Report on the AIDS Action Europe Member Meeting on
November 12, 2017, in Berlin
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1 Background

1.1 Aim of the Meeting

Last year, in 2016, AIDS Action Europe (AAE) organised its first AAE Member and Partner Meeting in Berlin. The first AAE Member and Partner Meeting was initiated by AAE’s Steering Committee to identify needs and demands of AAE’s member and partner organisations. It was a step forward to involve the member and partner organisations into the discussion on how to support civil society movement at national and European level and on how to build up capacities for advocacy in the WHO European region. The meeting became a platform with really great exchange between eastern and western NGOs. With this year’s meeting AAE wants to pursue this platform and link its outcomes to AAE’s further strategy.

1.2 Selection process of the representatives

The Member and Partner Meeting is open to all representatives of AAE’s members and partners. Furthermore, AAE called for abstracts to tend 10 scholarships to its member and partner organisations. Altogether 6 out of 10 scholarships were tended to participate in the meeting. The abstracts describe projects or actions in the field of HIV/AIDS and migration, labour migration and the refugee situation that identify as good practice with the following structure:

- Background
- Objective of the project or action
- Implemented activities to reach the objective
- Results and outputs achieved so far

Eligibility criteria for the participation in the selection process were:

- Being a member or partner organisation of AIDS Action Europe
- Being a member of the board or staff

All six applicants were invited to present their projects or actions in a presentation. The candidates were selected by a committee, composed of an AAE Steering Committee Member, an AAE office staff member and an independent expert. The only selection criteria was the quality of the abstract with 100 %. The selection was based on the above criteria and the capacity of ten scholarships. Scholarships were about to be given to 5 participants from European Union countries and to 5 participants from non-EU countries. After all, four
scholarships were given to applicants of non-EU countries and two to European Union/EEA countries.

The scholarships allowed representatives to participate in AAE’s Member and Partner Meeting in 2017, on November 12, in Berlin. Furthermore, the representatives had an opportunity to meet the AAE Steering Committee, its office staff and other AAE members to discuss, exchange ideas and to network.

All in all, 38 participants representing AAE Member and Partner Organisations attended the meeting, including 8 AAE SC Members, 6 AAE Office staff, 6 scholarship recipients. Translation was insured by LinguaTransFair, Berlin, the technics by green congress, Berlin, and the facilitation was taken over by Matthias Wentzlaff-Eggebert.

2 Opening and Welcome

2.1 Opening the meeting by AAE’s Steering Committee Chair, Anke van Dam
Anke van Dam opened the meeting introducing that there is an interest from the Dutch government to include the eastern region more into the IAS Conference 2018 (AIDS2018).

AAE is a network of the whole of Europe and during the last year’s Member and Partner Meeting it was a really great platform for exchange between eastern and western NGOs. The second meeting has also the aim to improve the exchange and networking between all, AAE’s Members and Partners. This year’s meeting has its focus on the conference AIDS2018 and migration. While discussing the way to AIDS2018 before lunch, the afternoon will focus on migrants – a very urgent topic – related to migrants from Syria, Africa as much as displaced persons in war zones and labour migrants in EECA countries.

2.2 Follow-up on the last Member and Partner Meeting by Michael Krone
Retrospective to the last Member and Partner Meeting we have discussed strategic directions and it was proven to be very successful.

Last year speakers of 10 member organisations introduced who they are and what they need regarding the strategic directions of AAE. The working group (WG) session was focused on discussions on how the needs in countries, in particular in EE and CA countries and capacity building should be involved in AAE’s work and how AAE can support these regions.

What happened with all of the results and discussions?
They are now part of AAE’s strategic framework. AAE has applied for another European Commission four-year program support, with the support of the Steering committee. Two weeks ago it was approved to have a partnership agreement with the European Commission. With the help of the current AAE Steering Committee, which come from Finland, Serbia, France, Ukraine, Greece, Latvia, Germany, the Netherlands and the UK/Scotland, AAE has expanded its mission to TB and Hepatitis – not only as co-infections but also as mono infections.

The changes in the mission statement are minor. However, they were necessary in order to reflect actual situation of AAE. AAE is tackling inequalities in health and are focusing on key populations. This is different from the former wording of the mission statement. Discussions from the working groups last year are now converted into three major objectives:

- AAE contributes effectively to HIV, Hepatitis, TB response in Europe
- AAE provides platforms to communicate and facilitate collaboration, networking and linking and learning – this includes communication and information
- Continuous improvement of networking, including the Steering Committee work, office work, and other sub-networks

The last year’s summary of the meeting helped make this list possible. Main topics have become, after the last year’s Member and Partner Meeting:

- Affordability and accessibility to medication: Conducting with training of trainers and webinars, which become core work in next four years
- Tackling legal barriers in response to HIV, TB and Hepatitis – benchmarking on undocumented migrants: AAE will continue its work and work further on HIV and discrimination
- EHLF meeting was carried out in the last two days: AAE plans to work on people in prison and detention
- Criminalization of non-disclosure: Working closely with the HIV Justice Network by building up on already implemented work in 2017
- Sexual and reproductive health and rights: Including PrEP, CHEMSEX and work on gay apps and prevention as well as focusing on key populations sexual partners
- Tackling stigma and discrimination: Cross-sectional

3 AAE in the Amsterdam 2018 World AIDS Conference

What are the ways AAE and AAE members can be involved in organisation and programming the conference?
The following presentation of Anke Van Dam introduces the state of play of the preparation of AIDS2018: How to become part of organisation, areas of involvement and activities. This will be discussed further in the working group session in connection to this part.

3.1 State of play of the Preparation of the Conference AIDS2018

The Conference will take place in Amsterdam, Netherlands, from July 23 to 27, 2018. Priority activities are around engaging Eastern Europe and Central Asia in the region. AIDS Foundation East-West (AFEW) is working in 11 countries, which will be part of the preparation work of the conference.

Why was AFEW asked by the Dutch ministry of foreign affairs to ensure more countries from the region at the international AIDS conference?

HIV is on the rise in the region and not many people know about that. To raise awareness of three epidemics from the region (HIV, TB, Hepatitis) not only challenges and concerns should be presented, but also successes because there are many. It is meant also to allow doctors, activists, researchers to access the latest developments regarding prevention, treatment and care of the three issues.

The statistics show that not many people from the region attend the international AIDS conferences due to the high costs but also language is a barrier. The whole idea of this engagement is to open the region and facilitate linking and learning and networking with the West.

Who is working on it?

AEFW works together with GNP+ and EHRN, which is now EHRA, in the core group and with other regional networks like ECUO, ECOM.

How to increase in the attendance of politicians and policy makers?

It is aimed to engage on a political level and increase the attendance of community-based organisations. Policy makers can be engaged through study tours – this will become a high level meeting in front of the conference.

Community based organisations are involved by scholarship funds

Scholarships are given by AIDS2018. AFEW tries to increase the number of scholarships to ensure that more people from the communities join the Amsterdam AIDS Conference. Furthermore, Russian translation will be implemented by AFEW. It’s called a language body program, to ensure that there are many people at the conference who speak Russian and they are eager to speak with Russian-speaking colleagues. A pool was set up.
How are communities and NGOs engaged?

Training on participatory research has started last year and then offered 25 grants for 25 proposals and this week a session on abstract writing will be conducted. Its aim is to look how to translate into advocacy language and to support abstract writing. A cultural initiative with small grants was launched; artists are invited to address stigma and discrimination. An announcement on Facebook invites artists to be in residence in Dutch-based organisations and to mingle with the Dutch colleagues, to promote and bring the attention to EE and CA.

Many trainings and support is planned and was conducted

Training on how to write abstracts starts this week. As soon as people are invited to do a presentation, AFEW will offer training on how to present, on the weekend before the conference AFEW offers E-leaning courses. An abstract writing module is already available via AIDS2018 website; AFEW has translated it into Russian, what is available now. Spread the word, it can help people. It’s crucial to have a good abstract because that will increase one’s chances of getting accepted. AFEW is engaging people or guiding people, to make the most out of this event.

What is AFEW going to do with policy makers and politicians?

There are SHR and AIDS ambassador, Lambert Grijns, who visited Central Asia and Belarus. His goal is to invite ministers to conference. AFEW will invite Dutch politicians to visit Ukraine in May next year and get them more informed about the region and related concerns. Politicians from EE and CA will come to the Netherlands in February to facilitate exchange on a policy and politician level. The focus of the high level political meeting together with WHO, UNAIDS, Global Fund and ECUO is access to treatment and sustainable financial mechanisms. Other people are invited too, through mapping of relevant stakeholders. Furthermore, famous people, VIPs and celebrities are looked up to bring them to AIDS2018. The close collaboration with EECA networks is aimed to make a zone at the global village. Clinicians, researchers and language support were contacted.

How to communicate?

Six focal points are promoting AIDS2018; AFEW’S newsletter, which is sent out twice a month; social media activities, having a spotlight on the region in the media and Facebook and Twitter accounts.

Key dates

From December 1, submission starts for abstracts, registration and satellites, for the conference and for global village and the youth program. The registration will be closed on February 5. In April is another opportunity to submit abstracts for the late breakers. And
then volunteers will be selected. The satellite and exhibition submission deadline closes in April.

Questions and discussion

Question1 (Q1): You talked about the high level meeting and access to drugs and treatment, especially around U=U. More discussion about diagnostics would be helpful to understand the impact of U=U and access to diagnostics to know if one is undetectable.

Anke Van Dam (AVD): When we talk about access to treatment, we take it broadly. That is of course about diagnostics, affordability and access to medication, it’s also about helping to support for treatment.

Q2: We will have a pre-conference beyond blame and struggling to figure out languages for translation. I’m surprised that the conference itself isn’t facilitating Russian translation if that is part of the reason to have the meeting. That it’s left to the civil society to do with whisper translation and I think it’s problematic. How can we lobby back to the International AIDS Society (IAS) to ensure that it will be more accessible?

AVD: Good point and thank you for raising it. We had many discussions with IAS. They say they have no funds for that. I totally agree that it is ridiculous that we as civil society have to arrange it. With regards to the whisper translation, the body language buddies will just be there to support and guide. We can’t ensure that the translation is correct. We would rather have professional translators to ensure that things are correctly translated. Our idea is to get interpreters from the region, to bring them over; at least 10 sessions per day will be translated into Russian. But that’s it. I agree, and we would welcome you lobbying IAS to get enhanced translation, but as always we also have Spanish, French, etc. I think that is a reason why they stick with English. The opening and closing will be translated into Russian but that’s it for now.

3.2 European Networking Zone at IAS Conference 2018

Sini Pasanen introduces the Conference Coordinating Committee and what AAE has planned for the conference.

The Conference Coordinating Committee (CCC) is responsible for organising the conference. AAE and EATG applied to have a regional leadership seat in the CCC as they are representing Civil Society Forum on HIV/AIDS (CSF), which is now including viral Hepatitis and TB.

Moreover, there are also smaller committees and working groups, for examples the community leadership program committee. All committees and working groups are working separately from each other and the CCC makes the final decisions.
AIDS2018 structure

The structure of the conference will consist of an opening and closing and the plenary. Concerning the abstract sessions, a huge part of the program is built on abstracts from public submissions, so it is important to have good submissions.

The invited speaker sessions are plenary sessions, special sessions, bridging sessions, symposia, these programs are almost finalised. The speakers will be invited. If there are good speakers who you would like to see in the conference, please let me know who and what topics.

State of play of the CCC

At the meeting in October 16 and 17 with the civil society organisations and community representatives it was discussed about the aim of the participation and what should be presented at AIDS2018 from the side of the civil society.

- It was agreed that, at the plenaries, the CSF wants that there are people living with HIV (PLHIV) in every plenary on every day. It was successfully accepted, but it has not been finalised by the moment.
- The EECA region is important in this conference. It was agreed on three speakers per day from EECA region. There are no high-level speakers from the Eastern European region what may be problematic.
- 120 abstracts were submitted in May 2017 for the plenary working group. It was decided on the thematic: vulnerable populations, care cascade and vulnerability and youth, each on one day. Having a young person speaking in every plenary was also on the list.

The plenary will be published on December 1, 2017. Co-chairs are contacting the speakers, so there is no information if they are available or if they are having a presentation on a plenary. And the implementation of EECA region is covered by AFEW.

What to get out of the conference, what should the feeling be after it?

High level speakers from Eastern Europe should be invited. Stigma and aging will be well covered in the conference and many abstracts on PrEP are expected.

The Global Village and the European Networking Zone (ENZ)

The location for ENZ will be good and it will be easy to access, between the registration and poster exhibition area, at the new metro station. People will pass at the Global Village every day.

Questions and discussion
Q1: Where do you see opportunities for member organisations of AAE to influence the content of the conference and in particular the goal to include the Eastern European and Central Asian region more?

AVD: One part of the program is abstract driven. I would urge people to think about good abstracts. Think about what kind of topics should be highlighted at AIDS2018 and submit an abstract on that. I suggest being very present at the Global Village because many people think that in Europe all is ok because there is money. I think we should also raise our voices about the European Commission. Let’s think of some actions, activities to make noise. And really put the European Commission on the spot for not having a communication (policy framework) set out. We have to make funding available so I would like to invite you to think along that way as well.

Sini Pasanen (SP): You had good examples about how to engage governments in your own countries. But there may be other people not even knowing that the conference is taking place next summer. Consider to invite PLHIV from the community and pay for the conference fees. We are contacting ministries, like foreign ministries and the ministry of health to cover costs of communities.

AVD: We are thinking of having the high-level political meeting in two phases. We would like to invite all ministries of health and ministries of finance by WHO at the European level, and the other phase – we call it a regional dialogue – that is where we want to focus on the political involvement of the Eastern Europe and Central Asia region and have civil society there to facilitate dialogue between their local authorities and civil society. I would like to add to what was said. I hope it will be clear at the end of the year to ensure that your ministries of health attend the meeting.

SP: The conference will most likely be a high-level meeting. So the conference will be interesting for high-level participants or government representatives on the first day.

Q2: In terms of checks and balances: It is important that we communicate not just on the government level, but also that the organisation committee is reaching out to the local media, especially because, if the local media is translating the conference on the ground, it will help the government to take responsibility.

AVD: The committee is actually reaching out to the media and has direct contact to media outlets. It will have big impact especially because there are re-elections in the region.

Q3: In terms of the ENZ: As AIDS2018 takes place in Europe, will the ENZ get more space in the Global Village? Is there a plan about making most of the space, visually? There are cost implications, but we can really tell the story of the Eastern Europe and Central Asia region through images on the wall. We want to know what we can contribute.
AVD: That is something we will discuss after the break.

Comment: There are no cost implications actually. As I know for the last IAS Conference, I was part of the committee for the networking zone in Durban, the size doesn’t depend on the funding. You tell them how much space you want and they tell you what place there is. We should concentrate more on the program then on fundraising for the zone.

Q5: Reflecting on the fact that we spoke much about the Eastern Europe and Central Asia region and that the region is made up of two parts: Western and Eastern. I was reflecting on what Sini Pasanen said about the tone of the conference, what we would like to feel at the end of the conference. One thing I imagine and hope is that there is no feeling of being two parts. I would like for the conference to make an effort to put abstracts together, covering the two parts so that we are one step closer to being a region and not two regions. Effort needs to be on this.

Q6: In this context let’s not forget about so-called low prevalence countries. These are in Central Europe. Recently, we had a conference organised by the DAH on the topic. Low prevalence countries are in reality “we don’t know prevalence countries”. Low prevalence means we don't care but there is low testing so we don’t know what the prevalence is. These are my peers. Gay men and low prevalence means they are dying; they don’t get testing or treatment. Among the groups who are affected, it is high prevalence, but we don’t know the prevalence because we don’t get tested; we always have the same 200 people who get tested. This deserves separate dedicated attention. It will otherwise be: we have problems in the East and big problems in Russia and everything else falls through the cracks.

3.3 Breakout session in working groups on what AAE should achieve at AIDS 2018

The working group part will be divided into three groups:

1. Abstracts, satellite sessions and workshops lead by Anke Van Dam
   - A part of AIDS2018 is abstract driven. This WG will discuss topics for abstracts that reflect a theme that is covered at the conference. Workshops are often organised with other organisations, this WG can talk about themes for workshops: What kind of themes should the conference have for workshops and
what kind of relevant parties can work on it? The satellite is organised outside of the program, interesting topic or food is needed to attract people. This WG will think about themes to influence the program.

2. Visibility of AAE lead by Michael Krone
   • During the last IAS Conference AAE, EATG and ECUO had organised a European networking zone. For Amsterdam the same is planned. THE ENZ will present AAE’s work. This WG should discuss ideas about what to do with other partners, also considering the experience we had with networking zones from other conferences. Furthermore, it should be discussed how visible AAE should be? What materials should be transported or transferred there? This WG will create ideas on how visible AAE can be during the conference.

3. Outcomes at the European level, political outcomes lead by Sini Pasanen
   • This WG group is the political advocacy group. It will discuss on the political situation at the European level at the moment, and how advocacy can work before, and during the conference. This WG will discuss if there is a particular political outcome to come from the conference.

3.4 Summary of the WG session

3.4.1 Working group on abstracts, satellite sessions and workshops

1. One topic can discuss the transition from external to domestic funding, related is budget advocacy. There are examples from the Eastern Europe and Central Asia region. This is an important topic at the conference, which should have looked up at the angle that AAE could take, and maybe from budget advocacy point of reference, could think of abstracts or workshops. There should be a day on PrEP, in both the Global Village and at the conference, also mention community-based PrEP, ensuring communities can provide PrEP. AAE should take this topic from a wider perspective and look at combination prevention, and also at the cost effectiveness of TasP, PrEP linked to the affordability to medications.

2. Quality of care and clinical standards is another topic. Are these well implemented? How is monitoring in countries for quality of care? It should look at the role of patients in that, because patients are crucial for improving treatment. Patients are too little listened to. The quality of care should be considered.

3. Human rights violations against MSM, HIV and decriminalisation in the Eastern Europe and Central Asia region are the following topics. Macedonia has an example of mandatory testing of sex workers. There should be a workshop. It was also mentioned at
the end of the working group session, looking at labour, so people can’t do some professions because they live with HIV. It is about looking at all kinds of human rights violations aspects together.

4. Next topic is harm reduction and drug policies.

5. Together with other issues, migration is a theme. It should be looked at the meta-level on work as NGOs and CBOs. Self-development, making space for NGOs and community-based research are part of it.

3.4.2 Working group on AAE’s visibility at AIDS2018

It was already agreed to apply for the European networking zone. In terms of experiences from last conferences, there should be session in the program with silent time, a time without drumming lessons in the Global Village. Three to four hours per day would be good, to have presentations without much noise around in the Village.

Furthermore, AAE should go on social media, internet, have installations etc. Having a video of marginalised groups telling their stories would be good. And to have interactive space, where one from ENZ can chat online and get into online interaction during the networking zone.

The third part is the networking part, people can come together and have small meetings. Also, we can have another AAE member and partner meeting in the Networking Zone.

AAE should specifically reach out to marginalized groups, specifically from key populations, not only as it happened in Durban via email, but really try to get those who AAE want to be there. As a way to get away from having just the HIV elite, we have to actively invite other stakeholders from the communities.

AAE will suggest to provide ongoing Russian/English translation for all parts of the networking zone.

Other organisations can work on and in collaboration with EATG if it also agrees, other organisations could be invited to the ENZ. The same for networks, such as ICRSE, are welcome to contribute, also the European alliance on affordability that EATG and AAE are both partners of, EHRA too. AAE will approach organisations with whom it would like to collaborate.
AAE should focus on core thematic days. AAE needs to elaborate further, to have one day on prevention, one day on treatment and access, one day on legal barriers. AAE should come up with topics.

3.4.3 Working group on outcomes at the European level, political outcomes

All agreed on five topics, between EATG, AAE and others. These topics will be on the wall in the ENZ. Government representatives and all civil society can come there and they can participate on what ENZ is talking about. The ENZ can discuss these five topics on the European level and on the country level.

These topics are:
1. A timeline of European policies, showing a list because there won’t be declarations
2. Policy on drugs, and harm reduction policies
3. Gay men and MSM and other mobile populations
4. Sexual and other reproductive health and rights
5. Young people: SRHR needs, sexual education
6. It would be good to have a “wall of shame” to point out which countries do badly on prevention

An idea was expressed to apply for funding from Lego to get people interactive at the ENZ, they could put together a rainbow bridge.

Questions and comments

Q1: The UK is in the middle of a discussion about the reduction of new infections around testing and PrEP. I am sorry to say that the language around PrEP is really old and we have to do better. It’s “combination prevention” and not only PrEP. We have to be ahead of this discussion theoretically. We don’t talk about PrEP in a wider context any more than I would talk about a medicine. PrEP is part of combination prevention and if not – it’s fake news. In Eastern Europe, people consider the notion that PrEP is something what is wrong. Combination prevention and not PrEP is our focus in a wider context.
Q2: We discussed that the minister of justice in addition to the minister of health should be invited, too. Minister of internal affairs regulates drugs for example. We should inform NGOs to put pressure.

4 Migrants and other populations in irregular situations and access to HIV/AIDS services

Following, three representatives of AAE’s member organisations present their good practice example on migrants and other populations in irregular situations and access to HIV/AIDS services in each session. In the first block of the presentation, Ferenc Bagyinszky provides an overview of the European HIV Legal Forum (EHLF).

4.1 Findings of the European HIV Legal Forum – Ferenc Bagyinszky

The (EHLF) started in 2012. It is difficult to wrap up a 5-year project and all outcomes. Hence, this presentation is a teaser of all that will be produced in the upcoming months.

The EHLF consists at moment of 15 representatives from Germany, France, UK, Turkey, Poland, Hungary, Netherlands, Romania, Italy, Finland, Greece, Portugal, Spain, Macedonia and Austria. Serbia was on board, but then the representative left and the report was not updated further.

The EHLF is about to come up with an extended and updated legal survey and report, which also includes court cases from the European court and directives and legislation that are European but applicable in this situation. A collection of good practices is also gathered, for migrants and people offering services for migrants. The results have also been transformed into an advocacy tool.

The European Centre for Disease Prevention and Control (ECDC) publishes every second year a report on the migrant situation. They collect their figures if countries provide treatment to undocumented migrants, with a yes or no answer. They are not looking for what is happening on the ground, beyond the treatment services. So EHLF looks at 16 countries. The questionnaire is asking about aspects of health for migrants with irregular status who in some countries are called undocumented. Important for the EHLF is that we talk about the situations people are in and not the people themselves. No people are undocumented or irregular – but the situation they are in is either regulated or not. Whether they are in a system of a country that has put them up or outside of system. It is also interesting to look up for other communicable diseases. Is there a difference between an adult and a minor and how they are treated by the law? EHLF also serves as a shadow report telling that there is a difference between the paper and practice.
The ECDC map shows figures which come from the Dublin Declaration monitoring, collected every second year. Is ART available for undocumented migrants? – Yes or no, green or red, but it doesn't show the details and practice. Eventually, the map is not correct. For example, Hungary, which has turned green after years of being red. It is because the ministry is reporting and it seems that they have no idea about what they are reporting. Ministries and focal points were encouraged to contact civil society and NGOs. EHLF has created a different, more colourful map, taking into consideration different aspects of access. The level reflects what people on the ground are reporting. It is different from what is on the ECDC paper. There might be differences even in this report as if the country representative or rather the legal advisor provides the answers, this report will have a different opinion from those working at the end of a help line then the ECDC report shows. Netherlands is a good example, because there are administrative barriers that make doctors refuse provision although it is legally accessible.

This year other six countries had been added to the EHLF: Portugal, Finland, Romania, Austria, Macedonia and Turkey. The information is still being collected and the map will be updated then. A legal report, an advocacy tool and information on the EHLF for the first part of the project is already published online at AAE’s website. A new report will be launched with six new country reports and updates from the “old” members of EHLF. At the last EHLF meeting Ronald Brands from the Netherlands shared the information that there is a new court decision of the European court of human rights. Migrants are sometimes sent back to their country based on whether the country minister says, that ARVs are available in their home country. And now according to the European court of human rights, the treatment has to be available, accessible and affordable, too. Unless all three are ensured, the migrants cannot be sent back based on availability.

Some highlights from countries: Italy and Spain are really different because they have different regional health systems. What also is interesting is how countries define the case of urgency. Most countries offer free access for undocumented migrants in case of emergency, but sometimes the emergency ends when the condition is stabilised, or when they leave the emergency car and are in the hospital.

Another finding of the project, when it comes to undocumented migrants: it doesn’t only refer to migrants but also to nationals who have no documentation and have the same legal barriers to accessing testing, treatment and care. In Romania for example, these are people outside of the system who don’t have an ID card or insurance so they cannot access testing or treatment in case they are living with HIV.

In conclusion, the situation in Europe is not as shiny as it seems when it comes to access to health services for migrants in irregular status. The updated and renewed report and advocacy tool will be published in the beginning of 2018.
4.2 Sexual violence and HIV in armed conflict settings – Marta Vasylyev

Marta Vasylyev is a medical doctor and a project coordinator from the SALUS Foundation. She introduces a qualitative assessment on the association between sexual violence and HIV status among internally-displaced women in L’viv, Ukraine. Ukraine is the biggest country in Europe with more than 600,000 square kilometres and 42.2 million people. 220,000 people are living with HIV in Ukraine. The prevalence is 0.9 and 16,000 new cases were reported last year. There were 79,000 AIDS deaths reported in 2016 and 28% of all reported PHIV are on ARV.

In August 2014, due to the escalation of the conflict in Eastern Ukraine, people left their homes in Crimea and Donbas region in Eastern Ukraine and moved to the Western part. In 2014, the conflict with Russian Federation and the fall of Ukraine’s president, Russia annexed Crimea, escalated. 10,000 people were officially registered dead. Unofficial data reports more victims. In the Western part of Ukraine, 1,200 kilometres from the war zones, several deaths per day were registered.

SALUS is a non-profit organisation, established in L’viv in January 1996 by physicians. Its mission is health promotion and disease prevention. SALUS works on prevention and cover infection diseases, HIV, STIs, viral hepatitis and TB. Furthermore, it promotes healthy lifestyle and safe sex. Victims of rape and violence, victims of trafficking in women, and internally displaced persons, detection of HIV and other diseases are topics SALUS works on.

Since 1997, SALUS works with victims of violence and rape. It provides medical and social services; doctors provide social services for free. Social workers and psychologists work for free with clients.

The research initiative was aimed to use data of the SALUS Foundation and to perform a qualitative assessment on the association between sexual violence and HIV status among internally displaced women in L’viv, Ukraine. During 2014-2016 the SALUS foundation provided medical and social services for 87 women from Crimea, who were between 16 and 49 years old. 11 clients reported sexual violence in the preceding 2 years. Only 9 agreed to in-depth interviews using MAXQDA for analysis of qualitative data.

The results of the study show 22% (2 women) were forced physically to have non-consensual sex. 7 women by means of verbal threats and psychological battering. 83% used protection. 2 persons reported a single violence episode, while 3 persons reported 2-5 violence episodes. Out of 9, 1 was tested HIV positive and didn’t know before the assessment.
In conclusion, Sexual violence is a frequent event among internally displaced women; More resources are needed for medical and social support; Sexual violence may be associated with HIV transmission; A wide range of factors influence HIV prevention intervention for women who are internally displaced.

Questions

**Q1:** How many women do you meet yearly?

*Marta Vasylyev (MV):* Up to 150. Not all of them are internally displaced.

**Q2:** The data is about internally displaced people. Do you have no data from the Donbass region? So you don’t know about the reality on the ground?

*MV:* No, we have data from colleagues in the L’viv region. We don’t know how it looks like in the Donbass region and Lugansk, they are not under Ukraine’s control so we don't have data on them.

**Q3:** How does service in general provide support for vulnerable populations? What are the methods?

*MV:* A social worker works with the Ukrainian Government’s social services, so we are looking for women who need medication and social assistance and they are invited to visit our centre. The social worker talks about needs with the women. And then the client has an appointment with a medical doctor or psychologist depending on the need. It is client oriented.

**Q4:** Is there a funding problem for the region?

*MV:* We have a lot of funders who have, during a certain period of time, funded the crisis centre. Mainly it was funded by our organisation. We also have the international Renaissance Foundation funding the centre.
4.3 “Food for Life”: All-Ukrainian Network of People Living with HIV/AIDS joint project – Valeriya Rachinskaya

Valeriya Rachinskaya presents the project “Food for Life” of the All-Ukrainian Network of People living with HIV/AIDS, which is the largest network of PLHIV in Ukraine. This network has been working for a long time, before and after the conflict.

When the state refused to provide the conflict region with health care for HIV and ART and anti-DB drugs, the network provided people with medications. From the start of the conflict, 35,000 people were covered with ART, continuously without breaks.

Around 25% are in detention in the region. 25,000 people are in prisons with continuous ART and health care, provided food, drinking water and a lot of necessary goods for them. Currently there is no access to all parts of the Donbass region because there are war zones. Some parts are controlled by separatists. The Global Fund provides drugs and medications as possible to this region. Five organisations are working to support local populations in the region.

The region has the highest prevalence of HIV. 35,000 people have tested with HIV infection in Luhansk oblast. About 50,000 people are living with HIV in Donetzk oblast. Around 15,000 people who have been newly registered, only 55% of all PHIV have access to ART for different reasons. Due to the survey of All-Ukrainian Network of People Living with HIV/AIDS – only 37% of the people living with HIV in Ukraine have access to food, 22% are at a critical
stage and have no access to food. 40% of these people make ends meet but it is hard to get access to food to provide for life. Only 36% are food secure.

This project was aimed to overcome those barriers. How the region with armed conflict does look like: some hospitals are closed or cannot work well or are really far, patients have to travel to 200 kilometres to get there. At the front line of Luhansk was a hospital and a check point, controlled by separatists and by the Ukrainian army, and people need one day to get to the hospital.

The average level of wages is 100 USD, the expenses for life are high, also stigma is high and the number of internally displaced persons (IDP) is high in Ukraine, 1.7 million in the whole country, around half a million have trouble making ends meet. All people face financial difficulties because factories closed and have trouble finding work or job or food.

This project worked in Luhansk on the basis of all 26 points of issuance of ART. The surveys were conducted at all points. Only 21% of all PHIV were covered and had access to ART through these points. Clients said that they are afraid of leaving their kids at home while their husbands are at war.

The projects’ goal was to close this gap. To provide food for people who can’t provide for themselves, single mothers, former drug users who can’t get jobs because of the high level of stigma. Nobody wanted to accept a former IDP for a job which bring them in a hopeless situation. The questionnaire was written by a system of points and if people had points showing lower than the level of existence, we supported them with 25 USD per month, which sounds little for European standards but for Ukraine, it was enough to survive. The money was provided as food vouchers for local and regional supermarkets, cigarettes and alcohol and junk food was blocked, to control on what the money was spent on.

The group that got ART increased by our aid by 8%. People who got food vouchers were required to come to the office once a month and have been told to get ART and to keep the ART working.

All together, we had 6.702 beneficiaries with a high mortality rate, increased by war. Some refused to use ART because while coming from the conflict zone to the Ukraine side and live there for a bit and leave again, they stopped the ART prematurely.

The beneficiaries first of all bought meat; they said the vouchers were their only possibility to get protein. Another goal was to provide these clients with food that is healthy and good for them.

Since the project is still running the results are semi-final: In total there are 7.100 potential beneficiaries. Some of them stopped the therapy but the rate of ART interruption decreased by 4 times compared to the figures in the beginning.
There are more challenges. It is difficult to find a job for PHIV and people who developed AIDS and generally for those from vulnerable groups. This project will continue in 2018. All who are in need are target groups, especially key populations, like sex workers, females, will be provided with vouchers, which can help them to live healthier lifestyles.

Questions

Q1: Thank you, usually food goes close to shelter. Where are these people sheltered? Do they have their own houses provided by the government? Where do they live?

Valerya Rachinskaya (VR): Shelter is a problem for all. The government doesn't want to provide shelter. IDP can receive small amounts of money, but not enough. There is no funding to cover that because it needs a huge amount of capacity. All possible funders say it is a problem of the government and the government replies it is not. There is a 6-month shelter for single mothers – these are only temporary solutions, not permanent.

Q2: Did you get any help from local municipalities? Do local governments help with logistics?

VR: No, local governments kicked international NGOs out. Nobody has an accreditation to work in the republic. They want to control all humanitarian aid.

Q3: I was in a teleconference with the UN body, inter-agency task team on HIV, they praised about that work in region. Your project was there before the UN agencies put in food and medication so you deserve a round of applause for your great work.
4.4 Responding to the Challenge: Meeting the Sexual Health Needs of Internal Displaced Persons in Georgia – Ilatamze Verulashvili

Georgia had a conflict, with a loss of 1/3 of its territory. 22 years ago and in 2008 Georgia was on war and it was a different situation concerning internally displaced people. Our organisation is 22 years’ old this presentation is about the work on reproductive health and rights. STIs, abortion, sex education, legal reform and trafficking: these are the main working areas. There is no collaboration with the Global Fund. This organisation tries to find funding for implementation by itself.

Why Georgia does have a high risk of HIV transmission?

The country doesn’t practice testing, 70% of its population doesn’t know about their status. The registered cases don’t reflect the actual situation. It is necessary to achieve 90-90-90 for 2020 – it is necessary that 90% of people know their status. To do so, improvement of early diagnosis is needed. Vertical transmission is very good; all pregnant women are screened. Now the attention is on IDPs in Georgia, they are 300,000 in the country, about 1 million migrants.

When 22 years ago the war started with Russia, IDP lived in the main town of Georgia in occupied houses and hospitals. They had their structure, government, hospital and ministry of education and any kind of project, which reaches target populations.
The situation of IDP changed, with the war in 2008 between Russia and Georgia and the loss of South Ossetia. In the country, the project built up new settings in small houses, with two rooms. These complement settings were placed in the free part of Georgia. Each complement setting has its medical centre and schools; this population lives compact in three places.

With the support of ASTRA, a network, it was decided to try to understand the knowledge of this population. The situation in the youth, people from 14 to 25 years, are experiencing sexual harassment. So sexual education was put in the focus. Furthermore, they have no idea about HIV and STIs, they should get the information from doctors or from nurses. It was the result of a survey, which was run with the support from ASTRA. As mentioned, best sources are doctors and nurses. And sexual education at school.

Following this, it was decided to involve the health sector in this activity. The health sector was monitored. Family doctors were trained. Doctors were sent to school and universities to help with trainings. They had dialogue with students. A new curriculum for post-graduate doctors was developed and implemented. It consisted of a prevention program, which was developed especially for schools, included lectures, training of health professionals, the establishment of communication between the community and government, public brochures with information on why it is necessary.

At the school level, the training was implemented into lessons and in the complement setting. 2.160 school children were involved. Beyond that, screening at the university was conducted, it was tried to make routine testing of youth. After consultations, more than 50 persons refused to undergo a screening because they are afraid of needles. Another reason, they are afraid of stigma and discrimination. If something is revealed, they fear they will lose friends, neighbours.

Volunteers were trained with informational brochures, who went door to door and visited each house and spread the information. It reached not only youths, but also parents and other family members.

**Why was this institutional mechanism of the health sector response developed?**

In Georgia the legislation says, if doctors take a post-graduate course and collect credit hours, they don’t have to take an exam to become a doctor. Our program is certificated, it was approved by the government and was implemented on the country level.

There was a research in primary health care settings on why students don’t use this kind of services? In every primary care there is a room with booklets, condoms, contraception but nobody uses them. So face-to-face consultations were adopted. There was no knowledge
about these services. It was raised to have a doctor and psychologist, who work at the university providing free services.

After the assessment, different medical centres were set up. Which could be reached 20 minutes by car from the refugee centres. They work independently, providing youth services, hotline services and testing. It is still in the beginning of the implementation phase. Free lessons that were held in schools were implemented on the country level and it was implemented in curriculum-based education. 8th grade school children have lessons on HIV, safe abortions and on contraception. These 3 topics were included into the project.

Furthermore, the implementation of the Paris community declaration has started. It was translated into Georgian and our organisation has organised a meeting with NGOs on reproductive health and rights representatives who have commented and raised suggestions on what is possible and available for its implementation in Georgia.

**Questions**

**Q1:** Is there a plan for the integration of IDP from the first war to have rights as citizens? 25 years have passed so far, right?

**Iatamze Verulashvili (IV):** The most terrible situation is for the next generation, children and grandchildren, 200.000 IPD are registered and 25 years have passed. The government gives them a building for apartments. Not more than 2.000 people are without shelter, they live in schools or hotels, where they have one room for each of them. It is more terrible because they need separate apartments and living conditions. The government began providing separate housing right away just for IDPs from Ossetia. They have a factory for milk, hygiene products, they live there and work there, but this community is isolated. They have the right to go, but they have their hospitals, schools, they live compact and need information. This community and the total Georgian community needs more information. At the university and school level there is no screening program. We think kids older than 13 years have to be screened, but we can’t tell them they have to. It has to go through education. That is why we are looking for funding to implement oral testing because if they are afraid of taking blood, they will not be afraid to make oral test. This would move testing from the current place.

**Q2:** What is the legal status of those people? Do they have Russian passports?

**IV:** Who have Georgian passports, are Georgian citizens. The Russians given them a passport if they stay in Russia but with a passport they can only stay in Russia or go to Armenia. All organisations with whom we are working from the Abkhazia side, say that the one place they can come is to Armenia. This population has no rights to go where they want. Georgia’s
population is Georgian. If people from Abkhazia want to come to Georgia they can have Georgian citizen. A lot of people come from Abkhazia to Georgia for operations.

**Questions and discussion for all three speakers**

Before the panel, questions were raised on IDP in the two countries.

**Q1:** Has the UN intervened and in which way concerning the situation in Ukraine?

**VR:** The UN represents 25 agencies. But there is actually no support from a lot of them. All that has been done during three years of war is one project on a referral system. In 2015 a UNICEF project was conducted for victims of violence and there was a small grant from UNDP. It was good to understand that people were interested in HIV content but real money was too little.

**MV:** Out of SALUS organisation, domestic NGOs, partners of SALUS, that were active in this region are still there, active and receive support of alliance of the global fund and try illegally to provide harm reduction in the occupied spaces.

**VR:** Agreed. But the global fund is not a UN agency directly and there are bigger expectations from UN. The UN has to learn that HIV is important. In all UN agencies is a small budget for HIV and in our context, we can't see that at all. I worked for the UN for a while so I know exactly about this.

**MV:** Additionally, there is no proper testing for soldiers due to the war conflict. They became a key group. A testing possibility for the army is needed.

**Q4:** Regarding the work with MSM in Ukraine: Homophobia is strong in Ukraine from the Baltic perspective and it seems not discussed.

**VR:** The MSM population is usually covered by other NGOs, who provide services for MSM. They are in big cities and the stigma is lower there. In rural areas, there is much discrimination and there is a lack of social activism in this field. But All-Ukrainian network for PHIV provides testing and gay-friendly doctors.

**Q4:** Does it means that data is underreported, if don't reach out?

**MV:** Of course, data concerning MSM is underreported in Ukraine.

**LR:** Yes, even big cities have discrimination of MSM, similar to the situation in most of the Eastern and Western parts. Nobody wants to implement projects with MSM because of stigma and discrimination. People don't want to disclose themselves. The level of homophobia started to be huge. It reminds of the Soviet times. MSM were like criminals. Society doesn't want to accept MSM.
**MV**: The situation is starting to change a bit. People start to accept and the representatives of NGOs need to work in this area more, to educate about MSM. It is crucial. I would say it is not a good situation for MSM in Ukraine but it is changing for the better.

**Q5**: Can you please say something about OST and harm reduction in Donbass?

**VR**: The general situation: There is access to OST. People in Ukraine live under the law of the Russian Federation and OST is against the law. 6 cases of suicide due to the interruption of OST were reported. 2015 was a special program conducted, donated by Public Health Alliance, about accommodation given opportunity to get OST, by UNFPI. It stopped at the end of 2015 and nobody wants to donate. The same situation was 2 years ago.

**MV**: When we talk about Donbass, it is the region with the highest HIV prevalence in Ukraine. Lots of clients live there who are on OST and now they are without therapy.

**VR**: Furthermore, the number of clients has decreased.

### 4.5 Labour migrants of the Republic of Tajikistan – Alloudin Boymatov

Alloudin Boymatov works at the NGO Apeiron based in Tajikistan. Apeiron was founded in 2005 and its mission is HIV, Hepatitis, STI prevention among drug users and sex workers. The project areas are in the regions of the Republic of Tajikistan, along the border. Global Fund, UNDPA and UNFPA are funding the organisation.

**What is the situation and what factors being responsible for the increase of transmission?**

Tajikistan has a lot of migrant workers. The country is one of the poorest in the world. 63% of the population lives on less than 2 dollars per day and the economy is dependent on the money earned by migrant labour. People migrate to Russia to seek work. More than 1.5 million people annually go to Russia to earn money. The overall population of Tajikistan is 7 million. Although Russia acknowledges only 600,000 labour migrants from the country, the remittance of migrants to the country is more than 3 billion dollars per year. Most migrants live and work without registration in Russia, thus illegally. They face legal problems, living in Russia.

Labour migrants are on the risk of disease infection including HIV. They are vulnerable due to risky behaviour and low awareness of transmission. Migrants without permission have no health insurance, they don’t use medical services. The other problem is the use of injection drugs, which increases the risk of HIV and Hepatitis infection.

The border to Afghanistan, is 1.400 kilometres long, every person can cross the border, there is an enormous risk of drug trafficking. The low price of drugs increases and attracts a
lot of youth drug users. At first it seems attractive but then dependency does the rest. Virtually all labour migrants who use drugs already come to Russia with addiction, they don't become addicted in Russia but come to Russia as drug users. Statistics of morbidity in St. Petersburgh show that there is more prevalence among migrants.

In 2012, the HIV infection rates were 60 people per 100.000 people of the population in St. Petersburgh and 83.2% of 100.000 migrants had TB among labour migrants. 43-46.7 migrants had STI rates. There is huge difference as you see. A study in St. Petersburgh from Central Asia says 46.4% did not know anything about HIV infection, 40.4% hadn't heard about STIs, 23% not about AIDS.

A lot of people didn't know about the difference between HIV and AIDS. Apeiron developed during the period of time in 2006 to 2012 a project with youths, who were planning to go to Russia as labour migrants. They were trained in workshops, training sessions, got information distributed to them about HIV, STIs. There was an information centre opened for this group of people.

The problems have not been solved. The need is to know all of labour migrants upon arrival in Russia. It is important to provide testing and health insurance. It is important to register all of them. The labour migrants buy flight tickets to Russia and might not go directly to Russia but go through Kyrgyzstan and other countries.

It is necessary to create two systems, a bi-lateral mechanism, to regulate labour migration and the health situation of labour migrants in Russia. There is no mechanism nowadays and labour migrants are left alone with their problems.

Questions

Q1: Thank you for the presentation. Do you have programs for families of labour migrants, because they return with HIV infection and it’s the problem of the Russian Federation not of Tajikistan?

Alloudin Baymatov (AB): Nothing has been done so far. It’s called the re-integration of labour migrants. At the Soros Foundation this summer, a challenge to reintegrate labour migrants back at home was posed. Nobody waits for them with flowers; there are no jobs for them. Empirical data say and the facts and the behaviour of authorities show that as the flow of migrant workers increases, the level of crime increases. It was presented that in Armenia this question was tackled quite well. A task force with different representatives from authorities and NGOs was set up. There are these initiatives but nothing has been done so far.

Q2: For this future program, will there be any testing of their partners? Testing of family members – of migrant labourers? Will it be implemented as part of a program?
**Q3:** How many PLHIV prevalent people get ART? What is the percentage of people who receive ART? And concerning the quality of medication, do you have all medications available or is there a selection?

**AB:** Compliance is poor in Tajikistan. All sets of medications are provided. Often the patients are convinced or they try to get ART, who are talked into ART and in the middle of the therapy they quit. It is impossible to find patients afterwards. That’s the picture. This year the Global Fund, through UNDP, had a grant for ART consistency or compliance enhancement. Three times there was a call for a grant and nobody wanted it so it wasn’t distributed. That’s the picture, it doesn’t look positive.

**Q4:** What I find really important within this context is that migration is discussed at the Western European level: migrants and key populations are well but still on radars. That is why this presentation is so important for the AAE member meeting. There is a real issue in Eastern European countries that needs to be emphasized. I was recently at a WHO Europe meeting and it seems that for this challenge, the Russian Federation is willing to collaborate. We may have more information from your experiences in your own countries but they have at least acknowledged there is problem. The health ministry is willing to work with specific countries to find solutions to the problem. It is a hope but it doesn’t change the situation on the ground.

**Q5:** This isn’t a question but a comment: Maybe the ART compliance is not given, or there cannot be ART, people can’t stay on ART because they need to go to Russia and if Russian authorities learn that labour migrants are having HIV, they probably will not allow them to stay, and they won’t get a job. So if I already have ART in Tajikistan I have to quit to go to Russia, do I understand correctly?

**AB:** The loss concerning HIV infected people and providing health care for these people are different in countries. In the Russian Federation I heard that if a foreigner comes to live in Russia, he will be deported. I never heard of deportations, actual persons being arrested and deported to Tajikistan. Concerning the question, of course staying on ART depends on the status of migration, status of HIV; and there are a high number of illegal migrants. 1.5 million are those who travel to Russia and come back, but there are also 2 million who stay. The overall population of Tajikistan is 7 million, please imagine the scope of this problem. Concerning medications, the medications provided by Global Fund are taken and there was
no claim. The medication quality is good because all of those who use ART never complained, but as soon as the Global Fund leaves, we will have global problems or problems of a global scope, because all medications are provided and bought by the Global Fund till today. And methadone therapy is provided by the Global Fund, too. The funding will be cut and will be enormously cut in 2018. By 2020 it will be completely gone. What will happen to people who have OST is impossible to know. The state has no money for these therapies, for medications. Budget advocacy to acquire money is needed.

4.6 Coping course for migrants who live with HIV – Girmay Assemahegn

Girmay Assemahegn is originally from Ethiopia and works for Aksept in Norway. The organisation focuses on care and support of PHIV and has been doing so for the last 30 years. It’s under the church mission of Oslo but not connected to religion or politics. The work focuses on all key populations.

Aksept is the only institution in Norway with a stationary unit: 12 rooms and 3 small rooms, where PHIV can come for recreation. There are open house hours, with good food for all PHIV and sometimes also includes other activists. Migrants who live with HIV in Norway is a big group in Norway. 45% of all PHIV in Norway come regularly to Aksept. Every year there are newly diagnosed people who come, asylum seekers, likely the same in other countries of Europe, too.

All groups which named were infected before arrival but now there are people arrive tested negative but became positive while living in Norway. This group of migrants generally doesn’t mean infected before arrival any more.

The coping course is what the organisation arranges three times per year. It’s a coping course for newly diagnosed persons, but also for those newly asylum seekers and who come with medications and stop medications while crossing the Mediterranean or Sahara. There are reception centers in Oslo with small communities for people who come after their diagnosis, or after first developing opportunistic infections. The coping course is a very important thing that migrants currently use.

It helps to recruit new clients for our institution. It’s not easy; the most difficult part is to reach PHIV at all. There is no system that all hospitals report to us as an NGO.

How did it begin?

There was a policy: Aksept and coping national strategy was under the ministry of health from 2009 to 2014. The objective was that all PHIV should get treatment, follow up and the stigma should be reduced. When the project started in 2011, the policy was in the implementation level in the dissemination of knowledge, particularly with vulnerable
migrant communities. The ministry of health funded it. It was conducted for asylum seekers, newcomers, 3-5 times per year. They are mostly from Africa, some from Asia, generally, from asylum reception centres and municipality centres.

The main motivation is to participate. The travel costs are covered by this project, for asylum seekers who live in room shared with others, they are usually motivated to come. That is what breaks the feel, but stigma is still very high. Brochures are sent to reception centres in different languages.

**Why do this?**

It increases the knowledge of HIV, mental health, rights, duties, diet for PHIV. This can contribute to good mental and physical health. It reduces stigma and prevents isolation and loneliness through network participants during the coping course and after the course, through personal contacts.

Since Norway introduces that the positive HIV status doesn't influence asylum application, not more clients come. Many want to marry, have a friend who lives in the same situation, normally we don't give dating services but this sort of connection helps participants to know each other better.

Professionals, psychologists, specialists from hospitals come to teach Aksept. My role is to ensure peer support, where I together with other veterans share our experiences, those who have been new to the country. It is based on our experiences in that country. The coping course collaborates with the university.

**Questions**

**Q1:** What are the operating languages?

**Girmay Assemahegn (GA):** Thank you for this question. From the veteran resource group, as we call it, we speak Somalia, etc. Most newly coming asylum seekers today are from Eretria, Somalia, francophone Africa, they also can get interpreters. All interpreters are PHIV. For many PHIV it is their right to have an interpreter, most of them don't use this right out of fear of being exposed. So they use body language instead of an interpreter from the same country and fear being exposed. But if the interpreter is also living with HIV they feel that they are living in the same situation.
4.7 Securing and Sustaining: Free HIV Treatment for Undocumented Migrants – Christopher Hicks

Christopher Hicks speaks about the securing and sustaining free HIV treatment for undocumented migrants in England. Introducing the history of the campaign and how secured treatment in the UK started.

The National AIDS Trust (NAT), the UK policy and campaigning organization, was set up in 1987. Its strategic goals are equitable access to treatment, early diagnosis, effective prevention and enhanced understanding of HIV, the organization doesn't provide services. The NHS provides free health care services. It is not insurance based or contribution based, it’s free to anyone except overseas visitors including undocumented migrants. Anyone living for more than 12 months could receive care but in 2004 it was changed for those with legal residency status. For the first time, undocumented migrants could face charges.

Why was it important, and why did the National AIDS Trust launch a campaign on the issue in 2012?

Migrants and asylum seekers are among most infected by HIV in the UK. Among black African men and women, with 31% access to HIV care. Finding the undiagnosed is a big issue in the UK, the proportion of black African men and women unaware of their status was 11 and 10%. While not all migrants are from black or ethnic minorities in the UK, for many it is important to defend their rights to HIV treatment and care.

Here is a graph of new diagnoses from 2006-2015

Diagnoses of those born abroad have decreased a bit, but are still a lot.

Who are the undocumented migrants?

People without lawful residency status; people who have overstayed after visa expires; people who had refusal of asylum claim; people who entered the country unlawfully

How to achieve the goal?

Firstly, it was important to debunk the myth of HIV health tourism. This was the first and main argument that the campaign looked to tackle because it was the first reason used to implement the changes. People came to get treatment for free. “Health tourism” had traction in UK by the general public, practice of choosing to travel to access treatment that is unavailable or too hard to access at home.

To look at evidence of whether health tourism was happening, the campaign started with the premise that to prove it existed, data had to show following: a sign of high number of
migrants coming with purpose to access treatment; came and being aware of their HIV status; migration patterns reflected distribution of HIV epidemiology across the world; migration patterns to and from UK are result of withdrawing treatment; HIV infection among migrants would be higher than those in their country of origin; people are seeking treatment immediately after arriving in the UK. But the research showed none of these were true. The desire to access benefits was not a factor in migration patterns. Migration patterns had no relation to the HIV prevalence across the globe. This evidence was used to challenge inaccurate media converge and forced retraction from media using this term.

Secondly, how people were deterred from treatment and confusing system? People absented themselves from HIV treatment and care. The organisation gathered case studies from both voluntary sector organisations and from HIV clinics through the relevant networks. There were two cases of people with HIV-TB co-infection where the patients abandoned their TB treatment early because of fears around the HIV related bill. The organisation gathered examples of NHS staff not understanding rules and denying access to treatment to those migrants who were in fact entitled to it, or of migrants entitled to HIV treatment not wanting to get tested because they felt would not be allowed to access treatment.

Thirdly, the impact on public health was crucial. This was the most important argument; it was the one listened to the most; it was the biggest interest of the government. More data supported treatment as prevention as an important tool in ending HIV epidemics. When evidence came from HIV prevention trials in 2011, showing that ART can prevent transmission, the government argument was crumbling away. Other studies showed no transmission if undetectable. It was continued to use this evidence to tackle other areas of health care system.

Fourthly is about the cost of implementing it into the system. It was never set up to charge people or check eligibility. It came with a lot of costs, but charging undocumented migrants came with its own set of bureaucracy. They were only diagnosed when they were seriously ill and required more extensive costs for in-patient care which couldn't be denied to migrants because of emergency care which cannot be denied. Furthermore, charging deterred people from accessing HIV testing and treatment so people would remain infectious and would pass on HIV and would remain costly in the long run. Additional lifetime costs to public purse were high.

Fifthly, the united voice from the wider alliance of the HIV sector was raised. The HIV/AIDS prevention sector was united, clinicians, public health bodies and public health England. They all were politically involved, including migrants’ rights organisations.
And sixthly: What was happening in other countries? There were examples where treatment was available to everyone. The health minister was very interested in this because it showed that the UK wasn’t being excessively generous.

What now?

Free HIV treatment in 2012 was established. But the government is pushing to charge in more areas of health care. Up-front charging, migrants will be charged and if they can’t pay, they will be denied care all together. There are charges for care outside of hospital setting, drug treatment for example. There are eligibility checks in HIV clinics as a way of identifying those eligible for health care, but not in HIV clinics.

This is the successes slide: Changes so HIV treatment and care is free for all; Primary care is still not chargeable for undocumented migrants; Inaccurate media coverage around health tourism is challenged.

Questions

Q1: In Scotland IDP were never charged. That was brought into discussion of other countries. Scotland was the other country. In future for UK – that won’t happen in Scotland or in Northern Ireland. You’re very correct talking about England, but be careful when using the term UK.

Christopher Hicks (CH): I agree, this is true.

Questions and discussions for all three speakers

Q1: To Alloudin Boymatov: I would like to ask if you think AAE can help strengthen your ability in advocacy efforts. It’s important that in this period of transition, when Global Fund will stop funding, you need help to strengthen the procedure of monitoring. Is additional support from the network needed or is it just a financial need?

AB: We have worked in our working groups and made a proposal on how to reduce harm in Tajikistan. Harm Reduction would be good; it would be good to have workshops on it. Furthermore, it’s a difficult situation for MSM, we tried to work on that for the last 3 years. It would be also good to have a workshop together with AAE. We are meeting to exchange words but also we come to conferences and experiential meetings to learn, especially from best practices. The program we did with the UK was meaningful and our UNDP, Global Fund and UNFPA programs. But when the basis for our activities changes, we need to learn how to work more closely together with the European HIV and AIDS movement. As soon as I get back to capital city, I will tell our NGOs what has happened here and we need to develop plans, all of us, to work together with AAE and European HIV NGOs. We need to learn how to monitor and further diagnostic schemes. Budget advocacy is what we need, too. We need
support of HIV and AIDS action group so that after, when the Global Fund is gone, we can keep working at the level we have achieved so far. Not a major leap, but at least we want ship in safe waters. This is why I am happy and always willing to cooperate and exchange information regarding developments in my country.

Q2: A question about whether in the UK and in Norway is consistency for treatment for migrants? In the UK people who have disruption in care while getting the residency, they can end up with no ARVs for several weeks nor change ARVs. Is this solved in the UK? Is it a problem in Norway? Is there a break in the care continuum?

CH: This issue is still not solved in the UK. There is a project on HIV treatment in immigration removal centres. HIV in prison also has a problem with the interruption of treatment. There is a problem in arrival and departure from immigration centres. We are looking at how to implement more consistent treatment in those contexts. This is not a problem that has been solved.

GA: In Norway, the system theoretically provides free ARVs for all documented migrants and sex workers from West Africa, if they go to nearest hospital without showing they have a residency permit, including dental care if it includes an infection and is not cosmetic. But recently, in relation to the coping courses, we faced a situation about a person from Afghanistan in prison, who had been registered as a minor and was staying in Norway but after turning 18 it was clear he had only a temporary residency permit and would be deported. He went back and forth in countries and was imprisoned in Sweden, too. It was claimed that he had no treatment at all in prisons. And we checked that, we had a project with UDI, the immigration dept. in Norway, that people were deported without medicines. So there are problems we have to work on.

5 Summary and closure

By Ferenc Bagyinszky:

In the first set of presentations and what was found out at the EHLF: migrant populations or mobile populations are very heterogeneous. Start with labour migrants working in black or grey zones, there are people who are mobile populations in their own country. We talked about Roma people who don't even exist officially in their own country. There is an issue which should be thought of, the vulnerability of migrants and mobile populations within the country and from one country to another even if moving in a regulated system such as in Greece, asylum seekers have to stay on the island where they landed. What we also learned from surveys are some people who decide to go on the road for any reason, may become key population because they engage in sex work or drug use. What is also interesting to look
at is the prevalence and the information they have in their country of origin and what is the situation in the country where they arrive.

**How different is the prevalence for key populations?**

The definition of key populations for UNAIDS does not include migrants aside from gay men, MSM, sex workers, trans people and other people determined by the national context. This is up to national organisations to push governments to understand key populations.

**What can AIDS Action Europe do?**

Different examples of support services were introduced, from Norway, going into war zone; all of it is your national competence. How to support this work is working at the EC level and at the Civil Society Forum, to bring these issues up so people are aware. At the European HIV Legal Forum was discussed whether to continue work on migration or pick up other topics. Another topic that was brought up in several discussions is people in prisons and other closed settings, migrants can be included, the camps are sometimes like prisons.

The final thought: the UN was mentioned a couple of times. AAE has a seat on the Programme Coordinating Board (PCB) of UNAIDS. This year’s report from the NGO Delegation will address the 10-10-10, growing concern from communities and civil societies is that some populations are disproportionately impacted by the 10-10-10. If 10 percent includes 40% of drug users who are undiagnosed or 50% of migrants, we will be ok on paper but it won’t lead to ending the HIV epidemic. AAE can promise to continue with this on the delegation and to look at the national context and see whether 10-10-10 is disproportionately impacting one population. It is always good and reassuring to hear what is happening on the ground.

**By Michael Krone:**

For the summary and closure of the day I would like to review the program. Anke van Dam’s and Sini Pasanen’s presentations were important in regards to the IAS Conference in 2018. We would like to encourage you as AAE members and partners to be there as much as possible as civil society organisations and to encourage you to work on abstracts and on participation. It is a unique opportunity to get as many politicians from the Eastern Europe and Central Asia region as possible to go to the conference in order to have an impact.

The three working group sessions, which were very creative, brought up ideas that AAE has to process as an office and it’s happy to do so. Similar to the last year, it is important for the office to get input from member organisations, all of the working groups did that. They were supposed to provide next steps to have a successful conference and make clear what AAE in collaboration with partners needs to do.
In the afternoon, Ferenc Bagyinszky summarised it pretty well what will be done at the EHLF. There were presentations about work in conflict zones and then other presentations of work on the ground, which all are very different. At the EHLF points were made about how to proceed with its work.

Questions and feedback

Ben Collins: I like to ask where will be the issue of migrants in 5 years or 10 years. I can see the political impact of migration not only in Europe but everywhere, this wasn’t discussed.

Marienella Kloka: I think personally if we don’t do something to tackle inequalities, poverty and wars, I can only imagine massive influxes and nothing less.

Michael Krone: I think some things are moving forward, some things on the political and national levels are disastrous. That is something the EHLF is facing in general, the situation of migrants and displaced persons and labour migrants, in all of the countries. Not only in the Eastern Europe and Central Asia region the stigma and discrimination is not getting better, even Western Europe face the same picture, like in DE and UK. This means that our work as civil society organisations in this field is more needed than ever. When thinking about a core thematic topic to address it is clear that it would be on migration. It doesn’t necessarily mean it would solve problems but, with regards to the remark I made on the WHO Europe region, the problem is acknowledged and people are aware. We have to keep working on that.

Benjamin Collins: One of the other issues is where we do want to be? The 90-90-90 has split people because people think we won’t achieve it, that only the West will achieve it. My fear is that we will know who will be in the 10 percent; it will be migrants, prisoners, all of the most disposed people in each nation. In 5 years, we need to be sure not to be obsessed with new targets of 95 if it means ticking boxes and forgetting that the people who are not being reached are the most vulnerable populations. This is something to work on for AAE.

This was a very good job of bringing in experiences from Eastern Europe and of organisations committed to issues of Eastern Europe. As Europeans, allowing IAS Conference to not provide full translation of its sessions it is something we should be able to do better. I know the intention for having the conference in Europe is to deal with Eastern Europe but if we don’t have translation and magnetic attraction it will be on paper. It’s a compliment of AAE and challenge for us as Europeans.

MK: I agree; this is something that we can do better on.

FB: I would like to add, that we tend to look at migration from the perspective of access for legal restrictions, but there are travel and entry restrictions connected to the status. Legal issues are complex. Access in countries where we go is only one bit of it.
Furthermore, a comment: To ensure that by 2020 we are not just moving onto another target. I heard the head of UNAIDS saying “we are running the last mile of the marathon”. Our response was that there are people who aren’t even running in the marathon. People will be celebrating 90-90-90 targets. At the Malta presentation was said that Europe is doing well but when asking back, they correct it to the European Union. Even in the European Union are plenty of countries who achieve less. Important is that we remain critical.

Matthias Wentzlaff-Eggebert opened the floor for people who like to say what they found valuable and good to take home with:

- “I like to pick up on what MK said, I would like to follow up on cure research. We will have a cure one day but even when we have the cure, we know AIDS activism won’t go away. With Hepatitis C, we have a cure but the issues keep piling up. In 5 years, I know that AAE will be in business and its big business, but the work may be double comparing to right now.”

- “Thank you for this meeting. I will bring with me all of the information from presentations for my colleagues dealing with migrants. People live in their own circles. We forget that we have a huge migration crisis all over Europe. Thank you for paying attention to this problem - to understand that we are not alone. To understand that we have solutions and good decisions.”

MK: Thank you for your participation and contribution.
AIDS Action Europe Member and Partner Meeting

HOTEL NH COLLECTION BERLIN MITTE
Leipziger Str. 106-111, 10117 Berlin

12. November 2017, 10.00 – 19.00

Facilitation: Matthias Wentzlaff-Eggebert
Simultaneous Interpretation: LinguaTransFair, Berlin.
Technics: green congress, Berlin

Programme

09.30 – 10.00  Registration
10.00 – 10:15  Welcome and Introduction
10.15 – 10.30  Follow-up on the last Member and Partner Meeting
10.30 – 11.15  AAE in the Amsterdam 2018 World AIDS Conference (1)
                •  State of play of the preparation of the conference
11.15 – 11.45  Coffee Break
11.45 – 12.45  AAE in the Amsterdam 2018 World AIDS Conference (2)
                •  Breakout session in working groups on what AAE should achieve in the conference
12.45 – 13.45  Lunch Break
13.45 – 15.15  Migrants and other populations in irregular situations and access to HIV/AIDS services (1)
                •  Findings of European HIV Legal Forum (EHLF)
                •  3 good practice examples from AAE Member organisations on displaced persons from Georgia and two from Ukraine
15.15 – 15.45  Coffee Break
15.45 – 17.15  Migrants and other populations in irregular situations and access to HIV/AIDS services (2)
                •  3 good practice examples from AAE Member organisations from Tajikistan, Norway and UK
                •  Outcome of the findings and presentations and plans to follow up through the EHLF
17.15 – 17.30  Summary and closure
17.30 – 19.00  Networking reception
Встреча членов Европейского действия по СПИДу

HOTEL NH COLLECTION BERLIN MITTE
Ляйпцигейр Штрассе 106-111 / Leipziger Str. 106-111, 10117 Berlin

12. ноября 2017, 10.00 – 19.00

Модерация: Матиас Венцлаф-Эггеберт
Синхронный перевод: LinguaTransFair, Берлин.
Техника: green congress, Берлин

Программа

09.30 – 10.00 Регистрация
10.00 – 10:15 Приветствие и введение в программу
10.15 – 10.30 Взгляд на встречу членов в прошлом году
10.30 – 11.15 ААЕ на Международной Конференции по СПИДу в Амстердаме (1)
   • Результаты подготовки на настоящий момент
11.15 – 11.45 Перерыв на кофе
11.45 – 12.45 ААЕ на Международной Конференции по СПИДу в Амстердаме (2)
   • Тематическая сессия в рабочих группах о том, что следует достичь
     ААЕ на конференции
12.45 – 13.45 Перерыв на обед
13.45 – 15.15 Мигранты и другие группы с неурегулированным статусом и их доступ
   к услугам по ВИЧ/СПИДу (1)
   • Результаты Европейского Правового Форума (EHLF)
   • 3 примера успешной работы организаций членов ААЕ с перемещенными лицами: один из Грузии и два из Украины
15.15 – 15.45 Перерыв на кофе
15.45– 17.15 Мигранты и другие группы с неурегулированным статусом и их доступ
   к услугам по ВИЧ/СПИДу (2)
   • 3 примера успешной работы организаций-членов ААЕ 3 примера из
     Таджикистана, Норвегии и Англии
   • Результаты Европейского Правового Форума (EHLF) представление
     следующих шагов и планов на будущее
17.15 – 17.30 Подведение итогов и закрытие
17.30 – 19.00 Неформальное общение
AAE Member Meeting
12 November 2017

Stronger Together
Impact of the Member Meeting 2016 on the application for a 2018 – 2021 FPA

Co-funded by the Health Programme of the European Union
Member Meeting 2016

1. Presentations from our members on strategic directions of AAE and the member organisation needs
2. Working groups on Monitoring, Communication and Information, Needs and Support in EECA countries, and Capacity Building
3. Prioritisation of core thematic areas
Change of the Mission Statement of AAE

- During the last Steering Committee Meeting in Athens the AAE SC decided to change the mission statement

Old: AAE’s mission is to bring together civil society to work towards a more effective response to the HIV epidemic in Europe and Central Asia. We strive for the best standards of human rights protection and universal access to prevention, treatment, care and support. We aim to reduce health inequalities, focusing on key populations and the epidemic.

New: AAE’s mission is to strengthen civil society to work towards a more effective response to the HIV/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.
Objectives

Objective I: AAE contributes effectively to the HIV, TB and hepatitis response in Europe (Monitoring, capacity building, EECA)

Objective II: AAE provides platforms to communicate and facilitate collaboration, networking, and linking and learning between NGOs, networks, policy makers and other stakeholders (Communication and information, capacity building, EECA)

Objective III: Continuous improvement of network collaboration through governance and internal management
Core Thematic Areas

• Affordability and accessibility to medication (ToT, webinars)
• Community based voluntary counselling and testing (international standards)
• Tackling legal barriers in the response to HIV, TB and hepatitis (EHLF, benchmarking and monitoring national legislation, access to HIV services for undocumented migrants)
• Criminalisation of HIV non-disclosure, exposure and transmission (EHLF, benchmarking and monitoring national legislation)
• Sexual and reproductive health and rights (SRHR) (Quality Action tools, PrEP, access to prevention means)
• Tackling stigma and discrimination (cross-sectional)
The Road to AIDS 2018

Action for community and political involvement in Eastern Europe and Central Asia

Anke van Dam, AFEW International
Why?

• To raise awareness of the HIV, TB and viral hepatitis epidemics in EECA, and present the challenges and the successes

• To allow doctors, activists, researchers, policy makers to get access to the latest developments in prevention, treatment and care

• To ‘open’ the region and facilitate linking, learning and networking
With whom?

• AFEW together with GNP+ and Eurasian Harm Reduction Network (EHRN) as Core group

• and the other networks ECUO, ECOM, SWAN, Eurasian women’s network on AIDS

• In close collaboration with the Dutch Ministry of Foreign Affairs
- Increased attendance of policy makers and politicians via active approaches, study tours and High Level meeting

- Increased attendance CBO representatives at conference: Scholarship Fund – efforts to raise extra funds; ensure translation into Russian
To engage communities and NGOs
Small Grants Funds

• Community based research – 25 proposals from communities from EECA region supported

• AIDS2018 Culture small grants fund to address stigma and discrimination – will start soon
Training and Support

• Training in community based research
• Webinars on data analysis
• Training in ‘how to write abstracts and translating a research into action’
• Training in ‘how to present’
• E-learning course on CBPR
• Free access to Abstract writing module in English and Russian
• Training and guidance in active participation in AIDS2018 work groups
To engage policy makers and politicians

• SRHR and AIDS Ambassador Mr Lambert Grijns visit to Central-Asia
• Study tour Dutch politicians to the EECA Region
• A group of politicians from EECA to the Netherlands
• High level political meeting with EECA politicians
To engage every one else.....

• Mapping and analysis of EECA stakeholders
• Coordination with the EECA Regional networks on joint agenda (Programme and Global Village)
• Contact clinicians and raise their interests
• Language support to delegates (volunteers, students)
Communication

• Promote AIDS2018 in the region by 6 focal points (2 newsletter per month)
• Social media
• EECA in the spotlight in the Dutch media
• FB @Aids2018EECA
• #Aids2018EECA
Key Dates

1 December 2017:
Open submission: Abstracts, registration, workshops, satellites, Global Village and Youth Programme, exhibition and scholarships

February 2018:
Close of: Abstracts, Global Village and Youth Programme, Workshops, scholarships

April 2018:
Open: Abstracts – late breakers, Volunteers
Close of: Satellites, exhibition
More Information

- www.afew.org
- www.facebook.com/AFEWInternational
- www.facebook.com/Aids2018EECA
- Twitter: #AFEW_Int, #AIDS2018EECA
Thank You!

Inviting Eastern Europe and Central Asia to AIDS 2018
AIDS Action Europe in the Amsterdam 2018 World AIDS Conference

Sini Pasanen
Conference Coordinating Committee

- AIDS Action Europe and EATG have Regional Leadership seat in the Conference Coordinating Committee
  - Representing CSF
- Started working in Durban
- Smaller committees and working groups
Committees

- **Conference Coordinating Committee (CCC)**
  - The CCC is the highest decision-making body of the conference and has overall responsibility for the final conference programme. This committee currently has 26 members.

- **Community and Leadership Programme Committee (CLPC)**
  - This committee is responsible for making sure that the community and leadership perspective is represented in the programme. It consists of 3 co-chairs and 6 members.

- **The Scientific Programme Committee** (SPC) is responsible for the scientific part of the programme including the abstract driven sessions.

- **Global Village & Youth Working Group** select sessions, booths, and networking zones for the Global Village at the Marathon Meeting.

- **Workshops Working Group** selects 30 workshops from the public submissions at the Marathon Meeting. This group is composed of 2 CCC members, 2 CLPC members and 2 SPC members.

- **Scholarship Review Committee**
Session types

**Opening and Closing Sessions**
The opening and closing sessions mark the kick-off and finale of the conference. They generally feature high-level speakers such as government officials, UN representatives, ambassadors and celebrities as well as community speakers.

**Abstract Sessions**
A large part of the programme is built on abstracts from public submissions.

**Invited Speaker Sessions**
Plenary sessions, special sessions, bridging sessions, symposia and workshops make up the invited speaker part of the programme, and are built by the SPC, CLPC and Bridging sessions connect the three programme components (science, community and leadership) and provide an opportunity for multi-disciplinary, multi-perspective dialogues on cutting-edge topics of common interest.

**Workshops, session in GV, Symposia sessions...**
17 October “Marathon meeting”

- Meeting with CSO on Monday 16 Oct
  - What we want as CSO and community
- Plenary working group
  - 120 submissions in May 2017,
  - Co-chairs distilled the topics into thematics:
    - Vulnerable populations and HIV
    - The Care Cascade and HIV
    - Sustainability and HIV
    - Youth are Our future
  - We have a speaker from EECA on three days, only US has more and they have 4 speakers.
  - We have a person living with HIV speaking on every plenary
- Plenaries will be ready and published on 1st Dec
  - “Bridging”
17 October “Marathon meeting”

• Eastern Europe and Central Asia
• Setting the tone for the conference
• Controversial speakers
• High level people
• Stigma and aging are very well covered and we are expecting Lot of abstracts about PrEP.
Global Village

- Global Village will be something never-seen-before 😊
- The location will be good. It will be in the conference center, and there is public transport right next to it. It will be in between registration and poster exhibition area.
Responding to the Challenge: Meeting the Sexual Health Needs of Internal Displaced Persons

MD PHD  Ia Verulashvili
Women’s Center
GEORGIA
Women Center is working in the following directions

- Reproductive health and rights,
- Family Planning
- Counselling services
- Abortion
- HIV/AIDS, STIs prevention
- Sexuality education
- Protection women’s rights, Domestic violence, trafficking
- Public education and advocacy
- Law and legal reform.
Current situation in Georgia

- Georgia bear high potential for rapid spread of HIV epidemic
- About 70% of population doesn’t know their HIV status
- In 2018 registered 6554 cases (4890 men, 1674 women) age 29-40 - 433 New cases
- Under treatment 3962 person (456 in Abkhazia)
- The registered number of HIV/AIDS cases does not reflect the actual spread of the infection in Georgia.
For ending AIDS in 2030

- Necessary achievement the 90/90/90 targets by 2020
- Getting 90% of people living with HIV (PLHIV) to know their status,
- 90% of diagnosed PLHIV on antiretroviral therapy (ART),
  - 90% of PLHIV on the bases of ART achieving viral suppression,
Concerning Georgia which is part of Eastern Europe and Central Asia (Georgia)

• Indicator toward Achieving the UNAIDS 90-90-90 Goals 3-45-7. Efforts are needed to improve earlier HIV diagnosis, to reduce the number of patients not in care, and to extend durability of viral suppression. (AIDS Res Hum Retroviruses.-2017 Georgia)
Risk Groups and Factors Affecting the Spread of HIV Infection

- Intravenous Drug Users: 67.3%
- Heterosexual contacts: 27%
- Blood recipients: 0.8%
- Vertical transmission: 0.8%
- Unknown: 0.5%
- Homosexual contacts: 3.4%
Vertical transmission of HIV/AIDS

25% Pregnancy

75% Breast feeding

3% - 9% delivery
Current situation IDP’s in Georgia

- 296,000 internally displaced persons (IDP’s) living in Georgia more than 25 years from two break-away regions of Abkhazia and South Ossetia
- 1 million migrant population (74% women)
- IDP’s from Abkhazia (result the Russian-Georgian conflict at 1992 year) have problems with housing and employment and lives in hospitals, empty offices in Tbilisi, Kutaisi, Batumi (more than 24 years)
- Abkhazian IDP’s have separate Governmental Structure Ministry of Health, Education, Medical Centers, Hospitals, Universities, Schools and ext
- IDP’s from Ossetia (result of 2008 Russian-Georgia conflict) lives compactly in 3 compliment settings Tserovani, Sashvebi, Kvernaki
MOST VULNERABLE SITUATION CONCERNING HIV/AIDS IN YOUTH COMMUNITY Specially In IDP’s

- Rapid growth of HIV/AIDS cases in age group (14-24) is determined by the following factors:
  - wide spread of drug abuse;
  - Critical situation in neighboring countries regarding HIV/AIDS;
  - Increasing migration of population

- Traditionally low demand on condoms;
- Low AIDS awareness of population.
- Country doesn’t practice sexuality education programs at school, universities
- IDP’s most vulnerable part of society lives compactly have very poor information and access to services
Experience of Working with IDP community

• Based on the survey was develop communities based strategy to reduce HIV/AIDS through creation community self groups, peer-to-peer educators

■ Develop and implement new curriculum in Post graduate medicine for licensing and requalification doctors on improvement testing on HIV and response on cases

• Run non-formal education on STI/HIV at Universities, Schools and develop of youth friendly service
Survey was conducted in IDP communities ON KNOWLEDGE OF SEXUAL AND REPRODUCTIVE HEALTH (ASTRA)

954 IDP (14-25 age)

Survey show absence of curriculum bases sexual education and the lack of non-formal education. They have lack of information on STI, HIV/AIDS and have no knowledge on risky sexual behaviors and 55.3% claim that the best source of information can be doctors/nurses. 46.2% need information on HIV, 24.5% on STI, 28.4% on prevention.
Survey ON KNOWLEDGE OF SEXUAL AND REPRODUCTIVE HEALTH IN IDP COMMUNITIES (ASTRA)

RESULTS OF SURVEY ON KNOWLEDGE OF SEXUAL AND REPRODUCTIVE HEALTH

- Circle the way of transmission of HIV/AIDS:
  - Sex
  - Blood transfusion
  - Mosquito bite
  - Contact
  - Drug consumption

- What means of protection will prevent the transmission of HIV/AIDS and pregnancy?
  - Condom
  - Antiretroviral therapy
  - Abstinence

- Sexual relation between two person of the same sex is wrong
  - Disagree
  - Agree
  - Do not know

- When you do have a question/problem related to STI, HIV/AIDS, you usually get information from:
  - Health facility
  - Family
  - Friends
  - School

- Have your parents given you the reliable information on sexual related issue?
  - Yes
  - No
  - Do not know

- The contraceptive pill does not protect you from a sexually transmitted disease (e.g. Syphilis, HIV/AIDS)?
  - Right
  - Wrong
  - Do not know

- Which of the following situations according to you prevent risky behaviors?
  - Frequent change of partners
  - Alcohol or drug use
  - Facilitating assistance and support to HIV positive individuals and those who have AIDS

- Is it acceptable for women to have sexual relations before marriage?
  - Disagree
  - Agree
  - Do not know

- In your universe there are sexuality education lessons?
  - Yes
  - No
  - Do not know

- The church should be involved in matters of sexual education?
  - Right
  - Wrong
  - Do not know

- It disturbs me to be a friend with someone who has AIDS?
  - Disagree
  - Agree
  - Do not know

- Do you think that the universities should have an active role in sexuality education?
  - Yes
  - No
  - Do not know

- Which of the following disease are sexually transmitted?
  - HIV
  - Syphilis
  - Gonorrhea
  - Chlamydia
  - Herpes

- What I see on radio, TV, newspapers influence my beliefs and generally my behaviors
  - Disagree
  - Agree
  - Do not know

- I believe that parents should talk to their children about sexuality and relationship with the other sex
  - Disagree
  - Agree
  - Do not know

- In your university there are books related to sexuality, hormones, contraception, period, sexual feelings...?
  - Yes
  - No
  - Do not know

- Have you ever had HIV testing?
  - Yes
  - No
  - Do not know
RESULT

• 24.5% need information on STI, 46.2% on HIV/AIDS
• 33.3% think that school should have active role in sexuality education
• 55.3% claim that the best sources for information doctors/nurses
Health Sector Response to Reproductive Youth Needs

Raising the awareness of the problem of HIV rapid growth in youth population among healthcare providers and necessarily of HIV/testing
Was trained 10 family doctors which provide services for IDP ‘s on testing and canceling and youth education
Trained university doctors on concerning and testing

Develop and implement new curriculum in Post graduate medicine for licensing and requalification doctors
Developed and implemented HIV/AIDS prevention program at schools for IDP

- Created education program for 10-11-12 grade school children
- Trained health personnel responsible for health of IDPs from camps
- Created Medical Consulting Centers in IDPs camps
- Involved journalists on HIV awareness
- Established coordination among community, NGO and governmental representatives
- Published informational Brochures
- More that 1000 IDPs were involved in behavior changing
Changing Health Related Behaviors at University Level

Run 20 discussion in Sukhumi University on topic safe sex, condoms, STI, HIV/AIDS and on rapid HIV/AIDS test.
Changing Health Related Behaviors at School Level

By trained doctors was provide 96 circle lectures at schools for 10,11,12 grade schoolchildren in Tserovani, Shashvebi and in Kvernaki and in Sukhumi School with participation 2160 school child
RESULTS OF RAPID CONFIDENTIAL HIV TESTING

Early diagnosis of HIV infection facilitates medical interventions and enables infected persons to reduce high-risk behavior and the likelihood of further HIV transmission. To determine the extent to which adolescents are being tested for HIV, data from the survey were analyzed. 467 students tested in confidential rooms at university and 97 practice home-based HIV-testing. 487 students refuse testing as they feared the results of an HIV test.

Result of interview show that non-testers were significantly more likely than testers to agree that they are risk for HIV infection (p< 0.6), to fear test result (p<0.002), to fear to loose family, friends as result of an HIV-positive diagnose (p<0.3). Majority of both group agreed that they were at risk for HIV infection and that they feared the results of an HIV testing. 98, 8 % of respondents were being testing for the first time. 57% noted that they are sexual active. No new infections were diagnosed.

- Held 92 group discussions at 10 faculty students got information on all aspects of sexuality, contraception, sexually transmitted diseases including HIV/AIDS, risk –reduction counseling, routine HIV testing.

- Using both qualitative and quantitative methods, the study gathered information on results of routine HIV testing of 564 students using urine HIV test manufactured by Seradyn, the "Sentinel" test. As this test is less sensitive than blood test, positive results must be confirmed by a traditional blood sample (ELISA).
Develop communities based strategy to reduce HIV/AIDS

Prepare volunteer group for door-to-door approach (12 person). By peer-educator – was visited 800 Families, house given information and brochures.
Developing the institutional mechanisms of health care system response

Develop special program for licensing and recertification for health care providers. This is a five-day program providing 25 credit hours for the doctors.
Work of Community Self-Groups

in complement setting created group which work on awareness, meetings, distribution of brochures on testing HIV/AIDS, ongoing governmental program which work in the country.
Research on Improvement Access to Youth Sexual and Reproductive Health Counseling services

Youth face barriers in accessing information on reproductive health and services. The main goal of the project is to research on students' attitude towards the sexual and reproductive health issues and their vision on health services, particularly low Youth-Friendly Reproductive Centers at Primary Health Care Level and Doctor's Offices at the University Level respond to the student's reproductive needs.

120 students (61 boys and 59 girls) randomly selected and interviewed face-to-face. Also was conducted three focus groups discussion.
RESULT

- Research on students attitude towards SRH and their vision on health services, particularly how Youth –Friendly Services work in Primary Health Care Level and Doctors Offices at Universities - 120 respondent
- Student from 3 University has no information about existed Youth –Friendly Services in Primary Health Centers (86%)
92% of students from 4 universities noted that the Health Cabinet of Universities is not active on RH issues. In case of involved university Health Cabinet in RH service, 43% want to see their doctors, 38.8% psychologists.
Focus group discussion revealed

- students do not aware about youth-friendly reproductive health centers available at primary health care level
- 12% of students never visited doctor.
- 75% reasons not visited is luck of anonymity.
- 59% get about STI, HIV from friends or internet
- 96% are interested in youth-friendly consultation centers and 62% attaching to it great importance.
- 43% wish to have qualified doctor
- 31% psychologist as a personnel service providers at youth-friendly consultation centers.
Develop Model of Youth Friendly Service in Mtsxeta for IDP youth

- Establishment of Consulting Center with hot-line, judicial consultation. Youth friendly Center provide hot-line consultation, condom distribution, education at schools, touting testing, face to face consultation and gynecological examination in case of reveal cases make link with AIDS Center in Tbilisi.
RESULT

- First time on the level of school children was speaking about HIV /AIDS, the way of prevention and where they can get information, help.
- Created educational programs for high schools (3 lessons) include the book of biology and teach at the 8 grade.
- 3. Preparing of special additional materials (posters, brochures, etc) for civic education.
- Prepared *health personnel which responsible for health of IDP’s in these camps*
- *Created Medical Consulting Centers in nearest Primary Health Center Mtsxeta*
- *Was establish in Tserovani Networks of communitte- self groups*
- *Make first steps on Education reform and submitted to Ministry of Health of Abkhazia*
CONCLUSION

- Universities must practice HIV prevention programs by including information on confidential HIV testing. It is necessary to establish collaboration of schools, universities with local health centers and community-based organizations in order to help students receive HIV testing.
- Health-care providers should provide HIV testing routinely to all patients aged ≥13 years.
Necessary implementation PARIS Community Declaration

Ending AIDS impossible without screening on HIV status and early gets treatment, and implement Behavioral, Biomedical, Structural Interventions for achievement Sustainable Development Goals (SDG) of ending AIDS as a public health threat by 2030
Necessary

- Deliver information and assistance about sexuality, reproductive health, and HIV/AIDS to most in need young women (especially under age 25)
- Implement rounding screening on HIV using oral Quick HIV self-test, make HIV Testing Linkage to Care, creating a “youth-friendly” services
Paris Declaration

PARIS COMMUNITY DECLARATION
JULY 2017

We, Key Affected Populations, living with or affected by HIV, reiterate that we are more than just numbers. We have essential needs that must be met equally. It is this right to life, health, dignity and future, that necessitates our political commitment and ensures them in the declarations we adopt in this Declaration. The definition of key populations may change, but ever-changing cultural, social, political and economic environments. Our rights and needs remain. We are people who have lost their lives, freedom, health, identity, dignity, family and children. We are people who have lost all rights to national identity, freedom and life, and human rights. We are people who have lost all rights to freedom of association, movement and expression. We are people who have lost all rights to education, employment and health care. We are people who have lost all rights to access to justice, social security, food, water and shelter. We are people who have lost all rights to health care, education, employment, housing, food, water, shelter, justice, social security, human rights and freedom. We are people who have lost all rights to life, health, dignity and future. We are people who have lost all rights to freedom of association, movement and expression. We are people who have lost all rights to education, employment and health care. We are people who have lost all rights to access to justice, social security, food, water and shelter. We are people who have lost all rights to health care, education, employment, housing, food, water, shelter, justice, social security, human rights and freedom. We are people who have lost all rights to life, health, dignity and future. We are people who have lost all rights to freedom of association, movement and expression. We are people who have lost all rights to education, employment and health care. 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Thank you for your attention!
Sexual violence and HIV in armed conflict settings

A qualitative assessment on the association between sexual violence and HIV status among internally-displaced women in Lviv, Ukraine

Marta Vasylyev, MD
Charitable Salus Foundation
Conflict of interest

• None
Ukraine

Area of 603,628 km\(^2\) (233,062 sq mi), making it the largest country within Europe with a population of 42.5 million
HIV data

Ukraine (2016)

- 220,000 people living with HIV
- 0.9% adult HIV prevalence
- 16,000 new HIV infections
- 7,900 AIDS-related deaths
- 28% adults on antiretroviral treatment

In March 2014, protests took place in the Donetsk and Luhansk regions of Ukraine, after the 2014 Ukrainian revolution and the Euromaidan movement.

These protests followed the annexation of Crimea by the Russian Federation and escalated into an armed conflict between the separatist forces and the Ukrainian government.

A total of 9940 deaths due to the war in Donbass was reported by the United Nations.
Internally Displaced Persons (IDP)

- In August 2014 due to escalation of the conflict people left their homes (Crimea and Donbas region in Eastern Ukraine) and moved to the western part of the country.

- There are 7900 internally displaced citizens officially registered in Lviv region.

- Estimates on sexual violence and HIV prevalence are not available.
Salus foundation

- A charitable non-profit NGO established in Lviv in January 1996 by physicians
- Active in Western Ukraine (10 million inhabitants)

Mission
- Promote Health
Salus foundation activities

- Prevention of infectious diseases (HIV/AIDS, STDs, viral hepatitis and TB) through medical and social care for the general and key populations

- Promotion of the healthy lifestyle and safe sex practices

- Implementation of new diagnostic technologies for HIV/STDs and other diseases
Aim

- Perform a qualitative assessment on the association between sexual violence and HIV status among internally-displaced women in Lviv, Ukraine.
Methods

- During 2014-2016, the Salus foundation crisis centre provided medical and social support for 87 women from Crimea and Donbas region seeking asylum in Lviv region.

- A survey of a representative sample of women aged 16–49 years (mean 32) was conducted.
- Analysis of obtained data was done with MAXQDA program.
- 11 clients (from 87) reported sexual violence in the preceding two years.
- 9 women signed consent to participate in indepth interviews.
Results

• 22% of study group (2 women) were forced, physically to have non-consensual sex

• 78% (7 women) by means of verbal threats and psychological battering

• 83% cases of sexual intercorses were protected, in 17% cases unprotected sex

• 52% of the women (4 person) reported single sexual violence episode, 21% (2 person) reported 2-5 episodes and 27% (3 person) more than 5 episodes
HIV status

- All 9 women were tested for HIV by ELISA.
- One woman was HIV positive
- She didn’t know her status before the survey
Discussion

• Sexual violence seems a frequent event among internally displaced women in the Lviv region
• Resources are needed for medical and social support for internally displaced women in Ukraine suffering from sexual violence
• Sexual violence may be associated with HIV transmission in particular cases
• A wider range of factors need to be considered for HIV prevention interventions for internally displaced women, victims of sexual violence
Acknowledgement

• Colleagues from Salus Foundation
• Participants of the study
Thank you!

*salus populi suprema lex esto*
Проект «Продовольствие для жизни»
Всеукраинская сеть людей, живущих с ВИЧ / СПИДом
Май-декабрь 2017 г.
Военный конфликт затронул юго-восточные районы Украины, всегда были наиболее затронутыми ВИЧ-инфекцией и имеют самую высокую распространенность ВИЧ в Украине.

15.6K ЛЖВ в Донецкой и Луганской областях

55% получают ART  45% не получают ART

63% Не уверены в ПБ. 37% Уверены в ПБ.

Жизнь и выживание ЛЖВ, включая беременных женщин и детей, зависят от международной гуманитарной помощи.

Предпосылки проекта: гуманитарной помощи и ВИЧ / СПИД (1)

11.4% всех украинских ЛЖВ

Конфликт продолжает усугублять отсутствие продовольственной безопасности и угрожает соблюдению АРТ среди ЛЖВ и блокировать начало АРТ среди ЛЖВ, еще не охваченных лечением.

Потенциальные последствия:
Увеличение количества случаев отказа от АРТ или снижения начала
Увеличение смертности
Эскалация местной эпидемии ВИЧ
Места антиретровирусной терапии (АРТ) Донецкая область

<table>
<thead>
<tr>
<th>ART</th>
<th>ЛЖВ</th>
<th>ЛЖВ на ART</th>
<th>% на ART</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mariupol City AIDS Center</td>
<td>5675</td>
<td>2707</td>
<td>48%</td>
</tr>
<tr>
<td>Donetsk Oblast AIDS Center</td>
<td>1172</td>
<td>686</td>
<td>59%</td>
</tr>
<tr>
<td>Dobropils'ky Hospital of Intensive treatment</td>
<td>1104</td>
<td>579</td>
<td>52%</td>
</tr>
<tr>
<td>Kramatorsk CH #2</td>
<td>762</td>
<td>493</td>
<td>65%</td>
</tr>
<tr>
<td>Toretskaya CCH</td>
<td>589</td>
<td>300</td>
<td>51%</td>
</tr>
<tr>
<td>Konstantinovskaya CH #5</td>
<td>544</td>
<td>320</td>
<td>59%</td>
</tr>
<tr>
<td>Mirogradska CCH</td>
<td>552</td>
<td>286</td>
<td>54%</td>
</tr>
<tr>
<td>Volnovaks'ka CRH</td>
<td>418</td>
<td>202</td>
<td>48%</td>
</tr>
<tr>
<td>Pokrovs'ka CRH</td>
<td>396</td>
<td>212</td>
<td>53%</td>
</tr>
<tr>
<td>Selidivs'ka CCH</td>
<td>345</td>
<td>138</td>
<td>40%</td>
</tr>
<tr>
<td>Druzhkovska CCH</td>
<td>270</td>
<td>151</td>
<td>56%</td>
</tr>
<tr>
<td>Bakhmuts'ka CRH</td>
<td>251</td>
<td>140</td>
<td>56%</td>
</tr>
<tr>
<td>Maryins'ka CRH</td>
<td>249</td>
<td>109</td>
<td>44%</td>
</tr>
<tr>
<td>Avdiivs'ka CCH</td>
<td>233</td>
<td>118</td>
<td>51%</td>
</tr>
<tr>
<td>Krasnolimanska CRH</td>
<td>204</td>
<td>130</td>
<td>64%</td>
</tr>
<tr>
<td>Slov'yanska CRH</td>
<td>194</td>
<td>105</td>
<td>54%</td>
</tr>
<tr>
<td>Mangush CRH</td>
<td>151</td>
<td>85</td>
<td>56%</td>
</tr>
<tr>
<td>CRH of the Nikolsky raion</td>
<td>117</td>
<td>25</td>
<td>21%</td>
</tr>
<tr>
<td>Velkonovolokovskaya CRH</td>
<td>88</td>
<td>37</td>
<td>42%</td>
</tr>
<tr>
<td>Ugledars'ka CCH</td>
<td>82</td>
<td>40</td>
<td>49%</td>
</tr>
<tr>
<td>Novgorodivs'ka CRH</td>
<td>73</td>
<td>19</td>
<td>26%</td>
</tr>
<tr>
<td>Alexandriivs'ki hospital for planned treatment</td>
<td>57</td>
<td>28</td>
<td>49%</td>
</tr>
</tbody>
</table>

Места антиретровирусной терапии (АРТ) Луганская область

<table>
<thead>
<tr>
<th>ART места</th>
<th>ЛЖВ</th>
<th>ЛЖВ на ART</th>
<th>% на ART</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lisichanskaya CCH</td>
<td>465</td>
<td>277</td>
<td>60%</td>
</tr>
<tr>
<td>Severodonetsk City Multidisciplinary Hospital</td>
<td>409</td>
<td>268</td>
<td>66%</td>
</tr>
<tr>
<td>Svativ'ska RAMU</td>
<td>219</td>
<td>178</td>
<td>81%</td>
</tr>
<tr>
<td>Luhansk Oblast AIDS Center</td>
<td>103</td>
<td>86</td>
<td>83%</td>
</tr>
</tbody>
</table>
Проект «Продовольствие для жизни» Всеукраинская сеть людей, живущих с ВИЧ / СПИДом

6,500 охвачены ЛЖВ с продовольственной неуверенностью

Ежемесячная продовольственная поддержка через Cash Based Transfer (CBT) 700 грн. **

26 мест выдачи антиретровирусной терапии (ART) в Донецке и Луганске

Распределение бенефициаров *

<table>
<thead>
<tr>
<th>Живут в</th>
<th>Donetsk oblast</th>
<th>Luhanska oblast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Гендер:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>53%</td>
<td>3440</td>
</tr>
<tr>
<td>Male</td>
<td>47%</td>
<td>3060</td>
</tr>
<tr>
<td>Возраст:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child 0-4</td>
<td>1%</td>
<td>36</td>
</tr>
<tr>
<td>Child 5-18</td>
<td>3%</td>
<td>219</td>
</tr>
<tr>
<td>Adult 18-60 y.o.</td>
<td>94%</td>
<td>6096</td>
</tr>
<tr>
<td>Elderly 60+ y.o.</td>
<td>2%</td>
<td>149</td>
</tr>
<tr>
<td>Включая:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naïve patients</td>
<td>7%</td>
<td>457</td>
</tr>
<tr>
<td>Restart ART after interruption</td>
<td>1%</td>
<td>80</td>
</tr>
<tr>
<td>Patients with TB</td>
<td>2%</td>
<td>144</td>
</tr>
<tr>
<td>Pregnant</td>
<td>1%</td>
<td>49</td>
</tr>
</tbody>
</table>

*Based on data from 5th round of project
** UAH 700 from Oct’17 (before UAH 550)
### Полуфинал реализации проекта

#### Количество раундов, полученных бенефициарами *:

<table>
<thead>
<tr>
<th># раундов</th>
<th># бенефициаров</th>
<th>Перечисленные средства (гривны)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 rounds</td>
<td>6 294</td>
<td>18 252 600</td>
</tr>
<tr>
<td>4 rounds</td>
<td>106</td>
<td>238 150</td>
</tr>
<tr>
<td>3 rounds</td>
<td>103</td>
<td>177 150</td>
</tr>
<tr>
<td>2 rounds</td>
<td>98</td>
<td>115 750</td>
</tr>
<tr>
<td>1 round</td>
<td>101</td>
<td>66 350</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6 702</strong></td>
<td><strong>18 850 000</strong></td>
</tr>
</tbody>
</table>

*For the period of project implementation*.

### Причина выбытия бенефициаров:

- Смерть: 80
- Прекращение ART/ Не пришли к врачу/ нет связи с пациентом: 71
- Государственный налоговый лимит на помощь (2,2 тыс. Грн.) Для нерезидентов районов АТО: 26
- Предыдущие СВТ не используются, участие в проекте приостанавливается до тех пор, пока не будут выяснены причины: 11
- Миграция в другую область Украины: 9
- Лишение свободы: 8
- Отказ от участия (самовольное / дорогая поездка на место *rounds*): 2

207 бенефициаров выбыло из проекта, и 207 новых бенефициаров были включены.
### Структура расходов КБТ * бенефициарами

<table>
<thead>
<tr>
<th>Перевод средств</th>
<th>Потрачено</th>
<th>Процент использования</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 850K UAH</td>
<td>17 381K UAH</td>
<td>92.2%</td>
</tr>
</tbody>
</table>

#### Самые покупаемые товары*:

<table>
<thead>
<tr>
<th>Категория продукта</th>
<th>Процент использования</th>
</tr>
</thead>
<tbody>
<tr>
<td>Мясо</td>
<td>20,3%</td>
</tr>
<tr>
<td>Пищевые продукты</td>
<td>98,4%</td>
</tr>
<tr>
<td>Булки</td>
<td>1,6%</td>
</tr>
<tr>
<td>Личное использование</td>
<td></td>
</tr>
<tr>
<td>Перевод средств</td>
<td></td>
</tr>
<tr>
<td>Потрачено</td>
<td></td>
</tr>
<tr>
<td>Процент использования</td>
<td></td>
</tr>
</tbody>
</table>

*For the period of 3 rounds of project (as of 13 of September)*
Полуфинал реализации проекта

- Уровень продовольственной необеспеченности был оценен для более чем 7100 потенциальных бенефициариев, из которых 6 702 были включены в проект;

- 6 294 получателя получили все 5 раундов помощи к октябрю 2017 года (2900 грн = 112 долларов США за 5 месяцев), что улучшило их продовольственную безопасность;

- 207 бенефициаров выбыло из проекта: 2 главных причины - 1) смерть пациента (80 бенефициаров); 2) Не посещал посещение врача / не принимал ART / не мог связаться с пациентом (71 бенефициарий). 207 новых бенефициаров были включены для замены тех, кто выбыл;

- Активная клиническая группа увеличилась на 8 процентов (537 бенефициаров из неактивной диспансерной группы, включая новых пациентов и пациентов, которые прервали ART);

- Прерывания ART уменьшились в 4 раза по сравнению с допроектной ситуацией;

- Оценки приверженности ART были проведены для 100% бенефициаров в этом проекте;

- Анализ покупок бенефициаров показывает, что целевая группа была выбрана правильно - только 1,6 процента помощи было направлено на непродовольственные товары, а товары с дорогостоящим ценовым сегментом не были приобретены.
Распространенность ВИЧ / СПИДа (1.07.2017)
ТБ (без HIV) распространённость (1.01.2017)
* Данные для Донецкой и Луганской областей отражают только ГСА

Количество ВПЛ:

<table>
<thead>
<tr>
<th>Категория</th>
<th>Кол.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ВИЧ/СПИД</td>
<td>137.0К</td>
</tr>
<tr>
<td>ТБ (без ВИЧ)</td>
<td>28.6К</td>
</tr>
</tbody>
</table>

Восточная Украина: количество ВПЛ, распространенность ВИЧ / СПИДа и туберкулеза (без ВИЧ)
Распространенность ВИЧ / СПИДа и пациентов на АРТ (по состоянию на 1.07.2017)

Вся Украина

- Распространенность ВИЧ / СПИДа: 58%
- Пациентов на АРТ: 79,7K
- Gap: 42%
- HIV/AIDS Prevalence: 137,0K

Восточные регионы

- Donetska: 13,5K (52%)
  - HIV/AIDS Prevalence: 7,0K
  - Patients on ART: 7,0K
  - Gap: 48%
- Luhanska: 2,1K (70%)
  - HIV/AIDS Prevalence: 1,5K
  - Patients on ART: 1,5K
  - Gap: 30%
- Dnipropetrovsk: 26,8K (53%)
  - HIV/AIDS Prevalence: 14,3K
  - Patients on ART: 14,3K
  - Gap: 47%
- Zaporizhsk: 4,5K (60%)
  - HIV/AIDS Prevalence: 2,7K
  - Patients on ART: 2,7K
  - Gap: 40%
- Kharkivska: 3,9K (64%)
  - HIV/AIDS Prevalence: 2,5K
  - Patients on ART: 2,5K
  - Gap: 36%

Показатель перехода: 70%
Планы на будущее (в ожидании финансирования на 2018 год)

<table>
<thead>
<tr>
<th>Составляющая</th>
<th>Целевая группа</th>
<th>Цели</th>
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</table>
| Общая продовольственная помощь (через СВТ) | • ЛЖВ (включая ВИЧ / ТБ) (количество бенефициаров 9 350)  
• ТБ (без ВИЧ) (Количество получателей 1 050)  
• Больше внимания уделяется домашним хозяйствам, возглавляемым женщинами, семьям с маленькими детьми и женщинам и девочкам. | ➢ Повышение продовольственной безопасности для ЛЖВ и людей с ТБ, проживающих в районах, пострадавших от конфликта в Донецкой и Луганской областях (ГКА), и в приграничных районах с высоким уровнем ВПЛ (Днепропетровская, Запорожская, Харьковская области);  
➢ Предотвращение прерывания лечения АРТ среди ЛЖВ и лечения туберкулеза из-за недостатка / отсутствия продовольствия.  
➢ Содействие соблюдению режимов АРТ и противотуберкулезных препаратов среди пациентов с низкой приверженностью АРТ или ТБ и пациентов, которые недавно начали лечение или собираются начать АРВ-терапию.  
➢ Достижение целей ЮНЭЙДС в борьбе с распространением эпидемии ВИЧ (90-90-90 целевых показателей быстрого отслеживания).  
➢ Улучшение результатов лечения ТБ для увеличения числа людей.  
➢ Предотвращение туберкулеза с множественной лекарственной устойчивостью (MDRTB) из-за прерывания лечения туберкулеза |
Если у вас есть какие-либо вопросы, предложения или идеи, пожалуйста свяжитесь с нами!

Всеукраинская сеть людей, живущих с ВИЧ / СПИДом

All-Ukrainian Network of People Living with HIV/AIDS

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"Проблемы трудовых мигрантов Республики Таджикистана"

Общественная Организация «Апейрон»
Наша организация формировалась в 2005 г. Миссия организации: профилактика ВИЧ/Гепатитов/ИППП среди лиц, употребляющих инъекционные наркотики (ЛУИИ) и секс работников (СР) в Республике Таджикистан (РТ). Наши проектные зоны: районы РТ, расположенные вдоль границы с Афганистаном. На сегодняшний день услугами снижения вреда охвачены 2703 ЛУИИ. Основные источники финансирования наших проектов это Глобальный Фонд, UNDP & UNFPA.
Экономическая ситуация

Республика Таджикистан является одной из наиболее бедных стран мира. По расчетам Международного валютного фонда, 63 % населения живут меньше чем на $2 в день. Экономика страны находится в огромной зависимости от средств, зарабатываемых трудовыми мигрантами. Отсталая, недоразвитая национальная экономика Таджикистана является основной причиной безработицы и нищеты большей части населения страны. Безработица и бедность, как основные социально-экономические факторы заставляют людей в поисках работы мигрировать в зарубежные страны, в основном в Российской Федерации.
Экономическая ситуация

Большая часть трудовых мигрантов, более 1 500 000 человек ежегодно, ездят в России на заработки, хотя официально властями подтверждаются только 600 000 мигрантов. Денежные переводы мигрантов в страну составляют более $3 млрд. в год, что соответствует примерно 40% ВВП Таджикистана. Основная часть таджикских мигрантов живут и работают в России без регистрации, т.е. нелегально. Отсюда, таджикские мигранты имеют множество проблем.
Проблемы трудовых мигрантов

У таджикских мигрантов высокий риск заболеваний, включая ВИЧ-инфекцию, они уязвимы по этой инфекции в силу рискованной поведенческой практики и низкой осведомленности о путях передачи и методах профилактики ВИЧ-инфекции. Мигранты, работающие без патента в России (не легально) не имеют медицинскую страховку, они практически не пользуются медицинскими услугами. Среди мигрантов выявлено множество больных туберкулезом, но у них нет доступа к медицинским услугам.
Проблемы трудовых мигрантов

Другой не менее сложной проблемой трудовых мигрантов является потребление наркотиков, что увеличить риск инъекционной передачи ВИЧ/Гепатитов. Таджикистан имеет чрезмерно большие линии границы с Республикой Афганистана. Много тяжелых наркотиков проходят через территорию Таджикистана, и сравнительно недорогие цены на наркотики соблазняют молодых людей. Практически все трудовые мигранты, употребляющие наркотики в трудовой миграции в России, приезжают в России, уже с опиоидной зависимостью.
Проблемы трудовых мигрантов

Статистика заболеваемости, например, по Санкт-Петербургу свидетельствует, что среди мигрантов более распространены опасные инфекции, чем среди коренного населения города. В 2012 году показатели по ВИЧ-инфекции составили 60,0 на 100 тыс. населения Санкт-Петербурга и 83,2 на 100 тыс. мигрантов, по туберкулезу соответственно 32,4 и 154,2, по венерологическим заболеваниям – 53,6 и 206,70. Как следует из этих данных, инфицированных ВИЧ среди мигрантов в 4 раза выше, заболеваемость туберкулезом выше в 5 раз, ИППП – в 4 раза.
Проблемы трудовых мигрантов

Исследование проводившее в Санкт-Петербурге показало, что среди респондентов из Центральной Азии не слышали о гепатите 46,4%, о ВИЧ-инфекции – 40,4%, об ИППП – 27,3%, о СПИДе – 17,3%, о туберкулезе – 12,7%. О ВИЧ инфекции осведомленность заметно хуже, чем о СПИДе.
Деятельность нашей организации с мигрантами

Наша организация в рамках программы CARHAP (Великобритания), в 2006-2012 гг. и в 2015 г. реализовала проект с молодежью, собирающихся поехать на трудовую миграцию в Россию и другие страны. Главной целью проекта была повышение уровня информированности трудовых мигрантов о рисках получения инфекции ВИЧ, Гепатитов, ИППП и ТВ. Был открыт Информационный Центр, где молодежь, прямо перед отъездом в трудовую миграцию, получала информационные сессии, буклеты и брошюры по профилактике ВИЧ, Гепатитов, ИППП и ТВ.
Деятельность нашей организации с мигрантами

В результате реализации проекта более 1000 трудовых мигрантов повысили уровень своей информированности и знания о ВИЧ, Гепатитах, ИППП, ТВ и путях их профилактики.

Нужно отметить, что количество трудовых мигрантов составляет более 1 500 000 человек в год, и охватить всех их информационными услугами нескольких Информационных Центров не возможно.

Необходимо открывать Информационные Центры во всех аэропортах, железно-дорожных станциях, и прямо перед отъездом в трудовую миграцию молодежи оказать информационные услуги по профилактике ВИЧ, Гепатитов, ИППП и ТВ.
Рекомендации

Очень важно, разработать механизм регистрации всех мигрантов по прибытию их в городах России. Выдать им патент на легальную работу, проводит медицинское обследование, и обеспечить их медицинской страховкой. Потому, что основная часть мигрантов работают в России не легально, и именно среди них существует множество медицинских, социальных и экономических проблем. А также, необходимо создавать двусторонний действующий механизм урегулирования проблем и трудностей трудовых мигрантов между Таджикистаном и Россией. Созданные до сих пор различные механизмы практически не работают, и трудовые мигранты до сих пор остаются со своим проблемами.
Источники информации для данной презентации

1. База данных ОО «Апейрон»;


4. ВЛИЯНИЕ МИГРАЦИОННЫХ ПРОЦЕССОВ НА ЭПИДЕМИЧЕСКУЮ СИТУАЦИЮ ПО ТУБЕРКУЛЕЗУ И ВИЧ-ИНФЕКЦИИ В РОССИИ.
   moscow.iom.int/.../SPb_Migrant_Disease_Awareness_Survey_Report_08.10.2014_ru

5. ВИЧ, ИППП, ТУБЕРКУЛЕЗ, ГЕПАТИТ. vestnik.mednet.ru › Архив номеров › №4 2015 (44)

6. Исследование «Мигранты Санкт-Петербурга: распространенность поведенческих рисков в отношении инфекционных заболеваний (ВИЧ, ИППП, и пр.) среди мигрантов из Центральной Азии. Vestnik.mednet.ru


8. И много других источников.
Спасибо за внимание
Coping course for HIV-positive migrants

Girmay Berhe Assemahegn
Aksept
Center for all affected by HIV
Migrants living with HIV

- Next largest group of HIV positive who use Akspet regularly.
- In 2011 in Norway 109 new HIV cases were diagnosed in the group, against 109 cases in 2011 in Norway. / Institute of Public Health /
- In conjunction with 3 coping courses that Aksept has conducted in 2011-2012 for newcomers, the Center has contacted 64 new users during the period.
Migrants living with HIV

- About 48 participated in 3 Coping courses and 16 used other services during the period from the center.
- 24 of these came in the period 2011-2012 (11% of the number of HIV positive in the group who arrived in 2011 and 2012)
- The rest 42 arrived in 2009 & 2010
- The above 64 new users for example represent only 15% of the group infected before arrival who have come to the country for the last 4 years.
Objectives

- Everyone living with HIV must be ensured of good treatment and follow-up regardless of age, sex, sexual orientation and / or practice, residence, immigration status, ethnic background and own finances.
- Reducing Stigma
- When Aksept, Church mission of Oslo, formulated the project for the first time in 2011 the strategic Steps in the National strategy was at the following implementation level.

Strengthen the dissemination of knowledge and coping strategies to particularly vulnerable immigrant communities.
• Since 2011 Aksept has been conducting coping courses for asylum seekers and newcomers living with HIV 3 times a year.

• 12 -15 PLWHA participated at each seminar. All from different countries in Africa and the middle east and Asia.

• They come from Asylum Reception centers and Municipalities in the whole of the country to our center in Oslo for week and stay at our guest house.

• Plain and train tickets are covered by the project as the project is consistently funded by the Ministry of Health of Norway (Helsedirektoratet)
Objectives of the Coping Course

• Increase the knowledge of HIV, safe sex, physical and mental health, diet and rights and duties as HIV positive in Norway.
• Contribute to good mental and physical health among the participants
• Reduce stigma

. Prevent isolation and loneliness through network participants during the coping course, but also after the course through personal contacts, Paltalk social media meetings etc.
Implemented activities to reach the objective

- Time frame and progress plan of the coping course project every year included the following phases in implementation.
- Phase 1: Preparation - Recruitment. February –
- Make simple brochure / information letter about the offer
- Send this to all asylum receptors in Norway, to hospitals, NAV and other relevant agencies
- Follow up the most relevant asylum reception centers and hospitals by telephone
- Recruitment work in own networks
- Develop program for the course
- Engage initiators and partners.
- Practical preparation
Phase 2: Conducting the Coping course

- A hectic week of the coping course in our center in Oslo.
- We collaborate with Oslo University Hospital, University Hospital in North Norway,
- HIVNORWAY, Nye plus and a pharmacist specializing in HIV medicines.
- In collaboration with the above organizations we developed the course material. We have now a professional course material that focuses on the following topics: HIV pure medical, sexuality and safe sex, rights, responsibilities and duties as HIV-positive in Norway, health and diet.
Phase 3:
Conclusion.

• Evaluation and learning in relation to next year's course
• Follow-up of participants who wish and need more help.
• Report writing
More than 230 asylum seekers in Norway have come to the capital for a week of coping course in 6 years.

The subject content was important and good for the participants according to their anonymous evaluation “Quest back” they fill at the end of the course. But what was even more important was that the participants met other people living with HIV in Norway.

They shared their stories, related friendships and contacts, and the feedback was that this was the most important side of gathering.

One of the obvious tangible results of the project is that Aksept now has a “Paltalk” audio video chat room that perfectly functions as a means of information, and self help among the participants of the coping course and beyond. The users of Aksept use the Paltalk audio video chat “closed” room after getting a password during their stay in the coping course.

Aksept uses the Paltalk medium to inform the users who live out of Oslo in many up dating themes. While the users themselves use it for self help purposes.

Users at Aksept contributed in the development and implementation of the course as resource persons and peers. Veteran and resourceful users of Aksept have participated in the coping course by sharing their experiences in each course. They have also helped as interpreters in different languages depending on the nationality of the participants. Users at Aksept contributed in the development and implementation of the course as resource persons and peers.
Securing and Sustaining Free HIV Treatment for Undocumented Migrants

AAE Members Meeting – 12th November 2017

Christopher Hicks– NAT (National AIDS Trust)
About NAT

UK’s policy and campaigning HIV charity dedicated to transforming society’s response to HIV (since 1987)

- Equitable access to treatment, care & support
- Eradication of HIV-related stigma and discrimination
- Early diagnosis of HIV
- Effective HIV prevention
- Enhanced understanding of HIV
Overview

- In the UK, the National Health Service (NHS) is a comprehensive health service providing free treatment and care to all UK residents. It is funded by taxation i.e it is not an insurance-based or contributory system.
- This in effect makes it one of the most accessible healthcare systems in the world. However, not for migrants.
- Some people in the UK are not entitled to free NHS care. This includes short-term visitors and undocumented migrants.
- Until 2004 anyone who had been living in the UK for 12 months or more could also access free NHS care. But the Government changed the regulations so that NHS care was free of charge after 12 months of 'lawful' residence.
- HIV treatment and care was a chargeable service.
- We won the campaign to make it free in 2012.
Why was this important?

- Migrants and asylum seekers, especially from sub-Saharan Africa, are amongst the most affected by HIV in the UK.

- Black African men and women living in the UK are disproportionately affected by HIV, making up 1.8% of the UK population but 31% of all people accessing HIV care.

- Levels of non-diagnosis are high in African communities. In 2015, the proportion of black African heterosexual men and women unaware of their infection was 11% and 10% respectively.

- Additionally, the highest proportion of late diagnoses of HIV in the UK is found amongst Black Africans. In 2015, 39% of people diagnosed with HIV were diagnosed late. This rose to 59% for black African men and 51% of black African women.

- While not all migrants are from black or ethnic minorities, a substantial proportion will be.
Figure 4: New HIV diagnoses by place of birth and gender: UK, 2006-2015

- **Born abroad**
- **UK born**

<table>
<thead>
<tr>
<th>Year</th>
<th>Born abroad</th>
<th>UK born</th>
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<tr>
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<td>2015</td>
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</table>
By undocumented migrants we mean people without current lawful residency status. In practice, the main groups included are:

• people who have overstayed after the expiry of their visa
• people who have had an asylum claim refused but remain in the UK, and
• people who have entered the country unlawfully
How did we secure free HIV treatment for undocumented migrants?

- Debunking the myth of HIV health tourism
- Deterrence from treatment and a confusing system
- Public Health
- United Voice of HIV sector / Wider Alliance
- Cost of implementing the system
- Other European Countries
Debunking the myth of HIV health tourism

• Research evidence shows that a desire to access particular benefits or healthcare provision is not a factor in migration patterns
• Migration patterns bear no relation to the distribution of HIV prevalence across the globe
• There are no discernible impacts of recently introduced NHS charges on migration of people to or from the UK
• Levels of HIV amongst migrants to the UK are in general significantly below HIV levels in their countries of origin
• There are on average very significant delays between migrants arriving in the UK and their accessing HIV testing and treatment

WE CHALLENGED INACCURATE MEDIA COVERGE, AND FORCED PRINTED RETRACTIONS FROM NEWSPAPERS
Deterrence from treatment and a confusing system

- People absented themselves from HIV treatment and care
- We gathered case studies from both voluntary sector organisations and from HIV clinics through the relevant networks
- Two cases were discovered of people with HIV/TB co-infection where the patient abandoned their TB treatment early (despite the fact it was free) because of fears around the HIV-related bill
- We gathered examples of NHS staff not understanding the rules and denying access to treatment to those migrants who were in fact entitled to it, or of migrants entitled to HIV treatment not wanting to get tested because they felt they would not be allowed to access treatment afterwards
- A disincentive to test
Impact on public health

- People deterred from accessing treatment will remain infectious and are more likely to pass on HIV

- Amongst those on ART in the UK more than 90% have an undetectable viral load

- RCT evidence of HPTN052

- Undetectable=Untransmittable (U=U)

- Need for prevention in a time of austerity
Cost of implementing the system

• Charging undocumented migrants for HIV treatment was a process with its own costs in bureaucracy, chasing up unpaid bills etc

• Charging deterred people from testing and thus from diagnosis and care - so instead of people being diagnosed in good time they were only diagnosed when seriously ill, requiring extremely costly intensive and/or inpatient care (as care could not be denied when considered urgent)

• Charging in deterring people from testing and thus from treatment also meant people did not alter risky behaviour which they might do following diagnosis nor could they take advantage of the preventive benefit of treatment
United Voice of the HIV sector / Wider Alliance

- HIV sector was united in opposing charges
- Voice of the HIV doctors' association, BHIVA (the British HIV Association) was a very important and authoritative voice arguing against charges
- Public Health bodies
- Migrant rights organisations
- We were a founder member of a coalition of voluntary sector and professional organisations aiming to challenge charging for NHS care – using migrant rights’ charities
Other European Countries

- We gave examples of other European countries where treatment was made accessible to undocumented migrants - the civil servants told us that the Minister was especially interested in such precedents since it would show that England was not being excessively generous when compared with other European countries.
What now?

- Continued charges in secondary care

- Upfront charging to be introduced

- Extending services that are chargeable to those provided outside a hospital setting – this means drug addiction treatment services could become chargeable

- This year, we had to fight against identification checks happening in infectious diseases departments and HIV clinics – but we won!

- Government are looking at introducing charges in primary care – we must fight this
Successes

- Securing legislative change so that HIV treatment and care became free for all
- Ensuring that primary care has not become chargeable for undocumented migrants
- Ensuring that public health arguments around ‘treatment as prevention’ continue to shape the Government’s policy-making
- Challenging inaccurate media coverage around ‘health tourism’ and HIV

BUT WE STILL NEED TO ENSURE THAT CHARGING IN OTHER AREAS OF OUR HEALTHCARE SERVICE DOES NOT EFFECT MIGRANTS LIVING WITH HIV.
Thank you!

christopher.hicks@nat.org.uk

www.nat.org.uk/publications

@NAT_AIDS_Trust
The European HIV Legal Forum – AIDS Action Europe Member and Partner Meeting

Ferenc Bagyinszky
AIDS Action Europe

November 12, 2017
<table>
<thead>
<tr>
<th>Organization</th>
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<td>National AIDS Trust</td>
<td>United Kingdom</td>
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Project objectives

• Deliverables:
  – Legal survey – 16 countries
  – Legal report
    • main international regulations in favour of the right to healthcare
    • leading European Laws Related to the Right to Healthcare
    • European case law
    • Country Profiles
  – Collection of good practices
    • rights literacy
    • prevention and treatment literacy
    • anti-discrimination tool etc.
  – Advocacy tool
  – Collaboration with other organizations and networks – national and European level
Research on access

• RIGHT TO HEALTH – in constitution or other legislation
• UNIVERSAL ACCESS TO HEALTH CARE – how healthcare is structured
• HIV TEST/HIV DIAGNOSIS
• HIV TREATMENT
• STI TEST/STI TREATMENT
• COMM. DISEASES (TB, viral hepatitis)
• EMERGENCY/ACUTE/CHRONIC/PRIMARY CARE
• Other services
Provision of ART for undocumented migrants in European countries, 2017
European Centre for Disease Prevention and Control

Figure 4. Availability of ART for undocumented migrants in Europe and Central Asia, 2016