

# MEETING REPORT



**Meeting of the National HIV Programme Managers  
in the WHO European Region**

**The Hague, Netherlands  
16 May 2019**



## Abstract

HIV and tuberculosis (TB) form a deadly combination. The risk of developing TB is far greater for people living with HIV and TB is a leading killer among this population. People suffering from TB/HIV coinfection are at increased risk of failing their treatment regimen and have amplified risk of mortality compared to people who have TB disease alone. Held back to back with the Wolfheze Workshops 2019, the WHO Regional Office for Europe gathered for the first time both HIV and TB national representatives and relevant partners in a joint National HIV Programme Managers Meeting to coordinate and to strengthen the response to the increasing rates of HIV and TB/HIV coinfection in the Region. The meeting took place in The Hague, Netherlands, on 16–17 of May, and focused on both the commitments made at the first ever United Nations General Assembly High-Level Meeting on Tuberculosis and those in (i) the Action Plan for the Health Sector Response to HIV in the WHO European Region, and (ii) the Tuberculosis Action Plan for the WHO European Region 2016–2020; with the aim of identifying the best ways for countries to move towards the agreed targets in the response to both epidemics. The meeting was jointly coordinated and hosted by the WHO Regional Office for Europe, the European Centre for Disease Prevention and Control (ECDC) and the KNCV Tuberculosis Foundation. This report focuses on the specific Meeting of the National HIV Programme Managers in the WHO European Region held on 16<sup>th</sup> May 2019.

### Key words

ASIA, CENTRAL  
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Representatives of member States of the WHO European Region and Civil society organizations who contributed to the discussions in the meeting.

## Abbreviations

ART	antiretroviral treatment
CSO	civil society organization
EECA	eastern Europe and central Asia
HBV	hepatitis B virus
HCV	hepatitis C virus
MDR-TB	multidrug-resistant tuberculosis
MSM	men who have sex with men
OST	opioid substitution therapy
PLHIV	people living with HIV
PrEP	pre-exposure prophylaxis
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS

## Introduction

In alignment with the 2030 Agenda for Sustainable Development, many countries in the WHO European Region are determined to make sure that no one is left behind in the response to HIV and tuberculosis (TB). However, sustained long-term health systems development, comprehensive and vertical public health strategies, and sustainable domestic financing schemes exercised through a human rights-based approach focusing on marginalized groups and key populations are urgently needed to close gaps in the response. Universal health coverage; integration of sexual and reproductive health services and rights, including gender equality issues, and empowerment of women and youth; and social and economic development also play a vital role in the response to these epidemics in the Region, which are strongly rooted in social determinants of health. However, efficiency increases require scale-up of intersectoral engagement, including support from the private sector, to halt and reverse the TB, HIV and viral hepatitis epidemics by 2030.

The continuous rise of new HIV diagnoses in eastern Europe and central Asia (EECA), accompanied by late diagnoses in just over half of all new HIV cases identified in the Region, and low access to antiretroviral therapy (ART) are serious challenges that require immediate solutions. Mortality is also increasing and is extremely high relative to the estimated number of infected people, in comparison to other WHO regions. TB/HIV coinfection and multidrug-resistant tuberculosis (MDR-TB) are also on the rise, as a proportion of newly diagnosed TB cases. Other continuing challenges in the Region include: unknown routes of transmission, lack of access to pre-exposure prophylaxis (PrEP), severe lack of harm reduction services, lack of entry into care, loss to follow-up, stigmatization, lack of people-centred approaches to care, poor engagement in the HIV continuum of care, and the need to integrate disease programmes in an efficient manner that is beneficial to patients and health systems alike. Regarding prevention, broad and mass public information campaigns coupled with testing in the general population in priority countries often seem to be the preferred strategy in the Region. However, prevention and testing services are best accessed when focused on specific key populations and locations of the reservoir of the disease of concern.

In 2019, the needs of people living with HIV (PLHIV) and those with TB are starting to become co-recognized by the public health community. Alignment between the relevant structures in the health response can and must be achieved as the benefits for patients through disease programme integration far outweigh the risks of continuing with siloed epidemic responses. Aiming to end these significant obstacles and move forward with programme integration, colleagues took stock of the development of the individual country roadmaps in the health sector response to HIV in the Region and assessed their strategic plan for implementation during the meeting.

## Setting the scene

Representatives from WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) presented on the HIV epidemiological trends in the Region, progress on the 90-90-90 targets by 2020, and how to bend the trajectory of the growing HIV epidemic.

### HIV and TB

Both HIV and TB are major public health threats which compromise the health of people living in the European Region, where there are an estimated 2.3 million PLHIV (estimated at 6% of the global burden). Although the general rate of TB infection is declining steadily, the same cannot be said for HIV, where each reporting year marks the highest number of new diagnoses in the Region and specifically in EECA, where the rate continues its dramatic increase. In 2017, just under 160 000 new HIV diagnoses were made and more than 80% of these originated from EECA alone. TB incidence has been declining steadily in the Region since 2000, now with an estimated 3% of the global burden of TB. However, the Region is home to 9 out of the world's 30 high-burden MDR-TB countries, as well as 350 000 people with rifampicin-resistant MDR-TB (RR/MDR-TB). This represents one quarter of the global RR/MDR-TB burden and means 1 in every 4 new TB cases is multidrug-resistant, thereby contributing heavily towards onward transmission of TB in the European Region.

TB/HIV coinfection has also increased fourfold in the Region over the last decade, from 3% in 2007 to 12% in 2017 – so 12% of TB patients, or 1 out of every 8 new TB patients notified in the European Region, was also HIV positive in 2017. Furthermore, of those TB patients who know their HIV status in the Region (91%), roughly two thirds of them are accessing ART (67%). This lack of treatment contributes to a 13.8% annual increase in the rate of mortality for TB/HIV coinfecting patients. These patients are dying and at a faster pace every year. Treatment coverage in the Region is unacceptably low for both HIV and TB/HIV coinfection, thereby leading to both onward transmission of HIV and increased mortality due to AIDS. Estimated new HIV diagnoses, currently at a historic high, would need to decrease by 78% by 2020 across the whole Region to achieve the 2020 targets. Even in the European Union and European Economic Area, where the overall trend has declined slightly in recent years, achieving the target would require a decline in new HIV infections of 74%.

## **Viral hepatitis**

In the European Region, 15 million people are estimated to be infected with hepatitis B virus (HBV), and 14 million to be chronically infected with the hepatitis C virus (HCV). It is also estimated that approximately 56 000 people die every year due to HBV-related and 112 500 due to HCV-related cirrhosis or liver cancer in the Region. Mortality due to hepatitis has been steadily increasing every year. Member States and the Regional Office remain steadfastly committed to improvements in blood safety and quality assurance, working towards testing of all donated blood for blood-borne infections including HBV and HCV. Since implementation of the Action Plan for the Health Sector Response to Viral Hepatitis in the WHO European Region, access to treatment for HCV has increased overall and many Member States have removed restrictions based on the stage of liver disease in line with the current WHO recommendation to treat all patients with chronic HCV infection. However, 1 in 4 new hepatitis cases and 1 in 3 hepatitis-related deaths are concentrated in people who inject drugs.

## **Technical assistance requests and HIV roadmap operationalization**

The session assessed the implementation and way forward for individual country roadmaps in the health sector response to HIV in the Region. Through group work and discussion, individual countries highlighted their country support needs and requests to WHO. Key issues included: prevention and ensuring adequate surveillance for key populations,<sup>1</sup> linking operational research to clinical practice, the particular unmet need of migrants in the Region in both the HIV and TB response (particularly in central Asia), and the need for amendments in discriminatory policy and legislation at the country level to leverage an equitable response to the epidemics that leaves no one behind by 2030.

The United Nations Common Position on Ending TB, HIV and Viral Hepatitis through Intersectoral Collaboration offers a platform from which countries may seek to address the social determinants of health in the response to HIV, TB and viral hepatitis. Four countries in the European Region are currently piloting its operationalization: Belarus, Portugal, the Republic of Moldova and Tajikistan. The WHO Regional Office for Europe encourages countries with the capacity to move forward in a similar endeavour (the publication is available in Russian and English language).<sup>2</sup>

In addition, the Regional Office established the HIV Treatment Reference Group (HIV-TRG) in 2018 to support countries in scaling up antiretroviral treatment and care, and to meet an urgent need for high-quality technical guidance on HIV treatment.

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<sup>1</sup> This includes moving to prospective cohort studies (including on incidence) and away from retrospective cohort-based estimates, which often overestimate the prevalence and incidence in the heterosexual population.

<sup>2</sup> United Nations Common Position on Ending TB, HIV and Viral Hepatitis through Intersectoral Collaboration. Copenhagen: WHO Regional Office for Europe; 2018 (<http://www.euro.who.int/en/publications/abstracts/united-nations-common-position-on-ending-hiv,-tb-and-viral-hepatitis-through-intersectoral-collaboration-2018>, accessed 31 July 2019).

Countries primarily requested strategic support, especially regarding intersectoral collaboration. Countries may benefit from assistance with intersectoral case management, as well as developing grounds for intercountry and bilateral relationships/visits in the responses to the epidemics. This was particularly true for countries transitioning from international to domestic funding, who wanted guidance on how to provide local support across a variety of sectors, especially for key populations. This should include prevention projects, which have been a mutual concern for all countries. Highly-skilled individuals working across a variety of sectors and recognizing health in all policies, with these specific diseases in mind, are needed. WHO and international agencies might play a role in developing the terms of reference of this human resource.

Adolescents also need to be engaged in the response in all countries. This was also a major conclusion from the 22nd International AIDS Conference and the Ministerial Policy Dialogue on HIV and Related Comorbidities in Eastern Europe and Central Asia in 2018.

Finally, approaches that consider all aspects, including social determinants of the epidemics are essential. Medicalization of the problem, by only focusing on treatment and care, risks losing primary prevention strategies, which are at the heart of epidemic responses.

During the session, countries took part in two panel style discussions to review technical successes and gaps in the response to the epidemics. See Annex 1 for country-specific responses to both panel discussions.

## **Country posters**

Countries also shared nine posters from EECA highlighting work in key populations. Good practice examples included: opioid substitution therapy (OST) expansion, social case management, HIV PrEP pilots (two countries), increases in treatment access for prisoners and others in enclosed settings, and community-based testing expansion for key populations.

Key messages from the country posters included:

- Laws and policies that assure HIV services are offered free of charge to key populations within national programmes are present in several countries.
- Bio-behavioural surveys are essential to understand the epidemic among key populations, but depend on external funding.
- Two countries cited that at least half or more of PLHIV who inject drugs had received treatment.
- All countries relying on support from the Global Fund to Fight AIDS, Tuberculosis and Malaria have increased the state budget for interventions, primarily for ART but also for some prevention work for key populations.
- Community-based testing services were mentioned.
- An accelerated response is urgently needed for key populations in prevention, testing, treatment and care.

## **Requests for WHO support**

Requests for technical support from WHO were also made by some countries. These included requests for WHO support to:

- understand the drivers of their epidemic (integrated biological and behavioural surveillance (IBBS) analysis and others) and the response (key populations cascades);
- revise testing approaches/protocols;
- provide expertise on how to use information and communication technology solutions to reach key populations and improve case finding;

- optimize ART regimens;
- implement and monitor low threshold HIV/hepatitis/TB harm reduction programmes for people who inject drugs;
- ensure migrants' access to services;
- facilitate smooth transition from Global Fund support to social contracting of civil society organizations (CSOs) to sustain prevention.

Countries have also requested WHO to facilitate intercountry exchanges. Individual country support needs will be compiled at a later stage.

## **WHO and other technical and regional updates**

Representatives from WHO and from civil society each presented on various technical and regional updates including: (i) WHO guidance updates on prevention of HIV and viral hepatitis in key populations, (ii) WHO updates on HIV treatment and care, (iii) sustainability of services for key populations in EECA, and (iv) people-centred approaches to care.

### **WHO guidance updates on prevention of HIV and viral hepatitis in key populations**

Key populations are at the highest risk of HIV and hepatitis B and C. Common issues regarding key populations in the Region include: poor surveillance and population size estimates, criminalization of both sex work and same gender sex, criminalization of drug use (most countries), lack of harm reduction services (needle and syringe programmes and OST), poor recognition of transgender issues, and overincarceration as a result of strict laws. In response, WHO developed a comprehensive package of evidence-based interventions for implementation among key populations. Updated guidance from 2016 is available.<sup>3</sup> However, these interventions are only successful with sufficient political will to address structural barriers, increase domestic financing and move towards universal health coverage. Differentiated service delivery, especially through decentralized/low-threshold services is needed. Finally, intersectoral stakeholder engagement is required from planning to implementation. This includes various ministries, international donors, CSOs, the private sector and key populations themselves.

### **WHO updates on HIV treatment and care**

The HIV treatment cascade for people who inject drugs and those who do not is alarmingly different, with much lower numbers for people who do inject. Some countries are doing well in monitoring this. Late presentation is a problem everywhere and the proportion of late presenters is higher in people aged 50 and over. Fortunately, the Global AIDS Monitoring report shows increased use of WHO recommended regimens, where dolutegravir is the first-line ART in low- and middle-income countries.<sup>4</sup> Despite these supportive policies, key populations are sometimes excluded from treatment. Integration of services, differentiated approaches and people-centred care that includes all populations will assist in filling in this gap.

Since 2016, WHO has recommended adopting new alternative antiretroviral 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<sup>5</sup>. In 2017, WHO issued a policy brief on transition to new antiretrovirals that recommend the use of dolutegravir in first-line regimens since it has higher tolerability, improved treatment outcomes and a lower risk profile for HIV drug resistance<sup>6</sup>. Fixed dose combinations of antiretroviral drugs need to be prioritized since they increase adherence to treatment. WHO released guidelines for managing advanced HIV disease and rapid initiation of ART in 2017<sup>7</sup>. The Organization recommends that a package of screening (including advanced screening methods), prophylaxis, rapid ART initiation and intensified adherence interventions be offered to everyone living with HIV presenting with advanced disease. The guidelines also include an algorithm to support decision-making for providing care to people with advanced HIV disease. WHO also recommends that rapid ART initiation should be offered to PLHIV following confirmed diagnosis and clinical assessment. Rapid initiation of ART is defined as within seven days of HIV diagnosis. People with advanced HIV disease should be given priority for clinical assessment and treatment initiation. WHO will issue updated ART guidelines before the end of 2019.

## **Sustainability of services for key populations**

The Alliance for Public Health in Ukraine has a large range of projects dedicated to expanding services for key populations in the EECA region.<sup>8</sup> However, the “#SoS project” represents the largest Global Fund regional project, with 14 countries and 24 cities involved in improving services delivery and access for key populations in the EECA region. The goals of the project are to:

- increase the financial sustainability and efficiency of HIV programmes
- remove the most important barriers to access to prevention and care services for PLHIV
- improve efficiency and affordability of HIV service delivery models for key populations.

Some novelties of the project include: an online system monitoring policy changes for equitable treatment of all people in the epidemic response; optimization of antiretroviral drug prices and unit costs; integration of TB, HIV and hepatitis efforts; support for the introduction of new testing and treatment initiation strategies; key population outreach screening; and partner notification. A focus on improving quantity and quality services in key populations, especially people who inject drugs, through major increases in harm reduction programming, equitable services for people in prisons, and vaccination for hepatitis B are warranted.

## **People-centred approaches to care**

Medicalization of the epidemics of TB, HIV, and hepatitis has been crucial to finding effective treatments to rollout for patients. However, as the medical community moves forward with well-established treatment regimens, meeting the needs of people in their medical and social contexts will allow for a more effective response. Services must always be accessible, including socially. However, in the EECA region, services are usually delivered in silos, are highly

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<sup>3</sup> Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. 2016 update. Geneva: World Health Organization; 2016 (<https://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/>, accessed 31 July 2019).

<sup>4</sup> Policy brief Transition to new antiretrovirals in HIV programmes. Geneva: World Health Organization; July 2017(<https://apps.who.int/iris/bitstream/handle/10665/255888/WHO-HIV-2017.20-eng>)

<sup>5</sup> Guidelines for managing advanced HIV disease and rapid initiation of antiretroviral therapy. Geneva: World Health Organization; 2017. (<https://www.who.int/hiv/pub/guidelines/advanced-HIV-disease/en/>)

<sup>8</sup> Eastern Europe and central Asia. Alliance for Public Health [website] (<http://aph.org.ua/en/our-works/eastern-europe-and-central-asia/>, accessed 31 July 2019).

specialized, and are primarily accessed by those who do not face legal and social barriers to care. For example, in one country, nearly 40 000 people are registered in the system but are not on ART. Primary health care is clearly essential, and the general practitioner is usually the first doctor who discovers the late presenter for HIV. Ageing and comorbidities play a role in treatment adherence, so high-quality primary health care services and family doctors, and specialists, who provide people-centred care are paramount. In this manner, a “one-stop shop” for diagnosis, treatment and initiation of care is vital to successful outcomes for those living with HIV, although this is not without challenges for health system development.

## **Concluding remarks**

In the WHO European Region, the HIV epidemic is highly concentrated among key populations and HIV incidence is rising every year. Countries need to continue to scale up evidence-based combination prevention interventions addressing HIV, hepatitis and TB, with a particular focus on harm reduction services for people who inject drugs. Sufficient scale-up has simply not occurred during the past years, especially in the EECA region. Many countries have strong expertise, but political commitment to address the epidemic is severely lacking in some countries. There is a need to strengthen the use of local evidence for policy and strategic decision-making while demonstrating outcomes and impact rather than simply citing programmatic outputs. Change, acceleration and scale-up need to happen now as the 2020 fast-track targets set by UNAIDS are to be met by the end of 2019.

These concentrated epidemics are rooted in social, religious and political cultures and reality. Ignoring these dimensions of the epidemics causes them to grow incredibly fast and at a rate that societies will eventually be unable to effectively cope with. First, countries need to remove punitive laws and policies. Second, harm reduction must be scaled up as the lack of these programmes takes lives every day in the Region. The drug use environment is also changing, but we have not yet protected our citizens from the health threats of the current environment. Finally, migrants must be recognized and cared for as vulnerable and key populations.

Ministries of health and justice are much more informed than just 10 years ago and are ready for continued action. However, it is not only governments that must provide leadership, but also key populations themselves, youth, and civil society if we expect to make a noticeable difference. Health is often political, but good health outcomes and accessible health care for all is a human right. There must be strong, equitable and progressive dialogue that reassures politicians across the Region that investment in HIV is not only a good idea for the health of their citizens, but for the growth of their societies as a whole. Countries are highly encouraged to invest in intercountry and intersectoral work to respond to the epidemics together. Consistent linkage to TB and hepatitis, to reduce costs and optimize service delivery is essential. The midterm progress report on the Action Plan for the Health Sector Response to HIV in the WHO European Region is being prepared for publishing by the end of 2019, and therefore colleagues must move forward in good faith, partnership and confidence towards 2020 and 2030 targets.

## **Annex 1. Country responses, panels 1 and 2**

Panel discussions on countries responses to HIV epidemic aimed at identifying current gaps and needed interventions for national HIV programmes. In two consecutive panel discussions moderated by WHO, speakers from selected countries informed on their respective strategies and roadmaps for the HIV response at national level. Various opinions from panellists clarified whether with existing strategic documents approved by the Ministry of Health, all measures are taken to ensure full coverage of HIV services or there are specific areas to address in the immediate future. Countries representatives were also invited to comment on domestic funding for national HIV programmes and suggest which areas of work deserve more attention by the Government, partners and civil society in 2019–2020.

### **Panel 1**

#### **Armenia**

Labour migration has become a major issue in the response to HIV and TB in Armenia. People may become HIV positive before, during or after the migration process, and in receiving countries, treatment may not be available. It also creates issues for monitoring the continuum of care in the countries where the migrant was first registered as they may decide to overstay or leave their country of origin altogether, which is a serious obstacle in Armenia for the HIV response.

#### **Belarus**

Belarus has been experiencing loss to follow-up during the journey to accessing treatment. Regarding key populations, the country has been trying to strengthen drug policy. People who use drugs may get left behind because they are afraid to report for care in the clinical institutions and then do not access care at all. Regarding procurement, there are complicated drug acquisition processes in Belarus. Disruptions in drug supplies have occurred and national manufactures are not yet participating in local-level bidding. Therefore, the country has problems purchasing new drugs and is using older regimens. These older drugs have side effects, resulting in poor treatment adherence. However, the country has strong representation by CSOs for adherence support and viral load monitoring.

#### **Kyrgyzstan**

The country is running a massive communications campaign to raise public awareness on HIV, is planning surveillance among labour migrants in collaboration with UNAIDS, and will soon include self-testing in the national HIV programme. There are also plans to urge the Ministry of Health to focus on MSM in the country. Kyrgyzstan has missed opportunities to complete surveys to better tailor prevention programmes. Representatives from the Ministry of Health visited all the country's regions and investigated the multisectoral committees on TB, HIV and malaria, many of which are very effective, with continued plans to engage across all sectors for the response.

#### **Lithuania**

The National Health Insurance Fund in Lithuania will be covering the treatment of prisoners for TB, HIV, and viral hepatitis to ensure equal care between the general population and people in prisons. The country is planning to decentralize testing and expand HIV testing services to the primary health care level. Reaching the second of the 90-

90-90 targets<sup>9</sup> is the largest obstacle in the country. Despite slight increases in ART coverage from 30% to 40%, there are still large gaps between testing, diagnosis and the ability to treat those patients who are HIV positive. Issues with the national testing algorithm are also present. A multisectoral approach is desired, but some municipalities require more advocacy to ensure that there is equity in the response.

## **Russian Federation**

From 2016, the Russian Federation rolled out a new strategic plan to respond to HIV. The country has not created a formal WHO roadmap in the health sector response to HIV but uses this strategic plan in its place. It addresses treatment, increasing public awareness, stigmatization and criminalization of behaviours and groups, and active involvement of CSOs to ensure compliance and adherence to treatment. Plans to provide social services and increase domestic funds to run the programmes are also included. The last three years have seen major increases in the overall numbers of tests delivered in the Russian Federation. Testing campaigns have been broadly covered by the media. Through these campaigns, 5 million people were tested. Provision of ART, especially for people who inject drugs, still persists as a major challenge in the country, especially considering the continuous rise of the number of people requiring ART. HIV drug resistance is also a growing issue. The Russian Federation reports that the HIV epidemic in the country is a generalized epidemic with 70% sexual transmission. The approach to HIV testing services also addresses those in the workplace. The work of CSOs to address the epidemic among key populations is recognized but the general population cannot be set aside in a country with so many people and territories, and micro-epidemics of their own nature within them.

## **Panel 2**

### **Azerbaijan**

The HIV response in Azerbaijan needs to be expanded to all key populations in the country. In particular, to transgender individuals, recognized by WHO as a key population, who are not covered at all. Heterosexual transmission still persists as an issue. HIV self-testing and community-based HIV testing services need to be readily available. Open discussions regarding the inclusion of self-testing in the national programme are ongoing. A pilot PrEP project targeted at MSM is expected to begin. Multidisciplinary teams are working on a range of issues and ministerial level support is high. Active programmes for HCV and HBV are being rolled out and HIV testing for people living with TB and is becoming better integrated with HIV services. The strategic plan is to ensure that all people living with TB or newly diagnosed with TB are also tested for HIV.

### **Georgia**

Georgia had the first HCV elimination programme in the EECA region, with support from the United States Centers for Disease Control and Prevention (CDC), a pharmaceutical company and local health authorities. HCV elimination served as a great platform for increases in both HCV and HIV testing services. The pilot project, launched in 2018 with the support of the Global Fund in one region in Georgia, triangulated all the testing and treatment of HIV, hepatitis and TB. The pilot project was successful and contributed towards achieving the first of the 90 target on diagnosis,<sup>10</sup> which has been a significant obstacle in the country. The Government of Georgia is committing to focus efforts on key populations. For example, a PrEP programme was also launched in 2017 and currently 150 people are taking PrEP

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<sup>9</sup> By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.

<sup>10</sup> By 2020, 90% of all people living with HIV will know their HIV status.

(no reported cases of seroconversion) with expansion planned. The key message to report to health authorities in the country is that they should increase HIV testing in high-risk populations, especially among MSM. HIV testing needs to be routine and decentralized, with specific focus on key populations.

## **Republic of Moldova**

A focus on key populations and specifically the expansion of OST is needed in the Republic of Moldova. By 2020, the country hopes 60% of people who use injection drugs, 60% of sex workers and 40% of MSM will be covered by the relevant services. The estimated total number of people from key populations nearly doubled in the last surveillance period. Health authorities would like to scale-up treatment and availability of treatment centres but are simultaneously having major problems with the monitoring and evaluation system. One single linked and integrated surveillance system across all relevant diseases, or at least TB, HIV and hepatitis, is urgently needed to monitor patients. Hepatitis data is lacking in the Republic of Moldova. This surveillance challenge seems to be the priority before advances can be made with key populations, so progress can be correctly monitored. CSOs need a greater platform to deliver services in the country. New ways of drug use and drug forms are also coming forward, but the national drug programmes only have services for injecting drug use, so immediate engagement of CSOs on service delivery should be leveraged in the anticipation of these new challenges.

## **Ukraine**

In Ukraine, the average time from diagnosis of HIV to starting ART is 15 days, as of 2019. In 2008, it was much higher. Diagnostics, the first 90 target,<sup>10</sup> is the greatest challenge in Ukraine. Some of the highest priority areas with the largest HIV burden are in rural populations, so expenditure and health-care financing needs to be adjusted to this context. The public health system has been recently reformed in Ukraine. Soon, all people will be linked to a family doctor/general practitioner, which will hopefully begin to close the gap between the estimated number of people living with HIV and those being diagnosed. The old reporting system needs to be addressed, as there is a large amount of paperwork, and the administrative process for doctors and medical staff stalls technical capacity to respond to the epidemic and care for patients. The primary message to the responsible ministers is to be open to new technologies and spaces to allow for the optimization of workload and workflow, which ensures speedy and efficient care for patients who need it.

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## The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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