Development of the Strategy and Action Plan for the NDPHS Expert Group on HIV/AIDS & AI – possibilities for collaboration and synergies



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Meeting of the UBC Commission on Health and Social affairs, Vaasa 5-6. 06.2012

Strategy and Action Plan Process

Reasons for the need to rethinking the situation

- Partners expect added value from the NDPHS
  - Expert Groups are the operational instruments of the Partnership
- Complexity and increasing challenges of the HIV – TB – IDU situation within the NDPHS Area
- Encouraging experiences from the planning of the Barents HIV Programme
- Deteriorating funding situation

Use of the LFA

Modified Logical Framework Approach

- Identification and analysis of problems and needs - development of the Problem Tree
- Identification of Working Areas and Objectives
- Definition of Activities – need for projects
- Definition of priorities
- Development of consistent action plan
- Making use of the information for advocacy and policy advice

Materialization of the planning process

Meetings, discussions and consultations

- Unofficial discussions, meeting in Porvoo, June, 2011
  - All EG members were invited in short notice for 1,5 days
  - Brain storm discussions about HIV and TB problems within partner countries
  - Preliminary analysis and the first versions of Problem and Objective Trees
- Official group meetings in October 2011 and March 2012
- Comments, corrections and complementary information asked from various stakeholders: "Give your views freely"
- New "Tree" versions after meetings and consultations

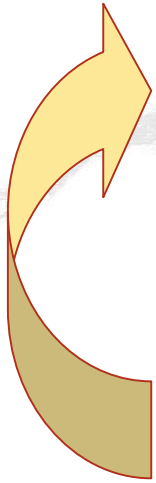
Overall objectives given from NDPHS

Restricts the "freedom" of the analysis of problems and especially definition of objectives

- Overall objectives had been set before the planning process
- The order should be opposite: overall objectives should be identified only on basis of problem analysis

Overall objectives given from NDPHS

Hierarchical order of different levels of objectives



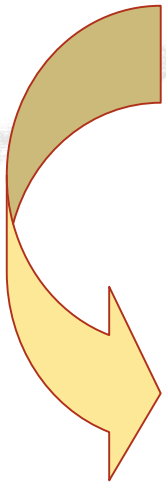
- Goals (from NDPHS):
  - **Prevention of HIV/AIDS and related diseases in the ND Area has improved**
  - **Social and health care for HIV infected individuals in the ND Area is integrated**
- Overall objectives (for the EG, from NDPHS)
  - **Reinforcing policy recommendations**
  - **Geographical and priority thematic areas as well as key populations at higher risk in urgent need for further local or regional projects are identified, partners to be involved in these projects are recommended and project planning supported**
  - **Best practices document(s) developed**
  - **Review of evidence based experiences and best practices on integration of social and health care services for HIV+ people is prepared**

Main areas of problems and needs

Results from identification

1. Existing policies and practices do not fully support the prevention of the spread of HIV and AIs
2. Unsatisfactory monitoring and provision of epidemiological info in the ND Area
3. Continuous spread of HIV, TB and associated infections
4. Deteriorating infectious disease situation of risk groups, migrants and other minorities
5. Complexity of the HIV-AIDS-TB situation is not properly responded by traditional approaches
6. Insufficient capacity of the health care systems to respond to the burden of HIV, TB and AIs

Definition of core problem and purpose of the Action Plan



- Ineffective prevention with harmful impacts of HIV, AIDS & AI (TB, hepatitis B & C, syphilis, gonorrhea) in the ND Area
  - due to insufficiency of international cooperation and joint activities (to be adapted according to prevailing conditions within countries)
- Strengthened prevention and reduction of impacts of HIV, AIDS & AI (TB, hepatitis B & C, syphilis, gonorrhea) in the ND Area
  - through facilitation of cooperation by joint international activities (to be adapted according to prevailing conditions within countries

Main working areas

Based on identified problem areas

0. Management component of the Strategy and Action Plan
1. Provision of support to **policy development** and cooperation
2. Improved monitoring and data on **epidemiological situation** in the ND Area
3. Effective **prevention** of the spread of HIV, TB and associated infections
4. Improved **tuberculosis** situation in risk groups, migrants and other minorities
5. Complexity of the **HIV and TB** situation recognized and new approaches developed
6. Improved capacity of the **health care systems** as response to the burden of HIV, TB and AIs

Current results from the process

- "Problem Trees" and "Objective Trees"
- Form the basis of the strategic thinking and planning of actions of the EG itself
- Provide basic information for advocacy and policy advice

NDPHS HIV/AIDS&AI EG
Third draft of the
"Problem Tree"
(blue boxes)
for internal Action Plan
040212

Goal 2: Prevention of HIV/AIDS and related diseases in the ND Area has improved

Goal 3: Social and health care for HIV infected individuals in the ND Area is integrated

O.T. 2.1. Reinforcing policy recommendations

O.T. 2.2. Geographical and priority thematic areas as well as key populations at higher risk in urgent need for further local or regional projects are identified, partners to be involved in these projects are recommended and project planning supported

O.T. 2.3. Best practices document(s) developed

O.T. 3.1. Review of evidence based experiences and best practices on integration of social and health care services for HIV + people is prepared

2012

Ineffective prevention with harmful impacts of HIV, AIDS & AI (TB, hepatitis B & C, syphilis, gonorrhea) in the ND Area due to Insufficiency of international cooperation and joint activities (to be adapted according to prevailing conditions within countries)

1. Existing policies and practices do not fully support the prevention of the spread of HIV and AIs

- 1.1. HIV+ should be involved in decision making
- 1.2. Insufficient follow-up of HIV+ in general
- 1.3. Insufficient follow-up of HIV+ in key groups
- 1.4. Necessity to integrate HIV surveillance with STI, hepatitis and TB surveillance
- 1.5 Existing services do not reach relevant groups
- 1.6. Insufficient research at international standards
- 1.7. Insufficient use of results from program monitoring and evaluations
- 1.8. Decision makers are not aware about future costs caused by infections and their treatment
- 1.9. Inadequacies and defects of legislation
- 1.10. Some countries do not include sexual health education in schools curricula
- 1.11. Insufficiency of advocacy and lobbying skills to inform decision makers in HIV recourse allocation and to recommend optimal choices based on local characteristics
- 1.12. The role of civil society is too weak
- 1.13. Insufficient understanding of HIV and AIs in the society
- 1.14. Insufficient knowledge about second generation HIV surveillance practices

2. Unsatisfactory monitoring and provision of epidemiological info in the ND Area

- 2.1. Prevalence and risk behavior patterns are not known (MSM, CSWs, IDUs)
- 2.2. Insufficient information about the situation of HIV, TB and AIs among IDUs
- 2.3. Insufficient information about bridging populations (sex partners of IDUs, female partners of MSM, clients of CSWs)
- 2.4. All pregnant women are not automatically tested for HIV and hepatitis
- 2.5. Insufficient services for migrants
- 2.6. Lacking information about ethnic minorities, including Roma and marginalized people
- 2.7. Neglected children, including minors involved in commercial sexual exploitation
- 2.8. Insufficient information from prisons
- 2.9. "Sex tourists" and travelers are not reached sufficiently

3. Continuous spread of HIV, TB and associated infections

- 3.1. High share of late presenters (low CD4) among new HIV+
- 3.2. PHC and GPs are not sufficiently involved in prevention and testing
- 3.3. Unsatisfactory quality of counseling not using established and evaluated methods
- 3.4. LTC services do not sufficiently cover needs of vulnerable groups
- 3.5. Insufficient public awareness about the need for active case finding and cross-testing between HIV TB, hepatitis and STIs
- 3.6. Lack of access to specific services for IDUs, including harm reduction and services outside big cities
- 3.7. Lack of sexual health education in schools' and other institutions' curricula, including sexual minorities, prevention of HIV and STIs
- 3.8. Insufficiency of youth-friendly services
- 3.9. Insufficiency of targeted prevention programs for specific groups (migrants, MSM, CSWs, HIV+, IDUs)
- 3.10. HIV+ are not sufficiently involved in planning and implementation of prevention programs
- 3.11. Insufficiency of collaboration partners
- 3.12. Lack of knowledge about and access to post-exposure prophylaxis

4. Deteriorating infectious disease situation of risk groups, migrants and other minorities

- 4.1. General awareness about TB is weak
- 4.2. MDR and XDR TB are increasing
- 4.3. Need for education about TB among population, medical professionals and decision makers
- 4.4. Insufficient TB infection control especially in HIV settings (including LTSCs)
- 4.5. Co-operation between civilian and penitentiary TB services is weak
- 4.6. Collaboration between TB and narcology services is insufficient
- 4.7. International treatment standards are not always met and followed properly
- 4.8. Lack of outreach work and social support among risk groups for TB

5. Complexity of the HIV-AIDS-TB situation is not properly responded by traditional approaches

- 5.1. Adherence to treatment is not satisfactory
- 5.2. Insufficient cross-sectoral control and management mechanisms and approaches
- 5.3. Too narrow involvement of stakeholders in development of TB and HIV projects and approaches
- 5.4. More & closer collaboration & projects with Russian drug police is needed
- 5.5. Wider scope is needed in consulting relevant authorities
- 5.6. Insufficient training of GPs and other PHC staff on raising awareness of mass media, general population and service providers on contacting, servicing and educating risk groups)
- 5.7. Insufficiency of new approaches for international collaboration and partnerships
- 5.8. The potential of EU Public Health Program not been used
- 5.9. Insufficient attention on promotion of best practices with country specific approach

6. Insufficient capacity of the health care systems to respond to the burden of HIV, TB and AIs

- **6.1. The health and social care systems are not sufficiently responding to and coping with prevailing challenges, including migration**
- **6.2. Insufficient access to treatment**
- **6.3. Insufficient adherence to treatment**
- **6.4. Adequate case management is not always in place**
- **6.5. Need to develop the service system according to practical needs**
- **6.6. Insufficient capacity of PHC in the identification, vaccinations and referring for treatment of associated chronic infections (e.g. HBV & HCV)**
- **6.7. HIV care needs to be more integrated in the PHC**
- **6.8. Currently, the approaches separating HIV and PHC and sexual health services are discriminating and violating basic human rights**
- **6.9. Work-places are Insufficiently covered**

KEVI consulting

NDPHS
HIV/AIDS&AI EG
Third draft of the
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internal Action Plan
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Goal 2: Prevention of HIV/AIDS and related diseases in the ND Area has improved

Goal 3: Social and health care for HIV infected individuals in the ND Area is integrated

O.T. 2.1. Reinforcing policy recommendations

O.T. 2.2. Geographical and priority thematic areas and key populations at higher risk in urgent need for further local or regional projects identified, partners for these projects recommended and project planning supported

O.T. 2.3. Best practices Document(s) developed

O.T. 3.1. Review of evidence based experiences and best practices on integration of social and health care services for HIV + people is prepared

Ineffective prevention with harmful impacts of HIV, AIDS & AI (TB, hepatitis B & C, syphilis, gonorrhea) in the ND Area due to insufficiency of international cooperation and joint activities (to be adapted according to prevailing conditions within countries)

2012

1. Existing policies and practices do not fully support the prevention of the spread of HIV and AIs

1.1. HIV+ not enough involved in decision making
1.2. Insufficient follow-up of HIV+ in general
1.3 Insufficient follow-up of HIV+ in key groups
1.4. Necessity to integrate HIV surveillance with STI, hepatitis and TB surveillance
1.5 Existing services do not reach relevant groups
1.5.1. Insufficient counseling, education and psychosocial support services
1.5.2. Quality of counseling is unsatisfactory
1.5.3. Insufficient knowledge about sites where individual HIV+ can be referred for further info and care in their own countries
1.6. Insufficient research at internatl standards
1.6.1. About behavior, needs assessment and knowledge of risk groups, including youth
1.6.2. About how to improve service provision
1.6.3. To show evidence from prevention progrs
1.6.4. About country specific research issues
1.7. Insufficient use of results from program monitoring and evaluations
1.8. Decision makers are not aware about future costs caused by Infections and their treatment
1.8.1. Insufficiency of assessments of cost effectiveness of expanded HIV screening, ARV and AI treatment
1.9. Inadequacies and defects of legislation
1.9.1.Legislations are not updated concerning equal financing of care, human rights, deportation of migrants, criminalization of HIV spreading and key populations at risk
1.9.2. Funding for treatment is not guaranteed for all HIV+ regardless from their legal status
1.9.3. Implementation of legislation and negative attitudes sometimes increase marginalization and promotes risk behavior (e.g. possession of condoms is used as a sign of practicing sex work)
1.10. Some countries do not include sexual health education in schools curricula
1.11. Insufficiency of skills for advocacy and lobbying to inform decision makers In HIV recourse allocation and to recommend optimal choices based on local characteristics
1.12. The role of civil society is too weak
1.13. Insufficient understanding of HIV and AIs in the society
1.14. Insufficient knowledge about second generation HIV surveillance practices

2. Unsatisfactory monitoring and provision of epidemiological info in the ND Area

2.1. Prevalence and risk behavior patterns are not known (MSM, CSWs, IDUs)
2.1.1. High level of stigma and discrimination concerning HIV AND TB
2.1.2. MSM-friendly services do not exist
2.1.3. Insufficient understanding about HIV and related infections
2.1.4. Insufficient knowledge about CSWs
2.1.4.1. Violence, trafficking and organized crime increase vulnerability of CSWs
2.1.4.2. Increasing international & intranational movement of CSWs
2.2. Insufficient information about the situation of HIV, TB and AIs among IDUs
2.2.1. Young and recently started IDUs are not sufficiently reached before contracting HIV or HCV
2.2.2. Drug policies need to be updated
2.3. Insufficient information about bridging populations (sex partners of IDUs female partners of MSM, clients of CSWs)
2.4. All pregnant women are not automatically tested for HIV and hepatitis
2.5. Insufficient services for migrants
2.5.1. Insufficient testing of other than asylum seekers
2.5.2. Lack of access to secured prevention
2.6. Lacking information about ethnic minorities, including Roma and marginalized people
2.7. Neglected children, including minors involved in commercial sexual exploitation
2.8. Insufficient information from prisons
2.8.1. HIV status not often known
2.8.2. Insufficient collaboration between prison and civil health authorities
2.8.3. Insufficient substitution therapy programs
2.8.4. Insufficient knowledge about the spread of HIV in prisons
2.8.5. Preventive measures are not implemented (condoms, ARV, needles, syringes etc)
2.8.6. Defects of prison staff education
2.8.7. Insufficient support for social adaptation after the release from prison
2.9. "Sex tourists" and travelers are not reached sufficiently

3. Continuous spread of HIV, TB and associated infections

3.1. High share of late presenters (low CD4) among new HIV+
3.1.1. All HIV+ are not willing to change risk-behavior
3.1.2. High quality counseling services are not sufficiently available for vulnerable groups
3.1.3. Unsatisfactory testing coverage of HIV & AIs for vulnerable groups
3.1.3.1. Insufficient accessibility for tests
3.1.3.2. Too few testing opportunities
3.1.3.3. Insufficiency of check point testing
3.1.3.4. Too few targeted testing opportunities

3.2. PHC and GPs are not sufficiently involved in prevention and testing
3.3. Unsatisfactory quality of counseling not using established and evaluated methods

3.4. LTC services do not cover sufficiently the needs of vulnerable groups
3.4.1. Insufficient contacts and collaboration between LTSCs and traditional medical institutions
3.4.2. LTSCs need referral partner institutions to take care of clients who have been tested positive
3.5. Insufficient public awareness about the need for active case finding and cross-testing between HIV, TB, hepatitis and STIs
3.6. Lack of access to specific services for IDUs, including harm reduction, total prevention packages and services outside big cities
3.7. Lack of sexual health education in schools' and other institutions' curricula, including sexual minorities, prevention of HIV and STIs
3.8. Insufficiency of youth-friendly services
3.9. Insufficiency of targeted prevention programs for specific groups (migrants, MSM, CSWs, HIV+, IDUs)
3.9.1. International standards in prevention activities are insufficiently applied
3.9.2 Lack of packages of positive examples for NGOs
3.10. HIV+ are not sufficiently involved in planning and implementation of prevention programs
3.11. Insufficiency of collaboration partners
3.12. Lack of knowledge about and access to post-exposure prophylaxis

4. Deteriorating infectious disease situation of risk groups, migrants and other minorities

4.1. General awareness about TB is weak

4.2. MDR and XDR TB are increasing
4.2.1. Detection of TB, including latent cases, is unsatisfactory
4.2.2. Adherence to treatment is not satisfactory
4.2.3. TB cases are often found too late, especially among HIV+
4.2.4. Insufficiency of prophylactic treatment among immigrants and other vulnerable groups

4.3. Need for education about TB among general population, medical professionals and decision makers

4.4. Insufficient TB infection control especially in HIV settings (including LTSCs)

4.5. Co-operation between civilian and penitentiary TB services is weak

4.6. Collaboration between TB and narcology services Is insufficient

4.7. International treatment standards are not always met and followed properly

4.8. Lack of outreach work and social support among risk groups for TB

5. Complexity of the HIV-AIDS-TB situation not properly responded by traditional approaches

5.1. Adherence to HIV and TB treatment is not satisfactory
5.1.1. Insufficiency of the provision of health education messages
5.1.2. Lack of adherence support
5.1.3. Insufficiency of training of medical personnel
5.14. IDUs need specific attention, related to human rights
5.1.5. High proportion of drop-outs from TB treatments at least in RF
5.1.6. Provision of medication not always guaranteed as required by international standards
5.2. Insufficient cross-sectoral control and management mechanisms and approaches
5.3. Too narrow involvement of stakeholders in the development of TB and HIV projects and approaches

5.4. Too little collaboration and too few projects with Russian drug police

5.5. Wider scope is needed in consulting authorities governing
5.5.1. drug use and supply
5.5.2. education
5.5.3. primary health with involvement of GPs
5.6. Insufficient training of GPs and other PHC staff on raising awareness of mass media, general population and service providers on contacting, servicing and educating risk groups)
5.7. Insufficiency of new approaches for international collaboration and partnerships
5.7.1. with Russia
5.7.2. on infectious and non-communicable diseases
5.7.3. in exchanging of info and knowledge
5.7.4. on medical statistics
5.7.5. on education and health Information
5.8. The potential of EU Public Health Program has not been used
5.9. Insufficient attention on promotion of best practices with country specific approach

6. Insufficient capacity of the health care systems to respond to the burden of HIV, TB and AIs

6.1. The health and social care systems are not sufficiently responding to and coping with prevailing challenges, including Migration and IDUs

6.2. Insufficient access to treatment of HIV and AIs

6.3. Insufficient adherence to treatment of HIV and AIs

6.4. Adequate case management does not always materialize

6.5. The service system is not sufficiently adapted to practical needs
6.5.1. Insufficient counseling skills of GPs
6.5.2. Quality of treatment not always satisfactory
6.5.3. Insufficient know-how of TB doctors to treat HIV

6.6. Insufficient capacity of PHC in the identification, vaccinations and referring for treatment of associated chronic infections (e.g. HBV & HCV)

6.7. HIV care needs to be more integrated in the PHC
6.8. Currently, the approaches separating HIV and PHC and sexual health services are discriminating and violating basic human rights
6.9. Work-places are insufficiently covered

NDPHS HIV/AIDS&AI EG Third draft of the "Objective Tree" for internal Action Plan 040212

Goal 2: Prevention of HIV/AIDS and related diseases in the ND Area has improved

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O.T. 2.1. Reinforcing policy recommendations

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Strengthened prevention and reduction of impacts of HIV, AIDS & AI (TB, hepatitis B & C, syphilis, gonorrhea) in the ND Area through facilitation of cooperation by joint international activities (to be adapted according to prevailing conditions within countries)

12

0. Program management

- 0.1. Develop updated Action Plan for the EG
- 0.1.1. Clarify the needs and expectations of members for the EG
- 0.1.2. Prepare long-term Action Plan, Including principles for EG meetings
- 0.2. Further development of reporting mechanisms and practices
- 0.2.1. Follow-up reporting of projects and EG activities
- 0.2.2. Reporting to the Secretariat and CSR
- 0.2.3. Reporting to governments as relevant
- 0.2.4. Making publicity as relevant
- 0.3. Promotion of project development
- 0.3.1. Identification of relevant project ideas, based on the EG Action Plan
- 0.3.2. Provision of support to identification of project partners
- 0.3.3. Provision of support to project planning
- 0.3.4. Provision of support for applications
- 0.4. Identification of funding sources and mechanisms

1. Provision of support to policy development and cooperation

- 1.1. People living with HIV more involved in decision making
- 1.2. Improved follow-up of all HIV+ , including medical care and counseling
- 1.3. Improved follow-up of HIV+ belonging to key risk groups
- 1.4. Improved integration HIV and STIs, hepatitis and TB surveillance
- 1.5. Improved access to existing services for relevant risk group
- 1.6. More research fulfilling international standards
- 1.7. Results from monitoring and evaluations of programs are effectively made use of
- 1.8. Decision makers are informed and aware of future costs caused by infections and their treatment
- 1.9. Updated legislation
- 1.10. Sexual health education included in schools curricula
- 1.11. Improved skills for advocacy and lobbying to inform decision makers on HIV resource allocation and to recommend optimal choices based on local characteristics
- 1.12. Civil society organizations are more involved in prevention and support
- 1.13. The understanding of HIV and Ais among the public has improved
- 1.14. Improved knowledge about second generation HIV surveillance

2. Improved monitoring and data on epidemiological situation in the ND Area

- 2.1. Improved data on prevalence of HIV and hepatitis among risk groups (MSM, CSWs, IDUs)
- 2.2. Mechanisms developed to deliver data on the situation of HIV, TB and AIs among IDUs
- 2.3. Effective approaches developed to collect relevant data on bridging populations (sex partners of IDUs, female partners of MSM, clients of CSWs)
- 2.4. Improved HIV and hepatitis testing coverage in pregnant women
- 2.5. Increased counseling and testing services for migrants
- 2.6. More and better data on prevalence and risk behavior in ethnic minorities, including Roma and marginalized people
- 2.7. More and better data on prevalence and risk behavior in neglected children, including minors involved in commercial sexual exploitation
- 2.8. Mechanisms in place to produce data on situation of infectious disease in prisons
- 2.9. Mechanisms developed to reach "sex tourists" and travelers more effectively

3. Effective prevention of the spread of HIV, TB and associated infections

- 3.1. Decreasing share of late presenters (low CD4) among newly diagnosed HIV+
- 3.2. More involvement of PHC and GPs in prevention and testing
- 3.3. The quality of counseling improved by using established and evaluated methods
- 3.4. Needs of vulnerable groups are met through LTC services
- 3.5. Improved public awareness about the need for active case finding and cross-testing between HIV TB, hepatitis and STIs
- 3.6. Access to specific services for IDUs, including harm reduction, total prevention packages and services outside big cities
- 3.7. Sexual Health education included in schools' and other institutions' curricula, including information on sexual minorities and HIV and STI prevention
- 3.8. Availability of youth-friendly services
- 3.9. Availability of targeted prevention programs for specific risk groups (migrants, MSM, CSWs, HIV+, IDUs)
- 3.10. People living with HIV are involved in planning and Implementation of prevention programs
- 3.11. Networks of collaboration partners established
- 3.12. Knowledge about and access to post exposure prophylaxis for HIV and hepatitis B are available

4. Improved tuberculosis situation in risk groups, migrants and other minorities

- 4.1. The general awareness among professionals and the public about TB is improved
- 4.2. The number of cases of MDR and XDR TB is decreasing
- 4.3. TB information Programs implemented among the public, professionals and decision makers
- 4.4. TB infection control programs implemented especially in HIV settings (including LTSCs)
- 4.5. Improved collaboration between civilian and penitentiary TB services
- 4.6. Improved collaboration between TB and narcology services
- 4.7. International treatment standards on TB are met
- 4.8. Outreach work and social support methods among risk groups for TB are developed

5. Complexity of the HIV and TB situation recognized and new approaches developed

- 5.1. Improved adherence to treatment of double infections
- 5.2. Improved cross-sectoral disease control, management, mechanisms and approaches
- 5.3. Wider involvement of stakeholders in the development of TB and HIV projects and approaches
- 5.4. More & closer collaboration & projects with Russian drug police developed
- 5.5. Guidance are developed to motivate the use of wider scope in consulting government authorities
- 5.6. Training of GPs and other PHC staff developed and implemented on raising awareness of mass media the public and service providers on contacting, servicing and educating risk groups)
- 5.7. New approaches developed for international collaboration ,partnerships and networking
- 5.8. Effective use of the potential of EU Health Program
- 5.9. Promotion of best practices with country specific approach

6. Improved capacit of the health care systems as respons to the burden of HI TB and AIs

- 6.1. The health and social care systems are capable to respond effectively to and cope with prevailing challenges including migration and IDUs
- 6.2. Functioning access to treatment
- 6.3. Improved adherence to treatment
- 6.4. Adequate case management is in place
- 6.5. Strengthened service systems to met clients practical needs
- 6.6. Improved capacity of PHC concerning the identification, vaccinations and referring for treatment of associated chronic infections (e.g. HBV & HCV)
- 6.7. Strengthened integration of HIV care in the PHC
- 6.8. PHC & sexual Health services are provided without stigmatization, discrimination and violation of basic human rights
- 6.9. Improved Involvement of workplaces

KEVI consulting

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0.4. Identification of funding sources and mechanisms

1. Provision of support to policy development and cooperation

1.1. HIV+ better involved in decision making
1.2. Improved follow-up of HIV+ in general
1.3. Improved follow-up of HIV+ in key groups
1.4. Improved integration of HIV surveillance with STI, hepatitis and TB surveillance
1.5. Improved coverage of existing services
1.5.1. Improved counseling, education and psychosocial support services
1.5.2. Improved quality of counseling
1.5.3. Improved knowledge about sites where individual HIV+ can be referred for further info and care in their own countries
1.6. Increasing research fulfilling intl standards
1.6.1. of behavior, needs assessment and knowledge of risk groups, including youth
1.6.2. about improving service provision
1.6.3. to show evidence base of prevention programs
1.6.4. referring to country specific research
1.7. Results from monitoring and evaluations of programs are effectively made use of
1.8. Decision makers are informed and aware about future costs caused by infections and their treatment
1.8.1. Assessments of cost effectiveness of expanded HIV screening, ARV and AI treatment implemented
1.9. Updated legislation
1.9.1. Updated legislation concerning equal financing of care, human rights, deportation of migrants, criminalization of HIV spreading, key populations at risk
1.9.2. Funding for treatment available for all HIV+ regardless from their legal status
1.9.3. Implementation of legislation and negative attitudes sometimes increase marginalization and promotes risk behavior (e.g. possession of condoms is used as a sign of practicing sex work)
1.10. Sexual health education included in schools curricula
1.11. Improved skills for advocacy and lobbying to inform decision makers in HIV recourse allocation and to recommend optimal choices based on local characteristics
1.12. Strengthened role of civil society organizations through training
1.13. Improved understanding of HIV and AIs in the society
1.14. Improved knowledge about second generation HIV surveillance practices

2. Improved monitoring and provision of epidemiological info in the ND Area

2.1. Improved prevalence data of hiv and hepatitis in risk groups (MSM, CSWs, IDUs)
2.1.1. Reduced stigma and discrimination concerning HIV AND TB
2.1.2. MSM-friendly services developed
2.1.3. Improved understanding about HIV and related infections
2.1.4. Increasing knowledge about CSWs
2.1.4.1. Effective approaches developed to decrease vulnerability of CSWs due to violence, trafficking and organized crime
2.1.4.2. Increasing international & intranational movement of CSWs
2.2. Mechanisms developed to produce information about the situation of HIV, TB and AIs among IDUs
2.2.1. Effective approaches are developed to reach young and recently started IDUs before they become infected by HIV or HCV
2.2.2. Updated drug policies
2.3. Effective approaches developed to collect relevant information about bridging populations (sex partners of IDUs female partners of MSM, clients of CSWs)
2.4. Improved testing coverage of pregnant women for HIV and hepatitis
2.5. Increased services for migrants
2.5.1. Increased testing of also other than asylum seekers
2.5.2. Improved access to secured prevent
2.6. Improved amount and reliability of information about ethnic minorities, including Roma and marginalized people
2.7. Neglected children, including minors involved in commercial sexual exploitation
2.8. Functioning approaches to produce information on inf. diseases from prisons
2.8.1. Improved awareness about HIV st.
2.8.2. Improved collaboration between prison and civil health authorities
2.8.3. Substitution therapy programs planned and tested
2.8.4. Improved knowledge and understanding about the spread of HIV
2.8.5. Improved implementation of preventive measures condoms, ARV, needles, syringes etc)
2.8.6. prison staff education implemented
2.8.7. Improved provision of support for social adaptation after release from prison
2.9. Approaches developed to reach "sex tourists" and travelers more effectively

3. Effective prevention of the spread of HIV, TB and associated infections

3.1. Decreasing share of late presenters (low CD4) among new HIV+
3.1.1. HIV+ are willing to change risk-behavior
3.1.2. High quality counseling is available for vulnerable groups
3.1.3. High testing coverage of HIV&AIs for vulnerable groups
3.1.3.1. Improved accessibility for tests
3.1.3.2. Improved opportunities for testing
3.1.3.3. Check point testing available
3.1.3.4. Targeted testing available
3.2. Improved involvement of PHC and GPs in prevention and testing
3.3. The quality of counseling improved by using established and evaluated methods
3.4. Needs of vulnerable groups are met through LTC services
3.4.1. Improved contacts and collaboration between LTSCs and traditional medical institutions
3.4.2. Referral partner institutions Identified for LTSCs to take care of clients who have been tested positive
3.5. Improved public awareness about the need for active case finding and cross-testing between HIV TB, hepatitis and STIs
3.6. Specific services are available for IDUs, including harm reduction, total prevention packages and services outside big cities
3.7. Sexual Health education included in schools' and other institutions' curricula, including sexual minorities, prevention of HIV and STI risk
3.8. Availability of youth-friendly services
3.9. Availability of targeted prevention programs for specific groups (migrants, MSM, CSWs, HIV+, IDUs)
3.9.1. Prevention activities are based on international standards
3.9.2 Positive example packages are available for NGOs to be widely used
3.10. HIV+ are involved in planning and implementation of prevention programs
3.11. Networks of collaboration partners established
3.12. Knowledge about and access to post-exposure prophylaxis are available

4. Improved infectious disease situation of risk groups, migrants and other minorities

4.1. Improved general awareness about TB

4.2. Improved control of the spread of MDR and XDR TB
4.2.1. Strengthened detection of TB, Including latent cases,
4.2.2. Improved adherence to treatment
4.2.3. Timely identification of TB cases also among HIV+
4.2.4. Prophylactic treatment among immigrants and other vulnerable groups properly implemented

4.3. TB education implemented among population, medical professionals and decision makers

4.4. TB infection control implemented especially in HIV settings (including LTSCs)

4.5. Improved co-operation between civilian and penitentiary TB services

4.6. Improved collaboration between TB and narcology services

4.7. Improved application of international treatment standards
4.8. Outreach work & social support methods among risk groups for TB are developed

5. Complexity of the HIV-AIDS-TB situation recognized and new approaches developed

5.1. Improved treatment adherence
5.1.1. Improved provision of health education messages
5.1.2. Strengthened support to
5.1.3. Increased provision of training for medical personnel
5.1.4. Guidance and possibilities developed for IDUs to get info related to human rights
5.1.5. Deceasing proportion of drop-outs from TB treatments in all countries and especially in RF
5.1.6. Provision of medication not always guaranteed as required by international standards
5.2. Improved cross-sectoral control and management mechanisms and approaches
5.3. Wider involvement of stakeholders in the development of TB and HIV projects and approaches
5.4. More & closer collaboration & projects with Russian drug police
5.5. Instructions and guidance are developed to motivate the use of wider scope is used in consulting authorities governing
5.5.1. drug use and supply
5.5.2. education
5.5.3. primary health care and GPs
5.6. Effective training of GPs and other PHC staff developed and implemented on raising awareness of mass media and general population service providers on contacting, servicing and educating risk groups
5.7. New approaches developed for international Collaboration and partnerships
5.7.1. With Russia
5.7.2. On infectious and non-communicable diseases
5.7.3. In exchanging info and knowledge
5.7.4. On medical statistics
5.7.5. On education and health information
5.8. Effective use of the potential of EU Public Health Program
5.9. Promotion of best practices with country specific approach

6. Improved capacit of the health care Systems to respond to the burden of HI TB and AIs

6.1. The health and social care systems are capable to respond effectively to and cope with prevailing challenges, including migration and IDUs
6.2. Functioning access to treatment
6.3. Improved adherence to treatment
6.4. Adequate case management is in place

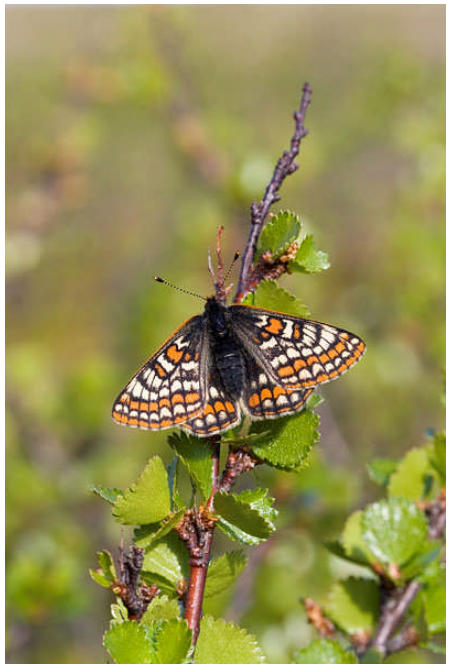
6.5. Strengthened service system according to practical needs
6.5.1. Improved counseling skills of GPs
6.5.2. Acceptable quality of treatment
6.5.3. Improved know-how of TB doctors to treat HIV
6.6. Improved capacity of PHC concerning the identification, vaccinations and referring for treatment of associated chronic infections (e.g. HBV & HCV)
6.7. Strengthened Integration of HIV care in the PHC
6.8. Updated Approaches integrating HIV and PHC & sexual health services without discrimination and violation of basic human rights
6.9. Improved coverage on work-places

You are welcome to give your comments

- **Additions and corrections in the contents of the Problem and Objective Trees**
- **Any other comments**
- **Ideas for synergy and collaboration?**

Effective projects!

- Steps for tomorrow's development impacts



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