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REGIONAL SUMMARY OF FINDINGS OF AN
ASSESSMENT OF HIV SERVICES PACKAGES FOR KEY
POPULATIONS IN SELECTED COUNTRIES IN EASTERN
EUROPE AND CENTRAL ASIA

April 2019



Assessment of HIV Service Packages for Key Populations Eastern Europe and Central Asia

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
CBO	Community-Based Organization
CCM	Country Coordinating Mechanism
CDC	Centre for Disease Control
DOH	Department of Health
EECA	Eastern Europe and Central Asia
FGD	Focus Group Discussion
FSW	Female Sex Worker(s)
GAM	UNAIDS Global AIDS Monitoring reports
GARPR	Global AIDS Response Progress Report
GBV	Gender-Based Violence
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HTA	High Transmission Area
HTC	HIV Testing and Counseling
IBBS	Integrated Bio-Behavioral Surveillance
IEC	Information, Education and Communication materials
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
M&E	Monitoring and Evaluation
MOU	Memorandum of Understanding
MSM	Man (Men) who has (have) Sex with Men
NGO	Non-Governmental Organization
NSP	Needle-Syringe Program
OST	Opioid Substitution Therapy
PEP	Post-Exposure Prophylaxis
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PLHIV	Person (people) Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PR	Principal Recipient(s) (of Global Fund funds)
PrEP	Pre-Exposure prophylaxis
PSE	Population Size Estimate(s)
PWID	Person (people) Who Inject Drugs
RDS	Respondent-driven sampling
SOP	Standard Operating Procedure
SR	Sub-Recipient(s) (of Global Fund funds)
SRH(R)	Sexual Reproductive Health (and Rights)
SSR	Sub sub-Recipient(s) (of Global Fund funds)
STI	Sexually Transmitted Infection
SW	Sex Worker(s)
TB	Tuberculosis
TG	Transgender people
UIC	Unique Identifier Code(s)



Assessment of HIV Service Packages for Key Populations Eastern Europe and Central Asia

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

The World Health Organization (WHO) has clearly outlined the comprehensive package of services that should be available for men who have sex with men (MSM), people who inject drugs (PWID), sex workers (SW), transgender people (TG), and prisoners (WHO, 2016). The Global Fund contracted APMG Health to assess the design, implementation, and monitoring of national HIV service packages for key populations in 65 countries, across six regions, in which the Global Fund has provided HIV grant funds.

This report describes the results of those assessments conducted in the region of Eastern Europe and Central Asia (EECA). The findings presented here are based on four country-specific desk reviews and eight in-country assessment reports. Each of the latter group of assessments consisted of an initial desk review and a field assessment. The Global Fund Country Team for each country provided data sources used for completing all desk reviews. For those eight countries with in-country assessments, fieldwork was conducted over the course of five days, with the exception of Ukraine, which was selected for an extended visit conducted over the course of ten days. For each visit, two key populations were selected for focus. For all five-day visits, two cities were selected for observation and for Ukraine, four cities were selected. All populations and sites were selected with guidance from Global Fund Country Teams and Country Coordinating Mechanisms (CCM), based on existing programs in the countries.

Table ES1. Eastern Europe and Central Asia Countries Assessed

Country	Key Populations Selected	Sites Selected
Armenia	PWID & FSW ¹	Yerevan & Vanadzor
Belarus	PWID & MSM	Minsk & Vitebsk
Georgia	PWID & MSM	Tbilisi & Batumi
Kosovo	PWID & MSM	Pristina & Prizren
Kyrgyz Republic	PWID & SW	Bishkek & Osh
Moldova	PWID & MSM	Chisinau & Balti
Ukraine	PWID & MSM	Kiev, Lvov, Odessa & Dnepr
Uzbekistan	PWID & FSW ¹⁴	Tashkent city & Bukhara
Desk Review Only: Azerbaijan, Bosnia and Herzegovina, Kazakhstan, Tajikistan		

Data were collected through the following mechanisms: document review; interviews with national stakeholders responsible for design of packages; visits to at least two sites where packages are implemented, including observation of service delivery, interviews with staff and key population focus group discussions (FGD) and interviews with and examination of monitoring forms, methods and databases. It should be noted that the primary method of assessing quality of services was through FGD with key populations. A desk review was also conducted on recent literature related to key populations in the region.

¹ The CCMs in Armenia and Uzbekistan specified female SW as a population of interest; therefore, the assessment did not include male SW.

There were several limitations in conducting this assessment process, including during the initial desk review portion of country assessments. For the ‘desk review only’ countries, APMG Health did not conduct an in-country assessment to collect data and information that could verify information found in the initial desk review. Data for these four countries has been included throughout this review. However, it has been noted that consultants were limited to those data provided by the Global Fund in quarter four of 2017.

Due to time restrictions of country visits, only two sites were selected for visitation during the in-country assessments (see Table ES1). It is important to note that because of this, country assessments are not national, and reports only speak to data available in the regions, districts, and cities that were visited or within other reports reviewed. Also due to time restrictions, only two out of the five key populations were assessed during in-country data collection in most countries. Prisoners and transgender people were not selected for focus in any country. This regional analysis is based on a selection of countries within a region, and therefore, it is not representative of the entire region.

This report is one of six regional reports produced to summarize the assessment findings.

DESIGN

All of the assessed countries have taken the opportunity to formally recognize some key populations in their national plans and strategies: PWID, MSM and SW (either female SW or all SW) are universally recognized. Transgender people are not recognized by any country as a distinct population. Most countries have acknowledged the importance of servicing key populations by designing tailored packages based on the WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2014, 2016). However, some countries do not have full or distinct service packages for all key populations.

The lack of universal inclusion of lubricant for MSM is a major concern, as is the uneven inclusion of post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP) for SW and MSM. Pre-exposure prophylaxis (PrEP) is also not included in any package, although most packages were designed prior to the 2016 recommendation that PrEP be made available for all key populations. While behavioral interventions are universally included in packages in some form, there is a notable lack of detailed standards for what these interventions include, how they are delivered, and what is considered sufficient coverage.

The inclusion of critical enabler interventions to enhance the enabling environment were sparse across the countries surveyed. Legal and policy elements are the most distinctly acknowledged of the critical enablers, but not country includes specific interventions for violence in its package.

RECOMMENDATIONS: DESIGN OF SERVICE PACKAGES FOR KEY POPULATIONS

1. Defined packages of services should be designed and specified in national reference documents for all key populations. For those populations that do not yet have a defined service package, the involvement of members of that key population should be seen as integral to the package design process.

2. While packages should specify services to be provided, they should allow for flexibility of methods of delivery (e.g. differentiation of care) for differing contexts. (See Implementation section for further discussion on this topic.).
3. Considering potential resource constraints, all countries in the region require at least the basic services for each key population to be in the designed service packages. All key population packages should contain condoms and lubricants distribution (with female condoms at least included in all SW programs), and needles and syringes and OST included in at least all PWID programs. When considering resource constraints of many transitioning countries, adequate coverage with these basic services should be prioritized for all KP in the country.
4. Needs-based services should also be included in service packages for all key populations, including the offer of PEP, PrEP, STI, TB, and hepatitis B and C services. Needs may vary from location to location, and by subgroup within each KP (e.g. by age, gender, biological sex, etc.). When operating under resource constraints and/or when looking towards transition to domestic financing, countries may consider differentiating needs-based packages to ensure investments are optimal for the population (or subgroup) being targeted.
5. All packages should explicitly consider and address as appropriate (including plans for investment and service provision) the four critical enablers. Where it is not feasible (or a long-term goal) to change law or policy on particular topics, greater investments are needed in reducing stigma and discrimination and empowering communities to find resilience in the current, suboptimal environment. For countries which are still eligible for external funding, donors should consider these critical enablers as equally worthy of investment, alongside health sector interventions.
6. Violence programming, which is not explicitly addressed any country's package currently, needs to be included. Many countries will need to start by doing assessments of the local relationship between violence and HIV risks.

IMPLEMENTATION

In general, service packages appear to be implemented as designed, in terms of interventions delivered. Though many interventions are not captured in regular reporting data, in-country assessments confirm that services are available at some level. There has been strong engagement by key population communities, most notably from PWID and SW, in the design and implementation of packages. It should also be noted that many of these countries were formerly part of the Soviet Union and inherited a particularly vertical approach to dealing with all health issues. To have OST provided in a TB service center or TB services in a narcological hospital, or HIV testing carried out by NGOs has required significant and intentional effort. Continued dissolution of vertical approaches to care, as part of broader health systems reforms, increasingly allows for the provision of multiple services from a single site. This in turn reduces time and transport cost problems for KP (Routh et al, 2007; Medecins sans Frontieres, 2017).

Perhaps the biggest challenge to HIV service provision for KP is the changing role of outreach workers and peer educators. In some countries, the same methods and approach have been used for many years: hiring outreach workers who are similar to or part of the KP, having the outreach worker work with peer educators, often embedded in the KP community, and using this network to distribute goods, provide or

offer services and refer KP to other services. Other countries have adopted a ‘test and treat’ approach, in which emphasis has shifted from providing ongoing services to finding new individuals within KP, encouraging them to test and, if positive, linking them to care. The simplistic either/or approaches used to date are unlikely to be effective at controlling HIV epidemics as the older style programs miss out on many KP by restricting their services to a fairly defined cohort, while test and treat may neglect the existing cohort’s prevention needs.

Added to these stresses are the changes to the way information is accessed, the ways that MSM arrange sexual contacts, and how SW and PWID do business. The widespread use of mobile phones and the internet has led to fewer physical spaces where KP congregate on a regular basis. While there are still known areas for drug dealing and street sex work in most of the region’s cities, there are increasing numbers of KP who avoid any places where other KP gather, either for reasons of personal preference or from fear of exposure or violence. The expanded use of secure, online outreach and programming may be critical to reaching KP in contexts where physical safe spaces are declining.

There are two important factors which are inconsistently captured in data and written sources: geographical reach and quality of services. In smaller countries, with a limited number of hotspots, geographical reach can be assessed to some degree through coverage data. However, for larger countries such as Kazakhstan and Ukraine, entire regions of the country may not be covered by services. The degree to which this is captured in programmatic data is variable, as further discussed below in the Findings section.

One concern noted in several country reports was the lack of feedback loops to ensure that problems encountered by KP were brought to the attention of PR and others involved in procurement, and that appropriate action was taken when necessary. There should be clear and regularly conducted processes to ensure not only that KP concerns are heard, but that problematic commodities and practices are replaced by those that better meet the clients’ needs. This may be an appropriate approach to quality assessment: the introduction and maintenance of regular feedback sessions with clients, whose concerns are acted on quickly through the chain of responsibility from SSR through SR to PR and, if needed, involvement of CCM or CCM Oversight Committee.

One unexpected finding is the reported importance of psychological counselling. For example, among PWID in Belarus, this was regarded as the second most important service after needle/syringe programs (NSP), and the top priority service for MSM. Among some MSM Kosovo and PWID and SW in Uzbekistan, the lack of mental health services was noted as a major shortcoming.

The finding on desire for more psychological support, coupled with the findings related to community violence for some MSM groups, police violence towards SW, legal issues for PWID and other non-medical needs suggests that there is a need for services beyond the basic prevention services such as condom and lubricant distribution, STI services (for SW and MSM), NSP and OST (for PWID). This may be an important point when determining how to develop effective programming to reach and retain more individuals, considered alongside the fact that KP in focus groups reported very low satisfaction with other behavioral interventions, including written IEC materials.

In most countries, there was little emphasis on human rights barriers to services or community empowerment processes, despite KP noting these as major barriers to services. Considering flexible approaches to deliver the globally agreed upon critical enablers, throughout approaches tailored to local needs and context, may yield more cost-effective results in service uptake and retention.

Where prevention services are being delivered as designed, there is an important question of sustainability of interventions delivered by NGOs and CBOs. Historically, most prevention services delivered by civil society have been funded by the Global Fund or other external donors. For countries in transition (which includes most countries in EECA), the concept of domestic funding for prevention is a relatively new idea. The concept of governments contracting NGOs to provide services such as condom distribution and harm reduction is both new and challenging from a practical standpoint, in terms of legal frameworks and financing mechanisms.

For all populations, the lack of coverage data for a large number of interventions leaves significant questions about their reach, as well as quality of services.

RECOMMENDATIONS: IMPLEMENTATION OF SERVICE PACKAGES FOR KEY POPULATIONS

1. After determining basic interventions which are to be provided per the national, defined service packages, ensure that all interventions are implemented at the scale needed to address the HIV epidemic in each country (including preventing HIV epidemics in countries with small numbers of PLHIV). Strategies need to be put in place to ensure that these basic interventions are available to the majority of KP in each country, and meet their needs based on differing local contexts at the sub-national level, regardless of funding source or service delivery agent.
2. All packages should allow flexibility in program design so that needs-based services can be tailored to local needs and contexts, including the provision of additional services (where needed or desired by key populations) in addition to basic services. This flexibility would allow service providers to attract clients to these services and to address some of the underlying reasons why uptake of priority services, such as HIV testing, ART or OST (for PWID), and retention in ART or OST programs is suboptimal for key populations. This should also allow for adaptation to intersectionality of risk for individuals or groups whose gender, age and overlapping identity present unique barriers to being served by more traditional PWID, MSM or SW programming.
3. Outreach to key populations must continue to evolve alongside both population needs and international trends such as Test and Treat. While progress towards the 90% testing target should continue to be a priority, individuals who test HIV-negative must have the option to receive high-quality prevention services which will contribute to them maintaining a negative sero-status. This hybrid approach, a “Test and Treat Plus” will require robust funding, as it must be acknowledged that a limited cadre of outreach workers cannot be expected to perform multiple functions for an ever-increasing number of clients.
4. In addition, the emergence of internet outreach as a viable model needs to be taken seriously, especially for MSM, SW and TG. Where this method is not already being utilized

widely, it should be considered for introduction (with respect to appropriateness in context). In all cases, an appropriate and ethical methodology for online outreach is recommended with protocols for confidentiality, transparency, and safety. Some guidance on this is available in the MSMIT, SWIT and TRANSIT (UNFPA, 2015; WHO, 2013; UNDP, 2016). However, while these tools indicate the importance of safety and ethics protocols, they do not sufficiently guide users in how to develop them. Therefore, there is a need for comprehensive and accepted global standards for using online outreach to meet and provide services to new KP clients.

5. Implementation should continue to move towards integration of services, including one-stop-shop models where feasible. This is particularly true for HIV and TB coinfection, where strong vertical HIV and TB systems have long suffered from lack of coordination. Greater integration is urgently needed between these two sectors, in order to meet the needs of PLHIV for regular TB screening, prevention and treatment in a familiar care setting which is sensitive to coinfection needs. Some of the key populations for both HIV and TB are the same (such as PWID and prisoners) and both government agencies and NGOs should increasingly offer combined education and access to services that assist key populations living with coinfection.
6. Outreach and support service models need to be reviewed to ensure that there are sufficient resources to ensure linkage to treatment for newly diagnosed PLHIV, and case-management models in place to cover at least the first three months following diagnosis.
7. Community HIV testing and self-testing models in the region need to be assessed and guidance for expanding access and improved quality developed.
8. Strategies to engage countries in transition planning for the outreach (demand-creation) workforce for KP need to be strengthened.
9. Key population (KP) NGOs need to be assisted to secure resources to pursue broad health goals for their constituents, including reduction of stigma and discrimination, responses to KP-related violence, gender-based violence and other issues that increase service access obstacles for people from KP.
10. Feedback loops should be established and required as part of national programs, with data being collected on a routine basis, under standard protocols to assure safety and security of beneficiaries, to aid in a full spectrum of quality improvement. This should include feedback on commodities as well as implementation approaches and the status of critical enablers. Feedback then needs to be routinely used by program implementers to assure accountability to communities, and to make necessary adjustments in programming (using needs-based funding, as described above) to meet the needs of key population clientele.
11. In order to overcome legal and policy barriers (which may be insurmountable or require long-term advocacy for change) and provide avenues of safety for key populations to access services, institutional-level partnerships between NGOs and government entities should be utilized. This may include partnerships between NGOs and medical facilities, and between health service providers (including NGOs) and law enforcement.

12. Countries need to turn more serious attention to the role of violence and safety (or lack thereof) for both key populations in accessing services and service providers in reaching key populations. Interventions to mitigate violence should be designed and funded.

MONITORING

The process of monitoring the implementation of packages of services against their design is multi-faceted. There are significant problems related to population size estimations (PSE) for some key populations in some countries. In addition, the way that coverage is compiled and reported for the Global AIDS Monitoring (GAM) reports varies across countries. As part of this assessment process, there was a requirement to rate the systems used to monitor key population service packages, which is presented in Table ES2, below.

Table ES2. UIC System Scores by Country in Eastern Europe and Central Asia

Desk review countries not included

- 0: No data/evidence of UIC found;
 1: Monitoring contacts, which disallow de-duplicated reporting;
 2: Partially using UIC, which disallows de-duplicated reporting. This includes scenarios where UIC are used in some regions of the country or different UIC are used in the country but not harmonized;
 3: Nationally using UIC, which allows de-duplicated reporting. This includes the scenario where different UIC are used but harmonized.

Country	Score ²	Notes
Armenia	2	UIC, which allows for de-duplication, for MSM, PWID and FSW; however, this is not used at the national level, only unique clients by the PR. Coding of the UIC is different for each KP.
Belarus	2	UIC, which allows for de-duplication, is used; currently used at individual NGOs and health centers and there is no unified patient tracking systems between service providers.
Georgia	3	UIC, which allows for de-duplication, used for all KP. There are several UIC used across all the data collection tools; however, linkage among databases is possible.
Kosovo	3	UIC for MSM, FSW PWID, which allows for de-duplication of cases. No linkages to the ARV database (prevention & testing only)
Kyrgyz Republic	2	UIC, which allows for de-duplication, only used in GF funded programs

² Score has been assigned based on available information from country assessments. Score may not apply to all key populations (MSM, FSW, PWID, and prisoners) in EECA. Please see notes for specifications.

Moldova	3	UIC for all KP, which allows for de-duplication of cases. No linkages to the ARV database (prevention & testing only)
Ukraine	3	UIC, which allows for de-duplication, used among Alliance for Public Health in Ukraine and their implementing partners.
Uzbekistan	3	UIC recently introduced for PWID and FSW, which allows for de-duplication. Used by all service providers and linked to the National AIDS Center and the Regional AIDS Centers.

As shown above, all of the countries visited have at least one functional unique identifier code (UIC), with many being used nationally. There are also promising signs that countries are moving towards more precise reporting on coverage, with less conflation between the concepts of unique client reach, and adequate client coverage.

However, there are examples of challenged in implementing monitoring practices. Mostly, these are caused by an ongoing reliance on paper and Excel-based forms, and overburdening of outreach workers with data reporting, alongside suboptimal utilization of data collected to improve program implementation.

However, the major gap in every country, as it is worldwide, is between prevention and treatment databases. For most countries studied in the region, there is no way to track individual service patterns from prevention through the treatment cascade and other services, in order to understand patterns not only by KP, but within subgroups of KP (e.g. by gender, age, coinfection status, method of referral, etc.). However, Georgia appears to be close to resolving this problem, and provides an example which should be considered by other countries.

RECOMMENDATIONS: MONITORING OF SERVICE PACKAGES FOR KEY POPULATIONS

1. All countries need to follow established guidelines when developing population size estimations, together with national consensus processes involving substantial representation from the key populations concerned (not merely one or two key population representatives on a 20-member working group). This may include the use of emerging methodologies for mapping and surveying populations using virtual/internet-based mechanisms. From these processes, more accurate, agreed-upon PSE should be derived.
2. In countries where some PSE appear to underestimate populations, sampling methodology should be considered for improvement, either including additional waves of sampling (if using RDS methodology), and/or exploring innovative methods for reaching subgroups that may not be linked to the networks previously accessed through current NGO clients. This is also applicable for all countries assessed here, in conducting PSE for TG populations for the first time.
3. Global AIDS Monitoring reports on service coverage for key populations should be based on either programmatic data or on separate research studies using well-established research

methods and standards. Where the coverage figure is available from programmatic data and IBBS, only the programmatic data should be provided in the GAM. However, it should be noted that some programmatic data also defy credibility - 99.8% of prisoners in one country receiving comprehensive HIV prevention programs for example – so programmatic data collection and analysis may also need improvement.

4. All countries should continue to progress towards a single unique identification code for all key populations and a single database, preferably accessible online for both uploading data and generating reports. In countries where there is a functioning National eHealth system (Ukraine, Belarus, Georgia, Moldova), this may be the most logical platform to host a functional UIC. In the absence of an eHealth system, and given the issues noted for outreach workers and peer educators in the Implementation section, the streamlining of data entry through the use of Syrex or similar products a reasonable alternative.
5. Tracking of service use and health outcomes for KP needs to be integrated into national e-health and unique patient record initiatives, where this can be done without compromising safety of KP.
6. All countries should continue to progress towards clear definitions of coverage (distinct from reach) for core elements of service packages, aligned with recommendations in international reference documents.
7. After determining a basic package during the design phases, establish routine surveillance to ensure that all coverage of all basic interventions can be regularly measured, independently of one another. (This is in response to the general lack of data available on coverage of many of the services in defined packages of services.)
8. Feedback loops, recommended in the Implementation section, should be extended throughout the reporting system so that problems with the quality of services or the commodities that they provide are quickly reported to the level at which action can be taken to remedy the situation. This should extend across governmental and non-governmental services. In the case of products such as syringes and condoms which are usually procured nationally, this may mean that rapid communication is enabled from the affected clients to the PR or the Ministry of Health entity responsible for procurement.
9. All countries should study the database being assembled in Georgia to consider whether such a database is feasible. A wealth of information about patterns of service usage could be obtained by anonymously linking UIC and health system data for KP.
10. It is important to stress that none of these data are useful unless they are used. There were occasional examples found of NGOs and others working with the available data to determine ways to attract more clients to services and increase levels of HIV testing – but many organizations lack the capacity to do this in a meaningful way. Capacity building may be needed for some agencies to help staff see the value in not merely collecting but analyzing service data and using this information as the basis for suggesting changes to services.

It was beyond the scope of this assessment process to conduct an in-depth financial analysis of costing, allocation and expenditure related to packages of services for key populations in EECA. However, what was found was a heavy reliance on Global Fund to support key population programming in many countries, and among those countries trying to shift towards a greater share of domestic funding, a lack of available strategic information to guide sufficient allocations for full funding of the designed packages of services. Cost information is a particularly critical input into the process of setting priorities and efficient allocation of resources and given the urgency of scale-up to meet Fast-Track targets, countries must urgently fortify their expenditure analysis and budget development processes to be sure that sufficient resources are available to implement the designed packages of services, as intended.

Table ES3. Summary of Key Findings in EECA

Survey/IBBS (S); GAM (G); Programmatic Data (P)³; Other (O); Desk Review Only (*); No Data Available (---)

Note: Details of dates and references contained in footnotes in the tables in the body of this report.

Service	Population	Armenia	Azerbaijan *	Belarus	Bosnia*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan *	Ukraine	Uzbekistan
Population Size Estimate	MSM	12,461	6,600	59,500	6,900	17,215	61,966	6,445	16,900	17,100	13,500	181,500	2,735
	PWID	12,700	71,283	66,500	12,500	49,000	120,500	5,819	26,700	36,900	23,100	346,900	48,000
	Prisoners	5,600	25,054	22,000	4,000	6,525	19,100	5,037	10,600	21,300	9,800	60,876	42,000
	SW	3,894	17,000	31,700	---	9,724	36,000	1,600	7,961	5,329	14,100	80,000	22,000
	TG	---	---	---	---	---	---	---	---	---	---	---	---
HIV Prevention Programming ⁴	MSM	30.0% (S)	23.5% (G)	11.2% (P)	64.6% (P)	22.5% (P)	80.0% (S)	21.8% (P)	32.2% (P)	21.3% (P)	41.4% (O)	24.0% (P)	---
		27.0% (P)	30.7% (P)										
	PWID	51.8% (G)	19.2% (S)	56.8% (P)	55.5% (P)	61.0% (P)	55.6% (P)	57.4% (P)	58.7% (P)	41.2% (P)	61.3% (S)	65.0% (P)	63.2% (P)

³ Coverage values have been calculated using available programmatic coverage data as numerators, and nationally accepted PSE as denominators

⁴ Coverage of HIV prevention programmes among the key population

Service	Population	Armenia	Azerbaijan *	Belarus	Bosnia*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan *	Ukraine	Uzbekistan
		27.6% (P)	18.8% (P)										
	Prisoners	44.6% (S)	---	25.4% (P)	---	21.0% (P)	99.8% (P)	---	16.3% (P)	29.3% (P)	48.0% (O)	---	---
	SW	71.3% (G) 40.2% (P)	33.3% (G) 30.0% (P)	25.4% (P)	61.5% (P)	48.6% (P)	90.0% (S)	5.3% (P)	57.0% (P)	26.3% (P)	69.5% (O)	48.0% (P)	61.3% (P)
	TG	---	---	---	---	---	---	---	---	---	---	---	---
Knowledge of HIV Status ⁵	MSM	29.6% (S) 12.0% (P)	24.5% (G) 0.7% (P)	5.5% (P)	---	12.0% (P)	62.7% (S)	47.0% (S) 4.8% (P)	15.7% (P)	2.0% (P)	40.3% (O)	21.0% (P)	
	PWID	12.0% (S) 10.0% (P)	3.9% (G) 20.7% (P)	16.5% (P)	---	56.9% (P)	60.6% (G)	66.0% (S) 12.9% (P)	38.6% (P)	5.4% (P)	46.4% (O)	47.0% (P)	32.0% (S)
	Prisoners	50.4% (S)	---	13.4% (P)	---	60.7% (P)	81.5% (S)	---	64.6% (P)	---	---	46.0% (S)	---
	SW	58.5% (S) 16.8% (P)	12.0% (G) 27.1% (P)	13.4% (P)	---	34.2% (P)	79.9% (S)	5.3% (P)	29.4% (P)	3.9% (P)	62.3% (O)	39.0% (P)	36.1% (S)
	TG	---	---	---	---	---	---	---	---	---	---	---	---

⁵ Percentage of the key population that have received an HIV test in the past 12 months and know their results

Service	Population	Armenia	Azerbaijan *	Belarus	Bosnia*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan *	Ukraine	Uzbekistan
Antiretroviral therapy ⁶	MSM	---	---	---	---	33.0% (P)	---	---	44.9% (P)	---	---	82.0% (P)	---
	PWID	---	---	25.9% (P)	---	---	---	---	37.4% (P)	---	---	79.0% (P)	---
	Prisoners	77.3% (O)	---	---	---	---	---	---	69.6% (O)	63.1% (O)	---	---	---
	SW	---	---	---	---	---	---	---	25.6% (P)	---	---	49.0% (P)	---
	TG	---	---	---	---	---	---	---	---	---	---	---	---

⁶ Antiretroviral therapy coverage among the key population living with HIV



BACKGROUND

In 2015, key populations and their sexual partners accounted for 80% of new HIV infections outside of sub-Saharan Africa; even in sub-Saharan Africa key populations account for 25% of new HIV infections (UNAIDS, 2017). A range of policy and legal barriers and harmful social factors increase the HIV vulnerability of key populations and undermine their access to HIV and other services. The criminalization of sex between men, sex work, drug use, and HIV transmission, as well as high rates of incarceration, homophobia, trans phobia, violence, and social marginalization, all serve to influence risk practices and undermine access to services. People from key populations often migrate to cities in search of safer and more secure communities (UNAIDS, UN Habitat, 2017). Women in key populations face specific challenges and barriers, including gender-based violence and poorly tailored services. These factors further intensify their vulnerability to HIV.

While the World Health Organization (WHO) has clearly outlined the comprehensive package of services which should be available for men who have sex with men (MSM), people who inject drugs (PWID), sex workers (SW), transgender people (TG), and prisoners (WHO, 2016), these populations rarely have access to the full range of recommended services (UNAIDS, 2015).

The Global Fund contracted APMG Health to review the design, implementation, and monitoring of national HIV service packages for key populations in 65 countries, across six regions in which the Global Fund has provided HIV grant funds. Countries were selected by The Global Fund Monitoring, Evaluation and Country Assessment team, on the basis on of availability of PSE for key populations and in discussion with Global Fund's regional teams and global partners. The specific objectives of this assessment were:

1. To determine whether HIV service packages as designed in the national guidelines or supported by Global Fund programs are in line with international standards and guidelines (e.g. WHO Consolidated Guidelines for Key Populations, Key Populations Implementation Tools, amongst others), and are appropriate to epidemiological context, available, accessible and utilized by relevant key population groups;
2. To examine the implementation of HIV service packages in reaching intended target groups, taking into account specific needs and vulnerabilities within sub-groups of key populations (e.g. age, sex), along with the coverage and reported quality of these programs;
3. To assess whether the monitoring framework, tools and other mechanisms set up by implementation partners are appropriate to local contexts, and are used effectively to regularly report on programmatic coverage;
4. To examine the enabling environment and other factors facilitating and inhibiting the availability, accessibility and utility of intervention services; and
5. To determine the degree to which financial resources are made available and used accountably for funding the implementation of service packages for KP.



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These objectives were completed through a mix of desk review and in-country visits, as further described below. This report is one of six regional reports produced to summarize the assessment findings.



METHODOLOGY

COUNTRY ASSESSMENT PROCESS

Each of the country assessments consisted of an initial desk review of documents provided by the GF Country Teams. The main data sources provided for desk reviews in Eastern Europe and Central Asia (EECA) were:

- Global Fund Performance Framework
- Integrated Bio-behavioral Surveillance Survey Reports (IBBS Reports)
- National Strategic Plans
- Monitoring and Evaluation Plans
- Global Fund Funding Request Reports & Concept Notes
- Global AIDS Monitoring Reports (GAM)
- Global Fund Program Update data
- Programmatic Spot Checks
- Cross checking of findings at a debrief with PR and other stakeholders

Out of the 12 countries selected for the EECA region for this project, data collection ended with the completion of the desk review for four countries. In eight of the countries, a follow-up field assessment was carried out to verify and expand data collected during the initial desk review process. These eight countries were selected by the Global Fund MECA team on the basis of relative disease burden, the advancement of programming for key populations, the history and level of Global Fund investments, and input from Global Fund Country Teams.

Each field assessment was conducted over the course of five days, with the exception of Ukraine, which was conducted over the course of ten days. For each country, two key populations and two sites were selected, with guidance from The Global Fund Country Teams and Country Coordinating Mechanism (CCM), with the exception of Ukraine where four sites were visited.

Table 1. Eastern Europe and Central Asia Key Population and Site Selection

Country	Key Populations Selected	Sites Selected
Armenia	PWID & FSW ⁷	Yerevan & Vanadzor
Belarus	PWID & MSM	Minsk & Vitebsk
Georgia	PWID & MSM	Tbilisi & Batumi
Kosovo	PWID & MSM	Pristina & Prizren
Kyrgyz Republic	PWID & SW	Bishkek & Osh

⁷ The CCMs in Armenia and Uzbekistan specified female SW as a population of interest; therefore, the assessment did not include male SW.



Moldova	PWID & MSM	Chisinau & Balti
Ukraine	PWID & MSM	Kiev, Lvov, Odessa & Dnepr
Uzbekistan	PWID & FSW ¹⁴	Tashkent city & Bukhara

One international consultant and one local consultant carried out each country assessment, with the exception of Uzbekistan where, due to visa restrictions, two local consultants conducted the assessment. The majority of the data collected during each country assessment were collected through:

- An initial meeting with representatives of CCM, PR and SR working with key populations, and other key informants to discuss design and enabling environment issues.
- Visits to at least two sites for observation of package delivery.
- Visits to SR/SSR to discuss implementation issues and to examine M&E forms and systems
- Additional key informant interviews.
- Focus group discussions with KP representatives: in each country, focus groups were held with KP representatives of each of the two selected key populations in each site visited.

REPORTING PROCESSES

For each of the eight countries visited, a report was produced with detailed findings and recommendations for that country. For each region, a summary report has been produced providing analysis of trends and recommendations for consideration for decision-makers and programmers working across the region. This report provides summary and analysis of the 12 countries assessed in the EECA region, as displayed in Table 2.

Table 2. EECA Countries Assessed

Eastern Europe & Central Asia	
Desk Review and Country Assessment	Armenia Belarus Georgia Kyrgyz Republic Moldova Ukraine Kosovo Uzbekistan
Desk Review Only	Azerbaijan Bosnia and Herzegovina Kazakhstan Tajikistan



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As the countries selected for this region were not selected on the basis of being a regionally representative sample, extrapolation of these results to other countries in the region should be done with caution. The findings of this assessment may be instructive for development of policy or practice across the region, but any country-level decisions should always be grounded in the reality of the specific country context.

FINDINGS

KEY POINTS

- General population prevalence is <0.9% in all countries assessed
- Despite a long history as a concentrated epidemic setting, key populations are off track to benefit from 90-90-90 achievement
- Population size estimates are available for PWID, MSM and SW; however, some PSE are likely to be underestimates
- PSE and HIV prevalence rates unavailable for TG in any of the countries assessed
- HIV prevalence varies greatly, but reaches heights of 22.6% and 25.1% among PWID in Ukraine and Belarus, respectively; and 22.3% among FSW in one Moldovan site
- Lack of sensitivity to age, gender and biological sex make it difficult to identify KP subgroups disproportionately impacted by the HIV epidemic in each country

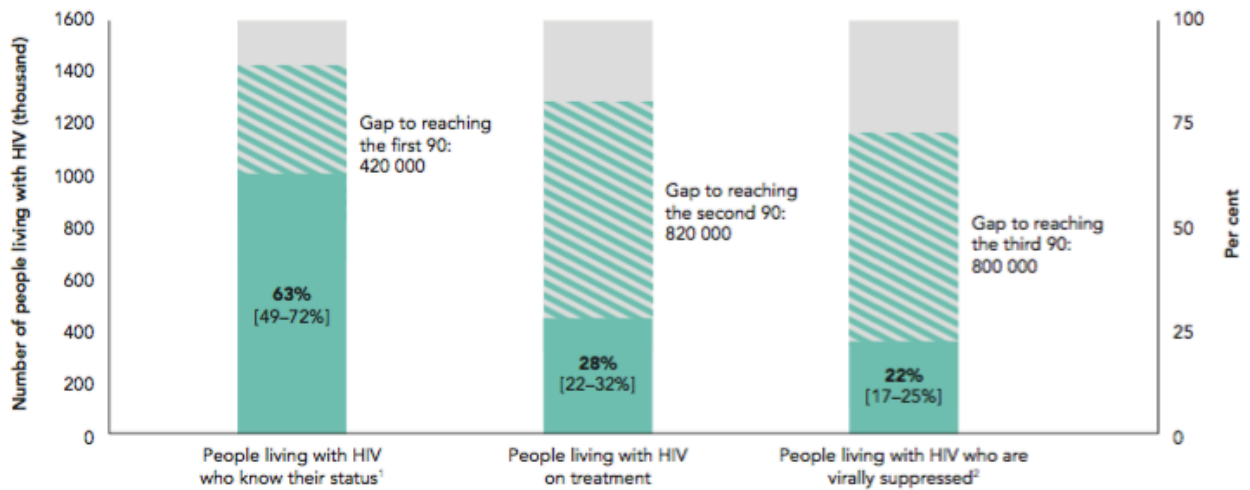
PART I: REGIONAL PROFILE AND KEY POPULATIONS CONTEXT

UNAIDS estimates that there are around 1,500,000 adults over the age of 15 living with HIV in the EECA region.⁸ This includes 660,000 women and 880,000 men, and the prevalence rate for men and women aged 15-49 years is 0.9% (0.8% among women and 1.0% among men in this age group).

UNAIDS 2017 cascade data for EECA estimate that the number of people with HIV in the region who know their HIV status is 970,000 (63%) - a large shortfall from the target of 90%. The number of PLHIV on ART is estimated at 430,000 (28%). The number of PLHIV who have a suppressed viral load is estimated at 340,000 (22%). These gaps represent a significant challenge to the goal of ending AIDS by 2030.

⁸ UNAIDS defines the Eastern Europe and Central Asia region to include the following countries: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, the Kyrgyz Republic, Montenegro, Republic of Moldova, Russian Federation, Tajikistan, Former Yugoslav Republic of Macedonia, Turkmenistan, Ukraine, and Uzbekistan. This differs from the list of countries included in this assessment, as discussed further in the limitations section.

Figure 1. Cascade Data for Eastern Europe and Central Asia (UNAIDS 2017)



According to the UNAIDS 2016 Prevention Gap Report, EECA is the only region in which the HIV epidemic is still growing.⁹ The prevalence of HIV is higher among key populations, including people who inject drugs (PWID), men who have sex with men (MSM), sex workers (SW), transgender people (TG) and prisoners.

⁹ It is important to note that the Russian Federation has the highest number of new HIV infections of the countries in the Eastern Europe and Central Asia region, and that the Russian Federation was not included in the list of countries assessed.

Table 3. Population Size Estimation¹⁰ and HIV Prevalence¹¹ by Key Population

Country	Armenia	Azerbaijan *	Belarus	BiH*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan*	Ukraine	Uzbekistan
Total Population ¹²	3,018,000	9,754,000	9,496,000	3,810,000	4,000,000	17,625,000	1,816,200	5,940,000	4,069,000	8,482,000	44,824,000	29,894,000
HIV Prevalence (15-49) ¹³	0.2% [2017]	0.2% [2017]	0.4% [2017]	---	0.4% [2017]	0.2% [2017]	<0.01% [2015] ¹⁴	0.2% [2017]	0.6% [2017]	0.3% [2017]	0.9% [2017]	0.3% [2017]
MSM PSE	12,461 [2016]	6,600 [2011]	59,500 [2016]	6,900 [2012]	17,215 [2014]	61,966 [2017]	6,445 [2016]	16,900 [2016]	17,100 [2017]	13,500 [2015]	181,500 [2016]	2,735 [2014]
MSM HIV Prevalence	0.76% [2016]	2.2% [2016]	5.7% [2015]	1.1% [2016]	20.7% [2016]	3.2% [2016]	<5.0% [2014]	6.6% [2016]	9.0% (Chisinau); 4.1(Balti) [2017]	2.7% [2016]	7.5% [2017]	3.3% [2015]
PWID PSE	12,700 [2016]	71,283 [2011]	66,500 [2016]	12,500 [2012]	49,000 [2015]	120,500 [2016]	5,819 [2016]	26,700 [2016]	36,900 [2017]	23,100 [2014]	346,900 [2016]	48,000 [2013]

¹⁰ Population size estimates are from IBBS, GARPR, programmatic mapping, the Global State of Harm Reduction, or UNODC (prisoners only)

¹¹ HIV prevalence rates are from IBBS or GARPR/GAM

¹² WHO Country Profiles (2015)

¹³ From various country sources as reported and displayed on AIDSinfo (2017)

¹⁴ UNAIDS (2015)



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PWID HIV Prevalence ¹⁵	<2.0% [2016]	8.5% [2016]	25.1% [2016]	0.0% [2016]	2.2% [2016]	8.5% [2016]	<1.0% [2014]	14.3% [2016]	13.9% (Chisinau); 17.0 (Balti) [2017]	12.9% [2014]	22.6% [2017]	5.6% [2015]
FSW PSE	5,600 [2016]	25,054 [2011]	22,000 [2015]	4,000 [2012]	6,525 [2014]	19,100 [2011]	5,037 [2016]	10,600 [2016]	21,300 [2017]	14,100 [2014]	80,000 [2016]	22,000 [2016]
FSW HIV Prevalence	<0.1% [2016]	2.3% [2016]	7.0% [2017]	0.0% [2016]	0.7% [2014]	1.3% [2015]	<1.0 [2014]	2.0% [2016]	3.9% (Chisinau); 22.3 (Balti) [2017]	3.5% [2014]	5.2% [2017]	2.8% [2015]
Prisoner PSE	3,894 [2015]	17,000 [2014]	31,700 [2015]	---	9,724 [2015]	36,000 [2016]	1,600 [2015]	7,961 [2016]	5,329 [2015]	9,800 [2016]	60,876 [2016]	42,000 [2015]
Prisoner Prevalence	1.2% [2016]	2.8% [2016]	0.5% [2014]	---	0.9% [2015]	2.7% [2016]	N/A	11.3% [2016]	3.8% [2017]	8.4% [2013]	7.6% [2017]	4.7% [2015]

¹⁵ PWID prevalence data are not disaggregated by sex or gender. In many cases, this may mean that data are heavily skewed to represent only males or men who inject drugs.



People Who Inject Drugs

People who inject drugs remain the most affected key population in the region, accounting for an estimated 39% of all new HIV infections in 2015.¹⁶ In the countries assessed, HIV prevalence ranges from 0.2% in Bosnia and Herzegovina (BiH) to 25.1% in Belarus. In the city of Balti, Moldova, the prevalence among PWID is 29.1%. Ukraine contributes a tremendous number of HIV cases among PWID in the region, with 22.6% prevalence amongst a sizeable population of 346,900 PWID.

The range of population estimates across the region is an important point on which to pause, for this population and for the others discussed below. While variations in population size estimates are partly due to relative size of the general population, they can also be driven by a range of factors affecting drug use patterns – such as economics, drug scene, and acceptability of injecting culture. Changing dynamics in drug use are particularly relevant in EECA, and while heroin remains an injectable drug of

BELARUS: “The State Registry for Drug Addicts for all PWID, including those enrolling in OST programs, does not provide motivation to seek treatment, as patients included in the database have obstacles securing employment”.

choice, some countries have reported that access to heroin has become significantly constrained in recent years. This has driven drug use patterns towards other narcotics, including pharmaceutical products, which may pose similar or increased risks relative to injecting heroin, due to frequency of injection. Alternative drugs which were reported to be in use during these assessments include:

- Synthetic stimulants, including amphetamines/methamphetamines and cathinones/methcathinones (Ukraine), and other unspecified substances (Belarus).
- Pharmaceutical products, not all specified but including opioids such as Tramadol (Ukraine); barbiturates such as Sedalgin (Uzbekistan); Tropicamide (a muscarinic antagonist reported in Uzbekistan); benzodiazepines such as Diazepam (Kosovo); and antihistamines such as Dimedrol (Uzbekistan)
- Alternative homemade opioids (sometimes known as *hanka*), which is often mixed with other drugs (Kyrgyz Republic, Ukraine, Uzbekistan)
- Opioid substitution agents including methadone (Georgia, Kosovo, Ukraine) and buprenorphine (Georgia, Ukraine) (both reported to be injected, off-label).¹⁷

Some use of desomorphine (also known as *Krokodil*) is still reported in Ukraine and Georgia, though it is noted that use has not increased and/or has decreased from the height of use in 2013. The

¹⁶ From UNAIDS special analysis, 2018.

¹⁷ It should be noted that thorough surveying of the non-heroin drug scene was beyond the scope of these assessments. Where trends in drug use were reported in literature or raised by focus group participants or key informants, details were included in country reports, and have been captured here. However, these results should not be considered to be complete and should be further verified and elaborated before being used as the basis of any policy or programmatic changes.



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continuing evolution of supply and demand will be important to take into account when designing and implementing harm reduction and other services for PWID in years to come.

While population size may be dynamic, obtaining accurate estimates is still critically important to for planning and implementation. The use of evidence-based sampling methods, as recommended by technical agencies including WHO and UNAIDS, is important to assure that estimates are as accurate as possible and do not miss sections of hard-to-reach individuals in their sampling. In addition to technical capacity, there must be the political will to conduct regular population size estimates, and there must be a desire to obtain accurate results – e.g. political or cultural desires to see reduction in drug use must not interfere with the integrity of estimations.

Finally, PWID must feel adequately safe that they can disclose their drug use without their information being divulged to anyone or facing punitive measures. These processes all occur against a background of criminalization of drug use across the region, and settings of heavy stigmatization of drug use. The continued use of outdated practices such as forced registration of drug users – common in many of the countries studied – provide a heavy disincentive to identify as a person who uses drugs.

To the degree that these factors may inhibit accurate estimates of the men who inject drugs, women who inject drugs may be even harder to estimate properly, given increased stigma and social pressure (Pinkham et al, 2012). As a result, women who inject continue to remain invisible in many epidemics, even where PWID are recognized as a key population; the lack of data results in downstream deficiencies in women-tailored programming. Therefore, all data on PWID should be approached with caution, noting that they may underrepresent the experience of women who inject drugs.

Generating reasonably accurate population size estimates is of the utmost importance – as discussed further below, this number provides the denominator for all downstream data analysis. Underestimates of PWID and other key populations can have a dramatic and distorting effect on how we view progress in program coverage.

Men who have Sex with Men

While the HIV epidemics in EECA have historically been driven by transmission related to injecting drug use, in recent years statistics have emerged showing an increasing burden amongst MSM. Although HIV prevalence among MSM is only higher than prevalence among PWID in Georgia (20.7%) and Kosovo (<5.0%), HIV is well established in many MSM populations across the region - 9.0% in the Moldovan capital, 7.5% Ukraine and 5.7% in Belarus.

MOLDOVA: “...personal drug use was decriminalized in 2008. Major amendments to the Penal Code and Administrative Offenses Code reformed criminal punishment, including promoting alternative punishments to imprisonment and excluding arrest for personal drug use, now constituted as an administrative rather than a criminal offense”.



These shifting dynamics are probably due to both long-time under-detection of HIV among MSM and an actual growth in transmission rates (Eurasian Coalition, 2016). Under-detection is partially driven by the invisibility of MSM as a population. As demonstrated by the PSE in Table 3, even within the context of HIV programming, some countries are reluctant to acknowledge an accurate size for the population. Notable examples include Uzbekistan, where it is estimated that there are just 2,735 MSM in a general population of over 29 million (only 0.02% of the adult male population of the country).¹⁸ Azerbaijan estimates only 6,600 MSM (only 0.18% of their adult male population). Neighboring countries, where MSM programming is more advanced, estimate MSM populations of 1.6% (Belarus), 0.9% (Georgia), 1.2% (Moldova), and 1.1% (Ukraine), of adult male population. These proportions are up to 80 times higher than those estimated by Uzbekistan. Even in the latter cadre of countries reporting relatively higher population sizes, most estimates fall well below the internationally accepted average of 2%-5% of the adult male population in low- and middle-income countries (Caceres et al, 2008).

This is likely due to the fact that in many countries in the region, stigma and fear of discrimination may lead many men to avoid identifying as MSM. Furthermore, for MSM who acquire HIV, it may be safer or more desirable to report that they acquired the infection through heterosexual sex.

The recent increases in HIV prevalence among MSM may be due to several factors, including an actual increase in transmission in this population. Until the past five years, little testing was carried out with MSM in the region and few programs were available to reach, educate, and provide prevention materials and testing to MSM. As these programs have expanded, significantly higher numbers of MSM have been tested, more countries have carried out IBBS studies in larger numbers of sites and, at least in some countries such as Ukraine, levels of stigma towards MSM may be falling (Eurasian Coalition, 2016).

As with PWID, accurate estimations of population size are dependent on use of appropriate sampling methods, political will to make the population visible and regularly update size estimations, and safety of MSM in disclosing their behaviors to surveyors. While same-sex behavior is not illegal in most of the countries assessed (exception: Uzbekistan), only three countries (BiH, Georgia, and Kosovo) have an anti-discrimination law in place protecting MSM and other lesbian, gay, bisexual, trans, queer and intersex (LGBTQI) populations outside of employment-related matters (ILGA, 2017). Stigmatization is still widely experienced by MSM throughout the region and violence, both state-sponsored and civilian, is a common experience for LGBTQI populations across EECA. Recent reports show trends of increasing attacks on activists and individuals in Armenia, Belarus, Kazakhstan and Kyrgyz Republic. (Amnesty Int, 2017). This was also borne out in the focus group discussions held with MSM in Georgia and Kosovo.

¹⁸ This and all subsequent calculations referencing adult male population size are based on statistics from the CIA World Fact Book, access 16 November 2018.



The implications of underestimated population sizes and suboptimal sampling are the same as for PWID. Underestimates make it impossible to plan adequate resources and serve to reinforce the hidden nature both of the population and the HIV epidemic that affects it.

Sex Workers

Sex workers have had a consistent place in the HIV epidemics in EECA, with overall prevalence being recorded as relatively lower than among PWID or MSM, with most countries ranging from <0.1% (Armenia) to 3.5% (Tajikistan). A few countries, such as Ukraine (5.2%) and Belarus (7.0%) are outliers showing higher rates of prevalence, and there are spikes in HIV prevalence in some specific hotspots, such as 22.3% among FSW in Balti, Moldova.

Population size estimates are remarkably consistent across countries, showing that sex workers represent between 0.1% and 0.3% of the total population, with Moldova (0.5%) being the only exception among the countries assessed here. However, as for the populations above, it should be noted that sex workers live in environments of great hostility. Sex work is illegal and criminalized in all countries assessed, and sex workers are particularly vulnerable to violence perpetrated by clients and law enforcement officials. In addition, some women may trade or occasionally sell sex, but not identify as sex workers (McMillan et al, 2018). These individuals may not be captured in population size estimates despite still being at risk for acquiring HIV, further contributing to the issue of under-estimation of the population.

Prisoners

The size of prison populations varies widely across countries, with fewer than 2,000 people incarcerated in Kosovo and over 60,000 incarcerated in Ukraine. Belarus reports the lowest HIV prevalence among prisoners, at 0.5%, and Kyrgyz Republic the highest at 11.3%. Though Ukraine's prevalence falls in the middle of the pack of assessed countries, at 7.6%, its large population size means that over 4,600 people are living with HIV in prison in Ukraine alone.

While estimation of population size is less problematic than for other populations (as population sizes come from official prison statistics), there are questions of the robustness of epidemiological data, which may not be collected on a regular basis, or may exclude certain prisons serving sub-groups such as female prisoners.

Transgender People

No PSE or prevalence data were available for TG in any of the countries assessed. Until recently, TG have often been considered a subpopulation of (or indeed the same population as) MSM, and therefore much of the information on this population remains integrated in MSM data. While major international donors and technical partners conflated these populations until recent years, they have now recognized them as distinct groups with differing needs and risk factors, and in order to respond to the public health needs of each population, countries must follow suit. Without a clear understanding of the size and HIV risk for TG as a distinct population, it is impossible to plan and resource programming at an appropriate scale. Until this is done, TG will remain extremely under-recognized and under-served by programs. Kyrgyzstan and



Ukraine should be commended for moving towards recognition of this population's unique needs. While all other countries assessed (and indeed countries across the region) will need to follow behind in order to fully meet population needs related to the HIV epidemic.

ANALYSIS: DO WE KNOW WHAT WE NEED TO KNOW ABOUT KEY POPULATIONS IN EECA?

Understanding the size, context of risk and epidemiology of key populations is critical for appropriate design, implementation and monitoring of services. Given the issues presented above, it should be noted that all further findings of these assessments should be viewed with caution. Where population size estimates may still be conservative because of larger social constructs and pressure which dissuade individuals from identifying as KP, it is not possible to accurately assess whether services are actually reaching the recommended levels of coverage. Underestimates of population size will produce artificially inflated statistics on service reach and may give the impression of coverage at epidemiologically significant levels (e.g. 90-90-90), when in reality a significant, hidden portion of the population remains under-serviced.

Critical elements for addressing this consistent underestimate of population size noted in several of the countries surveyed here is to meaningfully engage key populations in the design and implementation of surveys, and to continue to seek avenues of sampling access to harder-to-reach populations which may be excluded by current methods, including Respondent Driven Sampling (RDS) (Simic et al, 2006; McCreesh et al, 2012). Emerging methods that combine RDS with information and communication technologies, may help to overcome some of the balkanized effects that limit the accuracy of RDS in some KP (Arayasirikul, 2012). If countries in the region do not continue to seek to improve population size estimates, population under-estimation will be a self-reinforcing problem, which keeps the hardest-to-reach and most-at-risk segments of populations hidden and without access to programming or epidemiological surveillance.

Beyond reliability of PSE, it is also necessary to recognize some of the descriptive elements which are lost in quantifying population size. Specifically, gender and sex are often poorly controlled or poorly described when PSE statistics are developed and reported. For PWID, samples may be only men who inject drugs (a fact which may or may not be disclosed), or samples of women may be extremely limited and therefore subject to nonrepresentation. The SW PSE in many countries only include women in sampling, which excludes quantification of male SW populations.

Lack of sensitivity to gender and sex also underlies the lack of recognition of TG as a distinct population, as there is often an assumption that trans women can either be served as biologically male clients of MSM programming, or that their needs will be met through programming designed for female sex workers. Both assumptions are harmful to TG and program design (followed by implementation) must evolve beyond them.

Additionally, PSE often give the appearance of clean lines between populations, when there may be significant overlap between personal characteristics and behaviors associated with multiple KP. For instance, one individual may 'belong' to multiple key populations, e.g. a gay man may inject drugs and



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occasionally sell or trade sex. This intersectionality of risk factors is something that varies significantly by context, and therefore PSE must always be used alongside supplementary, contextual data in order to appropriately contribute to program design and implementation.



PART II: DESIGN AND DOCUMENTATION OF SERVICE PACKAGES

KEY POINTS

- National Strategic Plans (or equivalent) were available in all countries included in this assessment
- Only Armenia and Azerbaijan had no population-specific packages designed
- All countries identify PWID, MSM and either SW or FSW as key populations
- No countries identify TG as a key population
- Most packages include most of the recommended health sector interventions; however, critical enablers are insufficiently included in the design of all countries, and are entirely absent in some

For all countries assessed, consultants were able to assess the current national strategic plans, action plans, outlines of state-provided HIV services or national programs. Package design is assessed below based on key national reference documents, as detailed in Table 4. Azerbaijan and Armenia are the only countries which do not have a national reference document which includes packages designed for any of the five key populations addressed in this assessment exercise (despite both countries identifying those populations as key populations within the HIV epidemic).¹⁹ It should be noted that this is a sign of success in itself. Most countries in the region had no defined packages of services for key populations five or seven years ago. With most countries moving to include such packages in key national documents – rather than including them only in Global Fund funding requests – it is likely that these services will be seen as key activities to be continued as countries approach transition from external donor support. All assessment findings for the country are based on the package of services described in its latest HIV program review.

Two countries had national strategic plans which had lapsed: Uzbekistan and BiH. Uzbekistan has a new, one-year national plan that was used in conjunction with the previous national strategic plan to inform this assessment. In the case of BiH (which had a desk review only) the assessment was based on the previous national strategic plan, though it is not known to what degree this reflects the current state of services.

Table 4 below summarizes the key populations identified in national reference documents where packages are documented.

¹⁹ Armenia includes design for a package of services only for migrants; none of the key populations in this assessment are included in Armenia's package designs.

Table 4. Key Populations Identified in Countries Assessed

Country	Key Populations Identified in Nationally Endorsed HIV Strategies/Plans	Document(s) Defining Service Packages for Key Populations
Armenia	Migrants ²⁰ , PWID, MSM, FSW, prisoners ²¹	National Program on HIV/AIDS Prevention in the Republic of Armenia 2017-2021.
Azerbaijan*	PWID, FSW, MSM, prisoners	No national document available at the time of the desk review; Services being provided in Azerbaijan as of 2014, according to the Review of the HIV Programme.
Belarus	PWID, MSM, FSW, prisoners	Belarus National HIV/AIDS Prophylactic Program for 2016-2020.
Bosnia*	MSM, FSW, PWID, prisoners	Strategy to respond to HIV and AIDS in Bosnia and Herzegovina 2011 – 2016 is to ensure the universal approach towards prevention, treatment, care and social support; Phase II of the Global Fund funded Round 9 HIV Program in BiH (2013 – 2015).
Georgia	PWID, MSM, FSW, TG ²² , prisoners	The Georgian National HIV/AIDS Strategic Plan for 2016-2018.
Kazakhstan*	PWID, MSM, FSW, prisoners	Comprehensive plan on HIV prevention in Republic of Kazakhstan for 2014 – 2020 and Concept on development of the Service on HIV prevention and response in Kazakhstan for 2016 – 2020.
Kosovo	MSM, PWID, FSW, prisoners, at-risk youth ²³	National HIV/AIDS Strategic Action Plan Kosovo 2018-2020.
Kyrgyz Republic	PWID, MSM, SW, TG ²⁴ , and prisoners	The Government Program to Overcome HIV Infection in the Kyrgyz Republic for 2017-2021.
Moldova	PWID, MSM, FSW, prisoners	National Program of Prevention and Control of HIV/AIDS and STIs for 2016-2020.
Tajikistan*	PWID, SW, prisoners, MSM ²⁵	National HIV program 2017 – 2020 - Areas of strategic activities.

²⁰ Migrants and services tailored to them were not included in the scope of these assessments.

²¹ Prisoners are included as a vulnerable population.

²² Service package outlined is combined with FSW.

²³ Youth and services tailored to them were not included in the scope of these assessments.

²⁴ Service package outlined is combined with MSM.

²⁵ No separate service package is defined for MSM, despite being identified as a key population.



Ukraine	PWID and partners, MSM, SW and clients, prisoners ²⁶	National Targeted Social Program to Combat HIV/AIDS for 2014-2018.
Uzbekistan	PWID, MSM, FSW	Strategic Program to Control HIV Infection in the Republic of Uzbekistan 2013-2017.

*Desk-review only country

Methods used to develop the national KP service packages varied across the region. In Kazakhstan, the Kyrgyz Republic and Tajikistan, much of the work was carried out under a USAID-funded program (Quality Health Care in Central Asia) and included facilitated meetings of government staff and KP NGOs to discuss potential inclusion of various services. A similar process was used in Moldova. The Ministry of Health took the major role in designing service packages in Belarus, Uzbekistan and Kosovo. In Georgia and Ukraine, there was evidence of the inclusion of representatives of key populations either in the initial design of service packages or in later amendments to the packages.

People Who Inject Drugs

All of the assessed countries specify PWID as a key population in their national package design document. All include condom distribution as a core prevention intervention, though only three countries specify that lubricant be available as part of condom programming.

All countries also include some form of behavioral intervention, including information, education and communication (IEC) materials and/or peer education or counselling. However, these interventions are usually poorly defined in the package design, and do not correspond to any standards or description of the appropriate type and quality of services to be delivered. In order to ensure that these interventions are of sufficient quality, it is advisable to develop standards to guide these services. In addition, focus group participants in several countries stated that the type and variety of printed materials did not meet their needs: for example, the same pamphlet is often provided each time a client visits a needle-syringe program (NSP). Consequently, many of these materials are discarded.

All countries include at least basic harm reduction interventions (needles, syringes, and other injecting equipment and commodities) as part of their package. Five of the twelve countries include overdose prevention and treatment programming (including distribution of naloxone). Opioid substitution treatment (OST) is included as a harm reduction intervention in 11 of the countries, with Kazakhstan the exception, where OST is available, but it is not listed in the PWID service package.

All countries except Kazakhstan include access to rapid HIV testing in their package design; Georgia and Belarus further include testing of sexual partners of PWID. Ten of the twelve countries include HIV treatment and care in their package of services for PWID, with only Kazakhstan and Tajikistan not including this intervention. While there was no evidence that PWID are being systematically excluded from HIV services available to the general public, findings (presented below in Part III) indicate that, in

²⁶ Prisoners are included as a vulnerable population.



environments of criminalization and discrimination, PWID do not currently access these services at levels sufficient to meet 90-90-90 targets. International experience shows that tailoring services to PWID can increase their engagement and retention in care (Wolfe, 2010). In order to assure that services are effectively tailored and supported with appropriate resources, it is essential that they are specified in package design.

Management of related comorbidities and health issues was relatively rarely addressed. Testing and treatment for sexually transmitted infections (STI) (nine countries), TB (five countries) and hepatitis C virus (HCV; 3 countries) were the most commonly-included interventions, while only two countries made any provision for mental health support. Only two countries of the twelve included reproductive health service access for women who inject drugs. Notably, as shown in greater detail in Table 5 below, there is little overlap in the countries which offer these complementary interventions. This may indicate that countries are well attuned to their epidemics and have chosen to differentiate their packages to meet population needs; however, given inconsistencies in inclusion of even core elements in many countries, this may also indicate that countries do not see these services as central to preventing HIV in PWID.

Table 5. Comparison of national packages of HIV Services for PWID with the WHO Consolidated Guidelines for Key Populations

PWID	
WHO Guidance	Summary of Findings for Twelve Countries
1. Comprehensive condom and lubricant programming	All countries explicitly stated condom provision is part of their national package of services for PWID. Uzbekistan also states that female condoms are part of their program, and Georgia includes condom provision to PWID partners as well. Moldova, Ukraine and Bosnia are the only countries in which the national document specifically includes lubricant as part of the condom program for PWID.
2. Harm reduction interventions for substance use (in particular, needle and syringe programs (NSP) and opioid substitution therapy (OST))	<p>The majority of the countries selected for this project include the following basic harm reduction package for PWID: provision of needles and syringes, provision of other injection equipment (such as alcohol swabs and clean water), and referral and provision of OST. The only country that does not explicitly outline the provision of needles and syringes and other safe injection equipment free of charge is Kazakhstan, which outlines the purchase of needles and syringes.</p> <p>Georgia and Kazakhstan are the only countries in which OST is not integrated into their harm reduction package; however, Kazakhstan has implemented a pilot program, and Georgia has a well-established OST program.</p> <p>Naloxone and overdose prevention education is explicitly stated as part of the harm reduction program for PWID only in Uzbekistan, Moldova, Kyrgyz Republic, Georgia and Tajikistan.</p>

3. Behavioral interventions	All countries explicitly state that they distribute some form of IEC materials (in the form of a booklet or brochure) to PWID. This often times includes peer counselling and BCC.
4. HIV testing and counselling (HTC)	All countries, with the exception of Kazakhstan, outline the provision of free, rapid HIV testing for PWID. Georgia and Belarus also explicitly included HIV testing for partners of PWID. Kazakhstan included in their design that rapid HIV tests are available for purchase, but that there is a pilot project of non-governmental (NGO)-based HIV testing of PWID and their partners.
5. HIV treatment and care	All countries with the exception of Kazakhstan and Tajikistan explicitly state that HIV positive PWID are referred and linked to HIV treatment. In the national plans reviewed, Kazakhstan and Tajikistan do not provide any information about referral or linkage to HIV treatment for PWID; however, the funding request for Kazakhstan states that PWID will have “access to ART”.
6. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions	Few countries have outlined services for PWID pertaining to hepatitis, TB, or mental health conditions. Only Georgia, Moldova and Ukraine explicitly outlined any services related to HCV, including testing and referral to treatment. All but Kosovo, Kyrgyz Republic, Kazakhstan, Azerbaijan and Bosnia outlined TB services, such as referral to testing, treatment, and care for PWID. Only Kosovo and Belarus outlined any services for mental health conditions, including access and referral to a psychologist or social worker.
7. Sexual and reproductive health interventions	All countries, with the exception of Kazakhstan, Azerbaijan, and Ukraine explicitly outline the provision of or the referral to STI testing and treatment for PWID. Moldova and Bosnia also outline reproductive health services specifically provided to women who inject drugs.
8. Supportive laws and policies	Four countries specifically address law and policy improvements in their national reference documents: Georgia specifies legal aid for PWID. Kosovo pledges legal assistance for “those in need”, the Kyrgyz Republic includes activities related to aligning national legislation with human rights and eliminating discriminatory law and policy; and Moldova includes activities to reduce barriers to services by supporting strategic court cases. Four countries specify law and policy interventions for PLHIV, but not specifically for PWID: BiH, Tajikistan, Ukraine and Uzbekistan. Armenia, Azerbaijan, Belarus and Kazakhstan do not include any provisions for this area.
9. Addressing stigma and discrimination	Five countries specifically address stigma and discrimination: Azerbaijan, Belarus, Kosovo, Kyrgyzstan and Ukraine. Five countries include provision for reducing stigma and discrimination for PLHIV/related to HIV, but not for PWID/related to injection drug use: Armenia, BiH, Georgia, Tajikistan, and Uzbekistan. Moldova includes general principles in its National Strategic Plan, which include non-discrimination and equal access; however, no specific provisions are made for activities related to reduction of stigma and

	discrimination. Kazakhstan does not explicitly include stigma and discrimination mitigating investments as part of its package.
10. Community empowerment	Community empowerment is included in four countries: Azerbaijan, Kosovo, the Kyrgyz Republic and Moldova. One country, Tajikistan, includes community empowerment in its National Strategic Plan for PLHIV only, but not specifically for PLHIV from KP, nor for KP who are not HIV+. The remaining seven countries (Armenia, Belarus, BiH, Georgia, Kazakhstan, Ukraine and Uzbekistan) do not include community empowerment explicitly in their National Strategic Plans.
11. Addressing violence	None of the 12 countries assessed included any explicit interventions to mitigate violence, outside of those which may be contained in the law and policy category (e.g. to reduce state-sponsored or law enforcement-related violence) in their national reference documents.

In conclusion, the level of variability in PWID package design, while not extensive, is a matter of concern. Each country must be free to adapt international guidelines to its own circumstances, but there is little evidence that decisions to include or exclude services in these packages are based on epidemiological or other salient factors. In most countries there is at least some involvement of harm reduction NGOs in the design of service packages, but few countries seem to have an organized process by which the opinions of PWID themselves were sought about the most needed services.

Men Who Have Sex with Men

All countries include MSM as a key population in their country, and all but Tajikistan have developed a specific package of services to target MSM. Therefore, for the purpose of the analysis here, the total number of countries considered for MSM package assessment is eleven.

All packages include condoms as a primary prevention intervention, and unlike for other key populations, lubricants are also universally included in MSM packages. Behavioral interventions are in the design of nine out of the eleven countries, with IEC material distribution being central, but some countries including peer counselling or other behavior change communication. As with PWID, standards for what defines behavioral intervention coverage and quality are needed to ensure that funds invested in these interventions are being used effectively and measurably. Also, as above, MSM focus group participants found the type and variety of printed information provided to be generally unsatisfactory.

Testing for HIV (10 countries) and ART (eight countries) are generally included for MSM. The common exception is Kazakhstan, which includes neither. Kazakhstan and BiH (which is among the countries which does not explicitly include HIV treatment in their package) are also the only two countries which do not include STI testing as part of their package; about half of all countries also include treatment of STIs. Referrals for comorbidities were relatively rare, with half of the countries including TB referrals, only three including HCV referrals and two including mental health services.



Table 6. Comparison of national packages of HIV Services for MSM with the WHO Consolidated Guidelines for Key Populations

MSM	
WHO Guidance	Summary of Findings for Eleven Countries
1. Comprehensive condom and lubricant programming	All countries include the provision of condoms and lubricants for MSM within the design of their HIV service package.
2. Behavioral interventions	All countries except Azerbaijan and BiH explicitly state that they distribute some form of IEC materials (in the form of a booklet or brochure) to MSM. This often times includes peer counselling and BCC.
3. HIV testing and counselling (HTC)	All countries except Kazakhstan include referral to or provision of HIV counselling and testing.
4. HIV treatment and care	All countries except Azerbaijan, BiH and Kazakhstan, have included referral to HIV treatment.
5. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions	Only the Kyrgyz Republic, Moldova, and Georgia have explicitly stated referral to or provision of HCV testing and treatment as part of the package of services for MSM. Only half of the countries included referral to or provision of TB testing and treatment as part of the package. Only two countries (Kyrgyz Republic and Kosovo) included mental health services (such as referral or access to a psychologist or social worker).
6. Sexual health interventions	All countries except Kazakhstan and BiH include the provision of or referral to STI testing as part of their HIV package of service for MSM. About half of the countries also explicitly include provision of or referral to STI treatment.
8.Supportive laws and policies	Four countries specifically address law and policy improvements in their national reference documents: Georgia specifies legal aid for MSM. Kosovo pledges legal assistance for “those in need”, the Kyrgyz Republic includes activities related to aligning national legislation with human rights and eliminating discriminatory law and policy; and Moldova includes activities to reduce barriers to services by supporting strategic court cases. Four countries specify law and policy interventions for PLHIV, but not specifically for MSM: BiH, Tajikistan, Ukraine and Uzbekistan. Armenia, Azerbaijan, Belarus and Kazakhstan do not include any provisions for this area.
9. Addressing stigma and discrimination	Five countries specifically address stigma and discrimination: Azerbaijan, Belarus, Kosovo, Kyrgyzstan, and Ukraine. Five countries include provision for reducing stigma and discrimination for PLHIV/related to HIV, but not for MSM-specific issues: Armenia, BiH, Georgia, Tajikistan and Uzbekistan. Moldova includes general principles in its National Strategic Plan, which include non-discrimination and equal access; however, no specific provisions are made for

	activities related to reduction of stigma and discrimination. Kazakhstan does not explicitly include stigma and discrimination mitigating investments as part of its package.
10. Community empowerment	Community empowerment is included in four countries: Azerbaijan, Kosovo, the Kyrgyz Republic, and Moldova. One country, Tajikistan, includes community empowerment in its National Strategic Plan for PLHIV only, but not specifically for PLHIV from KP, nor for KP who are not HIV+. The remaining seven countries (Armenia, Belarus, BiH, Georgia, Kazakhstan, Ukraine and Uzbekistan) do not include community empowerment explicitly in their National Strategic Plans.
11. Addressing violence	None of the 12 countries assessed included any explicit interventions to mitigate violence, outside of those that may be contained in the law and policy category (e.g. to reduce state-sponsored or law enforcement-related violence) in their national reference documents.

Overall, while the core elements of prevention for MSM (condoms and lubricants) are more universally accessible, design of a full package of services in line with WHO standards appears to have received less commitment for MSM populations than for PWID. Critical enablers, as for PWID, are significantly lacking in designs.

Sex Workers

All countries assessed have identified sex workers as a key population in their national plans and designated a package of services for this population. While some countries specify female sex workers and others do not, it does not appear that any country is explicitly including male sex workers when designing packages. The assessment below considers primarily female sex workers (FSW).

As with PWID, all countries except Kazakhstan include condoms as part of their design for SW, and just over half include lubricant.

Behavioral interventions are also included in all twelve countries, and the range of services included is broader and generally provided in greater detail, signaling that behavioral interventions may be valued more highly for or by sex workers than for other populations.

As with MSM, most countries include HIV testing (ten countries) and treatment (nine countries); common exceptions for both interventions were Kazakhstan and Tajikistan.

Testing and treatment for STIs (ten countries) and TB (seven countries) were relatively commonly included. Only four countries include access to HCV testing and treatment, while two countries offer mental health services, and a different two include case management services for FSW. Moldova is unique in including full access to reproductive health services, while Georgia includes screening and response for gender-based violence.



Table 7. Comparison of national packages of HIV Services for sex workers with elements in the WHO Consolidated Guidelines for Key Populations

SW	
WHO Guidance	Summary of Findings for Twelve Countries
1. Comprehensive condom and lubricant programming	All countries except Kazakhstan include provision of and access to condoms. However, lubricants were not included in 5 (Armenia, Kosovo, Uzbekistan, Azerbaijan and Bosnia) of the 11 countries that provide condoms.
2. Behavioral interventions	All countries include behavioral interventions, including: publication and distribution of IEC materials, peer education and counselling, education sessions and trainings, and implementation of behavioral studies to better understand risk factors among this key population.
3. HIV testing and counselling (HTC)	All countries, with the exception of Kazakhstan and Tajikistan, include referral to and/or provision of HIV testing and counselling in their package of service for FSW.
4. HIV treatment and care	All countries except BiH, Kazakhstan and Tajikistan include referral to HIV treatment and care as part of the FSW package of services.
5. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions	Only Georgia, Kosovo, Moldova and Kyrgyz Republic include provision of or referrals to hepatitis testing and treatment, and only Moldova and Kyrgyz Republic include any kind of mental health service, including access to a mental health professional. More countries include TB services in their package of services, including: Georgia, Uzbekistan, Moldova, Kyrgyz Republic, Armenia, Belarus and Ukraine. Ukraine and Belarus are the only countries to specify case management services for FSW.
6. Sexual and reproductive health interventions	Ten out of 12 countries include providing access or referrals to STI testing and treatment; Kazakhstan and Belarus provide no information on STIs, so they appear to be exceptions. The only country that included reproductive services, access to safe abortion, and contraception in their design of services was Moldova. Georgia also included identification of and services for FSW experiencing gender-based violence.
8. Supportive laws and policies	Three countries specifically address law and policy improvements in their national reference documents: Kosovo pledges legal assistance for “those in need”, the Kyrgyz Republic includes activities related to aligning national legislation with human rights and eliminating discriminatory law and policy; and Moldova includes activities to reduce barriers to services by supporting strategic court cases. Five countries specify law and policy interventions for PLHIV, but not specifically for SW: BiH, Georgia, Tajikistan, Ukraine and Uzbekistan. Armenia, Azerbaijan, Belarus and Kazakhstan do not include any provisions for this area.



9. Addressing stigma and discrimination	Five countries specifically address stigma and discrimination: Azerbaijan, Belarus, Kosovo, Kyrgyzstan, and Ukraine. Five countries include provision for reducing stigma and discrimination for PLHIV/related to HIV, but not for SW-specific issues: Armenia, BiH, Georgia, Tajikistan and Uzbekistan. Moldova includes general principles in its National Strategic Plan, which include non-discrimination and equal access; however, no specific provisions are made for activities related to reduction of stigma and discrimination. Kazakhstan does not explicitly include stigma and discrimination mitigating investments as part of its package.
10. Community empowerment	Community empowerment is included in four countries: Azerbaijan, Kosovo, the Kyrgyz Republic and Moldova. One country, Tajikistan, includes community empowerment in its National Strategic Plan for PLHIV only, but not specifically for PLHIV from KP, nor for KP who are not HIV+. The remaining seven countries (Armenia, Belarus, BiH, Georgia, Kazakhstan, Ukraine and Uzbekistan) do not include community empowerment explicitly in their National Strategic Plans.
11. Addressing violence	None of the 12 countries assessed included any explicit interventions to mitigate violence, outside of those which may be contained in the law and policy category (e.g. to reduce state-sponsored or law enforcement-related violence) in their national reference documents.

Prisoners

Prisoners are included as a key or vulnerable population in eleven of the twelve countries assessed.²⁷ Uzbekistan is the exception. While it does not recognize prisoners as a key or vulnerable population, it does include some services for prisoners in its national strategic plan, as discussed further below. In addition, while Moldova identifies prisoners as a key population, it does not have a designated package to serve this population, and instead appears to provide prevention services which respond to different risk factors experienced by prisoners, which overlap with other key populations (e.g. injecting drug use, male-male sex).

Eight of the twelve countries include condom distribution in prison, though none includes lubricant. Only three countries include needle and syringe exchange, while seven include OST in the prison setting. Behavioral interventions are common in package designs, with three countries specifying distribution of IEC, three additional countries including counselling of some sort, and one country including both.

HIV testing of prisoners is relatively widely included, with ten countries including this intervention, and Tajikistan and Kosovo noting that scale-up of testing programs is a priority. However, only around half of the countries assessed include HIV treatment in their package of services for prisoners. This is particularly concerning because, unlike other key populations who may have the ability to access HIV testing and treatment which is available to the general population, prisoners only have access to what is made available in their closed setting.

²⁷ Armenia and Ukraine include prisoners as a vulnerable population, distinct from a key population.



Half of the twelve countries include STI testing and treatment, and five include TB testing and treatment. Only three include HCV testing and treatment, with one additional country providing HCV prevention only.

Table 8. Comparison of national packages of HIV Services for prisoners with the WHO Consolidated Guidelines for Key Populations

Prisoners	
WHO Guidance	Summary of findings for eleven countries
1. Comprehensive condom and lubricant programming	All countries except Uzbekistan, Kazakhstan, Moldova and Belarus provide condoms free of charge for prisoners. Kazakhstan does have condoms available for purchase within prisons. None of the countries included lubricant in their design of the HIV package of services for prisoners.
2. Harm reduction interventions for substance use (in particular, needle and syringe programs and opioid substitution therapy)	Only the Kyrgyz Republic, and Tajikistan include provision of needles and syringes in prisons. OST is included in Armenia, BiH, Georgia, Kazakhstan (pilot program), Kosovo, the Kyrgyz Republic, Moldova and Tajikistan. Ukraine does not include provision of needles and syringes or OST. However, it does include disinfectants and PEP for prisoners.
3. Behavioral interventions	The following countries include at least one behavioral intervention for prisoners: Bosnia (IEC and peer counselling), Georgia (BCC and counselling), Kazakhstan (IEC), Kyrgyz Republic (safe behavior practices), Kosovo (IEC), Uzbekistan (IEC) and Ukraine (educational counselling). Tajikistan does not provide a behavioral intervention, but includes conducting a study on HIV knowledge, attitude, and behavior in prisons.
4. HIV testing and counseling (HTC)	Testing and counselling services for HIV are available in 10 countries. The remaining countries, Kosovo and Tajikistan, specifically included in their design that they would be expanding these services within prisons.
5. HIV treatment and care	HIV treatment within prisons is included in the design of HIV service packages for prisoners in 7 countries. Two more countries also include the referral to HIV treatment (Kosovo and Tajikistan).
6. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions	It should be noted that TB services are provided for all prisoners in all countries, regardless of whether they are specified as part of the service package available for prisoners as a key population. Testing and treatment for TB is explicitly included in the prisoner package of services in Uzbekistan, Georgia, Kyrgyz Republic, Armenia and Ukraine. Hepatitis testing and treatment is included in Uzbekistan, Georgia and Kyrgyz Republic, though it

	<p>is worth noting that the Kosovo package for prisoners includes hepatitis prevention education. Mental health services of any kind are not included in any of the HIV packages of services for prisoners.</p>
7. Sexual and reproductive health interventions	<p>STI testing and treatment is included in the packages of services for prisoners in Uzbekistan, Georgia, Kosovo, the Kyrgyz Republic, Ukraine, and Tajikistan. Reproductive health interventions are not outlined in any of the packages for prisoners; however, Georgia does include programs to prevent physical and sexual violence for prisoners.</p>
8. Supportive laws and policies	<p>Four countries specifically address law and policy improvements in their national reference documents. Georgia specifies legal aid for PWID, Kosovo pledges legal assistance for “those in need”, the Kyrgyz Republic includes activities related to aligning national legislation with human rights and eliminating discriminatory law and policy; and Moldova includes activities to reduce barriers to services by supporting strategic court cases. Four countries specify law and policy interventions for PLHIV, but not specifically for prisoners: BiH, Tajikistan, Ukraine and Uzbekistan. Armenia, Azerbaijan, Belarus and Kazakhstan do not include any provisions for this area.</p>
9. Addressing stigma and discrimination	<p>Five countries specifically address stigma and discrimination: Azerbaijan, Belarus, Kosovo, Kyrgyzstan and Ukraine. Five countries include provision for reducing stigma and discrimination for PLHIV/related to HIV, but not for prisoner-specific issues: Armenia, BiH, Georgia, Tajikistan and Uzbekistan. Moldova includes general principles in its National Strategic Plan, which include non-discrimination and equal access; however, no specific provisions are made for activities related to reduction of stigma and discrimination. Kazakhstan does not explicitly include stigma and discrimination mitigating investments as part of its package.</p>
10. Community empowerment	<p>Community empowerment is included in four countries: Azerbaijan, Kosovo, the Kyrgyz Republic, and Moldova. One country, Tajikistan, includes community empowerment in its National Strategic Plan for PLHIV only, but not specifically for PLHIV from KP, nor for KP who are not HIV+. The remaining seven countries (Armenia, Belarus, BiH, Georgia, Kazakhstan, Ukraine and Uzbekistan) do not include community empowerment explicitly in their National Strategic Plans.</p>
11. Addressing violence	<p>None of the 12 countries assessed included any explicit interventions to mitigate violence, outside of those which may</p>

	be contained in the law and policy category (e.g. to reduce state-sponsored or law enforcement-related violence) in their national reference documents.
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As in most regions, design of prisons programming varies widely between countries.

Transgender People

Transgender people are not identified as a separate key population in any of the countries assessed, and therefore there are no service packages that have been designed around their needs. The two exceptions to this are Kyrgyz Republic and Georgia. However, in the former, the TG package is identical to the MSM package, and in the latter the TG package is identical to the FSW package. Therefore, this report does not further assess the design of TG packages of services.

ANALYSIS: ARE PACKAGE DESIGNS MEETING INTERNATIONAL STANDARDS?

Most of the assessed countries have taken the opportunity to formally recognize key populations in their national plans and strategies and have acknowledged the importance of servicing key populations by designing tailored packages based on WHO guidance.

However, there are some notable deviations from WHO standards. The lack of universal inclusion of lubricants for all populations except MSM signal a need for greater consideration of the WHO standards around condom programming, and the science underlying it.

The absence of biomedical prevention interventions is also clear: post-exposure prophylaxis (PEP) is included in only three packages across all assessed countries (prisoners for Ukraine; PWID and FSW in Moldova). Pre-exposure prophylaxis (PrEP) is not yet included in the MSM or FSW package for any population in any of the twelve countries, though this may be due primarily to timing, as most national reference documents were drafted before the 2016 recommendation to include PrEP for all KP. While these technologies have to be considered alongside population context and need, and balanced with financial restraints, it is important that they be considered for use as evidence-based interventions when they meet specific key population needs.

While behavioral interventions are universally included in packages in some form, there is a notable lack of detailed standards for what these interventions include, how they are delivered, and what is considered sufficient coverage.

Other complementary services, addressing comorbidities and related health needs, need more careful consideration in most countries. In particular, given the very large epidemics of drug-resistant TB in the region, it is remarkable how few countries have included TB testing and treatment in KP service packages. While services for TB, HCV, STI and other reproductive health issues may be available in the country in general, and some key populations may be able to access these services in the same manner as the general population, in environments of stigma, discrimination and violence, it is often necessary to tailor these services to be more accessible to key populations and to state explicitly in relevant



national reference documents (e.g. the National HIV Strategy) that key populations have the right to access them. Additionally, in settings where these services are under-resourced for the general population, careful consideration of real need relative to population size is critical to allow accurate resource planning.

The most notable gap is the inclusion of critical enablers as explicit elements of service packages. It appears that these elements have been interpreted in many settings as guiding principles or aspirations, but these do not translate into investments in or implementation of programming.

The availability of service access for key populations is particularly important for the core interventions needed to reach 90-90-90: HIV testing and treatment. It is concerning that these are not explicitly included in packages for MSM, FSW and prisoners in some settings. The availability of testing models designed specifically to reach harder to reach populations (e.g. rapid testing, in various venues and through different outreach methods) is highly variable, and warrants careful planning in the design phase, according to population size and distribution, as well as contextual information in the enabling environment.

It is also worth noting that key population package design is built around defined population characteristics, assuming that individuals who associate with one KP has a single identity or risk profile. However, the lived experience of individuals is often quite different, as individuals may belong to multiple risk groups and have overlapping risk factors. At the same time, engaging in multiple risk factors does not necessarily correlate to identifying as a member of *any* key population, nor to engaging as part of a community of others with similar risk factors, e.g. a man who has sex with other men but also has sex with women may not identify himself as gay or even as MSM. Similarly, a woman who engages in transactional sex for food while her husband is working as a migrant laborer abroad may not consider herself a sex worker. Therefore, while standard package designs are targeted towards individuals who belong to a standard profile, they may fail to accommodate the needs of those with overlapping identities or who do not consider themselves to be associated with key populations at all.

RECOMMENDATIONS: DESIGN OF SERVICE PACKAGES FOR KEY POPULATIONS

1. Defined packages of services should be designed and specified in national reference documents for all key populations. For those populations that do not yet have a defined service package, the involvement of members of that key population should be seen as integral to the package design process.
2. While packages should specify services to be provided, they should allow for flexibility of methods of delivery (e.g. differentiation of care) for differing contexts. (See Implementation section for further discussion on this topic).
3. Considering potential resource constraints, all countries in the region require at least the basic services for each key population to be in the designed service packages. All key population packages should contain condoms and lubricants distribution (with female condoms at least included in all SW programs), and needles and syringes and OST included in at least all PWID

programs. When considering resource constraints of many transitioning countries, adequate coverage with these basic services should be prioritized for all KP in the country.

4. Needs-based services should also be included in service packages for all key populations, including the offer of PEP, PrEP, STI, TB, and hepatitis B and C services. Needs may vary from location to location, and by subgroup within each KP (e.g. by age, gender, biological sex, etc.). When operating under resource constraints and/or when looking towards transition to domestic financing, countries may consider differentiating needs-based packages to ensure investments are optimal for the population (or subgroup) being targeted.
5. All packages should explicitly consider and address as appropriate (including plans for investment and service provision) the four critical enablers. Where it is not feasible (or a long-term goal) to change law or policy on particular topics, greater investments are needed in reducing stigma and discrimination and empowering communities to find resilience in the current, suboptimal environment. For countries which are still eligible for external funding, donors should consider these critical enablers as equally worthy of investment, alongside health sector interventions.
6. Violence programming, which is not explicitly addressed any country's package currently, needs to be included. Many countries will need to start by doing assessments of the local relationship between violence and HIV risks.



PART III: IMPLEMENTATION AND SERVICE USAGE

KEY POINTS

- Data are missing for many of the HIV service interventions in the countries assessed
- Service coverage rates are generally below recommended targets, though for PWID they are approaching targets
- Changes in outreach strategies and funding environments are challenging traditional outreach approaches, leading to need for significant innovation
- Where cascade data are available, they indicate difficulties in retaining KP in care
- The enabling environment plays an important role in facilitating or inhibiting KP access to services, with stigma, discrimination and violence being noted by all key populations
- Most services cater to a relatively homogenous clientele, leaving age, gender and biological sex unaddressed

Service packages are delivered along a continuum by civil society, private and governmental providers. Prevention services are provided primarily by NGOs and CBOs, often utilizing peer educators or peer navigators to conduct outreach or drop-in in ‘hot spots’ where PWID, MSM and FSW are found in the greatest density. Services may be provided through mobile outreach (e.g. through mobile units) or at static locations (e.g. drop-in centers).

The point of intersection between government and non-government service providers tends to be either HIV testing or linkage to care. In some cases, NGOs or CBOs are able to deliver community-based rapid testing on site (either mobile or static), and conduct referrals or accompaniment to care only for those who test positive. In other environments, clients are referred or accompanied to care facilities to initiate testing for HIV. Non-governmental organization (NGO) and CBO support beyond the point of HIV diagnosis may or may not continue, depending on models employed and resource availability. Human Immunodeficiency Virus (HIV) treatment and care is then generally provided by government service providers in government facilities.

Coverage of key populations with service packages varies widely across the region as does the definitions of coverage used for reporting purposes. As noted in Table 1, the key indicator should be coverage of a key population with the defined package of services (as shown in the Design section of this report). However, this is impossible in most countries because the service package often includes ART, for which coverage figures are usually not able to be disaggregated by key population. Additionally, not all services are available in all geographies, leaving some portions of the population covered by some of the services defined in the national package, but unable to access others (e.g. PWID in sites without access to OST). Where access to a full package is not universal, this assessment found that many countries default to reporting on core prevention services (i.e. condoms, IEC, and NSP for PWID), but do not systematically track coverage by the full package of services which are



outlined in the National Strategic Plan or other national reference document. These issues are further discussed in the Monitoring section of this report.

In addition, some countries use different definitions of coverage in GAM and other reports: as shown in the tables below, some coverage estimates come from research endeavors (e.g. those done by an independent party, not the country program) and others from IBBS surveys rather than from programmatic data. Recommendations on this issue are contained in the Monitoring section of this report's recommendations.

More detailed assessment of the implementation of packages is presented below, by population.

People Who Inject Drugs

In all assessed countries, a basic package of harm reduction services (needles and syringes, safe injection supplies, and IEC materials/peer education) is being provided as designed, through outreach, including the use of mobile units, and static services (e.g. drop-in centers).

Coverage of PWID with HIV prevention programs varies among assessment countries. Among countries whose data were verified with field visits, prevention coverage ranges from 27.6% in Armenia to 65% in Ukraine. While surveys in many countries report high rates of safe injecting practice, rates remain concerningly low in Belarus and Kyrgyz Republic (46.3% and 47.5%, respectively). From focus group discussions, the largest reason for low coverage was the lack of "anonymous" services, meaning that in this region most PWID need to be registered as drug addicts to receive many of the available narcological services (except in the case of NGO-provided services), including OST, other non-OST treatment forms such as detoxification, and psychological counseling for addiction.

Outreach is the main delivery mode for many harm reduction services in EECA, and the number of clients reached per outreach worker varies considerably between countries and within some countries. For example, key informant interviews with NGO staff (conducted during this assessment) suggested that low quality of outreach services may be related to the need for each outreach worker to reach more than 200 clients per month in Armenia; more than 190 per month in Moldova; 500-750 per outreach worker per year in Ukraine [Data source: Key informant interviews in Armenia, Moldova, and Ukraine respectively].

Coverage increases have come at the cost of some prevention goods and services. For example, in Belarus, where coverage with NSP and OST was among the highest in the region, a decision was made recently to remove sterile water from the package of injection equipment provided to PWID. Key informant interviews revealed that this has resulted in increasing cases of endocarditis. In Ukraine, naloxone was distributed in many sites in the past but is no longer available, and vaccination for hepatitis B, some informational materials, nutrition support, motivational packages and support of drop-in centers have not been provided since 2015 – changes which were reported by assessment informants as the result of a shift in focus to reaching more clients, with reduced range of services.

Coverage and quality of needle-syringe distribution was much higher than for other elements of the defined service package. Most countries have data on how many needles and syringes are being provided per PWID per year, with ranges from 41 (Belarus) to 187 (Moldova) among the visited countries. Only



Tajikistan reports distribution meeting the WHO minimum recommendation of 200 per year per PWID, but this information was not validated with a country visit. Focus group participants generally rated the provision of injecting equipment as the most important and useful service provided by harm reduction agencies (WHO, 2012).

It was heartening to note that many harm reduction programs are responding to local needs by modifying the national package to ensure PWID receive the goods and services they most value. In Georgia, interviews with services (confirmed through focus group discussions) showed that regular meetings are held with clients to discuss quality of syringes and needles, need for and quality of services, and additional services needed by clients.

ARMENIA: “Many barriers and restrictions to enter the OST program exist...geographic remoteness of OST sites, confidentiality issues as the names of PWID on OST are shared with police...involvement of police in the treatment process, very low level of integration with other services...and no opportunities to develop individual treatment plans”.

Coverage of opioid substitution therapy (OST) is consistently low in assessed countries. As Table 10 displays, for countries in which data exists, even the highest coverage of 32.0% in Georgia fall on the low end of the mid-range targets recommended by WHO-recommended (20-40%) (WHO, 2012). People who inject drugs (PWID) access OST at alarmingly low rates in Azerbaijan (1.1%), Armenia (1.2%), Kosovo (2.5%), Kazakhstan (0.3%), and Moldova (1.3%). As noted in focus group discussions with PWID, challenges remain in the implementation of and access to OST for PWID in this region. Some of these challenges included:

- Availability of OST at only a few sites, often geographically distant from the areas where PWID live, and for only a few hours each day: not only does this mean that PWID have to incur substantial time and cash costs for transport, it also means that PWID are unlikely to be able to gain paid

employment due to the loss of hours each day accessing OST. People who inject drugs (PWID) also risk missing out on treatment if they cannot visit the OST dispensary between very narrow opening hours.

- Discriminatory attitudes from both healthcare workers at OST sites and in some instances, from other PWID.
- Specific barriers for women to attend OST (especially if caring for children).
- Methadone dosage issues: concern was expressed in many focus groups that doses were too low and this was particularly problematic for HIV-positive PWID on ART who felt that the interaction between ART and OST medications was not being taken into account by their doctors.
- Lack of coordination with other services: partly this was seen as an issue of convenience – having a range of HIV, TB, STI and OST services in a single place would save substantial time and money for PWID – and partly this was expressed as a concern that OST services are not always available in the event of hospitalization for other conditions.
- High levels of dropout from OST programs (cited in Georgia and Kosovo) may be symptomatic of a lack of appropriate peer support and other psycho-social support services.

- Methadone stockouts were mentioned as a problem in Kosovo.

In all countries, HIV testing rates fall well below those needed for 90% of people living with HIV to know their status. For example, among those countries that were visited, the highest programmatic data reported 56.9% coverage in Georgia and 47.0% in Ukraine; meanwhile, extremely low coverage was reported in Armenia (10.0%) and Moldova (0.7%). Some of the issues cited included:

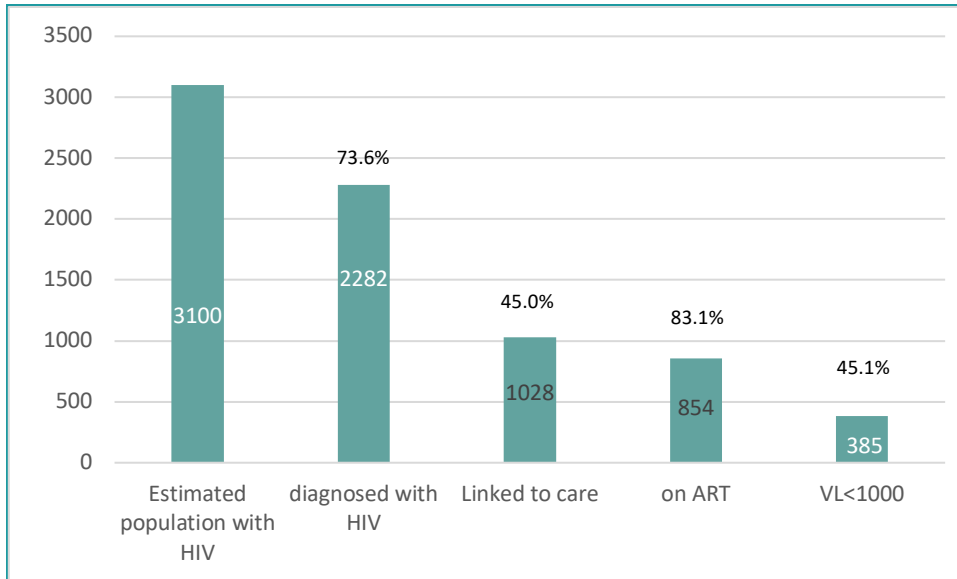
- Testing remains largely centralized in some countries (Armenia and Kosovo), and use of community-based rapid testing has become available just recently in Armenia.
- Until recently, most harm reduction programs saw HIV testing as a lower priority than education and distribution of prevention equipment. In several countries, PWID themselves stated that they did not believe HIV testing was as important as the ability to access sterile injecting equipment: an exception was in Ukraine, where FGD participants rated HIV testing as the most important service offered by harm reduction agencies.

The situation is changing in some countries. In Kyrgyz Republic, for example, during the period from October 2016 to September 2017, 8,752 people were tested via rapid testing in community-based settings in Bishkek and Osh with funding from PEPFAR, and 220 new HIV cases were found by the project (average testing yield 2.5%) with more than 90% linked to care.

Data on uptake and retention of PWID on ART are scarce, but available data from Belarus and Kyrgyz Republic paint a concerning picture, with less than 30% and 40% (respectively) of HIV-positive PWID accessing treatment. Even in Georgia, with 77.1% of PWID who know their status on ART, this is a lower rate than for MSM (84.9%) and those with HIV acquired through heterosexual transmission (86.1%). Late diagnosis remains a problem for PWID in the region: lowest CD4 cell count among all newly diagnosed PLHIV was reported among PWID (<200 CD4 cells/mm³).

The Kyrgyz Republic has been able to develop a Cascade of Care for PWID, highlighting the urgency of the situation. While Figure 2 shows that 83.1% of those linked to care are on ART, this still only represents 27.5% of the estimated population of HIV-positive PWID. The low rate of viral suppression also suggests that there may be problems with retaining PWID on ART, or that regimens being used are suboptimal to achieve suppression.

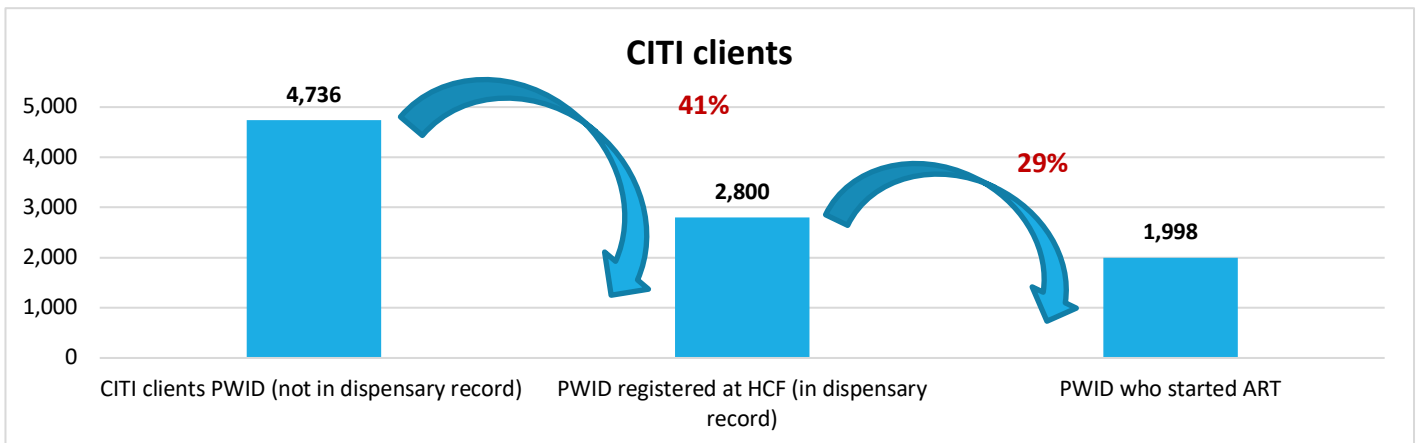
Figure 2: Continuum of care for PWID in Kyrgyz Republic, January 2017

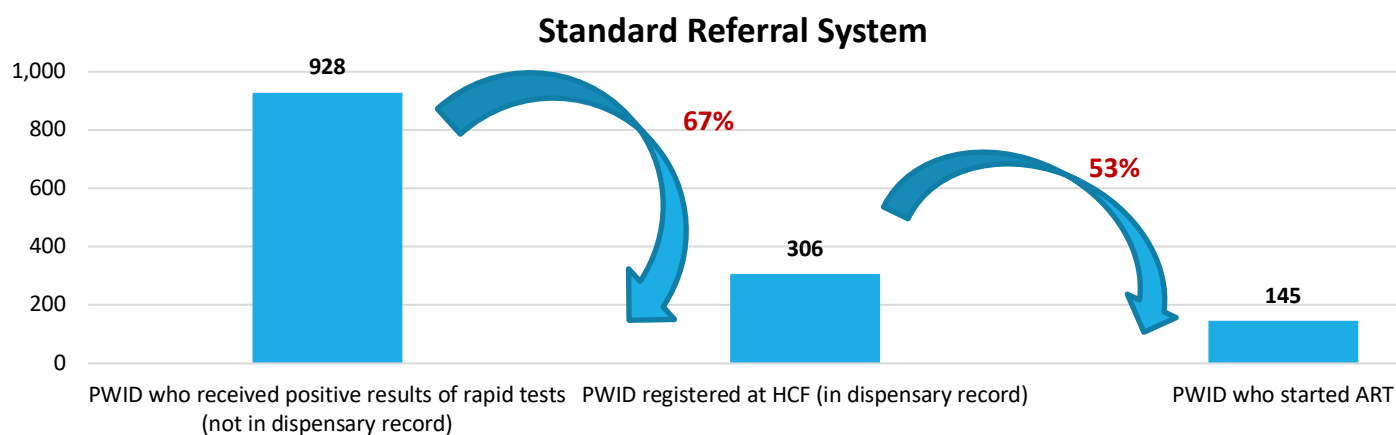


Source: Republican AIDS Centre, Kyrgyz Republic January 2017

In Ukraine, a case management approach has improved linkage to care, which results in early initiation of ART. The Community Initiated Treatment Intervention (CITI) approach has resulted in improvement of the cascade indicators among PWID, compared to the ordinary referral system (Figure 3): 92% of all PWID clients who were initiated on ART in 2017 were CITI clients.

Figure 3. Improved PWID Case Management Effect on Cascade in Ukraine





Source: Alliance for Public Health

Additionally, the need for ‘one stop shops’ for a range of services for PWID has been recognized in several countries. In order to improve service acceptability in Moldova, multidisciplinary teams provide a comprehensive package of services, including OST clinics, in Chisinau, Balti and Tiraspol, where the concentration of PWID is highest. Ukraine has 86 OST integrated care sites providing services to 67% of the total clients on OST: 31 sites are located at narcology settings, 11 sites at TB clinics, eight sites at AIDS Centers and 36 sites are located in general hospitals.

In many cases, there are interventions included in package design which are indeed being implemented, but for which no routine data are available to assess coverage. A good example is distribution of IEC materials and provision of peer education counselling. These were regularly confirmed as available by key informants and focus group participants in most countries, despite no or limited data to confirm this independent from general prevention coverage data. While these interventions are an important part of prevention services, key details on what kind of behavioral interventions and quantity delivered are lost when they are amalgamated with other prevention interventions such as condom distribution. While reporting burdens must be considered in deciding which data to collect routinely, the absence of any reliable data to describe coverage with specific services such as these can be problematic: it becomes impossible to judge whether increased or decreased investments in specific interventions are desirable to achieve improved outcomes.

Some focus group participants reported access to additional services not defined in national packages, including referrals to mental health and drug treatment services.

The enabling environment plays a major role in PWID access to services. One key concern expressed by informants in several countries is confidentiality of services. If key populations do not believe that their health information – or even the mere fact that they sought services – will be kept confidential within the health facility or the broader environment (e.g. the community or neighborhood in which they live, or within their family), this can be a significant deterrent to seeking services. Non-consensual disclosure of HIV status can lead to expulsion from family, violence (domestic or otherwise), loss of employment, and other consequences. Across key populations, informants in Ukraine reported lack of confidentiality in



medical services as an issue of great concern. In Armenia, OST clients report that their identities are regularly reported to the police, who in turn harass or extort from them. In Belarus, NGO partners expressed systemic concerns about confidentiality as the country moves toward transition to domestic financing and therefore ownership of prevention programming. If the government has access to patient databases on needle and syringe exchange, it provides them with a ready-made list of people who can be arrested for drug use.

Breaches in confidentiality can be particularly dangerous for women, who may be subject to domestic violence or loss of custody of children if drug use or HIV status is disclosed. Where women who inject drugs do access services, their service use patterns are rarely captured, because data are not gender-disaggregated. Further, during this assessment, it was challenging to find women to participate in focus groups, likely reflecting both heavy societal stigma and lack of engagement in services which are not sensitized to their gender-specific needs.

Physical safety is another key concern expressed by all PWID. Harassment by law enforcement is a long-standing concern and deterrent to accessing services. However, there are some limited signs of progress and good practice in terms of mitigating risks and creating a more enabling environment for PWID, including development of Memoranda of Understanding with police on alternatives to arrest and options for engaging PWID in care (Kosovo) and decriminalization of drug use (Moldova). In Belarus, in the city of Vitebsk, NGOs report that police suggest new spots for outreach to PWID, based on drug use patterns they have observed. Unfortunately, these practices remain the exception not the rule and significant barriers exist to understanding the size and heterogeneity of PWID populations.

There are several interventions which are included in the WHO Guidelines for packages of services for PWID which, regardless of inclusion or exclusion in national packages, did not have any data on coverage for any of the countries assessed. These interventions include:

- PrEP
- PEP
- Other harm reduction: overdose prevention and treatment (including naloxone), other treatments
- Management of ART drug interactions
- Hepatitis prevention and management of co-infections, with the exception of Georgia
- Nutrition
- Sexually transmitted infection prevention, screening and treatment
- Mental health and management of co-morbidities
- Community empowerment

Without any data on coverage for these services, it was not possible to assess the extent to which they are available in the countries assessed.

Table 9. Summary of Service Coverage for PWID

Survey/IBBS (S); GAM (G); Programmatic Data (P)²⁸; Other (O); Desk Review Only (*)

Health Sector Interventions	Armenia	Azerbaijan *	Belarus	BiH*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan*	Ukraine	Uzbekistan
Comprehensive condom and lubricant programming ²⁹	54.9% (G) ³⁰	7.7% (G) ³¹	51.1% (S) ³²	---	35.6% (G) ³³	49.8% (G) ³⁴	47.1% (Pristina) 39.6% (Prizren) (S) ³⁵	59.0% (S) ³⁶	25.9% (G) ³⁷	49.9% (O) ³⁸	43.9% (S) ³⁹	45.1% (S) ⁴⁰

²⁸ Where programmatic data is used, coverage values have been calculated using available programmatic coverage data as numerators, and nationally accepted PSE as denominators

²⁹ Percentage of people who inject drugs who report the use of a condom at last sexual intercourse

³⁰ GAM (2016)

³¹ GARPR (2014)

³² IBBS (2017)

³³ GAM (2016)

³⁴ GARPR (2015)

³⁵ IBBS (2014)

³⁶ IBBS (2016)

³⁷ GAM (2016)

³⁸ Report on the Achieved Progress in Response to HIV Epidemic (2015)

³⁹ IBBS (2017)

⁴⁰ IBBS (2015)



Assessment of HIV Service Packages for Key Populations Eastern Europe and Central Asia

Health Sector Interventions	Armenia	Azerbaijan*	Belarus	BiH*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan*	Ukraine	Uzbekistan
Coverage of HIV prevention programs among PWID	51.8% (G) ⁴¹ 27.6% (P) ⁴²	19.2% (S) ⁴³ 18.8% (P) ⁴⁴	56.8% (P) ⁴⁵	55.5% (P) ⁴⁶	61.0% (P) ⁴⁷	55.6% (P) ⁴⁸	57.4% (P) ⁴⁹	58.7% (P) ⁵⁰	41.2% (P) ⁵¹	61.3% (S) ⁵²	65.0% (P) ⁵³	63.2% (P) ⁵⁴

⁴¹ GAM (2016)

⁴² Coverage is of defined package of services in Armenia; Global Fund Program Update (2016).

⁴³ IBBS (2011)

⁴⁴ Program Data (2015)

⁴⁵ Program Update (2016)

⁴⁶ Program Data (2015)

⁴⁷ Program Update (2016)

⁴⁸ Program Data (2016)

⁴⁹ Program Update (2016)

⁵⁰ Program Data (2016)

⁵¹ Program Data (2017)

⁵² IBBS (2014)

⁵³ Program Data (2017)

⁵⁴ Program Report (2017)

Health Sector Interventions	Armenia	Azerbaijan*	Belarus	BiH*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan*	Ukraine	Uzbekistan
Harm reduction - NSP ⁵⁵	72 (G) ⁵⁶	---	41 (G) ⁵⁷	---	90.8 (G) ⁵⁸	127.9 (G) ⁵⁹	---	152.8 (G) ⁶⁰	186.2 (G) ⁶¹	214 (O) ⁶² 330 (P) ⁶³	71.3 (G) ⁶⁴	62 (G) ⁶⁵
Harm reduction - Safe injection practices ⁶⁶	97.0% (G) ⁶⁷	46.3% (G) ⁶⁸	87.9% (S) ⁶⁹	---	87.2% (S) ⁷⁰	52.6% (G) ⁷¹	83.0% (Pristina) 95.2% (Prizren)	47.5% (S) ⁷³	99.1% (S) ⁷⁴	88.9% (S)	96.6% (S) ⁷⁵	85.1% (S) ⁷⁶

⁵⁵ Needles and syringes distributed per person who injects drugs

⁵⁶ GAM (2016)

⁵⁷ GAM (2016)

⁵⁸ GAM (2016)

⁵⁹ GARPR (2015)

⁶⁰ GAM (2016)

⁶¹ GAM (2016)

⁶² Report on the Achieved Progress in Response to HIV Epidemic (2015)

⁶³ Program Data (2016)

⁶⁴ GAM (2016)

⁶⁵ GAM (2016)

⁶⁶ Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected

⁶⁷ GAM (2016)

⁶⁸ GARPR (2014)

⁶⁹ IBBS (2017)

⁷⁰ IBBS (2015)

⁷¹ GARPR (2015)

⁷³ IBBS (2016)

⁷⁴ IBBS (2017)

⁷⁵ IBBS (2017)

⁷⁶ IBBS (2015)

Health Sector Interventions	Armenia	Azerbaijan*	Belarus	BiH*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan*	Ukraine	Uzbekistan
							(S) ⁷²					
Harm reduction - OST ⁷⁷	5.3% (G) ⁷⁸ 1.2% (P) ⁷⁹	1.1% (P) ⁸⁰	4.7% (G) ⁸¹	11.3% (P) ⁸²	32.0% (G) ⁸³	0.3% (P) ⁸⁴	---	6.0% (P) ⁸⁵	3.3% (G) ⁸⁶	3.2% (P) ⁸⁷	3.2% (G) ⁸⁸	---
Harm reduction for PWID: Other drug dependence treatment ⁸⁹	---	---	---	---	---	---	---	---	---	---	---	30.0% (P) ⁹⁰

⁷² IBBS (2014)

⁷⁷ Coverage of opioid substitution therapy

⁷⁸ GAM (2016)

⁷⁹ Global Fund Program Update (2016)

⁸⁰ Program Data (2017)

⁸¹ GAM (2016)

⁸² Program Data (2016)

⁸³ IBBS (2017)

⁸⁴ Program Data (2013)

⁸⁵ Program Update (2016)

⁸⁶ GARPR (2017)

⁸⁷ Program Data (2016)

⁸⁸ GAM (2016)

⁸⁹ Percent of PWID covered by HIV prevention services and referred to drug dependence treatment

⁹⁰ Program Data (2016)

Health Sector Interventions	Armenia	Azerbaijan*	Belarus	BiH*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan*	Ukraine	Uzbekistan
Behavioral interventions ⁹¹	---	---	---	---	26.8% (S) ⁹²	---	---	---	---	---	---	---
Knowledge of HIV status ⁹³	12.0% (S) ⁹⁴	3.9% (G) ⁹⁶	16.5% (P) ⁹⁸	---	56.9% (P) ⁹⁹	60.6% (G) ¹⁰⁰	66.0% (S) ¹⁰¹	38.6% (P) ¹⁰³	5.4% (P) ¹⁰⁴	46.4% (O) ¹⁰⁵	47.0% (P) ¹⁰⁶	32.0% (S) ¹⁰⁷
	10.0% (P) ⁹⁵	20.7% (P) ⁹⁷					12.9% (P) ¹⁰²					

⁹¹ Provision of outreach and in point counseling on key topics like: HIV/AIDS, STI prevention, Healthy life and Drug dependence issues; Distribution of IEC materials

⁹² IBBS 2015

⁹³ Percentage of PWID that have received an HIV test in the past 12 months and know their results

⁹⁴ IBBS (2016)

⁹⁵ Global Fund Program Update (2016)

⁹⁶ GARPR (2014)

⁹⁷ Program Data (2016)

⁹⁸ Program Update (2016)

⁹⁹ Program Update (2016)

¹⁰⁰ GARPR (2015)

¹⁰¹ IBBS (2014)

¹⁰² Program Update (2016)

¹⁰³ Program Data (2016)

¹⁰⁴ Program Data (2016)

¹⁰⁵ Report on the Achieved Progress in Response to HIV Epidemic (2015)

¹⁰⁶ Program Data (2017)

¹⁰⁷ IBBS (2015)

Health Sector Interventions	Armenia	Azerbaijan*	Belarus	BiH*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan*	Ukraine	Uzbekistan
Community based testing and counseling ¹⁰⁸	---	---	---	---	---	---	---	22.0% (P) ¹⁰⁹	---	---	---	44.0% (P) ¹¹⁰
Linkage and enrolment in care ¹¹¹	---	---	---	---	---	---	---	45.0% (P) ¹¹²	---	---	80.0% (P) ¹¹³	---
ART coverage ¹¹⁴	---	---	25.9% (P) ¹¹⁵	---	---	---	---	37.4% (P) ¹¹⁶	---	---	79.0% (P) ¹¹⁷	---
TB Prevention and management of co-infections ¹¹⁸	---	---	---	---	---	---	---	---	---	---	31.9% (P) ¹¹⁹	5.7% (P) ¹²⁰

¹⁰⁸ Indicator not defined

¹⁰⁹ Program Data (2016)

¹¹⁰ Program Data (2016)

¹¹¹ Indicator not defined.

¹¹² Republic AIDS Center (2017)

¹¹³ Program Data (2017)

¹¹⁴ Percentage of the people living with HIV among PWID receiving antiretroviral therapy in the past 12 months

¹¹⁵ Reported by the Primary Recipient during in-country assessment (2017)

¹¹⁶ Republic AIDS Center (2017)

¹¹⁷ Program Data (2017)

¹¹⁸ PWID referred for TB diagnostics

¹¹⁹ Program Data (2017)

¹²⁰ Program Data (2016)

Men who have Sex with Men

While all countries visited during the assessment process were confirmed to be implementing prevention programs for MSM as designed, program coverage remains low, ranging from 11.2% in Belarus to 32.2% in Kyrgyz Republic.¹²¹ Survey data show highly variable rates of condom use at last sex, from 28.5% in Azerbaijan to 77.7% in Ukraine.

Condom and lubricant provision is regarded as important in all countries visited, but concerns were expressed about the quality of these items in Belarus, and about the range of condoms available in Ukraine.

Reaching MSM with any services appears to be more difficult than for other KP such as PWID and female sex workers. According to focus group participants, stigma and violence from the general community (as well as harassment and violence from police and armed forces) is common. For this reason, “we keep to ourselves”, as one participant in Kosovo put it. Finding ways into these closed networks has proved very difficult in most countries. For example, in Belarus, drop-in centers worked well in three major cities but were under-utilized in smaller population centers as MSM were afraid to be recognized attending events. Similar problems have occurred in Georgia.

Places where MSM congregate, including cruising areas, are often chosen as outreach sites but this can be problematic for clients of outreach services, who sometimes feel too much attention is being drawn to these areas from the general community by peer educators and NGO staff visiting to provide services. In Prizren in Kosovo, it was suggested by the national MSM NGO that a mobile outreach service could improve the ability of MSM in the town to receive services. However, focus group participants stated that they would not feel safe going to a mobile testing unit in Prizren due to fears that the mobile unit would eventually be recognized and targeted by members of the general community. Peer-driven interventions (PDI) were implemented in Chisinau in Moldova but, due to limited success, they will be discontinued from this year. Reaching bisexual men was uniformly described as very difficult, and most MSM NGOs had no specific services or ways of attracting MSM sex workers or transgender people.

KOSOVO: “Focus group discussion participants cited the information they are given regarding STIs and the video training sessions on HIV and STI prevention as being extremely beneficial”.

UKRAINE: “There is an increasing utilization of virtual outreach at least in the capital city. The internet provides a new pool of potential clients...”

Focus groups and key informants suggested the need for more effective internet-based outreach among MSM, particularly young MSM. Social networks like Facebook and Grindr were cited as popular venues for communication and finding sexual partners and as potential formats for outreach. At the same time, many respondents (both individuals from KP and service providers) noted the need for caution and the development of an appropriate, safe and ethical methodology for online

¹²¹ MSM programs were visited in Belarus, Georgia, Kosovo, Moldova and Ukraine



outreach. Concerns around protocols for confidentiality, transparency, and safety were raised and should be addressed in any moves towards expanding virtual outreach.

Unlike PWID programs, many MSM programs were established specifically with the goal of encouraging MSM to test for HIV and to assist or provide such testing, together with specific counselling suitable for MSM. Despite this, coverage remains low, with programmatic data ranging from 2.0% in Moldova to 21.0% in Ukraine. According to survey results, only Kazakhstan (which does not include HIV testing in its package of services for MSM) has testing rates above 50% (62.7% according to GARPR 2015); however, it should be noted that these are not programmatic data, and in other countries, programmatic data present significantly lower rates than survey data – reflecting that many MSM may opt for non-targeted testing in other facilities, where they do not need to identify as MSM. Only one country, Kyrgyz Republic, has data available for community-based testing of MSM.

Reasons for low testing rates varied by country. In Kosovo, all tests – either at the government infectious diseases facility or the head office of the MSM NGO – are conducted in Pristina: this means that all MSM must travel to the capital for every test, then wait for a result. In Ukraine, the assisted rapid test approach used by NGOs involves the client drawing a tiny amount of blood (due to government policies which prohibit NGO staff from carrying out HIV testing or any other testing): MSM in Ukraine focus groups said they hated this process and would prefer saliva testing.

KYRGZ REPUBLIC:

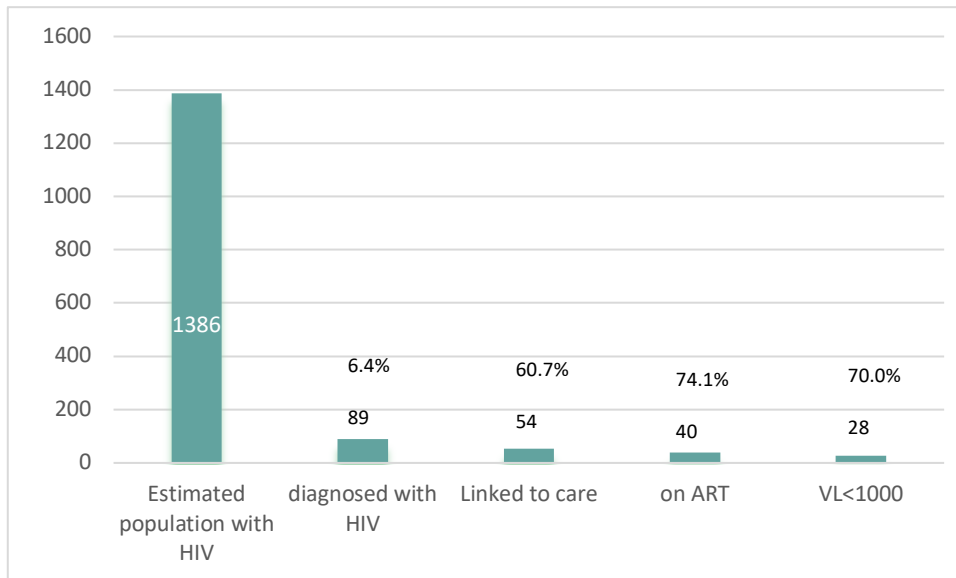
“HIV testing is primarily limited to public sector facilities, generally is provider-initiated, and disproportionately targeted to pregnant women and blood donors”.

Also, some MSM programs are finding that HIV testing does provide enough incentive for clients to continue to visit agencies or peer educators. In Georgia, it was thought that this may be related to some fatigue about HIV related information. Other options, such as services and referral to HCV and other disease testing, informational meetings, lectures and other events, were mentioned as possibilities to motivate more MSM to seek services.

Data on ART coverage is only available for three out of the 12 countries assessed, and the rate varies from 33.0% in Georgia to 82.0% in Ukraine. As with PWID, the lack of data on key population-specific access to ART make it difficult to further assess the situation. While MSM service packages were not assessed in the Kyrgyz Republic country visit, the desk review identified Cascade of Care data on MSM in the country.



Figure 4: Continuum of care for MSM, January 2017



Source: Republican AIDS Centre Kyrgyz Republic, January 2017

The MSM who participated in focus groups reported difficulties accessing care outside of NGO settings. In Ukraine, MSM reported sometimes complicated referral mechanisms between service providers, and the desire for a one-stop-shop model. Georgian focus group participants also reported challenges with medication adherence, and a need for more social support services to remedy this. This may be one of the driving factors behind data from Georgia, which show that MSM achieve less successful treatment outcomes than other groups, including other key populations.

In contrast to NGOs working with PWID, organizations providing services for MSM usually have other projects funded by a variety of donors. As a result, additional services are included, such as advocacy and legal service in Tbilisi (Georgia).

Many MSM living with HIV face double stigma. Individuals do not openly talk about their status within their MSM communities. While psychological support, such as access to a social worker, support groups, or another mental health professional was reported during some of the in-country visits in some of the countries, it is not captured in coverage data. Focus group participants in several countries stressed the importance of mental health support services in maintaining their health and wellbeing in environments of extreme stigma. Georgia plans to open mental health services for MSM later this year.

The operating environment can be dangerous for service providers, as well, limiting their ability to reach new and harder-to-reach clients. In Kosovo, outreach workers expressed concerns about identifying themselves as gay men when conducting outreach to MSM, both online and in person. The legal environment and the role of law enforcement are significant in either perpetrating or protecting against violence. In Ukraine, MSM report that police regularly raid cruising sites, and assault, steal from, or blackmail men found at these sites. In the Kyrgyz Republic, similar raids targeting MSM were also reported.



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As with PWID, there are several interventions which are included in the WHO Guidelines for packages of services for MSM which, regardless of inclusion or exclusion in national packages, did not have any data on coverage for any of the countries assessed. These interventions include:

- PrEP (Pilot in Georgia noted, but no coverage data available; plans for pilot in Ukraine in 2018)
- PEP
- ARV-related prevention: early initiation of ART/ARV regardless of CD4 count
- Behavioral interventions
- ART drug interactions
- Hepatitis prevention and management of co-infections
- TB prevention and management of co-infections
- Mental health and management of co-morbidities
- Nutrition
- Anal cancer treatment
- Sexually transmitted infection prevention, screening and treatment
- Community empowerment

Without any data on coverage for these services, it was not possible to assess the extent to which they are available in the countries assessed. One possible cause for the lack of coverage data for some of these services is that MSM may not want their sexuality disclosed when seeking STI, cancer and other services, so they do not want a referral from an MSM organization to these clinics. This was noted by focus group participants in Ukraine.



Table 10. Summary of Service Coverage for MSM

Survey/IBBS (S); GAM (G); Programmatic Data (P)¹²²; Other (O)

*Indicates Desk Review Only

Health Sector Interventions	Armenia	Azerbaijan*	Belarus	BiH*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan*	Ukraine	Uzbekistan
Comprehensive condom and lubricant programming ¹²³	77.4% (S) ¹²⁴	28.5% (G) ¹²⁵	73.8% (S) ¹²⁶	---	69.6% (S) ¹²⁷	70.7% (G) ¹²⁸	70.3% (Pristina) (S) ¹²⁹	81.1% (S) ¹³⁰	49.2% (G) ¹³¹	67.8% (O) ¹³²	77.7% (S) ¹³³	94.6% (S) ¹³⁴

¹²² Where programmatic data is used, coverage values have been calculated using available programmatic coverage data as numerators, and nationally accepted PSE as denominators

¹²³ Percentage of men reporting using a condom the last time they had anal sex with a male partner

¹²⁴ IBBS (2016)

¹²⁵ GARPR (2014)

¹²⁶ IBBS (2017)

¹²⁷ IBBS (2012)

¹²⁸ GARPR (2015)

¹²⁹ IBBS (2014)

¹³⁰ IBBS (2016)

¹³¹ GAM (2016)

¹³² Report on the Achieved Progress in Response to HIV Epidemic (2015)

¹³³ IBBS (2017)

¹³⁴ IBBS (2015)

Health Sector Interventions	Armenia	Azerbaijan*	Belarus	BiH*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan*	Ukraine	Uzbekistan
Coverage of HIV prevention programs among MSM	30.0% (S) ¹³⁵ 27.0% (P) ¹³⁶	23.5% (G) ¹³⁷ 30.7% (P) ¹³⁸	11.2% (P) ¹³⁹	64.6% (P) ¹⁴⁰	22.5% (P) ¹⁴¹	80.0% (S) ¹⁴²	21.8% (P) ¹⁴³	32.2% (P) ¹⁴⁴	21.3% (P) ¹⁴⁵	41.4% (O) ¹⁴⁶	24.0% (P) ¹⁴⁷	---

¹³⁵ IBBS (2016)

¹³⁶ Global Fund Program Update (2016)

¹³⁷ GARPR (2014)

¹³⁸ Program Data (2015)

¹³⁹ Program Update (2016)

¹⁴⁰ Program Data (2016)

¹⁴¹ Program Update (2016)

¹⁴² IBBS (2011)

¹⁴³ Program Update (2016)

¹⁴⁴ Program Data (2016)

¹⁴⁵ Program Data (2017)

¹⁴⁶ Report on the Achieved Progress in Response to HIV Epidemic (2015)

¹⁴⁷ Program Data (2017)

Health Sector Interventions	Armenia	Azerbaijan*	Belarus	BiH*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan*	Ukraine	Uzbekistan
Knowledge of HIV status ¹⁴⁸	29.6% (S) ¹⁴⁹	24.5% (G) ¹⁵¹	5.5% (P) ¹⁵³	---	12.0% (P) ¹⁵⁴	62.7% (S) ¹⁵⁵	47.0% (S) ¹⁵⁶	15.7% (P) ¹⁵⁸	2.0% (P) ¹⁵⁹	40.3% (O) ¹⁶⁰	21.0% (P) ¹⁶¹	---
	12.0% (P) ¹⁵⁰	0.7% (P) ¹⁵²					4.8% (P) ¹⁵⁷					
Community based testing and counselling ¹⁶²	---	---	---	---	---	---	---	11.2% (P) ¹⁶³	---	---	---	---

¹⁴⁸ Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results

¹⁴⁹ IBBS (2016)

¹⁵⁰ Global Fund Program Update (2016)

¹⁵¹ GARPR (2014)

¹⁵² Program Data (2015)

¹⁵³ Program Update (2016)

¹⁵⁴ Program Update (2016)

¹⁵⁵ GARPR (2015)

¹⁵⁶ IBBS (2014)

¹⁵⁷ Global Fund programmatic data report 44% achievement of target coverage; target was 700 MSM. The coverage statistic here is derived by using the available PSE (6445 from 2016 Programmatic Mapping) as a denominator and 307 (44% of 700) as the numerator; Program Update (2016)

¹⁵⁸ Program Data (2016)

¹⁵⁹ Program Data (2016)

¹⁶⁰ Report on the Achieved Progress in Response to HIV Epidemic (2015)

¹⁶¹ Program Data (2017)

¹⁶² Indicator not defined

¹⁶³ Program Data (2016)



Assessment of HIV Service Packages for Key Populations Eastern Europe and Central Asia

Health Sector Interventions	Armenia	Azerbaijan*	Belarus	BiH*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan*	Ukraine	Uzbekistan
Linkage and enrolment in care ¹⁶⁴	---	---	---	---	---	---	---	60.7% (P) ¹⁶⁵	---	---	78.0% (P) ¹⁶⁶	---
ART coverage ¹⁶⁷	---	---	---	---	33.0% (P) ¹⁶⁸	---	---	44.9% (P) ¹⁶⁹	---	---	82.0% (P) ¹⁷⁰	---

¹⁶⁴ Indicator not defined

¹⁶⁵ Republic AIDS Center (2017)

¹⁶⁶ Program Data (2017)

¹⁶⁷ Percentage of the people living with HIV among MSM receiving antiretroviral therapy in the past 12 months.

¹⁶⁸ Performance Framework (2015)

¹⁶⁹ Republic AIDS Center (2017)

¹⁷⁰ Program Data (2017)



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Sex Workers

Assessment of HIV Service Packages for Key Populations Eastern Europe and Central Asia

It is important to note that SW were only a key population of focus in three of the eight countries visited for this assessment: Armenia, the Kyrgyz Republic and Uzbekistan. In Armenia and Uzbekistan, assessment was limited to female SW only. In the Kyrgyz Republic, the assessment including SW of any gender and sex. Country visits verified that where prevention services are delivered according to package design, this is done primarily through outreach by peer educators. Most outreach is done at hotspots and through mobile units, though some is provided in static locations (e.g. drop-in centers). Internet-based outreach has begun but is only widely used in Armenia.

Outreach workers are expected to reach high numbers of clients: 220 per month in Armenia. In Belarus, due to a lack of funding, outreach staff said that the main emphasis in the FSW program has been placed on increasing coverage and finding new clients, without additional outreach workers or resources to support their work.

Ukraine has by far the largest program, with services for sex workers at 1,273 service provision sites in the country, all of which are operated by 43 NGOs. Prevention interventions for sex workers and their clients are conducted in 26 out of the 27 oblasts of Ukraine, with a focus on areas with the highest disease burden. Components tailored for FSW include peer driven interventions, distribution of pregnancy tests, training on how to use female condoms, response to violence against FSW, online counseling, skills training and employment, day care center for children, beautician and hairdresser services, and sewing and needlework courses. Peer driven interventions were also used in two cities in Moldova to recruit new clients but, due to limited funding, they will be discontinued in 2018.

UZBEKISTAN: “FSW stated that the limited operating hours of Trust Points where rapid HIV testing is available; requirements to show a passport and pass TB screening; and the use of video surveillance in the STI clinics as some of the most frequent deterrents to seeking care.”

In Uzbekistan, outreach to FSW is very risky because at any time, outreach work can be equated to organizing or assisting sex businesses, which can lead to detention or arrest by police. At the project level, work is under way to create safe conditions for outreach work, but this process is built on personal contacts and the reputation of the leaders of organizations.

Focus groups and key informants noted criminalization of sex work as the primary barrier to providing and receiving outreach services. Health care workers and peer outreach workers alike can face legal challenges in conducting outreach, including accusations of abetting a crime. Sex workers themselves report detainment and arrest for carrying condoms, which can be used as evidence of intent to commit a crime, as well as heavy surveillance and lack of anonymous services as deterrents for accessing facility-based services.

Condom distribution was confirmed as a core intervention, however the quality of condoms was noted as variable and the inclusion of lubricant was inconsistent. Nevertheless, IBBS-reported use of condoms at



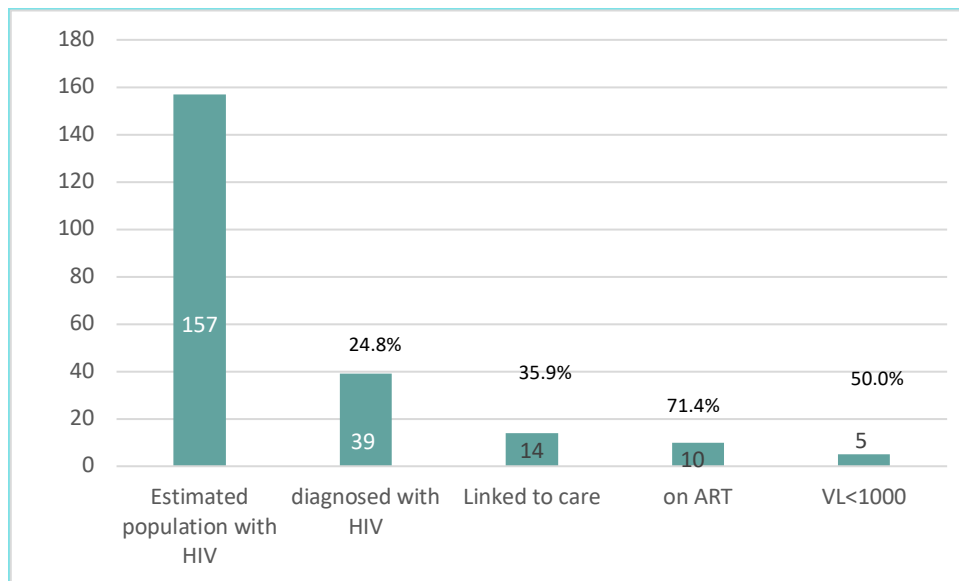
last sex was high, ranging from 80-100% in most countries. Notable outliers include Azerbaijan at 53% and Kosovo at 62%.

The percentage of sex workers that have received an HIV test in the past 12 months and know their results, from programmatic data, ranges from 3.9% in Moldova and 5.3% in Kosovo to 34.2% in Georgia and 39% in Ukraine. It should be noted that IBBS data shows much higher rates of testing: up to 62.3% in Tajikistan and 79.9% in Kazakhstan. In Kyrgyz Republic, low testing rates are mostly due to mass raids by police, as well as a high level of internal and external migration of SW, and stigma and discrimination in the community.

Testing and/or treatment of sexually transmitted infections is regarded globally as a key HIV prevention intervention, yet its availability is uncertain in several countries in the region. In Armenia, syphilis testing and treatment has been taken away from the list of free services provided by the government: there is co-payment of 50% of costs to be covered by the individual. In Bukhara in Uzbekistan, there is no free syndromic management of STIs, due to a lack of medicines.

Linkage to care was difficult to determine in most countries due to the lack of data about ART patients, disaggregated by KP. The Kyrgyz Republic has developed a Cascade of Care for SW.

Figure 5: Continuum of care for SW in the Kyrgyz Republic, January 2017



Source: Republican AIDS Centre, January 2017



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Assessment of HIV Service Packages for Key Populations Eastern Europe and Central Asia

It should be noted that across most countries, sex work is often assumed to be conducted by females, and the needs of male sex workers are neither assessed nor addressed in program design and implementation. As long as these population dynamics remain invisible, it is impossible to design or implement programs to meet this sub-population's needs.

Overall, coverage data outside of prevention and testing interventions (see Table 11) were so sparse that it is not possible to assess any regional trends. As with the populations previously discussed, there are several interventions which are included in the WHO Guidelines for packages of services for SW which, regardless of inclusion or exclusion in national packages, did not have any data on coverage for any of the countries assessed. These interventions include:

- PrEP
- PEP
- ARV-related prevention: early initiation of ARV/ART regardless of CD4 count
- ART drug interactions
- Hepatitis prevention and management of co-infections
- Nutrition
- Prevention of mother-to-child transmission
- Contraceptive services
- Safe abortion and post abortion care
- Cervical cancer screening and treatment
- Community empowerment

Without any data on coverage for these services it was not possible to assess the extent to which they are available in the countries assessed.

GEORGIA: Among OST clients, there was only one woman currently receiving OST, which reflects barriers for women to be enrolled in harm reduction activities...there were too few women to open a separate OST program”



Assessment of HIV Service Packages for Key Populations Eastern Europe and Central Asia

Table 11. Summary of Service Coverage for SW

Survey/IBBS (S); GAM (G); Programmatic Data (P)¹⁷¹; Other (O)

*Indicates Desk Review Only

Health Sector Interventions	Armenia	Azerbaijan*	Belarus	BiH*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan*	Ukraine	Uzbekistan
Comprehensive condom and lubricant programming ¹⁷²	99.0% (S) ¹⁷³	53.0% (G) ¹⁷⁴	85.0% (S) ¹⁷⁵	---	95.0% (S) ¹⁷⁶	95.4% (G) ¹⁷⁷	62.0% (S) ¹⁷⁸	97.2% (S) ¹⁷⁹	87.5% (G) ¹⁸⁰	71.4% (O) ¹⁸¹	94.0% (S) ¹⁸²	80.7% (O) ¹⁸³

¹⁷¹ Where programmatic data is used, coverage values have been calculated using available programmatic coverage data as numerators, and nationally accepted PSE as denominators

¹⁷² Percentage of sex workers reporting the use of a condom with their most recent client

¹⁷³ IBBS (2016)

¹⁷⁴ GARPR (2014)

¹⁷⁵ IBBS (2017)

¹⁷⁶ IBBS (2014)

¹⁷⁷ GARPR (2015)

¹⁷⁸ IBBS (2014)

¹⁷⁹ IBBS (2016)

¹⁸⁰ GAM (2016)

¹⁸¹ Report on the Achieved Progress in Response to HIV Epidemic (2015)

¹⁸² IBBS (2017)

¹⁸³ National Strategic Plan Assessment Report (2015)



Assessment of HIV Service Packages for Key Populations Eastern Europe and Central Asia

Health Sector Interventions	Armenia	Azerbaijan*	Belarus	BiH*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan*	Ukraine	Uzbekistan
Coverage of HIV prevention programs among SW	71.3% (G) ¹⁸⁴ 40.2% (P) ¹⁸⁵	33.3% (G) ¹⁸⁶ 30.0% (P) ¹⁸⁷	25.4% (P) ¹⁸⁸	61.5% (P) ¹⁸⁹	48.6% (P) ¹⁹⁰	90.0% (S) ¹⁹¹	5.3% (P) ¹⁹²	57.0% (P) ¹⁹³	26.3% (P) ¹⁹⁴	69.5% (O) ¹⁹⁵	48.0% (P) ¹⁹⁶	61.3% (P) ¹⁹⁷

¹⁸⁴ GAM (2016)

¹⁸⁵ Global Fund Program Update (2016)

¹⁸⁶ GARPR (2014)

¹⁸⁷ Program Data (2015)

¹⁸⁸ Program Update (2016)

¹⁸⁹ Program Data (2015)

¹⁹⁰ Program Update (2016)

¹⁹¹ IBBS (2011)

¹⁹² Program Update (2016)

¹⁹³ Program Update (2016)

¹⁹⁴ Program Data (2017)

¹⁹⁵ Report on the Achieved Progress in Response to HIV Epidemic (2015)

¹⁹⁶ Program Data (2017)

¹⁹⁷ Program Data (2016)



Assessment of HIV Service Packages for Key Populations Eastern Europe and Central Asia

Health Sector Interventions	Armenia	Azerbaijan*	Belarus	BiH*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan*	Ukraine	Uzbekistan
Knowledge of HIV status ¹⁹⁸	58.5% (S) ¹⁹⁹	12.0% (G) ²⁰¹	13.4% (P) ²⁰³	---	34.2% (P) ²⁰⁴	79.9% (S) ²⁰⁵	5.3% (P) ²⁰⁶	29.4% (P) ²⁰⁷	3.9% (P) ²⁰⁸	62.3% (O) ²⁰⁹	39.0% (P) ²¹⁰	36.1% (S) ²¹¹
	16.8% (P) ²⁰⁰	27.1% (P) ²⁰²										

¹⁹⁸ Percentage of FSW that have received an HIV test in the past 12 months and know their results

¹⁹⁹ IBBS (2016)

²⁰⁰ Global Fund Program Update (2016)

²⁰¹ GARPR (2014)

²⁰² Program Data (2016)

²⁰³ Program Update (2016)

²⁰⁴ Program Update (2016)

²⁰⁵ GARPR (2015)

²⁰⁶ Global Fund programmatic data report 79% achievement of target coverage; target was 340 FSW. The coverage statistic here is derived by using the available PSE (5037 from 2016 Programmatic Mapping) as a denominator and 269 (79% of 340) as the numerator; Program Update (2016)

²⁰⁷ Program Update (2016)

²⁰⁸ Program Data (2016)

²⁰⁹ Report on the Achieved Progress in Response to HIV Epidemic (2015)

²¹⁰ Program Data (2017)

²¹¹ IBBS (2015)



Assessment of HIV Service Packages for Key Populations Eastern Europe and Central Asia

Health Sector Interventions	Armenia	Azerbaijan*	Belarus	BiH*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan*	Ukraine	Uzbekistan
Community based testing and counselling ²¹²	---	---	---	---	---	---	---	12.1% (P) ²¹³	---	---	---	37.2% (P) ²¹⁴
Linkage and enrolment in care ²¹⁵	---	---	---	---	---	---	---	35.9% (P) ²¹⁶	---	---	63.0% (P) ²¹⁷	---
ART coverage ²¹⁸	---	---	---	---	---	---	---	25.6% (P) ²¹⁹	---	---	49.0% (P) ²²⁰	---
TB Prevention and management of co-infections	---	---	---	---	---	---	---	---	---	---	22.1% (P) ²²¹	18.0% (P) ²²²

²¹² FSW passed through rapid HIV testing

²¹³ Program Update (2016)

²¹⁴ Program Data (2016)

²¹⁵ Indicator not defined.

²¹⁶ Republic AIDS Center (2017)

²¹⁷ Program Data (2017)

²¹⁸ Antiretroviral therapy coverage among sex workers living with HIV

²¹⁹ Republic AIDS Center (2017)

²²⁰ Program Data (2017)

²²¹ Program Data (2017)

²²² Program Data (2016); FSW referred to TB diagnostics



Prisoners

It is important to note that in the eight countries assessed with follow-up field visits, prisoners were not selected as a key population of focus for data collection and data verifications. Therefore, there are limited implementation information and data on prisoners, and what has been recorded in desk reviews has not been verified in-country. In Ukraine, it was reported that only 13% of prisoners received free condoms during 2017, which decreased by 50% from 2011. Access to condoms (but not necessarily lubricant) and needles and syringes is reported as common, despite only five countries reporting condom use data and two reporting needle and syringe data.

Where data on condom use at last sex do exist, data points in Moldova (9.6%) and Ukraine (10.0%) in particular are concerningly low.

For the six countries with HTC data available, the percentage of prisoners who had been tested for HIV and knew their result ranged from 13.4% (Belarus) to 64.6% (Kyrgyz Republic). It is important to note that some countries in the region have implemented mandatory HIV testing upon entering the prison system. The data presented above reflect only voluntary, routinely offered HIV testing and counselling, in line with WHO recommendations. ART coverage ranges from 60-70% in Azerbaijan, the Kyrgyz Republic, Moldova, and Ukraine. Only Tajikistan (87.8%) and Belarus (100%) report figures within the range of the 90% target.

As with the populations previously discussed, there are several interventions which are included in the WHO Guidelines for packages of services for prisoners which, regardless of inclusion or exclusion in national packages, did not have any data on coverage for any of the countries assessed. For prisoners, the situation is even more serious than the data shortfalls for other populations, as missing data include core prevention interventions such as harm reduction services (OST, safe injection education).

The lack of coverage data on harm reduction services in prisons is particularly surprising, given that the region has a greater emphasis on OST and NSP in prison than virtually any other region in the world. For example, NSP was introduced in Moldovan prisons in 1999, and is currently available in ten of the twelve facilities, and OST was introduced in prisons in 2005; OST is available in seven facilities in Kyrgyz Republic (one female prison), and NSP was introduced within prison facilities in 2005 and is available in 10 facilities. In Armenia, OST was available at nine sites in the country's twelve prisons until 2016 though its future is uncertain, and negotiations are under way to introduce OST services in penitentiary institutions in Georgia. Two of the four prisons in Kosovo provide OST - the long-term male prison and the prison for women and juveniles.

Interventions with little or no coverage data include:

- PrEP
- PEP (service reported to be implemented in prisons in Kyrgyz Republic and Ukraine, despite lack of coverage data)
- Harm reduction—safe injection practices
- Other harm reduction – OST
- Other harm reduction: Naloxone, other treatments overdose prevention and treatment



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- ARV-related prevention: early initiation of ARV/ART regardless of CD4 count
- Behavioral interventions
- Knowledge of HIV status
- Linkage and enrolment in care
- ART drug interactions
- Hepatitis prevention and management of co-infections
- TB prevention and management of co-infections
- Mental health and management of co-morbidities
- Nutrition
- Sexually transmitted infection prevention, screening and treatment

Notably, about half of the countries assessed reported the implementation of TB, STI, and hepatitis testing and treatment in prisons; it is plausible that some of the other services above are also implemented in prison settings in some countries. However, without coverage data, and having not focused on prisoners in any of the in-country assessments, it is not possible to assess implementation any further.

Table 12. Summary of Service Coverage for Prisoners

Survey/IBBS (S); GAM (G); Programmatic Data (P)²²³; Other (O); Desk Review Only (*)

Health Sector Interventions	Armenia	Azerbaijan *	Belarus	BiH*	Georgia	Kazakhstan*	Kosovo	Kyrgyz Republic	Moldova	Tajikistan*	Ukraine	Uzbekistan
Comprehensive condom and lubricant programming ²²⁴	85.7% (S) ²²⁵	---	87.0% (S) ²²⁶	---	---	46.0% (S) ²²⁷	---	---	9.6% (S) ²²⁸	---	10.0% (S) ²²⁹	---
Coverage of HIV prevention programs among prisoners	44.6% (S) ²³⁰	---	25.4% (P) ²³¹	---	21.0% (P) ²³²	99.8% (P) ²³³	---	16.3% (P) ²³⁴	29.3% (P) ²³⁵	48.0% (O) ²³⁶	---	---

²²³ Where programmatic data is used, coverage values have been calculated using available programmatic coverage data as numerators, and nationally accepted PSE as denominators

²²⁴ Condom use among prisoners at last sexual partner

²²⁵ IBBS (2016)

²²⁶ IBBS (2015)

²²⁷ IBBS (2011)

²²⁸ IBBS (2017)

²²⁹ IBBS (2017)

²³⁰ IBBS (2016)

²³¹ Program Update (2016)

²³² Program Update (2016)

²³³ Program Data (2016)

²³⁴ Program Data (2016)

²³⁵ Program Update (2017)

²³⁶ Report on the Achieved Progress in Response to HIV Epidemic (2015)



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Assessment of HIV Service Packages for Key Populations Eastern Europe and Central Asia

Harm reduction - NSP	70.0% (S) ²³⁷	---	---	---	---	---	---	11.0 (P) ²³⁸	---	---	---	---
Knowledge of HIV status ²³⁹	50.4% (S) ²⁴⁰	---	13.4% (P) ²⁴¹	---	60.7% (P) ²⁴²	81.5% (S) ²⁴³	---	64.6% (P) ²⁴⁴	---	---	46.0% (S) ²⁴⁵	---
ART coverage ²⁴⁶	77.3% (O) ²⁴⁷	60.2% (P) ²⁴⁸	100% (P) ²⁴⁹	---	---	---	---	69.6% (O) ²⁵⁰	63.1% (O) ²⁵¹	87.8% (P) ²⁵²	62.0% (P) ²⁵³	---

²³⁷ Available in 9 out of 12 prisons, per Altice et al., 2016 (see full reference below)

²³⁸ Number of needles per prisoner; Program Data (2016)

²³⁹ Percentage of prisoners that have received an HIV test in the past 12 months and know their results

²⁴⁰ IBBS (2016)

²⁴¹ Program Update (2016)

²⁴² Program Update (2016)

²⁴³ IBBS (2011)

²⁴⁴ Program Data (2016)

²⁴⁵ IBBS (2017)

²⁴⁶ Percentage of the people living with HIV among prisoners receiving antiretroviral therapy in the past 12 months

²⁴⁷ Altice FL, Azbel L, Stone J, et al. (2016) The perfect storm: incarceration and the high-risk environment perpetuating transmission of HIV, hepatitis C virus, and tuberculosis in Eastern Europe and Central Asia. *The Lancet*. Sep 17; 388(10050): 1228–1248.

²⁴⁸ Program Data (2017)

²⁴⁹ Program Data (2017)

²⁵⁰ Altice FL, Azbel L, et al, op cit

²⁵¹ Altice FL, Azbel L, et al, op cit

²⁵² Program Data (2017)

²⁵³ Program Data (2017)

ANALYSIS: ARE PACKAGES BEING IMPLEMENTED AS DESIGNED?

In general, packages appear to be implemented as designed, in terms of interventions delivered. Though many interventions are not captured in regular data reporting, in-country assessments confirm that services are available at some level. Again, this should be seen as a success. It is evident that some interventions in some countries began prior to the introduction of defined packages of services, but that the guidance from international organizations, coupled with national design processes appears to have broadened the types of services available to KP. It should also be noted that many of these countries were formerly part of the Soviet Union and inherited a particularly vertical approach to dealing with all health issues. To have OST provided in a TB service center or TB services in a narcological hospital, or HIV testing carried out by NGOs has required significant and intentional effort. Continued dissolution of vertical approaches to care, as part of broader health systems reforms, increasingly allows for the provision of multiple services from a single site. This in turn reduces time and transport cost problems for KP (Routh et al, 2008; Medecins sans Frontieres, 2017).

Perhaps the biggest challenge to HIV service provision for KP is the changing role of outreach workers and peer educators. In some countries, the same methods and approach have been used for many years: hiring outreach workers who are similar to or part of the KP, having the outreach worker work with peer educators, often embedded in the KP community, and using this network to distribute goods, provide or offer services and refer KP to other services. This often results in a substantial set of services being offered to a relatively static group of clients but does not reach adequately focus on expanding reach of new clients as the population evolves over time. Other countries have adopted a ‘test and treat’ approach, in which emphasis has shifted from providing ongoing services to finding new individuals within KP, encouraging them to test and, if positive, linking them to care. While this approach is more likely to reach new clientele, it often results in a more limited range of services and does not place emphasis on keeping individuals from acquiring HIV – focusing instead on identifying those living with HIV and linking them to care.

Either approach can create stress on outreach worker, particularly if adequate funding is not available. Complaints about the number of clients each outreach worker must visit (in more traditional programs) or how many new HIV-positive KP the outreach worker must find (in test and treat) were repeated by OWs surveyed across the region. The simplistic either/or approaches used to date are unlikely to be effective at controlling HIV epidemics as the older style programs miss out on many KP by restricting their services to a fairly defined cohort, while test and treat may neglect the existing cohort’s prevention needs.

Added to these stresses are the changes to the way information is accessed, the ways that MSM arrange sexual contacts, and how SW and PWID do business. Widespread use of mobile phones and the internet have led to fewer physical spaces where KP congregate on a regular basis. While there are still known areas for drug deals and street sex work in most of the region’s cities, there are increasing numbers of KP who avoid any places where other KP gather, either for reasons of personal preference or from fear of exposure or violence. The expanded use of secure, online outreach and programming may be critical to reaching KP in contexts where physical safe spaces are declining.



There are two important factors which are inconsistently captured in data and written sources: geographical reach and quality of services. In smaller countries, with a limited number of hotspots, geographical reach can be assessed to some degree through coverage data. However, for larger countries such as Kazakhstan and Ukraine, entire regions of the country may not be covered by services; the degree to which this is captured in programmatic data is variable, as further discussed below in the Monitoring section.

Quality of services is also a multi-faceted issue which is not captured in most systematic data. The use of outcome indicators for proxy, such as condom use at last sex or use of a clean needle and syringe at last injection, may give some indication of service quality. However, these data rely on self-reported behaviors in surveys (which may be subject to sampling problems, as discussed in the next section), and may not accurately reflect real outcomes.

One concern noted in several country reports was the lack of feedback loops to ensure that problems encountered by KP were brought to the attention of PR and others involved in procurement, and that appropriate action was taken when necessary. For example, in Kosovo, an auto-destruct syringe was being distributed through NGOs, yet the NGO clients were very unhappy with this product. The syringe locked after the first attempt to press the plunger, meaning that most of the dose could be trapped in the syringe and unavailable for use if, for example, a drug user missed a vein on the first attempt. However, there was no mechanism in place by which those in charge of procurement were accountable to this community concern. In cases like this, there should be clear and regularly conducted processes to ensure not only that KP concerns are heard, but that problematic commodities (such as auto-destruct syringes) and practices are replaced by those that better meet the clients' needs. This may be an appropriate approach to quality assessment: the introduction and maintenance of regular feedback sessions with clients, whose concerns are acted on quickly through the chain of responsibility from SSR through SR to PR and, if needed, involvement of CCM or CCM Oversight Committee.

One unexpected finding is the reported importance of psychological counselling. For example, among PWID in Belarus, this was regarded as the second most important service after NSP, and the top priority service for MSM. Among some MSM Kosovo and PWID and SW in Uzbekistan, the lack of mental health services was noted as a major shortcoming.

The finding on desire for more psychological support, coupled with the findings related to community violence for some MSM groups; police violence towards SW; legal issues for PWID; and other non-medical needs, suggests that there is a need for services beyond the basic prevention services such as condom and lubricant distribution, STI services (for SW and MSM), and NSP and OST (for PWID). This may be an important point when determining how to develop effective programming to reach and retain more individuals, considered alongside the fact that KP in focus groups reported very low satisfaction with other behavioral interventions, including written IEC materials.

In most countries, there was little emphasis on human rights barriers to services or community empowerment processes, despite KP noting these as major barriers to services. Considering flexible approaches to deliver the globally agreed upon critical enablers, through approaches tailored to local needs and context, may yield more cost-effective results in service uptake and retention. For example,



because SW in Bishkek are particularly concerned about violence from police and this is the main obstacle to HIV testing and seeking HIV prevention and health services, then agencies working with SW in Bishkek have provided legal aid programming in addition to implementation of core prevention activities. A similarly flexible approach could be used to make needed service improvements for PWID in Kosovo, where drop-in centers have no working bathrooms due to a lack of funding for basic repairs; to promote PrEP in Kyiv (as is currently planned in the most recent funding application); or to increase psychological counselling for PWID and SW in Uzbekistan. These things, all identified as priorities by focus groups who informed these assessments, are potential avenues for investment of funds that could be designated for needs-based services/service improvements.

Where prevention services are being delivered as designed, there is an important question of sustainability of interventions delivered by NGOs and CBOs. Historically, most prevention services delivered by civil society have been funded by the Global Fund or other external donors. For countries in transition (which includes most countries in EECA), the concept of domestic funding for prevention is a relatively new idea; the concept of governments contracting NGOs to provide services such as condom distribution and harm reduction is both new and challenging from a practical standpoint, in terms of legal frameworks and financing mechanisms.²⁵⁴ Particularly the practice of NGO or CBO-delivered rapid testing, which is supported by WHO community-based testing guidelines, requires a legal and regulatory framework by which non-medical personnel are allowed to administer testing, as well as a mechanism by which the State can contract non-state actors to deliver such key services (WHO, 2017; Open Society Foundations, 2017).

For all populations, the lack of coverage data for a large number of interventions leaves significant questions about their reach, as well as quality of services.

It bears repeating that TG are not discussed at all in this analysis, because design of TG-specific packages was limited to two countries, and no separate coverage data are available for TG in those countries. However, lack of ability to analyze coverage of TG should not be interpreted as lack of importance of service provision for this population. It should be an urgent priority to improve the design, delivery and monitoring of services for this population at risk.

Additionally, it is worth reemphasizing that some subgroups of KP may not be adequately covered by services as currently implemented. In particular, young KP were noted as important populations at risk in many countries, and with its more robust data systems Georgia even documents that young PWID have lower linkage to care, enrollment on ART and achievement of viral suppression than PWID in other age groups. And yet, this population remains underserved in all countries. Programs to reach young PWID through outreach and to serve their needs through pharmacy-based NSP are available in the Kyrgyz

²⁵⁴ There has not yet been a systematic global analysis of policy frameworks and financing mechanisms for government contracting of local NGOs to provide services for key populations (sometimes called 'social contracting'). However, there have been extensive discussions on this topic among donors and implementers in recent years, and a summary of the global experience is captured in the draft report on an October 2017 global consultation held by the *Open Society Foundations, the United Nations Development Programme, and The Global Fund to Fight AIDS, Tuberculosis and Malaria*. For full citation and contact details, see reference list at the end of this document.

Republic, but these tailored services are the exception, not the norm. The continued lack of sensitivity to age, sex, and gender-differentiated needs is problematic in most countries, for most KP.

RECOMMENDATIONS: IMPLEMENTATION OF SERVICE PACKAGES FOR KEY POPULATIONS

1. After determining basic interventions which are to be provided per the national, defined service packages, ensure that all interventions are implemented at the scale needed to address the HIV epidemic in each country (including preventing HIV epidemics in countries with small numbers of PLHIV). Strategies need to be put in place to ensure that these basic interventions are available to the majority of KP in each country, and meet their needs based on differing local contexts at the sub-national level, regardless of funding source or service delivery agent.
2. All packages should allow flexibility in program design so that needs-based services can be tailored to local needs and contexts, including the provision of additional services (where needed or desired by key populations), in addition to basic services. This flexibility would allow service providers to attract clients to these services and to address some of the underlying reasons why uptake of priority services, such as HIV testing, ART or OST (for PWID), and retention in ART or OST programs is suboptimal for key populations. This should also allow for adaptation to intersectionality of risk for individuals or groups whose gender, age and overlapping identity present unique barriers to being served by more traditional PWID, MSM, or SW programming.
3. Outreach to key populations must continue to evolve alongside both population needs and international trends such as Test and Treat. While progress towards the 90% testing target should continue to be a priority, individuals who test HIV-negative must have the option to receive high-quality prevention services, which will contribute to them maintaining a negative sero-status. This hybrid approach, a 'Test and Treat Plus', will require robust funding, as it must be acknowledged that a limited set of outreach workers cannot be expected to perform multiple functions for an ever-increasing number of clients.
4. In addition, the emergence of internet outreach as a viable model needs to be taken seriously, especially for MSM, SW and TG. Where this method is not already being utilized widely, it should be considered for introduction (with respect to appropriateness in context). In all cases, an appropriate and ethical methodology for online outreach is recommended with protocols for confidentiality, transparency, and safety. Some guidance on this is available in the MSMIT, SWIT and TRANSIT (UNFPA, 2015; WHO, 2013; UNDP, 2016) however, while these tools indicate the importance of safety and ethics protocols, they do not sufficiently guide users in how to develop them. Therefore, there is a need for comprehensive and accepted global standards for using online outreach to meet and provide services to new KP clients.
5. Implementation should continue to move towards integration of services, including one-stop-shop models where feasible. This is particularly true for HIV and TB coinfection, where strong vertical HIV and TB systems have long suffered from lack of coordination. Greater integration is urgently needed between these two sectors, in order to meet the needs of PLHIV for regular TB screening, prevention and treatment in a familiar care setting which is sensitive to coinfection needs. Some of the key populations for both HIV and TB are the same (such as PWID and prisoners) and both government agencies and NGOs should increasingly offer combined education and access to services that assist key populations living with coinfection.



6. Feedback loops should be established and required as part of national programs, with data being collected on a routine basis, under standard protocols to assure safety and security of beneficiaries, to aid in a full spectrum of quality improvement. This should include feedback on commodities as well as implementation approaches and the status of critical enablers. Feedback then needs to be routinely used by program implementers to assure accountability to communities, and to make necessary adjustments in programming (using needs-based funding, as described above) to meet the needs of key population clientele.
7. In order to overcome legal and policy barriers (which may be insurmountable or require long-term advocacy for change) and provide avenues of safety for key populations to access services, institutional-level partnerships between NGOs and government entities should be utilized. This may include partnerships between NGOs and medical facilities, and between health service providers (including NGOs) and law enforcement.
8. Countries need to turn more serious attention to the role of violence and safety (or lack thereof) for both key populations in accessing services and service providers in reaching key populations. Interventions to mitigate violence should be designed and funded.

PART IV: MONITORING SYSTEMS

KEY POINTS

- Significant gaps exist between coverage reported in programmatic data vs IBBS
- Most countries have a UIC which is in use for all KP
- Some countries face difficulties obtaining accurate data on outreach, due to high reporting burdens for outreach workers
- Challenges exist in tracking individual client service use patterns, bridging the gap between prevention and testing to treatment

The process of monitoring the implementation of packages of services against their design is multi-faceted.

Revisiting the beginning of this report, there are significant challenges in obtaining reliable population size estimations for some KP in some countries, with significant under-estimation occurring in some cases. In addition, the way that coverage is compiled and analyzed for the Global AIDS Monitoring (GAM) reports varies across countries. In some countries' GAM reports, a mixture of programmatic and IBBS data is used as if the figures are interchangeable. The differences between IBBS results and programmatic data findings can be very large (see Tables 10-12). Given what has been reported below on monitoring systems, some of these problems may be attributable to issues in program reporting, but it seems likely that many IBBS studies continue to have sampling problems that over-represent the behavior of people who are regular clients of HIV prevention agencies.

As part of this assessment process, there was a requirement to rate the systems used to monitor KP service packages. The results of this process (Table 13) show that most countries have unique identification code (UIC) systems, generally with the same coding system used for all KP (except prisoners) across the country.

Table 13. UIC System Scores by Country

- 0: No data/evidence of UIC found;
- 1: Monitoring contacts, which disallows de-duplicated reporting;
- 2: Partially using UIC, which disallows de-duplicated reporting. This includes scenarios where UIC are used in some regions of the country or different UIC are used in the country but not harmonized;
- 3: Nationally using UIC, which allows de-duplicated reporting. This includes the scenario where different UIC are used but harmonized.

Country	Score ²⁵⁵	Notes
Armenia	2	UIC, which allows for de-duplication, for MSM, PWID, and FSW; however, this is not used at the national level, only unique clients by the PR. Coding of the UIC is different for each KP.
Belarus	2	UIC, which allows for de-duplication, is used; currently used at individual NGOs and health centers and there is no unified patient tracking system between service providers.
Georgia	3	UIC, which allows for de-duplication, used for all KP. There are several UIC used across all the data collection tools; however, linkage among databases is possible.
Kosovo	3	UIC for MSM, FSW PWID, which allows for de-duplication of cases. No linkages to the ARV database (prevention & testing only)
Kyrgyz Republic	2	UIC, which allows for de-duplication, only used in GF funded programs
Moldova	3	UIC for all KP, which allows for de-duplication of cases. No linkages to the ARV database (prevention & testing only)
Ukraine	3	UIC, which allows for de-duplication, used among Alliance for Public Health in Ukraine and their implementing partners.
Uzbekistan	3	UIC recently introduced for PWID and FSW, which allows for de-duplication. Used by all service providers and linked to the National AIDS Center and the Regional AIDS Centers.

**For countries which only received a desk review, there was not enough information available to adequately and reliably assess the existence and use of a UIC. Therefore, details are not included here.*

The EECA region is the birthplace of a key population services monitoring software now in use around the world. Alliance for Public Health in Ukraine uses an open access software (SyrEx) for monitoring and recording information on clients reached and services provided in community-based HIV prevention programs. It allows project implementation partners to uniquely register project clients with an agreed-upon UIC, to record commodities and services provided, as well as other key deliverables such as trainings. The code, developed with the participation of all HIV service partner organizations, is based on the unique personal data of a client. It includes eight symbols: the first letter of the client's surname; the first letter of the full name of the client's maiden surname; the first letter of the first name of the client's father; two digits from the client's day of birth; the last two digits from the client's year of birth, and the final symbol is the client's gender. The tool also allows for the generation of reports by a set of criteria, and collection and aggregation of data from multiple sites. It also calculates coverage of a vulnerable sub-group with essential services, including the possibility to disaggregate by sex and age. Belarus also uses Syrex for monitoring its KP prevention activities.

For many years, there had been confusion globally, at the implementer level, between reach (all clients met) and coverage (all clients receiving a specific set of services) (Shamra et al, 2007; 2008). This appears to be changing throughout the countries surveyed in EECA. For example, in Kosovo, PWID, MSM and FSW are considered 'reached' each time they receive their defined package of services, and they are considered

²⁵⁵ Score has been assigned based on available information from country assessments. Score may not apply to all key populations (MSM, FSW, PWID, and prisoners) in EECA. Please see notes for specifications.



'covered' if they receive their defined package of services four times over a six-month period, with the exception of HTC, which is one time every 6 months. Further, both the national MSM and PWID NGOs are able to record when individuals receive individual services (one or two services within the package) and able to see which clients are receiving what services over the reporting period with the use of their UIC system.

However, there are examples of challenged in implementing monitoring practices. Mostly, these are caused by an ongoing reliance on paper and Excel-based forms. In Moldova, NGOs had to establish parallel systems in the form of Excel databases to comply with regular reporting requirements. Existence of dual information recording requirements stretches already scarce M&E resources and limits M&E activities to pure data entry and superficial data validation.

In Belarus, sub-recipients noted some specific problems caused by asking PWID peer educators to fill out reporting forms. These PSE frequently have problems with police and may be detained or arrested, preventing them from regularly reporting on outreach activities. Uzbekistan has some unusual difficulties with coding: blood samples collected from narcological clinics are coded under #102 ("drug users"), the HIV testing results of which contribute to the national indicator of "HIV incidence rates among PWID". However, narcology clinics collect samples not only from PWID, but also from all other patients (homeless people and individuals using alcohol and other drugs) who receive narcological services, resulting in misleading statistics on HIV among PWID. Also, in Uzbekistan persons providing sexual services for consideration (PPSSC, which is the officially used terminology) includes all people who anonymously applied for HIV testing through STI services, as well as those FSW who have been tested for HIV through Trust Points, again confusing the real HIV testing figures for SW.

However, the major gap in every country, as it is worldwide, is between prevention and treatment databases. For most countries studied in the region, there is no way to track individual service patterns from prevention through the treatment cascade and other services, in order to understand patterns not only by KP, but within subgroups of KP (e.g. by gender, age, coinfection status, method of referral, etc.). However, Georgia appears to be close to resolving this problem. All prevention work with KP is recorded with the use of a 15-digit UIC. A prevention database, which is in the final stage of development (progress 80% as in November 2017), will enable real time data entry, improve data quality and reduce reporting burden for data managers at the service delivery sites. It will also provide linkages to the ART, HCV, TB and STI databases. This will be done by building into the coding a requirement that name and address (recorded on all health databases) be removed as the data is linked to the UIC database. As a result, it will be possible to produce a continuum of care for key populations which allows for more detailed disaggregation and examination of individual service patterns, as needed. In addition, there will be database for interventions provided for prisoners.

Georgia's ability to integrate UIC and ART data

Many countries are moving towards the development of Cascades of Testing and Care for key populations with HIV, but a key stumbling block has been the ability to disaggregate treatment data by key population. A unique identification code (UIC) system, used appropriately can at least tell us how many individuals from a key population are being reached by services and are being tested. In

some cases, such a system can also provide data on the number of positive test results. Those who test HIV-positive usually then enter a government-operated medical database designed to keep their results, treatment, effects of treatments and monitoring results confidential.

In Georgia, the PR for the GF HIV grant, the National Center for Disease Control (NCDC), is working on this issue. The country’s existing system of registration of prevention services for key populations uses a unified reporting form for all sub-recipients of the Global Fund grant and a universal UIC for all key populations. Originally, prevention programs used a 7-digit UIC, but following the integration with the governmental information system, a 15-digit code is used (see Figure 1). Use of the 15-digit code is time consuming for paper-based reporting, but there are plans to provide outreach workers with tablets this year.

Current data collection tools register all information about services provided to individuals based on the 15-digit codes. The data collection form enables registration of every component of the service received at a given time. This information is entered monthly into Excel by sub-recipients and sent to the principal recipient (PR). Available tools allow the disaggregation of HIV testing data for each key population. Tools also allow coverage calculations and provide data disaggregated by gender and age. Regular procedures are carried out to clean the database from duplicates and carry out analysis over time, selecting various criteria.

Figure 1. Composition of the UIC

The unique 7 digit code of the client							
	The first letter of the name	The first letter of the Last name	The first letter of the Mother's name	The first letter of the Father's name	The date of birth (The last 2 number)		The number of sex determination (1 -Male; 2 - Female.)

The unique 15 digit code of the client														
	The first letter of the name	The number of letters in a last name (ex."08", 12)	The first 2 letters of the mother's name	The first 2 letters of the Father's name	The date of birth (Day, Month, Year (The last 2 number)		The first letter of the place of birth)	The number of sex determination (1 -Male; 2 - Female.)						

A new prevention database, which was 80% complete in November 2017, will enable real time data entry, improve data quality and reduce reporting burden for data managers at the service delivery sites. It will also provide linkages to the ART, HCV, TB and STI databases. This will be done by linking UIC data with medical data for each HIV-positive person from key populations: when medical data (related to HIV treatment, monitoring or other medical issues) are downloaded to the new database, the name and address of the individual patient is automatically stripped from the data. Once fully functional, this database, with its links to medical data, should allow the construction of complete cascades for key populations including viral load suppression. It will also – by linking UIC data with HIV medical data – allow planners



to see how HIV-positive members of key populations are accessing KP programs. This can be extremely useful for ensuring that HIV-positive members of KP are getting the services they need.

The Georgian database – if it is completed as planned – is a significant breakthrough in enabling countries to determine the access KP have to prevention, testing, treatment and viral load suppression. It should be studied by all countries to determine how such a system can be replicated.



ANALYSIS: DO WE REALLY HAVE ENOUGH INFORMATION TO DETERMINE HOW WELL PACKAGES ARE IMPLEMENTED?

The use of a national UIC is of great importance as it is one of the cornerstones of coverage calculations. Just as the PSE is the important denominator, the UIC leads to the construction of the national coverage numerator. Countries can have excellent programs but, without a way to accurately report de-duplicated client numbers, no statements about coverage of the programs can be made with any certainty. It should be noted that the UIC also allows programs to distinguish between unique individuals (clients) and visits (occasions of service), a confusion that has plagued KP programs for many years. The fact that all countries visited have a functional, national UIC is a great achievement.

Beyond the UIC, it was heartening to find that most countries have developed ways to determine whether a client has received a defined package of services. However, there are still major limitations in being able to track unique individuals across a full spectrum of services (in most countries – as discussed above), and this limits the potential to identify service patterns and outcomes for specific subgroups within KP (including individuals who may identify across multiple KP). The continued improvement of strategic information – from regularly collected statistics to the implementation of community-led monitoring and other beneficiary feedback mechanisms – is necessary to assure that even the hardest-to-reach among key populations can and do access services.

RECOMMENDATIONS: MONITORING OF SERVICE PACKAGES FOR KEY POPULATIONS

1. All countries need to follow established guidelines when developing population size estimations, together with national consensus processes involving substantial representation from the key populations concerned (not merely one or two key population representatives on a 20-member working group). This may include the use of emerging methodologies for mapping and surveying populations using virtual/internet-based mechanisms. From these processes, more accurate, agreed-upon PSE should be derived.
2. In countries where some PSE appear to underestimate populations, sampling methodology should be considered for improvement, either including additional waves of sampling (if using RDS methodology), and/or exploring innovative methods for reaching subgroups that may not be linked to the networks previously accessed through current NGO clients. This is also applicable for all countries assessed here, in conducting PSE for TG populations for the first time.
3. Global AIDS Monitoring reports on service coverage for key populations should be based on either programmatic data or on separate research studies using well-established research methods and standards. Where the coverage figure is available from programmatic data and IBBS, only the programmatic data should be provided in the GAM. However, it should be noted that some programmatic data also defy credibility - 99.8% of prisoners in one country receiving comprehensive HIV prevention programs for example – so programmatic data collection and analysis may also need improvement.
4. All countries should continue to progress towards a single unique identification code for all key populations and a single database, preferably accessible online for both uploading data and generating reports. In countries where there is a functioning National eHealth system

(Ukraine, Belarus, Georgia, Moldova), this may be the most logical platform to host a functional UIC. In the absence of an eHealth system, and given the issues noted for outreach workers and peer educators in the Implementation section, the streamlining of data entry through the use of Syrex or similar products a reasonable alternative.

5. Tracking of service use and health outcomes for KP needs to be integrated into national e-health and unique patient record initiatives, where this can be done without compromising safety of KP.
6. All countries should continue to progress towards clear definitions of coverage (distinct from reach) for core elements of service packages, aligned with recommendations in international reference documents.
7. After determining a basic package during the design phases, establish routine surveillance to ensure that all coverage of all basic interventions can be regularly measured, independently of one another. (This is in response to the general lack of data available on coverage of many of the services in defined packages of services).
8. Feedback loops, recommended in the Implementation section, should be extended throughout the reporting system so that problems with the quality of services or the commodities that they provide are quickly reported to the level at which action can be taken to remedy the situation. This should extend across governmental and non-governmental services. In the case of products such as syringes and condoms which are usually procured nationally, this may mean that rapid communication is enabled from the affected clients to the PR or the Ministry of Health entity responsible for procurement.
9. All countries should study the database being assembled in Georgia to consider whether such a database is feasible. A wealth of information about patterns of service usage could be obtained by anonymously linking UIC and health system data for KP.
10. It is important to stress that none of these data are useful unless they are used. There were occasional examples found of NGOs and others working with the available data to determine ways to attract more clients to services and increase levels of HIV testing – but many organizations lack the capacity to do this in a meaningful way. Capacity building may be needed for some agencies to help staff see the value in not merely collecting but analyzing service data and using this information as the basis for suggesting changes to services.

PART V: FINANCING

KEY POINTS

- Most countries in the region will be transitioning from external donor support in the near future
- Increased domestic investments are needed to ensure sustainability
- Countries should conduct expenditure analysis and budget development processes to be sure that sufficient resources are available to implement the designed packages of services as intended
- There are positive examples of increased domestic expenditure in the region
- More regular and thorough expenditure data will be needed to accurately plan for and track transitions

Throughout the EECA region, the majority of countries are phasing out of eligibility for HIV funding from Global Fund. As a result, there is heavy focus on transition and sustainability of responses, particularly on mobilizing increased funds from national and local government sources in order to maintain current funding levels. The bars in Figure 6 below present 2017 data from UNAIDS on the share of domestic funding versus external donor support for HIV responses in the region. At the time, red dots in this figure indicate the level of funding needed to reach UNAIDS Fast-Track targets. Without dramatic changes resource mobilization in the region is far off track to achieve targets.

Figure 6. Funding Sources in Eastern Europe and Central Asia (UNAIDS 2017)





While the picture presented above is bleak, there is an even more concerning situation for key populations: in many countries, the share of domestic funds which are allocated to key populations are dwarfed by spending on other budget lines, including ART and laboratory, as well as medical personnel. While these items are necessary for key populations, they are not sufficient without targeted funding for prevention, testing and linkage to care.

Some countries in the region are actively increasing the share of domestic funding which is dedicated to key population services.

- In Belarus, the government share of funding for key population programming is actively increasing: by engaging both national and municipal funding sources, projections are that domestic funds will contribute more than twice as much as Global Fund to key population programming. This includes access to funding for NGOs through social contracting mechanisms, but it should be noted that there is still some concern about accessibility of these funds based on capacity of both government and NGO actors.
- Georgia has also increased the share of domestic funding over the last several years, so that it rose from 12% in 2008 to 32% in 2013. In 2014, state funding increased by an additional US\$3 million; however, it should be noted that as of the in-country visit conducted in late 2017, none of these funds were supporting outreach or basic prevention services for key populations, including needle and syringe programs, which remain fully dependent on Global Fund support.
- Kosovo has also actively increased its share of domestic funding, with a further 20% increase planned from 2016-2018. Increasing investments in Kosovo, like Belarus, come from diverse sources. In the case of the former: the Ministry of Health; infectious disease centers; the Prison Health Department; the National Institute of Public Health; the Blood Transfusion Center; Methadone Maintenance Centers; the Ministry of Culture, Youth and Sports; the Ministry of Internal Affairs; and, the Ministry of Education, Science and Technology were all planning to invest in the HIV response during the period of 2016-2018.
- Perhaps most promising example among the countries assessed is the 20-50-80 Transition Plan, developed and endorsed by the Government of Ukraine. This plan will guide the country to gradually take over HIV activities during next three years and increase financial contributions with the following priority areas:
 - (i) prevention and social support services to key populations and PLHIV, ensured by open and transparent service contracting, covering 50% of the needs in 2019 and 80% in 2020;
 - (ii) procurement and supply management, which is now temporarily implemented by international procurement organizations will be transferred to National Procurement Agency with capacity building and transfer of expertise and capacity to the Agency;
 - (iii) monitoring and evaluation activities will be taken on by Public Health Centre of Ukraine.

Other countries are not as advanced in the transition to domestic funding. The Kyrgyz Republic has a transition plan in place to increase the portion of domestic funding which is devoted to the national HIV response; the current contribution is 43.3% of the total response, though this does not include funding for any key population-targeted programming, and efforts are still in progress to introduce a system to allow the funding of non-state actors to deliver prevention services. Nevertheless, the example of multisectoral collaboration being used in the Kyrgyz Republic to plan and execute this transition may serve as instructive for other countries approaching transition.

Case Study: Multisectoral efforts to ensure the sustainability of HIV-related programs in Kyrgyzstan

A significant reduction in the funding of HIV-related services from the Global Fund in the period from 2014 to 2018, against the backdrop of the continued growth of the HIV epidemic, the commitments of the goals of "90-90-90" and the increase of the coverage treatment of HIV, required the adoption of emergency measures at the national level to ensure continuation of activities. At the same time, a long dependence on external financing had created the illusion that similar levels of support would continue indefinitely. Consequently, measures to combat the HIV epidemic had not been included in the priorities for the allocation of public funds and in the context of a large deficit in the national budget. Changing this practice and taking responsibility for financing domestically required significant effort and time.

As the initial step, it was necessary to develop a sequence of actions to allow the least strenuous and most timely set of measures to switch to national funding, while the external financial resources were still available for support. The civil society sector advocated for the development and approval of a national plan for the transition to public funding (the "Roadmap"). The Roadmap was developed under the leadership of the Ministry of Health and the CCM, with the support of international partners. It included several key areas: ensuring access to ART, introducing mechanisms for public funding of prevention programs through NGOs, improving coordination, and other measures. Acceptance of the need to include the Roadmap into the national HIV program came only after long and persistent action by civil society.

At the time of the approval of the Roadmap, the two most problematic areas were the availability of drugs and the mechanisms for financing preventive programs.

At the same time, an assessment was conducted in 2016-2017 under the leadership of the Public Council of the Ministry of Health, to determine the barriers to the availability of drugs for the treatment of 5 diseases, including HIV and TB. The assessment determined that the practice of multi-year supply of ART as humanitarian aid has led to the fact that most of the key ART drugs do not have state registration in the country and are not included in the essential medicines list (EML). These barriers made it impossible for the governmental institutions to assume responsibility for the procurement of ART. The Public Council of the Ministry of Health, based on the assessment, initiated the inclusion of ART in the EML – a process that was completed in 2018. At the same time, the Public Council participated in the promotion of the new law of the Kyrgyz Republic "On the circulation of medicines", which significantly simplified the registration of medications for the treatment of socially significant diseases, which includes HIV.

In addition, the Public Council worked to gain support for increasing funding for the procurement of medicines and services for priority diseases, including HIV. As a result, in regard to HIV, KGS 23m



(approximately US\$338,000) were allocated in 2017, KGS 43m in 2018 (US\$632,000), and KGS 75m (US\$1.1m) in the draft budget for 2019. Negotiations of funds for 2019 are continuing.

Another component of the Roadmap is the implementation of a service contracting program, by which the government can contract non-governmental service providers to implement key health services. The Ministry of Health has initiated the development of a 3-year state program for four disease groups, including HIV, TB, oncology and mental illness. The program provides all the necessary preventive services for key groups, including testing, commodities, social accompaniment and others. The Public Council held several discussions of the program, including meetings with the Ministry of Health, and on 24 August 2018, the program was approved. The Public Council also initiated the inclusion of additional funds for this program in the draft budget for 2019. At present, intensive negotiations are under way with the government, so that an amount of KGS 15m (US\$220,000) is supported in the next year budget.

Underlying these statistics is a concerning lack of reliable data, which has been documented elsewhere: countries do not routinely collect or analyze expenditure data, nor do they regularly cost specific packages of services for key populations to be sure that budget allocations are realistically sufficient (Matyushina, 2015). This echoes the findings of the present assessments, in which at least some costing was found to be undertaken in each country, but the full package of services was not costed to use for appropriate key population-specific budgeting in any country but Ukraine.

ANALYSIS: ARE COUNTRIES PREPARED TO ADEQUATELY FINANCE PACKAGES OF SERVICES FOR KEY POPULATIONS?

It was beyond the scope of this assessment process to conduct an in-depth financial analysis of costing, allocation and expenditure related to packages of services for key populations in EECA. However, what was found was a heavy reliance on Global Fund to support key population programming in many countries, and in those that are trying to shift towards a greater share of domestic funding, a lack of available strategic information to guide sufficient allocations for full funding of the designed packages of services. Cost information is a particularly critical input into the process of setting priorities and efficient allocation of resources and given the urgency of scale-up to meet Fast-Track targets, countries must urgently fortify their expenditure analysis and budget development processes to be sure that sufficient resources are available to implement the designed packages of services, as intended.



LIMITATIONS

There were several limitations in conducting this assessment process, including during the initial desk review portion of country assessments. It is important to note that four of the 12 countries within the EECA region were limited to 'desk review only', meaning that APMG Health did not conduct an in-country assessment to collect data and information that could disprove or verify that information found in the initial desk review. Desk review data from these four countries have been included throughout this review.

The desk review process was limited by contractual time allowed (an average of two consultant days was allotted to each review) and by the scope of the review: sources reviewed were limited to those provided by Global Fund Country Teams in the last quarter of 2017.

The list of documents used for conducting these assessments has been considerably expanded for those countries selected for an in-country assessment. To the degree possible, data were expanded upon and verified by follow-up country visits; however, this process was also subject to time restrictions. As such, only two sites and two key populations were selected for focus in each country. It is important to note that because of this, country assessments may not have been representative of the national situation and reports only speak to the data available in the regions, districts, and cities that were visited or within other reports reviewed. This has therefore limited the amount of data and information about the other key populations that were not selected for the in-country data collection. Within the regional report for Eastern Europe and Central Asia, this presents a particular limitation for the prisoner key population, which was not selected as a key population of focus in any of the eight countries visited.

Data were collected in country by only one international and one local consultant, which limited the amount of site visits, key informant interviews, and focus group discussions consultants were able to conduct while in country.

During the in-country data collection, focus group discussion participants were identified by programs through which they received services. Therefore, respondents may not have been representatives of key populations more broadly. Focus group participants could have experienced peer pressure or pressure from program staff to give biased answers to the moderator's questions. Focus group discussions also seemed to be made up of program participants who sought services fairly regularly, or were even peer educators themselves. Therefore, the viewpoints of those members of KP who do not receive services, or face more barriers in receiving services, may not be represented. Focus group discussions were often conducted in local languages, and therefore at times, were translated for the international consultant. One limitation of this is that only some of the information that participants gave was actually recorded and presented in the country report.

For country assessments that included data collection pertaining to HIV services provided to PWID, it was difficult to find women who inject drugs to participate in focus group discussions - therefore,



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majority of these focus group discussions were made up of only men, and only represent the opinions and viewpoints of men who inject drugs in Eastern Europe and Central Asia.

It is important to note that one limitation of this regional analysis is that it is based on a selection of countries within a region, and therefore, it is not representative of the entire region. Within the group of countries selected, significant diversity exists. More specifically, one of the countries selected does not belong to a UNAIDS region—Kosovo. Kosovo has been placed in the Eastern Europe and Central Asia region due to its geographical location.

None of the countries selected for country assessments had any data regarding transgender persons, and therefore, no data about this KP in this region is available for this regional analysis. In only two countries, a package of HIV services for TG was combined with another key population (MSM or FSW), which is a limitation in understanding the services that are provided and the barriers that this population faces in receiving HIV services.

Across all countries, the lack of data which could be reliably disaggregated by age and gender was a limitation for many indicators. While this limitation is in fact a key finding of the assessment process itself, it also limited the depth of analysis which could be conducted as a part of this regional report.



REFERENCES

- Amnesty International. (2017). *Less equal: LGBTI human rights defenders in Armenia, Belarus, Kazakhstan, and Kyrgyzstan*. Retrieved from <https://www.amnestyusa.org/reports/less-equal-lgbti-human-rights-defenders-in-armenia-belarus-kazakhstan-and-kyrgyzstan/>
- Arayasirikul, S., Chen, Y-H., Jin, H. & Wilson, E. (2016). A Web 2.0 and Epidemiology Mash-Up: Using respondent-driven sampling in combination with social network site recruitment to reach young transwomen. *AIDS and Behavior*. 20(6): 1265-1274.
- Cáceres, C.F., Konda, K., Segura, E.R. & Lyerla, R. (2008) Epidemiology of Male Same-Sex Behaviour and Associated Sexual Health Indicators in Low-and Middle-Income Countries: 2003–2007 Estimates. *Sexually Transmitted Infections* 84 (Suppl 1): i49–i56.
- Eurasian Coalition on Male Health. (2016). *HIV Among MSM in Eastern Europe and Central Asia – an Epidemiological Review*. (ВИЧ среди МСМ в Восточной Европе и Центральной Азии Эпидемиологический обзор – in Russian only). Tallinn, Estonia.
- Falkenberry, H., Gexha-Bunjaku, D. & Burrows, D. (2018). *Assessment of HIV Service Packages for Key Populations in Kosovo*. APMG Health, Washington, DC.
- International Lesbian, Gay, Bisexual, Transgender and Intersex Association. (2017). *Sexual Orientation Laws in the World Map*. Retrieved from <https://ilga.org/maps-sexual-orientation-laws>
- LikataVICIUS, G., Burrows, D., Parsons, D. & Falkenberry, H. (2018). *Assessment of HIV Service Packages for Key Populations in Armenia*. APMG Health, Washington, DC.
- LikataVICIUS, G., Burrows, D., Parsons, D. & Falkenberry, H. (2018). *Assessment of HIV Service Packages for Key Populations in Belarus*. APMG Health, Washington, DC.
- LikataVICIUS, G., Burrows, D., Parsons, D. & Falkenberry, H. (2018). *Assessment of HIV Service Packages for Key Populations in Georgia*. APMG Health, Washington, DC.
- LikataVICIUS, G., Burrows, D., Parsons, D. & Falkenberry, H. (2018). *Assessment of HIV Service Packages for Key Populations in the Kyrgyz Republic*. APMG Health, Washington, DC.
- LikataVICIUS, G., Burrows, D., Parsons, D. & Falkenberry, H. (2018). *Assessment of HIV Service Packages for Key Populations in the Republic of Moldova*. APMG Health, Washington, DC.
- LikataVICIUS, G., Burrows, D. & Falkenberry, H. (2018). *Assessment of HIV Service Packages for Key Populations in Ukraine*. APMG Health, Washington, DC.
- Matyushina, D. (2015). *Road to Success: Towards Sustainable Harm Reduction Financing*. Eurasian Harm Reduction Network. Vilnius, Lithuania.
- McCreeSh, N., Frost, S.D., Seeley, J., Katongole, J., Tarshj, M.N. White, R.G. (2012). Evaluation of Respondent-Driven Sampling. *Epidemiology. Jan; 23(1): 138-147*.



McMillan, K., Worth, H. & Rawstorne, P. (2018). Usage of the Terms Prostitution, Sex Work, Transactional Sex, and Survival Sex: Their Utility in HIV Prevention Research. *Arch Sex Behav.* 2018 Jul;47 (5):1517-1527. doi: 10.1007/s10508-017-1140-0. Epub 2018 Jan 5.

Open Society Foundations, UNDP & Global Fund. (2017). *A global consultation on social contracting: working toward sustainable responses to HIV, TB, and malaria through government financing of programmes implemented by civil society.* Unpublished draft report. For access please contact ekaterina.lukicheva@opensocietyfoundations.org

Pinkham, S., Stoicescu, C. & Myers, B. (2012). Developing effective health interventions for women who inject drugs: key areas and recommendations for program development and policy. *Adv Prev Med.* 2012:269123.

Routh, S. (2007). *An Assessment of the HIV/AIDS and Related Health Delivery Systems in Karaganda Oblast in Kazakhstan.* The USAID CAPACITY Project. Almaty, Kazakhstan.

Sharma, M., Burrows, D. & Bluthenthal, R. (2008). Improving coverage and scale-up of HIV prevention, treatment and care for injecting drug users: Moving the agenda forward. *International Journal of Drug Policy.* 19S S1-S4.

Sharma, M., Burrows, D. & Bluthenthal, R. (2007). Coverage of HIV prevention programmes for injection drug users: confusions, aspirations, definitions and ways forward. *International Journal of Drug Policy.* 18; 92–98.

Simic, M., Johnston, L.G., Platt, L., Baros, S., Andjelkovic, V. & Novotny, T. (2006). Exploring barriers to 'respondent driven sampling' in sex worker and drug-injecting sex worker populations in Eastern Europe. *Journal of Urban Health: bulletin of the New York Academy of Medicine.* 83 (6 Suppl): i6–15.

Tairova, Z. & Burrows, D. (2018). *Assessment of HIV Service Packages for Key Populations in Uzbekistan.* APMG Health, Washington, DC.

UNAIDS. (2017). *Ending AIDS: Progress Towards the 90-90-90 Targets.* Global AIDS Update 2017. Retrieved from http://www.unaids.org/sites/default/files/media_asset/Global_AIDS_update_2017_en.pdf

UNAIDS. (2015) *Fast-Tracking Combination Prevention: Towards reducing new HIV infections to fewer than 500,000 by 2020.* Geneva.

UNDP, IRGT, JHU, WHO, UNAIDS & USAID. (2016). *Implementing comprehensive HIV and STI programmes with transgender people: practical guidance for collaborative interventions.* New York.

UNFPA, Global Forum on MSM & HIV, UNDP, WHO, USAID, World Bank. (2015). *Implementing comprehensive HIV and STI programmes with men who have sex with men: practical guidance for collaborative interventions.* New York.

Wolfe, D., Carrieri, M.P. & Shepard, D. (2010). Treatment and care for injecting drug users with HIV infection: a review of barriers and ways forward. *Lancet*. 2010 Jul 31;376(9738):355-66. doi: 10.1016/S0140-6736(10)60832-X.

WHO. (2016). *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2016 Update*. Geneva. Retrieved from <http://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/>

WHO. (2017). *Consolidated guidelines on HIV testing services*. Geneva. Retrieved from <http://www.who.int/hiv/pub/guidelines/hiv-testing-services/en/>

WHO. (2004) *HIV Status Disclosure to Sexual Partners: Rates, Barriers, and Outcomes for Women*. Geneva. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/42717/9241590734_summary.pdf?sequence=2

WHO, UNFPA, UNAIDS, Global Network of Sex Work Projects, The World Bank. (2013). *Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions*. Geneva.

WHO, UNODC & UNAIDS. (2012). *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision*. Geneva. Retrieved from https://www.who.int/hiv/pub/idu/targets_universal_access/en/

IBBS AND KP STUDIES

Center for Health Policy Analysis. (2014) *Assessment of the number of People Who Inject Drugs in Kazakhstan*.

Center for Health Policy Analysis. (2014) *Assessment of the number of People Who Inject Drugs in Kyrgyz Republic*.

Curatio International Foundation & the Global Fund. (2014). *Population Size Estimation of Female Sex Workers in Tbilisi and Batumi, Georgia*.

Curatio International Foundation & the Global Fund. (2014). *Population Size Estimation of Men who have Sex with Men in Georgia*.

Curatio International Foundation & Bemoni Public Union. (2015). *Population Size Estimation of People who Inject Drugs in Georgia*.

Curatio International Foundation & Center for Information and Counseling on Reproductive Health – Tanadgoma. (2015). *HIV risk and prevention behavior among Men who have Sex with Men in Tbilisi and Batumi, Georgia: Bio-behavioral Surveillance Survey*.



APMG
HEALTH

Curatio International Foundation & Center for Information and Counseling on Reproductive Health – Tanadgoma. (2015). *HIV risk and prevention behavior among Female Sex Workers in Two Cities in Georgia: Tbilisi and Batumi.*

Handanagic, S., Bozicevic, I., Civljak, M., Dominkovi, Z., Sevic, S., Barbaric, J., ... Josip, J. (2015). *HIV and hepatitis C prevalence, and related risk behaviours among People Who Inject Drugs in three cities in Croatia: Findings from respondent-driven sampling surveys.*

International HIV/AIDS Alliance. (2013). *Monitoring behaviour and HIV infection among “high consuming” People Who Inject Drugs.*

International HIV/AIDS Alliance. (2013). *Monitoring behaviour and HIV infection among women who sell sexual services for food.*

Kassyanchik, M. (2015). *Size estimation of MSM in Tajikistan.*

Kechina, E.A. (2015). *Behavior and level of knowledge of Commercial Sex Workers in Belarus.*

Kechina, E.A. (2015). *Behavior and level of knowledge of Men who have Sex with Men in Belarus.*

Kechina, E.A. (2015). *Behavior and level of knowledge of People Who Inject Drugs in Belarus.*

Kechina, E.A. (2015). *Estimate of the number of Commercial Sex Workers in Belarus.*

Kechina, E.A. (2015). *Estimate of the number of Men who have Sex with Men in Belarus.*

Kechina, E.A. (2015). *Estimate of People Who Inject Drugs in Belarus.*

Ministry of Health and Social Protection of the population of the Republic of Tajikistan Republican Center for the Prevention and Control of AIDS. (2014). *Population estimate Sex Workers and People Who Inject Drugs in the Republic Tajikistan in 2014.*

Ministry of Health and Social Protection of the population of the Republic of Tajikistan Republican Center for the Prevention and Control of AIDS. (2013). *Report on Sustained Epidemiological Supervision among Migrants in Five Pilot Areas in Tajikistan in 2013.*

Ministry of Health and Social Protection of the population of the Republic of Tajikistan Republican Center for the Prevention and Control of AIDS. (2013). *Sentinel epidemiological surveillance among prisoners in two pilot cities (Dushanbe and Khujand) in Tajikistan in 2013.*

Ministry of Health, Armenia. (2016). *Integrated biological-behavioral surveillance survey among People Who Inject Drugs, Female Sex Workers and Men who have Sex with Men in Yerevan, Gyumri and Vanadzor.*

Ministry of Health, Kazakhstan. (2013). *Second Generation Surveillance Results HIV-Infection in MSM.*

Ministry of Health, Kazakhstan. (2016). *Global AIDS Monitoring Report.*

Ministry of Health, Kyrgyzstan. (2013). *Second Generation HIV Surveillance among PWID in the Kyrgyz Republic.*

Ministry of Health, Kyrgyzstan. (2013). *Second Generation HIV Surveillance among Sex Workers in the Kyrgyz Republic.*

Ministry of Health, Uzbekistan. (2013). *The results of the epidemiological sentinel HIV surveillance among Men who have Sex with Men in 2013.*

Ministry of Health, Uzbekistan. (2015). *The results of the epidemiological sentinel HIV surveillance among Men who have Sex with Men in 2015.*

Ministry of Health, Uzbekistan. (2013). *The results of the epidemiological sentinel HIV surveillance among people providing intimate services for remuneration in 2013.*

Ministry of Health, Uzbekistan. (2015). *The results of the epidemiological sentinel HIV surveillance among people providing intimate services for remuneration in 2015.*

Ministry of Health, Uzbekistan. (2013). *The results of the epidemiological sentinel HIV surveillance among People Who Inject Drugs in 2013.*

Ministry of Health, Uzbekistan. (2015). *The results of the epidemiological sentinel HIV surveillance among People Who Inject Drugs in 2015.*

Ministry of Health, Uzbekistan/ UNAIDS/ Central Asia Drug Action Program. (2013). *Estimate of the population size of PWID and SW in Uzbekistan.*

Ministry of Health, Uzbekistan. (2015). *Triangulation of data analysis of HIV infection in Uzbekistan.*

M-Vector. (2013). *Size estimate of Sex Workers in Kyrgyzstan.*

M-Vector. (2015). *Assessment of MSM and HIV in Kyrgyzstan.*

UNAIDS. (2013). *An evaluation of harm reduction programs in Moldova.*

USAID, RESPOND, PACT, FHI360. (2013). *HIV Epidemic Among Key Populations in Ukraine: Review of Secondary Data.*

Zohrabyan, L., Johnston, L., Scutelnicu, O., Iovita, A., Todirascu, L., Costin, T. Ionascu, G. (2013). *Determinants of HIV Infection Among Female Sex Workers in Two Cities in the Republic of Moldova: The Role of Injection Drug Use and Sexual Risk.* *AIDS Behav.* DOI 10.1007/s10461-013-0460-x.



APPENDIX 1: SUMMARY TABLE, WHO CONSOLIDATED GUIDELINES

Health Sector Interventions	
1	HIV prevention (condoms, lubricant, PrEP, PEP, VMMC)
2	Harm reduction interventions for substance use, in particular NSP, OST and naloxone for overdose management
3	HIV testing and counselling
4	HIV treatment and care
5	Prevention and management of co-infections and other co-morbidities, including viral hepatitis, TB and mental health conditions
6	Sexual and reproductive health interventions
Critical enablers	
1	Supportive legislation, policy and financial commitment, including decriminalization of behaviors of key populations
2	Addressing stigma and discrimination
3	Accessible, available and acceptable health services
4	Community empowerment
5	Addressing violence against people from key populations