Action plan for the health sector response to HIV in the WHO European Region

DRAFT
Action plan for the health sector response to HIV in the WHO European Region

DRAFT 5.4

This document remains in draft format until it is considered by the WHO European Regional Committee in September 2016. It may not be abstracted, quoted, cited, reproduced, transmitted, distributed, translated or adapted, in part or in whole, in any form or by any means without the permission of the World Health Organization.
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of abbreviations</td>
<td>i</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>0</td>
</tr>
<tr>
<td>Introduction</td>
<td>2</td>
</tr>
<tr>
<td>European context</td>
<td>2</td>
</tr>
<tr>
<td>Epidemiological context</td>
<td>3</td>
</tr>
<tr>
<td>Building on the lessons learned from the previous Action plan:</td>
<td>5</td>
</tr>
<tr>
<td>Challenges and achievements</td>
<td>5</td>
</tr>
<tr>
<td>The Action plan for the health sector response to HIV in the WHO</td>
<td>8</td>
</tr>
<tr>
<td>European Region</td>
<td>8</td>
</tr>
<tr>
<td>Purpose</td>
<td>8</td>
</tr>
<tr>
<td>Framework and guiding principles</td>
<td>9</td>
</tr>
<tr>
<td>Development</td>
<td>10</td>
</tr>
<tr>
<td>Vision, goal and targets</td>
<td>12</td>
</tr>
<tr>
<td>Prevention</td>
<td>13</td>
</tr>
<tr>
<td>Testing and treatment</td>
<td>13</td>
</tr>
<tr>
<td>AIDS-related deaths</td>
<td>13</td>
</tr>
<tr>
<td>Discrimination</td>
<td>13</td>
</tr>
<tr>
<td>Financial sustainability</td>
<td>13</td>
</tr>
<tr>
<td>Strategic directions and fast track actions</td>
<td>14</td>
</tr>
<tr>
<td>Strategic direction 1: Information for focused action</td>
<td>15</td>
</tr>
<tr>
<td>Strategic direction 2: Interventions for impact</td>
<td>18</td>
</tr>
<tr>
<td>Strategic direction 3: Delivering for equity</td>
<td>22</td>
</tr>
<tr>
<td>Strategic direction 4: Financing for sustainability</td>
<td>26</td>
</tr>
<tr>
<td>Strategic direction 5: Innovation for acceleration</td>
<td>28</td>
</tr>
<tr>
<td>Action plan implementation</td>
<td>31</td>
</tr>
<tr>
<td>Partnerships</td>
<td>31</td>
</tr>
<tr>
<td>Monitoring and evaluation</td>
<td>32</td>
</tr>
</tbody>
</table>
References .............................................................................................................................. 34

Annex. Key indicators to measure the regional health sector response to the HIV epidemic 38
List of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>antiretroviral therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>antiretroviral</td>
</tr>
<tr>
<td>CD4</td>
<td>cell cluster of differentiation antigen 4 cell</td>
</tr>
<tr>
<td>ECDC</td>
<td>European Centre for Disease Prevention and Control</td>
</tr>
<tr>
<td>EEA</td>
<td>European economic area</td>
</tr>
<tr>
<td>EECA</td>
<td>eastern Europe and central Asia</td>
</tr>
<tr>
<td>EMCDDA</td>
<td>European Monitoring Centre for Drugs and Drug Addiction</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>GARPR</td>
<td>Global AIDS Response Progress Reporting</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>IDU</td>
<td>injecting drug use</td>
</tr>
<tr>
<td>MSM</td>
<td>men who have sex with men</td>
</tr>
<tr>
<td>NCPI</td>
<td>National Commitments and Policies Instrument</td>
</tr>
<tr>
<td>OST</td>
<td>opioid substitution therapy</td>
</tr>
<tr>
<td>PLHIV</td>
<td>people living with HIV/AIDS</td>
</tr>
<tr>
<td>PreP</td>
<td>pre-exposure prophylaxis</td>
</tr>
<tr>
<td>PWID</td>
<td>people who inject drugs</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
</tr>
<tr>
<td>SW</td>
<td>sex worker</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis (MDR and XDR-TB to be added in case we add it in the text)</td>
</tr>
<tr>
<td>TRIPS</td>
<td>Trade-related aspects of intellectual property rights</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
</tbody>
</table>
Executive Summary
The WHO European Region is at a critical point with regard to HIV. While newly diagnosed infections are decreasing globally, new diagnoses increased by 76% in the European Region, and more than doubled in countries of eastern Europe and central Asia between 2005 and 2014. In many countries in the Region, up to half of all people living with HIV are unaware of their status and many are diagnosed at a late stage of infection. Coverage with life-saving antiretroviral therapy is low in the eastern part of the Region, and the epidemic has not been adequately addressed among key populations at higher risk.

This Action plan is a continuation of the work began and the lessons learnt from the European Action Plan for HIV/AIDS 2012–2015. The goals and targets are supported by the 2030 Agenda for Sustainable Development, the multisectoral strategy for 2016–2021 of the Joint United Nations Programme on HIV/AIDS, the Global health sector strategy on HIV for the period 2016–2021, and Health 2020, the European policy framework for health and well-being.

The Action plan is structured around five strategic directions: information for focused action, interventions for impact; delivering for equity; financing for sustainability; and innovation for acceleration.

The Action plan advocates an urgent and accelerated people-centred response to HIV by the health sector. Services should follow the principles of universal health coverage, the continuum of HIV services and the promotion of a public health approach. The Action plan promotes comprehensive, combination prevention and a “treat all” approach, asks Member States to define and deliver an essential package of HIV services, to be included in the national health benefit package, that are people-centred, accessible integrated and focus particularly on key populations in a manner appropriate to the local context.

The Regional Office for Europe developed this Action plan through a Region-wide participatory process drawing on the expertise of an advisory committee. It sought feedback through direct correspondence with Member States, major partners and people living with HIV. The Regional Office also held a broader public web consultation on the Plan.

After consideration and guidance from the Twenty-third Standing Committee of the Regional Committee, the Action plan was finalized. This background document is submitted to complement the working document (EUR/RC66/9), a draft resolution (EUR/RC66/Conf.Doc./5) and the financial and administrative implications for the Secretariat (EUR/RC66/9) for consideration by the 66th session of the Regional Committee.
for Europe.
Introduction
In 2015, the Global health sector strategy for HIV/AIDS 2011-2015 (1) and its regional implementation plan, the European Action Plan for HIV/AIDS 2012-2015(2) came to a close. To build on the momentum generated from this work, the World Health Organization (WHO) and Joint United Nations Programme on HIV/AIDS (UNAIDS) have developed ambitious global strategies with a goal to end the AIDS epidemic as a public health threat by 2030(3).

This Action plan for the health sector response to HIV in the WHO European Region is an implementation plan to contextualize the WHO Global health sector strategy on HIV for 2016-2021(3) to the epidemiological, social, and political context of the Region. It ensures that the Region can realize the global goal to end AIDS as a public health threat by 2030, which was adopted by consensus in June 2016 by the United Nations General Assembly (UNGASS; [4]).

Continuing the momentum generated by the 2030 Agenda for Sustainable Development (4), and Health 2020, the Region’s policy for health and wellbeing (5), and building on the lessons learned from the first European Action Plan for HIV/AIDS 2012–2015(2), this Action plan provides a roadmap for the next phase of the HIV response and suggests fast track actions to reverse the HIV epidemic in the Region.

European context
The WHO European Region is characterized by great diversity. Across the Region’s 53 Member States, people living with HIV (PLHIV) and the health systems that support them operate within a broad range of economic, political, social and cultural environments. The HIV epidemic in the Region is occurring alongside unprecedented political, social, and economic challenges.

While the organization and financing of health care differs substantially across the Region, a persisting concern for all governments is the efficiency of services and their return on investment. Some governments face additional challenges as international donors cease their financial contributions to domestic HIV programmes.

The Region is also experiencing the most significant movement of people in decades. This contributes to the epidemiological profile of HIV, introduces new HIV-related risks and vulnerabilities, and tests the capacity of national health systems to effectively adapt and respond(6). Migration patterns vary across the Region, and labour migration to neighboring
countries is more prevalent in the east. There is also significant migration into and within Europe, and recently the European Union (EU) is experiencing a considerable influx in the number of refugees and asylum seekers entering the region.

The Region also faces rapidly changing patterns of drug use (7). These changes present challenges for HIV programming and underscores the continued importance of delivering harm reduction interventions with proven efficacy.

**Epidemiological context**

Globally international and domestic investments in the HIV response are paying off with the number of new infections declining each year. However, in the WHO European Region, between 2005 and 2014 new diagnosed infections increased by 76%, and more than doubled in eastern Europe and central Asia (EECA); (8). More than 142 000 people were newly diagnosed with HIV in 2014, the highest number ever reported in a single year, and four in every five diagnosed (77%) were in the east (8). This is in contrast to the west, where new diagnoses have remained fairly stable over the past decade. A total of 2.5 million people are estimated to be living with HIV in the Region in 2015; 1.5 million in EECA and 950 000 in western and central Europe.

Irrespective of geographical location, the HIV epidemic remains concentrated in key populations at higher risk¹, with variations in the epidemic patterns and trends across the Region. While declining in the majority of member States the rate of HIV transmission attributable to injecting drug use (IDU) remains considerable in the east: in 2014 it accounted for almost half of all new HIV diagnoses with a known mode of transmission. Transmission through IDU remains low in western and central Europe, comprising just 4% of new diagnoses in the EU/European Economic Area (EEA) in 2014.

HIV transmission through sex between men dominates in the Region’s western and central areas, contributing to 42% of new diagnoses in the EU/EEA in 2014. It continues to increase in all parts of the Region, including in the eastern part where sex between men remains highly stigmatized and MSM-related HIV transmission is generally underreported.

---

¹ In line with the UNAIDS HIV Strategy (9) and the WHO Global health sector strategy on HIV for 2016–2021 (3), key populations at higher risk (referred hereafter as key populations) are defined as the groups of people who are most likely to be exposed to or to transmit HIV and whose engagement is critical to a successful response. In the WHO European Region key populations include: people living with HIV, people who inject drugs (PWID), men who have sex with men (MSM), transgender people, sex workers (SW), prisoners and migrants. The sexual partners of people in these groups are also considered key populations.
HIV prevalence among SW remained lower than among MSM and PWID at less than 3% in EECA and 2% in western and central Europe from 2011 to 2014 (8).

Heterosexual sex is the most frequently reported mode of transmission in the eastern part of the Region. Some emerging evidence suggests a considerable proportion of men reported as heterosexually infected may be MSM or PWID (10). Heterosexual transmission may also occur among PWID and sexual networks which include people who have both male and female sexual partners. In western Europe, heterosexual transmission is decreasing, largely due to a decline in new diagnoses among people originating from outside Europe.

People in prisons and other closed settings are particularly at risk of acquiring HIV, hepatitis B and C due to risks associated with unsafe IDU and sex. The prevalence of drug use, including IDU, is particularly high in prisons in the eastern part of the Region.

Refugees, asylum seekers and migrants experience vulnerability to social adversity and ill health. Evidence shows that there are inequities for refugees, asylum seekers and migrants, with respect to their state of health and the accessibility and quality of health services available to them (6). In 2014, migrants (including refugees)2 represented 31% of people newly diagnosed with HIV in the Region, including 22% non-European migrants3 and 9% European migrants4. New diagnoses among non-European migrants decreased by 41% but increased by 48% among European migrants between 2005 and 2014.

There is a high rate of tuberculosis (TB) and hepatitis B and C coinfection among PLHIV, and in 2014 TB was the most common AIDS-defining illness in the eastern part of the Region (7). The number of people coinfected with HIV/TB increased by 43% between 2005 and 2014 in the Region (11). Although in the east TB-related deaths among PLHIV decreased by 34% between 2004 and 2013, TB was still the leading cause of death among PLHIV.

Of the estimated 2.3 million PLHIV who are co-infected with hepatitis C virus globally, 27% are living in EECA. An estimated 83% of HIV-positive PWID in the eastern part of the Region and 70% of PWID in the west and center are coinfected with hepatitis C. Many of these individuals are difficult to reach and may have many other health and social issues that require attention.

---

2 Measured as people originating from outside the reporting country.
3 People originating from outside Europe.
4 People originating from a European country other than the country of report.
Building on the lessons learned from the previous Action plan: Challenges and achievements

In 2011, Member States endorsed the first ever European Action Plan for HIV/AIDS 2012–2015 (2) as an urgent call for action to respond to the public health challenge of HIV in the Region. The 2012-2015 Action plan encouraged Member States to develop national HIV plans with ambitious targets that were aligned with contemporary global and regional developments. It had three overall goals: 1) to halt and begin to reverse the spread of HIV in Europe by 2015; 2) to achieve universal access to comprehensive HIV prevention, treatment, care and support by 2015; and 3) to contribute to the attainment of Millennium Development Goals 6 and other health-related Millennium Development Goals (12). While the third of these goals had been partially met, the first two were not achieved by 2015 (13).

Despite the availability of HIV testing services in all countries and efforts by Member States, the WHO and its partners to scale up targeted HIV testing, in many countries up to half of PLHIV are unaware of their infection. The main barriers for reducing the number of people who are undiagnosed are country-specific and require a tailored response.

Across the Region, many are of those who are aware of their infection are diagnosed late. In 2014, 48% of people newly diagnosed had a CD4 cell count of <350 per mm$^3$ blood, with significant variation across Member States (ranging from 27% to 77%) and across transmission categories. The greatest percentage of late presenters found among PWID, followed by those infected through heterosexual contact and with the lowest percentage among men infected through sex with other men (7).

An enduring challenge is that the current level of antiretroviral therapy (ART) coverage in EECA is insufficient to end AIDS as a public health threat by 2030. The Region has made substantial progress in expanding the number of people receiving ART, and reached approximately one million people on treatment in 2015. This trend has been observed in all Member States. The most pronounced increase was in the eastern part of the Region with a 187% increase between 2010 and 2015, from 112 100 to 321 800 people. Despite these efforts, only 21% of estimated PLHIV$^5$ in EECA were receiving treatment in 2015, far below the global average of 46%. Low ART coverage also impedes the full realization of the HIV prevention benefits of treatment$^6$ at the population level.

It is equally important to monitor treatment outcomes though in some parts of the Region, viral load (VL) monitoring is not being used routinely, and in some countries it is not

---

$^5$ Diagnosed and undiagnosed and regardless of CD4 cell count.

$^6$ “treatment as prevention”
being used at all. In many countries the cascade of care lacks data on the number of PLHIV receiving treatment who are virally suppressed. This current situation is inadequate to reduce HIV transmission and ultimately to halt and reverse the increasing HIV incidence in the Region.

Partly as a result of the factors described above, the annual number of AIDS diagnoses increased by 49% in 2014 compared with 2010 while estimated AIDS-related deaths increased by 24% between 2010 and 2015 in the eastern part of the Region (13).

The population-level benefits of ARV treatment can only be achieved in the context of effective programs which are targeted at key populations. There has been a modest increase in the number of PWID receiving ART (from 26% among all people on ART in 2006 to 38% in 2013). In some EECA Member States access to harm reduction programs including drug dependence treatment has increased. However, some countries do not implement evidence-based prevention policies and interventions for PWID at all or at sufficient scale. Coverage with opioid substitution treatment (OST) remains below 5% in all but three Member States in the east. Access is significantly higher though still limited in most western European Member States: over 50% of people in need are receiving OST. Access to needle and syringe programs varies across countries and (with the exception of a few EU countries) remains below the recommended 200 clean needles and syringes per person who injects drugs per year (14).

The percentage of key populations at higher risk of HIV infection who were tested remained below the European target of 90% by 2015, with average testing rates ranging from 40–60% in 2014: the lowest rate across the Region was among men who have sex with men and in eastern Europe and central Asia among people who inject drugs, while the highest rate across the Region was among sex workers and in western and central Europe among people who inject drugs. This was despite the increase in the overall numbers of people being tested, which confirms that HIV testing strategies are not sufficiently targeted at key populations (13).

Political, legislative and cultural barriers related to sexual behavior, sexual diversity, sex work and drug use have created challenges for the effective implementation of the HIV response. They often drive behaviors and services underground where impact and scale are impossible. Stigma and discrimination continue to hinder access to health services for key populations.
The Region is moving towards the elimination of mother–to-child transmission (MTCT) of HIV and congenital syphilis: a significant achievement which demonstrates that curbing the HIV epidemic is possible with political commitment. Three Member States have successfully confirmed their elimination using the WHO global validation criteria (15), with many more preparing to undertake the process. The regional antiretroviral coverage for pregnant women living with HIV to prevent MTCT is among the highest reported globally (75–95%), as is the high rate of early infant diagnosis (70%\(^7\)) and HIV testing and counseling for pregnant women (75%\(^8\)). The majority of Member States in the eastern part of the Region adopted the WHO-recommended option B+\(^9\) for prevention of MTCT. Despite this progress, challenges remain in the effort to eliminate MTCT of HIV and congenital syphilis in pregnant women, whereby key populations (including PWIDs, SWs, migrant women and prisoners) require more attention.

Many European Member States have adopted national policies and guidelines on HIV prevention, diagnosis, treatment and care for the general and key populations. In particular there has been good uptake of the WHO guidelines for the use of ART to treat and prevent HIV infection. However many Member States are yet to comprehensively implement the “test and treat” agenda and undertake comprehensive and consistent monitoring of treatment outcomes.

Many Member States experience financial constraints and some are heavily dependent on donor funding to deliver their national HIV programmes. With changing donor priorities and their progressive withdrawal from the Region, it is critical that many Member States increase domestic funding for HIV programmes and expand the rollout of equitable and sustainable health financing systems. A failure to sustainably finance the HIV response presents serious risks to the accessibility and continuity of service delivery for PLHIV and has serious implications regional issues such as for HIV drug resistance.

The HIV epidemic in the European Region is moving faster than the programmes established to address it, and an urgent and accelerated health systems response is required.

\(^7\) 2014 data.
\(^8\) 2013 data.
\(^9\) Option B+ refers to the approach in which all pregnant women living with HIV initiate life-long ART regardless of CD4 cell count or clinical stage to prevent vertical HIV transmission, and for the benefit of own health and health of their sexual partners.
Innovative responses, with a strong focus on comprehensive, combination prevention\(^{10}\) (2) and a “treat all” approach are critical to decrease the rate of new infections and increase the number of people receiving HIV treatment and care. These responses will be based on a people-centered health-system approach to ensure universal coverage and enhance financial sustainability. Across the European Region, there should be a renewed focus on ensuring the cost efficiency, quality and effectiveness of existing HIV services and the financial sustainability of the response. The political commitment of Member States is critical to a successful response to the epidemic, including strong cross-border collaboration to promote access to services and prevent transmission in migrant populations. This change is required to meet globally accepted and ambitious goals, such as the Sustainable Development Goals (SDGs; [4]) and the Joint United Nations Programme on UNAIDS’ 90–90–90 targets (9).\(^{11}\) Investment today to address HIV will save resources and lives in the future.

The Action plan for the health sector response to HIV in the WHO European Region

Purpose
This Action plan advocates an urgent and accelerated health sector response to HIV in the WHO European Region, to end the AIDS epidemic as a public health threat by 2030. It builds on the lessons learned from the European Action Plan for HIV/AIDS 2012–2015 (2) and provides a new framework for the next phase of the HIV response. It calls for fast-tracked action to stop the increasing rate of new HIV infections and reduce the public health burden of HIV. It promotes comprehensive, combination prevention and a “treat all” approach; services that follow the principles of universal health coverage; the continuum of HIV services; and the promotion of a public health approach, underpinned by strong political leadership and a partnership approach, particularly with PLHIV. It asks Member States to define and deliver an essential package of HIV services that are people centered, accessible and integrated and focus particularly on key populations in a manner appropriate to the local context.

\(^{10}\) In line with the UNAIDS strategy (9) and terminology guidelines (15), combination HIV prevention seeks to achieve maximum impact on HIV prevention by combining human-rights-based and evidence-informed behavioural, biomedical and structural strategies in the context of a well-researched and understood local epidemic.

\(^{11}\) The global 90–90–90 targets are: 90% of PLHIV know their HIV status; 90% of people diagnosed with HIV receive ART; 90% of PLHIV on ART achieve sustained viral suppression (9).
Framework and guiding principles
The Action plan is based on three organizing frameworks: universal health coverage; the continuum of HIV services; and the promotion of a public health approach.

Universal health coverage ensures that all PLHIV, irrespective of their financial status, can access the full range of healthcare services they need (17). This ranges from prevention to treatment, care and rehabilitation in community, secondary, and tertiary care settings. Embedded in WHO’s definition of universal healthcare are a number of tenets that are central to the current Action plan: equity, high quality services, well integrated care and a service delivery framework which is responsive to individuals’ needs and the broader epidemiological context.

The cascade of care across the continuum of HIV services provides a basis for the contemporary evidence-based approach to tackling the epidemic. Using this and other tools, it is possible to accelerate the HIV response to meet the regional and global UNAIDS 90-90-90 targets to end the AIDS epidemic by 2030 (9).
Figure 1. The cascade of care across the continuum of services (25)

A public health approach is aligned with Health 2020 (5), the European policy framework to improve health and wellbeing. It proposes that Member States address their local HIV epidemics and responses through the application of scientific evidence, technical knowledge and innovative approaches, meaningful involvement of civil society (most critically PLHIV and key populations) and ensuring human rights, gender equality, equity and freedom from discrimination. It also requests governments’ utilize a “whole of government” approach using a partnership model across relevant sectors. A public health approach (18) enables the European Region to fully embrace the “treat all” approach following the 2015 WHO treatment guidelines (19).

**Development**

In 2015, the Global health sector strategy on HIV/AIDS 2011–2015 (1) and its regional implementation plan, the European Action Plan for HIV/AIDS 2012–2015 (2), came to a
close. To build on the momentum generated by this work, WHO and its partners developed ambitious global strategies with a vision of ending the AIDS epidemic as a public health threat by 2030. This global vision is supported by the 2030 Agenda for Sustainable Development (4), the multisectoral UNAIDS Strategy: On the Fast-Track to end AIDS 2016–2021 (9), WHO’s Global health sector strategies on HIV (3) and sexually transmitted infections (STIs) for the period 2016–2021 (20) and the United Nations General Assembly Political Declaration on Ending AIDS (20).

Member States requested the development of the Action plan for the health sector response to HIV in the WHO European Region at a regional consultation for the Global health sector strategies on HIV (3), viral hepatitis (22) and STIs (20), held in Copenhagen, Denmark, in June 2015.

This Action plan is intended to adapt the Global health sector strategy on HIV (3) to the epidemiological, social and political contexts of the countries in the European Region, for its better implementation.

The Plan is aligned with Health 2020, the European policy framework to improve health and well-being and to reduce health inequalities among people in the Region (5), the Tuberculosis Action Plan for the WHO European Region 2016–2020 (23), the European Action Plan for Strengthening Public Health Capacities and Services (224), and the European Child and Adolescent Health Strategy 2015–2020 (25). It is also aligned with other regional plans and strategies under development, such as the Action plan for the health sector response to viral hepatitis in the WHO European Region (working document EUR/RC66/10), the Action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind (working document EUR/RC66/13), the Strategy on women’s health and well-being in the WHO European Region (document EUR/RC66/14), and the Action plan for the prevention and control of noncommunicable diseases in the WHO European Region (working document EUR/RC66/11).

The Regional Office for Europe developed this Action plan through a Region-wide participatory process drawing on the expertise of a formal advisory committee. It formally sought feedback from all Member States, relevant United Nations agencies and programmes, nongovernment organizations (NGOs), international organizations and, most importantly, civil-society organizations and PLHIV in the Region. The Regional Office also held a web consultation on the Plan opened to the general public.
After consideration and guidance from the Twenty-third Standing Committee of the Regional Committee, the Action plan was finalized. This background document is submitted to complement working document (EUR/RC66/9), a draft resolution (EUR/RC66/Conf.Doc./5) and the financial and administrative implications for the Secretariat (EUR/RC66/9) for consideration by the 66th session of the Regional Committee for Europe.

**Vision, goal and targets**

The **vision**\(^{12}\) for 2030 is a WHO European Region with zero new HIV infections, zero AIDS-related deaths and zero HIV-related discrimination, in a world where people with HIV are able to live long and healthy lives.

The **goal** for 2030 is to end the AIDS epidemic as a public health threat in the European Region, in the context of ensuring healthy lives and promoting well-being for all at all ages.

In line with the principles of the UN Resolution\(^{13}\) relating to the Sustainable Development Goals and the Global health sector strategy on HIV \(^{(3)}\) countries should develop, as soon as practicable, ambitious national goals and targets for 2020 and beyond, which ideally would be guided by global goals and targets. Such goals and targets should take into consideration the country context, including the nature and dynamics of country HIV epidemics, populations affected, structure and capacity of the health care and community systems, and resources that can be mobilized. Targets should be feasible and based on the best possible data available on the HIV situation, trends and responses, and monitored through a set of standard and measurable indicators. The targets should apply to everyone, though in particular key populations.

Some of these targets are expressed as percentages, but low-prevalence countries may wish to adopt numerical targets as appropriate to their local contexts.

Ambitious targets for 2020 towards achieving the overall vision by 2020 and the goal by 2030 are presented below.

---

\(^{12}\) Aligned with the WHO global health sector strategy on HIV 2016–2021, the UNAIDS Strategy 2016–2021 and the Sustainable Development Goals.

\(^{13}\) United Nations General Assembly Resolution 70.1 paragraph 55.
Prevention

- Reduce new infections by 75% (or an appropriate numerical target for low-prevalence countries), including among key populations.
- Reduce MTCT to < 2% in non-breastfeeding populations and < 5% in breastfeeding populations.
- Reduce the rate of congenital syphilis and the rate of child HIV cases due to MTCT to ≤ 50 per 100 000 live births.

Testing and treatment

- Ninety per cent of PLHIV know their HIV status.
- Ninety per cent of people diagnosed with HIV receive ART.\textsuperscript{14}
- Ninety per cent of PLHIV who are on ART achieve viral load suppression.\textsuperscript{15}

AIDS\textsuperscript{16}-related deaths

- Reduce AIDS-related deaths below 30 000 (contributing towards reducing global AIDS-related deaths below 500 000).
- Reduce tuberculosis deaths among PLHIV by 75% (or an appropriate numerical target for low-prevalence countries).
- Reduce hepatitis B and C deaths among people coinfected with HIV by 10%.

Discrimination

- Zero HIV-related discriminatory policies and legislation.

Financial sustainability

- Increase the number of countries sustainably funded for the HIV response, with increased domestic financing, to more than 90%.

\textsuperscript{14} This translates into a target of 81% of PLHIV receiving ART.
\textsuperscript{15} This translates into a target of 73% of PLHIV achieving viral suppression.
\textsuperscript{16} The terms AIDS-related deaths and HIV-related deaths are used interchangeably throughout this report and other WHO documentation.
Guided by these **regional** goals and targets, Member States of the European Region should develop **national** goals and targets for 2020 and beyond. These should take into consideration the local context of each Member State, and should be based on the best available data, and monitored through a set of measurable indicators. The targets should apply to everyone, with a particular focus on key populations.

**Strategic directions and fast track actions**

To achieve the targets for 2020 and the goal for 2030, action is required in five strategic directions. This approach aims to maximize synergies for integrated health services delivery and to align the health sector’s response with other regional and global strategies, plans and targets for health and development.

These five strategic directions and their organizing principles are described below and presented in Figure 2.
Figure 2. The five strategic directions of the Action plan for the health sector response to HIV in the WHO European Region (3)

Under each strategic direction, fast-track actions are specified for Member States, the WHO and partners. These are based on the UNAIDS fast-track approach (4): an agenda for quickening the pace of implementation, focus and change at the global, regional, country, provincial and local levels to meet the 90–90–90 targets (9). The fast-track actions are the key strategies that should be adopted to meet the 90–90–90 targets and therefore the goals and targets identified in this regional plan. They are intended to guide countries’ efforts, with Member States selecting and implementing the actions that are most appropriate to their HIV epidemic and national context.

**Strategic direction 1: Information for focused action**

Know your HIV epidemic and response in order to implement a tailored response
Strategic direction 1 focuses on the need to generate and use high-quality strategic information about the HIV epidemic and response as a basis for focused national strategic planning, urgent and accelerated programme implementation, and advocacy to raise political commitment. Strategic information is critical to strengthening and, where necessary, transforming national and subnational structures and processes to ensure coordination across different stakeholders and the alignment of the HIV response with the broader health sector. Monitoring national responses and their impact on the epidemic makes it possible to focus HIV services more effectively, and to deploy or adapt services to reach greater numbers of people in need.

Developing a strong and comprehensive national HIV strategic information system that provides timely and high quality data for decision making and national strategic planning is vital. The system should use standardized indicators and methodologies, guided by WHO and UNAIDS guidelines and joint European center for Disease Prevention and Control (ECDC)/WHO surveillance protocols to inform policy and programme decisions.

Knowing who is affected, how they became infected and where they are is essential to the development of targeted high impact HIV treatment and prevention programmes. In turn, monitoring national responses and their impact on the epidemic makes it possible to focus HIV services more precisely and effectively, and to deploy or adapt services to reach greater numbers of people in need - including key populations.

The rigorous application of ethical standards in gathering and using data is important so as not to compromise the confidentiality and safety of individuals and communities. Greater community and stakeholder involvement in collection and analysis of the data has the potential to improve the quality and use of information.

High-quality strategic information on HIV, including epidemiological trends and data on the local context and national response, should form the basis for updating the national HIV strategies and plans to achieve goals and targets for 2020 and beyond. Progress towards achieving national targets should be monitored through a set of standardized and measurable indicators\(^\text{17}\) (26). National goals and targets should be aligned with regional and global goals and targets while taking into consideration national and local contexts, including the nature and dynamics of national HIV epidemics, the populations affected, and health systems’ organization and capacity.

\(^{17}\) WHO 2015 Consolidated strategic information guidelines on the health sector response to HIV recommends 50 national indicators for countries to consider at national level when measuring their health sector response along the cascade of HIV services, including 10 indicators that are identified for global monitoring.
Fast track actions to achieve the 2020 targets

Member States should take the following actions:

- collect and analyze timely and high-quality epidemiological data to understand how, where and among whom new HIV infections are occurring, develop HIV estimates, monitor risk behaviors and estimate the size of key populations in need of services;

- collect and analyze high-quality granular data on the HIV response – disaggregated by sex, age, population, location and other characteristics – to evaluate health systems’ performance along the continuum of HIV services (including the cascade of care) and evaluate impact to guide more focused HIV services and investments;

- set national targets and milestones, review and update national HIV strategies and develop costed work plans;

- link and integrate HIV strategic information systems with broader health information systems, including those focusing on coinfections and other comorbidities (particularly tuberculosis, viral hepatitis and STIs), and expand the cross-border sharing of information to ensure service continuity for refugees, migrants and other mobile populations; and

- strengthen the coordination of national HIV responses and ensure multisectoral action, strong collaboration and the involvement of civil society, particularly PLHIV and other relevant stakeholders.

Supporting actions to complement the fast track response:\(^{18}\):

Member States should take the following actions:

- build a strong investment case for HIV services and programmes to encourage the accountability and oversight functions that help to ensure quality, scale, impact, and political commitment;

- integrate drug-resistance surveillance and monitoring of early warning indicators into testing and treatment services and broader health information systems, including those for antimicrobial resistance;

---

\(^{18}\) As appropriate to Member States HIV epidemic and national context.
ensure strategic information systems measure clinical markers along the cascade of care using standardized indicators guided by WHO, ECDC and UNAIDS guidelines and protocols;

assess the efficiency, effectiveness and return on investment of the existing HIV response and its components to deploy or adapt services to reach the greatest numbers of people in need;

strengthen national and subnational capacity to monitor and measure changes in the enabling environment including the levels and types of stigma and discrimination experienced by PLHIV and the policy and legal environment; and

employ the use of qualitative data to assess the quality of life for PLHIV to supplement knowledge of the dynamics of and reasons for HIV transmission.

**WHO and partners will undertake the following:**

- support the revision and prioritization of national HIV strategies with a focus on achieving the targets by 2020 and the goal by 2030;
- support implementation of WHO and UNAIDS guidelines and tools related to HIV strategic information and joint (ECDC)/WHO surveillance protocols to strengthen national HIV strategic information systems;
- collect, analyze and disseminate regional strategic information about the HIV epidemic and health systems’ response in the WHO European Region with a particular focus on the cascade of care; and
- support continuing work to strengthen national HIV estimates in collaboration with UNAIDS and ECDC.

**Strategic direction 2: Interventions for impact**

**All people should receive the full range of HIV services they need**

Strategic direction 2 describes high-impact, evidence-based interventions across the continuum of HIV services, including the cascade of care and ranging from comprehensive, combination prevention to targeted HIV testing and the delivery of people-centered...
treatment and care. These interventions should ensure that PLHIV and those at risk of acquiring HIV have positive health outcomes and a good quality of life.

This strategic direction urges Member States to define and implement an essential and comprehensive package of prevention, testing, treatment and care interventions contextualized to the local epidemic, resources and capacity. This package should be developed with the involvement of NGOs, civil society and PLHIV, as evidence has repeatedly shown that such initiatives are most effective when designed with those who will access them. The essential package of HIV services should be included in the national health benefit package, with no out-of-pocket expenses to ensure affordability for PLHIV and the sustainability of the HIV response. It should cover a set of interventions, services, medicines, and commodities across the continuum of services, which follow the “test and treat” agenda and the principles of differentiated care which advocates for specific care packages based on the level and type of need.

Selection of the essential and comprehensive package of services should take place through a transparent process involving key stakeholders. It should consider a number of criteria, including effectiveness, cost, cost-effectiveness, acceptability, feasibility, relevance, demand, and ethics. The package should be regularly reviewed to ensure that the selected interventions reflect changes in the country epidemic and context, advances in technologies and service delivery approaches, and evidence of impact. Combinations of interventions should be specifically considered, recognizing that some interventions will only be effective, or achieve maximum impact, if they are delivered in combination with a core service package.

Service uptake at the scale vital to achieve the 90–90–90 targets requires a shift in the way health systems operate. The service delivery model should promote equity and human rights, universal health coverage, the continuum of HIV services (including the cascade of care) and a public health approach ranging from prevention to palliative care. This includes a shift to community-based services, a greater focus on key populations, accessible and equitable service provision, and the involvement of NGOs and lay personnel.

---

19 WHO guidelines make recommendations on the selection and use of interventions along the full cascade of HIV services, summarize the evidence of effectiveness of different interventions and services, and provide guidance on how such interventions might be applied in different contexts (27).

20 A more detailed discussion of differentiated care is presented in Strategic direction 3.
Fast track actions to achieve the 2020 targets:

Member States should provide affordable, accessible, high-quality services across the continuum of HIV services (including the cascade of care), using a public health approach under a model of universal health coverage. In this context, Member States should define an essential and comprehensive package of HIV services to be integrated into the national health benefits package. It should be based on the local context and the available capacity and resources.

To optimize prevention, Member States should:

- prioritize evidence-based comprehensive HIV combination prevention with particular focus on transmission in key populations, with the inclusion of novel approaches such as pre-exposure prophylaxis (PrEP) for populations at substantial risk of HIV acquisition\(^{21}\), and more traditional harm-reduction initiatives, including drug-dependence treatment, male and female condom lubricant programming, sexuality education and behavior change communication;
- maximize the preventive benefits of antiretroviral drugs by scaling up ART coverage for all PLHIV to achieve national and regional targets; and
- eliminate HIV and congenital syphilis in infants by setting national targets, expanding coverage with antenatal care and testing (including in key populations), providing lifelong ART for women during pregnancy and after delivery, and ensuring early diagnosis of infants and immediate treatment for all infants diagnosed with HIV and congenital syphilis.

To expand targeted HIV testing, Member States should:

- focus HIV testing services to reach key populations in settings where HIV prevalence is highest and ensure early linkage to treatment, care and prevention services; and
- promote rapid HIV testing through an expanded range of approaches as appropriate to the national context – including testing initiated by health care providers (for

---

\(^{21}\) Substantial risk of HIV infection is provisionally defined as an incidence of HIV higher than 3 per 100 person-years in the absence of pre-exposure prophylaxis (PrEP). Individual risk varies within groups at substantial risk of HIV infection depending on individual behavior and the characteristics of sexual partners. People at substantial risk of HIV infection are present in most countries, including some (but not all) people identified with key and vulnerable populations and some people not so identified.
example, in response to the symptoms of acute retroviral syndrome), testing of key populations through community and outreach services and lay service providers, testing in closed settings and self-testing (28) – and simplify the strategy for HIV diagnosis to ensure timely enrolment in treatment and care.

To expand HIV treatment and care, Member States should:

- adopt a “treat all” approach and update national guidelines on HIV treatment and care, including on the prevention and management of major coinfections and comorbidities responsible for morbidity and mortality in PLHIV, particularly STIs, tuberculosis, viral hepatitis C22 and drug dependence; and
- closely monitor ART success by implementing regular testing of the HIV viral load and strategies to minimize resistance to HIV drugs, and use the data to inform national policies and guidelines on ART.

Supporting actions to complement the fast track response23:

Member States should consider the following actions:

- guarantee treatment for opportunistic infection, comorbidities and provide chronic care to PLHIV on ART by addressing age-related health needs to ensure a good quality of life;
- provide psychological and social support to PLHIV and empower them to manage their condition by improving their health literacy thereby enabling them to self-manage their condition and improve treatment adherence;
- provide high quality HIV testing and laboratory monitoring of treatment efficacy by adopting strengthened and innovative HIV testing and laboratory technology and ensuring adherence to ethical testing procedures and internal and external quality control;
- certify health services practice a high standard of blood product safety, proper sterilization of medical equipment and consistent use of universal precautions; and

---

22 Where appropriate the approach will also address viral hepatitis B
23 As appropriate to the Member States HIV epidemic and national context
• prevent gender-based and sexual violence using structural interventions, such as addressing gender inequities and antisocial behavior as well as care for those who experienced sexual abuse including the provision of post-exposure prophylaxis.

**WHO and its partners will take the following actions:**

• provide regular updates on innovative, evidence-based guidelines and tools for effective comprehensive, combination prevention; testing; delivery of ART; and management of major comorbidities, including STIs;

• support countries to implement national HIV testing strategies, standardize ART regimens and plan the scaling up of ART coverage to reach national and regional targets;

• support countries to update their policies and practices to prevent MTCT of HIV and congenital syphilis, and strengthen their capacity to monitor progress in dual elimination and elimination validation; and

• provide guidance and support to countries to prevent and monitor resistance to HIV drug and optimize treatment approaches.

**Strategic direction 3: Delivering for equity**

**All people should receive the services they need, which are of sufficient quality to have an impact**

Strategic direction 3 responds to the need for an enabling environment and optimization of service delivery. HIV interventions and the health and community systems that provide them should be grounded in an environment that promotes equity and is based on human rights principles. The continuum of services needs to be tailored to different populations and locations to reach those most affected and guarantee that no one is left behind.

This continuum also relies heavily on the concept of service integration, both across the continuum, though also with other services focusing on comorbidities and related health conditions such as TB (including multi-drug resistant tuberculosis) and Multidrug resistance: resistance to at least both isoniazid and rifampicin.
extensively drug resistant TB\textsuperscript{25} (XDR-TB), viral hepatitis, sexual and reproductive health and drug dependence.

Decades of experience has shown that HIV interventions are most effective when they occur in the appropriate social, legal, policy and institutional environments. These environments should be accessible to a range of population groups and be free of stigmatization and discrimination. When properly enforced, laws and policies that discourage inequalities based on gender, race or sexuality and protect and promote human rights can reduce vulnerability to, and risk of, HIV infection while enhancing the efficacy of services.

This strategic direction also encourages countries to develop their HIV interventions, including the essential package of services for PLHIV, in line with the differentiated care framework (27). This framework requires the delivery of different HIV care packages for PLHIV based on their needs. It is characterized by four delivery components: the type of services being delivered, the location of service delivery, the provider of the services and the frequency of the services (as shown below in Figure 3). By providing differentiated care, Member States can support improvements in health outcomes and direct resources and activities towards those most in need in the most efficient and effective manner.

\textsuperscript{25} Extensive drug resistance: resistance to any fluoroquinolone and to at least one of three second-line injectable drugs (capreomycin, kanamycin and amikacin), in addition to multidrug resistance.
Fast track actions to achieve the 2020 targets

Member States should take the following actions:

- ensure the implementation of an essential package of services that is equitable and accessible, and employs differentiated care;

- ensure people-centered, integrated care by linking HIV with other health services, particularly in the context of the prevention, diagnosis and treatment of coinfections and other comorbidities, focusing on tuberculosis, viral hepatitis, STIs, drug dependence, and sexual and reproductive health;

- define and implement HIV interventions for key populations that are tailored to the local context, capacity and resources, including, where applicable, migrants and mobile populations; and ensure that services are relevant, acceptable and accessible and provided in an environment that protects the human rights of PLHIV;
• ensure that legal and regulatory frameworks respect the human rights of PLHIV and facilitate partnerships with NGOs, civil society and PLHIV to expand access to high-quality and evidence-based HIV services for key populations groups; and

• strengthen human resources for the response to HIV by making projections of the anticipated demand for health professionals, and develop the capacity of the health workforce by defining core competencies for different roles in the provision of comprehensive HIV services.

**Supporting actions to complement the fast track response**:

Member States should consider the following actions:

• undertake the strategic decentralization of services and ensure person-centered and integrated care to increase access, coverage, acceptability, and quality of care;

• seek opportunities for improved service delivery efficiencies by coordinating HIV interventions and services with other health programmes and the overall health system; and

• develop and implement quality improvement and assurance programmes to improve the service delivery for PLHIV.

**WHO and partners will undertake the following actions:**

• provide updated guidance on essential HIV and STI services, differentiated care and service delivery models, including such models for key populations and specific settings;

• support Member States to build the health workforce’s capacity to optimize HIV services, ensuring that such services are people centered, accessible, integrated, community based and focused on the continuum of HIV services throughout the life-course; and

• facilitate partnerships and encourage Member States to create an enabling environment for accessible, equitable and affordable HIV services through multisectoral collaboration and the engagement of civil society, including PLHIV.

---

26 As Member States deem appropriate to their epidemiological, political and social context.
**Strategic direction 4: Financing for sustainability**

All people should receive the services they need without experiencing financial hardship

Strategic direction 4 identifies the need for sustainable and innovative models of financing for the HIV response and for approaches to reducing costs, as well as protection systems, so that people can access the services they need without incurring financial hardship. This is possible when health services are delivered under a model of universal health coverage framework.

To meet the targets outlined in this Action plan, efficiencies and maximized results can be achieved through a focus on a number of key areas. The potential for efficiency lies in health services delivery; better integrated services, improved programme management, and the reorganization of the health workforce and its professional scope of practice should be aligned with strategic financial incentives. A focus on the improved selection, procurement and supply of high-quality, affordable medicines, diagnostics and related equipment, and other health commodities alongside improved integration with other health services will maximize the sustainability of the HIV response.

Strategic direction 2 defined an essential package of HIV interventions to be included in the national health benefit package. As much as possible, this package should be domestically financed and minimize out of pocket expenses for PLHIV and those at risk of acquiring HIV. This will ensure the sustainability, continuity, and accessibility of services for people in the greatest need without financial risk.

**Fast track actions to achieve the 2020 targets**

Member States should take the following actions:

- ensure the financial sustainability of HIV services, including defining and financing the essential package of HIV interventions to achieve the 90–90–90 targets (8);

- provide protection against health-related financial risk at the individual level by providing the essential package of HIV interventions, reducing financial barriers and eliminating out-of-pocket expenses; and at the health systems level by monitoring health expenditure and the cost–effectiveness of services to identify opportunities for savings; and
• ensure the procurement of affordable, quality-assured HIV medicines and diagnostics, including the consideration of using the WHO prequalification processes, aiming for sustainable cost reductions and strengthened national management of procurement and supply.

Those Member States reliant on external funding sources should develop plans to transition from external to domestic funding of HIV services, with a particular focus on protecting the essential services most reliant on external funding in order to avoid service interruption.

**Supporting actions to complement the fast track response**\(^{27}\): Member States should consider the following actions:

- expand innovative financing mechanisms and public-private partnerships which may include financial support mechanisms for non-governmental organizations;

- seek opportunities for improved efficiency in service delivery by coordinating HIV interventions and services with the broader health system;

- explore options for international, regional and national procurement options and amendments to pricing policies to achieve savings on medications and other HIV commodities. Where appropriate, leverage cost reductions through the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), including the judicious use of mechanisms for compulsory licensing;

- support interested Member States to adopt the WHO’s Health Accounts Country Platform;

- raise revenue and guarantee sufficient funding allocations for HIV services and interventions;

- undertake assessments on the economic efficiency of the HIV response in relation to intervention types, settings, and key populations to identify where the best return on investment will be generated; and

- provide funding for innovation and scientific research in the Region, including the rollout or scale up of best practice or initiatives shown to be successful in other parts of the country or Region.

**WHO and its partners will take the following actions:**

---

\(^{27}\) As appropriate to Member States HIV epidemic and national context.
• build strategic partnerships for the sustainable financing of the HIV response and encourage innovative financing models and new funding opportunities;
• support countries to develop national cases for HIV investment and plans for financial transition in order to facilitate the move from external to domestic HIV funding;
• provide guidance and tools for monitoring health-service costs and cost–effectiveness; and
• advocate that countries include the essential package of HIV interventions and services in their national health benefit packages and remove financial barriers for individuals in accessing HIV services.

Strategic direction 5: Innovation for acceleration
Changing the course of the response to achieve ambitious targets

Strategic direction 5 identifies areas where there are major gaps in knowledge and technology and innovation is required to shift the course of the HIV response so that action can be accelerated to achieve the targets for 2020 and goal for 2030. The ambitious yet achievable targets set in this Action plan require new thinking, technology, partnerships and models of collaboration, and approaches to service delivery. Innovation in the European Region should look beyond the biomedical to include innovations related to communication, behavior change, service delivery and economic modeling.

A particular focus should be given to the development of innovative service delivery models that effectively reach key populations with HIV prevention services and engage and retain them in the entire continuum of HIV services. Services required by key populations, including treatment of drug dependence that is currently underdeveloped should be prioritized throughout the Region.

Fast track actions to achieve the 2020 targets:

• Member States should take the following actions: undertake primary and implementation research to address gaps in national HIV responses, with a particular focus on reaching key populations and maximizing effectiveness and efficiency;
• allocate national resources to stimulate and encourage innovation and the sharing of innovations in technologies, models of collaboration and service delivery;

• establish multisectoral partnerships and collaboration opportunities focused on innovation and best practice that include NGOs and private sector organizations;

• ensure that key challenges in the European Region are highlighted for a focus on innovation, including the need to ensure that PLHIV learn their status at the earliest stages of infection and that HIV services effectively reach key populations; and

• deliver integrated health services covering HIV, tuberculosis, viral hepatitis, drug dependence, sexual and reproductive health, using innovative approaches that are designed in consultation with civil society, most importantly PLHIV.

Supporting actions to complement the fast track response:

Member States should consider the following actions:

• develop the capacity to undertake research to identify new and transferable service delivery models, and improve the transfer of research to practice;

• promote and facilitate public-private partnerships focused on service innovation, workplace HIV programmes and stigma-reduction; and

• leverage innovations in digital and information technology including social media and the use of social networks to strengthen combination prevention and monitoring and evaluation approaches.

WHO and its partners will take the following actions:

• support HIV research in four main areas: building the capacity of health research systems; convening partners to set priorities for research; setting norms and standards for good research practice; and facilitating the translation of evidence into affordable health technology and evidence-informed policy;

• provide guidance and technical assistance on using existing evidence-based interventions more efficiently and adapting them for different populations, settings or

---

28 As appropriate to Member States HIV epidemic and National Context.
purposes, in order to optimize prevention, expand access to testing and treatment, and maximize service delivery;

- exchange and transfer knowledge and experience from the global context and other WHO regions, and provide guidance and technical assistance in translating them for use in the national context; and

- continuously document and share best practices in the implementation of innovative service delivery models, including those focusing on community-based services.
**Action plan implementation**

Member States will be supported by the Regional Office and partners to develop ambitious national goals and targets for 2020 and beyond guided by global and regional goals and targets. National goals and targets should reflect the country context and be based on the best possible data available on the HIV situation, trends and responses, and monitored through a set of standard and measurable indicators. The targets should apply to all populations, with a specific focus on key populations.

**Partnerships**

Effective implementation of this Action plan requires the establishment of strong governance processes, a whole-of-government approach with multisectoral engagement, and continuing political commitment and resources at the highest levels. This should include strong partnerships and the involvement of civil society, particularly PLHIV, to ensure that linkages across disease-specific and cross-cutting programmes are established and strengthened.

The WHO has an important convening role in bringing together different constituencies, sectors and organizations in support of a coordinated and coherent health sector response to HIV. In addition to working with the ministries of health of Member States, the Regional Office for Europe Secretariat will work closely with other key partners, including:

- **Multilateral and bilateral institutions, donors, development agencies, funds and foundations:** In addition to working with the ministries of health of Member States, the WHO Regional Office for Europe will work closely with other key partners, the European Commission and its institutions, ECDC, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the Global Fund to Fight AIDS, Tuberculosis and Malaria, US Centers for Diseases Prevention and Control (CDC), The US President’s Emergency Plan for AIDS Relief (PEPFAR), and other multilateral donors and development agencies.

- **Civil society including people living with HIV:** Civil society and people living with HIV are represented in all the WHO Regional Advisory Committee, as well as being represented on the groups involved in the development of WHO policies, guidelines and tools. A range of civil society organizations have official relations with WHO, enabling them to attend as observers various WHO governing body meetings, including the World Health Assembly.
• **UNAIDS and partner United Nations agencies:** the Regional Office works collaboratively within the broader United Nations system to provide a comprehensive multisectoral HIV response. The 10 other UNAIDS cosponsors, along with the UNAIDS secretariat, contribute to the health sector response to HIV, guided by the UNAIDS “division of labour” which outlines key areas of responsibilities across the UNAIDS family.

• **Research organizations, professional associations and technical partners:** including the WHO Collaborating Centres, research institutions, national institutes of excellence and other partners and technical experts.

**Monitoring and evaluation**

No additional data to that already collected is foreseen. WHO is committed to reducing data collecting and reporting burden on Member States. Monitoring and reporting of progress towards regional goals and targets will be based on data received from Member States through various existing monitoring and evaluation mechanisms and processes. This includes the joint UNAIDS/WHO/UNICEF Global AIDS Response Progress Reporting (GARPR; [29])\(^29\) and the joint ECDC/WHO HIV surveillance in Europe. The Regional Office will also work with partners, including ECDC and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), to ensure that relevant data reported by Member States as part of the ECDC\(^30\) and EMCDDA monitoring processes will be used in the best possible manner to support monitoring the implementation of this Action plan.

GARPR collects data on the global HIV response through a joint agency online reporting tool that includes several components. First, it includes a set of standardized indicators (25, 30), including 10 to monitor the regional implementation of this Plan, which are organized along the continuum of HIV services, including the cascade of care (see Annex). They comprise the minimum requirements for national and regional monitoring and reporting on the progress of health systems’ response to HIV. GARPR also includes additional indicators: the WHO questionnaire on national policies and practices, which monitors countries’ uptake of WHO guidelines on HIV, and the UNAIDS National Commitments and Policies.

\(^{29}\) See http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting

\(^{30}\) As part of the Dublin Declaration reporting process.
Instrument (NCPI), which measures progress in implementing policy, legal and structural measures to enhance the HIV response.\(^{31}\)

Progress at the global and regional levels in moving towards the targets set out in this Action plan and the Global health sector strategy will be regularly assessed, including through annual global WHO reports on the health sector response to HIV and reports to the Regional Committee for Europe at its 69th and 72nd sessions in 2019 and 2022, respectively, on implementation of the Action plan for the health sector response to HIV in the WHO European Region.

\(^{31}\) NCPI is currently under review but will again be included in GARPR in 2017, as it was in 2010, 2012 and 2014.
References


### Annex. Key indicators to measure the regional health sector response to the HIV epidemic

<table>
<thead>
<tr>
<th>No</th>
<th>Result chain</th>
<th>Indicator</th>
<th>Indicator details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Know your epidemic</td>
<td>PLHIV</td>
<td>Estimated number of PLHIV</td>
</tr>
<tr>
<td>2</td>
<td>Inputs</td>
<td>Domestic finance</td>
<td>% of HIV response financed domestically</td>
</tr>
<tr>
<td>3</td>
<td>Outputs and outcomes (HIV services cascade)</td>
<td>Prevention for key populations</td>
<td>(a) for sex workers, % reporting condom use with most recent client; (b) for men who have sex with men, % reporting condom use at last anal sex with a male partner; (c) for people who inject drugs, needles–syringes distributed per person per year</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>PLHIV diagnosed</td>
<td>Number and % of people living with HIV who have been diagnosed</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>HIV care coverage</td>
<td>Number and % of PLHIV who are receiving HIV care (including ART)</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>Currently on ART</td>
<td>Number and % of PLHIV who are currently receiving ART</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>ART retention</td>
<td>Number and % of PLHIV and on ART who are retained on ART 12 months after initiation (and 24, 36, 48 and 60 months)</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>Viral suppression</td>
<td>Number and % of people on ART who have suppressed viral load</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>AIDS-related deaths</td>
<td>Number of AIDS-related deaths</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>New infections</td>
<td>Number of new HIV infections and rate per 100 000 population</td>
</tr>
<tr>
<td>11</td>
<td>Evaluate impact</td>
<td>MTCT rate</td>
<td>% infants born to HIV-positive women in the past 12 months who were HIV positive</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>HIV MTCT and congenital syphilis case rate</td>
<td>New congenital syphilis and HIV MTCT cases per 100 000 live births</td>
</tr>
<tr>
<td>13</td>
<td></td>
<td>Tuberculosis deaths among PLHIV</td>
<td>Number of tuberculosis deaths among PLHIV</td>
</tr>
<tr>
<td>14</td>
<td></td>
<td>Hepatitis deaths among PLHIV</td>
<td>Number of hepatitis B and C deaths among PLHIV</td>
</tr>
<tr>
<td>15</td>
<td></td>
<td>HIV-related discrimination</td>
<td>Discriminatory HIV-related laws, regulations or policies presenting obstacles to an efficient HIV response (according to the NCPI)*</td>
</tr>
</tbody>
</table>

**Notes:** The shaded indicators (1–10) refer to the 10 global indicators recommended by WHO for global reporting (Consolidated strategic information guidelines for HIV in the health sector. Geneva: World Health Organization; 2015 (http://who.int/hiv/pub/guidelines/strategic-information-guidelines/en/)). The NCPI is being revised but expected to be included in the 2017 round of Global AIDS Response Progress Reporting (GARPR), as it was in 2010, 2012 and 2014.
ART: antiretroviral therapy; MTCT: mother-to-child transmission; NCPI: National Commitments and Policies Instrument; PLHIV: people living with HIV