Combined meeting / EG on HIV, TB&AI and EG on Prison Health
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Submitted by	EG's leadership
Required action	For comments and further approval

Dr. Ali Arsalo, Chair of the Expert Group on HIV, TB and Associated Infections, opened the Meeting and greeted the participants.

1. Tour de table with focus especially on TB and HIV/TB

Poland, *Prof. Maria Korzeniewska –Kosela, Polish Institute of Lung Diseases an Tuberculosis*

Before describing the TB situation in Poland, **Prof. Korzeniewska –Kosela** made a short overview of the global and European situation. Globally, TB belongs to the top 10 causes of death. There are more deaths caused by TB than by HIV, but the TB mortality is declining. HIV prevalence among TB patients is quite high in sub-Saharan Africa – more than 70%, and the rate is also high in some European countries, e.g. Ukraine and Baltic Countries. In the EU, the incidence is 11,4 per 100,000 but Poland, Romania and the UK have 45% of all TB cases in the EU. In Poland, the incidence is 20,0 per 100,000 population. The percentage of TB cases with foreign origin is large in Cyprus, Italy, Norway, Germany. Relatively high MDR TB rates in the EU are recorded in Romania, Lithuania and Germany. Poland has one of the lowest MDR TB rates in Europe. 20 countries in the EU have universal screening for HIV among TB patients – the highest rates are in Malta, Portugal and Estonia. In Belarus, the TB incidence is 38,0 per 100,000 but nearly half of the cases are MDR. 98% of TB patients were tested for HIV. In Ukraine the TB incidence is 76,7 per 100,000 and MDR TB has the share of 28,6%. The situation in 2017 improved but no official data has been published yet.

In the 1950s, 50% of the Polish children and adolescents were infected with TB, but the situation improved and since the 1980s deaths are sporadic. In 2016, there were 6,444 new TB cases registered, and in 2017 around 500 cases less. The highest incidence is observed in age group between 45 to 64 years old. Most of these cases are attributed to reactivation of old infections and the transmission is low. The rate of culture-confirmed pulmonary TB cases is high – 4,475 cases. Identification of pulmonary sputum smear and culture positive is highest among 45 to 64 years old people. The regional differentiation of TB rates inside the country is distinct, and there is a large disparity between men and women – in some regions of Poland the rates among men are as high as in Belarus. Over-diagnosis among children takes place – local doctors are scared of TB. Altogether there are 84 TB cases of foreign origin and they are characterized by a young age. 10 out of total 46 MDR TB cases are of foreign origin (22%). The established procedure is that refugees are screened at arrival. The co-infection is low; the TB population is not screened for HIV and only aggregated data is collected – in the last three years there were 18 to 20 double infection cases each year. Co-infected patients are treated by infectionists, not by pulmonologists. Poland has no special national TB programme, and TB response is part of the National Infection Control Act. The sanitary inspection agency is responsible for contact tracing. The first-line drugs have always been available and drug susceptibility testing provided. The reporting is made on paper but then data is fed into a computer system.

Population based BCG vaccination is on, newborns are vaccinated in the first days while at the maternity home and in safe conditions. Last year the smear positive rate was 6,5, and according to WHO the rate should be under 5 for three consecutive years to shift from population to key groups. In Norway vaccination is moved from first week to 6th week because there were death cases and vaccine is suspected as the cause.

The DOT is in the inpatient healthcare, and follow-up of patients is exercised in the outpatient settings. Drugs are given for 2 weeks to 1 month. Treatment is started immediately, before test results are available.

Lithuania, *Joana Korablioviene, Center for Communicable Disease AIDS*

The Lithuanian Society of TB Response was established in 1921, and TB reporting in Lithuania started in 1926, and DOT was rolled out in 1999.

In 2017, in Lithuania, 1,387 new cases were reported, and the incidence rate was 48,7% per 100,000 population – the rate has been steadily declining for the last twenty years. Also, fewer new pulmonary TB cases are diagnosed every year (1,017 cases or 35,7 per 100,000 in 2017). The situation is alarming with TB in children (aged 0 to 18 years old) where the TB rate increased from 7,13 in 2014 to 13,9 in 2017. In 2017, 247 MDR TB cases on the records in Lithuania – the country's share in the EU's MDR TB burden is about 20%. Treatment success for XDR TB was 23,4%, and for MDR-TB – 11%, which was the lowest treatment success among the EU/EEA countries. From 2014 onwards, the number of TB/HIV co-infection cases has been growing - in 2017 there were 42 cases. All in all, the achievement of the Global End TB Strategy targets seems very challenging. The biggest social determinants of TB spread are unemployment, poverty, alcohol and drug use, and poor health literacy.

Finland, *Sirkku Grierson, Filha ry, project manager*

In 2017, there were 232 new TB cases recorded in Finland, which is almost the same as a year before – 231. The incidence is 4,2 per 100,000 population. The share of pulmonary TB is 74% of all new cases. MDR TB was diagnosed in 5 cases, of which 1 was XDR TB – all MDR TB of foreign origin. In all new cases the proportion of Finnish origin was in 55%, while a year before the proportion of domestically acquired TB was 50%. Most new cases were found in the age group of over 75 years old and between 15 and 29 years old.

The risk groups in terms of TB include immigrants from countries with high incidence, people of 75 years old and older, people vulnerable to TB due to diseases or medication, socially marginalized people, including homeless people. Since the 1980s the national authorities have been implementing national strategies to prevent and eradicate homelessness, in the first place, through provision of affordable or supported housing. The housing service is always followed by other supportive social and/or health services. There is now a pilot project going on together with infectious disease units of three municipalities and personnel working in housing units for homeless people and substance abusers in order to ensure early identification of TB. The project includes training and guidelines for social and health personnel and production of info materials for clients made together with clients. All new clients of temporary residential houses are offered chest X-ray. Also, chest x-ray is done when symptoms are present. Web resource www.tuberkuloosi.fi contains information related to TB for general population, and the material is also used in patient counseling. The information is given in 10 languages, and the Finnish-, Arabic- and Russian-language versions are in high demand. On average, the website has 800 visits per day.

Norway, *Hans Blystad and Karin Rönning, both Norwegian Institute of Public Hea*lth

The HIV incidence rate has been on decline since 2008, last year it was 4,1 per 100,000 population. It was noted that less HIV was diagnosed among MSM and migrants at arrival. PreP is available since January 2017 and by late 2017 some 700 MSM were on PreP. The 90-90-90 goal for HIV infection is achieved.

Hep B vaccination was included into the national vaccination programme for children. Universal screening hepatitis B for pregnant women will be introduced in 2018. A new national strategy plan for sexual health 2017-2022 replaced the old HIV strategy plan

There is a decrease in newly infected hepatitis C cases. Treatment available to all chronic hep C carriers regardless of genotype.

In the discussion that followed around hepatitis it was added that only PCR confirmed cases are reported, not antibody positives. The price of HepC is going down substantially.

Although testing policy and guidelines are available, it is not known how well key populations are reached, particularly MSM community.

There are discussions going on about the feasibility of treating asymptomatic gonorrhea in some countries. Pharyngeal gonorrhea disappears in a few weeks. The question is whether it is feasible to invest into diagnosis and treatment. The infection is being treated if diagnosed but generally doctors see no benefit.

The TB incidence started to fall in 2014 when refugees from Syria started to replace other nationalities. Between 4 and 10 MDR TB cases are found every year – all imported or infected from another MDR TB migrant. The only official risk factor now is the origin from a high prevalence country (or parents coming from such country). About 10 cases of HIV/TB co-infection are recorded every year. Nowadays, only IGRA tests are used because of their specificity and sensitivity. As regard latent TB – principle 'Intention to test means intention to treat" is used. If no conditions for follow-up and further treatment are seen, then no test is run.

In Norway, there is no special TB control programme, nor specific programmatic activities for socially vulnerable populations. There are NGOs that run activities for such population groups. There is only one TB-specific NGO in the country – LHL International – which does a lot of work inside and outside Norway, and due to economic reasons LHL International will drastically cut down on activities in three years. As for TB in prison settings, it is the task of the municipality where the correctional facility is located, to organize screening and contact tracing.

When treatment is started, a detailed treatment and follow-up plan is compiled. Patients receive social benefits during the treatment period. Norway is working on expansion of DOT through video communications, or VOT, by using Skype. The treatment is free of charge, including transportation costs and medication. Giving incentives, like food packages, pocket money, shopping stamps proved their effectiveness but there is no NGO which would perform this activity, and it cannot be done in the public sector.

Germany, *Ulrich Markus, Robert Koch Institute*

TB incidence was steadily declining between 2002 to 2008, then reached a plateau till 2012, and started to grow then with a growth peak falling down on 2015. Since then the rate started again to fall. Within Germany there are clear regional differences, with Berlin and Hamburg having the top incidence rates in the country. The most affected age groups are from 15 to 29 years old (migrants) and over 70 years old (Germans). Almost 75% are pulmonary TB cases. Most TB cases are found through passive case finding, i.e. diagnosis of symptomatic findings. According to regulations, those asylum seekers who are placed in communal housing are subject to testing. As for treatment success rate, Germany falls behind the WHO's 90% target with having reached only 81%.

Website Explain TB (http://www.explaintb.org) is available in various languages.

The data management system is under re-construction now to delete double notifications. Further decline is expected due to decline of immigration and decline in detection in the MSM community. The PreP situation changed rapidly – now a monthly course of Truvada costs about 15-17 euros – not covered by health insurance. According to estimates, there are now a few thousand people on PreP.

HIV testing is covered by insurance and STI testing is not, which creates a challenge – you either pay a lot of money to a private doctor or pay less but have to locate a checkpoint.

Syphilis is on increase now, no data is available for gonorrhea but it will become reportable from the next year. There are a lot of discussions now about what should be tested and what should be treated.

Comment from Poland (Anna Marzec-Bogusławska) regarding PreP: Poland started a PreP initiative based on the NGO sector. In three cities pharmacies were contracted for distribution of Truvada, which is available by prescription at about 40-45 euros per month.

Current situation with ESTICOM (Behavioral Survey for HIV/AIDS and associated infections and a survey and tailored training for community based health workers to facilitate access and improve the quality of prevention, diagnosis of HIV/AIDS, STI and viral hepatitis and health care services for men who have sex with men), *Ulrich Markus, Robert Koch Institute*

The survey was completed in late January 2018. There will be an expert meeting in Berlin with the presentation of preliminary results. Datasets will be available. The response rate was lower in the second round than in the first round (110,000-120,000 versus 180,000 in 2010). The country representation balance is good. Vast majority responded by using smartphones. Datasets for regional analysis will be made available at request. The training programme started with trainer training workshops. Country trainings will start in May in many countries as requested, including Russia.

Russia, *Nina Khurieva, Federal Institute for Health Organization and Informatics*
The figures for HIV exceed TB rates in prevalence, incidence and mortality. Tb screening coverage in 2017 was 71,3%, the screening for HIV antibodies was 23,8% in 2017. The share of inmates in TB incidence is reducing and in 2017 was 8%. In the penitentiary system, almost 52% are diagnosed with TB at entry (at pre-trial facilities) and 45% get infected in the prison. Every year between 2,500 and 3,000 migrants are diagnosed with TB, and about 4,000 with HIV. The medium age of HIV antibodies positively tested person in 2016 in Russia was 35.3 years (35.7 years for men and 34.7 years for women). Medium of patients who died from HIV-infection was 37.5 years (37.9 years for men and 36.6 for women). The mean life duration from HIV-infection diagnosis till HIV-related death in 2016 was 6.5 years; till death not related to HIV was 6,4 years. Time from HIV diagnosis till establishing diagnosis HIV-infection + tuberculosis in 2016 was 5.4 years; medium CD4 count before establishing diagnosis «tuberculosis» among HIV-infected patients was 225.7 cells/ml; mycobacterial infection dominates in structure of HIV-related death.

Current situation in EU JA HA-REACT Project, *Outi Karvonen, National Institute for Health and Welfare, Finland*

A series of three workshops will soon be organized in Hungary. A local NGO was contracted to do the job, but the activities of the NGO are closely supervised by the authorities. The harm reduction programme was closed in Hungary last year, now it will be opened for a short time for the HA-REACT. The third amendment to the contract is coming, and there will be more activities in Poland.

HA-REACT will have a satellite event at the HIV Amsterdam Conference.

The final conference of HA-REACT Project will be held in connection with the European Harm Reduction Conference by Correlation Network on 21-23 November in Bucharest.

2. Actual information concerning the HIV, TB and AI EG (*EG leadership and experts as relevant*):

- ***EG Progress Report 2017***

The EG Progress Report was drafted by the EG leadership in March, disseminated to the EG members for comments and in early April submitted to the NDPHS Secretariat.

- ***Overview of the current Work Plan and cross-checking of planned activities***

The EG Meeting cross-checked the current Work Plan for 2018. Attention was drawn to activity 2.6 “Prepare a list of relevant NGOs and other stakeholders and networks within partner countries and regionally”. The EG leadership suggested it prepare a draft inquiry form and send it to the experts for comments in May 2018. When the inquiry form is accepted the experts can collect information about relevant NGOs and relevant stakeholders from their respective countries.

- Overview of ongoing projects and programmes in HIV, TB and AIs in Northern Dimension area (EMIS 2017/ ECHOE survey, Nordic Council of Ministers’ Programme in NW Russia, Barents HIV and TB Programmes, EU JA HA-REACT, etc.)

EMIS 2017/ ECHOE survey and EU JA HA-REACT project were reported earlier (see above).

The Nordic Council of Ministers’ Programme in NW Russia – Mobilising efforts for better response in HIV and associated infections – is being administered by THL Institute (Finland) and working in six NW Russian regions. Dmitry Titkov, Manager of the NCM Programme, briefly reported about the key events of the Programme. The NCM Programme focuses on establishing a shared Nordic-Russian expertise platform and capacity building. The Programme completes its implementation in autumn 2018.

3. Any other business

It was suggested having one of the nearest meetings dedicated to Hepatitis C.

4. Next meeting

The EG leadership proposed the following procedure: If Dr. Saulius Čaplinskas, Director of Centre for Communicable Diseases and AIDS, Lithuania, plans to organise a Communicable Disease Summit in autumn 2018, the EG will try to organise its next meeting back-to-back with this event. Otherwise the EG leadership will negotiate in late April with Ms. Agnese Valjuliene, Director at the Latvian Ministry of Health and representative of Latvia at the NDPHS CSR, about Latvia's hosting the autumn meeting. The EG members will be informed about the progress in this matter by email.

5. Closing of the Meeting

Ali Arsalo, Chair of the Meeting, declared the meeting closed.