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# Desk Review Report

## **CROSS-BORDER COOPERATION FOR HIV/AIDS PREVENTION AND IMPACT MITIGATION IN SOUTHERN CAUCASUS AND RUSSIAN FEDERATION**

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# Contents

Acknowledgements .....	4
Glossary/Acronyms and Abbreviations .....	5
Introduction .....	6
1. Executive Summary .....	6
2. Desk Review Introduction/Background .....	8
3. Methodology .....	9
4. Limitations .....	10
5. Findings across the Specific Objectives.....	11
5.1. Country Profiles .....	11
5.2. Migration Stocks and HIV.....	15
5.3. Advocacy Intervention Areas on Policy Level .....	17
5.4. Advocacy Needs at the Level of Implementation of Prevention, Treatment and Care Services.....	19
5.5. Needs in Terms of Raising Awareness Among Migrants (including MARPs) About HIV Prevention, Treatment and Care .....	23
5.6. Needs in Terms of Promoting Strategic Partnership Among Stakeholders.....	24
5.7. Examples of Interventions and Good Practices .....	25
6. Conclusions and Recommendations .....	30
7. Lessons Learnt from the Desk Review Process .....	33
8. List of Materials Used for Review .....	34

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## Glossary/Acronyms and Abbreviations

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>CSA</b>	Civil Society Actors
<b>CCM</b>	Country Coordination Mechanism
<b>CDC</b>	Center for Disease Control and Prevention
<b>CoH</b>	Channel of Hope
<b>CSW</b>	Commercial Sex Worker
<b>DRC</b>	Desk Review Consultant
<b>EU</b>	European Union
<b>GO</b>	Governmental Organization
<b>HIV</b>	Human Immunodeficiency Virus
<b>IDU</b>	Injecting Drug Use
<b>IO</b>	International Organisation
<b>KII</b>	Key Informant Interview
<b>MARA</b>	Most At Risk Adolescent
<b>MARPs</b>	Most At Risk Populations
<b>MEER</b>	Middle East and Eastern Europe Region
<b>MMT</b>	Mobile Medical Team
<b>MSM</b>	Men Who Have Sex With Men
<b>NGO</b>	Non - Governmental Organization
<b>NO</b>	National Office
<b>NSA</b>	Non State Actor
<b>PHC</b>	Primary Health Care Providers
<b>PLHIV</b>	People Living with HIV (includes people with AIDS)
<b>PM</b>	Project Manager
<b>RF</b>	Russian Federation
<b>TGF</b>	The Global Fund
<b>TD</b>	Transit Driver
<b>SBC</b>	Strategic Behaviour Change
<b>STI</b>	Sexually Transmitted Infections
<b>ToR</b>	Terms of Reference
<b>UNAIDS</b>	Joint United Nations Program on HIV/AIDS
<b>VCT</b>	Voluntary Counseling and Testing
<b>WV</b>	World Vision

# Introduction

## I. Executive Summary

International community is on the verge of a significant breakthrough in the AIDS response. The vision of a world<sup>1</sup> with zero new HIV infections, zero discrimination, and zero AIDS-related deaths has captured the imagination of diverse partners, stakeholders and people living with and affected by HIV. New HIV infections continue to fall and more people than ever are starting treatment. With research providing solid evidence that antiretroviral therapy can prevent new HIV infections, it is encouraging that 6.6 million people are now receiving treatment in low and middle-income countries: nearly half of those eligible.

Sharp increase in HIV infections observed in the European Region is strongly correlated with social exclusion processes. Poverty, underdevelopment, illiteracy, unemployment, social breakdown and the absence of a positive outlook are factors that contribute to the spread of HIV/AIDS<sup>2</sup>. Special consideration should be given to key populations at higher risk, to further promote equity in the prevention and treatment of HIV<sup>3</sup>.

With regards to HIV prevention, existence of barriers to accessing medical and social services pose significant challenges for migrants<sup>4</sup>. Separation from families, poverty and exploitative working conditions all increase the risk of HIV infection.

In the European Union (EU) and European Economic Area (EEA) countries in 2009, an estimated 38% of heterosexually acquired infections were diagnosed in individuals originating from countries with generalized epidemics (ECDC & WHO Regional Office for Europe, 2010). Unacceptably, this may result in stigmatizing migrants, worsening social exclusion and impeding their access to services.

In the light of global developments the focus of WV is set to study migration and HIV situation within the four countries – Russian Federation, Georgia, Azerbaijan and Armenia. Migration stocks are significant between those four and reliable data are required in order to capture the existing situation on different levels: policy development, provision of services, strategic partnership etc.

This report reviews the available documents covering migration and HIV in four above listed countries and describes the HIV risks associated with the predominant migrant sectors from the three source countries which together comprise one of the largest majority of migrants<sup>5</sup> in Russia.

There is great diversity<sup>6</sup> of migrant groups in Russian Federation each with different risks and vulnerability to HIV. Efforts implemented by government, international and national non-governmental organizations have certainly achieved some level of success, although Russia's epidemic remains<sup>7</sup> on the rise. It is largely concentrated among injecting drug users (IDUs) and other high-risk groups: commercial sex workers, prison inmates and MSM, while the spread of HIV among the heterosexual population and MSM is accelerating. Approximately 75% of all HIV infections are registered in young people aged 15–30 years, an important consideration in light of Russia's demographic decline<sup>8</sup>.

In addition there are mobile groups that remain relatively unknown due to unavailable literature and unreached through programming that focuses on particular target population such as work migrants, commercial sex workers, MSM, and displaced persons.

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1 UNAIDS – World Aids Day Report – 2011

2 WHO Regional Office for Europe - 2004

3 MDG report for Europe - 2011

4 Matic et al., 2008

5 IOM global report

6 IOM World Migration Map, 2012 - <http://www.iom.int/cms/en/sites/iom/home/about-migration/world-migration.html>

7 UNAIDS – Country Progress Report - Russia, 2012

8 WHO, UNAIDS – epidemiologic fact sheet, Russian Federation, 2008

This desk review attempts to analyse the migration trends across countries as well as current efforts to address migrants' needs with regards to HIV.

Access to health care is offered mostly to documented migrants. However, it was found that in some instances, non-government healthcare services also cover those with undocumented status. Externally funded programmes implemented by NGOs and CBOs have been found to have had a significant role throughout the migrant communities.

The existing multi-sectoral coordinating body on migrant health and related issues needs to be strengthened and made more efficient. Facilitation of cross country cooperation and partnerships between state and non-state actors would make HIV related activities more effective for migrants.

All parties should acknowledge that the economies of the sending countries to some extent depend on migrants' activity and thousands of families stand behind the migrants.

While migration itself may not be the absolute risk factor for HIV infection, there is evidence that people on the move become particularly vulnerable to HIV and AIDS<sup>9</sup>.

The desk review results show that there are inconsistencies between the legislative, executive and NGO domains within the national policies and coordination processes related to migration and HIV. Universal access to HIV prevention, treatment, and care is an aspiration, although the programming, resources allocated and health professionals do not provide universal access to the listed services to migrants.

Complications due to illegal residence status, poorly functioning information systems, migration policies, justice and international policies e.g. deportation or fining of undocumented migrants, embargo, cross-country tensions lead to the counterproductive results.

Poor links and integration of migration and public health policies on national levels restrain effectiveness of HIV related efforts. There is no consistent legal framework for migrants' rights in the light of HIV or general healthcare. While issues of migration and HIV are on top of national agendas, they are separate, which puts HIV supportive programming under pressure while reaching the migrant populations. Legislation and programs do not have common definition of migration and migrants. This leads to challenges in obtaining reliable data on migration and HIV, making it difficult to address problems adequately and establish good cooperation between parties.

The desk review has identified several challenges with regards to provision of prevention, treatment and care services: administrative barriers to HIV prevention, treatment and care, limited affordability and funding of services, social seclusion and stigma preventing migrants to access the services, lack of integration and linkage between HIV prevention and treatment services, lack of programs targeting migrants, lack of trained health professionals.

Document review and focus group discussions have revealed that often migrants have lack of information about where and how to apply for an HIV test and where/how to access treatment (or funding for the treatment). Migrants do not possess sufficient information on HIV transmission, its manifestations, treatment possibilities and outcomes. Most of the interview respondents did not have information on legal rights of HIV patient and right of migrants to access health services. Migrants declare that they had no knowledge on HIV/AIDS and its prevention until they faced the risk of contraction of HIV in the host country. However, limitations of the employed tools (including focus group discussions) do not provide a resolution to the question whether the migrants from Georgia, Azerbaijan and Armenia are under greater risk while migrating, or, face the same risks in their home countries and carry them with as they migrate.

Strategic partnership between HIV stakeholders on national levels is ensured via CCM-s, where government agencies and civil society organizations hold dialogue and share information. Participation of affected or most at risk groups in these mechanisms is very limited. The limitation of CCMs<sup>10</sup> as a coordination and partnership mechanisms is underrepresentation of stakeholders and authorities dealing with migration.

9 IOM – Population and Mobility Report, 2010

10 As for Russian Federation, CCM it's not a functional, implementing body.

There is a distinction between services and leverage for systemic change between state and civil society actors whereby NGOs and non-formal associations are able to better respond the needs, while they lack effective leverages for systemic change.

This review seeks to highlight HIV related vulnerability of migrant populations to inform policy makers and programme implementers in creating effective strategies to address migrants' needs concerning HIV prevention, treatment and care.

Further research is needed also to gain better understanding on the needs, risks, vulnerabilities and obstacles faced by all migrant groups, and identify appropriate solutions.

## 2. Desk Review Introduction/Background

World Vision Georgia, Armenia, Azerbaijan and Russian Federation together with their local partner organisations within the Cross-border cooperation for HIV/AIDS Prevention and Impact Mitigation in Southern Caucasus and Russian Federation Project aims to create an enabling environment for capacity building of Non-State Actors (NSAs) for advocacy; strengthen partnerships and coordination among NSAs and public bodies on country and regional levels; and enhance access to HIV&AIDS prevention, treatment, care and support services for migrant workers and mobile populations including MARPs and PLHIV.

Currently policy research on HIV and mobility in Georgia, Armenia and Azerbaijan focuses on identifying gaps and insufficiencies in existing HIV and AIDS related public health and migration policies. Research has recommended development of a joint regional advocacy plan to focus attention on mobility and HIV and AIDS as well as the rights of migrating MARPs/MARAs and PLHIV. However, the mentioned research does not cover all the topics addressed by Cross-border cooperation for HIV/AIDS Prevention and Impact Mitigation in Southern Caucasus and Russian Federation Project and needs to be complemented. A policy and service gap analysis for Russia has not previously been attempted and should be part of this desk review.

One of the major contributing factors of the HIV epidemic in the Southern Caucasus and RF is widespread labour migration of men and women. Migrant workers bridge the epidemic between MARPs in destination countries and lower risk communities in source countries, making mobility a key fuelling factor of the epidemic<sup>11</sup>. Labour migrants from source countries generally move to the countries with unfavourable HIV epidemiological situation. As the "dual epidemic" of HIV and IDU is prevailing in the region, migrant workers include MARPs and PLHIV. Mobility is often a coping strategy for many vulnerable MARPs and PLWHA in the region who have been forced by stigma, discrimination and abuse of human rights to consider relocation and increases mobility among these particular groups.<sup>12</sup> One of the factors preconditioning migrant workers' and mobile populations' vulnerability to HIV&AIDS is that they are most of the time illegally residing in the destination country, which automatically limits their access to basic legal and social security which further results in discrimination, stigma and physical/sexual exploitation. Insufficient access to health facilities and services includes a lack of VCT as well as availability of the basic information on HIV transmission/prevention.

The targeted source countries have now included HIV&AIDS and migration in their 2010 planning and recognized the importance of a joint sub-regional approach to this issue, which was previously unacknowledged. Joint action of NSAs such as PLHIV networks, WV, relevant IOs and GOs will assist the development and implementation of a feasible advocacy and policy framework helping to prevent and mitigate the impact of mobility-exacerbated HIV/AIDS. The current HIV&AIDS response in target countries is largely led by AIDS centres and/or affiliated infectious disease hospitals with a lack of integration between medical, public health and social care approaches. This is particularly true for the RF, leading to poor accessibility/availability of HIV&AIDS services for PLHIV and MARPs from the Southern Caucasus, which further limits the overall potential for effective prevention and treatment. NSAs in target countries are the primary actors responsible for outreach, bridging the gaps between vulnerable/affected groups and state institutions and agencies.

11 Geographical distribution of HIV positive cases in Georgia – Georgian NCDC

12 Findings from the FGDS

Using the outputs of the Policy and Service Gap analysis from all 4 countries involved, a Regional Advocacy Action Plan has been developed by the Regional Network that has been strengthened within the framework of Cross-border cooperation for HIV&AIDS Prevention and Impact Mitigation in Southern Caucasus and Russian Federation Project.

The report addresses the following specific objectives – “5 Whats” - for each country listed above:

1. What are the advocacy intervention areas on policy level in terms of access?
2. What are the advocacy needs at the level of implementation of prevention, treatment and care services in all four countries?
3. What are the advocacy needs in terms of raising awareness among migrants (including MARPs) about HIV prevention, treatment and care existing services in source and destination countries?
4. What are the advocacy needs in terms of promoting strategic partnership among NGOs, IOs and key government agencies?
5. What are the best practices in the field of HIV/AIDS and migration from the four implementing countries with the aim to unify the effort to effectively respond to the issue?

The Desk Review Report provides possible advocacy intervention in the areas of HIV&AIDS and Migration for the Southern Caucasus and RF.

### 3. Methodology

The content of this desk review is based on information collected through a systematic review of the available documents relevant to Georgia, Azerbaijan, Armenia and RF in the light of HIV&AIDS and migration, as well as from web research and focus group discussions involving affected and MARP population, from consultations with experts in the relevant area. The number of respondents was limited per country and the number of questions was also limited due to the relatively limited resources for the review.

Qualitative research and its techniques have been used for the desk review:

**Literature review** by analyzing secondary data: During the desk review HIV and AIDS, migration, human rights, legal and socio-economic data (policies, strategies, reports, protocols, regulations and other related documents) has been reviewed. Interpretive techniques (coding and recursive abstraction) were applied while conducting the secondary data analyses. Validity was addressed as a central challenge in order to ensure credibility of the review - reference check, conformability and balance was observed as ways of establishing validity. The literature review covered global publications, such as WHO, IOM and UNAIDS documents, and publications related to the target countries itself Policy and Gap Analysis reports, analysis of HIV and migration related legislation and programming etc.

**Exploring Perceptions** by focus group discussions: As a qualitative data collection method, focus group discussions have been utilized to help researcher to learn the social norms of affected or MARP community or its subgroups, as well as to learn the range of experiences, opinions, perceptions and attitudes that exist within that community or its subgroups. A focus group discussion enabled understanding of a selected topic on the basis of common group characteristics (for example gender, age, ethnicity or socio-economic status). These key elements have been utilized for the focus group discussions within the desk review:

- The moderator guided the discussion by key questions;

- The discussion involved HIV and AIDS also migration as special topics which has been kept by the moderator;
- Results of focus group discussions have been generated by the dynamics of the participants with careful documentation of the important information generated during the discussion;

**Capturing best practices** by analyzing of unstructured data, shadow reports, including open-ended survey responses, forum memos; literature reviews audio and video clips, pictures and web pages.

## 4. Limitations

Information collected through the listed above techniques might be missing details, components or underreporting the specific issues, also it is important to acknowledge that the completeness of data may vary country by country. Consequently, the conclusions and recommendations should also be considered with caution.

## 5. Findings across the Specific Objectives

### 5.1. Country Profiles

#### GEORGIA



This map is an approximation of actual country borders and belongs to WHO.

#### Country Statistics<sup>13</sup>

Total population	<b>4,352,000</b>
Gross national income per capita (PPP international \$)	<b>5,350</b>
Life expectancy at birth m/f (years)	<b>68/76</b>
Under five mortality (per 1 000 live births)	21
Mortality between 15 and 60 years m/f (per 1 000 population)	<b>227/88</b>
Total expenditure on health per capita (Intl \$, 2010)	<b>564</b>
Total expenditure on health as % of GDP (2010)	<b>9.9</b>

#### HIV AND AIDS ESTIMATES (2011)<sup>14</sup>

##### Number of people living with HIV

4,900 [2,300 - 7,800]

##### Adults aged 15 to 49 prevalence rate

0.20% [0.10% - 0.30%]

##### Adults aged 15 and up living with HIV

4,900 [2,200 - 7,900]

##### Women aged 15 and up living with HIV

1,200 [<1000 - 2,000]

##### Children aged 0 to 14 living with HIV

N/A

##### Deaths due to AIDS

<200 [<100 - <500]

13 WHO Country Reports, 2012 - <http://www.who.int/countries/en/>

14 UNAIDS Country Statistics Update - <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>

## AZERBAIJAN



This map is an approximation of actual country borders and belongs to WHO.

**Country Statistics<sup>15</sup>**

Total population	<b>9,188,000</b>
Gross national income per capita (PPP international \$)	<b>8,960</b>
Life expectancy at birth m/f (years)	<b>69/74</b>
Under five mortality (per 1 000 live births)	45
Mortality between 15 and 60 years m/f (per 1 000 population)	<b>175/85</b>
Total expenditure on health per capita (Intl \$, 2010)	<b>523</b>
Total expenditure on health as % of GDP (2010)	<b>5.2</b>

**HIV AND AIDS ESTIMATES (2011)<sup>16</sup>**

## Number of people living with HIV

6,700 [5,000 - 8,800]

## Adults aged 15 to 49 prevalence rate

0.10% [0.10% - 0.10%]

## Adults aged 15 and up living with HIV

6,700 [5,000 - 8,800]

## Women aged 15 and up living with HIV

1,000 [&lt;1000 - 1,400]

## Deaths due to AIDS

&lt;500 [&lt;500 - &lt;1000]

15 WHO Country Reports, 2012 - <http://www.who.int/countries/en/>

16 UNAIDS Country Statistics Update - <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>

## ARMENIA



This map is an approximation of actual country borders and belongs to WHO.

**Country Statistics<sup>17</sup>**

Total population	<b>3,092,000</b>
Gross national income per capita (PPP international \$)	<b>6,100</b>
Life expectancy at birth m/f (years)	<b>67/75</b>
Under five mortality (per 1 000 live births)	<b>18</b>
Mortality between 15 and 60 years m/f (per 1 000 population)	<b>228/94</b>
Total expenditure on health per capita (Intl \$, 2010)	<b>250</b>
Total expenditure on health as % of GDP (2010)	<b>4.3</b>

**HIV AND AIDS ESTIMATES (2011)<sup>18</sup>**

Number of people living with HIV

3,600 [2,100 - 7,000]

Adults aged 15 to 49 prevalence rate

0.20% [0.10% - 0.40%]

Adults aged 15 and up living with HIV

3,600 [2,100 - 7,000]

Women aged 15 and up living with HIV

<1000 [<1000 - 2,000]

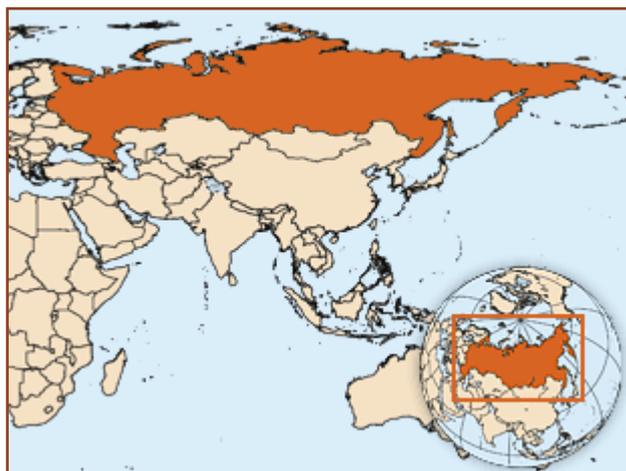
Deaths due to AIDS

<500 [<200 - <1000]

17 WHO Country Reports, 2012 - <http://www.who.int/countries/en/>

18 UNAIDS Country Statistics Update - <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>

## RUSSIA



This map is an approximation of actual country borders and belongs to WHO.

**Country Statistics<sup>19</sup>**

Total population	<b>142,958,000</b>
Gross national income per capita (PPP international \$)	<b>20,560</b>
Life expectancy at birth m/f (years)	<b>63/75</b>
Under five mortality (per 1 000 live births)	12
Mortality between 15 and 60 years m/f (per 1 000 population)	<b>351/131</b>
Total expenditure on health per capita (Intl \$, 2010)	<b>1,316</b>
Total expenditure on health as % of GDP (2010)	<b>6.2</b>

**HIV AND AIDS ESTIMATES (2011)<sup>20</sup>**

Number of people living with HIV

[730,000 - 1,300,000]

Adults aged 15 to 49 prevalence rate

[0.80% - 1.40%]

Adults aged 15 and up living with HIV

[720,000 - 1,300,000]

Women aged 15 and up living with HIV

[190,000 - 350,000]

Deaths due to AIDS

[38,000 - 78,000]

19 WHO Country Reports, 2012 - <http://www.who.int/countries/en/>

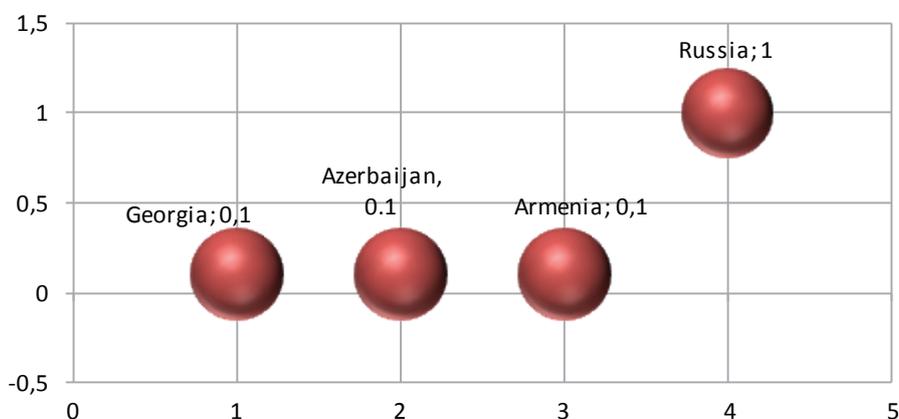
20 UNAIDS Country Statistics Update - <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>

## 5.2. Migration Stocks and HIV

Analyzing HIV and migration data for all four countries is of crucial importance to identify the real links between the mobility and HIV.

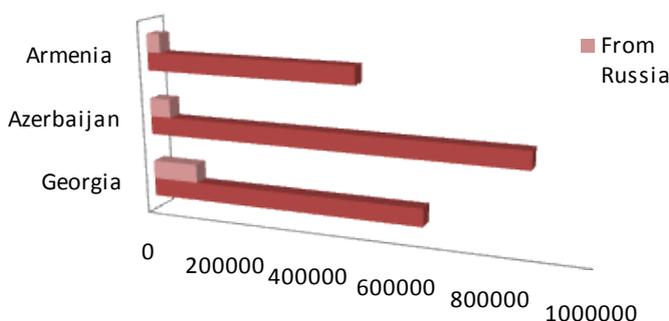
Cross-country comparison of prevalence rates (see Fig. 5.2.a) among the population aged 15 to 49, demonstrates that Georgia, Azerbaijan and Armenia stand on a lower indicator while Russian Federation stands on a higher. Without period prevalence and incidence indicators it's hard to judge the dynamics of spread of HIV in all four countries, although the prevalence data clearly indicates that proportion of a population found to have an infection is much higher in Russia than in other 3 countries.

Fig. 5.2. a  
Prevalence Rates (%) in all 4 Countries Among the Population Aged 15 to 49



Analyzing migration data<sup>21</sup> gives more room for identifying possible correlations and mapping the vulnerability risks for mobile population groups (See Fig. 5.2.b; c).

Fig. 5.2.b  
Migration stocks between Georgia, Azerbaijan, Armenia and Russian Federation



Country	To Russia	From Russia
Georgia	644390	109 968
Azerbaijan	866843	50 007
Armenia	493126	32 993

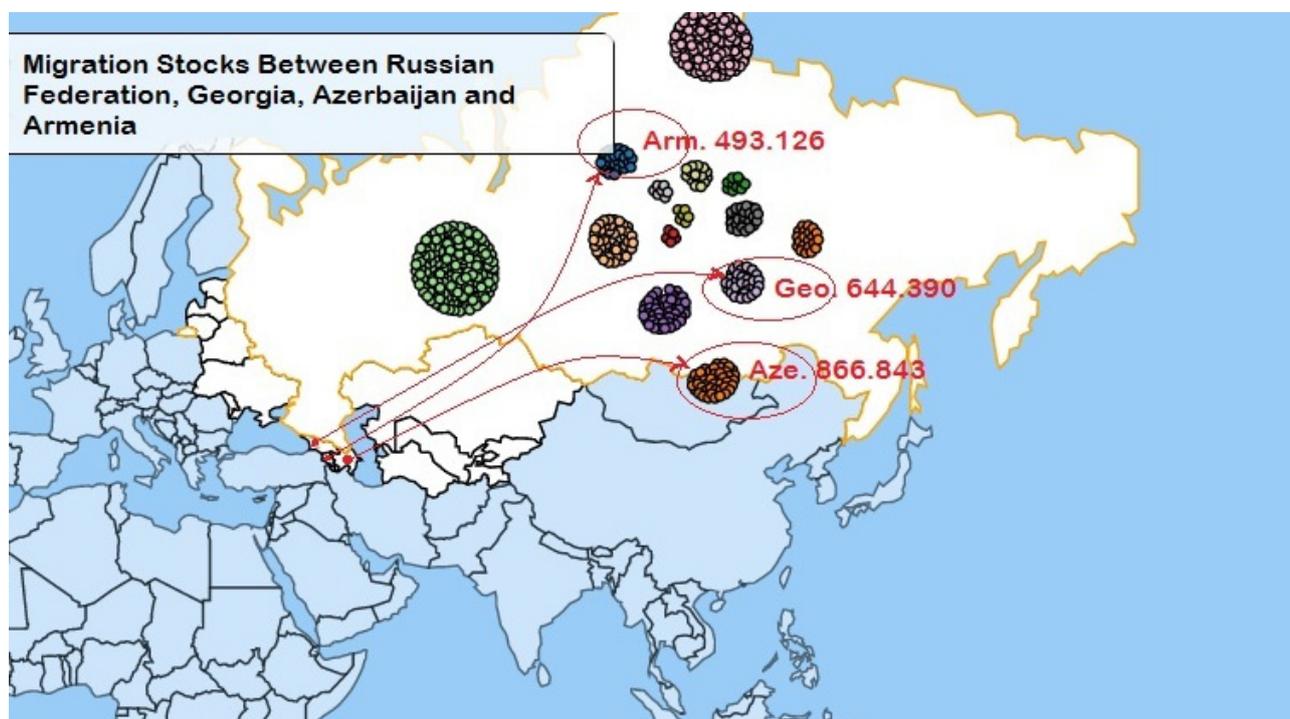
21 IOM World Migration Map, 2012 - <http://www.iom.int>

The findings demonstrate that Russian Federation where HIV prevalence is 1% currently hosts over 2 million migrants from Georgia, Azerbaijan and Armenia – from countries where HIV prevalence is not more than 0.1%<sup>22 23</sup>;

Russian Federation and Georgia, Azerbaijan, Armenia differs in terms of HIV epidemiology. HIV is a significant health issue in Russia, while in others HIV prevalence and incidence are comparatively low<sup>24</sup>.

Next chapters contain analyses whether the migrants from Georgia, Azerbaijan and Armenia are properly informed, protected from risks and targeted by the HIV specific programs.

Fig. 5.2.c<sup>25</sup>  
**Migration Stocks From Azerbaijan, Armenia and Georgia to Russia**



22 WHO Country Reports, 2012 - <http://www.who.int/countries/en/>

23 UNAIDS Country Statistics Update - <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>

24 <http://www.thelancet.com/themed/global-burden-of-disease>; Global Burden of Disease Study – 2010 " HIV/AIDS was the third-largest cause of premature death in Russia, where the number of cases has been growing rapidly"

25 IOM World Migration Map, 2012 - <http://www.iom.int>

### 5.3. Advocacy intervention areas on policy level

The Political Declaration<sup>26</sup> on HIV/AIDS adopted by the UN General Assembly in June, 2011 reinforces the commitment to address the vulnerabilities to HIV experienced by migrant and mobile populations and support their access to HIV prevention, treatment, care and support.

Migration, mobility and HIV and AIDS are further advancing on the global agenda. Rapid development of communications, transport and integration of economies make people to move from one place to another temporarily or permanently due to a host of push and pull factors.

There is an evidence to demonstrate a close association<sup>27</sup> between increased vulnerability during migration/mobility and the spread of HIV. The factors linking population mobility and increased vulnerability to HIV include social, cultural, policy and legal factors contribute to HIV transmission. Factors most often referred during the FGDs were language barriers, marginalization and social exclusion, and legal obstacles. Cultural stereotypes, religious beliefs, fear of discrimination and limited awareness of HIV within migrant communities were highlighted as factors that increase vulnerability, as were negative social attitudes towards migrants and poverty. Many of the inequalities that drive the spread of HIV are amplified during the migration process.

Migration policies and procedures that restrict the possibility to work or obstruct access to services for undocumented migrants<sup>28</sup> were among the specific policy and legal factors mentioned the reports and FGD results.

Formally only Azerbaijan out of four countries has ratified international convention<sup>29</sup> on the Protection of the Rights of All Migrant Workers and Members of Their Families, which refers to the effective access to healthcare services for migrants and migrant children. Delay to sign and ratify the convention demonstrates poor political commitment to address the problems migrants face in terms of access to healthcare: inadequate coverage by state health systems, difficulties accessing information on health matters and available services and fear to that health providers may denounce the migrants to immigration authorities.

As the political and economic climate between the countries changes, migrant rights in different context are in constant flux. National governments often change migration, labor and health laws and procedures, affecting migrants' rights to health services and protection.

Since 90-s, the authorities in Georgia, Azerbaijan, Armenia and Russia have attempted to address the HIV effectively on legislative and executive levels through creating national coordination, programming and changing regulative frameworks. In theory, this seemed a proactive and feasible attempt. Formally the states developed their legislation in a way that HIV status is not a formal reason to refuse an entry, however targeting of migrants and their vulnerability is still poor - registration process, as well as access to the health services and protection proved still to be difficult and expensive for migrants, often putting them at risk. There is little policy development focused on to explore and handle risks between mobility/migration and HIV.

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26 UN Official Documents System - ODS

27 See:

- International Migration, 36/4, 1998;
- Macdonald, D.S., 'Notes on the Socio-economic and Cultural Factors Influencing the Transmission of HIV in Botswana', *Social Science and Medicine*, 42(9) (1996): 1325-33;
- Williams, B. and C. Campbell, 'Understanding the Epidemic of HIV in South Africa: Analysis of the Antenatal Clinic Survey Data', *South African Medical Journal*, 88(3) (1998): 247-51;
- Barnett, T. and A. Whiteside, *AIDS in the Twenty- First Century* (New York: Palgrave, 2002);
- Kalipeni, E., et al., (eds.), *HIV and AIDS in Africa* (Oxford: Blackwell, 2004);

28 By the undocumented migrants we mean illegal migrants. In case of Russian Federation, it's worthwhile to note that even legal migrants are unable to get ARV treatment services through public facilities

29 The United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families

In all South Caucasus countries the overall coordination of the activities envisaged in the HIV/AIDS National Strategies are carried out by the Country Coordination Mechanisms on HIV/AIDS, Tuberculosis and Malaria issues (CCM<sup>30</sup>), even though the National Strategic Plans cover vulnerability of migrants non-efficiently. The strategies on the one hand provide quite extensive plans for actions in different areas of country's HIV and AIDS response (coordination, prevention, improving access to ART, care and support, etc.); on the other hand it is important to notice that mobile/migrant population is not clearly addressed under the strategic areas.

Cross country coordination to handle a migration process properly – to improve access to health services and provide better protection from HIV to millions of migrants – is very poor and is not well addressed in the policy documents.

Despite of the legislations generally holding good human rights standard: promoting voluntary counseling and testing and universal access to the treatment for HIV infection, protecting confidentiality and right to private life, particular legislative components still remain vague and do not read as it is guided in the general statement (criminalization of sex workers, mandatory testing while crossing the border, denial of the entrance due to the HIV status, obligation to submit personal data while getting beneficiary of the federal programs, criminalization of a drug use, barriers for granting the legal status, etc).

There is no direct reference to HIV and AIDS in the migration policy documents or federal programs in any of the South Caucasus countries not in the Russian Federation. On the other hand the migration is not reflected in the policy documents as a contributing factor to increased number of HIV and AIDS - it is mostly viewed as a security or national interest issue, but ignored as a public health issue. It is evident that migration and HIV policies exist and function independently and there is little synergy and joint effort between them.

Data and addressing of children affected by migration and HIV is missing completely. While families should serve as a protection environment for children and because of migration, high rates of unemployment and the current economic crisis leaves many children in the care of single parents, or unattended for long periods of time the issue of children cannot be ignored while evaluating HIV and migration response and gaps. For children infected or affected by HIV the likelihood of being abandoned is higher<sup>31</sup> than for other children. Although HIV per se may not be the main reason for abandonment, HIV tends to be a marker for a number of other factors of exclusion and vulnerability. In the Russian Federation about 6 to 10 per cent of children<sup>32</sup> born to HIV-positive mothers are abandoned in maternity wards, pediatric hospitals and residential institutions, with little opportunity for foster care, adoption or family reunification.

## Policy & Gap Analyses

Country reports and FGD responses indicate that HIV is not a policy priority in relation to migrant populations. HIV prevention is not well addressed by asylum centers or included in wider healthcare, education and integration services for migrants. Inconsistencies in the policies negatively influence effectiveness of provision of HIV prevention interventions and treatment services for these populations. In spite of global discussion on this issue the legal status of migrants still remains as the most cited problem to accessing HIV treatment. In some cases FGD respondents complained that treatment is not available to migrants without residence permits. Most of the respondents noted that prescription policies also block access to treatment, care and support. Some respondents refer to the reluctance of authorities and service providers to fund HIV related services for migrants because of concerns about legal and social status.

30 As for the Russian Federation, CCM in this country was almost dismissed by fall 2012 and even in old days was more of a nominal nature rather than implementing body

31 UNICEF – Blame and Banishment report, 2010

32 UNICEF – Blame and Banishment report, 2010

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## SHORT LIST OF PROBLEMS – POLICY

- Low political priority
- Eligibility to a legal status
- Policies, e.g. funding of the services, deportation, embargo, employment etc.
- Insufficient cross-country coordination
- Integration of labor markets

## SUGGESTED ACTIONS

- Establish common policy on universal access to HIV treatment and HIV related services for migrants in all four countries – introducing common standard between the sending and receiving countries;
  - Establish a clear and effective, easy to access mechanisms protecting migrants' rights and establish information system for migrants how to access the mechanisms – special focus should be made on undocumented migrants;
  - Increase the involvement of migrant communities in policy making process;
  - Sensitize policymakers on migration and HIV in all four countries;
  - Conduct monitoring of implementation of the Council of Europe's recommendations, resolutions and guidelines on right to health of the migrants – implement advocacy campaign based on the results;
  - Stimulate the cross-country dialogue on developing good and complementary policy with regards the migration and HIV – working group would be an ideal solution to be established within the Council of Europe<sup>33</sup>;
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### 5.4. Advocacy needs at the level of implementation of prevention, treatment and care services

Analyzing FGD reports and country situation analysis reports lead to the “dual reality”. Migrant respondents provide information about the factors that limit them from accessing HIV related services.

The factors mentioned as significant barriers during the FGDs are:

- Lack of information among migrants;
- Legal barriers;
- Legal status of migrants;
- Poverty, funding obstacles and affordability;
- Geographical access - need to travel long distances to medical facilities and personnel;
- Service delivery and qualification of health professionals available in rural areas;
- Social and cultural characteristics of migrant communities themselves (*Quote by respondent: “They don't apply to health care services in order the avoid revealing their HIV status”*)
- Attitude (stigma) of the wider society towards the mobile groups;
- Discrimination (*Quote by respondent: “migrant applied to a doctor for a surgery but the doctor refused to serve the patient after learning about his HIV positive status”*);
- Lack of culturally sensitive information in native languages;

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33 There are thematic working groups available within the CoE. e.g. CDPC, GRECO, GRETA etc.

Country reports do not fully agree with the concerns of migrants and speak about universal access, proper regulations in action and health professionals trained for service provision. Therefore a study with efficient sampling needs to be designed and conducted.

Analysis of the secondary data<sup>34</sup> leads to conclude that community based organizations reach migrant groups better in terms of service delivery. Medical staff, social workers and project managers are in a better capacity to adjust prevention, treatment and care efforts to the needs of migrants, than state funded programs or medical facilities. This circumstance should be taken into account while developing or enhancing HIV related programming. Review of the legislation and programming gives opportunity to map policies and practices regarding the access for undocumented migrants to the HIV and AIDS related services<sup>35</sup>:

Country	Healthcare System	Legislation	Practice	NGO run or private initiatives
Armenia	Tax-financed (indirect tax) healthcare system with universal access for Armenian citizens.	Right to free emergency care. Non-emergency care is limited. Citizen may request payment for particular services, depending on the individual case. Immigration service does not provide necessary, urgent or pain-relieving care for migrants in case needed.	Free emergency care ensured, but undocumented migrants may face formal barriers in access. Also practical obstacles occur due to referral to the proper service. Practitioners often refuse to provide necessary care to HIV infected. Non-emergency care is a subject to payment.	Donor funded initiatives provide limited preventive and care services to migrants in the bigger cities. Advocacy work is more intensive.
Azerbaijan	Global budgeted healthcare system with universal access for Azeri citizens.	Right to free primary, secondary, and tertiary care is ensured. Immigration service does not provide funding for medical services for undocumented migrants in case needed.	Free emergency care ensured, but undocumented migrants may face formal barriers in access. Practitioners often refuse to provide necessary care to HIV infected. Non-emergency care is a subject to payment. Inadequate referral mechanisms are also a problem.	Donor funded initiatives provide limited preventive and care services to migrants in the bigger cities.

34 And proved by the information collected during the FGDs

35 Information collected from Health Observatory, WHO and UNAIDS country profiles, FGD results and Policy Analyses documents provided by partners

Country	Healthcare System	Legislation	Practice	NGO run or private initiatives
Georgia	Tax-financed (indirect tax) healthcare system with universal access for Georgian citizens (recently moving from private insurance model to the social health insurance).	Right to free emergency care. Non-emergency care is limited by the positive list. Citizen may request payment for particular services, depending on the individual case. Immigration service does not provide necessary, urgent or pain-relieving care for undocumented migrants in case needed.	Emergency care is a subject to payment. Undocumented migrants may face formal barriers in access. Also practical obstacles occur due to language problems. Practitioners often refuse to provide necessary care to HIV infected. Non-emergency care is a subject to payment.	Donor funded initiatives provide limited preventive and care services to migrants in the bigger cities. Advocacy work is more intensive.
Russia	Decentralized, state funded healthcare system with regionally defined access for Russian citizens.	Right to free primary, secondary, and tertiary care is ensured for Russian citizens. Immigration service does not provide funding for medical services for undocumented migrants in case needed.	Emergency and non-emergency care is a subject to payment. Undocumented migrants may face formal barriers in access. Many regional entities have adopted policies of better coverage, but knowledge is often not spread among the target groups and to the health workers in the field. Lack of adequate administrative mechanisms also complicates the process.	Donor funded initiatives provide limited preventive and care services to migrants in the bigger cities.

Country reports and strategic documents speak of number of HIV infected migrants who contribute to the spread of HIV upon return. This indicates the need for a discussion on a common effort protecting migrants against HIV.

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## SHORT LIST OF PROBLEMS - SERVICES

- Lack of programs targeting migrants
- Lack of funding and insurance
- Administrative and legal barriers for undocumented migrants
- Lack of data routinely collected and analyzed by the health care providers on patients' migration history when contraction is verified
- Lack of integration and linkage between HIV prevention and treatment services
- Lack of trained health professionals in rural areas
- Lack of culturally sensitive services
- Stigma and discrimination
- Poverty

## SUGGESTED ACTIONS

- Conduct an assessment of services available and tailored for migrants in all 4 countries;
  - Improve collection and analysis of epidemiological data regarding migrant groups, in particular to put in place functional mechanism for the health care providers to routinely collect and analyze data on patients' migration history when the contraction of HIV is verified;
  - Assess the costs and benefits of ensuring universal access to HIV related services and mobilize additional resources from state and donor funds to provide services to the migrants and to put universal access in action;
  - Improve integration and linkage between HIV prevention and treatment services;
  - Strengthen regional prevention campaigns and interventions;
  - Work on eliminating administrative and legal barriers to access the services;
  - Training of health professionals in provision of migrant-sensitive prevention, treatment and care services;
  - Combat stigma and discrimination;
  - Stimulate the cross-country dialogue to share best practices and experience, to identify mutual benefit in improving access to the services;
  - Increase funding for community based organizations providing care and support;
  - Involve migrants in planning and delivery of preventive interventions.
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## 5.5. Needs in Terms of Raising Awareness Among Migrants (including MARPs) About HIV Prevention, Treatment and Care

*“In general both in home and host countries HIV related information is mainly spread out and provided during the special days dedicated to HIV and AIDS”.*

FGD Respondent

A transient and isolated lifestyle, limited opportunity to access a quality healthcare, little HIV/AIDS and STI knowledge and a tendency toward the risky behavior makes migrants vulnerable<sup>36</sup>.

Most of the interviewed respondents declare that they had no knowledge on HIV/AIDS and its prevention until they faced the risk of contraction of HIV in the host country.

FGD participants lack information about where and how to apply for an HIV test and where/how to access treatment (or funding for the treatment). Respondents do not possess sufficient information on HIV transmission, its manifestations, treatment possibilities and outcomes. Most of the interviewed did not have information on legal rights of HIV patient and right of migrants to access health services.

Some of FGD participants reported fear of refusal to the employment due to a positive HIV status. The fears mainly originate from the stigma and discrimination in their home countries.

The focus group discussions (FGDs) were held with groups of PLWHA, MSM, commercial sex workers and work migrants. A total of 118 respondents participated. Inclusion criteria for participation were being male or female aged 18-49 who migrated to the Russian Federation or remaining in migration. Participants were recruited through purposive sampling using community key-persons. Recruitment of respondents involved members of local and regional HIV prevention networks. Combining the above criteria, 12 focus groups have been formed. Proper interpretation has been ensured.

The FGDs were conducted using a guide assessing the following themes: (1) demographic (age, gender, ethnicity, residence of origin, education level, marital status), history and pattern of migration (e.g. length of stay, reason of migration), (2) health status and health care-seeking behaviors (general health condition, availability of health care resource), (3) HIV-related risk behaviors (e.g., multiple sexual partner, commercial sex activities, unprotected sex) and perceptions (HIV/AIDS stigma; attitudes towards protective behaviors), HIV/STD knowledge (e.g., HIV/AIDS awareness, general HIV/AIDS knowledge) (4) living and working conditions (e.g., housing, leisure time activities, job, income);

Analysis of the FGD results (frequency distributions, categorizing variables, qualitative sequencing) along to the observations provided by the local partner organizations suggest a high risk of HIV infection among the migrant population. In the absence of formalized access to the prevention and treatment services, education and health care migrant groups are vulnerable to HIV and AIDS.

For almost all FGD participants the legal and administrative barriers, social patterns, stigma, poverty and living environment significantly increases risk of the HIV infection. However, with the given sampling and period of time, it is difficult to characterize the nature and influence of these factors and barriers on the migrant population.

FGD results demonstrate the need for overcoming the barriers to VCT which requires more effective dissemination of culturally sensitive information tailored to the needs of the migrant groups. Secondly access to healthcare should be guaranteed for migrants that require complex approach to decrease the formal, administrative and service provision barriers.

<sup>36</sup> Findings come from the FGDs though same trend has been recorded in different regional reports from Asia or Africa.

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## SHORT LIST OF PROBLEMS - SERVICES

- Lack of information on HIV/AIDS among migrants;
- Lack of mainstream information system aimed at informing migrants about HIV- lack of outreach;
- Limited participation of migrants in the planning activities aiming at increased awareness;

## SUGGESTED ACTIONS

- Design a well organized programs in sending and destination countries aimed at awareness or outreach of mobile groups, providing full information on HIV, transmission routes, prevention, treatment and care, HIV rights, using all means of information delivery appropriate for mobile groups;
  - Collect evidence and study receptiveness of the HIV related information via different channels of communication: booklets, newspapers, articles on subjects like HIV/AIDS, sanitation, peer education, thematic meetings, demonstrations, displays, films and slides in the airports or railway stations, or other audio visual presentations;
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### 5.6. Needs in Terms of Promoting Strategic Partnership Among Stakeholders

Qualitative analysis of secondary data (country specific reports, as well as global reports) speaks on lack of strategic partnership among stakeholders and lack of cross country coordination. Strategic partnership between HIV stakeholders on national levels is ensured via CCMs, where government agencies and civil society organizations hold dialogue and share information, although participation of affected or most at risk groups is very limited in these mechanisms. The limitation of CCMs as a coordination and partnership mechanisms is underrepresentation of stakeholders and authorities dealing with migration.

There is a poor cooperation amongst health care providers, international agencies, government officials and people living with HIV on the level where prevention projects are planned and implemented. State legislative, programming and implementing domains are operating on a different level, as NGOs and non-formal associations are distinguished by better response to the needs, while they are missing effective leverages for systemic change.

Efficiency of the partnership by qualitative analyses of secondary data for different domains look as following:

- Networking and communication – efficient cooperation;
- Project design and development – limited cooperation;
- Advocacy for treatment and research advances and rollouts – limited cooperation;

Neither situation analysis reports describe what type of cooperation is between the four countries to deal with migration and HIV effectively, nor does the legislative analysis describe existence of such mechanisms between the countries. There is a need to establish cross-country cooperation and link efforts with regards the migration and HIV to generate proper statistics, to assess and map services available and to utilize resources in an efficient way.

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## SHORT LIST OF PROBLEMS - SERVICES

- Lack of cooperation between state and non-state actors;
- Lack of cross-country coordination;
- Limited engagement of affected people;
- Absence of policy domains regarding the migration and HIV;

## SUGGESTED ACTIONS

- Initiate discussion to establish common cross-country and cross-stakeholder policy standard on access to healthcare and HIV related services for undocumented migrants;
  - Advocate need for consistent and complementary action between the stakeholders dealing with HIV and migration;
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## 5.7. Examples of interventions and good practices

Country	Good practice example	Intervention Area
Armenia	<p><b>Prevention and Control of HIV and AIDS, STI and TB project, UMCOR/Armenia</b> - Project targeted 160 villages of 6 provinces. Project aimed at raising awareness on HIV/AIDS, STI and TB in the rural communities, strengthening the capacity of local health providers to implement preventive and clinical services; 2,021 participants have been trained in order to conduct peer education and information dissemination to community members; 55,614 community members have received information; 600 migrant workers from 48 target villages participated in one-day training on HIV/AIDS, STI and TB prevention issues; 84 PHC Providers participated in training “Voluntary Counselling and Testing for HIV”;</p> <p>59 PHC Providers participated in training “The role of PHCP in detection of new TB cases and follow up treatment of TB patients”; MMT Doctors conducted on-job training for 82 PHC providers on VCT;</p> <p>Mobile Medical Team provided Clinical Services including: Voluntary Counseling and Testing for HIV; Management of STI; Detecting of new TB cases; Consultancy of TB patients, TB contacted persons and risk groups representatives; Laboratory tests (smear, urine, etc.). In the frames of the project 225 migrant workers received voluntary counseling on HIV, of them 90 persons passed blood testing on HIV. Evaluation of the project that targeted general population in the communities demonstrated considerable increase in the knowledge of project beneficiaries. Most of them indicated they felt more protected and secure after getting the information<sup>37</sup>.</p>	Prevention and Control

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37 Information provided verbally during the discussion with the UMCOR representative

Country	Good practice example	Intervention Area
Armenia	<p><b>Attitude Change Towards HIV/AIDS Among Migrants Project - GF HIV grant (RCC)</b> – The project aimed at increasing level of knowledge about HIV and AIDS among migrants and their family members.</p> <p>29250 migrants and their family members have been reached. The target group was provided with information about HIV and AIDS in popular language.</p>	Prevention
Armenia	<p><b>HIV Prevention Among Labour Migrants and Their Families In Rural Armenia</b>, World Vision, RWRP - The project targeted five communities in Tashir region of Armenia where the concentration of migrants is observed. The project targeted MARPs with a comprehensive approach, utilizing various tools, methodologies and best practices for primary prevention of HIV - Strategic Behaviour Communication (SBC), Channels of Hope (COH), and Peer Education (PE) were utilized at individual, family and community levels. Evaluation results revealed combination of methodologies and tools including SBC, COH, PE at all three levels contributing to improvement of community capacities to address HIV related issues in terms of increased knowledge, enhanced self-confidence and ability to conduct discussions and convince peers, alert for risk perception, make informed decisions, and apply safe practices.</p>	Prevention
Armenia	<p><b>HIV and migration presented by the Armenian Delegation at the UNGASS High Level Meeting, New York, June 2011</b>. Real World, Real People NGO and World Vision had a meeting with representatives of the official delegation of Armenia before their departure to the UNGASS High Level Meeting held in New York (when??).</p> <p>Among the key topics discussed at the preparation meeting for the UNGASS High Level Meeting was Migration &amp; HIV and migrants' rights to health services.</p> <p>Issue of migrants, travel restrictions and obstacles for access to HIV related health services in host countries were proclaimed from the UN podium by the Head of Delegation of Armenia:  <a href="http://www.unmultimedia.org/tv/webcast/2011/06/armenia-mr-sergey-khachatryan-2011-high-level-meeting-on-aids-93rd-plenary-meeting.html">http://www.unmultimedia.org/tv/webcast/2011/06/armenia-mr-sergey-khachatryan-2011-high-level-meeting-on-aids-93rd-plenary-meeting.html</a></p> <p>Armenia government, through the Ministry of Health, recognizes the issue and has proved its readiness to have dialogue with the civil society organizations.</p>	Advocacy

Country	Good practice example	Intervention Area
Azerbaijan	<p><b>Community Mobilization and Peer Education Among International Transit Drivers From Azerbaijan</b>, Struggle against AIDS Public Union - Drivers working for long distance routes to different cities of Russian Federation were targeted by the project. Several drivers have been selected and trained as community mobilizers to ensure access to the target group. Around 15 persons were presented in the group and trainers regularly worked within the group through peer-to-peer methodology, also performing outreach visits to community. Basic information about HIV and AIDS has been conveyed. The trained participants were equipped with knowledge and skills on safe behavior and prevention ways in terms and encouraged to disseminate this information among their contacts – passengers, family members, friends, colleagues. Evaluation of the project results demonstrated improvement of awareness and capacity to address HIV related risks, enhanced self-confidence and ability to participate into the discussions and convince peers, make informed decisions and apply safe practices.</p>	Prevention
Azerbaijan	<p><b>Migrants as part of the risk groups under the GF grant; Contribution to the National HIV Strategy 2011-2012 of Azerbaijan</b>. Struggle Against AIDS Public Union (SAPU) has done advocacy efforts through representation at CCM and HIV working group of CCM to include HIV prevention activities among migrant population to RII Grant proposal for Azerbaijan, 2011. Although GFATM has changed the grant application procedures and country was not successful with RII Grant proposal, migrants - as a part of MARPs - are currently covered by GFATM R9 project which is currently in progress. Moreover SAPU jointly with other NGOs, through CCM, advocated on inclusion of migrants as a target group into the National HIV Strategy 2011-2012 developed by external expert who visited Baku and meet with SAPU staff several times. Development of the National strategy policy paper was facilitated by UNAIDS, GFATM PIU and World Vision.</p>	Advocacy
Georgia	<p><b>Mobility Exacerbated HIV Prevention and Impact Mitigation The Southern Caucasus Program</b>, World Vision, RPRV - 6 Health Care Cabinets (HCCs) were established providing face to face and telephone consultations to the beneficiaries in Marneuli, Tetrtskaro, Telavi, Akhaltsikhe, Ninotsminda and Batumi. The consultant-doctors of HCCs were trained in prevention and treatment of HIV/AIDS and STI. They were involved in the process of identifying migrants and providing them with information about HIV and AIDS. Family members have also been reached actively. The doctors used to inform rest of visitors/patients in order to improve awareness in the general population where the mobility is a widespread practice. Evaluation of the project demonstrated improvement of awareness about HIV related risks, enhanced self-confidence and ability to convey the information to peers, make informed decisions and apply safe practices while migrating.</p>	Prevention

Country	Good practice example	Intervention Area
Georgia	<p><b>Mobilization of Active Community Members in Shida Kartli -Cross-Border Cooperation For HIV/AIDS Prevention And Impact Mitigation In Southern Caucasus And Russian Federation Project</b>, Funded by EU-Implemented by World Vision and RPRV - The local implementing partner mobilized community leaders in the IDP community, IDP settlements of Shida Kartli and sensitized them on migration and HIV/AIDS, those community members are seen as an effective channels of communication among IDPs to spread information among mobile groups and their family members on health related issues. Evaluation of the project demonstrated increase of awareness, apply for safe practices and using VCT service.</p>	Prevention
Georgia	<p><b>The Peer Education project</b>, Norwegian Refugee Council (2004-2010) aimed at raising awareness on gender, and HIV/AIDS issues among displaced youth.</p> <p>The project was implemented in two stages: Initially, 60 young people were trained as peer educators in gender, trafficking and HIV/AIDS prevention issues and multiplied their training to a larger group of beneficiaries (approximately 3,000 high-school students in different competences). In the second stage, fifteen mobile teams travelled all over Georgia, including the conflict zone of Abkhazia, to train their peers. The training participants were provided with the opportunity to identify their own solutions, examine behavioral patterns in informal settings and to become a part of an active-learning process. Application of interactive teaching techniques was a key to the concept and included drama-in-education and forum theatre. The training contributed to positive personality development of IDP youth, strengthening their ability to handle problems and increased self-reliance.</p>	Prevention
Georgia	<p><b>HIV and the linkages with migration as part of the UNGASS Country Progress Report</b>. Real People Real Vision together with World Vision within the project Cross Border Joint Advocacy for HIV prevention project funded by Australian Government Overseas Aid Program (AusAID) managed to increase interest around HIV and Mobility by assessing existing policies and programming on HIV, Migration and related Human Rights, Gender, and Family issues to identify priorities and gaps.</p> <p>The Mobility project team researched the gaps in universal access to health care services, especially for migrants in home as well as destination countries and raised this issue during the workshop aimed at developing HIV and AIDS Country Progress Report together with implementing partners - Real People Real Vision. WV Georgia advocated for inclusion of HIV and migration issues in the Country Progress Report for the period January 2010 - December 2011, <a href="http://www.unaids.org/en/regionscountries/countries/georgia/">http://www.unaids.org/en/regionscountries/countries/georgia/</a>.</p>	Advocacy

Country	Good practice example	Intervention Area
Russian Federation	<p><b>Channeling Hope project</b>, Project was organized in consortium of World Vision Russian Federation; Moscow patriarchate - department for Church external relations; NGO "Positive Initiative" in Orenburg, AIDS center in Orenburg, AIDS center in St Petersburg, NGO "Diakonia" in St Petersburg. Project aimed to equip youth with life skills in order to reduce their vulnerabilities to HIV. Activities included: trainings and workshops for the staff of educational institutions; trainings and mobilization workshops for the faith communities training of the peers, development of peer educational manual, conference, HIV counselling and testing. At least 4 800 adolescents and youth were targeted , another 9000 targeted through trained peer educators, 50 priest from 2 regions, at least 50 staff of the educational institutions; at least 50 health providers targeted by trainings. Methodology for HIV prevention was approved by the Ministry of Education of Orenburg and became part of the education curriculum of the educational institutions.</p>	Prevention
Russian Federation	<p><b>Model of social follow up/assistance to the vulnerable groups: PLHIV/MARPs and migrants.</b> Project was implemented in Orenburg region jointly by NGO "Positive Initiative", AIDS center; All-Russian Union of people living with HIV; Ministry for Social Defense of Orenburg region, Anti-TB municipal centre and served as a good example cooperation between state institutions and NGOs. 179 people were targeted by counselling and though outreach work.</p>	Prevention

## 6. Conclusions and Recommendations

### CONCLUSIONS

**Policy level** - There are inconsistencies between the legislative, executive and NGO domains within the national policies and coordination related to migration and HIV. Universal access to HIV prevention, treatment, and care is an aspiration, although the programming, resources allocated and health professionals do not provide universal access to the listed services to migrants.

Complications due to illegal residence status, poorly functioning information systems, migration policies, justice and international policies e.g. deportation or fining of undocumented migrants, embargo, cross-country tensions lead to the counterproductive results.

Poor links and integration of migration and public health policies on national levels restrain effectiveness of HIV related efforts. There is no consistent legal framework for migrants' rights in the light of HIV or general healthcare. While issues of migration and HIV are on top of national agendas, they are separate, which puts HIV supportive programming under pressure while reaching the migrant populations. Legislation and programs do not have common definition of migration and migrants. This leads to challenges in obtaining reliable data on migration and HIV, making it difficult to address problems adequately and establish good cooperation between parties.

**Service delivery level** – The desk review has identified several challenges with regards to provision of prevention, treatment and care services: administrative barriers to HIV prevention, treatment and care, limited affordability and funding of services, social seclusion and stigma preventing migrants to access the services, lack of integration and linkage between HIV prevention and treatment services, lack of programs targeting migrants, lack of trained health professionals.

**HIV awareness** - FGD results demonstrated that migrants have lack of information about where and how to apply for an HIV test and where/how to access treatment (or funding for the treatment). Migrants do not possess sufficient information on HIV transmission, its manifestations, treatment possibilities and outcomes. Most of the interview respondents did not have information on legal rights of HIV patient and right of migrants to access health services. Migrants declare that they had no knowledge on HIV/AIDS and its prevention until they faced the risk of contraction of HIV in the host country. However, limitations of the desk review do not allow addressing the question whether the migrants from Georgia, Azerbaijan and Armenia are under greater risk while migrating, or, alternatively, the risks are same in their home countries and the risks “just transit” from one country, to another.

**Strategic partnership** - Strategic partnership between HIV stakeholders on national levels is ensured via CCM-s, where government agencies and civil society organizations hold dialogue and share information. Participation of affected or most at risk groups in these mechanisms is very limited. The limitation of CCMs<sup>38</sup> as a coordination and partnership mechanisms is underrepresentation of stakeholders and authorities dealing with migration.

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38 As for Russian Federation, CCM it's not a functional, implementing body.

## RECOMMENDATIONS

### Policy level

- Establish common policy on universal access to HIV treatment and HIV related services for migrants in all four countries – introducing common standard between the sending and receiving countries;
- Establish a clear and effective, easy to access mechanisms protecting migrants' rights and establish information system for migrants how to access the mechanisms – special focus should be made on undocumented HIV-positive migrants;
- Increase the involvement of migrant communities in policy processes;
- Sensitize policymakers on migration and HIV in all four countries;
- Stimulate the cross-country dialogue on developing good and complementary policy with regards the migration and HIV;

### Service delivery level

- Conduct an assessment of services available and tailored for migrants in all 4 countries;
- Improve collection and analysis of epidemiological data regarding migrants groups;
- Assess the costs and benefits of ensuring universal access to HIV related services and mobilize additional resources from state and donor funds to provide services to the migrants and to put universal access in action;
- Improve integration and linkage between HIV prevention and treatment services;
- Strengthen regional prevention campaigns and interventions (establish network of pre-defined organizations which refer and receive referrals, agree on common information activities, set up regular format for review of progress and discussion of challenges, etc)
- Work on eliminating administrative and legal barriers to access the services;
- Training of health professionals in provision of migrant-sensitive prevention, treatment and care services (identify migrants' "first come" points of the healthcare system and train the medical personnel working for those medical units);
- Combat stigma and discrimination;
- Stimulate the cross-country dialogue to share best practices and experience, to identify mutual benefit in improving access to the services;
- Increase funding for community based organizations providing care and support;
- Involve migrants in planning and delivery of interventions and services.

### HIV awareness

- Design a well organized programs in sending and destination countries aimed at awareness or outreach of mobile groups, providing full information on HIV, transmission routes, prevention, treatment and care, HIV rights, using all means of information delivery appropriate for mobile groups;

- Collect evidence and study receptiveness of the HIV related information via different channels of communication: booklets, newspapers, articles on subjects like HIV/AIDS, sanitation, peer education, thematic meetings, demonstrations, displays, films and slides in the airports or railway stations, or other audio visual presentations;

### **Strategic partnership**

- Initiate discussion to establish common cross-country and cross-stakeholder policy standard on access to healthcare and HIV related services for undocumented migrants;
- Advocate need for consistent and complementary action between the stakeholders dealing with HIV and migration;

## 7. Lessons Learned From the Desk Review Process

Despite the significant number of published resources, the desk review has identified gaps in available information. HIV and migration surveillance data is very limited. Country reports miss evaluations of the impact of legal regulations to the HIV and migration.

There are some good opportunities to get stewardship of international bodies dealing with surveillance, HIV, migration and policy analysis in the European union and this opportunities should be used.

More communication would be beneficial with state and non-state actors by countries – the communication should be standardized around pre-set topics.

Final release of the desk review for four countries will benefit from a joint meeting if it is organized for representatives of CSAs and state agencies dealing with HIV and migration.

## 8. List of Materials Used for Review

COUNTRY	REPORT
Armenia	HIV situation and response analysis - 2011
Armenia	UNGASS country progress report - 2011
Armenia	UNAIDS – Country Situation Overview - 2011
Azerbaijan	WHO - Epidemiological Factsheet - 2008
Azerbaijan	Legislative Analyses of Azerbaijan - 2011
Azerbaijan	Access to healthcare for drug addicts - 2011
Azerbaijan	National Strategic Plan – 2013-2017
Azerbaijan	Global AIDS response progress report - 2012
Azerbaijan	UNAIDS – Country Situation Overview
Georgia	Global AIDS response progress report - 2011
Georgia	Migration & HIV - Policy and Gap Analysis - 2011
Georgia	UNAIDS – Country Situation Overview - 2019
Georgia	Statistical Report on Migration by Ministry of Interior - 2011
Georgia	Health Legislation Analyses of Georgia - 2011
Russia	Epidemiological Fact Sheet on HIV and AIDS – Russia 2008
Russia	UNAIDS – Country Situation Overview - 2009
Russia	Concept for Handling of the Migration Process
Russia	Organisation of HIV Prevention Among Work Migrants - 2009
Russia	Migration, Mobile Groups and HIV – 2009 (Plavinsky)
Global	MDG Report for Europe - 2011
Global	UNICEF report - The underground HIV epidemic affecting children in Eastern Europe and Central Asia - 2010
Global	ECDC - HIV/AIDS Surveillance in Europe – 2010
Global	World Migration Database - IOM