



**The Barents HIV/AIDS Program**

**The Barents Euro-Arctic Council**

**Joint Working Group on Health and Related Social Issues**

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## **ABBREVIATIONS**

AIDS	Acquired Immunodeficiency Syndrome
ARV	antiretroviral
ARVT	antiretroviral therapy
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
PLHIV	People Living with HIV
MSM -	Men who have sex with men
PWID	People who inject drugs
LTSC	Low-Threshold Service Centre
RF	Russian Federation
NWFD	Northwestern Federal District
SC	Steering committee
SDG	Sustainable Development Goal
UN	United Nations
WHO	World Health Organization
JWGHS	Joint Working Group on Health and Related Social Issues

## BARENTS EURO-ARCTIC REGION



### 1. INTRODUCTION:

The Barents Programme for HIV/AIDS prevention and control for the period 2015-2019 is developed within the framework of cooperation in the Barents Euro-Arctic Region. The Steering Committee (SC) of the Barents HIV Programme and the SC consultant prepared the programme. The SC includes leading specialists on HIV/AIDS nominated by Finland, Norway, Sweden and the Barents Regions of the Russian Federation. The Joint Working Group on Health and Social Issues adopted the programme on 23 April 2015.

The purposes of the programme is to contribute to the joint effort of the Governments of the Barents Region Countries to meet Sustainable Development Goals and especially the ones related to Health.

To achieve the Sustainable Development Goals<sup>1</sup> (SDGs) and converge with the post 2015 development, countries need to address the range of social, structural and individual level barriers that have a negative impact on prevention, testing, treatment, care and support for people living with and at risk of HIV. They also need to reinvigorate health promotion to implement programs that fully engage with changing risky sexual practices and emerging technologies.

The strong partnership approach has been established during the implementation of Barents HIV/AIDS Programme in 2005-2013, which produced an effective response. In the meantime in the light of current developments, partner countries decided to review and revise the existing programme to ensure that the impact of traditional prevention messages, and new testing and treatment options, reach the population groups where surveillance shows that rates of HIV are high or rising. These include people who inject drugs (PWID), general population, men who have sex with men (MSM) and migrants from high HIV-prevalence countries.

Scientific advances in preventing and treating HIV have provided the knowledge and the means to make dramatic reductions in new HIV infections, HIV-related illnesses, and deaths. People living with HIV can now expect to live long and productive lives, with HIV managed as a chronic condition.

One of the main reasons for this shift in the HIV population is that heterosexual sex is now a primary route for HIV transmission. Alcohol use is one of the factors that increase the risk of HIV transmission among heterosexuals. Particularly among women, a strong association has been seen between alcohol and other drug abuse, infection with HIV, and progression to AIDS<sup>2</sup>. Although additional studies are

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<sup>1</sup> Full report of the Open Working Group of the General Assembly on Sustainable Development Goals is issued as document A/68/970

<sup>2</sup> NIAID. *Women's Health in the United States: Research on Health Issues Affecting Women*. NIH Pub. No. 04-4697. Bethesda, MD: NIAID, 2004.

needed to further define alcohol use patterns among infected and at-risk people, it is clear that alcohol use is closely intertwined with risk behaviour that promote to the spread of HIV.

The relationship between risk-taking, alcohol consumption, and HIV/AIDS risk is influenced by cultural and societal factors. For example, a study undertaken by WHO in eight countries found that inebriation was considered a culturally acceptable excuse for acting irresponsibly (including engaging in unsafe sexual activities) in Belarus, Kenya, Mexico, Romania, the Russian Federation, and South Africa. The WHO study supports this assertion, reporting that in the Russian Federation “there was a common misconception that a person without alcohol was incapable of engaging in sex<sup>3</sup>” (p. 46).

Research suggests too that alcohol may interfere directly with antiretroviral therapy (ART) medications used for HIV, essentially blocking their effectiveness<sup>4</sup>. Moreover, patients who drink are nine times more likely to fail to comply with their medication regimens compared to sober patients<sup>5</sup>. When HIV-infected drinkers fail to take their medications or do not take them correctly, it can lead to a higher viral load and an increasing likelihood that the virus will become resistant to the therapy

The countries representing the Barents Region agreed that they together need to meet the challenges countries face in 2014 and beyond and in this regard to implement the solutions that will raise community awareness that HIV can be defeated, increase the effectiveness of prevention messages, strengthen safer sex and sterile injecting practices, increase testing rates, reduce the time between infection and diagnosis, link people to treatment and support, and increase the number of people who stay on effective HIV treatment.

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<sup>3</sup>World Health Organization (WHO). (2005). *Alcohol use and sexual risk behaviour: A cross-cultural study in eight countries*. Geneva:  
[http://www.who.int/substance\\_abuse/publications/alcohol\\_sexual\\_risk-crosscultural.pdf](http://www.who.int/substance_abuse/publications/alcohol_sexual_risk-crosscultural.pdf)

<sup>4</sup> Pandrea, I.; Happel, K.I.; Amedee, A.M.; Bagby, G.J.; and Nelson, S. Alcohol’s role in HIV transmission and disease progression. *Alcohol Research & Health* 33(3):203–218, 2010.

<sup>5</sup> <sup>7</sup>Palepu, A.; Tyndall, M.W.; Li, K.; et al. Alcohol use and incarceration adversely affect HIV-1 RNA suppression among injection drug users starting antiretroviral therapy. *Journal of Urban Health* 80(4):667–675, 2003

The new HIV and AIDS Programme for the Barents Region aims at comprehensive interventions, improved quality of HIV/AIDS prevention and universal access to high quality and life-extending care, free from stigma and discrimination. The process of formulating the Programme has been designed and conducted as an open and flexible process. The new Programme has been developed taking into account the epidemiological situation and priorities identified by the member countries through the Steering Committee (SC) of the Barents HIV/AIDS Programme. The SC identified the following five priority areas for the region.

1. HIV prevention in key groups
2. HIV prevention in the general population including at workplace
3. Integrating alcohol and HIV prevention and control programmes and policies
4. Strengthening national coordination and capacity to respond HIV and AIDS
5. Strengthening international cooperation in HIV/AIDS prevention and control

The vision for the Barents HIV and AIDS Programme is that the Barents Region will become a place where new HIV infections are rare and when they occur, every person regardless of age, gender, race, sexual orientation or socio-economic circumstances will have unfettered access to high quality, life-extending care, free from stigma and discrimination.

The programme is in line with the following international declarations to which member countries are the signatories.

1. The Declaration of Commitment on HIV/AIDS adopted by the UN General Assembly Special Session on HIV/AIDS on 27 June 2001.
2. Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia on 24 February 2004.
3. “Vilnius Declaration” on Measures to Strengthen Responses to HIV/AIDS in the European Union and in Neighboring Countries on 17 September 2004.

## **2. Guiding Principles for Barents HIV/AIDS Programme**

The principles used at both international and national levels applicable to public health programs underpinned the development of the Programme, as follows:

- All HIV efforts/projects will have the promotion, protection and respect of human rights, including gender equality;
- In the implementation of the planned HIV activities/projects, involvement of the non-governmental and private sector, patient groups and PLHIV will be endorsed as well as the principles of transparency, independence, partnership and mutual confidence will be guaranteed.
- HIV prevention projects will be differentiated and locally adapted to the relevant epidemiological, economic, social and cultural contexts in which they are to be implemented.
- HIV prevention actions will be supported with evidence, based on what is known and proven effective from all available data.
- HIV prevention programs will be multisectoral and comprehensive in their scope, using the full range of effective policy and programmatic actions with built-in follow-up and monitoring and evaluation mechanisms
- The programme implies confronting the epidemic and relying on partnerships, cooperation with all entities that may contribute to achieve its specific objectives.



### **3. EPIDEMIOLOGICAL BACKGROUND**

#### ***3.1 NW Russia***

In 2013, eleven territories of the Northwestern Federal District (NWFD) of the Russian Federation, registered 6,472 new cases of HIV infection, which is 2.1% less than in 2012. The increase in the number of new HIV cases reported only in four areas of the Northwestern Federal District: Arkhangelsk (by 15.2%), Vologda (by 12.1%), Pskov (by 7.4%) and Murmansk (by 2.8%) regions. In the Russian Federation, the number of new cases in 2013 increased by 10.1%.

Since the beginning of the epidemic in 1989, the number of officially registered HIV cases in the NWFD totaled 102,623. During the same period, 17 283 people has died. As a result, it can be assumed that by the end of 2013, in the NWFD there were 85,340 people living with HIV and AIDS. Prevalence rate of HIV in the NWFD on 01.01.2014 totaled 617.2 per 100 thousand. As for the Russian Federation, it was - 479.0.

The number of HIV-infected individuals who are in the dispensary at the AIDS Centre is increasing every year. On 31.12.2013, there were 55 639 persons living with HIV registered at the dispensary of all 11 regional AIDS centers of the NWFD, accounting for 90.7% of all the patients to be monitored. In 40.7% of the observed individuals with HIV infection, the disease was on subclinical (latent) stage. Antiretroviral therapy in 2013 was received by 18,561 patient with HIV infection, accounting for 88.1% of all patients in need of treatment.

Detection of HIV infection among the foreign nationals (especially labor migrants from the former Soviet Union) in 2013 increased by 1.4% and reached 169.3 case per 100 thousand.

HIV incidence in the Northwestern Federal District almost all the years of observation exceeded all-Russian parameters (up to 1.5 times). However, since 2009 there has been a downward trend in the incidence, and in 2013, the incidence rate in

NWFD has been below the national average (44.7 and 54.3 per 100 thousand respectively).

During the last years, there is a tendency in NWFD, in increasing numbers of patients from the older age groups. Since 2011, the highest incidence rates are occurring among those aged 30-34 years, the second highest number of infected is in the age group of 25-29 years. The reasons for this are as following: a) the identification of patients infected at a younger age and b) a new stage of the epidemic, when the HIV transmission characterized mainly by sexual contacts.

In the overall structure of HIV-infected people in the Northwestern Federal District in 2013, the males are accounted for 56.7% of all cases. However, the proportion of women has been steadily increasing from 18.9% in 1995 and 26.2% in 2000 to 40.8% in 2011 and 43.3% in 2013

In 2013, for the first time in the last 18 years, the sexual transmission of HIV prevailed in NWFD. Among the newly diagnosed persons (excluding people with unknown paths of infection) in 2013, transmission of the virus through heterosexual contact was registered in 50.4% of cases. Second reason was intravenous drug use - 45.7% of cases. Only in St. Petersburg, intravenous drug use was a major risk factor in patients with established routes of infection (62.3%). It should be also noted, that heterosexual transmission of the infection is the main route in the female population. In 2013, the sexual way as the risk factor for infection was registered in 70.2% of cases. Other routes of transmission for the female population are as follows: intravenous drug use - 32.9%, heterosexual intercourse - 36.3%, homosexual contacts - 1.8%, from mother to child - 1%, unknown - 26%.

As well as in Russia as a whole, in Northwestern Federal District there is a tendency of increasing in the proportion of MSM among the HIV registered cases. In 2013, it reached a level of 2.5% of all registered cases. The percentage of HIV cases among the MSM in 2013, was above average (for the NWFD) in the Arkhangelsk region (10.8%), in the Pskov region (7.3%) and in St. Petersburg (3.8%).

Between the territories of the Barents Region of the Northwestern Federal District, the epidemiological situation is somewhat different. Least affected is the Arkhangelsk region - 61.1 per 100 thousand population, followed by the Republic of Karelia - 181.5, Komi Republic - 202.2 and the most affected is the Murmansk region - 503.5. In 2013, among the newly diagnosed cases of HIV infection (excluding persons with unknown routes of infection) the main way of transmission in those regions was the heterosexual way.

### **3.2 Sweden**

No major changes in the epidemiological situation in Sweden were noticed during 2012–2013. Up to December 2013 a total of ca. 10 700 cases of HIV have been reported in Sweden since the early 1980's, of whom ca. 6 500 people (prevalence: 66 per 100 000 inhabitants) are currently living in Sweden with a known HIV infection (Feb. 2014). Of them the majority (>92 %) are receiving antiretroviral therapy (ART). 461 new HIV cases were notified in 2013 (incidence: ca. 5 cases/100 000 inhabitants) of whom about 75 % were foreign born and most of them newly arrived immigrants. Among people infected via heterosexual route of transmission the percentage of foreign born in new reported HIV cases has been high since the early 1990's due to immigration from countries with a generalized HIV epidemic. Heterosexual route of transmission counts for about half of all reported cases during the last five years in Sweden, while MSM and IDUs counts for about 30 % respectively 5 % of the cases.

The endemic spread of HIV in Sweden has historically, and still today, mainly been focused to MSM in the three metropolitan city areas (Stockholm, Gothenburg and Malmö), and partly also to IDUs, mostly in Stockholm even if sporadic cases and small outbreaks or transmission chains in IDUs has been reported occasionally from other counties through the years. During the last decade a trend shift has been noticed in these two key populations. A substantial increase of foreign born people among new HIV cases has been reported in MSM and IDUs, in which groups Swedish born

people previously have dominated. Foreign born counted for the majority of reported HIV cases in these two groups 2012–2013. This emphasizes that the preventive efforts directed to MSM and IDU also must target migrants and be adapted to their needs of information, counselling and testing.

Previous studies has reported that foreign born are over represented among people who are diagnosed in a late stage of the HIV infection in Sweden. A new study published by the Swedish Institute for Communicable Disease Control in 2013 also showed that late diagnosis were common among Swedish born people, especially in heterosexual route of transmission and in IDUs.

The epidemiological situation in the Barents region of Sweden is quite similar to the rest of Sweden, with exception from the three metropolitan areas. The region constitutes of Västerbotten and Norrbotten counties, representing together about a half million inhabitants or ca. 5 percent of the total population in Sweden. The prevalence of people living with a known HIV diagnose in the region is 46 per 100 000 inhabitants, and 52 % of the PLWHIV are women (Feb. 2014). In 2013 there were 27 new HIV cases notified in the region, and during the last five years the incidence has varied between 25 to 50 cases per year (5-10 cases per 100 000 inhabitants). Most of these cases are migrants ( $\geq 90$  %), usually from countries with a generalized HIV epidemic and already infected before arrival to Sweden. Very few cases ( $< 8$  %) are reported to have been infected in Sweden. Heterosexual route of transmission is the most common reported (67 %) in the region. Only a few cases have been reported among MSM and IDUs (6 % respectively 2 %) during the last five years. There is no sign of any direct endemic spread of HIV in this region of Sweden today.

### **3.3 Finland**

The statistic data in Finland is based on National Infectious Diseases Register and some prevalence studies among populations most at risk. Information to the register comes from both physicians and laboratories, and they are linked with the help of the identification code of a person.

HIV incidence was 2.9/100 000 in 2013 . In the end of 2013 the total number of registered HIV cases was 3219. During 2013 there were 157 new HIV cases registered, of these 65% were in men and 35% in women. Transmission routes among those registered in 2013 were the following:

- heterosexuals accounted for 54 % of the cases
- men having sex with men 27 %
- injecting drug users around 1,9 %
- mother-to-child 0,6 %
- transmission route unknown 27%

Situation in Finland has remained relatively stable already for a long period –annually there are 150-180 HIV cases registered.

HIV continues to spread among the MSM. Most of the cases are among Finns, and most often the infection has been contracted in Finland. Two prevalence studies have been implemented among the MSM. The prevalence is approximately 20 higher than among general population.

The number of heterosexual infections has been steadily growing, among both foreigners and Finns. Often the infection has been contracted abroad, most often in Thailand, Estonia or Russia.

Foreigners represent about 5% of the population in Finland, but at the same time approx. 50% of new HIV-infections are detected among them. Most often transmission route is heterosexual and the infection has been contracted in the country of departure (Sub-Saharan African countries are most common, but altogether more than 60 countries of origin).

The HIV prevalence among people who injecting drugs is around 10 times higher than in the general population. However, effective preventive and treatment measures have kept infections from intravenous drug use in Finland at a low level after following the HIV epidemic in this group at the turn of the millennium.

### **3.4 Norway**

The 2013 figures show a further decline in the total annual number of diagnosed HIV cases notified anonymously by doctors to the Norwegian Surveillance System for Communicable Diseases (MSIS). Compared with the 2008 peak, there were 22 per cent fewer new reported HIV cases in Norway. In 2013, there were 233 newly diagnosed HIV cases (158 males and 75 females), giving an incidence rate of 4.6 per 100 000. The decline was mainly seen among heterosexuals. The most common mode of transmission in 2013 was heterosexual transmission with 132 reported cases in 2013. Of these 92 of the diagnosed were immigrants infected before arrival in Norway. Among men who have sex with men (MSM), the HIV figures remain high. In 2013, a total of 98 MSM were diagnosed with HIV. 41% of the HIV-positive MSM reported in 2013 were infected abroad, mainly in other European countries.

In recent years, high figures in this group have resulted in an increased number of MSM living with HIV and therefore a high infection pressure. This is reinforced by the fact that many newly infected people with high infectivity are unaware of their HIV status. Early diagnosis is a priority in preventive work. Effective treatment greatly decreases the infectivity of HIV positives. The importance of increased testing activity in this group is also confirmed by a significant number of MSM first becoming aware of their HIV status after they become severely ill due to immune deficiency. The proportion of HIV-positive MSM with an immigrant background has increased in recent years, and this trend intensified in 2013 where nearly half of the diagnosed MSM have an immigrant background. Almost 50 per cent of these come from other European countries. The incidence of HIV among drug users in Norway remains at a low level.

## 4. CHALLENGES

### 4.1 Nordic Countries:

- a) **Men who have sex with men (MSM):** This group has for the last decade been the most common group at risk for HIV among persons infected while living in the Nordic countries. Interventions to prevent and control HIV among MSM are the cornerstones of HIV response in the Nordic countries.
- b) **Migrants.** The increasing percentage of foreign born people among new reported HIV cases during the last few years underlines the importance of developing the efforts and methods to reach migrants, for the HIV preventive work, with information and to offer counselling and testing
- c) **Testing and late presenters.** Late diagnoses that are common among the newly reported HIV cases (regardless of the country of birth) emphasis the need of HIV testing services easy to access and the need to maintain and increase the knowledge and attention to HIV in general in the health care. To increase the rate of HIV testing among all the key populations<sup>6</sup> for HIV such as migrants, MSM and IDU, so that people who are tested HIV positive can get access to care and effective antiretroviral therapy as early as possible,
- d) **People who inject drugs (PWID).** HIV preventive efforts and Low Treshold Service Centres (LTSC) targeting PWIDs need to be strengthened. Needle and syringe exchange programs are still not available in most parts of the countries. The substitution therapy is also not introduced in the prison settings in all countries

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<sup>6</sup> **Key populations** are defined groups who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV. These guidelines focus on five key populations: 1) men who have sex with men, 2) people who inject drugs, 3) people in prisons and other closed settings, 4) sex workers and 5) transgender people. WHO. 2014

e) **Stigma.** Knowledge about HIV and the effect of treatment on infectiousness and effect on morbidity and mortality (low risk of spread of HIV from a well-treated patient) need to increase in the population and in the health care in order to reduce stigma and discrimination of people living with HIV.

## 4.2 Russian Federation

- a) **Heterosexual transmission.** The HIV epidemic continues to spread in the NW Region of Russia under some notable trends, such as increasing HIV sexual transmission. A part of the population still has improper awareness about HIV/AIDS. Risk behaviors of HIV in some groups such as injecting drug users, female sex workers is still high.
- b) **HIV Prevention among the risk groups.** The coverage of the harm reduction programs remains modest. There is a lack in financing of those programmes, the human resources for outreach activities were mainly from the NGOs, while an appropriate policy to ensure their rights and link their responsibilities to HIV/AIDS prevention and control is weak.
- c) **HIV prevention among the general population.** HIV prevention and the promotion of health-sustaining behavior activities are low and needs to be scaled up and strengthened. There is a need in raising debate in the society/community, providing of information and reducing HIV-related prejudice and discrimination.
- d) **HIV prevention at the work places.** There are problems in organisation of HIV prevention at workplace. Most of the employers are not interested to train their personnel.
- e) **Health system.** Improvement of HIV/AIDS prevention capacity has played an important role in the response to HIV. During the implementation, it has shown some specific limitations, such as a shortage of human resources and difficulty in financing.



## **5. Current Policies and legal documents relating to HIV/AIDS prevention and Control**

### **5.1 Sweden**

A new governmental agency, The Public Health Agency of Sweden, was established in January 2014 and has taken over the national responsibilities and monitoring of the National Strategy to Combat HIV/AIDS and Certain Other Communicable Diseases, adopted by the Swedish Parliament in 2006. The National Strategy applies to 2016. The Agency is also responsible for the national surveillance of HIV and other communicable diseases included in the new Act of Communicable Disease Prevention and Control from 2004.

An annual governmental grant of approximately 15.7 million euros, coordinated by Public Health Agency, are given to support HIV prevention projects and allocated to the 21 County Councils and the three major metropolitan municipalities as well as non-governmental organisations and to method studies and research aiming to develop the HIV preventive work. The National HIV Council, including governmental agencies, county councils and civil society organisations, has been established to give advice to the Public Health Agency and to benefit coordination of all involved sectors.

According to other regulations the health care is obliged to offer all pregnant women screening tests for HIV, syphilis and Hepatitis B. Further, HIV testing in Sweden can be done anonymous and testing and treatment for HIV is free of charge. The County Councils are obliged to offer asylum seekers and other groups of newly arrived immigrants a free health examination that is recommended to include HIV testing. Since 2013 paperless migrants who reside in Sweden also have the right to get a free health examination including HIV testing.

## 5.2 Finland

The responsibilities for controlling infectious diseases in Finland are defined in the Communicable Disease Act, which is currently under revision. According to the Act. HIV infection is a notifiable disease, same as gonorrhoea and hepatitis B and C.

HIV/AIDS treatment, care and support are integrated into public health care – on state, regional and municipal levels..

The Ministry of Social Affairs and Health is responsible for the general planning and legislation. The National Institute for Health and Welfare (THL) and other expert and research institutes are assisting the Ministry the. The tasks of THL are to monitor the epidemiology, ensure the dissemination of information, conduct research, develop laboratory tests, and provide expert scientific support for the prevention of HIV to municipalities and hospital districts. The municipal health services are responsible for the diagnosis and primary care of communicable diseases, information, health education and health counselling, the exchange of injecting equipment, and for vaccinations and health examinations. The municipal hospitals provide specialised medical care, organise training and assist in the detection and monitoring of communicable diseases. Medical treatment and care of HIV/AIDS is free of charge for all permanent/long-term legal residents

Civil society organisations have been involved in the HIV response in Finland since the beginning of the epidemic. Non-governmental organisations are well represented in the National HIV Expert Group, which has a mandate from the Ministry of Social Affairs and Health to follow-up and assess HIV response in Finland, discuss and take stand on matters linked with ethical and social issues related to prevention of HIV infection and the status of PLHIV, make proposals to the government authorities in the development of legislation and/or preparation of other actions related to HIV response, and follow-up the international progress and developments. The Expert Group includes representatives from several ministries and other governmental authorities, civil society, health professionals, and people living with HIV.

New national HIV strategy for 2013–2016 was published in December 2012. As the general prevalence in Finland is very low (estimated 0,1% among adults), the strategy concentrates on the key populations at higher risk to HIV exposure. The key populations in Finland are: people living with HIV, men having sex with men, migrants from high prevalence countries, travellers from Finland to other countries, people who inject drugs, sex workers and prisoners.

After the epidemic among people who inject drugs (1998-1999), a wide network of Low Threshold Service Centres (LTSC), which offer needle exchange, has been established in Finland (approx. 30 centres). The *Act on Communicable Diseases* from 2004 obligates municipalities to provide health counselling for PWID in their area, including exchange of injecting equipment.

### **5.3 Norway**

A National HIV Strategy was introduced in 2009 and runs until 2015. Six ministries and their underlying agencies, including the regional and local levels, play a role in the follow-up of the strategy. A new strategy for sexual health will be launched in 2016, which will integrate HIV prevention and control. The Communicable Disease Act was introduced in 1995 and has shown to be a good tool for infectious disease control of HIV. No major changes in the law have been added since 1995.

A National HIV and AIDS Council was set up in 2007 by the Ministry of Foreign Affairs and the Ministry of Health and Care Services. The Council has members from affected government agencies and from civil society, including representatives for people living with HIV and from organizations that work on international development cooperation and with youth. Each year the Ministry of Health and Care Services has granted financial support to non-governmental organizations which work to support government priorities within HIV prevention and control with approximately 3 mill Euros.

## 5.4 Russian Federation

The main legislative documents regulating the work in the field of HIV infection in the Russian Federation are the following:

- The Constitution of the Russian Federation;
- The Federal Law from 30.03.1995 No. 38-FZ (as amended on 25.11.2013) "On the spread prevention of the disease caused by human immunodeficiency virus (HIV) in the Russian Federation ";
- Federal Law of the Russian Federation dated 30.03.1999 No. 52-FZ (as amended on 25.11.2013) "On sanitary and epidemiological welfare of population";
- Federal law of 21.11.2011 No. 323-FZ "About the fundamentals of health protection of citizens in the Russian Federation";
- SanRaN (sanitary rules and norms) 3.1.5.2826-10 "HIV Prevention";
- SanRaN 2.1.3.2630-10 "Sanitary-epidemiological requirements to the organizations engaged in medical activities";
- Order of the Ministry of health and social development of the Russian Federation dated 09.06.2007, No. 474 "On approval of the standard medical care for patients with disease caused by human immunodeficiency virus (HIV)".
- Order of the Ministry of health and social development of the Russian Federation dated 17.09.2007 No. 610 "On measures on organization of palliative care for HIV patients";
- Order of The Ministry of health of the Russian Federation dated 08.11.2012 No. 689n "On approval of the procedure for providing medical care to the adult population in case of the disease caused by human immunodeficiency virus (HIV)".
- Order of The Ministry of health of the Russian Federation dated 09.11.2012 No. 758n "On approval of the standard of the specialized medical care for disease caused by human immunodeficiency virus (HIV)";
- Order of The Ministry of health of the Russian Federation dated 24.12.2012 No. 1511n "On approval of the standard for primary health care in case of disease caused by human immunodeficiency virus (HIV);
- Order of The Ministry of health of the Russian Federation dated 24.12.2012 No. 1512 "On approval of the standard of the specialized medical care for children with the disease caused by human immunodeficiency virus (HIV)";

## **6. Programme Goal**

To secure HIV prevention and care, reduce the morbidity and mortality caused by HIV and to minimize the impact of HIV and AIDS on individuals and society as a whole within the Barents Region.

## **7. SPECIFIC OBJECTIVES:**

To reach the Goal, five specific objectives were identified with aim to contribute to strengthening the national response, both in terms of (1) coverage and quality of programmes and services; and (2) an overall supportive environment.

1. To reduce HIV vulnerability and risk among key population groups with a special focus on people who inject drugs (PWID), men who have sex with men, migrants, sex workers and prisoners– by scaling up coverage of high-quality, key HIV prevention programmes and services
2. To reduce HIV vulnerability among the general population, including at workplaces, by raising awareness and promoting prevention behaviours with a special focus on the risk behaviours including unsafe sex practices, harmful use of alcohol and drugs.
3. To generate and use evidence for effective coordination of prevention and care strategies for alcohol-use disorders and HIV.
4. To strengthen the institutional capacity of coordinating bodies and the mechanisms to implement a well-coordinated multisectoral response at national and local levels
5. To increase international collaboration to promote implementation of comprehensive HIV/AIDS prevention, care and control

## **8. Programmatic activities**

The proposed programmatic activities are grouped around five specific objectives listed in Section seven. The list of the planned activities is provided in this section. The more details per each activity will be developed by individual projects.

### **8.1 AREA 1 - HIV prevention in the Key Population Groups**

HIV prevention is the key part for HIV/AIDS control in the coming years. Keep highlighting and promoting the roles of information, education and communication as well as harm reduction interventions for prevention of HIV/AIDS transmission in the Barents Region.

People who inject drugs constitute a considerable risk for the spread of HIV. The most important activity areas for HIV prevention in case of injecting drug users is harm reduction. We also need to improve availability of protective equipment so as to guarantee safety of the target group representatives (incl. condoms, syringes, sterilizers, etc.).

Men who have sex with men are a major risk group for HIV transmission in the Nordic countries and a potential risk group in Northwestern-Russia. A range of preventive measures should be directed towards this group including promoting condom use, testing for HIV and other sexually transmitted diseases, and use of anti-viral drugs as treatment for prevention or as pre- or post-exposure treatment. In addition, information and education targeted to this group is an essential part of prevention.

Activitites:

- Workshops and seminars on reviewing the regulations regarding Harm reduction
- Establishing new harm reduction sites and training of staff for each location
- Expanding the model of peer education, supporting establishment of peer groups

in the prevention of HIV/AIDS infection

- Study tours for health care staff on training and experience exchange on harm reduction for injecting drug users;
- Delivering effective health promotion and prevention activities among priority populations, particularly among gay men and other men who have sex with men (MSM)
- Expanding the counselling activities and the for information on HIV/ AIDS for MSM;
- Development and distribution of educational materials for migrants
- Organization of educational sessions on HIV/AIDS prevention in prison settings
- Development and distribution of the educative materials about HIV and AIDS prevention in prison settings

## **8.2 AREA 2 - HIV Prevention among general population**

In order to achieve a maximal response it is important that population has access to a common baseline of information about the current HIV epidemic. This includes knowing how HIV is transmitted and prevented, and knowing which behaviors place individuals at greatest risk for infection. Unfortunately in some places, many people no longer consider HIV a priority or something that could affect them personally. While we recognize that HIV is concentrated in certain groups, it is utmost important to provide general population with clear information about how to avoid HIV infection.

It is necessary to assist the employers in developing policies on HIV prevention at workplaces, social support and care policy and programmes for employees living with HIV. Training programmes on HIV/AIDS should be integrated into the existing programmes of training and retraining of personnel, as well as the instructions on

occupational hygiene and safety precautions. Strengthening the existing workplace programmes on promotion of healthy lifestyle concerning also such issues as alcohol Abuse and drug use, is also needed to highlight various aspects of the HIV/AIDS problem.

Activities;

- Master classes and seminars on preparing necessary legal regulations for conducting prevention programmes at workplace
- Organizing at workplaces educational and awareness programmes on HIV/AIDS, including educational activities at working hours, and dissemination of printed material
- Information and education activities among leaders and employees of trade and commercial firms and private businessmen
- Behavioural change communication activities targeting at HIV vulnerable groups and vulnerable people and youths and adolescents.
- Development of documentaries, meeting with specialists and people from HIV (PWIDs) community for/with target groups, organizing talk shows on HIV/AIDS prevention.
- Development of health promotion campaigns
- Training of journalists to build HIV/AIDS competence and provision of quality information about HIV and AIDS
- Training of the decision makers to build HIV and AIDS competence and increase the knowledge of the HIV.



### **8.3 AREA 3 - Strengthening and integrating alcohol and HIV Prevention and control programmes and policies**

Alcohol abuse can promote the spread of HIV by decreasing the awareness of practicing safe sex and unsafe injecting practices. In addition, alcohol abuse can increase illness and death in people with HIV as well as decrease patient compliance if on HIV treatment. Since the results of various surveys reveal a mutual connection between different risk behaviors—e.g. people who use drugs (alcohol) also exhibit a more risky behavior in sexual life—the connection between different risk behaviors must also be taken into consideration upon formulating a policy on alcohol and illicit drugs. Strengthen support to the National Alcohol policy, decreasing drinking and the behaviours it encourages will reduce these problems. A range of activities should be directed to create environment helpful for coordinated and integrated, as appropriate, prevention and treatment responses towards HIV/AIDS, and non-communicable disease, including the prevention responses addressing the shared risk factors.

Activities:

- Assessing the capacity of national health systems to address harmful use of alcohol in the context of HIV prevention and treatment
- Identifying training and programme needs
- Engaging relevant stakeholders, in discussing issues and developing plans to address the harmful use of alcohol in the context of HIV prevention and treatment
- Training of HIV and TB programme staff on early identification and management of alcohol and other substance use disorders.
- Training of staff in programs for Alcohol and substance use on HIV Prevention and treatment
- Implementing an information campaign about the risks of drinking during the ARV treatment
- Developing models for good organization of local work on Alcohol, drugs and HIV
- Improving collaboration between drug and alcohol and HIV services to address the care and support needs of people with HIV

#### **8.4 AREA 4 – Strengthen national coordination and capacity to respond HIV and AIDS**

Strengthening national capacity for inclusive governance and coordination of national HIV responses is important for the successful implementation of HIV Programme. Effective HIV/AIDS Prevention and control require leadership of the Ministry of Health and the active and informed participation of individuals, families and communities, civil society organizations, health care providers and the international community.

Community based organisations have great potential in combating HIV/AIDS. They have close contact with the target groups and can provide information and insights that are difficult to communicate. Those organizations should therefore be given a greater role in producing plans and strategies for measures to prevent HIV infection.

Activities:

- Promoting the active participation of the community organizations in providing education, prevention, support and advocacy services to key populations
- Training of community organizations, including the self-help groups and PLHIV networks to enable them contribute effectively to HIV/AIDS prevention and control
- Training of HIV testing and treatment providers in delivering the appropriate services
- Training of school teachers on HIV/AIDS.

Training of health and social workers for providing services in the youth Friendly Services;

- Training of health and social workers for providing social care program for

PLWHAs and members of their families

- Mobilizing the current training establishments of sectors, mobilizing specialists, experienced staff of educational sector to participate in lecturing and training on HIV/AIDS
- Monitoring and evaluation on training effectiveness.

## **8.5 AREA 5 - International Cooperation**

The epidemic is a global challenge that does not stop at national boundaries. Given today's international networking, mobility and migration, global measures are essential as a sign of solidarity and because they are in the interests of all countries. The aim of international cooperation is to encourage implementation of the UN resolutions, particularly access to prevention, diagnostics, therapy, counselling and nursing, and treating people with HIV/AIDS on an equal footing with non-infected individuals. It gives an opportunity to introduce best practices, accelerate the introduction of AIDS policies, strengthen capacity, improve the development of grassroots social organizations, and establish a platform for communication and experience sharing with the international community.

### Activities

- Tightening relations with international organizations and countries that have provided financial and technical supports to HIV/ADS prevention and control.
- Promoting regional, municipal cooperation between cities, rayon's in Barents Region of RF and neighbouring countries
- Supporting cooperation between the neighbouring countries to address common urgent problems, especially problems related to the spread of HIV / AIDS across borders,
- Implementing joint international activities that will be adapted to prevailing conditions in the countries of the Barents Region.

- Supporting the exchange of relevant information and experience among experts and between policy and decision makers within the Barents Region
- Cooperating and coordinating among different donor funded project through the SC

## 9. Programme Monitoring and Evaluation

The Steering Committee (SC) of the Barents HIV/AIDS Programme will carry out overall coordination of the Programme implementation. This committee includes members from all participant countries. The decisions of the SC will be informed by programmatic and epidemiological information collected by respective countries. The committee will review, decide and submit recommendations to the Joint Working Group on Health and Social Issues (JWGHS) of the BEAC.

Indicators can be used to monitor and evaluate the implementation of the Programme, report against progress in achieving objectives, and report changes in the response as required.

There are limitations in the availability and quality of indicators to measure progress against some objectives. The indicators identified below have an existing national collection mechanism, and can be reported on from the initiation of this programme.

Individual projects under this Programme will develop specific indicators for those projects.

	<b>Indicator</b>
HIV prevention in Key groups	<p>Percentage of key group population (PWID, MSM, Prisoners, Sex Workers, Migrants) who are HIV infected</p> <p>Number of PWID reached with specific services including harm reduction programmes and total prevention packages</p> <p>Number of key group population (PWID, MSM, Prisoners, Sex Workers, Migrants) reached with targeted HIV prevention programmes</p> <p>Percentage of key group population tested for HIV (disaggregated by each group)</p>
Prevention among the general population	<p>Percentage of 16-64-year-olds with accurate knowledge of the ways of HIV transmission</p> <p>Percentage of 16-64 years old who reject major misconceptions about HIV transmission (disaggregated by sex and age)</p> <p>Number of people reached through awareness raising efforts about HIV and AIDS</p> <p>Number of companies and institutions which have implemented HIV and AIDS prevention at workplace programmes</p> <p>Percentage of workers who have access</p>

	<p>to information and services on HIV/AIDS at their work place</p> <p>Number of Journalists trained</p> <p>Number of Decision makers trained</p> <p>Percentage of those tested for HIV where route of transmission is unknown</p>
<p>Strengthening and integrating alcohol and HIV prevention and control programmes and policies</p>	<p>Number of institutions from alcohol and drug sector participating in coordinated Programmes on response to HIV/AIDS</p> <p>Number of training of HIV and TB programme staff on early identification and management of alcohol and other substance use disorders.</p> <p>Number of training of staff in programs for Alcohol and substance use on HIV Prevention and treatment</p>
<p>Strengthening national capacity for inclusive governance and coordination of national HIV responses</p>	<p>Number of competent organizations and people actively involved in HIV prevention</p> <p>Number of trainings for the staff of NGOs on HIV prevention and cares issues</p> <p>Percentage of health/social agencies, NGOs, whose services are especially tailored up to the needs of the vulnerable groups</p> <p>Number of HIV/AIDS reports timely submitted to National and Regional Governments</p>

International collaboration	Number of SC meetings Number of events organized by the SC Number of joint projects financed by member countries
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