Proposal of the Monitoring Committee for a continued National HIV Plan 2020-2026 with particular attention to STI

Version 30th of January 2021

Acknowledgements

Since it's first conception in 2015 the Belgian HIV Plan brought together experts of all kinds and forged collaboration throughout Belgium. It has not been different for this edition of the Plan. And it would not have been possible without it either.

People living with HIV have been involved throughout the 30 years of existence of HIV in Belgium. Some as activists, some as silent witnesses, others as committed volunteers, many as generators for change. An HIV Plan would not have been the same without the recognition of these voices, their history and the active participation of many people living with HIV in order for the Plan to be serving actual needs and being future proof.

Many people, organisations and authorities have contributed to the process. The result is a unique bottom-up developed HIV Plan which is it's most striking characteristic at the same time.

The Monitoring Committee wishes to thank all it's members, a diverse and broad representation of the NGO and CBO working field, clinicians, laboratory specialists and scientists for their active support in drawing together the HIV Plan 2020-2026: Jessika Deblonde, Sandra Van den Eynde, Thierry Martin, Christiana Noestlinger, Charlotte Pézeril, Chris Verhofstede, Joelle Defourny, Anne-Françoise Genotte, Agnès Libois, Rémy Demeester, Steven Callens, Maureen Louhenapessy, Koen Block, Ria Koeck, Patrick Reyntiens and Grâce Ntunzwenimana. A particular mention goes to the writing committee of the Plan: Jessika Deblonde, Christiana Noestlinger, Dominique Van Beckhoven, Koen Block and Gert Scheerder.

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A special tribute goes to those who are no longer among us but left a big impression on us all, in particular in memory of Joelle Defourny. With her limitless dedication she pioneered in HIV prevention and will remain a source of inspiration for a long time.

Terminology

AIDS: Acquired Immune Deficiency Syndrome

AIDS Reference Laboratory (ARL): There are seven ARL in Belgium. Their task is to confirm or exclude HIV infection in case of a reactive screening test, to document new infections in a way that allows epidemiologic analyses and scientific research and to perform viral load and drug resistance analyses for HIV infected individuals.

Asylum seeker: Person who awaits a decision on the application for refugee status under relevant international and national instruments.

Cascade of care or continuum of care: A straightforward view of the sequential stages of HIV medical care for people living with HIV; it is a monitoring framework that can be used to identify gaps in care that need to be targeted to improve the response to the epidemic across the whole range of interventions.

Chemsex: Consumption of stimulant drugs such as GHB, GBL, metamphetamine / mephredrone and ketamine in order to engage in sexual activities either with one or several partners.

Combination prevention: A set of strategically-selected interventions 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

Community: A group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings. For example: HIV community, migrant community, LGBTI community [1].

Community health workers: People who provide sexual health and other health-related support (whether being paid or unpaid) to key-populations. A community health worker may deliver health promotion and/or public health activities outside of formal health settings. They may be members of, or connected to, the communities they serve (peers).

[1] MacQueen KM, McLellan E, Metzger DS, Kegeles S, Strauss RP, Scotti R, Blanchard L, Trotter RT. What is community? An evidence-based definition for participatory public health. American journal of public health. 2001 Dec;91(12):1929-38.

Confirmation test: Any test that is used to confirm a reactive screening test (Line Immunoassay, Western Blot etc). In accordance with the “state-of-the-art HIV testing strategy ”, this confirmation test has to be carried out by an ARL on a blood sample.

Demedicalised HIV testing: Rapid HIV test which is carried out by a non-medical provider in accordance with Royal Decree from 19/07/2018. These tests offer a quick first screening result from either a venal puncture, a finger prick or a mouth swab sample. A reactive rapid test needs a confirmation according to the state-of-the-art HIV-testing strategy.

Health-related quality of life: A multi-dimensional concept that includes domains related to physical, mental, emotional, and social functioning. It goes beyond direct measures of population health, life expectancy, and causes of death, and focuses on the impact health status has on quality of life.

HIV: Human immunodeficiency virus

HIV care: Medical HIV care, including ART treatment, as well as psycho-social care as corresponding to the inclusive vision of HIV care.

HIV testing: The process during which (1) samples are taken (2) the screening test is performed on these samples, and (3) the confirmation test is carried out in the event of these results being reactive.

HIV Reference Centre (HRC): There are eleven HRC in Belgium, geographically distributed across the country. HRCs are specialised outpatient clinics providing multidisciplinary HIV care.

Undocumented migrant: Non-national who enters or stays in a country without the appropriate documentation. This includes, among others: a person (a) who has no legal documentation to enter a country but manages to enter clandestinely, (b) who enters or stays using fraudulent documentation, (c) who, after entering using legal documentation, has stayed beyond the time authorized or otherwise violated the terms of entry and remained without authorization.

Key populations: defined groups who, due to specific higher risk behaviours and contextual vulnerabilities are at increased risk of HIV irrespective of the HIV epidemic type or local context. Also, they often have legal and social issues that increase their vulnerability to HIV and frequently lack adequately access to services.

Linkage to care: Completion of a first HIV-dedicated medical care visit as early as possible after the HIV diagnosis.

LGBTQI: Abbreviation for lesbian, gay, bisexual, transgender, queer and intersex. The acronym can contain other letters to express additional forms of gender identity or sexual orientation

Men who have sex with men (MSM): Men who engage in sexual activities or relations with other men.

Migrant: A person who moves to a country other than that of his or her usual residence for a period of at least 12 months, so that the country of destination effectively becomes his or her new country of usual residence.

MIPA: Meaningful Involvement of PLWH is the process of keeping people living with HIV central to the creation and determination of the policies, funding, services, research and initiatives that affect them. It replaces the previous term GIPA (Greater Involvement of PLWH), which is a principle that aims to realize the rights and responsibilities of people living with HIV, including their right to self-determination and participation in decision-making processes that affect their lives.

Partner notification: This concept refers to notifying the person(s) with whom one has had (unprotected) sex after being diagnosed with one or more STIs or HIV. Notification is voluntary and can be supported by the doctor.

PEP: Post-Exposure Prophylaxis, a short-term treatment started as soon as possible after high-risk exposure to HIV. The purpose of post-exposure prophylaxis (PEP) is to reduce the risk of infection

PLWH: People Living with HIV/AIDS

Population – location: In the context of HIV, population and location or local epidemic is a concept that is used to help prioritize programme activities within the HIV response. It refers to the need to focus on specific areas and specific populations where there is high HIV prevalence or incidence [2]. The result of using a population and location approach will be a more efficient HIV response based on a more distilled knowledge of the HIV epidemic in the country

PREMs: *Patient reported Experience Measures.* Instruments that measure the patient’s satisfaction with the care received.

PrEP: Pre-exposure prophylaxis (PrEP) is an HIV prevention method for people who are HIV negative and at high risk of HIV infection. It involves taking a specific combination of HIV medicines on a daily or non-daily basis.

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[2] UNAIDS 2015. On the Fast-Track to end AIDS by 2030. Focus on Location and Population. https://www.unaids.org/en/resources/documents/2015/FocusLocationPopulation

PROMs: *Patient reported outcome measures*. Instruments that measure the outcome of treatment from the perspective of the patient.

Quality of life (QoL): World Health Organisation has defined QOL as “individuals’ perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, standards, expectations and concerns.

Refugee: Person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his or her nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.

Regional health authorities: term used to refer to all government departments and policy makers involved in health policy, both those based on the competences of the communities (gemeenschappen/communautés) and those based on regionally organised competences (gewesten/regions).

Self-sampling (also home sampling): Term used to denote the sampling procedure performed as part of the HIV-test strategy. It indicates that the consumers/patients take these samples on their own. Samples collected in this manner should be sent to the laboratory for testing. In the event of the test result being reactive, the latter should always be confirmed with a confirmation test.

STI: Sexually transmitted infections other than HIV including chlamydia (including Lymphogranuloma venerum - LGV), gonorrhoea, syphilis, hepatitis, Human papillomavirus - HPV, herpes and trichomoniasis. More than 30 pathogens can be transmitted sexually.

Syndemics [3]: Synergistic interactions of two or more co-existent diseases including harmful social conditions that results into excess disease burden. Next to higher HIV prevalence and a higher reporting of depressive symptoms and other mental health problems, there is also evidence of substance dependence and sexual compulsivity often occurring simultaneously.

Treatment as Prevention (TasP): This concept refers to the use of antiretroviral medication by those who are living with HIV in order to reduce the amount of virus in their blood to undetectable levels so that there is effectively no risk of sexual transmission of HIV.

U=U: “undetectable = untransmittable”. When a person is living with HIV and is on effective treatment, it lowers the level of HIV (the viral load) in the blood. When the levels are low (below 200 copies/ml of blood measured) it is referred to as an

[3] Singer M, Bulled N, Ostrach B, Mendenhall E. Syndemics and the biosocial conception of health. The Lancet. 2017 Mar 4;389(10072):941-50

undetectable viral load. This is also medically known as virally suppressed. At this stage, HIV cannot be passed on sexually.

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I. Introduction

More than five years ago, the first national HIV Plan 2014-2019 was drawn up by numerous public health and community organisations. Over the past years, the HIV Plan has served as a valuable guidance for actors in the field, and it resulted into a number of important achievements. This HIV Plan 2014-2019 has come to an end and a new HIV Plan has been developed to guide the HIV response, taking into account epidemic trends and the recent evolutions in the HIV domain.

General principles

The HIV Plan 2020-2026 includes guiding principles to support a high-quality, evidence-based and equitable response to HIV. The HIV Plan is built upon the participation of all stakeholders in the HIV field. Perhaps most critical is the ongoing and meaningful participation of people with HIV, as well as the involvement of organisations targeting key populations. This is central to the partnership approach and is key to the success of this HIV Plan.

The general principles of the HIV plan are the following:

- Respect human rights, sexual and reproductive rights;
- Embrace combination prevention and health promotion;
- Devote particular attention to STI;
- Ensure participation of relevant stakeholders;
- Ensure the meaningful involvement of people living with HIV (PLWH);
- Ensure the participation and empowerment of key populations;
- Endorse guiding principles such as interdisciplinary quality services in prevention, treatment and care, and equity in access to all services;
- Ensure research and surveillance to inform evidence-based policies for all pillars as well as for evaluation purposes;
- Adopt principles of good governance.

Goals & targets

This plan aims at improving the various aspects of the quality of life and medical situation of PLWH, from infection to diagnosis, treatment and care, across their life course with special attention to their well-being and within the framework of universal access to treatment and care. This plan also covers the prevention of HIV acquisition while promoting the conditions for healthy and responsible sexuality.

The plan is guided by the aspiration to reach the targets defined by UNAIDS as a means to end the HIV/AIDS epidemic by 2030[4]. These include the 95–95–95 targets: by 2025, 95% of people living with HIV know their HIV status, 95% of people who know their status are receiving treatment and 95% of people on HIV treatment have a suppressed viral load, so their immune system remains strong and the likelihood of their infection being passed on through sexual contact is greatly reduced. UNAIDS has also set targets for primary prevention and targets for zero discrimination, which contributes to ending HIV and reaching an optimal quality of life of PLWH.

As the HIV Plan is the main instrument to frame the HIV response in Belgium, targets are important for assessing both accountability and the progress made through monitoring and evaluation. Therefore, specific targets grounded in the Belgian epidemiological and social context were designed to cover the multiple facets of the lives of people at risk of acquiring or living with HIV.

The targets related to the prevention of HIV acquisition and improvement of sexual health aim to ensure that all people at risk for HIV infection are aware of, have access to and receive the prevention tools adapted to their specific needs. Yet, for the actions relating to testing, treatment, care and quality of life, the choice of the targets was guided by the continuum of HIV care approach, completed by the fourth pillar on quality of life.

The following key-targets are proposed:

- Increase the number of people from key populations informed about existing prevention measures towards HIV and STI
- Increase the number of people who receive prevention services (including condom use, counselling on risk reduction strategies, chemsex, HIV testing)
- Ensure that all people at high risk of HIV acquisition have access to PrEP
- Ensure that all care providers receive training on combination prevention tools and up-to-date socio-epidemiological information on HIV to support testing
- Reach 95% of all PLWH knowing their status by 2025 (first UNAIDS target for the continuum of HIV care)
- Reduce the number of HIV infections diagnosed late
- Ensure that undiagnosed most-at-risk/key populations are reached by community-based HIV testing
- Ensure access of PLWH and PrEP users to regular STI screening

[4] UNAIDS. Understanding Fast-track. Accelerating action to end the AIDS epidemic by 2030. Available at: https://www.unaids.org/sites/default/files/media_asset/201506_JC2743_Understanding_FastTrack_en.pdf

- Ensure prompt linkage to HIV care following diagnosis and subsequent retention in HIV care
- Ensure that 95% of PLWH diagnosed with HIV receive ART by 2025 (second UNAIDS target for the continuum of HIV care)
- Ensure that more than 95% of PLWH on ART reach undetectable viral load by 2025 (third UNAIDS target for the continuum of HIV care)
- Ensure that tools to monitor patients' health-related quality of life are developed and implemented in HIV care settings
- Ensure that all PLWH have access to peer support through patient organisations according to their needs
- Reduce stigma and discrimination against PLWH

I. Background

1. HIV epidemic in Belgium

i. Trends in HIV diagnoses

After the decreasing trend in the number of new HIV diagnoses between 2012 and 2018, an epidemiological plateau was reached in 2019. Between 2019 and 2020, the number of new HIV diagnoses decreased by 21%. This sharp decline was clearly related to the COVID-19 pandemic and the measures taken to curb the circulation of COVID-19 virus. Both had an impact on HIV testing activities, sexual behaviour and migration dynamics.

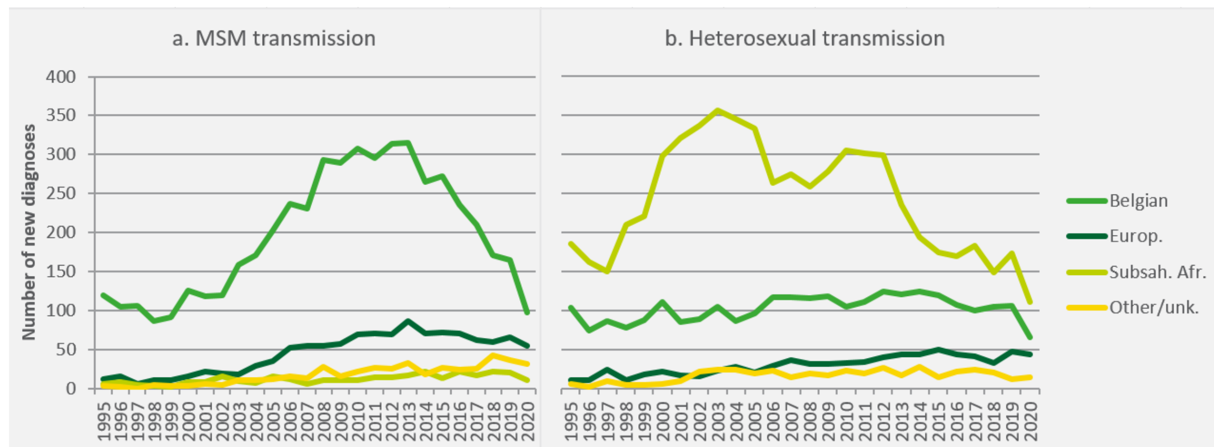
In 2020, there were 727 new HIV diagnoses, which corresponds to 2 new diagnoses per day. Belgium remains one of the Western European countries with proportionally the highest number of new HIV diagnoses (6.3/100 000 inhabitants)[1].

Since the start of the HIV epidemic in Belgium, two key populations have been particularly affected, namely men who have sex with men (MSM), of Belgian nationality, and heterosexual men and women from Sub-Saharan Africa. Given the declining trend of diagnoses in these key populations, the proportion of populations with other profiles has become relatively larger in recent years and the epidemic in Belgium is now more diversified. In 2020, 40% of the new HIV diagnoses were among Belgian MSM and heterosexuals from Sub-Saharan Africa.

The decreasing trend in the number of new HIV diagnoses among Belgian MSM continued in 2020; there was a slight increase among MSM from Latin America. Among heterosexuals of sub-Saharan African origin, the downward trend seemed to have stopped in 2019, but it resumed in 2020; there was also a decrease among heterosexuals with Belgian nationality (figure 1).

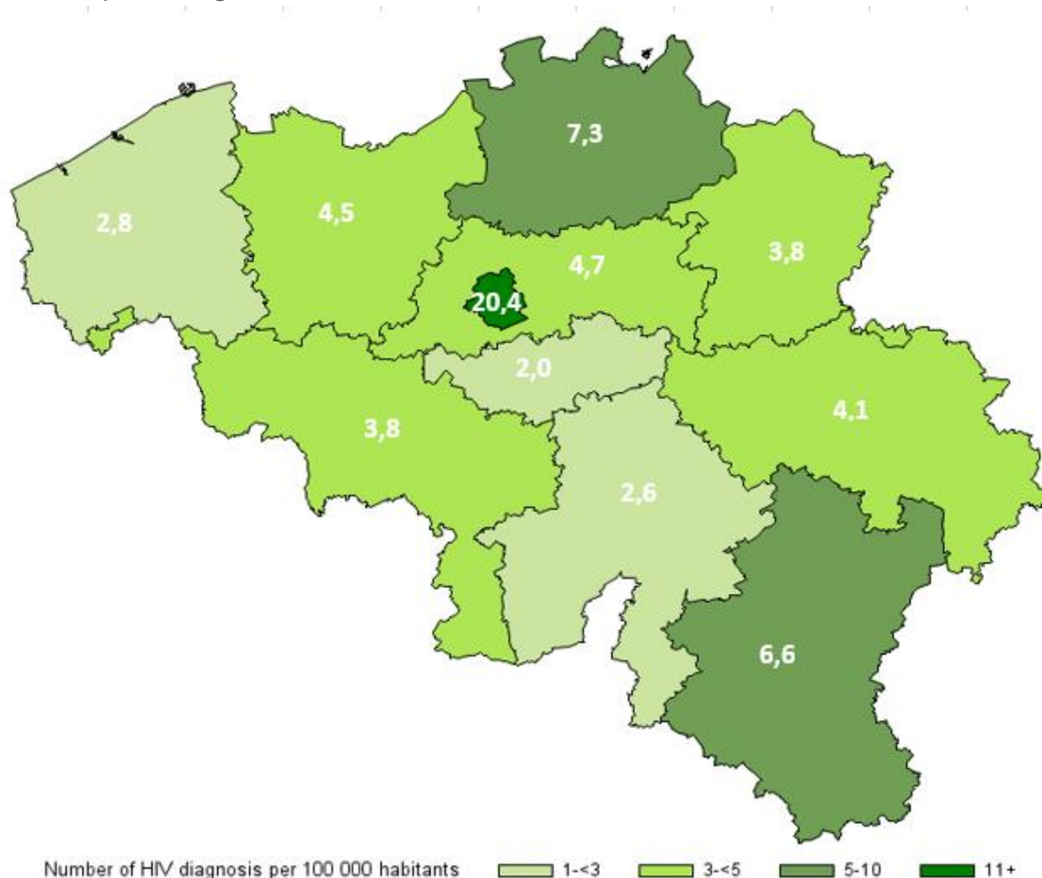
[1] Deblonde J, De Rouck M, Montourcy M, Serrien B, Van Beckhoven D. Epidemiology of AIDS and HIV infection in Belgium. Sciensano; 2020. Dutch version available through: https://doi.org/10.25608/bbbj-e471; French version available through: https://doi.org/10.25608/zepg-vg62

Figure 1: Evolution of the number of new HIV diagnoses by transmission mode and nationality, Belgium 1995-2020



In terms of geographical distribution, the highest number of HIV diagnoses in 2020 was reported in the Brussels Capital Region with 20.4 new diagnoses per 100 000 inhabitants (Figure 2). The number of diagnoses was higher in cities (12.3 diagnoses per 100 000 inhabitants) than in agglomerations and suburbs (3.5 per 100 000 inhabitants) or in sparsely populated areas (2.6 per 100 000 inhabitants). The higher number of diagnoses in Brussels therefore seems to be linked, on the one hand, to the urban nature of the region and, on the other, to the specific characteristics of the capital.

Figure 2: Number of HIV diagnoses per 100 000 inhabitants and per province and Brussels Capital Region, 2020



ii. Testing and diagnosis process

Late diagnosis of HIV infection remains a challenge as an HIV infection does not necessarily lead to an immediate diagnosis. The timing of the diagnosis is influenced by various factors such as the slow progression of the disease, as well as the availability and frequency of test activities. In 2020, 36% of HIV infections were diagnosed late (<350 CD4 /mm³ at the time of the HIV diagnosis). The number of late diagnoses has moderately decreased in the recent years and it remains more common among heterosexuals (47%) than among MSM (22%).

In 2020, half of the HIV tests in Belgium were carried out by general practitioners through whom 42% of the HIV diagnoses are made.

iii. Estimates of people living with HIV: diagnosed and undiagnosed

In 2020, 18 753 people were estimated to be living with HIV, this represents a prevalence of 1.7/1000 inhabitants. Recent surveys among most-affected populations reported HIV prevalence among migrants from sub-Saharan Africa of 5.9% for women and 4.2% for men[2]. Among MSM, reported HIV prevalence is about 12% in both the Sialon survey (based on biological sampling) in Brussels[3] and the EMIS online survey (based on self-reported data) in Belgium [4].

People living with HIV (PLWH) may remain unaware of their HIV status for a considerable time before diagnosis. HIV-infected people who are unaware of living with HIV cannot benefit from highly effective treatment and may unwillingly contribute to the on-going transmission of HIV infection. In 2020, an estimated 1585 were not aware of their infection. The estimated number and proportion of PLWH that was not aware of their serostatus decreased from 23.5% of PLWH in 2008 to 8.5% in 2020. Geographic areas hosting the biggest cities in Belgium accounted for the vast majority of undiagnosed HIV infections and individuals with foreign nationality were the most affected, especially MSM with non-European nationality[5].

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[2] Loos J, Nöstlinger C, Vuylsteke B, Deblonde J, Ndungu M, Kint I, Manirankunda L, Reyniers T, Adobea D, Laga M, Colebunders R. First HIV prevalence estimates of a representative sample of adult sub-Saharan African migrants in a European city. Results of a community-based, cross-sectional study in Antwerp, Belgium. PloS one. 2017;12(4). Available at: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0174677

[3] The Sialon II Project. Report on a Bio-behavioural Survey among MSM in 13 European cities. ISBN 978-88-98768-55-4 Cierre Grafica, 2016. Editors: Massimo Mirandola, Lorenzo Gios, Nigel Sherriff, Igor Toskin, Ulrich Marcus, Susanne Schink, Barbara Suligoi, Cinta Folch, Magdalena Rosińska. Available at : http://www.sialon.eu/data2/file/133_Sialon%20II_Report%20on%20a%20Bio-behavioural%20Survey%20among%20MSM%20in%2013%20European%20cities.pdf

[4] Vanden Berghe W, Deblonde J, Detandt S, Pezeril C, Sergeant M, Barris S. The European Men who have sex with men Internet Survey (EMIS) 2017. Brussel, België: Sciensano 2021; Observatoire du sida et des sexualités (ULB), D/2021/14.440/08. Te raadplegen via : https://www.sciensano.be/nl/biblio/european-men-who-have-sex-men-internet-survey-emis-2017-resultaten-voor-belgie

[5] Marty L., Van Beckhoven D., Ost C., Deblonde J., Costagliola D., Sasse A., Supervie V. and the HERMETIC Study Group. Estimates of the HIV undiagnosed population in Belgium reveals higher prevalence for MSM with foreign nationality and for geographic areas hosting big cities. JIAS. 2019, 22:e25371. Available at : https://doi.org/10.1002/jia2.25371

iv. Care of PLWH

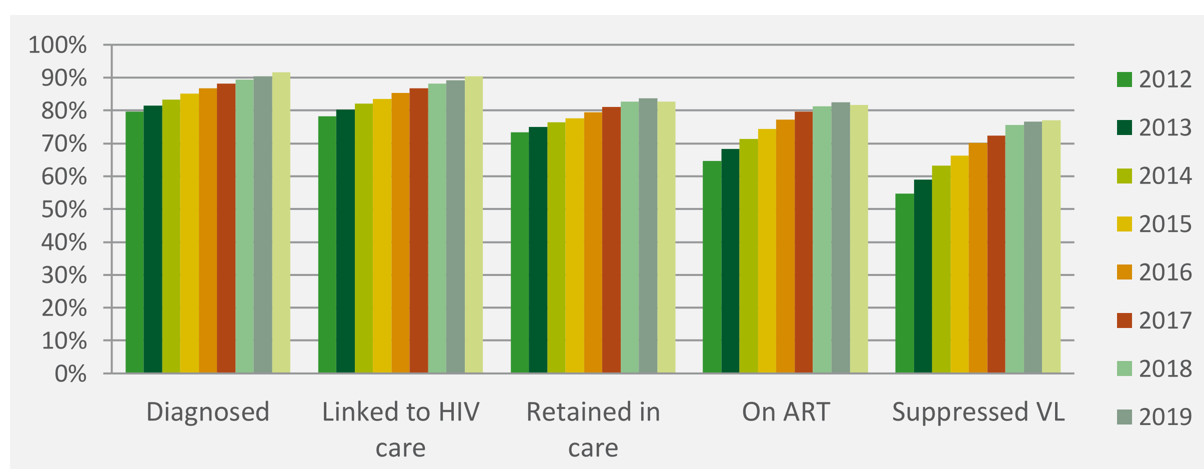
As a result of new infections and low mortality, the number of PLWH increases by an average 646 patients per year. Exceptionally in 2020, there was a slight decrease in the number of patients in medical follow-up due to the COVID-19 pandemic. In 2020, 17 018 patients were followed up for HIV care in Belgium. An increasing proportion of patients become elderly: from 19% of patients aged 50 years or more in 2006 to 44% in 2020. In parallel, patients have a longer average duration since infection and since ART initiation and are therefore at higher risk for (multi)comorbidities.

Clinical care indicators for the patients followed in the HIV Reference Centres (HRCs) are very good: ART coverage was 75% in 2008 and increased to 98% of the patients in 2020, and controlled viral load (<200 copies/mL) reached 98% of those on ART for at least 6 months.

Optimal care for HIV patients requires a continuity of services. From a clinical and public health perspective, early and sustained HIV care and treatment are associated with viral suppression, improved health outcomes and reductions in transmission risks. The following risk factors related to poorer retention in HIV care in Belgium were identified: being younger, using injecting drugs, being diagnosed recently and not being Belgian, whilst MSM had higher retention rates [6].

The continuum of HIV care is a monitoring framework that uses cross-sectional indicators to quantify the number of people diagnosed, linked to care, retained in care, on ART, and achieving a controlled viral load, as a proportion of the estimated number of people living with HIV. In 2020, of all people living with HIV in Belgium 92% were diagnosed, 90% had been linked to HIV care, 83% were retained in care, 82% were receiving ART and 77% were virally supressed (figure 3). Improvement in all stages of the continuum was observed over the years and particularly for the ART uptake and viral load suppression.

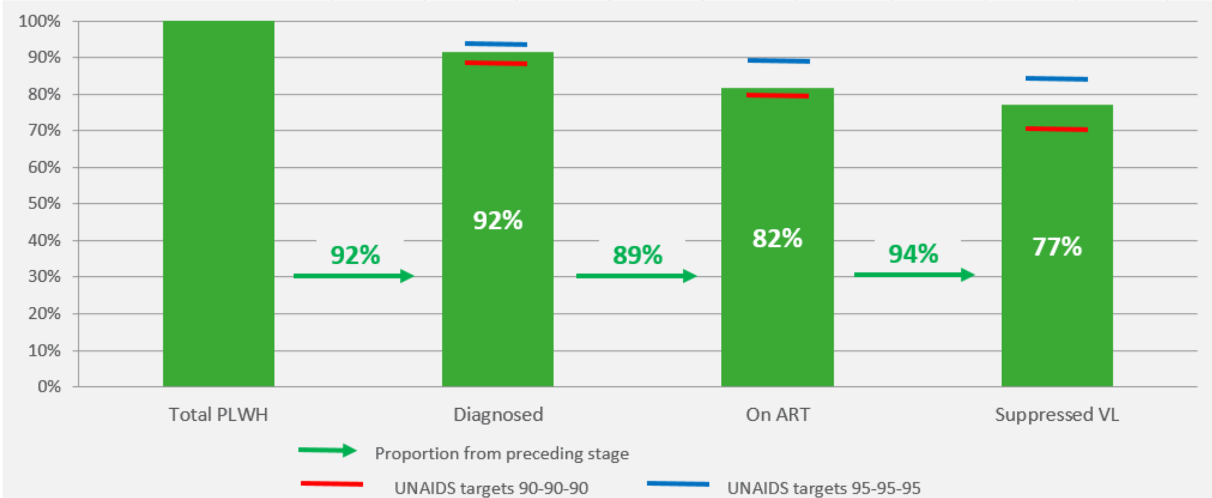
Figure 3: Continuum of HIV care in Belgium, 2012-2020



[6] Van Beckhoven D, Florence E, De Wit S, Wyndham-Thomas C, Sasse A, Van Oyen H, Macq J; Belgian Research on AIDS, HIV Consortium (BREACH). Incidence rate, predictors and outcomes of interruption of HIV care: nationwide results from the Belgian HIV cohort. HIV Med. 2020 Oct;21(9):557-566. doi: 10.1111/hiv.12901. Epub 2020 Jul 5. PMID: 32627351; PMCID: PMC7540395.

For 2020, UNAIDS has set the ambitious 90-90-90 global target: 90% of people living with HIV should know their positive serostatus, 90% of these should receive antiretroviral treatment and of these 90% should have an undetectable viral load. Once this triple target is met, the overall 2020 goal of at least 73% of people living with HIV having an undetectable viral load will have been achieved. Belgium has achieved this overall target: in 2020, 92% of the HIV population was diagnosed, 89% of them received antiretroviral treatment and 94% of them had an undetectable viral load, or 77% of all persons living with HIV (Figure 4). Additional efforts to reduce new infections, ensure early diagnosis and retention in care will be decisive in order to achieve the next targets of 95-95-95 in 2030.

Figure 4. Continuum of HIV care in Belgium in 2020 compared to the UNAIDS targets



2. Related STI epidemics

i. Epidemiological and behavioural dynamics

Recent ECDC expert guidance states that the integration of an STI prevention and control strategy within an HIV strategy is the most logical and advantageous model of practice [7]. Additionally, integration with a viral hepatitis strategy is recommended as a supplementary option [8].

The case for integration is strengthened by the common modes of transmission, leading to overlaps in the affected key populations. At the individual level this results in co-infections. The presence of an STI makes individuals more vulnerable for an HIV infection and being both infected with HIV and another STI may increase the risk of further transmission of HIV. At population level, HIV and STI epidemics are fuelled by similar epidemiological dynamics, the so called syndemics[9]. By joining prevention and testing efforts, a synergistic approach can be used to combat HIV and STI more effectively and efficiently.

However, not all most-affected populations for HIV are at equal risk of STI. In Belgium, as in most Western countries, the observed overall increase of syphilis and gonorrhoea diagnoses since 2002 has been predominantly due to transmission between MSM [10] [11].

Chlamydia, gonorrhoea and syphilis are highly prevalent among certain subgroups of MSM. At the behavioural level, this high STI prevalence is associated with less consistent condom use, having multiple sex partners and substance use or dependence. LGV (Chlamydia serovar L) and sexually acquired hepatitis C are proportionally more diagnosed among HIV positive MSM. Infection with hepatitis C is related to specific high risk traumatic sexual practices, such as the practice of fisting [12].

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[7] European Centre for Disease Prevention and Control. Developing a national strategy for the prevention and control of sexually transmitted infections. Stockholm: ECDC; 2019. Available through: https://www.ecdc.europa.eu/sites/default/files/documents/strategies-to-control-STIs.pdf

[8] European Centre for Disease Prevention and Control. Public health guidance on HIV, Hepatitis B and C testing in the EU/EEA - an integrated approach. Stockholm: ECDC; 2018. Available through: https://www.ecdc.europa.eu/sites/default/files/documents/hiv-hep-guidance-brief-6-december.pdf

[9] Singer M, Bulled N, Ostrach B, Mendenhall E. Syndemics and the biosocial conception of health. The Lancet. 2017 Mar 4;389(10072):941-50

[10] European Centre for Disease Prevention and Control. Gonorrhoea. In: ECDC. Annual epidemiological report for 2017. Stockholm: ECDC; 2019.Available through: https://www.ecdc.europa.eu/sites/default/files/documents/gonorrhoea-annual-epidemiological-report-2017.pdf

[11] European Centre for Disease Prevention and Control. Syphilis. In: ECDC. Annual epidemiological report for 2017. Stockholm: ECDC; 2019. Available through: https://www.ecdc.europa.eu/sites/default/files/documents/syphilis-annual-epidemiological-report-2017.pdf

[12] Apers L, Vandenberghe W, De Wit S, Kabeya K, Callens S, Buyze J, et al. Risk factors for HCV acquisition among HIV-positive MSM in Belgium. JAIDS J Acquir Immune Defic Syndr. 2015;68(5):585–593.

However, since the introduction of PrEP, these STI are also becoming more prevalent among HIV negative MSM on PrEP [13] [14].

STIs are far less prevalent among Sub-Saharan African migrants as compared to MSM. A recent study among Sub-Saharan African communities in Antwerp city revealed that STI diagnoses are associated with HIV infection.

ii. Reported cases [15]

Chlamydia is the most common STI in Belgium. The number of reported cases in Belgium increased from 9.5/100 000 inhabitants in 2002 to 77.0/100 000 inhabitants in 2019. Nevertheless, this increase has been associated with more sensitive diagnostics and more targeted and opportunistic testing in risk groups. At European level, more cases are reported among heterosexuals, mainly women. Nevertheless, 10% of chlamydia cases are diagnosed among MSM [16]. Between 2014 and 2019, there was a steady increase in the number of LGV (*Chlamydia serovar L*) cases among MSM.

Gonorrhoea showed an increasing trend since 2002 from 2.6/100 000 inhabitants in 2002 to 26.0/100 000 inhabitants in 2019. In 2019, gonorrhoea was mainly registered among men between 20 and 39 years of age. At European level and in countries with a similar social and epidemiological context such as the Netherlands up to 50% of cases are found in MSM [17].

Syphilis also increased over the same period (2002-2019) in Belgium from 0.4/100 000 inhabitants in 2002 to 21.6/100 000 inhabitants in 2019. In 2019, syphilis was mainly registered among men between 20 and 59 years old. European data on transmission of syphilis show that up to 75% of cases are diagnosed among MSM [18].

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[13] Sasse A, Deblonde J, De Rouck M, Montourcy M, Van Beckhoven D. Epidemiology of AIDS and HIV infection in Belgium. Sciensano; 2019. Dutch version available through: https://doi.org/10.25608/5c9n-4t26; French version available through: https://doi.org/10.25608/k6sn-n789;

[14] Vuylsteke, B., Reyniers, T., De Baetselier, I., Nöstlinger, C., Crucitti, T., Buyze, J., Kenyon, C., Wouters, K. and Laga, M., 2019. Daily and event-driven pre-exposure prophylaxis for men who have sex with men in Belgium: results of a prospective cohort measuring adherence, sexual behaviour and STI incidence. Journal of the International AIDS Society, 22(10), p.e25407

[15] Vanden Berghe, W., De Baetselier, I., Van Cauteren, D., Sasse, A., Quoilin, S. Surveillances des infections sexuellement transmissibles. Données pour la période 2017-2019. Bruxelles, Belgique : Sciensano. Numéro de rapport : D/2020/14.440/85. Available through: https://www.sciensano.be/sites/default/files/report_sti_sciensano_1719_fr.pdf

[16] European Centre for Disease Prevention and Control. Chlamydia infection. In: ECDC. Annual epidemiological report for 2017. Stockholm: ECDC; 2019. Available through: https://www.ecdc.europa.eu/sites/default/files/documents/AER_for_2017-chlamydia-infection.pdf

[17] European Centre for Disease Prevention and Control. Gonorrhoea. In: ECDC. Annual epidemiological report for 2017. Stockholm: ECDC; 2019.Available through: https://www.ecdc.europa.eu/sites/default/files/documents/gonorrhoea-annual-epidemiological-report-2017.pdf

[18] European Centre for Disease Prevention and Control. Syphilis. In: ECDC. Annual epidemiological report for 2017. Stockholm: ECDC; 2019. Available through: https://www.ecdc.europa.eu/sites/default/files/documents/syphilis-annual-epidemiological-report-2017.pdf

3. Key populations

MSM and Sub-Saharan African migrants are the most-affected populations in the Belgian HIV epidemic. However, not all people belonging to these most-affected populations are at equal risk: HIV transmission dynamics depend on the influence of the various risk and vulnerability factors to which they are exposed and which act in a mutually reinforcing way.

That is why the HIV Plan focuses on key-populations defined as groups who, due to specific higher risk behaviour and contextual vulnerabilities are at increased risk of HIV and related STI. These populations are key to the HIV epidemic and key to the HIV response in Belgium and include MSM, (undocumented) migrants from high HIV-prevalence countries, transgender people, sex workers, people who inject drugs and prisoners. Within each key-population, young people have specific age-or developmentally related needs, which the Plan's specific actions will consider.

Addressing key-populations for HIV implies therefore addressing a combination of vulnerability factors such as inadequate access to health care, multi- and intersectional discrimination, HIV-related stigma and socio-economic inequalities.

Despite the existence of support mechanisms to ensure universal health care, for example through the procedure of urgent medical care, complex administrative procedures may constitute important barriers to the actual accessibility of services. Also, Belgium provides a strong and progressive regulatory framework regarding discrimination that protects - among others - discrimination based on gender, ethnicity, sexual orientation, current and future health status [24]. Nevertheless, HIV-related perceived and real stigma and discrimination stemming from cultural practices, religious beliefs, legal restrictions and criminalization of HIV transmission continue to increase vulnerabilities to HIV infection. In addition to or intertwined with HIV, PLWH may face stigma and discrimination based on race, sexual orientation or gender identity. Discrimination and (self-)stigma may lead to not accessing care and self-exclusion from social support [25].

Additionally, some key populations face poverty and experience limited access to essential services such as housing, education, employment, protection and justice [26]. These factors represent additional vulnerabilities in the sense that they undermine control over sexual health and increase the risk of sexual violence and practices of transactional sex. Also the linkages between migration, poverty and HIV have been

[24] UNIA. The 19 grounds of discrimination. Available at: https://www.unia.be/en/grounds-of-discrimination/the-19-grounds-of-discrimination

[25] Pezeril C. Lutte contre le SIDA et promotion de la santé sexuelle. Santé Conjuguée, 2019 n° 86. Available at: https://observatoire-sidasexualites.be/wp-content/uploads/SC-86-in-lgbt-def-pezeril.pdf

[26] Gennotte et al. (2017). Oral presentation at the BEACH symposium 2017, Anderlecht; Belgium. Available at : http://www.breach-hiv.be/media/docs/BREACHSympo2017/AMASE,AFGennotteBreach3pourlesite.pdf

recognised across the world. Research in Belgium has shown that HIV infection among sub-Saharan African migrants is associated with socio-economic vulnerability, next to concurrency and having sex mainly within African sexual networks [27]. It has also been found that Sub-Saharan Africans migrants are mobile and that they may engage in sexual risk behaviours while travelling, increasing as such the risk of post-migration HIV-acquisition [28].

A number of good practices have shown that interventions, directly addressing key populations, can reach positive results. Within the Belgian context, harm reduction services have succeeded in keeping the impact of HIV among people who inject drugs relatively low compared to other countries. The efficient preventive approach towards – but also by – sex workers not only reduced the risk of HIV/STI infections, but also targeted other related risks such as violence. In addition, several community-based organisations have developed expertise in working within a participatory approach, thereby closely collaborating with the communities affected, increasing prevention demand and ownership for complementary services, such as peer support.

Summarizing, continuous interventions are needed to improve access to HIV prevention and care services. Comprehensive HIV prevention programs should address not only the biological drivers of HIV infection, but also the social context and structural factors that shape people's sexual agency and health seeking behaviour. Effectively fighting HIV means defending human rights and combating all forms of discrimination as well as working within a multisector approach to address the socio-economic inequalities.

[27] Loos J, Nöstlinger C, Vuylsteke B, Deblonde J, Ndungu M, Kint I, Manirankunda L, Reyniers T, Adobea D, Laga M, Colebunders R. First HIV prevalence estimates of a representative sample of adult sub-Saharan African migrants in a European city. Results of a community-based, cross-sectional study in Antwerp, Belgium. PloS one. 2017;12(4). Available at: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0174677

[28] Dias S, Gama A, Loos J, Roxo L, Simões D, Nöstlinger C (2020) The role of mobility in sexual risk behaviour and HIV acquisition among sub-Saharan African migrants residing in two European cities. PLoS ONE 15(2): e0228584. https://doi.org/10.1371/journal.pone.0228584

4. Mapping HIV stakeholders

i. HIV prevention & support organisations

Diverse organisations working on health promotion, prevention and support are part of the day-to-day implementation of activities towards key populations affected by HIV. These include organisations that provide one or more of the below services:

- general support towards key populations such as sex workers, LGBTI, migrants, people who inject drugs and prisoners.
- HIV/STI information and preventive services towards the general public or populations at increased risk of infection
- structural advocacy to defend and protect the rights of those at risk of stigma and discrimination (socially/structurally)
- direct support to those affected/infected by HIV via peer-to-peer support, information and counselling

ii. HIV Reference Centres

The Belgian HIV Reference Centres (HRC) are centres of expertise recognised by the government. An HRC is linked to a hospital, and provides accessible and multidisciplinary care for people with HIV, including medical treatment and care, psychosocial support and STI screening. The recognised HRC have a convention with the National Institute for Health and Disability Insurance (RIZIV/INAMI) which allows for the reimbursement of the medical treatment as well as the multidisciplinary care and support. Since 2017, the HRC are also in charge of PrEP service delivery. There are 12 recognised HRC in Belgium, with a geographical spread that ensures the accessibility of this specialized care. Five of these recognised HRC are located in Flanders (Antwerp, Leuven, Hasselt, Ghent, and Bruges), four in Brussels (UZ Brussels, St. Pierre, Erasmus, St. Luc) and three in Wallonia (Liège, Charleroi, Namur).

iii. AIDS Reference Laboratories

The Belgian Aids Reference Laboratories (ARL) are centres of expertise founded in 1987. They are working in close collaboration with HIV Reference Centres. There are three ARL in Flanders (Antwerp, Ghent and Leuven), three in Brussels (Jette, St Luc and Erasme) and one in Wallonia (Liège). Their tasks are to confirm or exclude HIV infection in case of a reactive screening test, to run analyses for the laboratory monitoring of HIV infection like viral load testing and drug resistance analysis; to evaluate the quality of tests used for diagnosis and follow-up of HIV infected patients and to document new infections in a way that allows epidemiologic analyses and scientific research. For the latter there is a close collaboration with Sciensano. The ARL are financed through a convention with RIZIV/INAMI.

iv. Low threshold screening centres

Based on Royal Decree from the 6th of March 2017 (previously the Royal Decree from the 28th of December 2006), RIZIV/INAMI finances three HRC as low threshold screening centres: Elisa Centre, HRC St Pierre; Sida Sol A.S.B.L, HRC Liège and Helpcenter, HRC Antwerp. The screening referred to in the context of this Royal Decree is intended for any person who is at increased risk of an HIV or STI infection and who belongs to one or more of the following target groups:

- Migrants from a country with an HIV prevalence that is at least 10 times higher than the HIV prevalence in Belgium;
- Men who have sex with men;
- Intravenous drug users and their partners;
- Sex workers and their partners;
- Prostitution customers and their partners;
- Persons who have unprotected sexual relations outside the context of a permanent relationship;
- Persons who have multiple partners or who have sex with a partner who has multiple partners.

These people can be offered a free (and anonymous) HIV test, supplemented if necessary with an STI screening. The screening activities may be offered outside the premises of the screening centre in order to improve accessibility for the target groups.

v. Sciensano

Sciensano, the Belgian Health Institute, is in charge of the epidemiological surveillance of HIV/AIDS in Belgium. To this end, Sciensano collects notifications of new HIV diagnoses from the ARL and of new AIDS cases from clinicians. Since 2006, Sciensano also collects individual routine data on HIV patients in medical follow-up from the HRC and ARL: this is the Belgian HIV Cohort. In 2018, the monitoring of PrEP and PEP users has been included in the HIV surveillance.
STI such as chlamydia, gonorrhea and syphilis as well as some other STI are monitored by Sciensano through different surveillance sources.

vi. BREACH

BREACH, the Belgium Research on AIDS and HIV Consortium, is a collaborative effort between the Belgian HIV Reference Centres, Aids Reference Laboratories, scientific research groups and interest organisations in the field of HIV infection and AIDS. BREACH aims to facilitate and support Belgian HIV research of all kinds (clinical trials, epidemiology, public health, basic and translational research, health economics) both at a national and at an international level and to increase its overall visibility. In this view, annual symposia and scientific meetings are organised. Within BREACH there is also a Public Health Working Group and a PrEP Task Force; both platforms provide opportunities for exchange and collaboration.

III. Major achievements of the national HIV Plan 2014-2019

The development of the HIV plan 2020-2026 is a good opportunity to look back at what the first HIV plan 2014-2019[29] managed to realize. Several positive achievements can be mentioned, upon which the new plan will be built.

To start with, perhaps the most important achievement of the plan was that it brought together scientists, clinicians, community health workers and other actors from the HIV field across Belgium. It was the first time that actors from prevention, testing, clinical care, and quality of life as well as PLWH worked together towards well defined goals for a six-year period. This created a pathway to provide the best possible support, care, and policy environment to PLWH and those at risk, with special attention to those most in need. The implementation of the plan was monitored within the Monitoring Committee, that was established by the Inter-ministerial Conference of Public Health on the 24th of February 2014 (action 54).

The first HIV plan was developed during a period of major changes within the field of HIV prevention, testing and care which were quickly taken up although new challenges came along. It is not without pride and gratitude to see how different actors not only welcomed the new developments, but even embraced and included them within their services.

During the period of the first HIV plan, research projects were set up to better understand the needs and behaviour of people at risk of HIV infection while using Pre-Exposure Prophylaxis (PrEP), in line with action 34 of the HIV plan. The high acceptability and feasibility of PrEP among MSM was demonstrated in a Belgian PrEP demonstration project [30]. Subsequently, HIV health care providers, community-based organisations in the prevention field and PLWH appreciated the decision by the federal Ministry of Public Health to reimburse PrEP for people at high risk of HIV acquisition. This has meant that Belgium was one of the first European countries where PrEP was rolled out at national level.

In line with action 1 and 3, the HIV plan provided the framework to review prevention messages and inform people at risk about the different options they have, to protect themselves and their partners. Many studies have shown by now that using a diversity

[29] National HIV Plan for Belgium 2014-2019. Available at: http://www.breach-hiv.be/media/docs/HIVPLan/NationalPlanEng.pdf

[30] Vuylsteke B, Reyniers T, De Baetselier I, et al. Daily and event-driven pre-exposure prophylaxis for men who have sex with men in Belgium: results of a prospective cohort measuring adherence, sexual behaviour and STI incidence. *J Int AIDS Soc*. 2019;22(10):e25407. doi:10.1002/jia2.25407

of preventive tools and tailoring them to people's needs is the most promising approach to finally reduce HIV transmission rates.

Another achievement has been the continued effort to test and treat people as early as possible. Access to timely HIV treatment has been improved specifically through action 36, which called for starting HIV treatment in people who are recently diagnosed regardless of their CD4 counts. This action resulted in earlier treatment for PLWH, earlier reach of undetectable viral load which is most probably leading to a lower transmission rate at community level.

Additionally, the decentralisation and de-medicalisation of HIV testing (action 38) allowed to reach out to most at risk populations who otherwise would not access HIV testing services. The legalization of de-medicalized HIV testing has been important for community-based organisations that provide testing services with the help of non-medical providers, also referred to as lay providers. A training programme for lay providers is developed and although its implementation is still in an early stage, a number of training sessions has already been provided.

This allowed for offering HIV/STI testing services outside formal health facilities in order to facilitate the accessibility to testing and uncover new diagnoses. However, it must be said that these community-based interventions are not only focused on testing. They aim to raise awareness, mobilize local communities and prevent new HIV/STI infections. This health promotion approach is therefore much broader than what is presented in terms of testing yield.

With the support of national and regional health authorities and RIZIV/INAMI, Belgium was able to ensure a combination of treatment, preventive services including PrEP and targeted testing initiatives for diverse communities. It can be plausibly assumed that the recent declining trend in newly registered HIV cases within the groups most affected by the epidemic, as evidenced by the national HIV surveillance results, is an effect of this combination prevention approach.

Success was also achieved in the field of treatment and care. At times of increased numbers of PLWH, the HIV Reference Centres managed to provide efficient multi-disciplinary support to PLWH. Belgium is doing quite well in its achievement of the 90-90-90 goals, with a high number of people getting tested, treated and linked to and retained in care (action 42, 43). As PLWH live longer, healthy ageing and quality of life have become important goals of the care for PLWH. Continued efforts will be needed to retain PLWH within care and prevent them from additional infections and co-morbidities. Longer term side effects remain a point of attention within care, especially for those diagnosed many years ago and aging with HIV.

As shown by recent needs assessment, stigma and discrimination remain an important barrier for PLWH to live their lives to the full. It has been positive to see how increasing numbers of PLWH from several communities and backgrounds are willing and able to

put a face to HIV and normalize it within society (actions 50 and 51). The creation of the Positive Council by the Inter-ministerial Conference of Public Health on the 24th of February 2014 has provided an important platform for PLWH to become an active partner within the national HIV plan (action 55).

The first Belgian HIV plan was a national effort and a bottom-up initiative and therefore met with great enthusiasm by all stakeholders in the HIV field. With its successor, the second plan 2020-2026, we hope to be able to build on its achievements and to counter the newly emerging challenges with similar success. While the HIV plan provides a sound policy framework to this end, continuous political commitment and collaboration of all partners are needed to reach the plan's ambitious goals.

IV. Towards a new HIV Plan: methods

In the course of 2018, the Monitoring Committee initiated the process for the development of a new national HIV plan.

A new plan was considered necessary since it provides a policy framework to collaborate and communicate with the health authorities. Therefore, the proposed priorities and actions should be framed within the competences of the federal health authority in the domains of public health and chronic diseases. Besides, it was also understood that the HIV Plan should be embedded within the respective regional frameworks concerning health promotion and prevention.

The content of the plan was constructed around the four strategic pillars to fight HIV: prevention, testing, care and quality of life, following the same structure as the previous HIV plan.

For each pillar, a working group made up of experts in the field was set up. Based on an assessment of the epidemiological context and gaps in the response, the working groups formulated a number of priorities and actions. In a first phase, these were presented to and validated by field organisations and other relevant stakeholders. For this purpose, different methods were used, such as focus group discussions, workshops, questionnaire surveys and a Delphi-consultation. The Positive Council provided a transversal feedback to the aforementioned pillars. In a subsequent phase, a consultation round with the regional health authorities was organised. The feedback received was incorporated and a writing group with representatives of each pillar was established to further coordinate the synchronization and completion of the plan. Various internal review rounds guided the redaction. Finally, the Monitoring Committee invited the UNAIDS Representative to the European Union to provide support to the HIV Plan 2020-2026.

V. Priorities and actions

1. PREVENTION PILLAR

General principles and background

A combination prevention approach comprising multiple strategies and interventions is critical for achieving effective HIV prevention. Belgium's response to HIV builds on the achievements and lessons learned over the past decades and is shaped by emerging key challenges and opportunities.

Today, the HIV prevention toolbox is enlarged by biomedical tools such as Post-exposure Prophylaxis (PEP) for individuals who may have been exposed to HIV, treatment of PLWH to prevent sexual transmission (TasP) and recently the provision of Pre-exposure Prophylaxis (PrEP) for individuals at increased risk for HIV acquisition.

The utilisation of biomedical HIV prevention tools, although highly beneficiary, may also represent challenges as those tools need to be applied applied by people in specific community settings and contexts. That is why HIV prevention should evolve towards the best integration of these biomedical tools with the already existing prevention offer. Another element to take into account are the common modes of transmission of HIV and STI. This leads to overlaps in affected key populations and requires an integrated HIV and STI prevention approach.

Therefore, this HIV plan presents a renewed focus on combination prevention with an emphasis on structural prevention measures embedded within an overall sexual health approach. Primary prevention efforts should provide people and communities with adequate knowledge and skills to be in control of their sexual health including a fulfilled and pleasurable sexuality. Access to the means of prevention should be adapted to specific community settings and contexts, including the ones of young people. This will also require the removal of institutional or structural barriers such as HIV-related stigma to access the means of HIV and STI prevention.

Scientific and practice-based evidence show that subgroups within the population are differently affected by HIV and related STI. Therefore, the prevention priorities and actions in this plan emphasize groups who face greater risks and vulnerabilities. These groups include men having sex with men and people with a migrant background, in particular sub-Saharan African migrants. People who share several of these characteristics such as MSM with an ethnic minority background may be particularly vulnerable and affected by HIV [31].

[31] Bil JP, Zuure FR, Alvarez-del Arco D, Prins JM, Brinkman K, Leyten E, van Sighem A, Burns F, Prins M. Disparities in access to and use of HIV-related health services in the Netherlands by migrant status and sexual

Finally, established HIV/STI prevention strategies are currently challenged by recent trends in declining condom use and increasing rates in STI other than HIV [32] [33], and sexualized drug use [34]. Combination prevention addressing these new phenomena will be most effective when considering the contextual factors that shape individual behaviours and when reaching out to the populations at increased risk in their own social settings.

The planned actions will embrace as much as possible a participatory approach. This will allow for tailoring them meaningfully to people's needs. It will also determine their success.

Objectives and priority areas

The objective of the prevention pillar is to reduce the transmission risk of HIV and other STI in the general population and among key-populations in particular, by combining available prevention strategies and tools.

Scope

The prevention pillar aims to cover primary HIV and STI prevention within the broad context of sexual health promotion. It comprises the combination of prevention components such as information and education, behaviour change and structural prevention interventions. It builds on an inter-sectoral response between the health sector – including community health workers, HIV specialists, general practitioners and mental health providers – and professionals from the education, social welfare, migration and research sector. Although HIV/STI testing and treatment are clearly part of combination prevention for HIV, these will be dealt with in the sections 'Testing Pillar' and 'Care Pillar'.

Involved competencies

The responsibilities and competencies for primary prevention are located within the regional health authorities. Subsidies are mostly provided on a short- and longer-term basis to community-based organisations, who are the most important actors in implementing primary prevention activities. Moreover, the family planning centres in

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orientation: a cross-sectional study among people recently diagnosed with HIV infection. BMC infectious diseases. 2019 Dec 1;19(1):906.

[32] Holt M, Lea T, Mao L, Kolstee J, Zablotska I, Duck T, Allan B, West M, Lee E, Hull P, Grulich A. Community-level changes in condom use and uptake of HIV pre-exposure prophylaxis by gay and bisexual men in Melbourne and Sydney, Australia: results of repeated behavioural surveillance in 2013–17. The lancet HIV. 2018 Aug 1;5(8):e448-56.

[33] Vuylsteke B, Reyniers T, De Baetselier I, Nöstlinger C, Crucitti T, Buyze J, Kenyon C, Wouters K, Laga M. Daily and event-driven pre-exposure prophylaxis for men who have sex with men in Belgium: results of a prospective cohort measuring adherence, sexual behaviour and STI incidence. Journal of the International AIDS Society. 2019 Oct;22(10):e25407.

[34] Rosińska M, Gios L, Nöstlinger C, Berghe WV, Marcus U, Schink S, Sherriff N, Jones AM, Folch C, Dias S, Velicko I. Prevalence of drug use during sex amongst MSM in Europe: results from a multi-site bio-behavioural survey. International Journal of Drug Policy. 2018 May 1;55:231-41

Wallonia and Brussels are key stakeholders in the field of prevention. Local municipalities may also contribute to the financing of prevention activities.

Yet, PrEP and PEP service delivery is organised by the federal health authority and financed by RIZIV/INAMI.

True combination prevention calls for a multi-sectoral approach including – next to the public health sector – also social welfare agencies, education and migration agencies on the regional or local level.

Priorities

Through a participatory process, relevant stakeholders in the primary prevention field agreed on the following priority areas and actions.

Priority area 1: Increase awareness and knowledge on sexual health, including combination prevention of HIV and STI and risk reduction strategies

1.1 Inform and educate the general population on sexual health, including combination prevention of HIV/STI through sexual health education in schools and media campaigns
1.2 Inform and educate key-populations on sexual health, including combination prevention of HIV/STI through targeted initiatives and media campaigns
1.3 Update, develop and implement informative and educational tools on HIV/STI prevention and risk reduction for key-populations, including reduction of HIV-related stigma and discrimination

Priority area 2: Increase accessibility and uptake of HIV/STI prevention and risk reduction means for key-populations

2.1 Ensure wide distribution of free male and female condoms and lubricants in community settings for key-populations, e.g. in venues such as gay businesses and locations where sub-Saharan African migrants gather including community organisations, bars and churches.
2.2 Promote the availability, accessibility and uptake of PEP, PrEP and vaccination programs for HAV, HBV and HPV
2.3 Offer pathways to care and support for people who adopt chemsex practices
2.4 Increase access and uptake of HIV/STI prevention and risk reduction means by reducing barriers at structural, provider and user level
2.5 Assess how the location-population approach for HIV/STI prevention, in particular the UNAIDS fast-track city initiative, can be adopted and expanded in the Belgian context

Priority area 3: Expand and improve PrEP service delivery

3.1 Map current PrEP delivery practices and investigate innovative service delivery models, including the involvement of general practitioners and peers-led delivery models
3.2 Ensure that PrEP service delivery is combined with sexual health counselling, STI prevention, access to condoms and lubricants, regular STI testing and support in the context of chemsex
3.3 Increase the knowledge and awareness of PrEP by key populations and counter misconceptions and negative attitudes
3.4 Increase access and uptake of PrEP by key populations by reducing barriers at structural, provider and user level

Priority area 4: Enable healthcare providers and community health workers to support key-populations in the uptake of the means of combination prevention and risk reduction for HIV and STI

4.1 Increase knowledge and awareness of the available prevention methods including PEP, PrEP, TasP and entry-points to HIV/STI testing
4.2 Increase knowledge and awareness of problematic drug use, including chemsex and address it within a context of mental health and well being
4.3 Improve communication skills and intercultural competences to pro-actively address sexual health in general and HIV/STI prevention without stigma and discrimination
4.4 Increase inter-sectoral collaboration between health care providers and actors outside the health field (e.g. education, migration, social welfare) to improve combination prevention interventions including structural prevention
4.5 Integrate sexual health and combination prevention of HIV and STI in the curriculum of students in the medical and psycho-social field

Priority area 5: Develop (action) research on major health determinants and key-population's behaviour to inform evidence-based prevention interventions

5.1 Develop qualitative, quantitative, mixed-methods and participatory action-research on major health determinants and key population's risk and protective behaviour to inform HIV/STI prevention and sexual health promotion
5.2 Continue to develop and improve (behavioural) surveillance to monitor HIV prevention and sexual health promotion

2. TESTING PILLAR

General principles and background

A priority measure to impact on the HIV epidemic and related STI epidemics is to diagnose people as early as possible after acquiring infection and link them to appropriate prevention, treatment, care and support services. As recommended in international guidelines, the organisation of HIV/STI testing activities should be approached within a public health and human rights perspective. Testing should therefore be accessible, voluntary, confidential and contingent on informed consent.

In Belgium, a strategic mix of HIV/STI testing services within both healthcare and community facilities is provided. In addition, there are three low-threshold screening centres in Antwerp, Brussels and Liège which offer the possibility of free and anonymous HIV testing for populations at high risk [35]. Since 2016, non-medical providers are allowed, under certain conditions, to perform HIV rapid tests [36]. There is also the HIV self-test that can be purchased in Belgian pharmacies.

Belgium has no national HIV testing policy. In 2019, clinical guidelines have been developed on the diagnosis and management of gonorrhoea, syphilis and chlamydia in primary care [37]. To guide primary healthcare practitioners in offering HIV/STI testing, an interactive screening tool "Testing STIs in a sexual health consultation" has been issued [38]. Finally, there are the STI screening strategies within HRCs, both for PLWH as for PrEP users.

Compared to other European countries, Belgium has a relatively high and stable HIV testing rate with more than 700 000 HIV tests per year. In 2019, 1.2 new diagnoses have been established per 1000 tests. More than half of the HIV diagnoses were made by general practitioners, followed by internists and gynaecologists. For now, no national data are available on the contribution of community-based HIV testing to the

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[35] Koninklijk besluit tot vaststelling van de voorwaarden waaronder het Verzekeringscomité overeenkomsten kan sluiten tot regeling van de tegemoetkoming van de verplichte verzekering voor geneeskundige verzorging in de prestaties voor specifieke vormen van aidsbestrijding (KB van 6 maart 2017, gepubliceerd op 23 maart 2017)

[36] Koninklijk besluit houdende de toepassing van artikel 124, 1° van de wet van 10 mei 2015 betreffende de uitoefening van de gezondheidsberoepen teneinde een kader te scheppen voor de diagnostische oriëntatietests voor het humaan immuundeficiëntievirus (KB van 19 juli 2018, gepubliceerd op 19 september 2018)

[37] Jespers V, Stordeur S, Desomer A, Carville S, Jones C, Lewis S, Perry M, Cordyn S, Cornelissen T, Crucitti T, Danhier C, De Baetselier I, De Cannière A-S, Dhaeze W, Dufraimont E, Kenyon C, Libois A, Mokrane S, Padalko E, Van den Eynde S, Vanden Berghe W, Van der Schueren T, Dekker N. Diagnosis and management of gonorrhoea and syphilis. Good Clinical Practice (GCP) Brussels: Belgian Health Care Knowledge Centre (KCE). 2019. KCE Reports 310. D/2019/10.273/21. Available through: https://kce.fgov.be/sites/default/files/atoms/files/KCE_310_Diagnosis_management_Gonorrhoea_and_Syphilis_Report.pdf

[38] Jespers V, Stordeur S, Desomer A, Cordyn S, Cornelissen T, Crucitti T, Danhier C, De Baetselier I, De Cannière A-S, Dhaeze W, Dufraimont E, Kenyon C, Libois A, Mokrane S, Padalko E, Van Den Eynde S, Vanden Berghe W, Van Der Schueren T, Dekker N. Sexually Transmitted Infections in primary care consultations: development of an online tool to guide healthcare practitioners. Good Clinical Practice (GCP) Brussels: Belgian Health Care Knowledge Centre (KCE). 2019. KCE Reports 321. D/2019/10.273/60. Available through: https://www.sti.kce.be/en/

new diagnoses. Due to significant barriers to HIV testing and migration flows, many people living with HIV in Belgium are diagnosed late in the course of the disease (<350 CD4/mm3). At population level, late diagnosis is responsible for the existence of a "hidden" epidemic which drives the further spread of the epidemic.

Concerning the testing rate of STI, a rising trend can be observed. For chlamydia this raised from 30 tests per 1000 inhabitants in 2017, to 37 tests/1000 inhabitants in 2019 and for gonorrhoea from 25 tests/1000 inhabitants in 2017 to 35 tests/1000 inhabitants in 2019. In men, for chlamydia there was an increase from 12 tests/1000 inhabitants in 2017 and 17 tests/1000 inhabitants in 2019, for gonorrhoea from 12 tests/1000 inhabitants in 2017 and 21 tests/1000 inhabitants in 2019. For syphilis, the RIZIV/INAMI data also show a rising trend in the number of treponemal tests. These rising trends may be linked to more opportunistic and targeted testing for STI as well as the implementation of screening programs among risk groups such as MSM [39].

Objective

The objective of the testing pillar is to improve the frequency, regularity and targeting of HIV/STI testing in key populations in order to increase the rates of early diagnosis, improve early uptake of sustained treatment and prevent transmission.

Scope

The testing pillar aims to cover the full procedure from screening to an eventual HIV/STI diagnosis, including informed consent, counselling, partner notification and linkage to appropriate prevention care and support services.

Involved competencies

The responsibilities and competencies for HIV/STI testing are distributed over the federal and regional health authorities. The cost of the HIV tests that are prescribed by a medical doctor are reimbursed according to the rules of RIZIV/INAMI. The confirmation of reactive screenings tests is exclusively performed in the ARLs which are financed by RIZIV/INAMI. The cost for the STI tests is also reimbursed according to the rules of RIZIV/INAMI.

Furthermore, RIZIV/INAMI finances the three low threshold screening centres, and provides subsidies to HIV/STI testing programs for sex workers in Flanders, Brussels and Wallonia. The regional health authorities and the municipalities also contribute to the financing of these socio-medical health centres for sex workers.

The organisation of HIV/STI testing activities in community facilities is financed by the regional health authorities. It concerns mainly project-based funding for which the

[39] Vanden Berghe. W, De Baetselier. I, Van Cauteren. D, Moreels. S, Sasse. A, Quoilin. S. Surveillance van seksueel overdraagbare aandoeningen. Gegevens voor de periode 2014-2016. Brussel, België: Sciensano ; 2020. 26p. Depotnummer : D/2020/14.440/2

assignments are determined in periodic calls fitting within the regional policy framework concerning health promotion and prevention.

Priorities

Through a participatory process, relevant stakeholders in the testing field agreed on the following priority areas and actions.

Priority area 1: Increase awareness and knowledge of healthcare providers, community health workers and key-populations of the indications for HIV/STI testing

1.1 Update, develop and implement informative initiatives for healthcare providers and community health workers on the indications for HIV/STI testing
1.2 Promote existing HIV/STI testing guidelines and recommendations for testing in primary care, in particular the KCE guidelines on diagnosis and management of gonorrhoea syphilis and chlamydia in primary care, and the screening tool "Testing STIs in a sexual health consultation"
1.3 Establish collaboration networks for training of lay-providers in community settings
1.4 Inform and educate key-populations on the indications for HIV/STI testing

Priority area 2: Increase accessibility and uptake of HIV/STI testing and tailor the testing approaches and services to the specific needs of the key-populations

2.1 Maintain an updated inventory of all available entry-points to HIV/STI testing both within healthcare and community settings
2.2 Improve the communication skills and intercultural competences of healthcare providers - in particular general practitioners - and community workers to pro-actively offer HIV/STI testing
2.3 Guarantee access to free and anonymous HIV testing
2.4 Further develop the legal framework for lay provider combined HIV and STI testing
2.5 Provide self-sampling kits for HIV and STIs to people in groups and communities with a high rate of HIV
2.6 Collect data on the purchase of the HIV self-test to assess whether its use can be better supported and promoted
2.7 Assess how the location-population approach for testing, in particular the UNAIDS fast-track city initiative, can be adopted and expanded in the Belgian context
2.8 Establish, in collaboration with relevant policy makers, a comprehensive HIV/STI testing policy, covering the combination of all existing testing approaches

Priority area 3: Implement evidence-based tools to identify undiagnosed PLWH and to address gaps in testing and prevention

3.1 Combine existing knowledge of different disciplines on the dynamics of the epidemic and the underlying behavioural patterns

3.2 Use modelling estimates and evidence on transmission networks as a mean to identify undiagnosed PLWH
3.3 Develop and implement practical tools to enable healthcare providers - in particular general practitioners - and community workers to identify undiagnosed PLWH
3.4 Enhance the acceptability of HIV/STI partner notification in the different key-populations by reducing barriers at structural, provider and user level
3.5 Facilitate the implementation of tools for partner notification

Priority area 4: Ensure that all diagnosed people with HIV and other STIs are promptly linked to prevention, care and (peer) support services without exception

4.1 Implement initiatives and develop guidance to support healthcare providers - in particular general practitioners - and community workers in test result management, including the delivery of HIV diagnoses
4.2 Improve the communication and collaboration between testing, care and support services
4.3 Define clear referral pathways from testing to care

Priority area 5: Consolidate a harmonized data collection of community-based HIV/STI testing

5.1 Harmonize the data collection of community-based HIV/STI testing activities
5.2 Improve the data quality
5.3 Integrate all applicable data to produce a meaningful national dataset that captures the testing activities of the various organisations
5.4 Coordinate the consolidation of national data collection.

Priority area 6: Gather and disseminate data to evaluate current STI screening practices and treatment strategies for key-populations, including PrEP users and PLWH

6.1 Continue to develop and improve surveillance activities to monitor STI within key-populations, including PrEP users an PLWH
6.2 Improve the evidence basis and evaluate the aim and impact of STI screening and treatment practices
6.3 Follow the new developments in the field of STI (rapid) testing and evaluate the performance and applicability of these procedures and assays.

3. CARE PILLAR

General principle - background

Sustained high quality care for PLWH is necessary to reduce morbidity and mortality among PLWH, prerequisite to a good health-related quality of life and a better integration in active life. Uptake of ART also reduces onward transmission of HIV and hence supports control of the epidemic. Therefore, high quality care is considered a cost-efficient investment. Nowadays, the indicators on clinical care for HIV infection in Belgium are excellent. The current efforts should, however, be further supported to maintain the high-level clinical care and ensure those high standards for all PLWH, including hard-to-reach and vulnerable populations by lowering barriers to accessing care. Enhanced attention to psychosocial support is important to reach similar standards of excellence.

Objectives

The objectives of the third pillar are to guarantee high-quality multidisciplinary care for all PLWH and thereby to ensure better health and health-related quality of life for all PLWH and contribute to the control of the HIV epidemic in Belgium.

The specific objectives are
(1) to contribute to the improvement of the cascade of care by optimizing the steps related to the care of HIV, namely:

- Ensure timely access to HIV care for all diagnosed PLWH
- Ensure retention in care for all those entered in HIV care
- Ensure prompt access to ART for all those in care
- Ensure achievement of an undetectable VL for all those on ART

(2) to provide all PLWH the support to reach the best quality of life possible in terms of medical and psychosocial aspects.

In addition to the priorities for care listed below, an efficient national epidemiological and surveillance of clinical and psycho-social HIV activities should be supported as it is necessary to monitor the HIV care and health-related quality of life, as well as operational and clinical research to improve it.

Scope

This pillar on HIV care aims to cover medical and psychosocial care for PLWH from the diagnosis of the HIV infection to the achievement of an undetectable VL, with an additional focus on health-related quality of life along the continuum of care.

Involved competencies

The responsibilities and competencies involved to ensure medical treatment and care in HIV reference centres or other medical structures are mainly located within the federal authorities.

For HIV patients with who benefit from the national health insurance, the expenses for medical care are covered by RIZIV/INAMI. CPAS-OCMW and Fedasil cover the costs for non-insured HIV patients. The Federal Public Services of Interior Affairs & Public Health finances the medical care for incarcerated patients.

Priorities

Through a participatory process, relevant stakeholders in the HIV care domain agreed on the following priority areas and actions.

Priority area 1: Guarantee access to high quality care and ART for all the PLWH living in Belgium, independent of administrative status

1.1 Ensure that all diagnosed PLWH receive adequate information on HIV care and multidisciplinary support
1.2 Ensure that all diagnosed PLWH are timely referred to HIV care specialized practitioners for full assessment
1.3 Ensure that all PLWH living in Belgium benefit of prompt access to the most adequate ART
1.4 Substantially reduce the administrative barriers to access ART for PLWH in an asylum procedure or depending of urgent medical care
1.5 Provide access to HIV quality care for PLWH in prisons or other detention facilities
1.6 Provide access to HIV quality care for PLWH in centres for asylum seekers
1.7 Provide access to HIV quality care for PLWH in psychiatric centres, nursing homes, retirement homes or other long-term inpatient settings
1.8 Inform PLWH about the availability of peer support via patient organisations

Priority area 2: Guarantee retention in HIV care of all PLWH through patient empowerment and a collaborative approach with general practitioners and patient organisations

2.1 Ensure a systematic tracing of patients lost to follow up
2.2 Systematically assess with each new HIV patient how they can be reached in the event of missed appointments
2.3 Identify patients at higher risk of disengagement who should benefit of targeted support to be retained in care
2.4 Support (peer) education and empowerment of PLWH about their (HIV) care and the use of eHealth

2.5 Increase the knowledge and awareness of general practitioners on the HIV epidemic in Belgium, TasP, U=U and UNAIDS 95-95-95 targets and health related quality of life
2.6 Ensure clear channels of communication between HRCs and general practitioners and inform them on the multidisciplinary HIV care offer that is available within the HRCs

Priority area 3: Provide to all PLWH the most adequate and efficient ART tailored to their clinical situation and expectations in order to reach an undetectable viral load

3.1 Ensure that ART is prescribed in line with European guidelines (EACS), in partnership with each patient
3.2 Inform and train HIV care specialised practitioners on the best available evidence on ART prescription in order to develop and maintain excellent care for PLWH
3.3 Monitor the participation of the HRCs to the national HIV surveillance
3.4 Support operational and clinical research

Priority area 4: Guarantee optimal quality of care for PLWH within a holistic approach, including prevention and management of complications and comorbidities

4.1 Ensure the complementarity of the care provided by general practitioners and HRCs (for example vaccination, STI screening and treatment, drug interactions) by clarifying the tasks of general practitioners in HIV care
4.2 Ensure the availability and accessibility, including reimbursement, of vaccines for PLWH as recommended by the European guidelines (EACS)
4.3 Improve collaboration between HRCs and other specialists and ensure the coordination of multidisciplinary care for patients with comorbidities, with a special attention for ageing patients and their specific needs
4.4 Increase access to multidisciplinary support, in particular for partner notification, STI screening and treatment, sexual and reproductive health, mental health, drug addiction including chemsex, dietary requirements, smoking cessation and social support
4.5 Integrate measures of health-related quality of life and well-being in the HRC practice with the aim to identify, in collaboration with PLWH, potential areas for care improvement

4. QUALITY OF LIFE PILLAR

General principles and background

Since the introduction of antiretroviral treatment, the life expectancy of PLWH has increased significantly to levels that are equal to the expectancy of the general population, at least in countries like Belgium where optimal treatment and access to the treatment is available.

The quality and safety of the treatment have improved during the last decade compared to the earlier treatments since halfway 1995. Considerable progress has been made in achieving the original UNAIDS 90-90-90 targets; Belgium is now embracing the 95-95-95 targets. This medical progress equally improved the quality of life of PLWH. However, PLWH continue to face difficulties to reach and maintain a good quality of life, in particular those with a recent diagnosis and those ageing with HIV.

Receiving the HIV diagnosis remains a challenge in several regards and generally includes a period of personal crisis. Yet the long-term survivors often are confronted with multiple co-morbidities and as such healthy ageing entails specific needs. In this view, there are increasing calls to shift attention to quality of life of PLWH and to add a 4th target to the UNAIDS goals 'beyond viral load', which indicates that being virally suppressed is not the endpoint[40].

So far, there is no consensus definition of what constitutes quality of life for PLWH[41], nevertheless several studies indicate the main associated factors[42]. In addition to clinical factors such as viral load, medication side effects, drug interactions and co-morbidities, other physical and mental factors such as sleeping quality, healthy lifestyles, anxiety, depression are to be considered. Finally, social support, experiences of stigma and discrimination, socio-economic and legal factors need to be addressed to achieve and maintain a good quality of life. A recent survey on quality of life of PLWH in Flanders (N=505) revealed that 26% was ever diagnosed with a depression, 43% had weak social support, 41% indicated stigma as the main barrier to living well with HIV, and 65% ever experienced discrimination due to HIV[43].

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[40] Lazarus, J., Safreed-Harmon, K., Barton, S., Costagliola, D., Dedes, N., del Amo Valero, J., Gatell, J., Baptista-Leite, R., Mendão, L., Porter, K., Vella, S. & Rockstroh, J. (2016). Beyond viral suppression of HIV – the new quality of life frontier. *BMC Medicine, 14*:94.

[41] Cooper, V., Clatworthy, J., Harding, R., Whetham, J. & Emerge Consortium (2017). Measuring quality of life among people living with HIV: a systematic review of reviews. *Health and Quality of Life Outcomes, 15*:220.

[42] Degroote, S., Vogelaers, D. & Vandijck, D. (2014). What determines health-related quality of life among people living with HIV: an updated review of the literature. *Archives of Public Health 72*:40.

[43] Scheerder, G., Van den Eynde, S., Reyntiens, P., Koeck, R., Deblonde, J., Ddungu, D., Florence, E., Joosten, C., Van Wijngaerden, E. & Dewaele, A. (2019). *Quality of life in people living with HIV: a regional survey in Flanders.* Poster presented at the 17th European AIDS Conference (EACS), Basel.

The quality of life pillar proposes and supports initiatives that improve the quality of life, including healthy lifestyles and a healthy sexual life, of PLWH. The connection with other pillars and the Positive Council within the HIV plan is obvious: people that receive optimal treatment and are retained within care, will also have higher chances for a good health. Good psychological support will help to better cope with HIV. Optimal treatment also makes PLWH less likely to transmit HIV, which supports a better sexual life and reduces the stigma of PLWH.

Those PLWH living in vulnerable conditions, such as migrants, asylum seekers, transgender people and people who inject drugs, still face higher risks of suboptimal treatment and care due to multiple barriers. The quality of life pillar invests in ameliorating the situation of those in need, not only by supporting them individually, but also by advocating for structural and legal changes that will ensure equal access to care.

Care and support within – but also outside – the clinical setting are fundamental for a good physical and mental health. Continued efforts are needed to avoid and prevent mental health problems, as well as to adopt a healthier lifestyle, considering for example the elevated use of tobacco, alcohol and drugs by PLWH. Hence it is crucial to optimally link support in between these settings. Training and capacity building of community health workers contributes to a better support of PLWH and helps them to better cope with their status. A variety of initiatives may be envisaged including thematic information sessions, peer support weekends, development of educational materials for PLWH, culturally adapted information for migrants.

Stigma and discrimination remain an important barrier for the quality of life of PLWH. According to the survey in Flanders, stigma was strongly related to negative self-image, coping with HIV and social support. Nearly half experienced internalised stigma (self-stigma) that withholds them for example from engaging in a relationship. Discrimination is reported most frequently with new (sex) partners, but also one in three encountered discrimination in general healthcare. Support is expected from those living nearby the PLWH, such as partners, relatives and friends but also from health care providers, employers, other service providers and peers. Tackling stigma within society at large, but also within the healthcare sector, as well as self-stigma, are therefore priorities within the quality of life pillar.

Finally, structural barriers and discriminatory measures that obstruct an active participation in society, such as restrictions to access insurance, housing and employment must be addressed. In line with other chronic diseases, efforts should be made to facilitate optimal (re-)integration in society, particularly in the working environment and with attention to the needs and capacities of those involved.

Objective

The objective of the quality of life pillar is to guarantee that all PLWH are able to achieve an optimal quality of life, including mental health and social support, within an environment that is free from stigma and discrimination in all aspects of their daily life.

Scope

The quality of life pillar aims at improving the overall quality of life of PLWH throughout their lifespan, with specific focus on the reduction of stigma and discrimination, removing barriers to access support and care services, vulnerable populations, healthy lifestyles, sexual health and (mental) wellbeing. This to meet the full needs of people living with HIV and a good health-related QoL.

Involved competencies

The responsibilities and competencies involved to ensure the quality of life of PLWH are mainly located within the regional health authorities as they concern prevention and wellbeing.

The fight against discrimination amongst other in the workplace, school, housing requires a cooperation between the federal government and the regional authorities for equal opportunities.

The fight against discrimination in the field of insurance - requires a cooperation between the federal authority for public health and the federal authority for economic affairs, in particular consumer protection.

Work is an important guarantee against poverty and promotes social welfare. The policy of return to the labour market and socio-professional reintegration is the result of the joint efforts of the federal authority for social affairs and the federal authority for employment and labour.

Priorities

Through a participatory process, PLWH and relevant stakeholders in the field agreed on the following priority areas and actions.

Priority area 1: Empower PLWH to make healthy lifestyle choices, enjoy a healthy (sexual) life and assert their rights

1.1 Improve the knowledge and awareness of PLWH on TasP, U=U, vaccinations, management of HIV and related comorbidities
1.2 Update, develop and implement informative and educational tools for PLWH, with a special focus on healthy lifestyle including impact of drug use, smoking cessation and physical exercise
1.3 Develop and implement initiatives addressing mental health and emotional well-being for PLWH with a special focus on the needs of an ageing population
1.4 Develop and implement initiatives that assist PLWH to cope with HIV, challenge (self-) stigma and discrimination, and build resilience

1.5 Increase the social support of PLWH through contact with peer groups and the enlargement of social networks
1.6 Enable PLWH, regardless of their administrative status, to take legal action against discriminatory treatment

Priority area 2: Ensure that health care providers, community health workers and patient organisations are sensitive and responsive to the needs of PLWH

2.1 Increase the knowledge and awareness of the care providers to deliver appropriate services that address the care and support needs of PLWH, particularly those in greater vulnerability
2.2 Define, in collaboration with all stakeholders including PLWH, a pathway of integrated care and support to improve physical and mental health of PLWH within an holistic approach
2.3 Support the capacity and role of community workers and patient organisations to provide education, prevention, support and advocacy services to PLWH
2.4 Review and streamline referral pathways, particularly those to support services outside the clinical settings, proposed by health care providers and community workers so that they reflect the needs and choices of PLWH
2.5 Increase the knowledge and awareness of healthcare providers in non-HIV-specific care settings so that they provide general health care services to PLWH free from stigma and discrimination
2.6 Reduce barriers and improve preparedness of retirement homes and other residential services to adequately respond to the specific needs of PLWH within these settings

Priority area 3: Ascertain that all PLWH achieve an optimal quality of life, free from stigma and discrimination

3.1 Promote a non-discriminatory environment for PLWH through informative and educational initiatives that normalize HIV and reduce stigma in society
3.2 Strengthen advocacy for non-discriminatory legislation and policies with regard to PLWH, particularly in the domains of access to care, employment, insurance, and housing
3.3 Report and challenge laws and policies that contain a discrimination of PLWH
3.4 Develop and implement initiatives that reduce structural stigma and discrimination and minimise the impact on people's health seeking behaviour and health outcomes
3.5 Enlarge the scope of the Law from the 4th of April 2019 so that PLWH are covered by "the right to be forgotten" in the context of certain insurance contracts
3.6 Ensure an enabling environment to facilitate, as for other chronic disease patients, the (re)-integration of PLWH in the working environment through programs such as weeraandeslag.be /jeveuxreprendre.be

3.7 Continue the fight against the criminalisation of HIV transmission by normalising HIV and disseminating the increasing evidence of TasP and U=U

3.8 Evaluate health-related quality of life and well-being of PLWH based on validated and sustainable assessment tools implemented within the HRC practice

VI. Monitoring of the implementation of the HIV Plan

1. Monitoring bodies

Monitoring Committee

The Monitoring committee has been established by the Inter-ministerial Conference of Public Health on the 24th of February 2014. It has been created based on action 54 from the HIV Plan 2014-2019 in order to support the monitoring of the implementation of the HIV Plan.

Together with the Positive Council, representatives of the prevention, testing, care and quality of life pillars of the HIV Plan constitute the permanent structure of the Monitoring Committee.

Throughout the past years, the Monitoring Committee used the HIV Plan 2014-2019 as a policy framework to communicate with the health authorities. Bi-annual meetings were organised to exchange on the recent developments in the HIV-field in Belgium. Annually, a short-list of priorities was proposed and advocated for.

Mission statement

The Monitoring Committee aims 1/ to monitor the progress made in the implementation of the HIV Plan and 2/ to reach out to involved health authorities both at the federal and regional level, in the realisation of the priorities and actions of the HIV Plan

The Monitoring Committee will achieve those goals through actions in the following domains:

- Organize at least two annual exchange meetings with representatives of each pillar and the Positive Council
- Propose an annual action plan
- Reach out to other involved policy partners
- Advocate for policy initiative in the realisation of the actions of the HIV Plan
- Monitor the follow up of actions of the HIV Plan by making use of monitoring indicators
- Analyse and review data, including the continuum of care by key-populations and geographic regions, to identify gaps and to propose adjustments in the response where needed

Positive Council

The Positive Council is a consultative body for PLWH as established by the Inter-ministerial Conference of Public Health on the 24th of February 2014. Since its establishment, the Positive Council is a permanent member of the Monitoring Committee.

It is entitled to provide expert advice, upon request or upon its own initiative, on any topic that concerns PLWH as for example medical treatment and follow-up, support, quality of life and well-being, education, legal context, socio-economic barriers and promotion of HIV research.

Despite the lack of operational and staff funding, the Positive Council has been very active. Throughout the past years, the Positive Council has been consulted by the Ministry of Health. At the occasion of the discussions regarding the new convention between INAMI/RIZIV and the HRCs (2018), the Positive Council provided input concerning the needs and concerns of PLWH.

In order to carry out its mission, the Positive Council needs support and collaboration from the different stakeholders involved in the response to HIV in Belgium. The expectation is that the Positive Council is consulted and involved whenever it is appropriate according to the MIPA principle.

Mission statement

The Positive Council aims 1/ to guarantee the meaningful involvement of PLWH at all the levels that concern them, 2/ to add the patient's perspective to the expertise of healthcare providers, community health workers and other professionals and 3/ to act as a consultation board for policy makers, patient organisations, community organisations, key-populations and the Monitoring Committee.

The Positive Council will achieve those goals through actions in the following domains:

Concertation

1.1 Consider the broad diversity of the PLWH community
1.2 Ensure communication with and consultation of PLWH through annual meetings and a consultation platform
1.3 Offer individual support to PLWH and take on a mediator's role whenever needed
1.4 Establish regular interaction with the array of patient organisations and community organisations
1.5 Maintain and increase contact with HRCs and policy stakeholders on a regular basis and whenever necessary

Collaboration

2.1 Reinforce the collaboration with the Monitoring Committee in order to ensure the involvement of the Positive Council in the implementation of the HIV plan
2.2 Embed the advisory activities of the Positive Council within the working procedures of the Monitoring Committee

Consultation

3.1 Liaise with HRCs to improve the referral pathways to support services so that they reflect the needs of PLWH and include peer-to-peer-referrals
3.2 Support the development of a monitoring tool to evaluate the implementation of the HIV Plan and ensure the integration of the PLWH's perspective

2. Monitoring indicators

The HIV plan will only have an impact on the HIV epidemic and the lives of PLWH if the proposed actions are implemented. To know if the implementation of the actions listed in the plan is effective, they have to be monitored.

Monitoring indicators will support measuring the progress towards reaching the plan's targets. The proposed indicators are a mixture of process and outcome measures. They are key indicators to be used at national level when possible, but also at regional or local level when more feasible. The estimation of those indicators might be based on reorganisation, triangulation and strategic use of indicators and data that already exist. The monitoring is a dynamic process and additional or alternative indicators might appear relevant whilst the plan is rolled out.

Targets	Monitoring indicators	Potential source of information
Increase the number of people from key populations informed about existing prevention measures towards HIV and STI	Proportion of target population informed on existing prevention measures towards HIV and STI	Surveys among key populations (for example EMIS[44], PROMISE[45])
Increase the number of people who receive prevention services (including condom use, counselling on risk reduction strategies, chemsex, HIV testing)	Number and proportion of target population who receive prevention services	Surveys among key populations (for example EMIS, PROMISE) Activity reports of community based organisations
Ensure that all people at high risk of HIV acquisition have access to PrEP	Number and proportion of people at high risk of HIV acquisition who receive PrEP	Surveys among people at high risk (for example PROMISE) National surveillance data on PrEP combined with estimate of number of people at high risk
Ensure that all care providers receive training on combination prevention tools and up-to-date socio-epidemiological information on HIV to support testing	Number and proportions of health care providers who receive training on combination prevention tools.	Audit of the training of physicians Monitoring of HIV & STI sessions organized in GP groups

[44] http://sigmaresearch.org.uk/projects/item/project76

[45] https://promise-prep.be/en/home-en/

Reach 95% of PLWH knowing their status by 2025 *(first UNAIDS target for the continuum of HIV care)*	Number and proportion of diagnosed and undiagnosed PLWH living in Belgium	Back-calculation estimates based on the national HIV surveillance data
Reduce the number of HIV infections diagnosed late	Number and proportion of late HIV diagnoses	National HIV surveillance data
Ensure that undiagnosed most-at-risk / key populations are reached by community HIV testing	Number and proportion of reactive tests and confirmed new HIV diagnoses among the tests performed in community facilities	Surveillance of testing activities provided by community based organisations (COBATEST[46] = network of community based testing services)
Ensure access of PLWH and PrEP users to regular STI screening	Proportion of PLWH and PrEP users screened for STIs according to the guidelines	National HIV surveillance data
Ensure prompt linkage to HIV care following diagnosis and subsequent retention in HIV care	Proportion of patients diagnosed with HIV who are linked to HIV care	National HIV surveillance data
	Proportion of people who interrupt HIV care (excluding patients who died or transferred out or migrated)	National HIV surveillance data
Ensure that 95% PLWH diagnosed with HIV receive ART by 2025 *(second UNAIDS target for the continuum of HIV care)*	Proportion of patients diagnosed with HIV who receive ART	National HIV surveillance data
Ensure that more than 95% of PLWH on ART reach undetectable VL by 2025 *(third UNAIDS target for the continuum of HIV care)*	Proportion of patients on ART who reach undetectable VL	National HIV surveillance data
Ensure that tools to monitor patients' health-related QoL are developed and implemented in HIV care settings	Documented evidence of development of QoL monitoring tools	Reports and communications on QoL monitoring tools in HIV care settings
	Proportion of patients in care who are assessed for health-related QoL	PROMs measures
Ensure that all PLWH have access to peer support through patient	Documented evidence of referral pathways to peer support in the domains of	Reports from support and patient organisations PREMs measures

[46] https://cobatest.org/

organisations according to their needs	prevention, testing, care and QoL	
Reduce stigma and discrimination against PLWH	Proportion of PLWH reporting stigma or discrimination	Surveys among key populations Official complaints and legal actions