



BORDER|NET *work*

CROSSING BORDERS, BUILDING BRIDGES

Combination prevention: interdisciplinary scaling up of HIV/AIDS/STI prevention, diagnostics, and treatment across Central, Eastern, and South Eastern Europe

OVERALL ACTIVITY REPORT

Impressum

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BORDERNETwork 2010–2012

Highly active prevention: scale up HIV/AIDS/STI prevention, diagnostic, and therapy across sectors and borders in CEE and SEE

More information about the project is available on the Internet: www.bordernet.eu

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Dear Reader!

With this brochure, we would like to introduce the most significant results and meaningful outcomes of the three-year BORDERNETwork project (2010–2012), a cooperation involving thirteen partners from eight EU and four non-EU countries.

First launched in 2004 as an initiative along the German-Polish border, BORDERNETwork has developed into a cross-country, multisectoral, interdisciplinary network cooperation in the fields of HIV/AIDS and STIs. During the course of EU enlargement, we focused on developing and strengthening regional networks in the countries of Central and Eastern Europe (CEE) and South Eastern Europe (SEE). Access to health care and social services as well as social inclusion are not only a basic human right and universal value but, moreover, a joint European responsibility. Working from within this broader approach of human rights and social equity, BORDERNETwork addressed marginalised and vulnerable groups who are at higher risk of contracting HIV/AIDS/STIs. The project promoted the active participation of professionals from multiple disciplines, members of civil society, and community representatives in improving prevention, diagnostics, and treatment.

The 'red thread' running through all of BORDERNETwork's concerted action is the concept of 'combination prevention'. The nine abstracts presented here highlight various facets and levels of its implementation in practice and can be read separately as stand-alone accounts. The full reports are accessible on the project website (www.bordnet.net) for in-depth review.

The abstracts allow glimpses into a range of material: the concept and methods of combination prevention as implemented by BORDERNETwork (page 7); reports on two second-generation sentinel surveillance surveys (pages 11 and 15); the results of five fact finding missions on HIV and STIs in four non-EU countries bordering the EU (page 19); a description of efforts to improve access to early HIV/STI diagnostics for most-at-risk groups (page 25); recommendations for

improved management of HIV and Hepatitis B and C co-infections (page 30); a call for enhanced participatory, community-based HIV/STI prevention among migrants and ethnic minorities (page 35); recommendations for training medical students in communication and counselling on sexual health (page 39); and the description of a new online tool for improving quality of youth HIV prevention and sexual health (page 43).

Our BORDERNETwork brochure addresses all HIV/AIDS/STI actors who are committed to implementing innovative, participatory, and cooperative approaches. We hope it contains inspiration and new ideas—and that it encourages you to take part in disseminating its results and recommended changes.

We gratefully acknowledge all of the contributors to the BORDERNETwork project: the authors and partners, the participating service-providers, and the many community representatives with whom we had the pleasure of working.

Elfriede Steffan and Tzvetina Arsova Netzelmann

Combination prevention: how can it work in practice? BORDERNETwork's perspective from the ground up

Elfriede Steffan; Tzvetina Arsova Netzelmann; Joyce Dreezens-Fuhrke

Introduction and objectives

BORDERNETwork (2010–2012) was an interdisciplinary, cross-border network project for implementing highly active prevention in the HIV/AIDS and STI fields. It was funded by the European Union within the framework of its Health Programme. BORDERNETwork connected thirteen partners from eight EU member states—six of which were from CEE and SEE—in a series of cross-disciplinary work packages (WPs). Civil society organisations from four European Neighborhood Policy (ENP) countries were also involved as subcontractors. The project's philosophy is grounded in the following conviction: that HIV prevention works effectively if stand-alone measures for prevention, diagnosis, and treatment of HIV/AIDS and STIs are integrated into comprehensive strategies and interdisciplinary efforts. Combination prevention is essential in the response to a still expanding HIV epidemic, as is a mix of interventions on policy and practice levels and via communication channels.¹

Despite thirty years of global joint efforts in HIV prevention, it is still a great challenge to overcome the structural borders that exist among disciplines and sectors (eg, prevention based on structural and behavioural interventions, HIV/AIDS/STI diagnostics, and the treatment and management of HIV and co-infections).

Even within a single thematic field, cooperation gaps exist among prevention and treatment experts, social scientists, and social work practitioners as well as physicians, members of civil society, and community

¹Thomas J. Coates et al. (2008). Behavioural strategies to reduce HIV transmission: How to make them work better. *Lancet* 372 (9639): 669–684.

representatives. Intersectoral commitment needs to be enhanced, and integrating HIV/AIDS/STI prevention into a holistic approach towards sexual health is required. Moreover, the development of rights-based, equity-based, evidence-based, and community-owned programmes must be strengthened.²

BORDERNETwork's objective was to balance the three core strands that constitute the bottom-up practice of combination prevention of HIV/AIDS (including co-infections) and STIs: prevention, diagnosis, and treatment. With a focus on CEE and SEE, BORDERNETwork aimed to improve the cross-links among these three strands, bridging gaps in practice, policies, cross-country cooperation, and interdisciplinary response.

Approach and methods

Both the concept of BORDERNETwork and its methodological approach were based on the principles of 'highly active prevention', a term coined by King Holmes (cited in Coates et al., 2008). Thomas Coates and his colleagues have presented strong evidence that highly active HIV prevention must be combination prevention.

Combination prevention of HIV is defined by UNAIDS (2010) as 'the tailoring and coordinating of biomedical, behavioural and structural strategies to reduce new HIV infections'.

The behavioural strategies that the BORDERNETwork partners jointly developed and applied in diverse local contexts in eight EU countries focussed not only on behavioural change at the individual level but also on social networks, intersectoral cooperation, institutions, and entire communities. Because efficacious behaviour change for HIV prevention in socially marginalised, vulnerable groups requires stigma reduction, among other things (UNAIDS, 2010), interventions designed to increase social justice, equity, and the human rights of most-at-risk groups complemented the range of methods.

² UNAIDS (2010). Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioural and Structural Strategies to Reduce New HIV Infections. A UNAIDS Discussion Paper.

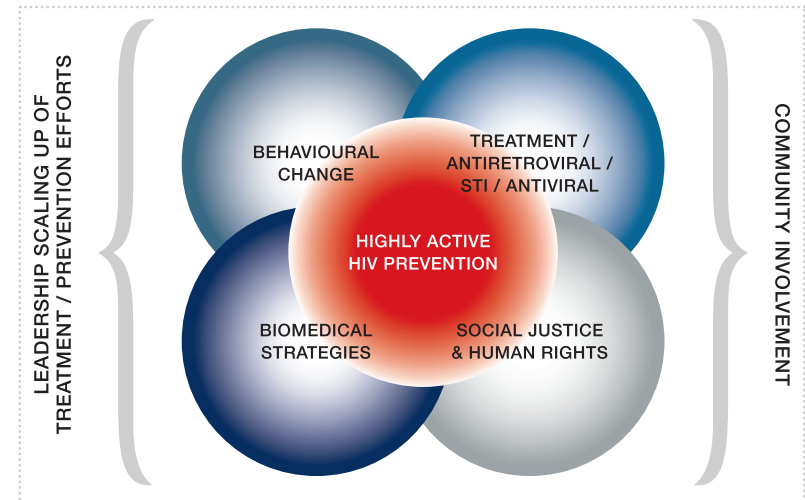


Figure 1: Highly active HIV prevention, Thomas J. Coates et al., 2008.

A core feature of the project was that all methods aimed to involve the participation and improved social inclusion of its final beneficiaries: vulnerable groups and communities. The surveys conducted using bio-behavioural research methods therefore offered direct diagnostic and counselling services to beneficiaries. The methods of competence and capacity building were combined with skills trainings and empowerment of peer, social, and community networks.

Sex workers (SWs), people who inject drugs (PWID), migrants and ethnic minorities, STI patients, people living with HIV (PLHIV), and vulnerable youth were among those reached in the work packages described below. They participated in a range of prevention interventions and took up various offers for HIV/AIDS/STI counselling, diagnosis, referral, and treatment.

A bundle of methods was applied in a coordinated manner within the interdisciplinary networks, in research, and in the prevention, diagnosis, and treatment of HIV/AIDS and STIs, so that synergy effects were sought among the thematic strands.

Outcomes

Within the context of the multifaceted, heterogeneous prevention methods currently practiced in CEE and SEE countries, BORDERNETwork strove to promote a better understanding of—and concerted commitment to—the complexity of combination prevention.

The results of BORDERNETwork are presented in this brochure by abstracts of the main areas of cooperation: the work packages (WP4, 5, 6, 7, 8 and 9, respectively). Taken together, they present the outcomes from a range of perspectives and levels of intervention. The long-term significance is an enhanced capacity on regional, national, and cross-border levels in the interdisciplinary response to HIV/AIDS and STIs.

HIV/STI sentinel surveillance: importance for HIV/AIDS/STI response at the European level

Viviane Bremer*; Karin Haar*; Matthias Nachtnebel; Eva-Maria Vinzelj-Horvath; Peter Komericki; Elena Petrova; Krasimira Chudomirova; Vasile Benea; George-Sorin Tiplica; Danica Staneková; Jaroslav Hinšt; Osamah Hamouda; Tzvetina Arsova Netzelmann

*Contributed equally to the project

‘A sentinel surveillance is very useful if there is a lack of specific data, because a representative survey is quite expensive and time-consuming.’

Elfriede Steffan, SPI Forschung

Objectives and methods used

The work package implemented a second-generation sentinel surveillance in 2010–2012, combining biological with behavioural data on HIV/AIDS/STIs and risk behaviour in Austria, Bulgaria, Romania, and the Slovak Republic. In Austria and the Slovak Republic, the predecessor BORDERNET project was performed in 2006–2007 using the same methods; in Romania and Bulgaria, data collection has been on-going since 2008. The objectives of the sentinel surveillance system were to record lab-confirmed STIs (Chlamydia, Gonorrhoea, Syphilis, or HIV) in clinical settings; acquire demographic and behavioural data; assess geographic distribution and migration status of STI patients; detect epidemiological trends; identify vulnerable groups; identify risk factors for STIs; generate hypotheses; and recognise the necessity of targeted interventions.

The population under surveillance included all persons attending participating sentinel sites during the study periods. Physicians reported

anonymised data on the number of clients and performed STI tests and positive tests on a monthly basis in monthly questionnaires (MQ). Diagnosis questionnaires (DQ) collected individual information for each STI patient on the nature of infection, co-infections, demographics, STI history, and assumed risk behaviour. Finally, patients were asked to fill out patient questionnaires (PQ) on socio-demographics, means of transmission, and sexual behaviour. Sentinel sites regularly transmitted their data to regional cooperation partners, who forwarded them to SPI Forschung. Data were analysed by the Robert Koch Institute (RKI).

Key findings and results achieved



Overall, there were 13 participating sentinel sites in Austria, 14 in the Slovak Republic, 13 in Romania, and 5 in Bulgaria. Data were available on the total number of clients, total number of STI tests performed, positivity rate, characteristics of STI patients (per STI), their co-infections, migration backgrounds, and sexual behaviour (such as possible source of infection or condom use). Figure 1 gives an overview of the data obtained.

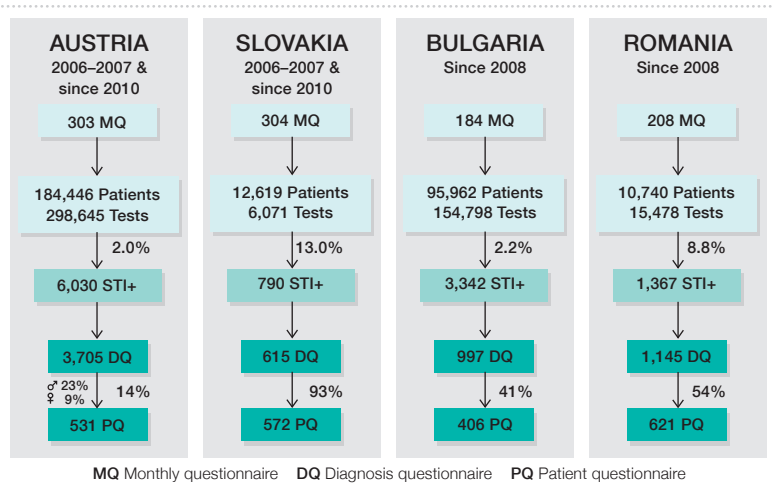


Figure 1: Number of questionnaires obtained, STI tests, proportion of positive STI tests, and STI patients by country.

A total of 467,797 tests were performed at the sentinel sites. Of these, 11,090 tests were positive. The overall proportion of positive tests was 0.5% for HIV, 4.6% for Chlamydia, 2.1% for Gonorrhoea and 2.4% for Syphilis. The four countries differed in the number of STI tests, positivity rate, patient characteristics, and sexual behaviour reported. For example, in Bulgaria, Romania, and the Slovak Republic, less than 15% of all STI tests were for Chlamydia, although Chlamydia tests were more frequently positive than other tests. Moreover, up to 22% of Gonorrhoea patients also had a Chlamydia co-infection. In contrast, over 70% of all STI tests in Bulgaria were Syphilis tests, as these tests are frequently performed under a variety of circumstances. Regular STI tests are compulsory for female SWs in Austria, which leads to a high number of STI tests in that country.



Source: SPI Forschung

In Austria, 79% of STI patients at the sentinel sites, especially women, had a migration background, whereas in the three other countries this was less than 7%. Regarding sexual behaviour, male patients in all four countries most often indicated casual partners as the possible source of infection, while women more often indicated regular partners as a source of infection. A lower rate of consistent condom use, especially with regular partners, was observed among female SWs and MSM in the Slovak Republic compared to Austria.

Strategy relevance

Structural benefits and disadvantages

Sentinel systems can be implemented alongside routine surveillance, or as an alternative when no surveillance system is in place. Sentinel systems allow biological and behavioural surveillance to be integrated, which provides a better picture of the diseases under surveillance. The sentinel surveillance helped strengthen local and regional partners by connecting them to BORDERNETwork's own strong network.

The strength of the sentinel system strongly depends, however, on the motivation of the sentinel sites. Building a strong network and keeping it alive is therefore essential for maintaining data quality.

Scientific benefits and disadvantages

The sentinel surveillance of the BORDERNETwork project allowed for comparison among partners and identified differences in diagnostics, vulnerable groups, and forms of risky behaviour. At the same time, the sentinel sites could not be considered representative of their respective countries.

Conclusions, lessons, and recommendations

Following the results of the sentinel surveillance, a diagnostic survey was performed to obtain more information on differences in diagnostic tests. Sentinel sites were asked about the diagnostic methods, type of samples taken, and their sampling strategies. The study revealed that some countries have difficulties in offering highly sensitive and specific diagnostics to STI patients at affordable costs.

As a consequence of the diagnostic survey, a 'diagnostics performance study' of women with vaginal discharge or lower abdominal pain was started in Bulgaria to compare the currently used diagnostic methods with cheap new nucleic acid amplification tests (NAAT). This study is on-going.

We recommend that standardised testing methods be used and that targeted screening recommendations be formulated. Low-threshold testing sites should be set up using cultural/language mediators to improve access to migrants and ethnic minorities. Also, compulsory STI testing should be replaced with testing that is guided by sexual history and by data on the client's risk behaviour.

Vulnerability of sex workers and their particular needs for HIV/STI prevention, diagnosis, treatment, and care: research findings, policy implications, and recommendations for comprehensive sexual health response

Tzvetina Arsova Netzelmann; Elfriede Steffan; Lillia Löhmus; Jury Kalikov; Anda Karnite; Alexander Leffers; Barbora Kucharova; Raina Dimitrova; Cristina Fierbinteanu

'The cooperation involved two parallel direct research studies (Sentinel surveillance in STI patients and Integrated bio-behavioural surveillance in sex workers) and yielded evidence with wide-ranging implications for combination prevention.'

Elfriede Steffan, SPI Forschung

Background and objectives

While prostitution has recently become a frequent and often controversial topic of discussion at expert and political levels in Europe, the evidence-based knowledge of sex work in general, and the situation of SWs in particular, is still scarce. Epidemiologically, SWs are not considered a population at higher risk for HIV exposure Europe-wide.

In its recommendations for prevention and treatment of HIV and other STIs for SWs in low- and middle-income countries (December 2012), WHO collated substantial evidence on the major vulnerability factors and occupational hazards of sex work—factors and hazards that are also applicable in high-income regions like Europe. Moreover, the legal context of sex work in various European countries plays an important role as a broader risk determinant. Sex work regimentations in the EU currently swing between partial and total criminalisation—from abolitionist to prohibitionist—with only rare exceptions of regulationist approaches. Despite the fact that all of the selected strategies and interventions share a common underlying objective—the fight against discrimination, violence, and social exclusion in the field of sex work—their approaches are very different and partly contradictory.

BORDERNETwork's WP5 addressed these discrepancies in the European context with an 'Integrated bio-behavioural survey' (IBBS). Its aim was threefold: to compile contextualised knowledge on the health and social situations of SWs in CEE and SEE; to detect the prevalence of and vulnerability to HIV/AIDS/STIs; and to formulate recommendations for prevention practice.

Methods used



Source: Health and Social Development Foundation, Sofia

Cross-sectional and cross-country behavioural and epidemiological data collection was carried out among female SWs in seven EU countries between March 2011 and February 2012. The survey comprised qualitative face-to-face interviews (an 85-item behavioural questionnaire) and blood tests (screening for HIV, Syphilis, HCV, and HBV). The survey locations were Berlin, Bratislava, Bucharest, the German-Polish border, Riga, Szczecin, Sofia, and Tallinn. A convenient sample was recruited, combining elements of respondent-driven and service/venue-based sampling techniques. A total of 956 respondents (predominantly from the outdoor sex work scene) participated—between 100 and 210 per country.

Key findings and results

The survey results corroborate the above-mentioned WHO findings. Multiple overlaps were noted among SWs and other marginalised, vulnerable groups. Evidence of several of the 'up-streaming context and behavioural risk indicators' was collated: alcohol, drug use (including injection drugs), migrant and/or ethnic minority background, mobility, youth, early start in sex work, unsafe and partly clandestine working conditions, and a low degree of control over negotiating safer sex practices in some sex work scenes. Almost 30% of the SWs (N=283) were younger than age 18 when they started sex work. Almost 60% (N=566) of the SWs had experience in sex work of three years or longer. Over 77% (N=734) of them had no other occupation and had subsisted on sex work in the past year. And more than half of the interviewed SWs (N=529) supported one or more dependants with their incomes. About 38% had experience injecting drugs.

One finding was of particular concern: that utilisation of general health care by SWs is hampered by the lack of health insurance, which was absent among 60% (N=571) of those interviewed. On the other hand, access to and uptake of an HIV test and counselling seems to be almost mainstreamed: 59% (N=560) of the interviewed SWs had had an HIV test in the past year. At the same time, STI/sexual health services are hardly utilised by SWs: 77.1% (N=704) had not attended an STI-service in the past year, and 51.1% (N=484) had not visited a gynaecologist/family planning specialist in the past year. Almost 60% (N=557) had had one or more abortion, and more than 30% (N=311) of those interviewed reported two or more abortions.

Further predictors of increased risk outlined by the IBBS findings are 1) drug and alcohol use before/during sex work and 2) inconsistent condom use during oral and vaginal sex with clients. These factors in particular were linked to increased prevalence of Syphilis, HBV, and HCV.¹

¹ Multivariate analysis of risk predictors for specific infections (OR).



Strategy relevance

The survey results unequivocally pointed out the necessity of a Europe-wide recognition of SWs (male as well as female) as an important target group for prevention, research, and policy efforts—efforts that should, furthermore, be embedded in human rights and decriminalisation approaches. This is in keeping with the good practice recommendation formulated by WHO, UNFPA, UNAIDS, and the Network of Sex Work Projects (NSWP): ‘All countries should work towards decriminalisation of sex work and elimination of the unjust application of non-criminal laws and regulations against sex workers.[...] Health services should be made available, accessible, and acceptable to sex workers based on the principles of avoidance of stigma, non-discrimination, and the right to health.’

Conclusions, lessons, and recommendations

The combination of social determinants of risk, including precarious living circumstances and social stigma, multiplies the vulnerability of SWs and impedes their access to prevention, diagnosis, and treatment of HIV/AIDS/STIs. A key message formulated in the IBBS is that health policy regulations should endorse the creation of structures for early and easy access to health care services for SWs. A minimum health care provision package (including sexual and reproductive health) should be envisaged especially for those SWs lacking health insurance and social insurance and for those suffering from the aggravating circumstances of illegal status.

The evidence produced by BORDERNETwork has been brought to the attention of national public health policy actors in the participating countries. Follow-up is needed to integrate the findings into practice.

Fact finding missions on HIV/AIDS/STI prevention, diagnosis, and treatment in four ENP countries along the EU borders

Natalia Vladicescu; Maryana Sluzhynska; Oleksandra Sluzhynska; Belma Lepir; Stasa Plecas; Joyce Dreezens-Fuhrke

‘A major achievement of the project was that it contributed to existing knowledge about the situation of HIV/AIDS/STI prevalence and risks beyond the EU borders, while highlighting vulnerable groups and communities to be addressed with further prevention interventions.’

Tzvetina Arsova Netzelmann, SPI Forschung

Background and objectives

The objective of the fact finding missions (FFMs) was to sort out gaps in and among the core strands HIV/AIDS/STI prevention, diagnosis, and treatment in border areas between EU and ENP countries. Four ENP countries were selected: Moldova, Ukraine, Bosnia and Herzegovina, and Serbia.

The main focus was on:

- obtaining information on the particularities of the local epidemiological situation (eg, HIV/AIDS/STIs and co-infections such as HCV and TB);

- detecting patterns of risk related to social determinants of various vulnerable groups—eg, at-risk youth, mobile groups, ethnic minorities and migrants, most-at-risk groups (PWID, SWs), and PLHIV;
- assessing barriers to available prevention measures;
- launching a needs assessment specific to the target group, taking into consideration prevention, medical and social offers, universal access to treatment, care and support for affected communities, human rights, and the ethics of research and prevention.

In the non-EU countries from CEE and SEE, four civil society organisations were subcontracted to carry out FFMs in the field of HIV/AIDS/STI prevention and treatment and to outline survey reports.

MOLDOVA: As one-fifth of the country's citizens (600,000) migrate for work (the more educated to western European countries, the less educated to Russia and other countries of the former Soviet Union), a high percentage of Moldova's teenagers live without their parents. These teenagers are considered a vulnerable population in terms of HIV and STIs. Against this background, the NGO CREDINTA carried out a FFM entitled 'HIV knowledge, attitude, practice (KAP) study on teenagers with parents working abroad'.

UKRAINE: Although HIV infection rates are lower in the western part of Ukraine compared to the east, the rate of growth in the west is one of the highest in the country. More than three million HIV tests are implemented in Ukraine each year, including obligatory HIV routine screening tests for all pregnant women. Nonetheless, it is estimated that around 70% of all HIV-positive cases are unregistered. PWID were and still are the main vulnerable group, however, the heterosexual transmission route is gaining new importance. The sexual partners of PWID—an especially vulnerable and hard-to-reach group—play a 'bridging role' within the general population. A 'Rapid assessment and response (RAR) of HIV/AIDS among vulnerable groups in the Lviv region (west Ukraine)' was conducted by the SALUS Charitable Foundation. A second rapid assessment was conducted by the

SALUS Foundation to furnish an overview of 'Referral and treatment systems for HIV and co-infections in the Lviv region'.

BOSNIA and HERZEGOVINA: The sex industry flourished in the 1990s during and after the war in the Balkans, giving rise to the phenomenon of 'survival sex work' (both forced and voluntary). UN-corps soldiers were the most frequent clients. In 2002 a major scandal broke out when NGOs estimated that around two thousand SWs from CEE and SEE were 'trapped' in Bosnian brothels and that the percentage of human trafficking victims among them was very high. As a result, sex work is illegal in Bosnia and Herzegovina today, and the completely clandestine situation of SWs hinders them from accessing health services. Association PROI carried out a 'Rapid assessment and response of HIV/AIDS among sex workers in Bosnia and Herzegovina' to analyse the situation of SWs and obtain an overview of their risk to HIV/AIDS/STIs.

SERBIA: Significant barriers to health services exist for SWs and members of other vulnerable groups (eg, mobile and ethnic minorities such as Roma) in Serbia, which is populated by a large number of different ethnic groups. To assess the scope of these barriers, the NGO JAZAS conducted a FFM examining 'Patterns of risk related to social determinants, barriers, and access to services of sex workers, including Roma and young people, in two Serbian EU-bordering cities'.

Methods used

During the operating time of the project (2010–2012), four NGOs were given methodological guidance in producing their FFMs by SPI Forschung and Aids Hilfe Wien. The methods of the FFMs were based on the 'rapid assessment and response' (RAR) methodology, which comprises desk reviews, small-scale field surveys (including observation, qualitative interviews with individuals, groups, and key informants, and focus-group discussions), and round-table meetings.



Key findings and recommendations



MOLDOVA: In-depth interviews undertaken by the FFM in Moldova led to the key finding that teenagers whose mothers are absent (most often working in an EU country) are prone to a higher level of vulnerability and risk-taking behaviour compared to teenagers whose mothers live at home. Another major finding is that young people fear getting infected with HIV but are afraid to talk about it.

Sexuality and sexuality education remain taboo subjects in Moldova. Nevertheless a focus on sexual education is seen as the most effective response to this situation. CREDINTA will further use the results of the FFM to implement prevention and sexuality education in school settings. The efforts to reduce the age of consent for an HIV test from 18 to 14 years should be given further support.

Public authorities were informed about the results of the FFM, and as a consequence, awareness of the need to expand HIV voluntary counselling and testing (VCT) services for young people is increasing.

UKRAINE: The FFM showed a key finding: that the sexual partners of drug users have a high level of knowledge about HIV/AIDS transmission routes and prevention, but behavioural change based on this knowledge is still absent.

The FFM also showed that drug rehabilitation therapy and HBV and HCV treatment is inaccessible and unaffordable to those living in the countryside; most of the services are located in Lviv and therefore hard-to-reach due to long distances and high travel costs. Moreover, HCV treatment is unaffordable for those who are most affected—eg, drug users who are infected with both HIV and HCV.

A further decentralisation of health and social services is needed in the Lviv region, including mobile services for vulnerable groups such as SWs, PWID, and (pregnant) HIV-positive women.

The second FFM not only drew attention to the restricted access to diagnostics for opportunistic infections in western Ukraine today but also revealed a low level of clinical alertness to HIV/AIDS among physicians working in primary health care.

An appeal to the Ukrainian AIDS Centre and to the Ministry of Health to develop protocols for diagnostics and treatment of HIV patients suffering from co-infections and to map out a course for referrals is recommended.

BOSNIA and HERZEGOVINA: The FFM showed clearly that SWs are well informed in terms of HIV but that overall knowledge of STIs should be improved. A key finding is that SWs are familiar with the way HIV and STIs are transmitted but do not understand the importance of HIV testing. With regard to HIV treatment, their level of information is generally low.

Some of the recommendations for future actions include 1) spreading HIV/AIDS/STI prevention, diagnosis, and treatment programmes for SWs to small cities and villages; 2) integrating the outreach approach of voluntary confidential counselling and testing (VCCT) services among vulnerable populations; and 3) establishing a specific drop-in centre for SWs with low-threshold services for HIV/AIDS prevention, including harm-reduction services.

SERBIA: The FFM revealed two poles. In one of the cities, experts stressed that all services are open to society as a whole and stated that people who fail to make use of those services—including members of specific groups—have themselves to blame. The existing barriers to service utilisation are thus seen as individual failures on the part of individuals. In the other city, in contrast, there was a deep understanding of vulnerable groups and of the necessity to tailor services to their needs.

In terms of utilizing existing health services, SWs apparently think that therapies provided free of charge in Serbia (eg, HIV therapy) are not confidential and therefore prefer to go to Hungary for treatment, even though they have to pay out of their own pockets for health services there.

It will be important to address local and regional stakeholders and service providers in the smaller towns (who often have a ‘small-town mentality’) and to work to raise their awareness of the importance of supporting vulnerable groups like SWs and PWID and their partners.

Strategy relevance and conclusion

To improve effectiveness of European HIV prevention strategies, the border areas between EU and ENP countries must also be addressed.

The FFMs in the four non-EU countries unequivocally pointed out the necessity of a Europe-wide recognition of the vulnerable situation of SWs, PWID, young people, ethnic minorities, and migrants with regard to HIV/AIDS and STIs—and therefore their importance as target groups for prevention, research, and policy efforts that are informed by human rights and decriminalisation approaches. PLHIV are also vulnerable in terms of barriers that prevent their access to medical treatment.

Health and rehabilitation services as well as referral systems for treatment of HIV/AIDS/STIs and co-infections should be made available, accessible, and acceptable to hard-to-reach populations. The social determinants of health should also be taken into account. As in the ‘Integrated bio-behavioural survey’ (WP5), the necessity of involving members of the mostly marginalised target groups in the development of the interventions is recognised. Efforts are needed at the local and at national level. The legislative environments in the four countries described above give grounds for concern.

Improved early access to HIV/STI diagnostics for vulnerable groups

Kristi Rüütel

‘Despite modern technology, old-fashioned face-to-face methods are better—people are more challenged to participate actively.’

Dr Kristi Rüütel, PhD,
National Institute for Health Development

Background and objectives

International policy stresses that HIV testing and counselling must meet the needs of most-at-risk and vulnerable populations and that HIV testing services must expand beyond clinical settings to involve civil society and community-based organisations. Different models and methods exist to provide HIV/STI services for most-at-risk populations.

The main aim of WP6 was twofold: 1) to intensify efforts in the early diagnosis of HIV and STIs for most-at-risk groups based on principles of human rights and gender equity and 2) to decrease the number of those who are unaware of their infection status. Target groups included PLHIV and their sexual partners, SWs, members of the Roma community, migrants, and MSM. The aim was to be achieved through increased coverage and quality of HIV testing and counselling (HTC) and improved overall access to STI diagnostic services. Testing and counselling services were provided in a range of different settings, including outreach and harm-reduction services.

Methods

The methods included:

- assessment of quality of HIV/STI voluntary counselling and testing (VCT) services based on the Code of Good Practice for NGOs (using the self-assessment checklist on HIV-testing services developed by the IPPF);
- desk-review of the situation and existing services in order to identify the population groups most in need of these services and to correctly address the gaps and barriers in the existing system;
- establishment of pilot programmes for different models of HIV/STI diagnostic services (eg, outreach programmes, drop-in centres, STI/HIV services) and development of a practical recommendation guide on how to improve access to early HIV/STI diagnostics for vulnerable groups.

Highlights of the work package

The pilot programmes for different models of HIV/STI diagnostic services reached a total of 1,246 vulnerable individuals who had previously been poorly reached by mainstream services (eg, prison inmates, non-paying and regular sex partners of SWs and PWID, Roma male SWs, among others). The breakdown of beneficiaries by country follows below:

- Austria: HIV/STI community-based VCT for MSM (n=217)
- Bulgaria: STI testing for Roma males SWs (n=58)
- Estonia: STI testing for female SWs and their regular partners (n=31) and intensified partner notification in a STI clinic for vulnerable groups (mainly PWID and their sexual partners) (n=86)
- Germany: STI testing for female SWs in the state of Brandenburg and the border region between Germany and Poland (n=10)

- Latvia: STI testing for regular (non-paying) sexual partners of SWs (n=22)
- Poland: STI testing for prisoners (n=14) and STI/HIV testing for male and female SWs, their clients and regular sexual partners (n=548)
- Romania: STI testing for PWID and for SWs and their partners/families (n=81)
- Slovak Republic: STI testing for PWID and SWs (n=179)

Key findings and results achieved

Based on self-assessment checklists completed by individual services, the majority of participating organisations stated that they had adequately trained staff, adequate systems and regulations in place, and sufficient resources to ensure the availability of good-quality, confidential HTC services. Every organisation identified areas for improvement, including continuous training and supervision of staff members, collaboration with different stakeholders, greater involvement of target groups in service planning and provision, and strengthening the monitoring and evaluation of the services. On-going quality assessment and improvement of the testing and counselling services should be a regular part of service management in order to offer high-quality services that meet the needs of clients (which may change over time).



A desk review confirmed that the highest burdens of HIV and Hepatitis are carried by vulnerable groups—including PWID, MSM, members of the Roma community, migrants, and SWs. The major problems identified in all countries included project-based financing of services for vulnerable groups (perceived as a threat to the sustainability of the services as well as a hindrance to expansion and quality improvement) and the fragmentation of services. (HIV, STI, TB, and Hepatitis services, for example, are often provided by different health professionals and organisations, and clients must seek out different locations to get help.) Systematic data on access and barriers to services among vulnerable groups are rather limited.



Different pilot models for HIV/STI diagnostic services confirmed that, with careful planning and implementation, even the most hard-to-reach populations can be accessed. Project partners implemented a range of projects, including community-based HTC, active involvement of sexual partners of members of vulnerable groups, and testing in a prison setting. Our experience also confirms that a pilot project can play the role of a needs assessment study—that is, checking the uptake of a new service, evaluating a target group’s level of satisfaction with the services, and judging the appropriateness of the mode of service delivery. The protocol and report templates developed in the frame of the BORDERNETwork project can be used for similar exercises in the future.

Strategy relevance

HIV/STI early diagnostic services should be offered in non-traditional settings, they should rely on interdisciplinary cooperation (in which medical experts work with social and outreach workers), and they should highlight the importance of involving most-at-risk group members. Our experience confirms that improving the quality of existing services and developing new methods to target the most vulnerable and hard-to-reach populations is feasible within the current legislative environment if internationally developed instruments are used and evidence gained elsewhere is adapted. A critical issue is the need to involve different stakeholders, including members of the target groups, in every step of the service provision (from initial planning to final evaluation).

Conclusions, lessons, and recommendations

The Code of Good Practice for NGOs (specifically, the self-assessment checklist on HIV-testing services, developed by IPPF) proved a useful tool for assessing testing services within the European context. The protocol and report templates for piloting new service provision models that were developed in the frame of the BORDERNETwork project can be used for similar exercises in the future.

Main lessons of the experience:

- Specially tailored services facilitate outreach to new, less visible members of well-known and generally well-reached target groups as well as to regular and/or casual sexual partners of vulnerable group members.
- Effective models of service provision for hard-to-reach groups follow the principles of accessibility and flexibility, including appropriate opening hours, service provision locations, etc.
- Well-equipped, mobile medical services are essential for offering high-quality HIV/STI diagnostics in non-medical settings. Mobile services are especially important in rural areas and remote border areas, where stationary services are unfeasible.
- Integrating different services that address the various needs of vulnerable groups (eg, providing STI screening in addition to HIV tests) will contribute to improved access and make services more attractive.
- Addressing new client groups with available services does not necessarily require special resources but can be achieved with a creative approach, commitment, and the right recruitment channels.
- The support of local authorities (including prison officials) is decisive in opening doors to collaboration among organisations (ie, NGOs and health care service providers) and essential to ensuring the sustainability of services.

Improving links among diagnostics, referral, and treatment of HIV and Hepatitis co-infections: recommendations for treating HIV and HBV/HCV co-infections

Wolfgang Güthoff; Alexander Leffers

'In addition, it was a new experience for the NGO staff members to contact medical institutions and clinic heads. (Doctor-to-doctor contact is easier.)'

Alexander Leffers, AIDS-Hilfe Potsdam

Background and objectives

As the leading partner of WP7, AIDS-Hilfe Potsdam (AHP) launched the co-operation on 'Referral, treatment, and care of HIV and co-infections' in 2010. The aim was to augment the country-specific evidence on treatment and care of HIV and co-infections by mid 2012 and to enhance interlinks in referral systems for diagnosis, treatment, and care of STIs, HIV/AIDS and co-infections

Why did WP7 concentrate on HIV and co-infections? In general, in each of the participating six countries (Bulgaria, Estonia, Germany, Poland, Romania and Slovak Republic), the diagnosis and treatment of HIV, HBV, and HCV follow the guidelines of the European AIDS Clinical Society (EACS), but there was no common systematic initiative for tackling HIV/HBV and HIV/HCV co-infections. Moreover, in addressing this, the programme also needed to respond to a lack of specialised knowledge of HIV and co-infections. Linking the diagnosis and treatment

of HIV/AIDS with that of co-infections is important because of the higher mortality rate (caused by liver cirrhosis or liver cancer).

In addition to this, in every country examined, the number of HIV late presenters is very high—ie, diagnosis is made after the virus has made significant inroads into the patient's system. A handbook and treatment algorithms were therefore worked out to tackle the unique challenge posed by HIV late presenters. (If an HIV-infected person starts anti-retroviral therapy [ART] very late, the prognosis for a successful treatment and care is much worse.)

Methods

The first method applied included conducting a stocktaking survey to collect relevant information on country-specific treatment and care systems for HIV and co-infections. The most important aspect of this survey was to encourage the participation of medical experts and stakeholders active in the fields of HIV, HBV, HCV, and co-infections. These experts have the most detailed practical knowledge in their fields and were able to identify realistic opportunities as well as context barriers, including financial ones. The second method involved medical exchange workshops and on-site observational rotations (German: *Hospitation*) in select HIV (inpatient and outpatient) treatment centres.

Highlights of the work package

Two exchange meetings were organised in 2011—the first in Potsdam, Germany and the second in Rostock, Germany/Szczecin, Poland. The aim was to deepen the discussion of the findings of the stocktaking surveys and to exchange ideas on good practice and advanced standards in the treatment of HIV and HBV/HCV co-infections. An impressive exchange of experience took place among 35 experts from Poland, Estonia, the Slovak Republic, Bulgaria, Romania, and Germany. HIV treatment experts from one non-EU country (Ukraine) were also invited and took part in the two medical workshops.



Key findings and recommendations

The discussions described above served as the basis for compiling a handbook comprised of educational materials (to be used separately) and consolidated recommendations of strategic relevance on many different EU levels.

- The first general recommendation is to establish a Central Registry for Hepatitis B, Hepatitis C, and HIV Co-infections. This would provide an overview of the number of people with an HIV co-infection and serve as a basis for assessing the financial costs of related treatment.
- Another recommendation for improving HIV diagnostics is to decrease the number of HIV late presenters. This would be accomplished by means of improved screening programmes as well as via education campaigns to raise awareness among general practitioners of the importance of early HIV diagnosis. Incorporating HIV rapid testing into the diagnostic routine is of special importance here, since early diagnosis is one of the best ways to prevent new HIV infections.
- Another recommendation is that ART be started earlier, namely when CD4 cells decrease below <math><500\text{/math>/ml, which would improve the health outcomes for the patient. The new starting point is a major means of reducing transmission risks and therefore a good opportunity to improve overall prevention of HIV/AIDS/STIs. An HIV-infected person who goes without therapy and carries a high viral load is more infectious than a person undergoing ART, whose viral load is not detectable.
- An important recommendation relating specifically to HBV diagnostics and treatment is to avoid the drug lamivudine in order to prevent multidrug resistances. Lamivudine is a drug with low antiretroviral potency and a low genetic barrier. Using a drug with high antiretroviral potency and a high genetic barrier is therefore suggested in order to prevent multidrug resistances. (Multidrug resistance limits the opportunities for a successful treatment and increases the costs of therapy.)

- New therapies for HCV were developed in 2011. We recommend conducting the new HCV therapy in connection with HIV co-infection with Boceprevir and Telaprevir within the framework of clinical studies.
- Our final recommendation is to provide post-exposure prophylaxis to all people exposed to HIV: to prevent mother-to-child transmission, to offer screenings to members of special groups (pregnant women, MSM, SWs and PWID), and to offer HBV vaccination to children and risk groups. These measures are very easy to implement.

Strategy relevance

Our recommendations for the prevention of HIV co-infections with HBV and HCV are an important step in preventing new infections and decreasing costs to regional and national health care systems. While each recommendation is effective on its own, the recommendations can be jointly implemented for improved coordination effects. Medical professionals can make use of the educational materials included in the handbook, or design their own trainings and treatment algorithms according to their individual context features and financial capabilities.



Source: SPI Forschung

Conclusions

The handbook with educational material provides a good opportunity for improving the education programmes in different clinics. The more knowledge physicians have, the better their awareness and the greater their accuracy in diagnosing positive cases of HIV and co-infections.

Improving early diagnosis of HIV, HBV, HCV and co-infections is the best way to prevent new infections and bad health outcomes for patients.

By providing screening and diagnosis for HBV and HCV to all PLHIV, including pregnant women, the physician can undertake an early intervention.

Offering HIV testing and counselling to all patients with HBV and HCV, to all patients with indicator diseases or symptoms, and to all patients with elevated liver enzymes is a good example of the targeted use of resources.

The access to ART for HIV/HBV/HCV co-infected people and the treatment of chronic HBV and HCV should be conducted if resources are available. Access to these treatments should be a universal right.

Enhancing participatory prevention among migrants and ethnic minority communities: from cultural sensitivity to community-based prevention

Silvia Vassileva; Radostina Antonova; Elena Kabakchieva

‘Major results were good communication with the partners, a high level of experience exchange, and a useful product: the Manual for participatory community-based prevention among migrants and ethnic minorities.’

Silvia Vassileva, PhD,
Health and Social Development Foundation

Background and objectives

Effective behaviour change interventions are a crucial part of contemporary preventive policy in the health sector. Community participation and quality assurance of services are key elements of new policy approaches. A particularly important point for interventions is addressing the needs of migrants and ethnic minorities. Communities believe in their own myths and follow their own norms. It is difficult to influence individual behaviour without paying special attention to community beliefs and social norms. Behaviour change interventions should therefore be undertaken on a number of levels: individual, couple, family, social network, and community. The main objectives of WP8 were to study, assess, and select HIV/STI prevention models with three special areas of focus: community participation, community development, and quality assurance.

Methods

To this end, a range of participatory methods and approaches were piloted. Evidence-informed methods of community-based HIV prevention—eg, community-based participatory research and the ‘popular-opinion-leader’ model (POL) based on the theory of the diffusion of innovation—were implemented and transferred through a network of civil-society organisations working with migrants and minority communities in nine European countries: Austria, Bosnia and Herzegovina, Bulgaria, Estonia, Germany, Latvia, Romania, Serbia, and the Slovak Republic.

The methodology for selecting good practice models included several strategies:

- a specially designed assessment questionnaire;
- the active participation of all partners in WP8;
- exchange of experiences on different practices and discussion of strengths and difficulties;
- capacity building in selected practices.

Highlights of the work package

The good practice models selected were:

- the evidence-based participatory model of prevention among POLs implemented by the Health and Social Development Foundation (HESED) of Sofia (especially effective within the Roma community);
- the ‘PaKoMi’ project organised by Deutsche AIDS-Hilfe, Berlin (DAH) to foster ‘participation and cooperation in HIV prevention with migrants’;
- the project organised by Aids Hilfe Wien (AHW) for the ‘prevention of AIDS with the resources of communities’ (PARC);
- the AIDS & Mobility project of the AIDS Information and Support Centre (AISC), Tallinn.

The prevention models promoted by these programmes encompass various approaches to behavioural change. These include education of cultural mediators and peers, diffusion of innovation, and network-based interventions such as mapping. All approaches were implemented on a number of levels (individual, couple, family, informal network, and community).

The collective outcome was a practical manual on effective models of participatory community-based HIV/STI prevention among migrants and ethnic minorities. The manual offers definitions (eg, of ‘community’, ‘ethnic minority’, and ‘migrant group’), as well as theoretical background material on matters such as ‘participatory approach’, ‘participatory research’, ‘cultural sensitivity’, ‘cultural competence’, and ‘cultural humility’. The main part is dedicated to the comprehensive description of the four good practices models.

Key findings and results

All four good practice models share not just a focus on affected migrants and ethnic minorities as target groups but also a focus on the participatory and inclusive approach—that is, they involve beneficiaries as co-authors and social agents of change. Community participation, empowerment, community development, and quality improvement were identified as intrinsic components of the models and the main factors driving their efficiency.



The four models also share several important features that can be implemented regardless of the target population:

- Combined research was conducted into how the community’s particular features influence risk behaviour.
- Activities were directed toward easy-to-change factors at both community and individual levels.
- Methods were tested successfully in practice.
- Practices were cost-effective and evidence-based.



Strategy relevance

In order to improve effectiveness of strategies throughout Europe, it will be very important to strengthen community-based interventions, especially among migrants and ethnic minorities. The research conducted by the PaKoMi project of Deutsche AIDS-Hilfe showed the great importance of the community approach. According to PaKoMi, it is almost impossible to achieve an effective intervention among migrants if they do not consider themselves part of a community. As a first step it is therefore necessary to build the community and then plan the interventions. Behaviour change is a difficult process, and support from within a circle of friends, as well as from the bigger community, is needed.

Conclusions, lessons, and recommendations

All four community-based prevention models are still in a process of development and improvement, constantly adjusting themselves in order to meet the needs of their target populations. The stabilisation and sustainable dissemination of their cost-effective and evidence-based practices would contribute to overall quality improvement and programme efficiency, which is of great importance in a period of economic stagnation. These would, furthermore, play a decisive role in the social inclusion of migrants and ethnic minority groups. Community-based programmes can only succeed, however, if strong institutional support and the respective capacity and method competence for implementation are available and financially safeguarded.

As the stakeholders of these models are representatives of the health and social sectors in the participating European countries, as well as of the municipalities in regions with ethnic and migrant communities, further dissemination of these models can take place through experience transfer and effective capacity building at the implementing sites.

Communication and counselling training in sexual health and HIV/AIDS/STI prevention for medical students: a cross-border pilot project in the German-Polish border area

Ottmar Herchenröder; Kathrin Bever; Elfriede Steffan

‘Communication has to be learned by medical students. Talking about sexuality is difficult for both the physician and the patient.’

Dr Ottmar Herchenröder,
University Clinic of Rostock

Background and objectives

Counselling is an indispensable part of HIV testing. Whatever approach for scaling up HIV diagnostics is applied, efforts should be maintained to guarantee that sufficient, high-quality counselling be delivered to clients. The competence required for its delivery should therefore be promoted and assured on multiple levels.

The findings of the cross-country assessment study conducted in the frame of BORDERNETwork’s predecessor project (BORDERNET, 2005–2007), confirmed existing gaps in communication skills among health care staff and medical doctors, especially regarding sexual issues, sexual behaviour, risk exposure, and behaviour change. On the one hand, counselling is strongly dominated by medical professionals; social workers and other non-medical helping professionals are not present in sufficient numbers. On the other hand, medical doctors often

lack the competence and skills to communicate effectively with clients and counsel them on topics related to sexuality.

Translating these findings into steps for practical action, BORDERNETwork's German partner, MAT (Mobile Health Education Team for AIDS and Sexual Education in Mecklenburg Western-Pomerania) (in cooperation with the University Clinic of Rostock) worked jointly with its Polish project partner, the State Clinical Hospital of the West Pomeranian Voivodeship (in cooperation with the University of Szczecin) to develop recommendations for communication training courses. The aim was to build up medical students' counselling competence in communicating about sexual issues.



Source: SPI Forschung

Method used

The doctor-patient relationship presumes an environment of trust, and a certain degree of familiarity is necessary for frank discussion of topics related to sexuality, sexual behaviour, and the risks associated with HIV/AIDS/STIs. In this context, it is even more important that helping professionals be able to communicate clearly and comprehensibly about topics related to sexual health, aiding client/patients to overcome

shyness, shame, and other personal barriers and accompanying them in an effective, professional manner. Evidence-based scientific theories of communication therefore served as the background against which training courses and 'train-the-trainer' courses for medical students and other medical staff were developed.

A series of six cross-border pilot training workshops involving a total of 115 medical students were carried out, as were three train-the-trainer workshops with a total of 24 participants. The evaluation of these activities formed the basis for recommendations for improving sexual health counselling and STI prevention competences for medical students and other medical staff.

Key findings and results

The training workshops for medical students were very successful, especially the interactive methods employed, which included role plays in which actors performed as patients. Participants expressed a high demand for such training, which helped them develop self-confidence and learn to offer solution-oriented counselling that takes individual situations and patient needs into account.

However, it should be noted that the interdisciplinary structure that made up the innovative character of the training courses was not easy to implement. Discrepancies occurred between social-pedagogical professionals and medical staff, which made the cooperation more complex and time-consuming for participants from both disciplines.

For these reasons recommendations were created that allow a flexible usage corresponding to the structures of each institution and makes it possible to tailor individual approaches.

Strategy relevance

The recommendations can be seen as a 'pool of ideas' to be used flexibly in EU countries according to existing local conditions and characteristics and taking different cultural, social, and structural factors into account.



Conclusions, lessons, and recommendations

The improvement of communication skills of medical doctors and other medical staff in sexual health is essential for the successful response to HIV/AIDS and STIs. Capacity-building projects are therefore very important and should exist as an on-going component of training courses for medical students and other medical staff.

Improving quality in HIV youth prevention

Isabell Eibl

'Extensive time was needed to develop a common understanding of quality.'

Isabell Eibl, Aids Hilfe Wien

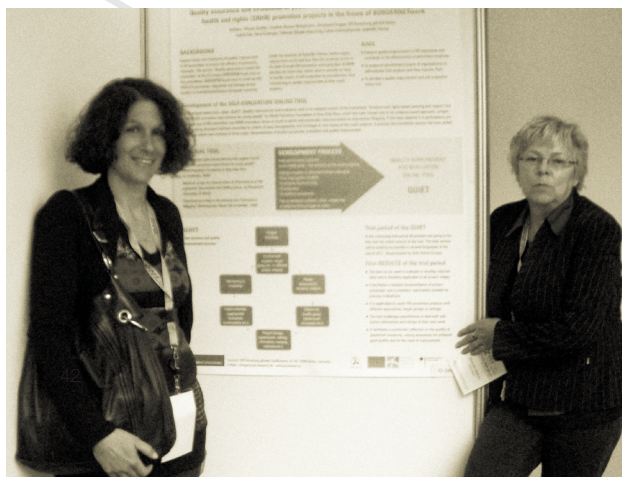
Introduction and objectives

In the frame of the EU project BORDERNETwork and under the leadership of Aids Hilfe Wien and SPI Forschung, partners of WP9 worked to develop an online tool for quality improvement in HIV prevention for young people: QUIET (Quality Improvement and Evaluation Tool).

Young people are a very important target group in every country, regardless of whether the prevalence of HIV infections is high or low. Accordingly there are many interventions on offer for this population. The quality of the programmes and projects differ greatly, however. Especially for small NGOs with limited resources, planning projects and programmes is a challenge in the face of the abundance of scientific and evidence-based knowledge available today.

Highlights of the work package

With regard to this challenge, one of the project tasks of BORDERNETwork was to develop an online tool for quality improvement and evaluation. The QUIET links HIV Prevention with the general tenants of sexual and reproductive health and rights (SRHR). This approach is evidence-based and is also geared towards the particular rights of young people. Furthermore it was synchronised with the 'European Standards for Sexuality Education' published in 2010 by



WHO and the German Federal Centre for Health Education (BZgA). The QUIET is based on the 'Evidence and rights based planning and support tool for SRHR/HIV prevention intervention for young people', a brochure published in 2009 by STOP AIDS NOW! (a Dutch development organisation) and WPF (World Population Foundation). WP9's participants working in the field of youth prevention built the online tool using a participatory process.

Key findings, results, and outcomes



The QUIET helps to assess and improve the quality of existing projects and to plan new projects. A user-friendly self-evaluation instrument with roots in the 'Plan-Do-Check-Act' management cycle (PDCA)¹ and the framework developed by Dr Avedis Donabedian, it allows for structured reflection in a relatively short span of time. The tool includes documenting and evaluating a project's processes and encourages the user to improve strategic planning and the processes. Its structure is based on the following six-step intervention mapping model:

After involving all stakeholders concerned (step 1), a comprehensive analysis of the problem is conducted (step 2). This analysis results in detailed objectives (step 3). In the next step, all the programme activities and materials are studied to find out whether every objective has been met (step 4). To make sure the programme has been adopted and implemented effectively, any barriers and possible structures and resources are analysed and addressed (step 5). Monitoring and evaluation are at the end of the process (step 6).

Strategy relevance

The QUIET is a self-evaluation tool and does not provide any individual external expertise or guidance. The project's trial period showed that it was beneficial to build a team to fill out the instrument's individual sequences. Assembled expertise improved the documentation, and different perspectives of team members enhanced evaluation of the project. Last but not least, the tool led to fruitful discussions, and the

¹A four-step management method to continuously improve processes and products.

input of different team members led to more creativity and to a broader approach for better results.

The QUIET will be available free of charge on the website of BORDERNETwork and on <http://quiet.allproducts.info>, respectively, beginning in late March 2013.

Conclusions, lessons, and recommendations

Instruments for quality development and improvement have proven to be very important for HIV prevention. This is also demonstrated by the EU joint action on quality improvement in prevention, which will start this year. The QUIET is currently the only online tool geared to programmes that offer SRHR and HIV prevention to young people.

Source: Aids Hilfe Wien



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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome	STI	Sexually Transmitted Infection
ART	Antiretroviral Therapy	SW	Sex Worker
CEE	Central and Eastern Europe	TB	Tuberculosis
EACS	European AIDS Clinical Society	UN	United Nations
ENP	European Neighbourhood Policy	UNAIDS	Joint United Nations Programme on HIV/AIDS
EU	European Union	UNFPA	United Nations Population Fund
FFM	Fact Finding Mission	VCCT	Voluntary Confidential Counselling and Testing
HBV	Hepatitis B Virus	VCT	Voluntary Counselling and Testing
HCV	Hepatitis C Virus	WHO	World Health Organisation
HIV	Human Immunodeficiency Virus	WP	BORDERNETwork Work Package
HTC	HIV Testing and Counselling	WPF	World Population Foundation
IBBS	Integrated Bio-Behavioural Survey		
IDU	Injecting Drug Use		
IPPF	International Planned Parenthood Federation		
KAP	Knowledge, Attitude, Practice		
MSM	Men who have Sex with Men		
NGO	Non-Government Organisation		
PLHIV	People Living with HIV		
PWID	People Who Inject Drugs		
QUIET	Quality Improvement and Evaluation Tool		
RAR	Rapid Assessment and Response		
SEE	South Eastern Europe		
SRHR	Sexually and Reproductive Health and Rights		



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