A Europe free of AIDS, TB and viral hepatitis - and no one left behind

Meeting report: 9th April 2021
Western and Central Europe Civil Society Consultation for the UN High Level Meeting on HIV/AIDS

Content

1. About the consultation meeting

The 8-10 June 2021 UN General Assembly high-level meeting on HIV/AIDS (HLM) will provide an opportunity for UN member states (MS) and selected Civil Society (CS) members to review progress of commitments made in the 2016 Political Declaration (towards the 2030 Agenda for Sustainable Development. A new declaration will be adopted.

On 23 April 2021, a Multi-Stakeholder Hearing (MSH) will take place to inform the preparation of the UN meeting. The preparation of this hearing will be supported by the Multi-Stakeholder Task Force (MSTF), composed of representatives from civil society and the private sector. Consultations are expected to be

organized in two sections: Section 1: Inputs from communities and civil society to the HLM 2021 Political Declaration; Section 2: Inputs from communities and civil society to the work of the MSTF.

The MSTF shall produce a document that captures the vision, priorities, and demands of CS.
Such content may be collected by reaching out to the community and CS for a consultation.

On 26 March, UNAIDS and the EU Civil Society Forum on HIV, TB and Hep (hereafter CSF) coordination team agreed that the latter would organise a consultation of civil society organisations operating in Western and Central Europe on 9 April and send back a report by mid-April. The CSF coordination team sent invitations to a diverse range of participants representing people living with HIV and key populations in the following domains: community and civil society representatives, organizations and networks.

Prior to the meeting, registrants were provided with the following background documents: Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030; UNAIDS Strategy 2021 - 2026; and the key messages found on the UNAIDS intranet page for the 2021 HLM. The consultation centred around 3 main questions namely:

1. What have we learnt in the last 5 years since the last High-level Meeting on AIDS, that are game changers in the HIV response?
2. What progress has been achieved and what challenges remain in realizing the commitments set out in the 2016 Declaration of Commitment and the Political Declarations on HIV/AIDS?
3. Are these challenges addressed in the new Global AIDS Strategy and what commitments need to be included in the 2021 Political Declaration to see progress in your country and/or region?

Due to the short timeframe to plan the consultation, the participants who attended may not be representative of their region(s) as a whole, and some Central/Western European countries did not participate. The list of participants can be found in Annex A.

This document reports on the CSF consultation of Western and Central Europe civil society organisations in preparation of the upcoming UN High Level Meeting on HIV/AIDS.

2. Consultation agenda

10:00 - 10:10 Welcome and short introduction to the aims and context of this consultation
Sini Pasanen - HIV Finland, AAE, CSF Coordination team

10:10 - 10:40 Reflections on the 2016 Political Declaration - what has been achieved in the region and where are the obstacles? *Ferenc Bagyinszky* - AAE

10:40 - 10:45 Explanation of breakout group process, Sarah North, EATG

10:45 - 11:35 Break-Out Rooms (I)

Group 1 | Facilitator: Sini Pasanen, AAE | Rapporteur: Roberto Perez Gayo, C-EHRN
1. Access to Services
2. Breaking down Structural barriers

Group 2 | Facilitator: Frank Amort, EATG | Rapporteur: Louise Cliff, TBEC
3. Funding, integration & COVID-19
4. Cross cutting issues, political leadership, advocacy, community led Monitoring.

11:35 - 11:45 Break

11:45 - 12:35 Break-Out Rooms (II) (50 min)

Group 2 | Facilitator: Sini Pasanen, AAE | Rapporteur: Roberto Perez Gayo, C-EHRN
1. Access to Services
2. Breaking down Structural barriers

Group 1 | Facilitator:Frank Amort, EATG | Rapporteur: Louise Cliff, TBEC
3. Funding, integration & Covid-19
4. Cross cutting issues, political leadership, advocacy, community led monitoring.

12:35 - 12:55 Feedback from Break-Out Rooms Roberto Perez Gayo, C-EHRN, Correlation & Louise Cliff, TBEC

12:55 - 13:00 Next steps and closing remarks, F*erenc Bagyinszky* - AAE

3. Report from consultation

3.1. Introduction

The meeting started with an overview on the UN HLM process and the 2016 Political Declaration.

Key chapters of the Declaration from the perspective of civil society:

i. Resources – domestic and donor funding;
ii. access to testing and treatment;
iii. gender equality and the empowerment of all women and girls;
iv. enabling legal environments for access to services and end HIV-related stigma and discrimination;
v. engaging and support people living with HIV and *key populations* (referenced in the Declaration as 'people at risk');
vi. regional leadership and institutions – more effective AIDS responses;
vii. Governance, monitoring and accountability (for and with people)

Participants were polled at the beginning of the consultation and brought up some reflections among the group of participants. It was pointed out that there is a lack of indicators to monitor and measure questions related to adequate national financial resource distribution. There is a need for more granular reporting on this. Also, some governments may claim to be adequately funding HIV prevention services, yet these are not equally distributed to Key Populations (key populations), nor does it include the range of combination HIV prevention interventions. It was noted that many governments are exclusively funding testing as prevention, and even exclusively HIV treatment as prevention, services to the general public.

It was underlined while the assumption behind targets is that evolutions will be positive when in fact, the reality is that there has been regression in several locations. Central European countries are having more restrictive laws imposed which violate human rights of people living with HIV and key populations, and reduce/eliminate funding for harm reduction services. It was mentioned that authoritarian political forces are gaining ground also in Western Europe.

	N=37		
Statement	**Agree (%)**	**Don't know / not sure (%)**	**Disagree (%)**
Number of new infections among people over age 15 have been reduced by 75%	4	33	62
Number of new infections among children and youth under age 15 have been reduced by 95%	27	50	23
The UNAIDS treatment targets (90-90-90) have been reached	24	0	76
The financial resources for prevention are adequate (at least 25% of all HIV/AIDS spending)	12	23	65
Resources are targeted to evidence-based prevention measures that reflect the specific nature of each country's epidemic	38	15	46
Gender inequalities have been reduced, the situation and human rights, including SRHR of women have improved	23	19	58
Access to combination prevention services for all at risk have improved	38	4	58
Laws and policies have changed to enable access to prevention and treatment services	23	12	65
Laws and policies have changed and have been introduced to eliminate HIV-related stigma and discrimination	12	23	65

3.2. Report from the breakout groups

Form provided by UNAIDS	
Section 1 Inputs from community and civil society to the HLM 2021 Political Declaration	

List 5-6 key issues that have been prioritized for inclusion in the new Political Declaration	1. *All* key populations are being left behind in MS countries where governments are funneling HIV prevention funds exclusively into testing geared towards the general public. 2. Explicit inclusion and naming of harm reduction interventions. 3. MS legislation and policies must be evidence based. 4. Prioritise sexual and reproductive health rights. 5. In order to effectively pursue and monitor progress towards the UNAIDS 2025 targets, the role of governments and the 'community-based monitoring' must be defined. A more comprehensive set of indicators must be defined. 6. COVID-19 has drawn attention to "structural barriers". When being addressed, these barriers must be explicitly named (legislation on sex work, drug use, housing, exclusion of health coverage, etc.)
List 5-6 key issues that are red flags/difficult issues in the region that post a problem during the negotiations of the new Political Declaration	1. Authoritarian governments in Central Europe are imposing laws and policies that violate the basic human rights of people living with HIV and key populations. They shrink the space for CSOs working with these populations. This is a growing threat in Western Europe 2. While it is important for key populations, sexual and reproductive health rights, and harm reduction services to be explicitly named; Populist governments are unwilling to do so. 3. Chronic underfunding and lack of government accountability on how HIV services funds are allocated. NGOs have been filling in gaps but funding is unreliable. 4. The lack of MS accountability measures, in regards to reporting and implementation, at the EU and international levels is skewing the reality on the national/local levels. 5. Lack of CSO understanding on how to communicate/relay messaging to HLM if governments are blocking/censoring the information they provide.. 6. People who use drugs and sex workers (particularly those who are trans, migrants) were named as key populations experiencing heightened mental health issues as a consequence of COVID-19. Lockdown restrictions resulted in disruptions to harm reduction programming, and loss of sex work income.
Section 2 Inputs from civil society to the work of the Multistakeholder Task Force for the production of the community and civil society statement to the HLM	

List 3 key messages, priorities and demands to each one of the following areas:	
1) Maximize equitable and equal access to HIV services and solutions	**Key messages** 1. "Nothing about us without us". Supporting and *defining* community-led and community-based services, in order to apply a structured approach. Key populations must be involved at all stages of service delivery models (from inception, to implementation and evaluation). 2. Advocacy is an essential component in HIV services and solutions. 3. Naming and prioritizing of key populations is crucial to maximizing access. Also, stronger language on combination prevention is needed in general. Prevention is not limited to testing and treatment.
	Key priorities 1. Address HIV prevention disparities between urban and rural areas. Solutions such as self-testing should be invested in. 2. The provision and maintenance of safer spaces for community, NGOs, and at regional level is critical. 3. The inclusion of closed settings (ie. prisons) in prevention services is essential.
	Key Demands 1. Data collection and reporting require better indicators to move forward, and identify who is being left behind. 2. Comprehensive and integrated services for the sexual health of key populations that go beyond HIV testing to include comprehensive HIV prevention programmes including harm reduction, PreP, STI prevention (testing as prevention, but also vaccination). 3. Better collaboration between national authorities and CSO.
2) Break down barriers to achieving HIV outcomes	**Key messages** 1. COVID-19 has put forward epidemiological discourse in the general population regarding health inequalities. This can potentially facilitate dialogue of different/new HIV advocacy

	strategies, with the possibility to generate support from the general population. 2. The contributions made by non-state actors are often self-resourced and go unacknowledged by governments. 3. *Preventing* stigma is just as important as eliminating stigma.
	Key priorities 1. Funding for services and advocacy should be at the forefront of advocacy efforts, both nationally and internationally 2. Intersectionality, service delivery integration, and collaboration across sectors 3. Attention must also be drawn to the stigma and discrimination experienced by people living with HIV and key populations in healthcare settings. Medical professionals in Central Europe do not seem to be receiving/receptive to *sensitizing* training.
	Key Demands 1. Develop mechanisms to ensure MS are accountable to standards of evidence-and rights-based decision making 2. Address and reduce criminalisation and *inappropriate use* of criminal law in relation to people living with or most affected by HIV. 3. Universal Health Coverage must become a cornerstone of the HIV response
3) Fully resource and sustain efficient HIV responses and integrate into systems for health, social protection, humanitarian settings and pandemic responses	**Key messages** 1. Diversion of funding and reprioritization of resources to pandemic have negatively impacted HIV responses. Stigma remains a major barrier and harm reduction funding of needle exchange programmes and opioid substitution therapy has decreased substantially. Testing among PWUD is also limited. 2. Lockdowns have impacted access to community-based services, by way of physical distancing restrictions and/or key populations losing jobs/income. Concerns of the long-term mental health effects of COVID on people living with HIV and key populations. Also, the shift to online communication has posed challenges to organizational development within NGOs.NGOs continue to struggle to maintain services due to COVID-19 and funding barriers.

	3. The UNAIDS Strategy and some national plans are well thought out but there is no budget for implementation to reach the objectives. There have been advances in harm reduction services which are now considered among essential national health services. These services should be ensured but they are not implemented /sustained because of lack of funding.
	Key priorities 1. Sex workers (especially those who are trans and migrants) and peope who use drugs continue to be ignored/invisible. Reduced access to harm reduction/HIV services during the pandemic is likely to result in poor health outcomes and increased infection rates. This is something to monitor. 2. Investments in HIV prevention services must go beyond simply providing HIV testing, and include the full range of harm reduction and biomedical prevention strategies. 3. There is confusion over the vulnerability of people living with HIV to COVID-19, which is not helped by poor communication on behalf of governments which has created anxiety as risk has been overstated for all people living with HIV . Moreover, across MS, people living with HIV are not consistently prioritised for COVID-19 vaccination.
	Key Demands 1. Funding and integration of comprehensive prevention services that goes beyond exclusively testing and treatment. 2. Sustainable restoration/adaptation/continuation of HIV services that have been disrupted during the pandemic. These solutions must be accessible to key populations in rural/urban settings, and include a range of approaches (ie. home-testing, mobile services, adjusting number of clinical visits, e-health, etc) 3. Build on opportunities created by an increased attention to communicable diseases and socio-economic determinants of health outcomes.
Accountability and advocacy: What systems need to be in place to support national governments to meet this commitments and to ensure communities living with and	**Key messages** 1. There are some progressive strategies/legislation/policies/recommendations at EU level regarding harm reduction and the basic human rights of key populations, but the national level does not always

affected by HIV can monitor and hold stakeholders accountable?	align/follow. There is a discrepancy of what governments discuss at UN level compared to what is implemented at national level. 2. Discrepancy between what governments and CSOs define as "progress" in HIV strategies. There is an assumption of progress when reviewing targets when in reality laws and policies have regressed compared to 2016 in some locations within these regions . 3. Monitoring and reporting in some countries actively excludes NGO/community input (some Central European countries explicitly named). Reporting at the EU level is currently provided by national government bodies.
	Key priorities 1. Need to promote community-led services by and for key populations 2. Government setbacks and negative backlash towards people living with HIV and key populations must be accounted for at the European-level. 3. There is a need for community-level shadow monitoring and reporting.
	Key Demands 1. Regional and international collaboration to ensure accurate national monitoring. Concise and clear indicators and metrics that capture all key populations for effective monitoring and reporting. 2. UNAIDS should check which HLM country delegations include civil society. 3. A platform is needed for CSOs to advocate for the basic human rights of key populations in the face of state sponsored criminalization and moralistic policies. CSOs feedback is being blocked from reaching the EU/international level.
Any other issues:	

A. How to maximize equitable and equal access to HIV services and solutions ?

CENTRAL EUROPE

Participants stressed the importance of supporting and defining community-led and community-based services, in order to apply a structured approach. Regardless, key populations must be involved at all stages of service delivery models (from inception to implementation). “Nothing about us without us”.

The UNAIDS 2030 target of 30% all HIV services should be delivered by community led, however the lack of definitions makes it unclear what is being referenced. Participant comments made that communities must lead services *and* advocacy efforts.

Right-wing populist governments have demonstrated a complete lack of respect and responsibility to the equitable and equal access to HIV services and solutions, therefore it is difficult to answer how to maximize this. Such authoritarian governments have caused the shrinking of safer spaces for civil society. Community-based organizations fear being penalised for speaking out/advocating when they are dependent on the meagre funding from some local authorities.

Governments need to be held accountable. At the HLM they say what the donors/UN want to hear in regards to harm reduction and drug policy for example, but there is no follow-up on the national level. Community organisations in some regions provide advocacy documents to governments, only to see them blocked not shared at UN level.

Some participants reported being uncertain about how to work with UNAIDS - difficult to navigate this and interpret the language used.

Comprehensive and integrated services for the sexual health of key populations that go beyond HIV testing to include HIV prevention programmes, and STI prevention (testing as prevention, but also vaccination).

Communities such as sex workers, LGBTQI+, undocumented migrants, PWUD, and people living with HIV are vulnerable to criminalization which impacts access to essential HIV services. Criminal law must be used appropriately, evidence-based and free from moralistic and stigmatizing influence.

As the majority of HIV services are based in cities, key populations in rural settings can have increased access via the demedicalization of testing. Specifically, mobile testing service delivery and self-testing/sampling options.

NORTHERN/WESTERN EUROPE

Literally and figuratively meet key populations where they’re at. This is in reference to the location of service delivery, as well as accessibility of language, tools, and methods used.

Structural barriers need to be removed for populations in enclosed settings. State closed-setting environments (ie.prisons, structural/institutional exclusion of refugees, etc.) continue to be excluded from national health programmes, and are unsafe spaces for the prevention and control of communicable diseases.

The criminalization of sex work (whether the workers or clients), especially those who are undocumented migrants, continues to hinder access to HIV services. However, during the pandemic some countries have recognized the need to decriminalise Sex Work (Belgium and France were mentioned).

There was an overall sense of fatigue, that the challenges discussed have been happening for many years now. There is a frustration due to a lack of political support, and fear of offending political views. Attendees agreed, feeling unheard, and highlighted the need for a unified voice (that includes those outside of CS networks) to maintain what we have and strengthen advocacy efforts.

In order to answer this question, key population indicators must be developed by UNAIDS to adequately measure access to HIV prevention services, and the impact. One suggestion was to develop these in collaboration with the Global Fund, where country-level key performance indicators have been developed. Such data collection must: be granular in reporting, however adapt to changes in key population demographics and/or behaviours; and ensure the protection of the rights and confidentiality of those who are undocumented.

While Central European countries might prioritize the de-medicalization of testing services, Western European countries with UHC, high-resourced HIV services, and high-uptake of sexual healthcare have concerns that self-testing resulting in key populations disengaging with the healthcare system and not receiving the required counselling and/or treatment.

There was a clear demand expressed for better collaboration between national authorities and CSO. This is particularly relevant in the face of shrinking safe(r) spaces for CSOs working with key populations. While it is necessary to maintain forward-thinking, it's crucial that CS maintain what has already been achieved. And although it may not be possible to eliminate the 10-10-10 goals at this moment, at the very least work can be done to ameliorate them.

In the 2016 declaration there was a specific target to have three million people on PrEP. Participants highlighted that the same targets could be asked for priority settings and key populations for high prevalence countries. Strong language on prevention is missing in general in Europe.

B. How to break down barriers to achieving HIV outcomes?

CENTRAL EUROPE

The issue of populist governments was raised again, and its impact on safety for NGOs to even develop and implement their work with key populations. Transparency and accountability at the EU level is still needed. Further, NGOs require adequate funding and guidance to continue operating in politically hostile environments where legislation violates the basic human rights of people living with HIV and key populations (anti-LGBT, sex work, harm reduction). Such legislation must be scrutinized to ensure the inclusion of evidence-based rationale, and protection of human rights.

There is a disconnection between messaging at the international and national levels. Questions were raised regarding how countries can be held accountable for excluding population groups/violating basic human rights of people living with HIVand key populations in the delivery of HIV services/programming. What are the political consequences, if any, for governments in this regard? One suggestion was to draft a Civil Society Declaration to accompany the consultation report.

Universal Health Care must be embedded into the HIV response to achieve better outcomes. Currently, varying migration policies and the level of HIV services funding across the region are hindering its realisation. The new global strategy includes regional strategies, one of which states that all migrant

populations will receive HIV services, regardless of legal status. This has been flagged as something for CSOs to monitor.

Attention must also be drawn to the stigma and discrimination experienced by people living with HIV and key populations in healthcare settings. In general terms, medical professionals in Central Europe do not seem to be receiving/receptive to *sensitizing* training.

Questions were raised regarding how to translate and link community-led research to different political levels. Participants expressed uncertainty about how the HLM works, and if/how CS can flag documents/legislation that governments have postponed/blocked? CS/NGOs continue to carry out data collection, monitoring and reporting activities - in the absence of state funding and acknowledgement. There is a need to recognize the importance and value of CS work.

NORTHERN/WESTERN EUROPE

It is crucial to recognize, and differentiate between, decriminalization and the *inappropriate use* of criminal laws in relation to people living with HIV and key populations (ie. sex work, drug use, disclosure, same-sex relationships, etc). Further, interpretations of legislative progress can vary significantly among MS. For example, there continues to be a lack of consensus on sex work decriminalization, with some countries and stakeholders promoting the Nordic model. There was a suggestion for future research exploring the relationship between sex work (de)criminalization and health outcomes; in the same vein as existing research on policing and HIV disclosure.

The intersectional social determinants of health outcomes must be taken into consideration. People living with HIV and other key populations are surviving multiple experiences of vulnerability. There is a need for the delivery of health and social services that is integrated, people-centered, trauma-informed, and transversal to all initiatives. However, to implement such services adequate funding is still required.

COVID-19 has re-prioritized discourses around global health security, while human rights discourse has faded. However, at the same time, COVID-19 has brought to the forefront discussions about communicable diseases and socio-economic determinants. This may allow for different/new HIV advocacy strategies with the potential to generate an increased support from the general population. COVID19 has also fostered partnership, knowledge exchange and mutual support among NGOs/communities in an attempt to find solutions. Such alliances and movements rooted in human rights should be fostered and supported. Finally, *preventing* stigma is just as important as eliminating stigma.

C. How to fully resource and sustain efficient HIV response, and integrate into systems for health, social protection, humanitarian settings and pandemic responses?

CENTRAL EUROPE

The diversion of funding and reprioritizing resources due to COVID-19 and lockdowns have worsened HIV responses. On paper, national HIV programmes appear adequate, yet on the ground there is no budget set for harm reduction services.CBOs that do provide these services are losing funding.

Funding for harm reduction at local level fluctuates (funding /no funding).In some countries it was available from the Global Fund for transition to national funding. Some other countries are covering costs nationally. However, in these cases treatment and not prevention is founded.In Romania, for instance virtually no funding is made available from the ministry of health, and local authorities provide funding ad hoc. Many countries are not funding opioid substitution treatment(OST)/harm reduction services. In some cases, testing and treatment is considered THE prevention intervention (e.g. poland). Under these conditions, planning and budgeting is complicated for NGOs and service providers.

Stigma and discrimination remains a major barrier to the access of services. Needle-exchange program funding has decreased substantially, and testing among people who use drugs is also limited. Many countries are not funding opioid substitution treatment(OST)/harm reduction services. In some cases, testing and treatment is considered THE prevention intervention (e.g. poland).

Integration of services has changed during COVID-19. Where treatment used to be provided only at hospitals on a monthly basis (treatment, bloodwork, refilling prescriptions), there has been a shift with some clinics now providing quarterly visits. ART/PrEP clinics are typically housed in infectious disease hospital clinics, but are now only dedicated to COVID-19. Communication of this has been very difficult because those doctors are now no longer available to see other patients. Prevention/harm reduction is being sustained as much as possible by NGOs with their own fundraising. This has also impacted the capacity to integrate services..

The impact of lockdowns on key populations has been more serious than expected, and it has highlighted the importance of community based and community led organisations in the response to COVID19. Oftentimes these have been the only ones able to provide support. Members of key populations have lost income sources (especially those living outside of big cities) which in return has limited their ability to access services.

A shift to online communication has been difficult for workers (organizational development) and many NGO staff have lost their jobs. Ultimately, governments were ill-prepared to shift to online services, and questions/concerns remain on the digitization of healthcare services can be sustained, and whether this is supported at a national level. Further, digitalization of services and use of digital tools has raised concerns regarding the rights of key populations.

Some regions saw good cooperation and integrated response. An example was Estonia delivering ART, OST, and harm reduction prevention packages. In some cases, the digital provision of services, and e-health has opened the door for good collaboration on harm reduction services. In some countries, harm reduction services and PWUD were in fact prioritized, rather than left behind. However, CS advocacy in other regions for HIV self-testing initiatives have received no government support.

Community voices often contradict national messaging. Community based services are the basis of success for community led advocacy.

NORTH/WEST EUROPE

The funding and availability of PrEP in some countries is quite good. However, changes in funding methods, medicines procurement procedures and prescribing privileges has presented access issues resulting in long waiting times (eg. Norway). In addition, female sex workers continue to struggle in accessing PrEP because they not are not considered a high risk population given the low HIV prevalence among their clients (i.e. cisgender straight white men).

While there have been some improvements in PrEP funding, there has been a noted reduction of investment into combination prevention interventions.

Less funding is available for harm reduction than previously. Drug policies are in place in the region, but still they focus on prevention and treatment. Austerity measures in the UK have impacted service provision, particular for people who use drugs. Interruption of drug services (harm reduction) will be reflected in new diagnoses.

Overall, the international and national situation has deteriorated since the 2016 Political Declaration. Many countries are no longer eligible for international funding.

COVID-19 has had a tremendous impact, both financially and in terms of service provision. In some cases, prevention / outreach activities for key populations have stopped. In some other, CBOs have tried to mitigate the disruptions, to fill gaps and to address emerging needs. CBOs are uncertain of the sustainability of these services and long-term impacts of the pandemic on funding.

Some progress regarding gender was noted. Recent changes in Spain legistlation on transgender rights in terms of access to health services. There has been improved funding for the inclusion of non-binary people and women using drugs in programmes. In addition, COVID-19 has pushed some Governments (e.g. BE and to some degree France) to look at including SWs in HIV funding. Participants hope that this trend continues.

It was brought into focus the importance of the integration of different healthcare services to include comorbidities e.g. vaccines for hepatitis C. COVID-19 has highlighted a limited access to services among key populations (particularly migrants) in the region. Appointment-based approaches to access services has become a barrier for many key populations. In hospitals, people had had issues accessing treatment, particularly those outside major cities.

There is confusion over the vulnerability of people living with HIV to COVID-19, which has led to an increased anxiety among this community. Poor communication on behalf of governments had a big impact, in which risk has been overstated for all people living with HIV, despite having no other health conditions. Additionally, prioritization for COVID-19 vaccination among people living with HIV varies between MS.

There is no clear picture on how sex workers have been impacted. At the moment and it continues to be difficult for sex workers to get social and economical support from goverments. In many states there is a conflation of sex work and gender-based violence preventing them from accessing funding. An ideological push to abolish sex work has also impacted access to funding to address the issues faced by sex workers.

Reference was made to the Sex Workers' Rights Advocacy Network (SWAN) June 2020 publication COVID-19 crisis impact on access to health services for sex workers in Europe and Central Asia, and the Internatinoal Committee on the Rights of Sex Workers in Europe (ICRSE) webinar recording and report for 'Sex Workers on the Frontline'. It was noted that sex workers have experienced difficulties in accessing services during the pandemic, and have been forced to negotiate the health risks associated with working versus as receiving income, as government financial support was not an option. Next to this, at the moment there is a mental health crisis in the community, particularly among intersections of non-normative gender identities and sex work, or migrant sex workers, among others.

Currently there is data where 30% of people living with HIV don't have access to treatment, this is caused by a lack of funding. UNAIDS fund figures show a reduction of 1.3B USD. These figures highlight the need for further analysis, and for discussions regarding human rights and pricing. Further, it urges for an UNAIDS that is more political and willing to advocate in the interest of people living with HIV and other key populations. Funding issues should be at the forefront of advocacy efforts, both nationally and internationally.

The UNAIDS Strategy and some national plans are well thought-out, and harm reduction services are now considered as an essential component among national health services. However, still there is not an adequate implementation budget to reach the objectives set by these strategies, or to ensure an adequate implementation and sustainability of harm reduction services. NGOs continue to struggle to maintain their services due to COVID-19 and these funding barriers.

There exist examples of PrEP being promoted as being effective. However there are no frameworks in place for the reimbursement of medication and clinical visits.

HIV does not exist in a silo. There is a need to deal with issues of inequalities in access to health and take into account intersectionality or vulnerabilities/risks.

Although there are examples of successful implementation of online services, this modality has also excluded a great number of people, particularly those experiencing higher levels of vulnerability or already underserved communities. Online services need to be adequately complemented with essential in-person outreach services.

The COVID-19 pandemic has also evidenced how data collection can be swiftly implemented with the adequate political will. It was highlighted how the experiences and lessons learned from the HIV epidemic on community engagement can benefit the responses to COVID-19.

C. How to improve accountability and advocacy ?

CENTRAL EUROPE

It was reported that in countries where NGOs depend on state funding exists a fear of speaking out against regressive HIV policy and programming. There mention of NGOs who have spoken out and lost funding. Consequently, there is a noted silence on behalf of NGOs at this time.

The monitoring of progress and gaps is a priority for CS in a number of countries, and there are examples of community reporting on quality of services, but this is not equally prioritized by national/local governments. In some regions, reporting at the EU-level is exclusively done by national government bodies, and excludes NGO/community input. In some cases, NGOs disagree with the perspective provided by national authorities.

There is a conflict of interest between community versus national monitoring. There is a need to collaborate regionally and internationally to ensure accurate national monitoring. There is a need for platforms for more efficient advocacy. In central Europe, governments use state sponsored homo/transphobia. Some governments are unwilling to recognise community reporting/feedback or enter in dialogue. The LGBTQ situation is worsening in the region and it is becoming difficult to have dialogue with them. In that context, supporting community monitoring is critical.

Last, in countries where conventions and treaties have been signed to preserve the basic human rights of people living with HIV and key populations, accountability is essential at all levels to ensure that countries align and comply with these legal obligations.

NORTH/WEST EUROPE

National government reporting is questioned and community-led and civil society reporting and monitoring is becoming increasingly more important to highlight gaps and priorities. National governments have the authority to include/exclude CSOs in reporting activities, therefore there appears to be the need for shadow reporting to capture community perspective.

While civil society shadow reporting is invaluable, it is also labour intensive and often goes unrecognized and/or unsupported by governments. Considerations regarding clear objectives and rationale must be given when surveying communities. The UK participants mentioned good examples of community collaboration with government agencies in strategic recommendations and monitoring: Public Health England's Positive Voices Survey; and the UK HIV Commission. In addition, there has been great progress in the last 10-15 years with the inclusion of NGOs and Civil Society in the Dublin Declaration monitoring.

Furthermore, existing monitoring tools are obsolete and inadequate. New metrics and indicators are needed to ensure effective and comprehensive data collection for all key populations. Also, mechanisms must be put in place to carry-out community monitoring that is ethically-sound and does not compromise the confidentiality and human rights of key populations. Specifically, protections around communities (often intersecting) most criminalised: undcoumented migrants, sex workers, LGBTQI+, PWUD, and people living with HIV.

There are some progressive strategies at EU level regarding drug policy but the national level does not always align/follow. There is a discrepancy of what governments discuss at UN level compared to what is implemented at national level. CSOs are aware that despite any progress made, there is always the concern of this being reversed and/or leaving communities behind. For example, the UK is currently seeing an HIV outbreak among PWUD.

HIV services do not appear to be a political priority given that funding has remained static. There is a significant variation in situations across the EU but everywhere funding for services for key populations is an issue.

Ultimately, participants stressed the need to have key populations inform and lead HIV services. One suggestion made was to request UNAIDS to indicate which HLM country delegations include civil society.

E. Key issues to be prioritised in the UN declaration

CENTRAL EUROPE

- Respect for the human rights of people living with HIV and key populations (LGBTQI+, PWUD, sex workers, migrant communities, etc.)
- Address the discrepancy of national government reporting of combination prevention to UNAIDS, compared to the reality of governments actively stigmatizing and violating human rights of people living with HIV and key populations.
- MS governments must acknowledge the role of NGO/community-led and based initiatives when reporting successes (in spite of little-to-none government funding)
- Monitor if national authorities are aligning with the adoption of LGBTQI strategy, and ensure key populations are considered.
- COVID-19 has opened the door for dialogue around poverty and exclusion and we need to name the Issues and problematic stakeholders.

WESTERN/NORTHERN EUROPE:

- Fund harm reduction – it saves lives and is evidence based
- Huge gap in Europe – some countries have good practices that can be used as a model to apply in other regions
- Stop the funding cuts, increase testing and focus more on key populations who have been excluded
- HIV ain't over & the last 5 percent are going to be the first
- Decriminalise sex work.
- Central and Western Europe – services are not integrated, the landscape changes vastly from one nation to another. Collaboration on this front should strive for improving the status quo on the respective national levels, as opposed to advancing progress to get all regions on the same level.
- Service delivery – seen tremendous decreases that have not recovered. Less diagnoses due to COVID.
- Visibility of communities – this is decreasing. We don't know if we will be able to recover this in the long run.
- Better collaboration between UNAIDS, Global Fund, political will, etc. emergency modus and the current emergency discourse: other Infections have not gone and we cannot stay in emergency mode
- Need to address late/delayed HIV diagnoses among key populations in Europe
- We are in a public health emergency but we need to address the discourse and shift ideas around the public health threats that still exist. Other issues are still here and will still be here after COVID. We can't exist in this emergency mode for too long.
- There isn't a lot of political commitment on HIV or how to address late diagnosis which is an easily preventable issue

- COVID has demonstrated how difficult it is to access vulnerable groups -similar vulnerable groups with COVID and HIV/TB
- We need to ensure women and transgender people are included in services
- COVID has drawn attention to structural factors (legal barriers, access to housing) but we also need to name where there are issues. There is a tendency to hide reality behind "structural barriers" and "key population"language, but need to name names.
- This discourse has been pushed for a long time but as Luca says - not naming names means it is not translated into effective actions. There needs to be a strong statement by the EU putting money where their mouth is. They need to actively push policies in MS. It can't just remain discourse. We need to ensure communities and civil society have funding and need to counter movements pushing setbacks.
- The EU should commit funding and resources to actively push these policies in MSs. There has to be action, not just discourse

F.Red flags in negotiations for certain UN member states

CENTRAL EUROPE

- There is a growing trend of EU level slow reactions and consequences to MS governments violating basic human rights of people living with HIV and key populations. As a result, countries are not concerned with being held accountable. This begs the question of what the roles are here at the UN and MS levels.
- Harm reduction was mentioned twice in the 2016 Declaration. First explicitly as 'harm reduction', then a second time in UNGASS wording. It is critical that 'harm reduction' communication is explicit and consistent.
- In parts of Central Europe, there is a danger for CSO advocacy on issues related to HIV and basic human rights of key populations. This is due to populist governments wanting to maintain political power and excluding/discriminating against any group who does not comply with right-wing agendas.

NORTHERN/WESTERN EUROPE

- Among Northern/Western European participants, there was more of a push to advocate for the basic human rights of people living with HIV and key populations. In this context, it is believed that politicians are more likely to comply with CSO demands in the interest of maintaining votes.

Annex - List of Civil Society Participants

Name	Region	Affiliation
1. Latsin Alijev	Estonia	Estonian Network PLWHIV
2. Frank Amort	Austria	European AIDS Treatment Group
3. Magdalena Ankiersztejn-Bartczak	Poland	Foundation for Social Education
4. Ferenc Bagyinszky	Germany	AIDS Action Europe
5. Janko Belin	Slovenia	Društvo AREAL & Kooperativa ROG
6. Olå Belyaeva	Ukraine	Eurasian Network of People who Use Drugs
7. Judy Chang	Italy	International Network of People who Use Drugs
8. Louise Cliff	UK	TB Europe Coalition
9. Lella Cosmaro	Italy	Fondazione LILA Milano ONLUS
10. Robert Csak	UK	Harm Reduction International
11. Nicoleta Dascălu	Romania	Romanian Anti-AIDS Association
12. Ganna Dovbakh	Lithuania	Eurasian Harm Reduction Association
13. Roman Drozd	Ukraine	Light of Hope
14. Carmine Falanga	Italy	ANLAIDS (National Association for the fight against HIV/AIDS)
15. Halvor Frihagen	Norway	HIV Norway
16. Julian Hows	NL	HIV Justice Network
17. Zeki Kilicaslan		
18. Lena Kucheruk	Ukraine	International Renaissance Foundation
19. Michael Krone	Germany	AIDS Action Europe
20. Sabine Lex	Austria	Aids Hilfe Wien
21. Anni Mattinen	Finland	HIV Finland
22. Luís Mendão	Portugal	GAT - grupo português de activistas sobre tratamentos de VIH/SIDA - Pedro Santos
23. Joaquin Negro	Spain	UNAD
24. Sarah North	Norway	European AIDS Treatment Group

25. Sean O'Neil	UK	National AIDS Trust
26. Sini Pasanen	Finland	HIV Finland, AIDS Action Europe
27. Chris Pavlakis	Greece, UK	
28. Roberto Perez Gayo	The Netherlands	Correlation European Harm Reduction Network
29. Aura Roig	Spain	Metzineres
30. Daniel Simões	Portugal	Coalition Plus
31. Eberhard Schatz	The Netherland	Correlation European Harm Reduction Network
32. Luca Stevenson	Netherlands	International Committee on the Rights of Sex Workers
33. David Subeliani	Georgia	International Drug Policy Consortium
34. Olga Szubert	Ukraine	Harm Reduction International, ENPUD
35. Ann Isabelle Von Lingen	Belgium	European AIDS Treatment Group
36. Olena Voskresenska	Ukraine	AIDS Foundation East-West
37. Peter Wiessner	Germany	Action against AIDS
38. Yuri Yoursky	Estonia	ECOM/ILGA-Europe