EG on Prison Health
Third Meeting
Paris France
18-19 June 2007

Reference	PH 3/5/1/
Title	Draft Working program/strategy - HIV EG.
Submitted by	Chair of the HIV/AIDS EG
Summary / Note	Prof. Pauli Leinikki has been invited to the PH EG meeting in order to discuss co-operation between the two expert groups. Required Action:. Jeg synes også at vi kan legge ved Dublin declarationen om HIV i fengsler til orientering.
Requested action	For information and discussion

Working Program/Strategy for the collaboration in the prevention of HIV (within the context of Northern Dimension Partnership programme)

Draft Update May 2007
Pauli Leinikki, chairman of the HIV Expert Group for the Northern Dimension Partnership programme

Summary

This strategy update is intended to complement the previous strategy describing the epidemiological situation, main concerns and priority areas for common actions for the HIV expert group working within the Northern Dimension Partnership Programme that has previously been approved by the CSR (www.npdhs.org). Details about the epidemiological developments are not reiterated and the background texts for the recommendations are only briefly updated where significant changes have taken place during the last two years.

Annex 1 contains a list of objectives and possible output criteria.

The HIV epidemic continues to spread mainly through injecting drug use but increasingly the infection is also spreading to other parts of the population. Significant change has taken place through the possibility to widely implement highly active antiretroviral treatment (HAART) not only improving the situation of those infected but also by enhancing prevention efforts and reducing the stigma and discrimination known to drive the epidemic further. The future of the epidemic in the region is markedly shaped by the ability to use HAART so that all vulnerable groups, injecting drug users (IDU) in particular, can be reached.

Recommendations for priorities are categorized under five headings: surveillance, general awareness and policy development, legislation, prevention and treatment, care and support. International recommendations for the organization at country level (i.e. “Three Ones” principle launched by WHO) are recognized as well as the role of major funding mechanisms at country level such as the Global Fund.

Most partners in the NDP are now members of the European Union which through its financing and political instruments is able to shape and direct HIV-related activities within member states. New financing instruments to cover the costs of projects that involve countries within and outside EU have not yet been fully developed and projects covering the NDP geographical area must be compiled by including bilateral projects involving Russia and network projects covering the EU member states.

Background

Defining the target geographical area for NDP HIV activities.

The NDP programme involves partners with equal rights and obligations. Both sovereign states and international organizations participate in the work. The NDP should bring social and economic well being through enhancing collaboration between the partners and developing common best practices for regional collaboration. The HIV expert group should in particular take into consideration the severity of the HIV epidemic in NW Russia and the Baltic countries. Resources of the other partners should be networked so that they help these countries to overcome the threat.

Recent epidemiological development

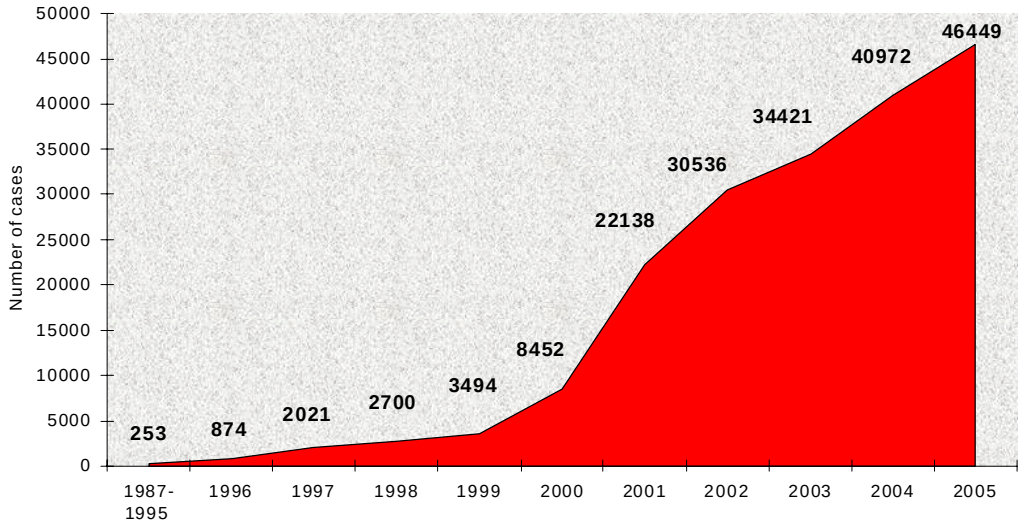
NW Russia

The number of reported cases continues to increase rapidly although not as fast as 5 years ago. The epidemic is still driven by infections among injecting drug users (IDUs) although increasingly infections are also reported from people (often women) who report heterosexual transmission. The number of children born to HIV-infected mothers is quite high and not all women have been counceled or treated during their pregnancy. The most affected areas are St. Petersburg and Leningrad Region, Murmansk show a clearly rising trend while in the other regions the situation is still stabile or satisfactory. Availability of HAART?

Kaliningrad

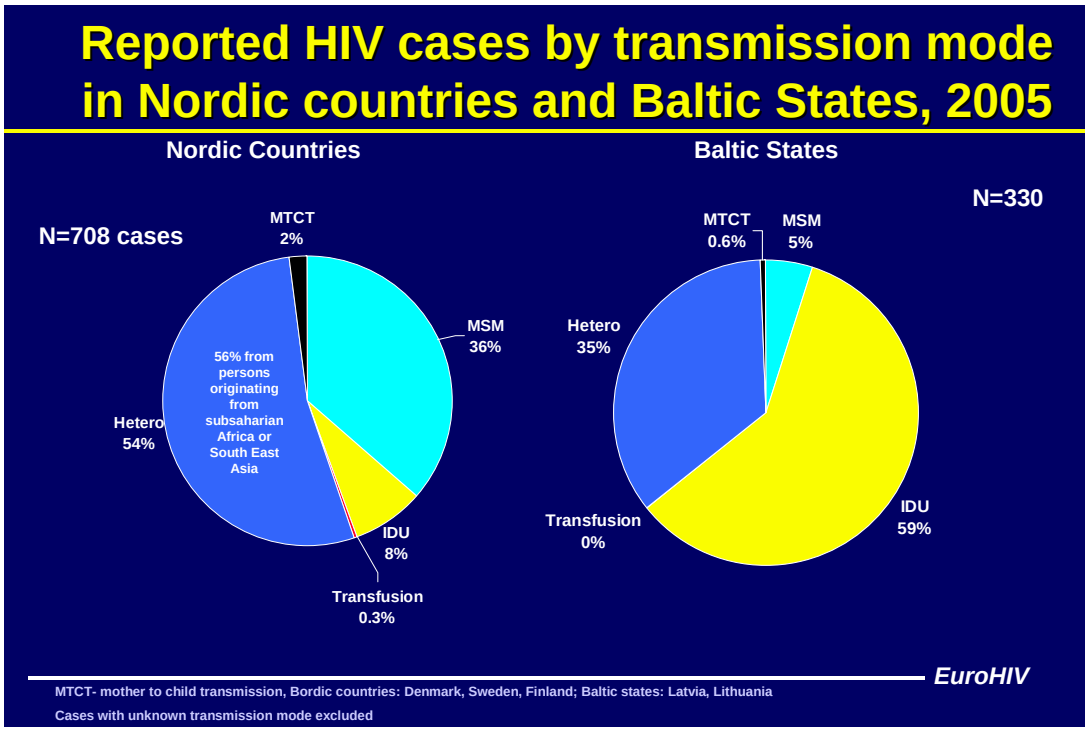
The rate of new cases reported annually has remained high after the peak in the 1990:s with a prevalence among the highest in the region (400/million at the end of the year 2005). What else to be said?

Number of people living with HIV/AIDS (PLWHA) in North-West Russia by year



Source: National AIDS Centres

The Baltic Countries



Estonia

New cases appear still quite rapidly although the rate is declining. Regional differences are considerable. The disease burden is among the highest in Europe, in Narva region up to 4 per cent of adult population may carry the infection. Practical arrangements for the provision of HAART to everybody who need it have proceeded rapidly but the epidemiological impact is yet to be seen. A common cross-border prevention project is under development with Russia. A larger proportion of those infected belong to younger age groups (less than 30 years) than in other Baltic countries.

Latvia

Latvia has also a heavy burden of infections, injecting drug use being the most common vehicle for transmission. Low-treshold services have been organised as well as universal provision of HAART.

Lithuania

Lithuania has the lowest prevalence and incidence of infections among the three Baltic countries. Drug use is an important vehicle for transmissions.

Western Europe

In most western European countries the numbers of newly detected HIV infections have recently grown. The two categories with greatest increase are heterosexually acquired infections among people from high-endemic areas and, among men who have sex with men (MSM). The latter category has potentially more impact on the development of the epidemiology since it is a reflection of increased risky behavior while in the former category the risk may have mostly been linked with the circumstances in their native countries and environments.

Social and political impact, future

In most European countries the situation has stabilized after initially large and sudden outbreaks in the late 1980s and early 1990s concomitant with a considerable reduction in risk behavior like unprotected sex, needle sharing, increased use of methadone maintenance treatment for drug addicts and a shift from criminalisation to medicalisation of drug dependence. These countries have been able to adjust their social support and health care delivery to meet the challenges posed by the slowly but steadily growing population of HIV-infected people, and the outlook is favourable even if the implementation of HAART will require further adjustments and resources in the near future.

In contrast, some of the partner countries face a different scenario. In Russia and Estonia, as examples, will have to be able to deal with a big group of HIV-infected population requiring life-long treatment and support. While the size of this group in Finland is around 200 / million inhabitants, in Estonia it will be in the proximity of 4000 / million. In order to adjust to this, the national health policies may need to be revisited frequently and social and health care will consume much more resources than what used to be the case only 5-10 years ago. Also, approaches that are used in other countries may not be appropriate. All this is a challenge not

only to the health policies but to the entire political structure. Providing equal opportunities to infected people and avoiding discrimination will need political courage and advocacy.

Recommendations

1. Surveillance

Surveillance is a key for adequate response. Information to politicians and lay people about the dynamics of the epidemic as well as the dynamics of the underlying risk factors and impact of interventions are necessary for making correct decisions. Good surveillance needs access to groups at high risk of infection that are often difficult to reach through traditional surveillance methods. Ideally, surveillance should be linked to preventive interventions that are targeted to drug users, commercial sex workers, migrant populations etc. Signs of suboptimal coverage of populations include the rapidly increasing rate of HIV-positive women giving birth to children in Russia without having had contact with the health care during pregnancy. Underreporting may also become more prevalent as many patients seek treatment in private clinics. Monitoring changes in the risk behavior patterns that are associated with HIV spread will become more and more important indicators for the development of the epidemic. Significant improvements in the surveillance of sexually transmitted infections are also needed in almost all of the countries. In many instances, legal obstacles and discrimination is posing challenges to good surveillance. More extensive use of sentinel surveillance could in many instances provide the missing data and indicate trends.

Availability of effective treatment for HIV infection as well as for drug abuse will probably increase the willingness of people to seek for testing and other contacts with health care providers. This will improve the sensitivity of surveillance. Voluntary Counseling and Testing (VCT) is an important instrument whose utilization should be enhanced by applying approaches that promotes reaching of vulnerable groups. One way to do this is through low-threshold service centers (LTC) for drug users and for commercial sex workers. Another way is through technical improved test methods that provide immediate results, so that repeated visits will not be needed to learn the result.

Wide use of HAART will bring along the problem of monitoring the efficacy and compliance among people receiving medication. This should become part of the basic surveillance of the epidemic. Data collection linked to outreach programs is feasible for secondary surveillance. All these elements could be brought together under the concept of “extended case management” that includes early detection of cases, targeted counceling and secondary prevention and follow-up of treatment and patient’s compliance in addition to the elements traditionally associated with case management.

***Recommendations for actions/priorities (1, surveillance)*:**

- Promote effective VCT with special emphasis on reaching the vulnerable groups. (low threshold centers, outreach studies, anonymous testing, technical improvements)
- Easy access to (anonymous) VCT should be ensured for IDUs, CSWs and their clients, ethnic minorities, foreign students, migrant populations, adolescents etc.

- Second generation surveillance according to standards set by UNAIDS and WHO should be promoted to receive information about changes in risk behavior and other, societal exposing factors.

2. General awareness, policy development

The World Bank projects that the cumulative number of HIV cases in Russia in 2020 to be 5.4 million as an "optimistic scenario" and 14.5 million as a "pessimistic scenario". The corresponding increase in mortality and possible net population loss are projected to be 5 to 13 million by 2020. The impact will be hardest in Russia's most affected regions, some of which border EU and the Northern countries. The possible outcomes to the Baltic countries have not yet been analysed in detail. Modeling of the outcome of HIV-epidemic in the Baltic region could be a fruitful field of international collaboration including ND.

National policies should recognize the severity of the threat and raise the general political awareness of the situation. Measures to eliminate discrimination whether people living with the infection or people who need help because their behaviour puts them at particular risk for the infection, are necessary. National policies should also ensure that all people at risk get adequate information about the risks and access to means to avoid it. HIV should also become an issue in all policies in order to create the necessary human and financial resources that are needed to change the course of the epidemic.

***Recommendations for actions/priorities (2. Policies)*:**

- General awareness about the impact of the emerging threat and measures to control the situation on individual and societal level should be promoted. Political leadership at all levels is needed
- HIV/AIDS cannot be considered just a health issue. Input and support from other sectors should be promoted for effective planning and implementation of the response
- Human and financial resources for the fight against HIV should be created both within the national health and other sectors of administration (economy, security, industry etc.), localities and the entire civil society
- The human rights of people living with HIV/AIDS should be equal to those of non-infected people. People are more vulnerable to the effects of HIV infection when they do not have the respect and support of their community. Discrimination due to sexual orientation, drug abuse, ethnic background etc. is a contributing factor in making people vulnerable to infection because of their behavior.

3. Development of legislation and policies

Legislation should promote the participation of the entire civil society in the fight against HIV. Preventive work is much more effective if the authorities get full support from civil organisations (NGOs) and self help groups including people with the infection. Private business might have a significant role by reaching their employees in situations useful for preventive interventions.

Modeling studies demonstrate that focusing preventive measures to IDUs in an epidemiological situation like present day NW Russia is the most effective way to prevent the infections at the entire population level also. Scientific studies show that harm reduction is an

essential element in effective HIV prevention among IDUs. Legislation should not prevent effective, evidence-based prevention strategies. It should ensure access to free, voluntary, anonymous or confidential HIV/AIDS counseling and testing, and nondiscriminatory access to treatment and care. It should promote the rights of prisoners to receive the same quality health care as the rest of the population. Legislation should also ensure necessary education concerning prevention of sexually transmitted diseases and infections linked with drug use at all levels of education

***Recommendations for actions/priorities (3. Legislation and policies)*:**

- Develop legislation to promote partnership between NGO:s, civil societies, private business and governmental agencies in their fight against HIV. This process could be assisted by common, international projects, training etc.
- Develop policies to ensure universal, non-discriminating access to anti-retroviral drug treatment to all infected people, using medically justified criteria.
- Develop legislation to allow implementation of evidence-based prevention strategies among vulnerable groups such as drug users, other socially excluded groups, sexual minorities etc. The policies should combine harm reduction programs with medical and social rehabilitation.

4. Prevention

HIV-prevention must be a joint effort shared by various sectors of administration such as education, health, justice, economy, defense and internal security. Administration is responsible for successful recruitment of NGO:s and the civil society to work side by side with public bodies. Most affected countries need to scale-up their national HIV/AIDS prevention efforts to allow much broader coverage of at risk populations and other preventive measures to stop the epidemic.

Targeted interventions are necessary to initiate behavioral changes and diminish the transmission risks. In vulnerable groups efforts should be focused as much to those already infected as those not yet infected. HAART should be seen as an integral element of prevention. Extended case management should include elements such as early case finding, appropriate primary and secondary prevention and monitoring of compliance and treatment outcome. Involvement of members from the target population is essential. The ability to reach the target populations should be monitored carefully; it may take some time before an intervention becomes sufficiently accepted by the target population to achieve its goal.

Basic education at schools should give sufficient information and life skills to average children to be able to avoid HIV-infection. This means that the curricula at schools should be re-evaluated and restructured, also teachers need training to be able to communicate the necessary messages effectively. HIV must be integrated into a broader sexual health agenda. Young people themselves should participate in designing and delivering educational activities. A big challenge is to reach young people who are particularly vulnerable to HIV for various reasons.

Prevention of other sexually and parenterally transmissible diseases should be closely linked to HIV prevention. STI control projects should be able to reduce the rate of new infections in particular among young people.

Several minority groups are often left outside proper information concerning HIV. This may be due to language problems but also to social marginalization. The status and needs should be investigated and appropriate intervention programs developed. Representatives of target populations should participate in the planning and deliverance of interventions.

Reduction of mother-to child transmission (MTCT) to very low levels is possible today with the help of HAART. All infected pregnant women should have the possibility to get proper treatment free of charge. This should be integrated into comprehensive and non-discriminating antenatal services linked with necessary social and economic support. HIV infected women should have the sane right to take reproductive choices as uninfected women. Projects to develop best practices and proper surveillance of this particular problem should be encouraged.

Overcrowded prisons pose a significant threat for the spread of communicable diseases in the region. Both behavioural risks (sexual and parenteral infections) and risks due to crowding (tuberculosis, other respiratory infections) both contribute. At the same time prisons should also be seen as potential sites for successful preventive work both for HIV and for drug abuse. HIV testing should be made readily accessible to inmates of all prisons, discretely and at their own request; it should always be voluntary and accompanied by counseling also in the case of negative test results. Needle exchange programs can be useful and integral parts of a general approach to drug and health services in prisons. They should be integrated into other health promotion measures, counseling and social rehabilitation. Continuation of preventive work and support after the inmates return to the civil society must be properly organised.

***Recommendations for actions/priorities (4. prevention)*:**

- Promote networks of “low-threshold centers” (easy access sites for medical and social support) for hard-to-reach target groups. Established networks should continue and develop best practice documents. Links with medical and social rehabilitation should be strengthened.
- “Youth clinics” supporting the development of important life skills to lessen the vulnerability of young people to HIV should be established.
- Work towards the acceptance of school education programs, with the main aim to increase knowledge, encourage healthy attitudes, develop essential life skills and support non-risk-taking behavior. Create networks to improve life skills of young people.
- In prisons harm reduction strategies should be implemented, including support and rehabilitation programmes for those having completed their sentence. Pilot projects for needle/syringe distribution/ exchange should be established.
- Prevent mother-to-child transmissions. Health services that serve women of reproductive age should be strengthened and reshaped to enhance non-discriminating detection and treatment of HIV-infection during pregnancy. Specific approaches are needed to reach socially marginalised pregnant women with drug dependence.
- Promote frequent and interactive evaluations of current interventions. Peer reviewing using international experts could be applied through the NDP.

5. Treatment, care and support

Anti-retroviral treatment has the promise to significantly enhance HIV prevention but it may also fail. Widespread unregulated access to anti-retroviral drugs could lead to rapid emergence and spread of resistant virus strains. To be successful, a universal and non-discriminating access to treatment based only to objective medical criteria is essential. Lowering the price for medicines, technical improvements for simpler dosage and development of new antiviral drugs through research are all necessary ingredients for future success.

Delivery of HAART should be linked with proper medical and social support organised in such a way that normal life is possible ("one-door delivery"). Since the need is life-long, it may become necessary to arrange the service outside the normal health services. When necessary, the services should also include harm reduction measures to keep the patients attached to the treatment. Monitoring should include among other things compliance and possible emergence of drug resistance.

Education of health care workers (HCW) in counselling and care of HIV infected people and AIDS patients become even more important in the future. Well-informed HCW will also help disseminate information and an anti-discriminatory attitude into the society.

***Recommendations for actions/priorities (5. Treatment and care)*:**

- Create national case management guidelines based on scientific evidence. These guidelines should be harmonised as much as possible in the region. The case management should include elements from early case detection and primary prevention to secondary prevention, harm reduction, medical and social care and support to home care and compliance monitoring.
- Develop a network of diagnostic laboratories to enable monitoring of disease progression, evaluation of treatment success and resistance testing in case of treatment failure.
- Strengthen NGOs and communities in their role in supporting home-based care and clinical management of infected persons.
- Establish and develop effective education of HCW in counseling and care of HIV-infected people and AIDS patients