Meeting report

HIV in Europe and central Asia in the era of the SDGs

Operationalizing goals and achieving targets

ECDC/WHO joint meeting

Berlin, Germany
23–25 April 2018

Abstract

The ECDC/WHO joint meeting "HIV in Europe and central Asia in the era of the SDGs: Operationalizing goals and achieving targets" reviewed national and regional progress towards achieving the regional goals and targets that need to be met in order to end AIDS by 2030, and the challenges that have been encountered in doing so. It assessed how data are used to inform HIV prevention and control efforts at national and regional levels and provided a platform for countries to share their experiences of successful interventions on HIV prevention, testing and treatment.

The meeting brought together national HIV programme managers, HIV surveillance experts and a wide range of partners for two-and-a-half days to discuss experiences and ways forward related to: the Fast-Track Cities initiative, HIV prevention (particularly pre-exposure prophylaxis (PrEP) and harm reduction), HIV testing, surveillance and estimates, and treatment measurement and implementation issues.

In addition to the main plenary and parallel sessions, two "European cafés" provided opportunities for smaller groups of people with interest in specific topics to learn more about them and to discuss them in greater depth.

Much joint work will continue going forward, and 2018 provides many opportunities for countries and organizations to continue sharing experiences and learning from each other.

The 22nd International AIDS Conference which will be hosted in Amsterdam, from 22 to 27 July 2018, provides a special opportunity for the WHO European Region, especially for the countries in eastern Europe and central Asia (EECA) for whom a Ministerial Policy Dialogue on HIV and related comorbidities is being organized on 23 July 2018 by WHO, the Government of the Netherlands and UNAIDS.

Key words

HIV infection
HIV prevention, testing and treatment
HIV surveillance and estimates
Europe and central Asia

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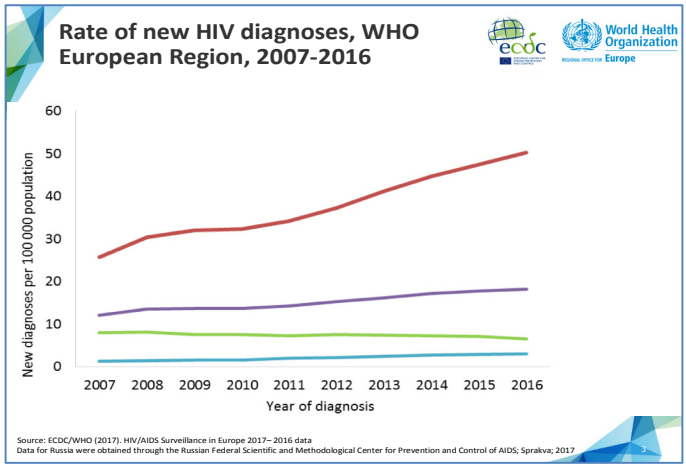
Abbreviations

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral drug
CDC	US Centers for Disease Control and Prevention
CHIP	Centre of Excellence for Health, Immunity and Infections
DTG	dolutegravir
EC	European Commission
ECDC	European Centre for Disease Prevention and Control
EEA	European Economic Area
EECA	eastern Europe and central Asia
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
HA-REACT	Joint Action on HIV and Co-infection Prevention and Harm Reduction
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HIVDR	HIV drug resistance
IAPAC	International Association of Providers of AIDS Care
IAS	International AIDS Society
IBBS	Integrated Biological and Behavioural Surveillance
IDU	injecting drug use(r)
MPP	Medicines Patent Pool
MSM	men who have sex with men
MTCT	mother-to-child transmission
NNRTI	non-nucleoside reverse-transcriptase inhibitor
OST	opioid substitution therapy
PHE	Public Health England
PWID	people who inject drugs
PLHIV	people living with HIV
PrEP	pre-exposure prophylaxis
SDG	Sustainable Development Goal
STI	sexually transmitted infection
TB	tuberculosis
TESSy	The European Surveillance System
UNAIDS	Joint United Nations Programme on HIV/AIDS
VL	viral load
WHO	World Health Organization

1. Introduction: opening and welcome

Ines Perea (German Ministry of Health), **Andrew Amato (European Centre for Disease Prevention and Control (ECDC))** and **Masoud Dara (WHO Regional Office for Europe)** welcomed participants to the meeting (see Annex 1 for the programme; Annex 2 for the list of participants). All three pointed out that – despite significant progress in many areas – there are still alarming trends in the HIV epidemiology and response in the WHO European Region. In 2016, 160 000 people in the Region were diagnosed with HIV, the highest number ever, and 80% of them were diagnosed in the eastern part of the Region. Another challenge is that half the people newly diagnosed with HIV are diagnosed late,[1] with even higher proportions of late presenters among people who inject drugs (PWID), heterosexuals and people of older age groups. HIV and coinfections such as tuberculosis (TB) are also on the rise, again especially in the eastern part of the Region, where one in eight newly notified TB patients is coinfected with HIV. In the era of the Sustainable Development Goals (SDGs), there is a need to do more, but also an opportunity to do more. In order to progress towards ending HIV, we need to integrate HIV services with other services such as TB and viral hepatitis, as highlighted in a UN common position on ending TB, HIV and viral hepatitis through intersectoral collaboration, authored by several United Nations organizations. Sharing experiences is essential to progress, and this joint ECDC–WHO meeting provides a perfect opportunity for cross-country exchange of ideas and experiences. More examples of country actions on HIV will be published in July 2018 in a Compendium of good practices in the health sector response to HIV in the WHO European Region.



The main focus of the meeting was to review and discuss national and regional progress and challenges towards achieving the WHO European Region's HIV goals and targets to end AIDS by 2030. A key objective of the meeting was also to provide a platform for countries to share experiences on successful interventions on HIV prevention, testing and treatment.

This report provides a summary of the main points from the meeting. More detailed information is available in the individual presentations, which have been disseminated to meeting participants.

Opening remarks were also given by representatives from the Joint United Nations Programme on HIV/AIDS (UNAIDS), the European Commission (EC), the International AIDS Society (IAS) and civil society organizations.

Tim Martineau (UNAIDS) drew attention to some of the successes in the WHO European Region, but also to the challenges facing it. Global successes include the progress that has been made in scaling up

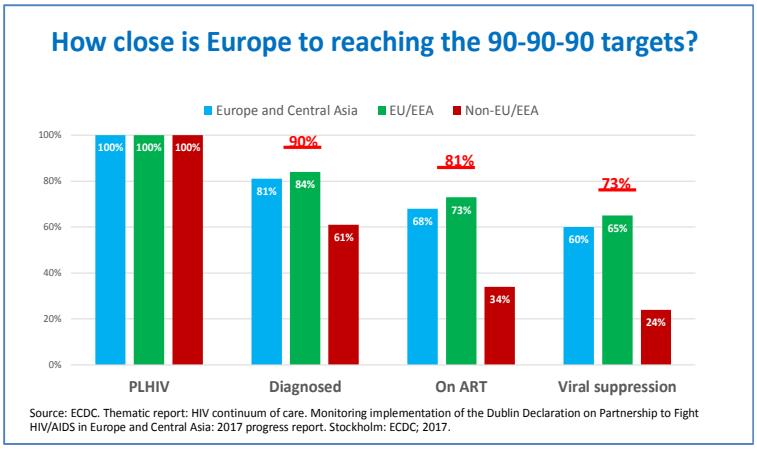
[1] With a CD4 cell count below 350 cells per ml at time of HIV diagnosis.

treatment and the world being well on track to reaching 30 million people accessing treatment. Key challenges in the Region are that new HIV infections continue to climb and that the 90–90–90 targets[1] are off track, particularly among key populations. Solutions to these challenges include political commitment and community-based responses, which have proven to lead to an increased likelihood of access to treatment, greater use of prevention services, and growing numbers of people being tested. The Fast-Track Cities initiative is a perfect example of how local communities can respond to the HIV epidemic.

Jean-Luc Sion (EC) highlighted some of the actions taken by the EC on HIV and emphasized that – although EC actions primarily relate to European Union (EU) countries – commitment to ending HIV goes beyond the EU to neighbouring countries. He highlighted the need to work in a cross-sectoral manner and reach out to key populations. Addressing stigma and discrimination is essential in this context. An upcoming European Commission Staff Working Document on Combatting HIV/AIDS, viral hepatitis and tuberculosis, sharing the experiences of successful HIV projects and serving as a "toolbox" for actions related to HIV, will be made available to facilitate the continuous exchange of ideas and experiences.

Finally, **Daniel Simões (Grupo de Ativistas em Tratamentos, Portugal)**, replacing Nikos Dedes and Vitaly Djuma at short notice as representatives for civil society, stressed that, despite progress, we are still not where we need to be. We need to act more, act faster and act better. To do so, it is essential to include civil society and not work in silos; we must integrate all components of the response and work together across sectors. We have the tools and we know what to do with them, but they need to be used effectively.

"Can Europe end AIDS? What will it take to get there?" was the title of the keynote presentation given by **Anton Pozniak (IAS)**. Despite several decades of research and commitment to fighting HIV, the fact remains that there is still no cure and no vaccine. The world has never ended a global epidemic without a vaccine or a cure, so if we want to end AIDS, we need to step up our game; and if Europe wants to contribute to this, the 3% of resources currently put into research must increase. In addition to finding a cure and a vaccine, a number of other issues need to be addressed. In the first place, health and medicine must be regarded as non-excludable and non-competitive public goods. As long as this is not the case and as long as stigma exists, constituting a major impediment to HIV prevention and treatment, we will face problems financing HIV programmes. Addressing stigma and discrimination is thus key. We need to know our local epidemics, so we can react accordingly. The UNAIDS global 90–90–90 targets are essential, and although the WHO European Region overall is not the worst-performing region globally, there is still some way to go to reach the treatment cascade targets (see graph to the right).



To get closer to the 90–90–90 and related cascade targets (90–81–73, see red lines on graph), more effort is

[1] 90% of people living with HIV know their HIV status; 90% of people diagnosed with HIV receive ART; 90% of people on ART achieve viral suppression.

needed to improve testing and immediate treatment, as well as HIV prevention programmes including pre-exposure prophylaxis (PrEP) and harm reduction. And there needs to be a special focus on key populations throughout. To conclude:

- Europe, as a region, is not on track to reach the 90–90–90 targets by 2020 or to end AIDS by 2030.
- Innovations and effective interventions – frequent testing, immediate antiretroviral therapy (ART) initiation, and linkage to care and PrEP – need to be implemented urgently and at scale in many European countries.
- Political will, community activism and social acceptance are key.

Following the presentation, a short discussion focused primarily on issues relating to stigma and decriminalization. Using all opportunities to articulate these topics was considered essential – adopting a human rights perspective, for instance, and working around the edges to develop a strong community voice. Finally, it was reiterated that – as many countries face similar problems – it is essential to share experiences and good practices in order to learn from each other's efforts, successes and failures.

2. Scaling up the HIV response: the Fast-Track Cities initiative

The main objective of Session 2 was to discuss how to translate global and regional goals, objectives and targets on HIV into local implementation plans.

Bertrand Audoin (International Association of Providers of AIDS Care (IAPAC)) opened the session with an overview of the Fast-Track Cities initiative, which was launched in Paris on World AIDS Day 2014. More than 90 cities around the world have to date signed the Paris Declaration on Fast-Track Cities Ending AIDS, all with the main objective of achieving the global 90–90–90 targets and zero stigma and discrimination. The Fast-Track Cities initiative provides a platform for thinking and partnering globally and locally to leverage existing programmes and resources, and to share best practices.

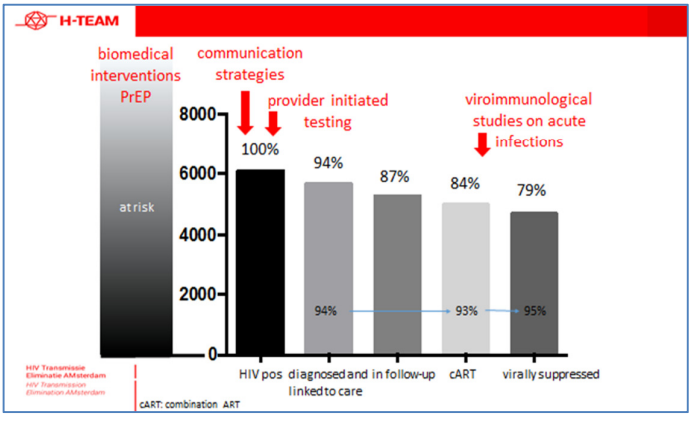
The importance of cities, as opposed to countries, in ending AIDS is not to be underestimated. Cities often have more leeway to implement initiatives and to apply innovative approaches. The Fast-Track Cities initiative offers various support options for participating cities. One example is a web portal, which functions as a dashboard and can help cities in making data public. Not all cities need such help, but it is a good way to demonstrate transparency in handling data and services. Cities are also offered support in developing advocacy and communication plans, as well as guidance on fundraising and proposal templates. There is currently great diversity in how far cities have gone in implementing the Fast-Track initiative. Some have only signed off on the declaration but not yet started implementation, while others are deep into implementation. The next steps for the initiative include a series of European workshops on best practices and bringing all European Fast-Track Cities to a level where they have a strategy, timeline and budget. Finally, it is the ambition to bring more cities on board the initiative. Bertrand Audoin closed by inviting all cities interested in the initiative to join and benefit from the experience already gained by other countries.

Three Fast-Track Cities shared their experiences, including the important process leading up to becoming a part of the initiative.

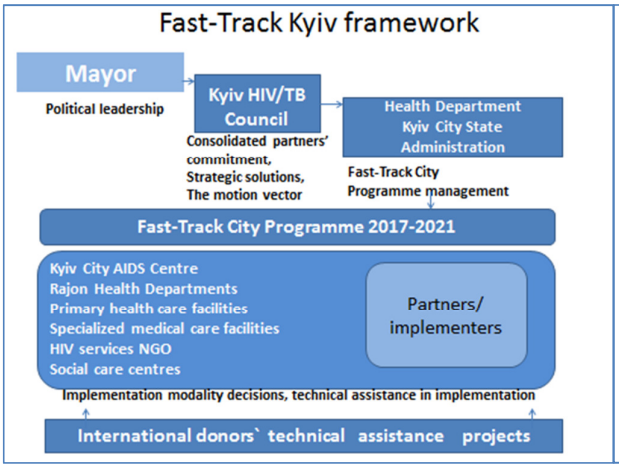
The Fast-Track City experience of **Amsterdam** was presented by **Godelieve de Bree (Amsterdam Institute for Global Health and Development)**. The initiative in Amsterdam is led by the H-TEAM, which includes all HIV stakeholders in the city. The HIV epidemic in the Netherlands is concentrated in cities, but even within cities like Amsterdam there are large differences in the HIV prevalence. Taking these factors into consideration is necessary for an effective city-based approach.

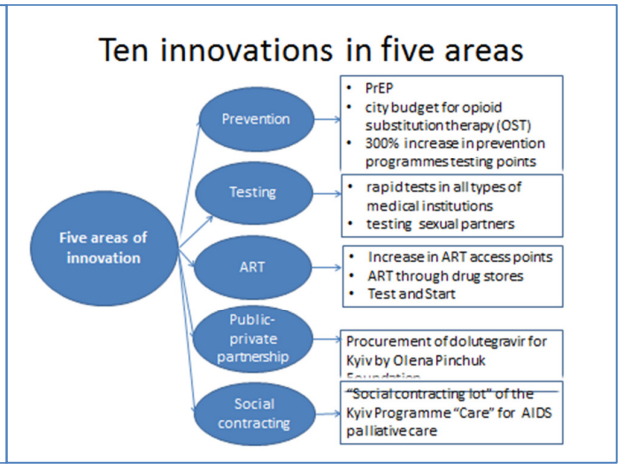
There are three main challenges facing Amsterdam: (1) the HIV incidence in the city is not declining rapidly enough; (2) there is ongoing transmission of HIV by individuals unaware of their status; and (3) 39% of individuals enter into care at a late stage of infection.

The aim of the H-TEAM is to reduce the HIV incidence and improve prognosis by earlier testing and immediate treatment. Several different projects which address specific pillars in the HIV cascade of care are in place. An example was given of an online campaign on acute HIV infections targeted at men who have sex with men (MSM) to improve rapid diagnostics and referral trajectory. The campaign contributed positively to an increase in diagnosis of recent infections in Amsterdam compared to the Netherlands as a whole.

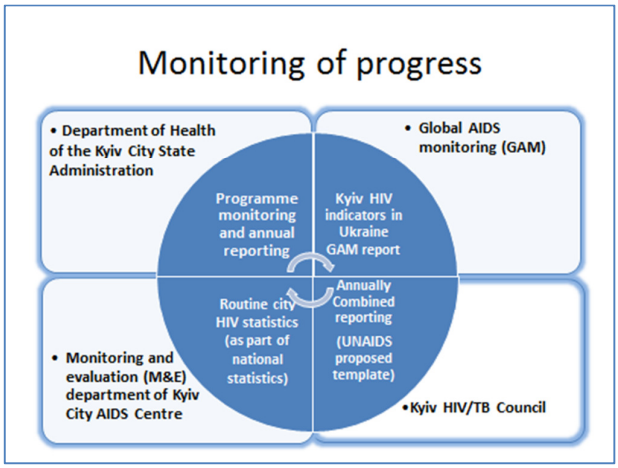


Oksana Naduta-Skrinnik (Kyiv City State Administration) presented the Fast-Track experiences of **Kyiv**. Kyiv joined the initiative in 2016 with a Fast-Track programme running from 2017 to 2021. The Fast-Track framework for the city and the programme's five main areas, with a total of 10 new actions/ innovations, are illustrated in the slides below.





For testing, the plan is to offer rapid testing in medical institutions at all levels and thereby achieve a 31% increase in testing (all tests) coverage and 76% increase in rapid testing coverage. For ART, there will be more ART access points, from the current four ART sites at the city AIDS centres to include 26 polyclinics with ART on site and 12 drugstores. In addition, the programme recommends that treatment be initiated within a maximum of 30 days from diagnosis. A monitoring plan has also been developed, which involves several different partners and data sources as shown in the third slide.



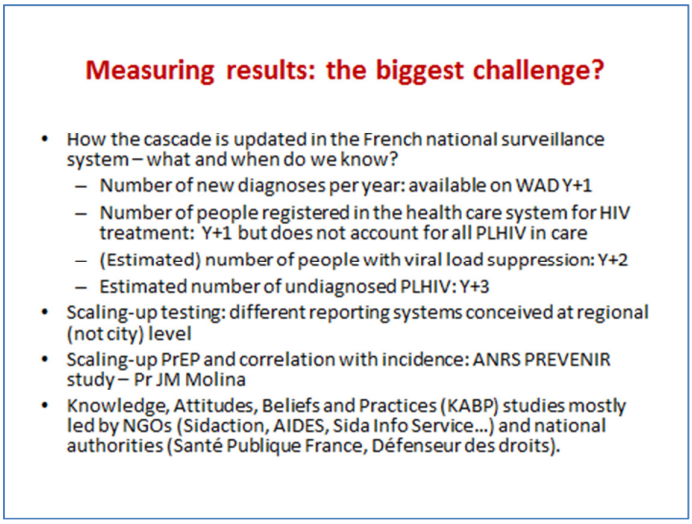
Eve Plenel (Public Health Division, City of Paris) gave an overview of the Fast-Track City initiative "Paris sans SIDA" in **Paris**. Creating a local consensus by getting together scientists, communities and political leaders has been the backbone of the Paris Fast-Track initiative. It was a time-consuming process, taking about two years from the first meetings until the first actions were implemented, but the process has ensured that all relevant partners are involved and committed. The programme has three main goals: (1) to prioritize key affected populations; (2) to foster safe and inclusive social environments; and (3) to promote positive messages about sexuality and sexual well-being. The governance of the programme is structured around four principles: (1) political impetus from local government with dedicated funding and human resources; (2) policy led by the City of Paris together with local state authorities for public health; (3) roots in the communities, with a strategic committee of 50 key local actors; and (4) public–private funding.

The HIV epidemic in France is stable and concentrated both geographically and socially. France is already well on track to meet the 90–90–90 targets. There has been universal access to ART since 2013 and an inclusive health care system with a strong network of non-profit organizations to support people living with HIV (PLHIV). In Paris, in 2015, more than 95% of diagnosed PLHIV received ART and more than 95% of

them had a suppressed viral level. In addition, there is community consensus on combination prevention and a favourable legal framework.

However, three persistent challenges remain: testing; scaling up PrEP; and stigma and discrimination. Several activities to address these challenges have therefore been initiated. These include a large communication campaign to promote frequent HIV testing and the message "Undetectable equals Untransmittable (U=U) and a scaling-up of resources for testing and PrEP.

A fourth challenge lies in measuring the results (illustrated in the slide to the right).



Following the country presentations, a dedicated and lively plenary discussion, also involving the Fast-Track Cities **Lisbon**, **London** and **Berlin**, touched upon the following issues:

Engaging providers to buy into PrEP

- In **Paris,** this required time and money. Every single provider was addressed and time was put aside to convince them of the importance of PrEP. In addition, the City of Paris came up with money for the required additional doctors and nurses, which of course also made a difference.
- In **Amsterdam,** the necessary financial resources for treatment are in place, which makes engaging providers a bit less of a challenge.

Monitoring systems

- In **Paris,** a better and faster monitoring system at local level would be a big help, allowing the programme to be adapted even more effectively.
- Also, in **Amsterdam** data and better insight into the local epidemic are important. Just scaling up testing is not necessarily the right thing to do – there is a need for data to prove that we are testing the right people.
- In **Kyiv**, the current data collection system does not reflect the number of people who know their HIV status; for this reason, amendments and new ways of collecting data would be a big help in order to analyse gaps in the cascade and identify people lost to follow-up.

Ensuring political commitment and (new) funding

- In **Paris,** national health insurance is pretty comprehensive. The job of the "Paris sans SIDA" programme has been to make investments more targeted and specific, rather than attracting new funds. Campaigns and other activities are financed through Paris sans SIDA.
- In **Amsterdam**, the financing system reflects the whole process of becoming a Fast-Track City, with funding initially coming from scientific sources, then also from industries through unrestricted grants and charitable organizations, and eventually from the City of Amsterdam, when it was possible to prove that the programme was effective. The next step may be to engage health insurance companies. In this process the consortium with broad stakeholder representation has added value.

- In **Kyiv,** the HIV programme has been adopted at national level with government funding for treatment. In addition, the Global Fund and the President's Emergency Plan for AIDS Relief (PEPFAR) are contributors. Financing is also secure at regional and city level. Political commitment and the coordination council under the mayor of Kyiv have helped secure funding.
- In **Berlin,** financing has been supplemented with fundraising activities.
- In **Lisbon,** the Paris Declaration was signed in the lead-up to elections and before there was real political commitment. Progress has therefore been slow, partly as a result of changes in political leaders, who have had to be convinced anew of the merits of the project. The experience here is that committed people, rather than committed funding, are the key to making things happen.
- In **London,** the long process leading up to signing the Paris Declaration has been key. Ensuring commitment and agreement between 33 councils, the mayor and national health bodies has been valuable in getting everyone on the same page.

Coordination with other diseases such as TB and multidrug-resistant TB

- All the cities in the panel discussion agreed that there was a need to focus more on TB and to push for more TB testing and integrated care. It is especially a problem among migrants, who are often undocumented. However, the reality is that there is competition for funding between diseases and the result is often that projects end up focusing on single diseases.

Consequences for neighbouring cities – risk of inequalities

- The potential negative effects on neighbouring cities that are not part of a Fast-Track City initiative should be recognized; however, it is important to remember that a large proportion of people who go to clinics in big cities live outside the city and as such are part of the target group.

2.1 Main messages and action points from the session

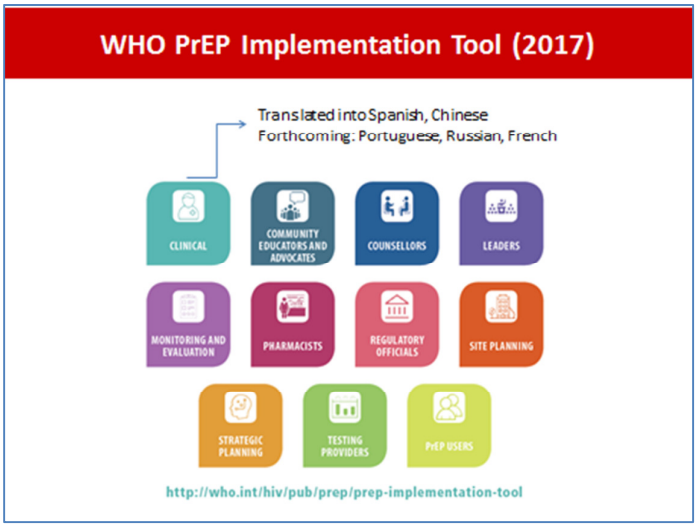
- Impressive progress has been made in many Fast-Track Cities, but it is clear that the process to getting there is not "one size fits all"; approaches have to be adapted to meet the needs of local contexts and stakeholders.
- Becoming a Fast-Track City requires patience – applying to join and signing off on the Paris Declaration does not automatically result in progress. It is a process where time put aside to ensure that all relevant partners and stakeholders are around the table and committed to the programme is time well spent.
- "Know your epidemic" – which are the key populations? This must be the mantra – also at city level.
- There is a need for better and faster local monitoring systems in order to analyse gaps in the cascade and to identify people lost to follow-up – also at city level. Data need to be easily and quickly available.
- Funding structures for Fast-Track Cities vary greatly from one city to another; they can include, among other things, public funding through national and/or local government, fundraising activities, international donors, scientific funding and health insurance companies.
- The experiences of Fast-Track Cities prove that cities can raise the bar for all of us; there is a sense of urgency and a will to think and act innovatively. This is encouraging for all of us.

3. Prevention

The main objective of Session 3 was to share experiences on successful HIV prevention interventions.

The session was opened by **Axel J. Schmidt (Sigma Research, London School of Hygiene and Tropical Medicine)**, who presented preliminary results from the European MSM Internet Survey (EMIS 2017). The aim of the survey is to generate data on morbidities, sexual behaviour, and unmet sexual health needs of, and interventions for, MSM (including gay, bisexual and transgender men who have sex with men). The data will also help to develop direct HIV and sexually transmitted infection (STI) prevention programmes. The final results will be published in 2019. Once published, Axel encouraged anyone interested in analysing the data to contact the EMIS Editorial Board. More information can be found at www.emis2017.eu.

Introducing the parallel sessions on prevention, a plenary presentation was given by **Ioannis Mameletzis (WHO headquarters)** on the status of PrEP in Europe. WHO strongly recommends the use of oral PrEP for persons at substantial risk of HIV infection as part of combination prevention and has included PrEP in the updated WHO consolidated guidelines on antiretroviral drugs (ARVs) and the WHO model list of essential medicines. Also published in 2017 was a WHO PrEP implementation tool, which is modular. Demand for PrEP is steadily growing worldwide. It is worth noting that implementing PrEP can have broader benefits beyond the impact on reducing HIV incidence, such as increased uptake of HIV testing, linkages to care of those who test positive, and integration with other services including family planning and STIs. The status of formal PrEP implementation in Europe is illustrated in the map on the right. The Global PrEP Coalition, led by WHO, was established in 2017 to facilitate global dialogue and to foster collaboration between stakeholders on PrEP as part of HIV combination prevention.



Thomas Seyler (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)) gave an introductory presentation on the status of harm reduction in Europe. Data on the number of people who inject drugs (PWID) in Europe are incomplete, with recent data only available for 16 of 30 countries. This information gap makes it difficult to estimate the prevalence of injection, as well as the characteristics and needs of PWID in Europe. Looking at HIV among PWID in western Europe, there is a continuing decline in the number of HIV diagnoses attributed to injecting drug use (IDU), but local outbreaks – mainly associated with injection of stimulants – are still occurring. In eastern Europe and central Asia (EECA), new diagnoses of HIV in PWID have declined between 2007 and 2016, but IDU remains a major risk factor for HIV transmission in many countries. Effective measures to prevent transmission of bloodborne viruses are well known, but coverage remains low in many countries. There is thus a need to step up harm reduction interventions, improve monitoring, and empower PWID to prevent infections.

3.1 Pre-exposure prophylaxis (PrEP) (parallel session)

Teymur Noori (ECDC) presented an overview of the results form a 2017 ECDC/Hornet survey on the use of PrEP and willingness to use it among MSM in Europe. A key finding is that formal PrEP roll-out in the WHO European Region is slow. At the same time there is evidence of significant informal PrEP use across European countries, and that a significant number of informal users are doing so without informing their sexual health care providers. The survey also finds that many men using PrEP appear to be appropriately assessing their risk of contracting HIV and are more likely to be screened and diagnosed for STIs.

Country experiences with implementing PrEP were presented by **Jean-Christophe Comboroure (France)**, **Ann Sullivan (United Kingdom)**, **Viviane Bremer (Germany)** and **Ihor Kuzin (Ukraine)**.

In **France**, PrEP has been formally authorized and fully reimbursed by the health care system since 2016. Since then, nearly 7000 people who initiated PrEP have been identified. The majority (97.5%) are men with an average age of 38 years. About 60% use PrEP daily and approximately 40% on demand. The majority of PrEP prescriptions are issued in hospital settings, but they can also be prescribed by doctors in STI centres and renewed by general practitioners. It is a challenge to increase the number of MSM who take PrEP and to ensure access to PrEP for migrants, among whom there is often a lack of information, misrepresentation and worries over the effect of PrEP on fertility. It is therefore important that PrEP offered to migrants takes into account social and health needs, including the need for STI treatment and contraception.

In the **United Kingdom**, PrEP is available through both formal and informal channels. Formal sources include a three-year impact trial delivered at sexual health clinics. The main target group for the trial is MSM, but there are places reserved for women. Interest in participating in the trial has been overwhelming, which has led to long waiting lists and, in some places, a pause in recruitment of new participants, resulting in people being turned away. Unofficial provision of PrEP is mainly through self-sourcing from the internet and the PrEP Shop. HIV activists have been campaigning to make PrEP more widely available.

In **Germany**, before September 2017, PrEP was formally available only at a very high price (about €800 a month) and not reimbursed through health insurance. It was therefore mostly used informally without counselling and monitoring. In July 2017 the patent for Truvada expired, and the application for a supplementary protection certificate made in August of the same year was rejected. To allow discounts to patients, PrEP is individually repackaged by a company, making it available at a much lower price. The project is being monitored and the results are still not available. Other generic manufacturers are now also offering PrEP at a low price.

In **Ukraine**, a pilot project on PrEP is currently being implemented in Kyiv. The project aims to reduce the rate of HIV transmission among MSM and transgender people by introducing PrEP as part of a combined prevention and care programme in the country. Implementation challenges include organizational issues related to harmonization of the involved doctors' schedules (holidays, participation in seminars, meetings, training sessions). This has been resolved by alerting the social workers' schedules to fit in with the doctors'. Another challenge is the long delivery time of test results for HIV, hepatitis and STIs testing (which is required within seven days under the pilot project). This issue has been resolved by introducing time restrictions requiring that the test results be returned to doctors on the same day as the test is taken.

The subsequent discussion touched upon the following topics:

<u>STI and behavioural data and monitoring</u>

- **WHO headquarters** is undertaking a review of STI screening approaches and data (e.g. diagnoses, incidence) from open-label studies and PrEP programmes. PrEP service delivery can be

a gateway to STI services and presents an opportunity to optimize STI case management in people at risk of HIV and other STIs.

Targeted and actual PrEP demand

- **France**'s experience indicated that the demand for PrEP was a bit lower than expected, as it takes time to scale up. The combination of data from two national surveys makes it possible to estimate that the population which could benefit from PrEP amounts to several tens of thousands of people.
- Globally, **WHO** recommends that PrEP be offered to people at "substantial risk" (populations or settings with HIV incidence above 3 per 100 person years).
- In **Ukraine**, 35% of MSM have indicated that they are interested in taking PrEP, and 90% that they would be ready to start on demand (i.e. not on a daily basis). However, is it important to take into account that many MSM will say that they want to take PrEP but may not be ready to do so in practice.

Reaching non-MSM populations

- The **United Kingdom** is trying to commission health promotion in the community, as women are not as easily reached through sexual health clinics. It is necessary to use genealogical clinics, district/community nurses and others medical specialists to raise awareness among women.
- **France** also has experience with reaching transgender populations with PrEP. Since the end of 2017, a team from the Saint-Louis–Lariboisière–Fernand Widal University Hospitals (AP-HP) in Paris has been experimenting with outreach PrEP to transgender people.
- **WHO** is working across the WHO regions to sensitize other providers (e.g. pharmacists) on PrEP.

Financing the "package" beyond the drug

- **Germany** is working on having the rest of the package (STI testing, condom and health promotion) covered by health insurance while the drug is paid for out of pocket (e.g. €55 per month for a course of generic drugs). Currently some providers are offering the rest of the package despite the risk of not being reimbursed.

Valentina Cambiano (University College London, United Kingdom) presented a pilot study on PrEP use in people newly diagnosed with HIV. The study is an observational cross-sectional study to assess the prevalence of HIV drug resistance before ART initiation in people newly diagnosed with HIV and exposed to PrEP. The study relies on clinical visits and completion of a questionnaire within three months of HIV diagnosis. The PrEP questionnaire is available for others to use, including clinics not participating in the study.

All countries/clinical centres that would like to participate are welcome: please contact Valentina Cambiano for more details (v.cambiano@ucl.ac.uk; respond.righospitalet@region.dk).

Finally, **Valerie Delpech (Health Protection Agency, United Kingdom)** gave a presentation on monitoring PrEP and standardizing data collection. The United Kingdom has 5700 people on PrEP at over 120 sites and does not want to add additional data collection to busy clinical services. The idea is to use information already collected on STI and HIV reporting systems to monitor PrEP. Routine STI systems have been adapted to monitor PrEP, including information on whether individuals are on PrEP, how long they have been taking PrEP, etc. HIV and STI surveillance systems can be linked. There is enhanced surveillance of persons recently infected (in the last year) through a study called SHARE. The counties involved in PrEP

provision have raised several questions on PrEP's effectiveness and how to measure it and also what a minimum output dataset would look like.

In the **subsequent discussion on PrEP monitoring**, the great importance of sensitizing all stakeholders on the need for effective monitoring was highlighted; and there was further discussion of a harmonized way of bringing this about. Progress in this area can be facilitated through ECDC and/or WHO, as well as bilaterally by countries sharing information on how they are already monitoring or planning to monitor PrEP.

3.2 Harm reduction associated with drug use (parallel session)

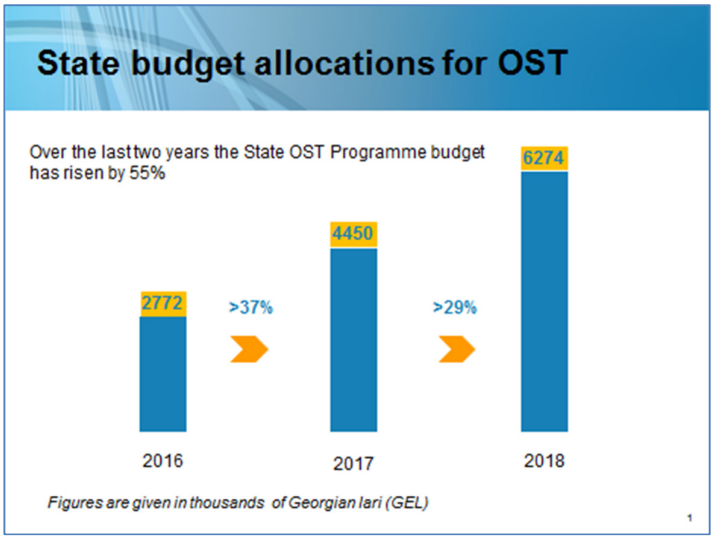
The session opened with country presentations from **Portugal (Daniel Simões)**, **Georgia (Ketevan Stvilia)**, **the Republic of Moldova (Igor Condrat)** and **Luxembourg (Carole Devaux)**.

In **Portugal**, a focus for harm reduction has been on integration beyond what are normally regarded as integrated services. There is a need not just to focus on health care services and needle exchange services but on the people themselves and the context of their lives. Responses must be comprehensive. Two examples from projects in Portugal were presented. IN-Mouraria is a low-threshold drop-in centre for people who use drugs; it is open all weekdays and free of charge. The centre offers peer support, escort to services, case management and social support. Another example is the NPISA case management network, which is a network of organizations and services working with homeless people in the city of Porto. The network enables personalized and shared case management at a city level. Since it is impossible for one organization or service to provide all necessary responses, well-structured network articulation maximizes access to an integrated response, tailored to each individual. Some key partners are still missing from the network, which limits some aspects of its response. Its experience, however, is that community involvement can make a difference in reaching people, bringing them to the services they require and keeping them there, as well as in identifying what is not working well in existing systems.

Questions prompted by Portugal's experience included discussion of data protection issues when working across institutions and organizations. It is an issue that has also caused much concern in Portugal; they have attempted to overcome it by remaining transparent, explaining to users the structure of services and the purpose of sharing data.

Decriminalization of drugs in Portugal was highlighted as one element playing a role in reducing the barriers that prevent reaching out to PWID, but it cannot stand alone. Decriminalization without provision of an adequate, comprehensive range of services, and without tackling stigma and discrimination, will not be enough.

In **Georgia**, the number of PWID is increasing, but HIV prevalence is stable at 2.3%. An HIV programme funded by the Global Fund includes a needle-and-syringe programme and an opioid substitution therapy (OST) programme. Coverage of the OST programme has been increasing since a transition to domestic funding that started in 2016. From 2020 Georgia will still be eligible for Global Fund resources but with a 50% reduction for both HIV and TB programmes. In response, Georgia has increased the state budget for OST and is



scaling up its response to HIV prevention among PWID. Challenges in moving to state funding include competition with other interventions that are being transferred to state funding; operating on fixed state budgets; further increasing the number of beneficiaries; and improving access to services while not compromising quality. Finally, there is a plan to get Global Fund support for a pilot programme to develop and test two new mobile OST clinics; expansion with the addition of two OST clinics; and testing an OST scheme in prisons.
Questions following the presentation clarified that one of the driving forces behind the harm reduction programme is prevention of hepatitis C virus (HCV). Integrating HIV prevention among PWID with other prevention programmes has been an effective way of aligning government and community interests. Presentation of evidence, including cost–benefit data, has resulted in good outcomes that are aligned with the interests of several different parties involved. Through this effort, it has been possible to secure higher government commitment to HIV and harm reduction.

In the **Republic of Moldova**, approximately 6% of new HIV cases are among PWID. Harm reduction services, which began in 1999, are offered to PWID, sex workers and MSM. The epidemiological situation varies greatly across the country, with a significantly higher HIV incidence on the left bank of the Dniester river (44.8 per 100 000). In recent years, harm reduction services, including OST, have been scaled up so that, since 2017, services in the civilian sector and penitentiary institutions have been supplemented by two mobile clinics and services provided by two commercial pharmacies. Scale-up has also included introduction of community-based HIV testing with rapid tests, gender-specific activities and management of overdoses.

Questions following the presentation touched upon OST services in prisons and ensuring that prisoners receiving OST are not lost once they are released. In the Republic of Moldova, this task is primarily undertaken by civil society organizations.

Finally, **Luxembourg** presented their national strategies to improve harm reduction services and decrease HIV and hepatitis infections. Harm reduction services are in general highly developed, diversified, decentralized and available in prisons, and they include OST. The main challenges include the large number of people migrating in and out of Luxembourg every year; an increase in people who inject cocaine; and a very high HCV prevalence in PWID of 75%. The country has a national surveillance committee on HIV, viral hepatitis and STIs and several national action plans. Both health and harm reduction services in prisons are highly developed, and a stay in prison is regarded as an effective opportunity to test and treat a group of patients or PWIDs who otherwise have very limited access to therapy. Innovations such as a safe tattoo project in prisons were launched in 2017. However, prevention services for prisoners and linkage to OST prescribers after discharge from prison should be further strengthened, as should opening of prisons to NGOs and other services and reintegration of prisoners into the community after release.

Questions following the presentation enquired about separate (rather than joint) strategies for HIV and viral hepatitis. Luxembourg hopes to move towards a joint plan, but in order to showcase the viral hepatitis problem to policy-makers, it has been effective to have a separate and specific viral hepatitis strategy.

In addition to the country presentations, the Joint Action on HIV and Co-infection Prevention and Harm Reduction (**HA-REACT**) was presented by **Blanca Iciar Indave Ruiz**. HA-REACT addresses existing gaps in the prevention of HIV and other coinfections, especially TB and viral hepatitis, among PWID. The three-year project was launched in late 2015 with core funding from the EU and is implemented by 23 partners in 18 EU Member States. Twelve collaborating partners contribute additional expertise, among them ECDC and EMCDDA. Latvia, Lithuania and Hungary have been selected as focus countries. One of the eight work packages focuses on scaling up harm reduction and aims to: (1) assess PWID epidemiology and harm reduction interventions; (2) identify the requirements of, and barriers to, harm reduction implementation; (3) provide a training package for care providers and policy-makers on key interventions, including face-to-

face training, guidelines and manuals; and (4) provide direct support to harm reduction interventions. Progress towards each objective is available in the slides from the session on harm reduction.

In the concluding discussions of the parallel session on harm reduction, the following issues were discussed:

Decreasing Global Fund support for harm reduction

- Many EECA countries have, to some degree, supported and implemented harm reduction programmes because it was "the right thing to do" and because the Global Fund has provided financial support. However, with the Global Fund withdrawing, there is a pressing need to be strategic and demonstrate the life-saving effects of these programmes, in order to persuade all health ministries and every city administration of the importance of both sustaining and scaling up harm reduction services.

Easy access to tools and programmes

- There are many tools and much experience in the European Region that countries can learn from and use; however, these are not always easy to find. The European Commission Staff Working Document will help to make these resources more widely available, as will WHO's forthcoming publication on good practices in HIV in the European Region and EMCDDA's portal on best practices.

Need for harm reduction services to also address TB

- PWID are known to be at high risk of both contracting and dying from TB. However, this has been missing from many discussions and should be included in future strategies on harm reduction.

3.3 Main messages and action points from the session

- Once published, the results and data from the European MSM Internet Survey 2017–18 (41 country-level datasets) will be open to anyone interested in using them for further analysis.
- It is important that countries share their experiences of introducing PrEP and scaling up harm reduction services, using the platforms that already exist to share experiences as well as forthcoming documents such as the EC Staff Working Document and EMCDDA's portal on best practices.
- Pre-exposure prophylaxis (PrEP)
    - WHO strongly recommends the use of PrEP as part of combination HIV prevention and includes it in the updated WHO consolidated ARV guidelines and the WHO model list of essential medicines.
    - Formal PrEP roll-out is slow in the European Region, but significant informal PrEP use occurs; there is a need to scale up PrEP services.
    - It is necessary to sensitize all stakeholders on the need to harmonize PrEP monitoring.
    - With the support of ECDC and WHO, countries are encouraged to share information on how they are monitoring PrEP, or planning to do so.
    - Ensuring access to PrEP for migrants has proved to be a challenge; social and health needs, including STIs and contraception, need to be taken into account.
    - PrEP service delivery can be a gateway to STI services, presenting an opportunity to optimize STI case management in people at risk of HIV and other STIs.

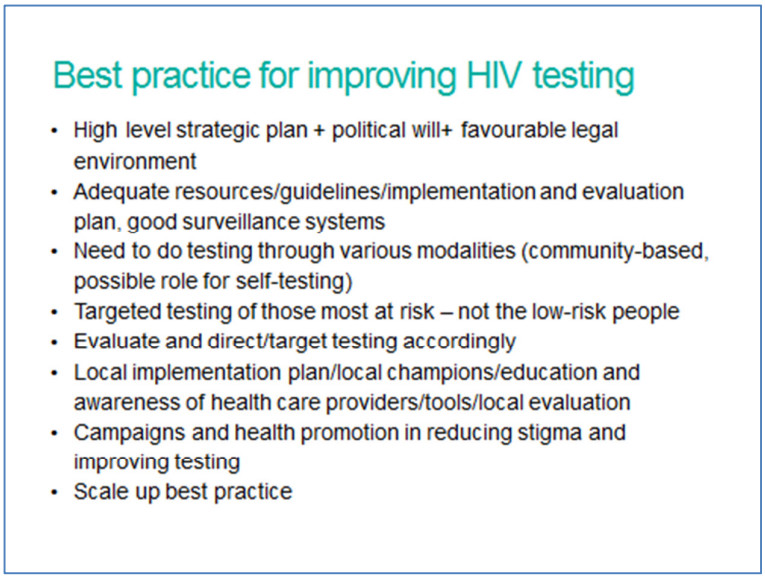
- Harm reduction
    - Data on the number of PWID in Europe are incomplete (available for 16 of 30 countries) and need improvement.
    - There is a need to scale up harm reduction interventions, improve monitoring and empower PWID to prevent infections.
    - Integration of harm reduction with other services, including in prison settings, is a key challenge.
    - Community involvement can make a difference in reaching people, bringing them to the services they require and keeping them there, as well as in identifying what is not working well in existing systems.
    - Decriminalization can play a role in scaling up coverage of harm reduction, but it is not sufficient on its own.
    - New drugs and new situations with changing drug user profiles require innovative responses.
    - Harm reduction programmes continue to be unsustainably funded in many countries. National and local governments need to be convinced of the importance of funding such programmes. Integrating HIV prevention among PWID with other prevention programmes, such as hepatitis C, can be an effective way to align government and community interests.
    - TB should be included in future discussions of harm reduction strategies, as PWID are known to be at high risk of both contracting and dying from TB.

4. HIV testing

The main objective of Session 4 was to share successful HIV testing practices and to discuss how to improve measurement and implementation of HIV testing programmes.

Valerie Delpech (Public Health England (PHE)) gave a general presentation on challenges and best practices for improved HIV testing in the WHO European Region. Her presentation included preliminary data from the Dublin Declaration 2018 monitoring round. Levels of testing have improved; however, there is still a problem with late diagnosis, and in the eastern part of the Region there are still high levels of undiagnosed infections, which also lead to high proportions of late presenters.

To improve testing in the Region, we need to include the message "Undetectable equals Untransmittable" (U=U) in public health messaging, etc. The latest evidence on strategies to increase uptake and coverage of HIV testing is given in a systematic review of literature for 2010–2017, implemented by PHE, the Centre of Excellence for Health, Immunity and Infections (CHIP), the St Stephen's AIDS Trust and ECDC to inform forthcoming ECDC guidance on HIV and hepatitis testing. Its key finding is that there is a variety of interventions aimed at increasing HIV testing implemented in the EU/EEA, but that there are few studies published from eastern Europe. Another finding is that, due to a lack of before-and-after data, there is limited ability to show improvement in testing following interventions. An overview of key elements of best practices for improving HIV testing is presented in the slide to the right.



So what works? Test-and-treat and PrEP walk-in clinics have proven to be effective in Amsterdam, Kyiv, Paris and London. It is important to follow the core principles: (1) know your local epidemiology; (2) implement and evaluate; (3) record best practice; (4) adapt; and (5) scale up. The challenge is to persuade policy-makers to follow these principles. In this context, surveillance officers and public health practitioners are crucial in providing the necessary evidence; however, it is exactly these people who tend to be isolated. Surveillance officers are essential to continuously assess if the right people are being tested. New testing methods such as self-testing and home sampling (in the United Kingdom) offer choice and represent new ways of ensuring that the right people are being tested. Finally, there is a need to continue to address stigma. A stigma survey such as "Positive Voices" carried out in the United Kingdom provided valuable insights.

Throughout the presentation, the OptTEST website was recommended as a useful source to pull together materials to convince policy-makers of the importance of HIV testing. It provides links to tools, national resources and documents on HIV testing from the countries involved in OptTEST.

Ann Sullivan (INTEGRATE) introduced the participants to the working group sessions with the question of how to make better use of available data to inform expanded HIV testing. The objective of the working

group session was to discuss the data sources used to inform and target HIV testing programmes with a view to increasing the effective coverage of such programmes in the WHO European Region.

In order to effectively apply the WHO's Consolidated guidelines on HIV testing services and the forthcoming ECDC guidance on HIV and hepatitis testing in the European Region, the working group discussed to what extent routinely collected programme data from HIV testing sites and HIV case notification data are available and might be used to better inform and strengthen HIV testing programmes.

The main points raised in the four groups are summarized below:

- New diagnosis data are available for all countries.
- Late diagnosis, avidity testing results, positivity rate and local testing data are in place for most countries; however, it is not always possible to disaggregate these by key population and geographical area.
- Countries found these indicators useful, although most are not routinely using them and it was difficult to agree on absolute thresholds.
- Most countries thought that it would be feasible and useful to add a "site of test" variable to TESSy reporting; however, categories may need consideration as they may mix site and reason for testing and who orders the test and where it is performed. It was suggested that "self-testing" and "self-sampling" should be separated and that "pharmacy", "laboratory" and "abroad" should be added as categories.
- It is necessary to specify if we are talking about the first reactive test or the first confirmatory test.
- It was suggested that an indicator should be added which captures the gap between the current test and the most recent negative test, possibly operationalized through "date of last negative test".

The session on testing closed with a plenary keynote presentation by Jens Lundgren (CHIP), who shared his views on the way forward for improved HIV control in the WHO European Region, focusing on testing and treatment. There has been significant progress on all fronts of HIV control in recent years, with more and more robust scientific evidence available. However, despite 30 years of HIV testing, we have still not got it right. The focus has mainly been on limiting transmission and less on improving the health of PLHIV. To get it right, we need to focus more on the overlap between HIV testing and its linkage to care. We know that PrEP works, yet it is not fully integrated as a part of preventive packages. We also know that in many countries there is an unmet testing need. A testing programme is working well if it detects one positive person for every 1000 tested. If fewer people are detected, then we are probably testing the wrong people. To reach those most at risk, we need to diversify and intensify testing approaches. Self-testing and lay provider testing are good examples. Treatment coverage is still lagging behind in some countries, especially in EECA countries. We need to optimize linkage to and retention in care and to integrate social and medical support structures. We also need to continue to optimize ART and to ensure that we use highly effective and low-cost ART. Finally, all countries are encouraged to continue to do research, given that health policy driven by evidence works.

4.1 Main messages and action points from the session

- There has been significant progress on all fronts of HIV testing and control in recent years and an increasing body of scientific evidence is available.

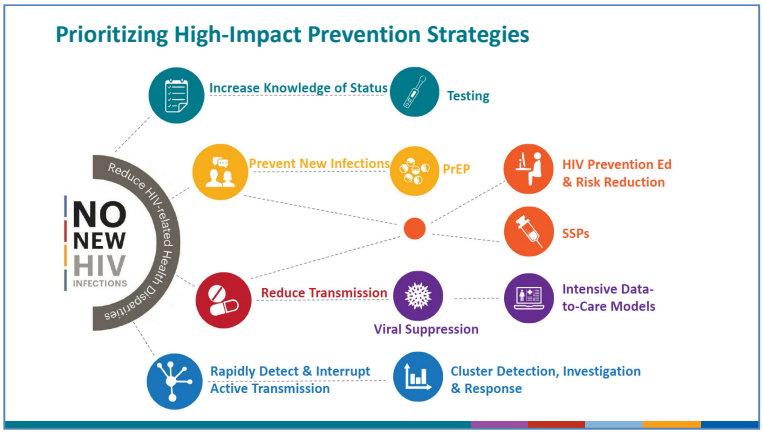
- A variety of interventions aimed at increasing HIV testing have been implemented in the EU/EEA, but few studies from eastern Europe have been published.
- HIV testing should follow the core principles: (1) know your local epidemiology; (2) implement and evaluate; (3) record best practice; (4) adapt; and (5) scale up.
- An HIV testing programme is working well if one positive person is detected for every 1000 tested.
- The focus has mainly been on limiting HIV transmission, less on improving the health of PLHIV; there needs to be more focus on the overlap between HIV testing and the linkage to care.
- The collaboration between ECDC and WHO on HIV surveillance is good and welcomed by countries; real progress has been made in reporting on late diagnosis at European level.
- Surveillance experts and public health practitioners play a central role in providing the necessary evidence to inform and convince policy-makers; however, in many countries surveillance experts are too isolated.
- Collecting data on site of testing would be useful, but the list of sites and definitions needs to be revisited.
- We need to make sure that we are testing the right people and continue to diversify and intensify testing approaches, including through self-testing.
- The OptTEST website is a useful source to pull together materials to convince policy-makers of the importance of HIV testing.

5. Measuring the number of people living with HIV (PLHIV)

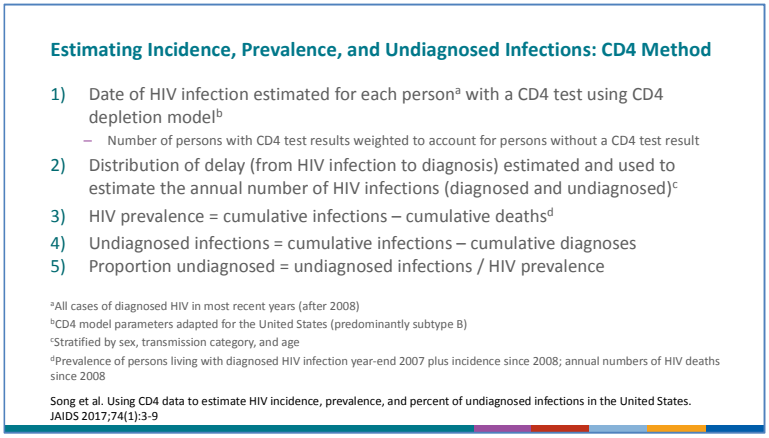
The fifth session focused on "the first 90" with the objective of assessing how to improve HIV case surveillance and how estimates guide HIV response.

Irene Hall (US Centers for Disease Control and Prevention (CDC)) started the session with a keynote presentation on the use of surveillance data to monitor and inform HIV prevention programmes in the United States. With an estimated HIV incidence of 38 500 in 2015, the number of new infections has been decreasing since 2010, primarily among heterosexuals, and it is estimated that 15 800 cases have been averted, with an estimated saving of US$ 7.6 billion. The highest incidence is found among MSM and, by ethnicity, among blacks/African Americans. Geographically, the southern states bear the greatest burden of HIV. It is estimated that 1.1 million people are living with HIV, of whom 85% are diagnosed, 62% are in receipt of care, and 49% have achieved viral suppression.

Prevention includes four high-impact prevention strategies as shown in the illustration below.



To estimate incidence, prevalence and undiagnosed infections, the CD4 method described in the slide below is applied.

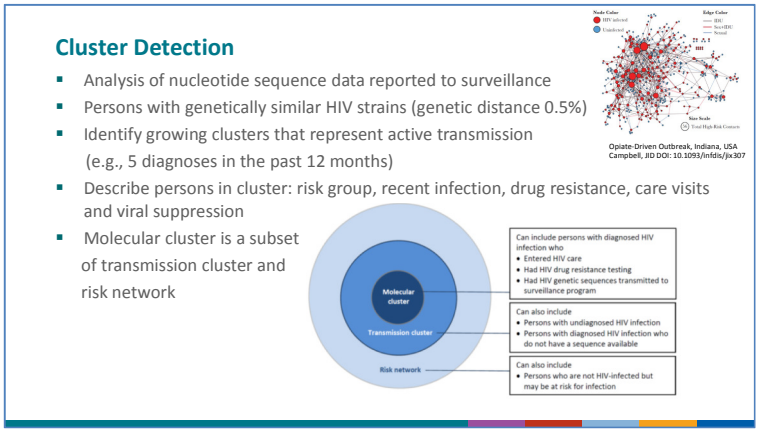


It is estimated that about 40% of new HIV cases are people who do not know their HIV status. There are many missed opportunities to test people at high risk – it is estimated that seven in 10 people at high risk who were not tested for HIV in the past year saw a health care provider during that time. More than 75% of them were not offered a test.

To estimate the number of people with indications for PrEP and PrEP coverage, national behavioural surveys, pharmacy data on PrEP prescription and HIV surveillance data are used. It is calculated that 1.1 million people have indications for PrEP and that 8% are prescribed it; however, there are disparities by jurisdiction and race/ethnicity. The need for PrEP is confirmed by the fact that more than 40% of new HIV infections are assessed to be transmitted by people who know they have HIV but are not virally suppressed. HIV surveillance data are used to support the HIV care continuum and to monitor health outcomes.

The newest approach to rapid detection and interruption of active HIV transmission is cluster detection, described in the slide below.

In conclusion, there is encouraging, but uneven, progress in reducing the number of annual HIV infections in the United States. The HIV prevention toolbox is better than ever – viral suppression and PrEP are game changers and the goal of no new infections seems within reach.

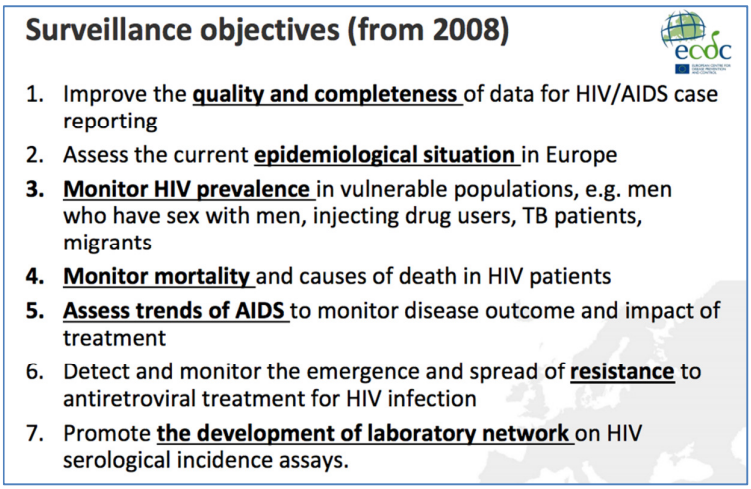


Questions and answers included:

- It is a challenge to track care of individuals who move from one state to another or receive care in another state. A new system put in place by CDC has introduced a "black box" where confidential data sent by the individual states are merged and returned to the states and indicated in the surveillance system. This is helping to identify and remove duplicates.
- Despite progress, the United States have not yet reached the 90–90–90 targets. Although much treatment is covered by the government, the fractured health system and the lack of trust in the system may make some people reluctant to get tested and receive care. Viral suppression might be underestimated, but regardless there is still a need to do more to reach the UNAIDS targets.
- Calculations of the savings made from reducing the incidence of HIV are based on a health economists' estimate of a lifetime cost of US$ 450 000 for a person infected with HIV.

Over the past 10 years WHO and ECDC have successfully collaborated on HIV surveillance in the WHO European Region. **Anastasia Pharris (ECDC)** illustrated what has been achieved since 2008.

Almost all countries (50/53) in the Region report data and have set up functioning HIV case-based surveillance systems.



A set of surveillance objectives was agreed upon in 2008 and has not been revised since then. An evaluation of the surveillance system performed with EU countries (the EU/EEA Surveillance System (EPHESUS) project) gives some insights into the extent to which the objectives have been achieved and if they need to be revisited.

Based on the evaluation, the following recommendations were made:

(1) Retain routine HIV case surveillance: "there is no more efficient and effective alternative".
(2) Review the list of variables collected (e.g. related to HIV drug resistance and future relevance of AIDS surveillance).
(3) Make strategic decisions regarding:
    a. amount of follow-up clinical data to collect;

b. usefulness of introducing an HIV laboratory network.

(4) Joint European HIV surveillance by ECDC and the WHO Regional Office for Europe has many advantages and should be continued.

Using case surveillance data for modelling is facilitated by the ECDC HIV Modelling Tool which can be used to estimate the annual number of new infections, the time between infection and diagnosis, and the size of the undiagnosed fraction.

Areas for improved surveillance and modelling estimates include migration-related issues, mortality, data missingness and reporting delay.

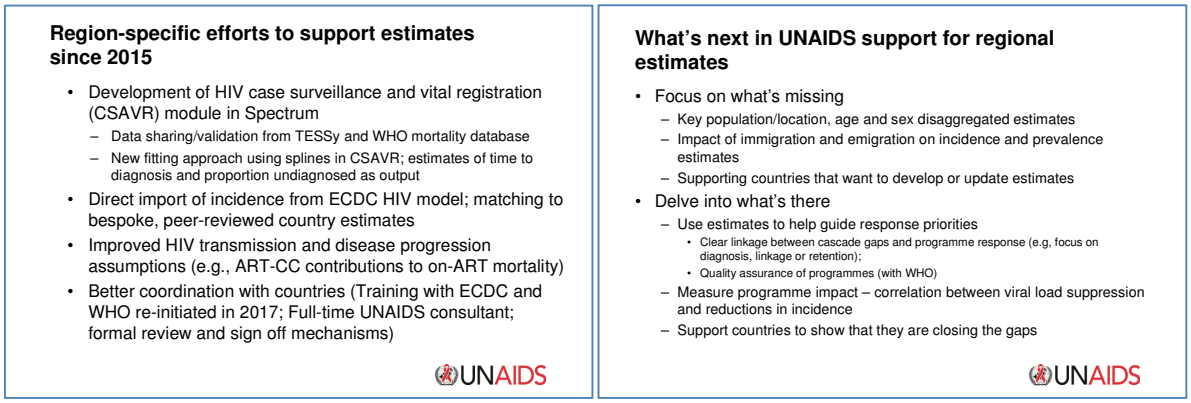
In conclusion, the European HIV/AIDS surveillance network has made substantial progress in expanding robust case surveillance in the Region. The collection of mortality data and longer-term clinical variables should be reviewed. The possibilities for modelling have expanded, leading to improved variable completeness, and data on mortality will further improve estimates. Finally, the network's surveillance objectives could be reviewed with respect to inclusion of modelling and continuum-of-care indicators and HIV drug resistance surveillance.

Questions and answers included:

- Mortality data presented in the 2017 ECDC/WHO HIV/AIDS surveillance report are underestimated, partly as a result of underreporting but also because of difficulties linking surveillance registries with national vital statistics registries. Other challenges include that people with HIV who die from other causes are hard to distinguish from those who die from AIDS-related causes.
- The EC's new legal framework General Data Protection Regulation has given rise to concern in some countries about its consequences for HIV reporting. ECDC is aware of the concern and is consulting with its legal advisers to make a statement on the issue. It is reckoned that it will not have consequences for reporting to TESSy, but could have implications at national and local levels where data are collected (and not just for HIV data).
- To ensure ownership and representativeness of the evaluation of the joint ECDC/WHO surveillance system, it would be beneficial to seek input also from non-EU countries.
- Training on the use of TESSy is no longer done systematically, in part because fewer countries are struggling with the system; but it might be worth revisiting this and perhaps reinstating online TESSy training materials, both in response to staff turnover in countries and for countries who are not currently reporting.

Kimberly Marsh (UNAIDS) gave a presentation on the status of the HIV estimates process at global level and how HIV estimates support the HIV response. The global HIV estimation process is important to monitor countries' commitments to the 2016 SDGs and the 2016 High-Level Meeting on Ending AIDS. Estimates play a key role in advocating for resources and ensuring they are sufficient and used efficiently; they also inform national strategic planning for prevention and care services. The global estimation process helps ensure comparability across countries, transparency, quality assurance and accessibility (through www.aidsinfo.unaids.org).

Current UNAIDS support and next steps in supporting HIV estimates in the WHO European Region are described in the two slides below.



Questions and answers included:

- The published data on HIV prevalence only include age groups up to age 50. Estimates for all age groups, including 50+, are available as an output from the SPECTRUM estimation package and can be obtained by contacting UNAIDS directly (they are not currently available on AIDSinfo).
- Despite movements at many levels to integrate efforts across diseases, rising trends of HIV/TB and HIV/HCV coinfections, and existing international indicators on coinfections, it is striking how vertical surveillance systems are. Involving people from the TB community, perhaps through a small working group, could be useful to explore possible linkages and integration.
- Being in an elimination phase for both HIV and TB, it is important that we link the two communities. To make this link at a national level, it is important to have international recommendations and to discuss how international agencies such as UNAIDS can support this linkage.

Experiences with modelling HIV incidence and the undiagnosed fraction were presented for three countries.

Ard van Sighem (Netherlands) presented the country's progress in estimating the number of people living with undiagnosed HIV. Overall, the Netherlands is well on track to meet the 90–90–90 targets. One main trend is a decrease in the number of newly diagnosed HIV infections over the most recent years. As in most countries in Europe, the total population of PLHIV is both increasing and aging; so, whereas in 1996 approximately 10% of people in care were 50 years of age or older, by 2016 this proportion had increased to 46%. Over the past 20 years, the median CD4 cell count at time of diagnosis has increased; in 2016 it was 380 cells/mm^3. Finally, PLHIV start ART increasingly earlier after their HIV diagnosis.

Common issues and barriers that many countries face when using the ECDC tool relate to mortality and migration. Thus, mortality data are often incomplete and sometimes only AIDS deaths or deaths close to time of diagnosis are reported. If you know the number of PLHIV who are in care, it is possible to get around the data incompleteness. For migration, before using the modelling tool it is necessary to exclude migrants who are already on treatment. If the aim is to estimate the number of newly acquired HIV infections in a country, migrants who are aware that they have HIV should also be excluded, otherwise the estimates will be biased. Immigration is reasonably well recorded in surveillance, but data on emigration are often not available, although, again, one could get around this by using other estimates of the size of the diagnosed population in care. Finally, the ECDC HIV Modelling Tool makes estimates of the undiagnosed population regardless of whether people are already living in the country for which estimates are obtained.

Hristo Taskov (Bulgaria) presented the country's experience with transitioning from using Integrated Biological and Behavioural Surveillance (IBBS) data to case surveillance data for estimates and projections of HIV infection. Estimates and projections of HIV infection were made from 2006 to monitor implementation of the National AIDS Programme (2001–2007) and the Global Fund grant (2004–2007); subsequently, the estimates and projections were used to prepare, monitor and evaluate the National AIDS programmes and Global Fund grants. The main challenges in making these estimates and projections relate to key populations, which in Bulgaria are MSM and PWID. The ECDC HIV Modelling Tool does not generate projections and the CSAVR (case surveillance and vital registration) model in SPECTRUM does not generate results for subpopulations. In the transition from using IBBS data to case surveillance data, they are – with support from UNAIDS and ECDC – looking for models appropriate for case surveillance data in a concentrated epidemic with outputs for key populations.

Finally, **Andre Sasse (Belgium)** presented the country's experience with modelling HIV diagnoses to estimate the prevalence of unreported mortality and migration and the challenges they present. If all reported HIV diagnoses are included in the model, there is a risk of overestimating the HIV prevalence. Using the Kaplan–Meier method to estimate survival, they attempted to take into account emigration and unreported deaths. The calculation was done by ethnicity.

The conclusion to be drawn from Belgium's experience is that taking into account emigrations, unreported mortality and unrecognized duplicates has a crucial effect on prevalence estimates. It is also clear that work is still needed to perfect the method.

5.1 Main messages and action points from the session

- Substantial progress has been made in national surveillance systems and reporting to ECDC/WHO over the past 10 years. However, we need to make sure that data are not just provided but also used at national and local level to plan, adjust and implement interventions.
- The 2008 objectives for ECDC/WHO HIV/AIDS surveillance should be revisited.
- With rising HIV/TB coinfections in the Region and growing political awareness of the need to integrate services across infectious diseases, it is necessary to explore ways to achieve better linkage and integration.
- The ECDC HIV Modelling Tool is being used by many countries but does not yet allow optimal management of unreported mortality and migration; it also lacks options for making forward projections.
- Taking into account emigrations, unreported mortality and unrecognized duplicates has a crucial effect on prevalence estimates.
- There is a need to continue ECDC/WHO training on HIV surveillance and modelling and to ensure availability of online TESSy training materials.

6. Treatment, viral suppression and mortality

The sixth session focused on the "second and third 90s", with the objective of discussing how to improve measurement and implementation issues for HIV treatment and viral suppression. The session was divided into two parallel sessions.

6.1 Measurement issues related to treatment and viral suppression (parallel session)

In the past couple of years there has been a rapidly changing landscape in measuring treatment and viral suppression. These changes include:

- development and publication of standardized definitions of the continuum of care;
- a clear move by countries to implement guidelines recommending initiation of treatment as soon as HIV is diagnosed; and
- the ability of more countries to provide continuum-of-care data – even when they do not have cohorts, they are using other methods such as clinical audit of services.

Overall ART coverage is increasing and more people are virally suppressed. However, good overall figures can mask inequalities, both between and within countries, as well as among different age and risk groups.

Caroline Hurley presented **Ireland**'s experiences using clinical audits as a method to assess the number of diagnosed PLHIV on treatment and viral suppression. Clinical audits were used to assess:

- if the proposed adapted definitions are feasible for Ireland;
- the level of current practice in Ireland with respect to provision of ART for all PLHIV in line with national policy; and
- the level of viral suppression being achieved.

Data collection is described in the slides from the session distributed to all meeting participants. In conclusion, it was found that nationally agreed definitions enabled standardized monitoring of the HIV continuum across Ireland. It was also found that clinical audit allowed accurate data on ART and viral suppression to be collected in those attending HIV services. And finally, audit demonstrated that those attending HIV services in Ireland are doing very well. Based on these findings, an HIV outcomes register would ease and improve monitoring of the continuum of care in Ireland.

Alison Brown (PHE) gave an overview of treatment and viral suppression in Europe. The presentation included data on ART coverage in EECA, but since it was based on provisional Dublin 2018 data, they are not included in this report. The overall conclusions included that ART coverage and viral suppression appear to be improving in Europe and central Asia. Improvements seem to be driven by changing ART guidelines. However, high performance overall can mask substantial inequalities within regions and between populations.

Finally, **Virginie Supervie (France)** presented improved measures for the HIV continuum of care: time to treatment and viral suppression. Attention has focused on the cascade of HIV care. The cascade of care, which is a cross-sectional snapshot of ART uptake and viral suppression coverage, may, however, fail to identify gaps in the care continuum. High levels of ART uptake and viral suppression coverage can hide poor engagement in care for individuals infected in the recent past. It is also important to examine the time

between steps in the continuum of care, and the factors associated with delays. In general, the majority of people are not really lost to follow-up but may take longer to progress through the various stages.

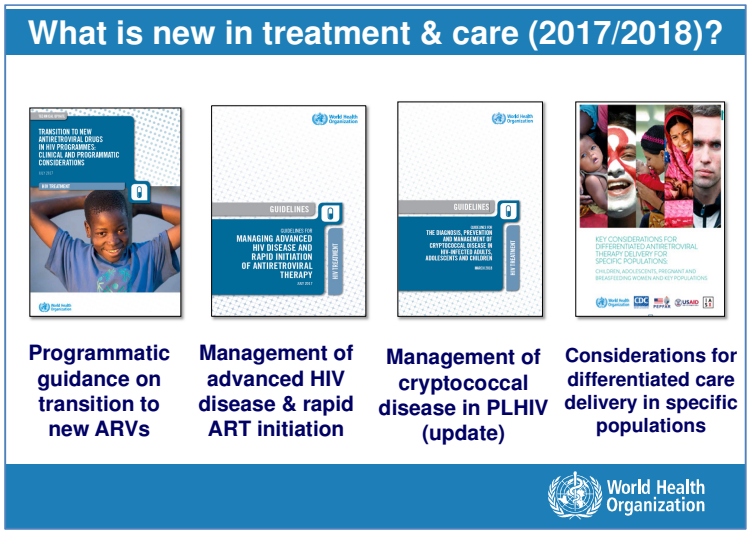
Findings from a systematic literature review revealed that:

- there is a growing interest in measuring time intervals between steps of the care continuum;
- delays in ART initiation and viral suppression are mainly driven by delays in HIV diagnosis;
- only a few studies measured the time to ART initiation or viral suppression;
- median time from HIV infection to diagnosis is around 3 years, and time from HIV infection to ART initiation is over 3 years;
- treatment eligibility expansion has contributed to reducing time from HIV diagnosis to ART initiation or viral suppression;
- besides accessing ART and reaching viral suppression, it is also important to maintain viral suppression.

6.2 Treatment implementation issues (parallel session)

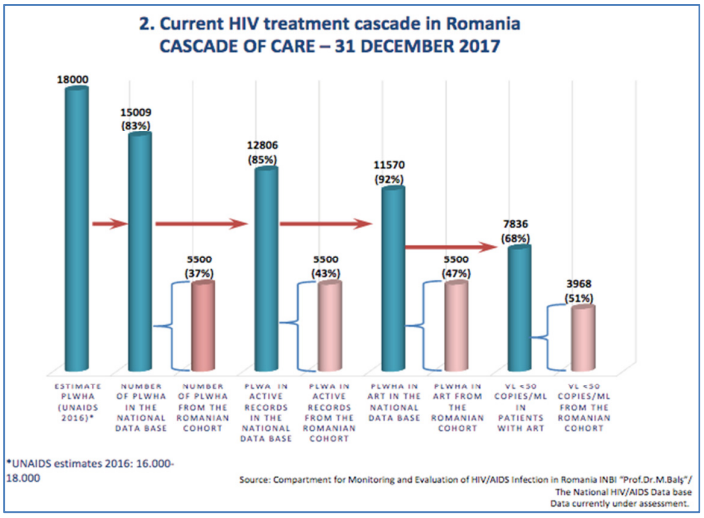
Marco Vitoria (WHO) gave an overview of new developments in global WHO HIV treatment and care guidance. An overview of major publications is given below.

Key points in the presentation included:

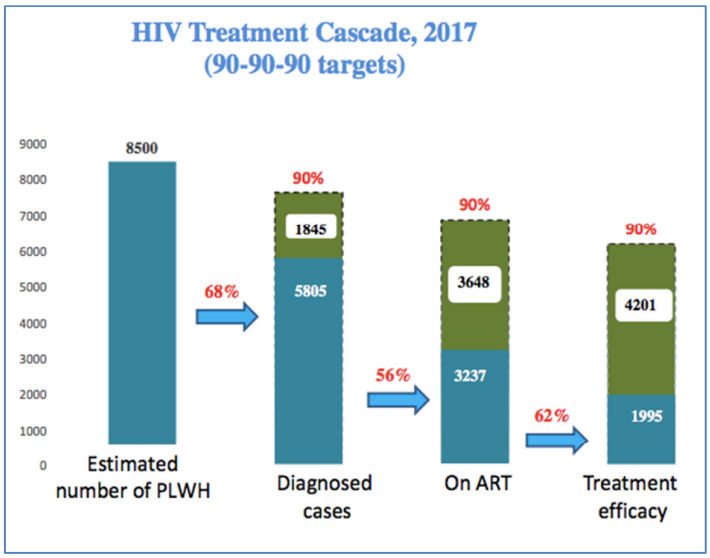


- To optimize treatment, it is recommended to include dolutegravir (DTG) in first-line regimens as it acts faster and is less toxic, more robust and cheaper.
- Pre-treatment resistance to non-nucleoside reverse-transcriptase inhibitors (NNRTIs) is increasing.
- It is recommended to change to new ARVs. WHO offers support through:
    - updated guidelines to be released in July 2018;
    - tools for monitoring drug toxicity and HIV drug resistance (HIVDR);
    - advice on how to phase in new drugs;
    - affordable access, e.g. demand forecasting;
    - sharing of country experiences;
    - technical support for HIVDR, toxicity monitoring and safe introduction of DTG and other new ARVs.
- WHO has recommendations on management of advanced HIV disease, rapid ART initiation, management of cryptococcal disease in PLHIV, as well as guidance on differentiated care in specific population groups.

Mariana Mardarescu gave an overview of the HIV epidemic in **Romania**, which is characterized by a cohort of long-term survivors and a new wave of young heterosexual adults, MSMs, IDUs and 2% mother-to-child transmission (MTCT). The overall HIV incidence is 2 per 100 000. The current HIV treatment cascade is seen in the graph on the right. A historic overview of the national programme efforts for PLHIV explained how an epidemiological situation arose in which a large group of long-term survivors are receiving different treatment schemes. A short overview of the current standards of care and perspectives in Romania was also presented; standards for MTCT, ART, IDUs, comorbidity and aging people were highlighted. New challenges include how to handle risk populations and how to adapt national efforts to risk groups' needs.



Next, the country experience of **Kyrgyzstan** was presented by **Aibek Bekbolotov**. The treatment cascade is shown in the graph to the right. The presentation also included the findings from a study on adherence to ART, which has been a problem in Kyrgyzstan and leads to low levels of viral suppression; it showed that adherence is 50.5%. In order to improve adherence, it was recommended to: (1) prescribe the single-tablet regimen of combination drugs; (2) provide quality counselling on ART; and (3) focus on individuals younger than 40 years of age and users of psychoactive substances.



Finally, **Liudmyla Maistat** gave an insight into the **Medicines Patent Pool (MPP)** and its licences in EECA, explaining how it has helped, and can continue to help, secure ART at lower prices. Some of the key accomplishments of the MPP include 13 HIV medicines and one HIV technology platform licensed; 130+ ongoing pharmaceutical development projects; 14.6 million patient years and 5.3 billion doses of treatments delivered through MPP's generic partners; and US$ 391 million saved.

Issues raised in the presentation and discussions included:

- Although international guidelines on HIV treatment differ in detail regarding which drugs to use, their main message remains clear: "treat all and treat fast".
- However, following the continuously shifting landscape of international guidelines is a challenge to EECA countries and requires capacity to develop multiple implementation strategies.

- Development of the Medicines Patents and Licences Database (MedsPal) aims to initiate benchmarking in which drugs to use, giving over 130 resource-constrained countries access to highly potent and low-toxicity ARVs.
- Cost–effectiveness is an important factor when countries choose their national approach to scale up ART towards their ART coverage targets (because country incomes and resources are different).
- The main goal in all countries across the Region should be to test PLHIV in a timely manner to allow rapid initiation of treatment, to accelerate efforts to increase ART coverage, and thus to ensure effective treatment that allows those on ART to achieve viral suppression – i.e. to reach the second and third 90s: to reduce AIDS rates and AIDS-related deaths.

6.3 Main messages and action points from the session

Measuring treatment and viral suppression

- Overall ART coverage is increasing and more people are virally suppressed; improvements seem to be driven by changing ART guidelines.
- However, good overall figures can mask inequalities, both between and within countries, as well as among different age and risk groups.
- The continuum of care is important not only as a cross-sectional snapshot of ART treatment and viral suppression; it is also important to examine the time between steps in the continuum of care, and the factors associated with delays. In general, the majority of people are not really lost to follow-up but may take longer to progress through the various stages.

Treatment implementation

- The main goal in all countries across the Region should be to test PLHIV in a timely manner to allow rapid initiation of treatment, to accelerate efforts to increase ART coverage, and thus to ensure effective treatment that allows those on ART to achieve viral suppression.
- A continuously shifting landscape of international guidelines is a challenge to EECA countries and requires capacity to develop multiple implementation strategies.
- The MPP has played an important role in making HIV drugs available at affordable prices; countries should be aware of the licences that are currently available and stay updated as new licences are added.

7. European cafés

In addition to the plenary sessions and workshops, two European cafés of approximately one hour each took place during the three-day meeting. The objective of the cafés was to provide opportunities for smaller groups of people with interest in a specific topic to learn more about it and discuss it in depth. At each café, four topics were presented simultaneously by one or more presenters in four different rooms, and each meeting participant could choose to attend the café topic of greatest interest to them. The four topic presentations were repeated twice over the one-hour period, allowing each participant to attend two topics during each café.

The first European café was attached to Session 4 and focused on innovative approaches to HIV testing in the WHO European Region. This café covered the following four topics:

- Community-based testing (Daniel Simões, Portugal, and Viktor Liashko/Ihor Kuzin, Ukraine)
- Self-testing (Susan Cowan, Denmark, and Sniazhana Biadrytskaya, Belarus)
- Indicator-condition testing (Ann Sullivan, INTEGRATE)
- Using European Testing Week to enhance testing activities (Dorthe Raben, HIV in Europe).

The second European café was part of Session 5 on measuring the number of people with HIV and focused on four HIV surveillance-related topics:

- Tools to address missingness and reporting delay (Magdalena Rosinska, Poland, and Chantal Quinten, ECDC)
- Electronic data linkage (Florence Lot, France; Helena Cortes Martins and Isabel Aldir, Portugal; Otar Chokoshvili, Georgia)
- Piloting recency testing for surveillance (Derval Igoe, Ireland)
- HIV drug resistance surveillance (Eeva Broberg, ECDC).

8. Summary and closing

The three-day meeting was closed with a plenary discussion where session rapporteurs of the six technical sessions shared their reflections on the main outcomes of each session. A summary of the reflections is given below.

Session 2 Scaling up the HIV response: the Fast-Track Cities initiative (Bertrand Audoin)

- Fast-Track Cities is not a one-size-fits-all initiative; it needs to be adapted to local needs, the composition of stakeholders, etc.
- The initiative helps to bring together cities with different problems around the same objectives.
- The level of detail of data is very diverse – some cities have local disaggregated data, others have to interpret on the basis of national data. More work is needed to make disaggregated data available for cities to use. City-level data would bring added value to the initiative.
- The mantra needs to be: know your epidemic. We need to know our epidemic also at local/city level, and to do that, we need data.
- The meeting has been excellent in showcasing and sharing the various approaches taken by different cities.

Session 3 Prevention (Ioannis Mameletzis and Ganna Dovbakh)

Pre-exposure prophylaxis (PrEP)

- There are several good examples of how countries are adopting recommendations on PrEP.
- The overall trend is that the WHO European Region is moving from informal to more formal uses of PrEP.
- We need to know our PrEP use – to do that we must monitor.
- The many country presentations in this session (and throughout the whole meeting) have been useful and inspiring; they are a good way to share experiences between countries and cities within the Region.
- It is important that we all continue to share experiences with PrEP implementation and monitoring.

Harm reduction

- The compendium on best practices is useful and much needed.
- Integration of harm reduction is about much more than HIV. For example, basic social care services are an essential part of a successful harm reduction initiative.
- The role of testing and treatment was discussed, as was the importance of involving the community in the planning and implementation of harm reduction services.
- Harm reduction in prisons is an important component of HIV and harm reduction.
- Criminalization and stigma are real barriers, and although decriminalization plays a role in removing stigma, it can and should never stand alone.
- New drugs, new drug users and new situations also demand innovations in harm reduction.
- Money is needed – harm reduction programmes are not funded at a sustainable level. We need to convince national and local governments to invest more in harm reduction.

Session 4 HIV testing (Yusef Azad)

- Real progress has been made in surveillance. We have better data reported on late diagnosis, success in collaboration and a general interest in collecting more data.
- There is great openness and engagement among countries, with an appetite to try out innovations in testing and to implement new testing methods.
- The Region is still challenged in going beyond the low-hanging fruit: we need to reach the target of a testing programme that finds one HIV positive for every 1000 people tested.
- We need to be better at using our data to secure more funding. Community clinicians need to know about data and surveillance people must help make the case why more funding is needed.

Session 5 Measuring the number of people living with HIV (Danijela Simic)

- The first stage of the cascade of care is to know how many you have. Mortality data are difficult to monitor.
- The first two 90s appear to be the most critical for all countries.
- We heard several success stories from many countries with good data.
- We need to use data, not just provide it: use it to plan and implement interventions.
- The next steps include improving surveillance data, especially in relation to mortality surveillance, and considering revision of some variables – this will be done over the coming months and years.
- There is a need to continue ECDC/WHO training on HIV surveillance and modelling and to ensure availability of online TESSy training materials.
- We also need to get input from EECA countries on the evaluation of surveillance.
- It is essential that we continue to do what this meeting has been all about – sharing good practices and best-case studies and experiences.

Session 6 HIV treatment and viral suppression (Derval Igoe and Justyna Kowalska)

<u>Measuring HIV treatment and viral suppression</u>

- Overall ART coverage is increasing and more people are virally suppressed. However, good overall figures can mask inequalities, both between and within countries, as well as among different age and risk groups.
- The continuum of care is important not only as a cross-sectional snapshot of ART treatment and viral suppression; it is also important to examine the time between steps in the continuum of care, and the factors associated with delays. In general, the majority of people are not really lost to follow-up but may take longer to progress through the various stages.

<u>HIV treatment implementation</u>

- International guidelines on HIV treatment differ in detail regarding which drugs to use, but their main message remains clear: "treat all and treat fast".
- A continuously shifting landscape of international guidelines is a challenge to many EECA countries and requires capacity to develop multiple implementation strategies.
- We learned about the great results of the MPP making drugs available at affordable prices – countries need to know that the tree is there and that there are apples to pick.

- Cost–effectiveness matters when countries come to choose a national approach to scaling up ART and reaching an appropriate ART coverage (countries incomes and resources are different).

After a brief plenary discussion, Masoud Dara and Andrew Amato closed the meeting by thanking the participants for productive and useful discussions, the ECDC and WHO technical and administrative staff for organizing the meeting, and finally the interpreters who had ensured simultaneous English and Russian interpretation throughout the meeting. The meeting ended but the work continues – 2018 provides many opportunities for sharing experiences and learning from each other. The 22nd International AIDS Conference which will be hosted in Amsterdam, from 22 to 27 July 2018, provides a special opportunity for the European Region, and especially for EECA countries, for whom a Ministerial Policy Dialogue on HIV and related comorbidities in eastern Europe and central Asia is being organized on 23 July 2018 by WHO, the Government of the Netherlands and UNAIDS.

Annex 1 Programme

MONDAY 23 APRIL 2018 **Location: Crowne Plaza, Potsdamer Platz, Berlin Room: post-Palais I–III**	
12:30–13:00	REGISTRATION
Session 1 Opening and welcome Chairs: Masoud Dara (WHO/Europe) and Andrew Amato (ECDC)	
Session objective: Set the stage and provide an overview of the regional response to HIV	
13:00–13:30	Welcome, meeting scope and main milestones since 2016 • German Ministry of Health (Ines Perea) • WHO (Masoud Dara) • ECDC (Andrew Amato)
13:30–14:00	Opening remarks by partners • UNAIDS (Tim Martineau) • European Commission (Jean-Luc Sion) • Civil society (Daniel Simões, European AIDS Treatment Group (EATG), and Vitaly Djuma, Eurasian Coalition on Male Health (ECOM))
14:00–14:30	Keynote presentation: Can Europe end AIDS? What will it take to get there? (Anton Pozniak, IAS)
14:30–15:00	**COFFEE**
Session 2 Scaling up the HIV response: the Fast-Track Cities initiative Chairs: Ines Perea (Germany) and Vinay Saldanha (UNAIDS)	
Session objective: How to translate global and regional goals, objectives and targets into local implementation plans	
15:00–15:30	Fast-Track Cities initiative (Bertrand Audoin, IAPAC)
15:30–16:30	Fast-Track Cities presentations • Amsterdam (Godelieve de Bree) • Kyiv (Oksana Naduta-Skrinnik) • Paris (Eve Plenel)
16:30–17:30	Panel discussion on Fast-Track Cities in Europe • Amsterdam (Godelieve de Bree) – London (Yusef Azad) • Kyiv (Oksana Naduta-Skrinnik) – Berlin (Christoph Weber) • Lisbon (Isabel Aldir) – Paris (Eve Plenel) • IAPAC (Bertrand Audoin)
19:30	ECDC and WHO-hosted dinner (Crowne Plaza, Potsdamer Platz)
TUESDAY 24 APRIL 2018	
Session 3 Prevention Chairs: Teymur Noori (ECDC) and Antons Mozalevskis (WHO/Europe)	
Session objective: To share experiences of successful HIV prevention interventions	
09:00–09:20	Preliminary results from the European Men's Internet Survey 2017–18 (Axel J. Schmidt)
09:20–09:40	Introduction to parallel sessions: Regional overviews of the status of PrEP and harm reduction in Europe (Ioannis Mameletzis, WHO headquarters, and Thomas Seyler, EMCDDA)

<table>
<tr><td>09:40–11:00</td><td>Parallel session 1: Pre-exposure prophylaxis (Room: Marlene Dietrich + Hildegard Knef)
Chairs: Teymur Noori (ECDC) and Caroline Hurley (Ireland)</td><td>Parallel session 2: Harm reduction associated with drug use (Room: post-Palais I–III)
Chairs: Antons Mozalevskis (WHO/Europe) and Ganna Dovbakh (Eurasian Harm Reduction Association (EHRA))</td></tr>
<tr><td></td><td>09:40–10:00 Formal and informal use of PrEP in Europe: Results from an ECDC/Hornet survey (Teymur Noori)

10:00–11:00 PrEP implementation experiences
• Jean-Christophe Comboroure (France)
• Ann Sullivan (United Kingdom)
• Viviane Bremer (Germany)
• Ihor Kuzin (Ukraine)

Discussion</td><td>09:40–09:55 Integrated service delivery for people who inject drugs (Daniel Simões, Portugal)

09:55–10:10 OST services: transition from Global Fund to national funding (Ketevan Stvilia, Georgia)

10:10–10:25 EU Joint Action: HA-REACT (Blanca Iciar Indave Ruiz)

10:25–10:40 Scaling up comprehensive harm reduction services in the Republic of Moldova (Igor Condrat)

10:40–11:00 Discussion</td></tr>
<tr><td>11:00–11:30</td><td colspan="2">COFFEE</td></tr>
<tr><td>11:30–12:30</td><td>What will be important with regard to measuring and monitoring PrEP?

11:30–11:45 PrEP use in people newly diagnosed with HIV (Valentina Cambiano, UCL)

11:45–12:00 Standardizing data collection on PrEP use (Valerie Delpech, United Kingdom)

12:00–12:30 Discussion</td><td>11:30–11:45 Harm reduction interventions, best practice example (Carole Devaux, Luxembourg)

11:45–12:15 Panel discussion
• Scaling up harm reduction services
• What are the barriers and key challenges
• Monitoring harm reduction response, including population size estimates

12:15-12:30 Discussion</td></tr>
<tr><td>12:30–13:45</td><td colspan="2">LUNCH

12:45—13:45 Drop-in ECDC HIV modelling tool helpdesk, post-Palais I–III (Ard van Sighem, Netherlands, Chantal Quinten, ECDC)</td></tr>
<tr><td colspan="3">Session 4 HIV testing
Chairs: Dorthe Raben (CHIP) and Ann Sullivan (INTEGRATE)</td></tr>
<tr><td colspan="3">Session objective: To share successful HIV testing practices and to discuss how to improve measurement and implementation of HIV testing programmes</td></tr>
<tr><td>13:45–14:05</td><td colspan="2">Challenges and best practices for improved HIV testing in the European Region (Valerie Delpech, United Kingdom)</td></tr>
<tr><td>14:05–14:15</td><td colspan="2">Introduction to working groups (Ann Sullivan, INTEGRATE)</td></tr>
<tr><td>14:15–15:30</td><td colspan="2">Working groups: improving measurement of HIV testing
• Group Marlene Dietrich: moderator Tatjana Nemeth Blazic (Croatia)
• Group Hildegard Knef: moderator Roland Bani (Albania)
• Group Albert Einstein: moderator Barbara Suligoi (Italy)
• Group post-Palais I-III: moderator Otar Chokoshvili (Georgia)</td></tr>
<tr><td>15:30–16:00</td><td colspan="2">COFFEE</td></tr>
<tr><td>16:00–16:30</td><td colspan="2">Feedback from working groups</td></tr>
</table>

16:30–17:00	Way forward for improved HIV control in the European Region: focus on testing and treatment (Jens Lundgren, CHIP)
European Café I	
17:00–18:00	Innovative approaches to expanding HIV testing in the European Region (all sessions run 2 x 25 minutes, participants choose which two to attend) • Community-based testing (Daniel Simões, Portugal, and Viktor Liashko, Ukraine) (Room: post-Palais I–III) • Self-testing (Susan Cowan, Denmark, and Sniazhana Biadrytskaya, Belarus) (Room: Marlene Dietrich) • Indicator-condition testing (Ann Sullivan, INTEGRATE) (Room: Hildegard Knef) • Using European Testing Week to enhance testing activities (Dorthe Raben, CHIP) (Room: Albert Einstein)

WEDNESDAY 25 APRIL 2018	
Session 5 The first 90: Measuring the number of people living with HIV Chairs: Chantal Quinten (ECDC) and Annemarie Stengaard (WHO/Europe)	
Session objective: To assess how to improve HIV case surveillance and how estimates guide HIV response	
09:00–09:30	Keynote presentation: Use of surveillance data to monitor and inform HIV prevention programmes (Irene Hall, CDC)
09:30–09:50	Current status of HIV case surveillance and modelling in Europe: focus on the first 90 (Anastasia Pharris, ECDC)
09:50–10:10	How the estimates process can support the HIV response (Kimberly Marsh, UNAIDS)
10:10–11:00	Country experiences with modelling HIV incidence and the undiagnosed fraction • Ard van Sighem (Netherlands) • Hristo Taskov (Bulgaria) • Andre Sasse (Belgium)
11:00–11:30	**COFFEE**
European Café II	
11:30–12:30	Sessions on improving HIV surveillance (all sessions run 2 x 25 minutes, participants choose which two to attend) • Tools to address missingness and reporting delay (Magdalena Rosinska, Poland, and Chantal Quinten, ECDC) (Room: Albert Einstein) • Electronic data linkage (Florence Lot, France; Helena Cortes Martins and Isabel Aldir, Portugal; Otar Chokoshvili, Georgia) (Room: Hildegard Knef) • Piloting recency testing for surveillance (Derval Igoe, Ireland) (Room: Marlene Dietrich) • HIV drug resistance surveillance (Eeva Broberg, ECDC) (Room: post-Palais I–III)
12:30–13:45	**LUNCH**
12:50–13:45	Dialogue with countries from eastern Europe and central Asia (EECA) in preparation for the *Ministerial policy dialogue on HIV and related comorbidities in EECA*, 23 July, Amsterdam (Michel Kazatchkine, UNAIDS Special Adviser, and Masoud Dara, WHO/Europe)

<table>
<tr><th colspan="3">Session 6 The second and third 90s: HIV treatment and viral suppression</th></tr>
<tr><td colspan="3">Session objective: To improve measurement and implementation issues for HIV treatment and viral suppression</td></tr>
<tr><td>13:45–15:00</td><td>Parallel session on measurement issues related to treatment and viral suppression
(Room: Marlene Dietrich + Hildegard Knef)
Chairs: Anastasia Pharris (ECDC) and Cristiana Oprea (European AIDS Clinical Society (EACS))</td><td>Parallel session on treatment implementation issues
(Room: post-Palais I–III)
Chairs: Elena Vovc (WHO/Europe), Samvel Grigoryan (Armenia) and Justyna Kowalska (EACS)</td></tr>
<tr><td></td><td>13:45–13:50 Introduction to parallel session

13:50–14:10 Overview: what is the status of treatment and viral suppression in Europe? (Alison Brown, United Kingdom)

14:10–14:25 Clinical audit as a method to assess the number of diagnosed PLHIV on treatment and virally suppressed (Caroline Hurley, Ireland)

14:25–14:40 Improved measures for the HIV continuum of care: time to treatment and viral suppression (Virginie Supervie, France)

14:40–15:00 Discussion</td><td>13:45–13:50 Introduction to parallel session

13:50-14:00 New developments in global WHO guidance (Marco Vitoria, WHO headquarters)

14:00-14:10 Romania on 2nd and 3rd 90s (Mariana Mardarescu)

14:10-14:20 Kyrgyzstan on 2nd and 3rd 90s (Aibek Bekbolotov)

14:20–14:30 Overview of Medicines Patent Pool (MPP) model, issues and implications for procurement and treatment delivery (Liudmyla Maistat, MPP)

14:30–15:00 Discussion (Elena Vovc)
• West, Centre and East – different or same approach for reaching 2nd and 3rd 90s in the WHO European Region?
• Is ART optimization to be considered?
• Innovations to improve linkages to care</td></tr>
<tr><th colspan="3">Session 7 Summary and closing
Chairs: Masoud Dara (WHO/Europe) and Andrew Amato (ECDC)</th></tr>
<tr><td>15:00–16:00</td><td colspan="2">Panel discussion – Reflections from session rapporteurs

• Bertrand Audoin (Session 2: Fast-Track Cities)
• Ioannis Mameletzis and Ganna Dovbakh (Session 3: Prevention)
• Yusef Azad (Session 4: HIV testing)
• Danijela Simic (Session 5: Measuring PLHIV)
• Derval Igoe and Justyna Kowalska (Session 6: HIV treatment and viral suppression)
• Michel Kazatchkine (Lunch dialogue with EECA countries)</td></tr>
<tr><td>16:15</td><td colspan="2">Summary and closing (Masoud Dara and Andrew Amato)</td></tr>
</table>

Annex 2 List of participants

Nominated country experts

Name	Country
Roland Bani	Albania
Samvel Grigoryan	Armenia
Trdat Grigoryan	Armenia
Ziad El-Khatib	Austria
Irene Kaszoni-Rückerl	Austria
Farhad Singatulov	Azerbaijan
Tarana Nazarova	Azerbaijan
Migal Tatyana	Belarus
Sniazhana Biadrytskaya	Belarus
Andre Sasse	Belgium
Tommi Asikainen	Belgium
Tonka Varleva	Bulgaria
Hristo Taskov	Bulgaria
Tatjana Nemeth Blazic	Croatia
Linos Hadjihannas	Cyprus
Vratislav Němeček	Czech Republic
Marek Malý	Czech Republic
Susan Cowan	Denmark
Salla Toikkanen	Finland
Kirsi Liitsola	Finland
Jean-Christophe Comboroure	France
Florence Lot	France
Ketevan Stvilia	Georgia
Otar Chokoshvili	Georgia
Ines Perea	Germany
Gesa Kupfer	Germany
Ulrich Marcus	Germany
Viviane Bremer	Germany
Osamah Hamouda	Germany
Barbara Gunsenheimer-Bartmeyer	Germany
Vasilios Raftopoulos	Greece
Magdalini Pylli	Greece
Caroline Hurley	Ireland
Derval Igoe	Ireland
Daniel Chemtob	Israel
Barbara Suligoi	Italy
Vladimir Kazakov	Kazakhstan
Aibek Bekbolotov	Kyrgyzstan
Sharipa Suvanalieva	Kyrgyzstan
Šarlote Konova	Latvia
Irma Čaplinskienė	Lithuania
Carole Devaux	Luxembourg
Igor Condrat	Republic of Moldova

Name	Country
Iulian Oltu	Republic of Moldova
Eric Voiglio	Monaco
Ard van Sighem	Netherlands
Hilde Kløvstad	Norway
Piotr Wysocki	Poland
Katarzyna Szmulik	Poland
Magdalena Rosinska	Poland
Isabel Aldir	Portugal
Helena Cortes Martins	Portugal
Mariana Mardarescu	Romania
Adrian Marinescu	Romania
Evgenii Voronin	Russian Federation
Valeria Gulshina	Russian Federation
Danijela Simic	Serbia
Danica Staneková	Slovak Republic
Peter Truska	Slovak Republic
Maja Milavec	Slovenia
Asuncion Diaz	Spain
Viktor Dahl	Sweden
Gabriella Hök	Sweden
Saifuddin Karimov	Tajikistan
Sharipov Turakhon	Tajikistan
Emel Ozdemir Sahin	Turkey
Ayla Aydin	Turkey
Ihor Kuzin	Ukraine
Viktor Liashko	Ukraine
Valerie Delpech	United Kingdom
Alison Brown	United Kingdom

Consultants, guests and speakers

Name	Affiliation
Anke van Dam	AIDS Foundation East–West (AFEW) International
Ann Sullivan	Chelsea and Westminster Hospital, United Kingdom
Anton Pozniak	International AIDS Society/Chelsea and Westminster Hospital NHS Foundation Trust, United Kingdom
Axel J. Schmidt	European MSM Internet Survey/London School of Hygiene and Tropical Medicine
Bertrand Audoin	International Association of Providers of AIDS Care (IAPAC)
Blanca Iciar Indave Ruiz	Joint Action on HIV and Co-infection Prevention and Harm Reduction (HA-REACT)
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