

# UNAIDS STRATEGY DEVELOPMENT



## UNAIDS STRATEGY REVIEW:

The Eastern Europe and Central Asia Region

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## UNAIDS STRATEGY REVIEW: Focus Group Synthesis template

Please use the template to organize your feedback from the session. Please keep responses succinct and as clear as possible to ensure our synthesis is a reflection of the focus groups hosted.

You can enter your report directly into a form on SurveyMonkey:

If you are not able to enter it on line you can send us a copy via e-mail [strategyteam@unaids.org](mailto:strategyteam@unaids.org)

Would you accept for UNAIDS to make your report publicly available: **Yes** / No

### SECTION 1: Information about the focus group (to be completed by host of Focus Group)

Organization leading discussion:

The discussion was organized by a group of regional networks of communities of key populations (ECOM, EHRA, EWNA, SWAN). The prepared pre-final version of the report was submitted to other regional networks (AFEW, REG on Migration and Health, ENPUD) for additions.

Date of discussion: July-August 2020

Theme to be discussed:

- 1. Access to HIV-related health services.**
- 2. Meaningful participation of organizations of communities of key populations in the formation and implementation of national and global policies, strategies, and programs of the HIV response.**

Participants (types of organizations participating):

Country, regional or global focus: **Regional**

### Introducing the theme

Please enter the main characteristics of the theme being explored in 5 sentences (please share the presentation if possible by email)

- Marginalization, including criminalization, stigma, and discrimination are the main barriers to fighting the HIV epidemic in Central and Eastern Europe and Central Asia. Marginalization is the active exclusion of individuals and entire communities from the life of society, the creation of unequal access to the existing opportunities for the protection of health and life. Stigma distorts people's knowledge of each other and destroys cooperation within society, making any national health program less effective. Discrimination leads to destruction of the law as the basis for cooperation and mutual assistance in society, and to the emergence of conflicts.*

Together, they create inequalities in the right to life and to health, leaving large groups of people without help and protection, thereby creating permanent and uncontrolled breeding grounds for HIV in countries. *Discriminatory and stigmatizing legislation, as well as self-stigma, undermine mutual assistance at the family and community levels, which are the basis for health protection in low- and middle-income countries.* Much has already been done to understand these phenomena, but further efforts are required to reduce stigma and marginalization, and to prevent discrimination in relation to health, education, and other aspects of wellbeing of key populations.

- The growing need for HIV-related resources is associated with both the continued growth in the number of HIV infections in the region, as well as with a growing understanding of the relationship between the HIV epidemic and other phenomena: the spread of tuberculosis, STIs, viral hepatitis, non-communicable diseases, and mental health; drug addiction and drug policy; sexuality, sex work, the sexual socialization of adolescents, and gender and family equality; aging populations, homelessness and poverty; wars, conflicts and environmental disasters; the development of technology and knowledge. *The significant complexity of the situation requires an effective investment and cooperation strategy.* It is necessary to take into account all links between the HIV epidemic and the listed phenomena. Strengthening and broadening cooperation between all those affected by any of these phenomena, and an increased focus on innovation and knowledge management in different areas are essential for effective investment. CEECA countries are not in the priority list for majority of international donors and development agencies, as well as UN agencies; GF is cutting down its financial support from year to year to programs in the region while proper transitioning to domestic funding was not prepared and conducted.
- The situation is constantly evolving and, in addition to existing opportunities and challenges, new ones appear. For example, increasing the availability and quality of antiretroviral drugs has saved millions of lives, and has also led to an aging population of PLH, with co-morbidities like cardio-vascular diseases, and cancer, and to the mainstreaming of mental health and care issues for older people. The creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria has increased the availability of medical care, which has led to an increase in the relevance of issues related to the diagnosis and treatment of co-morbidities, as well as social and legal issues. Meanwhile, the sudden COVID-19 pandemic has shown the fragility of the entire HIV treatment, care and prevention system. The response to the HIV epidemic must be flexible and sustainable. Cooperation and mutual assistance are essential for quickly responding to new opportunities and threats. *Cooperation and sustainability require high-quality and adaptive collaboration systems that include both participatory mechanisms for the development of policies and programs, as well as the availability of resources for the active participation of all those affected by the HIV epidemic, including organizations and networks of key populations.*

## SECTION 2: People-centered response to HIV – key emerging messages

Please enter the main messages coming out, up to 5 points maximum per section

<b>REACHING THE PERSON</b>	
<p>How do we see the current situation?</p>	<ul style="list-style-type: none"><li>• ARV therapy has become more accessible, prices for ARV drugs have decreased, higher-quality and more convenient drugs have emerged, and local drug production is developing. The quality of ARV drugs for newborns and children has improved.</li><li>• Mother-to-child HIV transmission remains well-controlled and low.</li><li>• The market for ARV drugs that PLH and PrEP users can purchase at their own expense is developing.</li><li>• The development and standardizing of client-centered services targeting key populations continues in the region. Community organizations of key populations and UN agencies/programs are leading in this work.</li><li>• The quality of support to help people accept their HIV+ status, and for developing and maintaining adherence to treatment is increasing.</li><li>• The availability of PrEP and post-exposure prophylaxis for HIV is increasing slowly. Most often, this happens thanks to the support of international donors and UN organizations.</li><li>• The availability of vaccinations for HIV+ girls against human papillomavirus and hepatitis B is increasing. Unfortunately, national funding is still not available for this purpose.</li><li>• The coverage of hepatitis C diagnostics and treatment has increased significantly, particularly for PLH, as well as for HIV+ representatives of key populations.</li><li>• Work is being developed to protect reproductive health and family equality for PLH. For example, access to reproductive technologies for PLH is expanding. At the same time, the possibility of family equality for LGBT people remains without support from governments.</li><li>• The availability of products for the artificial feeding of infants of HIV-positive women remains high, and in most countries is already financed by the state budget.</li><li>• New technologies for accessing sterile needles and syringes are being introduced in some countries (for example, vending machines in Georgia). But, in general, a comprehensive package of social-medical services for people using drugs is not developed, and the services providing are even cut down in majority of countries due to shrinking of international financial and political support.</li><li>• The active development of the provision of online counseling and support services, including medical counseling and monitoring, has begun. For example, online DOT in Moldova, self-testing programs in Russia and Ukraine. Online counseling, training and support groups already exist in almost every country in the region.</li></ul>

	<ul style="list-style-type: none"> <li>• The number and quality of services provided through organizations of key populations and PLH, in coordination or cooperation with local medical institutions, is growing.</li> <li>• The coverage of key populations with HIV testing has increased slightly. This primarily relates to rapid testing through community NGOs, including self-testing (both fully independent testing, as well as self-testing with online support, so-called “assisted self-testing”).</li> <li>• The COVID-19 pandemic has accelerated the development of remote and contactless HIV-related services, such online counseling, support and education, and the ordering and home-delivery of self-test kits, PrEP drugs, and ARV therapy.</li> <li>• The quality and sustainability of HIV services in areas of military conflicts and in various “disputed” territories remain extremely low in general. A client-centered approach to working with key populations in these territories cannot be used.</li> <li>• Despite some individual breakthroughs, in general, assistance and support in the field of human rights protection for representatives of key populations and PLH is developing very slowly. Due to pressure from populist politicians and religious organizations, the number of community NGOs working in this field remains extremely low. The amount of available assistance is growing slowly, and not keeping pace with the growing demand from representatives of key populations.</li> <li>• Prohibitions on adoption of children by PLH are being removed with difficulty.</li> <li>• Legal support, including for protection from violence and discrimination, has become more in demand from key populations and people living with HIV. It was made more available by NGOs of communities of key populations and PLH. The practice of para-legal assistance is increasing, however, this is still financed solely by international donors.</li> <li>• Cooperation between key populations’ community NGOs, human rights defenders, and feminist organizations continues to be strengthened.</li> <li>• Shelters are being developed for vulnerable women and for LGBT people who have survived violence and/or who have been made homeless due to stigma. There are more organizations and specialists with experience in creating and maintaining shelters and providing healthcare services to their clients. However, in general, the number of shelters in countries of the region remains catastrophically low.</li> <li>• Peer counseling and mutual assistance is developing. It is important that this happens both as part of the work of NGOs, and in the form of spontaneous mutual assistance between community members. Social networks and community activists play a leading role in this process.</li> <li>• There is a growing debate among specialists and HIV activists about the equality of trans people in accessing client-centered services for the prevention and treatment of HIV and co-morbidities, as well as psychosocial assistance and support for socialization in one’s preferred gender. Trans community activists are the main driver of this process.</li> </ul>
What concerns us?	<ul style="list-style-type: none"> <li>• When planning and financing services for key populations, governments and the GF aim to reduce costs per client, without considering the issue of the</li> </ul>

quality of services and consumables, which makes services much less effective, gender sensitive, and attractive for recipients.

- Due to the growth of the demand for the support and treatment is not responded with the adequate increase in funding, people who use drugs, including those of them who belong to MSM, sex workers or trans people, have limited access to HIV and HCV services, including harm reduction outreach and counselling. Harm reduction services are often focused on HIV only and do not address such issues as homelessness, mental health and disability, overdose prevention, sexual and reproductive health, and mental health.
- The comprehensiveness of service provision is recognized as an important developmental theme, but very often, an integrated approach is only used for services directly related to HIV infection (the 90-90-90 cascade), without attention to services that are needed in connection with other problems related to HIV (co-infections, mental health, drug addiction, social and economic insecurity, aging, gender sensitivity, discrimination).
- The role of nurses is not considered in comprehensive provision of HIV treatment, adherence to treatment and psycho-social care.
- The lack of confidentiality, privacy, and protection from violence for KPs and PLWH is a barrier to access health services.
- The attitude of doctors that keeps a providers-centred approach instead of a person-centered approach
- Still many people need to justify the negative HIV status, which leads to many HIV testing of students, workers in the food industry, medical doctors; this increases involuntary testing and further discrimination.
- Disruptions to the procurement and supply of ARV therapy continue to occur, due to underdeveloped national and local procurement and supply systems.
- New ARV drugs in EECA countries are registered and introduced much later than in other countries.
- Interruptions to viral load testing continue to occur in a number of countries.
- The availability of free specialized medical services not directly related to ARV therapy remains low. For example, the services of an andrologist and proctologist for MSM, an endocrinologist for trans people, a gynecologist and infectious disease specialist for sex workers, and narcologists, psychiatrists, and psychotherapists for representatives of all key populations and PLH. Diagnosis and treatment of diseases associated with age-related changes in PLH are almost completely absent.
- Psychosocial services for children and adolescents living with HIV are underdeveloped and not very accessible.
- Mental health services and support are almost completely unavailable and are underdeveloped.
- The package of harm reduction services for people who use drugs, including opioid substitution therapy, programs providing sterile needles and syringes, overdose prevention, the treatment of co-morbidities, and psychosocial support, remains inaccessible and stagnant. The increase in the number of clients of substitution therapy programs receiving long-term medication was

only possible due to the COVID-19 pandemic. However, this practice is not properly studied and has not been institutionalized.

- The availability and quality of services in the field of reproductive and sexual health for representatives of all key populations and people living with HIV is decreasing. This happens most often in connection with the transition from Global Fund funding to national funding.
- For adolescents aged 18 and under, the region lacks targeted prevention services for HIV, STIs, hepatitis B and C, and harm reduction for drug use. The situation is the same for adolescents aged 18 and younger in relation to HIV and STI testing activities. There are only ineffective and costly informational and educational campaigns run by government agencies, which are built on intimidation rather than on training and support. School based sexual education is absent at all.
- While a number of basic HIV prevention and treatment services exist and are developing, significant inequalities remain in relation to the availability of these services. Access to such services is severely limited for marginalized and stigmatized groups, such as migrants, and especially those belonging to key populations, such as sex workers, trans people, adolescents, prisoners, and people who use psychoactive substances (including MSM and others).
- Many services, such as the package of harm reduction assistance and support services for people using psychoactive substances, and pre- and post-test counseling and psychosocial support, are provided based on outdated standards, or without any standards or quality assessment at all.
- COVID-19-related quarantine restrictions have highlighted the fragility of the entire system for providing HIV services.
- Despite the significantly widespread use of psychoactive substances, including stimulants and other new psychoactive substances, services for people using these substances are not being developed. This applies to both the recreational use of these substances, as well as to the practice of chemsex among MSM and the sexualized use of psychoactive substances among other key populations.
- All countries of the region maintain, apply, and enact new laws that criminalize and marginalize PLH, drug use, sex work, sex between people of the same sex, and which pathologize trans people. Antidiscrimination legislation is being developed extremely slowly and is often not accompanied by regulatory acts and an administrative system for its application.
- Lack of access to justice remains main challenge for key populations, and key barrier to community empowerment, mobilization and engagement.
- Community activists are highly vulnerable to the risk of physical violence from right-wing organizations, as well as stigma and harassment from politicians. Cases of such violence and persecution are rarely investigated properly, and the perpetrators rarely face any punishment or blame. In addition, cases of violence, extortion, discrimination, provocation, and unjustified harassment by police are still observed.
- A high level of inequality in relation to access to existing services continues to exist. Thus, harm reduction services for drug use are significantly less accessible for women and adolescents, primarily due to stigma, prohibitive legislation, and widespread discrimination against women and adolescents who use psychoactive substances. HIV and co-infection prevention services



	<p>remain inaccessible for trans people. Prevention and treatment of HIV and co-infections are nearly completely unavailable for migrants and prisoners.</p> <ul style="list-style-type: none"> <li>• Criminalization of migrants living with HIV in Russia is a severe issue for the EECA region as far as Russia is the central destination country for migration in the region. Beyond that, migrants living with HIV are subject to deportation with a lifelong ban to re-enter Russia and other member countries of the Eurasian Economic Union. It compels migrants to stay in the host country in an irregular situation with no access to HIV care and other health services. Without access to treatment, they contribute to further dissemination of HIV throughout EECA.</li> <li>• Stigma towards trans people remains very high. The needs of trans people are often ignored by both governments and HIV activists. The process of official depathologization is proceeding very slowly, despite WHO recommendations.</li> <li>• Due to stigma and discrimination, representatives of key populations and PLH experience significant restrictions in access to both specialized and primary health care. Stigma and discrimination are the main barriers to expanding HIV prevention and diagnosis coverage for all key populations. As a result, PLH belonging to key populations do not receive timely access to ARV therapy and other assistance and support.</li> <li>• There is still high level of reported cases of stigma, discrimination and human rights violations from medical staff and police officers against representatives of key populations and people living with HIV.</li> <li>• Up till now little discussion and policy development on UHC.</li> <li>• Lack of knowledge – little research done among communities, about specific needs and how to address best.</li> <li>• Too few community led HIV services.</li> </ul>
<p>What gives us hope?</p>	<ul style="list-style-type: none"> <li>• Increase in the capacity of community organizations and activists and their active participation in the introduction of innovative prevention and support interventions and human rights protection. Emergence of young activists in communities.</li> <li>• Increased attention of national governments and municipal administrations towards cooperation with NGOs of key populations.</li> <li>• High rate at which hepatitis C treatment is expanding.</li> <li>• Increased availability of ARV therapy through national funding.</li> <li>• Persistent promotion by UN agencies and programs (UNFPA, UNAIDS, UNODC, UNDP, WHO and others) of a client-centered approach to HIV prevention and treatment.</li> <li>• Adopting and actively promoting “Leaving no one behind” approach, which gives opportunities to key populations to catch up and address inequalities in access to health and rights.</li> <li>• Women living with HIV increased their engagement in planning and implementation of PMTCT policy and interventions.</li> </ul>
<p>What constrains our ability to achieve our goals?</p>	<ul style="list-style-type: none"> <li>• Funding deficit in relation to the provision of quality services to the representatives of key populations and PLH that need them.</li> </ul>

	<ul style="list-style-type: none"> <li>• Slow implementation of the “test-and-treat” principle (providing ARV therapy as soon as HIV infection is detected).</li> <li>• Poor coverage of key populations by targeted HIV prevention and testing programs.</li> <li>• Insufficient data about the number of migrants living with HIV and their needs due to their predominantly irregular status in the host countries.</li> <li>• Little priority of national governments and international community to address specific needs of migrants in relation to HIV services.</li> <li>• The percentage of representatives of key populations living with HIV who do not know their HIV+ status remains significantly higher than among the general population.</li> <li>• During the transition to national funding, little attention is paid to the quality of services. Meanwhile, the comprehensive and client-oriented nature of prevention, testing, and support services is decreasing.</li> <li>• High level of stigma and frequent cases of discrimination by medical professionals and police officers in relation to key populations and PLH.</li> <li>• There is not enough information for ‘knowing your epidemic’. Too little knowledge of specifics of KPs, and what works best to meet their needs.</li> </ul>
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<h2><b>THE STRUCTURES THAT RESPOND TO HIV</b></h2>	
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<p>How do we see the current situation?</p>	<ul style="list-style-type: none"> <li>• Over the past 3-5 years, there has been a growing understanding by leaders and health professionals about the role of key populations in the epidemiological process, and about how effective work with these populations can be organized. This is leading to increased national funding for NGOs providing HIV prevention and support services to key populations. However, the amount of funding allocated by governments and local administrations is still very low.</li> <li>• Cooperation, including joint projects and initiatives, between NGOs and medical institutions, as well as with ministries and other governmental agencies, is more often developed based on interpersonal contacts, and to a lesser extent as part of a health systems development strategy. This cooperation is not regulated by indicators of national programs or ministerial strategies.</li> <li>• UNAIDS’ current “90-90-90” strategy has been shown to be effective in terms of access to therapy, but does little to advance HIV prevention and develop community systems that can provide community members with meaningful protection and support, including in relation to human rights issues.</li> <li>• The Global Sustainable Development Goals and the UHC agenda provide a broad framework for working on health issues, including HIV. But this political framework lacks the necessary content in the form of targeted and resourced programs and international cooperation initiatives.</li> <li>• The decision-making process in place among government health administrators is overly centralized and closed to civil society participation. Innovation in national programs is very limited and implemented very slowly.</li> </ul>
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	<p>Decisions are often made on the basis of moralistic or corrupt motivations, rather than economic and epidemiological calculations.</p> <ul style="list-style-type: none"> <li>• With the active participation of community organizations and activists, work continues to sensitize doctors and other specialists in order to improve the effectiveness of service provision to representatives of key populations, and protection of their rights.</li> <li>• Communities are receiving more technical assistance to collect data on violence, discrimination and stigma, and are more actively using tools of influence, such as shadow and alternative reporting to UN human rights treaty bodies, which creates more opportunities for protection in specific cases of health-related rights violations. This is particularly evident in relation to women.</li> <li>• The work of community NGOs of key populations in countries of the region is supported by many large and small national and international programs and funds for development and humanitarian aid. These include: Astrea, ITF, MamaCash, OSF, UAF, AllOut, Global Fund, PEPFAR, USAID, PATH, UNAIDS, WHO, UNICEF, UNFPA, UNDP, UNODC, governments and municipal administrations of countries of the region, EJAF, NiDA, ViiV healthcare, UNFPA, European Union/Commission, SIDA and others. The diversity of their goals allows for maintaining the diversity of the activities of community NGOs. However, the amount of available funds continues to decline.</li> </ul>
<p>What concerns us?</p>	<ul style="list-style-type: none"> <li>• Institutional stigma remains high. For example, in a number of national HIV strategies, key populations are not explicitly named. Rather, outdated generalized terms (“groups at increased risk of HIV infection”) or moralistic euphemisms (“persons engaged in prostitution”, “persons engaging in non-traditional sexual relations”) are used to designate them. In addition, programs do not include indicators for assessing the impact of national programs on the epidemiological situation among specific key populations.</li> <li>• The low amount of national funding for the work of NGOs does not allow organizations of communities of key populations to have a significant impact on the epidemiological process. The systems for financing NGOs and civil initiatives are poorly developed.</li> <li>• Unreasonable lowering the costs per client for the purpose to fit the limits of national and/or GF allocations always leads to decrease in interventions effectiveness and squeezes community organizations out of the service provision.</li> <li>• The quantity and quality of data on the impact of stigma and discrimination on the HIV epidemic and national HIV responses in EECA countries remain low. Most often, data on this issue is collected sporadically and only by international bodies and community organizations. However, even when such data is available, it is rarely used by government agencies for decision-making.</li> <li>• The gender assessment of national policies and practices is not prioritized and funded by national governments.</li> <li>• Governments often only focus on protecting PLH from discrimination, and argue that other key populations are already protected by general legislation that guarantees protection on the basis of race, age, sex, religion, ... “and other grounds”. The lack of explicit references to grounds for discrimination, such as homo- or transphobia, as well as involvement in sex work, for</li> </ul>

example, leads to a lack of protection against discrimination based on these grounds.

- The availability and quality of data on the HIV epidemic and key populations remain low. For example, estimates of the population sizes of key populations have not been carried out in all countries, while the quality of such assessments that have been conducted is questionable.
- Best and innovative practices for prevention, support, and treatment in connection with HIV and co-infections, as well as in the field of sexual and mental health, are slowly being introduced in EECA countries. The use of outdated working methods and the lack of effective M&E, forecasting, and planning systems lead to the ineffective use of both national resources and international assistance.
- Funding from the Global Fund and other international donors is declining and is not adequately compensated for by national funding and/or the development of commercial services. The quality of plans for transitioning from Global Fund funding to national funding is often poor, and the plans themselves are not being implemented.
- CCMs in countries remain structures primarily focused on the execution of projects funded by the Global Fund, and are not being transformed into coordinating bodies for national programs. Therefore, community participation in CCMs has limited impact on national programs.
- The marginalization and criminalization of key populations is on the rise, and neglect and discrimination towards key populations continues, all of which creates new barriers to the response to the HIV epidemic. Religious leaders often play a significant role in the promotion of intolerance and violence.
- In many countries, the process of developing service standards is moving slowly, and is rarely based on international best practices. In the transition to state funding, these standards focus almost exclusively on HIV and tuberculosis treatment, as well as on the least expensive forms of prevention and support (for example, the provision of small quantities of condoms often without lubricants, minimal counseling, the quality and delivery of which are difficult to control, as well as syringes and needles without overdose prevention). Opioid substitution therapy remains under threat of discontinuation.
- Medical and social assistance is linked to the residence registration system. In most countries, migrants can only receive ARV therapy through the Global Fund, or must buy it at their own expense. They risk being deported from the country if government authorities become aware of their HIV+ status.
- With the transition to national funding, all services provided through the state budget are only provided subject to the provision of personal data. In a situation where services can only be obtained at the place of registration, and with a high risk of breaching the confidentiality of health data, governments are not developing anonymous health services for highly marginalized and stigmatized people, such as migrants, sex workers, (ex)prisoners or adolescents from key populations.
- So far, no state HIV program in any EECA country has plans to provide PrEP services and self-testing for HIV through national funding.

	<ul style="list-style-type: none"> <li>• The excessively high centralization of ARV therapy, which can only be obtained in specialized medical institutions (AIDS centers) continues.</li> </ul>
<p>What gives us hope?</p>	<ul style="list-style-type: none"> <li>• Development of mutual assistance with communities of key populations, and between communities. In recent years, new community organizations and activists, and new vibrant community initiatives have emerged.</li> <li>• The commitment of country and regional office staff of UNAIDS and other UN organizations and agencies to the mission of their organizations, and their sincere commitment to helping in the response to the HIV epidemic and fostering collaboration between governments and civil society.</li> <li>• The increasing attention from community organizations and activists to availability and quality of data.</li> <li>• Increase in the quantity and availability of high-quality data on the epidemiological situation, including the emergence of disaggregated data for specific key populations and specific territories within countries within the framework of the “90-90-90” cascade. Increased availability and quality of information on best practices in the field of HIV.</li> <li>• Increased capacities and mobilization of community led groups into advocacy, self-representation and community-led interventions.</li> <li>• Increase in the number of representatives of key populations who are employees of national health structures and international organizations, who openly position themselves as representatives of key populations.</li> <li>• The growth of the women’s movement in the region, the development of national women’s networks, and the increase of gender sensitive policies in the HIV response.</li> </ul>
<p>What constrains our ability to achieve our goals?</p>	<ul style="list-style-type: none"> <li>• Low level of intersectionality of national programs and fragile cooperation at local level.</li> <li>• Very slow process of institutionalizing and standardizing mechanisms of cooperation between NGOs and healthcare institutions.</li> <li>• Lack of effective quality control systems for prevention services and psychosocial support.</li> <li>• Reduction in resources available to support the work of NGOs and networks of key populations and PLH, while demand for community-based services is growing.</li> <li>• Weak development of national policies in the field of health, and more specifically, in relation to HIV. Lack of clear prioritization of cooperation between NGOs of communities of key populations and medical structures to combat HIV and tuberculosis.</li> <li>• Ignoring or an unreasonably slow implementation of norms related to the depathologization of trans people proposed in the ICD-11.</li> <li>• The use by governments and organizations of low-quality or irrelevant data in the planning and financing of national programs, and a neutral attitude towards this on the part of international organizations.</li> <li>• Lack and fragility of key populations’ communities, including migrants, engagement in the transition from GF funding to national funding.</li> <li>• Low and slow investments into community mobilization interventions.</li> </ul>

	<ul style="list-style-type: none"> <li>• Rigid systems, which still do not recognize community representatives as valuable asset in effective HIV response beyond peer-support.</li> <li>• Poor development of community-based monitoring.</li> <li>• Very weak response of health systems to the spread of the use of new stimulants, new psychoactive substances, etc.</li> <li>• <u>The comitment to provide 30% of all HIV-services through civil society and community based organisations is not clear enough because the “community based” and “community led” can be interpreted both as 1) decentralization of service provision and the development of locally (geographically) set up and managing service, and as 2) the development of client cantered services on the basis of key populations community organizations. These two important and different types of targets have to be separated in policy documents, funding allocation, and MEL documents.</u></li> </ul>
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<b>CONTEXTUAL ENVIRONMENT</b>	
<p>How do we see the current situation?</p>	<ul style="list-style-type: none"> <li>• International disease control systems are responding significantly faster than before to challenges posed by new epidemics (for example, COVID-19). However, significant inequalities in access to health services prevent large numbers of people, including those belonging to key populations in relation to HIV, from taking advantage of new knowledge and protection mechanisms.</li> <li>• National health systems are overly centralized and closed to the participation of civil society structures. Innovations are not introduced, or are only implemented in a very limited way. Decisions are often made based on moralistic or corrupt motives, rather than on economic and epidemiological calculations. Communication with civil society is weak.</li> <li>• International donors are lowering the priority of the region for their programs, and reducing financial and technical support. Following the curtailing of donor programs, the activities of UNAIDS and other UN bodies in the region are also being cut back, which reduces the level of support for dialogue and cooperation between governments and civil society.</li> <li>• The COVID-19 pandemic has not only diverted some political and financial resources from the field of HIV, but has increased the disregard for the sexual health and HIV-related needs of people from the most marginalized populations.</li> <li>• Stigma in society based on HIV or tuberculosis, mental health, sexuality, sex, gender, age, homelessness, economic well-being in general, involvement in sex work, or drug use remains high. Moreover, some politicians contribute to such stigma and use it as a basis for their political career. Populist politicians continue to demand the criminalization of homosexual behavior, increases in punishments for drug use and sex work, as well as an increase/return to criminal punishment for HIV transmission.</li> </ul>

<p>What concerns us?</p>	<ul style="list-style-type: none"> <li>• Advocacy continues to be perceived by governments as a conflict, a manifestation of disloyalty, or as opposition. The idea that advocacy constitutes feedback from civil society that governments can use to improve the quality of national health programs is not accepted.</li> <li>• The influence of individual countries (such as Russia and the USA) on the content and activities of UNAIDS work in the region as a whole continues to grow.</li> <li>• Some UN bodies do not work with organizations of key populations in the EECA region (ILO, OHCHR), or have greatly reduced the volume and ambition of such work (WHO, UNDP, UNODC, UNFPA, UNICEF). The activities of UNAIDS in the region are also being scaled back.</li> <li>• The level of corruption in countries of the region remains high and affects both the general situation in countries, as well as the availability of funds from local and national budgets for NGOs.</li> <li>• Legal obstacles for official registration of key populations' community NGOs and receiving of public funding for community groups are remaining significant and event increasing after the adoption of discriminatory changes in Constitutions and laws such as the introduction of "foreign agent" status for NGOs, the prohibition of so-called "gay and transgender propaganda", and defining family as a union of male and female persons only.</li> <li>• Poor social support systems, social safety nets which leads marginalized groups into poverty with an increased risk of (further) deteriorating health.</li> <li>• Many governments and some UN agencies still invest more funding in ineffective punitive responses to drugs instead of life saving harm reduction services. In CEECA region country governments invest 4-15 times more in putting and keeping people using drugs in prison than into providing them with harm reduction services . Which in turn reinforces status quo where stigma, discrimination and criminalization are driving forces behind lack of funding for HIV services for key affected populations.</li> <li>• COVID-19 epidemic will not be stopped in the near future. It creates additional challenges to ensure that HIV prevention, treatment and care are not ignored in times of crises and that particular vulnerabilities of key populations during these crisis and emergency situations are properly addressed.</li> </ul>
<p>What gives us hope?</p>	<ul style="list-style-type: none"> <li>• Increase in general HIV-related literacy among the general population.</li> <li>• Common understanding between key population organizations and UN agencies that access to justice, addressing stigma and removing legal barriers and criminalization of marginalized communities/behaviors are crucial for effective HIV response.</li> <li>• COVID 19 pandemic frothed the discussion about a wider meaning of harm reduction as a generally applicable approach and social determinants of health. Increasing number of civil society and governments recognize that harm reduction is not limited to medical responses on HIV or TB only but also encompasses housing, legal and social care, and human rights.</li> <li>• Significantly increased number of community social networks and media supporting and facilitating the discussion and cooperation related to health and rights for community members, including the awareness about HIV,</li> </ul>

	other STIs, sexual health and pleasure, mutual support between community members, and harm reduction.
What constrains our ability to achieve our goals?	<ul style="list-style-type: none"> <li>• Growth of xenophobia, traditionalism, criminalization of marginalized populations, denial of human rights, and isolationism as a reaction to the COVID-19 crisis.</li> <li>• The risk of the loss of the global dimension in the work of the Global Fund.</li> <li>• The focus on average income of a country instead of looking at epidemiology, equity, and needs of the most affected and key populations.</li> </ul>

### EMERGING PATTERNS:

- Considering sustainable growth of the ART availability and quality in the region, the influence of the factors creating the environment and conditions for the effective use of ART is dramatically increasing. These are such factors as the following:
  - prevention of interruptions in the national procurement and distribution of ART drugs, and availability of the viral load testing during crisis situations such as the epidemic of COVID-19,
  - the introduction of innovations and suffusion funding for HIV prevention and ART adherence support services, first of all the Internet based,
  - access to new ART drugs with less side effects and more comfortable regimen of uptake,
  - access to ART for prevention (PrEP and PEP),
  - access to timely and of well quality diagnosis and treatment of co-infections and age-related conditions; special attention has to be paid to mental health issues such as long-term distress, depression, cognitive impairment, and the interconnection between psychiatric diseases and the use of psychoactive substances,
  - effective socialization, protection from violence and discrimination for people from key communities and PLHIV,
  - unemployment and poverty.
- The growth of general awareness of HIV in general population and upbuilding of the experience of life with HIV in certain communities (MSM and drug users first of all) require for more targeted preventive interventions using holistic approach to health protection.
- Civil society organizations became significantly more professional in the prevention and support services delivery, and in policy and investments in the area of health and social wellbeing. Thus they naturally began pretending to be more influential in the area of national and international policy and financing related to the HIV epidemic and health in general. Although, majority of national governments are not ready to consider community organizations as an integral part of national health programming and implementation system (have no properly developed policy, M&E, and financing tools) and still perceive them as rivals.
- Economic stagnation and the increasing fragmentation of the society caused the increase in radical political populism and conflicts between “traditional” and new communities in the society. This confrontation has been reflected in the multidirectional development of legal environment: general antidiscrimination laws and targeted laws protecting women and PLHIV have been enacted at the same time with laws discriminating certain communities, such as MSM, trans people, sex workers, youth, and drug users.
- The raising feministic agenda and social and professional liberation of women require the development of new policies, education tools, and meaningful engagement channels in the



area of reproductive and sexual health that will equally support women and men during this social transition.

- International cooperation:
  - Increasing deficit in the funding of the UN system makes some agencies subjected to the influence of certain countries' policy (USA and Russia, for instance) those not consider the interests of and situations in other countries and key populations.
  - The transition from the international financial support to national funding in the CEECA region has sharpened the issues of systemic xenophobia and corruption. On the other hand, the transition to national funding decreases the possibility to promote innovations in HIV prevention and treatment, the human rights based approach, and the oversight of the effectiveness of national strategies and programs from the side of civil society.
  - The SDGs have shown themselves as a logical, but not effectively operationalized strategy of international cooperation.

The new and more intensive international cooperation programs are required for ensuring transparency of national efforts and coordinating national programs in such areas as economic and humanitarian migration, tourism, life-long health education for all (ages), quality of medicines, timeliness of anti-pandemic measures, cooperative investments in health and knowledge management, and other.

## SECTION 3: RECOMMENDATIONS World Café

Please enter the main messages coming out, up to 5 points maximum per section

What are the key recommendations back to UNAIDS in terms of the strategy specifically?	
<b>CONTINUE</b>	<ul style="list-style-type: none"> <li>• <i>Support of international cooperation in the area of HIV, co-infections, and social enablers.</i></li> <li>• <i>Mediation for the increase of cooperation between governments and civil society organizations.</i></li> <li>• <i>Improvement of the epidemiological and sociological data quality and availability, and the use of these data for decision making at national and international level.</i></li> <li>• <i>Bridging the HIV response with responses to other epidemics (TB, Hep, C, STIs, COVID-19...)</i></li> <li>• <i>Technical assistance for organizations and networks of key populations and PLHIV.</i></li> </ul>
<b>STOP</b>	<ul style="list-style-type: none"> <li>• <i>Prioritize medical issues before social and psychological factors influencing the epidemic, legal and economic impact of outdated and unconfirmed by proper M&amp;E services and approaches.</i></li> <li>• <i>Support not-evidence based, not-gender sensitive, stigmatising programmes based on morality and/or so-called "traditions".</i></li> <li>• <i>Putting the use of drugs together with crime. The use of drugs need to be placed in health agenda.</i></li> <li>• <i>Follow donors' agenda instead influencing it.</i></li> </ul>
<b>START</b>	<ul style="list-style-type: none"> <li>• <i>Intensify the advocacy with international donors and national governments for the implementation of such approaches as "nothing for us without us", "no one left behind", and the point 19 of the Political Declaration that says: "Invest at least a quarter of AIDS spending on HIV prevention and invest at least 6% of all global AIDS resources for social enablers, including advocacy, community and political mobilization, community monitoring, outreach programmes and public communication by 2020, and ensure that at least 30% of all service delivery by 2030 is community-led."</i></li> <li>• <i>Analyze the failures of the global initiatives and let governments and communities to learn from these failures.</i></li> <li>• <i>Intensify a leader and a moderator role of UNAIDS among othe UN agencies, programs, and organizations for the increase of their input in the HIV response.</i></li> <li>• <i>Active monitoring and operationalization of all SDGs directly or indirectly linked to the HIV response.</i></li> <li>• <i>Intensify cooperation with national scientific communities.</i></li> </ul>
What is the one key recommendation you want to reiterate for strong consideration?	<p><i>UNAIDS should improve and operationalize the process of international cooperation for reaching the targets set up under SDGs and other UN initiatives and agreements as the base for ending AIDS by 2030.</i></p> <p><i>This includes</i></p>

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|  | <ul style="list-style-type: none"><li>- <i>mobilization of the UNAIDS co-sponsors and partners for further development of an internationally recognized and flexible set of indicators and interim targets for these initiatives,</i></li><li>- <i>support of the corresponding fundraising for international and national cooperation,</i></li><li>- <i>more intensive moderation of multisectoral cooperation (at the national level first of all), and</i></li><li>- <i>further promotion of the recognition and meaningful engagement of civil society (key populations and PLHIV) organizations and networks as equal partners for governmental structures in national and international work on ending AIDS by 2030.</i></li></ul> |
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