



Subject: Preliminary assessment of RELEX L/3 based on the replies provided by Delegations to the questionnaires on the HIV/AIDS situation in the ENP, Russia and Central Asian partner countries.

A first examination of the received questionnaires¹ from our Delegations in the framework of the Communication on combating HIV/AIDS in the EU and in the neighbourhood 2010-2014, shows several geographical trends as regards changes in the HIV/AIDS overall situation of our partner countries.

In particular, our Delegations in Egypt, Syria, Morocco and the occupied Palestinian territory (oPt) reported no significant changes in the overall HIV situation, with generally low HIV prevalence and low reported number of HIV cases while at the same time a steady growth rate especially in high-risk groups combined with underreporting and general public unawareness. The Delegations in Morocco and Egypt reported high levels of stigmatisation and discrimination against the affected populations (migrated sub-saharian population coming to Morocco from countries with a “generalised” HIV epidemic and intravenous drug users (IDU) in Egypt).

The spread of the pandemic (50 new cases per million inhabitants) together with the sector of the affected population where the increase of the absolute number of cases is higher (heterosexual intercourse and Men having sex with men, MSM), situates Israel among most of Western countries as regards HIV.

Both in Azerbaijan and in Georgia the prevalence of HIV is currently low but the rapidity of the epidemic spread is remarkable. The geographical situation of those countries, along the transit of the “opium route” from Afghanistan to Europe, is the main reason for the increase in the number of IDU and for HIV spread.

Positive news came from Moldova and Ukraine. According to the World Bank report on “Complex HIV Response Index”, Moldova has been awarded the first place based on the results of the implementation of the tripartite principle (HIV/AIDS prevention and control programme, adherence to antiretroviral treatment schemes and implementation of preventive programs in high risk groups). As for Ukraine, indicators show a significant improvement as regards HIV morbidity growth rates and HIV mortality growth rates.

¹ Headquarters received information concerning: Azerbaijan, Egypt, Georgia, Israel, occupied Palestinian territory, Moldova, Morocco, Syria and Ukraine (as regards ENP partners); Kazakhstan, the Kyrgyz Republic, Tajikistan and Uzbekistan (as regards Central Asian partners).

As regards Central Asia, Delegations reported a gradual increase of affected people in Kazakhstan and the Kyrgyz Republic. In Tajikistan the HIV epidemic is rapidly accelerating, with the number of reported HIV cases tripling since 2006. The strict censorship of the Uzbek authorities as regards the impact of HIV in the country, together with harsh policies in place (e.g. homosexuality is typified as a crime) complicates the gathering of data and the efficient fight against the disease.

As to the question about the extent to which the intravenous drug user community is affected by the spread of HIV, exact estimates of its size could not always be presented. However, we can say that IDU constitute the main HIV driven force in the following four Central Asian republics: Kazakhstan, the Kyrgyz Republic, Tajikistan and in Uzbekistan; also in Azerbaijan, Georgia and in Ukraine. In Azerbaijan and in Georgia, about 60% of all registered cases are associated with injecting drug use. On the other hand, in the partner countries which are geographically outside the “opium route” the scenario is different: IDU come last in Syria, with only 2.7% of the total number of cases while unsafe heterosexual intercourse constitutes the most frequent way of transmission, also in Israel IDU figure last and the same in the occupied Palestinian territory (oPt) where only 3 out of 64 reported cases are IDU.

The degree of involvement of Commission Delegations’ in HIV prevention activities depends on the listing of health / HIV as a priority in the Country Strategy Paper, which is normally linked with the gravity of the situation in the partner country. We find some exceptions like Syria where the spread of the disease is low (182 reported cases in 2007), but nevertheless the Delegation supports projects related to the reduction of the spread of sexually transmitted diseases.

The Delegation of the European Commission in Kazakhstan manages the regional programme Central Asia Drug Action Programme (CADAP 4) (<http://cadap.eu-bomca.kg>) whose overall objective is to foster a public health approach to drug demand together with an interdiction approach to drug supply in line with the European Commission drug strategies. Harm reduction measures are implemented under CADAP, concretely in prisons. As previously said, IDU constitute the most HIV affected sector of the population in Central Asia, therefore programmes like CADAP are steps in the good direction but not enough to address the existing / upcoming needs.

Another regional programme which included harm reduction is the Programme for the Prevention of Drug Abuse and the Fight against Drug Trafficking in Belarus, Ukraine and Moldova BUMAD. BUMAD 3 finished on 31 March 2009, however there is no similar initiative foreseen to replace it.

The South Caucasus Anti Drug Programme (SCAD) constitutes the third regional programme addressing, *inter alia*, harm reduction. Targeted countries are Armenia, Azerbaijan and Georgia. The overall objective of SCAD is the gradual adoption by beneficiary authorities of EU good practices in the field of drug policies, covering both supply and demand reduction aspects. SCAD 5 will finish in September 2009. Among the main achievements by SCAD I-IV (2001-2006) projects one could mention a limited

but direct impact on reducing HIV infection via the needle exchange actions. Methadone programme had been established in two countries partly with the support of SCAD and are stabilising drug users.

The information received from our Delegations highlights the fundamental role that the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has acquired in the field of HIV. In most of the partner countries targeted by the upcoming Communication the GFATM is developing some kind of HIV related action. Some examples to illustrate what was just said: In August 2007, Ukraine received a grant from the GFATM to commence the Round 6 programme for up to \$151M over five years – the largest grant for HIV ever given to any country in Eastern Europe. In January 2009 a 5 year project of the GFATM has started in the Republic of Kazakhstan, the project has been funded for a total of \$35 M. In the Kyrgyz Republic the national system of epidemiologic supervision is financed at the expenses of the GFATM. Some Delegations of the European Commission (e. g. Georgia, Morocco and Ukraine) participate at the GFATM Country Coordination Mechanism, thus allowing a higher degree of coordination between the GFATM and the Commission and avoiding possible duplication.

Apart from two cases (Kazakhstan and Tajikistan) so far the global crisis is not affecting the amount of financial resources allocated by Health Ministries of partner countries to fight against HIV. Nevertheless, the return of migrants who have lost their job as a result of the crisis will imply an impact on Health Ministries of some countries. For instance, four million Uzbeks are expected to come back from Russia and Kazakhstan where they were working. The Kyrgyz Republic will suffer the same phenomenon.

When asked about which measures would they recommend in order to improve the Commission's current policy on combating HIV in the partner countries:

- Most delegations suggested supporting relevant activities of the government or international organisations in the field of HIV/AIDS fight and prevention on the basis of a need assessment and dialogue with the respective governments and other donors at a local level. As regards dialogue with other donors, a bigger co-ordination between Commission Delegations and the GFATM would result very positive given the weight (both in expertise and in funds) that the latter has gained. Moreover, the European Commission is the forth biggest donor to the GFATM (EU as such is the first contributor by far providing 58% of the total amount of its funds). Only 3 out of the 13 Delegations which responded to the request from HQ participate at the Country Co-ordination Mechanism, sometimes this low degree of involvement from Delegations is due to a lack of information on how the GFATM functions. Aiming at fostering interaction between Delegations and the GFATM, Headquarters are preparing Guidelines for Delegations on partnership with Global Fund, which will be sent to all Delegations before summer 2009.
- At the same time some Delegations underlined that additional work should be done in terms of awareness of HIV related issues, especially HIV/AIDS

prevention. The Delegation in Morocco suggested the possibility of launching a regional programme on that issue since most of the ENP partner countries around the Mediterranean (with the exception of Israel) suffer from some degree of illiteracy and ignorance over HIV resulting normally in stigmatisation and discrimination against affected populations.

- Being harm reduction part of the Commission's policy on drugs and a key element to prevent further spread of HIV among IDU, special attention should be dedicated to the partner countries where authorities support and implement harm reduction measures (e. g. Azerbaijan, Georgia, Kyrgyz Republic or Ukraine). Success stories in those countries could be used as empiric arguments when talking to other international actors who are not yet supportive of harm reduction.
- Taking an overview of the information sent by the Delegations, one can observe that the HIV situation in partner countries follows regional trends, therefore regional drug programmes such as CADAP or SCAD, which address harm reduction and which sustain a health approach to drug demand, should continue and probably be reinforced.