

MEETING OF NATIONAL HIV PROGRAMME MANAGERS OF EASTERN EUROPEAN, CENTRAL ASIAN AND NON-EU/EEA COUNTRIES



Meeting report

25–26 September 2017

Copenhagen,

Denmark



Abstract

The Meeting of National HIV Programme Managers of Eastern European, central Asian and other non-EU/EEA countries was held in Copenhagen, Denmark, on 25–26 September 2017. The meeting reviewed the countries' progress and challenges, and provided a platform to exchange good practices in HIV prevention, testing, treatment and care and coinfections (viral hepatitis, tuberculosis) in eastern Europe and central Asia (EECA) as well as central Europe (non-European Union/European Economic Area (EU/EEA) countries). The meeting was hosted by WHO Regional Office for Europe and included participants from Member States from EECA and non-EU/EEA countries, as well as international experts, relevant United Nations agencies, the European Centre for Disease Prevention and Control, the Global Fund, and representatives of other organizations involved in HIV response the EECA region and non-EU/EEA countries, civil society organizations, professional associations and WHO collaborating centres. National health authorities/decision-makers and delegated national experts of Member States from 15 Member States in eastern Europe and central Asia and other non-EU/EEA countries attended the meeting.

KEYWORDS

HIV
HIV STRATEGY
HIV ACTION PLANS
WHO POLICIES
WHO GUIDELINES
NON-EU/EEA COUNTRIES

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Abbreviations

ART	antiretroviral therapy
ARV	antiretroviral (drug)
CD4	cell cluster of differentiation antigen 4
ECDC	European Centre for Disease Prevention and Control
EECA	eastern Europe and central Asia
EU/EEA	European Union/European Economic Area
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV DR	HIV drug resistance
IOM	International Organization for Migration
MSM	men who have sex with men
NGO	nongovernmental organization
PLHIV	people living with HIV/AIDS
PrEP	pre-exposure prophylaxis
SDG	Sustainable Development Goals
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNODC	United Nations Office on Drugs and Crime
VL	viral load

Introduction

This report presents a summary of the discussion points of the Meeting of National HIV Programme Managers of eastern European, central Asian and non-EU/EEA countries, held in Copenhagen, Denmark, on 25–26 September 2017, as well as action points that resulted from the discussions. More details are available in speakers' presentations and key findings from poster presentations by participating country delegations.

HIV remains one of the most important public health challenges in the WHO European Region. HIV cases are increasing in the WHO European Region, mainly in eastern and central Europe. The cumulative number of people diagnosed with HIV in the WHO European Region is over two million. There have been improvements in the implementation of some key interventions in the Region. Coverage with life-saving antiretroviral (ARV) treatment more than doubled over the last decade. Several countries successfully validated the elimination of mother-to-child transmission of HIV and syphilis. However, despite the moderate progress in moving towards achieving universal access to HIV prevention, treatment, care and support across the Region over the last decade, the response to the HIV epidemic still faces many challenges.

In September 2016, the 66th session of the WHO Regional Committee for Europe (RC66) endorsed the Action plan for the health sector response to HIV in the WHO European Region. The Action plan calls for fast-tracked actions and guides Member States in accelerating the response to the HIV epidemic at national level and contributing to regional and global efforts to end the HIV epidemic. By September 2017 some countries had taken prompt action and developed or updated their national strategies, action plans on HIV. Other countries are in the process of revising national policies or plan to do so in 2018–2019.

The meeting aimed to review countries' progress and challenges, and exchange good practice, in the field of HIV prevention, testing, treatment and care in eastern Europe and central Asia (EECA) as well as other EU/EEA countries of the WHO European Region). The following themes were covered during the meeting:

- prevention interventions to achieve better impact and effective HIV response in the region;
- scaling up HIV testing and strengthening linkages to care to enable better access to treatment;
- scaling up HIV treatment through a “treat all” approach and treatment optimization;
- strengthening of HIV surveillance and monitoring to support decision-making; and
- financial sustainability for accelerated and maintained response of national programmes.

Objectives

The objectives of the meeting were to:

- obtain an overview of the HIV epidemic in the WHO European Region;
- present and exchange information on national HIV action plans or relevant national strategies and their financing;
- review the latest evidence, WHO guidance, tools and policies;
- address cross-cutting issues and opportunities, particularly in regard to coinfections, key and vulnerable populations; and
- present and discuss best practices.

Expected results and outputs

The following results and outputs were expected from the meeting:

- a comprehensive overview of national HIV strategies and action plans developed and/or updated in the participating countries;
- participants briefed on and exchanging the latest evidence and good practices in the field of HIV prevention, testing, treatment and care and coinfections (viral hepatitis, tuberculosis (TB)); and
- a report describing the outcomes of the meeting.

Format

The meeting took place over two days (25–26 September 2017) and was held in the WHO Regional Office for Europe in Copenhagen. The meeting was envisaged as an extended forum of partners and leading experts, comprising plenary sessions, poster session and parallel working groups on defined topics. The meeting agenda was aligned with latest developments in science and public health but also responded to the needs of countries invited to the meeting. WHO proposed a scientific committee consisting of WHO staff, country representatives, civil society and researchers which oversaw the development of a detailed agenda and priority issues to be addressed at the meeting.

The event was followed by a one-day meeting for representatives of central Asian countries to discuss specific actions related to HIV and migration. A separate report describes the discussions and results of that specific meeting.

Participants

The Action plan for health sector response to HIV in the WHO European Region calls for coordinated efforts by all including Member States, communities and stakeholders including civil society and community-based organizations, research and academic institutions,).

Following this principle, participants who attended this meeting included:

- national health authorities/decision-makers and delegated national experts of Member States from eastern Europe and central Asia (Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Tajikistan, the Russian Federation, Ukraine and Uzbekistan); and from central Europe (non-EU/EEA countries: Israel, Montenegro, Serbia and Kosovo¹ and The former Yugoslav Republic of Macedonia);
- international experts;
- representatives from the Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Office on Drugs and Crime (UNODC), United Nations Population Fund (UNFPA), and United Nations Development Programme;
- representatives from the European Centre for Disease Prevention and Control (ECDC), the Global Fund to Fight AIDS, Tuberculosis and Malaria ("the Global Fund"), and other organizations active in the EECA region (see the list of participants in Appendix 2);
- staff of WHO country offices, Regional office and headquarters; and
- representatives of civil society organizations, professional associations and WHO Collaborating Centres



Photo by JTH/WHO Regional Office for Europe. 2018

¹ Invitations were extended to technical programme representatives of Kosovo (without prejudice to positions on status, and in accordance with United Nations Security Council resolution 1244 (1999).

Day 1, Monday, 25 September

Introduction

The WHO Regional Office of Europe welcomed participants to the meeting and briefly set out the expected outcomes of the meeting. The meeting had been convened to enable countries and partners to share actions taken in the framework of the national action plans for HIV and viral hepatitis endorsed by the Regional Committee in 2016. Since the European Union Member States had met earlier in 2017 in Malta, under the Maltese presidency of the Council of the European Union, this meeting was aimed at non-EU/EEA countries; there are plans to have a pan European meeting in 2018 covering the full WHO European Region. The programme was designed to allow as much interaction as possible, also ensuring that concrete priorities for actions would emerge at the end of the meeting.

In the introductory session, the UNAIDS Regional Support Team representative expressed gratitude to WHO for inviting UNAIDS to join the meeting, in the context of strengthening partnership between WHO and UNAIDS in the Region. It was noted that the main focus of activities being conducted in countries by both governmental entities and other organizations and partners, with respect to fast-track actions, should specifically aim at ending the AIDS epidemic, which calls for greater speed and 'out-of-the-box' thinking. As a reminder, it was clearly highlighted that the commitment to end AIDS and achieve the 90-90-90² targets, set by UNAIDS and partners in 2014 as a global strategic goal, will expire at the end of 2020.

WHO stressed the importance of increasing cooperation between the Division of Health Systems and Public Health and the Joint TB, HIV and Viral Hepatitis Programme that operates under the Division of Emergency Health and Communicable Diseases of the WHO Regional Office for Europe. Such cooperation promotes combined action in countries and enables structural barriers to be addressed in a timely manner by WHO, country governments and other partners working on the ground.

Strategic and technical context (plenary session)

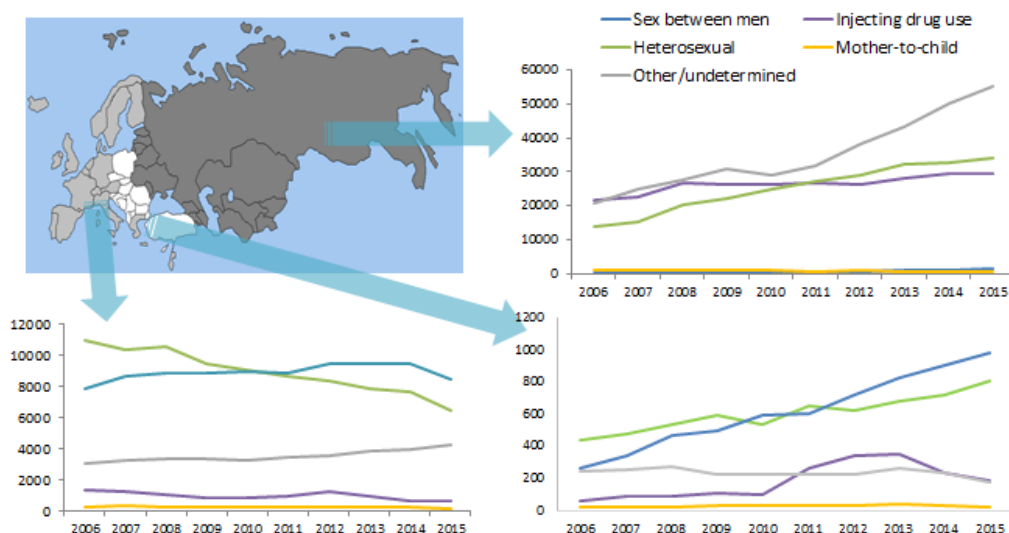
WHO's presentation focused on new HIV diagnoses made in 2015 and trends during the period between 2006 and 2015 (see Fig. 1). Overall, for the period covered there was a 75% increase in the WHO European Region and a 109% increase in the East³ of the Region. In 2016 there were over two million people living with HIV/AIDS (PLHIV) in the Region.

² "In 2014, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and partners launched the 90–90–90 targets; the aim was to diagnose 90% of all HIV-positive persons, provide antiretroviral therapy (ART) for 90% of those diagnosed, and achieve viral suppression for 90% of those treated by 2020. This is estimated to result in 73% of people with HIV achieving viral suppression, a crucial step in ending the AIDS epidemic by 2030." Bain LE, Nkoko C, Noubiap JN. UNAIDS 90–90–90 targets to end the AIDS epidemic by 2020 are not realistic: comment on "Can the UNAIDS 90–90–90 target be achieved? A systematic analysis of national HIV treatment cascades". *BMJ Global Health* 2017;2:e000227. doi:10.113.

³ There are 15 countries in the East of the WHO European Region: Estonia, Latvia, Lithuania, Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine, Uzbekistan

As regards the mode of transmission, men who have sex with men (MSM) comprise the majority of people newly diagnosed with HIV in the Centre and West of the Region, and injecting drug users in the eastern part. Elimination of mother-to-child transmission is one of the successes that have been achieved in several Member States of the WHO European Region, as a result of focused efforts by countries. This achievement must be acknowledged particularly in light of specifics of existing healthcare systems in the eastern European countries.

Fig. 1. New HIV diagnoses by mode of transmission, West, Centre and East, 2006–2015



Source: HIV/AIDS Surveillance in Europe. WHO/ECDC Surveillance report 2016.

Addressing late presenters issue, there are differences to consider between groups (MSM, heterosexuals, injecting drug users). According to data from 39 countries, in 2015 there were more late presenters among people infected via injecting drug use and heterosexual contact (55%) compared with MSM (37%).

Progress towards achieving the 90-90-90 target shows that 72% of PLHIV had been diagnosed, 64% of diagnosed PLHIV received treatment and 83% of people on treatment were virally suppressed in 2016. However, there are significant differences between EECA on the one hand, and western and central Europe on the other, in the percentages of PLHIV receiving treatment (28% and 76%, respectively), and even more striking in the percentages of PLHIV who are virally suppressed. The actions that need to be taken to address the low treatment coverage in the eastern part of the region include, but are not restricted to, optimizing treatment regimens, bringing prices down and improving treatment adherence.

According to epidemiological data, HIV coinfection among TB patients is increasing. Between 2011 and 2015, TB/HIV coinfection almost doubled, from 5.5% to 9.0%.

In 2015, the percentage of people diagnosed with AIDS who had TB as an AIDS-defining illness was highest in the eastern part of the region (40%), as compared to the western (13%) and central (27%) parts.

The burden of both viral hepatitis B and C is also significant. As estimated in the first Global Hepatitis Report (2017), there were 14 million people living with HCV (overall regional prevalence of 1.5%) and 15 million people living with HBV (overall regional prevalence of 1.6%) in 2015.

The action plans for the health sector response to HIV and viral hepatitis in the WHO European Region were developed and endorsed at the same time, providing a new framework for the for the HIV and viral hepatitis responses in the Region.

The plans require countries to define and deliver an essential package of interventions, prioritizing key and vulnerable populations and guided by the local context, and promote a comprehensive combination of prevention and a “treat all” approach. In order to support implementation, WHO has published a number of technical guidelines and tools to support countries in reviewing and revising national HIV guidelines, strategies and targets, while WHO is committed to provide technical leadership, facilitate partnership and exchange good practices.

The next steps that need to be taken, also addressed by the meeting, include reviews of national strategies, policy dialogues with Member States, strengthening the public health approach, including provision of integrated care, improving policies on testing, supporting the implementation of a “treat all” approach, strengthening prevention efforts and improving cross-border HIV response, also making sure that undocumented migrants are not forgotten.

UNAIDS Regional Support Team presented the overall progress towards the 90-90-90 targets in EECA, based on the most up-to-date data available.

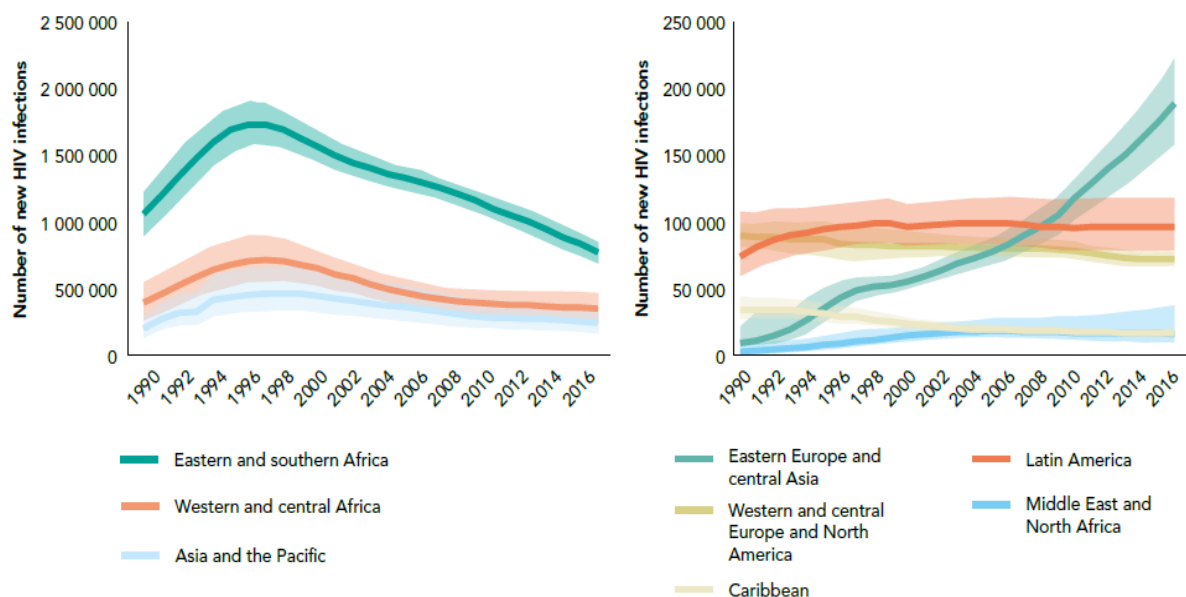
According to UNAIDS’ Global HIV estimates, there is an alarming rise in new HIV infections in EECA countries (see Fig. 2). By contrast, the countries worldwide most affected by the HIV epidemic (in eastern and southern Africa, western and central Africa) are seeing a sustained and significant reduction in new HIV infections. The estimated 190 000 (160 000–220 000) people newly infected with HIV in the EECA region⁴ in 2016 correspond to a 60% increase from the 120 000 (100 000–130 000) in 2010.



Photo by JTH/WHO Regional Office for Europe. 2017

⁴ UNAIDS includes the following countries in the EECA region: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, Montenegro, Republic of Moldova, Russian Federation, Tajikistan, The former Yugoslav Republic of Macedonia, Turkmenistan, Ukraine, and Uzbekistan.

Fig 2. Rise in new HIV infections in EECA. Source: UNAIDS 2017 estimates.



Comparing estimated ART coverage⁵ in countries in eastern and southern Africa with EECA countries, countries like Botswana and Kenya have reached coverage of 81% and 68%, respectively. These examples show that countries with more severe developmental and financial hurdles have made greater progress, which can serve as an example for EECA countries.

The Region’s HIV epidemic is concentrated primarily within two countries: the Russian Federation and Ukraine. These countries accounted for an estimated 81% and 9% of new HIV infections in 2016, respectively. The Russian Federation’s epidemic continues to grow rapidly: the number of newly reported infections increased from 89 744 in 2010 to 103 438 in 2016. Several other countries in the region also have rapidly growing epidemics, while Kyrgyzstan and Tajikistan have achieved modest declines in new infections, of 5% and 9% respectively.

AIDS-related deaths also continue to increase. All Member States are making progress, but until the vast majority of at least those diagnosed with HIV are in treatment, no significant reduction in AIDS-related morbidity and mortality will be seen.

Only 63% of people estimated to be living with HIV know their status. Urgent public health measures need to be taken to ensure that every person diagnosed with HIV is offered treatment (in EECA countries, only 45% of 63% diagnosed are on treatment).

The biggest challenge in EECA is the fact that only 28% of people estimated to be living with HIV are receiving treatment (despite economic growth). An estimated 820 000 PLHIV are not receiving treatment.

⁵ Measured as the number of people on treatment / the estimated number of people living with HIV.

Progress between 2015 and 2016 is significant, but there is still a long way to go if the 90-90-90 target is to be met by the end of 2020.

As at the end of 2016, 53% of all people in the world estimated to be living with HIV were receiving HIV treatment.

Adopting a “treat all” approach is currently the most significant challenge in terms of treatment scale-up in the world and in EECA countries (see Fig. 3).

Fig. 3. Countries who had adopted the “treat all” approach as of 1 September 2017

Country	“Treat All” approved/implemented
Armenia	Yes
Azerbaijan	Pending approval
Belarus	Yes, to be implemented early 2018
Kazakhstan	Yes , to be implemented early 2018
Georgia	Yes
Kyrgyzstan	Pending approval
Moldova	Pending approval
Tajikistan	Pending approval
Ukraine	Yes
Uzbekistan	No
Russia	No

In terms of cost, in 2015 Kazakhstan paid around US\$ 1000 per person per year for the fixed dose combination of a recommended treatment regimen of first-line antiretroviral therapy (ART) comprising tenofovir, emtricitabine and efavirenz (TDF+FTC+EFV), significantly lower than the European average but still too high to extend treatment to everyone in need of it. UNAIDS, in collaboration with WHO and under the leadership of UNICEF, brokered a new deal allowing for impressive cost savings, leading to increased coverage of treatment.

Last but not least, political mobilization is essential to accelerate the end of AIDS. In this regard, the President of Belarus expressed support for what is being done in the field of HIV, also undertaking to make Belarus the first country to end AIDS by the end of 2020.

Four programmatic interventions are essential to fast track an end to AIDS:

1. “democratize” HIV testing (i.e. revise approaches to make it faster, easier, more innovative considering for ex. inclusion of self-testing);
2. make testing accessible for everyone, treat all those diagnosed with HIV and retain them in care;
3. lower the cost of HIV treatment to a minimum (the costs of a 1st line ART regimen using fixed dose combination reached US\$ 75 per person per year); and
4. reduce multiple CD4 count⁶ testing and scale-up viral load (VL) testing, while keeping it under the recommended frequency.

These interventions combined will result in greatly reduced AIDS morbidity and mortality plummet and decreasing new HIV infections.

ECDC presented the situation regarding HIV in the European Union and European Economic Area (EU/EEA). The number of HIV diagnoses in EU/EEA countries (2015) was 29 747, corresponding to a rate of 6.3 per 100 000 population (adjusted rate). The most common transmission mode was sex between men (accounting for 42%), followed by heterosexual (32%) and injecting drug use (4%).

The distribution of HIV diagnoses in the EU/EEA shows a homogenous picture. The age-specific rates of new HIV diagnoses show a predominance of men in all age groups. In some countries (for example, Sweden), most new infections are confined to migrants. Late diagnosis is still common, with 47% of people newly diagnosed being late presenters⁷.

Presented data on the new HIV and AIDS diagnoses per 100 000 population monitored through 2006-2015 indicate that the rate of new AIDS diagnoses is declining rapidly in the EU/EEA; however, there is no reduction observed in new HIV diagnosis. The trends show that heterosexual transmission is declining while there is a growing epidemic among MSM.

Several EU/EEA countries have implemented innovative programmes and accelerated test-and-treat policies and programmes particularly aimed at MSM. London, for example, was the first city in England to bring about a reduction in new HIV infections among MSM. Their model might be reproduced in other countries with high levels of HIV among MSM.

ECDC has developed an HIV modelling tool to estimate numbers of people living with HIV and the undiagnosed fraction. The results for the EU/EEA suggest that there are 810 000 PLHIV, of whom one in seven (122 000) remain undiagnosed (the same proportion as in the United States of America).

In terms of progress toward achieving the 90-90-90 targets, an average of 83% of PLHIV in the countries of EU/EEA know their status, 83% of those diagnosed are on ART, and 89% of those on ART are virally suppressed.

⁶ WHO 2016 guidelines recommend treatment at all CD4 counts as soon as HIV is diagnosed. A CD4 count is a test that measures the number of T cells expressing CD4 (cell cluster of differentiation antigen 4) in the blood. CD4 counts are used to assess the immune system of a patient.

⁷ CD4 cell count below 350 at the time of HIV diagnosis.

In summary, HIV transmission continues in the EU/EEA, particularly among MSM; about one in seven PLHIV in the European Union are undiagnosed and nearly half (47%) are diagnosed late. Despite improved test-and-treat policies, one in six people diagnosed with HIV are still not on treatment. Data from EU/EEA countries show that once on ART, most people are virally suppressed.

The presentation from WHO headquarters focused on the WHO guidelines and latest updates on HIV treatment and care.

At the global level there are several successes, such as increasing access to treatment, but important gaps remain. WHO is now focusing its work on optimizing technical support to reach the 90-90-90 targets by 2020.

The key messages from the 2016 WHO Consolidated guidelines on the use of antiretroviral (ARV) drugs for treating and preventing HIV infection are: offer treatment of all once diagnosed with HIV infection regardless of the CD4 counts and irrespective of the stage of HIV infection; introduce and use optimized regimens; consider task shifting, decentralization, integration, and differentiated care packages; and perform routine VL as preferred approach for monitoring treatment outcomes.

The evolution of the WHO guidelines over the past 10 years shows how issues have evolved. For the “treat all” policy, implementation is still a challenge (as of July 2017).

The new recommendations on treatment and care released in July 2017 were as follows:

1. Transition to new ARVs – clinical and programmatic considerations
2. WHO recommendations for the management of advanced HIV disease and rapid initiation of ART

The key principles for ARV drug optimization are to: reduce toxicity; improve palatability/pill burden; increase resistance barrier; reduce drug interactions; safe use across different age groups and populations (harmonization); and reduce cost. Since 2016, WHO has recommended adopting new alternative ARV drug options in HIV treatment regimens: dolutegravir (DTG) and efavirenz 400 mg (EFV400) for first-line therapy and darunavir/ritonavir (DRV/r) and raltegravir (RAL) for second- and third-line therapy. Every year, new ARVs and options are becoming available in low- and middle-income countries as generic fixed-dose combinations at lower prices than the current preferred first-line regimens. An analysis of optimization profiles of new ARVs explains certain advantages that served as a strong evidence for WHO to recommend transition to new ARVs in 2017. For example DTG is associated with improved tolerability, higher antiretroviral efficacy, lower rates of treatment discontinuation, a higher genetic barrier to resistance and fewer drug interactions than other ARV drugs. EFV400 has comparable efficacy and improved safety compared with EFV at the standard dose (EFV600) (see Table 1 for more details).

Table 1. Summary of optimization profiles of new ARV recommended in 2016 WHO ARV guidelines (comparative analysis).

Optimization criteria		DTG	EFV400	DRV/r	RAL
Efficacy and safety	High virologic potency	✓	✓	✓	✓
	Low toxicity	✓	✓	✓	✓
	High genetic barrier to resistance	✓	✗	✓	✗
Simplification	Available as generic FDC	✓	✓	✗	✗
	Low pill burden	✓	✓	✗	✗
Harmonization	Use in pregnant women	?	?	✓	✓
	Use in children	?	✗	✓	✓
	Use in HIV-associated TB	?	?	✗	✓
	Few drug interactions	✓	✗	✗	✓
Cost	Low price	✓	✓	✗	✗

✓ yes ✗ no ? ongoing studies

DTG= dolutegravir; EFV400= low dose efavirenz; DRV/r= darunavir/ritonavir; RAL= raltegravir

There are ongoing clinical trials of dolutegravir (DTG) use, with robust data expected to be available in 2018.

WHO has also developed a new policy brief and guidelines on the public health response to pretreatment HIV drug resistance (HIV DR), and recommendations for advanced HIV disease. These recommendations are as follows.

1. A package of interventions including screening, treatment and/or prophylaxis for major opportunistic infections, rapid ART initiation and intensified adherence support interventions should be offered to everyone presenting with advanced HIV disease.
2. Rapid ART initiation should be offered to all PLHIV following a confirmed HIV diagnosis and clinical assessment. Rapid ART initiation is defined as within seven days from the day of HIV diagnosis; people with advanced HIV disease should be given priority for assessment and initiation.
3. ART initiation should be offered on the same day to people who are ready to start.

The rationale behind these recommendations is that a significant proportion of patients continue to present with advanced HIV. In 2015, 37% of people starting ART did so at CD4 cell count <200 cells/mm³. For adults and adolescents, and children older than five years, advanced HIV disease is defined as CD4 cell count <200cells/mm³ or WHO stage 3 or 4 event (includes both ART-naïve individuals and those who interrupt treatment and return to care). All children younger than five years old with HIV are considered as having advanced HIV disease.

In 2016, WHO developed a framework for a differentiated approach to HIV treatment and care services, recognizing that ‘one size for all’ will not work, as HIV programmes continue to expand and the context of countries and regions is different.

National HIV strategies, policies and action plans

Poster presentations, prepared by participants prior to the meeting, described the current status of national HIV strategies, policies and action plans in the following 15 participating countries: Armenia, Azerbaijan, Belarus, Georgia, Israel, Kazakhstan, Kyrgyzstan, Montenegro, Republic of Moldova, Russian Federation, Serbia, Tajikistan, the former Yugoslav Republic of Macedonia, Ukraine, and Uzbekistan. The key points of discussions and findings related to (1) HIV testing, (2) treatment and care were subsequently summarized by WHO staff and presented at the beginning of the technical sessions focusing on countries' progress on test-and-treat.

Countries' progress in implementing "test-and-treat"

To set the scene for discussions in this session, WHO staff reported back from the poster session, summarizing the following issues that countries and partners had flagged in relation to HIV testing.

- The percentage of people diagnosed with HIV infection is estimated to be about two thirds of the total number of PLHIV (range 51%–81%) in countries that presented their posters.
- Late presentation is still common.
- The majority of non-EU/EEA countries reported having a national HIV testing strategy in place.
- There are no user fees for HIV testing (in countries that reported on this).
- The majority of countries include rapid test assays in their national HIV testing algorithm.
- Immunoblot/western blot is still used as a confirmatory test (in countries that reported on confirmatory tests).
- Few countries reported on their simplification of HIV testing algorithms/strategies.
- Provider-initiated HIV testing is still common.
- Most countries reported increased focus on testing of key populations.
- Community-based testing approaches, including mobile units, were reported by some countries, but testing provided by lay providers was reported by only very few.
- Very few countries reported implementation of HIV self-testing.
- Some countries mentioned integrated approaches to HIV testing, and only a few of them mentioned implementation of combined testing (HIV/syphilis, viral hepatitis, TB).
- Some countries mentioned campaigns to increase HIV testing.
- Very few countries mentioned specific activities to increase linkage to care after HIV testing.



Photos by JTH/WHO Regional Office for Europe, 2017

A panel discussion facilitated by WHO followed, with representatives from Belarus, Israel, Kyrgyzstan, Montenegro, Republic of Moldova and Ukraine. The purpose of the discussion was to gain a better understanding of the main barriers to scaling up for testing, as well as to share good examples. The selection of countries invited onto the panel was based on the existence of good examples that merited being shared.

The first question explored the main barriers/key problems in scaling up HIV testing and reaching the 90-90-90 targets at country level.

Input from countries represented on the panel discussion included the following.

- In Belarus, 12–13% of the general population is tested annually, mainly among key population groups. Recently, the testing procedure has been modified, in line with WHO recommendations, to include rapid diagnosis tests, especially for vulnerable population groups, to reduce the number of visits to health-care facilities. The necessity to keep the western blot as a confirmatory HIV test was discussed with experts at national level and it was decided to keep this, regardless of higher costs, on the basis that the system is in place and it would take more time and resources to switch to a new approach right now.
- In Kyrgyzstan, a new testing algorithm was approved in 2016 for all levels in the health-care system. Initially, there was opposition to the initiative, so a transition time was proposed by national experts. However, since January 2017, everyone has followed the new protocol – immune-enzyme assay using a rapid diagnostic test, shortening the time for confirmation of HIV diagnosis to two weeks. Stigma and discrimination are significant problems in Kyrgyzstan, further reflected in clinicians' unwillingness to initiate HIV testing, which eventually leads to late diagnosis. Also, physicians do not always refer patients appropriately. Another issue is the lack of proficiency of laboratories. Many laboratories operate within hospitals and lack capacity and reagents. The government ordered an investigation into the work of the laboratories, which resulted in 11 laboratories being closed because of the risk of false negatives and false positives. There is also difficulty reaching some categories of patients (considering that 1 million people live outside the country).
- In the Republic of Moldova, the process of changing testing and confirmation algorithms is ongoing and there is some experience of using combined rapid tests. Given a pretty

complex HIV testing strategy in the country, it can take from one to three months between 1st HIV test and the confirmation of HIV diagnosis, implying complicated referrals and use of more costly laboratory based technology. Because of high prevalence in key populations and their interest in being tested for other infections as well, rapid diagnosis tests were proposed to be introduced. Capillary blood rapid tests are used only in antenatal-care. Nongovernmental organizations (NGO) use oral fluid tests within community based projects. As such, the undergoing revision of HIV testing policy aims at simplifying the approach, aligning with WHO recommendations, using RDTs, allowing lay providers to conduct also the capillary blood test and, consequently, reducing the time of confirmation of HIV diagnosis.

- In Israel, the HIV epidemic is low; the challenge, however, is with HIV in migrants and MSM. Testing in Israel has been free of charge since 1985. However, the health budget had to be increased to ensure preventive activities were not affected. Some of the budget is directed towards key populations.
- In Ukraine, testing is being provided free of charge for key populations, by immune-enzyme assays and rapid tests through mobile laboratories. When HIV is detected by a mobile laboratory, the same laboratory can provide confirmatory testing. However, to reach the first 90 target, an additional 85 000 infections need to be detected. National guidelines have therefore been adapted in line with international guidelines, making changes to national clinical protocols and Ukrainian legislation. The aim is to bring services closer to key population groups. As for self-testing, Ukraine has had some experience of self-testing being performed in the presence of a health worker. The first year showed good results, showing that it could be used for triage, helping to bring patients into care. At the community level, testing should be performed by qualified people. For this to happen, Ukraine still needs to introduce changes in legislation. In health-care facilities, it is recommended that testing be based on clinical conditions. Recently, a high percentage of HIV infection has been noted among partners of PLHIV, hence they also need to be targeted. Another need is to change the definition of testing and counselling services, as well as link them to medical services and testing of partners. Currently, patients sign one informed consent for provision of medical services, and another for HIV testing. This needs to be reduced to only one informed consent form.

After the country representatives had shared their experience, feedback was taken from the audience, allowing questions and reflections about the new approaches described.

The representative from Kazakhstan reported that community-based testing in the presence of health workers had been implemented in two pilot projects in two regions, with support from two international agencies.

The following points were also raised during the discussion.

- The 90-90-90 targets are not UNAIDS targets, but countries' targets, because governments agreed to work toward achieving them.

- There are clinics in London, Paris and Amsterdam, where patients come in the morning, saliva or blood is collected appropriately, and the clinics regularly perform polymerase chain reaction (PCR) tests. Patients have ART prescribed within as little as two or three hours, and treatment is available the same day (or the day after), which can last for several months. This allows the time for diagnosis to be shortened. The purpose is to retain patients in care, and patients do not have any time in which to consider whether or not to be treated. However, this approach might not be suitable for EECA countries, although it could be considered for possible inclusion in national plans.
- GeneXpert[®] molecular diagnostic systems should be made available at the point of care. This would allow easier access to monitoring of HIV treatment outcomes and allow faster communication of results of viral load (VL) tests.
- Ukrainian experience is that ART prescription should be done within seven days, and no later than 30 days, from diagnosis. This is one of the performance indicators.
- According to WHO Guidelines for managing advanced HIV disease and rapid initiation of antiretroviral therapy (2017) rapid initiation of ART should be no later than 7 days from confirmation of HIV diagnosis, while in cases when the patient is ready and/or in cases of advanced HIV disease it is recommended to start immediately⁸
- The speed and rate of treatment initiation should not jeopardize the quality of treatment (for example, for children whose parents are not yet ready to put them on treatment, parents should be encouraged to initiate treatment early, as it may save children's lives and offer better health gains).
- New clinical protocols are to be adopted in Kyrgyzstan: test-and-treat will be done immediately. Two independent experts recommended rapid testing in the presence of the patient, with confirmatory tests the following day.
- For Armenia, the most important tasks are to start immediate treatment, and also to retain patients in health care. People often quit treatment and go abroad to work.
- In Georgia, 51 GeneXpert systems⁹ have been used for TB diagnosis; additional cartridges for HIV-1 VL testing need to be bought. Community-based testing has been tried for screening for HCV. Community workers need training on testing procedures, and a pilot project is being launched and implemented this year.
- Although all health-care professionals in Kyrgyzstan must undergo continuous education, awareness on HIV prevention, treatment and care approaches among primary care physicians is almost non-existent. In Ukraine, awareness varies by region and by health-care provider specialty.

⁸WHO Guidelines for managing advanced HIV disease and rapid initiation of antiretroviral therapy (2017) available at <http://www.who.int/hiv/pub/guidelines/advanced-HIV-disease/en/>

⁹ The Cepheid GeneXpert system, a platform for rapid and simple-to-use nucleic acid amplification tests (NAAT). The Xpert MTB/RIF is a cartridge-based nucleic acid amplification test (NAAT) for simultaneous rapid tuberculosis diagnosis and rapid antibiotic sensitivity test. The Xpert HIV-1 Viral Load is a quantitative test that provides on-demand molecular testing, automates the test process including RNA extraction, purification, reverse transcription and cDNA real time quantitation in one fully integrated cartridge. Both Based Xpert MTB/RIF test and Xpert HIV-1 Viral Load test are based on the GeneXpert technology.

- Community-based testing in Kyrgyzstan is now being funded by the Global Fund, with injecting drug users as the target population. It has proved quite effective, with more than 100 new infections identified.
- Belarus introduced HIV self-testing in the national strategy and self-testing kits are available in pharmacies in the two regions selected for the pilot project. It is too soon to report or discuss the results of the nationwide campaign and policy of introducing self-testing, or to assess its full impact.
- Armenia and Belarus shared their experience in maintaining efforts to eliminate mother-to-child transmission of HIV. Belarus has a high level of HIV testing among pregnant women, with only a small percentage of pregnant women not being tested. The rates of ART coverage are high. Over the last couple of years, no children of HIV infected mothers have been born HIV positive. The plan is to use fourth-generation testing and also to evaluate partners of pregnant women. There were some cases when HIV infection was not detected early enough, probably because third-generation tests were used. In 2017 Armenia, alongside Belarus, had to undergo annual verification to maintain its certificate of elimination of mother-to-child transmission of HIV received in 2016. Recently the country received a letter from WHO stating that the country had maintained previous results. The main indicators for coverage and impact were in line with the global requirements. Armenia also introduced fourth-generation HIV tests, which has proved successful. The programme of eliminating mother-to-child transmission has been one of the most successful in the country.
- Political commitment was a significant component of the success stories of Armenia and Belarus, and political support is crucial.

WHO reported back from the poster session with a summary of key messages highlighted by countries in relation to HIV treatment and care.

- About one third of the estimated number of PLHIV are on ART.
- About half of those diagnosed with HIV are on ART.
- All countries report having a national protocol on ART.
- Almost all countries reported centralized ART provision.
- No country reported user fees for ART.
- Very few countries reported on task shifting and decentralization of ART provision.
- Five countries (out of 16) reported that they have adopted the “treat all” approach or were planning to do so during 2017.
- The vast majority of countries reported first-line regimens in line with WHO guidelines.
- ART optimization was mentioned by some countries.
- Some countries reported that fixed dose combinations (FDC) are preferred.
- ARV price reductions were mentioned by some countries as a key strategy to scale up treatment.

- Accelerated ART (for advanced cases) was reported by a few countries.
- Few countries mentioned a patient-centred approach and using differentiated care models, or integrated service delivery approaches.
- The ART coverage among PLHIV from key populations is not reported.
- Almost all countries reported routine VL testing as part of clinical protocol, but some reported difficulties with its implementation.
- Shortage of funding was often mentioned.



Photos by JTH/WHO Regional Office for Europe. 2017.

The panel discussion that followed focused on the 90-90-90 targets, but more specifically on the second and third 90s, as well as providing an overview on the uptake of the “treat all” approach in countries. As well as the adoption of policies by the highest federal entities like the ministry of health, the implementation of those policies is key to improving people’s health. Despite all the advantages and benefits, more needs to be known about the challenges faced by countries in their daily work.

The input from panellists highlighted the following issues.

- Armenia has adopted a new protocol on ART and HIV testing, fully aligned to the WHO “treat all” approach. Armenia plans to reach the target of providing treatment to all in the next few months. Moreover, the target for 2020 is integrated into the national strategy. As regards implementation, in addition to infrastructure, equipment, drugs, medical products, and test systems, another important component is staff. Taking into consideration the number of patients on treatment (about 1600), the number of physicians who provide ART needs to be increased. The same could be said about the third 90 – the number of medical personnel should be increased. Other challenges include the rapid turnover of staff and burnout.
- The Russian Federation has identified pricing policies, insufficient treatment adherence (especially in key populations) and drug supply at federal level as barriers to treatment coverage. In January 2017, a federal registry of confirmed diagnoses of HIV was introduced, with restricted access and coding of information so that it is not possible to see any individual records, to maintain patient confidentiality. Attention is being paid to improving patient adherence, for instance by engaging psychologists. Adherence is carefully monitored and evaluated for those on ART.

- In the former Yugoslav Republic of Macedonia, ART provision began in 2005 with the support of the Global Fund. Since 2011, ART costs have been covered by national funds. The “treat all” strategy was implemented in 2016. Over 90% of the people diagnosed with HIV are on treatment. The main challenges relate to timely procurements and still scarce resources.
- In Uzbekistan, the majority of the population is Muslim and there are cultural related issues to consider also for counseling PLHIV on adherence to treatment. For example, during Ramadan people cannot eat or drink, hence they cannot take medication and they need counsellors and medical professionals advices and better explanation on benefits of uninterrupted ART and on consequences of treatment interruptions. Overall, annual national evaluation shows that adherence is 83–85% maintained over time by timely and correctly optimized treatment regimens. Latest data for the HIV drug resistance (HIV DR) surveillance in the country detected 3% of patients with HIV DR. Based on WHO recommendations and with support from the Global Fund, third-line drugs were purchased. Procurement and supply of ARVs is very slow, taking on average 16–28 months because many ARVs producing companies are not interested in registering the drugs as the number of patients is quite small. Annual surveys of barriers to adherence among patients and doctors are performed with support from international experts and covered by external funding.
- In Serbia, treatment has been decentralized. All treatment is free of charge, and available in the four existing treatment centres. Lifelong ART is provided for pregnant or nursing women. The existing barriers relate to the very demanding administrative procedures for referral from general practitioners and verification by health insurance. People are afraid that their names will be disclosed during this process, and cause stigma and discrimination. A second barrier is monthly prescriptions, which will be resolved when introducing electronic health records. Treatment literacy needs to be improved: a 2013 survey showed that adherence was only 60%. In Belgrade there are only three doctors and no psychological support is available. Peer support would be useful and is needed, but will require motivation and appropriate education and training of the peer-workers.
- System-wide changes have taken place in Georgia, but challenges persist. For instance, the government needs to pay rent for the AIDS centre premises. The same centre is also responsible for HCV, leading to a shortage of professionals. The government has started decentralization of HCV care, followed by HIV. The Global Fund funding is used for ARVs procurements and for supplying the medicines on time. At the same time, gradual increase in state allocations share for ARVs procurement has already started in 2017 as the country prepares for transition from GF funding for HIV programme to increased national funding.
- Countries reported on the involvement of local communities in the test-and-treat approach. In Georgia, the strategy is expected to be updated in 2018. Not all community members are knowledgeable enough. In Armenia, community members help increase the level of awareness and participate in counselling. The Russian Federation is engaging NGOs in HIV prevention and care activities. When the strategy and action was developed,

various NGOs were brought together. In the Former Yugoslav Republic of Macedonia, community members and civil society have direct input into policy-making. These organizations also help significantly to fight stigma. In Serbia, civil society organizations have been involved since 2005 and are also members of the Republican Commission on HIV.

- A range of concerns and remaining challenges regarding the HIV care services for migrants was brought into the discussion. WHO was asked for advice on how many and how often ARV drugs could be provided to a person receiving ART, for example to a stable patient that simply needs ART refill. WHO representatives referred to recent WHO recommendations on the differentiated care¹⁰. Accordingly, if a patient is stable and adherent to treatment, he/she can be given the ARV drugs for three months of treatment, i.e. one refill can cover the needs of 3 months of ART for one person. Migration issues, however, go beyond this kind of specific recommendations that may help solve individual cases. Countries should consider offer services to all those in need. Countries should not limit the services only to citizens. Hosting countries should consider covering the needs of labour migrants and their families instead of referring them or even sending them out of the hosting countries to their country of origin to seek HIV care.
- Countries also reported on patient concerns about initiating antiretroviral treatment – namely frequency and causes (either literacy or resources) being the main challenge to overcome. In The Former Yugoslav Republic of Macedonia, there is a lack of information about the importance of early treatment. Newly diagnosed patients refuse to start therapy. In Georgia, community engagement is key – some people would not travel to seek treatment services but expect treatment services to be available where they are.
- Good practices from countries on monitoring treatment and care were shared. In Armenia, one reference laboratory provides a comprehensive package of services for monitoring and improving the quality of tests required at initiation of ART and for monitoring the HIV treatment outcomes. Treatment provision in Armenia ensures equal access to patients from key populations or vulnerable groups. The Russian Federation provides health care to all people, ensuring equal access. AIDS centres are established and well-functioning in all Russia's regions. Treatment services may be provided in infectious disease units in hospitals all over the country. Patients need to be prepared and appropriately counselled by professionals before starting treatment (for instance, by seeing a doctor or psychologist) to assure adherence to treatment.

¹⁰ Differentiated care is a client-centred approach that simplifies and adapts HIV services across the cascade to reflect the preferences and expectations of various groups of people living with HIV (PLHIV) while reducing unnecessary burdens on the health system. (Source: WHO Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection, 2016)

Day 2, Tuesday, 26 September

Achieving 90-90-90 – fast-track actions, cooperation for impact

The panellists included several strategic partners of WHO Regional Office for Europe, including relevant United Nations agencies, the Global Fund, the International Organization for Migration (IOM) and ECDC, who were asked to reflect on what can be done to meet the ambitious 2020 targets and what collective actions should be the focus in the countries.

The panellists highlighted the following issues.

- The countries in the Region face several critical challenges. One of them is the question what should be done next in light of what has been achieved in the last 15–20 years. There must be savings gained from HIV prevention to be invested in increasing coverage with treatment. Efforts need to be made to identify places where 90-90-90 targets can be achieved first – creating success and expectations that a chain reaction will ensue (for instance, finding specific populations to start with). Also, in the context of less and less money for the Region, the expectation is that governments will pick up the costs, followed by more sustainable models.
- All resources should be used to ensure that services are available and activities to prevent and fight stigma and discrimination are supported and funded, but countries also need to think what approach should be used for politicians. A health systems approach is needed (noting the challenge with high prices for ARVs, the need to promote and support integrated care and people-centred approach). A regional grant is needed to allocate enough resources for services provisions for migrants. Under the WHO Regional Director's leadership, a United Nations common position paper on Ending HIV, tuberculosis and viral Hepatitis through intersectorial collaboration will be issued from by 14 United Nations agencies. This will be a platform where different United Nations agencies can collaborate and work in an intersectoral approach.
- Funds are needed to address both communicable and noncommunicable diseases affecting migrants. Investing in migrants' health means also identifying funding sources within the national programmes as well as funding sources other than national funds. Anti-migration sentiment and perception in the public and in the healthcare sector can affect the process of implementation of programmes which have been developed. World Health Assembly resolution 61.7, adopted by governments and referenced in strategies and global plans, needs to be seen more at national level. In line with the Sustainable Development Goals (SDG), no one should be marginalized from accessing health services. Programmes should be inclusive, to improve coverage of migrant populations, to reduce marginalization and reduce vulnerability. For assuring access to HIV services for cross-border populations, collaboration is vital.
- From the UNODC perspective, stigma and marginalization are significant barriers to achieving the 90-90-90 targets. Effective interventions need to be implemented based on the rights and needs of people.

- UNFPA stated that more work should focus on youth and adolescents. For sexual transmission, youth are vulnerable for several reasons. Firstly, sexuality education is often not sufficiently available in EECA countries, despite the existence of comprehensive guidelines. Comprehensive sexuality education should be provided in the long-term. Second, there are young people among vulnerable groups and key populations and this should be considered
- Public health needs must be driven by existing and accumulating evidence, therefore more implementation research is needed. The high number of tests performed to diagnose HIV demonstrates efforts to increase the number of people being tested and aware of their HIV status (first 90). However, these efforts are not always focused where they would offer most benefit. ART programmes need to be optimized, for example by removing people from old regimens that are costly, thus allowing more people to receive treatment within the same budget.
- During the past 30 years, activities have focused on the easy-to-do interventions, effective in illustrating the magnitude of the epidemic but less effective in stopping it. The time has come to focus more on self-testing, rapid testing for those at high risk, test-and-treat strategy, and HIV prevention (since no country has successfully reversed the epidemic purely by testing and treatment). Not only those who test positive on HIV should be counselled and advised on HIV prevention, treatment and care. Those people who test negative for HIV should be provided with timely information, risk behaviour assessment and offered prevention tools to understand and know how to prevent HIV-infection in future.

The panel discussions concluded by opening the floor for questions from the audience, for more engagement by participants and a free dialogue. The feedback from the audience and reflections from panellists included the following points.

- Migrants are recognized as a “key population” group in the Action plan for health sector response to HIV in the WHO European Region adopted by all Member States.
- Financial support for HIV prevention and care in the region should not decrease. All efforts should aim for active collaboration with partners.
- The purpose of ART optimization should be to put people on treatment they can tolerate. There are situations where countries use ARVs which are obsolete and associated with considerable side effects.
- Sexuality education needs to be provided by trained staff, at schools or at young-people-friendly facilities. Across the Region, 15–18-year old adolescents often do not have access to condoms.
- Harm reduction programmes need to be more effective.
- Health is a political choice, but it is not clear whether making HIV a political issue would help or not. HIV should be depoliticized, and the focus should be on working in partnership, with support from the Global Fund and national sources.

Actions to accelerate countries' response to the HIV epidemic in the WHO European Region

Participants were assigned to 10 groups (six people per group) and each group nominated one person as rapporteur to give a summary of group discussions. The groups discussed two questions:

1. What are the two major public health approaches and fast-track actions to be undertaken for the next three years for non-EU/EEA countries?
2. What are the two major actions that need to be undertaken by countries or partners to assure sustainable financing of HIV national plans/programmes?

Feedback for first question included the following suggestions.

- Standardize treatment in line with international guidelines.
- Ensure availability of ART schemes.
- Adapt the 90-90-90 targets at national level and adjust legislation.
- Introduce a public health approach in HIV patient management.
- Increase coverage and effectiveness of HIV testing and treatment.
- Increase the level of awareness in the medical community.
- Introduce and implement HIV self-testing.
- Increase human resources, consider rotations (often there is a lack of healthcare professional in the specialised settings, especially nurses or social care workers and physicians are overloaded with counselling and pills refill tasks)
- Scale up people-centred “test-and-treat” services (with an emphasis on key populations).
- Strengthen the continuum of care through integrated services.
- Implement harm reduction programmes.
- Integrate HIV screening services into existing public health programmes (for example, within the HCV elimination programmes).
- Identify patients with any of the three diseases (HIV, TB, viral hepatitis) and provide care for any of the diseases.
- Accelerate registration of generic medicines in countries.
- Increase patient awareness about availability of medicines.
- Promote a non-judgmental attitude toward patients amongst clinicians.
- Scale up more focused HIV testing in key populations and ensure that these are offered in different settings.

- Improve linkages to care – physicians should encourage patients to continue treatment and to contact additional specialized services if they have other health problems, such as coinfections.
- Strengthen community involvement through supporting community-based projects to increase access to services for key populations.
- Transition from AIDS centres or other specialized HIV care settings to primary care services and entities that may offer the same services closer to those who need such services.
- Transition from a ‘silo’ approach through disease-specific programmes to integrated health systems.

Feedback for question 2 included the following.

- Assess the economic experience of various applicable approaches.
- Governments should commit to sustainable funding for the most promising areas of work.
- Technical assistance will be required from WHO/United Nations agencies – for innovative approaches and models of care.
- National programmes should be supported by national budgets. Countries should prepare internal regulations and policies in a timely manner to ensure a smooth transition from external funding to domestic funding of national HIV programmes where national programmes are still supported by the Global Fund or other international funding entities.
- Develop short-term budgets for three years, as needs may change year by year and a five-year plan may need to be changed radically.
- Develop and implement annual budgets, but consider feasible timeframes for disbursements and reporting, as this is a common fiscal-year funding practice in EECA countries.
- Develop a sound approach to budgeting, so that country budgets meet the needs of the programme.
- Strengthen, boost and ensure political commitment (government, ministries of health, and ministries of finance).
- ARV prices should be further reduced, especially given transition and a fast switch from external, Global Fund support to increased and full national allocations to cover HIV programmes.
- Improve pricing policies (for syringes, ARV, methadone) bearing in mind the positive experience in Ukraine and Kazakhstan.
- Review, standardize and optimize essential HIV service packages.

- Develop and endorse sustainability and transition plans.
- Engage municipalities to run programmes.
- Rationalize national programme costs.
- Seek support from international agencies.
- Consider collective drug procurement mechanisms (for a group of countries, if feasible) to ensure availability of generic drugs and lower the cost of ARV.

Sustainability of HIV prevention, treatment and care programmes for key populations

The objective of this session was to identify the challenges that still need to be addressed regarding prevention in key populations and overcoming inequities in and low access to prevention services.

Summary of key points and contributions from the panellists

- Current efforts are not enough to stop the HIV epidemic. The level of satisfaction with services is low. According to a survey in Ukraine, patients were dissatisfied in both health-care facilities and nongovernmental settings. About 21% of patients had had their ART regimen changed without their consent or any medical tests; about 54% of those patients subsequently showed worsening conditions. When asked where they would like to receive services, 63% of respondents said they did not want to receive ART in primary health care facilities, and 64% did not want to receive them in pharmacies, which they thought would lead to a high level of discrimination and stigma (even higher for drug users and MSM). Some 17% thought that ART was harmful rather than beneficial, and 15% did not think the benefit of ART was greater than the harm. Reaching the third 90 will not be possible without improving patients' quality of life.
- Ukraine has been using an integrated approach in narcology clinics – integrated care for patients, provided by narcologists, HIV specialists and/or NGO staff. About 80% of people receive ART. Of those, 25% received treatment for HCV as well.
- Community involvement is essential; this also applies both to services for HIV and HCV infection.
- Savings can be made in ART, by not providing second-rate drugs in a second-rate way, and by finding mechanisms to minimize corruption.
- According to UNAIDS Global AIDS Update 2017, nearly two thirds of the 1.6 million people living with HIV in eastern Europe and central Asia at the end of 2016 were aware of their infection. Of those who knew their HIV status, 45% were accessing antiretroviral therapy, and among those who were, 77% were virally suppressed. These data translate to treatment coverage of 28% and viral suppression of 22% among all people living with

HIV in the region. According to International Treatment Preparedness Coalition (ITPCru) group monitoring reports and assessments in EECA countries the numbers of people receiving ART are increasing, as well as number of new HIV infections. Regardless noted progress in some countries to increase treatment coverage, the number of people on treatment should clearly be doubled. For this, ITPCru estimates that an additional US\$ 6.5 million would be needed.

- Measures of work with key populations in national programmes should be included under prevention activities. As a success story, the experience of the Czech Republic decriminalizing injecting drug use was mentioned.

Implementing WHO guidelines in the European Region through national policies and plans

Recent advances in patient-centred monitoring were presented by staff from WHO headquarters. The key challenge is to use data to make national programmes more people-centred. In this process, three things need to be highlighted:

1. data collection and analysis should be considered a key strategic intervention
2. WHO strategic information priorities: 5 key areas from global reporting to local data use
3. person-centred monitoring and evaluation – patient and case guidelines.

Person-centred HIV patient monitoring and case surveillance guidelines are part of key activities leading to achievement of SDG, which have two data targets:

1. real, disaggregated data (SDG 17.18: “By 2020 enhance capacity building support ... to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ...”)
2. data for planning (country accountability and statistical capacity: to use data for planning).

Data are part of the package of the primary HIV response: at all levels for decision-making. Work should be done at three levels:

1. global: measure and manage programmes (epidemiological and impact reviews: regular, practical evaluation; improved estimates with surveillance data, including key populations);
2. district and facility: focus and differentiation (standard dashboards: testing, treatment, VL); and
3. individual and community: linkage to care, retention, quality of care (interventions at this level affect 60% of higher-level decisions related to HIV; evidence from national programmes and projects focused on key populations offer more programmatic benefits, while it is important to ensure confidentiality of these data).

WHO global strategic information priorities are structured under five key areas covering the whole process, from reporting to use of local data, as follows:

1. global reporting and validation of treatment, policies and prices
2. monitoring and evaluation guidelines: closing cascade gaps, and impact reviews
3. surveillance and strengthening district health information systems
4. procurement supply chain and access to medicines linked to District Health Information Software (DHIS) 2 platform
5. patient monitoring and individual level monitoring and evaluation to improve retention.

Prevention interventions and programmes developed without data are less effective, and so is treatment and care when it comes to assessing the goal of achieving viral suppression.

The key data targets are:

1. to achieve global impact – 90% of global fast-track countries evaluated for impact on incidence and mortality, using reported data and modelling;
2. to achieve district-level impact – 90% of countries have routine, real-time district-level data on testing, treatment and viral load with analyst capacity to feed back to programmes; and
3. to assure individual monitoring and evaluation – 90% of patients covered by robust, secure patient monitoring and case surveillance the whole way from testing to evaluation of treatment outcomes.

The audience was given the opportunity to reflect on and discuss why losses occur along the HIV care continuum, at different stages of the cascade of HIV care. Input from the audience on where most people are lost in follow-up during the continuum of HIV care included the following points:

- There is a need to develop unified databases of patients tested and taken into care, linked to a treatment database.
- Data and evidence from different data analyses need to be published and disseminated to all implementation partners, ensuring data confidentiality and using coding. The weakest part of the cascade is the testing and diagnosis (the first 90).
- In Kazakhstan, the HIV data monitoring system was developed in 2005 with support from international agencies. An electronic database tracks patients and produces quick inputs for standard indicators on a regular basis. It is used in the development of analytical reports. Data is entered online, generating cumulative rates, which are then analysed. As soon as new guidelines on monitoring and evaluation of HIV programmes are published, national experts review them to consider updating the national system to keep it up to date. The database is secure; individual patient data are coded and protected.

Development and update of HIV national plans was presented and discussed in light of the WHO Global Health Sector Strategy on HIV for 2016–2020 and the Action plan for health sector response to HIV in the WHO European Region. Both the global and regional strategic documents were adopted through the highest governing bodies of WHO at global and regional levels in 2016. The expectation and the suggested follow-up was to monitor and assist further the implementation of these strategies at national level. Some countries had undertaken some actions at national level to revise and update the national strategies and plans; others are in the process of doing so, and a few countries had requested WHO technical assistance to revise and guide the national strategy developments.

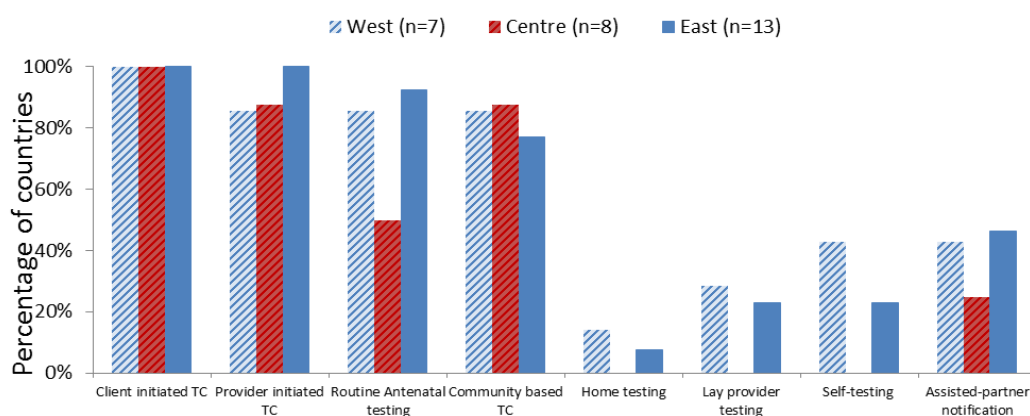
A similar situation was observed regarding the uptake of WHO recommendations on HIV testing, treatment and care. In developing national programmes and plans, WHO can support Member States by providing reference to published documents, guidelines, systematic reviews to verify the evidence and data, and also providing desk reviews. Where it is necessary (and feasible) to get involved with national activities and technical groups created by ministries of health for accelerating the revisions of national strategies, policies and protocols, WHO may respond with country missions. Key WHO guidelines cover most of the technical areas that reflect each of the 90-90-90 targets and suggest approaches and ways to address the issues from a public health perspective. These facilitate the integration of WHO recommendations into national plans and suggest what needs to be done to implement the guidelines within the national plans.

Towards reaching first 90

The following points were made by conference participants:

- Business as usual will not take countries forward. Projections for 25 years ahead showed that if interventions continue to be implemented at the current speed, it will take 25 years to reach the targets set for 2020.
- Latest data from the Global AIDS Monitoring reporting tool showed that very little has been done over the last year to boost involvement of lay providers in HIV testing services, while many countries report provider-initiated HIV testing policies and practices in place.
- HIV testing in some countries still must be paid for, and it is well known that services not being available free of charge for migrants is a specific challenge in some countries.
- In the East of the Region, linkages to care are included in national HIV policies or strategies about half of the time.
- Some countries are thinking about, or have already undertaken, initiatives to review policies on testing (see Fig. 4). Immunoblotting is no longer a recommended approach to confirm HIV diagnosis. WHO recommends the use of rapid tests and the involvement of lay providers in scaling up HIV testing services.

Fig. 4. HIV testing approaches in the WHO European Region (data from reporting countries, Global AIDS Monitoring 2016)

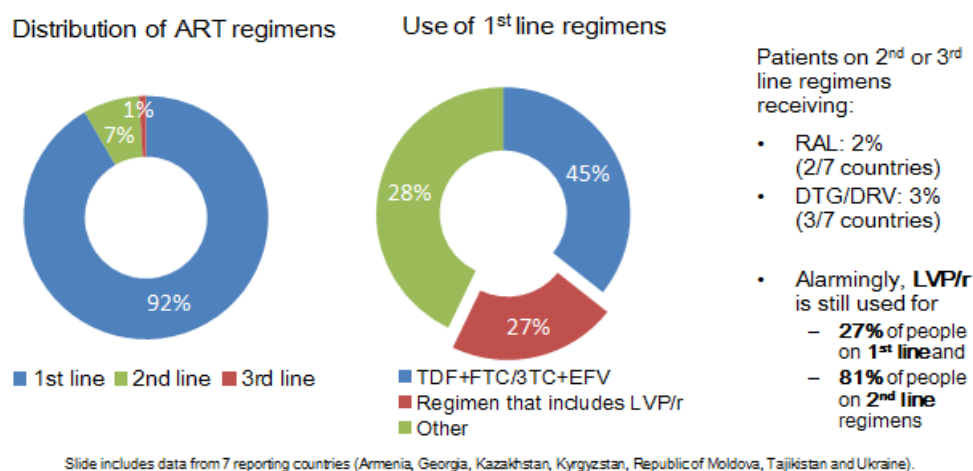


Towards reaching second 90

The following points were made by conference participants:.

- As regards the status of implementing the “treat all” approach, the “mapping” of countries that have adopted or already implement the policy shows differential progress.
- Priority areas of action by countries to implement WHO HIV and hepatitis guidelines were discussed at a WHO EECA meeting on guidelines dissemination held in Minsk, Belarus in September 2016. Countries identified priority areas for actions for the two years and planned to start updating the national HIV testing and treatment policies.
- Across seven reporting EECA countries with data available, 92% or more people receiving ART are on first-line regimens. WHO recommends wide use of first-line regimens with a view to optimizing ART use from a public health perspective.
- In first-line ART, a number of countries use ARV that are not recommended either by WHO or by any other international entity that develops international HIV treatment guidelines (see Fig. 5). For example, regimens that include lopinavir/ritonavir (LVP/r) are still used in first-line ART.

Fig. 5. Use of ARVs in EECA countries, 2016



- The current price of dolutegravir (DTG) in low/middle-income countries varies and depends on countries' agreements and licences. However, even where such arrangements exist, national action to register and procure the drug may be slow, or even non-existent. There needs to be more timely action at country level to register, procure and supply new ARV.
- Some country examples show that countries can save US\$ 100 000–300 000 a year by embarking on ART optimization and/or transitioning to using new ARV, where feasible. This is the case of countries that can register and procure the new ARV for reduced costs based on special agreements and existing special licences that allow procurements for reduced costs.
- Brazil is one of the first countries to move to a public health approach, and to offer ART to all PLHIV. It was able to treat more PLHIV specifically because it used new ARVs that were made available for a lower price, under special agreements and licences. As a result the number of people receiving treatment increased dramatically.

Third 90

The following points were made.

- WHO recommends measuring VL as the preferred monitoring approach to diagnose and confirm ART failure, using the threshold of virological failure of 1000 copies/ml based on two consecutive VL measurements using plasma specimens within 12 months, with adherence support interventions between measurements.
- WHO recommends strong collaboration between national TB and HIV programmes. This is relevant and opportune especially for countries using GeneXpert systems¹¹, given equipment already in place procured for national TB programmes in EECA countries.

¹¹ http://www.who.int/tb/publications/2017/considerations_multidisease_testing_devices_2017/en/

- New guidelines for the management of advanced HIV infection reiterate the role of CD4 count in monitoring disease progression and treatment outcomes. Advanced HIV disease is considered when CD4 cell count is <200 cells/mm³ or WHO clinical stage 3 or 4. The new guidelines propose a package of care interventions for advanced HIV disease. The public health response to pre-treatment HIV drug resistance is described in the new guidelines issued by WHO in July 2017.
- Differentiated care stands for different approaches to ART provision at different sites and refers to the need for task shifting where feasible. In 2016 WHO reached a consensus about the definition of stable patients on ART and those with advanced disease.
- Despite supportive policies, key populations are often still excluded from treatment, based on physician's decision.
- Continued work is needed to increase access to testing, increase the effectiveness and equity of service provision, increase the quality of HIV testing, ensure the scale-up and optimization of ART, apply models of differentiated care, ensure good monitoring of treatment outcomes and prevent drug resistance.

The key points raised in the discussion that followed the presentation included:

- consider the feasibility of using the Brazilian example for the second 90;
- improve regimens and make better use of resources;
- offer all PLHIV free treatment, irrespective of residence or location; and
- Intensify efforts to implement all WHO recommendations.

Countries face the challenge of discontinuation of treatment due to factors that cannot be easily controlled at the level of specialized HIV settings. These may need adjustment of intercountry agreements or regulations. As an example, one out of five patients in Armenia is under treatment but not located in the country (six, nine or 12 months outside the country). If treatment is stopped, there is increased risk of drug resistance and such cases are already recorded.

In this session, countries were asked to reflect and provide feedback to WHO on upcoming plans to revise national policies to align with WHO recommendations and to review implementation of the revised policies. The feedback from country delegations is summarized in Table 2.

Table 2. Priority areas of action by country and anticipated timeframe to implement WHO guidelines related to HIV prevention, treatment and care

Areas of action	Armenia	Azerbaijan	Belarus	Georgia	Kazakhstan	Kyrgyzstan	Republic of Moldova	Tajikistan	Ukraine	Uzbekistan
“treat all” approach	2017	2017–2018	2018	2015	2018	2017–2018	2017–2018	2018	2017	2018–2022
PrEP		2019		2017	2018–2019	2018	2017–2018		2017	
HIV testing strategies & quality assurance	2017	2017	2017	2017	2018–2019	2017	2017	2017	2017	2018–2022
HIV care & prevention in key populations (including migrants)		2017 (except migrants)		2017	2018–2019	2017	2017	2017, implemented		
Differentiated care & decentralization of services	2017	2017		2018	2018–2019	2017	2018–2019	2018	2017	2018–2022
New HIV drugs (DTG)	2017	2017		2017	2017	2018	2017–2018	2018		

Areas of action	Armenia	Azerbaijan	Belarus	Georgia	Kazakhstan	Kyrgyzstan	Republic of Moldova	Tajikistan	Ukraine	Uzbekistan
eMTCT & congenital syphilis (CS) (validation)	HIV&CS certif. 2016 ¹	2018	eMTCT & eCS 2016 ²	2019	2018	CS 2018	CS 2016 ³ eMTCT for 2018		2016– 2018	
Lab monitoring (VL)		2017		2017	2017	2017	2017	2017		
HIV drug resistance (HIV DR) surveillance	2017 ⁴	2017 ⁴	2017 ⁴	2017	2017	2017 ⁴	2019	2017 ⁴	2017	2017 ⁴
System information strengthening (90/90/90 indicators)	2017	2017		2017	2018	2017	2017	2017	2017	2018–2022

¹ Armenia received certification of validation of elimination of mother to child transmission of HIV (eMTCT) in 2016.

² Belarus received certification of validation of eMTCT and elimination of congenital syphilis (CS) in 2016.

³ The Republic of Moldova received certification of validation of CS in 2016.

⁴ Some HIV DR activities started 2016–2018 (with Russian Federation support).

Closing Session

WHO greatly appreciated the national contributions and timely efforts to ensure progress toward global and regional HIV related commitments in the Region, despite all the challenges, by (1) following the principle of “leaving no one behind”; and (2) mobilization of political commitment. The latter may be assured through making policy makers aware of the HIV epidemic situation in their countries and in the Region, working on sustainability of national programmes, and promoting more integration of HIV/TB/hepatitis services at all levels of government. This requires documenting existing evidence on services integration models, informing on changes to occur, explaining implications for each service or settings that may be affected by the change, building multisectoral partnerships, which in turn means full engagement of professionals from all the three areas and cooperation on a daily basis. Evidence sharing and advocacy for improved political commitment will be prioritized for government representatives at key WHO regional events: the Global Ministerial Conference on TB (Moscow, 15–16 November 2017), the ECDC/WHO joint meeting on HIV in Europe and central Asia in the era of the SDGs (Berlin, 23–25 April 2018), and the regionally driven events within the Global AIDS Conference 2018 (Amsterdam, 22–27 July 2018).

During the current meeting, country representatives were asked to respond to a range of questions following from the fast-track actions set out in the Action plan for health sector response to HIV in the WHO European Region. The questions were structured around five strategic areas of the action plan and aimed to assess the alignment of current national policies with the actions stipulated in the regional WHO HIV Action plan. The self-reported data were presented during the closing session and showed that most of the actions and interventions recommended by the regional Action plan are integrated into national strategies. Major gaps included lower levels of integration of: needle and syringe exchange programmes in prisons (27%), pre-exposure prophylaxis (PrEP) for populations at substantial risk (33%), HIV testing by lay providers (33%) and HIV self-testing (20%). In 60% of countries the national HIV strategy defines an essential comprehensive package of HIV services integrated into the national health benefits package. The results are presented in more detail in Table 3. The table shows only policy uptake that ranked less than 70% in the analysis of what EECA and non-EU/EEA countries reported regarding the alignment of national policies with the WHO policy.

These informal findings indicate that overall regional policy uptake is on the right track. However, prevention interventions for people who inject drugs and provision of PrEP, HIV testing by lay providers and HIV self-testing are areas requiring stronger advocacy and policy improvements. Integrating the essential comprehensive package of HIV services into the national health benefits package is essential to reach the 90-90-90 targets. This is particularly important for EECA countries given the trend over the last decade with the majority (nearly 80%) of people newly diagnosed being from the eastern part of the WHO European Region. Also, policy change does not equal implementation in practice and the current data for the WHO European Region show clearly that policy implementation must be strengthened to generate epidemic impact sufficient for the Region to reach the targets it has committed to.

Table 3. Implementation of the Action plan for health sector response to HIV in the WHO European Region: early results from EECA and non-EU/EEA countries

Policy intervention from the Action plan on health sector response to HIV in the WHO European Region	No of countries, EECA & non-EU/EEA, aligning with the WHO policy	% of EECA and non-EU/EEA countries aligning with the WHO policy
National HIV strategy defines an essential comprehensive package of HIV services integrated into the national health benefits package	9	60%
National strategy is aligned with national HIV testing and treatment protocols	10	67%
National HIV strategy prioritizes community-based HIV service provision	9	60%
National strategy includes needle and syringe exchange programmes in prisons	4	27%
National strategy includes opioid substitution therapy programmes in prisons	9	60%
National strategy includes PrEP for populations at substantial risk of HIV	5	33%
National strategy promotes early congenital syphilis diagnosis of infants and immediate treatment for all infants diagnosed with congenital syphilis	8	53%
National strategy promotes HIV testing conducted by trained lay service providers	5	33%
National strategy promotes HIV self-testing	3	20%
National strategy encourages innovative financing in the HIV response	10	67%



Appendix 1 – Meeting agenda

Day 1, Monday 25 September		
08.30–09.00	Registration	
09.00–09.30	Session 1: Introduction	
	Welcome & Opening Remarks Review of meeting objectives and agenda	Nedret Emiroglu , WHO Regional Office for Europe Masoud Dara , WHO Regional Office for Europe Vinay Saldanha , UNAIDS RST
09.30–10.15	Session 2: Strategic and technical context – Plenary session	
	Scaling up the response to HIV epidemic in the WHO European Region Ending AIDS. Progress towards the 90-90-90 targets in eastern Europe and central Asia HIV/AIDS in the European Union and European Economic Area (EU/EEA) Global context. Latest technical updates and WHO guidelines	Masoud Dara , WHO Regional Office for Europe Presentation (10 min) Vinay Saldanha , UNAIDS RST Presentation (10 min) Andrew Amato , ECDC Presentation (10 min) Marco Vitoria , WHO Headquarters Presentation (10 min)
10.15–10.45	Break	
10.45–12.30	Session 3: National HIV strategies, policies and action plans - Poster session, Lounge area 9	
	<u>Posters from:</u> Armenia, Azerbaijan, Belarus, Georgia, Israel, Kazakhstan, Kyrgyzstan, Montenegro, Republic of Moldova, Russian Federation, Serbia, Tajikistan, The Former Yugoslav Republic of Macedonia, Ukraine, Uzbekistan.	<u>Facilitators:</u> Masoud Dara , WHO Regional Office for Europe Andrew Seale , WHO Headquarters <u>Note:</u> The session may continue through the lunch time to allow discussions and questions.
12.30–13.30	Lunch (Lounge area 9)	
13.30–15.50	Session 4: Test and treat – progress in countries	
	Key messages on HIV testing from poster sessions. Panel discussion 1: Countries' progress on increasing access to and coverage with HIV testing	Maiken Mansfield , WHO Regional Office for Europe (10 min) Panel discussion (70 min) Facilitator: Elena Vovc , WHO Regional Office for Europe

	Key challenges in HIV testing policies Solutions and examples of success stories from countries	<i>Panellists: Irina Hlinskaya, Belarus; Daniel Chemtob, Israel; Igor Condrat, Moldova; Aleksandra Marjanovic, Montenegro; Ulan Kadyrbekov, Kyrgyzstan; Larisa Hetman, Ukraine</i>
	Q&A, Discussion	<i>Discussion (40 min)</i>
15.50–16.20	Break	
16.20–17.30	Session 4: Test and treat – progress in countries (continuation)	
	Key messages on HIV treatment from poster sessions.	<i>Maiken Mansfield, WHO Regional Office for Europe (5 min)</i>
	Panel discussion 2: Countries progress in scaling up HIV treatment & care Integration of “treat all” approach in countries’ policies Reaching and maintaining good ART coverage and good ART results	Panel discussion (60 min) <i>Facilitator: Marco Vitoria, WHO Headquarters</i> <i>Panellists: Samvel Grigoryan, Armenia; Ketevan Stvilia, Georgia; Vladimir Mikik, Macedonia; Valeria Gulshina, Russia; Daniela Simic, Serbia; Dildora Mustafaeva, Uzbekistan</i>
	Q&A, Discussion	<i>Discussion (15 minutes)</i>
17.45–19.30	Reception, UN City	
Day 2, Tuesday 26 September		
09.00–10.25	Session 5: Achieving 90-90-90 – fast track actions, cooperation for impact in the Region	
	Focus on: <ul style="list-style-type: none"> • Highlight the biggest gaps and actions needed to change the situation • Feasible solutions for accelerated response 	Panel Discussion (60 min) <i>Facilitator: Andrew Seale, WHO Headquarters</i> <i>Panellists: Andrew Amato, ECDC; Jaime Calderon, IOM; Masoud Dara, WHO; Zhannat Kosmukhamedova, UNODC; Dumitru Laticevschi, Global Fund; Jens Lundgren, WHO CC; Vinay Saldanha, UNAIDS RST; Ilya Zhukov, UNFPA</i>
	Questions & answers from the audience	<i>15 min</i>

10.15–10.45	Session 6: Actions to accelerate countries response to HIV epidemic in the WHO European Region – Discussion Groups format	
	Themes and arrangements for small group discussions, instructions for facilitated discussions	<i>Chairs: Masoud Dara, WHO Regional Office for Europe Andrew Seale, WHO headquarters Elena Vovc, WHO Regional Office for Europe (5 min)</i>
10.45–11.15	Break	
	Session 7: Discussion Groups	
11.15–12.00	Theme 1: Integrating the public health approach into national policies. Fast track actions for countries (Facilitated small group discussion)	<i>Facilitators: tbc (45 min)</i>
12.00–12.45	Theme 2: Finance for Sustainability. Fast track actions for countries (Facilitated small group discussion)	<i>Facilitators: tbc (45 min)</i>
12.45–13.00	Summary of the Session	<i>Andrew Seale, WHO headquarters (15 min)</i>
13.00–14.00	Lunch	
14.00–15.15	Session 8: Sustainability of HIV prevention, treatment and care programmes for key populations	
	Access to HIV services for key populations, interventions for impact Integration into the national HIV strategies and policies	<i>Panel Discussion (50 min) Facilitators: Naira Sargsyan, UNAIDS RST; Elena Vovc; WHO Regional Office for Europe Panellists: Michael Krone, AIDS Action in Europe; Martin Donoghoe, WHO Country Office in Ukraine; Anna Zhakovic, AHF; Serhii Riabokon, Ukraine; Natalia Khilko, ITPC; Vladimir Zhovtyak, ECUO</i>
	Questions & answers from the audience	<i>25 min</i>

15.15–15.45	Session 9: Implementing WHO guidelines through national policies and plans	
	Plenary 1: Strategic information for national strategies and plans	<i>Chairs: Daniel Low-Beer, WHO Headquarters; Andrew Amato, ECD; Annemarie Stengaard, WHO Regional Office for Europe.</i>
	Person centred monitoring – data for improving programs and estimates Questions & answers	<i>Presentation (15 min) Daniel Low-Beer, WHO Headquarters 15 min</i>
15.45–16.15	Break	
16.15–17.00	Session 9: Implementing WHO guidelines in the European Region through national policies and plans (continuation)	
	Plenary 2: Guiding principles on HIV testing and treatment - implications for national programmes and policies revisions.	<i>Chairs: Marco Vitoria, WHO Headquarters; Naira Sargsyan, UNAIDS RST; Elena Vovc, WHO Regional Office for Europe</i>
	Aligning national policies with WHO guidelines on HIV testing and treatment. Questions & answers	<i>Presentation (15 min) Elena Vovc, WHO Regional Office for Europe Marco Vitoria, WHO Headquarters Discussion (30 min)</i>
17.00–17.30	Session 10: Summary of key outcomes from the meeting	
	Next steps Conclusions, recommendation Closing remarks.	<i>Elena Vovc, WHO Regional Office for Europe Naira Sargsyan, UNAIDS RST Andrew Seale, WHO Headquarters Masoud Dara, WHO Regional Office for Europe Vinay Saldanha, UNAIDS RST Michel Kazatchkine</i>
17.45	Adjourn	

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