As leaders of the HIV response gather in New York on June 8-10 for the 2016 High-Level Meeting on HIV/AIDS, we, civil society networks of Eastern Europe and Central Asia, prepared this report to draw attention to the catastrophic situation in our region and solutions that would enable us to catch up to the rest of the world on the track to move towards ending AIDS by 2030 and achieving Strategic Development Goals.

Eastern Europe and Central Asia:

Let's Not Lose Track!

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

HIV incidence and deaths due to AIDS continue to increase

70% of PLHIV live in high-income countries

1 in 5 people live below the national poverty line

1 in 5 PLHIV receive ART.

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I. Summary and key recommendations

While the world celebrates declining rates of new HIV infections and deaths from AIDS, in Eastern Europe and Central Asia (EECA), the only region in the world that did not achieve the 6th Millennium Development Goal. New infections and AIDS-related deaths continue to grow. HIV, drug-resistant tuberculosis and hepatitis C epidemics remain concentrated among key populations including people who inject drugs, sex workers, gay and other men who have sex with men, transgender people, and prisoners. Ninety six percent (96%) of new HIV infections were among key populations and their sexual partners in 2014.[1] Faced with rapid transition to domestic funding, the EECA countries are not adequately financing programming for the HIV care continuum (including prevention, testing, linkage to care and retention) in particular for stigmatized and criminalized key populations.

Recommendations

1 Governments must **commit to the development of domestically-funded AIDS responses** that encompass a comprehensive package of services for all who need it with a special focus on **key populations and their sexual partners**.

2 Transition plans should be designed to **gradually increase domestic spending** including investment in **25% of the budget on prevention programming** as recommend by UNAIDS to complement the 90-90-90 treatment target.

3 Governments must acknowledge the HIV, tuberculosis and hepatitis C burden borne by key populations and **ensure that 90% of key populations are reached** with targeted low threshold programming including prevention, testing and linkage to treatment and care.

4 National programs must provide **antiretroviral therapy for all PLHIV who want to start treatment** and counselling should encourage early start of treatment in line with WHO recommendations.

5 **Integration and collaboration of HIV, TB, OST harm reduction and social services** must be enhanced to ensure linkage to and retention in care and barriers to access to care for **migrant populations must be removed.**

6 The main source of vulnerability of key populations, must be addressed by **countering stigma, discrimination, criminalization and human rights violations.**

7 Donors including The Global Fund, bilateral donors and others must **adapt eligibility criteria that do not neglect inequitable access to services** within middle and high income countries.

8 The International community, including the European Commission, EU member states, the Global Fund, UN agencies and others, should **facilitate a dialogue** with EECA countries on addressing challenges in achieving universal access to prevention, treatment, care and support.

9 **Meaningful involvement of people living with or affected** by diseases and key populations and civil society in national and regional dialogue must be supported.

10 **Health system strengthening** efforts should target the need governments and NGOs urgently prepare for the transition to **domestic funding of institutionalization of self regulated NGO services.**

11 Governments should utilize **transparent, flexible and innovative approaches in the procurement of ARV medicines** to ensure lowest possible prices for effective medicines including encouraging generic competition and application of TRIPS flexibilities and to ensure sustainable access to HIV quality treatment.

12 **Population size estimations** must be conducted according to international standards and **data on access to services must be disaggregated by key population, gender and age** to enable meaningful evaluation and improvement of approaches to access to services all along the continuum of care.

II. Introduction

As leaders of the HIV response gather in New York on June 8-10 for the 2016 High-Level Meeting on HIV/AIDS, we have an opportunity to envision how the global HIV response will contribute to the achievement of the world's new Sustainable Development Goals (SDGs). Reversing the tide of HIV, TB and hepatitis C virus (HCV) in Eastern Europe and Central Asia (EECA), where far less progress has been made so far than in other parts of the world will be essential in order to achieve the SDGs.

II.A EECA lags behind the rest of the world in countering HIV, TB and HCV

While the world celebrates declining rates of new HIV infections and deaths from AIDS, in EECA, new infections and deaths related to AIDS continue to grow. Globally, between 2000 and 2014, the rate of new infections decreased by 35%[2] while in EECA it grew by 30%[3] over the same period. Between 2010 and 2015 new infections grew by 53% in EECA.[4] AIDS related deaths declined globally by 41% between 2004 and 2014[5] but increased by 27% in EECA between 2005 and 2014.[6] High rates of co-infection plague the region, with tuberculosis cases increasingly linked to HIV infection and opiate use,[7] and hepatitis C virus approaching 80% prevalence amongst PWUD in many countries.[8] The EECA region has the highest rates of multi-drug resistant tuberculosis (MDR-TB) in the world.[9]

While a growing number of new infections are attributable to heterosexual transmission, 96% of HIV transmissions were among key populations and their sexual partners.[10] In 2014, 51% of new infections were among people who use drugs (PWUD), 31% were among sexual partners of key populations, 6% were among sex workers (SW) and 6% were among men who have sex with men (MSM). There is alarmingly high rates of HIV prevalence among key populations in some areas. PWUD face up to 60% prevalence[11] in some cities. Transmission among MSM accounts for an increasing portion of all new infections, with prevalence up to 25%[12] in some major cities in the region. Mother to child transmission is significantly higher among women who use drugs compared to other women living with HIV. In Ukraine for example it is 11% among women who use drugs vs 4% for the general population.[13]

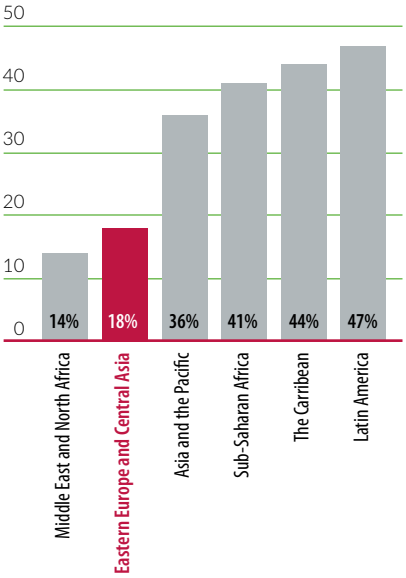
II.B Transition must not make matters worse

While still far from reaching targets for access to prevention, testing, treatment, care and support, the countries of EECA (most of which are in middle and high income categories according to the World Bank classification) are faced with rapid transition to domestic funding as they lose eligibility for financial support from the Global Fund and other donors. The Global Fund's eligibility criteria do not take into account of governments' limited willingness to pay for programming targeting stigmatized and criminalized populations. As countries embark on transition and donor funding reduces, funding for programming like harm reduction for people who inject drugs and sex workers, for example, often begins to decrease as was the case in Bulgaria,[14] Serbia[15] and Belarus.[16] In Romania, where Global Fund support was phased out, the state continued to purchase antiretroviral medicines but did not support community-led prevention efforts which resulted in a 20-fold increase in the number of new infections among people who use drugs by the end of 2012.[17]

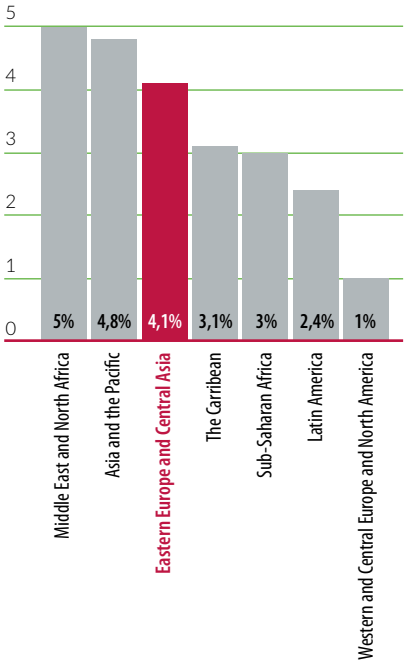
And the quick transition required does not leave societies with enough time nor technical support to assure that governments are prepared to take over a full range of program governance

HIV Epidemics in Eastern Europe and Central Asia

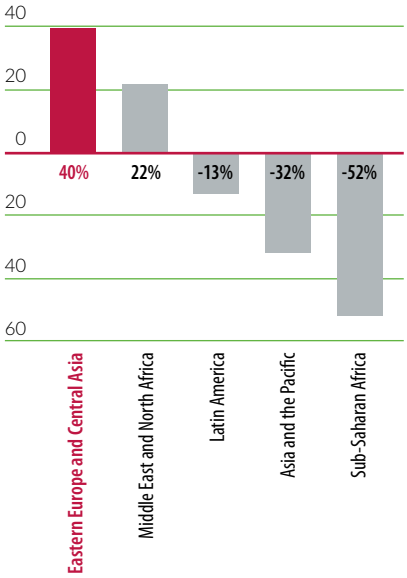
Access to antiretroviral treatment
in 2014



Number of AIDS-related deaths
in 2014 relative to amount
of HIV+ in region



New HIV infections
between 2000 and 2014



Data from
UNAIDS fact sheet
"How AIDS changed
everything"

and core management functions (e.g. procurement and supply management); to develop systems that enable governments to finance NGOs to continue conducting outreach work, case management or patient-led adherence support services for HIV, TB and HCV treatment, [18] or to build community capacity to implement their own, cost-effective community-led responses.

Recommendations:

- Governments must **commit to the development of domestically-funded AIDS responses** that are evidence-based, **focused on key populations** and are gender and age responsive.
- The **international community must provide technical support** for countries to develop realistic plans and mechanisms for sustainable transition over the next 5 to 10 years.
- An **emergency support mechanism** must immediately be made available to countries which have become ineligible for Global Fund support and finished their last grants, but have not been able to undertake any sort of structured transition planning process.
- There must ultimately be a **safety net mechanism** to safeguard key populations in countries which fail to transition successfully.

III. What must be done?

III.A Prioritize low-threshold prevention services for key populations

Despite bearing the burden of the HIV epidemics in EECA, key populations, including women and girls among them, still lack access to low-threshold prevention – and in turn linkage to timely testing and treatment services. Fifty one percent (51%) of new HIV infections in EECA are among **people who use drugs.**[19] Access to harm reduction services including syringe programming (NSP) and opioid substitution therapy (OST) and other needed social support services remains limited. A six-country survey conducted by the Eurasian Harm Reduction Network (EHRN) reports access to needle and syringe programs (NSP) ranging from 11.7% of people who inject drugs in Georgia to 37% in Tajikistan and 37.5% in Belarus; only Kazakhstan, which reports reaching 59.2%[20] of all PWID with NSP in 2013, approaches the WHO-recommended coverage levels of 60%. Access to opioid substitution therapy is even more limited, with access ranging from 0.3% in Kazakhstan to 10.6% in Lithuania – falling far short of the ideal of 40% coverage of all opioid users that is recommended by WHO.

Sex workers across the region fare no better. Prevalence amongst sex workers throughout the region ranges from less than 1% to 10%[21]; and sex workers who inject drugs or who experience imprisonment are particularly likely to acquire HIV.[22] These overlapping risk factors, taken in conjunction with an environment of criminalized profession and extreme violence from both clientele and law enforcement,[23] leave sex workers vulnerable to HIV infection despite the significant progress made in prevention and treatment amongst other populations.

Across the region, **gay and other men who have sex with men** experience HIV prevalence multitudes higher than the general population, with prevalence ranging from an elevated 1.2%

in Kazakhstan[24] to alarming rates of 16.9% in Ukraine[25] to 25% in Georgia.[26] In official statistics, homosexual transmission is under-reported.[27] These rates are not surprising given the historic and ongoing lack of programmatic attention to the health and HIV risk of MSM. While most national HIV/AIDS programs in EECA recognize MSM as a risk group, little to no money from national budgets is allocated to targeted HIV interventions for MSM. As a result, low-threshold programming is extremely limited, and even the most progressive countries in the region do not approach the coverage levels recommended by the World Health Organization in order to have a significant impact on HIV transmission.

Where MSM face barriers to accessing low threshold prevention services and other health care, **transgender people** face an even more dire situation. While extremely limited epidemiological data are available for the region, HIV prevalence as high as 27% has been documented amongst trans* sex workers[28]; this echoes global experience that shows transgender women worldwide having an HIV risk ratio of 48.8 compared with all adults of reproductive age.[29] Despite this documented level of risk, transgender people remained excluded from HIV responses both in policy and in practice; currently, no EECA country recognizes transgender people as a distinct key population in their implementation or monitoring of the HIV response. While some transgender individuals may benefit from services designed for MSM,[30] there is no reliable data on comprehensive prevention coverage for transgender populations.

Punitive drug laws lead to high levels of incarceration of people who use drugs. Between 56% and 90% of people who use injection drugs will at some point in their lives be incarcerated.[31] While limited data is available on access to prevention, testing, treatment care and support in closed settings, it is known that rates of HIV, TB and HCV are high and access to services is often inadequate.

Vulnerable women and girls have special needs that are not being met. In the EECA region, though men are twice as likely to be infected as women,[32] key affected women often experience heightened HIV risk over their male counterparts. In Kazakhstan, Uzbekistan, Kyrgyzstan, Belarus, and Ukraine, HIV prevalence among female PWID is higher than HIV prevalence among male PWID.[33] Women who inject drugs tend to be younger, to engage in more risky sexual behaviors, and to share injecting equipment more often than men who inject drugs.[34] Many women who use drugs also engage in sex work (62% in Kyrgyzstan and 84% in Azerbaijan).[35] In Eastern Europe, only 0.003 per cent of women who inject drugs have access to OST.[36] Women who inject drugs also have poor access to sterile injecting equipment and condoms, as well as limited access to sexual and reproductive health (SRH) services. These service shortfalls are particularly acute in prisons and other closed settings. Most countries in the EECA region, including those with concentrated epidemics among PWID, have very few harm reduction programs designed to address the needs of women.[37] Added stigma and gender-based violence faced by women inhibit access to prevention and treatment services alike.

Recommendations:

- Governments must acknowledge the HIV, TB and HCV burden borne by **key populations** (including by women and girls among them), and support evidence and human rights based, gender-responsive targeted low-threshold prevention services for them.
- Approximately of **25% of the budget for response to the epidemic should support evidence-based prevention** programming as recommended by UNAIDS to complement the 90-90-90 treatment target.

III.B Reduce Stigma and Discrimination and Increase Access to Justice for Key Populations

People who use drugs and people who sell sex are penalized or criminalized in all EECA countries.[38] The UN Special Rapporteur on health emphasizes that people who use drugs may be deterred from accessing services owing to the threat of criminal punishment, or may be denied access to health care altogether. Criminalization and excessive law enforcement practices also undermine health promotion initiatives, perpetuate stigma and increase health risks.[39]

In most of EECA countries sex work is either directly prohibited and penalized, or criminalized indirectly by anti-brothels and other anti-prostitution laws. The Special Rapporteur on the right to health highlights the denial of sex workers' enjoyment of the right to health that results from the criminalization of sex work and related practices (such as solicitation). Criminalization drives the sex industry underground, where labour exploitation can flourish, and deters sex workers from the criminal justice system when they experience violence, because they may fear that they and/or their employer may be charged with prostitution-related offences.[40]Policing practices, including violence, increase vulnerability to HIV by sex workers[41] and women who use drugs.[42]

While same-sex relations are not criminalized in most countries in EECA (Turkmenistan and Uzbekistan excepted), MSM remain highly stigmatized and proxy legislation often allows for human rights violations which go un-redressed. A limited number of countries have anti-discrimination legislation in place for lesbian, gay, bisexual and transgender (LGBT) populations,[43] and legislation to ban so-called 'gay propaganda' (including health information for LGBT populations) in Russia have incited violence,[44] and inspired similar legislative initiatives in other countries throughout the region.

Migrants, including internal migrants face significant regulatory barriers to access to care as access to health services is often tied to an address of official registration. In Russia, the country which is the main destination for migrant workers in the region, foreign citizens need to have negative HIV testing result if they apply for the work or resident permit unless they have family members with Russian citizenship. Travel restrictions on HIV status not only affect migrants' access to HIV prevention and testing, but also impair linkage to care.

In all countries of EECA the HIV transmission and/or the exposure to HIV is penalized or criminalized. The Special Rapporteur on the right to health highlights the strong negative impact of the criminalization of HIV transmission with respect to the right to health, including the far-reaching impact of criminal laws on the enjoyment of the right to health has well as the failure of such laws to achieve legitimate public health aims or the objectives of the criminal law. [45]

Other legal issues that serve as barriers to accessing services include regulations that limit the ability of community-based services to provide HIV testing, including rapid testing. In many countries, testing can only be done in clinical settings, limiting access to mobile and community-based services, which can improve uptake of testing by key populations. Another legal administrative barrier that is essential to address is the lack in many countries of a legal framework to enable state funding of community-based services, often referred to in the EECA region as a "social orders" or "social contracting".

Recommendations:

- Advocacy work should focus on **decriminalizing key populations,** protecting their human rights including and adopting **anti-discrimination legislation** and fulfill recommendations given by the Special Rapporteur on the Right to health in reports of April and August 2010.
- **Legal services and legal literacy** programmes should be available in low threshold settings for key populations
- Efforts to **reduce stigma and sensitize** law-makers, law enforcement and health care providers to legal protections of rights of key populations should be supported.
- Governments should undertake measures for **elimination barriers to health services related to HIV and TB for migrant populations.**
- Legal frameworks should be adjusted to enable **social contracting of NGOs for low threshold prevention, testing and linkage to treatment and other services.**

III.C Optimize testing and linkage to care

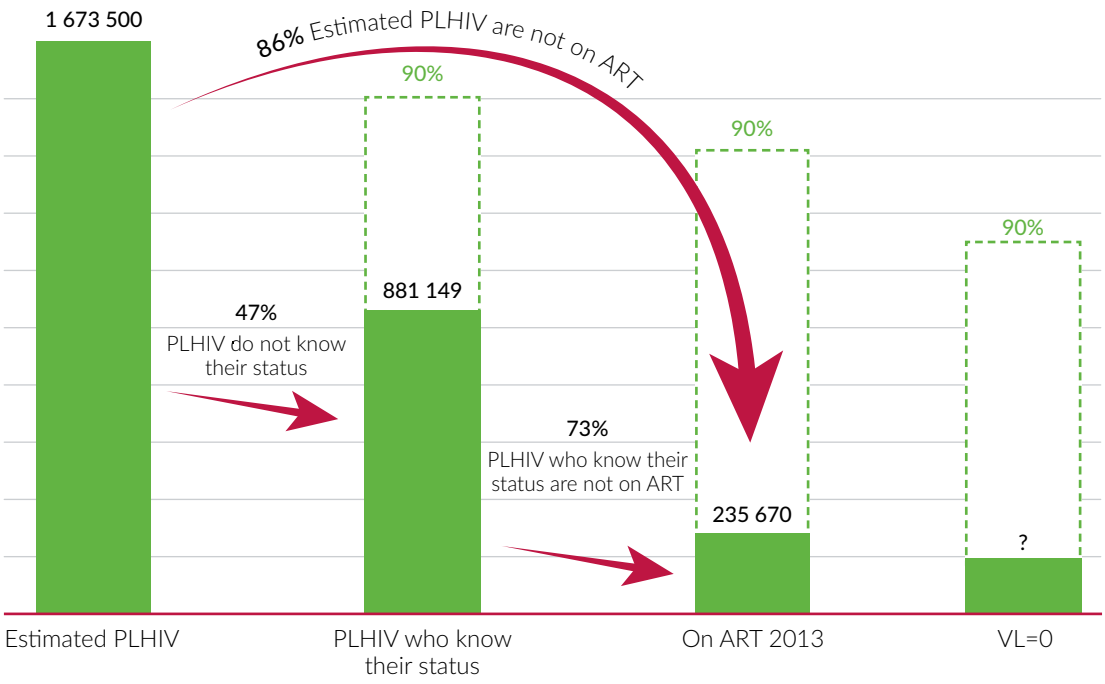
Approximately 47% of PLHIV in EECA countries do not know their HIV status.[46] With the low levels of access to low threshold programming described above, it is no surprise that key populations are not accessing testing and linkage to care. Among MSM in Kyrgyzstan, Moldova and Ukraine, for example, only 11-13% of MSM received HIV testing over the last year. Moreover, testing and linkage to care happens late in EECA; 50% of PLHIV have a CD4 of less than 350, when they test positive.[47]

Low testing rates and late entry to care are likely driven by the high-threshold nature of current testing services: few countries offer rapid testing for key populations. Even where community-based rapid testing exists, testing algorithms are not updated to allow rapid testing to serve as a valid preliminary test, meaning key populations must still go through rigorous testing (usually 2 or 3 separate visits/testing events) in order to get final confirmation of HIV status. Sexual and reproductive health and rights and HIV strategies and policies should be interconnected to increase comprehensive service provision, and effective responses must go beyond health services to address human rights and development.

Recommendations:

- **Low-threshold programs for key populations** and vulnerable women and girls among them must be expanded and offer testing and linkage to care, including sexual and reproductive health services.
- **Linkage to care** must be prompt, and strengthened through formalized and mutually respected partnerships between non-governmental outreach workers and/or case managers and health care workers in the government sector.
- **HIV, TB, OST, harm reduction and social services should cooperate** to enable retention in care including provision of OST in TB and other in-patient care settings.

Lack of access to key services for PLHIV in EECA



Source: ECUO (2015) Regional Concept Note.

III.D Close the gap in ART access and retention in care

Globally, 41% of all adults living with HIV access antiretroviral therapy (ART), while in EECA, ART is accessed by only 18% of adults living with HIV. This dramatic gap underscores the systems of stigma, discrimination and violence in which those who need ART – overwhelmingly individuals from key populations at risk – exist and struggle to access health services. For instance, while PWID account for over 56% of all registered HIV cases across the region, they receive only 38% of the ART dispensed.[48] PWID themselves cite lack of convenience in accessing medications, lack of trust in the medical system, and lack of appropriate legal documentation (identification, proof of citizenship) as major barriers that account for these low levels of enrollment on ART. OST programming is available only on pilot levels in most EECA countries and in Russia, Uzbekistan and Turkmenistan is not available at all. This further inhibits retention in care throughout the region. Throughout the region, there are no reliable data on the percentage of those on ART who are from MSM, SW or transgender populations.[49]

Recommendations:

- National programs must provide **ART key for all PLHIV who want to start treatment** and counselling should encourage early start of treatment.
- **Opioid substitution therapy** must be scaled up to WHO recommended levels to support retention of PLHIV who inject opioids.
- Governments should utilize **transparent, flexible and innovative approaches in the procurement of ARV medicines** to ensure lowest possible prices for effective medicines including encouraging generic competition and application of TRIPS flexibilities and to ensure sustainable access to HIV treatment.

IV. How to get there?

IV.A Generate the knowledge we need to make rational decisions

Throughout EECA, the quality of data available to monitor and evaluate responses to HIV, TB and HCV remains inadequate. Population size estimations of key populations are often sub-standard, due to inadequate sampling methodologies and, in some cases, political motivations to downplay the existence of certain subgroups. Additionally, much data on access to services along the continuum of care cannot be disaggregated by key population, gender and other important demographics.

In some settings, there are significant challenges in obtaining a harmonized picture that shows services provided by both governmental and non-governmental entities. Unique identifier codes employed by NGOs to track clients are rarely harmonized with government records of patients, making it impossible to determine whether individuals receiving prevention or community-based testing services are ever effectively linked with care and treatment services, and thus limiting the availability of robust data on the continuum of care.

While all key populations are affected by these shortcomings, of particular concern is the thorough lack of data on transgender populations – from population size estimation to access to services, we know virtually nothing about this highly vulnerable group. In addition, most epidemiological data fails to include data from penitentiary systems, leaving prison-based programming and results excluded from discussion, despite the known elevated levels of HIV, TB and HCV prevalence in these settings. In order to truly end the AIDS epidemic by 2030, data systems will need to be strengthened significantly and include these highly vulnerable groups which are currently absent from most dialogues on HIV in EECA.

Recommendations:

- **Population size estimations** must be conducted according to international standards.
- State and NGO services should work together to enable harmonized collection of data **disaggregated by key population**, gender and other key demographic information.
- Special attention must go to generating reliable **data on transgender and prisoner health risks and outcomes.**

IV.B Use scarce resources wisely

EECA must use its scarce financial resources wisely, ensuring cost efficiency of programming along the entire continuum of care. The middle-income countries of EECA pay very high prices for pharmaceuticals and many countries have yet to make adequate efforts to reduce pharmaceutical prices through generic competition. In Russia, for example, until 2016, tenofovir was purchased for as much as 4185.55 USD per patient per year while it is acquired in other countries (many of which have higher levels of access to ART than Russia) for as little as 48 USD per patient per year.[50] TRIPS flexibilities have not yet been used in the EECA region to ensure sustainable access to affordable medicines. The use of fixed-dose combinations in the region is rare; in Russia, which is home to the region's largest population of PLHIV, less than 1% of those on ART receive all-in-one regimens. Many countries do not procure

first and second line HIV medicines in accordance with WHO recommended treatment schemes which also leads to increased cost; atazanavir, for instance, is absent from second line regiments in most of the region. Though the countries in the region have a high burden of HCV, none have yet to issue a compulsory license for Direct Acting Antiviral medicines, despite appeals from civil society and other stakeholders. The waste of resources on high pharmaceutical prices contributes to the lack of resources for much needed services along the continuum of care.

The tendency, mentioned above, for EECA countries to under-invest in programmes for key populations is also costly. Inadequate support for prevention, early testing and initiation of antiretroviral therapy by key populations lower cost-effectiveness of interventions as more people continue to become infected with HIV, require more intense medical care and, in some cases, require earlier switches to second-line treatment.[51] Using unique knowledge of programme beneficiaries to improve quality and efficiency can help identify areas where costs can be saved.[52] Over-hospitalization for TB in EECA countries is costly and leads to the spread of resistant forms of the bacteria – leading in turn to costlier and less effective treatments.[53]

Inappropriate Legal frameworks also add to cost. When there is not a supportive legal environment for harm reduction services for example by ensuring that needle and syringe distribution cannot be construed as promoting drug use, lead to turnover of outreach workers and thus increased costs of services as was reported for example in Georgia.[54] When regulations force community-based HIV testing programmes to use more expensive oral test kits due to prohibition of non-medical personal from working with blood additional costs are incurred.

Recommendations:

- States must commit to taking all appropriate steps to **ensure that 90% of key populations at risk of HIV infections are reached** with a comprehensive package of services.
- Governments should utilize **transparent, flexible and innovative approaches in the procurement of ARV medicines** to ensure lowest possible prices for effective medicines including encouraging generic competition and application of TRIPS flexibilities and to ensure sustainable access to HIV treatment.
- Private multinational companies should **apply greater flexibility** in decision-making in matters of pricing and voluntary licensing and use other criteria in addition to the classification of the World Bank regarding upper middle and low-middle income countries.

IV.C Fund programming for key populations

The portion of funds committed and/or invested in responding to HIV and TB that come from domestic sources is steadily growing.[55] Funding for HIV from domestic sources has gone from less than 45% in 2008 to 58% in 2016.[56] While this is an important achievement, a closer look reveals the dangerous tendency for governments to have limited "willingness to pay" for programmes targeting key populations. Low-threshold programming for key populations are still dependent of foreign sources for 81% of their funding.[57] International funding sources still account for 93% of funding for programs for sex workers, 96% for programs for MSM and 78% for programs for PWID.[58] National Strategic Plans on HIV in most EECA countries mention the need to increase state funding, but refer specifically to funding for antiretroviral medicines, and not prevention activities.[59] Modeling conducted in Belarus suggests that combined with treatment scale-up, if 25% of the HIV budget could be allocated to prevention for key populations, 43% of new infections would be averted. This would help Belarus avert 10,000 new infections and reverse its tendency (similar to other countries in the EECA region) to have a growing concentrated HIV epidemic.[60]

Recommendations:

- Donors and states should ensure that **approximately 25% of the budget for response to the epidemic is allocated to evidence-based prevention activities** as recommended by UNAIDS.
- Transition plans should be designed to **gradually increase domestic spending** on low-threshold programming for key populations.

IV.D Integrate non-governmental organizations into state funded programming

Non-governmental organizations and community-based organizations have an essential role to play in delivering services along continuums of care for HIV, TB and HCV. Historically, the services they provide in EECA are almost exclusively funded by foreign donors, but recent legislative change in many countries is enabling funding of NGOs to provide services including those related to HIV, TB and HCV through so-called 'social contracting' mechanisms. However, few countries have quality standards for services provided by NGOs, and there is often little incentive for governments to fund services targeting stigmatized and/or criminalized populations. Thus, even in countries where social contracting is possible, it remains underfunded and sub-optimally executed. Adding to these challenges, there is increasing political pressure in many countries to limit the activities of foreign-funded NGOs; countries such as Russia and Azerbaijan, require foreign-funded NGOs to be labeled as "foreign agents," leading many NGOs to close.

Recommendations:

- Governments need continued technical support to **develop legal frameworks enabling social contracting** of NGOs
- **NGO accreditation or self-regulating systems** should be established to build and ensure high standards of quality of service and access to technical support needed to work well with government funding.
- High level dialogue and support for NGO-led advocacy for **state funding of NGOs** should be supported.
- Governments and NGOs urgently prepare for the transition to **domestic funding of institutionalization of self regulated NGO services.**

IV.E Ensure meaningful involvement of people affected by HIV, TB and HCV

In all countries in the EECA region, individuals and affected communities are engaged to varying degrees in policy dialogue and in service provision. Most countries have networks or unions of PLHIV, though fewer have unions or advocacy groups of representatives of key populations and people affected by TB or HCV. The governance policies of the Global Fund, with funding dedicated to "community systems strengthening," and financial and technical support from other international sources have contributed to giving PLHIV and representatives of key populations opportunities to drive policy dialogue. People living with HIV and representatives of key populations increasingly lead calls for evidence- and human rights-based programming.

Regional networks including, the Eurasian Network of People who Use Drugs (ENPUD), the Sex Workers Rights Advocacy Network (SWAN), the Eurasian Coalition on Male Health (ECOM) and the Eurasian Women's Network on AIDS (EWNA) are relatively new and still building their organizational capacity.—The Eurasian Harm Reduction Network (EHRN), the East Europe and Central Asia Union of PLWH (ECUO), the Eurasian Coalition on Male Health (ECOM) and the TB Europe Coalition are running regional programmes supported by The Global Fund which are making important contributions to supporting appropriate responses to TB and HIV in the region.

A significant number of regional and national civil society organizations were excluded from the list of organizations accredited to attend the upcoming High Level Meeting on AIDS on June 8th to 10th 2016. This exclusion is unacceptable. Whether by intention or omission, community organizations from populations most directly affected by HIV have been excluded, namely Men Who Have Sex with Men, People Who Use Drugs.

Recommendations:

- Governments and other stakeholders must support the **meaningful involvement of people living with or affected by diseases and key populations** in national dialogue on responses to HIV, TB and HCV epidemics, health systems strengthening, and work to decriminalize key populations and provide legal protections against discrimination.
- Donors should enhance support for **civil society and key population-led advocacy work**.
- The Global Fund and other donors should continue to support programming by **regional networks** to build cross-border capacity for advocacy and sharing of good practices.
- **Organizations representing key affected populations should not be excluded** from meaningfully participating in the High Level Meting on AIDS on June 8th to 10th 2016 and other such forums.

Endnotes

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- International Treatment Preparedness Coalition in Eastern Europe and Central Asia (ITPCru)
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