

A review on EU's aid effectiveness

Advanced access to HIV & AIDS prevention, treatment & care in Eastern Europe

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List of abbreviations

AAE	Aids Action Europe
AFEW	AIDS Foundation East-West
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
AVERT	AVERTting HIV and AIDS
CSOs	Civil Society Organizations
CSF	The HIV/AIDS Civil Society Forum
DCI	Development Cooperation Instrument
EaP	Eastern European Partnership
EATG	European AIDS treatment group
ECDC	European Centre for Disease Prevention and Control
EHRN	Eurasian Harm Reduction Network
EMCDDA	European Monitoring Centre for Drugs and Drugs Addiction
EU	European Union
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IDU/IDUs	Injecting drug use(rs)
IHRA	International Harm Reduction Association
IMG	Investment Monitoring Group
LGTB	Lesbian, Gay, Transgender, Bisexual
MS	Member States
MSM	Men-who-have-Sex-with-Men
NGOs /NGOs	Nongovernmental Organization(s)
NSP	Needle and Syringe Programmes
OST	Opioid Substitution Therapy
PLWH	People Living with HIV
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
SRHR	Sexual and reproductive health and rights

SWs	Sex workers
TB	Tuberculosis
TFEU	Treaty on the Functioning of the European Union
TNI	Transnational Institute
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
UORN	Union for HIV/AIDS Prevention and Harm Reduction in Moldova
VCT	Voluntarily counselling and testing
WHO	World Health Organization

Executive Summary

Background: Although the incidence of HIV/AIDS has decreased globally, it is on the rise in Eastern Europe. The primary mode of HIV transmission in the region is injecting drug use (IDU) due to the smuggling routes of Afghan heroin into Europe, which makes drugs widely available. The widespread sharing of HIV-contaminated needles and syringes among injecting drug users (IDUs) plays a major role in the spread of HIV. While there is still no cure for HIV, early diagnosis and adequate HIV treatment and care can suppress the virus.

Objective: The objective of this study is to determine to what extent the European Union (EU) has contributed to advanced HIV prevention, treatment and care in Eastern Europe. In Western Europe, implementation of effective HIV interventions have resulted in a less severe HIV epidemic. Therefore, this study identifies and evaluates current EU strategies on HIV/AIDS, focussed on eastern neighbouring countries.

Method: The research methods of this study comprise primary and secondary research. Primary research consist of two in-depth interviews. Secondary research consist of gathering information available in books, catalogues, and on the internet, especially 'Google Scholar', 'EBSCOhost', and 'Springer' for journals and research.

Results: First, Elena Voskresenskaya, director of 'AIDS foundation East-West (AFEW)' in Ukraine, provided a clear view of the HIV/AIDS situation in the region. According to her, access to HIV prevention treatment and care has increased. However, this remains limited to marginalized groups, such as drug users, due to stigma and discrimination, low political investment, reduced funds from international donors and sustainability issues. Second, Anke van Dam (director of 'AFEW, the Netherlands') and Corie Leifer (project manager of 'AFEW, the Netherlands') elaborated on current issues at EU-level, which includes the need for a reformed HIV/AIDS Action Plan and a debate on the Global Fund's withdrawal of funds in the region.

Conclusion: The EU has contributed to advanced access to HIV, prevention, treatment and care through state-channelled actions. It includes 'the Communication on HIV/AIDS in Neighbouring Countries' (extensively funded through the Global Fund), 'European Neighbourhood policy (ENP)', 'the Civil Society Forum' and 'the Think Tank'. NGO-channelled actions include bringing the EU and its policies closer to the ordinary citizen, providing input to policy dialogue and implementing EU-funded projects, which have decreased. The following recommendations are in place: 1) keep HIV/AIDS a priority 2) reform current policies and 3) ensure funding and sustainability.

1. Introduction

1.1 Statement of the problem

Thirty-five years have passed since the first reported cases of human immunodeficiency virus (HIV), which is responsible for causing Acquired Immunodeficiency Syndrome (AIDS). Until the present, it remains a global public health concern and political priority, especially for the EU. While new HIV infections are decreasing globally, new HIV infections continue to increase in Eastern Europe (UNAIDS, 2015). Eastern Europe refers to the EU's eastern neighbouring countries: Azerbaijan, Armenia, Georgia, Moldova, Belarus, and Ukraine. While there is no cure for HIV/AIDS, there are a range of HIV prevention, treatment and care services, and HIV may start to be considered a chronic disease (Eramova, I., Matic, S., Munz, M., 2007). However, these HIV services remain unavailable or limited to some HIV-affected patients, especially in the most affected Eastern European countries, such as Ukraine and Moldova (Michael Bird, 2015). It is therefore important to address the HIV epidemic in these countries to protect the health of individuals and the public. The EU has recognised the need improve cooperation among Member States (MS) and to support neighbouring countries to develop HIV/AIDS strategies (European Commission, n.d.). Barriers to health care should be addressed at both political and operational level. The EU's commitment is expressed in the EU Treaty, especially in Article 168 (1) Treaty on the Functioning of the European Union (TFEU) which states that governing public health across these territories and groups requires action through policy domains such as health, development cooperation, external action and research (Hervey and McHale, 2015). However, since ten years have passed since the EU's first policy on combating HIV/AIDS in eastern neighbouring countries was developed and HIV remains a major public health issue in the European region, it is crucial to evaluate and ensure beneficial EU level action.

This leads to the following research question:

“To what extent is the EU contributing to advanced access to HIV/AIDS prevention, treatment, and care in the most affected Eastern European countries?”

In order to answer the central question, the following sub-questions were designed:

- 1) *What are the recent patterns and trends of the HIV/AIDS epidemic in Eastern Europe?*

This question will help to clarify the current characteristics of the HIV/AIDS epidemic in Eastern Europe. It includes the number of HIV/AIDS cases, the main mode of HIV

transmission, HIV-related discrimination/stigma, and a comparison of the HIV epidemic in Western and Eastern Europe and major developments over time.

2) *What are the EU strategies for tackling the HIV epidemic in Eastern Europe?*

It is an essential step to first observe current EU strategies for addressing the HIV epidemic in Eastern European countries, which will help to determine how the EU is contributing to improved access to HIV/AIDS prevention, treatment and care in these countries. The following aspects should be identified: the main strategies, collaboration with eastern neighbouring countries and evaluations of these actions.

3) *How is access to HIV prevention, treatment, and care developed in Ukraine and Moldova?*

A clear perspective is needed on how the EU policies on HIV/AIDS are presented in the eastern neighbouring countries. Since evaluating the EU's aid effectiveness in each Eastern European country might be too broad, this paper focuses on Ukraine and Moldova. These two countries are closest to EU borders and have one of the most severe HIV epidemics. Therefore, it is interesting to examine how both countries' access to HIV prevention, treatment, and care has developed over the years. This paper focuses, on the EU and how its initiatives have contributed to the effectiveness of specific interventions.

4) *What is the role of nongovernmental organizations (NGOs) ,as main civil society actors, in EU initiatives halting the spread of HIV/AIDS?*

Especially HIV/AIDS-related NGOs are interested in reversing and halting the spread of HIV/AIDS. These NGOs have years of expertise and experience in promoting better health care for people living with HIV (PLWH), which includes improved access to HIV prevention, treatment and care. It is interesting to examine EU cooperation with NGOs in order to achieve greater impact.

1.2 Definition of terms

For a better understanding of this study, the following terms are defined:

- *Eastern European countries:* refers to the EU's eastern neighbouring countries, which are Azerbaijan, Armenia, Georgia, Moldova, Belarus, and Ukraine. Throughout this paper, the focus remains on Eastern European countries in general, and in some parts of the study (especially chapter 4 and 5), the focus is on Ukraine and Moldova. These two countries are examined due to their geographical position, which is closest to the EU border. Moreover, these are two of the EU's eastern neighbours, where the rates of new infections are the highest. Curbing the HIV epidemic in these countries therefore is especially important.

- *HIV/AIDS prevention, treatment, and care*: Because there is no cure or vaccine to prevent HIV, the only way to prevent infection from the virus is to avoid high-risk behaviours, such as having unprotected sex. In terms of treatment, researchers have developed drugs to fight HIV infection. In combination with early detection through HIV testing, available HIV therapies can greatly extend life expectancy and quality of life. In the context of care, it is important to deal with the psychological and social problems of PLWH and approach these people with care. Important factors include dignity, independence, and self-respect. Overall, it is essential that HIV prevention, treatment, and care are comprehensive and are scaled-up. If services are able to reach the majority of vulnerable people, the epidemic can possibly be prevented, halted, and reversed.

1.3 Purpose of the Study

In order to ascertain the effectiveness of EU aid to Eastern Europe in the context of HIV/AIDS, it must be borne in mind that the impact of such aid depends on increased HIV prevention, treatment and care in most affected Eastern European countries (including Ukraine and Moldova) and the most affected population (injecting drug users) in the region. Examination of the EU's political and operational level in combating HIV/AIDS in Eastern Europe could be useful in identifying key challenges and current gaps. The ultimate goal is to improve current response to the HIV epidemic in the region and to suggest new concrete ways to address it effectively.

1.4 Significance of the study

Addressing the HIV epidemic is important to reduce considerable harm to the individual and to public health. Since most research is out-dated, strategies on HIV prevention, treatment, and care efforts need to be adapted and should reflect updated information and new realities. A clear image of the current HIV/AIDS situation in Eastern Europe can enable tailoring of HIV programming to the specific dynamics of a country. It is crucial to improve our understanding of the epidemic and its dynamics. It must include in-depth interviews with civil society, social and political analyses, and examination of national experiences throughout the region, in order to identify challenges and gaps in existing knowledge and to serve as inspiration for future research efforts. The findings of this study could be of interest to civil society and policy and decision makers employed in the health arena, especially HIV/AIDS.

2. Methodology

2.1 Strategy and Research Design

This chapter describes the application of research methods in this study. Two types of approaches were used which are primary and secondary research. Primary research, also known as field research, includes in-depth interviews in order to generate new information that is not yet available. It allows the interviewees to answer specific questions and provide detailed information. The two interviews included in this paper were conducted through a face-to-face meeting and a Skype-call. Both meetings lasted approximately one hour and were recorded and transcribed. The interviews included informal discussions prior to the formal interview. The questions were prepared in advance to ensure that the data collected covered the objectives of the research, but discussions were allowed to flow freely.

Secondary research, also known as desk research, comprised gathering information that is already available from sources such as websites, databases, catalogues, newspapers, and magazines. Secondary research aims to examine existing and to build on that knowledge. The sources used for this research include 'Google Scholars', The Hague University Library's online e-Books system 'EBSCO Host', and 'The Lancet', which is world's leading independent general medical journal. It provides research and articles of the highest standard and covers all aspects of human health. Finally, sources were used from the internet that were written by professionals in their fields and published on reliable sites, in peer-reviewed publications, or on professional organization sites.

2.2 Data Collection and Analysis Methods

Both primary and secondary research help to answer the sub-questions and, consequently, help to answer the central question of the study. In the context of secondary research, important gathered information includes extensive HIV statistics, published strategies of the EU, and statements from civil society and institutions. These include, for examples, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), which are actively involved in the HIV/AIDS epidemic.

With regard to primary research, the interviews can be divided as follows:

- 1) A nongovernmental organization (NGO) based in Ukraine, which is familiar with the HIV/AIDS situation on a national (Ukrainian) and regional (Eastern European) level.

The interviewee, Elena Voskresenskaya, is director of 'AIDS Foundation East-West, Ukraine'. 'AFEW-Ukraine' promotes health, access to prevention, treatment and care for public health concerns such as HIV, tuberculosis (TB), hepatitis, sexual and reproductive health and rights (SRHR) (AFEW, n.d.). It focuses on vulnerable groups that are usually excluded from the traditional models of service delivery: people who inject drugs (PWID), sex workers (SWs), men who have sex with men (MSM) and prisoners. It believes that every individual, regardless of their HIV status, has the right to access healthcare and other services based on their need. 'AFEW-Ukraine' develops HIV programmes that address issues in the fields of prevention, treatment, care, and support for people living with HIV (PLHIV). Making services accessible means getting services to vulnerable and hard-to-reach individuals who are often most in need. Voskresenskaya has extensive expertise in the health field in Eastern Europe, in which she has been active for more than fifteen years. She has a Master Degree in Public Health from 'Emory University, Atlanta'. Her work as Deputy Regional Director for 'AFEW-Ukraine' commenced in 2004. Prior to that, she worked for 'the American International Health Alliance (AIHA)' in Kyiv, managing health partnerships projects in Ukraine, Moldova, and Belarus (AFEW, n.d.). This paper benefits from her extensive expertise and experience in the context of HIV/AIDS, which provide a comprehensive view of the current HIV situation in the region, especially in Ukraine. This includes detailed information regarding access to HIV/AIDS services for people who are most affected, gaps in services, establishment of civil society, attitude of government and perceived EU contributions.

- 2) A nongovernmental organization (NGO) based in the Netherlands, which is familiar with the decision-making process on national (Dutch), EU and international level.

This interview comprised two interviewees. The first interviewee was Anke van Dam, director of 'AFEW, the Netherlands'. The second interviewee was Corie Leifer, project-manager of 'AFEW, the Netherlands'. 'AFEW, the Netherlands' is based in Amsterdam and is the international secretariat of AFEW's network of six independent offices in Eastern Europe and Central Asia: Ukraine, Georgia, Russia, Kyrgyzstan, Kazakhstan, and Tajikistan (AFEW, n.d.). The organization strives to build partnerships with various sectors and institutions, and engages public officials, health professionals and other stakeholders in making the delivery of health services more appropriate, more user-friendly, and more responsive to individual needs. Van Dam is a medical doctor (graduated from Erasmus University in Rotterdam) with a specialist degree as a general practitioner and graduated as a community health specialist. She has worked on issues related to sexual health and HIV as a trainer, an advisor, and a consultant, including proposal writing and programme evaluation. Her work experience covers Southeast Asia and Africa to Eastern Europe and Central Asia. In addition to her position as director of AFEW, she is also the chair of AIDS

Action Europe (AAE). Leifer's expertise includes project management, conference planning, specialist medical communications, and as a public health promoter at AFEW. She has managed projects within the fields of HIV/AIDS, SRHR, key population support, female empowerment, and prison health. Moreover, she represented AFEW in the EU's 'Civil Society Forum'. Van Dam and Leifer are strong advocates for universal access to HIV services, especially for vulnerable groups (PWID, SWs, MSM, and prisoners). Both engage in dialogue with EU institutions regularly and participate in international AIDS conferences (AFEW, n.d.). Due to Van Dam and Leifer's years of expertise and experience in advocating and lobbying on EU level in the context of HIV/AIDS, valuable information was added to this paper by means of a comprehensive view of current EU strategy, policies, implementation, funded projects, and recommendations for the EU.

2.3 Research Ethics

This research aims to explore sensitive topics (primarily HIV/AIDS in former Soviet countries) that affect a vulnerable and stigmatized group (injecting drug users). Information was gathered from interviews with experts in the field of public health care in Eastern Europe. Due to the sensitivity of the topic, all participants were fully informed regarding the objectives of the study. Moreover, they were reassured that their answers would be treated as confidential and would only be used for academic purposes in this particular research.

3. Recent patterns and trends of the HIV/AIDS epidemic in Eastern Europe

This chapter explores the evolving patterns and trends of the HIV epidemic in Eastern Europe. First, this chapter addresses the number of HIV cases over the years. Second, it focuses on injecting drug use (IDU) as the primary HIV transmission mode due to the geographical characteristics of most Eastern European countries. Third, it emphasizes the stigma and discrimination among the most-affected key populations. Fourth, it makes a comparison between Eastern and Western Europe in the context of measures to combat HIV/AIDS. Finally, major accomplishments in thirty-five years of HIV/AIDS are mentioned.

3.1 HIV statistics throughout the years

In the mid-1990s, after the dissolution of the Soviet Union, the number of new HIV cases reported in Eastern Europe began to increase (Zahorka, 2003). In 1994, countries in the region were reporting less than thirty thousand infections. The first rapid increase in registered HIV cases started a year later in 1995. It began in Ukraine, and spread to Belarus and the Republic of Moldova (Zahorka, 2003). In 1996, approximately 8000 HIV infections were registered, most of them in Ukraine (Donoghoe, Lazarus and Matic, 2006). In the following years, the reported HIV cases in the region were as follows:

- In 1997, 15 000 new reported HIV cases;
- In 1998, 15 000 new reported HIV cases ;
- In 1999, 27 000 new reported HIV cases ;
- In 2000, 68 000 new reported HIV cases;
- In 2001, 101 000 new reported HIV cases.

The number of HIV infections in Eastern Europe continued to grow, from less than 30000 reported cases in 1995 to an estimated more than 440 000 HIV infections in 2005 (Donoghoe, Lazarus and Matic, 2006). Moreover, the percentage increase of deaths due to AIDS-related complications is considerable. In Ukraine, 18,100 people died of AIDS in 2012 compared to 11,000 people in 2001, which is a 164% increase (Indexmindi, 2015). In Moldova, 1,300 AIDS-related deaths were reported in 2012 while the number reached 300 in 2001, which is a 433% increase (Indexmindi, 2015). The HIV epidemic in the region was and remains the fastest growing in the world. According to the UNAIDS document, 'Aids by number 2015', which focussed on registered HIV cases in 2014, 36,9 million people live with HIV (PLWH) globally (UNAIDS, 2015). Furthermore,

two million new HIV infections are reported globally which indicates that new HIV infections have decreased by 35% compared to 2000. However, HIV infections in Eastern Europe continue to increase (UNAIDS, 2015). The WHO European Region has recently reported numbers of HIV cases in the region. It has registered 142 000 new HIV infections, which is the highest number of new diagnoses in one year since the start of reporting in the 1980s (WHO, 2015). In 2013, there were 136,235 new infections and in 2014 42,197 new cases. This represents a 4.4% annual increase. The report points out that the eastern part of the region, where the number of new HIV cases has more than doubled during the past decade, mostly accounted for the growth (WHO, 2015). Since 2008, the 'European Centre for Disease Prevention and Control (ECDC)' and the 'WHO Regional Office for Europe' have collaborated to gather HIV/AIDS data from across the European region (European Commission, 2008). Data is submitted once a year to 'the European Surveillance System', which is a joint database. Each end of November, the data is published in the HIV/AIDS surveillance report (European Commission, 2008). In some cases, the actual number of HIV cases was estimated much higher. There is some uncertainty regarding the reliability of data. No agreement has been reached about the precise scale of the HIV epidemic in Eastern Europe, as there is a lack of clear data about the magnitude of the epidemic (WHO, 2011). The change in HIV-testing procedures played an import role in the lack of available data, as it changed from mandatory and non-anonymous testing to voluntary and anonymous testing, which makes data regarding HIV prevalence difficult to interpret (Zahorka, 2003). Most people are reluctant to seek out testing and counselling services due to the fear of a positive test result and the negative consequences of HIV/AIDS. Therefore, people often remain hidden and avoid settings where researchers might obtain data. This results in many cases remaining unreported. Moreover, estimating the size of a population, especially a hidden population, can be difficult. Low-threshold services, outreach, and internet sites are possible solutions. As a result of data surveillance and epidemiological models, estimates can be calculated. Although published HIV cases are estimates rather than precise indicators, these estimates provide an indication of the scale and severity of the HIV epidemic. Consequently, these estimates indicate whether there is a need to scale up efforts in HIV prevention, treatment, and care. Most statistics mentioned during this report rely on estimates from the World health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

3.2 Drugs related HIV epidemic

The HIV epidemic in Eastern Europe is closely linked to the rise in injecting drug use, which developed after the fall of the Soviet Union, a time of severe political, social, and economic crisis. This was also when Afghanistan became one of the world's largest opium producers (Abubakar et

al., 2011). According to the UNODC, Afghanistan and Colombia were the world's main producers of illegal drugs. In 2001, 75% of the world's heroin supply originated from Afghanistan (Ecosecretariat, n.d). Afghanistan's production of opium has increased from 3,600 metric tons of opium in 2003 to 4,200 metric tons of opium in 2004, which made the country a narco-state (Berniker, 2004). Afghanistan's 2006 production of over 6,400 metric tons of opium is one of the largest the world has ever seen (Beyrer and Celentano, 2008). As a result, drugs production and use have been on the rise in the region. Opium and heroin are widely available and, in Moldova and Ukraine, the injection of home-produced opioids such as 'hanka' or 'shirka' is reported alongside heroin injection (Hickson, 2015). Patterns of drug use in Eastern European countries are influenced by easy access to drugs and decreasing prices, which increase demand. People that would normally smoke or drink alcohol are switching to heroin. Moreover, instead of smoking or snorting the substances, people are switching to injecting because the effects of the drugs are experienced more rapidly. The easy access to drugs and strong demand for illegal drugs has increased consumption dramatically. Currently, Russia has the highest number of PWID, 1.8 million, in the region which is about 2.3% of the adult population (AVERT, 2015, a). Other countries have also report significant numbers: Moldova 1% and Ukraine 0.8-1.2% (AVERT, 2015, a). The extremely high prevalence of injecting drug use in the region results in many HIV cases because people who use drugs (PWID) are more vulnerable to contract and transmit the HIV virus. PWID are often involved in risky behaviour: the widespread sharing of non-sterile and often HIV-contaminated equipment, such as needles and syringes, among multiple users. Due to such sharing, in addition to HIV, other communicable diseases such as tuberculosis (TB) and hepatitis B and C (particularly C), are easily and rapidly spread (Gannon, 2000). This is an equally serious health problem in the region. Injecting drug users (IDUs) are often found in complex environments where risky behaviours are shaped by no or limited availability of clean syringes or hygienic places to inject. Moreover, an overlap between injecting drug use and commercial sex work further explains the rising HIV infections from heterosexual transmission and suggests that the epidemic is also rapidly spreading from IDUs to their sexual partners.

3.3 Stigma and discrimination

It has gradually become apparent that in all societies, regardless of the degree of prosperity, the HIV epidemic affects the most marginalized population of society (Parker, 2002). Since the early days of the epidemic, misconceptions about the disease abound. Although the first identified cases were found among men who have sex with men (MSM) in the United States and Western Europe, the syndrome was re-named AIDS, as it became clear that it does not just affect MSM

(Acton, 2013). The key affected populations often include MSM, Lesbian, Gay, Transgender, Bisexual (LGTB), sex workers (SWs), prisoners, and injecting drug users (IDUs), who are widely viewed by society as second-class citizens and have unequal social, political and economic opportunities (Aids Action Europe, 2014). Marginalization of these key affected populations is based on sexual orientation, economic-, political- or social status. The individuals do not conform to societal norms, which results in discrimination and stigmatization, low levels of social and economic power, and living in a legal and policy environment that focuses on social control and punishment. Discrimination and stigmatization appear in members of all layers of society, including prosecutors, judges, lawmakers and health care providers.

The limited perspectives and opportunities significantly restrict these individuals' ability to access HIV prevention services, even if they do exist. For instance, IDUs are treated in an unfriendly manner and are prejudiced by health-care providers, who are often deeply judgemental about their HIV status or drug use (Donoghoe, Lazarus, and Matic, 2006). HIV-related stigma and discrimination are major barriers to accessing health-care services. It affects the lives of individuals through neglect, denial, and violation of their rights, while they should have the right to access medical services, which will allow them to lead normal lives in society and to participate in the economy. According to Elena Voskresenskaya, director of an HIV/AIDS related NGO in Ukraine, much work is still required at the community level (E, Voskresenskaya, personal communication, 16 February 2016). Nonetheless, some projects implemented by NGOs focus on stigma and discrimination among the police. Project activities include workshops and training, which focus on providing HIV/AIDS-related information to gain a better understanding of populations most at risk. During these workshops and training dialogues are arranged between drug users and the police, which enables the police to understand the challenges and struggles of drug users. These projects deliver positive results. Instead of police harassing drug users, they now refer the HIV-infected drug users to the appropriate HIV health services. However, these projects are not integrated into the system (E, Voskresenskaya, personal communication, 16 February 2016). Thirty years of AIDS activism and education has not made it much easier for HIV-positive people to disclose their status, whether privately or publicly. Identifying and dealing with HIV-related discrimination and consideration of the rights and dignity of the infected and affected still plays an important role. Despite vast need, few of the key populations have access to adequate HIV-, TB-, and hepatitis prevention, testing, and treatment services (UNAIDS, 2014). There is an important link between the HIV-infected and society: the sharing of responsibilities in the HIV epidemic. It would be considered a generalized epidemic if it was defined as a heterosexual epidemic, where effects are distributed relatively evenly among the entire

population. However, this is not the case. Some societies still do not accept the shared responsibility of allowing marginalized groups to express their HIV-status without being judged. The exclusion of HIV-positive people by refusing to place them on an equal footing persists. Therefore, the debate on HIV-related stigma and discrimination must be kept alive and remain a high priority in public health. If society wants PLWH to behave responsibly, with adequate behavioural change, it must provide them with a climate of acceptance and guarantee their rights. This is not the case since organizations throughout Eastern Europe still report numerous cases of HIV discrimination (ECDC, 2012).

3.4 Western and Eastern Europe compared

The regional impact of HIV has shifted over the years. Western and Central Europe have reported relatively stable increases, while Eastern Europe has indicated a continued increase in HIV cases (Cairns, 2016). It is important to remember that the HIV epidemic in Europe is diverse. Different countries in the region are at different stages of the epidemic, economic, social, and political development. Some European countries are among the richest and most powerful in the world, while other European countries are among the poorest. In contrast to Western European health systems, Eastern European health systems are rooted in the traditional Soviet 'Semashko model' (Coker, Rifat and McKee, 2008). This is defined as a strictly controlled, highly hierarchical system, with limited civil involvement and a smaller proportion of the economy going to health care and less payment to health providers than in Western Europe. Beside health systems, public health responses to HIV/AIDS also revealed different approaches. These ranged from an extremely repressive approach in most Eastern European countries to more liberal policies in Western European countries (Donoghoe, Lazarus, and Matic, 2006). The repressive approach included the compulsory testing of entire populations, the isolation of infected individuals, and punishment if they did not follow health care professionals' recommendations regarding safe sex practises and stopping drug use. Policies that are more liberal included respect for an individuals' human and civil rights. It relied on the effectiveness of health promotion efforts and behavioural change of a voluntary nature. The focus remained on maintaining the dignity of individuals at risk of or living with HIV (Donoghoe, Lazarus, and Matic, 2006).

The late 1980s and early 1990s represented a time of significant improvement in prevention efforts in Western Europe (Donoghoe, Lazarus, and Matic, 2006). In the late 1980s, the first drug for HIV treatment was approved in Europe. Its approval was primarily the result of effective and often inspirational advocacy efforts by PLWH. Community-based organizations, originating from the United States and Western Europe, also led the movement for Lesbian, Gay, Transgender,

Bisexual (LGTB) rights. Furthermore, there were extensive public information and awareness campaigns and safer sex promotion efforts (Donoghoe, Lazarus, and Matic, 2006). Among the prevention efforts, the most prominent and most effective were 'harm reduction' initiatives. The concept of 'harm reduction' refers to a strategy or a set of practical interventions aimed at minimizing the negative consequences related to injecting drug use (IHRA, n.d.). It focuses on the prevention of harm, rather than on the prevention of drug use. It accepts individuals as they are and avoids being judgemental. There is a need to provide people who use drugs with options that help minimise risks and help keeping themselves or others healthy and safe (IHRA, n.d.). The concept harm reduction emerged as a response to the high numbers of HIV infections among people who inject drugs. People from different fields are involved to reduce the harms to people who use drugs. The concept encompasses drug users as well as public health specialists, drug treatment workers, doctors, nurses, social workers, teachers, politicians, and drug-law reformers. Harm reduction was used in Western European countries to prevent the spread of HIV through injecting drug use. At that time, IDU was one of the two primary modes of transmission in the Western European countries with the highest prevalence of HIV/AIDS (Donoghoe, Lazarus, and Matic, 2006). Harm-reduction efforts were effective on a large-scale among IDUs who were at high risk for contracting HIV. It included large-scale outreach to drug users, the removal of obstacles to the use of appropriate health services, creating user-friendly services, access to sterile needles and syringes, broad access to drug dependence treatment, and other targeted interventions (for more detail on harm reduction see chapter 5).

These changes in the prevention of HIV were all important to prevent the crisis that took place in Eastern Europe ten years later. Because of these and other prevention efforts, there was a stabilization of around 10% annually in newly reported HIV cases between 1990 and 1997 (Donoghoe, Lazarus and Matic, 2006). However, the number of new AIDS cases and AIDS deaths decreased after 1999 (Donoghoe, Lazarus and Matic, 2006). In Western Europe, an early response was critical to halt the rise of HIV cases, while in Eastern Europe, the response has been less systematic and achievements have been disappointing. The HIV cases in Europe appear to have been increasing since 2003 (Alcorn, 2013). The primary factor could be the failure of policy-makers in Eastern Europe to introduce harm-reduction measures in the late 1980s and early 1990s, which increased HIV cases from 1995 onward (Donoghoe, Lazarus, and Matic, 2006). Although the history of the epidemic in Western Europe demonstrates that initiating harm reduction in the late 1980s was highly effective, these experiences seem to be ignored for the most part. Even where such interventions have been implemented, programmes are available on a limited scale, coverage of IDUs is generally insufficient, and most interventions lack

sustainability (Atun and Kazatchkine, n.d.). The extent to which such interventions are brought to scale will determine the level of impact on the population. The lack of harm reduction in Eastern Europe results in late HIV diagnoses and delayed initiation of life-saving HIV treatment. People who are diagnosed late have increased risks of HIV transmission, ill health, and death. Numerous people, unaware of their HIV status, reach out to medical care at a well-advanced stage of the infection, which contributes to the high number of AIDS-related deaths. By this time, their immune system has already started to fail. A lack of early understanding about the infectious nature of the disease, combined with prejudice, poverty, poor health, inferior education services, and armed conflicts in some regions, has created a series of missed opportunities for the early introduction of effective, large-scale prevention programmes in Eastern Europe.

3.5 Major achievements

In more than three decades of HIV/AIDS epidemics in Europe, much has been learned about prevention, treatment, and care. In addition, much has been learned about the laws, policies, and strategies that support or improve an effective response. These have helped extend, improve, and save the lives of countless PLWH. The most important interventions are examined: antiretroviral therapy (ART), needle and syringe programmes (NSP), and opioid substitution therapy (OST). All have demonstrated to be an essential part of successful HIV prevention, treatment, and care programmes for injecting drug users (IDUs). Firstly, the development of ART was a turning point in the epidemic. It first became available in 1996 with high coverage in developed countries, of which most were Western European countries (Smith and Whiteside, 2010). ART shifted HIV from an acute to a chronic disease. ART undoubtedly has the effect of reducing the amount of virus in circulation (Donoghoe, Lazarus, and Matic, 2006). It does not eradicate the HIV virus from the body, but it does control the virus. The prognosis of those already infected had much improved. It radically extended thousands of lives and improved their quality of life. A push for expanded access to ART in low- and middle-income countries, which includes most Eastern European countries, occurred in early to mid-2000s (Mallitt et al, 2014). The WHO's "3 by 5" initiative aimed to have three million people on ART by 2005 (WHO, n.d.). However, in practice, high coverage of ART access took place in these countries from 2006–2010 (WHO, n.d.). This increase of ART coverage has dramatically improved survival and longevity among PLWH. Another turning point in the epidemic was NSP, which was included in the global AIDS strategy of the WHO in 1986 (Donoghoe, Lazarus and Matic, 2006). The strategy recommended that sterile injecting equipment should be made available to drug users to prevent the spread of HIV. NSP was developed to prevent or decrease the transmission of HIV, tuberculosis (TB), and hepatitis B and C, through the sharing of injecting equipment (Burrows,

2000). The main NSP services distribute clean needles and syringes. It also encourages safe disposal by the return of unsterile drug injecting equipment, thereby reducing the possibility of HIV transmission (Burrows, 2000). In addition to ART and NSP, OST has rapidly expanded since the mid- 1990s (Kastelic, Pont, and Stöver, 2008). OST is the practice of replacing an illegal opiate with a prescribed medicine such as methadone or buprenorphine (Paul and Remski, 2012). The effects are that patients experience a reduced or less intense urge to use drugs and it helps improve the user's stability and social function. This results in the reduction of injecting use, sharing of injecting equipment and ultimately preventing HIV infections (Paul and Remski, 2012). OST and NSP also aimed to achieve face-to-face contact with PWID, to provide information about HIV risk reduction, and to refer PWID to the appropriate services. While all countries in Eastern Europe now have NSP and OST as harm reduction interventions, the coverage in terms of the number of locations and the number of injectors reached is inadequate (Burrows, 2006).

It is clear that the HIV epidemic has shifted over the past thirty-five years and has spread to every corner of the world, while millions of people are still being infected. Today, HIV/AIDS is regarded as a global concern that burdens not just the health sector, but also all public sectors. HIV prevalence in Eastern Europe continues to rise, despite the wealth of knowledge regarding prevention and treatment of HIV. Factors blamed for this increase include lack of political will, poor levels of awareness, public ignorance, criminalization of risky behaviours, social exclusion, discrimination, and stigmatization that discourage people with HIV and AIDS from seeking out HIV information, testing, treatment, and support services. The public debate on appropriate responses to the epidemic continues on different levels after thirty-five years of HIV/AIDS. The limited access to effective HIV prevention measures, treatment, and care in Eastern European countries clearly illustrates the continuing negative impact of political and philosophical forces. Adequate political measures are required to address the epidemic. Since injecting drug use is so widespread in many countries of Eastern Europe and because it plays such a leading role in HIV transmission there, optimizing effectiveness of HIV prevention, diagnosis, and treatment for people who use drugs is crucial.

4. EU strategies focussed on HIV/AIDS epidemic in Eastern Europe

4.1 Communication and Action Plan on HIV/AIDS

The European Commission's 'Communication and Action Plan on HIV/AIDS in the EU and neighbouring countries 2009-2013' is a HIV/AIDS policy on EU level and has been the basis for EU action since 2009 (Bienkowska-Gibbs et al, 2014). It builds on the previous Communication and Action Plan 2006-2009. The main goals of the European Commission's 'Communication and Action Plan on HIV/AIDS in the EU and Neighbouring Countries 2009-2013' were:

- A decrease in new cases of HIV-infected people across all European countries by 2013;
- To enhance access to prevention, treatment, care and support;
- To better the quality of life of people who are infected with HIV/AIDS, who are influenced by or are most exposed to HIV/AIDS in the EU and neighbouring countries.

The Communication and Action Plan 2009-2013 was aimed at all EU Member States, EU candidate countries, European Neighbourhood Policy (ENP) countries, and the Russian Federation. The 'Communication and Action Plan' is an invitation to these countries to help bring about the achievement of the goals set out in this plan. It emphasised increasing prevention strategies across Europe, focussing on priority regions, supporting those most at risk of and most vulnerable to infection. It emphasizes injecting drug use (IDU) as the main driver of HIV transmission in Eastern Europe, which account for two third of all new infections. Drug addiction calls for an integrated medical and social response. Access to sterile needles, evidence-based addiction treatment, including substitution and other harm reduction measures have proven to be effective. This is especially the case in high prevalence areas and in settings such as prisons. Investment in a comprehensive IDU health care should help to decrease the number of new HIV infections among drug users. Moreover, it would help to decrease or lighten the burden associated with drug use.

'The Action Plan' mapped out how all stakeholders were to realize the goals set out in the plan by identifying six areas for action: 1. Politics, policies and involvement of civil society, wider society and stakeholder, 2. Prevention, 3. Priority regions, 4. Priority groups, 5. Improving knowledge on HIV/AIDS and 6. Monitoring the evaluation (Bienkowska-Gibbs et al, 2014).

4.1.1 Financial Inputs for the Action Plan

Funding of these actions originated from the Global Fund to fight AIDS, Tuberculosis, and Malaria (hereafter called the Global Fund), the Development Cooperation Instrument, the EU Health Programme 2008-2013, the EU Structural Fund, the Seventh Framework Programme, and the

European Neighbourhood and Partnership Instrument (ENPI) (Bienkowska-Gibbs et al, 2014). The first three funding mechanisms are explained. First, 'the Global Fund' has contributed significant amounts of money in the fight against HIV in Eastern European countries since its formation in 2002 (Attawell et al, 2013). As a financing institution aimed at eradicating AIDS, tuberculosis, and malaria epidemics, it supports projects carried out by local experts in countries and communities most in need. It collaborates with governments, civil society, the private sector, and people affected by the diseases. By 2012, the Global Fund had granted 872 million USD to address HIV. The European Commission has been a significant contributor of funding to the Global Fund. Since the Global Fund's establishment, 5,9% of the financial contributions to the Global Fund originated from the European Commission, making the European Commission the sixth largest financial contributor after the US, France, the United Kingdom, Germany, and Japan. Thus, from the total grant of 872 million USD, 52 million USD (5,9%) originated from the European Commission. The 52 million USD was to support national responses to HIV within the EU, ENP countries, and the Russian Federation. Ukraine and the Russian Federation received the largest proportion of total grants provided by the Global fund. In 2012, 51% of funds granted to countries in the region went to Ukraine. An example of a country programme supported by Global Fund's financing is Moldova. Moldova received 9.8 million USD for the project 'Scaling up access to prevention, treatment and care under the national programme for prevention and control of HIV/AIDS/sexual transmitted diseases(STIs) 2006-2010' and 'Reducing morbidity, mortality and HIV-related impact on people living with HIV/AIDS, 2010-2014'.

Second, the European Commission's financial contribution to the Global Fund is a component of a broader programme, 'Investing in People' under the 'Commission's Development Cooperation Instrument (DCI)'. Apart from the European Commission's financial contribution to the Global Fund it established a 9 million euro programme through the 'Investing in People' programme aimed at increasing the capacity of non-state actors involved in HIV/AIDS prevention, treatment and care for the ENP countries. The distribution of funds began in September 2010 and supported various HIV/AIDS projects in Eastern Europe (Attawell et al, 2013).

Third, the implementation of the Action Plan is funded partially by the 'European Health Programme 2008-2013'. One of the programme objectives was to improve citizens' health security by developing the capacity of the EU community to respond to communicable and non-communicable disease and health threats. Part of this objective is the implementation of good practices for cost-effective prevention, diagnosis, treatment, and care of HIV/AIDS. The total budget for the programme was 321 500 000 euro (European Commission, 2016). The programme was implemented by means of annual work plans, which set out priority areas and criteria for

funding actions under the programme. 'The European Health Programme' supported responses to HIV that are in line with the European Commission's Communication Action Plan on HIV/AIDS. Funding that 'The European Health Programme' allocated to HIV-related activities dropped from 6.9 million EUR in 2009-2010 to 2.6 million EUR in 2011-2012 (Attawell et al, 2013).

4.1.2 Evaluation of the Action Plan

The implementation of the European Commission's Action Plan was evaluated to identify the success of the 'Action Plan 2009-2013' in terms of decreasing the number of new HIV-infection cases, improving access to key services, and improving the quality of life for those living with HIV (Bienkowska-Gibbs et al, 2014). In addition, the evaluation attempted to identify obstacles to the success of HIV prevention and the challenges arising as a results the implementation of HIV-related policies.

Bienkowska-Gibbs et al (2014, p.18) reported that new HIV cases increased in the WHO Eastern European Region between 2009 and 2013. The East included among others Armenia, Azerbaijan, Belarus, Georgia, Moldova, and Ukraine. In 2012, Eastern Europe had the highest rate of new HIV diagnoses compared to West Europe and Central Europe (HIV/AIDS Surveillance in Europe, 2012, p.10). Thirteen of the fifteen countries in the East reported 24458 new infections. The highest numbers were reported by Ukraine, Moldova, and Belarus. Ukraine was responsible for 69% of new HIV infections in the East (HIV/AIDS Surveillance in Europe, 2012, p.10). In Eastern Europe, PWID and their sexual partners were still the primary transmission group (Bienkowska-Gibbs et al, 2014, p. 19).

Bienkowska-Gibbs et al (2014, p.20) reported that between 2009 and 2012, more EU and European Economic Area (EEA) countries, which exclude Ukraine and Moldova, submitted data on HIV testing to the ECDC and found that there was an increase in the number of tests conducted. Though the overall amount of testing had increased, there was much variation among the different countries. Countries were only included in the surveillance if they reported data for at least three out of the years 2009, 2010, 2011, and 2012. Therefore, data on Moldova and Ukraine is not presented. However, Culyba et al (2013) stated that due to the low availability of voluntary counselling and testing services in Ukraine, only approximately 28% of HIV-infected people have undergone testing and are aware of their HIV status (p.89, p.90).

Bienkowska-Gibbs et al (2014, p.22) reported that the data for HIV treatment across the WHO European Region indicates an increase in the number of HIV-infected people who did receive antiretroviral therapy (ART) treatment. Moldova and Ukraine reported low access to treatment (Bienkowska-Gibbs et al, 2014, p.22). Though the actual numbers on access to treatment were

lower than that of other WHO European Region countries, there was an increase in the number of people requiring treatment and those who accessed treatment in Eastern Europe (Bienkowska-Gibbs et al, 2014, p.23). The Action Plan places great value on harm reduction programmes, as an important factor in an effective response to HIV. In Eastern Europe, the Global Fund has been actively financing harm reduction programmes. The European Commission has contributed indirectly to harm reduction for injecting drug users through their financial contribution to the Global Fund (Attawell et al, 2013, p. 32). It is estimated that through the European Commission's financing of the Global Fund, it has helped to provide (Attawell et al, 2013, p. 33):

- harm reduction services for over 35 000 people who inject drugs;
- opioid substitution therapy for almost 800 people who inject drugs;
- HIV prevention programmes for over 10 000 sex workers and their clients;
- HIV prevention programmes for over 15 000 men who have sex with men;
- HIV prevention programmes for over 25 000 prisoners;
- almost five million condoms;
- HIV testing and counselling for almost two million people;
- and antiretroviral therapy for over 6 000 people.

Globally, Eastern Europe has the lowest coverage of ART, which is of great concern. Attawell et al, reported that approximately 23 % of people requiring treatment received it (2013, p. 33). The European Commission has contributed through the Global Fund to increase access to ART in Eastern Europe, as demonstrated above. The concern, however, is the extent to which countries will be able to continue this increase once the Global Fund's support ends or shifts. In 2012, the Global Fund adopted a new allocation model, in which resources focus on countries with the highest disease burden and the lowest ability to pay (The Global Fund New Funding Model Brochure, p.2).

The interviewee also highlighted the importance of the Global Fund contribution (E, Voskresenskaya, personal communication, 16 February, 2016). The following question was asked: *Have you noticed support from the EU in improving access to HIV/AIDS prevention and treatment or was it mainly because of Global Fund?* The interviewee responded: 'To a great extent due to the support of Global Fund. Without Global Fund, we would not have harm reduction and opioid substitution therapy. With regard to EU contributions, we do not see them at the moment. EU funding from the EU Commission has decreased. Before we had quite a lot of funding from the European Commission, but they seem to have changed their priorities. Now they allocate more funds to democratization reforms, supporting internally displaced people that have moved from

Eastern Ukraine after the military conflict. Funding has decreased significantly over the last 7 to 8 years. I think there is a tendency for many EU donors to think “we have given money to the Global Fund, so why should we provide some additional support?”. *When asked: There is an EU ‘Communication and Action Plan for combating HIV/AIDS in the neighbouring countries’. Eastern neighbouring countries include Ukraine and Moldova. Could you identify a certain year where you noticed significant improvements in these countries?* The interviewee responded: “I would say that the situation did start changing in 2008/2009. In terms of the availability of services because the infections were still high and continue to grow, it did not stabilize. The prevalence started to level out. Sometime after 2008, the additional prevalence was more or less stable. Services had just become more accessible, mostly due to the Global Fund. However, if the EU is working through the Global Fund, the EU has contributed as well. You hear about many of the donors, though not necessarily the EU. For example the Swiss provided huge support. The Swedish government, through Swedish international development agencies, supported ‘HIV campaign starting in solidarity with people living with HIV: condoms/prevention’. However, then the government said it had given enough money to the Global Fund. Moreover, they do not see much commitment from the Ukrainian government, so they completely changed their policy and excluded HIV from their priorities. The same happened to many other donors, unfortunately”.

Additional assessment of the ‘EU’s Action Plan on HIV/AIDS’ comes from ‘the Civil Society Forum’, which is part of a networking structure established by the European Commission to function as an advisory body that brings together different networks and parties, such as NGOs and PLWH, within the European Union. ‘The Civil Society Forum’ advises the ‘HIV/AIDS Think Tank’ on policy formulation and implementation. ‘The HIV/AIDS Think Tank’ is a forum to exchange information between the European Commission, the Member States, and the neighbouring countries. Relevant international and regional organisations and pan-European NGOs are invited to the meetings.

Overall, respondents of ‘the Think Tank’ and ‘the Civil Society Forum’ survey did not believe the European Commission’s Communication and Action Plan had contributed to noticeable changes in the HIV epidemic or had influenced access to key services. However, they did believe that the Communication Action Plan had an indirect impact through its focus on people most at risk and through the stimulation of political support for providing services and interventions for these people (Bienkowska-Gibbs et al, 2014, p. 37). The Civil Society Forum was recognized as having played a role in the fight against HIV/AIDS in Europe during the period of the Communication Action Plan on HIV/AIDS 2009-2013 (Bienkowska-Gibbs et al, 2014, p. 52).

Firstly, the Civil Society Forum facilitated the exchange and discussion of key HIV/AIDS issues, informing Civil Society Forum members and Think Tank members on the development of HIV policies within the European Union, which also made the exchange of experience possible. Furthermore, different players were able to cooperate in a less formal setting. Secondly, through the Civil Society Forum meetings, members were able to plan the implementation of actions and to support and assist each other in influencing HIV policies.

Regarding the actions of 'the Civil Society Forum', the Ukrainian representative stated that after 'the Civil Society Forum' had made a statement on universal access to treatment, the 'All-Ukraine Network of People Living with HIV/AIDS' set a campaign in motion in 2011 called "Let Me Live" (Attawell et al, 2013, p. 31). The Ukrainian president then requested the government to fully fund the national HIV/AIDS programmes in 2011 and 2012. This resulted in an increased state budget for ART between 2011 and 2012. In 2011, 22000 people were on state-supported treatment, while in 2012, this number increased to 42000 people. Representatives of the 'Think Tank' from Moldova have stated that action taken by the 'Think Tank' has helped to make HIV/AIDS a public health priority and to maintain the debate regarding HIV/AIDS on the political agenda (Attawell et al, 2013, p. 30).

4.2 European Neighbourhood Policy (ENP)

Addressing HIV/AIDS in Eastern neighbouring countries can be difficult, due to state fragility in terms of the quality of domestic governance guaranteeing rule of law, democracy, respect for human rights, and respect for and protection of minorities (Lupu, 2010). Through the ENP, which was launched in 2004, the EU has worked especially on strengthening these values of democracy, the rule of law, respect for human rights, and social cohesion with the EU's southern and eastern neighbours (European Union External Action, n.d.). Moreover, it addresses combating public health threats, especially communicable diseases such as HIV/AIDS. The Eastern Partnership (EaP) consists of Armenia, Azerbaijan, Belarus, Georgia, Moldova, and Ukraine. However, Belarus remains outside most ENP structures due to the reluctance of Belarusian authorities. Other partner countries fully participate and have agreed to function as ENP partners. The partnership is a jointly owned initiative and plan implementation requires action on both sides. The ENP sets out the partner country's needs and capacities, as well as the EU's interests with short and medium-term priorities of three to five years (European Union External Action, n.d.). The progress report of the ENP objectives in 2014 was adopted on 25 March 2015. In the context of the HIV epidemic, the main outcomes of the ENP objectives in Ukraine and Moldova are discussed below.

4.2.1 Ukraine review

Reforms in Ukraine were carried out in a difficult political, economic, social, and military/security context due to armed conflict with Russian military intervention in eastern Ukraine. Ukraine's position of strengthening relations and eventually joining the EU has been called into question. Current government struggles between Russian and EU demands, adding the Crimea annexation, the war in East Ukraine, and the MH-17 crash, have complicated the relationship between the EU and Ukraine (A, van Dam, personal communication, 18 February 2016). However, local civil society expects the EU to apply pressure to reluctant regimes and to assist the governments of the region that are willing to democratise, establish the rule of law, and support human rights (E, Voskresenskaya, personal communication, 16 February, 2016). The outcome of the progress report was that Ukraine made headway on deep and sustainable democracy, human rights, and fundamental freedoms (European Commission, 2015,a). The situation improved with regard to freedom of expression, media, and assembly. In addition, anti-discrimination legislation was improved and need to be implemented. Civil society continued to progress in Ukraine. Since 2014, municipalities provided civil society organisations (CSOs) insight into their decision-making process. However, the need for comprehensive reforms in some areas remains.

There was no progress on public health. International donors such as the WHO were alarmed by the critical shortage of lifesaving medicines stock since November 2014, especially in the conflict area in the Donetsk and Luhansk regions. It put at risk the implementation of the fourteen national programmes focused on the most critical diseases, including HIV/AIDS and TB. According to the Joint United Nations Programme on HIV and AIDS, the HIV/AIDS epidemic in the country worsened and the number of registered cases increased by 12% in 2014. Meanwhile, representatives of Ukrainian civil society were participating in the 'HIV/AIDS Civil Society Forum' in Luxembourg. The negotiations with the Global Fund started for comprehensive support to combat HIV/AIDS and TB in Ukraine. The Ukrainian government announced that the functions of 'State Service for Socially Dangerous Diseases' would be abolished and transferred to the Ministry of Health. Moreover, the new Ukrainian government agreed with the EU that specific cooperation related to the health sector should be identified and corresponding actions need to be prioritised (European Commission, 2015, a). However, the interviewee highlighted the imprecise approach of the Ukrainian government (E, Voskresenskaya, personal communication, 16 February 2016). The following was asked: *Does the Ukrainian government have a good approach toward HIV/AIDS?* The interviewee responded: it is still unclear who is responsible for HIV at the governmental level. Traditionally, it was the Ministry of Health. However, the Ministry of Health

does not want to take responsibility for treatment. Since it is quite unclear who is responsible for prevention, I would say the approach of the government is much disaggregated. Especially in the current situation when countries are experiencing economic crisis, statements from the Ministry of Health indicate that HIV is not a priority.

While it may appear that there is a lack of political leadership in the country, Ukraine continued technical cooperation with the 'European Centre for Disease Prevention and Control (ECDC)' (European Commission, 2015, a). A national correspondent for relations with the ECDC was nominated, to participate in the 'National ECDC Correspondent meeting' and furthermore, attended the technical workshops on 'HIV/AIDS and vaccine preventable diseases' and 'the annual European Scientific Conference on Applied Intervention Epidemiology' (European Commission, 2015, a).

4.2.2 The Republic of Moldova review

Moldova has demonstrated a pro-European attitude and a willingness to implement the EU's reform agenda (Lupu, 2010). 2014 was a year of general political stability for Moldova (European Commission, 2015, b). Moldova made less progress than in preceding years with regard to deep and sustainable democracy, respect for human rights, and the recognition of fundamental freedoms. Although civil society in Moldova has grown in a favourable environment, it is still weak. The partnership between public authorities and civil society organisations (CSOs) allowed continuous progress, which resulted particularly in a more significant decision-making role for civil society.

Moldova implemented a national public health strategy for 2014-20. Access to antiretroviral therapy for HIV and TB treatment improved. The medicines legislation was aligned to EU directives and the capacities of the 'National Medicines and Medical Devices Agency' were strengthened. Moldova continued technical cooperation with the 'European Centre for Disease Prevention and Control (ECDC)' under an EU-funded regional project on preliminary measures to support the participation of ENP countries in ECDC activities. Moldova nominated a national correspondent to facilitate relations with the ECDC and this correspondent carried out a short-term expert agreement. Moldova participated in the first 'National ECDC Correspondent meeting' in May 2014, attended technical workshops on HIV/AIDS and vaccine-preventable diseases, and took part in the annual European scientific conference on applied intervention epidemiology (European Commission, 2015,b).

4.2.3 Critics ENP

The EU's performance is questionable, attracting criticism regarding the effectiveness of the aims set out in the Action Plans. Stefan Lehne (2014) is critical towards the concept of the European Neighbourhood Policy and advocates for radical changes. He states the following: "Ten years after the ENP's launch, it is clear that the policy is not working. Adjusting the ENP to the changing reality on the ground, sharpening its tools, and bettering its credibility should be a top priority for the EU's foreign policy leadership". Stefan Lehne is not alone in his criticism. Other critics are Harper (2015) and, Forbeig and Inayeh (2015), who together with Stefan Lehne (2014) have three main arguments to support their stance. First, the ENP lacks differentiation, as it is a single framework. In this regard, it is often questioned whether this 'one-size-fits-all' policy can be effective in countries that have different aspirations concerning the EU and which differ considerably in terms of their levels of economic development, political system, and cultural and historical backgrounds. Any attempt to develop one conceptual framework applicable to such diverse countries was bound to be difficult. Second, the ENP is articulated vaguely, and merely indicate areas for action such as 'the development of civil society', 'ensuring freedom of the press' and 'strengthening the involvement of political parties in the democratic process', without clarifying the measures required to achieve these goals. Third, the EU has limited systematic awareness of what it is trying to promote in its eastern neighbourhood under joint ownership. The creation of the policy was driven by the necessity to build good neighbourly relations in the eastern region after the 2004 enlargement. In addition, the eastern neighbours, some of whom were going through significant political transformation processes, began to express and expect hope for EU accession. Partners from the Eastern Partnership report the lack of a key message about the EU's eastward enlargement (Zajackowski, 2015). These attitudes are especially prevalent in Ukraine, Moldova, and Georgia, because they believe the ENP promises too little and might not guarantee EU accession. Catherine Ashton, EU High Representative for Foreign Affairs & Security Policy (Los, 2014), confirmed this perception in her presentation of the latest update on EU relations with its neighbouring countries. She stated, "The fundamental flaw of this policy lies thus in its very own design, where ENP countries are promised 'everything but institutions'" (Los, 2014). This implies that, in the absence of the membership, the danger is that these countries become more discouraged about complying with the norms or standards of the EU when they are not receiving the full benefits in return. Fourth, some ENP partners have drifted further away from the EU, rather than moving closer toward it. The EU initially viewed itself at the centre of its universe and neglected the strength of other actors, such as Russia. When the EU

established the Eastern Partnership, Russia's attitude toward the policy turned openly hostile. As much as the EU underscore that the initiative was not directed against Russia and that reforms and economic development of the Eastern European states would equally benefit Russia, Russia continued to view the Eastern Partnership as a setback for Russia. In 2011, Russia and Belarus, launched their own alternative integration project the 'Eurasian Customs Union' (Dragneva and Wolczuk, 2012). It invited other Eastern European countries to join. Against the EU's will, it entered into a geopolitical competition with Russia, a situation for which it was not prepared.

Criticism towards the ENP does not mean that the EU's idea of supporting structural change in neighbouring regions was mistaken. However, it has become clear that the EU urgently needs to develop tools better suited to today's challenges in which such efforts have a real chance of success. The EU will first need to re-examine whether the overall policy framework is the correct one. Change is needed in order to increase the coherence, appropriateness, suitability and effectiveness in a fast-changing and challenging environment. Despite criticisms of ENP Action Plans, the EU is willing to improve. Similar to the 2013 edition, the 2014 version of the ENP Communication acknowledged the need for a differentiated approach that is adapted to each individual country (Los, 2014). It is a positive sign that the Commission recognised that, although the ENP demonstrates progress and benefits for ENP countries and the EU, there is still room for improvement.

5. Access to harm reduction in Ukraine and the Republic of Moldova

Years of experience in HIV management has provided essential knowledge on effective measures to prevent and treat HIV. These measures include scaling up access to harm reduction (EHRN, 2015, a). Although prevention relies on targeting safer sexual behaviour among the general population, tackling drug use is equally important. This is especially important in Eastern Europe due to the high number of HIV cases attributed to injecting drug users in the region. The earliest forms of harm reduction propose abstinence from drug use and reducing its incidents (AVERT, 2015, b). Subsequently, at the beginning of the HIV epidemic, the concept of harm reduction was extended by providing clean needles and syringes to people who inject drugs (AVERT, 2015, b). Both of these harm-reduction interventions are currently known as opioid substitution treatment (OST) and needle syringe programme (NSP). Despite the growing acceptance of harm reduction approaches, opposition to the concept persists (Atun and Kazatchkine, n.d.). This is particularly the case in many Eastern European countries, where harm reduction remains controversial. Ideological and political obstacles to implement harm reduction programs in the region continue to exist, particularly by governmental and professional actors, (Atun and Kazatchkine, n.d.). Therefore, people in most Eastern European countries who use drugs have difficulty obtaining access to these essential services. This chapter examines arguments of proponents for and opponents of harm reduction and the coverage of OST and NSP among people who use drugs in Ukraine and Moldova.

5. 1 Proponent versus opponent

Since the conception of harm-reduction, ethical debates continue between proponents and opponents. An early statement originates from John Stuart Mill (1892), who introduced the 'harm principle'. He states: "If an individual wants to do something, even if it may harm them, then that is their business unless it harms someone else". In the context of the HIV epidemic, IDU is not only harming the person that is using drugs for their own purpose, but it is also harming others when HIV or other diseases are transmitted through the sharing of needles or by sexual contact. Supporters of harm reduction argue that the use of drugs negatively affects the dignity of people who use drugs, who are already part of a marginalised group (Ashcroft, 2005). For instance, one must consider the increase in mental illnesses, the lack in ability to make independent decisions, social disadvantage, and lack of education. Therefore, ethical measures are needed for drug-related problems in order to maintain or enhance the dignity of people who use drugs (Ashcroft, 2005). It is argued that society should intervene and make decisions on behalf of this marginalized

group, which may result in restoring the dignity of these people and enhance their ability to make decisions. In contrast, critics such as Husak (1992), Hathaway (2001), Cohen and Csete (2006) assert that harm reduction sends the wrong message that drug use is acceptable, or at least not strongly disapproved. Further arguments are firstly, the reduction in possible harm associated with drug use will encourage people to use drugs. Secondly, it will enable drug users to continue in their addiction pattern. Thirdly, it is argued that the hidden intention is drug law reform and the promotion of drug legalization.

Arguments of critics, while not supported by evidence, are taken into account. This paragraph addresses the three main criticism disputed by studies investigating the impact of harm-reduction programmes. Firstly, the argument that harm reduction encourages people to use drugs is examined. While harm-reduction initiatives may result in an increased frequency of use, there is no evidence that they are responsible for causing previous non-users to use drugs. While it may be true that harm reduction results in a small increase in drug use with regard to frequency of use. However, it also results in decreased related harms (Caulin et. al, 2010). Caulin et. al state “People do often decide to participate in an activity more frequently when it is safer, but the increases are smaller, proportionately, than the reductions in harm. So total harm is generally reduced when an activity is made less harmful”. Secondly, the argument that harm reduction will enable drug users in their pattern of addiction is challenged by a study of European medically supervised injecting centres, where the following was found: “Consumption rooms often reach a population of older, long-term users, some of whom have had no previous treatment contact (Hedrich , 2004)”. These services appear particularly successful in reaching groups that are difficult to reach. No evidence was found to suggest that people who were already users are initiated into injecting as a result of the presence of consumption rooms.” Thirdly, the argument that the underlying intention is to achieve drug-law reform and to promote the legalization of drugs is addressed. It is an unquestionable fact that some supporters of harm reduction are also defenders of drug law reform or some form of legal regulated market for some or all drugs (Lenton and Single, 1998), while others object to advocating on drugs within criminal law but defend civil penalties for drug use. Yet others strongly disapprove any of these developments (Lenton and Single, 1998). Clearly, there are different views and there is no unity on this issue among harm reductionists. However, the most common statements of harm reduction principles are clear on neutrality regarding drug-law reforms.

There is a range of evidence, from research and well-conducted observational studies, that demonstrates the positive effects of harm reduction programs. International health bodies also support positive effects of harm-reduction, including UNAIDS, WHO, and the UNODC, who affirm a protocol of nine essential interventions for a broad HIV response targeting drug users (WHO, 2009). These include NSP and OST (both part of harm reduction). Implementation of these measures could greatly reduce new HIV infections in people who use drugs. The effects of NSPs and OST on HIV incidence in PWID are minor when delivered as disjointed strategies. Therefore both are recommended as part of a comprehensive set of measures for people who use drugs (WHO, 2009).

5.2 Harm reduction Eastern Europe

Even though harm reduction programmes are being implemented in all Eastern European countries, they often lack coverage among people who live with HIV, particularly PWID. According to a technical guide from the WHO, UNODC, and UNAIDS, needle and syringe programs ultimately need to reach a minimum of sixty per cent of PWID, which is defined as high coverage (WHO, 2009). Opioid substitution treatment ultimately needs to reach a minimum of forty per cent of PWID, which is defined as high coverage (see figure 1 below).

Figure 1: indicative targets

NSP coverage	OST coverage
Low: 20– 60%	Low: <20–40%
Medium: >20– 60%	Medium: <20–<40%
High: >60%	High: >40%

(source: WHO, 2009).

Moreover, to have a meaningful impact, the frequency of access to a service should also be taken into account. In order to be most effective, some interventions such as NSP are needed at least once per month, while others such as OST need daily reach (WHO, 2009). This is due to the medications used for OST, which are tightly controlled, treatment brings users into regular contact with the health care system. A six month duration of OST with psychosocial support is

required (WHO, 2009). Globally, there is no consensus on the level of coverage that is sufficient for all situations. However, according to estimates of a report by the 'Eurasian Harm Reduction Network (EHRN)' only 10% of people who inject drugs in Eastern Europe are able to access NSPs (Votyagov, 2013). This is clearly a low coverage, which can be explained by the national governments that are still either reluctant or entirely resistant to invest in harm reduction programs. Most harm reduction programmes have been designed and implemented by nongovernmental organizations (NGOs) in the region and have had to obtain financial support from outside the region. Over the last decade, the Global Fund has played a crucial role in responding to the HIV epidemic by being the major funder of harm reduction services in the region. For example, the largest funding allocation within the region (28 per cent) was allocated to Ukraine (Global Fund, n.d.). Moreover, according to EHRN (2015), in the period of 2012-2013, NSP and OST programmes in the Republic of Moldova were funded by Global Fund (100% - 99,9%). However, in 2011 the Global Fund announced the development and implementation of a new funding model Global Fund's Strategy 2012-2016. These changes in the funding model have resulted in severe short- and long-term implications for harm reduction programme start-up, sustainability, and expansion in the region (IHRA, n.d.).

5.3 Ukraine

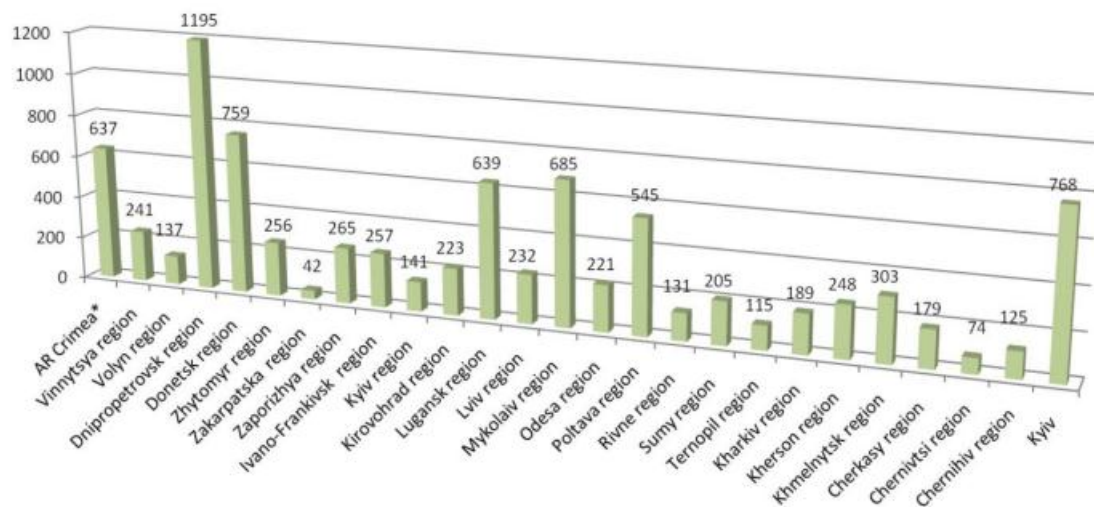
Ukraine is a lower middle-income country in Eastern Europe with a population of 45 million (UNDP, n.d, a). Currently, PWID have the highest percentage of HIV infection, that is 20% of the estimated 310,000 Ukrainian PWID are HIV-positive (Saliuk and Sazonova, 2015). However, harm reduction programmes cover only one-third of the estimated 310,000 PWID and receive a minimal package of prevention and care services (UNAIDS, n.d.). There is no consensus regarding which cities have the highest number of HIV cases among PWUD. Nonetheless, Odesa and Dnipropetrovsk, the southern and eastern regions of the country, are frequently stated. Donetsk and Lugansk, conflict-affected eastern parts of the country, are also mentioned. People with HIV who live in these regions face a critical shortage of essential services (E, Voskresenskaya, personal communication, 16 February, 2016). 'International HIV/AIDS Alliance Ukraine' is the largest provider of harm reduction services in Ukraine (International HIV/AIDS Alliance, 2015). A response that began at the end of 2000 and was increased from 2004 to current year at national scale. The Alliance works in close collaboration with local NGO partners and the Ministry of Health (International HIV/AIDS Alliance, 2015).

5.3.1 Opioid substitution therapy (OST)

As of 2004, OST was provided in Ukraine (Schauba et al., 2009). Soon after buprenorphine was approved in Ukraine, the WHO conducted a study on OST in seven developing and emerging countries (Booth et Al, 2014). It included China, Indonesia, Thailand, Iran, Lithuania, Poland, and Ukraine. The aim was to see if the results of OST were equivalent regardless location. The study involved 726 patients from 2003 and 2005. During OST treatment, the participants (people who use drugs) were evaluated after two weeks, three months and again at six months period. In every country there was a focus on methadone, except for Ukraine because buprenorphine was the only medication available for OST at the time. In every country, the results showed significant decrease in opioid use risk of injecting (which also include HIV injecting). In most countries, reductions in criminal behaviour and improved physical and mental health were shown. This study showed the successful implementation of OST in Ukraine among drug users. Therefore, it was highly recommended to continue the scale-up of OST in Ukraine (Booth et al, 2014). In collaboration with the 'International HIV/AIDS Alliance', the Ukrainian Institute for Public Health Policy, WHO Regional Office for Europe and staff of existing treatment locations, six buprenorphine maintenance treatment locations started in 2006 (Schauba et Al., 2009) .

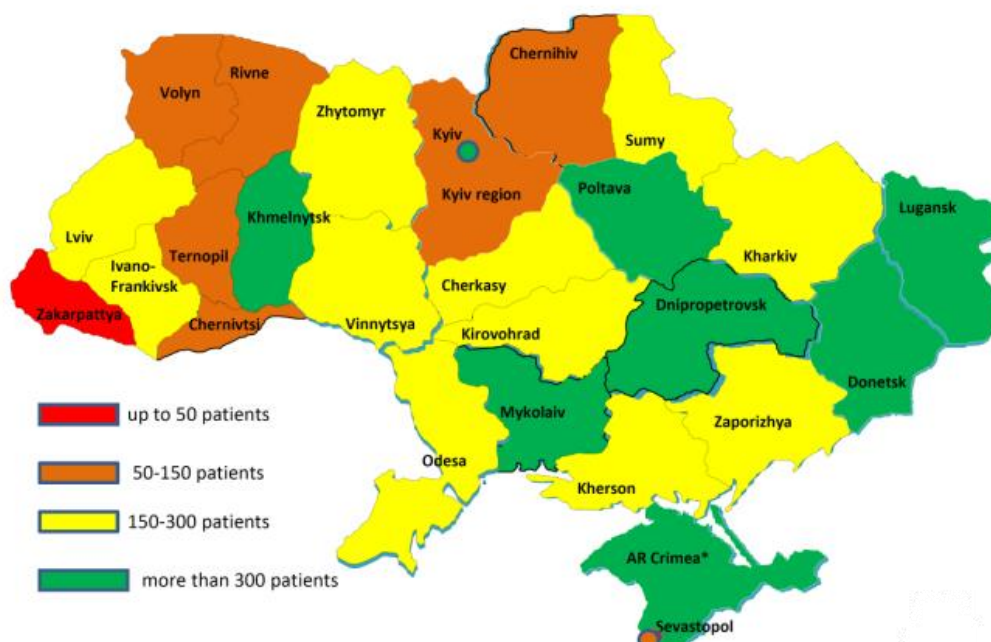
Due to scepticism towards OST from politicians and clinics, buprenorphine was the only medication available for OST from 2004 till 2007. However, after strong advocacy, methadone maintenance therapy became available in May 2008 (Altice, 2014). There was a rapid scale up, partially due to the extensive investment of Global Fund, between 2008 till 2009 (Schauba et Al., 2009). In 2008, 941 patients were receiving OST (114 methadone and 827 buprenorphine) and in 2009, 4052 patients were receiving OST (3221 methadone and 831 buprenorphine) (Booth et Al., 2014). The number of OST programs increased from 12 to 87. In a follow-up of 6-month, 140 patients that started methadone treatment in eight Ukrainian cities showed 85% retention and significant reductions in opioid use and HIV risk. (Booth et Al., 2014). In 2014 OST was available to few drug users, approximately 9000 out of 310,000 people using drugs in the whole country in March 2014 (Ritter, 2014). In the same year, 8175 people were covered in OST (Crimea not included) of which 7299 are receiving methadone and 876 buprenorphine (Ritter, 2014). The number of treatment channels for buprenorphine treatment is limited because of the higher price of buprenorphine. See below (figure 2 and 3) the number of OST patients in Ukraine.

Figure 2: Number of OST patients in Ukraine (regions)



(source: International HIV/AIDS Alliance Ukraine, 2014)

Figure 3: Number of OST patient in Ukraine (regions)



(source: International HIV/AIDS Alliance Ukraine, 2014)

OST is provided at different health care facilities. These include narcological centres, AIDS centres, hospitals treating communicable diseases, TB centres, as well as at hospitals (WHO, 2014). Most people receiving OST live in Eastern and South-Eastern Ukraine, this is excluding the conflict countries. How many people can be treated in each facility is depending on the regulation of local government. Current OST programmes are only partly financed by Ukrainian health authorities (E, Voskresenskaya, personal communication, 16 February, 2016). Most of them are still heavily

dependent upon funding from the Global Fund. Therefore, the Global Fund's 2011 decision to reduce its next funding round in 2016 risks future OST services in Ukraine unless Ukrainian government decides to subsidize it. This is however unlikely because the budget is scarce. Moreover, due to stigma and discrimination in the country a politician is not eager to allocate funds to drug users, because this politician becomes very unpopular among society. The provision of OST services in prison is not yet supported. However, there are agreements regarding a couple of pilot projects for providing methadone in pre-trial. So methadone is slowly introduced in prisons. (E, Voskresenskaya, personal communication, 16 February, 2016). Elena Voskresenskaya director of AFEW has been working in the field of HIV/AIDS for fifteen years and has experienced the going discussion about introducing harm reduction including methadone in prison over the years.

5.3.2 Needle and syringe programming (NSP)

In 2000, a needle and syringe programme was established in the Sumy, in the North-Eastern part of Ukraine (Burrows, 2006). The outreach worker was a former injecting drug user. He began distributing sterile needles and syringes among people he knew, while explaining the aims and content of programme. Former injecting drug user are currently involved in needle exchange programs because they have personal experience using drugs and can therefore build a relationship of trust with PWIDs. As a result, NSP have operated in different parts of the city from 2000. The programmes are free of charge to PWID at facilities as well as through mobile and outreach services and have increased since 2008 (Burrows, 2006). There is limited data available on coverage of NSP. Most recent data originates from 2012-2013. During 2012, 171,958 PWID received at least one sterile needle or syringe through Alliance Ukraine and its partners, equating to 56% of the estimated total population of PWID in Ukraine (WHO, 2014). The Alliance Ukraine target for 2013 was to reach 179,800 individual PWID in Ukraine per year, representing 58% of the estimated number of PWID in Ukraine. However, the target of providing each of the 179,800 PWID with 150 sterile needles or syringes does not meet the recommendation of WHO, UNODC and UNAIDS of 200 or more sterile needles/syringes distributed to each individual PWID per year. In 2012, 121 sterile needles or syringes were distributed to each PWID by Alliance Ukraine and its partners. In 2013, this number increased to 138 sterile needles or syringes per PWID. By the end of 2013, fixed sited were implemented by 104 local partners of Alliance Ukraine, and at 747 places NSP outreach took place: amounting for 1,606 NSP throughout the country (WHO, 2014). In Ukraine, sterile needles and syringes can be purchased in any pharmacy. Legislation does not

yet support the provision of NSP services in prisons. The 'Ukrainian Law on AIDS and policy' (guidelines) specifically supports NSPs (E, Voskresenskaya, personal communication, 16 February, 2016). It emphasises client confidentiality, low-threshold and no specific requirements to access services. The government's funding for NSP is available but it is low and mostly funded by Global Fund. Government funds especially cover HIV treatment with some medications such as antiretroviral therapy (ART). Funds for prevention especially for harm reduction is not sufficient. Moreover, statements from the Ministry of Health include that HIV is not a priority. (E, Voskresenskaya, personal communication, 16 February, 2016).

5.4 The Republic of Moldova

The Republic of Moldova is a lower middle income country in Eastern Europe with a population of 4.1 million people (UNDP, n.d., b). The largest part of the country lies between the 'Dniester' river, therefore there is often referred to either the left or right bank of Dniester River. The most affected area of HIV cases among people who inject drugs (PWID) is the region of Transnistria (left bank of Nistru River) (UNAIDS, 2014). Additionally, the cities of Chisinau, which is the capital city, and Balti are among the most affected cities (UNAIDS, 2014). From estimates in 2013, there are 30.200 people who inject drugs in the country. This is 19,400 people on the right bank of the Dniester River and 10,800 people on the left bank of the Dniester River (UN, 2015).

Moldova is one of the most progressive countries of harm reduction in the region. Especially, Moldova's harm reduction programs in prisons are unique, not only in the region but globally. Harm reduction programs take part in 28 cities and 16 prisons (EHRN, n.d., b). Although most prisoners living with HIV are infected before imprisonment, there is a high risk of getting infected in prison through the sharing of contaminated injecting equipment. Numerous countries have introduced HIV programs in prisons since the 1990s (WHO, 2007). Yet, many of these programs exclude necessary interventions such as harm reduction. However, since 1999 the 'Moldavian Department of Penitentiary Institutions' has authorised NGOs to provide HIV prevention programs (including harm reduction) inside prison (AIDS, n.d). In 1999, the first prisoner in need of a sterile needle actually received one and in 2005, the range of harm reduction programmes were expanded and it included methadone programs (Doltu, 2015). The harm reduction program was not easy. For example, the programs had severe constraints in funding. From 2008, it was unable to expand projects related to harm reduction inside all prisons.

In the beginning, when harm reduction was introduced in prisons in Moldova, most local staff had never heard of the strategy. The first reaction was that it was in conflict with their strong

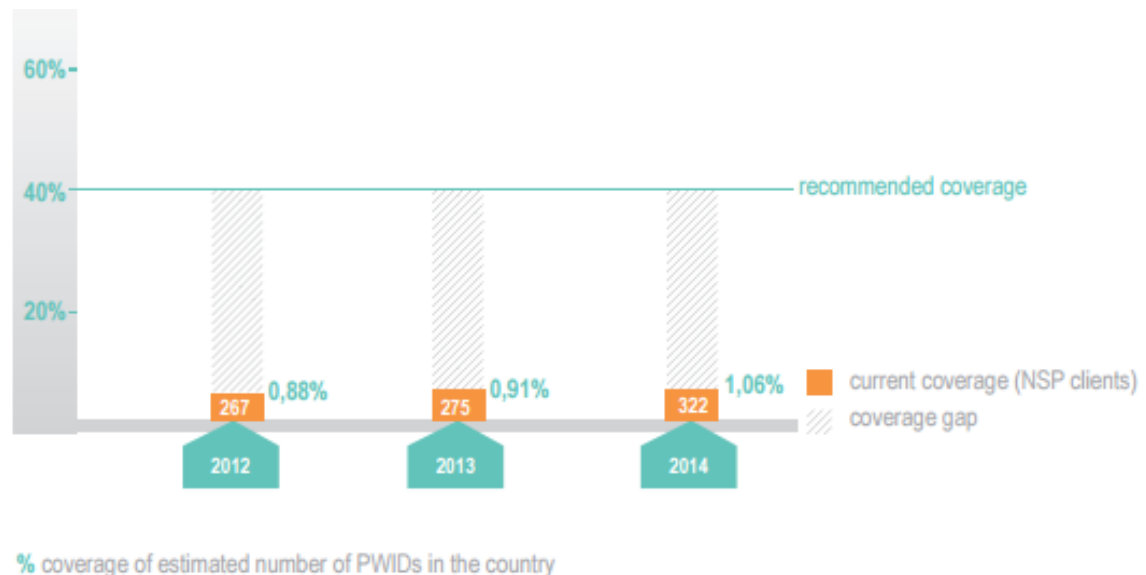
believe to punish prisoners that have violated laws (Hoofer and Jürgens, 2009). There was less opposition among directors of medical units because prisoners' health is their primary responsibility. Moreover, they have experienced the related health effects of injecting drugs among prisoners. Yet, others changed their opinion regarding harm reduction. Nataliya Cioran, director of a medical unit, is an example. At the beginning she was against harm reduction services. She only implemented it because she was ordered to do so. Her view was that consequences of harm reduction would be an increase in overdoses and crazy and dangerous behaviours. Later on, when she was interviewed in 2007, Cioran had a different view on harm reduction. Her fears were not reality, there has been no increase in overdoses and crazy or dangerous behaviour. Instead, knowledge and awareness had increased about HIV and risk behaviour among prisoners and staff due to training and service delivery. The introduction and expansion of harm reduction measures have been experienced positive. Findings were that needles have never been used as weapons against prison staff or other prisoners, drug use has not increased, and there was a reduction in HIV and hepatitis C cases. Therefore Moldova's prisons have attracted international attention over the years. Officials from Ukrainian prisons but also from Azerbaijan, Bulgaria, Poland, Lithuania and Canada have visited Moldova and observed the offered harm reduction services in prison. (Hoofer and Jürgens, 2009). The example of Moldova of harm reduction in prisons demonstrates an important issue. When high level persons have an dedicated and proactive attitude in order to implement an idea, despite opposition to the idea, it can eventually achieve positive results. It is therefore important for certain people to use their authority to remove obstacles and changed views from the opposition.

5.4.1 Opioid substitution therapy (OST)

Since 2004, OST has been implemented in the Republic of Moldova. In 2005, the government adopted a strategy on OST. It specifies methadone substitution therapy as an HIV prevention strategy, which was also included in the 'National Program on Prevention and Control of HIV/AIDS and STIs for 2011-2015 (NAP)' (UNAIDS, 2014). In 2012–2013, two organizations implemented OST at three locations. In 2012, 267 patients were included and in 2013, 275 patients were included (EHRN, n.d.). By the end of 2014 methadone substitution therapy reached 392 people (of which 70 people in prison) (EHRN, n.d.). OST and harm reduction, in general, have been evaluated in 2013 and 2012. Findings include low coverage and quality of the services provided (UNAIDS, 2014). Based on these finding, recommendations were formed which resulted in a harm reduction strategy for 2014-2016. The strategy included scale-up of OST in five locations in the Southern, Central and Northern regions of the country. For 2015, four new OST locations were to be established in four cities and in two prisons. Currently, OST is implemented

at five civil society locations (three in Chisinau, one in Balti and one in Comrat) and inside 11 prisons. (UNAIDS, 2014). See below, figure 4, current and recommended coverage levels: OST.

Figure 4: Current and recommended coverage levels: OST



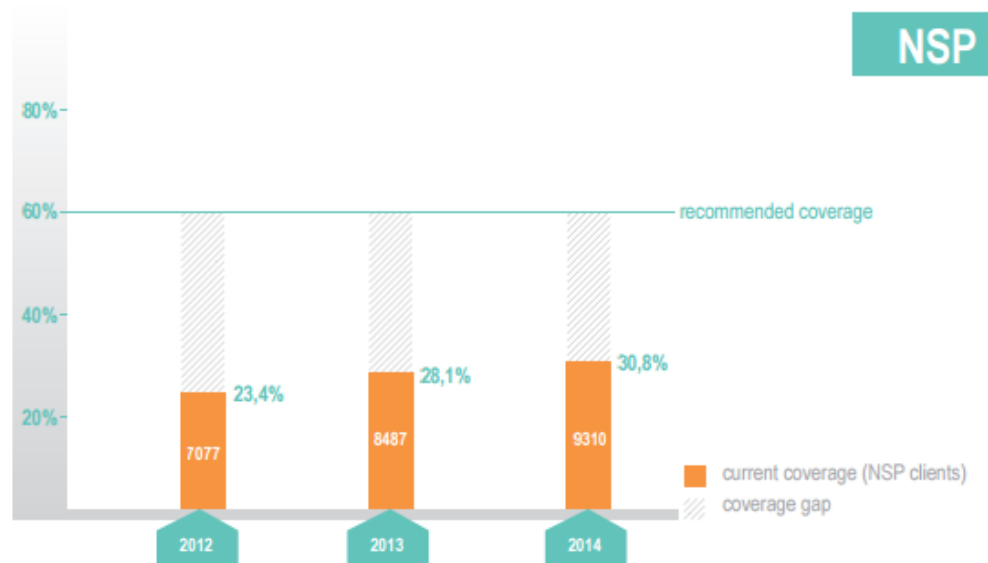
(source: UORN, n.d.)

5.4.2 Needle and syringe programming (NSP)

At the beginning, 2000-2002, NSP was available in most affected areas (UNAIDS, 2014). The current situation is a low coverage of NSP in the most affected cities, especially in Chisinau. Five organizations implemented NSP at 14 locations: In 2012, it included 7077 clients and in 2013, it included 8487 clients (EHRN, n.d.). According to the Investment Monitoring Group (IMG), the estimated coverage of NSP in 2013 is 10% of the 30.200 PWID (EHRN, n.d.). According to data from 2015, 9310 IDUs have been reached by NSP during 2014, which is a coverage of 30.8% of the 30.200 estimated IDUs in Moldova (UNAIDS, 2014). Nevertheless, the NSP programs coverage level does not meet the levels recommended by the WHO, UNODC, and UNAIDS (2009). It does not manage to reach the recommended 60 %. Other major issues are the quality of services, which include meeting the needs of PWIDs, in terms of the assortment of commodities, the introduction of gender-sensitive services, and sufficient funding (UORN, n.d.). Up until now harm reduction programs (NSP and OST) have been greatly funded by international donors, specifically the Global Fund. With the introduction of their new funding model (which emphasises the disease prevalence and economic situation of the country), the Global Fund expects the Moldovan governments to co-finance the HIV programs. In 2014, the Moldovan government actually made the first approach by committing to funding NSP and OST programs in 2014 - 2015 (UORN, n.d.).

However, there is a chance that co-financing of NSPs will not appear due to lack of mechanisms to fund local NGOs and the unstable political situation in the country. Currently, there are 28 locations in the country with NSP and additionally 16 prisons are providing NSP (UORN, n.d.). One of the main priorities related to harm reduction programs in the country is the scaling up of NSP and OST programs, reaching significant more clients and thereby ensuring adequate coverage. However, this also includes the increased needs for resources. See below, figure 5, current and recommended coverage levels: NSP.

Figure 5: Current and recommended coverage levels: NSP



(source: UORN, n.d.)

The access to HIV prevention, treatment and care, especially harm reduction, in Ukraine and Moldova are difficult to compare due to among other things the size of the population. Ukraine has a population of 45 million and Moldova 4,1 million. In a smaller country with less conflict, less conservatism and progressive attitude among government it might be easier to work effectively in combating HIV/AIDS. Though some people feel that providing needles may encourage others to start using drugs, this view underestimates the complexity of factors that shape people's decisions about whether or not to use drugs. Numerous scientific studies have shown no evidence that the introduction of needle exchange or other harm reduction strategies increase drug use. Nor do they compromise the safety and well-being of the surrounding community. In fact, they have been found to do the opposite. They have a positive impact on public health by reducing the prevalence of blood-borne viruses such as HIV and hepatitis C. Therefore, scaling up of treatment and harm reduction strategies, including NSP and OST, is the best way to reduce

misuse of opioids and the associated HIV epidemic in PWID. It includes immediate action (supply the tools needed to reduce risk) and longer-term steps (educate people about sexual risks and change sexual behaviour). Further scale-up of these harm reduction interventions would lead to substantial additional gains in health. Increased resources need to be secured (including domestic and international funding) to maintain and expand coverage and ultimately avoid reducing the initial return on investment.

6. Role of NGOs as main civil society actors in EU initiatives on HIV/AIDS

The EU measures on HIV/AIDS, as explained in chapter 4, are channelled through NGO's actions. NGO refers to a non-profit, independent of government, citizen-based organization, aiming to serve a specific social or political purpose through collective action. Whereas, civil society refers to the collection of NGOs, associations, groups and movements that represent various interests of citizens. According to the 'Communication Action Plan on HIV/AIDS', "Civil Society is a key actor in combating HIV/AIDS at all levels in the response to HIV/AIDS in the European Union and neighbouring countries" (European Commission, n.d.). The Commission supports the involvement of civil society organisations, including those representing PLWHA and affected communities and emphasises that it is instrumental in keeping HIV/AIDS on the political agenda. Civil society organisations (CSOs) function at the local, national, regional and international levels and their activities include all aspects of 1) Developing political solutions: policy dialogue, advocacy and planning and 2) Developing practical solutions: implementing, programming, campaigning, delivery of services, monitoring and evaluating. The Commission wants to ensure that civil society stays involved in HIV/AIDS and are seen as major partner in a coordinated response, sharing responsibility for meeting commitments.

In order to understand the role that civil society plays in the EU's initiatives halting the spread of HIV/AIDS it is important to keep in mind that the EU is a supranational organization (Schulze, 2015). This is an governmental system formed by Member States (MS) working closely together while having various perspectives. The EU's representative system is shaped by an indirect form of representation which creates more distant from the EU citizens than a national government would. Therefore, this structure is often criticized of its lack of representation of the everyday citizen (Schulze, 2015). It resulted in the EU involving civil society, including NGOs which results in a more democratic system and ability to bring itself closer to the citizens. A study done by Jamil (1998) revealed that NGOs stand advantageous over government in dealing with social problems of HIV/AIDS as they are more democratic and result oriented compared to government bureaucracies which are process oriented (Islam, 2015). Throughout the years, the partnership between the EU and NGOs has expanded on all fronts from policy dialogue to project and programme management, which both will be explored in this chapter.

6.1 Decision-making process

Civil society including NGOs are vital partners for decision-makers of the EU. When EU actors are developing policies, NGOs are engaged in the policy dialogue to help defining priorities and objectives (Alhadeff, 2002). It involves input to agenda-setting by providing specialised knowledge and by raising issues and questions that government's will normally not include. NGOs have access to information, experiences and perspectives, which are often competing ideas from outside the normal governing channels which widens the policy debate. NGOs enhance democratic and transparent decision making. Civil society can also help to increase the dissemination of information, thereby enhancing broader public understanding of policy issues. NGOs are serving as additional channels for the Commission to ensure that information on the EU policies are known among people concerned by and affected by its policies (Alhadeff, 2002). They can express the interests of persons not well represented in EU decision-making process such as people affected by or living with HIV (PLWH) including injecting drug users. These people feel left behind, have minimum political income, and wish to be heard and gain more influence. Many NGOs have the ability to represent these most disadvantaged people. NGOs can be the voice for those not sufficiently heard at local, national and EU levels and address their health needs.

Civil society is at the forefront of advocating for and serving the interests of vulnerable and socially excluded groups, as well as those most affected by drug policies. Generally large NGOs have enough resources to provide strong facts and evidence based information in their advocacy work. It might be difficult for small NGOs to be influential and part of the decision-making process. In response, increasing numbers of NGOs are creating European associations or networks, together with numerous other small and large NGOs, focussed on the same issue. The most important ones are as follows:

- ❖ AIDS Action Europe (AAE) is a partnership of approximately 450 AIDS-related NGOs from 45 European and Central Asian countries.
- ❖ European AIDS treatment group (EATG) is a European network of nationally-based volunteer activists consisting of more than 110 members from 40 countries in Europe.
- ❖ The International HIV AIDS Alliance is a global alliance of 33 organisations led by community leaders, activists, programme managers, policy specialists and civil society practitioners and advocates.
- ❖ 'Stop Aids Alliance' is a joint partnership between the International HIV/AIDS Alliance and STOP AIDS NOW!.

The EU's willingness to communicate with civil society is noticed by 'The HIV/AIDS Civil Society Forum (CSF)' which is established in 2005 by the European Commission to aid the participation of NGOs within and outside Europe and extending the scope of their work (National AIDS Trust, n.d.). CSF exist of about forty members, including 'All-Ukrainian Network of People Living with HIV/AIDS' based in Ukraine and 'Soros Foundation Moldova' based in Moldova. The 'HIV/AIDS Think Tank' is linked to CSF, which is a forum to exchange information between representatives of NGOs and the EU. The Commission is committed to work closely with the Member States and NGOs through the HIV/AIDS Civil Society Forum and the Think Tank on HIV/AIDS to facilitate the appropriate response to HIV/AIDS (National AIDS Trust, n.d.).

The specific expertise and dedication that NGOs put in the decision-making process contributes to a set of recommendations and ultimately could result in better initiatives and policies. Recently, at the end of 2015, thirty-four European civil society organisations issued a policy paper (TB Coalition, 2015). It called on the EU to adopt a comprehensive policy framework on communicable diseases, notably HIV/AIDS, Tuberculosis (TB) and Hepatitis C epidemics, for 2016-2020 in the neighbouring countries. Specific recommendations were addressing the specific nature of the epidemics and strengthening the political response to these diseases. This includes working together in the upcoming EU Presidencies (the Netherlands, Slovakia & Malta) with Member States and Eastern Partnership countries to agree on concrete strategies to address the three diseases. Moreover, to set up mechanisms to ensure HIV/AIDS, TB & Hepatitis civil society have meaningful involvement in policy implementation and cooperation among international organisations (TB Coalition, 2015). The Civil Society Organisations that issued this paper included NGOs Global Health Advocates (GHA), Aids foundation East-West (AFEW), AIDS Fonds, Act for involvement (AFI), Tuberculosis Foundation of Latvia (LTBF) and Stop AIDS now. Advocacy networks included TB Europe Coalition (TBEC), Aids Action Europe (AAE), European Aids treatment Group (EATG), Eurasian Harm reduction Network (EHRN), the Eurasian network of people who use drugs (ENPUD). According to Anke van Dam, director AFEW, the organization together with civil society have an urgent push to obtain a new Communication and Action Plan from the EU, with commitments on how to curb the HIV, TB and hepatitis epidemic (A, van Dam, 18 February, 2016). This is especially important with the upcoming meetings. In April, there will be a meeting regarding this Communication and Action Plan. In June 2016, there will be a High-Level Meeting on HIV/AIDS organized by the UN in New York, US. In July 2018, there will be a 22nd International AIDS Conference (AIDS 2018), which will be organized in Amsterdam, the Netherlands. Moreover, AFEW also encourage the Minister to seize the opportunity of the Dutch EU-presidency and the UNGASS on Drugs in 2016 to strongly advocate for an international harm-

reduction approach and address the international funding gap for harm reduction (A, van Dam, personal communication, 18 February, 2016). Due to Global Funds reducing funds to the region, there is a strong lobby among Civil Society, that emphasises the need for continuing funding from Global Fund in the region (Civil society support, 2011). In November 2011, the Global Fund Board decided on a new and exciting Strategy for 2012-2016. Civil society believes that this is a mistake and that this new funding model would severely undermine the achievements made so far by the Global Fund, which has been a crucial donor over the last decade. Reduction of funds would undermine the success and would weaken urgently needed resource efforts (Civil society support, 2011). The Global Fund has been the biggest donor, actively supporting HIV prevention and supporting harm reduction (E, Voskresenskaya, personal communication, 16 February, 2016). According to Voskresenskaya, representative of AFEW in Ukraine, due to the Global Fund the region has made major developments in HIV prevention among drug use. Since the government is reluctant to fund harm reduction and the country programmes rely on international donors, funding from Global Fund is crucial in order to have adequate coverage of effective harm reduction services among PWUD (E, Voskresenskaya, personal communication, 16 February, 2016).

6.2 Implementation

Certain functions within the implementation of EU's policy on HIV/AIDS can only be effectively fulfilled through the involvement with civil society. This is particular the case in relation to the EU's aid programmes in neighbouring countries. NGOs play a significant role as direct implementers of programs and delivering services. Since it is very difficult for the EU itself to work with civil society in these countries, assistance must be channelled through European NGOs. In contrast to the EU, European NGOs have been more respected and are considered legitimate by the government of the recipient country over the years. They have expertise regarding the local conditions and have better contacts on the ground. This is particularly helpful for reaching rural areas and disadvantaged groups, referred to as priority regions and priority groups in the HIV/AIDS action plan. The contribution of NGOs is particularly important in tackling social exclusion and discrimination. Unlike other infectious diseases, AIDS has been associated with stigmatization, discrimination, persecution and a wide range of human rights abuses (cf. Tomasevski, 1992; Csete, 2007). These European NGOs can provide support to Eastern European countries by implementing programmes and projects funded by the EU while having a high degree of ownership of the actions financed. Through a variety of mechanisms in the Commission, The European Commission has allocated sizable amounts of money annually to

NGOs provided they are active in EU policy areas (NGOMONITOR, 2015). The EU provides funding in the form of grants for a broad range of projects and programmes covering areas such as health. NGOs and civil society can apply for funds by policy area, usually following a public announcement known as a 'call for proposals'. However, in recent years, the EU has stopped funding through NGOs, such as AFEW. Every year the organization had projects funded by the European Commission (A, van Dam, personal communication, 18 February, 2016). An example of a campaign organized by AFEW is 'Prevention Clips for Ukrainian Television' in 2014 which was regarding drug prevention and had the Pompidu Group of the Council of Europe as a donor. However, since three years direct funding to the organization has ended because the term 'public health organization' does not fit in the human rights and democracy criteria. Although AFEW has tried several times to talk about human rights, this has not worked. The only connection now is 'AIDS Action Europe' and other joint AIDS organizations that receive a grant from the European commission (A, van Dam, personal communication, 18 February, 2016). The resources available for specific public health initiatives and programmes are thus a minimal proportion of the EU budget and is likely to remain so.

Corie Leifer, project manager of AFEW, adds that the EU has certain struggles (C, Leifer, personal communication, 18 February, 2016). First of all, it has difficulties to reach consensus on harm reduction. About an AIDS/HIV Civil society platform which was regarding drug, Corie said: "it was more in benefit of against harm reduction. Some countries, such as Ireland and Malta, are very conservative and view harm reduction as a way to decriminalize drugs. Second, the EU had other emerging issues to work on, such as the current migrants and refugees across Europe. Moreover, AFEW has to compete with other emerging public health issues such as the Zika virus for instance". (C, Leifer, 18 February, 2016).

Clearly, NGOs play a major role in EU initiatives focussed on halting the spread of HIV-AIDS. Thanks to NGOs, transparency and democracy at the EU level is increased. NGOs raise awareness, obtain important standpoints of society and challenge policy-makers to address their concerns about current policies. NGOs advocate for specific groups of citizens such as minorities (PLWH and IDUs) or specific issues on HIV/AIDS (reform policy and increasing funding). NGOs are included in the policy dialogue, implementation and monitoring of EU governance on initiatives focussed on halting the spread of HIV-AIDS. However, implementation of projects through NGOs has reduced significantly. Although this seems justified due to hard to reach consensus among MS and additional emerging issues to handle, keeping HIV/AIDS on the agenda (including allocating adequate funding) remains important. HIV/AIDS policies are important, however meaningless

without the implementation of NGOs, who have years of expertise and experience on HIV/AIDS and can make a real change at the grass root level for instance in terms of service delivery. Ultimately, this results in a most efficient way to address HIV-AIDS issues and the related policies.

7. Conclusion

The EU has definitely contributed to advanced HIV prevention, treatment and care in Eastern Europe. Its efforts on HIV/AIDS led to PLWH living longer and healthier lives, which was a stated aim: “better the quality of life of people who are infected with HIV/AIDS”. This aim was realized due to the EU's actions in optimizing access to HIV prevention, treatment and care in Eastern Europe. These actions can be divided into state channelled actions and NGO channelled actions.

7.1 State channelled actions

Three state channelled actions are explained. First, with the ‘Communication and Action Plan on HIV/AIDS in the EU and neighbouring countries 2009-2013’, the EU placed emphasis on combatting HIV/AIDS in eastern neighbouring countries. The objective of the Action Plan, focussing on priority regions and on those most at risk, was mostly reached in the form of funding to the Global Fund. As a sixth largest financial contributor, the EU has contributed indirectly to harm reduction for injecting drug users. It resulted in harm reduction services for over 35 000 people who inject drugs, opioid substitution therapy for almost 800 people who inject drugs, delivery of almost five million condoms, HIV testing and counselling for almost two million people and antiretroviral therapy for over 6 000 people. Second, the EU created ‘The Civil Society Forum’ and ‘The Think Tank’ which have played a role in the fight against HIV/AIDS in Europe during the period of the Communication Action Plan on HIV/AIDS 2009-2013. It were valuable platforms for policy dialogue, exchange of information and experience and promoted effective communication on HIV/AIDS across Europe. Finally, the EU's ENP is equally important in the context of HIV/AIDS. In the Ukraine, it led to progress of civil society, anti-discrimination legislation, democracy, human rights and fundamental freedoms. Although the Republic of Moldova is one of the most progressive countries of harm reduction in the region, less progress was made in deep and sustainable democracy, the respect of human rights and fundamental freedoms. Civil society has grown in a favourable environment but it is still weak. Both countries continued its technical cooperation with the ECDP and attended the technical workshops on HIV/AIDS and vaccine preventable diseases.

7.2 NGO channelled actions

Three NGO channelled action are discussed. First, in order to enhance democratic and transparent EU decision-making, NGOs bring the EU and its policies closer to the citizens by spreading information and encouraging meaningful involvement. Second, NGOs are closely

involved in the policy dialogue to help defining priorities and objectives, by providing specialised knowledge and by raising issues and questions for those not sufficiently heard. Third, NGOs are used to play a major role in service delivery to reduce stigma and discrimination of populations most vulnerable to HIV/AIDS for instance. While the distribution of EU-funded projects was extensively in 2010 and the EU supported different HIV/AIDS projects in Eastern Europe, distribution of EU funds is currently minimal. More funds are allocated to democratization reforms, supporting internally displaced people that moved from Eastern Ukraine after military conflict. The reduction of funds might be a consequence of changing priorities and more pressing issues of the EU such as terrorism, refugees, 'Braxit' and 'Zika' virus. Moreover, the EU might feel it is already contributing to the Global Fund, therefore additional funds are not needed.

7.3 Recommendations

- ❖ **Keep HIV/AIDS a priority.** A strong commitment to address the challenges to advanced access to HIV prevention, treatment and care in Eastern Europe is needed. Although the EU has a supranational structure and consensus is not always easy to reach due to diverse views of MS, there should be an on-going debate. HIV/AIDS should become more systematically part of the policy dialogue.
- ❖ **Reform of policies - Communication on HIV/AIDS Action Plan and ENP.** Renewed commitment or increased focus suited to today challenges. For instance, harm reduction in settings such as prisons in Ukraine, where it in contrast to Moldova is not yet provided. The EU should avoid previous criticism such as 'one-size-fits-all' policy. It should focus on clarifying the measures required to achieve these goals. Avoid geopolitical competition with Russia, where eastern countries are further away from the EU. Moreover, be conscious of what a certain policy is trying to promote in eastern neighbouring countries.
- ❖ **Funding and Sustainability.** There are areas in which the EU in close collaboration with its partners the Global Fund could do better and more. The risk of funds shifting away from EU neighbors is real due to the Global Fund's new allocation model. Harm reduction services are at risk due to Eastern European governments reluctance to subsidize it because the budget is scarce and appropriate mechanism are not in place. Removal of ideological and political obstacles for the government to allocate domestic resources for harm reduction programs is needed. Promote sustainability, build strong and sustainable systems and attracting domestic resources.

The EU's efforts on HIV/AIDS in Eastern Europe have not led to a decrease in new HIV cases, which was as a stated aim: "decrease in new cases of HIV-infected people across all European

countries by 2013". Till this day, new HIV incidence continues to increase in the region, with the highest number in Ukraine and Moldova. The mentioned recommendations in this study can help curbing the HIV epidemic in Eastern Europe. However these recommendations require further reflection and monitoring by other researchers and scholars to successfully achieve advanced access to HIV prevention, treatment and care and ultimately zero new HIV incidence.

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8. Appendices

Interview 1

Interviewer: Sephala Spekkers.

Interviewee: Elena Voskresenskaya (Director of AFEW-Ukraine).

Interview setting: Interview conducted through Skype call, at 14.00 p.m. on Tuesday the 16th of February 2016.

(Start of interview)

Representation HIV cases

Interviewer: Do you think current data on HIV cases represents reality?

Interviewee: As you know the statistics that is being gathered in Ukraine includes both estimates, which is being done by UNAIDS, and official statistics. According to the official data, I think we had about 260 000 cases of HIV infections registered cases and UNAIDS estimates indicate 290 000. So from 260 000 till 290 000, the difference is quite small between the data and estimates. It is more or less representative but I am not sure that the coverage of HIV testing is sufficient. Especially related to the key population. For example we do not know for sure the rates of HIV among men having sex with men. According to the latest statistics, it might be growing and it is quite a hidden population. We have a little bit data statistics about injecting drug users because the coverage of harm reduction has grown over latest years. Of course the official data are still not hundred per cent certain. I am sure the real data is a bit higher but not as it was, let's say ten years ago.

Interviewer: What are the most affected cities in Ukraine?

Elena: It is Kiev and Odessa, these two cities are the most affected. There is also Dnipropetrovsk. We had very high rates of infection in Eastern Ukraine, in Donetsk and Lugansk (which are now a lot out of our scan). This is a real problem because there are now military actions, so it is difficult to know what is happened there now.

Interviewer: How are the military actions affecting the HIV situation in the Eastern part of Ukraine?

Interviewee: Well, the Eastern part of Ukraine is yet almost completely out of reach. Because it is very difficult to even transport the drugs. Many people with HIV actually had to leave from that part and had to move to 'Ukrainian' Ukraine let's say. But for some drug users that cannot move

and who were on opioid substitution therapy, there is no way bringing methadone now to the border because you cannot move methadone to the place of military actions and that is a real problem. There were reported cases of death among drug users that stopped methadone.

Interviewer: Are there still numerous drug users underground?

Interviewee: Well, drug use is not as severely criminalized but yes definitely it is still underground. The access to services improved for drug users but you know the problem is the drug use scene is changing. And of course it is not legalized, not even for lighted drugs. The norm is for example if a person has some drugs that he or she want to use for its own use. The people can still be arrested for possession of certain amounts of drugs, I do not remember what the current doses are but they are not very high. So, officially by law in Ukraine you can get arrested for possession and you can be arrested for distribution. So a person can be charged with possession/distribution of drugs and put in prison that problem causes people being underground. And of course level of stigma and discrimination is quite high.

Interviewer: How is the current situation on stigma and discrimination?

Interviewee: There still needs to be a lot of work done on the community level, also talking about drug use. There are a lot of campaigns that are now being done by activist: 'treat not punish' for example. We do not yet talk about decriminalization of drug use but at least there can be a different attitude on the community level. Well, the police is now much more easier to cooperate with. We have new police and try to involve the police. Most of the projects that are done by nongovernmental organizations, are trying to work with local police. Training them, talking with them, bringing them to the needle exchange projects and bringing them to opioid substitution therapy sites where they can talk to drug users. So it changes, but it is not yet systematically. It needs to be brought in the system. In some regions it is very well build for example in Central Ukraine. There was a very good experience that the local NGO established very good relationships with police. Police referred the person that uses drugs and started bringing arrested persons to harm reduction projects, which is (I think) an excellent example of operation. But it is not in place centrally yet, it is not like a legal way of action.

HIV programmes

Interviewer: Have you seen development, in terms of adequate coverage of services (harm reduction) for people who use drugs?

Interviewee: It is getting better. I think we have a very strong influence of the Global Fund. Speaking about the EU contribution, the Netherlands was the first. The example of the Netherlands allowed to bring harm reduction to the region. I think the first harm reduction projects started with Dutch experiences. And further, they were supportive and are still supported by the Global Fund now with harm reduction projects. Opioid substitution therapy was completely unavailable in the country and there was a very strong revolution of law enforcement and the ministry of justice/police. But there was a very strong push that if opioid substitution therapy is not introduced that the country might not get the Global Fund grant. So, it started very slow but now there is quite a good coverage of methadone treatment. It is provided in every region. But if you are interested in more statistics, I can look it up and send it to you. There is quite a good coverage already there. The problem is that maybe not the drug scene is changing and methadone treatment can only be good for opioid (drug users on opioid). Many people are on stimulance, and opioid substitution does not help if you inject anything other than opioids. But now less people are on opioid and less people injecting drugs.

Interviewer: Are there current gaps in providing harm reduction?

Interviewee: Well, I would say sustainability. Because currently, harm reduction services are provided only by nongovernmental organisations and all of them are funded by the Global Fund. Global Fund leaves the country, the current ground of the Global Fund is until 2017. It is very unlikely that the government will be eager to needles and syringes for drug users because the budget is scarce. Now there is a strong advocacy of the civil society for including funds to drug users but I am afraid we will have to rely on international donors.

Interviewer: What will be the consequences of international donors reducing their funds?

Interviewee: Current situations, when the budgets and especially money for social activities are cutting down and if the global fund stop (there is a real treat 2017 stop of the global funding) there will be no money to fund harm reduction. Because if there will be still money for medication, I think the government will pay for drugs for antiretroviral therapy, it is very unlikely they will pay for prevention. They might and I think there was already a discussion that they might allocate some money for opioid substitution therapy but not sufficient to cover all those in need. Harm reduction is really under the big question. It is very unpopular because when you have a choice in the country whether you could give money for example to people with diabetes or somebody else, and buying needles for them or you buying syringes for drug users, and if you are sitting in this major office, you will be very unpopular among the community if you use this

money for drug users and not for others. So when you have limited budget, it is very difficult to ask to give most of the money to the drug users. That is why international support is very much needed.

Ukrainian Government

Interviewer: Does the Ukrainian government have a good approach toward HIV/AIDS?

Interviewee: That is a good question. In declaration, well it also changes over years. In principle we do have national policies on HIV/AIDS and we have national strategy and national program. The funding for HIV is available but it is not sufficient. It covers treatment some medications: antiretroviral therapy. Money for prevention are not available and money for harm reduction are not available. So the government, I would say, they do not object that nongovernmental organizations are working and are providing prevention. In certain cases they create mechanism that allows society to talk to the government but at the same time they are not doing that much. They do not have or it is still unclear on the governmental level who is responsible of HIV. Traditionally, it was the ministry of health, but ministry of health does not want to take responsibility for treatment. While, who is responsible for prevention it is very much unclear. So I would say the approach of the government is very disaggregated and especially in the current situation when the countries are undergoing funding process and situation of economical crisis there have been some statements from the ministry of health that HIV is not the priority. Now UNAIDS and civil society are working very hard on making the government put it on the agenda. Some policies are changing, I would say it improves, but it is really the contribution of the civil society not of the government. The government has to submit to the pressure from civil society.

Interviewer: Is the government also respecting human rights or do they have repressive and discriminatory laws that might affect people living with HIV?

Interviewee: The laws are changing. There were times when there was a criminal prosecution for infecting somebody with HIV but the laws have changed. And now in this move from Ukraine to Europe there has been a good window for opportunity for civil society to be developed and to contribute to the developments of laws. So I would not say we have discriminatory laws and regulations.

Interviewer: Is the Ukrainian government supportive in the context of harm reduction?

Interviewee: Needle exchange is not available in prisons we cannot talk about that, they do not want to do that. Methadone is introduced and now there will be some kind of project about it in prisons. Methadone is not provided at the moment but there are agreements that there will be a couple of pilot projects for doing methadone is pre-trial, like facility where the person is kept from court before he is send to prison. So there is still a discussion and I have been working in the field for like fifteen years and for all this fifteen years there was an un going discussion about harm reduction and methadone in prison.

Interviewer: And compared to Moldova (because I have read that Moldova has the best example , in the region but also globally, of harm reduction in prisons)?

Interviewee: Moldova is one of the best practices and provide to show our prison services that we see how it works but it is very difficult. It is mostly because they are not acknowledging very well that there is injecting drug use in prison. They are saying that they are secure anyway and sometimes they refuse to acknowledge that drugs are being used in prison. Moldova is much more progressive.

Interviewer: Is Ukraine ahead of other countries in the region when it comes to developments and improving the HIV/AIDS approach?

Interviewee: In context of harm reduction, compared to Russia, yes because Russia has none. Compared to Moldova in terms of percentages I think Moldova is doing better. Georgia has very strict legislation related to drug use. It is difficult to compare because the epidemic in Ukraine in Moldova and Georgia are completely different. The prevalence and incidence is much higher of course in Ukraine and population wide Ukraine has 40 something million and Georgia 4 million, so it very difficult to compare. I think Ukraine is a pioneer and ahead of everyone in developing the community, empowering key population, developing civil society response and civil society ability to advocate. I think Ukraine is leading in that. Moldova is much easier in terms of government and the country is small and the country is very poor. We used to work in Moldova, and you know it is so much easier to do something in a smaller country. Yet, they do not have so much to choose from. For example, if the Global Fund comes and they demand the substitution treatment, they are eager to try. They are eager to do new things and they are eager to change and that was much easier in Moldova. In Ukraine, I think the corruption levels was quite high in our ministries and the level of conservatism is different. The country itself is so big and now it is getting more decentralized. So in Ukraine we have to work more on a

regional level. And a level of acceptance by different administrations on the municipal level also differs in different parts in Ukraine.

Civil society

Interviewer: How is civil society approaching HIV in the country, do they have networks or associations were they come together?

Interviewee: Yes, first of all we have a very strong civil society in Ukraine. Civil society is representing in the country coordinating mechanism. At Country Coordinating Mechanism (CCM) we have a representative of international nongovernmental organizations (NGOs), and AIDS Foundation East-West (AFEW) is a part of that. I am representing international NGOs and the CCM. We have representation from the 'Network of people living with HIV' and we have representation from 'The Coalition of HIV-Service Organizations'. Meetings are quite frequent. In terms of civil society discussion I think it goes pretty well. Through many ministries, so called working group on working with the community or something like that, each NGO is trying to tailgate their representative to each of the working group. Alliance Ukraine, biggest provider of harm reduction. Alliance is one of the principle recipients of the Global Fund. They are not providing directly but they are supporting some grant to local NGOs of harm reduction that goes through the Alliance.

Contribution of the EU

Interviewer: Have you noticed support from the EU in improving access to HIV/AIDS prevention/treatment?

Interviewee: The Global Fund have been the biggest donor: support HIV prevention and supporting harm reduction. I think only due to the Global Fund we have made such big developments on HIV prevention among drug use because now, looking up at the statistics, the number of HIV of new infections among drug users have decreased overall (you know the percentage of drug users). I do not know what is the reason behind that but we all think successful harm reduction.

Interviewer: And since when had is decreased?

Interviewee: It started decreasing I think several years ago. Like three years ago there was the first. For example in 2008, there were over the last 7 years I would say, high cases of HIV among first registered HIV among drug users, in 2014 it was going down.

Interviewer: Was it mainly because of Global Fund, or have you experienced some contributions from the EU as well?

Interviewee: To a great extent due to the support of Global Fund. Without Global Fund we would not have harm reduction, we would not have opioid substitution therapy. As of EU contributions, not at the moment. EU funding for the EU Commission: before we had quite a lot of funding from the European Commission but now they have changes their priorities. Now they give more money to democratization reforms, supporting internally displaced people that moved from Eastern Ukraine after military conflict. I think there is a tendency from many EU donors "we are given global money to the Global fund so why should we give some additional support". It decreased significantly over the last 7/8 years.

Interviewer: Does democracy and human rights support of EU helped development in HIV approach?

Interviewee: Human rights program, they do help especially when it comes to working with MSM (men who have sex with men). The Dutch government is very much supportive of the human rights of MSM. We are working very closely with the embassy of the Netherlands. The amount of funding they provide is not huge because the embassy funds are also limited. But they are quite supportive of human rights issues among MSM. Definitely when the people can speak up, they can definitely get access to services and they do not have to be hidden. It does help identify new cases and refer people for prevention and treatment.

Interviewer: There is an EU 'Communication and Action Plan for combating HIV/AIDS in the neighbouring countries'. Eastern neighbouring countries include Ukraine, Moldova, Georgia and Belarus. Could you identify a certain year where you noticed main improvements in the country?

Interviewee: I would say that the situation did start changing in 2008/2009. In terms of availability of services because the infection are still high and it continues to grow, it didn't stabilized. But just starting being more easily available. Prevalence a little bit started going to the go flat . In some period after 2008 additional prevalence was more or less flat level. Mostly the Global Fund, but if the EU is working through the Global Fund. You know many of the donors, not necessarily EU, because for examples Swiss was at a huge support. From Swedish government through Swedish international development agencies, they were supporting HIV campaign starting in solidarity with people living with HIV: condoms/prevention. But then they said they have given sufficient money to the Global Fund and they do not see much commitment from the Ukrainian

government. So they completely changed their policy and excluded HIV from their priorities. And the same happened to many other donors, unfortunately.

Interviewer: Do you have examples of projects? If not from the EU, perhaps from EU Member States?

Interviewee: The Netherlands, if you talk to Anke and Corie, probably you know that there was a big project of 'Bridging the gaps'. Key populations has been a part of that for the last 4,5 years and now also the Dutch government funded big advocacy project for the 'AIDS Fonds' with AIDS epidemic, it is not specifically targeted to Ukraine but Ukraine is one of the countries included in the advocacy project. So for the Dutch embassy, small but still, AIDS remains their area of interest. They are very supportive and we did get funding from them for HIV related projects. So for the Netherlands HIV in Ukraine has always remained a priority. Funding goes down but it is still on the list of priorities. I think funding goes down because of the general tendency like economical crisis and other things but we do feel their support.

Interviewer: How is the support of EU or Netherlands compared to other countries in the world?

Interviewee: Several big US projects that are targeted specifically at complemented Global Fund activity and they are coordinated closely. There is one project on working with key populations and the second project on helping health system strengthening in terms of HIV.

Interviewer: Do you have any recommendations for the EU? What are main issues that need to be addressed at EU level to improve their approach to HIV/AIDS in Eastern European countries, including Ukraine?

Interviewee: Well, I think since the EU have been the pioneer in harm reduction, maybe EU can now put more pressure on Ukrainian government. And help civil society to advocate for sustaining harm reduction services and developing it further: developing aids sensitive approaches. Because now we are working with young drug users and they do not have access to harm reduction. Of course, for young people (for people below sixteen) there can be and there should be different approach to harm reduction but there is still little done in this field. The EU can contribute to work because there are very good examples in European countries on how to do that. I think the EU can be the bigger advocate. Since it is much closer to us, culturally and demographically than the US let's say, and has more progressive practices. I think it would be really great if the EU can bring more influence.

Interviewer: Has the EU previously pressured the government to step up ?

Interviewee: The EU, through the embassies, we had very good practice that. I think the embassy of Germany. They used to gather all representative of all EU embassies to talk about HIV and what they can do. There was this mechanism in place, I do not know whether it is happening now, but it was trying to push together to develop some joint advocacy plans. As much as I know, I am not really sure about this, but at least there has been instruments and there have been meetings with governments talking at least about trying to put HIV on the agenda. It did happen, I do not know what is happenings now.

Interviewer: Are targets, like ending the aids epidemic by 2030, manageable or will it take more years to see significant lower HIV cases?

Interviewee: Well, theoretically it will be possible. If testing and treatment becomes slightly available and HIV prevention becomes a priority for the government on the agenda and if funding is linked to that. Theoretically it is possible but the current situation, well I do not know, it is a very ambitious goal. But at least there can be very good developments. It is possible to have very successful mechanism that will help to address HIV.

Interview 2

Interviewer: Sephala Spekkers

Interviewee 1: Anke van Dam (Director of Aids foundation East West (AFEW) - the Netherlands).

Interviewee 2: Corie Leifer (Project manager of Aids foundation East West (AFEW)- the Netherlands)

interview setting: Interview conducted at the office of AFEW, the Netherlands, at 11.00 a.m. on Thursday the 16th of February 2016.

(Start of interview)

Interviewer: What is your understanding of what the EU is currently doing to improving access to HIV prevention/treatment in Eastern Europe (Ukraine, Moldova, Georgia and Belarus) ?

Interviewee 1: There was an 'Communication Action Plan on HIV/AIDS'. I think it was developed from 2009 until 2013. So that was a policy paper developed by the European Commission. By the Member States of the European Commission in how to deal with HIV, to have a kind of pan-European Union plan on HIV. But it ended in 2013 and so for 2014 and 2015 they just continued that plan. It is quite the fact that civil society said "well we need a new plan", but the EU said "well lets continue. It is not yet time, it should be evaluated and so on". But still in 2016 there is no new communication and action plan. So we as civil society forum actually urge the European Commission to come up with a plan. And it not only important for the European Union but also for the neighbouring countries. Because more and more institutes like the World health organization (WHO), European Centre of Disease Prevention and Control (ECDC), AIDS foundation East West (AFEW) and European Monitoring Centre for Drugs and Drugs Addiction (EMCDDE), all these institutes raise awareness on the problems and the concerns in Eastern Europe and Central Asia. HIV, tuberculosis (TB) and hepatitis are all on the rise and they also think that the European Union and the European Commission should take some responsibility for that region as well.

Interviewer: How are NGOs and these institutions trying to influence the EU?

Interviewee 1: So there will be a meeting in April again from the civil society forum on HIV/AIDS where we will push again the European Commission for that Communication and action plan. Why is it now so important to push in April? First of all because the previous one is finished. But there will be a high level meeting on HIV/AIDS organized by the UN in June, that will be organized in New York, in the US. What we actually want is that the European Commission takes a stand point from the high level meeting, so that they speak out what they intend to do, how to curb the HIV epidemic and also the TB and hepatitis epidemic. So first we had only an 'HIV

Communication Action Plan' but I think and we all, also as civil society, agreed to make it broader and also include TB and hepatitis C. We want that the European Commission makes clear what they want with these epidemics. So this April meeting is important to get out a document that can be presented at the high level meeting in June. So this is one thing. The other thing is that there will be an International AIDS Conference in Amsterdam in 2018. And Amsterdam and the Dutch ministry actually want that bit because of the problems in Eastern Europe and Central Asia. They want to have a focus on the region at that AIDS conference. So it is 2018, the region will be the spotlight. What we also actually use as a kind of instrument to the European Commission is that AIDS Conference because what would it not be nice if at that 'AIDS Conference 2018', the European Commission at the AIDS Conference could present that Communication and Action Plan. So that would create a win-win situation for the communities in Europe, for the European Commission because they can demonstrate look we have done it, and of course for 'AIDS Conference 2018' that will be a great achievement because also through or via that AIDS conference we managed to get that Communication and Action Plan. So there all kind of pressure on the European Commission to come up with that plan and why is it so important, because we feel that the attention for HIV is decreasing/diminishing and there is less money, especially for the region Eastern Europe.

Interviewer: Why is support reducing in the region?

Interviewee 1: One important reason for that is that countries in Europe are middle income countries, so no developing countries anymore. So they should have enough money to deal with their own problems and to serve their own citizens. But they do not do that, there is very little political will in the region to fill these financial gaps. So there is still, we as civil society think, financial support needed, also from the European Commission or at least to support the NGOs to with their work.

Interviewer: Who are the main NGOs, networks or associations AFEW works with at the European level?

Interviewee 1: There is a civil society forum on HIV/AIDS, there are many civil societies flora. There is also on drugs and there is also an EU/Russia civil society forum. And all these flora are there to consult the European Commission. So from the perspective of civil society (non-governmental organisations) they advise the European Commission in policies actions/plans and so on. So like I said it is not only the civil society form on HIV/AIDS that is aware of the need. So there are several networks. And pan-European networks like AIDS Action Europe also the European AIDS treatment group, they deliver the culture/voyeur of the sub society on HIV/AIDS.

But also other advocacy bureaus are very interested in getting some movement within the European Commission so there is this 'AIDS Fonds' and 'Stop aids now' and 'SOA Aids Netherlands', the big Dutch AIDS organizations. There is a big international HIV AIDS Alliance in the UK. They both have an office in Brussels and they both, that is called 'Stop AIDS Alliance', and that bureau is also presence in Brussels. So now we are working together as civil society forum with that 'Stop AIDS Alliance' to push. That 'Stop Aids Alliance' wanted to have a donor meeting. And a preparation for that donor meeting for the region most lightly will also be organized in April but for sure there will be a donor meeting for the region in 2017 and that is organized by a network 'The Eastern Europe Harm Reduction Network'. They have a regional proposal financed by the Global Fund and one of the activities is to ensure that money is going to the region. So a donorship conference should be organized and a better place to organize it is of course in Brussels close to the European Commission. So that is what is going on from the civil society. So there is somehow a feeling that something should be done for the region because the problems are growing and growing but there is not yet so much action.

Interviewer: Did the European Union came up with the Communication Action Plan on its own?

Interviewee 1: At that time there was political will from the European Commission to do so. Mainly focussed on European Union , on the Member States. But is also included the neighbouring countries somehow. There was not so much focus on the neighbouring countries, because at that time the problems started to rise but were not that big. And now you see an enormous increase in prevalence, so now people really start to worry. So six year late. And what you see is the epidemic is not anymore with just the people that use drugs or sex workers. Still of course they are most at risk but through the partners women get more and more infected and children then get infected. So it is spread into the general public and that is of course a big concern because then it is like an oil spot. So it really quickly goes to the whole population. And that is why, there are also still problems within the European Union. Men who have sex with men, they are very at risk of HIV. Epidemic is not decreasing and in some countries even increasing under men who have sex with men. Okay they have the treatment, so they have no viral load anymore or no virus is in the blood and they are not infectious but still people getting infected. So that is a concern. And well, PrEP (pre-expositie profylaxe) for instance, that you use medicines as a prevention to get HIV. Also this is now only in one country, France, so far accepted and also played by the insurance company . Of course if you really want to curb the epidemic than you should also introduce PrEP. All these new interventions should also be introduced and this is not happening, countries are very reluctant. So it is not only for the region, Eastern Europe, that it is necessary but it is also for Western Europe very much necessary. But I think now, and that is also

what we are emphasizing, that it should also be more emphasis on Eastern Europe within that Communication and Action Plan because we also think the European Commission should take responsibility for that.

Interviewer: How is the EU supporting the region, do you have examples?

Interviewee 1: The EU is supporting the region with grants, directly, but that is mainly in the field of human rights and democracy development. So not so much on health anymore. It used to be but since a couple of years, four years or so no, they very much focus on that. And the European Commission gives money to the Global Fund, but the Global fund is although still active in a few countries, also withdrawing from the region. There is financially very little support nowadays from the European Commission to the region and we can feel it as well because we used to have a European Union Commission grant until 4 years ago. Our last EC grant was finished five years ago in Belarus. And there is also one other thing, with the economic boycott to Russia. There was already a bad relationship between the European Commission and Russia, but of course after the Crimea annexation, the war in East Ukraine and the MH-17 crash that relationship is very bad. So that makes it also very difficult as civil society in Russia. There was also a bad relation Belarus but that has been lifted now because apparently the president, that is Loekasjenko, somehow well did something's were the European Commission is quite happy with and they have lifted that ban for Belarus. But again it is very much on democracy, human rights, these kind of programs. And you know, talking in the region about human rights is very difficult.

Interviewee 2: I would like to add, that comes up a lot with Anke and I, when we were discussing these kind of things. That we work for a not sympathetic population. So it is a stigmatized population: sex workers, men who have sex with men or injecting drug users. Society already has a sort of attitude, towards prisoners may be the worst. If we bring up prisoners it is really hard. I think it is difficult for these politicians, let's say you are a politician in Russia, and you want to make a speech. You want it to be: "we need to help children, everyone need an education". All of these light topic that everyone agrees on. Nobody will tell you: "no I do not think we need to help children, they do not need our help, they can do it their selves". But when you talk about people who use drugs, that is a lot of time their attitude, like: "let them do it". So I think it is really hard. You really need to have a approach from a human right perspective. You cannot approach it like we need to help people that use drugs, but everyone is a human and everyone has these rights. But then like Anke said, that is not really accepted in Russia either. So it is a very difficult topic to approach. To get support for these populations from anybody, not just the European Commission, is very difficult.

Interviewer: You have mentioned Russia, how is the situation in other countries in Eastern Europe?

Interviewee 1: Belarus is difficult and Russia it is not allowed. But Ukraine, Georgia and Moldova they receive money from the European Commission. Because the European Commission has several grants systems. So they have grant for a country. Moldova is one of it and also Ukraine and Georgia and other countries. So there it works. And they also have regional grants. So sometimes you can include Russia but it is complicated. Because that is another thing, and I think also important for you to know, that it has become more and more difficult to work as civil society in Russia, especially if you receive money from abroad. Because you cannot spend that money. There even was a human rights organization who received donations and their work was also blocked because some donations could include international money. Therefore the Russian government said you have to register as foreign agents and you cannot work. So it goes already that far. It has become really difficult now in Russia to work. We also see it with our partner AFEW-Russia, they cannot do anything anymore, they do not even want to be linked to us, as an international organization.

Interviewer: And how is it in Ukraine?

Interviewee 1: Ukraine is much easier. Also because of the war, the new president Poroshenko is quite open and very outgoing to the European Commission. So Ukraine, you know that there was this association treaty or so between the European Union and the Ukraine, okay that was blocked by Jankovic I think was his name. And then the whole revolution started, so there is definitely and there is again an approach from the European Union to Ukraine. And in that light. This referendum that will be held in the Netherlands about Ukraine and this Association Treaty. If people in the Netherlands say no we do not want to have such an agreement. that can be very damaging for our relationship with Ukraine but also our relationship with the European Commission. So people have actually their hopes, when you talk to people in the region, they have very much their hopes to the European Commission, also in Central Europe. They look very much at what is the European Commission is reading and doing and the same accounts for Eastern Europe and Central Asia.

Interviewer: Are there examples of EU funded projects in Eastern European?

Interviewee 1: Not anymore, every year we had projects funded by the European Commission but like I said since three years no more. Because well we are a public health organization and we work on health issues like HIV and TB and that does not fit in the human rights and democracy criteria. Although we have tried several times to talk about human rights, talking about HIV and

drugs, but still we did not manage. Because we are a public health organization, we are not a human rights organization and we are not a political organization. So I understand why we did not get the grant. So the only connection is now 'AIDS Action Europe'. That is the network of AIDS organizations and I am the chair of that, that receives a grant from the European commission. So the European Commission supports a network that support AIDS organizations in the region.

Interviewee 2: But 'AIDS Action Europe' their focus is not on Eastern Europe or Central Asia, but it is all of Europe. And I think where we losing a lot of funding is with this middle income country idea and the fact that poor countries going to need their money. If you are talking about countries in Africa then people are starving and there is not going to be people starving on the streets in Ukraine. So people have a much different image what Ukraine must be compared to developing countries. So you picture Africa being much poorer than it is much easier to say Africa really needs our money. When you say Ukraine really needs our money, they are like "no Ukraine should take care of themselves". Where we work are not developing countries. If you go there, they have nice building and they have a government and seem to do okay. And because HIV because does not necessarily kill people, at the international scene they do not attach the same level of importance. But also I think, well the Dutch Ministry of Affairs maybe the exception, but generally the governments in Europe kind of say they have other issues we have to worry about.

Interviewee 1: There is also a big lobby going on for the Global Fund to stay in the countries and to support the NGOs. But what the director, Mark Dybul, of the Global Fund tells them look I receive development cooperation money and how can I explain to governments who give that cooperation development money that I use it for countries that are developed or have a good GDP. So he says he cannot explain that. What we now also try to do is push indeed the European Commission to talk to Global Fund and to maybe give more money to Global Fund to at least stay a bit longer in the region.

Interviewer: Do you think the government will eventually allocate money or fund HIV programmes themselves? If not, what will be the consequence?

Interviewee 1: Not in the short term. People will suffer, more HIV infections will happen and then it will be a disaster. And maybe then, when there is a disaster, people react.

Interviewee 2: When we talk about EU funding, from the Commission, we are involved with the Certificate on the Financial Statement (CFS). I went to the EU Commission then, Anke was going to the European Commission in Luxembourg. There is interaction but there is no funding. No not directed to AFEW.

Interviewee 1: But there are NGOs that receive money in the region, I know. I know that the Russian harm reduction network is its final stage to get some money. And Aids Eastern Europe is somehow involved in that. Ukraine is now given as the example, where Global Fund support harm reduction really has an effect. So that there are less people who use drugs infected. So the epidemic is getting stable and hopefully also very slowly decreases. But in other countries it is still on the rise. You know the HIV prevalence in Kyrgyzstan and Tajikistan is still not that high, but there is an increase of 250% since 2001 so in 14 years of time that is quite still a lot. Once you have a kind of mass of people who got infected then it really spread very quickly.

Interviewer: Has HIV testing increased?

Interviewee 1: Well UNAIDS has developed a test case model and also to get to zero in 2030, so they made a new strategic plan. So in 2030 there should be no new HIV cases anymore. And they made a model for that, and that means that if you test 90% of people that have HIV, than from that 90% again 90 should have treatment, and from that 90, 90 % should have a zero viral load. So that is called the test case. So if 90% of people that know their status, 90% of this, so that is than 81%, from 90 from 90 is 81 % should be on treatment and then again 90% from that so 76% or so should have a zero viral load. Then, if we reach that, then we really can stop the new incidence. So that model is now implemented by governments because for that you need data. So you must have also have registration and monitoring system in order, to know that. So we really urge people to get tested. The first step is know your status, know if you have HIV. As soon as you have HIV, immediately treatment. Not like before you must have a CD4 cell account, first it was 250 than it was 350 and then it was 500. No, immediately treatment, as soon as you know it. And of course that also does not happen in the countries. Because if you want everyone on treatment that costs more money. So some countries still have it on the 250 CD4 cell account even. So we made a very strong lobby for instance in Latvia. There people were only treated with a CD4 cell account of 250, we at least lobbied to get it to 350, we managed. But actually it was already 500, and actually the WHO said no everybody should do this. So there is still a long way to go for some countries to get everyone on treatment. The next step is no stock outs, so enough medications and so on . And then they should also test again people on their viral load. And of course, equipment is needed and you should have people adhere to treatment , that is very difficult. So it is nice this test case 90, 90,90 but there is still a lot of work behind it. And that should now be implemented. Like I said the first step is testing and that is why we have an European HIV Testing week in November linked to the World AIDS day. So that initiative is from civil society within Europe, to draw attention to that. Hopefully the rest will follow.

Interviewee 2: A lot of time, in the countries where we work, it is better to not know. You do not want to know your status. When the women came over here, when I order that study tour, they were all like "If we know and we then have sex and somebody else catches it we can be sent to prison. But If we never knew in the first place we cannot. So I do not want to know because I do not want to go to prison, problem solved". So the problem is their solution to the problem, which in this case, having women sent to jail when they have sex with people because they have HIV, is causing a bigger problem. So the 90,90,90 test case is a lovely idea if you want to know. It could be Anke or Sephala want to know their HIV status because you think I need to take care of myself to go get help and treatment. But a lot of times, especially within the population that we work with, this is not their attitude. They are not like "I am going to get medication that sounds great and that I am going to live my healthy life". This is not their priority.

Interviewee 1: This is a very concerning problem that you are put to jail, when people find out that you might have infected someone else. We should also lobby for decriminalizing that and that is now also going on with the European Commission. Because recently cases happened in the Czech Republic, this week actually: 13 gay men got an sexual transmitted infection (STI). They were HIV positive but they got an STI and they transmitted it to others. And then they were actually arrested by the police by intentionally infecting other people. And that is horrible. They say you should have sex with a condom, you should always use a condom.

Interviewee 2: but these women were saying even if they used a condom or even if they had said to the men I have HIV, the men says understands that it is okay with me we can have sex without a condom anyway. And then they said unless we had it in writing, like with a stamp and stuff, than it is his word against mine. So you can imagine that this 90,90,90 test case is one big obstacle, in that you do not even want to know it yourself. It is much easier to deny it.

Interviewee 1: So you have to do campaign about that, that is also behind it, you actually cannot accept this. That there is an environment that decriminalizes it. So you should also tackle that and that is now also happening with the European Commission. So what happened in the Czech Republic, there are now petitions going on. Also again from civil society to get as much mass behind it to the European Commission but of course also to the Czech Republic.

Interviewer: what is happening in Czech Republic is it happening in the whole region?

Interviewee 2: In some. I would say women are more vulnerable to it. I think in general because of the way the status of women in our region. I think they are much more vulnerable. If it is the situation between the men and the woman and the men that has already agreed and says it is

fine, I was under the impression that the men his word against the woman her word, they will believe the men every time. That is the impression they gave me. Also because women are less worthy in these places. Often that will go against them or men who have sex with men, that is another story. So these key populations are already stigmatized, they are already people that are not within the system. So they are not people that get a yearly check-up because they are worried about their health. They are outside the health care system anyway and then they do not want to be part of the health care system because it is easier to say I do not know it. I do not know my status and then I cannot be at fault for passing it on. Also because they feel stigmatized by the medical community. So when they walk in and say “ I am an injecting drug users”, the doctor often makes a face. So you do not want to get judged. I think the first thing, is the hardest 90 per cent. So once somebody knows , you can say it is really important to get treatment and maybe you can convince them of that. And then once they are getting treatment, they are coming so often anyways, and then you can test their viral load. But this first 90 %, getting people to know their status in my opinion is the hardest.

Interviewee 1: But I think adherence to treatment is also hard because you have to take it a lifelong and of course there are side effects, although less than before, but still. And what I also heard in the region, when I was in Kazakhstan, is that people really do not like to take the medication, they fear it because of the side effects. They think it is poison and that they will die even earlier than with the HIV. There is a lot of illiteracy about treatment and so on. And like you said, I understand that people actually so not want to know but of course if you actually convince them.

Interviewee 2: it is deniability then, I didn't know. In English we say it better to ask forgiveness than permission. So it is better to just go ahead and just do it than to ask in the first place and have to be told like you have HIV and don't spread it, and then go spread it anyway.

Interviewer: Do you have any recommendations for the EU?

Interviewee 1: There should be a Communication and Action Plan for sure. Decriminalisations is a big one as well and funding. There will be 'The UN General Assembly Special Session on Drugs(UNGASS)' in April 2016. And the EU actually had a very progressive document for that. It is talking about decriminalization of drug use and about involving drug users in developing programs and involving civil society.

Interviewee 2: Maybe this is also important I think, that within the European Commission and within the civil society forums, there are also people that work against it. So it is not just people,

like us, that go in and say well it is really the drug laws that are the problem. Whenever, there are people that know drugs are not the problem. So it is not just all of these things that we are saying, everyone agrees with us. We can present it that way, but it is not true. And I do know about the AIDS/HIV Civil society platform, but I was at the one on drug and it was maybe even split, like more in benefit of against harm reduction. So we were having a discussion and someone said "well, if we are decriminalizing marihuana". And then this women said "do not do that". And then he said "no, what I am saying". And then she said "no, drugs are bad". And then he said "but what I am trying to get at" and then she said "no". She would have none of it, no matter what he said. "But harm reduction is", "No, I want none of it". So you also have to work to come up with an opinion. these papers, these position papers, these suggestions and contributions that is everybody happy with. When you have different points of view. So for instance at the CFS on drugs (The Civil Society Forum on Drugs), I felt like we were just going back and forward because we would say "well, we really think there should be something about decriminalization". And then for instance someone from Ireland, they are really conservative, said "no", I do not agree with that statement, I will not sign the paper if that is in it". So it is easy for us to present it to you like we go to the European civil society meetings and then we come up with an paper and everyone is happy, but it is not how it works. So the EU is not just getting pressured by us to make progressive laws, they are also getting pressure from the other side to make not progressive laws.

Interviewer: So overall has the EU contributed to a better situation?

Interviewee 1: I think so. I do not know the amounts of money was available but I think they have supported civil society and actually the countries driven on the work of civil society. The capacity of the civil societies has strengthened by the contributions of the European Commission and they do most of the work. They reach out to the people, they offer services, they facilitate treatment and so on, they advocate and lobby and they really make their governments accountable so that is definitely the contribution of the European Commission.

Interviewer: Is there a year when of major achievements?

Interviewee 1: I think before their financial crisis, financial crisis started in 2008, I think before that it was really at its height.

Interviewee 2: And I wonder, the Netherlands is the head of the Commission, if they had some powerful position and I wonder if that will also influence for instance the civil society on drugs. Because the Netherlands has progressive outreach method. A progressive way of working. I wondered if maybe that will steer the EU Commission to also work in more progressive ways.

Interviewee 1: They have a voice, but I do not know what role the Netherlands have played in that, could be that they played an unimportant role. All the preparatory work was done under other presidencies. I know there has been a lot of diplomatic work in the background. The Netherlands decided to present the EU declaration and of course they lobbied also for the decriminalization and these kind of things. And I heard it was also very difficult because like Corie said, there are not only within civil society but also within in countries, were you have very conservative countries, Malta for instance. And it is the same on the high level meeting on AIDS in June. What I understood is not yet anything from the European Commission and I talked to the Ministry of Foreign Affairs. Ministry of Health should actually do that but Ministry of health in not so active, they have another agenda. It is really worsened that there is no commitment from the Member States to do something about HIV/AIDS. Somehow you can understand because we have the epidemic more than 30 years now and somehow it is kind of organized at least in Western Europe.

Interviewee 2: A lot of people were like, but we have been contributing for this for 30 years and we are still contributing to it. There is a feeling, not necessarily from us, but there is a feeling that it is not solving anything.

Interviewee 1: It is solving. But also about this vaccine development. Five years ago, or maybe eight years ago we were like within ten years we will have a vaccine against HIV. And now people are saying maybe in ten years time. So we are eight years further and again ten years so people will not believe it anymore.

Interviewee 2: I think that is also a part of the funding issue. People are like enough, we have given you money, we have tried to solve it, it is not going anywhere now we have to work on other public health issues . It also influenced our work as a public health organization that there is always an emerging disease. Now it is the Zika virus, so then all the money has to go to that. Maybe if you were a environmental group you can say we really need to focus on the ocean. But we are really competing with lots of other public health concerns and some of those are more timely, it has more to do with right now. For example we have to solve this Zika virus right now and aids is like well we have been working on it, we keep working on it. But it is not as emerging or necessary right now. That is also where a lot of funding that could go to us, goes to these emerging issues.

Interviewee 1: So the European Commission is important but like I said they have many problems. Like I said, the refugees, the Braxit and the financial crisis with Greece . And what I also hear, and

that has been the case all the time, is that the Member States do not want to give up their independence, they really say that they want to represent their own constituents, they do not want to have a kind of federal government like in the US. That is maybe the biggest problem within the European Commission. The European Commission cannot put a mandate and say like all Member States should like this, because all Member States do not want it. They do not want to give up their own independence, or their own way of working and that is what you hear constantly. That is also the reason why there is still no Communication and Action Plan, that is what the European Commission says. Nowadays we cannot have such a common plan because Member States will not accept it. So actually you see the interest of Member States in having a European Commission diminishing. Economically it is of interest but all the other things not so much. And that is of course a concern and it could even increase and aggravate when the UK is getting out of the EU, when there is really a Brexit.