AIDS ACTION EUROPE

WORKING TOGETHER
TO END INEQUALITIES

# AIDS ACTION EUROPE STRATEGIC PLAN 2022-2026

# IMPRESSUM


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1. Auflage, 2021
Bestellnummer: 024151

Redaktion: Steering Committee and the Executive Office of AIDS Action Europe
Gestaltung: Alina Gladkikh
Druck:

This publication of an activity received funding under an operating grant from the European Union's Health Programme (2014–2020).

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# AAE STRATEGIC PLAN 2022-2026

People living with HIV (PLHIV), TB, and viral hepatitis, and key populations (KP) experience inequalities in the promotion, protection, and enjoyment of human rights. These inequalities occur in accessing services within our region, between countries, and within countries. Therefore, the AIDS Action Europe (AAE) Steering Committee (SC) decided to address these inequalities in this strategic plan. The framework of human rights is utilised to define our strategic goals, objectives, and areas of work toward reducing and eliminating these inequalities.

The AAE 2022-2026 Strategic Plan "Working Together to End Inequalities" was developed after analysing the available epidemiological situation and examining the context of our region as it relates to inequalities and human rights. In addition, our members' priorities and needs, building on previous strategic plans were considered.

# OUR CORE THEMATIC AREAS

AFFORDABILITY AND ACCESSIBILITY TO MEDICATION

COMMUNITY BASED VOLUNTARY COUNSELLING AND TESTING (CBVCT)

CRIMINALISATION OF HIV NON-DISCLOSURE, EXPOSURE AND TRANSMISSION

HARM REDUCTION

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR)

TACKLING LEGAL BARRIERS IN THE RESPONSE TO HIV, TB AND HEPATITIS

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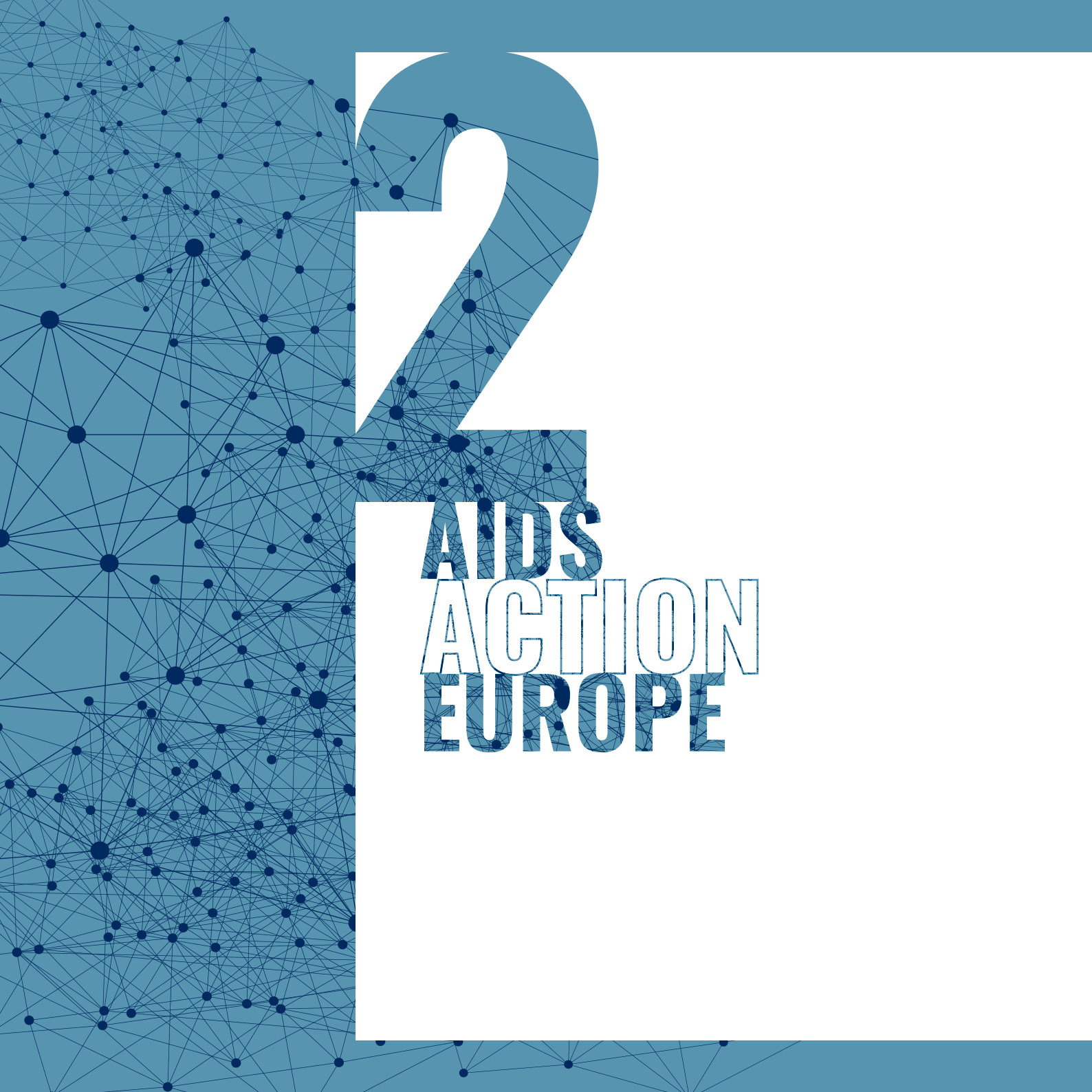
COMMUNITIES AND CIVIL SOCIETY ENGAGEMENT AND PARTICIPATION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## OUR VISION

Our vision is that equally across Europe and Central Asia, people living with, affected by and vulnerable to the life-threatening and chronic infections of HIV and AIDS, TB and viral hepatitis, lead as fulfilled and productive lives as possible, free from stigma, discrimination and persecution, and access the necessary prevention, treatment, care and support.

## OUR MISSION

Our mission is to strengthen civil society to work towards a more effective response to the HIV and AIDS, TB and viral hepatitis epidemics in Europe and Central Asia. We are striving for the best standards of human rights protection and universal access to prevention, treatment, care and support, tackling health inequalities and focusing on key affected populations.

## WHO WE ARE

AIDS Action Europe is a regional network of a diverse group of 399 NGOs[1] , national networks and community-based groups, most of which are AIDS service organisations, in 48 countries[2] spanning the World Health Organisation European (WHO/Europe) Region[3] (hereinafter "the Region"). Membership is free and open to all civil society entities (non-governmental organisations, national networks, community-based/-led groups etc.) operating on local or national level, are based in one of the 53 countries of the Region, and are active in the field of HIV and AIDS, and/or TB, and/or viral hepatitis.

Established in 2004, AAE has grown into one of the largest bilingual (English and Russian) HIV and AIDS networks of AIDS-service organisations in the Region. AAE´s governing body is the AAE Steering Committee (SC), who makes all decisions on programme issues related to policy, strategy, finance, monitoring, and evaluation. The SC is comprised of representatives of AAE member organisations, striving to have a balance in terms of HIV status, gender, key population, and geographic representation.

In April 2017, the AAE Steering Committee expanded the network's mission to reflect a more integrative approach, addressing tuberculosis (TB) and viral hepatitis not only as co-infections of HIV, but also as mono-infections, in order to use synergies and avoid duplications wherever and whenever possible. This is especially relevant for key populations who are particularly affected by, and vulnerable to the three epidemics of HIV, TB and viral hepatitis.

AAE is not a registered legal entity but by decision of the founding interim SC members, it is hosted by one of its member organisations. Deutsche Aidshilfe (DAH) has been hosting AAE since mid-2014, providing the legal and financial representation for of the network, and hosting its Executive Office in Berlin, Germany.

[1] At the time of writing this strategic plan (September 2021)

[2] https://www.aidsactioneurope.org/en/map/members

[3] WHO Europe region includes 53 countries of Europe and Central Asia, and Israel

# OUR GUIDING PRINCIPLES

In our work, we are guided by the following principles:

## ACCOUNTABILITY

*we understand that internal accountability in all its aspects – towards our members and the communities they work for and with, towards our partners, towards our funders, and towards each other – is essential if we are to keep policy and decision makers, governments, and other stakeholders in the HIV and AIDS, TB, and viral hepatitis responses accountable.*

## TRANSPARENCY

*we believe in the principles of being transparent in all aspects of our work, including our activities, our organisational structure, our decision-making and financial procedures. Therefore, we strive to communicate openly on all aspect of our work with our network members and other stakeholders.*

## EVIDENCE AND HUMAN RIGHTS BASED APPROACH

*we believe that all aspects of the HIV and AIDS, TB, and viral hepatitis responses should be evidence and human rights based. Therefore, we ensure that all our activities and decisions are informed by the most up to date evidence and research. We advocate that human rights should be the basis of all HIV and AIDS, TB, and viral hepatitis policies, legislation, and decisions.*

## GIPA PRINCIPLE

*we believe in the principle of "nothing about us without us". Therefore, we ensure that people living with HIV and AIDS (PLHIV), TB, and viral hepatitis and key populations are informed, listened to, and included in all our decision-making processes, their voices are heard at the national and regional policy development and decision-making, and they are included in the design and the implementation of services intended for them.*

## INTERSECTIONALITY AND INCLUSIVITY

*we understand that HIV and AIDS, TB, and viral hepatitis affect each person or community in unique, multiple, and often overlapping ways. Therefore, we strive to apply an inclusive approach in our work and include, listen to, and learn from the lived experiences of individuals and communities living with or affected by HIV and AIDS, TB, and viral hepatitis.*

## PARTNERSHIP AND NETWORKING

*we believe in the power of networking and bringing different stakeholders together for solidarity, learning from each other, and joining forces in the fight against HIV and AIDS, TB, and viral hepatitis. Therefore, we strive to facilitate a networking and partnership culture in all aspects of our work.*

Framed by our mission, vision, guiding principles, and core values, AAE's general goal in Europe and Central Asia is to strengthen civil society's contribution to a more effective response to the HIV and AIDS, TB and viral hepatitis epidemics.

# 3 BACKGROUND AND CONTENT

# 2.1 POLITICAL COMMITMENTS IN THE CONTEXT OF HIV AND AIDS, TB, AND VIRAL HEPATITIS

## GLOBAL COMMITMENTS

In 2015, all United Nations (UN) Member States committed to ending the epidemics of AIDS, TB, and combating viral hepatitis[4] by 2030 as part of the Sustainable Development Goals (SDGs) – Goal 3 – Good Health and Wellbeing. Further to the commitment on combating viral hepatitis, in 2016, the World Health Organization (WHO) adopted the first Global Health Sector Strategy on Viral Hepatitis, calling for the elimination of viral hepatitis as a public health threat, with specific targets on reducing new hepatitis C infections by 80% and mortality by 65% by 2030.

In March 2021, during its special session, the UNAIDS Programme Coordinating Board (PCB) adopted the new Global AIDS Strategy (GAS) 2021-2026 – Ending Inequalities. Ending AIDS. The GAS set ambitious targets for the world to reach by 2025, with a focus on ending inequalities that fuel and perpetuate the AIDS pandemic. These new targets build on the 90-90-90 treatment targets of the previous strategy.

Targets set in the GAS are 95% of all people living with HIV (PLHIV) know their status, 95% of those knowing their status receive antiretroviral therapy (ART), and 95% of those on ART reach an undetectable viral load. In addition, further targets were added: 95% of all people at risk of HIV accessing combination prevention, 95% of women accessing sexual and reproductive health services, and 95% coverage of services for eliminating vertical transmission. The 2025 targets also include targets for accessing preventive TB treatment (90% of PLHIV) and linkage to integrated health care services (90% of PLHIV and people at risk of HIV), including viral hepatitis and STI prevention, treatment and care services.

The GAS commits that PLHIV and communities at risk should be at the centre of the HIV response with additional targets by 2025, the 10-10-10 targets. These targets call for less than 10% of PLHIV and key populations to experience stigma and discrimination, less than 10% of women and girls and

[4] Sustainable Development Goal 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.

key populations to experience gender based inequalities and violence, and less than 10% of countries to have punitive and discriminative laws that perpetuate the AIDS pandemic and contribute to human rights violations.

The UN General Assembly Special Session on HIV and AIDS in June 2021 further strengthened the global commitments to ending AIDS by 2030 with the Political Declaration on HIV and AIDS, with clear commitments to ending inequalities and getting the AIDS response back on track. In their commitment recognising that

*"[...] social, economic, racial and gender inequalities, restrictive and discriminatory laws, policies and practices, stigma and multiple and intersecting forms of discrimination, including based on HIV status, and human rights violations [...] perpetuate the global AIDS epidemic".*

## REGIONAL COMMITMENTS

In 2004, all member states of the Region signed the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia, setting the basis of the Regions political commitment. The Declaration was followed by a progress monitoring framework coordinated by the European Centre for Disease Prevention and Control (ECDC) and the European Commission´s (EC) two consecutive communications (2005 and 2009), setting the policy framework on combating HIV and AIDS in the European Union (EU) and its neighbouring countries, with two successive Action Plans (2009-2013 and 2014-2016). Despite strong advocacy from civil society, the EC failed to produce a consecutive communication but a Commission Staff Working Document on HIV and AIDS, viral hepatitis, and tuberculosis, signalling a decreasing interest in combating these three pandemics in the EU and its neighbouring countries. However, in May 2021, in preparation for the UN High Level Meeting on HIV and AIDS, the European Parliament (EP) adopted a resolution on HIV and AIDS, signalling hope for the EU´s global and regional commitment to end inequalities and end AIDS by 2030.

[5] UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners and other incarcerated people as the five main key population groups that are particularly vulnerable to HIV and frequently lack adequate access to services.

# 2.2 EPIDEMIOLOGY

Despite the range of international and regional commitments to end the HIV and AIDS, TB, and viral hepatitis pandemics, all three diseases continue to be of a major public health concern for the Region.

## HIV AND AIDS

### THE EUROPEAN UNION AND EUROPEAN ECONOMIC AREA (EU/EEA)

According to 2019 data from ECDC and WHO/Europe, in the EU/EEA region there were 24,801 new HIV diagnoses, and an estimated 120 000 persons living undiagnosed with HIV in the area. Although these numbers show a declining trend compared to previous years, they are far from the global 75% reduction in new infections target and they substantially vary by national level. Most countries in the west and south of EU/EEA region have reported a decline in new HIV diagnosis. This is mostly due to the decrease in new HIV cases among gay and bisexual men, and other men who have sex with men (MSM), which is a significant change as gay and bisexual men and other MSM have been the key population where new HIV infections kept increasing in the last years. However, in the centre part of the EU/EEA region and in the non-EU countries of the central region of Europe, new HIV diagnosis rate increased by 50% in some countries in the last decade with similar trends observed among gay and bisexual men and other MSM. Migrants continue to be disproportionately affected by HIV and AIDS and constituted 44% of new HIV-diagnosis reported in the EU/EEA region, with a significant proportion of them acquiring HIV after arrival in the EU/EEA region.

### EASTERN EUROPE AND CENTRAL ASIA (EECA)

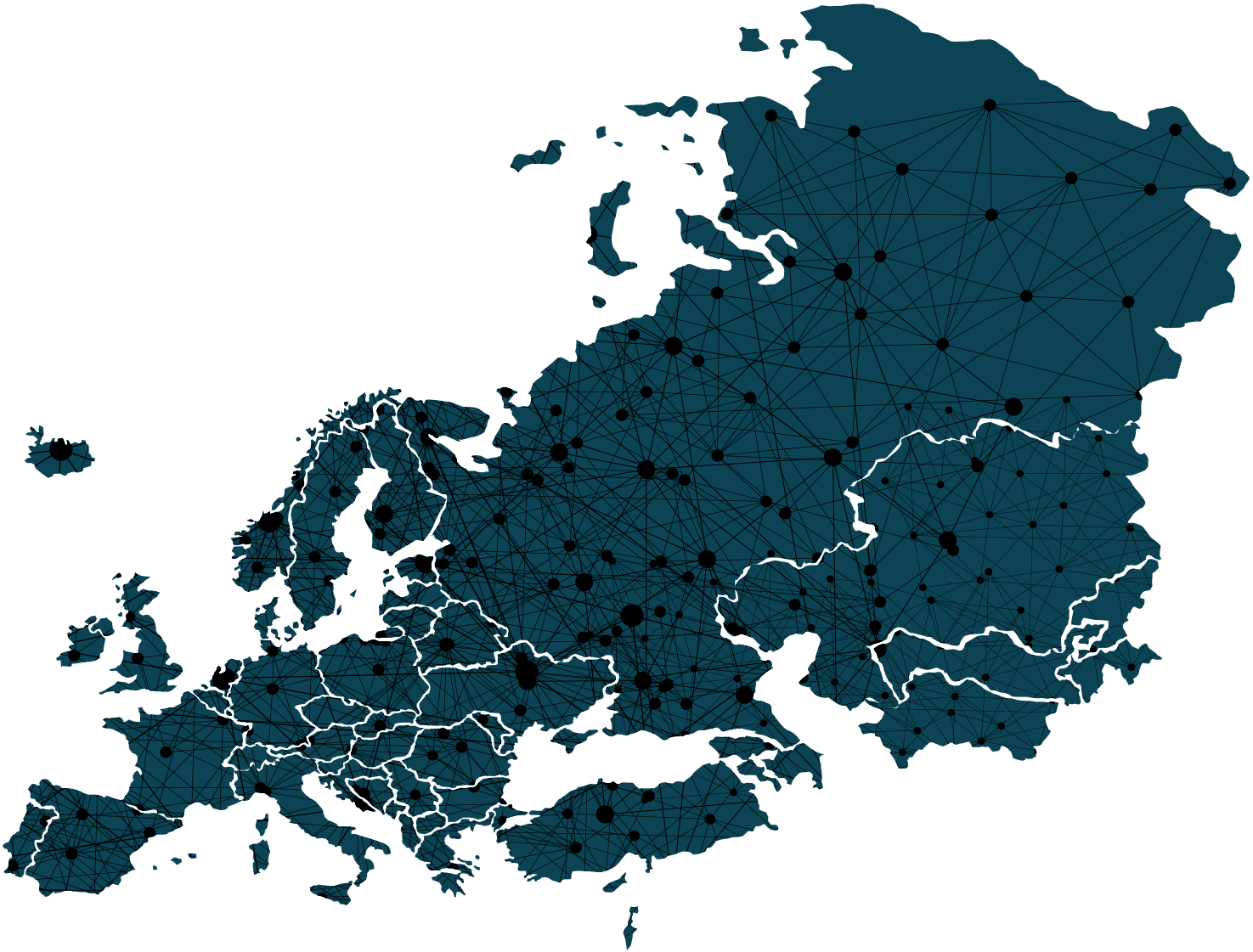
According to data from the GAS 2021-2026, Eastern Europe and Central Asia is one of the three regions of the world where the number of new HIV-infection have been on the rise, with an estimated 72% increase of annual number of new HIV-infections in the last decade being the fastest growing HIV and AIDS epidemic globally. ECDC and WHO/Europe reported 107,842 new HIV-infections in EECA in 2019, with almost 80%, 80,124 cases reported in the Russian Federation alone. Although HIV-infection among people who inject drugs (PWID) have decreased by 36% in the last 10 years, there has been significant increase in the numbers of sexual transmissions, 47% increase in heterosexual and an almost 5 fold increase among gay and bisexual men and other MSM. AIDS-related deaths also increased in the EECA by 27% in the last decade, primarily due to late diagnosis and limited access to antiretroviral therapy (ART), with only 41% of PLHIV being on ART in EECA, according to the data in the GAS.

## TUBERCULOSIS (TB)

Despite the decline in the number of TB-cases, TB remains a substantial burden in the whole Region with multidrug-resistant (MDR) and extensively drug resistant (XDR) TB disproportionately affecting the east of the Region. According to the latest 2019 estimates, about 246,000 new TB cases and 20,000 deaths were reported in the Region, mostly from eastern and central European countries. TB in prisons remains a major health concern. However, a substantial lack of data from the Region is noted. Based on the data available, TB relative risk in prisons is 19.2 compared to the general population, resulting in substantially worse health outcomes for people in prison and other closed settings. Other communities disproportionately affected by TB are homeless people, seasonal migrant workers, gay and bisexual men and other MSM, people who use drugs (PUD), and PLHIV with an estimated 12% of incident of TB cases were co-infected with HIV, with substantially higher percentage in EECA, the Russian Federation, Turkmenistan, and Ukraine reporting a 23% HIV-coinfection in TB cases.

## VIRAL HEPATITIS – HEPATITIS B (HBV) AND HEPATITIS C (HCV)

Despite the available vaccination for HBV and the highly effective treatment for HCV, viral hepatitis infections remain a major public health concern in the Region. The WHO targets to eliminate viral hepatitis as a public health threat by 2030 – a challenging goal given the epidemiologic situation. According to the 2021 report from WHO/Europe, there were an estimated 14 million people living with HBV and 12 million people with HCV in the Region. According to recent estimates, there are 19,000 new HBV cases and 43,000 deaths due to HBV in the region yearly. HCV causes an estimated 64,000 deaths annually with 300 000 new HCV cases reported per annum. Two-thirds of the people diagnosed with HBV and HCV in the Region live in EECA. Within the EU/EEA in 2019, ECDC reported 37,733 cases of HCV, a crude rate of 8.9 per 100,000 population, and 29 966 cases of hepatitis B (7.4 cases per 100,000 population). Co-infection with viral hepatitis has a major impact on the health status of PLHIV. Other communities disproportionately affected by viral hepatitis, in particular HCV, are PWID.



# 2.3 INEQUALITIES IN THE CONTEXT OF HIV AND AIDS, TB, AND VIRAL HEPATITIS

Despite progress and efforts in all three pandemics in the Region, inequalities have prevailed, and in many aspects have increased in the Region, reflected in the epidemiological data and observed in inequalities of health outcomes of individuals and communities living with or affected by HIV and AIDS, TB, and viral hepatitis.

The most striking inequality is between the western and eastern part of the region. With the west in general reaching the treatment targets and observing a decrease in new cases and deaths connected to the three epidemics, the HIV and AIDS, TB, and viral hepatitis pandemics in EECA are characterised as one of the worst globally. The main drivers behind the pandemics are the major gaps in accessing combination prevention and treatment, especially for key populations who are disproportionately affected by these three diseases. Harmful gender norms, gender based violence, including against communities and individuals of sexual orientation and gender identity outside heteronormativity and the gender binary context, discriminatory and punitive laws, policies, structural barriers, and the lack of adequate domestic funding to replace the phasing out of international donor funding further worsen the situation.

Although the western part of the region is on a good track to end AIDS, progress is uneven and there are inequalities between sub-regions, and between key affected communities in each national context. The countries of central and southeast Europe have not managed to reverse their trends and keep experiencing a steady increase in the number of new infections, especially HIV-infections among gay and bisexual men and other MSM. The inequalities in epidemiological trends are due to blocking or delaying low-threshold, combination prevention programmes, including pre-exposure prophylaxis (PrEP), integrated sexually transmitted infections (STIs) services, and substantially underfunding harm reduction services, risking outbreaks among people who use and/or inject drugs, similar to the situations in Romania in 2011 and in Greece in 2012.

In countries in the west where the UNAIDS 2020 treatment and testing targets[6] have been reached or even exceeded, progress has been uneven for migrant communities and people of colour. Due to structural barriers, including stigma, xenophobia, and systemic racism, people with migration background and people of colour, especially those who are members of other key populations are often left behind by the national responses, resulting in increased vulnerabilities to the three pandemics and in worse health outcomes.

[6] By 2020, 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, and 90% of all people receiving antiretroviral therapy will have viral suppression.

The recent outbreak of the COVID-19 pandemic has put additional burdens, especially on those individuals and communities that have been already left behind in the HIV and AIDS, TB, and viral hepatitis pandemics. There is growing concern that the responses have been further pushed off the track with funding redirected to COVID-19, and sexual health services, including testing for HIV, viral hepatitis, and STIs were made more difficult to access or completely halted due to the public health measures imposed due to the COVID-19 pandemic.

According to the latest Global AIDS Update from UNAIDS,

*"COVID-19 lockdowns and other restrictions badly disrupted HIV testing, and in many countries, they led to steep drops in HIV diagnoses, referrals to care services and HIV treatment initiations. Health facilities (including HIV-focused clinics) were repurposed to handle the influx of COVID-19 patients, face-to-face services were suspended, and many people either avoided or were unable to access health care."*

During 2020, AAE conducted a two-phase survey[7] among their member organisations, mostly community based testing centres and other HIV-service providers, to measure the impact of COVID-19 pandemic and the subsequent public health measures and restrictions on their services and the communities they are serving. Despite their resilience and innovation, AAE member organisations report that the extended public health and hygiene measure negatively affect their services. There are substantial losses reported in activities that provide community building and peer-to-peer support. In addition, the organisations have suffered significant distress due to the additional service costs, as well as redistribution of funding to projects to combat the COVID-19 pandemic.

The results of the survey also demonstrate that the COVID-19 pandemic disproportionately affects the most marginalized communities and surfaces the existing inequalities in the society, PLHIV and KPs, especially sex workers and migrant sex workers were disproportionately affected by the COVID-19 public health restrictions, losing their community contact, being further isolated, or losing their livelihood and housing.

[7] https://www.aidsactioneurope.org/en/publication/impact-covid-19-pandemic-report; https://www.aidsactioneurope.org/en/publication/follow-report-continued-impact-sars-cov-2covid-19-pandemic-member-organisations-within

# 2.4 HUMAN RIGHTS IN THE CONTEXT OF HIV AND AIDS, VIRAL HEPATITIS, AND TB

One of the major drivers for these inequalities is the different levels of progress on human rights especially for PLHIV, key affected populations and other communities who have increased vulnerabilities due to social and structural barriers. Our fundamental human right, the right to health[8], defined as *"the enjoyment of the highest attainable standard of physical and mental health"* cannot be realised and enjoyed on its own, but as an organic part of all other economic, social, and cultural rights, and civil and political rights.

According to the Committee on Economic, Social and Cultural Rights[9], the body responsible for monitoring the International Covenant on Economic, Social and Cultural Rights, the right to health is an inclusive right in itself; it includes several factors that are necessary for a healthy life. Besides the self-evident access to healthcare services, adequate food, drinking water, and housing, these factors also include access to health-related education and information, or gender equality.

Besides the economic, social and cultural rights, the right to health contains civil and political freedoms, such as freedom of speech, freedom of assembly and association, and the right to be free from cruel, inhuman and degrading treatment.

The full enjoyment of the right to health also implies that accessing basic health services, including sexual and reproductive health services, prevention and treatment of communicable diseases, and health and sexual education should be accessible for all based on the principles of non-discrimination and equal opportunity.

The right to health also implies participating in decision making related to one's own health, and in health related policy setting and decision-making at the community and national level.

Although all countries of the Region have adopted and ratified both the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights, there are major inequalities in the legal environments that directly or indirectly influence the enjoyment of human rights, including the right to health in the Region.

In almost every country of the Region, some key affected populations, such as PUD, members of the LGBTIQ+ community, or sex workers and their clients can face criminal and administrative charges.

[8] International Covenant on Economic, Social and Cultural Rights General Assembly resolution 2200A (XXI) of 16 December 1966 https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx

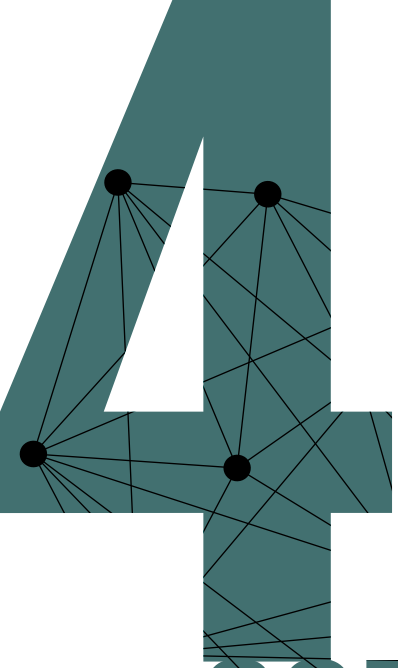
[9] https://www.ohchr.org/en/hrbodies/cescr/pages/cescrindex.aspx

Their networks and organisations, especially in the central and eastern part of the Region, due to their advocacy work toward decriminalisation and human rights development are under attack from governments. In the Eastern part of the Region, human rights development work has been labelled as a foreign invention and interference into national sovereignty and values, and there are legislative and administrative barriers in place against accessing funds from international donors, their only source of funding. As a result, although freedom of association and registering an organisation are granted by national legislation, other administrative and legislative tools hinder the existence and operation of these organisations and networks, working for and with PLHIV and other key affected populations.

Freedom of speech is also limited as due to the criminalisation of behaviour and practices of key populations, targeted information for these communities is either not available or limited by the accessibility of funding sources. There are several countries implementing similar policies and legislations to the Russian “gay propaganda law”, under the disguise of protecting children. In reality, these laws, the most recent one from Hungary, prohibit LGBTIQ+-specific information and limit or ban comprehensive health and sexuality education for young people and limit service provision for the LGBTIQ+ community, resulting in lack of access to health related information and services.

All these human rights violations directly or indirectly affect the right to health and further increase inequalities within the region, within societies and between communities.

Decision makers and service providers often disrespect the principles of non-discrimination and equal access, regardless of polices and/or legislation in place. Seeking remedies is often further limited due to fear of stigmatization, discrimination, inhuman treatment, and fear of breaching one´s privacy.



# CORE THEMATIC AREAS 2022-2026

During 2020, AAE conducted an intensive, multi-phase consultation process with our member organisations to evaluate our work and the relevance of our current core thematic areas and identify possible new themes for the future (July – August 2020). Our members expressed their support and interest in working on the already existing six core thematic areas building on the previously conducted work under the Strategic Framework 2018 – 2021, with the addition of harm reduction as a seventh issue to work on in our strategic plan from 2022. In the next phase of the consultation, our member organisations conducted working group discussions to develop further the activities, working methods, and specificities of each core thematic area. Considering the results of the consultation, the needs and priorities of our member organisations, and the regional priority actions for Eastern Europe and Central Asia and Western and Central Europe, set in the Global AIDS Strategy, the AAE SC decided to work on the following seven core thematic areas in the AAE Strategic Plan 2022-2026.

## AFFORDABILITY AND ACCESSIBILITY TO MEDICATION

Access, despite the availability of quality treatment, care and prevention services (e.g. PrEP), is often limited by the prices, i.e. the affordability of medications, diagnostics, and other health interventions. Access to affordable and quality medicines are essential for the right to health of each individual affected by HIV and AIDS, TB, and viral hepatitis. At the community and public health level, accessing affordable and quality medicines is essential for reducing transmission rates and ending all three pandemics as public health threats by 2030.

Building on the activities of the 2018-2021 strategic period, AAE will continue to support strengthening the capacities of our member organisation in the 2022-2026 strategic period, in order to improve access via making quality treatment, diagnostics, and prevention methods affordable.

## COMMUNITY BASED VOLUNTARY COUNSELLING AND TESTING (CBVCT)

The early detection of HIV and AIDS, TB, viral hepatitis, and STI cases with linkage to care and treatment services is a cornerstone in the response to the epidemics to reduce infection rates and improve the health outcomes of individuals and communities. CBVCT has proven effective to detect new HIV cases, especially in communities where access to health care services is limited. Based on the WHO's guidelines on HIV Testing Services (HTS) and with the introduction of rapid and self-sampling testing options for HIV, viral hepatitis, and STIs, CBVCT services are an essential and indispensable element of the responses to the three pandemics.

In the 2022-2026 strategic plan, AAE will continue working on CBVCT, facilitating good practice knowledge exchange, capacity building and dissemination of results and news. As part of our activities on CBVCT, AAE will continue its work with the COBATEST and EURO HIV/EDAT networks and their coordinating organisation CEEISCAT in Barcelona.

## CRIMINALISATION OF HIV NON-DISCLOSURE, EXPOSURE AND TRANSMISSION

Despite the progress of scientific evidence and recent positive developments in the practice surrounding investigations and prosecutions in some European countries, criminalisation of HIV transmission, exposure, and non-disclosure, HIV-criminalisation remains a key issue both for PLHIV and for preventative measures across the Region. According to the latest data from the Global HIV-Criminalisation Database[10], 16 countries in the Region have HIV-specific criminalisation laws, and

[10] https://www.hivjustice.net/global-hiv-criminalisation-database/

24 countries have prosecuted PLHIV for alleged exposure. A further 28 countries have prosecuted PLHIV for alleged transmission of HIV. Besides harming the human rights of PLHIV and key affected populations, HIV-criminalisation also harms HIV prevention efforts. It increases HIV-stigma and deters people, particularly those in key populations, from testing and learning their status.

AAE has been increasingly involved in activities around advocacy against HIV-criminalisation, with a production of a comprehensive legal report of 10 EU/EEA countries within the framework of our European HIV Legal Forum (EHLF) project and via our participation in the Steering Committee of the HIV Justice Worldwide (HJWW) movement.

## HARM REDUCTION

AAE members also identified harm reduction services that are sensitive and responsive to the needs of women and other key populations who are left behind by traditional harm reduction services as a priority in the Region and as a core thematic area that AAE should work on in the 2022-2026 strategic period. Further to this, harm reduction services, especially in central and southeast Europe and in the EECA countries are systematically underfunded and thus disrupted. Moreover, there is not an adequate legal context for those services, resulting in continued and regular harassment of frontline workers by the police and municipal authorities. In collaboration with other regional networks working on harm reduction, AAE will focus on supporting and providing capacity-strengthening activities to our member organisations, and identifying the gaps in harm reduction services for women, migrant communities, and the LGBTIQ+ community, specifically in the phenomenon of ChemSex.

## SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR)

SRHR are challenged in a growing number of countries in the Region, as it is being reduced to reproductive health only, not taking into consideration the sexual health and sexual and reproductive rights. If we are to reduce gender-based inequalities and inequalities affecting member of KP communities, there is an urgent need for increased access to sexual health information and access to comprehensive prevention methods and services, including treatment as prevention (TasP) and PrEP. In coordination with other regional networks, AAE will continue working on SRHR, with special focus, besides supporting and advocating for SRHR, on combination prevention and access to sexual health information, including U=U for PLHIV and key populations.

## TACKLING LEGAL BARRIERS IN THE RESPONSE TO HIV, TB AND HEPATITIS

Legal barriers, especially the practical application of some legislation, continues to hinder the degree to which a given country is able to implement solutions related to HIV, TB and hepatitis prevention, testing and healthcare services. This is particularly true for key populations, including sex workers, drug users, gay and bisexual men and other MSM, trans* and other people on the gender identity spectrum, who face discrimination and/or criminalisation within existing legislation. Besides the clear negative effect on an individual's health, these restrictive legal barriers threaten public health and increase health inequalities across Europe.

AAE will continue working on addressing legal barriers within the framework of its EHLF project in the 2022-2026 strategic period. EHLF has so far produced two comprehensive reports on legal barriers to accessing HIV, TB, and viral hepatitis services for migrants with irregular status (undocumented migrants) and people in prison and other closed settings, in order to identify good European practice and innovative solutions consistent with international human rights. This forum also acted as a catalyst for change where the legal framework or the practice remains poor.

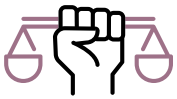
## TACKLING STIGMA AND DISCRIMINATION

HIV-related stigma, that is negative attitude, abuse, and prejudice towards PLHIV and members of KPs, has been a major obstacle to people accessing services, can result in worse quality of life and health outcomes, and have been a ground for discrimination in many fields of life, including healthcare, education, housing, and work etc. As such, reducing and eliminating stigma and discrimination is key in reaching our prevention, testing, and treatment goals. Therefore, the AAE SC decided that tackling stigma and discrimination should remain a core area of focus for AAE.

AAE has started working on stigma and discrimination within the framework of our EHLF project, looking at discrimination against PLHIV in health care settings, and discrimination against PLHIV working in health care settings, producing comprehensive legal reports, collecting and sharing good practice and promoting legal and policy reform to reduce and eliminate stigma and discrimination. AAE will continue working on the issue of stigma and discrimination affecting PLHIV in different fields of life.

# 5 STRATEGIC GOALS

Our 2022-2026 Strategic Plan was developed after thorough analysis of the epidemiological situation, the context analysis of our region, regarding inequalities and human rights, and taking into consideration of our members' priorities and needs, building on previous strategic plans to achieve our mission. In the 2022-2026 strategic period, we are going to work towards the following strategic goals:



## HUMAN RIGHTS AND RIGHTS-BASED APPROACH

Advocate for the full respect, protection, and fulfilment of human rights for all, and that rights-based approach is at the centre of national and regional public health policy development in order to reduce and end inequalities.

## REDUCTION AND ELIMINATION OF STIGMA AND DISCRIMINATION

Reduce and eliminate all forms of stigma and discrimination relating to people living with or affected by HIV and AIDS, TB, and viral hepatitis.

## UNIVERSAL ACCESS

Ensure access to combination prevention, including comprehensive information and sexual education, harm reduction, and voluntary counselling and testing for HIV, TB, and viral hepatitis services for all. Ensure available, accessible, affordable, and quality HIV, TB, and viral hepatitis treatment for all.

## COMMUNITIES AND CIVIL SOCIETY ENGAGEMENT AND PARTICIPATION

Ensure that the voices of communities and civil society are represented, heard, and included at national and regional level policy development and decision-making.

# 6 STRATEGIC OBJECTIVES AND WORKING METHODS

FOCUSING ON OUR CORE THEMATIC AREAS, AND IN ORDER TO ACHIEVE AAE'S GENERAL GOAL AND STRATEGIC GOALS, THE FOLLOWING OBJECTIVES WERE SET.

## Objective I: AAE will contribute effectively to the HIV, TB and hepatitis response in Europe and beyond

**1. Continue organising and coordinating with our partner organisations the EU HIV/AIDS, viral hepatitis and TB Civil Society Forum (CSF)**

This includes managing the CSF coordination team, organising CSF meetings, managing the online CSF group, and communicating and facilitating communication with NGOs, stakeholders and partners.

**2. Monitor European HIV, TB, viral hepatitis, and STI policy developments at national and international levels, contribute to the work of regional and global agencies, and coordinate civil society responses and inputs on policy development and implementation.**

**3. Coordinate EHLF**

This includes enabling the monitoring and reviewing of HIV and co-infections related and relevant legislation, linking and learning between HIV legal specialists and NGOs, and producing locally relevant resources.

**4. Advocate for civil society concerns regarding European policy initiatives**

This includes participating in key European events and advocating for European issues at the global level, via participation in consultations, forums, and boards such as the UNAIDS PCB NGO delegation.

## Objective II: AAE will provide platforms to communicate and facilitate collaboration, networking, and linking & learning between NGOs, networks, policy makers and other stakeholders

**1. Deliver improved bilingual (EN/RU) communication across AAE communication platforms and channels, including the Clearinghouse and AAE website**

This includes improved linkage of member profiles, projects and initiatives, newsletter and tailor-made mailings, printed materials and face-to face meetings.

**2. Intensify bilingual social media communication**

This includes increased activity on Facebook, Twitter and Russian speaking communication channels (VKontakte), and by building links and seeding content.

**3. Provide and disseminate health innovation and knowledge in the field of HIV, TB and viral hepatitis through the AAE Clearinghouse, website, newsletters and social media.**

## Objective III: AAE will provide activities and supports the activities of its member organisations to strengthen their capacities

**Support and facilitate national and regional advocacy efforts via capacity strengthening activities of our member organisations in our core thematic areas and beyond**

This includes providing and supporting trainings, webinars, working meetings, and e-learning activities of our member organisations.

## Objective IV: AAE will strengthen the network through improved governance and internal management

**1. Coordinate topic-related sub-network cooperation, provide working meetings, exchange, and decision making opportunities.**

**2. Guarantee transparent and accountable AAE Governance by regular meetings, teleconferences and written communication.**

**3. Implement, monitor, evaluate, follow up and fundraise for the work programme.**

# STRATEGIC PARTNERSHIP

AAE has developed long-standing relationships with its civil society partners and with different international agencies. AAE SC members and Executive Office staff members participate on advisory groups and panels of European institutions such as ECDC and WHO Europe, and have regular contact with the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the UNAIDS regional office representatives.

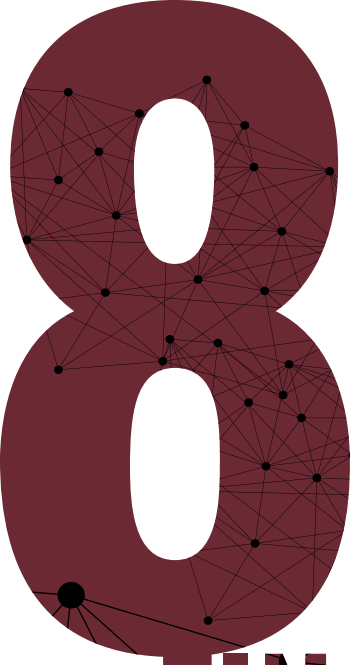
AAE is a member of the WHO Europe Regional Consultation Committee on TB, HIV, and viral hepatitis, a multi-stakeholder advisory and consultation body, focusing on issues related to the three disease areas in Eastern Europe and Central Asia and inadequately served populations (ISP) affected by these epidemics.

AAE served as a Europe Delegate on the NGO Delegation to the UNAIDS PCB from 2016 to 2018 and is still in regular contact with and participates in civil society advisory groups and calls initiated by the NGO Delegation.

AAE also participates in relevant European initiatives, being a member of the Steering Committee of HJWW and the PrEP in Europe Initiative, and has participated in several EU funded Joint Actions and projects.

Having co-chaired the CSF since its establishment in 2005, we have built strong working relations with the other former co-chair from the European AIDS Treatment Group (EATG). Since the relaunch of the CSF in its renewed format, we have continued our strong working relation with EATG and have built further strong working relations with the current Coordination Team members - Correlation Network, Eurasian Harm Reduction Association (EHRN), and TB Europe Coalition (TBEC). These relationships further enable us to maintain good working relations with numerous regional projects and networks more broadly.

AAE has had a Memorandum of Understanding with WHO Europe since 2006. Together, we work on a variety of issues that include testing and counselling guidelines. In the CSF, we coordinate with the ECDC to monitor the Dublin Declaration and other key issues.



# FINANCIAL COVERAGE OF THE STRATEGIC PLAN

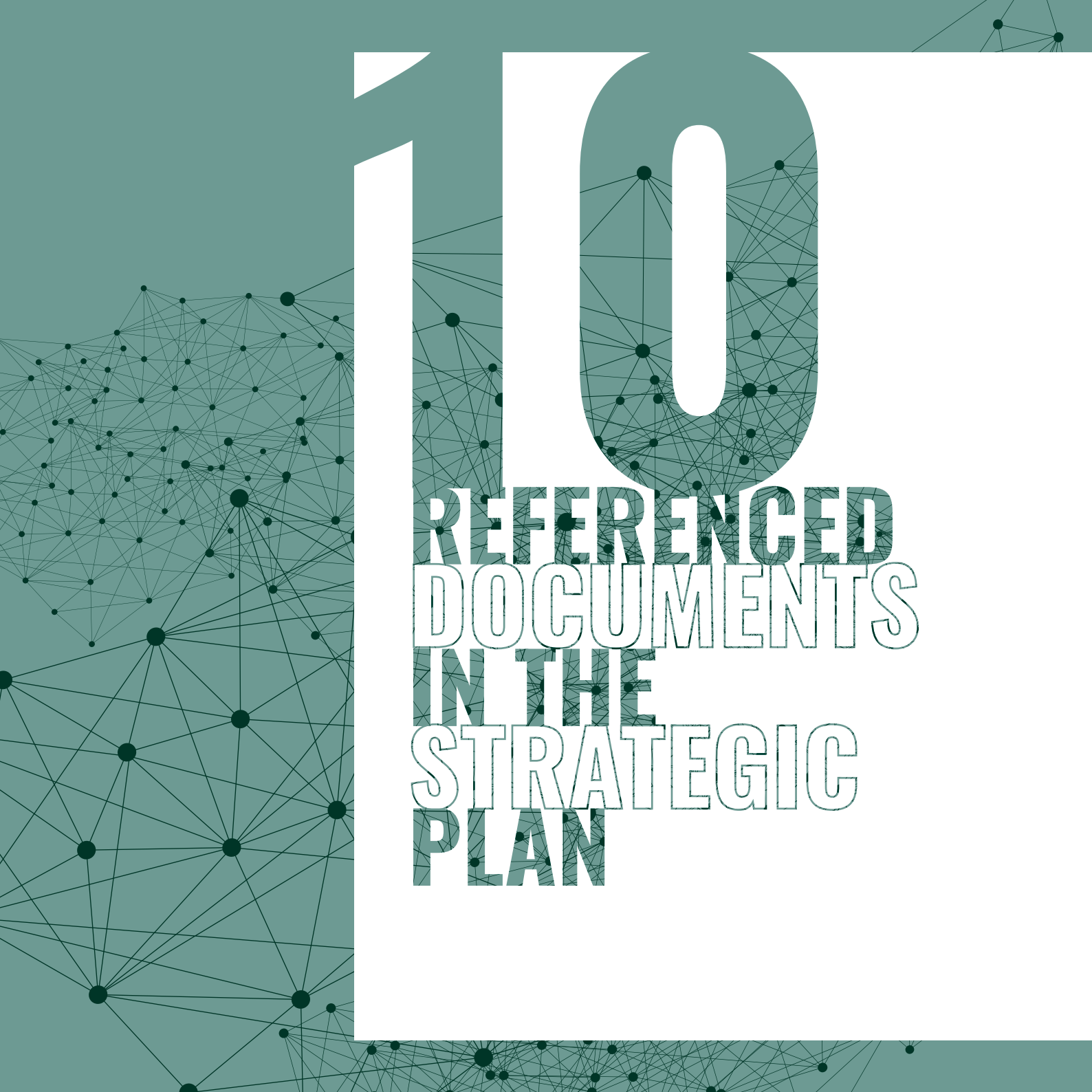
AIDS Action Europe has received financial contributions and grants from the following:

- **The European Commission Third EU Health Programme (2014-2020) through the Consumer, Health and Food Executive Agency (CHAFEA)**
- **Deutsche Aidshilfe**
- **Gilead Sciences Europe Ltd.**
- **MSD (Merck and Co., Inc.)**
- **ViiV Healthcare Positive Action Programme**
- **International AIDS Society**
- **and others**

Diversifying and growing our funding sources is a core aim. AAE aims to secure resources for two key areas: first, for core programme functions related to advocacy, policy advice, communication and information dissemination, and network management, and second, for funding specific projects related to capacity development, shadow reporting, and linking and learning.

# 9 LIST OF ABREVIATIONS

| | |
|---|---|
| AAE | AIDS Action Europe |
| AIDS | Acquired immune deficiency syndrome |
| ART | Antiretroviral therapy |
| CBVCT | Community-based voluntary counselling and testing |
| CSF | EU HIV/AIDS, Viral Hepatitis, and Tuberculosis Civil Society Forum |
| EC | European Commission |
| ECDC | European Centre for Disease Prevention and Control |
| EEA | European Economic Area |
| EECA | Eastern Europe and Central Asia |
| EHLF | European HIV Legal Forum |
| EP | European Parliament |
| EU | European Union |
| HBV | Viral hepatitis B |
| HCV | Viral hepatitis C |
| HIV | Human immunodeficiency virus |
| HJWW | HIV Justice Worldwide |
| KP | Key populations |
| MSM | Men who have sex with men |
| NGO | Non-governmental organisation |
| PLHIV | People living with HIV |
| PrEP | Pre-exposure prophylaxis |
| PUD | People who use drugs |
| PWID | People who inject drugs |
| SC | Steering committee |
| SRHR | Sexual and reproductive health and rights |
| TasP | Treatment as prevention |
| TB | Tuberculosis |
| UNAIDS | The Joint United Nations Programme on HIV/AIDS |
| UNAIDS PCB | UNAIDS Programme Coordinating Board |
| UNGASS | United Nations General Assembly Special Session on AIDS |
| U=U | Undetectable equals untransmittable |
| WHO | World Health Organisation |
| WHO/ Europe | The WHO Regional Office for Europe |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diversity
support
HUMAN RIGHTS
people
work
life
child education
opinion
group
respect
discrimination
indivuaduals
peace
civil
universal
normal
educ ation
independent
solidarity
support
diversity
principles
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ethnic
globalization
Access
pride
expression
solidarity
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Freedom
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