Ministerial policy dialogue on HIV and related comorbidities in eastern Europe and central Asia (EECA)[1]

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Meeting Report

[1] EECA Member States of the WHO European Region: Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Uzbekistan and Ukraine.

Abbreviations

AIDS	Acquired immune deficiency syndrome
CSO	Civil society organization
EECA	eastern Europe and central Asia
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human immunodeficiency virus
NGO	Non-governmental organization
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
MSM	Men who have sex with men
PREP	pre-exposure prophylactic treatment
SRHR	sexual reproductive health and rights
PEP	post-exposure prophylactic treatment

INTRODUCTION

Background

Mr James Chau (United Nations Goodwill Ambassador) opened the meeting by noting the unique design of the closed-door framework and welcomed the presence of all ten honourable Minister and Deputy Ministers. Mr Chau focused on the meeting as a unique platform where Ministers may learn from each other before moving to to an overview of Regional epidemiology.

Ministers of Health unanimously endorsed the Action plan for the health sector response to HIV in the WHO European Region during the 66th session of the Regional Committee for Europe in September 2016, thereby expressing enhanced commitment to scale-up response efforts to the growing HIV epidemic. Member States, key partners, including civil society groups, communities of people living with HIV and donors agreed to reach key 90-90-90 targets[2] by 2020 through evidence based HIV prevention, accessible and affordable testing, treatment and care services to end AIDS by as a public health threat by 2030 in accordance with Sustainable Development Goal 3.3

On 25 and 26 September 2017, the WHO Regional Office for Europe, in collaboration with UNAIDS, convened a meeting of HIV programme managers, at which representatives of EECA countries and Member States not members of the European Union or European Economic Area presented the status of their national HIV strategies and action plans. Countries reported national efforts to revise and optimize their HIV testing and treatment policies. Several countries have started the "treat all"[3] approach and others have endorsed new national HIV testing and treatment protocols and/or implemented nationwide innovative interventions, such as self-testing. Building on the lessons learned from successful interventions and programmes, there is an urgent need to scale up effective preventive measures, early diagnosis and quality treatment and integrated/coordinated care for all, with a specific focus on key populations, to curb the epidemic. Several countries in the EECA part of the Region are transitioning from international donor funding towards domestic funding of the HIV response. Finding innovative and inclusive mechanisms for financing the HIV response in this context is a pressing topic.

Ministerial policy dialogue on HIV and related co-morbidities in eastern Europe and central Asia

Partnership: the meeting was jointly organized by the WHO Regional Office for Europe, Government of the Netherlands, and UNAIDS back-to-back with the 22nd International AIDS Conference to bridge further between the eastern European and central Asian countries where the epidemic continues to rise.

Ministerial Representation: To provide quality and timely people-centred services and curb the epidemic, there is a need for strong political will, adequate funding and exchange of know how to address barriers. To this end, the Ministers of Health of eastern Europe and central Asia countries were invited to a Ministerial Policy Dialogue[4]. This is one of the first times such number of high-level Ministerial delegation was present to share good practices in the health sector response to HIV in the WHO European Region.

Outline: to compliment the AIDS2018 theme *"Breaking Barriers, Building Bridges"* and recognizing bridges must exist between politicians, geographical regions, governments, civil society organizations (CSOs), including representatives of key populations, the meeting was designed with the following six main components back-to-back with a Civil Society Dialogue organized by AIDS Foundation East-West[5]:

(1) Welcome remarks (to review the scope and purpose of the event and urgency of taking actions by all)

(2) Setting the scene [to present people perspective, political dimension and WHO recommendations);

(3) Panel Discussion [to showcase good practices in the response to HIV epidemic on the Ministerial level];

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[2] By 2020: 90% of all people living with HIV will know their HIV status; 90% of all people diagnosed with HIV infection will receive sustained antiretroviral therapy; 90% of all people receiving antiretroviral therapy will have viral suppression.

[3] Antiretroviral treatment is recommended for all people with confirmed HIV infection, however severely affected their immune system, i.e. regardless of their CD4 count.

[4] See Annex 2 (List of Participants)

[5] See Annex 1 (Programme)

(4) Roundtable Discussion [to gather inputs from key partners];
(5) Conclusion (to present the next steps)

(6) Launch of the Compendium of good HIV practices[6] [to identify and facilitate the exchange of best practices and experiences among Member States; and to produce evidence-informed tools for an effective HIV response];

Aims & Objectives

(1) to present the countries' pioneering approaches to sustainable, innovative, and evidence-based response to HIV and related comorbidities and discuss the opportunities to scale these up in line with the resolution EUR/RC66/R9;
(2) to exchange information on sustainable financing;
(3) to launch the Compendium of good practices for the implementation of the Action plan for the health sector response to HIV in the WHO European Region;

Outcomes

(1) Good practices on political commitment in response to HIV and related comorbidities are shared among countries.
(2) A report of the event including conclusions and the next steps is prepared.

Opening Remarks

Mr Lambert Grijns (Ambassador for Sexual and Reproductive Health and Rights & HIV/AIDS, Government of the Netherlands) opened the meeting expressing the excitement and intention the Government of the Netherlands has had for more than five years to host the 22nd International AIDS Conference (AIDS2018) proceedings in Amsterdam to initiate a dialogue on the growing HIV epidemic in Europe, especially with regard to the eastern and central parts of the Region. Mr Grijns proposed the success of health interventions primarily depend on political leadership, in addition to technical and financial capacity, underscoring the importance of the Ministers, Deputy Ministers and State Secretaries' attendance. He cited the examples of the Netherlands successfully eliminating HIV transmission among people who inject drugs, of which cost savings have been monumental, and thriving for innovative approaches with recently providing pre-exposure prophylaxis (PrEP) for men who have sex with men (MSM).

The theme is of AIDS2018 was *"Breaking Barriers, Building Bridges"*. Mr Grijns highlighted that bridges are needed between all HIV stakeholders including politicians, regions, governments, civil society organizations (CSOs), all HIV key populations[7] and marginalised groups, and the private sector. In addition, the need to engage the private sector where and when feasible was highlighted.

Dr Zsuzsanna Jakab (Regional Director, WHO Regional Office for Europe) reminded participants the WHO European Region is the only region worldwide where the number of new HIV infections is rising. For several consecutive years the Region has recorded the highest-ever number of new cases and the eastern part of the Region hosts almost 80% of these new HIV infections[8]. In 2016, more than 160 000 were newly diagnosed with HIV (corresponding to a rate of 18.2 diagnoses per 100 000 population). In regard to 90-90-90 targets, one quarter of people living with HIV in eastern Europe and central Asia are not aware of their infection, over half are diagnosed late resulting in delayed treatment, higher AIDS-related morbidity and mortality, and increased rates of transmission persist despite availability of the needed diagnostic tools and newly recommended innovations to reduce the undiagnosed fraction and number of late presenters. However, the WHO European Region had the largest amount of data and number of Member States reporting since HIV reporting began in the Region. The second target of getting 90% of those diagnosed with HIV on treatment represents the most significant challenge for the Region. In eastern Europe and central

[6] Compendium of good practices in the health sector response to HIV in the WHO European Region

[7] In the European Region, key populations include people living with HIV, people who inject drugs, men who have sex with men (MSM), transgender people, sex workers (SW), prisoners and migrants.

[8] Two out of 53 countries accounted for 80% of all new cases in 2016.

Asia, half of those diagnosed with HIV and only one third of the estimated number of people living with HIV have access to treatment. However, the WHO European Region proudly reports over 95% HIV treatment coverage for pregnant women[9]. Regarding viral suppression[10], four out of five persons reach viral suppression once they are diagnosed and on effective treatment[11] and recent evidence shows that people who achieve and maintain an undetectable viral load have no risk of sexually transmitting the virus to an HIV-negative partner. With timely diagnosis, treatment for all, leading to suppressed viral loads, provided alongside evidence-based combination prevention, it is possible to halt, reverse, and stop the HIV epidemic in the Region. Examples of good HIV practices were submitted to WHO by 32 Member States to honour RD's commitment during the 66th Session of the Regional Committee for Europe's resolution "to identify and facilitate the exchange of best practices and experiences among Member States and to produce evidence-informed tools for an effective HIV response".

Despite the Region's slow trajectory to reach 2020 targets, **Mr Vinay Saldanha (UNAIDS)** called upon stakeholders to focus on successes responding to the HIV epidemic and discover areas where Member States, Ministers, and health providers are willing to leverage a cheaper, faster, and more effective HIV response.

Cheaper Rather than spend more financial resources on HIV, Member States were encouraged to spend more effectively the resources currently available. Allocation needs to be optimised to eliminate inefficiencies. Examples may include: leveraging reduced unit costs for first line ARV treatment to make sure they fall under 100 USD[12] based on a fixed dose combination recommended by WHO; performing multi-joint, bulk drug purchases for the most effective medicines; and purchasing the best diagnostic equipment offers for the lowest cost.

Faster Full integration of HIV and TB services is essential, but HIV needs to be the launchpad for integration with maternal and child health, viral hepatitis and STIs. The Member States should consider the effective and impressive role of CSOs which consistently implement highly technical and cost-effective programmes. Ministries of Health and Governments of the Region view them as one of the highest priorities for government funding & efficient spending in the eastern European and central Asian part of the Region. Increasing net HIV investment is important, but the tools to assure every dollar spent by governments is spent efficiently already exist and are underused.

Effective Political commitment and leadership is evidenced through the Ministerial Delegation present at the meeting, but even more leaders should be engaged. Mayors and cities in the eastern and central part of the WHO European Region should be fully engaged and sign the Paris Declaration[13] to become Fast-Track Cities. In addition, leadership through the heads of state are the cornerstone to remove the epidemic of HIV stigma and discrimination. Although difficult, writing inclusive policy and removing stigmatising legislation is a cheap and cost-effective way to form partnerships with people living with HIV.

Setting the Scene

Professor Michel Kazatchkine (Special Advisor for Eastern Europe and Central Asia, UNAIDS), acknowledged the enormous potential of the EECA countries to end AIDS by 2030. The following improvements in the HIV response would realise this potential;

Integrate all technical areas & surveillance systems for MDR-TB/TB, HIV, viral hepatitis, and STIs within all aspects of prevention, testing, treatment, and care;

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[9] Since 2016, three countries in eastern Europe have validated the elimination of mother-to-child transmission of HIV and syphilis, and others may soon qualify for this same milestone.

[10] Full achievement of 90–90–90 is equal to viral load suppression among 73% of all people living with HIV.

[11] Virological failure: viral load above 1,000 copies/ml based on two consecutive viral load measurements in a 3-month interval, with adherence support following the first viral load test, after at least six months of starting a new ART regimen.

[12] per person per year

[13] On World AIDS Day 2014, mayors from around the world came together in Paris, France, to sign a declaration to end the AIDS epidemic in their cities. In signing the 2014 Paris Declaration, the mayors commit to putting cities on the Fast-Track to ending the AIDS epidemic through a set of commitments.

Harness efforts to obtain better data and real time evidence on the epidemics to better align strategies to the specific epidemiological contexts in which they occur;

Scale-up access to treatment and life-saving, evidence-based prevention interventions [referencing the upcoming Alma Ata conference Global Conference on Primary Healthcare, 25-26 October 2018[14]]

Increase political commitment (e.g. through policy making and key decision makers), where changes in policy often result in cost-efficient solutions within the HIV epidemic;

Focus on prevention of HIV transmission especially within key populations and others most-at-risk;

Allocate state and international donor funds efficiently in addition to increasing state financial contributions;

Dr Masoud Dara (WHO Regional Office for Europe) emphasized the need to improving efficiencies and efficacy of HIV response on: Prevention, Testing, Treatment, and Programmatic Performance & Evaluation.

Prevention is the key to an effective HIV response and in many countries in eastern Europe and central Asia there is a need to offer scaled-up preventive services[15] which includes a combination prevention approach tailored to the needs of the local epidemiological context(s).

Testing is the required to ensure timely diagnosis and treatment initiation, and hence to avoid excess morbidity and mortality due to TB, AIDS, and other co-morbidities. Half of people in the WHO European Region (51%) are diagnosed late and this is a challenge in all parts of the Region (West, Centre, and East)[16]. The five C's recommended by WHO should guide all testing efforts: **consent**, **confidentiality**, **counselling, correct test results**, and **connection** (e.g. linkage to care). Testing services should also be: **accessible**, **affordable**, and **acceptable**. Scale-up of HIV self-testing, community-based testing and low-threshold HIV testing sites offered by lay providers is an urgent need in the Region.

Treatment is recommended by WHO since 2015 for all people diagnosed with HIV regardless of CD4 count or stage of infection. An impressive 80% of Member States of the WHO European Region have adopted this policy. Differentiated care models suitable to the national context (e.g. decentralised ART provision through services like mobile units) which are integrated to manage co-infections and strongly link patients to care are urgently requested to Member States by WHO.

Programme Performance includes high quality: **(1)** Strategic Information, **(2)** Intervention Design, **(3)** Implementation, and **(4)** Monitoring & Evaluation. Recognising the complex, local, national, and regional context of generating evidence and a fully informed HIV response that engages all sectors, WHO revises its guidelines every 2-3 years to provide updated recommendations. Moreover, a human approach recognising the dignity of all persons and need to address and remove stigma from the HIV conversation is paramount to ensure AIDS is no longer a public health threat by 2030. As one example, WHO no longer classifies gender incongruence (e.g transgender persons) as a mental

[14] http://www.who.int/primary-health/conference-phc/en/

[15] Including but not limited to: rasied public awareness, sexual and reproductive health and rights, behavioural change interventions, condom distribution programmes, harm reduction for people who inject drugs like opioid substitution therapy (OST) and needle and syringe programmes (NSP), treatment as prevention (TasP), pre-exposure prophylaxis (PrEP), and post-exposure prophylactic treatment (PEP).

[16] The grouping of countries into the West (23 countries), Centre (15 countries) and East (15 countries) of the WHO European Region is based on epidemiological considerations and follows the division of countries used in the joint ECDC/WHO HIV/AIDS surveillance in Europe reports. See the 2017 report for details.

illness[17], underscoring the need to work with this marginalised group by increasing access to prevention and care through a non-discriminatory and inclusive public health approach. WHO has been leading an interagency effort in Europe and central Asia to finalize a UN "common position paper". This paper – the first of its kind – provides a platform for catalysing multisectoral efforts, and commits all 14 participating UN agencies to work together to help end AIDS, Tuberculosis and viral Hepatitis.

Ms. Yana Panfilova (Founder of Eurasian Union, Person living with HIV, Youth Teenergizer) turned the attention on the increasingly vital role of young people and adolescents in responding to the HIV epidemic, which was one of the most recurring theme(s) throughout the Ministerial dialogue as well as the 22nd International AIDS conference proceedings. Ms. Panfilova, was born with HIV. In 2017, 68 000 adolescents (aged 15-24 years) were living with HIV (although statistics among this group are poorly recorded). She founded *Teenergizer*[18] which is the only youth/adolescent-run programme dealing with HIV in eastern Europe and central Asia in order to focus on adolescents as both a key population driving solutions in the HIV response and to fully leverage and integrate the adolescent perspective in HIV programming decisions. The power of youth to move HIV response efforts forward in the Region both politically and in terms of programme implementation is poorly harnessed.

Two primary barriers to adolescent HIV care are highlighted:

(1) Testing barriers caused by pitfalls of the health system like age restrictions on delivery of HIV test results and the need for parental consent to access voluntary HIV testing services that are both speedy and youth-friendly;

(2) Poor quality sexual and reproductive health and rights (SRHR) education within school curriculums, including quality HIV education;

Many adolescents who are living with HIV lost parents or guardians to AIDS, underscoring the need for mental healthcare and psychosocial support to sustain adherence to ART and improve quality of life among this population.

Ministerial Panel Discussion

During this session, ten Ministers and deputy Ministers/State Secretary in a half round panel, and in alphabetic order, presented official speeches and country progress, challenges and plans to scale up HIV response. In order to follow the nature of the meeting which aimed at a free dialogue, in agreement with the co-organizer, this report does not present each country's interventions but provide a summary of interventions across the panellists. The panel discussion is summarized along the five strategic directions of the Action plan for the health sector response to HIV in the WHO European Region[19] and good HIV practices presented by the ten Ministers in attendance under each direction.

Ministerial Panel Delegation

Armenia, Minister of Health	Dr Arsen Torosyan
Belarus, The Deputy Minister of Health	Dr Dimitri Pinevich
Georgia, The Minister of Labour, Health and Social Affairs	Dr David Sergeenko
Kazakhstan, Vice Minister of Health	Mr Olzhas Abishev
Latvia, Deputy State Secretary on Health Policy Issues, Ministry of Health	Ms Daina Murmane-Umbraško
Lithuania, Vice Minister of Health, Ministry of Health	Mr Algirdas Šešelgis
Republic of Moldova, State Secretary, Ministry of Health	Dr Rodica Scutelnic
Russian Federation, Deputy Minister of Health	Dr Oleg Salagay

[17] On June 18 2018, WHO released the new International Classification of Diseases (ICD-11) which classifies gender incongruence as a sexual health condition rather than mental illness.
[18] http://teenergizer.org/
[19] Action plan for the health sector response to HIV in the WHO European Region

Tajikistan, The Minister of Health	Dr Nasim Hoja Olimzoda
Ukraine, The Acting Minister of Health	Dr Ulana Suprun

Strategic Direction 1 **Information for Focused Action**

Improvement of granular[20] HIV surveillance systems, including collection and monitoring of population-based data in addition to strengthened or well-functioning routine HIV surveillance systems, is a high priority in the Region. One Member State reports designing a new system for 2019 implementation, some have already begun to optimise reporting, and but others need to scale-up solutions in this area. Integrating monitoring systems for co-infections like Tuberculosis, Hepatitis, and STIs (in order of frequency mentioned) was a key theme highlighted by all meeting participants and Ministers. Three countries in particular report strong integrated HIV surveillance systems. However, existing challenges mentioned by health authorities included systems which do not preserve the anonymity of HIV patients (potentially interrupting adherence) and vertical silo-based and fragmented services in the health systems lacking interlinked databases which may only be accessible by disease specialists.

All participants recognised the HIV epidemic is concentrated among key populations in their settings and hence need to focus the work on them, while raising awareness among general population and ensuring access to quality care for all. Few Ministers additionally acknowledged *all relevant key populations*, especially with regard to men who have sex with men (MSM) and people who inject drugs. The three Member States who acknowledged all relevant key populations (including MSM) also highlighted robust HIV surveillance with integrated co-morbidity reporting.

HIV among migrants (especially labour migrants) was a commonly reported challenge in the Region. Three countries have created a bi-lateral agreement and strategy to control TB among the migrant population. A similar effort by the same three countries is being planned for HIV. Similarly, The Interparliamentary Assembly of the Commonwealth of Independent States (CIS)[21] is also considering cross-border initiatives to deliver care and treatment to the HIV positive labour migrant population.

Strategic Direction 2 **Interventions for Impact**

Many participants highlighted the successful beginning of an era of prevention programmes in the EECA countries of the WHO European Region, including a growing number of countries which are financing opioid substitution therapy (OST) and/or needle and syringe exchange programmes (NSP) through their state budgets or national health insurance bodies. Most countries present have functioning harm reduction programmes with OST and/or NSP in place.

Although pre-exposure prophylaxis (PrEP) has been recommended by WHO since 2015, only one country mentioned having started a pilot-project by providing PrEP to men who have sex with men at high risk for sexual acquisition of HIV infection. PrEP is a highly effective and WHO recommends that people at substantial risk of HIV infection should be offered PrEP as an additional prevention choice, as part of comprehensive combination prevention. Discussions regarding PrEP and post-exposure prophylactic treatment (PEP), including the intentions for implementation and scale-up for those at substantial risk of HIV may benefit this part of the Region. Active training programmes for human resources for health strengthening within HIV are taking place in some countries in the Region. Sexuality education on the primary education level and within curriculum design was not discussed although highlighted as a key issue by **Ms Yana Panfilova.**

[20] Data which are disaggregated by sex, age, population, location etc.

[21] At present, the CIS unites: Azerbaijan, Armenia, Belarus, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Uzbekistan and Ukraine (as of 7 August 2018).

Three Member States have received WHO certification of elimination of mother-to-child transmission (EMTCT) of HIV and/or syphilis and others may soon qualify for the same milestone. Seven out of ten Ministers present noted continuously working on their elimination programmes. Prevention activities for mother-to-child transmission of syphilis were not mentioned. More than half of the Ministerial delegation discussed the role their countries are taking in decentralising services for HIV-testing, counselling, and treatment including through the use of mobile and stationary units and use of CSOs for social contracting of services in the HIV response. All meeting participants recognised and confirmed the vital importance of CSOs in the implementation of HIV programmes and many countries in the Region are working to fully engage this sector. Just under half of Ministers reported rapid HIV testing availability and HIV self-testing in their countries. Two countries in particular have excelled in their implementation of both rapid and self-testing on country-wide scales. Testing of key populations is facilitated through decentralisation of the response, while few countries mention designing tailored strategies in order to test these populations.

"Treat all" policies are present in many countries, but implementation level and scale vary considerably among them. Official reports from the countries to WHO and UNAIDS mention adoption of these policies in national HIV plans during the last two years.

Strategic Direction 3 **Delivering for Equity**

All key populations in the HIV response need to be considered for all programmes. Interventions focused on HIV prevention and care in MSM, sex workers, and others were only mentioned by few Ministers. The majority of countries in the meeting operate under universal health coverage models which prioritise primary care and prevention, but this is contradicted by relatively few "treat all" policies, some of which are only partially implemented.

The need to remove legislation that stigmatises both certain populations and criminalises certain actions, such as sex work or injecting drug use/possession of illicit substances was highlighted by key partners (see Roundtable Discussion below) as one of the most cost-efficient solutions in the HIV response. Ministerial leadership plays and invaluable role in creating stigma-free societies while also benefiting from more active involvement partnerships with communities of key populations and people living with HIV once stigma dissipates. The following active efforts are being used to help reduce HIV stigma in the Region: removing travel bans/ restrictions for people living with HIV, removing mandatory HIV testing, signing agreements between Ministries of Health and groups/ associations of people living with HIV to implement programmes, and media campaigning to educate and assist youth/ adolescents. One example of a strong partnership through stigma reduction was partnering with cured hepatitis C (HCV) patients who have since become leaders of change within the country to reduce stigma within the HIV response. Although these examples were cited, some countries mentioned the need to reduce stigma but did not discuss active ways to do so. Following arguments for cost-effectiveness, additional studies to determine stigma reduction activities and stigma reduction strategies will benefit from scale-up in the Region.

Strategic Direction 4 **Financing for Sustainability**

Most countries present substantially increased state budgets in order to fund the HIV response in attempts to reduce the percentage of international donor-based funding and some, although few, no longer require GFATM funding. Progress towards eliminating out-of-pocket expenses for people living with HIV (e.g price reductions in ARV medicines, manufacturing ARVs within the country, or adjusting procurement mechanisms) were the most frequent examples of successfully implementing financially sustainable interventions. Three Member States explicitly noted the need for continued funding from international donors like the GFATM in their presentations. Requests for continued international funding were typically in relation to providing prevention, testing, treatment, and care to migrant populations in the countries.

In summary, countries in the Region are successfully increasing state contributions to progress towards replacing the need for international funding. All health authorities present in the meeting assured commitment in this direction. However, cost-efficient solutions as opposed to simply raising the state contribution as a crucial intervention are essential. For example, some reported conducting studies in their countries to determine what percentage of the state budget should be reserved social contracting via CSOs to stay on track in the HIV response. Similar exploration of cost-efficient tools to sustainably finance the HIV response are

encouraged, such as: tools which monitor health expenditure, advocacy work for sustainable financing, adjustment of pricing policies to leverage cost reductions, or adopting the WHO Health Accounts Country Platform Approach[22].

Strategic Direction 5 **Innovation for Acceleration**

In coordination with the Action plan for the health sector response to HIV in the WHO European Region, innovative approaches to the HIV response may include: innovative service delivery models to reach key populations, unique partnerships for collaboration, technology, financing, or research to optimise impact and promote innovation. Strong innovations cited in EECA countries by health authorities were changing the pattern of allocating funds in silos and finding ways of improving intersectoral work to integrate care and funding mechanisms. Social contracting of NGOs for programme implementation including funding of these initiatives were also noted as key areas for EECA countries. Some countries also mentioned implementation of country-wide HIV self-testing or most up to date diagnostic methodologies and machines and use them for HIV, TB and Hepatitis integrated services.

Regarding innovative financing options, adjustment of policies related to financing in the EECA countries may yield the cheapest, fastest, and most effective turnovers in responding to HIV half of countries present specifically cited their work in this area. In terms of innovations and major change, financing mechanisms appear to be the cornerstone of this strategic direction for the EECA part of the WHO European Region.

Roundtable Discussion- Key Partners

Ms Ganna Dovbakh (Eurasian Harm Reduction Association) commended the strong uptake of harm reduction programmes in the Region. However, she re-emphasized the need to address all key populations in the HIV response and de-criminalise activities, like sex work. She reiterated MSM were only referenced as a key population by only three out of ten countries and was one of the only during the meeting to cite transgender people. If these key populations are stigmatised and/or criminalised, they will reject services even if comprehensive packages including prevention, testing, and treatment are in place. Adjusting legislation to be inclusive is the most cost-effective way to respond to HIV.

Ms. Dovbakh provided the example of several countries, where it costs less to de-criminalise possession/use of drugs to country than it does to house another inmate in the penitentiary system. Around half of inmates in some countries are incarcerated for possession/use of illicit drugs, but one year in prison costs the system 3-4 times more than providing comprehensive harm reduction service package and unemployment benefits. Decriminalising possession of illicit drugs saves money, removes people from prisons, and allows them to work and contribute towards the economy. Eliminating stigmatising policies, like criminalisation of drug possession/use, does not require additional financial costs and renders the HIV response more effective.

Mr Wojciech Jerzy Tomczyński (Eastern Europe and Central Asia Union of People Living with HIV) highlighted treatment for all as the primary aim, especially for all key populations and supported the Ministers drive to scale-up and fully engage CSOs in the HIV response to reach this goal. However, the reality does not match the road to end AIDS by 2030. He cited only 28% of persons in the Region having access to ARVs as the Regional average. Echoing Ms. Yana Panfilova, young people were referred to as the future leaders of countries and should be fully engaged. He referenced the speech from the Acting Minister of Health of Ukraine, who highlighted additional gaps to ensure to treatment for all is possible and uninterrupted. Comparison of ARV treatment rates in the EECA countries to highlight any differences between having access and receiving treatment is suggested.

Mr John F. Ryan (The European Commission (EC) Representative of DG Sante) noted the European Commission recently wrote a "Commission Staff Working Document on Combatting HIV/AIDS, viral hepatitis and tuberculosis in the European Union and neighbouring countries - State of play, policy instruments and good practices"[23] since these

[22] WHO Health Accounts Country Platform Approach
[23] https://ec.europa.eu/health/sites/health/files/communicable_diseases/docs/swd_2018_387_en.pdf , accessed 14 August 2018).

diseases pose the greatest risk to key populations and the most marginalised groups in the EU. Although there is no 'one size fits all' approach, collecting and evaluating the existing science and literature is an asset when preparing grant applications, understanding implementation scope, and building bridges. Following Dr Masoud Dara's lead, prevention was highlighted by Mr Ryan as the EU supports diagnosis/testing and decentralised responses for key populations, and ensuring the continuum of care from testing, to follow up, linkage to care and retention especially for all key populations. Echoing Ms Dovbakh, Mr Ryan also recommends adjusting legislation & regulations to improve access to care for the most vulnerable groups as a cost-efficient solution.

Mobile populations (e.g refugees, migrants, prisoners, homeless people, among others) have the most pronounced difficulty within the HIV prevention and care continuum and become vulnerable to this HIV infection, especially after arrival in the European Region. Mr Ryan referenced the excellent work of Council of Europe for setting high standards of the entire European Region in improving access to high quality prevention, particularly within the area of prison health. To support countries, the European Commission hosts a regular policy dialogue, a think tank for all technical disease areas, and the EU Civil Society Forum which is also open to non-EU Member States, for which membership is encouraged. The European Centre for Disease Prevention and Control (ECDC) and the European Medicines Agency (EMA) have invested in developing technical evidence-based guidance to help develop national strategies and provide a regional perspective to compliment global recommendations issued by the WHO, including opportunities for country visits. The European Commission also has a financial instrument for pre-accession assistance to support reforms with financial and technical assistance. The EU Commission supported the GFATM since 2002, but has the European Structural Funds available for transition funding. Mr Ryan notes the health programme and research programme, which has funded 1 billion EURO per year, to focus on these three areas.

Dr Marijke Wijnroks (The Global Fund to Fight AIDS, Tuberculosis and Malaria) confirmed other partners' requests to focus more intensely on all key populations and need to integrate all technical areas. It seems countries address the epidemic they would like to have rather than the epidemic they do, which requires acknowledging all key populations and ensuring high quality surveillance systems to measure the epidemic among them exist. Treatment outcomes have been surprisingly low as compared to the high financial investment to address key populations and engage CSOs for social contracting of programme implementation including harm reduction for key populations. Dr Zsuzsanna Jakab who highlighted this when presenting the second 90 concerning treatment being the most off-track of the 90-90-90's in the Region and Mr Vinay Saldanha who noted efficient spending and stigma reduction through strong leadership needs to be continually exercised to reach these targets. The legal barriers which exist in countries and limit access to care need to be identified, including procurement systems and mechanisms to deliver the medicines and care which are vital to care delivery. Some countries in the Region have successfully covered harm reduction services, like OST and CSOs have an increased role for implementation in a number of countries, but actions fall short of reaching 2020 targets. The GFATM is optimistic the epidemic can be stopped, but the window is closing fast.

Dr Lucica Ditiu (Stop TB Partnership) reminded that the WHO European Region has the highest rates of multidrug resistant tuberculosis (MDR-TB) She highlighted 19% of the new cases of TB in the Region are either MDR or rifampicin resistant and 55% of previously untreated TB cases are MDR-TB. About one third of those persons with MDR-TB are missed and continue transmitting the disease to the general population. There is a need to perform drug susceptibility tests and harness timely data referencing the impressive expansion of the number of HIV tests reported by a country in the panel. There is also a need to focus on the quality of procurement systems because lack of quality in these systems contributes to development of antimicrobial resistance. In regard to advancing the TB agenda and hitting the 2020 targets, Ms. Ditiu advocated for Minister of Health of countries in the WHO European Region to attend the UN High-Level Meeting (UNHLM) on TB at the UN Headquarters in New York, New York on 26 September 2018.

Mr Ian McFarlane (UNFPA) requested members of the delegation to focus on three primary areas; (1) prevention-noting several countries employ very strong prevention approaches which preserves financial resources; (2) integration of technical areas, health systems and data surveillance/ reporting mechanisms is crucial to respond to the needs of individuals, and; (3) engagement of both CSOs, all key populations, and youth in the response to HIV on the country-level. He supported Ms. Yana Panfilova in that the youth are the leaders of tomorrow and their efforts should be embraced fully and in meaningful ways. UNFPA plans to continually support these works wherever possible.

Ms Nina Ferencic (UNICEF) confirmed previous comments regarding the Regional successes within prevention of mother-to-child transmission. Maternal and child health services became fully integrated in the Region, providing evidence that continued integration of technical areas is achievable in the Region. However, to fully eliminate MTCT, it is necessary to work on:

(1) *Prevention*: including removing age restrictions and barriers for HIV testing, notification of results, and related issues; (2*) Quality of Care*: including optimization of treatment regiments, procurement, and early infant diagnosis, and; (3) *Gender and Human Rights Issues*: including women's sexual and reproductive health rights strengthening and supporting healthcare delivery and quality education of the adolescent and youth population.

In alignment with Ms. Yana Panfilova's introductory remarks, quality of HIV and sexual health and reproductive rights and education is extremely low in the EECA countries. As a result, the youth population turns to the internet for educational purposes. Within all of the countries, adolescent services is missing despite a wide array of health sector reforms. These should be strengthened moving forward.

Concluding Remarks

During her closing remarks, **Dr Zsuzsanna Jakab** expressed full confidence that with sustained implementation of evidence-based approaches to prevention, testing, treatment and care, the number of new HIV infections will decrease and the quality of life for people living with HIV would improve. Promising trends in several countries of our Region are already being observed. To continue progress, ensuring inclusive planning through a whole-of-government and whole-of-society approach, destigmatizing HIV and people affected by HIV, prioritizing the needs of all key populations, removing legal barriers and providing services are accessible and fully financed responses is paramount.

During the 69th Regional Committee for Europe in September 2019, the mid-term progress in implementing the Action plan for the Health Sector Response to HIV in WHO European Region will be reviewed. The Ministerial policy dialogue hosted by the Government of the Netherlands today allowed participants to reflect on the progress, exchange good practices, and provide peer to peer support to countries and partners. Moving forward, Dr Jakab assures the 2020 and 2030 targets will be achieved by closely examining the achievements and the gaps which need to be addressed to leave no one behind.

Next Steps: WHO and Partners

⇒ Mid-term progress report for the Action plan for the health sector response to HIV in the WHO European Region's implementation will be prepared and presented at 69th Regional Committee for Europe, September 2019;

⇒ Develop roadmaps for Action plan implementation solutions for countries and partners in the EECA part of the Region from now until 2020, to close gaps in prevention, testing, treatment, and care;

⇒ Ensure ongoing policy dialogue to move faster towards the 90-90-90 targets;

⇒ Disseminate widely the just launched *Compendium of good practices in the health sector response to HIV in the WHO European Region* (English and Russian) and prepare an online repository of future good practices;

⇒ To plan regular/annual meetings with the Ministers to review the progress;

⇒ During 2018, the 40th various meetings require participation of Governments, Agencies and Key Partners including: the anniversary of the Alma-Ata Declaration on Primary Health Care, the first ever UN General Assembly High-level Meeting on Ending Tuberculosis, and the third UN General Assembly High-level Meeting on Noncommunicable Diseases; in this regard, Heads of State are encouraged to attend these meetings;

Next Steps: Member States

⇒ Continued adoption of "treat all" policies to initiate treatment for all those diagnosed with HIV, as soon as possible after diagnosis and regardless of CD4 count;

⇒ Continue strengthen efforts on improving linkages to care, seeking more intersectoral cooperation to better prevent and timely treat co infections and co-morbidities and optimise funding for an integrated care and people centred approach

⇒ Fully engage youth and adolescents in the response to HIV as is being done with CSOs;

⇒ Continue to integrate innovative testing and prevention efforts within the standard HIV package offered through the local health system, including oral PrEP (containing tenofovir) as recommended by WHO since 2015, HIV self-testing, community-based testing, assisted partner notification, among other strategies:

⇒ Continue to decentralise ART provision through services like mobile units which are integrated to manage co-infections, strongly link patients to care, and leverage lay personnel for delivery and care;