EG on HIV/AIDS
Tenth Meeting
Ottawa, Canada
18 - 20 March, 2008

Reference	HIV/AIDS 10
Title	Meeting minutes
Submitted by	HIV/AIDS EG ITA in coordination with the HIV/AIDS EG Chair
Annexes	Annex 1 List of Participants Annex 2 List of Documents

1. Opening of the meeting and welcome

The Chair Pauli Leinikki opened the meeting and noted that this is the10th meeting of the HIV/AIDS Expert Group. He expressed his satisfaction that the Group has stayed together and that so many could come to this Ottawa meeting.
Gloria Wiseman, Director of the International Health Division in Health Canada, welcomed the participants on behalf of the local host.

2. Adoption of the Agenda

The agenda was adopted.

3. Introduction by the Canadian hosts

Gloria Wiseman reported that domestic and international responses to HIV by Canada are dealt by different branches of administration, but are coordinated with each other. Canada is very interested to participate in the NDPHS activities - its representatives take part already in HIV/AIDS, Prison Health and SIHLWA groups. Robert Shearer is active in CSR, PAC and Strategy Working Group.

Nina Arron, Director of HIV/AIDS Division in the Public Health Agency of Canada presented Canada's domestic response to HIV and Aids. Canada has a population of 33.4 million; it has a federal government, 10 provincial and three territorial governments. Responsibility of direct health care is at a provincial level, the federal government leads in health policy and legislation and is responsible for First Nations health. Funding responsibilities are shared at the federal, provincial and territorial levels.

Approximately 58,000 people were living with HIV in 2005 in Canada; the biggest group among them is MSM. Infection rate is not declining. 89% of HIV+ pregnant women receive ARV treatment (2006). There are more new HIV cases as well as PLWHA among the indigenous people than among other populations in Canada.

Canada's response can be divided into three parts: 1. Federal initiative, 2. Vaccine initiative – in collaboration with Gates foundation, and 3. CIDA international response. An interesting publication has been produced by the federal initiative - "Leading Together", a vision document, and an action plan – what should be done, if there were all resources needed, to eradicate HIV.

Global engagement under the federal initiative is lead by the International Affairs Directorate of the Health Canada. It aims "to establish a strong, coherent health sector response to fulfil

international commitments and to contribute to global efforts to address HIV". To coordinate responses there are working groups between domestic and international efforts.

One of the major challenges is that there are many epidemics in Canada, not one. All levels and different organisations need to collaborate in a coordinated way to get results. In addition to research, networks and policy networks are needed.

The presentation is available at the meeting web page
http://www.ndphs.org/?mtgs,hiv/aids_10__ottawa

4. Brief country reviews

Russia
24 million people were tested for HIV in 2008, and altogether 52,521 new cases were detected. This means growth by approximately 18% compared with year 2007, mostly due to increase of cases among IDU. Cumulative number of HIV-infected was 470,643 in the end of 2008. 32,000 PLWHA have died.

There are gender differences in transmission routes: 85% of newly detected HIV+ men had got the infection through IDU in 2008, among women the sexual transmission is most common. 11% of all HIV cases are among prisoners; from them 91% are men.

7,453 new HIV cases were registered in North-West Russia during 2008, which means slight increase comparing to the previous year. The incidence was 54.9 per 100,000 population. In the end of 2008, cumulative number of registered HIV cases was 67,882. Altogether, 7745 HIV- infected people have died, and the amount of PLWHA is 60,137.

One of the big challenges is HIV/TB co-infection. There is a HIV/TB WHO working group and a federal TB/HIV co-infection centre is being established. Approximately 67% of HIV-infected people who die, die of tuberculosis. In St. Petersburg the majority of co-infections are detected in prisons.

Migrants are another big challenge. Prevention activities aim at awareness raising, promotion of condom use and integration of migrant workers into the health care system. Another issue is that all foreigners, who stay more than 3 months in Russia, are tested. 1.2 million foreigners were tested in 2007, among them 17,908 HIV cases were detected.

Poland
Approximately 800 new HIV are detected annually in Poland (809 in 2008). The registered number of PLWHA is 12,068; but estimations vary from 30,000 to 35,000. In 85% of cases the transmission route is unknown. On basis of different surveys it can be estimated that transmission related to IDU has decreased and sexual transmission increased. In 2008 the biggest age group among newly infected was 30-39. The worst affected regions are close to the border with Kaliningrad.

Poland is divided into Voivodships, and each of them has an own VCT Centre (26 centres altogether). In 2008, approx. 20,400 tests were done in VCTs, from which 246 tests were found positive. Only VCTs give information on transmission routes. Among cases detected in VCT centres in 2008 the division was following: 37% homosexual, 27% heterosexual, 8.5 % bisexual, 6.9 % IDU.

Targeted HIV prevention programmes are implemented for women, youth, families (2005), pregnant women (2007), people who travel much (2008-2009) etc.

Treatment is available for everyone in need. Each year about 25 % from those receiving ARV treatment have tuberculosis. More precise data would be needed. Tuberculosis incidence per 100,000 population was 22.7 in 2007.

From the budget available for HIV and AIDS, 95% is used for treatment, and only 5% for prevention on national level. Small resources are added by the local level. The budget per capita used for HIV prevention is very small if compared with other EU countries.

Portugal

Costs for ARV treatment are increasing every year; in 2007 they were 142 MEUR. Rather big amount of new HIV cases are detected annually, whereas AIDS has decreased sharply. There is no feminisation in the HIV epidemic.

Exchange of needles and syringes was started already in 1993 in Portugal. These activities are organised by NGOs, and they have also mobile units. Almost half of all pharmacies also exchange kits which include syringes and other materials. A pilot programme was launched in two prisons in 2007, and has been continued since then. These harm reduction activities have been very successful; HIV infections among IDU have decreased significantly since the mid-nineties.

A survey was conducted among clients of drug treatment centres to assess the gap in the awareness of HIV serological status. There were 11,411 respondents. The survey included a questionnaire and HIV testing (with pre- and post-test counselling). According to the results, 95.7 % of HIV-positive respondents were aware of their status, and 3.4 % were not (52 persons). On basis of the research, rapid HIV tests are recommended to be used especially among young and first-time clients of the drug treatment centres.

Another big survey was implemented among the general population. Respondents were chosen by random sampling, and 3603 participants were selected. They were asked if they had been tested for HIV, reason for testing, and if not, why. 44% had been tested, 56% not. From those who had not been tested, 15.5 % estimated that they will not get tested in the future, either.

TB incidence is declining in Portugal; “if this tendency continues it is possible that there will be no more new TB cases in 2020”. From 3338 tuberculosis cases about half were tested for HIV in 2006. From those tested, 26.5% were HIV-positive. There is no increase in MDR cases in Portugal.

Latvia

Annual number of new HIV cases has not been very high lately (358 in 2008, and 350 in 2007), but the prevalence remains high (191 per 100,000 population). There are 2.2 million people living in Latvia, and cumulative number of registered HIV case is 4339 (in December 31, 2008). 656 AIDS cases had been registered by the same date.

Prevention of HIV, TB and STI is organised through Action Plans, now it is the IV Action Plan (2009–2013).

Tendencies in the epidemic of HIV show increase in sexual transmission and decrease in infections related to IDU. The biggest age group (age at the moment of detection, cumulative cases) is 20-24. Some feminisation can be noted among younger age groups.

In the frames of the ENCAP project a research was carried out among IDUs in 2007. The aim was to study prevalence of HIV, Hepatitis B and C, Syphilis and TB among IDUs, amount of respondents was 407. The results were: HIV+ - 22.6 %; HBV - 55.8%; HCV 74.2%; Syphilis -

4 % and TB - 21.9%. It seemed very typical to have several co-infections in addition to HIV; from HIV-positive IDUs 68% had also HBV and HCV.

HIV prevalence among TB cases is increasing. The good phenomenon is that new TB cases and MDR TB are decreasing sharply. (See the presentation at the meeting web page http://www.ndphs.org/?mtgs,hiv/aids_10__ottawa)

Estonia

In Estonia the regional differences remain high. Eastern Estonia had 166 new HIV cases per 100,000 population in 2008; the most affected area in Eastern Estonia is Narva (241 new cases per 100,000 and prevalence among adult population in the age of 15-49 years is 5.9%). The incidence of whole Estonia was 41 per 100,000 in 2008.

There is too little information about transmission routes to give exact figures. Anyhow, it seems that amount of new cases among IDUs is decreasing. Hepatitis B and C have been decreasing since 2001 Last year Hepatitis tests were offered free of charge in AIDS counselling centres for the first time.

There were 42 deaths of AIDS in 2007. Typically, AIDS is detected approximately 12 months after HIV diagnosis. This means that people go for testing too late.

TB incidence is diminishing each year. Last year 60 patients had MDR TB. There were 39 TB+HIV cases in 2008.

IDUs remain to be the main risk group; the amount of IDUs is estimated to be 13,800. In Tallinn 48% of IDUs have HIV, in Kohtla-Järve 59%. It is also very problematic to get IDUs into TB tests; there are no mobile TB screening units.

National strategy against HIV and AIDS is valid from 2006 until 2015. This year financing is reduced from what was planned, but it remains on the same level as in 2008.

Lithuania

Statistics for 2008 are not yet ready, but in 2007 there were 106 new HIV cases in Lithuania (incidence 2.74; population of Lithuania is 3.4 million). Cumulative number of HIV-infected is 1306. From them 76% have contracted the infection through IDU. Majority of HIV-positives are men (86%).

One risk group is prisoners; the biggest outbreak in Lithuania was in one prison in 2002. Prisoners are offered an HIV test when they arrive and again when they leave. Quite few prisoners refuse testing. Approximately 8000 people are in prison at any given time, from them 18% are IDU and 250 have HIV.

Links between injecting drug use and HIV are strong. Majority of people living with HIV have a long history of drug use - in average 5 years. Practically all HIV-positive IDUs have Hepatitis C (98%). Exchange of needles and syringes was started in 1991.

One specific group among vulnerable groups is Roma people. They are a mobile population, and many of them are involved in illicit drug business. Integration of Roma is a big problem.

Sweden

2008 data for Sweden is not yet ready, but preliminary data is available. The Swedish surveillance system is based on four different reasons for testing: 1. Voluntary HIV testing, 2. Suspicion for clinical reasons, 3. Contact tracing and 4. Screening (pregnant women, blood donors). The surveillance system has some problems in it, mainly connected with anonymous coding system which includes year of birth and 4 last figures of the personal identification

number. There is a possibility that the same patient may have been reported several times with different codes. It is not known how many of the reported HIV-positive people are living in Sweden now, how many have died, how many have co-infections.

Cumulated number of registered HIV cases in Sweden is about 8,500 (1985-2008). Out of them ca 2,300 were AIDS cases. According to estimations, about 4,700 people are currently living with HIV in Sweden.
Preliminary number of new HIV cases in 2008 is 441. This means 18% decrease if compared with 2007. Incidence is ca 5 cases per 100,000 inhabitants. The most common transmission route is heterosexual, then homosexual, and third - IDU. The biggest group among newly registered are those who got the infection before immigrating to Sweden.

Tuberculosis in Sweden is rare. According to the preliminary data, there were 545 TB cases reported in 2008; from those 78% among immigrants. 4% of them were multi resistant. Co-infections HIV+TB are impossible to find out from register data, as HIV is reported by coded notification and TB with full identification.

Norway
About 3500 people are living with HIV in Norway; from them 30-40 are children. Approximately 40% of PLWH are heterosexuals, mostly of immigrant background. Typically immigrants have been infected before coming to Norway, but many of them get infection also while in Norway. Most of HIV cases are registered among immigrants from Africa, then Asia (Thailand) and then Europe. Asylum seekers are easy to test, but now most immigrants are because of uniting families – which makes it more difficult to test.

MSM is a big group among newly infected and also among all PLWH in Norway. Among them the biggest age group was 30-39 years at the moment of detection in 2008. Prevention among MSM is problematic, there are discussions e.g. about the role of gay saunas.

Increase of new HIV cases has continued some years now, and this is a worrying tendency. HIV is on political agenda, royal family is also interested in it.

Information on HIV+TB cases is difficult to collect, because it is not allowed to register personal identification information. Anyhow, the amount of HIV+TB cases is not high, and it is not a problem at the moment.

Finland
There were 148 new HIV cases reported in Finland during 2008. From them 104 were men, and 44 women. 62 of cases were among foreigners. Sexual transmission was most common, only 6 cases were related to IDU.

Low threshold activities have been very successful in Finland, an evaluation of their effectiveness has been carried out and results published in 2008 (Arponen A, Brummer-Korvenkontio H, Liitsola K & Salminen M.Trust and Free Will as the Keys to Success for the Low Threshold Health Service Centers (LTHSC). *Publications of the National Public Health Institute B24/2008.)* It can be clearly seen how HIV infections associated with IDU use have decreased simultaneously when amount of exchanged injection equipment has increased.

As Syphilis cases are increasing in Finland especially among MSM, it can be expected also increase of HIV among MSM.

5. News from the NDPHS secretariat

Unfortunately, Marek Maciejowski was not able to come to this meeting; so the Chair informed on latest news on behalf of the Secretariat.

A strategy working group was established after the evaluation of the NDPHS. The group has gathered twice, and the third meeting will invite EG chairs and ITAs. This meeting will be in Gdansk in connection to the SCR meeting (22-24 April), and before that a questionnaire will be sent to the EG members concerning the role of expert groups.

What comes to the role of the expert groups in the context of NDPHS, the Chair presented the view that the current working format of the HIV/AIDS Expert group is fruitful, because it provides a forum for sustainable network of national experts enabling exchange of views on HIV epidemiology developments, national strategies, prevention policies etc. The EG deserves full support from the CSR and the Secretariat. He emphasized also that everything that the EG reports should have a scientific basis. The group shared these views.

The partnership annual conference (PAC) will be organised in Norway in November (about the side event in the agenda point 9). The prison health group is organising a side event with HIV and TB high in the agenda. Further discussions will be organised during the coming Gdansk meeting.

The database project has been completed, but updating of database needs to be done continuously. The EG's have an important role in the process.

6. Report on latest events

The 2008 PAC was organised in Ottawa, Canada in November 19; and it was followed by a side event on health of indigenous and remote northern communities. (PAC minutes are available in page http://www.ndphs.org/?mtgs,pac_5__ottawa and the side event documents in http://www.ndphs.org/?mtgs,health_of_indigenous_communities.) (SIHLWA Expert Group has taken up the theme of health among the aboriginal population and will develop it further in their next meeting in Sweden.)

A representative of the circumpolar collaboration, Dr. Alan Parkinson took part in the Ottawa seminar and invited the Chair and ITA into the ICS steering committee meeting in Helsinki in May 15.

The EU-Strategy for the Baltic Sea Region – 2nd Stakeholder Conference was organised in Rostock, Germany, in February 5-6. List of actions was created. All expert groups have given their input into the strategy plan.

Prison Health Expert Group had its latest meeting in Vilnius in 9-10 February, and the HIV/AIDS EG Chair participated. Minutes of the meeting are available in http://www.ndphs.org/?mtgs,ph_7__vilnius.

EG Chairs and ITAs meeting was organised in March 3 in Brussels. The main issue was the strategy development of the NDPHS. (See the minutes in http://www.ndphs.org/?mtgs,eg_chairs_&_itas_8__brussels.)

7. Work plan 2009

The Work plan for 2009 was examined on basis of the EG plan (ref. HIV/AIDS 10/7/1) and the common tasks for all Expert Groups in the NDPHS work plan for 2009 (http://www.ndphs.org///documents/1343/PAC_5-8.2-1__Proposed_NDPHS_Work_Plan_for_2009.pdf)

The next issue of e-Newsletter of the NDPHS will be compiled by the HIV EG. There should be two thematic articles from our group (about 2 pages each). The third article could be written by "an independent contributor", a guest-writer. Dead-line for articles is the end of April.

After a vivid discussion it was decided that one article should be on the overall epidemic situation around the Baltic Sea (by the Chair). The second article could describe problematic of post-exposure-prophylaxis (PEP) and also the epidemic among MSM (by Hans Blystad). The Canadian hosts were invited to write the third article on the Second Generation HIV Surveillance in Canada (Susanna Ogunnaike-Cooke, Public Health Agency of Canada).

The program of **the 5th European AIDS Conference on Clinical and Social Research on AIDS and Drugs** was distributed by Saulius Caplinskas. The cheaper registration is open until April 1, after that the registration fee will be a bit higher. Almost the whole Expert Group will participate at the Conference. A declaration is planned to be published as the outcome of the Conference. The meeting web page is http://www.aidsvilnius2009.com. Most of the presentations will be recorded and they can be downloaded from the meeting page.

The 8th Nordic Baltic Congress on Infectious Diseases will be organised in St. Petersburg in September 23-26, 2009. All Group members are invited into the Congress; a brochure was distributed by Tatiana Smolskaya. The event is suffering of lack of financing and searches for additional funds.

The Thematic Report will get some more annexes. Ulrich Marcus has promised to write on MSM and Hans Blystad on PEP. The Chair is planning to update the epidemiological part of the Report. It was agreed that articles should be prepared before the autumn meeting of the EG.

8. Project review

The list of projects under the umbrella of the EG was presented by the ITA. There are 21 projects ongoing, 8 project proposals and 16 projects completed. Nine **ongoing projects** have more active involvement by the members of the Group:

1. ***Controlling the spread of HIV/AIDS in the Barents and Northern Dimension Partnership Programme Regions, Phase II (2008-2010).*** The financing for coordination of the EG comes from this project, this year from the NDPHS pipeline by the Finnish Ministry for Foreign Affairs. Coordination of the Barents HIV/AIDS Programme is financed by the same project. The Chair has recently evaluated Norwegian HIV projects in Archangelsk in the frames of the Barents collaboration. The Barents HIV Steering Committee will have the next meeting in Luleå, Sweden, in April 16-17. A brochure on HIV projects in the Russian Barents Region is being planned.
2. ***Further Development of Low Threshold Services in Murmansk and Kantalahti. (2008-2010)*** Pilot project of the above mentioned programme and the flagship project of the EG. An HIV seminar was organised for school nurses in Murmansk in last December. The meeting with project coordinators was in Helsinki in February.
3. ***Prevention of HIV infection in the Republic of Karelia in 2007–2009***. A training seminar was conducted for prison psychologists and staff concerning HIV prevention

and treatment, discrimination and stigma. Collaboration is done with FILHA concerning prevention of HIV+TB, e.g. a leaflet on this issue will be published.

4. ***Psychological and social support to HIV infected women in Leningrad Oblast 2007–2009.*** The project gives strong input into the WHO seminar "Current issues on HIV and adjacent disciplines" which will be in St. Petersburg in 24-25 March. A study tour will be organised into Finland in May.
5. ***Expanding Network for Coordinated and Comprehensive actions on HIV/AIDS Prevention among IDUs and Bridging Population (ENCAP, Development of Low Threshold Centre activities in the Region).*** This project will be presented in the Vilnius Conference, and all participants are invited to listen.
6. ***Strengthening of inter-sectoral action to fight drug abuse and drug related harm in Murmansk Region 2008 – 2009.*** The project working group includes representatives of drug control, health, education, youth, social, NGOs, municipality level actors etc. The project meeting will be in Helsinki next week.
7. ***TB/HIV collaboration in Murmansk. Project planning phase 2009.*** The Chair participated in an expert meeting in Murmansk. It was organised so that TB experts (local and international) visited the HIV and AIDS services, and HIV experts visited TB services. This was very fruitful approach to enhance collaboration and discussion between these two fields.
8. ***Research project "Governance of HIV/AIDS prevention in North-West Russia".*** The field work (interviews of key experts and authorities) will start soon in St. Petersburg, Leningrad Region and Archangelsk. The Public Health School in Archangelsk is involved and very motivated.
9. ***European MSM Internet survey on knowledge, attitudes and behaviour as to HIV and STI.*** The project will start this week and last 30 months. The survey will be online probably in 2010. The project is still looking for financing of the Russian part of the research.

From the **projects** which are **under development**, two deserve special attention:

1. ***Narva – Ivangorod – prevention of HIV among drug users.*** This project idea can be combined with another: "Development of low threshold services in Leningrad Oblast". A seminar was organised for experts from Leningrad Region, Estonia and Finland in Narva-Joesuu in last December. The HIV situation in Narva and Leningrad Region was discussed, and collaboration ideas developed. A project planning seminar with Logical Framework Approach will be organised in June in Narva.
2. ***Actions against spreading of HIV/Aids and tuberculosis among vulnerable groups in Kaliningrad and other parts of NW Russia.*** Coordination: Aids Centre and TB Dispensary of Kaliningrad, Information office of NCM in Kaliningrad. Applied from NCM. Approximate budget 1,5 million DKK. This is a new initiative, and coordinator Arne Grove wishes the HIV/AIDS group to participate in the Reference Group of the Project. The first seminar will be in Kaliningrad in April, and the invitation was distributed for the whole Group. It was decided to ask Inga Upmace, who is the Latvian vice-member, to take part in the seminar, and probably also in the Reference group.

9. Contribution by the Prison Health EG

The next PAC will be organised in November in Oslo, The side event is on the responsibility of the Prison Health EG. All other EGs are invited to contribute. The theme of the side event is that good prison health is good public health. A declaration will be prepared to be drafted by the meeting and presented for the PAC. HIV (and TB) theme will be a natural part of the program. Ministries of Justice will be invited, as well as WHO health in prisons project, EMCDDA and UNODC.

The Prison Health EG is planning a programme on HIV and TB in Northwest Russia, as an umbrella programme concerning especially penitentiary system. The basic idea of the Programme follows the model of the Barents HIV/AIDS Programme. Collaboration is planned with the HIV/AIDS EG in development of this new programme.

10. Organisational issues

Financing for 2009–2010 for coordination of the EG is quite sure (confirmed annually). At the moment there is no information, what will happen after 2010.

Dr. Mika Salminen from National Institute for Health and Welfare, Finland, has left to work in ECDC (with two years contract). This offers a good possibility to get closer contacts to ECDC, and to invite him into our future meetings.

11. Any other business

No other issues were discussed.

12. Date and place of the next meeting

The Vice-Chair Anna Marzek-Boguslawska invited the Group to have the next meeting in autumn in Gdansk. Concerning timetable, two important meetings in Poland should be taken into account: the EUROEPI2009 Congress **"Epidemiology for Clinical Medicine and Public Health",** which will be held in Warsaw, Poland 26th-29th August 2009 (http://www.euroepi2009.org) and **The second joint European Conference on Public Health** 26 to 28 November 2009 in Lodz, Poland http://www.eupha.org/site/upcoming_conference.php.

The next meeting should be sometimes in August–September. The following possible dates were discussed: 24-25 August (before the EuroEpi), the week which starts in September 14 and October 1-2. The date will be decided after the meeting. The ITA will send suggestions by e-mail to all participants. The Vice-Chair expressed worries about difficulties with financial situation, which might reduce amount of participants in the forthcoming meeting.

13. Closing of the meeting

The Chair thanked the Canadian Hosts for excellent organisation of the meeting and the meeting was closed at 15.15.

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Reference	Annex 1 to the Minutes
Title	List of participants
Submitted by	HIV/AIDS EG ITA

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Reference	HIV/AIDS 10/Info 4
Title	List of documents
Submitted by	ITA
Summary / Note	-
Requested action	For reference

Main documents

Code	Title	Submitted by	Date
• HIV/AIDS 10/2/1	Draft provisional agenda	EG ITA in coordination with the EG chair	12.1.2009
• HIV/AIDS 10/2/1	Provisional agenda	EG ITA in coordination with the EG chair	5.3.2009
• HIV/AIDS 10/2/2	Provisional annotated agenda	EG ITA in coordination with the EG Chair	5.3.2009
• HIV/AIDS 10/7/1	Work plan for 2009 of the Expert Group on HIV/AIDS	EG ITA	5.3.2009

Auxiliary documents

Code	Title	Submitted by	Date
• HIV/AIDS 10/Info 1	Practical information for participants	EG ITA	12.1.2009
• HIV/AIDS 10/Info 2/Rev. 1	Revised draft timetable	EG ITA	5.3.2009
• HIV/AIDS 10/Info 3	Program of the Thematic Day	Canada	5.3.2009
• HIV/AIDS 9/ Info 4	List of documents submitted to the Meeting	EG ITA	25.5.2009