Joint Engagement Strategy 2018-2020

Joint Engagement Strategy to counteract the HIV epidemic among MSM and trans people in Central and Eastern Europe and Central Asia

Scope and purpose

Joint Engagement Strategy emerged from the increased recognition and interest of multiple national and regional stakeholders in addressing the ongoing HIV crisis among gay and other men who have sex with men and increased concerns over health and rights of trans people. The Strategy aims to identify approaches and activities at regional level that can support national work towards improving health, rights and well-being of gay and other men who have sex with other men (MSM) and trans people[1] in Central and Eastern Europe and Central Asia (CEECA).

The Joint Engagement Strategy follows the goals and spirit of the Sustainable Development Goals[2] and countries' commitment to reach the HIV-focused 90-90-90 goal by 2020.

In the initial period, the Joint Engagement Strategy focuses on Eastern Europe and Central Asia, particularly the five countries in focus of the Regional Program "Right to Health", which provides opportunities for a greater collaboration and operates in the same period as the Strategy. HIV is seen as an entry point to health at large and well-being of MSM and to some degree for trans people.

Development

The Regional Platform for Policy Reform on HIV among MSM and trans people in CEECA leads the development of the Joint Engagement Strategy. A broad range of stakeholders contributed to the JES development at the 2nd Regional Consultation on HIV among MSM and Trans People in Eastern Europe and Central Asia on 31 May – 1 June 2018. The document has been developed using detailed analysis and research which are made available below.

Situation: needs, gaps and opportunities

The geographical scope of the region

Central and Eastern Europe and Central Asia (CEECA) is a politically diverse region. The following definitions of sub-regions are used for the purpose of this analysis:

Baltic States: Estonia, Latvia, Lithuania
Caucasus: Armenia, Azerbaijan, Georgia
Central Asia: Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan
Central Europe: Bulgaria, the Czech Republic, Hungary, Poland, Romania, Slovakia, Slovenia
Eastern Europe: Belarus, Moldova, Russia, Ukraine
South-Eastern Europe: Albania, Bosnia-Herzegovina, Croatia, Kosovo, Montenegro, North Macedonia, Serbia

[1] See note on terminology at the end of the document
[2] The following SDGs are particularly relevant for the purpose of the Joint Engagement Strategy:
- Achieve universal health coverage, access to quality essential health-care services for all
- End the AIDS epidemic, combating hepatitis and other communicable diseases
- Promote mental health and well-being
- Ensure universal access to sexual and reproductive health-care services

Political and human rights context in CEECA

The countries of the Baltic States, Central Europe and Croatia are part of the European Union (EU). The EU constitution explicitly prohibits discrimination based on sexual orientation[3]. Moreover, a special agency, Fundamental Rights Agency (FRA) annually reports on the status of the implementation of this norm, feeding the work of the EU Council, the Parliament and the Commission, as well as supporting stakeholder capacities and cross-country learnings. The European Parliament created a special intergroup on LGBT issues, uniting over 100 of its members[4].

Many South Eastern European countries[5] are candidate countries for the EU membership and others seek the candidacy status. These countries report on their progress to the EU how they align their human rights standards with these of the European Union. Three other countries – Georgia, Moldova and Ukraine – signed comprehensive partnership agreements with the EU where they committed to seeking implementation of the EU human rights standards and similarly report on the progress. Health is the national competence in the EU, however, the EU sets some general standards for national health systems; one of the important developments is developing cross-border access to healthcare within the EU[6].

Eurasian Economic Union[7] includes Armenia, Belarus, Kazakhstan, Kyrgyzstan, and Russia. The Union sets for a strong implementation of the freedom of movement across the territories of its member states but this work is still evolving. The Union has not developed its own human rights framework or health agenda.

All the countries, with the exception of the Central Asian Republics and Belarus, are parties to the Council of Europe (CoE) and its European Convention on Human Rights. The CoE Commissioner on Human Rights[8] has been an active voice that exposes discrimination, the need for protection and promotion of LGBTI rights. The European Court on Human Rights has made some landmark decisions to protect gender identity, same sex partnership rights and against arbitrary detention of LGBT asylum seeker.[9]

All the countries of the region are parties of the UN Conventions on Human Rights, notably Universal Human Rights Declaration, Covenant on Economic, Social and Cultural Rights, Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and Convention on the Elimination of All Forms of Discrimination against Women.

Opportunities from the HIV field in the new SDG era

The new Sustainable Development Agenda (SDG agenda) sets an ambitious target for ending the AIDS epidemic by 2030, following a similarly ambitious agenda for HIV in the Millennium Development Goals. But at the same time, the complexity of the SDG agenda means that the world moves towards a more holistic approach to address health, justice, migration and other

[3] Article 21 of the EU Constitution with related explanation and case law are available at: https://fra.europa.eu/en/charterpedia/article/21-non-discrimination
[4] Its website: http://www.lgbt-ep.eu
[5] The list of the candidate countries and the progress of the EU dialogue with these and other countries in special relations with the EU is available at: http://ec.europa.eu/environment/enlarg/candidates.htm
[6] More information is available at: https://ec.europa.eu/health/cross_border_care/overview_en
[7] More information is available at: http://www.eaeunion.org
[8] The thematic LGBTI corner on the CoE Commissioner for Human Rights lists the statements, reports, and guidance on the subject: https://www.coe.int/en/web/commissioner/thematic-work/lgbti
[9] ILGA monitoring of the relevant cases is available here: https://ilga-europe.org/tags/echr

areas for people-centered approaches[10]. Still, HIV presents unique opportunities for promoting health and rights of men who have sex with men (MSM) and trans people, because of the strong progress in the field and interconnections of HIV with multiple health and social justice issues. MSM and/or trans people are identified as priority populations in international political documents on HIV and, more recently, one European document on hepatitis. These documents include the UN political declarations on HIV of 2016 and others, Dublin and Malta Declarations, WHO Health Sector Action Plans on HIV and viral hepatitis in Europe. Most of the national HIV programs explicitly identify MSM as a key population (unlike in other health areas). Trans people are not mentioned in the national programs on HIV, with Armenia, Kyrgyzstan, Tajikistan and Ukraine being few exceptions. The prioritization of the two populations in the HIV area has been instrumental to raise broader aspects linked to the right to health, structural barriers why people get exposed to infection and why they cannot access health services. Stigma, discrimination, violence and other broader legal and other type of constraints contribute to creating barriers for the representatives of the two groups. The HIV area is among few that have realized the importance of promoting the meaningful participation of affected communities in policies, approaches and services, also addressing broader social determinants including promotion of rights, addressing economic, cultural and other barriers. The HIV area often offers the only platform for activists to interact with state institutions: the activists are recognized there as a key partner by all stakeholders and are part of multi-sector HIV governance bodies in some countries of the region.

Concerns over high or increasing HIV among MSM

The HIV levels among MSM remains of great concern across CEECA for both countries already experiencing the epidemic and those which record fewer HIV cases in this group. In contrast with the global tendencies, the HIV epidemic continues expanding with a greater number of new cases every year in most countries of the region, with exception of Central Europe and parts of South-East Europe. Low HIV prevalence among MSM is reported in one third of the CEECA countries, notably Albania, Armenia, Azerbaijan, Bosnia-Herzegovina, Bulgaria, Croatia, the Czech Republic, Lithuania, Kazakhstan, Tajikistan, and Uzbekistan (between 0.5-4.8%[11]). In others, Belarus, Kyrgyzstan, Latvia, Moldova, North Macedonia Poland, Serbia, Slovenia, and Ukraine, the level of HIV prevalence passed the 5%-threshold for concentrated epidemics, reaching up to 9.8%. Moreover, other five countries (Hungary, Georgia, Montenegro, Romania and Slovakia) recorded the prevalence stepping above 10%, with the major recent jump taking place over short periods of time in Georgia, Montenegro, and Romania.

There are differences on the portion of new HIV cases contributed to the homosexual transmission route in the official records of the countries. In most countries of Central and South-East Europe, majority of new HIV cases are registered among MSM[12]. In the East, only 3% of new HIV cases are attributed to MSM despite a concentrated stage of the epidemic in

[10] E.g. in the health sector, the World Health Assembly agreed on the *Framework on integrated people-centred health services* in 2016. In Europe, the Health 2020 strategy agreed in 2011 explicitly aimed for integration of disease responses and people-centered care and set a roadmap how to achieve this in Strengthening people-centred health systems in the WHO European Region: a roadmap

[11] Prevalence data are used from UNAIDS database of data of 2017 available at: http://www.aidsinfoonline.org and the ECDC Dublin Declaration thematic report on MSM 2017. There was a conflicting information available for Hungary – above 10% prevalence in the ECDC publication, while in the UNAIDS database it was just 4%. The ECDC data was used in this case, as the same prevalence was found in scientific literature.

[12] European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2017 – 2016 data. Stockholm: ECDC; 2017.

some countries. Researchers suggest homosexual transmission is grossly underreported in the official registration of the HIV cases[13].

Optima modeling, which guides countries how to increase efficiencies and what resources are needed for reaching the UN global goals, suggests the epidemic might grow among MSM in the region in the future, if not yet, and recommends increased action among MSM for such a diverse group of countries like Belarus, Bulgaria, North Macedonia, and others[14]. This recommendation is consistent with the global nature of the high levels of HIV epidemic among MSM around the world.

The level of targeted health responses among MSM remains low in CEECA. Few countries report their data to UNAIDS and European CDC. Countries, like the Baltic States, Poland, report major gaps in HIV programming among MSM.[15] When it comes to reaching the 90-90-90 targets for HIV diagnosis and care, the biggest progress among the countries with the full set data reported, is in the Czech Republic where 59% of all HIV-positive MSM had their virus suppressed and lowest in Azerbaijan where this number was only 10%[16]. Notably, in a study in Moscow[17], the research found this number to be only 3%. One trend seen in the limited data available is that HIV positive MSM manage to reach good treatment results if they are diagnosed and receive treatment. In Moscow, Russia, and Kazakhstan the level of suppression was lowest with 60-64%, while the Czech Republic and North Macedonia reported achieving 94%. There might be major gaps in diagnosis (e.g. only 12-14% in Azerbaijan and Moscow, Russia, while Belarus reports 100% of HIV-positive man are diagnosed) and/or with treatment (e.g. only 22% in Belarus).

HIV services in South-Eastern Europe and Eastern Europe and Central Asia, particularly specialized anonymous services provided by civil society, depend on international funding. But the Global Fund, the main donor in the HIV field, is now moving away from South-East Europe and the Russian Federation and is reducing its support for the HIV responses by 50% in the current 3-year cycle in comparison with the previous one across EECA. Moreover, there is a limited progress in securing national ownership and domestic funding of these specialized services by civil society. Positive recent exceptions are Montenegro and North Macedonia, where Ministries of Health starts funding a range of HIV prevention services among key populations including among MSM. Belarus, too, started establishing the legislative framework for social contracting and delegated allocation of funding to local authorities within its national HIV sub-program. In 2018, in Moldova the National Health Insurance Company contracted an NGO to deliver some HIV prevention services among MSM for the first time.

Other health concerns for MSM

In addition to HIV, MSM might be experiencing higher levels of sexually transmitted infections (STIs) and other needs related to sexual health, particularly syphilis in some countries, though data is fragmented and come only from few countries. Data on active syphilis data shows different trends with the lowest prevalence in Armenia, Lithuania and Slovakia (0-1.4%) and higher in others with available data: from 4.7% in Belarus to 9.7% in Romania and from 13.3-

[13] Spindler H, Salyuk T, Vitek C, Rutherford G. Underreporting of HIV transmission among men who have sex with men in the Ukraine. *AIDS Res Hum Retroviruses*. 2014;30(5):407-8.
[14] Optima studies are available at: http://optimamodel.com/hiv/applications.html
[15] ECDC. HIV and men who have sex with men. Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2017 progress report. Stockholm: ECDC; 2017.
[16] ECDC. Continuum of HIV care. Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2018 progress report. Stockholm: ECDC; 2018
[17] Wirtz AL et al. The HIV care continuum among men who have sex with men in Moscow, Russia: a cross-sectional study of infection awareness and engagement in care. Sex Transm Infect. 2016 March ; 92(2): 161–167

13.6% in Azerbaijan and Moldova to 36.7% in Georgia[18]. Significantly lower levels were found for HBsAg for viral hepatitis B, e.g. between 0 and 0.2% in Armenia, Belarus, Bulgaria and 2.4% in Moldova[19], while the EU-level review shows very low levels of 0-1.4%[20]. Slightly higher levels are found in case of viral hepatitis C: ranging between 0.9% and 4.7% in different studies in Croatia, Estonia, Lithuania and Slovakia but found 22.8% in Bucharest, possibly because of the recruitment of high number of MSM who inject drugs[21] [22]. Evidence shows the higher prevalence of STIs and hepatitis among HIV co-infected MSM.

Little data is available on access to primary care, like general practitioners. In Serbia, 19% of MSM reported avoiding healthcare settings due to stigma and discrimination.[23]

Trans people and health

There is nearly no data about trans people, HIV and health issues in CEECA, as shown in a review of epidemiological data available, published by ECOM in 2019[24]. A recent study in Armenia shows an HIV prevalence of 2% among trans women, while in Ukrainian community survey 21% of trans people self-reported having HIV. A 2013 global systematic review and meta-analysis of 39 studies in 15 countries around the world showed that the pooled HIV prevalence in trans women was 19.1% and that trans women are 49 times more likely to be living with HIV than the general population.[25] According to the limited global data mapped by UNAIDS[26], in 15 out of 20 countries HIV prevalence among trans people exceeded 5% and reached up to 32%. The only European country with data, Spain, shows HIV prevalence of 13.3%. For trans people, in various parts of Europe mental health remains the issue that is "overdiagnosed" and "underserved"[27].

Trans people suffered from their pathologization by the system and high restrictions to healthcare for gender affirming procedures. Only in June 2018, the World Health Organization announced the completion of the process of revision and reform of the *International Classification of Diseases* (ICD). The revision removes all pathologizing references to trans and gender diverse people from the ICD Chapter on Mental Health; and creates a new Chapter on Conditions Related to Sexual Health and includes two new categories (1) Gender Incongruence of Adolescence and Adulthood and (2) Gender Incongruence of Childhood. The new ICD version, the ICD-11, still must be approved in May 2019 by the World Health Assembly (WHA). In parallel, this reform at the WHO level needs to branch out the application of the revised ICD at national levels, i.e. depathologizing trans and gender diverse people's access to legal gender recognition and related rights, and promoting universal access to healthcare for accessing gender affirming procedures and treatment with full respect to human rights and dignity.[28]

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[18] 2017 data from UNAIDS on active syphilis data from http://aidsinfo.unaids.org and syphilis data for Bratislava, Bucharest and Vilnius from Sialon II are used here as proxies for national data
[19] 2017 data from UNAIDS from http://aidsinfo.unaids.org
[20] Falla AM et al. Hepatitis B/C in the countries of the EU/EEA: a systematic review of the prevalence among at-risk groups. BMC Infectious Diseases (2018) 18:79.
[21] Ibid.
[22] ESTICOM. Review of HIV and sexually transmitted infections among men who have sex with men (MSM) in Europe. Conducted by Robert Koch Institute, 2017.
[23] 2017 data from UNAIDS from http://aidsinfo.unaids.org
[24] ECOM. Trans People Needs: Break the Wall of Invisibility! 2019. Accessed at https://ecom.ngo/en/ecom_trans_data/
[25] Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. Baral, S.D. et al. The Lancet Infectious Diseases, Volume 13, Issue 3, pp. 214-222, 2012
[26] European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2017 – 2016 data. Stockholm: ECDC; 2017.
[27] Transgender Europe, Overdiagnosed but Underserved: Trans Healthcare in Georgia, Poland, Serbia, Spain, and Sweden: Trans Health Survey, 2017
[28] The paragraph adapted from the GATE's statement of 21 October 2018 on Joint Statement for Depathologization and TDoR 2018, available at: https://transactivists.org/depath-tdor-joint-statement-2018/

When it comes to gender identity, Belarus, Kyrgyzstan and Ukraine serve as positive examples: medical procedures for changing gender identity are available there and these countries legally recognize changes in gender identity including official documents and records[29].

Mental health and substance use

Data on mental health and other non-communicable diseases among MSM and trans people are scarce. There is an increasing range of evidence of significant levels of sexualized drug use – so called chemsex – across Europe, though no extensive studies are available in the region. A study in Ukraine easily found MSM who reported use of psychoactive substances in the capital city. This study confirmed unsafe drug use practices (high levels of mixing different drugs, parallel use of alcohol, overdose experience in nearly half of respondents), inconsistent condom use in multi-partner sex parties without PrEP available and one quarter of MSM experienced problems at work or other aspects of life due to substance use.[30]

Evidence from outside the region shows a high interlink between internalized and other stigma, poor mental health and taking risks and substances, like alcohol, drug use and riskier sexual practices.[31] [32] Within the context of HIV, mental health is often called a "blind spot" of the current responses. Research shows that competent mental health improves access to HIV services.[33]

Mobility and migration

There is evidence of migration of LGBT people to larger cities in their own countries (internal migration) and cross-border migration for coming to safer spaces and more infrastructure for social, health and other life. Moreover, community leaders including from the Regional Platform for Policy Reform report about greater interactions between communities in the times of larger mobility opportunities and connections through local LGBT scenes and social networks, interlinkages with the cities in the European Union. After removing visa requirements for entering Schengen states for nationals of South East Europe some 10 years ago and more recently for Georgia, Moldova and Ukraine, migration from these countries towards EU countries has increased. Georgian members of the Regional Platform report a dramatic increase in asylum requests from Georgian queer community members. Few states in the European Union have explicit guidelines on interviewing LGBT asylum seeking on the basis of LGBT prosecution in their home countries[34], there is no data whether there is a significant portion of LGBT asylum seekers from CEECA. In the East, the region hosts the major migration corridor leading to Russia with the fourth largest migrant population globally[35], with particularly high populations coming from Central Asia, parts of Caucasus and Eastern Europe, engaging there in documented and undocumented, seasonal and longer-term labor migration. A large labor migration corridor connects the Central Asian states to Kazakhstan.

[29] TGEU, Trans Rights Europe Index 2018. Data on Kyrgyzstan from ECOM.
[30] ALLIANCE. GLOBAL and Center of Social Expertises of the Institute of Sociology of the National Academy of Sciences of Ukraine. Analytical report based on the results of the study "Chemsex and drug use among MSM in Kyiv: new challenges", 2017.
[31] Zhu, Y et al. The relation between mental health, homosexual stigma, childhood abuse, community engagement, and unprotected anal intercourse among MSM in China. Nature *Scientific Reports* Volume 8: 3984 (2018)
[32] Evidence for HIV Prevention in Southern Africa. Mental health services are necessary for a holistic HIV prevention and care package for MSM, May 2018
[33] Irin News. Mental health "blind spot" limits MSM HIV interventions, 5 August 2013, accessed at: http://www.irinnews.org/report/98523/mental-health-"blind-spot"-limits-msm-hiv-interventions
[34] Epsilon project. Lesbian, Gay, Bisexual, Transgender And Migrant: A European Story Of Discrimination And Empowerment, 2018
[35] UN. International Migration Report 2017

Access to health for migrants is limited. According to the global HIV travel database, few CEECA countries continue using deportation for HIV and/or have other travel restrictions, notably Azerbaijan, Kazakhstan, Kyrgyzstan and Russia[36]. More political dialogue is starting on the subject of finding cross-border health care solutions. As mentioned above, the European Union implements cross-border health care directive but that is designed for EU citizens. Kazakhstan, Kyrgyzstan and Tajikistan consider cross-border care agreements in the area of tuberculosis, which might be further expanded to other health areas in the future.

Evolving scientific guidance and innovation

There is global and European guidance how to address HIV among MSM, notably there is a *MSMIT - Implementing comprehensive HIV and STI Programmes with Men Who have Sex with Men*. The instruments for testing have been expanded with community-based testing and self-testing, both recommended by the WHO. The individual and public health benefits of treatment including as prevention are recognized and all people living with HIV are recommended to start treatment early. New scientific evidence expanded the comprehensive prevention package to include pre-exposure prophylaxis (PrEP) which has proven to be effective in reducing new HIV cases among MSM in several high-resource settings in Amsterdam, London among others. Two countries in the region, Georgia and Ukraine, started the implementation of PrEP among MSM and trans people in 2017- early 2018. PrEP pilots are planned or being launched in some other countries, like Armenia, Croatia, Moldova.

There is an improved global guidance how to better address trans people needs in the context of such issues like HIV with development of a *TRANSIT, Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for Collaborative Interventions*.

Limited data

The recent review of data on size estimation, behaviors, needs and HIV-related data of MSM and trans people showed major gaps, with improved availability of data on MSM, but major issues in quality, harmonization of terminology and concepts, and extremely little data on trans people.

Phobias, stigma and rights – some progress and still major gaps in the context of health

Internalized homophobia remains high, while more positive trends observed in the Western part of the region and less progress seen yet in Caucasus and Central Asia, according to a recent major survey of nearly 8300 respondents in 13 countries of Eastern Europe and Central Asia. Acceptance of his own homosexuality or bisexuality was identified as a facilitating factor for the uptake of HIV services and engagement in civil society work[37].

A 2017 survey in 5 countries[38] showed the trends of social workers having less stigmatizing and discriminative attitudes to their clients based on sexual orientation (homophobia) in comparison with health workers, while the latter had better attitudes in comparison with police officers. 20-25% of social, health and law enforcement staff noticed homophobic behavior of their colleagues. There are reported cases from at least two EECA countries of breaching

[36] Accessed at: http://www.hivtravel.org/Default.aspx?PageId=143&Mode=list&StateId=4
[37] М. Касянчук, А. Шестаковский, A. Garner, S. Howell. Внутренняя гомофобия МСМ 13 стран региона, для ЕКОМ, 2017.
[38] Н. Дмитрук, М. Касянчук, Р. Москотина, Ю. Привалов, О. Трофименко Гомофобия среди сотрудников ключевых социальных сервисов, для ЕКОМ, 2017.

confidentiality and/or use of sensitive private information for blackmailing. The perceived and/or experienced stigma and discrimination in health settings are the reasons why people turn to civil society services and private sector (at fee).

Legal norms and their application limit acceptance of LGBTI in societies and their possibilities to protect discrimination cases based on sexual orientation and gender identity, as well as addressing LGBTI health[39]. The sub-region of Eastern Europe traditionally is ranked lower among other CEECA countries in the *Rainbow Europe Index*[40], which analyses legal norms towards LGBTI. In 2018, Croatia, Hungary, Estonia, Montenegro and Albania (in that order) were ranked highest among all the CEECA countries, while Azerbaijan, Armenia, Russia and Moldova were ranked lowest in the *Rainbow Europe Index*. The positive example is also Georgia which explicitly prohibits discrimination based on sexual orientation in its anti-discrimination law, unambiguously secures right to assembly and freedom of speech in the context of LGBTI, as well as no longer puts formal or informal challenges for LGBTI to donate blood. In Russia, in 2018, so called "anti-propaganda" legislation of protecting minors from information about "untraditional" sexual orientation enabled recent termination of operations in Russia of the main gay health sources in Russia *gay.ru* and HIV and health specialized site for LGBTI *Parni Plus*.

Community development and participation

According to a survey of 287 LGBTI organizations across Europe including Central Asia conducted by ILGA Europe[41], the LGBTI movement grows but a significant number of LGBTI organizations struggle with funding and have no funding from government or private foundations. One quarter of LGBTI organizations in our region reported no external funding. This demonstrates the need for alternative funding mobilization, work with external funding donors and help strengthening fundraising capacities of the groups. ECOM's study in 5 countries showed that the level of participation of community and activists in government policies varies depending on openness from the government side and community capacities. So far, the engagement has been most successful in the HIV field in comparison with other areas, and a correlation was seen between the higher level of funding of HIV programming including community system strengthening and the comparative higher level of participation – in Georgia and Kyrgyzstan. Reportedly, the level of integration of HIV issues in LGBTI activist agenda varies from country to country but it is at high level in Kyrgyzstan, Moldova, and Ukraine, there is work in progress in Belarus, Georgia, and North Macedonia.

[39] ECOM. Legislative analysis related to LGBT rights and HIV in CEECA, 2017.
[40] ILGA Europe, Rainbow Europe: Country Ranking 2018.
[41] ILGA-Europe "Funding for LGBTI activism in Europe and Central Asia: priorities and access to resources", April 2018

JOINT ENGAGEMENT STRATEGY

JES Goal 2018-2020

- To support and mobilize countries and stakeholders to end the HIV epidemic among MSM and trans people in CEECA, as part of SDG 2030 agenda

Approaches

- **EVIDENCE:** Improve evidence and knowledge base on needs, gaps, opportunities and exchange good practices
- **DIALOGUE**: Support regional (and national) dialogue among stakeholders from multiple sectors and multiple disciplines
- **CAPACITY**: Support civil society and other stakeholders' capacity to mobilize communities and engage in the dialogue

Value added

Regional level work of supporting national work is in the focus of the strategy, with a focus on work that could be implemented.

Priorities and activity areas

1. **SERVICES:** 90-90-90-90 goals for HIV continuum of services by 2021

    1.1. Support country-level analysis and consultations of progress in the 90-90-90 goal

    1.2. Support the development and implementation of country roadmaps for achieving the 90-90-90 goal overall and specifically for MSM and trans people

    1.3. Map and promote regional models of services developed based on MSMIT and TRANSIT. This include practices, national service standards, approaches to integration of services to address multiple needs, collaboration between government and community groups in services, implementing innovations and approaches that make services attractive and acceptable to diverse sub-groups of communities

    1.4. Promote innovative approaches and concepts including PrEP and U=U with particular focus on the Russian speaking communities

2. **RESOURCES:** Financial sustainability of HIV targeted services, activism, dialogue

2.1. Together with other HIV stakeholders, establish and feed a resource hub on social contracting and NGO-run service funding from state funding, with special sections for the needs of government institutions, technical partners and civil society

2.2. Mobilize international resources for activism and services to soften the transition of Global Fund, other HIV and human rights donors out of sub-regions and across the region, while the HIV epidemics are increasing and the LGBTI rights remain in crisis in several countries and only starting to get greater protections

2.3. Compile and promote arguments for state investment including on cost-effectiveness, effectiveness, optimization, models from other countries and financial arguments from CEECA and global sources

2.4. Strengthen capacity of civil society to engage in state budget processes and advocacy and influence transition-related developments and engage in dialogue on the changed models of planning, operation, funding and accountability of CSO-run services in post-donor era

2.5. Support exchange of practices among countries in developing their financial sustainability models of services

3. **MORE THAN HIV:** Comprehensive health needs, health sector reforms

3.1. Map and produce recommendations of needs, practices and opportunities for addressing broader health needs of MSM and trans people including sexual reproductive health and rights, mental and gender-transition-related health

3.2. Support rolling-out awareness and implementation of removal of gender transition-related provisions from the WHO's International Classification of Diseases in selected countries of the region

3.3. Gather evidence and good practices on migration- and mobility-related health needs of MSM/trans people, which could be further used for promotion of services in countries of origin and destination, initiatives to address internal migration and in the ongoing cross-border initiatives

3.4. Increase awareness of civil society on health sector reforms and universal health coverage discussions and how this could be relevant for LGBTI

4. **ACCEPTANCE & LEGAL ENVIRONMENT:** Partnerships for eliminating LGBTI and HIV related discriminative norms, policies and practices in health

4.1. Support alternative reports to UN and other human rights bodies and follow up on implementation of UN human rights body recommendations

4.2. Explore needs and opportunities for a cross-country dialogue among parliamentarians, ombudsman, health professionals and ethicists

Coordination and Implementation

As part of this strategy, the following coordination work will be conducted:

- Regional Platform will review new evidence of the needs, share country-level examples of successes, lessons learnt, challenges and needs, and discuss opportunities for regional dialogue and work

- National dialogue platforms will be supported to facilitate discussions among different sectors and stakeholders

- Think Tank on Trans People will be supported to provide space for more specific discussions on the needs, opportunities, progress and challenges in the region

- Ongoing initiatives and research in the region will be mapped, updated and shared with the Regional Platform and key stakeholders

- An operational plan will be outlined for the Joint Strategy Implementation

Terminology

Men who have sex with men is a public health term developed for the purposes of epidemiology, interventions and research. It refers to males who engage in sex with other males, regardless of how they identify themselves. Some of them do identify themselves as gay, bisexual or homosexual and some do not.

Gay and bisexual person refers to a person's sexual orientation and identity, in the first case, of males being homosexual and preferring the same sex/gender, while in the case of bisexual person the sexual attraction is towards to people of any sex and gender identity.

Trans people[42] is an umbrella term which includes those people who have a gender identity which is different to the gender assigned at birth, and those people who wish to portray their gender identity in a different way from the gender assigned at birth. It includes those people who feel they have to, prefer to, or choose to, whether by language, clothing, accessories, cosmetics or body modification, present themselves differently to the expectations of the gender role assigned to them at birth. This includes among others, transsexual and transgender people, transvestites, cross dressers, no gender, multigender, gender-queer people, intersex, and gender variant people who relate to or identify as any of the above.

[42] The definition is adapted from Transgender Europe's glossary, available at: https://tgeu.org/glossary/ and the Council of Europe's Questions and Answers on Sexual Orientation and Gender Identity.