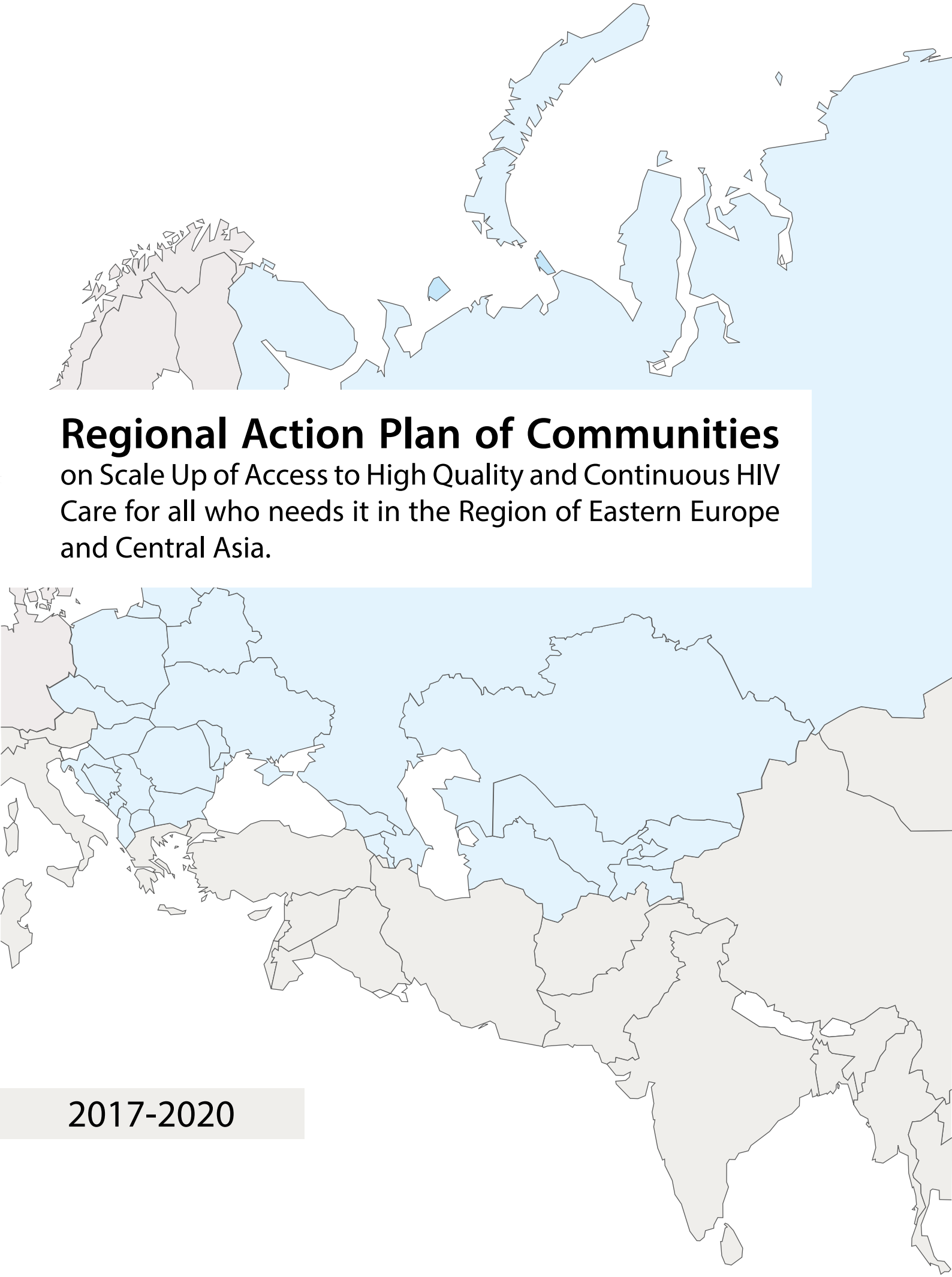

Regional Action Plan of Communities

on Scale Up of Access to High Quality and Continuous HIV Care for all who needs it in the Region of Eastern Europe and Central Asia.

2017-2020

Regional Community Action Plan for 2017-2020 has been developed on initiative of East Europe and Central Asia Union of People Living with HIV (ECUO) within the Regional Program "Partnership for Equitable Access to HIV Care Continuum in EECA " with financial support of Global Fund to Fight AIDS, Tuberculosis and Malaria.

On cooperation and related to the use of Regional Plan and its attachments issues, please, contact ECUO Secretariat (Kiev) at secretariat@ecuo.org, www.ecuo.org.

Efforts of EECA key networks, cooperating since 2015, were consolidated within Regional Plan development and implementation: East Europe and Central Asia Union of People Living with HIV (ECUO), Eurasian Harm Reduction Network (EHRN), Sex Workers' Rights Advocacy Network (SWAN), Eurasian Coalition on Male Health (ECOM), Eurasian Women's Network on AIDS (EWNA), Eurasian Network of People Who Use Drugs (ENPUD), International Treatment Preparedness Coalition in Eastern Europe and Central Asia (ITPC-ru), Eurasian Association of Adolescent and Youth "Teenergizer", Eastern European and Central Asian Network of people with experience of TB (TB-people), Regional HIV Legal Network.

with the support of

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CONTENTS

To be edited and numbered in the website version

LIST OF ABBREVIATIONS AND DEFINITIONS

ARV	antiretroviral
ART	antiretroviral therapy
DM	decision makers
EECA	Eastern Europe and Central Asia
GF	the Global Fund to Fight AIDS, Tuberculosis and Malaria
IDU	injecting drugs users
KAP	key affected populations
MDR-TB	multidrug-resistant tuberculosis
MSM	men who have sex with men
OST	opioid substitution therapy
PLWH	people living with HIV
PUD	people who use drugs
RN	regional networks
SRH	sexual and reproductive health
SW	sex workers
TB	tuberculosis
TS	technical support
VL	viral load
VH	viral hepatitis

CONTEXT OF DEFINITIONS IN DOCUMENT

A continuum of HIV care or the provision of uninterrupted HIV services, according to the "Consolidated guidelines on the use of antiretroviral drugs for treatment and prevention of HIV infection," WHO, 2013, refers to provision of comprehensive package of prevention, diagnostics, treatment and care services for PLWH and their families, including: primary diagnostics of HIV and establishment of connections with care services; treatment of opportunistic infections and other concomitant diseases; initiation, provision and monitoring of ART; transition to second and third line ART regiments; palliative care.

Overview of the barriers that prevent access to HIV services was conducted by the ECUO in 2016 within the framework of the regional program "Partnership for equitable access to HIV care continuum in the EECA region"(hereinafter "Barriers overview").

Monitoring access to drugs was conducted by the ECUO in 15 countries of the EECA in 2016 within the framework of the regional program "Partnership for equitable access to HIV care continuum in the EECA region" (hereinafter "Monitoring of access to drugs")

SUMMARY

The region of Eastern Europe and Central Asia is in disastrous situation regarding access of PLWH to continuous care. In many countries of the region, up to half of HIV-positive people are not aware of their HIV status, and many people with newly diagnosed HIV are already in late stages of the disease. The access to ART is extremely low, and sufficient measures are not taken to combat HIV epidemic among the key affected populations.[1]

In response to the current situation in the Eastern Europe and Central Asia, the regional networks and communities have developed the Action Plan to scale up access to sustainable, high quality and continuous HIV care for all who need it. The main goal of the Action Plan is to define priorities and stages of the following actions that communities have agreed to implement jointly, so that everyone living with HIV, regardless of whether they know about their status, and regardless of their religion, sexual and other preferences, age, gender or citizenship, had access to high quality and continuous HIV care. It is not a comprehensive and detailed plan of all activities for each of the communities. It focuses on the needs and interests of certain target groups, such as:

- people living with HIV;
- people who use drugs;
- sex workers;
- men who have sex with men;
- transgender people;
- people without documents and migrants;
- prisoners;
- PLWH affected by tuberculosis,

It applies to all of these groups with special attention paid to gender and age. The Action Plan aims to address challenges in three key areas for regional communities:

- Access to effective HIV services;
- Sustainable financing of HIV/AIDS programs;
- Coordination of the communities' actions.

It is expected that the plan will be implemented not only by the organizations of communities but other groups that share our interests as well.

The Action Plan has been developed based on the results of research and consultations with the communities' representatives, regional networks, governmental agencies, international organizations, and UN agencies. It provides basis for joint planning, fundraising, and public campaigns. Various networks can implement and coordinate different components of the Plan, depending on available resources and experience.

[1]Draft of the Health Care Action Plan for HIV in the European Region (p.1)

PREREQUISITES

Currently, more than 10 regional organizations and communities of PLWH, IDU, MSM, SW, women, adolescents, people affected by TB and activists in the area of access to treatment have been established and actively operate in the EECA region, including harm reduction networks and networks that provide legal assistance to HIV-affected people. They implement regional activities within the framework of main projects and initiatives aimed directly or indirectly at improvement of access to HIV services. Often these activities are of similar nature and implemented in the same countries, but aimed at different communities and advocacy of PLWH and KAP access to different types of care continuum. Please, refer to Attachment 1 for the description of the main regional initiatives that are currently being implemented in the EECA countries.

Since 2012, the ECUO PLWH, as a regional network of PLWH networks, joining the representatives of all key affected populations, and aiming to increase access to HIV treatment for all the groups and communities, has initiated a series of meetings and negotiations to unite efforts of the regional networks and organizations for better coordination of actions in the area of access to HIV services. The partnership between the regional networks in the Eastern Europe and Central Asia (EECA)[2] is documented by the Memorandum of Understanding and Cooperation, signed in 2015 in Yerevan. The cooperation continues to develop in the framework of joint initiatives and projects supported by the Global Fund and the Robert Carr Fund for civil society networks. An example of such cooperation is the joint report of the regional networks of civil society: "Eastern Europe and Central Asia: Let's Not Lose Track!"[3] presented at the High-Level Meeting on HIV/AIDS at the UN General Assembly in New York, June 8-10, 2016 and during the International Conference on HIV/AIDS, aiming to draw attention of country leaders and world community to catastrophic situation in the region, and take decisions that will help to "catch up" with the rest of the world in bringing AIDS epidemic to end and achievement of Sustainable Development Goals by 2030. Thus, the development and implementation of the joint Action Plan is a logical step in further cooperation among regional networks and communities that aim to scale up sustainable access to high quality and continuous HIV care for all who need it in the Eastern Europe and Central Asia region.

The following regional networks and associations participated in the development of the regional Action Plan:

- Eastern European and Central Asian Union of PLWH (ECUO),
- Eurasian Harm Reduction Network (EHRN),
- Sex Workers' Rights Advocacy Network (SWAN),
- Eurasian Coalition on Male Health (ECOM),
- Eurasian Women's Network on AIDS (EWNA),
- Eurasian Network of People Who Use Drugs (ENPUD),

[2] The "EECA region" refers to the narrow meaning of the countries in which most regional networks operate. It should be remembered, however, that such priorities and coordination of work are needed outside of these countries as well. For the purposes of this document the following countries are included into the notion of "EECA region": Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Poland, Russian Federation, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan.

[3] http://ecuo.org/ru/orc/video/2016/06/03/veca-trebuet-vnimaniya-vyshla-poziciya-soobshestv-vostochnoj-evropy-i-centralnoj-azii-po-situacii-s-vich-v-regione/

- International Treatment Preparedness Coalition in Eastern Europe and Central Asia (ITPCru),
- Eurasian Association of Adolescent and Youth "Teenergizer",
- Eastern European and Central Asian Network of people with experience of TB (TB-people),
- Regional HIV Legal Network.

The regional communities' action plan is based on recognition of the following:

- While appreciating the significant achievements of our countries over the past two decades, we are concerned about the large gaps in access to HIV and TB services, especially among key affected populations (KAP) in the EECA region, being one of the few regions in the world where the rates of new HIV cases and HIV-associated deaths continue to grow, and that also has the highest rates of multidrug-resistant tuberculosis in the world.

- There is an urgent need to expand and stabilize state investment in response to HIV, while the cost of drugs and medical services should be optimized, and their quality and availability are maintained.

- There are examples of contracting among the state and NGOs to provide a continuum of HIV services for KAP in the EECA region; this practice should be expanded further.

- The response to HIV and TB should be coordinated in line with existing commitments of our countries outlined in the UN Political Declarations for 2001, 2009 and 2016, the WHO action plans for HIV and TB in Europe, the Dublin Declaration and other documents.

- Human rights are the basis of our activities; they are essential to overcoming HIV epidemic and achievement of better quality of life and social justice for all, as indicated in the UN Sustainable Development Goals by 2030.

- Elimination of legal barriers, especially those concerning criminalization of KAP and the HIV transmission, is a prerequisite for ensuring full access to public health services, and HIV services, in particular.

- Donor support, especially from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), was crucial to building meaningful participation of our communities, and civil society as a whole, in response to HIV in our countries; while its decline at the background of the economic growth of our countries, requires urgent innovative approaches for creation and maintenance of effective response to HIV.

- There are examples of fruitful cooperation among communities, state and non-state actors in area of public health, social security, human rights and justice that contribute to efficient and sustainable response to HIV; such cooperation should be supported in the future.

CONTEXT

The worldwide trend is a decline in the number of new HIV infections, while in the EECA the annual number of new cases has increased by 57%. The epidemics of HIV, resistant TB and hepatitis C is still concentrated among KAP, SW, MSM and prisoners. While a growing number of new HIV infections happen due to heterosexual intercourse, 96% of HIV transmission has been reported among KAP and their sexual partners. Fifty one percent of new HIV cases in the EECA countries are attributed to people who use drugs[4].

HIV prevalence among gay men and other MSM is many times higher than among general population, despite the fact that, as a rule, the official statistics underestimates the frequency of HIV transmission via homosexual contacts[5]: from high - 3.2% in Kazakhstan[6] to the frightening 16.9% in Ukraine[7] and 25% in Georgia[8]. HIV prevalence among sex workers ranges from less than 1% to 10%[9]. Also, the EECA region has the highest MDR-TB rates in the world[10].

Catastrophic situation with access of PLWH and KAP to HIV services in the region is confirmed by the results of the Barriers overview, in particular, HIV cascades of treatment[11] in the countries of EECA. The massive drop out of PLWH and KAP from the continuum of HIV care occurs at all stages and in all countries of the region, with some differences. For example, in Azerbaijan, more than 50% of PLWH are not aware of their HIV status, in Kyrgyzstan 50% of PLWH who are aware of their HIV status are not involved in HIV-related medical care, in Kazakhstan and Estonia, a low number of PLWH receive ART (less than or about 30%), and in Russia there is no evidence available in open sources on the effectiveness of ART among PLWH. It is obvious that the reasons for the drop out of PLWH from the continuum of care differ in the countries of the region, as well as the situation with access to these services. At the same time, as the results of the Barriers overview showed, we can see common trends among all the countries of the region that negatively affect PLWH access for each key population group, MSM, IDU, and SW, to vital HIV services. A range of legislative, institutional/organizational, social and personal barriers to accessing HIV services in the EECA region are as follows.

The legislative barriers include, first and foremost, the existence of discriminatory legislation, including the criminalization of HIV transmission, which is one of the most important obstacles in obtaining any medical assistance, and HIV assistance, in particular. IDUs and SW are subjected to punishment or criminalization in all EECA countries[12], they are afraid to seek medical care because of the threat of criminal sanctions for drug use or the provision of the paid sexual services, and/or the threat of HIV infecting their partners.

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[4] GLOBAL AIDS UPDATE UNAIDS-2016
[5] Cakalo JI, Bozicevic I et al. Misclassification of Men with Reported HIV Infection in Ukraine. AIDS Behav (2015) 19:1938–1940
[6] Respublican Center for AIDS Prevention and Combat
[7] Ukraine CDC 2015
[8] Curatio (2015) HIV Risk and Prevention Behavior among Men who Have Sex with Men in Tbilisi and Batumi, Georgia. Georgia
[9] UNAIDS (2014) The Gap Report: Sex Workers, p. 5.
[10] TB Europe Coalition (2016) Transitioning From Donor Support HIV& TB Programmes In Eastern Europe & Central Asia: Challenges & Effective Solutions
[11] The HIV treatment cascade is a monitoring system for PLHIV, which involves the continuous provision of PLHIV with ART combined with care, provision of various social services and maintaining a high level of adherence to treatment, and as a result - a reduction in the level of viral load
[12] WHO (2014) Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, Geneva. P. 90.

"I had no wish to register because I understood that this is a criminal responsibility for providing sexual services for money,"
a respondent from Belarus.

The forced drug treatment or registration at narcological dispensary, as well as forced testing for HIV, are common in many countries of the region. Although same-sex relationships in most EECA countries (except Turkmenistan and Uzbekistan) are not criminalized, MSM are highly stigmatized. Only a small proportion of countries have introduced legal provisions against discrimination of lesbian, gay, bisexual and transgender (LGBT)[13], and the law banning the so-called "gay propaganda" (including health information for LGBT groups) in Russia provoked violence[14] and pushed other countries in the region to similar legislative initiatives.

Among other legal aspects that impede access to services are regulations that limit the provision of HIV testing services, including rapid testing, on a community basis. Only in Kyrgyzstan, 20 NGOs have the right to conduct such testing by their organizations, which is allowed by an appropriate order. Another administrative and legal barrier that we need to overcome, especially during the period of the transition to state funding of HIV/AIDS programs, is the lack of legal framework for state financing of the community-based services for the communities in many countries.

Institutional and organizational barriers include issues with regard to readiness of health care system to provide client-centered HIV services, especially when it comes to integration of HIV, TB and drug addiction treatment services, as well as to institutionalization of services provided by communities within healthcare system. Long algorithm for diagnostics of "HIV infection" that exists in practically all of the EECA countries prevents the timely initiation of ART and results in the drop out of PLWH from medical surveillance. For example, two blood drawings from vein, and up to two months of waiting for the test results, an inconvenient work schedule of AIDS centers (appointment to the infectious disease doctor has to be arranged 3 weeks before the visit to doctor in Estonia, or lines in AIDS centers, especially in large cities of Russia , Ukraine and Estonia). The referral of patient to a large number of medical testing procedures (examination by gynecologist, ophthalmologist, ultrasound, etc.) during the initial visit to infectious disease specialist in Belarus and Russia. The low level of training among health workers on the issues of HIV/AIDS in small settlements or within the primary health care system in Azerbaijan, Kyrgyzstan, Kazakhstan, Estonia, Russia and Belarus, and as a consequence, negative attitude of medical workers towards PLWH, and in particular to KAP, as well as non-compliance with the confidentiality of diagnosis.

"A patient, who underwent HIV testing, anonymously or not, needs to visit the health facility at least 5 times. We just checked how many times he/she had to go to an institution to be tested or receive results. For a person who uses drugs - it is a very long period of time." Focus group participant, Belarus.

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[13] Eurasian Coalition on Male Health (2016) Analysis of Legislation Related to LGBT Rights and HIV in Eastern Europe and Central Asia. p19. Accessible at: http://ecom.ngo/wp-content/uploads/2016/05/ECOM-legislation-ENG.pdf

[14] Human Rights Watch. (2014) License to Harm: Violence against LGBT People and Activists in Russia. December.

Poor access to HIV testing for KAP can be attributed to both legislative and institutional barriers, but certainly not to financial ones. Practically all countries of the EECA region perform HIV testing for general population by ELISA method in large volumes. Given HIV prevalence among KAP, it is not feasible and is economically disadvantageous. For example, in Russia, in 2015 only, the ELISA method was used for 30,661,034 people, including 28,275,430 (92%) of the general population. At the same time, the share of KAP representatives accounted for less than 1% of those tested.[15]

Worldwide 41% of adults living with HIV receive ART, while in the EECA – only 18% of HIV-positive adult patients. Although IDU represent 56% of all the registered HIV cases in the region, they receive only 38% of the ART services[16]. IDU point out inconvenience in obtaining medications, distrust to health care system, as well as lack of documents (identity card, passport) as serious obstacles that contribute to low rates of ART coverage. OST programs in most of the EECA countries are still at the piloting stage, while in Russia, Uzbekistan, and Turkmenistan they are not available at all. In countries where OST is available, only a small share of program participant receives ARV treatment. In Kyrgyzstan among 1424 IDU/OST (representing 5.6% of all the IDU in the country, incl. 410 PLWH) only 74 people receive ART[17]. In Kazakhstan, among 224 IDU/OST (representing 0.2% of all IDU in the country, including 51 PLWH) only 17 people receive ART[18]. In Azerbaijan, two OST clinics operate in Baku. One of them is next to the AIDS center facilitating the IDUs' access to health care. In Belarus, out of 18 OST centers, only 2 sites provide integrated HIV/TB services. The issue of low access of IDU to OST, generally, and poor integration of services at existing OST sites, particularly, can be attributed to both organizational and legal barriers.

There is no reliable data on percentage of patients receiving ART among MSM, SW and transgender people in the EECA[19]. The ECUO confirmed it in 2016 while monitoring quality of access to drug supply: only few countries in the region collect disaggregated data on KAP to construct HIV treatment cascade, incl. Kazakhstan and Kyrgyzstan[20]. The data of the National Center for AIDS Prevention and Control[21] in Kazakhstan, presented in the table below, reflect the situation with access to health services for KAP: only 40% of IDUs among all the registered HIV cases are "D-registered" (registered in the dispensary); only 35% of MSM among D-registered MSM receive ART; and only 20% of SW among all reported HIV cases among sex workers are under medical supervision! The recording of the disaggregated data on VL in Kazakhstan is absent.

Table. Disaggregated data on KAP as of 31.07.2016, where

	Registered	D-registered		Receive ART	
IDU	14 529	5929	40%*	4 090	68%**
MSM	302	229	75%	79	35%
SW	291	59	20%	28	47%
SW/IDU	118	16	14%	0	
		* % of all registered cases		** % of those D-registered	

[15] Federal AIDS Center, 2015
[16] WHO (2016) Where we stand with implementation of the WHO guidelines. Regional stock taking meeting on the implementation of the Investment Approach in EECA. Vienna Austria
[17] Kyrgyzstan. Evaluation report. December 2014. M. Mansfeld, M.i Ristola, G. Likatavicius\ WHO 2015 P20
[18] National report on progress in the implementation of the global AIDS response 2015
[19] Eurasian Coalition on Male Health (2016) Regional Concept Note to the Global Fund to Fight AIDS, Tuberculosis and Malaria.
[20] PResults of monitoring access to drug supply, ECUO, 2016
[21] Letter of request No.06-756 of 22.08.2016, cumulative data as of 31.07.2016

Despite the fact that disaggregated data is not available in most of the EECA countries, we can assume that the situation of unequal access to services for KAP is common to many countries of the region. It is confirmed by the data from the National Report of the Russian Federation on measures to combat HIV/AIDS. For example, in 2014 ART was received by only 26% of HIV-infected IDUs among those D-registered[22].

The organizational barriers include shortcomings of the existing procurement and supply system of ARVs. Its consequences affected almost all EECA countries, resulting in the threat of ART interruption or interruption itself. This issue remains urgent for Belarus, Russia, Moldova and Ukraine - countries that transferred or are in transition to state provision of ART, and in which the cases of ART interruption or replacement of ARV drugs due to non-medical reasons were recorded in recent years.

The high cost of ARV drugs and, as a consequence, almost complete lack of access to third-line drugs for HIV treatment in the region, is another critical barrier to improving access to effective HIV treatment. The use of fixed-dose combinations in the EECA region is rare. For example, in Russia, which is home to the largest PLWH group in the region, less than 1% of those infected receive ART under the scheme "all in one" which is not in line with the latest international recommendations. At the same time, opportunities offered by the TRIPS agreement for stable access to affordable drugs in the EECA region has not yet been used. While the local production of ARV drugs in Russia, Kazakhstan[23], Ukraine[24] and Belarus[25] do not effectively reduce the cost of ARVs. In some cases, the price for generic drugs is even higher. As an example let's consider the drug Abacavir (international non-proprietary name) in Russia. The cost per 300mg pill of Ziagen drug (commercial brand name of Abacavir) produced by Viive Helsker is $ 1.0932, while the cost of the similar generic drug under the trade name "Olitid" produced by Pharmasintez is $ 1.1333 per 300 mg pill (according to the results of the monitoring access to drugs, the results of which is partially included in the ARV drugs database, procured in our region http://arv.ecuo.org/.

In addition to the high cost of antiretroviral drugs, particularly in the background of the local production development, raises another issue of their quality. In all of the EECA countries, there is a system to monitor cases of side effects. In some systems, these cases can be registered, while in others are obligatory for registration in the respective regulatory bodies of the country (usually at the Ministry of Health) according to the national legislation. In Kyrgyzstan, Moldova and Ukraine the medical personnel of public health institutions is obliged to provide information on development of all side effects of drugs to the appropriate regulatory body. To register side effect, the health worker has to fill out from 1 to 6 special forms per one case of side effect. In Ukraine and Moldova, in addition to health care workers, the drug manufacturer or its representative has to submit regular reports on any side effects or lack of effectiveness of drugs in medical use. However, the data on the number of such appeals is absent in open resources in all countries except Latvia (according to the monitoring results of access to drugs in 2016). In this connection, we can assume that the existing system of quality control and effectiveness of drugs in EECA does not function in reality.

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[22] http://www.unaids.org/sites/default/files/country/documents/RUS_narrative_report_2015.pdf (P.8)
[23] Law No. 13 of March 12, 1997, approved by the Government Decision No. 704 of 15 October 2002
[24] Annex No. 1 to the Order of the Ministry of Health of the Republic of Moldova No. 20 of 12.01.2006
[25] Order of the Ministry of Health of Ukraine No. 898 of December 27, 2006, registered at the Ministry of Justice under No. 73/13340 29.01.2007

It is important to note that except for a small number of sites that provide integrated services for HIV, TB and drug addiction, the excess hospitalizations frequency due to TB in the EECA leads to high costs and the spread of drug resistant forms of the disease, in its turn causing more expensive and less effective treatment.[26]

Social and cultural barriers include those associated with negative attitudes within the society, and by the health care workers, to KAP and PLWH; gender inequality in access to services; insufficient level of involvement of KAP and PLWH representatives in the development of HIV/AIDS programs; and the mobilization level of PLWH and KAP communities, in general. Gender inequality in access to services is confirmed by the following data: in the EECA only 0.003% of women who inject drugs have access to OST.[27] The special needs of vulnerable women and girls are not considered sufficiently, despite the fact that in Kazakhstan, Uzbekistan, Kyrgyzstan, Belarus and Ukraine, HIV prevalence among women-IDU is higher than among men-IDU.[28] Many women who inject drugs are also sex workers (62% in Kyrgyzstan and 84% in Azerbaijan).[29] Such women also do not have sufficient access to sterile injecting equipment and condoms and are faced with limited access to services in the field of sexual and reproductive health (SRH). These problems are particularly acute in prisons and other detention sites. Stigma and gender-based violence, faced by women, also hinder their access to prevention and treatment services.

While recognizing the importance of decentralization of health services in the context of HIV, which is already happening in nearly all of the EECA countries, it is important to note the barriers hindering it: the low level of public awareness about HIV/AIDS in small towns, including the level of training of health workers, including in health not specialized facilities that generates negative social attitudes towards PLWH and KAP, in particular, and which indirectly contributes to disclosure of HIV diagnosis confidentiality.

The negative attitude of the society and government representatives to prevention programs for SW, MSM, and IDU, as well as to the OST programs in almost all countries of the region can also be attributed to the social barriers of access to HIV treatment. In many countries, SW, MSM, and IDU are pushed beyond the society due to stigma and criminalization of the same-sex relations, drug use, sex work. This marginalization restricts access to HIV services.

The personal barriers hindering access to the care continuum include the following factors:

- The low value of their own life, and, consequently, the health of most PLWH and KAP;
- Lack of knowledge about HIV and its treatment, and as a consequence, a great number of myths;
- Lack of legal awareness of their rights;
- The lack of necessary support in the nearest environment;
- Prejudice against treatment, ART;
- Negative experience of acquaintances when seeking care services;

[26] The Global Fund. EECA Investment Guidance "reality check," EECA Consultation on Sustainable Impact. Istanbul, Turkey.
[27] EHRN (2016) Access of women who use drugs to harm reduction services in Eastern Europe, forthcoming report from the Eurasian Harm Reduction Network (EHRN)
[28] UNAIDS. (2014) The Gap Report. P. 109.
[29] UNAIDS. (2014), The Gap Report. The Gap Report. UNAIDS. 2014. P. 109.

- Development of the movement that denies HIV/AIDS (HIV/AIDS dissidence) at the background of the denial stage while accepting the HIV diagnosis among many PLWH.

These barriers lead to drop out of PLWH from HIV care continuum. According to the results of the focus groups, the most common reason for PLWH's refusal to receive ART and/or unwillingness to know about their HIV status are various fears.

> ***"I fear that if I start drinking (taking pills) everything else will come out. It will be even worse. I feel fine now."*** *A respondent from the Russian Federation,*

> ***"It is a fear, a lack of information about the disease and general lack of understanding of what to do about it. I'm frightened to say it to the relatives. I do not know how to say it. My relatives are still not aware. I'm afraid of losing contact with them."*** *A respondent from the Republic of Belarus,*

> ***"Many people do not want to know about their disease, especially those who lead such a lifestyle, for example, those taking drugs do not want to know about their status as they know that it can happen. Fear is the biggest reason."*** *The respondent from Azerbaijan.*

In addition to the above, it is important to note that financial barriers actualized at the background of a sharp transition of the countries to domestic funding sources. The EECA countries can not provide sufficient funding for comprehensive HIV program (prevention, testing, social support for the provision of care and patients' retention in ART programs), especially for the stigmatized and criminalized key groups, exacerbated by the reduction in international financial aid.

In response to the existing in the EECA region legislative, organizational, social, personal and financial barriers to access high-quality, stable and continuous HIV services, the regional organizations, communities of PLWH, IDU, MSM, SW, women, adolescents and TB affected people have developed the regional action plan aimed at improvement of access to HIV services for everyone who needs it. A harmonized coordinated set of activities among regional organizations in the provision of technical and methodological support to the national communities, facilitating the exchange of best practices and experiences existing in the countries of the region regarding the access to care continuum and budget advocacy will contribute to overcoming systemic barriers at various levels hindering access to services for all who need it at the national level. The regional advocacy aimed at reduction of the cost of drugs will allow optimization of financial resources at the national level.

While involvement of the representatives of the communities in the formation of international and regional HIV/AIDS policies and procedures will allow to take into account the needs of the EECA region. The availability of the reliable evidence base, data about the new guidelines and methods of their implementation, as well as the systematic support to the national communities by the regional organizations will contribute to the systemic and structural changes. In particular, the simplification of bureaucratic procedures, the integration of services provided by the community organizations into the health care systems, strengthening the relationships among various services, the involvement of community members in health care reform, and increase of the national investment to continue the implementation of HIV/AIDS programs in full at the national level.

GOAL, TASKS, AND MILESTONES

This section describes the goal, tasks, and milestones that will help to track the progress towards the set targets.

GOAL Coordination of joint efforts of the communities to increase quality and ensure sustainability and continuity of HIV and TB services for all who need it in the EECA region.

TASK 1: Access

to vital HIV services

Contribute to better access to high quality continuous HIV services

TASK 2: Financing

Promote a dialogue on state investment and costs optimization, as well as donor policies for the responsible transition of HIV/AIDS programs to state funding

TASK 3: Cooperation

Enhance coordination and joint work among various community groups at the regional and national level

TASK 1

ACCESS TO VITAL AND EFFECTIVE HIV SERVICES.
Contribute to better access to high quality continuous HIV services (care continuum).

1.1. The national standards of the community-based services (including, for example, out-reach, formation of adherence to ART, etc.), are developed with full participation of all the communities affected by HIV, have a strong link with health services, and are institutionalized in close cooperation with partners in the area of health reform.

1.2. The communities monitor the implementation and update of the national standards in accordance with the latest WHO and UN recommendations and, where appropriate, facilitate their integration into the national guidelines and systems, particularly in the following fields:

- strong links between community-based and medical services;
- community-based T&C, self-testing, a simplified diagnostic procedure;
- integration of HIV, drug dependence, TB, VH and SRH services;
- formation and maintenance of adherence to client-oriented treatment of TB, HIV and VH.

1.3. The communities monitor the quality of services provided by them and other structures, facilitate their integration into the state M&E system and participate in a dialogue about the results of the monitoring.

1.4. The communities contribute to the inclusion of specific goals and indicators to ensure equal access to HIV services for all KAP, including migrants and refugees without documents, and prisoners (who are not directly represented by the regional networks), within the national programs and transition plans to state funding of HIV/AIDS programs, including specific national targets on ART treatment for IDU, MSM and SW.

1.5. Stigma, discrimination and other human rights violations are documented, tracked, immediately made public by the initiative of the communities and receive feedback from the communities, national health and justice systems, UN bodies and the media, if necessary.

TASK 2

FINANCING.
Promote a dialogue on public investment and costs optimization, as well as donor policies for the responsible transition of HIV/AIDS programs to state funding.

2.1. The community groups jointly build capacity in budget advocacy, including the following matters: possible funding sources; budget cycles; costs calculation; opportunities and needs for costs optimization within health reform and the response to HIV and TB; identification of priority measures in response to the HIV/TB epidemic.

2.2. The communities are involved in the dialogue on funding of the response to HIV and TB and have their representatives in the relevant key decision-making committees.

2.3. Mechanisms for allocation of public funding to provide prevention services, timely diagnosis, care, and support, are developed and piloted by the communities' organizations, while the scale of their implementation increases.

2.4. The challenges and opportunities in the drug policy for the treatment of HIV, TB, hepatitis and drug addiction (registration matters, lists of essential medicines) are documented, known to the community, and used while negotiating with key stakeholders.

2.5. The community groups are involved in the discussion on the pricing of drugs and diagnostics, suggest practical steps, such as: the use of TRIPS flexibilities, increased transparency of public procurement procedures, voluntary and compulsory licensing, technology transfer and prequalification of the locally produced generics, the use of the international procurements and technical support mechanisms.

2.6. The donors and technical partners, including the Global Fund, expand their activities and conditions of the transition to public funding policy of the HIV/AIDS and TB programs, including, and in response to the communities action.

TASK 3

COOPERATION

Enhance coordination and joint work among various community groups at the regional and national level.

3.1. The communities' committees are established at the national level to promote effective and sustainable action in response to HIV and TB, reflected in the following:

- clearly identified advocacy priorities among the communities;
- developed uniform opinion on key matters
- strategic monitoring and evaluation of the response to HIV and TB (including cases related to stigma, human rights and criminalization).

3.2. The regional networks collaborate to achieve synergy, especially in the context of large regional projects, and support the national communities, ensure joint advocacy and technical support at the national, regional and global level, and avoid duplication of activities via:

- clearly identified advocacy priorities among the communities;
- developed uniform opinion on key matters
- strategic monitoring and evaluation of the response to HIV and TB (including cases related to stigma, human rights and criminalization).

APPROACHES AND KEY ACTIVITIES OF THE PLAN

This section describes main activities of the regional action plan needed to reach the set tasks. The plan of activities is presented in Attachment 2 and includes a list of main measures and performance indicators classified by milestones. It also shows the planned activities of the regional networks and communities for the next few years.

TASK 1

ACCESS TO VITAL AND EFFECTIVE HIV SERVICES

Contribute to better access to high quality continuous HIV services (care continuum).

To reach the milestones of the Task 1 we foresee:

1.1.1. TS provision to the national organizations and communities in the development, review and/or adaptation of the national standards of PLWH and KAP care, including those provided by the community-based organizations based on recommendations developed by WHO, UNAIDS and key communities and service-delivery guidelines for PLWH and KAP, including the following: Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, WHO 2014; and 2016 update Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions, WHO 2015; Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection, WHO 2016, second edition; and others. Priority action: In addition, it is planned to develop (describe) an algorithm/mechanism for standardization of services provided by the communities, building on the existing expertise and mechanisms of the services standardization in the region, including lessons learned, on risks prevention as well.

1.1.2. Collection and dissemination of the best practices that exist in the EECA countries on HIV care continuum, including SRH services, violence prevention, and advocacy, to be regularly circulated among the communities, NGOs, representatives of the state structures.

1.1.3. Active participation of communities in working groups and committees to develop standards for the community-based services, followed by negotiations with key stakeholders and partners, including round tables, dissemination of the official claims and communities' statements, if needed, and aiming to institutionalize these services in the health care system.

1.2.1. ! Priority action! Regular monitoring by patient organizations and/or community organizations to track the updates of the national standards and their compliance with the latest international recommendations on links between the services; community-based T&C, self-testing, a simplified diagnosis procedure; services integration; formation of adherence with the focus on KAPs. The results of monitoring will be disseminated among key stake-

holders and used as evidence and arguments in negotiations with decision-makers; as well as the results will ensure feedback to international organizations and UN agencies on implementation of their recommendations at the national level.

1.2.2. ! Priority action! TS provision to the communities and capacity building around the opportunities and the role of communities in the health reform. It includes the development of guidelines, briefs, information messages, video messages, a selection of arguments to be used by the national communities during a dialogue with key partners on changes and/or proposals for the development of the national strategic HIV/AIDS documents, such as: the national HIV/TB Program, standards for the care continuum, and other documents regulating provision of services at the national level. The development of such tools can be carried out either at the request of the national communities or on a regular basis according to the needs of the national communities. Also, this measure encompasses training of the national communities on their involvement in the process of health care reform, including strengthening cooperation with WHO and the World Bank to submit the community proposals and/or initiate a dialogue on the development and/or implementation of the national standards.

1.2.3. ! Priority action! Dialogue with representatives of state structures, including those supported by international partners (e.g., the UN), on the introduction of high quality system of integrated services in line with international standards, through the organization of the round tables, preparation of the official consolidated requests from the communities and partners to the authorities, organization of personal meetings with assistance of reputable and well-known partners in the region (for example, during the visit of the Special Advisor to the UN Secretary-General to the country), speaking to the relevant politicians (if necessary) and other activities.

1.2.4. ! Priority action! Organization of international meetings, including parallel sessions during other regional and international events (e.g. AIDS 2018, regional consultations of WHO and UNAIDS, EECAAC-2018), attended by the communities, governments, and international partners, aiming to hold a multi-sector dialogue and compare the situation across the countries on scale up of access to HIV services, as well as to highlight the challenges and best practices that exist in the EECA region.

1.3.1. Integration the "Community-based monitoring" approach into the state system of M&E. It includes the development or preparation of the "resource package" for the communities' organizations that will collect all the necessary information, experience, practice, necessary arguments and justifications related to "Community-based monitoring." It is expected that this package will help communities to negotiate with relevant structures to integrate the approach of "Community-based monitoring" and qualitative indicators based on the feedback from the community, into the state M&E system.

1.3.2. It is planned that the communities will begin to monitor the service provision quality covering both community-based and other organizations and institutions, as well as use the monitoring while negotiating with the decision-makers.

1.4.1. Monitoring of the implementation of key national indicators on equal access to HIV

services, particularly among KAP. The action includes tracking and analysis of the key performance indicators progress at the national and regional level, held by the communities with technical support from the regional organizations. Particular attention will be paid to the disaggregated data to draft the HIV treatment cascade for all KAPs. The analysis of key indicators under GARPR reports at the regional level is defined as the priority action for several years ahead.

1.4.2. Priority action! Advocacy for the inclusion of concrete targets and key performance indicators to the strategic national documents on HIV and TB to ensure equal access to HIV services. It involves active community participation in the national dialogue in the framework of the meetings of the State Council on AIDS and TB, CCM and other committees, working on the development and implementation of the national plans and other strategic documents on HIV/AIDS and TB, using the results of the monitoring that was conducted, and development of consolidated and individual community statements on this matter.

1.5.1. Provision of emergency response to the violation of the PLWH and KAP's rights and prevention of all other sorts of crises suggests the development of joint complaints, requests and statements, as well as their distribution among the major agencies and bodies, and the provision of legal support for cases of human rights violations and the actualization of other critical issues, such as police violence, etc.

1.5.2. Monitoring of violations of the PLWH and KAP rights, including monitoring of discriminatory policies in the EECA countries, is planned to be conducted on a regular basis. The results will be presented in the form of reports, analytical documents or policy briefs and distributed among stakeholders and decision-makers.

1.5.3. Preparation and distribution of shadow reports, position statements on the violations of PLWH and KAP rights (including and based on the results of the monitoring of violations of PLWH and KAP rights) among key players, relevant structures, decision-makers and during the high-level meetings or other international and regional events.

1.5.4. Organization of regional campaigns, negotiations with decision-makers and other measures to protect the rights of PLWH and KAP, which are held separately by many regional organizations on various specific matters. As part of the action, it is planned to organize joint campaigns on the most relevant to the communities of the region subjects, providing its further promotion within the operation of a regional organization and/or as part of key regional and international events on HIV/AIDS, for example, AIDS 2018.

TASK 2

FINANCING.
Promote a dialogue on state investment and costs optimization, as well as donor policies for the responsible transition of HIV/AIDS programs to state funding.

To reach the milestones of the Task 2 we foresee the following measures:

2.1.1. ! Priority action! Training of the community groups and exchange of experience on budget advocacy that include training events, webinars, exchange visits and internship in the organizations with successful experience in budget advocacy.

2.1.2. ! Priority action! TS for IDU, SW, MSM and PLWH communities on budget advocacy and fundraising, including the development and application of tools to monitor the realization of the state budget, assistance in formulation of proposals on optimization of resources and in holding constructive dialogues with the representatives of the Ministry of Finance and the Parliament. Also, within the framework of this activity, it is planned to create and maintain a database of donors working in the region, create a regional database of all the tools and benefits that contribute to effective budget advocacy.

2.2.1. Provision of the technical and methodological support to IDU, SW, MSM and PLWH communities on their involvement in the dialogue on funding of the response. Particularly, to prepare communities to participate in the CCM meetings, or prior to speaking in the Parliament, while dealing with concrete budgets, amounts, lines and their compliance with the national indicators, and in preparation of proposals from the communities on the issues of their choice, presentation of experience from other countries, etc. Some communities will receive TS with their inclusion into respective national committees.

2.2.2. Participation of communities in a dialogue on financing of the response, including via their participation in key committees. It includes roundtables, workshops, as well those community-driven, collecting arguments for public investment, community meetings before CCM meetings and other key committees, etc. As part of the action, it is also expected that communities will participate in national and regional high-level meetings to present reasoned and a consolidated communities' opinion on financing of the HIV/TB response.

2.3.1. ! Priority action! TS to IDU, SW, MSM and PLWH communities in the allocation of public funding to NGOs for the provision of a care continuum implies the description of the algorithms to receive public funding, assistance in the development of the relevant standards/mechanisms, if necessary, training of the community organizations to receive public funding, considering the peculiarities of its provision, collection and dissemination of the best practices of allocation of public funding for the prevention services, timely diagnosis and support for PLWH and KAP, study tours and facilitation of the national dialogue on the transition to the public funding of the HIV/AIDS programs.

2.3.2. Priority action! Participation of communities in the dialogue on the allocation of state funding to the communities' organizations for provision of care continuum. The action implies training of communities for the dialogue (collection and preparation of arguments, the experience of other countries, development of the consolidated proposals) to be held within the framework of the implementation of the national action plans. When implementing this action, it is important to take into account the activities described in paragraph 2.2.2. and p.1.4.2.

2.4.1. Documentation of challenges by communities related to the policies and procedures on the medicines for HIV, TB, drug use, and drug addiction, and ensure distribution of such records among the communities. Particularly, tracking those aspects that hinder the expansion of access to quality drugs, including the following: drugs registration, lists of essential medicines, patent legislation, release of new forms of drugs, etc. It is assumed that communities' organizations will regularly share the information and raise awareness about the respective challenges among their communities. When implementing this action, it is important to take into account the activities described in p. 1.2.1

2.4.2. Negotiations with key partners, pharmaceutical companies and decision-makers on improvement of access to medicines for TB, hepatitis and drug addiction by the means of the following measures: updating the lists of essential medicines, simplifying drug registration system, release (procurement) of other forms of drugs, public funding of medicines to treat drug addiction, overdose prevention, etc. To implement the action, it is planned to prepare and distribute the official requests and letters from the communities, strengthen partnerships with the major global players in the field of access to treatment, hold joint meetings, round tables, briefings, press conferences and direct actions, if necessary.

2.5.1. Organization of events and negotiations with representatives of state agencies and pharmaceutical companies on pricing of drugs, which encompasses regular meetings of the EECA CAB (being a platform for a dialogue with representatives of the pharmaceutical companies on pricing, quality and registration of ART), preparation of letters to the pharmaceutical companies, organization of round tables, press conferences, briefings, direct actions, if necessary, using the results of the monitoring and recording of the existing challenges. Within this activity, the communities are expected to participate in the process of drugs procurement under the state budget and monitoring of ART cost at the stage of tendering for procurement of drugs.

2.6.1. Negotiations with donors to ensure gradual transition of HIV/AIDS programs to the public financing, including preparation of consolidated appeals from the community, organization of joint sessions in the framework of the regional and international activities, as well as involvement and meaningful participation of the communities in shaping the donors' policy in our region, including through the participation of community representatives in the delegations of the Board of the Global Fund, UNAIDS and other governing bodies of the international and donor organizations and structures. international and donor organizations and structures.

TASK 3

COOPERATION

Enhance coordination and joint work among various community groups at the regional and national level.

3.1.1. Creation and support of the communities' platform at the national level assumes the formation of the committees/consortia/informal associations of all the existing communities affected by HIV and TB at the national level that will act under the documented agreements (committee regulations, a memorandum of cooperation, rules of interaction, etc.) , develop joint positions with regard to issues that are important for all the communities, especially before meetings with key national HIV/AIDS committees, conduct joint advocacy work, coordinate activities at the national level, share experience, and represent the interests of all the communities.

3.2.1. Coordination of efforts of regional communities and networks includes regular meetings of the representatives of regional communities, including in the framework of the regional activities and events, the formation of the consolidated opinion, organization of joint regional forums dedicated to concrete topic, preparation of reports (at least once a year) on the progress of implementation the regional action plan.

3.2.2. Preparation and implementation of joint initiatives and projects that includes development of actions, campaigns, joint activities that involve more than three partners.

IMPLEMENTATION AND MANAGEMENT OF THE PLAN

The regional action plan (RAP) will be implemented during 2017-2021 with the support of ECUO, EHRN, ECOM, SWAN, EWNA, ENPUD, ITPCru, «Teenergizer», TBpeople and the Regional HIV Legal Network. ECUO in partnership with EHRN and consultation with other networks provides overall coordination, while the Regional Expert Group (REG) consisting of representatives of the regional communities' networks will be responsible for measuring progress and adjusting the plan on an annual basis. The first interim report on implementation of the Regional Action Plan (RAP) and milestones progress will be presented in 2018 combined with activities planning for the next RAP period. Given the large volume of tasks and activities of the action plan, the limited financial and human resources, and a broad coverage of vast number of RAP issues, the regional networks identified the priority milestones and measures. It is expected that in the nearest years, i.e. by 2018, the joint efforts of the regional organizations and communities will mostly target these priority actions. The plan also shows the priority activities and milestones defined by the ECUO for the implementation of the regional project "Partnership for equitable access to HIV care continuum in the EECA region" which is implemented jointly with EHRN under the new funding model of the Global Fund. The priority actions are presented in the Attachment 2, second spreadsheet.