was launched in 2005 as the centerpiece of his effort to improve healthcare. Pay for doctors and nurses was boosted, new equipment for medical centers was provided, and the number of ambulances was increased. With the injection of added funds from the National Priority Health Program, healthcare spending in Russia in 2006 finally rose above the level of such spending during the Soviet period.

In late 2007, President Putin issued a decree to implement a *Concept for a Demographic Policy for the Russian Federation up to 2025* that called for an increase in life expectancy to 75 years of age and increases in childbirth and immigration. Through these means, it is hoped that Russia’s population will stabilize at 142-143 million by 2015 and will increase to 145 million by 2025. These hopes may be unrealistic, since even Russia’s State Statistical Agency forecasts that the population will decline to less than 136 million by 2025. The Concept may be relying on an unlikely surge in non-ethnic Russian immigration, which many ethnic Russians oppose.<sup>17</sup> In late 2008, a Russian government commission released an associated *Healthcare Development Concept to 2020* that called for improving the quality of medical care; educating people to adopt healthy lifestyles; reversing the decline of the population; and increasing life expectancy. To achieve these goals, the Concept called for increasing the provision of medicines; reducing out-of-pocket expenses for medical care; boosting the qualifications of healthcare personnel and

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<sup>15</sup> USAID. *The Europe and Eurasia Health Vulnerability Analysis*, March 2010.

<sup>16</sup> Analyst Patricio Marquez argues that Russian government and private health expenditures are comparable to those of other countries with similar GDPs, but that “health outcomes in Russia are similar to countries which spend 30-40% less on health. This finding suggests considerable inefficiency in the Russian Federation health system.” He calls for Russian authorities to impose restrictions on alcohol and tobacco consumption, encourage healthy diets, and improve road safety. *Addressing Health Challenges in the Russian Federation: From Theory to Action*, The World Bank, June 2009.

<sup>17</sup> Anatoly Vishnevsky, *The Challenges of Russia’s Demographic Crisis*, French Institute of International Relations (IFRI), August 2009; Nicholas Eberstadt, *Russia’s Peacetime Demographic Crisis: Dimensions, Causes, Implications*, National Bureau of Asian Research, May 2010.

creating a system of incentives to ensure high-quality work; and providing exercise and sports facilities and taking other measures to facilitate healthy lifestyles. Summing up the 2009 results of the National Health Project, Deputy Prime Minister Alexander Zhukov announced in early 2010 that the size of the population for the first time in fifteen years grew slightly; that life expectancy increased by 1.2 years to over 69 years for both sexes; that mortality rates for most diseases decreased; that the number of deaths caused by alcohol poisoning fell by 32%; that a pilot program had resulted in fewer road deaths; and that healthcare for infants had improved.<sup>18</sup>

At a government meeting in mid-April 2010, Prime Minister Putin stated that he had “dramatically increased” healthcare spending from 225.4 billion rubles in 2000 to 1.5 trillion rubles in 2009. He stressed, however, that healthcare problems still existed, as indicated by the low level of public satisfaction with healthcare, regional disparities in the funding and availability of healthcare, inefficient spending on unnecessary hospitals, out-of-pocket expenses for necessary procedures, and inadequate outpatient and preventative care.<sup>19</sup> In his state of the government address to the legislature on April 20, 2010, Putin announced that he was boosting funds for the National Health Project.

Faltering healthcare in Central Asia has been reflected in decreasing life spans, high infant and maternal mortality rates, and increases in cardiovascular/circulatory, parasitic, infectious, and respiratory diseases. While the spread of TB and hepatitis in Central Asia is most worrisome, the U.N. office coordinating U.N. interagency and international aid efforts on HIV/AIDS (the Joint United Nations Program on HIV/AIDS, or UNAIDS) has pointed to rising HIV prevalence (the number of people living with HIV) in Kazakhstan and elsewhere in Central Asia as a global concern.<sup>20</sup> Poor sanitation and increasing drug abuse, tobacco and alcohol use, malnutrition, diet deficiencies, and tainted blood supplies contribute to declining health. Healthcare reforms have focused on making the healthcare system more efficient by closing excess hospitals and on obtaining more funding through taxes and payroll deductions. The latter efforts have faltered, resulting in a heavy reliance on user fees for service. Kyrgyzstan has made the most progress in healthcare reform (though its fragile economy places them at risk), and Tajikistan and Turkmenistan the least. The health consequences of poor quality healthcare seriously constrain economic development in the region, according to many observers.

## **Selected Health Indicators**

### **Life Expectancy, Childhood Mortality, and Maternal Mortality**

**Table 3** shows life expectancy rates for adult males and females, maternal mortality rates, and mortality rates for children under five years of age throughout the Eurasian region. Life expectancy at birth is perhaps the most commonly used indicator of health status in a country. Life expectancy had continued to decline between 1990 and 2008 in Belarus, Kazakhstan, Russia, and Ukraine. There are large gaps between average life expectancy for males and females in

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<sup>18</sup> Government of Russia. *Deputy Prime Minister Alexander Zhukov Holds a Video Conference to Discuss the Results of the Implementation of the Priority National Projects Health, Education, Affordable and Comfortable Housing for Russians in 2009 and the Projects' Blueprints for 2010*, February 17, 2010, at <http://www.government.ru/eng/>.

<sup>19</sup> Government of Russia. *Prime Minister Vladimir Putin Chairs a Meeting to Discuss Issues of Healthcare Modernization*, April 14, 2010, at <http://www.government.ru/eng/>.

<sup>20</sup> UNAIDS. *AIDS Epidemic Update*, November 2009.

Eurasia and life expectancy in OECD countries. There is a twelve-year deficit between the average male lifespans in Eurasian and OECD countries, and a ten-year deficit between female lifespans in Eurasian and OECD countries. According to most demographers, major factors accounting for these deficits in life expectancy in the Eurasian countries include higher rates of heart-related disorders, cancers, and injuries, while infectious diseases account for a smaller portion in most of the states. Alcoholism underlies many diseases and injuries, and helps explain the large gap in mortality rates between men and women. Accidents or violence and alcohol poisoning accounted for the most alcohol-related deaths, but alcohol contributed to many diseases as well, such as heart disease, liver disease and certain cancers.<sup>21</sup>

USAID estimates that mortality rates over the period from 1990-2007 for children under five years of age declined significantly in Moldova and Tajikistan and somewhat less in the rest of Eurasia.<sup>22</sup> Tajikistan and Turkmenistan had the highest rates of under-5 child mortality in Eurasia. According to USAID, the relatively high mortality rates in the Eurasian states among children under five years old (as compared to most European countries) are telling signs of the poor healthcare and the plight of many families suffering from poverty and malnutrition. Rates of maternal mortality—the death of women during pregnancy, childbirth, or in the immediate period after delivery—also are much higher in the Eurasian states than in most other European countries. Maternal mortality rates have declined in recent years in all the Eurasian states except Georgia.<sup>23</sup> Causes of maternal mortality likely would include poor nutrition, lack of maternal care, and high rates of abortion. According to the World Bank, the Eurasian countries are unlikely to meet Millennium Development Goals (targets for development from 2000 until 2015) for child and maternal mortality.<sup>24</sup>

High rates of abortion are being reduced in several Eurasian states by education and access to other contraceptive methods. In 2006, the Russian government launched a plan to budget \$1.3-1.7 billion annually for ten years to boost the birthrate and reduce abortions, including by providing free care at maternity hospitals, increasing childcare benefits, permitting 18 months of partially paid maternity leave, and building new prenatal centers.<sup>25</sup> In January 2010, Russian Health Minister Tatyana Golikova hailed these initiatives as boosting the number of children born in 2008 to 1.7 million. However, she also reported that the overall abortion rate in Russia remained too high.<sup>26</sup>

## **The Incidence of Infectious Diseases**

The sharp deterioration of the health infrastructure due to economic conditions has contributed to a dramatic increase in levels of infectious diseases, particularly TB and HIV/AIDS, in all the Eurasian states since they gained independence. **Table 4** shows the number of new cases of TB and the numbers living with HIV. Although HIV/AIDS is currently spreading throughout Eurasia

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<sup>21</sup> “Russia: Population Decline is Unlikely to Reverse,” *Oxford Analytica*, May 22 2008.

<sup>22</sup> USAID. *Europe and Eurasia Health Vulnerability Analysis*, September 2007.

<sup>23</sup> Margaret Hogan, Kyle Foreman, Mohsen Naghavi, Stephanie Ahn, Mengru Wang, Susanna Makela, Alan Lopez, Rafael Lozano, and Christopher Murray, “Maternal Mortality for 181 Countries, 1980–2008: A Systematic Analysis of Progress towards Millennium Development Goal 5,” *The Lancet*, May 8, 2010, pp. 1609-23.

<sup>24</sup> The World Bank. *Millennium Development Goals: Progress and prospects in Europe and Central Asia*, 2005.

<sup>25</sup> *Oxford Analytica*, May 22, 2008.

<sup>26</sup> *ITAR-TASS*, January 18, 2010; “Illegal Abortions Worsening Russia’s Demographic Problems,” *RIA-Novosti*, April 2, 2010.

largely among injecting drug users, rising rates of sexually transmitted disease (STD) are a worrisome sign that HIV/AIDS may spread into the general population.

Childhood vaccination rates in Eurasia declined dangerously in the late 1980s and early 1990s, contributing to a diphtheria epidemic in the early 1990s. By the mid-1990s, this epidemic accounted for 90% of worldwide cases. Ukraine, Russia, and Tajikistan were hardest hit. The George H.W. Bush Administration and USAID collaborated with the World Health Organization (WHO) in delivering vaccines and the United States later advocated international donor assistance for childhood immunizations. By the latter 1990s, diphtheria cases had declined greatly, as had some other childhood diseases. In Russia, the National Schedule of inoculations against diphtheria, tetanus, pertussis, mumps, measles, poliomyelitis, and tuberculosis reached 96%-99% coverage for children less than two years old in 2004. However, rates of coverage for older children remained low, reportedly because not enough vaccines were available. In most other Eurasian countries, childhood vaccination rates had reached 96-99% coverage in the late 1990s. However, coverage in Armenia and Georgia in 2006 (the latest date of information) was still below this range, and coverage in Azerbaijan, Kyrgyzstan, and Tajikistan had barely met this range.<sup>27</sup>

### *Tuberculosis*

The number of cases of TB in Eurasia is much higher than in the OECD countries (**Table 4**). The increases in new TB cases in the Eurasian states are not as rapid as in previous years, except for Tajikistan. The highest numbers of new TB cases are in Kazakhstan, Russia, Ukraine, and Uzbekistan. In 2001, Russia refused a World Bank loan to fight TB and HIV/AIDS, reportedly because the World Bank would not permit Russian drug manufacturers that did not meet international standards to participate. However, Russia accepted the aid in 2003 and has worked with USAID and WHO to disseminate Directly Observed Treatment Short-course (DOTS) more widely and integrate the treatment into the general healthcare system. Russia is classified as among the twenty top priority countries for U.S. assistance to treat TB.

Continuing poor living conditions and inadequate treatment has fueled the rise of multi-drug resistant TB. The release, through amnesties or the completion of sentences, of tens of thousands of prisoners with TB into the general population has contributed to the spread of drug-resistant TB in Russia. Also, convicts with the final stages of TB (or cancer or AIDS) have been released on humane grounds, possibly spreading the disease. Multi-drug-resistant TB can be extremely costly to treat, further burdening already strained healthcare finances in the Eurasian states.<sup>28</sup>

All the Eurasian states except Turkmenistan are considered by WHO to have “high burdens” of multi-drug resistant TB cases.<sup>29</sup> Even more striking, among nine countries worldwide reporting in recent years that over 12% of new TB cases were multi-drug resistant, all but two were Eurasian countries (Azerbaijan, Kazakhstan, Moldova, Russia, Tajikistan, Ukraine, and Uzbekistan). Also, the only countries where over 50% of previously treated TB cases were multi-drug resistant were in Eurasia (the just-mentioned states excluding Ukraine). WHO has hailed Russia’s successful

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<sup>27</sup> UNICEF. Innocenti Research Center. *Transmonee Database*, May 2008, at <http://www.unicef-irc.org>.

<sup>28</sup> WHO. *Multidrug and Extensively Drug-Resistant TB*.

<sup>29</sup> WHO. *Multidrug and Extensively Drug-Resistant TB: 2010 Global Report on Surveillance and Response*, March 18, 2010. Countries with “high burdens” of multi-drug resistant TB are responsible for 85% of the global estimated cases that arose in 2008 (p. 19).



efforts since the discovery of such high rates of infection in 2006 to reduce the number of cases, and has reported that by late 2009, Armenia, Azerbaijan, Georgia, Kazakhstan, Moldova, Tajikistan and Ukraine were developing plans to combat multi-drug resistant TB.

## ***HIV/AIDS***

Eurasia is the only area of the world where HIV prevalence (the number of people living with HIV) remains on the rise.<sup>30</sup> The prevalence of HIV would be even higher, except that numbers of new HIV cases have slowed since the 1990s, when the rate of new infections was the highest in the world. Injecting drug use, prostitution, and population mobility are the main contributors to increasing HIV prevalence in most of the Eurasian states. Like the case with TB, HIV prevalence in Eurasia is higher among prisoners and the partners of those just released.

According to UNAIDS, there were about 1.46 million adults and children with HIV/AIDS in Eurasia in 2007. Ukraine has the highest HIV infection level in Europe, more than 1.6% of the population aged 17-49. Under one scenario, by 2014 Ukraine could experience a 1.6 percent reduction in GDP associated with the healthcare and other economic costs of HIV/AIDS, and AIDS mortality could reduce employment in the labor force by 10.4 percent.<sup>31</sup>

Russia has the largest number of adults and children in Eurasia living with HIV, an estimated 940,000 in 2007 (the latest available data), or about 0.66% of the population (among adults aged 17-49, about 1.1% have HIV), according to UNAIDS.<sup>32</sup> Reflecting on the epidemic in Russia, UNAIDS has stated that “a decade ago, few would have predicted that one million or more people would be living with HIV in the Russian Federation alone.”<sup>33</sup> The Russian government has somewhat reversed many years of “malign neglect” regarding HIV/AIDS by increasing its spending from \$6 million a year on the disease in the early 2000s to \$13 million (400 million rubles) in 2009.<sup>34</sup> Among other Eurasian states, Azerbaijan, Belarus, Kazakhstan, and Ukraine funded over 50% of their spending on HIV/AIDS programs from their domestic budgets, while the rest depended heavily upon the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS, or other international donors.

AIDS mortality in Russia and other Eurasian states is concentrated among those aged between 17-49, reducing the working age population and contributing to demographically-older populations. Despite an emphasis on treatment over prevention, less than one-fourth of the people needing antiretroviral therapy in Eurasia receive anti-retroviral medications, a level far below that of other countries with comparable GDPs, according to UNAIDS.<sup>35</sup>

Most new HIV cases in Eurasia still originate from IDUs, and is spread through their partners to the general population. Heterosexual transmission is the most common, although social stigma

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<sup>30</sup> UNAIDS and WHO. *AIDS Epidemic Update*, December 2009.

<sup>31</sup> USAID. *HIV/AIDS Health Profile: Europe and Eurasia Region*, September 2008.

<sup>32</sup> In contrast to UNAIDS estimates, Russia estimates fewer cases of HIV/AIDS and reported a declining number of new cases in recent years, perhaps related in part to a fall-off in testing for new cases among prisoners and injecting drug users. In 2008, however, 50,670 new HIV cases were registered, an increase of 18.9% compared to 2007.

<sup>33</sup> UNAIDS. *2008 Report on the Global AIDS Epidemic*, August 2008, p. 16.

<sup>34</sup> UNAIDS. *2008 Report on the Global AIDS Epidemic*, p. 254. On the judgment of “malign neglect,” see Nicholas Eberstadt, “The Future of AIDS,” *Foreign Affairs*, November-December 2002, pp. 22-45.

<sup>35</sup> UNAIDS and WHO. *AIDS Epidemic Update*, December 2009, pp. 17-18.



and punitive laws may keep men who have sex with men from seeking treatment and being reflected in official data on new cases. In Turkmenistan and Uzbekistan, consensual sex between same-sex adults is outlawed. Many observers call for the Eurasian states to spend more money on HIV prevention, including by providing IDUs with opioid substitution treatment (OST), involving methadone or buprenorphine. The Russian medical establishment remains opposed to OST on the grounds that one addiction should not be substituted for another.<sup>36</sup>

There have been some efforts at cooperation among the Eurasian states, including the launch of the *Program of Urgent Response to HIV/AIDS* by the Commonwealth of Independent States (CIS)<sup>37</sup> in 2002, under which a Coordination Council on HIV/AIDS meets periodically to discuss joint efforts. In an effort to strengthen regional responses to the continued increase in HIV prevalence, the CIS prime ministers in November 2008 approved a 2009-2013 program that called for all CIS countries to establish single national AIDS programs with unified monitoring and evaluation systems. The program also urged greater efforts to enhance access to free, voluntary, and confidential HIV counseling and testing and to bolster prevention programs for young people and populations at higher risk. The CIS program is supported by UNAIDS.<sup>38</sup>

Seeming to illustrate problematic data reporting, Turkmenistan's deputy minister of health reportedly boasted in October 2009 that the country had opened an HIV prevention clinic, but that "to our great happiness, not a single case of HIV has been reported anywhere in the country."<sup>39</sup> In Uzbekistan, the chairman of the trustees' council of the Sen Yolgiz Emassan (You Are Not Alone) state child foundation, President Karimov's daughter Lola Karimova, has directed HIV prevention efforts for youth. UNICEF has supported some of these efforts. Perhaps indicating some problems with HIV/AIDS prevention programs in Uzbekistan, however, an HIV/AIDS activist was sentenced to seven years in prison in February 2010 after he published an HIV prevention brochure—partly funded by UNICEF—that the government alleged encouraged immoral behavior.

## Drug Addiction

All of the Eurasian states face increased illegal drug use, with the greatest estimated levels of opiate use in Russia, Ukraine, Kazakhstan, Kyrgyzstan, and Uzbekistan and the greatest levels of cannabis use in Kazakhstan, Kyrgyzstan, and Uzbekistan (see **Table 4**). In all of the Eurasian states, demand reduction efforts are inadequate, according to the U.S. State Department's *International Narcotics Control Strategy Report*, because of inadequate budgets, inadequate treatment services, and a lack of focus on drug use prevention by officials.<sup>40</sup>

Drug treatment is poor or lacking in most of Eurasia, and where available, often entails involuntary confinement after arrest. Laws are mostly aimed at interdiction and punishment of drug traffickers and users, and drug users avoid seeking treatment out of fear of arrest. Where available, treatment mostly consists of detoxification with little or no follow-up rehabilitation efforts. For instance, OST pilot programs have been introduced in Azerbaijan, Belarus, Georgia,

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<sup>36</sup> Tom Parfitt, "Russia's Health Promotion Efforts Blossom," *The Lancet*, June 27, 2009, pp. 2186-2187.

<sup>37</sup> CIS members include all the Eurasian states except Georgia.

<sup>38</sup> UNAIDS. Feature Stories. *Regional Body Adopts Program of Joint Action on HIV for Commonwealth of Independent States*, March 9, 2010.

<sup>39</sup> "Turkmenistan: Public Health Remains in Critical Condition," *Eurasia Insight*, January 8, 2010.

<sup>40</sup> U.S. Department of State. *International Narcotics Control Strategy Report*, March 1, 2010.

Moldova, Tajikistan, and Uzbekistan, and partially scaled-up programs have been implemented in Kyrgyzstan and Ukraine, but access remains limited. Armenia, Kazakhstan, Russia, and Turkmenistan still do not provide OST.<sup>41</sup>

Since 2000, drug use in Russia has increased steadily, dominated by heroin and other opiates. In 2004, Russia enacted a new law—which amended a 1998 Russian narcotics law that mandated the involuntary commitment of drug users—to in principle permit drug treatment options to imprisonment. However, law enforcement has continued to emphasize imprisonment and the healthcare system resists OST.<sup>42</sup> In late 2005, the government launched a program to reduce the total number of drug users by up to 20% by 2010 by cracking down on drug traffickers, but these efforts have appeared to fail. The U.N. Office of Drugs and Crime stated in late 2009 that the rate of heroin and opium use in Russia is the second highest in the world (first is China), about 1.7 million users, and that one out of three overdose deaths worldwide occurs in Russia.<sup>43</sup> In March 2010, Russia’s Federal Narcotics Control Service reported that there were 550,000 registered drug addicts, and that 30,000 Russians die each year from overdoses. It termed the addiction and overdose rates a national security problem. Russia increasingly has demanded that the United States and NATO combat drug production in Afghanistan as a primary mission.<sup>44</sup>

In Eurasia, drug treatment programs have struggled to meet burgeoning needs. According to the State Department’s *International Narcotics Control Strategy Report*:

- In Armenia, a Drug Detoxification Center, part of the Narcological Clinic, provides short-term drug treatment. Two new drug treatment facilities opened in 2009, one of which is part of the prison hospital system. These new facilities should help alleviate the lack of long-term treatment and counseling that previously limited the success of treatment efforts. In 2009 the Narcological Clinic began offering methadone substitution treatment.
- In Belarus, drug addicts are generally treated in psychiatric hospitals or at 21 outpatient narcotics clinics, either as a result of court remand or self enrollment. Addicts are also treated in prisons. On the whole, treatment emphasizes detoxification over stabilization and rehabilitation. Three OST clinics are operated by the Ministry of Health, and serve several hundred addicts. There are at least twelve small-scale NGO-run rehabilitation centers. On the whole, availability and quality of services have improved somewhat. NGO-run centers provide fee rehabilitation services to both registered and anonymous drug addicts, while government-run centers provide similar services for free, but only to registered addicts. Because the official drug addict registry is readily available to Belarusian law enforcement agencies, drug addicts still often avoid seeking treatment.

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<sup>41</sup> WHO. Regional Office for Europe. *Progress on Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia*, 2008; *Monitoring and Evaluation of Opioid Substitution Treatment in Ukraine*, International Harm Reduction Conference, 2007; *Evaluation of Opioid Substitution Therapy in the Kyrgyz Republic*, 2009.

<sup>42</sup> Richard Elovich and Ernest Drucker, “On Drug Treatment and Social Control: Russian Narcology’s Great Leap Backwards,” *Harm Reduction Journal*, June 24, 2008.

<sup>43</sup> UNODC. *Addiction, Crime and Insurgency: The Transnational Threat of Afghan Opium*, October 2009.

<sup>44</sup> *Oxford Analytica*, July 10, 2009; *RIA Novosti*, March 11, 2010.

- In Georgia, demand for detoxification and substitution therapy far outstrips supply. In addition to current NGO-supported OST centers, which treat approximately 450 patients, the government opened six new treatment centers in 2009. These centers co-finance OST with clients and serve approximately 1,200 patients. A pilot methadone program began in the penitentiary system in 2008.
- In Kazakhstan, a pilot project to test methadone therapy was launched in two cities in 2009, and 29 heroin addicts, including 11 that were HIV-positive, took part.
- In Kyrgyzstan, insufficient funding is hampering prevention and treatment programs and training of professional staff. Programs providing treatment for drug users are conducted by state institutions in partnership with civil sector organizations. UNODC also supports a number of drug treatment assistance programs.
- In Moldova, there is no formally structured, integrated approach to treatment for drug addiction. The after-care and reintegration system is underdeveloped. Detoxification is available in two government medical institutions on an out-patient basis. A few private healthcare institutions are also authorized to offer detoxification treatment. Detoxification services are included under the National Health Insurance Fund for insured people. Uninsured persons must pay for detoxification. If anonymity is desired, insured patients must go to private healthcare institutions and pay out-of-pocket. Some NGOs offer rehabilitation and reintegration programs free-of-charge on an anonymous basis.
- In Turkmenistan, the Ministry of Health operates seven drug treatment clinics. Addicts can receive treatment at these clinics without revealing their identity and all clinic visits are kept confidential. Drug addiction is a prosecutable crime and persons convicted are subject to jail sentences, although judicial officials usually sentence addicts to treatment.
- In Ukraine, the government has implemented pilot OST programs using buprenorphine and is shifting to methadone treatment and is expected to cover up to 20,000 addicts in 111 clinics countrywide by 2013.
- In Uzbekistan, hospitals with drug dependency recovery programs are inadequate to meet the increasing need for detoxification and treatment, although the government is making an effort to open new treatment facilities.

## **Alcoholism and Smoking**

According to the WHO, smoking prevalence in most of Eurasia increased during the 1990s but began to decline somewhat at the turn of the century as anti-smoking campaigns appeared to make some headway. WHO data listed Austria and Bosnia as having the highest prevalence rates of smoking in the world, at 47% and 38% of adults, respectively in 2002-2005. In Eurasia, Russia and Ukraine had the highest smoking prevalence among adults (36%) surveyed in the same time period. In Russia, almost two thirds of adult males reportedly smoke, with many starting at young ages. While the percentage of males who smoke has stabilized in recent years, the percentage of females who smoke has risen from about 10% in 1994-1998 to 15% in 2002-2005. In Ukraine, the percentage of males who smoke has risen from about 48% in 1994-1998 to 62% In 2002-2005, while the percentage of females who smoke has fluctuated between 14%-20%. Smoking has been linked to high percentages (more than 33%) of male deaths among those aged 35-69 in

Russia, Armenia, Belarus, Kazakhstan, and Ukraine, rates that are substantially higher than in the United States. Of all the Eurasian states, only Azerbaijan does not restrict tobacco advertising on television.<sup>45</sup>

Alcohol consumption in Russia and many other Eurasian states remains much higher than in most of the world. Moldova and Russia have the largest per capita consumption of marketed and home-brewed spirits in the world, according to the U.N. Food and Agriculture Organization. Ukraine has the highest rate of alcohol consumption among children and youth, according to WHO. Alcohol consumption in Russia declined briefly in the mid-1980s as a result of a sobriety campaign, but rose thereafter. Beginning in 1993, there was a large increase in male alcohol poisoning in Russia, along with increases in male homicide and suicide, traffic accidents, and circulatory and respiratory diseases.<sup>46</sup> In June 2009, the *Lancet* reported that alcohol poisoning and alcohol-induced heart failure were among the major causes of early death of Russians aged 15-54, and that other causes of death related to alcohol consumption included depression, pancreatic disease, tuberculosis, and pneumonia. The report claimed that excess alcohol and tobacco usage among Russians accounted for most of the divergence between Russian and West European life expectancy.<sup>47</sup>

In 2009, Russian President Medvedev became increasingly concerned about the prevalence of alcoholism in the country. At the end of June 2009, he stated that he was “surprised to learn that we now drink more than we did in the 1990s, even though those were very difficult times,” and called for Health Minister Tatiana Golikova to work out plans for an anti-alcohol campaign.<sup>48</sup> A few days later, he warned that about 18 liters of alcohol are being consumed per capita per year, and that “this is a monstrous figure. After 9-10 liters [of alcohol per person per year], gene pool problems arise, and degradation begins.”<sup>49</sup> In September 2009, the Health Ministry reportedly had drafted a plan for discussion, and in November 2009, the Federal Service for Regulating the Alcohol Market (Rosalkogolregulirovaniye) had drawn up proposals to increase the minimum price of vodka, crack down on the illicit production of alcohol, increase penalties for selling alcoholic beverages to underage youths, and develop sports and other programs advocating healthy lifestyles.<sup>50</sup> In January 2010, Putin approved the anti-alcohol campaign. As per his decree, alcohol consumption per capita is to be reduced by 15% by 2012 and 55% by 2020. In the second stage of the campaign, from 2013-2020, sports and healthy living will be stressed.<sup>51</sup> Reportedly, legislation to carry out the campaign has bogged down in the legislature because of resistance from government officials and commercial interests that rely on revenues from alcohol sales.

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<sup>45</sup> United Nations. World Health Organization. Regional Office for Europe. *Tobacco Control Database*, at <http://data.euro.who.int/tobacco/?TabID=2402>.

<sup>46</sup> Vladimir Treml, “Alcohol Abuse,” in Horst Herlemann, *The Quality of Life in the Soviet Union* (Boulder, CO: Westview Press, 1987), pp. 151-162. According to Russian analysts Vladimir Shkolnikov and Alexander Nemtsov, “in the period from 1988-1992, the biggest share of the increase in Russian mortality was attributable to alcohol consumption.” *Premature Death in the New Independent States*, National Research Council (Washington, D.C.: National Academy Press, 1997), pp. 232-233, 240-241, 256.

<sup>47</sup> David Zaridze, Paul Brennan, Jillian Boreham, Alex Boroda, Rostislav Karpov, Alexander Lazarev, Irina Konobeevskaya, Vladimir Igitov, Tatiana Terechova, Paolo Boffetta, and Richard Peto, “Alcohol and Cause-Specific Mortality in Russia: A Retrospective Case-Control Study of 48,557 Adult Deaths,” *The Lancet*, June 27, 2009, pp. 2201-2214.

<sup>48</sup> *ITAR-TASS*, June 30, 2009.

<sup>49</sup> *ITAR-TASS*, July 4, 2009.

<sup>50</sup> CEDR, November 11, 2009, Doc. No. CEP-950094.

<sup>51</sup> *CEDR*, January 14, 2010, Doc. No. CEP-950200.

## **Water-Borne Diseases, Poliomyelitis, and Viral Hemorrhagic Fever**

Some Eurasian states have made progress in recent years in repairing water and sewer systems that deteriorated after the collapse of the Soviet Union (or were always sub-standard), but in Kyrgyzstan and Tajikistan and some other Eurasian states, water-born illnesses such as hepatitis, cholera, and typhoid fever apparently still remain serious problems. In April 2010, WHO confirmed an outbreak of poliomyelitis (a water-borne virus) in Tajikistan that had killed twelve children and may have paralyzed nearly 300, the first such cases since 1997. Reportedly, the disease spread from Afghanistan, one of the four countries in the world where polio is still endemic. By the end of April 2010, UNICEF had rushed oral polio vaccines sufficient for 1.1 million children to the country for an immunization campaign being carried out in May-June 2010. Following the polio outbreak, Kazakhstan, Uzbekistan, and Russia announced restrictions on travel or trade with Tajikistan. Some Russian military personnel stationed in Tajikistan rushed to send their children home. Tajik health officials urged the families to submit their children to polio immunization before such travel. Some of the children entering Russia were found to have polio.

The numbers of Crimean-Congo hemorrhagic fevers in Russia's Bashkortostan republic increased in 2009 to over 3,200 cases, compared to about 2,200 in 2008, linked to increasing numbers of host rodents, other animals, and ticks, which are the vectors of infection. Russia's Penza region also reported a surge in cases in 2009 to over 2000. Other regions of Russia reported lower incidences of hemorrhagic fever over the previous year, but there were still dozens of infections and several deaths. The deputy health minister in Tajikistan reported in August 2009 that about one to two dozen cases of viral hemorrhagic fever are suspected in Tajikistan each year, with some recent cases being reported in southwestern Tajik towns and one in Dushanbe. Picnics and outings to popular recreational areas were banned in South Kazakhstan Oblast in Kazakhstan in late April 2010 because of the risk of contracting Crimean-Congo hemorrhagic fever.<sup>52</sup>

## **Non-Medical Indicators**

Increasing numbers of people in Eurasia belong to subgroups that face special health needs, including orphans, refugees, and the internally displaced.

### **Refugees and Displaced Persons**

Eurasian health conditions have been impacted by the large number of persons who have fled warfare and discrimination since the breakup of the Soviet Union. The U.N. High Commissioner for Refugees (UNHCR) has estimated that during the 1990's there were as many as nine million internally displaced persons or refugees in Eurasia.

Major humanitarian emergencies caused by conflict have occurred in Armenia, Azerbaijan, Georgia, Russia, and Tajikistan. During the 1990s, conflict resulted in the exile or displacement of over 1.5 million Armenians, Azerbaijanis, Georgians, and Chechens and other residents of

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<sup>52</sup> *CEDR*, May 15, 2010, Doc. No. CEP-339001; April 25, 2010, Doc. No. CEP-339002; February 5, 2010, Doc. No. CEP-339002. See also A. M. Butenko and G.G. Karganova, "Crimean-Congo Hemorrhagic Fever in Russia and Other Countries of the Former Soviet Union," in Onder Ergonul and Chris Whitehouse, *Crimean-Congo Hemorrhagic Fever* (Dordrecht: Springer Netherlands, 2007), pp. 99-114.



Russia, according to UNHCR.<sup>53</sup> Other population shifts have included ethnic Russians leaving former republics where they are ethnic minorities and returning to Russia (3 million between 1992 and 1996), Crimean Tatars returning to their homeland in Ukraine (250,000 between 1988-1999), and Georgians displaced during the Russia-Georgia conflict (158,000 in August 2008). While many of those displaced have returned, UNHCR estimates that as of January 2009, there still were 987,804 displaced persons in Eurasia.<sup>54</sup> Despite efforts by aid agencies to address the urgent health needs of the displaced, the longer-term health needs of this vulnerable population are harder to address, particularly if the displaced continue to face inhospitable living conditions and limited access to local healthcare facilities. **Table 5** shows the current estimates of refugees and displaced in Eurasia.

### **Children in Residential Care**

According to UNICEF, the numbers of children placed in residential care (infant homes, orphanages, boarding homes and boarding schools) has increased in Eurasia since 1991, from an average of about 574 children per 100,000 population in 1991 to an average of about 879 children per 100,000 in 2006. While numbers of institutionalized children have been growing, declining public funding has contributed to poorer care. Most of the children are in boarding schools and a fewer number are orphans. Kyrgyzstan and Tajikistan are increasingly relying on boarding schools to help children from poor families benefit from schooling. The orphanages in Eurasia, unlike in most of Europe, often include children with birth defects, mental disabilities, and chronic health conditions.

USAID and international donors have increasingly provided assistance, including urgent and other healthcare, and have encouraged the establishment of a foster care system to replace orphanages and of community-based services so that parents can continue to care for their challenged children. Over the period 2002-2008, USAID provided advice and training in Russia on early crisis identification, family preservation and reunification, social support for families with HIV, development of a university curriculum on child welfare, and the establishment of regional supervision systems for social workers. In the Western Eurasian states (Belarus, Moldova, Russia, and Ukraine), the number of children in foster care has increased from an average of 59 per 100,000 population in 1991 to 122 per 100,000 in 2006, but progress in implementing foster care systems in other Eurasian states has been halting.

The numbers of homeless and street children in Russia and other Eurasian states reportedly also may have decreased in recent years following a boost in such cases after the Soviet collapse. Still, HIV-positive youth face stigmatization that reduces prospects for foster care placement or residential care and may contribute to homelessness. In St. Petersburg, Russia, USAID supported a program from 2004-2008 to provide medical and psychological services for street and neglected children to ensure their rehabilitation and transition from streets to birth families, foster-care, or independent living.<sup>55</sup>

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<sup>53</sup> United Nations. High Commissioner for Refugees. *The State of the World's Refugees 2000*, p.185-209.

<sup>54</sup> United Nations. High Commissioner for Refugees. *UNHCR Statistical Yearbook 2008*, December 31, 2009, pp. 65-68.

<sup>55</sup> United Nations. UNICEF Innocenti Research Center. TransMONEE Database, Table 8: Child Protection, May 2008; *System, In Support of Children Without Parental Care in the Russian Federation*, November 2006; Leonardo Menchini, Sheila Marnie and Luca Tiberti, *Child Well-Being in Eastern Europe And Central Asia: A Multidimensional Approach*, October 2009. USAID. Health in Russia, 2007, at <http://www.usaid.gov/locations/europe.../health.../docs/> (continued...)



## U.S. and International Health Aid to Eurasia, FY1992-FY2011

**Table 1** and **Table 2** show the amount of health aid to the Eurasian states provided or proposed for FY1992-FY2011 (data for FY1992-FY2008 include all funding sources and agency spending, while data for FY2009-FY2011 include “function 150” foreign assistance funding). U.S. assistance budgeted for FY1992-FY2010 for health was less than 5% of total aid to Eurasia of about \$35.3 billion (excluding the value of privately donated cargoes), indicating the relatively low priority of such aid.<sup>56</sup> U.S. government health aid to Eurasia has been far less than private donations of medical goods and expertise, which were worth about \$4.2 billion during FY1992-FY2010.

The biggest change in appropriations for healthcare over the period FY1992-FY2011 appears to be associated with the terrorist attacks on the United States on September 11, 2001, which led to greater recognition of the national security implications of world health problems. Before 9/11, health aid held fairly steady at about 3% or less of Eurasian funding from FY1998 through FY2001, and amounted to an average of about \$39 million per fiscal year. For FY2002 and thereafter, funding tripled as a percentage, to about 9%, and amounted to an average of about \$66 million per fiscal year.

Although levels of funding appear linked to the events of September 11, 2001, programmatic emphases have changed over various U.S. Administrations. The former Clinton Administration asked Congress in 1997 to begin supporting a new “Partnership for Freedom” initiative as part of boosted Eurasian assistance that would emphasize grass-roots economic and social reforms, including health. Additional aid was sought for hospital and health facility partnerships, programs to combat infectious diseases, and efforts to bolster clean water supplies, childhood survival, and maternal health.<sup>57</sup> The request for a large boost in Eurasian aid was not supported by Congress, but many of the programmatic emphases, including health aid, were endorsed by Congress.

Building on the “Partnership for Freedom” initiative, USAID increasingly emphasized social needs in Eurasia. USAID came to argue that economic reforms in the Eurasian states had not always contributed to the growth of middle classes, and also helped create “a new class of chronically poor,” who lost the meager state benefits they received under communism. While democratization and economic reforms remained U.S. objectives, USAID stressed that without adequate healthcare and other social services, populations in the Eurasian states would lose faith in the reform process. USAID stated that it would increasingly take social issues into account in

(...continued)

country\_profile\_russia.pdf. See also Darshak Sanghavi, “The Lonely Lives of Russia’s Orphans,” *The Washington Post*, April 25, 2010, p. B-2. After Russia indefinitely halted adoptions to the United States in April 2010, some officials in Russia called for bolstering the foster care and family support systems.

<sup>56</sup> The State Department’s Office of the Coordinator for Assistance to Europe and Eurasia has compiled foreign assistance data to Eurasia from all agencies and authorities up through FY2008. Data for FY2009-FY2011 are available for the Assistance for Europe, Eurasia, and Central Asia (AEECA), Global Health and Child Survival (GHCS) accounts, Foreign Military Financing (FMF), International Military Education and Training (IMET), and Non-Proliferation, Anti-Terrorism, De-Mining, and Related (NADR) programs.

<sup>57</sup> Spurring these emphases, conferees on Foreign Operations Appropriations for FY1997 (H.Rept. 104-863) had criticized the Administration for not including health and environmental health as Eurasian aid priorities, and had urged that the treatment of childhood illnesses in Ukraine related to Chernobyl supersede other aid objectives.

designing and implementing programs, so that “the broadest possible spectrum of [Eurasian] citizens ... have the opportunity to enjoy the benefits of reform.”<sup>58</sup>

In 2005, USAID’s Bureau for Europe and Eurasia launched a *Health Sector Strategy: 2005-2010 and Beyond* that called for U.S. health assistance to be used “to improve the health of [Europe and Eurasian] populations in order to support a successful transition to democracy and free-market economies.” The strategy “builds upon the region’s current epidemiological and economic realities and USAID’s experience and successes to date. It preserves a focus on HIV/AIDS, tuberculosis and reproductive health, while explicitly recognizing the enormous deleterious effect that non-communicable disease is having on the region.”<sup>59</sup>

USAID has long stressed the restructuring of post-Soviet healthcare systems in order to improve measures of health in Eurasia. Programs to “strengthen” healthcare systems deal with public-private partnerships; finance, policy, management, and organization (including devolution and decentralization and provider payment systems); procurement (including rational drug use); primary care, family medicine, and public health; quality improvement; information systems; human resources development; privatization, and NGO development.<sup>60</sup> USAID’s Quality Public Health and Primary Health Care in Central Asia (“Zdrav-reform,” “Zdrav Plus,” and “Zdrav Plus II”) began in 1994 (involving four of the five regional states; Tajikistan joined in 2005), and by the end of 2009, \$30 million had been allocated to the program to restructure the health care systems of the states to bolster the government’s stewardship (policies, laws, and institutions) of healthcare, financing, and delivery, particularly of primary care. USAID has leveraged the program through partnership with the World Bank and the Asian Development Bank, and has reported that the program “has helped Central Asian countries make tremendous advances in structuring their health systems to operate efficiently and to respond to the health care needs of their populations.”<sup>61</sup> Among other programs, beginning in 2005, the Global Fund to Fight AIDS, Tuberculosis and Malaria—a governmental public/private partnership organization that receives the largest share of funding from the United States—has permitted countries to apply for funds for health systems strengthening purposes as well as for disease-specific components. Among Eurasian states, only Georgia has applied for such funds, but its proposal was not funded.<sup>62</sup>

Private donations of medical goods and expertise include those provided through the Health Partnerships program, implemented by the American International Health Alliance (AIHA; a public-private organization that leverages government and private funding to foster cooperation between U.S. hospitals and healthcare providers and Eurasian medical facilities and experts for

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<sup>58</sup> USAID, *Budget Justification FY2001, Annex III, Europe and Eurasia*, p. 9. See also USAID, *Broadening the Benefits of Reform in Central and Eastern Europe and the New Independent States: A Social Transition Strategy for USAID*, Bureau for Europe and Eurasia, February 2000, pp. 8-9, 23-24.

<sup>59</sup> USAID, Bureau for Europe and Eurasia, *Health Strategy*, at [http://www.usaid.gov/locations/europe\\_eurasia/health/strategy.html](http://www.usaid.gov/locations/europe_eurasia/health/strategy.html). In March 2008, USAID transferred responsibility for aid for the Central Asian states from the Europe and Eurasia Bureau to its newly created Asia Bureau. However, the 12 Eurasian countries continue to be tracked together for comparisons and trends.

<sup>60</sup> USAID, *Sustaining Health Gains-Building Systems: Health Systems Report to Congress*, October 2009.

<sup>61</sup> USAID, *Mid-Term Evaluation of USAID/CAR Project Quality Public Health and Primary Health Care in the Central Asian Republics “ZdravPlus II,”* April 17, 2008. See also Armin Fidler, Caryn Bredenkamp, and Sally Schlipfert, “Innovations in Health Services Delivery from Transition Economies in Eastern Europe and Central Asia,” *Health Affairs*, July/August 2009, pp. 1011-1022.

<sup>62</sup> USAID, Bureau for Global Health, Office of HIV/AIDS, *Strengthening Health Systems to Improve HIV/AIDS Programs in the E&E Region Using Global Fund Resources*, January 2006

aid efforts focusing on educational activities and professional exchanges). Private donations that do not use U.S. subsidized transport are not included in this total. Dozens of primary, urgent, or other healthcare partnerships launched by AIHA are active in all twelve Eurasian states.<sup>63</sup> Operation Provide Hope, an interagency program launched in 1992, and USAID's ocean freight program provide U.S. funded transport services for private donations of medical goods. The value of health-related donated cargoes has declined somewhat over the years, from a high of \$372 million in FY1993 to \$150 million in FY2008. When the value of the privately donated cargoes that are transported with government support are added, U.S. public and private health-related assistance amounts to about \$4.9 billion in total aid to Eurasia in FY1992-FY2008 (see text box).

Besides USAID health-related programs, the Department of State coordinates efforts by the Department of Health of Human Services and other agencies to redirect former Soviet biological warfare scientists to peaceful research, with a focus on healthcare (such as drug and vaccine development for the control of tuberculosis, hepatitis, HIV/AIDS and other infectious diseases). In addition, some activities of the Moscow and Kiev Science and Technology Centers, funded by the State Department, deal with biomedical research by Eurasian scientists. With major U.S. backing, a Civilian Research and Development Foundation NGO was set up in 1995, including a Biomedical and Behavioral Sciences Program that carries out collaborative medical research, funded by the U.S. State, Defense, and Commerce Departments, NIH, and others. Programs involving retraining for scientists from Russia, Ukraine, and from Central Asia who previously worked on biological and chemical warfare have increased in keeping with post-9/11 U.S. security emphases.<sup>64</sup>

Among other Eurasian health programs, the Peace Corps has carried out preventive health education in Armenia, Kazakhstan, and Moldova, and community health development activities in Turkmenistan and Uzbekistan. Peace Corps programs in Kazakhstan, Moldova, Turkmenistan, and Uzbekistan stress education on preventing HIV/AIDS, and in Kazakhstan, Turkmenistan, and Uzbekistan emphasize maternal and child health. The Defense Department has donated military hospitals under the Excess Defense Articles program and has provided follow-on equipment packages and training to virtually all of the Eurasian states during FY1992-FY2008.<sup>65</sup>

The Obama Administration boosted health aid as a percentage of assistance to Eurasia in FY2010 and FY2011 (see **Table 2**). In FY2010, the Administration increased health assistance by about \$10 million, mainly to Tajikistan, Ukraine, and Uzbekistan, while continuing to support relatively high health funding in Russia. In boosting health aid to Tajikistan and Uzbekistan, the Administration emphasized that they are on the "front lines" of counter-terrorism efforts in Afghanistan, and in the case of Ukraine, that its integration with the West is a priority. The Administration averred that in Tajikistan, "support to strengthen border security, counter-narcotics efforts, democratic reforms, health, education, and economic growth is key to improving Tajikistan's role as a bulwark against regional threats such as terrorism and drugs," and warned that "Tajikistan's needs in health and education are so severe that they jeopardize progress in other priority objectives." The Administration stressed that "Ukraine has one of the world's fastest rates of increase in pre-epidemic HIV and TB infection. Assistance programs to arrest the spread of HIV/AIDS will also help prevent mother-to-child HIV/AIDS transmission, address the spread of multi-drug resistant TB strains, and stem the potential long-term disruption HIV/AIDS

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<sup>63</sup> For details, see the AIHA website, <http://www.aiha.com>.

<sup>64</sup> *Congressional Budget Justification, Foreign Operations, FY2011*.

<sup>65</sup> *Peace Corps, Congressional Budget Presentation, FY2011*.

poses to Ukraine's economic growth." The Administration stated that bilateral relations with Uzbekistan appeared to be improving and that the United States would engage the Uzbek people directly through health assistance.<sup>66</sup> For FY2011, USAID has called for health assistance to continue to all the Eurasian states to address needs that still place them within the category of "developing countries" in terms of some communicable and non-communicable diseases.<sup>67</sup>

## **European Union and International Health Assistance Efforts**

In 2008, the European Union provided \$68 million for healthcare, including reproductive health, under the European Neighborhood and Partnership Instrument for Eastern Europe, which covers Armenia, Azerbaijan, Belarus, Georgia, Moldova, and Ukraine. The EU also provided \$1.3 million in 2008 for healthcare for Central Asia. EU-Russia talks about drawing up a new Partnership and Cooperation Agreement resulted in 2009 in a decision to hold meetings on public health issues. However, the Russian side cancelled the first two planned meetings. In 2009, the EU allocated \$8 million for Chechnya, some of which was used to bolster maternal and child health services. Over the period 2007-2009, the EU provided \$5.3 million for rehabilitating disabled persons in Russia.<sup>68</sup>

International organizations with health programs in Eurasia include the World Health Organization, the U.N. Fund for Population Activities, UNICEF, the U.N. Development Program, the Global Fund to Fight AIDS, TB, and Malaria, and the World Bank. WHO's budgetary emphasis is on functional programs and regions, so a breakdown of spending in each Eurasian state is not available. Each Eurasian state has a WHO special representative who coordinates in-country programs. Among recent efforts in Eurasia, WHO deployed experts in late April 2010 to perform a field-based risk assessment of a polio outbreak in south-west Tajikistan, the first imported polio outbreak in the WHO European Region since the Region was certified polio-free in 2002. In November 2009, WHO deployed experts in western Ukraine to characterize the clinical and epidemiological features of a suspected outbreak of pandemic flu (H1N1) in the country, and to recommend best-practice scenarios for treatment. In October 2009, WHO launched a project with the European Commission to help Kazakhstan's Ministry of Health to reduce maternal and neonatal mortality rates in Kazakhstan, which were said to be almost 90% higher than those in the European Union.

According to the database of the Global Fund to Fight AIDS, TB, and Malaria (a global public-private organization), it has disbursed funding of \$805 million to combat these diseases in Eurasia, with over one-third going to Russia (\$321 million), about one-fifth to Ukraine (\$167 million), and the rest to other Eurasian states, excluding Turkmenistan. Turkmenistan has a pending grant of \$7 million for combating TB, but its Health Ministry has been slow in implementing TB programs, although drug-resistant TB rates in the country reportedly are

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<sup>66</sup> U.S. Department of State. *Congressional Budget Justification for Foreign Operations for FY2010, Book 2*, May 28, 2009.

<sup>67</sup> U.S. Department of State. *Congressional Budget Justification for Foreign Operations for FY2011, Annex: Regional Perspectives*, March 2010.

<sup>68</sup> European Commission. *Annual Report 2009 on the European Community's Development and External Assistance Policies and their Implementation in 2008, 2009; EU-Russia Common Spaces: Progress Report*, March 2010, at [http://ec.europa.eu/external\\_relations/russia/index\\_en.htm](http://ec.europa.eu/external_relations/russia/index_en.htm).

increasing. The United States is the largest donor to the Global Fund, contributing \$841 million in 2009 and pledging \$1 billion in FY2010.<sup>69</sup>

The U.N. Children's Fund (UNICEF) has health and nutrition programs throughout Eurasia. Spending in the Eurasian states over the last five years (these periods were mostly from 2006-2010) was \$68 million, and ranged from \$12.9 million in Uzbekistan to \$3.3 million in Belarus, according to UNICEF. The United States is the largest donor to UNICEF programs.<sup>70</sup> UNICEF programs in Uzbekistan have focused on improving access to basic services for women and children and on training authorities on how to deliver social services. Aid aims to ameliorate high rates of infant, child and maternal mortality, the poor quality of basic education, increasing numbers of children in conflict with the law and in institutions, and inadequate care for disabled children.<sup>71</sup>

The U.N. Population Fund (UNFPA) also has programs in all the Eurasian states. Among the UNFPA programs carried out in 2005-2009, those for Armenia (\$4.2 million), Kazakhstan (\$3.8 million), Tajikistan (\$1 million), Turkmenistan (\$2.3 million), and Uzbekistan (\$7.7 million) devoted a substantial portion of to reproductive health and family planning issues.<sup>72</sup>

Active World Bank projects involving some health component in the Eurasian states (except Russia) amount to \$485 million. These include projects supporting avian influenza control in Armenia, Kyrgyzstan, Moldova, Tajikistan, and Turkmenistan; health sector reforms in Armenia, Azerbaijan, Moldova, Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan; and AIDS control in Central Asia.<sup>73</sup>

## Issues for Congress

### How Significant are Health Issues in Eurasia to U.S. Interests?

There is considerable debate about U.S. health assistance to Eurasia. Many of the arguments focus on the merits of maintaining health assistance, the application of health assistance, and the extent to which the recipient countries demonstrate a commitment to improving health. Those who endorse continued or expanded U.S. health aid to the Eurasian states argue that disease outbreaks in Eurasia, whether the result of nature or bio-terrorism, are among those that might spread to U.S. shores. Particularly since 9/11, they emphasize the significance to homeland

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<sup>69</sup> The Global Fund to Fight AIDS, TB, and Malaria, Grant Portfolio Database, at <http://portfolio.theglobalfund.org/?lang=en>; Country Page for Turkmenistan, at <http://portfolio.theglobalfund.org/Country/Index/TKM?lang=en>.

<sup>70</sup> UNICEF. *UNICEF Annual Report 2008*, June 2009.

<sup>71</sup> UNICEF. *Background Information: UNICEF in Uzbekistan, Country Program 2005-2009*, at [http://www.unicef.org/uzbekistan/about\\_7917.html](http://www.unicef.org/uzbekistan/about_7917.html)

<sup>72</sup> UNFPA. Executive Board Documents, Annual Session, May 26-June 5, 2009. Program Results and Performance Data, Decision 2006/9. *Country Program Performance Summary Country Armenia; Program Performance Summary Kazakhstan; Country Program Performance Summary Tajikistan; Country Program Performance Summary Turkmenistan; Country Program Performance Summary Uzbekistan.*

<sup>73</sup> The World Bank Group. *Projects Database*, at <http://web.worldbank.org/WBSITE/EXTERNAL/PROJECTS/0,,menuPK:41389~pagePK:95863~piPK:95983~tgDetMenuPK:228424~tgProjDetPK:73230~tgProjResPK:95917~tgResMenuPK:224076~theSitePK:40941,00.html>.



security of disease prevention and surveillance beyond U.S. shores. Other observers argue that infectious disease rates are not as high in Eurasia as in other developing countries, and do not threaten U.S. interests as severely.

A number of analysts concerned about the possible impact of infectious diseases on security are particularly troubled by the vulnerability of U.S. defense personnel involved in exchanges, exercises, training, or transit in Eurasia.<sup>74</sup> U.S. security interests may be served by bolstering the health of Eurasia's military forces and civilian populations. Declining health in the military and security forces can harm their ability to combat terrorism and drug trafficking, to ensure the safety and security of weapons of mass destruction, and otherwise to defend the territorial integrity of the states. If the military forces are less capable of carrying out these missions, then U.S. border, customs, and security aid (recently boosted by the Administration and Congress), may be less effective than anticipated, according to this argument. U.S. health aid has been considered by several Eurasian military establishments as a major benefit of military-to-military cooperation, according to U.S. defense officials. Critics counter that the U.S. military is always concerned about protecting personnel from disease, and that Eurasian military personnel are no more dangerous than the personnel of other countries with large health problems.

Many observers stress that U.S. interests in economic and political reforms in Eurasia may be undermined by health problems in the countries. Adverse health trends in Russia may be a drag on economic reforms, foster civil unrest, encourage a countervailing political authoritarianism, and perhaps lead to a more internationally belligerent, nuclear-armed Russia, they argue. Even small increases in health aid may pay big dividends in discouraging such developments in Russia, some observers argue. However, as **Table 3** indicates, governments of the Eurasian states are spending a very small percentage of their budgets on health. Without greater commitments by the states to healthcare, U.S. and international assistance may not have a lasting impact on healthcare. In addition, the states must address the societal roots of health problems such as alcohol and drug abuse, and homicides and suicides.

## **How Much Can the United States do to Improve Health Conditions in Eurasia and What Types of Health Aid are Appropriate?**

The United States faces competing priorities for its aid dollars and limits on its ability to fund healthcare reforms in Eurasia. Observers who urge greater emphasis on U.S. health aid to Eurasia argue that small increases in such aid may pay big dividends in lowering disease rates and ameliorating social discontent in the Eurasian states. Some call for much larger commitments to meet pressing health needs in Eurasia, perhaps by shifting aid from democratization and economic reform programs. Many urge caution in taking on new Eurasian health aid commitments unilaterally. The states face interrelated and costly healthcare, public health infrastructure, and environmental problems—such as deteriorating hospitals, failing water and sanitary systems, radiation hazards in Kazakhstan's Semipalatinsk nuclear testing site, and pollution around the Aral Sea—that demand large-scale, sustained, and in many cases, multinational attention.

Congress and the executive branch have clashed for several years over how much aid to provide for Eurasia. Annual U.S. health aid to the Eurasian states rose somewhat after 9/11. One possible

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<sup>74</sup> CIA. National Intelligence Council. *Strategic Implications of Global Health*, ICA 2008-10D, December 2008.



way to address the need for more health assistance in the region would be to increase the percent of foreign aid devoted to health or to establish Congressional guidelines for the amount of aid to be provided for health assistance to Eurasia. Either of these changes would require further shifts in U.S. policy, which for a long time focused on democratization and economic reforms and arms control in Eurasia. Also, there may be a need to consider longer-term health aid commitments, particularly if U.S. assistance is targeted more to healthcare institution-building and reform efforts that aim to bolster the ability of the Eurasian states to meet their own needs.

In recent years, FREEDOM Support Act authorized health assistance has been supplemented by funding from other accounts, seemingly reflecting a greater recognition of specific health needs in Eurasia. The regional states have received \$84.2 million from the Child Survival and Health Programs Fund (CSH) account since FY2001 and \$13.5 million from the Global HIV/AIDS initiative since FY2005. In addition, Russia and Ukraine received \$2.2 million in Economic Support Funds devoted to healthcare improvements in FY2004.

Other analysts urge Congress to alter the distribution of aid among the Eurasian states. Between FY1992 and FY2008, the largest aid amounts have gone to Armenia, Kazakhstan, Russia, Ukraine and Uzbekistan. Much less health assistance has been provided to Azerbaijan, Belarus, Moldova, and Turkmenistan. Some experts maintain that this distribution of aid is not clearly matched to the health status of the states. Instead, a number of considerations seem to influence decision-making on the distribution of aid besides targeting it to the most needy Eurasian states, including the degree to which aid should be targeted to the closest or most strategic U.S. friends or to the most democratic and market-oriented states. Such determinations are complicated by the added desirability of targeting U.S. aid to Eurasian states where governments are receptive, honest, and efficient at carrying out healthcare reforms, although these conditions are scarcely met in any of the Eurasian states.<sup>75</sup> In Russia and other Eurasian states, many critics charge, the governments are highly corrupt, inefficient, and not focused on health budgets, policies, and stewardship. In such conditions, U.S. and international medical assistance to the Eurasian states risks being undermined or redirected for political purposes. In some cases, Eurasian governments have blocked medical as well as other humanitarian aid to civilians for political and military purposes (such as in Chechnya), using it as a weapon to bring populations and separatist movements into line. To help circumvent problems with governments, some observers have argued that U.S. health aid should focus more on high-quality indigenous health-related NGOs in Eurasia, to ensure that aid is used properly and to strengthen long-term self-help capabilities, while others caution that in most of Eurasia, such local NGOs are still hard to find.

Among possibly clashing U.S. aid objectives, U.S. health aid shifted to disaster assistance or to IDPs and refugees in an Eurasian state may shortchange health aid support for the rest of a country's population. This problem was avoided in the wake of the August 2008 Russia-Georgia conflict by providing supplemental funding for Georgia and directing that already allocated aid could not be reprogrammed without notification. USAID family planning programs in Eurasia must comply with policy promoting maternal health and the provision of modern contraception methods that counteract the inordinately high rates of abortion throughout the region.

USAID has argued that while most Eurasian states have made at least some progress in health sector reform in recent years, a few have witnessed worsening health conditions since the early

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<sup>75</sup> WHO argues that governments should not only provide adequate budgetary support and policies facilitating public and private healthcare, but also proper "stewardship" to maximize healthcare performance dollar for dollar.

1990s, and it will take several more years before they are ready to have such aid phased out. In a 2007 report analyzing the health situation in Europe and Eurasia, USAID judged Turkmenistan, Tajikistan, Kazakhstan, Kyrgyzstan, and Russia as the countries where health status was the poorest and where democratization and the transition to free markets appeared to be most vulnerable to setbacks because of health problems. Although public expenditures on health had increased in Eurasia over the years, they were still low relative to needs and contributed to a low supply of medicines, low quality of services, and low salaries for health workers, according to USAID.<sup>76</sup>

**Table I. Cumulative Funds Budgeted FY1992-FY2008 for Health and Related Programs in Eurasia**

(\$ millions)

Agency	Amount
Centers for Disease Control: Health Surveillance	0.72
Dept. of Commerce: Health Partnerships	0.73
Dept. of Defense: GHAI	0.23
Dept. of Health & Human Services: GHAI	1.7
National Science Foundation: CRDF	155.88
Peace Corps: GHAI	0.26
Dept. of Agriculture, Environmental Protection Agency, and Health & Human Services: Bio-Chemical Redirect	144.93
Dept. of Agriculture and Trade & Development Agency: Other Health	0.63
U.S. Agency for International Development: Global Health	854.9
Dept. of Defense: Overseas Humanitarian, Disaster, and Civic Aid (OHDACA)	5.8 <sup>a</sup>
Dept. of State and Dept. of Defense: Transport costs	350.0 <sup>b</sup>
Peace Corps: Other Health-Related	58.2 <sup>c</sup>
Subtotal U.S. Government Health Aid	1,573.98
Coordinator's Office: Value of privately donated cargoes transported	3,345 <sup>b</sup>
<b>Total</b>	<b>4,918.54</b>

**Sources:** State Department, Office of the Coordinator of U.S. Assistance to Europe and Eurasia; FREEDOM Support Act Annual Reports for FY1993-FY2009; The Peace Corps, Congressional Budget Presentation, FY2011.

- a. Health-related; Estimate that a little over two-thirds of OHDACA spending involves health. See Margaret Bourdeaux et al., "Involvement of the US Department of Defense in Civilian Assistance," *Disaster Medicine And Public Health Preparedness*, No. 4 (2010). This estimate for the health-related share of OHDACA was used by the Stimson Center, an NGO. See Julie E. Fischer, Eric Lief, Vidal Seegobin, and Jen Kates, "Mapping The United States Government Engagement In Global Public Health," The Stimson Center and the Kaiser Family Foundation, August 2009.
- b. The State Department's Office of the Coordinator of U.S. Assistance to Europe and Eurasia estimates that about 80% of the value of donated cargoes are health-related.
- c. Estimated: a program breakdown by health activities in the Eurasian states is not available, but the Peace Corps reports that about 20% of global projects involve health.

<sup>76</sup> USAID. *The Europe and Eurasia Health Vulnerability Analysis Annual Report*, September 2007.

**Table 2. U.S. Health Aid to Eurasia, FY2008-FY2011**

(U.S. \$ millions)

Country	Actual FY2008 health funding <sup>a</sup>	Actual FY2009 health funding <sup>b</sup>	Estimated FY2010 health funding <sup>b</sup>	FY2011 request <sup>b</sup>
Armenia	6.1	5.5	5.88	5.88
Azerbaijan	4.192	3.116	4.118	4.118
Belarus	0.0	0.24	0.646	0.65
Georgia	5.835	12.5	7.475	7.95
Kazakhstan	2.914	2.948	4.6	4.6
Kyrgyzstan	2.946	3.749	5.051	4.686
Moldova	0.0	0.0	0.0	0.0
Russia	25.751	21.117	19.768	19.373
Tajikistan	3.918	4.835	8.974	8.639
Turkmenistan	1.351	1.506	2.75	2.606
Ukraine	11.419	20.858	25.961	24.012
Uzbekistan	3.078	2.943	4.875	4.876
Eurasia and Central Asia Regional	3.616	14.548	13.566	13.467
Total	71.12	93.86	103.664	100.857
Other Agency Health-related Aid	14.42 <sup>c</sup>	12.83 <sup>d</sup>	13.1 <sup>d</sup>	6.2 <sup>e</sup>
<b>Grand Total</b>	<b>85.54</b>	<b>106.69</b>	<b>116.764</b>	<b>107.057</b>
As Percent of Eurasian Funding	5 <sup>f</sup>	14 <sup>g</sup>	19 <sup>g</sup>	18 <sup>g</sup>
Value of Privately-Donated Cargoes	120	98	53	NA

**Sources:** U.S. Department of State. Office of the Coordinator of U.S. Assistance to Europe and Eurasia.

- a. Health programs in the Assistance for Europe, Eurasia, and Central Asia (AEECA), Global Health and Child Survival (GHCS), Economic Support Fund (ESF), Development Assistance (DA), and Global HIV/AIDS Initiative (GHA) accounts.
- b. U.S. Department of State. *Congressional Budget Justification for Foreign Operations for FY2011, Annex: Regional Perspectives*. Totals are for AEECA and GHCS accounts.
- c. Includes estimates of health-related Peace Corps activities, Department of Defense assistance, the bio-chemical redirect program, and medical-related transport costs. The value of health-related privately donated cargoes is not included.
- d. Includes estimates of health-related Peace Corps activities and medical-related transport costs.
- e. Includes estimates of health-related Peace Corps activities.
- f. The Total Eurasian Funding denominator consists of “all spigots” of foreign assistance, including AEECA and other agency funding.
- g. The Total Eurasian Funding denominator consists of “Function 150” foreign assistance as reported in the *Congressional Budget Justification for Foreign Operations for FY2011*, which includes AEECA and GHCS accounts, Foreign Military Financing (FMF), International Military Education and Training (IMET), and Non-Proliferation, Anti-Terrorism, De-Mining, and Related (NADR) programs.

**Table 3. Health Spending and Life Expectancy**

Country	Public health spending per capita 2000 (U.S. \$)	Public health spending per capita 2006 (U.S. \$)	Total health spending as % of GDP 2006	Life expectancy 2007 male (years)	Life expectancy 2007 female (years)	Under 5 mortality 2008 per 1,000 live births	Maternal mortality per 100,000 (adjusted) 2008
Armenia	23	112	4.7	70.1	76.7	23	30
Azerbaijan	19	67	3.4	67.6	72.3	36	37
Belarus	251	428	6.4	63.1	75.2	13	19
Georgia	26	76	8.4	68.1	75.0	30	37
Kazakhstan	101	214	3.7	59.1	71.2	30	44
Kyrgyzstan	27	55	6.4	63.9	71.4	38	69
Moldova	43	107	7.8	64.5	72.1	17	20
Russia	246	404	5.3	59.9	72.9	13	34
Tajikistan	8	16	5.0	63.7	69.3	64	46
Turkmenistan	39	172	4.8	60.6	68.8	48	22
Ukraine	95	298	7.0	62.7	73.8	16	30
Uzbekistan	37	89	4.7	64.5	70.9	38	45
Eurasia Avg.	76	170	67.6	64	72	30.5	36
OECD Avg.	1,402	2,098	8.5	76.2	81.8	4.9 (2007)	11

**Sources:** Health spending per capita (purchasing power parity) and as a percent of GDP are from the U.N. World Health Organization, Global Health Observatory, at <http://apps.who.int/ghodata/>. Life expectancy data are from UNDP, *The Human Development Report 2009*. Under 5 mortality rates are from UNICEF, *The State of the World's Children*, November 19, 2009. Maternal Mortality rates are from *The Lancet*, May 8, 2010, pp. 1609-23. For the OECD, see *OECD Health Data*, at <http://www.oecd.org>.

**Table 4. Tuberculosis, HIV/AIDS, STD Rates, and Drug Use**

Country	Estimated TB, all cases, 2008	Multi-drug resistant TB, all cases, 2008	People living with HIV, end of 2007	Newly registered cases of syphilis & gonorrhea per 100,000 population, 2006	Drug abuse as % of population aged 15-64	
					Opiates	Cannabis
Armenia	2,200	480	2,400	27.2	0.3	3.5
Azerbaijan	9,600	4,000	7,800	29.8	0.27	3.5
Belarus	4,200	800	13,000	89.6	0.41	1.1
Georgia	4,600	670	2,700	39.1	0.58	1.1
Kazakhstan	27,000	8,100	12,000	108.5	1.0	4.2
Kyrgyzstan	8,600	1,400	4,200	55.7	0.8	6.4
Moldova	6,300	2,100	8,900	119.6	0.1	NA
Russia	150,000	38,000	940,000	129.2	1.64	3.5
Tajikistan	14,000	4,000	10,000	20.7	0.54	3.4
Turkmenistan	3,400	160	>500	36.4	0.32	NA
Ukraine	47,000	8,700	440,000	67.6	1.16	2.5
Uzbekistan	35,000	8,700	16,000	37.3	0.8	4.2
Eurasia	311,900	77,110	456,000	760.7 / 63 (Avg.)	0.66 (Avg.)	3.34 (Avg.)
OECD	172,872 (2007)	4,120	—	—	—	—

**Sources:** WHO, *Global Tuberculosis Control: A Short Update to the 2009 Report*, December 8, 2009; WHO, *Multidrug and Extensively Drug-Resistant TB: 2010 Global Report on Surveillance And Response*, 2010; UNAIDS, *2008 Report on the Global AIDS Epidemic*, July 2008; for sexually transmitted diseases, see U.N. Children's Fund (UNICEF), Innocenti Research Center, Monitoring in Central and Eastern Europe, the Commonwealth of Independent States and the Baltics (TRANSMONEE) on-line database, at <http://www.unicef-icdc.org>. Drug abuse data are varying estimates made in 1998-2006. See U.N. Office on Drugs and Crime, *World Drug Report 2009*, June 24, 2009. OECD data are from <http://www.oecd.org>.

**Table 5. Refugees and Internally Displaced Persons**

<b>Country</b>	<b>Refugees (as of December 31, 2008)</b>	<b>Asylum seekers (pending cases as of December 31, 2008)</b>	<b>Internally displaced (as of December 31, 2008)</b>
Armenia	3,953	171	0
Azerbaijan	2,061	41	603,251
Belarus	609	54	0
Georgia	996	19	293,048
Kazakhstan	4,352	126	0
Kyrgyzstan	375	765	0
Moldova	148	33	0
Russia	3,479	1,800	91,505
Tajikistan	1,799	46	0
Turkmenistan	79	0	0
Ukraine	7,201	1,307	0
Uzbekistan	821	0	0
Eurasia Total	25,873	4,362	987,804
OECD Total	1,936,577	388,119	—

**Source:** U.N. High Commissioner for Refugees. *UNHCR Statistical Online Population Database*, at <http://apps.who.int/globalatlas/dataQuery/default.asp>.



## **Appendix. Current Health-Related Legislation**

S.Res. 499 (Feingold). A resolution supporting the goals and ideals of World Malaria Day, and reaffirming United States leadership and support for efforts to combat malaria as a critical component of the President's Global Health Initiative. Introduced on April 22, 2010. Submitted in the Senate, considered, and agreed to without amendment and with a preamble by Unanimous Consent on April 22, 2010.

H.R. 5121 (Clark). The Global Sexual and Reproductive Health Act of 2010. To promote the sexual and reproductive health of individuals and couples in developing countries, and for other purposes. Introduced on April 22, 2010. Referred to the House Committee on Foreign Affairs.

H.R. 4933 (Lee). The Global Health Act of 2010. To establish a strategy to coordinate all health-related United States foreign assistance, to assist developing countries in improving delivery of health services, and to establish an initiative to assist developing countries in strengthening their indigenous health workforces, and for other purposes. Introduced on March 24, 2010. Referred to the Committee on Foreign Affairs and the Committee on Financial Services.

S. 3135 (Durbin). The Global Health Care Cooperation Act. To enhance global healthcare cooperation, and for other purposes. Introduced on March 17, 2010. Referred to the Committee on the Judiciary.

S.Res. 454 (Brown). A resolution supporting the goals of World Tuberculosis Day to raise awareness about tuberculosis. Introduced on March 15, 2010. Referred to the Committee on Foreign Relations.

S. 1966 (Dodd). The Global Child Survival Act of 2009. To provide assistance to improve the health of newborns, children, and mothers in developing countries, and for other purposes. Introduced on October 28, 2009. Referred to the Committee on Foreign Relations.

H.R. 3560 (Sires)/S. 1591 (Murray). The 21<sup>st</sup> Century Global Health Technology Act. To amend the Foreign Assistance Act of 1961, to establish the Health Technology Program in the United States Agency for International Development to research and develop technologies to improve global health, and for other purposes. The Senate version was introduced on August 6, 2009. Referred to the Committee on Foreign Relations. The House version was introduced on September 14, 2009. Referred to the Committee on Foreign Affairs.

H.R. 1878 (Christopher Smith). The Global Autism Assistance Act of 2009. To establish a health and education grant program related to autism spectrum disorders, and for other purposes. Introduced on April 2, 2009. Referred to the House Committee on Foreign Affairs.

H.Con.Res. 103 (Payne). Supporting the goals and ideals of Malaria Awareness Day. Introduced on April 21, 2009. Referred to the Committee on Foreign Relations.

H.R. 1410 (McCollum). The Newborn, Child, and Mother Survival Act of 2009. To provide assistance to improve the health of newborns, children, and mothers in developing countries, and for other purposes. Introduced on March 10, 2009. Referred to the House Committee on Foreign Affairs.

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