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| Subject: | 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 |

Delegations will find attached document SWD(2018) 387 final.

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# 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

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## EXECUTIVE SUMMARY

This staff working document provides an overview of EU action to support the fight against three epidemics in the Union and its immediate neighbourhood: HIV/AIDS, viral hepatitis B and C and tuberculosis. With the global objective under target 3.3 of the sustainable development goals (SDGs) seeks to end by 2030 the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases, the Union has shown its commitment to play its role in this important endeavour. This paper presents the EU policy frameworks and actions used to help Member States improve their response to these three epidemics and reach the SDGs.

The staff working document presents the current epidemiological situation of HIV/AIDS, viral hepatitis and tuberculosis in Europe. The current epidemiological data reveal that these diseases pose the greatest risk to populations that are often also socially marginalised, such as prisoners, injecting drug users, homeless people, migrants or the poor and groups potentially subject to social stigma like men who have sex with men (MSM). Exacerbated social conditions make it even harder to reach out to these groups, necessitating specific tailored measures to ensure that prevention and medical care efforts are effective.

Chapter 3 of this document discusses the distance the EU as a whole still has to cover to reach the SDG objectives for each disease. For HIV/AIDS, with sustained efforts the EU/EEA as a region appears to be on track to meet the identified targets, while differences may still exist between countries. For hepatitis, the current major gaps and limitations in the available surveillance data make it difficult to assess the exact distance left that still needs to be covered. This situation is not aided by the fact that hepatitis often remains symptomless until major liver damage has occurred, making it hard to monitor as an epidemic. That is why it is dubbed ‘the silent killer’. For tuberculosis, while many EU Member States have low incidence rates, sustained efforts are needed in certain Member States if the EU as a whole is to reach the objective of ending tuberculosis.

Chapter 4 presents what the EU is doing to tackle these epidemics, focusing on the relevant EU policy areas, measures, instruments and activities that constitute the EU’s efforts to support the fight against HIV/AIDS, hepatitis and tuberculosis. From public health, research, development cooperation, accession and neighbourhood policy to regional policy and the use of European Structural and Investment Funds (ESFI), the Union policy actions are for the EU and beyond.

Chapter 5 outlines the major examples of technical guidance and good practices developed at EU level and funded under EU projects to fight the HIV/AIDS, viral hepatitis and tuberculosis epidemics in Europe. These are related to interventions, such as: early diagnosis, encouragement of testing, wider outreach to vulnerable groups, integrated care across the diseases, rapid linkage to care, treatment as prevention, health promotion and support to networks and civil society organisations. The chapter also presents the technical guidance developed at EU level.

Chapter 6 sets out the overall observations on the EU contribution to combating the three diseases.



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## 1. SCOPE, OBJECTIVES AND PURPOSE

This staff working document takes stock of EU policies and action against HIV/AIDS, viral hepatitis B and C and tuberculosis. It presents activities undertaken pursuant to:

- the Commission Communication on combating HIV/AIDS within the European Union and in the neighbouring countries, 2006-2009[1];
- the Commission Communication on combating HIV/AIDS in the European Union and neighbouring countries, 2009-2013[2]; and
- the Commission Communication of November 2016 on 'Next steps for a sustainable European future' which concerns implementation of the 2030 Agenda for Sustainable Development[3].

The Commission Communications on combating HIV/AIDS in the European Union and neighbouring countries also provided a basis for EU action against viral hepatitis B and C and tuberculosis as co-infections to HIV/AIDS.

The 2016 Communication on a sustainable European future envisages that the Commission, in contributing to SDG 3 'Ensure healthy lives and promote well-being for all at all ages', will help Member States to reach the SDG targets, including ending HIV/AIDS and tuberculosis and reducing hepatitis.

As the three infectious diseases concerned may pose cross-border threats to health, the staff working document covers the EU action in the Union and beyond — in the countries that are members of the European Economic Area *(*EEA*),* the EU candidate and potential candidate countries and the countries covered by the EU neighbourhood policy.

This document presents instruments, interventions and good practices developed under projects funded by the EU that have generated impact on the quality of life of people at risk or living with these diseases. It discusses EU-level action that has helped to generate economies of scale in addressing challenges EU-wide and globally. The staff working document focuses on:

- highlighting existing policy frameworks, approaches, guidance, experiences and good practices that have been used, transposed and adapted to help Member States improve their response and reach the SDGs;
- describing how coordination at EU level acts on these often cross-border health threats affecting mostly vulnerable groups across the Union.

The ultimate purpose of this paper is to support decision makers, stakeholders, and interested members of the public with an overview of policies, approaches, guidance,

[1] Communication from the Commission to the European Parliament, the Council on combating HIV/AIDS within the European Union and in the neighbouring countries, 2006-2009, 5.12.2005 COM(2005) 654 final.
[2] Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions combating HIV/AIDS in the European Union and neighbouring countries, 2009 -2013 COM(2009) 569 final, 26.10.2009.
[3] Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on Next steps for a sustainable European future: European action for sustainability COM(2016) 739 final, 22.11.2016.



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experiences and good practices that have proven to generate impact on HIV/AIDS, viral hepatitis and tuberculosis prevention, control and treatment.

# 2. EPIDEMIOLOGICAL SITUATION

## 2.1. Main threats to health posed by each disease

### *2.1.1. HIV/AIDS*

Human immunodeficiency virus (HIV) attacks the immune system and, if left untreated, causes acquired immunodeficiency syndrome (AIDS). HIV infection is spread by sexual contact with an HIV-positive person with a detectable level of virus in the blood, by sharing needles, syringes or other injection equipment with someone who is infected, or through transfusions of infected blood or blood clotting factors, although this is extremely rare today in European countries. Mother-to-child transmission is also extremely rare today in the EU/EEA.

Since its introduction in the mid-1990s, antiretroviral treatment (ART) has had a profound effect on the course of HIV infection, improving quality of life and reducing the rate of AIDS and death in HIV-infected individuals. There is also evidence that persons who adhere to effective antiretroviral treatment achieve viral suppression and do no transmit HIV to sexual partners[4].

Although HIV is preventable, significant HIV transmission continues in EU/EEA Member States, accession countries, neighbourhood policy countries and in the broader European Region as defined by the World Health Organization[5]. It is estimated that about 810 000 people were living with HIV in the EU/EEA in 2015 and about 15 % of these (120 000) had not yet been diagnosed[6]. In 2016, 29 444 cases of HIV were reported to the European Centre for Disease Prevention and Control (ECDC) from 31 EU/EEA Member States, corresponding to a crude rate of 5.9 new diagnoses per 100 000 population[7].

In 2016, the highest proportion of HIV diagnoses in the EU/EEA was reported[8] to be in men who have sex with men (MSM) (40 %), with heterosexual contact being the second most common mode of transmission (32 %). Transmission due to injecting drug use accounted for 4 % of HIV diagnoses, and for 23 % of new HIV diagnoses the transmission mode was not reported or was reported to be unknown. Forty per cent of those diagnosed in the EU/EEA in 2016 were migrants, defined as originating from outside the country in which they were diagnosed. However, this varied widely from 80 % of cases in Sweden to less than 5 % of cases in Bulgaria, Latvia, Lithuania, Poland and Romania. There is evidence that more migrants are becoming infected with HIV post-migration.

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[4] INSIGHT START Study Group. Initiation of antiretroviral therapy in early asymptomatic HIV infection. New England Journal of Medicine. 2016:373(9):795-807; and Cohen MS, Chen YQ, McCauley M, Gamble T, Hosseinipour MC, Kumarasamy N, et al. Prevention of HIV-1 infection with early antiretroviral therapy. New England Journal of Medicine. 2011;365(6):493-505.

[5] The WHO Europe region extends beyond the European Union to cover countries in eastern Europe and Central Asia.

[6] Pharris A, Quinten C, Noori T, Amato-Gauci AJ, van Sighem A, the ECDC HIV/AIDS Surveillance and Dublin Declaration Monitoring Networks. Estimating HIV incidence and number of undiagnosed individuals living with HIV in the European Union/European Economic Area, 2015. Euro Surveillance. 2016;21(48):pii=30417.

[7] ECDC/WHO (2017). HIV/AIDS Surveillance in Europe 2017– 2016 data. Stockholm: ECDC; 2017.

[8] Ibid.



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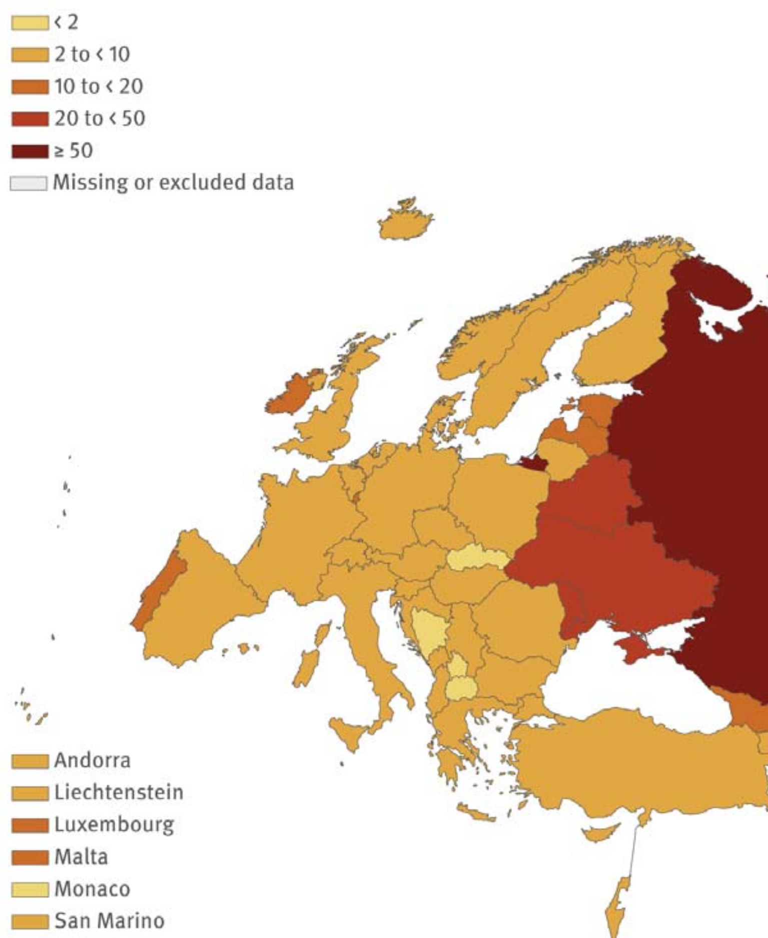
**Figure 1. New HIV diagnoses per 100 000 population, 2016**




*Source: ECDC/WHO, 2017*

Regarding past trends, over the period 2007-2016, the trend in reported HIV diagnoses remained relatively stable, with rates of 6.8 and 6.9 per 100 000 in the earlier part of the period and a slight decline to 6.5 per 100 000 in more recent years, and to 5.9 in 2016. For the first time in recent years, several countries in the western part of the region have reported a decline in new HIV diagnoses (mainly among MSM). However, in many of the central and eastern countries in the EU/EEA and in the countries in the neighbourhood policy area, HIV rates have increased in some key risk groups during this period, particularly among MSM. At the same time, the rate of new HIV diagnoses in non-EU/EEA countries of the WHO European Region has increased substantially over the period, from 18.8 per 100 000 population in 2007 to 36 per 100 000 in 2016.

Prevention remains the critical response to this epidemic, and it should be given higher priority in the EU/EEA if it is to reduce the number of new cases of HIV and their resulting impact on individuals and health budgets. Two out of three countries report that funds available for prevention are insufficient to cover all the demands in reducing the number of new HIV infections[9]. Outreach to key affected groups, most specifically MSM, and uptake of HIV testing help to reduce the proportion of people living with HIV who do not know their status and who are diagnosed late. This in turn provides an opportunity for rapid linkage to care, which leads to suppressing the virus and stopping the further spread

[9] European Centre for Disease Prevention and Control. The status of the HIV response in the European Union/European Economic Area, 2016. Stockholm. ECDC: 2017.

of the epidemic. Innovative approaches such as community-based testing, self-testing and home sampling and more targeted approaches for hard-to-reach groups like prisoners, sex workers, people who inject drugs, undocumented migrants, etc. need to be more widespread. Tackling stigma and discrimination is another important pillar of effective prevention. Prevention has been a main priority for European Union action, as is discussed in Chapter 5.

Finally, treatment remains paramount, and the rapid linkage to care is therefore essential. Treatment changes HIV from a life-threatening disease to a manageable chronic condition. Treatment also plays an important role in preventing HIV transmission. All global and regional guidelines[10] recommend that immediate treatment be offered to all HIV-positive persons as soon as the HIV virus is detected and regardless of CD4 count[11]. The provision of treatment and healthcare services remains the prerogative of the Member States.

#### *2.1.2. Viral hepatitis*

Hepatitis B virus (HBV) and Hepatitis C virus (HCV) infections affect the liver and the acute infection may become chronic hepatitis disease, with serious potential consequences such as cirrhosis or hepatocellular carcinoma. Current transmission of hepatitis in Europe occurs sexually or via injecting drug use through the sharing of injection equipment, with nosocomial (i.e. hospital) transmission remaining a key reported route of transmission in a few countries. Viral hepatitis continues to have a serious disease burden in the EU. Deaths from hepatitis B and C together now exceed deaths from HIV/AIDS and tuberculosis combined, and latest estimates show that an estimated 96 000 people die each year in EU/EEA countries from HBV and HCV-related liver disease[12]. As hepatitis is asymptomatic until there is serious damage to the liver, it is dubbed ‘the silent killer’, making it difficult to gauge the exact breadth of the epidemic.

Similarly to HIV/AIDS, socially excluded people such as migrants, sex workers, prisoners and people who inject drugs are affected by hepatitis as these viruses can be easily transmitted by sharing injection equipment and to some extent by sexual transmission. Vaccination rates appear to be lower in some of these groups, which further contributes to higher risk and prevalence. Migrants from countries of high prevalence are another highly affected population. Also, lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals including MSM are exposed to a significantly higher risk of common challenges and barriers to access healthcare due to stigma, administrative barriers, low health literacy, and even perceived or actual criminalisation. The epidemics can be tackled effectively if specific actions are targeted at these groups.

An effective HBV vaccine exists, but there is currently no HCV vaccine, and prevention depends on reducing the risk of exposure to the virus or on identifying cases early and linking them to curative therapy. At the same time, a very effective treatment for HCV curing the patient is available. However, the financial costs associated with these new treatments remain high in many countries.

[10] European AIDS Clinical Society Guidelines, 2017; World Health Organisation Guidelines, 2015.

[11] CD4 count refers to the number of CD4 cells in the blood, which are attacked by the HIV virus once infected. When the CD4 count drops below 200, a person is diagnosed with AIDS.

[12] GBD 2013 Mortality and Causes of Death Collaborators. Global, regional, and national age-sex specific all-cause and cause-specific mortality for 240 causes of death, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. The Lancet. 2015 Jan 10; 385(9963):117-71.



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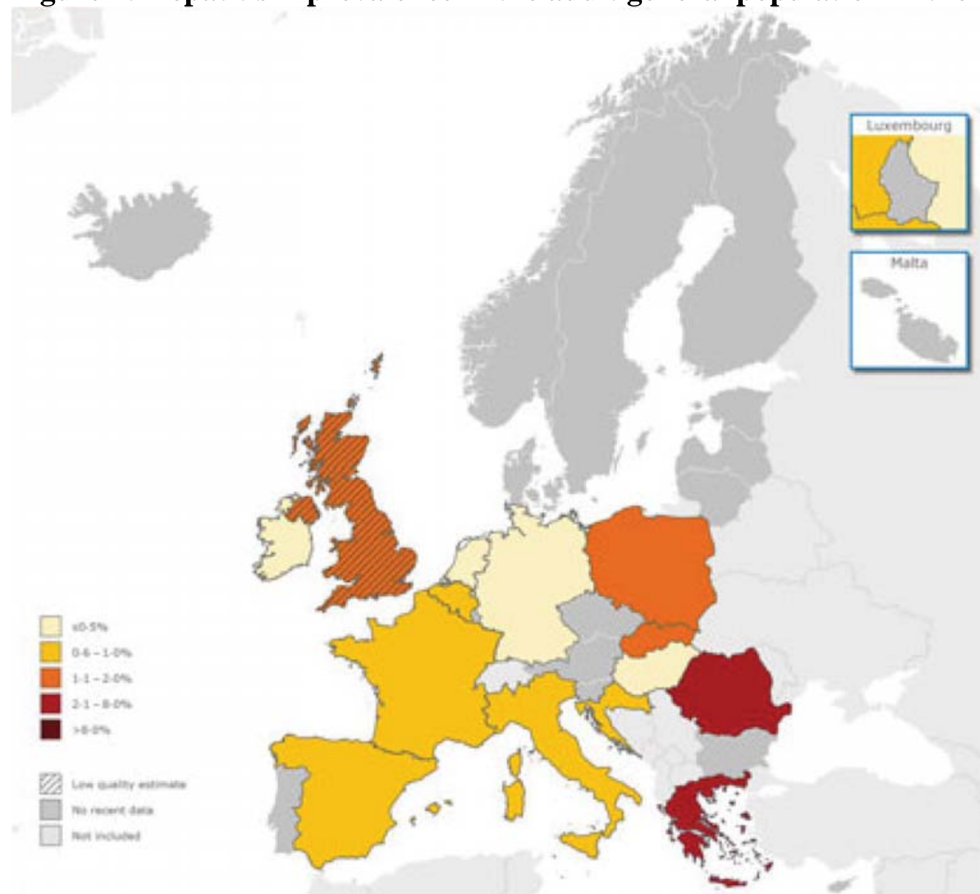
*Hepatitis B*

The prevalence of hepatitis B infection across the EU/EEA as a whole in 2015 was estimated to be 0.9 %, equivalent to almost 4.7 million chronically affected people. In 2016, 2529 cases of acute hepatitis B were reported to ECDC from 29 EU/EEA Member States, corresponding to a crude rate of 0.6 cases per 100 000 population. However, this data refers to diagnosed and notified cases, and the data are known to be an underestimate of the true rate of new infections.

In EU/EEA countries, the burden of hepatitis B infection is highest among MSM, people who inject drugs, prisoners and migrants from countries of intermediate or high endemicity. Migration from countries of high endemicity has a key impact on the hepatitis B prevalence, and migrants from China and Romania were found to account for the largest number of infections, with over 100 000 chronic hepatitis B cases each, followed by migrants from Turkey, Albania and Russia[13].

**Figure 2: Hepatitis B prevalence in the adult general population in the EU/EEA**




*Source: ECDC, based on studies published between 2005 and 2015.*
*Note: Variability between the study size and method needs to be taken into account when comparing rates between countries.*

Data on acute cases of hepatitis B reported to ECDC indicate a steady decline from 1.2 cases per 100 000 population in 2007 to 0.6 cases per 100 000 population in 2016. This is

[13] Ahmad AA, Falla AM, Duffell E, Noori T, Bechini A, Reintjes R, Veldhuijzen IK. Estimating the scale of chronic hepatitis B virus infection among migrants in EU/EEA countries. BMC Infectious Diseases. 2018 Jan 11;18(1):34. doi: 10.1186/s12879-017-2921-8.

in line with global trends and most likely reflects the impact of national vaccination programmes[14]. Recent analysis has indicated that this decline is significantly more marked in countries with higher vaccination coverage (≥ 95 %) compared to those with lower vaccination coverage and highlights the importance of comprehensive vaccination programmes[15]. While a decline in HBV prevalence has occurred in some EU countries, a few countries have reported a slight increase. This may in part be due to an influx of migrants from countries with high endemicity[16].

Vaccination is central to prevention efforts for hepatitis B, and most European countries have a universal childhood vaccination programme in place with high levels of coverage. However, coverage in a few countries is suboptimal, and epidemiological evidence indicates that the targeting of vaccination at key risk groups such as MSM could be further improved in many countries. As with hepatitis C, most countries have developed robust infection prevention and control strategies to address hospital-related transmission in healthcare settings and have implemented robust systems for blood safety. However, hepatitis B continues to be transmitted through injecting drug use. To prevent transmission, there needs to be a scaling-up of prevention efforts including the provision of needles and syringes and opioid substitution therapy, in combination with targeted vaccination of injecting drug users.

Antiviral therapy against hepatitis B can suppress viral replication and reduce long-term disease-related complications, but unlike hepatitis C, this therapy is not curative. The public health benefits of individuals knowing their status are substantial, but it is estimated that only 16 % of people chronically infected with hepatitis B are aware of their infection[17]. Targeted testing among key populations such as migrants, people who inject drugs and MSM in combination with efforts to scale up testing in community settings and to simplify the diagnostic pathway is important.

*Hepatitis* C

The estimated prevalence of chronic HCV infection across the EU/EEA was 0.77 % in 2015, equalling 3.9 million cases of chronically infected people[18]. In 2016, 33 860 cases of newly diagnosed hepatitis C were reported to ECDC from 29 EU/EEA Member States, corresponding to a crude rate of 7.4 cases per 100 000 population[19]. However, the data is limited as these newly diagnosed include both new ‘acute’ infections but also previously undiagnosed long-standing infections as well. The true incidence of hepatitis C in Europe is unknown, as data from notifications of acute infection do not provide the full picture. This is because the disease is largely asymptomatic.

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[14] 2016 Hepatitis B Annual Epidemiological Report, ECDC, in press.

[15] Miglietta A, Quinten C, Lopalco PL, Duffell E. Impact of hepatitis B vaccination on acute hepatitis B epidemiology in European Union/European Economic Area countries, 2006 to 2014. Euro Surveillance**.** 2018;23(6):pii=17-00278. https://doi.org/10.2807/1560-7917.ES.2018.23.6.17-00278.

[16] Hahné SJ, et al. Prevalence of hepatitis B virus infection in The Netherlands in 1996 and 2007. Epidemiology and Infection 2012; 140: 1469–1480.

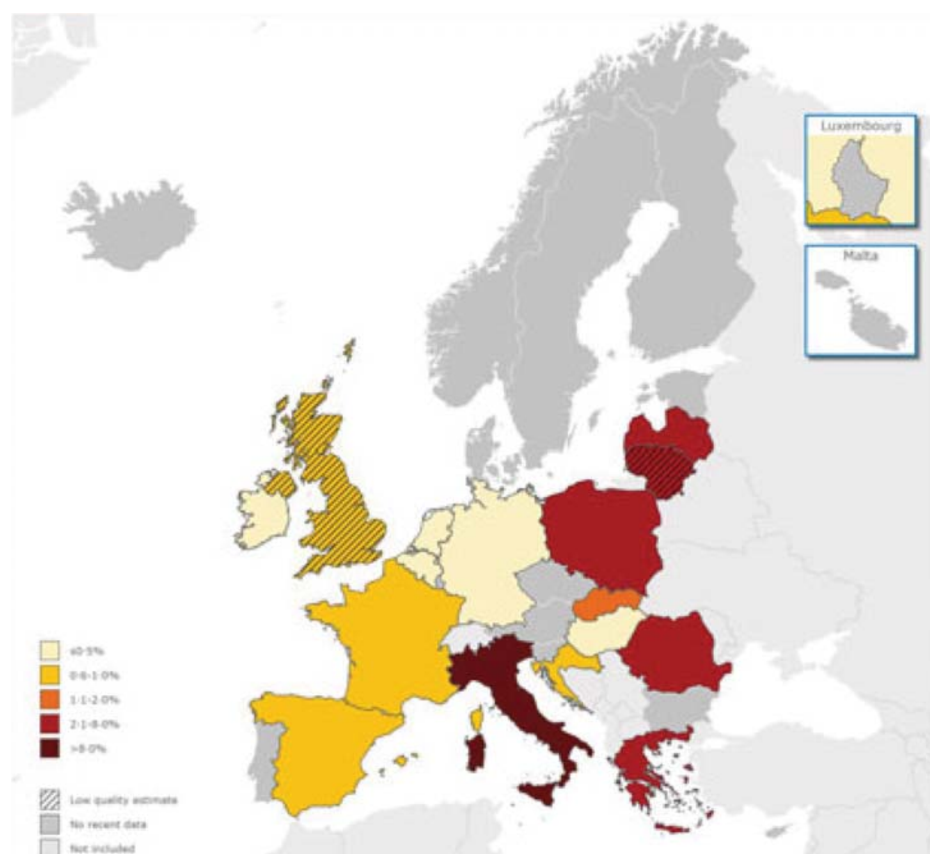
[17] The Polaris Observatory Collaborators. Global prevalence, treatment, and prevention of hepatitis B virus infection in 2016: a modelling study. The Lancet Gastroenterology & Hepatology 2018; 3 (6): 383 – 403.

[18] Hofstraat SHI, Falla AM, Duffell EF, Hahné SJM, Amato-Gauci AJ, Veldhuijzen IK, Tavoschi L. Current prevalence of chronic hepatitis B and C virus infection in the general population, blood donors and pregnant women in the EU/EEA: a systematic review. Epidemiology and Infection. 2017 Oct;145(14):2873-2885.

[19] 2016 Hepatitis C Annual Epidemiological Report, ECDC, in press.

In Europe, HCV transmission through blood products has effectively been halted thanks to effective blood safety policies, leaving injecting drug users, or people who have injected in the past, as the group most affected by HCV infection today[20]. There are high numbers of injecting drug users in most prison populations, with the burden of HCV therefore often high among prisoners. In Europe, the most recent data from studies on people who inject drugs, conducted in 2014-2015, indicate that the prevalence of antibodies to HCV (anti-HCV) is between 16 and 84 %[21]. Since 2000, European countries have reported several outbreaks of acute HCV among HIV-positive men having sex with men, who have not indicated injecting drug use[22]. Migrants from high burden countries are also disproportionately affected by chronic hepatitis C and are an important population for targeted case findings and treatment.

**Figure 3: Hepatitis C prevalence in the adult general population in the EU/EEA**




*Source: ECDC, based on studies published between 2005 and 2015.*
*Note: Variability between the study size and method needs to be taken into account when comparing rates between countries.*

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[20] Memon MI, Memon MA. Hepatitis C: an epidemiological review. Journal of Viral Hepatitis 2002 Mar;9(2):84-100; and van de Laar TJ, Matthews GV, Prins M, Danta M. Acute hepatitis C in HIV-infected men who have sex with men: an emerging sexually transmitted infection. AIDS 2010 Jul 31;24(12):1799-812; and Wiessing L, Guarita B, Giraudon I, Brummer-Korvenkontio H, Salminen M, Cowan SA. European monitoring of notifications of hepatitis C virus infection in the general population and among injecting drug users (IDUs) — the need to improve quality and comparability. Euro Surveillance 2008 May 22;13(21):pii=18884.
[21] European Monitoring Centre for Drugs and Drug Addiction (2017), Drug-related infectious diseases in Europe: update from the EMCDDA expert network, October 2017, Publications Office of the European Union, Luxembourg.
[22] Boesecke C, Grint D, Soriano V, Lundgren JD, d'Arminio MA, Mitsura VM, et al. Hepatitis C seroconversions in HIV infection across Europe: which regions and patient groups are affected? Liver International 2015 Nov;35(11):2384-91.

Regarding past trends, recent modelling of the HCV epidemic has concluded that the overall annual incidence of HCV infection in the general population has reached its peak in most countries[23]. The level of transmission among injecting drug users remains high with substantial transmission among young people (those under 25 years old) and among new injecting drug users (those injecting for less than 2 years)[24]. There have been no clear trends in the prevalence of hepatitis C in the general population over time, but there is an expectation that as treatment is scaled up in countries, it will have an impact on the number of infected individuals.

#### *2.1.3. Tuberculosis*

Tuberculosis (TB) is an infectious disease caused by a group of bacteria species called the *Mycobacterium tuberculosis* complex. Although tuberculosis typically affects the lungs (pulmonary TB), it can cause disease in any organ (extra pulmonary TB). Tuberculosis is transmitted from person to person, for example, when people with pulmonary TB expel bacteria by coughing.

Tuberculosis remains an important cause of suffering in the EU/EEA, with 58 994 cases reported in 2016[25]. In the same year, the accession countries reported 15 581 cases and the neighbouring countries 125 600 cases[26]. Most EU/EEA countries are low-incidence countries (i.e. with a notification rate below 10 per 100 000) where tuberculosis predominantly affects vulnerable populations, such as migrants, prison inmates or people co-infected with HIV. Country-specific notification rates differ considerably. They ranged from 1.8 in Iceland to 68.9 per 100 000 in Romania in 2016 (Figure 4). In most EU/EEA and accession countries, the notification rates are decreasing. Five EU Member States are defined as high priority countries according to WHO Europe: Lithuania, Latvia, Estonia, Bulgaria and Romania, where greater efforts are needed[27].

The number of people infected with tuberculosis, but without active TB disease, is not known in the European Union. This latent TB infection does not show any symptoms or signs and can only be diagnosed with specific tests (the tuberculin skin test or interferon gamma release assays). People infected with TB constitute a reservoir for subsequent progression to active TB disease. Latent TB infection is not included in the list of notifiable diseases.

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[23] Hatzakis A, Chulanov V, Gadano AC, Bergin C, Ben-Ari Z, Mossong J, et al. The present and future disease burden of hepatitis C virus (HCV) infections with today's treatment paradigm — volume 2. Journal of Viral Hepatitis 2015 Jan;22 Suppl 1:26-45.

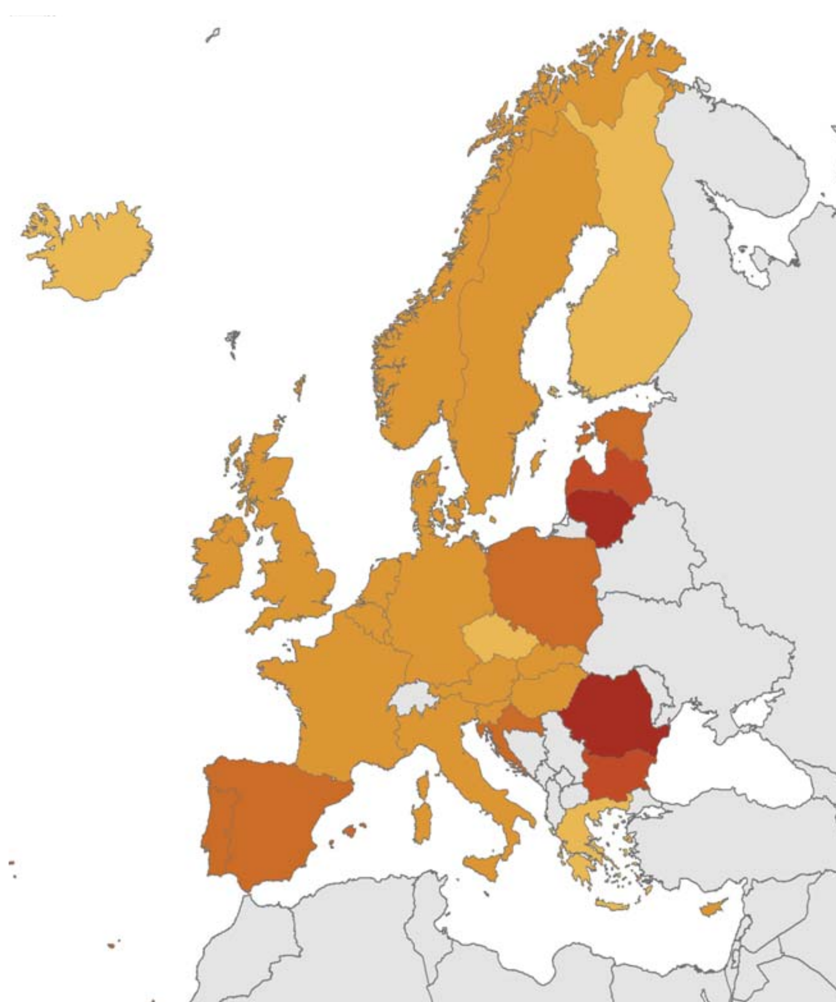
[24] Giraudon I, Hedrich D, Duffell E, Kalamara E, Wiessing L (2016). 'Hepatitis C virus infection among people who inject drugs: epidemiology and coverage of prevention measures in Europe'. pp. 17 – 30. Hepatitis C among drug users in Europe.2016; Lisbon: EMCDDA. EMCDDA Insights 23, Publications Office of the European Union, Luxembourg.

[25] European Centre for Disease Prevention and Control/WHO Regional Office for Europe. Tuberculosis surveillance and monitoring in Europe 2018 – 2016 data. Stockholm; ECDC: 2018, https://ecdc.europa.eu/en/publications-data/tuberculosis-surveillance-and-monitoring-europe-2018

[26] Global tuberculosis report 2017. Geneva: World Health Organization; 2017, http://www.who.int/tuberculosis/publications/global_report/en/

[27] http://www.euro.who.int/en/health-topics/communicable-diseases/tuberculosis/tuberculosis-read-more.

**Figure 4: Tuberculosis notification rates in the EU/EEA, 2016**



*Source: ECDC/WHO 2018*

A serious issue linked to bacterial infections such as TB is anti-microbial resistance (AMR), i.e. the growing resistance of microbes to available antibiotics. This is a worldwide problem in both humans and animals and leads to limited or poor options for treatment. Multidrug-resistant tuberculosis (MDR-TB) poses a further problem for the control of tuberculosis, since it is difficult to treat. In the EU/EEA, the proportion of MDR-TB cases is low (3.7 % or 1 322 cases in 2016). However, in 2016, Estonia, Latvia and Lithuania reported between 10 and 20 % of their cases with MDR-TB, and with 463 MDR-TB cases, Romania diagnosed one third of all MDR-TB cases in the EU/EEA. In the eastern neighbourhood countries, MDR-TB is a public health problem, with an estimated 30 000 cases in 2016 and up to 48 % of all TB cases diagnosed as MDR-TB. Russia reported 25 971 MDR-TB cases in 2016 (45 %). Standard treatment of non-resistant tuberculosis consists of a six-month regimen of four first-line drugs (isoniazid, rifampicin, ethambutol and pyrazinamide). MDR-TB requires longer treatment lasting up to 24 months with more drugs, and it often results in lower success rates.

### 2.2. The most vulnerable populations

All four infections – HIV/AIDS, viral hepatitis B and C and tuberculosis – often affect a similar range of most vulnerable groups, i.e. marginalised people with insufficient access to prevention and health care services, at times affected by one or several concurrent

infections. Thus, the social dimension of these diseases is a major factor affecting the ability to tackle them as epidemics and to eliminate them in the EU. Efforts to reach out to vulnerable groups are therefore crucial.

Men who have sex with men are the population most severely affected by HIV in the EU/EEA (and one of the main risk groups for hepatitis B and C) and also the only population in the region still experiencing a continued increase of new HIV infections in most countries. Existing stigma, discrimination and social marginalisation lead to diminished access to healthcare and decreased readiness to seek medical help (e.g. for tests or treatment) due to fear of further negative judgment because of the sexual orientation or HIV status. This in turn exacerbates the epidemics and only leads to further unchecked transmission of the diseases. Additionally, drug use may be increasing the HIV risk among some men who have sex with men, especially considering the anecdotal evidence from a growing number of countries reporting increased sexualised drug use among sub-groups of men who have sex with men. There are very recent encouraging signs of falling rates among MSM coming from a handful of countries that may indicate the way forward to dealing with this issue.

Prisoners are another at-risk group experiencing barriers to accessing prevention and linkage to care. Prison inmates tend to have a higher prevalence of the blood-borne viruses, mainly due to prior exposure from injecting drugs[28]. They also tend to suffer higher rates of tuberculosis, most likely due to the relationship between tuberculosis and poverty or social deprivation (associated with overcrowding, poorly ventilated housing, malnutrition, smoking, stress and limited social interaction).

People who inject drugs experience a higher incidence of tuberculosis compared to the general population due to social and demographic risk factors such as poverty, unemployment, homelessness, imprisonment, HIV infection, malnutrition and lack of access to health care. Sharing contaminated needles remains a major risk factor for hepatitis B and C and for HIV transmission.

Recently arrived immigrants or refugees from countries with high endemicity of HIV/AIDS, hepatitis or tuberculosis are found to have higher rates of these diseases. The tuberculosis infection prevalence in migrants mirrors the infection prevalence in their home country. Migrants are also often exposed to tuberculosis during migration, and they may have been exposed to poor living conditions and overcrowding in refugee settlements. Hepatitis is more prevalent in migrants due to chronic infection occurring in their home country. There is evidence that many migrants become vulnerable to HIV infection after they settle in the EU/EEA[29,30].

Untreated or poorly managed cases of people living with HIV, especially those who are not diagnosed and unaware of their status, are more vulnerable to co-infection with tuberculosis and viral hepatitis, particularly when this occurs among the more socially deprived members of society.

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[28] Falla AM, Hofstraat SHI, Duffell E, Hahné SJM, Tavoschi L, Veldhuijzen IK. Hepatitis B/C in the countries of the EU/EEA: a systematic review of the prevalence among at-risk groups. BMC Infectious Diseases. 2018;18:79. doi:10.1186/s12879-018-2988-x.

[29] Rice BD, Elford J, Yin Z et al (2012). A new method to assign country of HIV infection among heterosexuals born abroad and diagnosed with HIV in the UK. AIDS 26 (2015): 1961-6.

[30] Alvarez-Del Arco D, Fakoya I, et al. High levels of post-migration HIV acquisition within nine European countries. AIDS. 2017 Sep 10;31(14):1979-1988.



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### 2.3. Costs for health systems, economic consequences

Halting and eventually eliminating these epidemics requires investment in health, where the biggest direct cost is currently treatment. The costs vary significantly across EU countries due to large differences in health systems and are thus difficult to quantify and compare. Besides the direct costs for treatment and prevention, the epidemics also inflict indirect costs due to work absenteeism, reduced quality of life and loss of productivity.

#### *2.3.1. HIV/AIDS*

Global and regional HIV treatment guidelines[31] recommend that all individuals who test positive for HIV be offered antiretroviral treatment. With growing numbers of people living with HIV, treatment costs are increasing and, in many settings, constitute the large majority of funding for HIV. Although difficult to estimate in a standardised way, the reported cost of first-line antiretroviral treatment per patient per year across the WHO European Region ranged from EUR 1 000 to 20 000 in 2016[32]. The cost of second- and third-line antiretroviral therapy needed as a result of the emergence of HIV-resistant strains is several times higher. Many countries in the East of the region struggle to treat large numbers of persons diagnosed with HIV due to treatment costs. Still, the effect of this treatment in preventing and reducing transmission is very substantial and worth the investment. The treatment will affect incidence levels if it covers a high enough number of cases.

#### *2.3.2. Hepatitis*

Recent direct-acting antiviral drugs for treating hepatitis C are highly efficacious and safe but substantially more expensive than previous therapies. Recent studies have indicated that the new treatments are cost effective but recognise that treating all eligible patients with these new regimens will have a significant budgetary impact for private and government providers, and may require prioritising[33,34]. Even with unrestricted access to the new treatments, it is also widely recognised that more needs to be done to scale up prevention and harm reduction if there is to be an impact on transmission. Indeed, recent modelling has indicated that maintaining the current standard of care would keep the number of infections high. To increase treatment uptake, screening programmes would need to be scaled up to find undiagnosed individuals and link them to care[35].

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[31] Op. cit. see footnote 12.

[32] European Centre for Disease Prevention and Control. HIV treatment and care. Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2017 progress report. Stockholm: ECDC; 2017.

[33] Cousien A1, Tran VC2, Deuffic-Burban S1.2, Jauffret-Roustide M3.4, Mabileau G1, Dhersin JS5, Yazdanpanah Y. Effectiveness and cost-effectiveness of interventions targeting harm reduction and chronic hepatitis C cascade of care in people who inject drugs; the case of France. *Journal of Viral Hepatitis*. 2018 Apr 16. doi: 10.1111/jvh.12919.

34 Chhatwal J,Kanwal F, Roberts MS, Dunn MA. Cost-Effectiveness and Budget Impact of Hepatitis C Virus Treatment With Sofosbuvir and Ledipasvir in the United States. *Annals of Internal Medicine*. 2015 Mar 17; 162(6): 397-406.

[35] The European Union HCV Collaborators. Hepatitis C virus prevalence and level of intervention required to achieve the WHO targets for elimination in the European Union by 2030: a modelling study. *Lancet Gastroenterol Hepatol* 2017; 2: 325-36.



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### 2.3.3. *Tuberculosis*

The average direct costs of drug-sensitive tuberculosis are estimated at around EUR 10 000 per case. [36] The costs are significantly higher for MDR-TB cases, i.e. EUR 55 000. In addition to the direct costs, there are indirect costs due to work absenteeism and loss of productivity.

## 3. THE RESPONSE: TOWARDS IMPLEMENTING THE SUSTAINABLE DEVELOPMENT GOAL 3.3.

Globally, while positive trends have been identified in some areas, it is recognised that continuous efforts are still needed to eliminate HIV/AIDS, viral hepatitis and tuberculosis as global health threats. The sustainable development goals (SDGs) agreed by the United Nations in 2015 include Goal 3 and its specific health targets to end by 2030 the epidemics of AIDS and tuberculosis, among other diseases, and to combat hepatitis and other communicable diseases. All EU Member States have subscribed to these goals.

The political commitment at EU level to support Member States in their reaching the objectives under the SDGs, by complementing Member State action on HIV/AIDS, viral hepatitis B and C and tuberculosis, was reaffirmed in 2016 in the Communication on Next Steps for a Sustainable European Future[37]. The European Commission has taken up the commitment to monitor progress on meeting the SDGs while also providing continued support to Member States through existing policies and instruments, such as the EU Health programme, Horizon 2020, etc. The Commission will provide regular reporting on the EU's progress in implementing the 2030 Agenda. An annual report was prepared by Eurostat and published in November 2017[38]. The 2018 reporting[39] will include a specific indicator on the death rate due to tuberculosis, HIV and hepatitis under Goal 3.

*HIV/AIDS*

The Joint United Nations programme on HIV/AIDS (UNAIDS) is leading the global effort to end AIDS as a public health threat by 2030 as part of the sustainable development goals. Core targets in this context are the so-called '90-90-90' treatment targets by 2020: 90 % of people living with HIV know their HIV status, 90 % of people who know their HIV-positive status are accessing treatment and 90 % of people on treatment have suppressed viral loads. As antiretroviral therapy leads to viral suppression, it is expected that successfully linking and keeping HIV positive individuals in treatment will result in

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[36] Gullón JA, García-García JM, Villanueva MÁ, Álvarez-Navascues F, Rodrigo T, Casals M, Anibarro L, García-Clemente MM, Jiménez MÁ, Bustamante A, Penas A, Caminero JA, Caylà J; Grupo de Trabajo del Programa Integrado de Investigación en Tuberculosis (PII TB). Tuberculosis Costs in Spain and Related Factors. *Archivos de Bronconeumología*. 2016 Dec;52(12):583-589; and Fløe A, Hilberg O, Wejse C, Løkke A, Ibsen R, Kjellberg J, Jennum P. The economic burden of tuberculosis in Denmark 1998-2010. Cost analysis in patients and their spouses. *International Journal of Infectious Diseases*. 2015 Mar;32:183-90; and Diel R, Vandeputte J, de Vries G, Stillo J, Wanlin M, Nienhaus A. Costs of tuberculosis disease in the European Union: a systematic analysis and cost calculation. *The European Respiratory Journal*. 2014 Feb;43(2):554-65.

[37] COM(2016) 739 final.

[38] http://ec.europa.eu/eurostat/web/sdi/publications.

[39] http://ec.europa.eu/eurostat/web/sdi/indicators#2018review.



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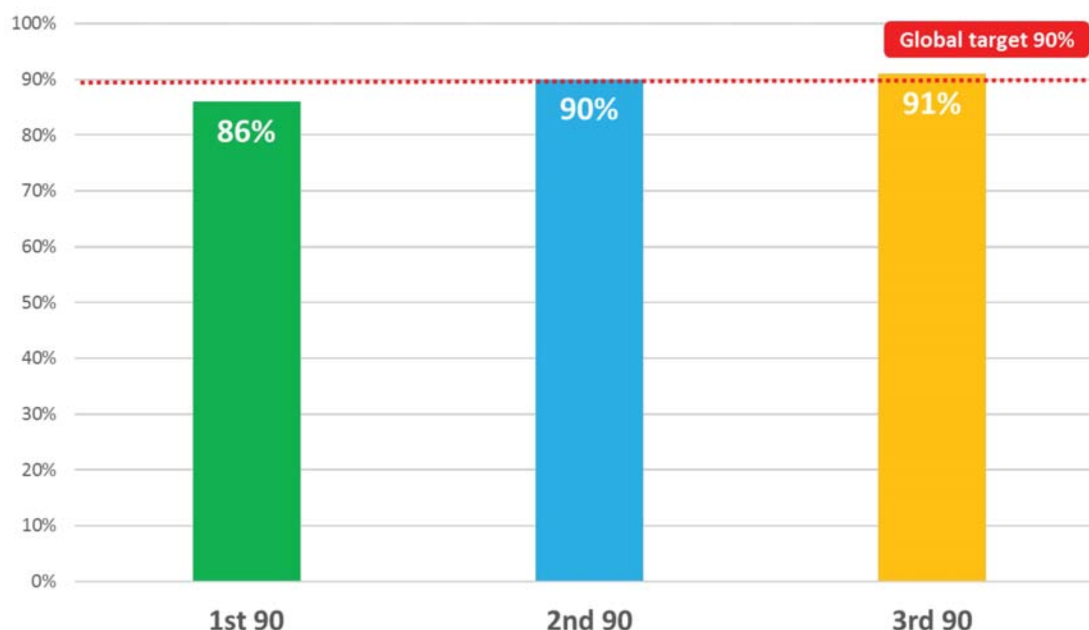
stopping further spread of the disease. Once these treatment targets have been achieved, UNAIDS' modelling suggests that the AIDS epidemic could be eliminated[40].

With sustained efforts, the EU/EEA overall appears to be on track to meet the 90-90-90 targets. Of the countries that reported data to ECDC in 2018, 86 % of all people living with HIV were diagnosed, 90 % of all people diagnosed were on treatment and 91 % of all people diagnosed and on treatment were virally suppressed[41]. However, it is important to stress that there is diversity across European countries and several of them are facing major challenges in meeting the 90-90-90 targets.

**Figure 5: Progress toward achieving the 90-90-90 treatment target for HIV by 2020 in the EU/EEA, 2018**




*Source: ECDC, Dublin Declaration monitoring 2018; validated unpublished data*
*Note: '1st90' data based on latest available data reported, ranging from 2014-2017.*

EU Member States agreed to further 'Fast-Track' commitments enshrined in the 2016 United Nations Political Declaration *On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030*, which sets out several additional concrete targets to measure progress, including targets on incidence, such as reducing the number of new infections among young people and adults (aged 15 and older) by 75 per cent[42]. For the broader WHO European region to meet these incidence targets, it would require a sharp reversal of the increasing trend while for the EU/EEA there needs to be a steeper downturn in the current stable trend. The Declaration also entails commitments to reduce the high rates of HIV, TB and viral hepatitis co-infections, recognising their significant cause of ill-health and mortality.

[40] UNAIDS. 90-90-90 An ambitious target to help end the AIDS epidemic. Geneva: UNAIDS; 2014.
[41] European Centre for Disease Prevention and Control. Validated unpublished data from the 2018 round of monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia. Stockholm: ECDC; 2018.
[42] http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2016/june/20160608_PS_HLM_PoliticalDeclaration

*Viral Hepatitis*

It is noteworthy that viral hepatitis has been explicitly mentioned in the SDGs as a separate disease for the first time, testimony that it is a considerable world health burden. The WHO has adopted the first ever global health sector strategy (GHSS) on viral hepatitis, whose aim is to eliminate viral hepatitis as a public health threat, thus contributing to the achievement of the SDGs[43]. The WHO Regional Office for Europe has further developed an action plan to guide the implementation of the GHSS in the European Region that has been approved and adopted by all the EU Member States[44]. Achieving the hepatitis goals requires significant scaling-up of key interventions, including case-finding, access to treatment and the development of a monitoring and evaluation programme.

As there are still major gaps and limitations in the available surveillance data based on notifications and prevalence estimates, particularly for hepatitis C, it is currently difficult to assess the exact remaining distance that EU Member States need to cover to reach the SDG target. While some EU/ EEA countries have already made considerable progress in implementing primary and secondary prevention measures, only a few countries have developed reliable monitoring programmes and data to assess progress. To date there has not been a systematic, comprehensive EU/EEA wide system that is able to support countries in monitoring their responses or collect data at EU/EEA level to inform an effective response; however, the ECDC plans to launch such a monitoring system later this year.

In the EU, the ECDC and the European Monitoring Centre for Drugs and Drug Addictions (EMCDDA) collaborate with WHO Europe to support Member States in monitoring progress towards the elimination goals. In November 2017, ECDC brought together stakeholders to discuss the development of a hepatitis monitoring framework for Europe with specific input from EMCDDA on people who inject drugs. ECDC is now piloting a monitoring system for EU/EEA Member States for hepatitis B and C that is closely aligned with the targets and milestones developed by WHO and is in line with monitoring the SDGs. The expected timeline for full implementation of this system is late 2018.

*Tuberculosis*

The SDG objective for tuberculosis aims to end the epidemic by 2030. While many EU Member States have low incidence of TB, sustained efforts are needed in certain Member States to reach this goal for the EU as a whole.

The World Health Organization has further broken down the SDG 2030 target into specific indicators on measuring progress in its *End TB Strategy*[45], i.e. a 90 % reduction in tuberculosis deaths compared to 2015, an 80 % reduction in the tuberculosis incidence rate compared to 2015 and 0 % of TB-affected families facing catastrophic costs due to the disease. In 2016, there were an estimated 4 270 deaths from tuberculosis (0.8 per 100 000) in the EU/EEA. To reach a 90 % reduction in TB deaths compared to 2015, the decline would need to be almost 15 % per year. For the second indicator, the TB incidence was

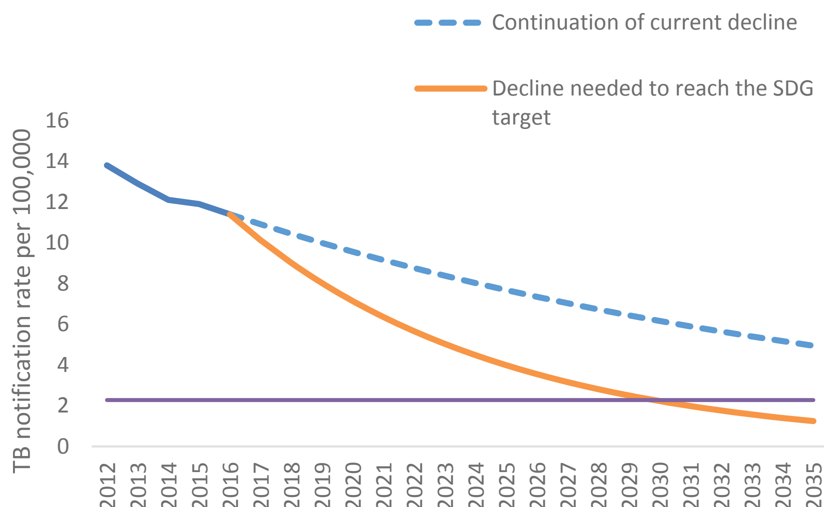
[43] World Health Organization. Combating Hepatitis B and C to reach elimination by 2030. Geneva: WHO; 2016.

[44] World Health Organization Regional Office for Europe (WHO/Europe). Action plan for the health sector response to viral hepatitis in the WHO European Region. Copenhagen: WHO/Europe; Sep 2016.

[45] The WHO *End TB Strategy* extends to 2035 but contains interim milestones for 2020, 2025 and 2030; the data used here are shown for 2030 to be consistent with the SDG goal to end the TB epidemic by 2030. http://www.who.int/tb/post2015_strategy/en/

estimated at 12.7 per 100 000 in 2015[46] and 12.3 per 100 000 in 2016[47], a reduction of 3 %. To reach the target by 2030, incidence rates would need to decline by more than 10 % per year. Currently, in the EU there is no information available on the percentage of TB-affected families facing catastrophic costs due to tuberculosis.

**Figure 6: Tuberculosis trends and progress toward the 2030 SDG target, EU/EEA**




*Source: ECDC*

## 4. EU ACTION TO TACKLE HIV/AIDS, VIRAL HEPATITIS AND TUBERCULOSIS

### 4.1. Main EU policy areas relevant to the fight against HIV/AIDS, viral hepatitis and tuberculosis

At EU level, several policy areas, programmes and instruments are involved in the fight against these major diseases. These policy areas deal with the diverse aspects of addressing the challenges: from issues of public health to continued research, development cooperation beyond the EU and assistance to neighbourhood and accession countries.

#### *4.1.1. Public Health: main policy action*

Public health remains the key policy area in addressing infectious disease. As regards Union competence, Article 168(1) of the Treaty on the Functioning of the European Union provides that 'Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education, and monitoring, early warning of and combating serious cross-border threats to health.'

[46] European Centre for Disease Prevention and Control/WHO Regional Office for Europe. Tuberculosis surveillance and monitoring in Europe 2017. Stockholm; ECDC: 2017, https://ecdc.europa.eu/sites/portal/files/documents/ecdc-tuberculosis-surveillance-monitoring-Europe-2017-WEB.pdf

[47] European Centre for Disease Prevention and Control/WHO Regional Office for Europe. Tuberculosis surveillance and monitoring in Europe 2018 (2016 data). Stockholm; ECDC: 2018, https://ecdc.europa.eu/en/publications-data/tuberculosis-surveillance-and-monitoring-europe-2018

EU action against HIV/AIDS has a long history, with viral hepatitis and tuberculosis initially considered as HIV co-infections and gradually taken up as diseases in their own right. In the early 2000, political action galvanised and culminated in the Dublin Declaration of 2004[48] on Partnership to Fight HIV/AIDS in Europe and Central Asia. It was signed by representatives of states and governments from Europe and Central Asia. It called on the European Union to be actively involved in the common effort to strengthen coordination and cooperation in the fight against HIV/AIDS and to monitor progress. For the latter, ECDC has developed a robust and comprehensive monitoring system, enabling the EU not only to track but also to analyse the HIV epidemic in Europe in order to tailor the response where it is most needed[49].

The EU first delivered a policy instrument to address HIV/AIDS at European level in 2005 with its Commission communication on combating HIV/AIDS[50]. This was the basis for EU action from 2006 to 2009. With HIV/AIDS remaining a public health concern and a political priority for the European Union and neighbouring countries, a second Communication on Combating HIV/AIDS in the European Union and neighbouring countries was adopted in 2009[51]. This second Communication stressed the importance of scaling up the implementation of prevention strategies, supporting an effective response to HIV/AIDS in priority regions and developing the means to reach and support the populations most at risk across Europe. Accompanied by two successive action plans, it sought to give political impetus to the fight against HIV/AIDS, engaging all relevant stakeholders in Member States, civil society and industry to undertake action related to prevention, priority regions and groups, improved knowledge, monitoring and evaluation.

The 2009 Communication was evaluated in 2014 and found to have been instrumental in providing the necessary stimulus, continuous pressure and leverage for various stakeholders to advocate for and take actions against HIV/AIDS in Europe[52]. The evaluation indicated that the Communication added value in a number of areas:

- it helped focus efforts and resources on priority regions and groups;
- it empowered civil society in advocating for HIV/AIDS;
- it facilitated exchange of experience among countries; and
- it enabled funding of collaborative research and public health projects.

In the fight against infectious disease, another key EU legal instrument is Decision 1082/2013/EU on serious cross-border threats to health[53], which sets out the common rules for epidemiological surveillance of communicable diseases and related special health

[48] http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/policy/guiding-policy-documents-and-frameworks-for-whoeuropes-work-on-hiv/dublin-declaration-on-partnership-to-fighthivaids-in-europe-and-central-asia.

[49] https://ecdc.europa.eu/en/infectious-diseases-public-health/hiv-infection-and-aids/prevention-and-control/monitoring.

[50] COM(2005) 654 final.

[51] COM(2009) 569 final.

[52] Evaluation of the implementation of the Commission Communication ‘Combating HIV/AIDS in the European Union and the neighbouring countries, 2009-2013’; https://publications.europa.eu/en/publication-detail/-/publication/9f1ca762-6279-4b34-abfa-6e6367efeab8/language-en.

[53] Decision No 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious cross-border threats to health and repealing Decision No 2119/98/EC.



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issues such as antimicrobial resistance. HIV/AIDS, viral hepatitis and tuberculosis are included in the list of notifiable diseases subject to epidemiological surveillance[54].

ECDC publishes regular surveillance and monitoring reports with the latest epidemiological information on the spread of the diseases in the EU/EEA[55]. A network for the epidemiological surveillance of the communicable diseases has been set up. It is operated and coordinated by the ECDC, bringing the Commission, the ECDC and the competent authorities responsible for epidemiological surveillance at national level into permanent communication. ECDC works in close cooperation with WHO Europe, and the surveillance reports are often produced jointly, thus covering the wider WHO Europe area (including eastern Europe and Central Asia) beyond the EU. ECDC also provides direct country support (to help build capacity) and manages technical networks. ECDC develops further common guidance to EU Member States on managing the diseases, as further shown in Chapter 5.

The Commission maintains regular policy dialogue with Member States through the EU HIV/AIDS, Hepatitis and Tuberculosis Think Tank — a forum to address and strengthen cooperation and comprising representatives of EU Member States and neighbouring countries who exchange information on national and international developments[56]. A similar forum of major European networks and non-governmental organisations advising the Think Tank on policy formulation and implementation — the EU Civil Society Forum — provides an opportunity to engage directly with civil society organisations. There has been broad support for continued EU action in the area and general endorsement of an integrated approach covering the three disease areas of HIV/AIDS, viral hepatitis and tuberculosis in order to combine efforts and promote cost-efficient, effective interventions.

The main funding instrument to support targeted cooperation among EU countries and to underpin and develop EU health activities is the EU Health programme[57]. Currently in its third phase (2014-2020), the Health programme has an overall budget of EUR 449.4 million and includes a thematic priority on 'HIV/AIDS, tuberculosis and hepatitis; up-take of good practices for cost-effective prevention, diagnosis, treatment and care'. EU funding has been invested to implement the Health programme's objective 1: *Promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle*, in particular the two most relevant priorities:

- priority 1.3. 'Support effective responses to communicable diseases such as HIV/AIDS, tuberculosis and hepatitis by identifying, disseminating and promoting the uptake of evidence-based and good practices for cost effective prevention, diagnosis, treatment and care' and
- priority 1.2. 'Measures to complement the Member States' action in reducing drug-related health damage, including information and prevention'.

[54] Commission Implementing Decision (EU) 2018/945 of 22 June 2018 on the communicable diseases and related special health issues to be covered by epidemiological surveillance as well as relevant case definitions.

[55] https://ecdc.europa.eu/en/infectious-diseases-public-health/hiv-infection-and-aids/surveillance-and-disease-data/annual.

[56] https://ec.europa.eu/health/communicable_diseases/sexually_transmitted_infections_en.

[57] Regulation (EU) No 282/2014 of the European Parliament and of the Council of 11 March 2014 on the establishment of a third Programme for the Union's action in the field of health (2014-2020) and repealing Decision No 1350/2007/EC, OJ L86, 21.3.2014, p. 1.



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Since 2003, over 72 actions have been funded under the Health programme, with a total investment of EUR 46 million. These include projects, joint actions, conferences and support to EU networks related to HIV/AIDS, hepatitis, tuberculosis and sexually transmitted infections. During the first phase of the Health programme (2003-2007), EUR 19 million were spent, and during the second phase (2008-2013) EUR 15.6 million were spent. So far in the third phase, the EU has invested over EUR 11.6 million for prevention, early detection and linkage to care, harm reduction and outreach to vulnerable groups. The good practices generated are further discussed in Chapter 5, and a list of all funded activities is available in the Annex.

#### *4.1.2. Additional health-related policy action*

*Access to medicines*

Certain recently authorised medicinal products, such as those for the treatment of hepatitis C, have made headline news because of their high cost per patient and consequent impact on health budgets. A number of Council conclusions[58] in recent years have called for closer cooperation between Member States to ensure all European patients have accessibility to medicinal products, while at the same time preserving the long-term sustainability of the health systems.

In line with its powers, the Commission supports the Member States in addressing the challenge of access to medicines. In particular, the Commission aims to increase communication between all the different players (Member States, regulators, health technology assessment bodies, payers, industry, health care professionals, patients, academia, etc.) to better define the problems and the expectations of each party and to combine efforts through open dialogue.

*Blood, tissues, cells and organs*

Blood, tissues, cells and organs are used in a variety of medical therapies, such as blood transfusion, transplants or in vitro fertilisation. HIV and hepatitis pose serious risks for transmission through blood or transplants. The rise of HIV in the 1980s has led to the infection of a significant number of patients dependent on blood or transplant therapies.

The legal framework defining the quality and safety standards for blood and its components is set out in Directive 2002/98/EC[59], for tissues and cells the framework is set out in Directive 2004/23/EC[60] and for organs it is set out in Directive 2010/53/EU[61]. These Directives cover all steps in the transfusion/transplantation process from donation, collection, testing, processing, and storage to distribution. Securing the supply of blood, tissues, cells and organs of these communicable diseases is an important objective of EU

[58] See in particular the 2016 Council conclusions on strengthening the balance in the pharmaceutical systems, which provided a roadmap for the Member States and the Commission to improve access to medicines; http://www.consilium.europa.eu/en/press/press-releases/2016/06/17/epsco-conclusions-balance-pharmaceutical-system/.

[59] Directive 2002/98/EC of the European Parliament and of the Council of 27 January 2003 setting standards of quality and safety for the collection, testing, processing, storage and distribution of human blood and blood components and amending Directive 2001/83/EC, OJ L 033, 8.2.2003, p. 30.

[60] Directive 2004/23/EC of the European Parliament and of the Council of 31 March 2004 on setting standards of quality and safety for the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells, OJ L 102, 7.4.2004, p. 48.

[61] Directive 2010/53/EU of the European Parliament and of the Council of 7 July 2010 on standards of quality and safety of human organs intended for transplantation, OJ L 207 6.8.2010, p. 14.



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legislation in the field. All relevant pieces of EU legislation provide for mandatory testing for HIV, hepatitis B and C, while Member States can add further tests (more stringent measures being allowed). The blood legislation also provides for blood donor screening for risk behaviours, which increase the risk of prevalence of HIV and hepatitis.

The Commission works closely with expert bodies such as ECDC to develop practical guidelines for blood establishments on implementing this binding legislative framework. The ECDC prepares risk assessments and preparedness plans whenever epidemiological outbreaks are of relevance for blood, tissues, cells and organs.

*Combatting Antimicrobial Resistance (AMR)*

Resistance to antimicrobial therapies greatly increases the risk of death or serious complications in people suffering from HIV/AIDS, tuberculosis and hepatitis. It is also associated with much higher treatment and care costs. Multi-drug resistant tuberculosis (MDR-TB) and extensively drug resistant tuberculosis (XDR-TB) are more likely to arise when anti-TB drug therapy is mismanaged, for example when there is incomplete diagnostic information; when the correct drugs are not being started; or when the full course of treatment is not completed. Drug resistance is now becoming an important emerging problem in HIV treatment and in some patients with hepatitis.

In 2017, the Commission adopted a new European One Health Action Plan against Antimicrobial Resistance[62] to combat AMR in human and animal health. It is motivated by the need for the EU to play a leading role in the fight against AMR and to add value to Member States' actions. It contributes towards implementation of the Global Action Plan on AMR and related initiatives. The plan contains more than 70 actions grouped under three pillars:

1. making the EU a best practice region,
2. boosting research, development and innovation, and
3. shaping the global agenda.

Activities will include jointly funded action by the EU and Member States to prevent and control infection in vulnerable groups, in particular to tackle resistant strains of tuberculosis. The research strategy gives special attention to the WHO priority list of pathogens and to tuberculosis, HIV/AIDS, malaria and neglected infectious diseases.

*Vaccination*

Vaccination policy is also pertinent in the fight against the epidemics. For two of the diseases, hepatitis B and tuberculosis, vaccines are a key method for prevention. Most EU Member States include hepatitis B in their vaccination calendars, about 10 Member States include tuberculosis vaccination as a general recommendation and an additional 10 include it as a recommendation for specific groups only.

To address major challenges with declining vaccination coverage, supply shortages and growing vaccine hesitancy, the Commission has proposed a Council Recommendation on strengthened cooperation against vaccine preventable diseases[63]. The proposal calls for EU-level action to strengthen cooperation and coordination between EU countries,

[62] https://ec.europa.eu/health/amr/sites/amr/files/amr_action_plan_2017_en.pdf
[63] COM(2018) 244/2.



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industry and other relevant stakeholders, in line with the objectives of a recently adopted Resolution of the European Parliament on vaccine hesitancy and the drop in vaccination rates in Europe[64]. This should help to increase vaccination coverage, ensure equal access to vaccination, promote vaccine acceptance and address lack of information and misconceptions, support vaccine research and strengthen vaccine supply, procurement and stock management.

A joint action on vaccination with EU co-funding of EUR 3.55 million is planned under the Health programme for 2018. The project will focus on sharing best practices on national vaccination policies and identifying technical requirements for electronic immunisation information systems, vaccine forecasting, prioritisation of vaccine research and development and research to address vaccine hesitancy.

#### *4.1.3. Drugs control*

People who inject drugs are a high-risk group for infectious diseases, in particular HIV and/or viral hepatitis. The 2013-2020 EU drugs strategy[65] and its two consecutive action plans, which advocate an integrated, balanced and evidence-based approach to drugs policy, guides efforts at EU level. The EU drugs strategy also aims at ensuring a high level of human health protection, through a coherent, effective and efficient implementation of measures, interventions and approaches in drug demand reduction at national, EU and international level. One of its objectives is to help reduce in a measurable way the demand for drugs, drug dependence and drug-related health and social risks and harms. By reducing demand and ultimately therefore the number of people who use drugs, and in particular those injecting drugs, the number of infected drug addicts would decline.

In October 2017, the European Monitoring Centre for Drugs and Drug Addictions (EMCDDA) released a European Guide to Health and Social Responses[66]. The guide and related online material provides a reference point for planning or delivering health and social responses to drug problems in Europe. The most appropriate responses will depend on the specific drug problems, the contexts in which these occur and the types of intervention that are possible and socially acceptable. By providing key information on some of the most important drug issues for Europe, related health problems and the responses available, the guide aims to assist those involved in tackling these challenges to develop new programmes and improve existing ones. In addition, the EMCDDA has numerous other publications on the different infectious diseases that drug users can catch.

Similar to the HIV/AIDS, hepatitis and tuberculosis Civil Society Forum, the work of the Civil Society Forum on Drugs also includes drugs and health-related issues[67].

Finally, the drugs part of the Justice programme[68] is regularly financing prevention projects by expanding the knowledge and skills of key stakeholders. This can include and has included in the past projects on the infectious diseases of drug users.

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[64] European Parliament resolution of 19 April 2018 on vaccine hesitancy and the drop in vaccination rates in Europe (2017/2951(RSP)).

[65] https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A52012XG1229 %2801 %29

[66] http://www.emcdda.europa.eu/publications/manuals/health-and-social-responses-to-drug-problems-a-european-guide_en.

[67] https://ec.europa.eu/home-affairs/what-we-do/networks/civil-society-forum-drugs_en.

[68] Regulation (EU) No 1382/2013 of the European Parliament and of the Council of 17 December 2013 establishing a Justice Programme for the period 2014 to 2020.

#### 4.1.4. *EU research and development*

As these diseases continue to be a threat to public health, the EU is investing in research on HIV/AIDS, viral hepatitis and tuberculosis through the EU framework programmes for research and development. Horizon 2020 has addressed these diseases in a systematic way with a strong focus on developing better vaccines, drugs and diagnostic tools, including their uptake in clinical practice and health systems. Under this programme, the Commission has so far invested EUR 150 million in research on HIV/AIDS, hepatitis and tuberculosis.

All stages of product development from basic research to clinical testing have been supported, with different funding instruments being used depending on whether the research is basic, preclinical or clinical. It is important to have a balanced mix of pull and push funding mechanisms that can support the full ecosystem of research and innovation, from early discovery and clinical development to scaling and implementation, so that new tools and products can reach the end users. In that light, various kinds of funding instruments have been created including two major partnerships: the European and Developing Countries Clinical Trials Partnership (EDCTP)[69] and the Innovative Medicines initiative (IMI)[70]. EDCTP is a public-public partnership supporting clinical trials and capacity building for poverty-related and neglected diseases in sub-Saharan Africa and has become a key player in the global health arena. The current programme, EDCTP2, has already invested EUR 100 million in clinical trials and capacity development for HIV and tuberculosis. The Innovative Medicines Initiative (IMI), a public-private partnership between the Commission and the European Federation of Pharmaceutical Industries and Associations, has helped to increase collaboration between the public and private sectors. The infectious diseases area is identified as one of the priorities in the strategic research agenda of the second phase of the partnership, IMI2. The Commission has further increased the variety of funding instruments by developing a de-risking loan mechanism, InnovFin Infectious Diseases, which is funding high-risk projects to reinvigorate and attract co-investment by incentivising R&D activities for an uncertain market. Loans have been signed for over EUR 100 million, including for HIV/AIDS, hepatitis and tuberculosis.

As HIV/AIDS, tuberculosis and hepatitis pose a number of scientific challenges, a multi-sectoral, coordinated response to these challenges is the best way forward. This approach has worked well, and the field has progressed significantly with the support of EU framework programmes for research and innovation. Strong links have also been created with other funders in this area, and common initiatives, like the Global Tuberculosis Vaccine Partnership, are being created to align research strategies with the work of other international organisations. However, global needs for investment in research on these diseases are estimated to be well above the current global investment. With increasing international collaboration and prioritisation, Horizon 2020 and the next framework programme Horizon Europe will continue building on the achievements of previous programmes and contribute to boosting the scientific, economic and societal impact of EU research on HIV/AIDS, viral hepatitis and tuberculosis.

[69] http://www.edctp.org/.
[70] https://www.imi.europa.eu/.



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#### 4.1.5. Development cooperation

*EU health sector development policy — New European consensus on development*

EU development aid pursues a rights-based approach to health, supporting policies that promote universal access to quality health services in accordance with the values that health systems within the EU are built upon. This approach is also enshrined in the new European consensus on development[71] — a renewed joint vision for development policy for the EU and its Member States and part of the EU response to the 2030 Agenda for Sustainable Development.

Key to EU development cooperation and health sector policy is strengthening all areas of a health system, including the availability of qualified health workers, the provision of affordable medicines and the adequate financing of the sector. This is central to moving towards universal health coverage with quality health services accessible and affordable for all. For the 2014-2020 financial framework, the overall EU aid budget allocated to health is about EUR 2.6 billion. This includes about EUR 1.3 billion for direct support to 17 countries where health is a sector of bilateral cooperation.

*Support to Global Fund to fight HIV/AIDS, Tuberculosis and Malaria*

Complementary to the EU's direct support of the health sector in partner countries is the funding of global health initiatives. These include the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (GFATM), the Vaccine Alliance (Gavi) and UNFPA-Supplies, the thematic programme of the United Nations Population Fund dedicated to expanding access to family planning. The Commission has been a long-time supporter of the Global Fund and has pledged EUR 475 million for 2017-2019. The Commission is a founding member of the Global Fund and currently its sixth largest donor (about 5 % of the total or EUR 1.8 billion since 2002). The EU collectively donates about 50 % of the Fund's resources. The Global Fund spends about USD 3.5 billion every year and is the single most important external financer of the health sector in many African countries.

The EU's support for the Global Fund has contributed to impressive results according to the latest Global Fund Results Report[72]:

- 22 million lives saved by the end of 2016;
- 11 million people on life-saving HIV treatment in 2016 with access to such treatment growing from 3 % coverage in 2005 to 21 % in 2010 and 52 % in 2016;
- a decline by one third in the number of people dying from HIV, tuberculosis and malaria since 2002 in the countries where the Global Fund invests;
- 17.4 million people have received tuberculosis treatment.

[71] New European Consensus on Development — 'Our world, our dignity, our future', https://ec.europa.eu/europeaid/new-european-consensus-development-our-world-our-dignity-our-future_en.

[72] The Global Fund Results Report 2017, available at: https://www.theglobalfund.org/media/6773/corporate_2017resultsreport_report_en.pdf?u=636602522780000000.



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The EU has highlighted the need to ensure the right balance between HIV prevention and treatment components in the grant-making process. While the need to ensure treatment continuity is paramount, including for HIV/tuberculosis co-infection, prevention components, especially in the case of young people and adolescents, cannot be forgotten if we are to end the epidemics by 2030.

Several countries in eastern Europe and the European neighbourhood region need to focus on the graduation and transition strategy. These countries have been supported by the Global Fund, but as they move along the development continuum, they will gradually become ineligible for Global Fund support, if that is not the case already. The sustainability, transition and co-financing policy of the Global Fund outlines a framework for ensuring successful transitions from Global Fund financing. Experience shows that helping countries make a sustainable transition from Global Fund support takes a lot of time. This sustainability, transition and co-financing policy of the Global Fund is work in progress, and the EU, through its presence on the Global Fund board, will ensure that this policy is successfully implemented.

*Links with universal health coverage*

In the end, the response to HIV and to issues such as drug resistant tuberculosis relies heavily on strong and functional health systems. This is where the EU is investing too, complementing its support for global initiatives.

In 2011, the European Union took a leading role in pursuing sustainable development goal 3.8 on universal health coverage (UHC), joining with the WHO to create the UHC Partnership. The EU-WHO Universal Health Coverage (UHC) Partnership is a thematic fund to strengthen policy dialogue on national health policies, strategies and plans related to universal health coverage in more than 30 partner countries. It aims to be country-led, with WHO serving as the main convener and broker of the policy dialogue, with support from staff in EU delegations who are specialised in health management.

#### *4.1.6. Accession, neighbourhood policy and external relations*

Accession to the European Union is a process that involves the candidate country adapting its institutions, standards and infrastructure to enable it to meet its obligations as a member state. Compliance with the relevant EU legislation on HIV/AIDS, viral hepatitis and tuberculosis falls under Chapter 28 of the *acquis* — Consumer and Health Protection, specifically within the sub-area of infectious diseases.

*Instrument for Pre-accession Assistance*

The Instrument for Pre-accession Assistance (IPA) is the means by which the EU supports reforms in the candidate countries with financial and technical help. IPA funding helps the countries build up their capacities throughout the accession process, resulting in progressive, positive developments in the region. Current beneficiaries are: Albania, Bosnia and Herzegovina, the former Yugoslav Republic of Macedonia, Kosovo[73], Montenegro, Serbia, and Turkey.

[73] This designation is without prejudice to positions on status and is in line with UNSCR 1244/1999 and the ICJ Opinion on the Kosovo declaration of independence.



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Under IPA, multi-country grants have been provided to ECDC for activities linked to preparatory measures so that relevant IPA beneficiaries can participate in the Centre. These grants totalled EUR 940 000 under IPA I and EUR 660 000 under IPA II.

IPA funds support the transfer of EU good practices to accession countries, including the strengthening of health systems in accordance with the EU *acquis*, including provisions on infectious disease. The EU has funded various projects, devised in accordance with the specific needs of each country. The projects have been instrumental in supporting the development of national strategies, strengthening local civil society, increasing the acceptance of people living with HIV/AIDS and ensuing outreach to key vulnerable groups such as MSM, sex workers, prisoners, injecting drug users and the Roma. The IPA multi-country grants have also been provided for activities linked to preparatory measures in health. These have totalled EUR 1.6 million, and there is an additional grant in the pipeline for an indicative amount of EUR 400 000.

*Montenegro:* The IPA was used for HIV/AIDS, hepatitis B and tuberculosis in Montenegro, mostly to support NGOs. Here, a civil society facility grant was awarded to the NGO Juventas to carry out the first ever assessment of the implementation and effects of the national strategic response to HIV (2010-2014). This national response led to the elaboration of the new strategy in this area for 2015-2020. Another civil society facility grant was awarded to the NGO CAZAS and used to develop a cost benefit analysis of services provided to the most vulnerable populations to prevent HIV/HCV. Montenegro has proposed to invest in two clinics for infectious diseases and venerology using 2018 IPA funds. This should contribute to the objectives of the 2015-2020 national strategy for the fight against HIV/AIDS by helping to oversee and provide adequate care to patients with HIV/AIDS and people at risk (LGBT, persons injecting drugs, etc.).

*Serbia:* EU support is concentrated on prevention with a project to ensure the safety of blood transfusions (establishment of the National Blood Transfusion Service using a EUR 5.5 million fund). IPA 2018 will continue this with EUR 4 million in funding. In addition, the project *Acceptance and Participation of People Living with HIV/AIDS* was carried out in Serbia and Montenegro. The project's final beneficiaries were people living with HIV, their dependants and other excluded groups — MSM, sex workers and drug users and the Roma population. The EU contribution was EUR 647 328.

*Albania and Bosnia and Herzegovina:* To date, IPA funds have not been allocated specifically to the fight against HIV/AIDS, hepatitis and TB, but these countries are benefiting in these areas through the Global Fund.

*The European neighbourhood policy*

The European neighbourhood policy governs the EU's relations with 16 of the EU's closest southern and eastern neighbours: Algeria, Egypt, Israel, Jordan, Lebanon, Libya, Morocco, Palestine[74], Syria and Tunisia to the south and Armenia, Azerbaijan, Belarus, Georgia, Moldova and Ukraine to the east. Russia takes part in cross-border cooperation activities under the European neighbourhood policy, while not being a part of the policy as such.

[74] This designation is not to be construed as recognition of a State of Palestine and is without prejudice to the individual positions of the Member States on this issue.



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HIV/AIDS, hepatitis and tuberculosis are diseases that have a higher disease burden in some of the European neighbourhood countries, in particular those to the east, as indicated in annual surveillance reports by WHO Europe. As infectious disease does not stop at borders, it is critical to support the active fight against those diseases by strengthening health systems.

Support in neighbourhood countries focuses on fighting infectious disease by strengthening their health systems. The established technical cooperation helps the health authorities of those countries build their capacity to ensure prevention, detection and diagnosis of communicable disease and blood safety, with a key focus on HIV/AIDS, hepatitis and tuberculosis.

Examples of support to neighbourhood countries in the fight against HIV/AIDS, hepatitis and tuberculosis include:

*Ukraine:* The EU has supported the Global Fund to Fight AIDS, Tuberculosis and Malaria, the main funding instrument for the HIV response in Ukraine, since its creation in 2002. The European Neighbourhood Instrument has provided EUR 3 million to the Ministry of Health for technical cooperation activities for 2018 to support a modern and sustainable public health system and the national blood system. The European Neighbourhood Instrument has also provided support for smaller-scale health-related projects (e.g. on palliative care) implemented by civil society organisations or for mapping studies (e.g. on the pharmaceuticals regulatory framework). The draft 2018 people-to-people contacts programme provides for support for professional exchanges of medical personnel as suggested by the Ministry of Health. ECDC has also been mobilised via the Technical Assistance Instrument EXchange (TAIEX) to assess the status of preparedness of the surveillance system for communicable diseases and the blood safety system. In doing so, ECDC has been helping to prepare related national strategies.

*Azerbaijan:* A grant project with the Council of Europe on prison management was implemented. The project was primarily focused on mental health in prisons and had an overall budget of EUR 556 000, of which EUR 500 000 was provided by the EU. Under this project, the medical personnel of prisons received training in dealing with the most prevalent diseases: HIV/AIDS, viral Hepatitis B and C.

*Belarus:* More than EUR 1.8 million was invested in the project *Improvement of Epidemiological Safety at the Polish-Belarusian Border Zone*. The overall objective of the project was to increase the epidemiological safety of residents living in the border area, by improving the accessibility of health services and raising awareness on infectious disease and their risks (hepatitis C and HIV/AIDS).

*Libya*: EU health cooperation with Libya started in November 2004 with the launch of the 'EU HIV Action Plan for Benghazi'. This came after the accident in the Benghazi children's hospital, where patients were treated with HIV-infected blood transfusions. Consequently, four Benghazi action plans were implemented between 2004 and 2009 (total EUR 4.6 million). Following the Benghazi action plans, the EU decided in collaboration with Libya to expand the activities to the entire country and to include the management of infectious diseases. This was carried out through a EUR 3.9 million project managed by the Belgian Red Cross 'the Libyan European Partnership for Infectious Diseases Control'. The overall objective of the project was to tackle HIV/AIDS and other infectious diseases and therefore improve the health of the Libyan population. In 2017, a more global health programme, the 'European Union Health and Accountability Programme in Libya', was decided (EUR 10.9 million — contracts to be signed before the



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end of 2018). The project will, among other things, provide for a multi-sector investment in the delivery of Libya's health services. HIV/AIDS, hepatitis and sexually transmitted infections are not the focus, but prevention of those diseases will be duly taken into account during implementation.

*Syria:* On this issue, there is no structured cooperation with the Middle East countries, and the health sector is not an EU focal sector. However, the Syrian crisis has triggered the need to provide health support to refugees and hosting communities, and this is being financed through the EU Regional Trust Fund.

*Lebanon:* The EU gives financing to UNICEF so that it can provide medication and vaccines that include hepatitis B and provide medical supplies to primary health care centres that offer services covering reproductive health, sexually transmitted infections and HIV.

*The Northern Dimension*

The Northern Dimension (ND) is a joint policy framework established between the EU, Russia, Norway and Iceland in 1999 and renewed in 2006. The policy covers a broad geographic area stretching from the European Arctic and Sub-Arctic to the southern shores of the Baltic Sea and includes Iceland and Greenland in the west and north-west Russia in the east. To facilitate sectorial cooperation and project implementation, four sectorial partnerships have been established under the Northern Dimension, including a partnership on public health and social well-being.

This Northern Dimension Partnership in Public Health and Social Well-being (NDPHS)[75] is a cooperative effort of 10 governments, the European Commission and eight international organisations. The NDPHS supports cooperation and coordination in two main fields whose priority is to:

- reduce the spread of major communicable diseases and prevent life-style related non-communicable diseases. These diseases include HIV/AIDS, tuberculosis, sexually transmitted infections, cardiovascular diseases, resistance to antibiotics, and other major public health problems that arise from the use of illicit drugs and socially distressing conditions;

- improve people's levels of social well-being and promote socially rewarding lifestyles. Here, the emphasis is on encouraging proper nutrition, physical exercise and safe sexual behaviour, ensuring good social and working environments and supporting alcohol, drug and smoke-free leisure activities. Within this priority field, special attention is on young people as the primary target group.

During 2015-2020, the partnership's work is guided by the new NDPHS 2020 strategy, which is accompanied by an action plan.

[75] http://www.ndphs.org/.



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### 4.1.7. *EU Structural and Investment Funds*

The EU Structural and Investment Funds (ESIF) comprise five main funds[76]. They work together to support economic development in all EU countries by investing in job creation and a sustainable, healthy European economy, in line with the objectives of the Europe 2020 strategy[77]. These funds are not intended to replace national, regional or local investment in the Member States but to provide co-funding for such investment. All EU regions are eligible to receive structural funds, but the level of co-financing differs from region to region and depends on GDP per capita[78]. The national and regional operational programmes (OPs) adopted in the individual Member States for the European Regional Development Fund (ERDF) and the European Social Fund (ESF) provide the framework for investments in health in the Member States.

The ESIF offer opportunities for co-financing Member State actions against HIV/AIDS, viral hepatitis and tuberculosis. Each EU Member State determines how it will manage the funds and at what level of public administration, with some countries having a decentralised system. Therefore, the data on how the funds are used is scattered across large numbers of local authorities. Also, data on how the Structural Funds are used is not collected comprehensively on a sectoral basis in the Member States but according to the set-up of the operational programmes (i.e. how much is allocated per OP, priority axis, project, beneficiary, region, etc.). Furthermore, health is a sector overlapping with many different areas, such as social affairs, education, employment, public administration or research and development, resulting in a number of various OPs managed by different authorities.

So far, in the case of health, the ESIF have been used to deal with three epidemics in three EU Member States: Romania, Lithuania and Estonia. Romania is, for example, using the ESI funds for early detection, screening, diagnosis and treatment of major diseases, such as heart disease, cancer, diabetes, chronic obstructive pulmonary disease, chronic kidney disease, chronic hepatitis, tuberculosis or HIV/AIDS. The health sector is a priority for Romania. The focus is on deprived communities and promoting alternatives to hospitals, such as primary care, ambulatory care and e-health services. Efforts are also being made to shift from institutional structures to community-based solutions for children, the elderly and people with disabilities[79]. One of the main priority areas of the current partnership agreement with Romania is to promote social inclusion and reduce the number of people at risk of poverty or social exclusion. This means in particular helping disadvantaged people, including Roma and people suffering from addictions, to access the labour market and improve their health and social status. Some of the planned actions seek to improve vulnerable groups' access to health care and support the transition to community-based care models. Implementation of the actions covered by the partnership agreement with

[76] The European Regional Development Fund (ERDF); the European Social Fund (ESF); the Cohesion Fund (CF); the European Agricultural Fund for Rural Development (EAFRD) and the European Maritime and Fisheries Fund (EMFF).

[77] https://ec.europa.eu/info/business-economy-euro/economic-and-fiscal-policy-coordination/eu-economic-governance-monitoring-prevention-correction/european-semester/framework/europe-2020-strategy_en

[78] Cf. European Commission. DG Regio. Cohesion policy eligibility 2014-2020; http://ec.europa.eu/regional_policy/sources/what/future/img/eligibility20142020.pdf.

[79] Cf. ibid. and European Commission. Summary of the Partnership Agreement for Romania, 2014-2020.; https://ec.europa.eu/info/sites/info/files/partnership-agreement-romania-summaryaug2014_en.pdf.



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Romania relies on collaboration with a range of social partners, including NGOs and community-based organisations[80,81].

Another example is Lithuania whose stated priorities include reducing poverty and social exclusion. Both are key issues in Lithuania, where more than 30 % of the population is at risk of poverty or social exclusion. To address these issues, the agreement will ensure that active labour market policy is compatible and works in harmony with social inclusion measures and that adequate social and healthcare services are equally available for all residents throughout Lithuania, in particular by promoting a shift towards community-based services (‘de-institutionalisation’)[82].

The ESF does not support harm-reduction activities directly, but it does focus on improving the labour market competitiveness of vulnerable groups, including people who inject drugs. After identifying funding gaps and possibilities, Estonia was able to use the ESF to provide psychological, social and peer counselling services to people who inject drugs and people living with HIV and to fund related media campaigns. By transferring some counselling services from national to EU structural funding, Estonia was able to increase its funding of the harm-reduction services where funding gaps existed, including NSPs, OST and condom distribution. In 2010-2015, ESF provided an estimated EUR 500 000 to finance counselling services for HIV-positive people. These funds were used to set up and run social counselling to help people over 16 years old facing stressful challenges that might trigger mental problems and to help people close to them. The aim of the counselling services was to help patients sort out their mental and social problems, reassure them that it is possible to learn to live with HIV and that their life can evolve normally. Counselling services for those close to such persons concentrated on teaching them how to motivate and encourage the infected person to face the situation[83].

## 5. Technical guidance and good practices developed at EU Level

### 5.1. Technical guidance to tackle the epidemics

In the EU, ECDC has invested in developing technical, evidence-based guidance to support Member States’ efforts to tackle the epidemics including HIV/AIDS, hepatitis and tuberculosis. The guidance serves to support EU Member States in devising effective national strategies and provide a regional perspective to compliment global

[80] Ministry of European Funds. Romanian Partnership Agreement for the 2014-2020 programming period, March 2014; http://www.fonduristructurale.ro/Document_Files/Stiri/00014830/sfvjd_Acord%20de%20parteneriat%20oficial.pdf.

[81] HA-REACT. Guidance on funding mechanisms for harm-reduction programmes in European Union Member States, 22 March 2018; http://www.aidsactioneurope.org/sites/default/files/HA%20React%20D2_WP8_22 march2018-FINAL.pdf.

[82] Ibid and European Commission. Summary of the Partnership Agreement for Lithuania, 2014-2020. [Online] 20 June 2014: https://ec.europa.eu/info/sites/info/files/partnershipagreement-lithuania-summary-june2014_en.pdf.

[83] Cf. HA-REACT. Guidance on funding mechanisms for harm-reduction programmes in European Union Member States, 22 March 2018; http://www.aidsactioneurope.org/sites/default/files/HA%20React%20D2_WP8_22 march2018-FINAL.pdf and Väärt, Jaan, Kurbatova, Aljona and Stuikyte, Raminta. Estonian case of financing harm reduction with EU Structural Funds. http://www.harm-reduction.org/sites/default/files/inline/files/7 %20Estonia%20structural%20funds%20Convictus%20experience%20-%20Jaan.pdf.



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recommendations issued by the WHO[84]. The most prominent examples are presented below.

### 5.1.1. *HIV/AIDS*

ECDC produced guidance in 2015 on *HIV and STI prevention among men who have sex with men*[85] that aims to reduce HIV and STI incidence and morbidity among MSM in the EU/EEA, including sexually transmitted hepatitis B and C. The guidance details a comprehensive list of evidence-based actions to help guide national and sub-national policy makers, and programme implementers in the EU/EEA Member States. The guidance may also be useful for NGOs, advocacy organisations and others working in the fields of sexual health and disease prevention with MSM.

In 2010, ECDC delivered guidance on *HIV testing: increasing uptake and effectiveness in the European Union*[86] that provides key information on why, where, how and when to test for HIV. The aim is to inform existing national HIV testing strategies in Member States to adopt a strategic, evidence-based approach to develop and implement effective HIV testing procedures. In addition, the guidance gives detailed advice on how to identify potential barriers to testing, define strategies to increase the uptake of national HIV testing and monitor and evaluate testing programmes.

### 5.1.2. *Tuberculosis*

The *Guidance on tuberculosis control in vulnerable and hard-to-reach populations*[87] (2016) from ECDC provides an overview of interventions to improve early diagnosis of tuberculosis and treatment completion in these populations. It also looks at factors to consider when developing programmes for health communication, awareness and education, and programme monitoring and evaluation.

In 2015, ECDC published an *Expert Opinion on the introduction of new drugs for tuberculosis control in the EU/EEA*[88]. This guidance outlines some pre-conditions that may be considered essential at the national level prior to the use of new drugs for the treatment of tuberculosis, as well as specific conditions needed to implement successfully new TB drugs/regimens.

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[84] In addition to the normative work, WHO Europe is currently preparing a compendium of best practices identified by the 53 Member States of WHO European Region which will be presented at the AIDS 2018 Conference.

[85] European Centre for Disease Prevention and Control. HIV and STI prevention among men who have sex with men. Stockholm: ECDC; 2015. https://ecdc.europa.eu/sites/portal/files/media/en/publications/Publications/hiv-sti-prevention-among-men-who-have-sex-with-men-guidance.pdf

[86] European Centre for Disease Prevention and Control. HIV testing: increasing uptake and effectiveness in the European Union. Stockholm: ECDC; 2010.

[87] European Centre for Disease Prevention and Control. Guidance on tuberculosis control in vulnerable and hard-to-reach populations. Stockholm: ECDC; 2016, http://ecdc.europa.eu/en/publications/Publications/TB-guidance-interventions-vulnerable-groups.pdf

[88] European Centre for Disease Prevention and Control. Expert Opinion on the introduction of new drugs for tuberculosis control in the EU/EEA. Stockholm: ECDC; 2015. ISBN 978-92-9193-626-7, http://ecdc.europa.eu/en/publications/Publications/expert-opinion-introduction-new-TB-drugs-march-2015.pdf.



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The report *Investigation and control of tuberculosis incidents affecting children in congregate settings*[89] (2013) brings together the different components of generic outbreak management and tuberculosis-specific policies and guidelines to develop a more comprehensive package of guidance to capture the elements that are specific for TB incidents affecting children in congregate settings.

#### *5.1.3. Cross-cutting*

In 2018, ECDC and EMCDDA issued joint guidance[90] on supporting the planning and implementation of effective active case finding, prevention and control measures for high-burden communicable diseases in prison settings, i.e. viral hepatitis B and C, HIV, and tuberculosis. The target population consists of adult individuals aged 18 and older detained in prison for custody, remand or awaiting trial.

In 2017, ECDC published *Antenatal screening for HIV, hepatitis B, syphilis and rubella susceptibility in the EU/EEA — addressing the vulnerable populations*[91]. This guidance aims to support the strengthening of antenatal screening programmes for HIV, HBV, syphilis and rubella susceptibility in the general population and in groups identified as vulnerable to mother to-child-transmission in the EU/EEA.

In 2011, ECDC and EMCDDA published *Prevention and control of infectious diseases among people who inject drugs*[92]. This is guidance for HIV, hepatitis and tuberculosis that aims to help policy makers in Europe to plan adequate, evidence-based, pragmatic, and rationally designed public health responses for the prevention and control of infections among people who inject drugs.

EMCDDA also published *Guidelines for testing HIV, viral hepatitis and other infections in injecting drug users*[93] (2010), a manual for provider-initiated medical examination, testing and counselling.

ECDC is also currently developing guidance[94] to build on the previous HIV testing guidance and integrate hepatitis with a focus on more testing among vulnerable populations and in community settings.

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[89] European Centre for Disease Prevention and Control. Investigation and control of tuberculosis incidents affecting children in congregate settings. Stockholm: ECDC; 2013. ISBN 978-92-9193-542-0, http://ecdc.europa.eu/en/publications/Publications/guidance-investigation-control-tb-incidents-children-in-congregate-settings.pdf

[90] European Centre for Disease Prevention and Control, European Monitoring Centre for Drugs and Drug Addiction. Public health guidance on active case finding of communicable diseases in prison settings. Stockholm and Lisbon: ECDC and EMCDDA; 2018.

[91] European Centre for Disease Prevention and Control. Antenatal screening for HIV, hepatitis B, syphilis and rubella susceptibility in the EU/EEA — addressing the vulnerable populations. Stockholm: ECDC; 2017. https://ecdc.europa.eu/sites/portal/files/media/en/publications/Publications/antenatal-screening-sci-advice-2017.pdf

[92] European Centre for Disease Prevention and Control and European Monitoring Centre for Drugs and Drug Addiction. Prevention and control of infectious diseases among people who inject drugs. Stockholm: ECDC; 2011. http://www.emcdda.europa.eu/system/files/publications/638/ECDC-EMCDDA_IDU_guidance_-_web_version_328027.pdf

[93] European Monitoring Centre for Drugs and Drug Addiction. Guidelines for testing HIV, viral hepatitis and other infections in injecting drug users. A manual for provider-initiated medical examination, testing and counselling. Luxembourg: Publications Office of the European Union; 2010; http://www.emcdda.europa.eu/publications/manuals/testing-guidelines_en

### 5.2. Good practices implemented through the EU Health programme

Actions supported by the EU Health programme have helped to develop and implement good practices for attaining international commitments to eliminate AIDS and TB, and reduce viral hepatitis. The most prominent examples of good practices developed at EU level are presented below. The specific actions are grouped according to their main themes and focus on:

1) promoting early diagnosis for HIV, hepatitis and tuberculosis, including the reduction of late presenters as well as interventions addressing the needs for improving treatment as prevention[95];

2) integrating treatment and care, ensuring access, integrated diagnosis and case management, bridging health services in the community and health services, including prison health care; and

3) supporting civil society for their specific involvement in the response against the diseases.

The actions discussed below are further complemented by additional information and more details on additional activities presented in annex.

#### *5.2.1. Early diagnosis of HIV, viral hepatitis and tuberculosis*

To support the target that by 2020 90 % of all people with HIV will know their HIV status, the Health programme has funded the scaling-up of testing for HIV and co-infections, reaching out to vulnerable groups to better understand the challenges and barriers they face in order to devise targeted and effective prevention interventions.

One such example is the project *European Surveys and Trainings to Improve MSM Community Health (ESTICOM)*[96] (2016-2019) that is providing sound evidence about the sexual health of MSM in Europe, including evidence about new behaviour trends in their life style. The project will also assess and define the knowledge, attitudes and practices to ensure the effective implementation of targeted prevention strategies by community-based health workers when providing health services for MSM. The project will develop a training programme for community health workers working with gay, bisexual, and other men who have sex with men, which will be piloted in more than 20 European countries[97]. The project is run by a consortium of five EU countries and benefits from EUR 2 million in EU funding. Until now, the project has developed the following two examples of good practices:

- The *European Community Health Worker Online Survey (ECHOES)* provides a detailed description of community health workers in Europe, with more than a thousand Community Health Workers participating in the survey.
- The *European MSM Internet Survey (EMIS) 2017* is an online questionnaire available simultaneously in 33 languages. The survey collected data on 130 000

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[94] European Centre for Disease Prevention and Control. Integrated HIV-Hepatitis testing guidance. Awaiting publication.

[95] http://www.who.int/hiv/pub/mtct/programmatic_update_tasp/en/.

[96] https://www.esticom.eu

[97] https://www.esticom.eu/Webs/ESTICOM/EN/training-programme/country-piloting-of-training-modules/country-piloting-of-training-modules-node.html.



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MSM in the 50 target countries, with 100 000 responses in the EU. The EMIS 2017 survey should describe the level and distribution of HIV transmission risk and precautionary behaviours, present related HIV prevention needs and assess self-reported STI testing behaviours, testing performance and STI diagnoses, including viral hepatitis.

Another example of EU support is *EUROHIVEDAT*[98] — a project lasting over three years (2014-2017) that involved 11 EU countries. The project aimed to generate harmonised monitoring and evaluation data from community-based voluntary testing and counselling (CBVTC) across Europe. For this, the project used the indicators and data collection instruments developed by the previously funded project *HIV community-based testing practices in Europe HIV-COBATEST*[99]. The project also aimed to explore the acceptability, feasibility and effectiveness of innovative strategies, like point of care technologies for HIV and STI diagnosis, HIV self-testing and web-based outreach and counselling approaches. The EU funding amounted to over EUR 1 million. In particular, the project financed the development of an internet-based toolkit[100] for NGOs which had recently established a CBVTC Service/Checkpoint for MSM or were interested in starting one.

A further example is the *OptTEST* project (2014-2017) whose aim was to help reduce the number of undiagnosed people with HIV infection and newly diagnosed late presenters in the European region and to promote timely treatment and care. The objective was met by providing tools on how to implement indicative conditions-guided testing and ensure the cost effectiveness of alternative HIV screening strategies by risk groups. *OptTEST* was very useful in demonstrating the gaps in the HIV continuum of care in Europe. The partners produced relevant reviews, country assessment, innovative testing strategies, cost-benefit analysis of testing per priority group, and identified examples on how to address existing barriers. Five EU countries participated, with EU funding of over EUR 1.4 million.

In 2010-2012, the EU funded the project *Highly active prevention: scale up HIV/AIDS/STI prevention, diagnostic and therapy across sectors and borders in CEE and SEE — Bordernet work*[101]. This was an interdisciplinary cross-border network project to scale up the HIV/AIDS and STI response by implementing 'highly active prevention' also known as 'combination prevention'. The project helped to improve prevention, diagnosis and treatment of HIV/AIDS (including co-infections) and sexually transmitted infections by bridging gaps in practice, policies and cross-country cooperation and by increasing capacity in interdisciplinary response. Twelve EU/EEA countries were involved. The EU funding amounted to over EUR 1 million.

The project *Capacity building in combining targeted prevention with meaningful HIV surveillance among MSM (Sialon II)*[102] created a multicentre bio-behavioural survey protocol and survey report covering 13 EU cities. It developed city profiles as policy briefs highlighting the results for each participating city and listing specific recommendations for the prevention actions prioritised. In 2011-2015, the EU provided almost EUR 1 million in funding for this project.

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[98] https://eurohivedat.eu/

[99] https://webgate.ec.europa.eu/chafea_pdb/health/projects/20091211/summary

[100] http://www.msm-checkpoints.eu/

[101] https://bit.ly/2rk8jeJ

[102] www.sialon.eu



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Another prominent example is *EU-HEP-SCREEN*[103]. The aim of this three-year project (2011-2014) was to assess, describe and communicate to public health professionals the tools and conditions necessary for implementing successful screening programmes for hepatitis B and C in migrants. The project studied screening strategies that can be used for different health settings and good practices that had positive effects on health. Seven EU countries were involved. *EU-HEP-SCREEN* developed the HEPscreen toolkit for health professionals, enabling the replication of good practices in the design, implementation and evaluation of migrant-specific viral hepatitis screening programmes. The EU funding amounted to over EUR 1 million.

#### *5.2.2. Integration of treatment and care*

Several actions focus on improving treatment as prevention, with a particular focus on personalised care, integrated early diagnosis for HIV and co-infections, linkage to care and harm reduction. These actions are helping to reach the goal set by WHO for 2020, i.e. 90 % of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and will be screened for the other co-infections, such as hepatitis and tuberculosis and linked to adequate treatment and care. The following joint actions[104] and projects can be highlighted.

The first example is the *Joint Action on HIV and Co-infection Prevention and Harm Reduction (HA-REACT)*[105], a three-year project funded until September 2018 by the Health programme and involving 18 countries. This joint action addresses gaps in the prevention of HIV and other co-infections, especially tuberculosis and viral hepatitis, among people who inject drugs. It is helping to eliminate HIV and focusing particularly on Member States with gaps in effective and evidence-informed interventions or where such interventions are missing. The project is expected to contribute to the overall objective of no new HIV infections, reduced viral hepatitis and tuberculosis among people who inject drugs in the EU by 2020. To carry out the activities, the project has brought together partners working in the health, social affairs and security sectors (drug monitoring agencies and prison services). The EU funding amounts to over EUR 3 million. The project has developed two examples of good practices:

- the implementation of a mobile harm reduction unit by the non-governmental organisation DIA-LOGS. This unit is supervised by the Centre for Disease Prevention and Control in Latvia, which since January 2017 provides harm reduction services for people who inject drugs in Riga and its surrounding areas. In its first 6 months of activity, the mobile harm reduction unit performed 398 consultations of 93 different clients and distributed 432 condoms and 8 436 syringes and needles. In addition, 143 HIV tests were completed.

- the development of training for capacity building on harm reduction. The training aims to provide the means and tools to overcome reluctance towards harm-reduction interventions and to influence decision makers in the focus countries. In addition, it improves knowledge among professionals, facilitating communication and debating between institutions and civil society and facilitating direct observation and bench marking of successful experiences from other EU countries.

[103] www.hepscreen.eu

[104] A joint action is a type of EU-funded project (grant) with Member States competent authorities (in this case with health authorities).

[105] http://www.hareact.eu/en



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Another example is *QHP — Improving Quality in HIV Prevention: Quality Action.* This joint action[106] (2013-2016) aimed to improve the quality of the response to HIV and AIDS in Europe. Quality Action integrated evidence-based quality improvement (including quality assurance) practices into HIV prevention across Europe. It built a network of trained HIV-prevention stakeholders, such as from civil society, community-based service providers, government authorities, etc., to apply practical quality improvement tools to projects targeting priority groups in demonstration pilots. For quality improvement to become a mainstream part of HIV prevention, the joint action developed and disseminated an agreed 'Charter for Quality in HIV Prevention' and a policy kit. The joint action brought together 25 partners from 18 countries. They adapted five practical quality improvement tools, which were adopted by more than 400 prevention stakeholders trained in using the five practical quality improvement tools. The practical application of the quality action prevention tools has led to the creation of a searchable database with 98 case studies. The EU funding for this joint action was 1.4 million EUR.

Currently, the *INTEGRATE* Joint Action on Quality of HIV/AIDS, sexually transmitted infections, viral hepatitis and tuberculosis prevention and linkage to care aims to integrate early diagnosis and linkage to prevention and care of HIV, viral hepatitis, TB and sexually transmitted infections in 16 EU Member States by 2020. The three-year project started in September 2017. It is targeting key populations at increased risk of HIV, sexually transmitted infections, HCV and TB, mainly MSM, people who inject drugs, sex workers and migrants. INTEGRATE focuses on how effective tools for diagnosis and linkage to care for one disease can be used for other diseases. This will be done by reviewing existing tools and then adapting and piloting the tools in other disease areas. The EU is providing almost EUR 2 million in funding for the project.

The project *Eurosupport 6 (ES 6)*[107] took 4 years (2009-2013) and involved 10 EU countries. The project aimed at improving the sexual and reproductive health of people living with HIV in Europe. This was achieved by developing a training and resource package for HIV service providers to support people living with HIV to improve their health. The focus was on enabling people living with HIV to adopt sexually healthy lifestyles, avoiding transmission. Evaluation of the project showed that this intervention significantly increased condom use 3 months post-intervention and fulfilled other criteria, testifying to the intervention's effectiveness. The EU funding amounted to almost EUR 700 000.

The *Correlation II project*[108] (2009-2012) aimed to improve prevention, care and treatment services, targeting blood-borne infectious diseases, in particular hepatitis C and HIV/AIDS, among vulnerable and high risk populations (e.g. drug users and young people at risk). It did this by increasing the access to services and the quality of health promotion interventions, strengthening capacities among health service providers and influencing health policies, The *Correlation II* network of experts came from 9 EU countries. They developed guidance documents and strengthened the capacities of service providers in order to encourage the implementation of evidence-based interventions. In the prevention of blood-borne infectious diseases, namely HIV/AIDS and hepatitis C, a number of community-based health promotion interventions were identified as effective (evidence-based) and cost-effective. This applies particularly to interventions, such as outreach/early intervention, e-health and peer education. The EU funding was almost EUR 900 000.

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[106] www.qualityaction.eu.
[107] http://www.eurosupportstudy.net/research.htm.
[108] http://www.correlation-net.org/; e-Health tool: www.sittool.net.

The *Health Promotion of young prisoners (HPYP)*[109] was a three-year project (2010-2013) with seven participating EU countries. The project`s general objective was to develop and improve health promotion for young vulnerable people in prison, with the specific aim of subsequently implementing across the EU a health promotion toolkit for prison health professionals working with young prisoners. The EU provided almost EUR 500 000 in funding for the project.

#### *5.2.3. Civil society involvement in the response*

The *TB Coalition network*[110], comprising 171 members, was supported through a specific grant covering 2014-2017. The aim was to strengthen the role of civil society in the tuberculosis response in Europe and to map civil society organisations working on TB in 43 countries in the region, including all 28 EU Member States. This is the only regional civil society network working exclusively on TB issues in the EU and the WHO Europe region. Since the network's creation, it has actively searched and engaged with national civil society organisations and individuals, increasing its membership. The project helped to produce country visit reports for Romania and Bulgaria and two thematic reports: *How to leverage European Union funding for health in Eastern Europe and Central Asia?* and *Moving to people centred care: Achieving better TB outcomes*. The EU provided almost EUR 250 000 in funding for this project.

A specific grant has been provided annually since 2008 to support the activities of *AIDS Action Europe (AAE): Public Policy Dialogue and linking and Learning*[111]. The aim of this 8-year grant (2008-2016) to support the AAE network was to unite civil society in working towards a more effective response to the HIV epidemic in Europe, striving for a better protection of human rights and universal access to prevention, treatment, care and support. AAE aims to reduce health inequalities by focusing on key vulnerable populations and on eastern Europe and Central Asia. This project has helped to maintain the HIV/AIDS Clearinghouse and the CSF secretariat to enable public policy dialogue on EU policies and to set up the European HIV Legal Forum network. AAE is a comprehensive network of 415 NGOs, national networks, AIDS service organisations, and community based groups in 47 countries in the WHO European Region. EU funding amounted to over EUR 2.4 million.

## 6. FINAL OBSERVATIONS

This staff working document takes stock of the activities at EU level that have helped to fight the HIV/AIDS, viral hepatitis and tuberculosis epidemics in Europe. Based on a long-lasting firm political commitment, the EU has invested in policy dialogue and direct funding for action on the ground to support Member States and neighbouring countries in their ambition to reach the global objectives to eradicate these diseases. The EU has been instrumental in setting up policy measures and developing good practices for targeted interventions that make a difference on the ground. The success of what the EU has done so far in tackling HIV/AIDS, viral hepatitis and tuberculosis demonstrates that only continuous and efficient efforts will help to reach the SDGs before 2030.

[109] https://webgate.ec.europa.eu/chafea_pdb/health/projects/20091212/summary.
[110] http://www.aidsactioneurope.org/.
[111] http://www.aidsactioneurope.org/.



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The numerous good examples and good practices described in this paper confirm that solutions exist to improve the situation of populations mostly affected by these infections. The most vulnerable groups require approaches tailored to their specific circumstances, which are often exacerbated by social marginalisation, poverty, stigmatisation or barriers in access to preventive and care services. All good practices identified confirm that there is no one-size-fits-all solution or approach but that each particular situation requires a thorough and targeted analysis, involving all stakeholders in the implementation of preventive and treatment measures.

The EU has invested most strongly in prevention, because it is still the most effective way to end HIV/AIDS, viral hepatitis and tuberculosis in Europe, in line with the SDGs. This is why EU projects have focused on supporting early diagnosis. It has done this by promoting testing and supporting efforts to reach out more to hard-to-reach vulnerable groups such as prisoners, injecting drug users and MSM to better understand the barriers that impede the effective prevention of these diseases.

Last but not least, the EU has been a strong advocate for the continued and sustained efforts to tackle these three epidemics, maintaining its political commitment and ensuring regular policy dialogue with stakeholders in Member States and with civil society organisations. Externally, beyond its borders, the EU has also supported efforts in third countries to fight these diseases. Epidemics do not stop at borders, and the Union, within the remit of its powers, remains committed to continue playing its role in the active fight against major diseases.



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# Annex: Good practice examples developed under the EU Health Programme 2008-2013 and 2014-2020

## Joint Action on HIV and Co-infection Prevention and Harm Reduction (HA-REACT)

The Joint Action on HIV and Co-infection Prevention and Harm Reduction (HA-REACT) addresses existing gaps in the prevention of HIV and other co-infections, especially tuberculosis (TB) and viral hepatitis, among people who inject drugs (PWID). In order to contribute to the elimination of HIV, this JA is focusing particularly on Member States, which have gaps in effective and evidence-informed interventions, or where such interventions are not being implemented at a sufficient level. The HA-REACT project has been carried out in three focus countries: Latvia, Lithuania and Hungary. In addition, Czech Republic and Poland are focus countries of the prison work package.

The project is expected to contribute to the overall objective of zero new HIV infections, reduced HCV and TB among PWID in the EU by 2020, and its purpose is to improve capacity to respond to HIV and co-infection risks and provide harm reduction with specific focus on people who inject drugs (PWID). In order to carry out the activities HA-REACT partners work across the Health, social affairs and security sectors (drug monitoring agencies and prison services).

| **EU funding: EUR 3 750 000,00** |
|---|
| Duration: 36 M, October 2015 – September 2018 |
| Coordinator organisation (country): THL (FI) |
| Partnership: 22 partners and 14 collaborating partners, including the European Centre for Disease Prevention and Control (ECDC) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) |
| Countries: 18 countries |
| Website: www.hareact.eu/en |



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Operational Objectives:

- To improve early diagnosis of HIV, TB and viral hepatitis as well as linkage to care for PWID (WP4);
- To scale up harm reductions services in the EU, based on Latvian and Lithuanian case studies (WP5);
- To increase harm reduction and improve continuity of care for PWID in prison settings (WP6);
- To improve the provision of integrated HIV, HCV and TB treatment and harm reduction for PWID;
- In order to update national programmes to overcome barriers (WP8) to responding to HIV, TB and HCV-related needs of PWID in the EU, with particular focus given to Latvia, Lithuania and Hungary.

Main results (ongoing):

- An interactive training manual and e-learning package on HIV, HCV and TB testing in low threshold settings for personnel who work with people who use drugs, with special focus on women and peers;
- Training for low-threshold services on testing of HIV, HCV and TB, and leaflets and posters to encourage PWID to take rapid HIV and HCV tests;
- Seminars/training workshop to illustrate service provision process in relation to different harm reduction interventions and facilities, as well as related problem solving strategies, in Latvia and Lithuania;
- One mobile unit has started its work in Riga, Latvia in as part of the National exchange needles and syringes programme, to test PWID on HIV, to distribute condoms and to give counselling in health and social issues;
- Training for prison health and security professionals (Poland, Luxembourg, Czech Republic); a pilot on condom distribution in a Czech prison after training of personnel and prison authorities;
- Harm reduction website: http://harmreduction.eu with four e-learning courses concerning harm reduction and treatment in prisons and a toolbox with supplementary material on prison issues;
- Survey on harm reduction services in Europe concerning barriers to access; meetings on financing of harm reduction services and their sustainability organised in Hungary and Lithuania and guidance on funding mechanisms developed.

Best Practice:

- Mobile harm reduction unit (MOU) implementation, supervised by the Centre for Disease Prevention and Control (CDPC) of Latvia. This MOU provides since January 2017 harm reduction services as syringe and needle exchange, condom distribution, rapid HIV testing and counselling for People Who Inject Drugs in Latvia's capital city Riga and surrounding areas. The activity is still ongoing but according to collected data of its first six months, it is already contributing to reduce the incidence of HIV and other blood-borne infections across the region;
- Training package addresses capacity building and training on Harm Reduction by providing the means and tools to overcome reluctance towards Harm reduction Interventions and influence decision makers in the selected focus countries. The package also aims to improve knowledge among professionals, facilitate communication and debate between institutions and civil society, and facilitate direct observation and bench marking of successful experiences from other EU countries.

**European Network Social Inclusion and Health EU: Correlation II**

The aim of the Correlation II project is improving prevention, care and treatment services, targeting blood-borne infectious diseases (BBID), in particular Hepatitis C and HIV/AIDS, among vulnerable and high risk populations (e.g. drug users and young people at risk). Therefore, the access to services and the quality of health promotion interventions has been increased, capacities among health service providers has been strengthened and has influenced health policies

Correlation II network of experts have identified and reviewed various interventions, develop guidance documents and strengthen the capacities of service providers, in order to encourage the implementation of evidence-based interventions. In the prevention of BBID's, namely HIV/AIDS and Hepatitis C, a number of community-based health promotion interventions have been identified as effective (evidence-based) and cost-effective. This applies particularly to interventions, such as outreach/early intervention, e-health and peer education.

| **EU funding: EUR 894 145 28,00** |
|---|
| Duration: 36 M, 1 April 2009 – 31 March 2012 |
| Coordinator organisation (country): Foundation De Regenboog Groep (NL) |
| Partnership: 12 associated partners from 9 countries, and more than 100 collaborating partners |
| Countries: 9 countries |

| Website: http://www.correlation-net.org/ and www.sittool.net (e-Health tool) |
|---|
| Operational Objectives:<br>• Identify and develop strategies and interventions by reviewing models of good practice, by implementing field-testing and by developing guidance documents for practitioners;<br>• Support and strengthen capacities of health service providers and other relevant players by maintaining a European network in the field of health promotion, prevention, care and treatment (facilitating exchange and mutual support), by providing information and data (centre of expertise) and by developing and implementing training and skill-building modules;<br>• Develop policies by evaluating the health, social and economic impacts of existing policies and by formulating evidence based policy recommendations with respect to BBID in Europe. |
| Main results:<br>• Manual for Outreach and Early interventions;<br>• Peer Support Manual and website;<br>• Social Intervention Tool (SIT) - Interactive web-based tool for e-health promotion;<br>• Hepatitis C Trainings Tool;<br>• Hepatitis C transmission and injecting drug use: harm reduction responses;<br>• HIV and Aids Policy Recommendations. |
| Best practice:<br>• Peer Support Manual and website;<br>• Social Intervention Tool (SIT) - Interactive web-based tool for e-health promotion;<br>• Hepatitis C Trainings Tool;<br>• Correlation project as established network. |



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**EARLY DETECTION AND INTEGRATED MANAGEMENT OF VIRAL HEPATITIS IN EUROPE: HepCare Europe**

The HEPCARE EUROPE project aims to support the development of national hepatitis strategies, screening and treatment guidelines, taking into account available treatment options. It will help to bridge primary, secondary care, and outreach in the community to facilitate access to and uptake of testing and treatment services particularly among key risk groups including drug users and homeless. It will also assess the potentially considerable economic impact of available treatment and testing strategies on health systems, which are under the responsibility of the EU Member States, with a view to inform decisions on balancing access to medicines with the financial sustainability of health systems.

HEPCARE EUROPE objective is to optimize Hepatitis C diagnosis, linkage between primary, secondary and outreach community care, and access to treatment for at risk populations in the European Union. To introduce a new model of care and have it adopted.

| **EU funding: EUR 1 000 000,00** |
| --- |
| Duration: 36 M, 1 May 2016 – 30 April 2019 |
| Coordinator organisation (country): UNIVERSITY COLLEGE DUBLIN, NATIONAL UNIVERSITY OF IRELAND, UCD (IE) |
| Partnership: 5 partners from 4 countries |
| Countries: 4 countries |
| Website: http://www.ucd.ie/medicine/hepcare/ |
| Operational Objectives:<br>• Enhance screening of at risk and vulnerable populations;<br>• Integrate primary and secondary care, by developing an integrated model of HCV care, delivering this model of care and determining the feasibility, acceptability and likely efficacy of this model of care;<br>• Develop and implement multidisciplinary inter-professional education in Hepatitis C care for Health Care Professionals across Europe;<br>• Assist in vulnerable populations accessing care in Hepatitis C, Tuberculosis and HIV through peer education;<br>• Examine cost effectiveness of the HepCare Europe system of care;<br>• Share learning's between consortium members, engage policy makers / stakeholders nationally and in the EU and to disseminate findings to and raise awareness HCPs and the scientific community. |



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Main results (ongoing):

- Protocol and piloting of an intensified screening and linked to care using the established care pathways, including the specific interventions such as use of project fibroscan (HEPCHECK);
- Education of the community practitioners, outreach of HCV trained nurse into community health centres where clients who already know their HCV status and have been looked after by methadone prescribing GPs will become engaged in care (HEPLINK);
- Peer support model aimed to assist vulnerable populations to access the community care pathway, using community partnership trained peer support volunteers(HEPFRIEND);
- Developed and implemented multidisciplinary inter-professional education in Hepatitis C care for Health Care Professionals across Europe (HepEd)
- Health economic analysis of the interventions undertaken as part of the HepCare model (HepCost).

Best practice:

- Intensified screening and linked to care using the established care pathways, in primary health care (HEPCHECK);
- Education of the community practitioners, outreach of HCV trained nurse into community health centres to ensure adherence to care (HEPLINK);
- Peer support programme for community trained peer support volunteers(HEPFRIEND);
- Inter-professional education in Hepatitis C care for Health Care Professionals across Europe (HepEd);
- Health economic analysis of the interventions undertaken as part of the HepCare model (HepCost).

**Correlation Network –CN**

The Correlation Network (CN) aims to reduce health inequalities and improve the accessibility of social and health services for marginalised groups and to enhance prevention, treatment and care in the area of blood-borne infectious diseases (BBID), in particular Hepatitis C and HIV/AIDS.
The general objectives of Correlation network are to:

- Facilitate exchange of information, experience and skills between health and social service providers, policy makers, researchers and community members;
- Strengthen capacities of health and social service providers, policy makers, researchers and community members;
- Contribute to evidence-based policy making in the field of BBID.



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**EU funding: EUR 100 581,00**

Duration: 12 M, 1 January 2013 – 31 December 2013

Coordinator organisation (country): Foundation De Regenboog Groep (NL)

Membership: 160 organisations

Countries: with focal points in 30 European countries

Website: www.correlation-net.org, www.peerinvolvement.eu; https://sittool.net

Operational Objectives:

- Consolidate, expand and maintain the existing network and stimulate European cooperation and exchange:
- Set up thematic expert groups in the field of outreach, eHealth, peer involvement, sex work, Hepatitis C and policy and set up a resource Centre;
- Promote the implementation of Correlation I and II documents;
- Support service providers, policy makers and communities in the development and implementation of interventions in the field of BBI by stimulating the exchange between policy makers, service providers, researchers and target group representatives and contribute to the development of evidence-based policies, targeting marginalised groups;
- Contribute to the knowledge of civil society and stimulate active citizenship.

Main results:

- Establishment of an online resource centre and promote standards and a professional profile for outreach workers in harm reduction settings;
- Update best practice examples in the field of peer involvement on eHealth and promote the Social Intervention Tool (SIT), an online chat tool and the use of the online training version for the implementation of the SIT;
- Promotion of existing QA and QI principles / practices in the field of HIV/AIDS and HCV;
- Development of the Correlation Peer Involvement booklet.

Best practice:

- Training manual in regard of new HCV medication and treatment options.



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**Health Promotion for Young prisoners – HPYP**

The Health Promotion for Young prisoners - HPYP project general objective was to develop and improve health promotion for young vulnerable people in the prison setting specifically aiming at the subsequent implementation of a health promotion toolkit for young prisoners widely across European Member States.

| **EU funding: EUR 499 976,00** |
|---|
| Duration: 36 M, 1 April 2010 – 31 March 2013 |
| Coordinator organisation (country): Wissenschaftliches Institut der Ärzte Deutschlands (WIAD) (DE) |
| Partnership: 7 associated partners and 3 collaborating partners |
| Countries: 7 countries |
| Website: http://ec.europa.eu/chafea/documents/health/hiv-cluster-meeting-material/hpyp.pdf |
| Operational Objectives:<br>• To identify existing health promotion for young prisoners;<br>• To gather the views of young prisoners on health promotion;<br>• To gather the views of prison staff on health promotion;<br>• To evaluate existing health promotion practice;<br>• To develop and pilot a toolkit on health promotion for young prisoners. |
| Main results:<br>• Comprehensive literature survey on the policy context of youth justice system and health promotion based on national research report;<br>• Toolkit with a set of best-practices for prison health professionals aiming to increase the knowledge of juvenile offenders about health issues (including health promotion initiatives about sexuality, alcohol, tobacco, and drug use, interventions regarding mental health needs, self-harm and suicide). |



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Best practice:

- Health Promotion for Young Prisoners: A Toolkit for Prison Staff.

**European Surveys and Trainings to Improve MSM Community Health, ESTICOM**

The aim of this study is to provide sound evidence about the sexual health, including new behaviour trends in life style and behaviour of men who have sex with men in Europe. In addition, at same time, it will assess and define the knowledge, attitudes and practices that should be employed to ensure the effective implementation of targeted prevention strategies by community based health workers, when providing health services for men who have sex with men.

| **EU funding: EUR 2 000 000,00** |
| --- |
| Duration: 36 M, 1 June 2016 – 31 May 2019 |
| Coordinator organisation (country): Robert Koch-Institut (RKI) (DE) |
| Partnership: consortia with 8 partners |
| Countries: 5 countries |
| Website: https://www.esticom.eu/Webs/ESTICOM/EN/homepage/home-node.html |
| Operational Objectives:<br>• Develop and perform second generation behavioural survey amongst MSM;<br>• Create and carry out a survey of community base health workers providing health services for MSM;<br>• Develop a training package (including pilots) for community based health workers, aiming to improve access, quality of prevention, diagnosis of HIV/AIDS and associated infections and health care services for MSM. |
| Main results (ongoing):<br>• Review of HIV and sexually transmitted infections among MSM in Europe;<br>• European MSM Internet Survey – EMIS 2017; |

- Scoping review of Community Health Workers' (CHW) knowledge, attitudes and practices relating to the sexual health of MSM;
- European Community Health Worker Online Survey – ECHOES;
- Community Health Worker Training Programme: training of trainers and national training package.

Best practice :

- European MSM Internet Survey – EMIS 2017;
- European Community Health Worker Online Survey – ECHOES;
- Community Health Worker Training Programme.

**HIV community-based testing practices in Europe - HIV COBATEST**

The HIV COBATEST project objective was to promote early diagnosis of HIV infection in Europe by improving the implementation and evaluation of community-based testing practices. Its focus was on community base voluntary counselling and testing (CBVCT) practices, obtaining a deep understanding of these programmes and services across countries and standardizing protocols and indicators to improve their implementation and evaluation.

The COBATEST contributed to improve the quality of CBVCT work with regard to testing policies and resource management, thus improving the possibility of early diagnosis.

**EU funding: EUR 499 663,00**

Duration: 37 M, 1 September 2010 – 30 September 2013



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| Coordinator organisation (country): Fundacio Institut d'Investigacio en Ciencies e la Salut Germans Trias I Pujol (ES) |
| --- |
| Partnership: 10 associated partners and 21 collaborating partners |
| Countries: 8 countries |
| Website: www.cobatest.org |
| Operational Objectives:<br>• Gain a thorough understanding of CBVCT programmes and services in different countries;<br>• Identify and describe good practices in the implementation of CBVCT;<br>• Identify a core group of indicators that can be used to monitor and evaluate CBVCT;<br>• Establish a network of community-based VCT in which to perform operational research.<br>• Assess the acceptability, feasibility and impact of introducing oral rapid test technologies at community-based VCT. |
| Main results:<br>• HIV-COBATEST project cross-national survey on the implementation of CBVCT programmes;<br>• A guide to do it better in our CBVCT centres. Core practices in some European CBVCT centres;<br>• Core Indicators to Monitor Community Based Voluntary Counselling and Testing (CBVCT) for HIV - Guidelines for CBVCT services.; Standardised data collection form to monitor and evaluate HIV screening activity in CBVCT services and a web based apps for data collection. |
| Best practice:<br>• A guide to doing it better in our CBVCT centres: Core practices in some European CBVCT centres;<br>• Core indicators to monitor (CBVCT) for HIV;<br>• Acceptability, feasibility, and impact of introducing the rapid oral test in the CBVCT services network : Study Report. |



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**Joint Action: Quality Action in HIV Prevention – Improving Quality in HIV Prevention**

The general objective of Quality Action was to improve the quality of the response to HIV and AIDS in Europe. Quality Action integrated evidence-based quality improvement (including quality assurance) practices into HIV prevention across Europe, built a network of trained HIV prevention stakeholders to apply practical quality improvement tools to projects targeting priority groups in demonstration pilots. Furthermore, it mainstreamed quality improvement use into HIV prevention through development and dissemination of an agreed Charter for Quality in HIV Prevention and a policy kit.

| **EU funding: EUR 1 493 180,00** |
|---|
| Duration: 36 M, 1 March 2013 – 29 February 2016 |
| Coordinator organisation (country): Bundeszentrale Für Gesundheitliche Aufklärung (BZgA) - Federal Centre for Health Education (DE) |
| Partnership: 25 associated partners from 18 countries, and collaborating partners. |
| Countries: DE, SE, BE, IE, UK, AT, NL, ES, LT, SL, HR, EL, SK, IT, LU, HR, PL, RO |
| Website: www.qualityaction.eu |
| Operational Objectives:<br>• Develop and deploy a training package with general and tool-specific modules to train at least 60 trainers/facilitators in Member States to provide capacity building and technical assistance to programs/projects using quality improvement tools;<br>• Ensure that the trainers/facilitators from Member States have reached and can demonstrate a level of quality improvement knowledge and skill required to provide on-going technical support to programs and projects using quality improvement tools to improve the quality of their work;<br>• Support and liaise with all participating HIV prevention programs and projects to support at least 80 applications of the Quality Action tools and to collect data on the process and results;<br>• Develop, adopt and disseminate a ‘Charter for Quality in HIV Prevention’ with agreed quality principles and criteria for use in assessing and improving the quality of HIV prevention programs and projects;<br>• Produce a set of recommended policy statements and strategic actions for incorporating quality improvement into HIV prevention strategies, policies and action plans at the European, regional and Member State levels. |
| Main results: |



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- A significant proportion of HIV prevention stakeholders in Europe is sensitised to the benefits of using structured quality improvement in projects and programmes;
- Five practical quality improvement tools and supporting materials for a range of applications are freely available;
- More than 400 prevention stakeholders are trained in using the five practical quality improvement tools;
- A searchable database of 98 case studies of practical quality improvement tool applications;
- A broad consensus on principles and criteria for quality improvement, represented by the Charter for Quality in HIV prevention and a policy kit as a concise advocacy tool for further dissemination.

Best practice:

- Five quality action tools: Quality in Prevention (QIP); Participatory quality development (PQD); Succeed - a knowledge base tool; SCHIFF (PROGRAM TOOL) Method; PIQA (health promotion and prevention for people who inject drug Quality Assurance Tool);
- A searchable database of 98 case studies of practical quality improvement tool applications.

**EARLY DETECTION AND INTEGRATED MANAGEMENT OF TUBERCULOSIS IN EUROPE: E-DETECT TB**

The overall objective of the consortium is to contribute to a decline, and the eventual elimination of TB in the EU in line with the ECDC Action Plan and the WHO Europe TB Action Plan 2016 to 2020. This will be achieved by utilising evidenced-based novel outreach digital x-ray and molecular diagnostics, and supported referrals and treatment supervision to ensure early diagnosis, improve integrated care and support community and prison screening activities in low- and high-incidence countries.

| **EU funding: EUR 1 800 000,00** |
|---|
| Duration: 36 M, 3 May 2016 – 2 May 2019 |
| Coordinator organisation (country): UNIVERSITY COLLEGE LONDON, UCL (UK) |



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Partnership: 11 associated partners from 6 countries

Countries: 6 countries

Website: www.e-detecttb.eu

Operational Objectives:

- Ensure early diagnosis in vulnerable populations- defined as homeless individuals, Roma, those with a history of drug use within the community, and prisoners- in two high incidence European countries (Romania and Bulgaria);
- Strengthen care integration using an outreach strategy within the same vulnerable populations in Romania by providing a one-stop "shop" (clinic) which brings together all required procedures, social support to vulnerable groups, peer support, and close links to the national TB programme to ensure treatment completion;
- Evaluate approaches to consolidate migrant TB detection and improve European cross-border management;
- Support the development of action plans in member states by taking best practice approaches from countries where E-DETECT TB partners have developed national and international strategies and evidence from this project and providing a framework, in collaboration with ECDC, to support the adaptation and implementation of these measures across other EU member states.

Main results (ongoing):

- Review of the evidence of best practice for high impact TB control interventions, to inform national TB strategy development in the EU/ EEA;
- Outreach for Early Diagnosis in Romania, using a mobile health unit with digital x-ray unit (MXU) and GeneXpert equipment, for screening high risk populations in Romania;
- Migrant Screening protocol for active TB in temporary settled migrants, with development and in-field evaluation of an m-Health system, including a phone application for on spot data recording, and retrospective analysis of the cascade of screening and care of active TB and LTBI among asylum seekers and evaluation of the determinants of losses of follow-up in the cascade;
- Data sharing agreement and protocol for data sharing and analysis of migrant screening data from participating countries;
- A survey of national TB programmes in EU/EEA countries;
- A systematic review of reviews of interventions for TB control and prevention in countries with low to medium TB incidence.



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| Best practice:<br>• Outreach for Early Diagnosis in Romania, using a mobile health unit for TB screening high risk populations in Romania;<br>• Data sharing agreement, protocol for data sharing and analysis of migrant screening data;<br>• A survey of national TB programmes in EU/EEA countries;<br>• A systematic review of reviews of interventions for TB control and prevention in countries with low to medium TB incidence. |
|---|

**AIDS Action Europe: Public Policy Dialogue and linking and Learning**

AIDS Action Europe’s mission is to unite civil society to work towards a more effective response to the HIV epidemic in Europe, striving for better protection of human rights and universal access to prevention, treatment, care and support. AAE aims for a reduction of health inequalities focussing on key vulnerable populations and Eastern Europe/Central Asia.

AAE`s general strategic objectives is to strengthen civil society`s contribution to a more effective response to the HIV epidemic, make an effective and meaningful contribution to European and national HIV/AIDS policies and facilitate continuous exchange among NGOs on good practices and lessons learned related to HIV and AIDS.

| **EU funding: 2nd HP: EUR 1 380 233,00 and 3rd HP: EUR 773 277,00** |
|---|
| Duration: Operating grants 2008- 2013, annual yearly grants from 01/01 to 31/12. A framework partnership agreement (FPA) covering 2014 – 2017 with three annual specific grant agreements (2014-2016) |
| Coordinator organisation (country): Stichting Aids Fonds - STOP AIDS NOW! - Soa Aids Nederlands – SANL (2008-2013), transfer of the hosting of AAE network to Deutsche AIDS Hilfe (DE) 2013-2017 |
| Membership: more than 430 AIDS-related non-governmental organisations |
| Countries: 53 European and Central Asian countries (144 members in the EU 27 countries) |
| Website: http://www.aidsactioneurope.org ; http://www.aidsactioneurope.org/clearinghouse |
| Operational Objectives: |

- Advocacy & public policy dialogue: increasing public policy dialogue and advocacy on global, European and national level, to enable NGOs to make an effective and meaningful contribution to European HIV/AIDS, viral hepatitis and tuberculosis policies;
- Linking & learning: to facilitate continuous exchange among NGOs on good practices and lessons learned related to HIV and AIDS, viral hepatitis and tuberculosis;
- Manage effectively the work programme and network.

Main results:

- Improved impact of Civil Society Forum on European HIV/AIDS, viral hepatitis and tuberculosis policy development;
- Clearinghouse used more actively and by wider audience for dissemination;
- Effective & efficient management of AAE network;
- Regional trainings were conducted on the topic of affordability and pricing of medications;
- European HIV Legal Forum (EHLF) creation with the aim to develop effective means of improving access to HIV prevention, counselling and testing, treatment; care and support for all those who have limited access to HIV services due to legal obstacles.

Best practice:

- HIV/AIDS Clearinghouse allows quick and easy cross-border information sharing;
- CSF secretariat with public policy dialogue on EU policies;
- Regional trainings were conducted on the topic of affordability and pricing of medications;
- European HIV Legal Forum (EHLF) network.

**Strengthening the role of civil society within the TB response in Europe: TB Coalition (TBEC)**

TB Europe Coalition is the only regional civil society network working exclusively on TB issues in the EU and WHO Europe region. Since the creation of the network, TBEC has actively searched and engaged with national civil society organisations and individuals, increasing its membership.

| **EU funding: 2015 (EUR 79 110,00), 2016 (EUR 86 858,00), 2017 (EUR 79 702,00)** |
| --- |
| Duration: Framework partnership agreement 2014-2017, with annual specific grant agreements (SGA) for 01/01 to 31/12 for the years 2015, 2016, 2017 |

Coordinator organisation (country): Results (UK)

Membership: 171 members

Countries: European Region

Website: http://www.tbcoalition.eu/

Operational Objectives:

- Increase understanding of the civil society contribution to the TB response across the EU region;
- Maintain and strengthen the TBEC website as a regional platform serving civil society stakeholders working within the TB response;
- Provide access to TBEC support and representation to civil society stakeholders;
- Strengthen the voice of civil society in all accessible EU and regional forums/ consultations;
- Manage TBEC's governance and internal processes for the successfully implementation of this work programme throughout 2017.

Main results:

- Mapping of civil society working on TB in 43 countries in the region, including all 28 EU MS was collected;
- Thematic report : How to leverage European Union funding for health in Eastern Europe and Central Asia";
- Transitioning from donor support HIV and TB programmes in Eastern Europe and Central Asia: challenges and effective solutions" position paper
- Country visits included Romania, Bulgaria, Ukraine, Kazakhstan, Armenia and Kyrgyzstan;
- 2 sets of webinars focused on the access to the EU funding, and the second one on the engagement with the Global TB Caucus and engagement with members of parliament;
- Case studies of successful practices highlighted a success story of transitioning from international donor funding to a fully domestically funded national system for TB control and care:
  - Romania (project encouraging journalism on TB issues),
  - Ukraine (establishment of national network of persons who recovered from TB),
  - Bulgaria (STOP TB Partnership's supported project on engaging religious leaders in fight against TB in Roma communities in Sofia) and
  - Estonia (Transition from donor support for TB&HIV in Europe: Estonia – a health systems approach to TB & HIV response).
- Policy paper "Tuberculosis – the corner stone of the AMR threat;



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- Thematic report on moving to people centred care: Achieving better TB outcomes.

Best practice:

- Mapping of civil society working on TB in 43 countries in the region, including all 28 EU MS was collected;
- Thematic reports: How to leverage European Union funding for health in Eastern Europe and Central Asia" and moving to people centred care: Achieving better TB outcomes;
- Country visits report on Romania and Bulgaria.

**Support to EATG in promoting Universal Access in the new MS and Neighbourhood countries**

EATG's mission is to achieve the fastest possible access to state of the art medical products, devices and diagnostic tests that prevent or treat HIV infection or improve the quality of life of people living with HIV, or who are at risk of HIV infection.

**EU funding: EUR 131 388,00**

Duration: 12 M, 1 January 2009 – 31 December 2009

Coordinator organisation (country): European Aids Treatment Group (EATG) (DE)

Membership: 91 volunteers

Countries: 35 countries

Website: www.eatg.org

Operational Objectives:

- Support for enlarging the EATG network in New Member States and new neighbouring countries;
- Organise four workshops and training trainers to impart knowledge and information on HIV/AIDS and on how to engage in advocacy work;

Main results:

- Workshops on treatment literacy and one on advocacy targeted to community base organisations;



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| • Two manuals on treatment literacy and one on advocacy. |
|---|
| Best practice:<br>• Two manuals on treatment literacy and one on advocacy. |

**Developing a training and resource package for improving the sexual and reproductive health of people living with HIV/AIDS - Eurosupport 6 (ES 6)**

Eurosupport 6 (ES 6) project aimed at improving the sexual and reproductive health (SRH) of people living with HIV in Europe. This was achieved by developing a training and resource package (TRP) for HIV service providers to support people living with HIV to improve their SRH. The project's focus was on enabling people living with HIV to adopt sexually healthy lifestyles, avoiding onwards transmission. However, embedded in an overall context of 'positive prevention' (i.e. positive health, dignity and prevention), by linking HIV with SRH and rights.

Evaluation report of the study showing that the CISS intervention significantly increased condom use three months post-intervention, and fulfilled other criteria for good evidence of the intervention's effectiveness.

| **EU funding: EUR 697 412,22** |
|---|
| Duration: 48 M, 1 March 2009 – 28 February 2013 |
| Coordinator organisation (country): Prins Leopold Instituut voor tropische Geneeskunde (ITM) (BE) |
| Partnership: 11 associated partners from 10 countries, and collaborating partners |
| Countries: 10 countries |
| Website: www.eurosupportstuyd.net and wwwcissweb.com |
| Operational Objectives:<br>• Develop evidence-based and theory-guided target group specific interventions to improve SRH of PLHA;<br>• Develop an evidence-based training and resource package (TRP) for service providers in clinical care and community-based settings in the HIV/AIDS field working with the two envisaged target groups; |



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- Develop a policy tool, which specifies the elements necessary to integrate SRH-related and positive prevention services in routine HIV care by defining mechanisms of effective task division, integration and specialisation, screening, local care pathways, and referral systems;
- Expanding and maintain a network to promote SRH and positive prevention of both HIV and SRH field organisations in Europe.

Main results:

- Computerised-assisted counselling intervention (CISS) on sexual health and safer sex for two key populations: MSM and heterosexual migrants;
- Training and resource package (TRP) sexual risk reduction and sexual health counselling for people living with HIV.

Best practice:

- Computerised intervention tool for safer sex (CISS) as a brief counselling intervention, targeting MSM and migrants;
- Training and Resource Package for Improving the Sexual and Reproductive Health of People living with HIV and a Training workshop for counsellors on how to use CISS .

**Operational knowledge to improve HIV early diagnosis and treatment among vulnerable groups in Europe project - EUROHIVEDAT**

The EURO HIV EDAT project aimed to generate harmonized monitoring and evaluation data from CBVTCs across Europe using the indicators and data collections instruments developed by the HIV-COBATEST Project and to explore the acceptability, feasibility and effectiveness of innovative strategies, like point of care technologies for HIV and STI diagnosis, HIV self-testing and web based outreach and counselling approaches.

| **EU funding: EUR 1 179 927,00** |
|---|
| Duration: 42 M, 1 April 2014 – 30 September 2017 |



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Coordinator organisation (country): Fundacio Institut d'Investigacio en Ciencies e la Salut Germans Trias I Pujol (ES)

Partnership: 14 associated partners and 21 collaborating partners

Countries: 11 countries

Website: https://eurohivedat.eu/

- MSM CBVCT toolkit: http://www.msm-checkpoints.eu/
- Two websites to delivery test results and post-test counselling: www.swab2know.eu and www.lapruebaencasa.com

Operational Objectives:

- Monitor and evaluate (M&E) community based voluntary HIV counselling and testing (CBVCT) services in Europe;
- Identify determinants for HIV test seeking behaviour and sexual risk behaviour among MSM in Europe;
- Describe and improve approaches of linkage to health services for HIV, among MSM in Europe;
- Improve the implementation of CBVCT services specifically addressed to MSM in Europe;
- Describe HIV testing patterns and to identify barriers to testing and care among migrant populations in Europe;
- Assess acceptability and feasibility of innovative strategies and interventions aimed at increasing HIV counselling and testing.

Main results:

- Guide on Optimal linkage to care among MSM: a practical guide for CBVCT's and Points of Care;
- Core indicators for monitoring and evaluation of community based voluntary counselling and testing (CBVCT) for HIV and "The guide to do it better in our CBVCT centre;
- KAB/P study on the implementation of innovative HIV Testing strategies: Main results and recommendations of a study conducted among MSM and stakeholders;
- A pilot intervention to assess the acceptability and feasibility of an outreach intervention for HIV testing among MSM and migrants and online communication of test results;
- Swab2know Manual: Manual for the development and implementation of an HIV testing approach using outreach and home sampling strategies and online communication of HIV test results".

Best practice:



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- Internet based Toolkit to support NGOs that recently established or want to start a CBVCT Service/Checkpoint for MSM (http://www.msm-checkpoints.eu/);
- Assessment of acceptability and feasibility of innovative strategies and interventions aimed at increasing HIV counselling and testing, using outreach and home sampling strategies and online communication of HIV test results".

**Improving Access to HIV/TB Testing for marginalized groups – Imp.Ac.t**

The Imp.Ac.t project general objective was to improve the access to HIV and TB testing, prevention, treatment and care for Drug Users (DU) and migrants, through outreach work using provider-initiated counselling on TB and HIV testing. Rapid HIV and TB tests have been offered to drug users (DUs) in street units, drop-in centres and on the streets.

**EU funding: EUR 410 980,15**

Duration: 27 M, 1 October 2010 – 30 November 2012

Coordinator organisation (country): Fondazione Villa Maraini o.n.l.u.s. (IT)

Partnership: 5 associated partners from 4 countries and 4 collaborating partners

Countries: 4 countries

Website: www.projectimpact.eu

Operational Objectives:

- Develop a framework and model to improve the effectiveness of HIV and TB testing and counselling among DUs and migrants DUs;
- Increase the percentage of DUs and migrants having access to HIV and TB testing;
- Ensure that people living with HIV and TB receive treatment for both conditions;
- Promote healthier ways of life and risk reduction among drug users and migrants;
- Assess the effectiveness of street HIV and TB testing in terms of proportion of new infection identified.

Main results:

- Situation analysis of DUs in four cities in Europe, the HIV and TB prevalence and incidence rate among DUs and the (perceived) barriers for DUs



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| to access HIV and TB testing, treatment and care report;<br>• Role of NGOs – social workers when implementing applied research, for example the conflicting role of social workers when asked to implement data collection and ensuring data protection and privacy protection for socially excluded groups such as DU and migrants;<br>• Training Manual on HIV/TB rapid testing of DUs/migrants in low-threshold services;<br>• Guide Manual on HIV and TB Testing for DUs and migrants in low-threshold services. |
|---|
| Best practice:<br>• Guide Manual on HIV and TB Testing for DUs and migrants in low-threshold services. |

**Developing HIV/AIDS & Mental Health Programs in new EU countries (Poland, Estonia, Latvia, Lithuania, Bulgaria) – MAIDS**

The Mental Health and AIDS (MAIDS) project objective was to improve the quality of life of people living with HIV/AIDS (PLHA) with dual/triple diagnosis in new members of European Union due to improved access to and quality of mental health services for PLHA and key populations at risk of HIV-infection with higher rates of mental illness.

The project was aimed at increasing awareness of the relation between HIV/AIDS and mental health problems among professionals in relevant sectors. Another important objective was disseminating best practices existing in old EU member countries in the area of integrated approach towards mental health and HIV/AIDS (e.g. Dutch multidisciplinary treatment team model from the Global Initiative on Psychiatry Netherlands) in order to build the capacity of health care professionals in nine new EU member countries.

| **EU funding: EUR 292 037,23** |
|---|
| Duration: 36 months, 1 September 2009 – 31 August 2012 |
| Coordinator organisation (country): Spoleczny Komitet ds AIDS (SKA) (PL) |
| Partnership: eight associated partners |
| Countries: 8 countries |
| Website: www.mentalhealthhiv.eu |



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Operational Objectives:

- Perform the needs assessment in order to identify existing gaps in the field of mental health and HIV/AIDS;
- Implement research activities on mental health and HIV/AIDS as a basis for training and advocacy throughout the project;
- Set up sustainable expert centres on mental health and HIV/AIDS in 3 EU countries (PL, EE, LT) and strengthening existing centre in BG);
- Create a sustainable training structure aimed at enabling relevant care givers to improve the services rendered to patients;
- Incorporate training modules and manuals in mainstream professional training of doctors, nurses, social workers and other relevant groups in PL, EE, BG, LT;
- Disseminate information among policy-makers and opinion-formers on integrated mental health/HIV approach and its importance for PLHA in improving their quality of life and HIV-prevention among populations with higher risk of HIV-infection.

Main results:

- Research report: Developing HIV/AIDS Mental Health Programs in new EU countries (Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, Slovenia);
- Health care professionals training on HIV/AIDS and mental health, e-learning program available in English, Polish and Russian;
- Trainings for Trainers (TOT), having 22 trainers that have replicated at national level, with 76 national trainings for change agents conducted, reaching 1253 change agents: medical staff, psychologists, social workers).

Best practice:

- Training modules and courses on HIV/AIDS and Mental Health targeting psychiatrists, psychologists, social workers.

**Optimising testing and linkage to care for HIV across Europe - OptTEST by HiE (HIV in Europe)**

The OptTEST project aimed to contribute to reducing the number of undiagnosed people with HIV infection and newly diagnosed late presenters in the European region and to foster timely treatment and care. The objective was met by providing tools and assessment methods to analyse and effectively respond to late presentation for HIV care and treatment with strong emphasis on the most affected regions/groups.



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The OptTEST by HiE project was very useful to demonstrate the gaps in the HIV continuum of care in Europe; the partners have produced relevant reviews, country assessment, innovative testing strategies, cost benefit analysis of testing per priority groups, and identified examples on how to address existing barriers.

| **EU funding: EUR 1 429 984,00** |
|---|
| Duration: 39 M, 1 July 2014 – 30 September 2017 |
| Coordinator organisation (country): HOVEDSTADEN (CAPITAL REGION OF DENMARK) (RegionH) (DK) |
| Partnership: 7 associated partners from 5 countries |
| Countries: 5 countries |
| Website: http://www.opttest.eu, http://legalbarriers.peoplewithhiveurope.org/index.php |
| Operational Objectives:=<br>• Improve multi-profession, multi-country stakeholder dialogue to develop strategies to improve early diagnosis and care of people with HIV across Europe;<br>• Increase knowledge on linkage to and retention in HIV care after diagnosis across geographical and health care settings and target groups;<br>• Create understanding and suggest evidence-based solutions to provider barriers to testing through pilot implementation of a novel HIV testing strategy (Indicator Condition-guided) in selected European healthcare settings and countries;<br>• Assemble and evaluate various existing HIV testing strategies in Europe;<br>• Increase knowledge of how stigma and legal barriers to HIV testing affects the uptake of HIV testing and treatment, particularly in most affected groups and regions. |
| Main results:<br>• Working surveillance definition of linkage to care that was piloted in eight countries;<br>• Tools on how to implement IC-guided testing based on the pilot work;<br>• Cost effectiveness of alternative HIV screening strategies considering different populations/risk-groups and testing frequencies;<br>• Data on legal and regulatory barriers to accessing HIV testing and accessing care was collected, document strategies to address legal and regulatory barriers were summarised as case studies; |

| • Best-practice manual on evidence based interventions to reduce HIV related stigma. |
|---|
| Best practice:<br>• Continuum of care definition, including the surveillance linkage to care monitoring;<br>• Tools on how to implement Indicative Conditions-guided testing;<br>• Cost effectiveness of alternative HIV screening strategies by risk-groups;<br>• Best-practice manual on evidence based interventions to reduce HIV related stigma. |

**Joint Action on Quality of HIV/AIDS/STI, viral Hepatitis and tuberculosis prevention and linkage to care, INTEGRATE**

The INTEGRATE Joint Action aims to integrate early diagnosis and linkage to prevention and care of HIV, viral hepatitis, TB and STIs in EU member states by 2020. INTEGRATE will target on key populations at increased risk of HIV, STIs, HCV and TB, mainly MSM, people who inject drugs, sex workers and migrants, INTEGRATE will focus on how effective tools for diagnosis and linkage to care in one disease area can be used in others. This will be done through review of existing tools followed by adaption and piloting of the tools in other disease areas.

| **EU funding: EUR 1 999 877,08** |
|---|
| Duration: 36 M, 1 September 2017 – 31 August 2020 |
| Coordinator organisation (country): OVEDSTADEN (CAPITAL REGION OF DENMARK) (RegionH) (DK) |
| Partnership: 29 associated partners from 15 countries and 19 collaborating partners |
| Countries: 16 countries |
| Website: http://integrateja.eu/ |

Operational Objectives:

- Support collaborative implementation of the Joint Action activities through timely reporting, dissemination and evaluation;
- Strengthen national policy on integrated activities related to early diagnosis of HIV, viral hepatitis, TB and STI's and linkage to care;
- Increase the normalisation of testing and linkage to care for HIV, viral hepatitis, TB and STI's in EU member states;
- Improve the monitoring and evaluation (M&E) of testing and linkage to care for HIV, viral hepatitis and STIs and integration of data into national surveillance and M&E systems in EU member states;
- Improve the use of Information and Communication Technology (ICT) tools and partner notification in combination prevention for HIV, viral hepatitis, TB and STIs in the EU member states;
- Improve the capacity of health care professionals, civil society organizations and public health institutions on integration of diagnosis and linkage to care for HIV, viral hepatitis, TB and STIs in EU member states.

Main results (ongoing):

- Mobile Unit Inventory for early diagnosis and linkage to care of HIV, viral hepatitis, tuberculosis and harm reduction services;
- ICT tools review mapping on improving test uptake and linkage to care, PN, adoption of safer sexual behaviours and harm reduction approaches.

Best practice:

N/A

**The Current state of play of the 2003 Council Recommendation on the prevention and reduction of health-related harm, associated with drug dependence, in the EU and candidate countries**

The Council recommendation 2003 report provides an updated overview of the implementation of the Council Recommendation, including country profiles, as well as analyses of regional and EU trends in epidemiology (e. g. HIV-infections via injecting drug use), and assesses the availability of, access to and coverage of harm reduction measures (e. g. provision of sterile needles to injecting drug users).

**EU funding: EUR 99 900,00**

Duration: 12 M, 1 January 2012 – 31 December 2012



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Consortia coordinator (country): SOGETI Luxembourg S.A (LU)

Partnership: 2 consortia members (AT and UK) and done in collaboration with DG JUST and EMCDDA

Countries: 27 EU countries, the acceding country Croatia and the candidate countries: the former Yugoslav Republic of Macedonia, Iceland, Montenegro and Turkey

Website: http://ec.europa.eu/chafea/documents/health/report-drug-dependence_en.pdf

Operational Objectives:

- Producing a report on the current state of play of the 2003 Council Recommendation (CR) of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence. The CR mentions the following main objectives:
  - Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly;
  - In order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-induced deaths, Member States should make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction. To this end, bearing in mind the general objective, in the first place, to prevent drug abuse;
  - Member States should consider measures, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks.

Main results:

- An online-survey for policy makers and a consultation of stakeholders;
- Current state of play of the 2003 Council Recommendation on the prevention and reduction of health-related harm, associated with drug dependence, in the EU and candidate countries report;
- Country profiles focusing on drug-related harm (reduction);
- Five literature reviews: general literature review on harm reduction measures and four systematic literature reviews ("peer naloxone programmes", "needle exchange programmes in prison", "prison release management" and "measures to influence the route of administration").

| Best practice:<br>• Current state of play of the 2003 Council Recommendation on the prevention and reduction of health-related harm, associated with drug dependence, in the EU and candidate countries report. |
|---|

**HBV-HCV-HIV: Three different and serious threats for European young people. A Network to study and face these challenges in the EU: H-Cube**

The general objectives were to identify and disseminate good practices, contents and tools about Hepatitis B (HBV), Hepatitis C (HCV) and HIV training programmes and prevention campaigns, targeting youths.

| **EU funding: EUR 580 000,00** |
|---|
| Duration: 30 M, 1 April 2009 – 30 September 2011 |
| Coordinator organisation (country): UNIVERSITÀ DEGLI STUDI DI SASSARI (UNISS) (IT) |
| Partnership: 13 associated partners from 10 countries and 1 collaborating partner |
| Countries: 11 countries |
| Website: http://learn.hcube-project.eu/h3/ |
| Operational Objectives:<br>• Identify best practice (HBV, HCV and HIV training programmes and prevention campaigns);<br>• Transfer of the identified good practices in the New European Member States;<br>• Create of a knowledge base (multilingual and multimodal) platform;<br>• Organise a prevention campaign in several meeting places (schools, discos, pubs, bars, sport centres etc.) attended by young people |
| Main results:<br>• Identification of best practices of HBV, HCV and HIV targeted services, training programmes and prevention campaigns;<br>• E-learning training course: digital platform that allowed training organisers/trainers to manage quiz, questionnaires, chats and forum in each |



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| collaborate language;<br>• Prevention campaign: self-administered questionnaire addressing young people knowledge, attitudes and practices. |
|---|
| Best practice:<br>• Manual with the best practices assessment methods about HBV, HCV and HIV programmes and prevention campaigns;<br>• HIV, hepatitis B and C e-learning training course. |

**European MSM internet survey on knowledge, attitudes and behaviour as to HIV and STI – EMIS**

The EMIS project aimed to give input for improving 2nd generation surveillance and prevention work among MSM in the participating European countries. To achieve this objective, EMIS have generated comparable data about HIV and STI behaviour, HIV and STI prevention needs, gay community characteristics, and other sexual health-related issues among MSM in Europe by means of a common Internet survey, advertised and promoted on popular MSM websites.

| **EU funding: EUR 718 515,37** |
|---|
| Duration: 30 M, 14 March 2009 – 13 September 2011 |
| Coordinator organisation (country): Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH/German Development Cooperation (DE) |
| Partnership: 6 associated partners from 5 countries, with collaborating partners include organisations from 35 European countries, including 27 EU member states |
| Countries: 5 countries |
| Website: www.emis-project.eu |
| Operational Objectives:<br>• Perform an Internet survey, advertised and promoted on popular MSM websites and conducted in various European languages;<br>• Identify HIV and STI prevention needs, by analysing the characteristics, differences and similarities of the MSM community, and other sexual health-related issues among MSM in Europe; |

- Generate comparable data about HIV- and STI- related behaviours, including co-infections HVB/HVC;
- Identify prevention needs unmet across diverse groups of MSM (priority aims), and identifying subgroups of MSM who have many prevention needs poorly met (priority target groups);
- Disseminating survey reports and spreading information in European MSM communities to orient the planning of prevention interventions for MSM
- Inform European policy maker on the national and supranational level on the survey result.

Main results:

- European common questionnaire, with a common set of core questions to ensure better comparability of future national or regional surveys and reporting on international level and it was carried out as a common multilingual (25 languages) internet survey;
- The EMIS survey have a large response rate, with 180,000 people took the survey – 160,000 from the European Union, and additional numbers from Russia, Ukraine and Switzerland.

Best practice:

- European Men who have sex with Men (EMIS) internet survey questionnaire;
- EMIS 2010: The European Men-Who-Have-Sex-With-Men Internet Survey: Findings from 38 countries with over 180,000 responses from 38 countries.

**Screening for Hepatitis B and C among migrants in the European Union: EU-HEP-SCREEN**

The EU HEP Screen project objective was to assess, describe and communicate to public health professionals the tools and conditions necessary for implementing successful screening programmes for hepatitis B and C in migrants. The project studied screening strategies that can be used for different health settings, and using best practices contributed for positive effects on health.

| **EU funding: EUR 1 321 360,00** |
| --- |
| Duration: 36 M, 1 October 2011 – 30 September 2014 |
| Coordinator organisation (country): Erasmus University Medical Center Rotterdam (NL) |



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Partnership: 11 partners from seven countries

Countries: 7 countries

Website: www.hepscreen.eu

Operational Objectives:

- Collect and analyse information on screening practices, counselling, health care and patient management of hepatitis B and C in migrants in the EU;
- Develop an information and communication platform for health care professionals;
- Design and field-test pilot screening programmes using systematic, opportunistic and outreach approaches for case detection of chronic hepatitis B and C and targeting different migrant groups;
- Collect the data necessary to assess the cost-effectiveness of the screening pilots;
- Integration results and develop of a toolkit for public health professionals and a short policy document for public health authorities and other health policy oriented parties.

Main results:

- Current screening, counselling, referral, clinical management and treatment practices for Hepatitis B and C in the study countries as well as the available management guidelines;
- Reports of identification of best practices of communication, on screening and patient management practises of hepatitis B/C;
- Four pilot studies on hepatitis screening among migrants in different health settings implementation report, including assessment for the cost-effectiveness of the screening pilots;
- A policy brief on implementation of successful screening programmes about screening for chronic hepatitis B and C and of the cost benefit of a viral hepatitis screening programme;
- HEPscreen Toolkit for health professionals.

Best practice:

- HEPscreen Toolkit for health professionals, innovative and evidence-based resource, enabling the replication of good practices in the design, implementation and evaluation of migrant-specific viral hepatitis screening programmes.



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**WHO Scaling-up access to high-quality harm reduction, treatment and care for injecting drug users in the European region**

The Scale up Harm reduction project aim was to undertake qualitative research and other related activities to improve the accessibility and quality of harm reduction services for injecting drug users (IDUs) in Europe, especially regarding HIV treatment, integrated HIV-TB services, hepatitis C treatment, and opioid substitution treatment.

| **EU funding: EUR 299 109, 00** |
|---|
| Duration: 30 M, 18 December 2009 – 17 June 2012 |
| Coordinator organisation (country): WHO Regional Office for Europe (DK) |
| Partnership: WHO and two collaborating partners (UK and LT). Advisory Group: EMCDDA, ECDC and Correlation network |
| Countries: EU and WHO European Region |
| Website: http://www.euro.who.int/en/what-we-do/health-topics/communicable-diseases/hivaids/activities/ec-who-project-scaling-up-access-to-high-quality-harm-reduction/ec-who-grant-agreement-on-harm-reduction |
| Operational Objectives:<br>• A strategy for improving the accessibility and quality of harm reduction services in the EU and WHO European Region developed;<br>• The accessibility and quality of HIV treatment and delivery systems among injecting drug users (IDUs) assessed;<br>• The tuberculosis related service needs, and accessibility and quality of HIV/TB integrated service provision, among IDUs assessed;<br>• The accessibility and quality of hepatitis C treatment services and delivery for IDUs assessed;<br>• Accessible and quality opioid substitution treatment services for IDUs promoted;<br>• Training on the delivery of high-quality harm reduction services in the WHO European Region developed and enhanced;<br>• The formation of policies supporting the delivery of high-quality harm reduction services at European and country level promoted. |
| Main results:<br>• Practical Guidance Toolkit How to implement and scale up opioid substitution therapy (OST);<br>• A training module on tuberculosis prevention, treatment and care for people who use drugs was developed;<br>• Operational research based on literature review, qualitative data collection in Estonia and the UK and a rapid assessment in Portugal – to better |



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| understand the barriers and facilitators influencing universal access to harm reduction services among people who inject drugs and the quality of harm reduction services delivered. |
| --- |
| Best practice:<br>• Findings and recommendations from three linked studies investigating the social contexts of access to treatment and care for HIV, hepatitis C and tuberculosis among people who inject drugs in European cities. |

**Empowering Civil Society and Public Health System to Fight Tuberculosis Epidemic among Vulnerable Groups - TUBID**

The TUBIDU project general objective was to contribute to the prevention of the tuberculosis (TB) epidemic related to people who inject drugs (PWID) and people living with HIV (PLHIV) through national and international networking for the purposes of improving the knowledge and building public health systems' and civil society's capacity to deal with TB, HIV, and PWID related issues.

The project has aimed at affecting in particular areas of Europe with high epidemiological challenges of MDR TB. In addition, emphasis was put on improving horizontal collaboration between HIV, TB and other relevant sectors on policy, services and community levels.

The TUBIDU project indicated a grave lack of comprehensive services in the project countries and Europe that would approach drug use, TB and HIV in vulnerable groups as a whole. So far, the majority of services and policies are partial. Furthermore, creating a sustainable and integrated approach that would fit the target groups' needs cannot be achieved with a weak political will or collaboration between service providers and policy makers.

| **EU funding: EUR 620 575,11** |
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| Duration: 36 M, 1 June 2011 – 1 June 2014 |
| Coordinator organisation (country): National Institute for Health Development, NIHD (EE) |
| Partnership: 7 associated partners from six countries and five collaborating partners from ENP countries (UA, RU, AL, BoH) |
| Countries: 6 countries |
| Website: www.tai.ee/en/tubidu |
| Operational Objectives: |



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- Enhancing horizontal, vertical and cross-border collaboration in the field of TB, injecting drug use and HIV;
- Describing the TB and HIV related knowledge and behaviours and identifying the barriers to access to TB and HIV related health care services among PWID and PLHIV;
- Raising the awareness of TB and HIV related prevention, treatment and care among vulnerable groups and PLHIV, general population and professionals on services and policy level;
- Raising the awareness of TB and HIV among community based organizations and health care and public health institutions personnel;
- Intensified training including study materials and guidelines were provided for target groups on TB infection control, case finding, and TB/HIV related health care systems and services;
- Developing guidelines for TB-prevention activities for community based organizations working with PWID and PLHIV and providing recommendations for policy makers on future actions in the field.

Main results:

- TB related training programme and materials for community based organizations and health care personnel;
- TB services provision guidance for community based organizations on how to support the integrating in harm reduction services of TB prevention and to improve access and adherence to treatment for people who inject drugs and are affected by HIV;
- Recommendations for policy-making in the TB-HIV field.

Best practice:

- Guidance for community based organizations on tuberculosis services for people who inject drugs;
- TUBIDU Handbook for training community based organizations on tuberculosis services for persons who inject drugs (PWID).



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