

As leaders of the HIV response gather in Durban on July 18-22 for the AIDS 2016, we, civil society networks of Eastern Europe and Central Asia, prepared this fact sheet to draw attention to the catastrophic situation in our region and solutions that would enable us to catch up to the rest of the world on the track to move towards ending AIDS by 2030 and achieving Strategic Development Goals.

Eastern Europe and Central Asia:

Let's Not Lose Track!

EECA is the only region that failed to achieve MDG6 on HIV

HIV incidence and deaths due to AIDS continue to increase

70% of PLHIV live in high-income countries

1 in 5 people live below the national poverty line

1 in 5 PLHIV receive ART

While the world celebrates declining rates of new HIV infections and deaths from AIDS, in Eastern Europe and Central Asia (EECA), the only region in the world that did not achieve the 6th Millennium Development Goal. New infections and AIDS-related deaths continue to grow. HIV, drug-resistant tuberculosis and hepatitis C epidemics remain concentrated among key populations including people who inject drugs, sex workers, gay and other men who have sex with men, transgender people, and prisoners. Ninety six percent (96%) of new HIV infections were among key populations and their sexual partners in 2014.¹ Faced with rapid transition to domestic funding, the EECA countries are not adequately financing programming for the HIV care continuum (including prevention, testing, linkage to care and retention) in particular for stigmatized and criminalized key populations.

Recommendations

- 1 Governments must commit to the development of domestically-funded AIDS responses that encompass a comprehensive package of services for all who need it with a special focus on key populations and their sexual partners.
- 2 Transition plans should be designed to gradually increase domestic spending including investment in 25% of the budget on prevention programming as recommend by UNAIDS to complement the 90-90-90 treatment target.
- 3 Governments must acknowledge the HIV, tuberculosis and hepatitis C burden borne by key populations and ensure that 90% of key populations are reached with targeted low threshold programming including prevention, testing and linkage to treatment and care.
- 4 National programs must provide antiretroviral therapy for all PLHIV who want to start treatment and counselling should encourage early start of treatment in line with WHO recommendations.
- 5 Integration and collaboration of HIV, TB, OST harm reduction and social services must be enhanced to ensure linkage to and retention in care and barriers to access to care for migrant populations must be removed.
- 6 The main source of vulnerability of key populations, must be addressed by countering stigma, discrimination, criminalization and human rights violations.
- 7 Donors including The Global Fund, bilateral donors and others must adapt eligibility criteria that do not neglect inequitable access to services within middle and high income countries.
- 8 The International community, including the European Commission, EU member states, the Global Fund, UN agencies and others, should facilitate a dialogue with EECA countries on addressing challenges in achieving universal access to prevention, treatment, care and support.
- 9 Meaningful involvement of people living with or affected by diseases and key populations and civil society in national and regional dialogue must be supported.
- 10 Health system strengthening efforts should target the need governments and NGOs urgently prepare for the transition to domestic funding of institutionalization of self regulated NGO services.
- 11 Governments should utilize transparent, flexible and innovative approaches in the procurement of ARV medicines to ensure lowest possible prices for effective medicines including encouraging generic competition and application of TRIPS flexibilities and to ensure sustainable access to HIV quality treatment.
- 12 Population size estimations must be conducted according to international standards and data on access to services must be disaggregated by key population, gender and age to enable meaningful evaluation and improvement of approaches to access to services all along the continuum of care.

