SPECIAL REPORT

Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2010 Progress Report

Summary

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Summary

The full report ‘Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2010 progress report’, of which this is a summary, is also published by ECDC.

The report was coordinated by Teymur Noori (ECDC). ECDC is particularly grateful to the members of the advisory group, participants in the workshop held in Stockholm in June 2009 and all those who contributed to country responses, for making this report possible.

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Contents

Abbreviations

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ECDC	European Centre for Disease Prevention and Control
EFTA	European Free Trade Association
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
HIV	Human immunodeficiency virus
IDU	Injecting drug users
M&E	Monitoring and evaluation
MSM	Men who have sex with men
OST	Opioid substitution therapy
PLHIV	People living with HIV
STI	Sexually transmitted infections
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organization

EXECUTIVE SUMMARY

In 2004, high level representatives of European and central Asian countries issued the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and central Asia. One of its actions called on the European Union and other relevant regional institutions and organisations, in partnership with the Joint UN Programme on HIV and AIDS (UNAIDS), to establish forums and mechanisms to closely monitor and evaluate the implementation of the Declaration's actions. This report provides a brief summary of findings from a review of progress made towards implementing the Dublin Declaration. It is based on data from 49 countries and reflects the contributions of a wide range of individuals and organisations.

Political leadership and partnership

HIV is a political priority for the European Union and countries of Europe and central Asia. This has been reflected in a number of declarations during the past decade. The high priority given to HIV is also reflected in European Commission policies and plans, including the Communication on Combating HIV/AIDS in the European Union. The Commission has recently issued a follow-up Communication and accompanying Action Plan for the period 2009–2013.

At the national level, almost all countries report having a strategic framework for their response to HIV (92%) and a management/coordination body (84%). Eight countries reported that they had developed their strategic frameworks in the last five years, i.e. since the Dublin Declaration. However, it is unclear whether these generic measures are appropriate proxies for political leadership on HIV in the region. More appropriate measures might be:

- the degree to which financial resources for HIV prevention are appropriately targeted on key populations, such as injecting drug users (IDU), men who have sex with men (MSM) and sex workers (see Section 1.3);
- the extent to which countries are implementing key interventions, such as harm reduction programmes for IDU (see Section 2.2) and prevention programmes for MSM (see Section 2.3) on a sufficient scale; and
- the extent to which countries have tackled difficult but essential policy issues, such as the provision of harm reduction programmes for IDU in prison settings (see Section 2.6), access to services for migrants from countries with generalised HIV epidemics (see Section 2.5) and creating a supportive policy environment for work with MSM (see Section 2.3).

In general, there is evidence that civil society is recognised as an important player in the response to HIV across the region and that it is heavily involved in that response. Almost all countries (98%) reported involving civil society to some extent in developing their strategic framework. Both government and civil society reported specific benefits of including civil society in HIV responses, and civil society commented that the context for their involvement in responses improved between 2005 and 2007. Information on involvement of the private sector in responses to HIV is more limited.

HIV epidemics in Europe and central Asia are largely concentrated among specific populations. There is evidence that some countries in the region are effectively focusing their funding for prevention efforts on the most affected populations (see Section 1.3, Figure 5). However, doing this more would not only ensure better value for money but would result in a more effective response overall. Although financing for national HIV responses in the region is coming increasingly from domestic sources, ongoing financial support for HIV responses in the low- and middle-income countries of the region is likely to be needed for the foreseeable future (see Figure 6). Given the global financial crisis, the increased focus on the poorest countries with the largest burden of HIV infection and the increasing focus on strengthening health systems, low- and middle-income countries in the region are concerned about the likelihood of current funding streams (such as those from the Global Fund) to these countries being sustained.

There has been an almost fivefold increase in funds available for the global response to HIV since the Dublin Declaration (see Figure 7). Prior to the Declaration, in 2002, resources available for the global response to HIV were $1.2 billion. These rose more than sixfold to $7.7 billion in 2008. This increase has been driven by the US and several European countries, through both bilateral and multilateral initiatives. In 2008, 40% of all disbursements for international AIDS assistance from donor countries came from European Union Member States, European Free Trade Association (EFTA) countries and the European Commission. Given the current global financial crisis and competing priorities for funding, it could be challenging for European countries and institutions to maintain and further increase these levels of funding.

Prevention

There is strong evidence that certain key populations are particularly affected by HIV in Europe and central Asia. It is well known that IDU (see Section 2.2) are particularly vulnerable to HIV infection and this is certainly the case across the region (see Figure 14). Evidence from many countries shows that HIV transmission among IDU can be

controlled if effective services are provided on a sufficient scale to make a difference. Key measures include the number of needles/syringes distributed per IDU per year and the percentage of IDU receiving opioid substitution therapy. There is a need for all countries to aspire to the high levels of programme coverage that have already been achieved by some.

It is well known that MSM (see Section 2.3) have been particularly affected by HIV in certain countries and regions, including parts of Europe. MSM are particularly affected by HIV not only in the western part of the region (see Figure 16), but there is also evidence that they are more affected than previously recognised in other parts of the region and that, in some countries, infection rates among MSM are continuing to rise. Although it is not clear how coverage of programmes for MSM can be precisely measured, it can nevertheless be seen that coverage remains low in many countries and rates of unprotected anal sex remain unacceptably high among some MSM. There is also evidence from some countries that particular groups of MSM – the young, those outside capital cities, those who are less well educated and those who identify themselves as bisexual – are less likely to be reached by HIV programmes.

Although sex workers (see Section 2.4) are seen as being particularly at risk of HIV infection globally, there is less evidence that this is the case in the region. For example, HIV prevalence rates among sex workers are relatively low in many countries (see Figure 18). However, this is not true of all sex workers. Some categories of sex workers have higher rates of HIV infection, including those who also inject drugs, male and transgender sex workers, those from countries with generalised epidemics and those who work on the street. Among sex workers as a whole, reported rates of condom use during commercial sex are relatively high and probably more relevant than generic measures of knowledge and programme coverage.

Migrants (see Section 2.5), particularly those from countries with generalised HIV epidemics, are especially affected by HIV (see Figure 21). Although some countries are concerned about other groups of migrants, such as those from other European countries, there is little evidence that these groups are disproportionately affected by HIV, independent of other risk behaviours such as injecting drug use. Issues relating to migrants do not only relate to HIV prevention but also arise in relation to treatment and care (see Section 3.1). There are particular issues, in many countries, relating to the access of undocumented migrants to critical services, such as antiretroviral therapy (ART).

Prisoners (see Section 2.6), especially those that inject drugs, are also highly vulnerable to HIV infection in the region. Although the same HIV services should be available in prisons as in the community, this is not the case in many countries of the region. EU/EFTA countries have demonstrated a strong lead in providing opioid substitution therapy in prisons (see Figure 23), but this approach has not been taken up in many other countries of the region and has not been reflected in the provision of sterile injecting equipment in prison settings (see Figure 23).

The extent to which young people in general (Section 2.7) are vulnerable to HIV infection in countries of the region proved to be a contentious issue for this review. However, it is clear that young people cannot be considered a homogeneous group in terms of HIV risk. Some are at significant risk, e.g. young IDU and young MSM and there is some evidence that programmatic responses are less able to reach these groups than older age groups. Although more than three quarters of countries reported that HIV education is part of the curriculum in secondary schools, comprehensive sexual health education is not available for all young people in the region, particularly for the youngest, e.g. in primary schools.

Living with HIV

All countries with trend data available reported an increase in the number of people on ART (see Figure 25) since the Dublin Declaration was adopted. In some countries, e.g. Estonia, Russia and Ukraine, these increases have been considerable. However, there are concerns about the low base from which these countries started and whether or not all those who need treatment receive it promptly. Current medical evidence indicates that all people living with HIV with a CD4 count < 350 cells/mm^3 should be receiving ART. The issue is not really one of access to treatment for those who have been diagnosed as HIV-positive and have been shown to need treatment. Rather, the issue relates to late diagnosis, i.e. those who need treatment but have not yet been diagnosed. ECDC data for 2008 show that in reporting countries more than half of those who had a CD4 count had a CD4 count of < 350 cells/mm^3 when diagnosed (see Figures 26 and 27). This is a concern because these people start ART later than recommended.

Almost all countries (84%) report that stigma and discrimination is addressed in national strategies or action frameworks for HIV and AIDS, but this is not consistently reflected in policies and programmes (see Figure 30). There is also strong evidence of residual stigmatisation and discriminatory attitudes in countries of the region and the extent to which available mechanisms, such as relevant laws and policies, are used to combat stigma and discrimination is unclear.

Monitoring the Dublin Declaration

As mentioned above, this report embodies the commitment to monitor the implementation of the Dublin Declaration. Two of the principles followed in compiling it have been, first, using existing data and indicators wherever possible and, second, ensuring that indicators being tracked are relevant to the context of European and central Asian countries. At times, there has been tension between these principles, particularly over the extent to which UNGASS indicators and data can be used for the process.

UNGASS indicators have been used wherever possible. Where countries previously submitted data for UNGASS this has been used. Data was received from 12 countries that did not submit reports to UNGASS in 2008.The review specifically allowed countries to submit available data for particular topics even if it did not correspond exactly to UNGASS indicators. In addition, information has been collected for some population groups for whom there are no specific UNGASS indicators, e.g. prisoners and migrants from countries with generalised epidemics. One of the conclusions of the review is that more relevant data could be collected and higher response rates achieved if UNAIDS adopted a regional approach to UNGASS reporting in Europe and central Asia. ECDC is committed to play a leading role in such a regional process.

BACKGROUND

In 2004, high level representatives of European and central Asian countries issued the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and central Asia. One of its actions called on the European Union and other relevant regional institutions and organisations, in partnership with the Joint UN Programme on HIV and AIDS (UNAIDS), to establish forums and mechanisms to closely monitor and evaluate the implementation of the Declaration's actions. This report provides a brief summary of findings from a review of progress made towards implementing the Dublin Declaration. It is based on data from 49 countries and reflects the contributions of a wide range of individuals and organisations.

The European Commission mandated the European Centre for Disease Prevention and Control (ECDC) to monitor progress on a regular basis. This report documents progress using country-based reports, against a selected number of indicators of relevance to the countries of the region. It uses existing data, where possible, and builds on previous work, including the first progress report[1], published in 2008 by the World Health Organization (WHO) Regional Office for Europe and UNAIDS, with funding from the German Ministry of Health. The review was conducted between November 2008 and June 2010.

Methodology

ECDC established an advisory group, consisting mainly of country representatives, which met four times. A framework was developed based on thematic areas identified in the first progress report. A total of 38 indicators were identified for inclusion. Countries were requested to provide available data on these indicators using a questionnaire designed specifically for that purpose. Where countries had previously reported relevant data, e.g. to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) or as part of the process to monitor the UN General Assembly Special Session (UNGASS) Declaration of Commitment, they were not asked to do this again.

A training and orientation workshop was held at ECDC in Stockholm from 16 to 18 June 2009. This was attended by representatives from 33 European and central Asian countries. Following the workshop, tailored questionnaires were sent to 55 countries. Responses were received from 49 countries, including from 12 countries that did not submit returns to UNGASS in 2008.

Overview of the HIV epidemic in the region

HIV infection remains an important public health issue in Europe, with no signs of a decrease in the overall number of newly diagnosed cases of HIV infection. Since 2000, the rate of newly diagnosed HIV cases reported has more than doubled from 44 per million population in 2000 to 89 per million in 2008, based on the 43 countries that have consistently reported HIV surveillance data during this period. This is particularly due to increasing infection rates in the eastern part of the region.

In 2008[2], 51 600 newly diagnosed cases of HIV infection were reported by 49 countries in Europe and central Asia[3]. The highest rates were reported from Estonia, Latvia, Kazakhstan, Moldova, Portugal, Ukraine and the United Kingdom (see Figure 1). In the same year, EU/EEA countries reported 25 656 newly diagnosed cases of HIV infection[4], with the highest rates reported by Estonia, Latvia, Portugal and the United Kingdom.

In 2008, 7 565 cases of AIDS were reported by 47 countries[5]. While the number of AIDS cases has declined overall, from 12 072 cases in 2000, the number is increasing in the eastern part of the region.

[1] WHO Regional Office for Europe/UNAIDS. Progress on Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia. Copenhagen: WHO Regional Office for Europe; 2008.

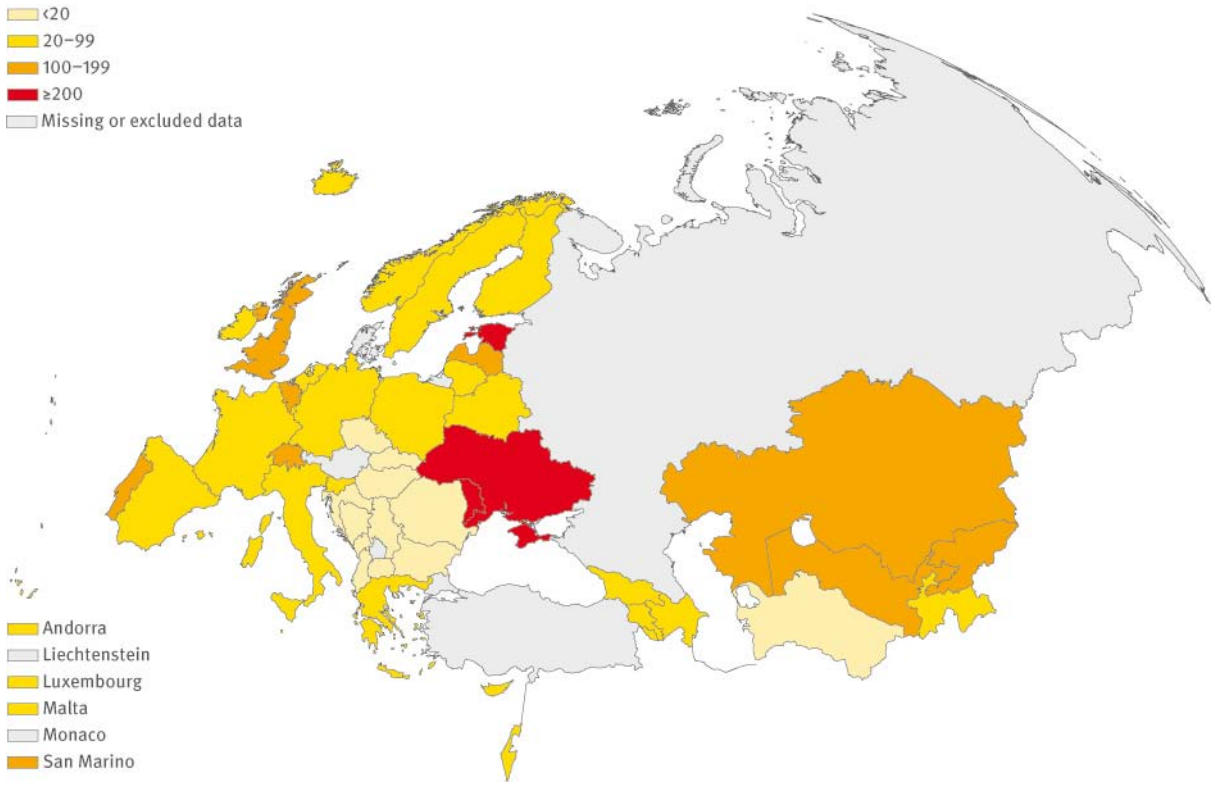
[2] Data on HIV/AIDS for 2008 are taken from: ECDC/WHO Regional Office for Europe. HIV/AIDS Surveillance in Europe 2008. Stockholm; 2009.

[3] Data not available from Austria, Denmark, Liechtenstein, Monaco, Russia or Turkey.

[4] Data not available from Austria, Denmark or Liechtenstein.

[5] Data not available from Denmark, Kazakhstan, Liechtenstein, Monaco, Russia, Sweden or Turkey.

Figure 1: HIV infections newly diagnosed per million population reported for 2008



Source: ECDC/WHO Regional Office for Europe. HIV/AIDS Surveillance in Europe 2008

In EU/EEA countries, the highest proportion of the total number of HIV cases was diagnosed among men who have sex with men (MSM). Among injecting drug users (IDU), there seems to be a general decline in the number of HIV diagnoses. However, this is still the predominant transmission mode in the Baltic countries. Despite the relatively low absolute number of cases diagnosed in these groups, IDU and MSM are disproportionately affected by the HIV epidemic compared with the heterosexual population because of the relatively small sizes of the populations and the high prevalence of HIV in these groups. Around 40% of cases of heterosexual transmission were diagnosed in individuals originating from countries with generalised epidemics who may have been infected outside of Europe. These cases influence the nature of the HIV epidemics in Europe.

In countries in the centre of the region, levels of HIV remain low and stable, although there is evidence of increasing sexual (both heterosexual and homosexual) transmission in many countries. The nature of the epidemic in this region is diverse, with sexual transmission among MSM dominating in some countries.

In countries in the east of the region, the number of HIV cases has increased substantially. This is mainly driven by an increase in cases acquired through injecting drug use. Among IDU in the east of the region, the number of cases of HIV infection has increased in almost all countries.

1 LEADERSHIP AND PARTNERSHIP

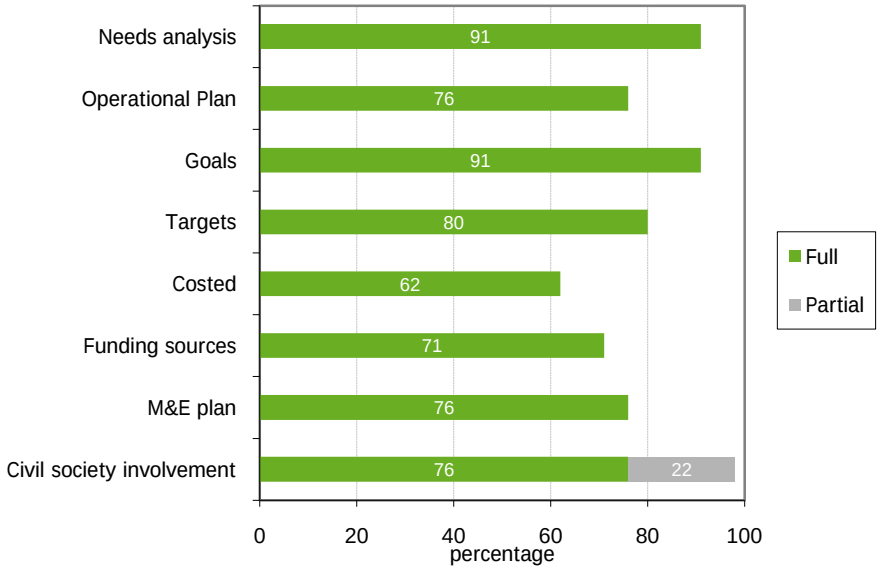
1.1 Political leadership: planning and coordination

Strong and effective political leadership is absolutely vital for an effective HIV response. This is particularly true in countries where marginalised populations, such as IDU (Section 2.2), MSM (Section 2.3), sex workers (Section 2.4), migrants from countries with generalised epidemics (Section 2.5) and prisoners (Section 2.6) are disproportionately affected by HIV. So, it is important that effective political leadership can be identified and recognised.

Countries in the region score highly on international measures used to gauge political leadership. Almost all countries report having a strategic framework for their response to HIV (92%) and a management/coordination body (84%). Several countries had developed their strategic frameworks (eight) or introduced management/ coordination bodies (nine) since the Dublin Declaration was made.

Almost all country frameworks (91%) were based on a needs assessment and include a clear statement of goals. Just over three quarters (76%) include operational and monitoring and evaluation (M&E) plans. However, less than three quarters (71%) of these frameworks have identified funding sources and less than two thirds (62%) are costed (see Figure 2). In general, the findings indicate that strategic frameworks have not been consistently translated into operational plans, M&E plans and budgets.

Figure 2: Percentage of countries in Europe and central Asia reporting particular features in their strategic framework for their national response to HIV



There are similar issues with management/coordination bodies. Although almost all have terms of reference (95%), active government leadership and participation (93%) and a functioning secretariat (88%), fewer have an action plan (68%) and less than two thirds (61%) have quarterly meetings, which raises questions about the extent to which these bodies function in practice.

All but one of the responding countries had involved civil society in the development of their strategic framework. Over three quarters (76%) had done this fully and 22% had done this partially (see Figure 2). Similarly, almost all countries (83%) included people living with HIV (PLHIV) and civil society in their management/coordination body. In contrast, the proportion (29%) of such bodies that involve the private sector is low. The high rate of involvement of civil society in these processes and structures is positive.

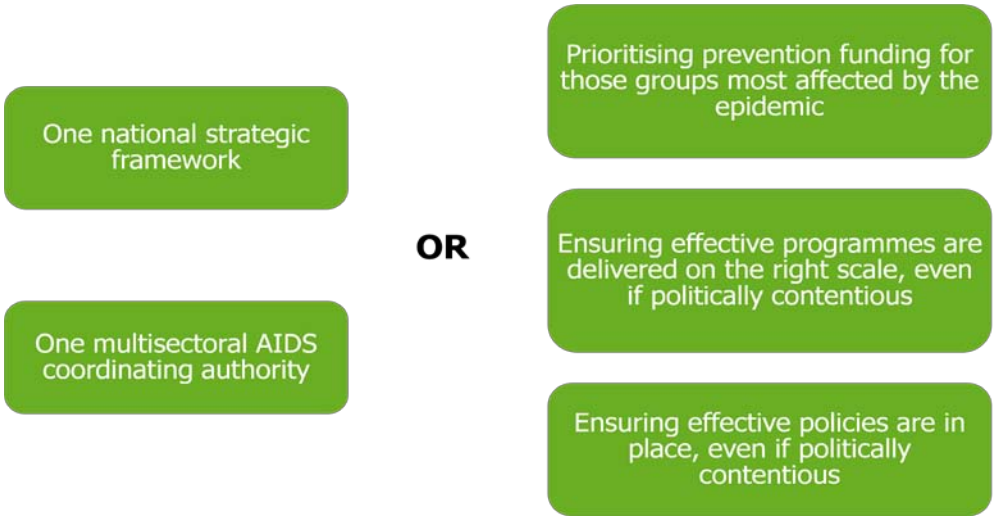
The biggest question though is about the relevance of these proxy measures of political leadership for the region (see Figure 3). Given that almost all countries in the region have these frameworks and coordinating bodies, does this mean that political leadership is equally good across all countries? Or does political leadership vary between countries? If it does vary, how can strong and effective political leadership be recognised? Evidence from this review indicates that stronger and more discerning measures of political leadership might be:

- the extent to which HIV prevention funding is prioritised towards those sub-populations most affected by HIV in a country (see Section 1.3);
- the extent to which essential programmes are delivered at scale, even if, as for harm reduction programmes among IDU, they are politically contentious;

- the extent to which effective policies are in place, even if, as for non-discriminatory policies for MSM and provision of harm reduction services in prisons, they are politically contentious;
- the extent to which countries are providing antiretroviral therapy (ART) coverage for key populations, particularly IDU, migrants and prisoners (see Section 3.1).

This review argues that it is by taking bold and decisive measures to control its HIV epidemic that a country demonstrates its political leadership, rather than by having a well crafted framework and a well constituted coordination body. This does not mean that these things are unimportant or that countries should abandon them. Rather, that they are not effective proxy measures of political leadership.

Figure 3: What is political leadership?



In conclusion, ECDC has identified the following issues that need further action:

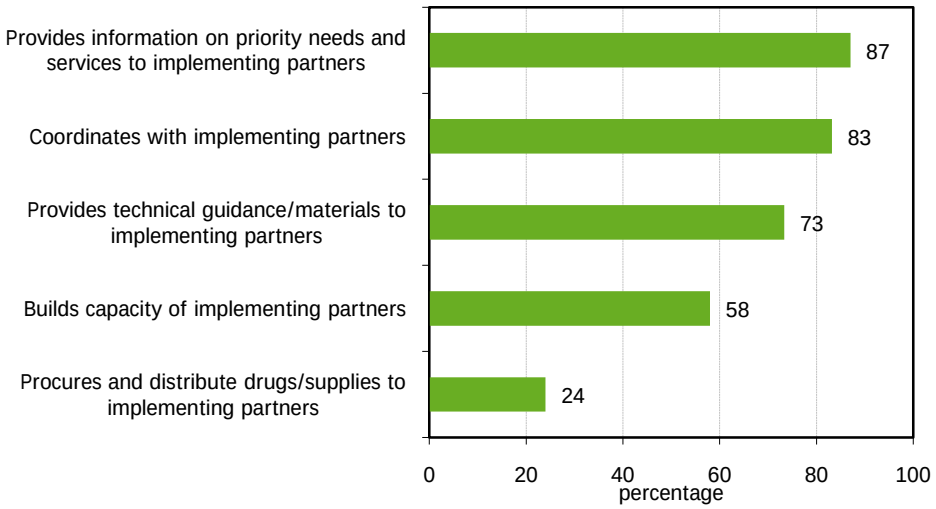
- There is a need to ensure that plans and structures translate into practical actions.
- There is a need for countries to maintain strong political leadership in relation to their responses to HIV. In particular, they need to demonstrate the political courage to focus the response on populations most affected by HIV.
- There is a need to consider replacing the current indicators of political leadership used internationally with others which are more relevant to the region, more focused on actions rather than structures and policies and more focused on appropriate responses to concentrated HIV epidemics, such as:
  - the degree to which financial resources for HIV prevention are appropriately targeted on key populations and the level of resources allocated to prevention among these populations (see Section 1.3);
  - the extent to which countries are implementing programmes for IDU, MSM, sex workers and migrants on a sufficient scale and these populations have access to treatment, care and support as well as to effective prevention services (see Sections 2.2–2.5);
  - the extent to which countries have tackled difficult but essential policy issues, such as the provision of harm reduction programmes for IDU in prison settings (see Section 2.6); and
  - the extent to which countries are providing ART coverage for key populations, particularly IDU, migrants and prisoners (see Section 3.1).

1.2 Civil Society

Data presented in this chapter provide strong evidence of the perceived value of civil society organisations in national responses to HIV. Almost all (90%) countries report fully or partially involving civil society in the development of the strategic framework for the response to HIV and AIDS. Almost all countries include civil society representatives (87%) and people living with HIV (82%) on their management/coordination bodies. Almost all (88%) countries report that civil society has opportunities to influence decision-making on these bodies. Nearly two thirds (65%) of countries include most-at-risk populations in governmental HIV policy design and programme implementation. Both governments and civil society provided comments on the benefits of involving civil society in national HIV responses.

In addition to issues of inclusion of civil society in management and coordination bodies for the national HIV response, the review considered the working relationship between government and civil society. Findings are based on civil society responses. Figure 4 shows that coordination between government and civil society more often takes the form of talking, e.g. sharing of information, than practical actions, such as provision of technical guidance and materials or commodities to support programme implementation.

Figure 4: Percentage of positive responses by government showing support from AIDS management/coordination bodies for civil society organisations



Civil society representatives were also asked to rank, on a scale of one (poor) to ten (good), the extent to which efforts were made to increase civil society participation in 2005 and 2007. The mean score reported by civil society showed an improvement from 5.14 in 2005 to 6.45 in 2007.

Although relationships are perceived to have improved, there are some common limitations across countries of the region with regards to government and civil society partnerships. Limited access to financial and technical support seriously constrains civil society's capacity to contribute fully to the response. Civil society organisations find it difficult to get their activities included in national budgets in many countries. Further, limited involvement of civil society in monitoring and evaluation activities means that an important opportunity for review and scrutiny is missed in many countries of the region.

Much of the focus of this review, and the questions in the UNGASS National Composite Policy Index used for reporting, is on civil society critique of government policies and performance. This is, of course, important. However, such a review would be stronger if it provided opportunity for an independent, balanced and constructive review of the strengths and weaknesses of civil society from a governmental perspective. Such a review could focus on issues such as governance, financial management, quality of service delivery, and monitoring and evaluation.

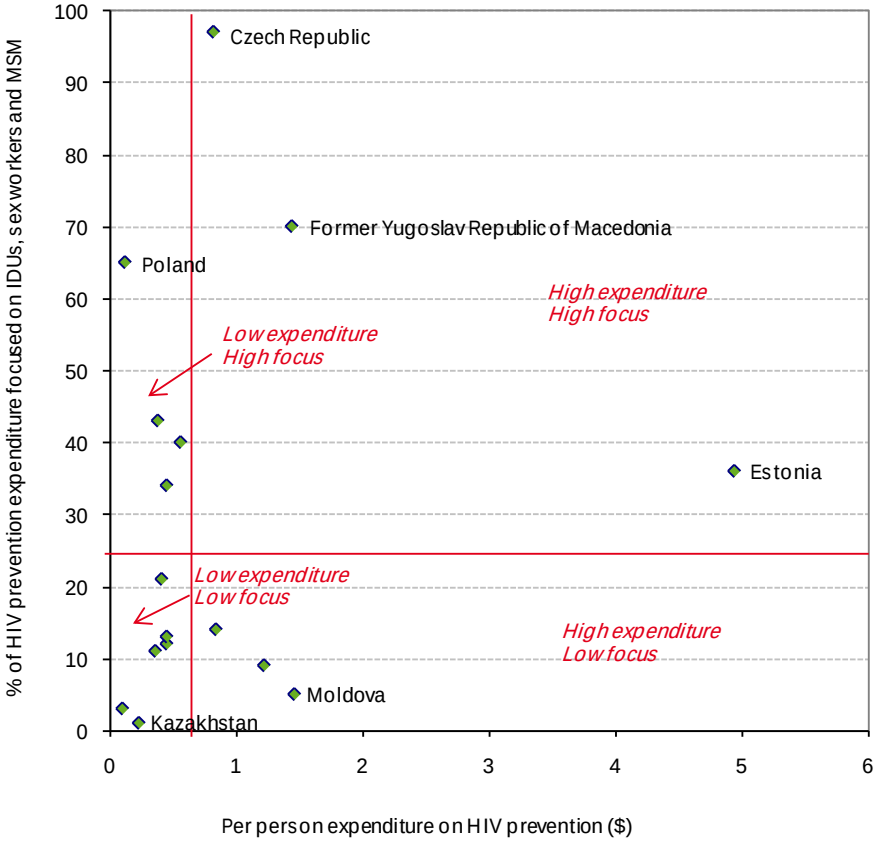
In conclusion, ECDC has identified the following issues that need further action:

- There is a need to promote partnership between government and civil society based on mutual accountability.
- There is a need for all countries to involve key populations in all aspects of programmes that affect them.
- In order to have a balanced perspective, there is a need to evaluate civil society's contributions and ability to contribute to the national response, e.g. by delivering essential HIV services for most-at-risk populations.
- There is a pressing need for adequate and sustainable financial support for the work of civil society. Access to financial support is critical for effective participation by civil society in the national response to HIV. Sustainable funding strategies will inevitably include government sub-contracting/grants to civil society organisations but they will also require civil society organisations to develop their own comprehensive fundraising strategies, including exploring opportunities to for sustainable public–private partnerships.

1.3 Financial resources

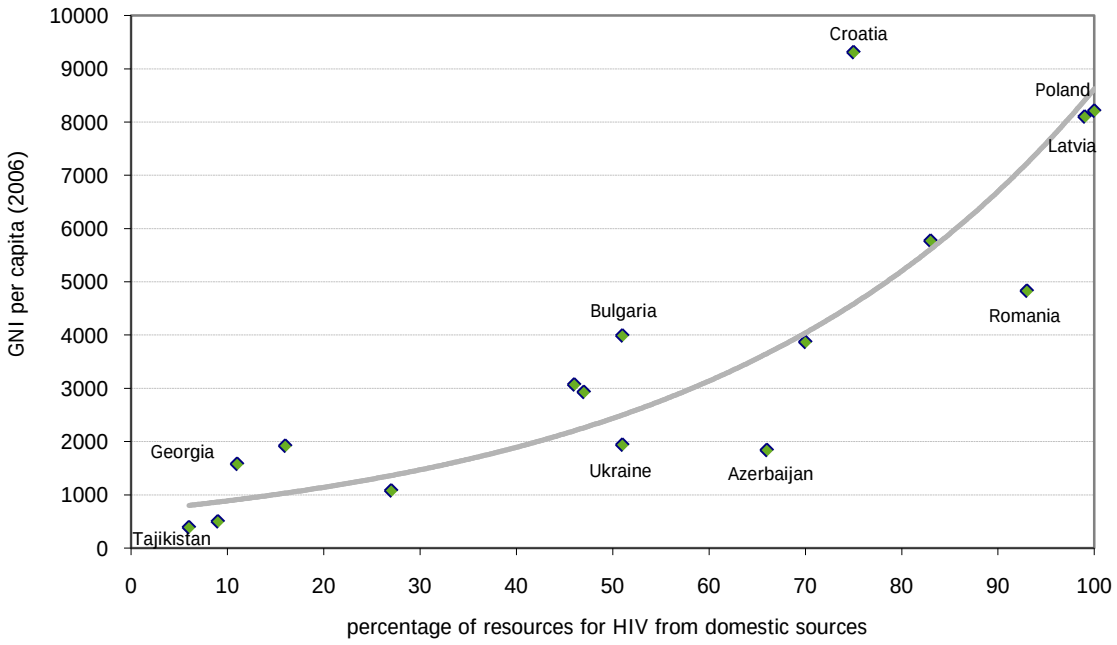
More than three quarters (76%) of countries responding were able to provide some quantitative data relating to their expenditure on HIV prevention. When adjusted for population, per person expenditure on HIV prevention ranged from $0.06 in Malta to $5.81 in Luxembourg. The extent to which countries' prevention expenditure was focused on specific populations – IDU, sex workers and MSM – varied from 1% in Kazakhstan to 97% in the Czech Republic. Figure 5 compares these two variables and identifies four patterns.

Figure 5: Comparison of per person expenditure on HIV prevention and percentage of prevention expenditure focused on IDU, sex workers and MSM by European and central Asian countries



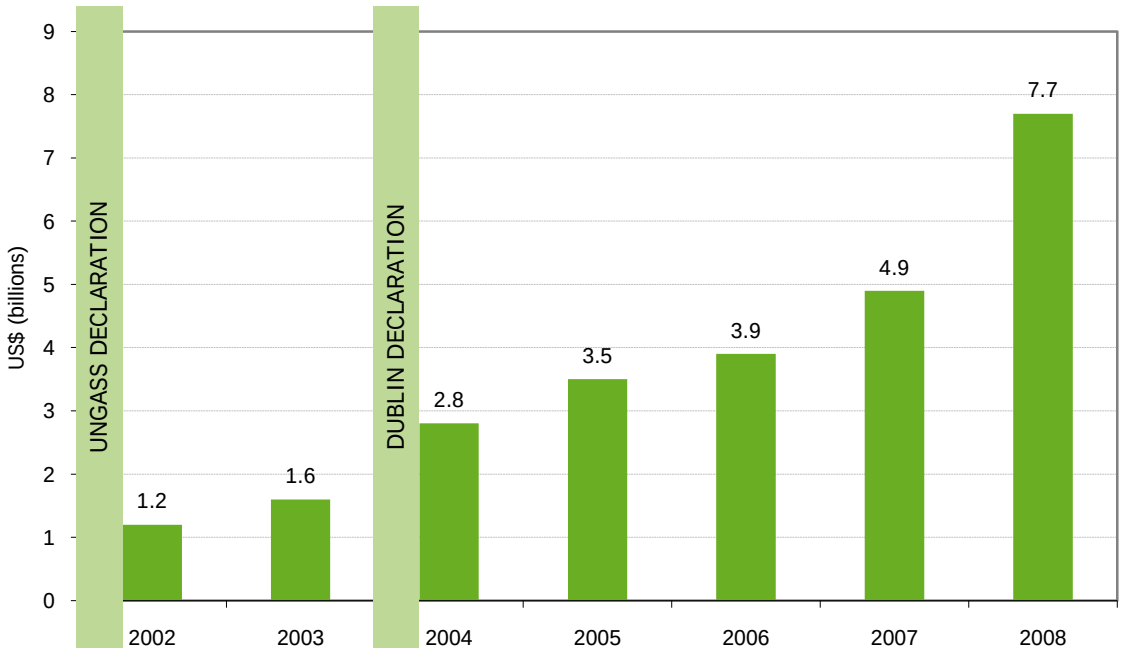
Although it has been suggested that the percentage of funds from domestic resources can be used to assess political commitment to the response, Figure 6 shows that this is largely related to a country's wealth. However, there are some outliers, e.g. Croatia and Azerbaijan. The most significant external funder of HIV responses in the region is the Global Fund to Fight AIDS, TB and Malaria. In the years for which data was reported, the Global Fund was providing more than one third of the funding to national HIV responses in eight of the countries reporting to UNGASS 2008.

Figure 6: A comparison of percentage of resources for the national HIV response from domestic resources compared with gross national income per capita among European and central Asian countries reporting to UNGASS 2008 (Switzerland excluded)



Since the UNGASS Declaration of Commitment in 2001, there has been an increase in disbursements from donor countries as international AIDS assistance (see Figure 7). These increased more than sixfold from $1.2 billion in 2002 to $7.7 billion in 2008. This increase gained further impetus after the adoption of the Dublin Declaration in 2004.

Figure 7: International AIDS assistance: Trends in G8/European Commission and other donor government assistance, 2002–2008: Disbursements

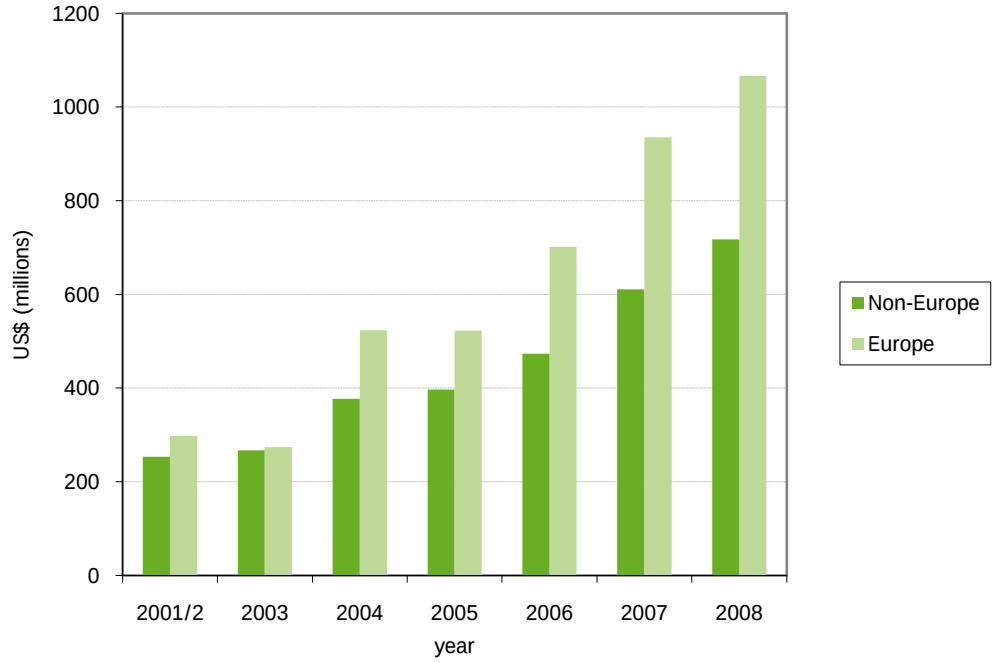


Source: Kates J, Lief E, Avila C. Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from the G8, European Commission and Other Donor Governments in 2008 Report of Kaiser Family Foundation and UNAIDS; 2009

This increase has been driven by a relatively small number of donor governments, including several EU Member States. In 2008, 40% of all disbursements for international AIDS assistance from donor countries came from EU Member States, EFTA countries and the European Commission. Of this, over three quarters (79%) came from four Member States: France, Germany, the Netherlands and the United Kingdom. Other significant donors included Norway, Sweden, Italy, Ireland and the European Commission.

In addition, European countries have been significant funders of major international institutions in the response to HIV. For example, HIV-related contributions from Europe to the Global Fund rose from $297 million in 2001/02 to exceed $1 billion in 2008 (see Figure 8).

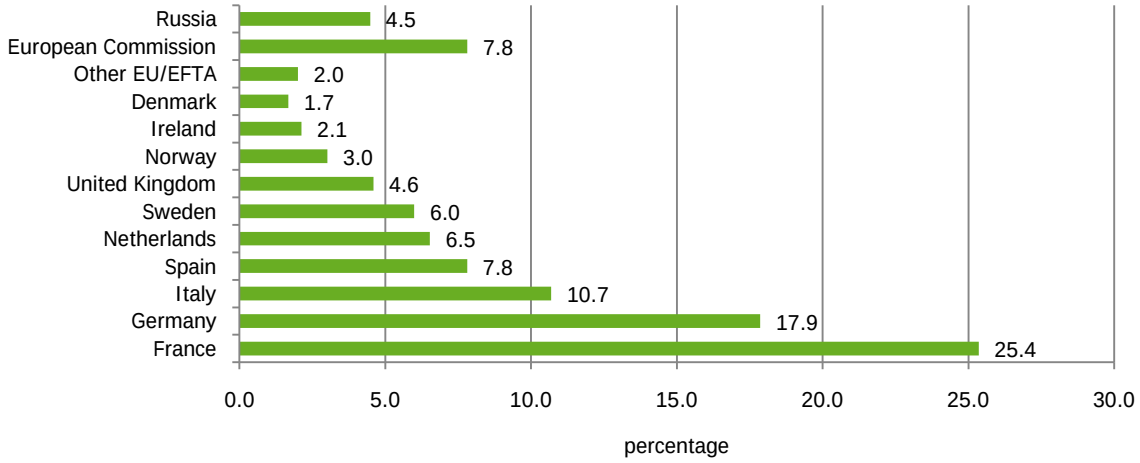
Figure 8: HIV-related contributions by countries to the Global Fund, by origin, 2001–08



Source: Global Fund, 2009

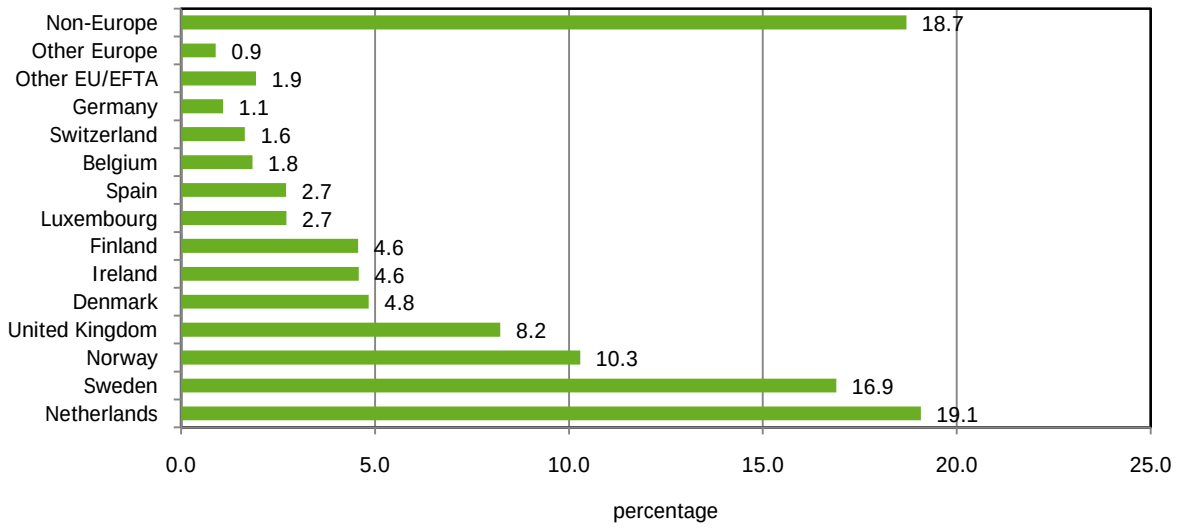
The majority of contributions to the Global Fund (84.3%) and to the Joint UN Programme on AIDS (UNAIDS) (83%) come from EU Member States. Member States making the largest contributions to the Global Fund included France, Germany and Italy (see Figure 9). Those making the largest contributions to UNAIDS included the Netherlands, Sweden, Norway and the United Kingdom (see Figure 10).

Figure 9: Percentage of European HIV-related contributions to the Global Fund, by origin, 2008



Source: Global Fund, 2009

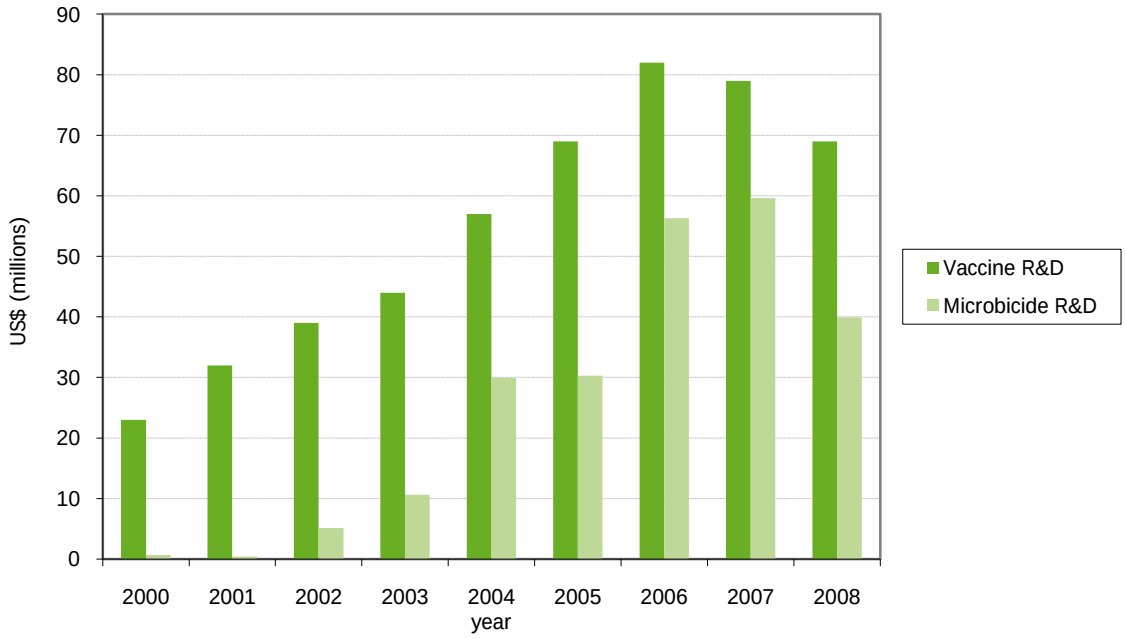
Figure 10: Percentage of total country contributions to UNAIDS, by origin, 2008



Source: UNAIDS, 2009

Finally, Europe has been a significant funder of vaccine and microbicide research and development (see Figure 11). Although this funding increased from 2000 to 2006, it declined from 2006 to 2008. Suggested reasons for the reductions in European funding for vaccine and microbicide research and development since 2006/07 include the beginnings of an escalating economic downturn, shifting of funding away from HIV and AIDS, cyclical funding for projects or an adjustment in scientific priorities. The latter explanation relates to a number of trials that released results in 2007 and 2008 which were considered disappointing.

Figure 11: European funding to vaccine and microbicide research and development, 2000-08



Source: HIV Vaccines and Microbicides Resource Tracking Working Group, 2009

In conclusion, ECDC has identified the following issues that need further action:

- There is a need for countries to increase funding for their responses to HIV from domestic resources. However, there is an ongoing need for external financial support for responses to HIV in low- and middle-income countries in the region. To date much of this funding has come from European countries through the Global Fund. A clear strategy is needed for ensuring the sustainability of future financing.
- There is a need for countries to focus HIV prevention spending on those key populations most affected by HIV. This would result in a more effective HIV response and efficiency savings, i.e. services being delivered at a lower overall cost.
- There is a need for the countries of Europe and central Asia to agree a common approach for monitoring HIV-related expenditure. This could involve a thorough review of the National AIDS Spending Assessment approach to identify what changes would make it more applicable for the regional context.
- There is a need to further demonstrate European leadership through funding for the global HIV response. All European countries could seek to emulate the example of the relatively few EU/EFTA countries that have been spearheading this financing.
- There is a need to review European financing for microbicide and vaccine research. Questions that need to be addressed include whether such research should continue to be funded, whether funding should be reoriented or further scaled back.

2 PREVENTION

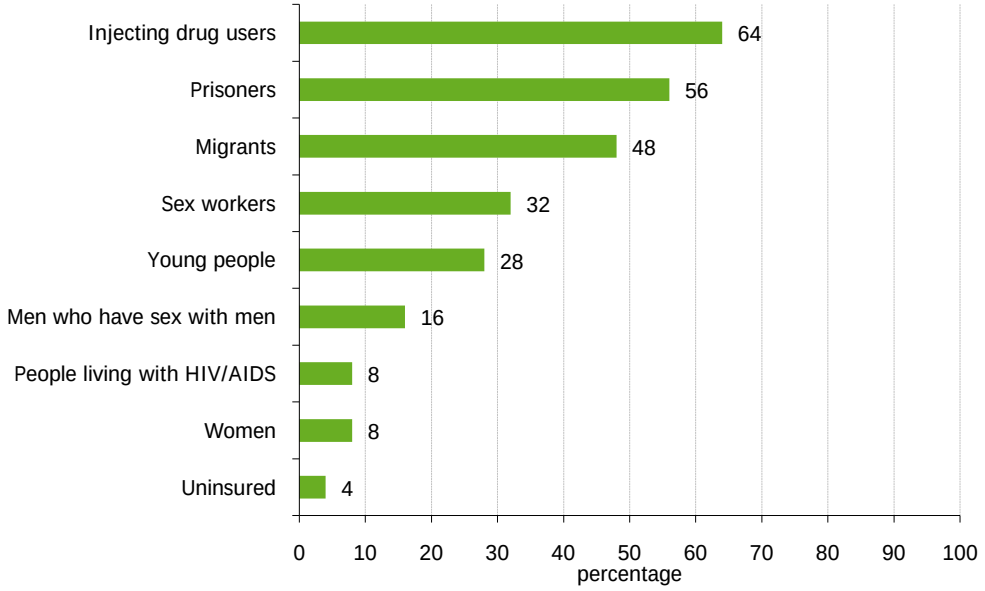
2.1 HIV prevention: an overview

The Dublin Declaration takes a strong position on prevention of HIV, stating that prevention 'must be the mainstay of the sub-national, national, regional and international response to the epidemic.' It also acknowledges the importance of ensuring universal and equitable access to HIV prevention. In a section on prevention, the declaration identifies a number of actions, ranging from scaled-up harm reduction services for injecting drug users to access to enhanced surveillance; from reduced incidence and prevalence of sexually transmitted infections to broad access to information, services and commodities by most-at-risk populations.

Governments and civil society clearly recognise the importance of prevention in their countries' responses, although perceptions vary on the extent to which prevention programmes are being implemented effectively. In general, countries recognise the importance of providing prevention services for key populations. However, difficulties in focusing prevention on key populations have been identified in a considerable number of countries.

First, more than half (54%) of countries report having laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations. These obstacles are particularly commonly identified for injecting drug users (64%), prisoners (56%) and migrants (48%) (see Figure 12). Unfortunately, these populations are marginalised and stigmatised in many countries and may lack champions in government who are willing to work to address these obstacles.

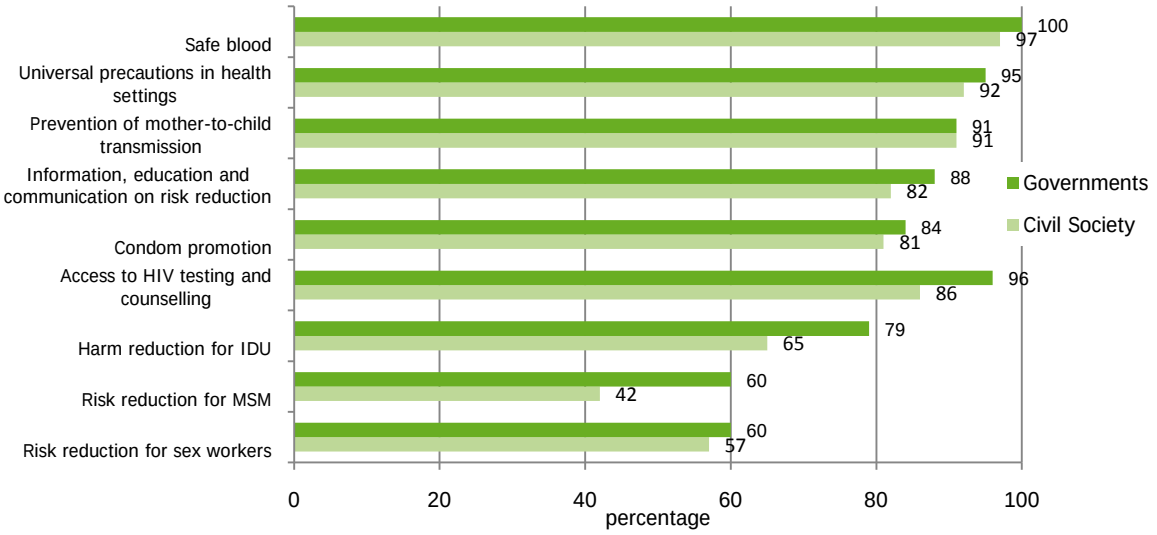
Figure 12: Percentage of countries reporting legal, regulatory and policy barriers for specified populations to access HIV prevention, treatment, care and support (n=25)



Second, it is of concern that policies/strategies that are more likely to be politically acceptable, such as provision of information, are in place in more countries than those that are more challenging politically, such as provision of harm reduction services for prisoners.

Third, it is of particular concern that implementation of activities shows a similar pattern to that seen regarding the availability of policies and strategies, i.e. those interventions that are politically more acceptable, such as provision of safe blood, are more likely to be implemented than those that are more challenging, such as harm reduction services for prisoners (see Figure 13).

Figure 13: Percentage of countries reporting that particular prevention services are available to the majority of those in need: Government and civil society responses



In conclusion, ECDC has identified the following issues that need further action:

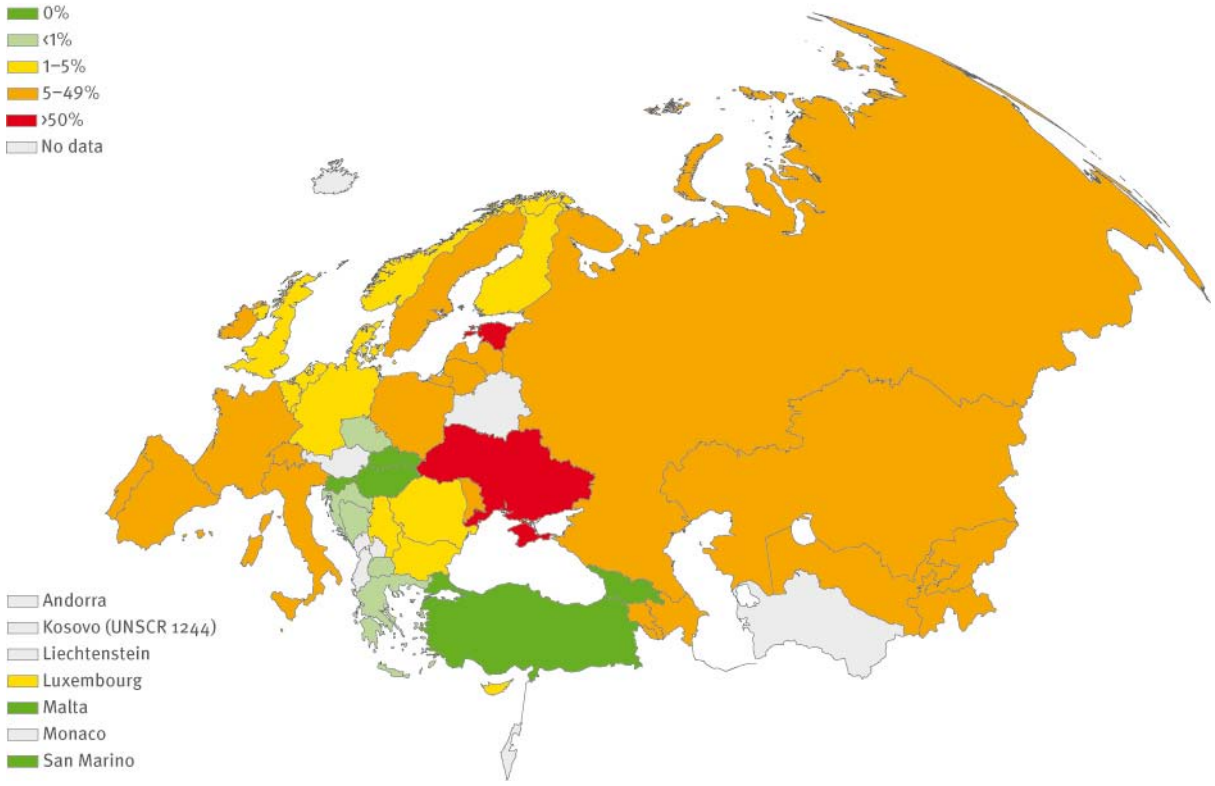
- There is a need for countries to maintain and expand their focus on key populations affected by HIV, e.g. injecting drug users, men who have sex with men, migrants from countries with generalised epidemics, and prisoners. This requires strong political leadership to ensure that evidence-based policies and programmes are developed and implemented (see Section 1.1) and to remove laws, regulations and policies that present obstacles to effective prevention, treatment, care and support for these populations.
- There is a need to ensure that policies and strategies are translated into decisive action through the implementation of prevention programmes, particularly those programmes focused on key populations. While policies and strategies are a fundamental component of the response, the availability of and access to prevention services based on those policies/strategies is critical if the response is going to have significant impact on the transmission of HIV. It is essential that key services are delivered on a sufficient scale to make a difference.
- There is a need for countries to resist political pressure to divert limited prevention resources to spending on activities for populations at significantly lower risk of HIV infection and to ensure that spending is targeted in line with the epidemiology of the epidemic.

2.2 Injecting drug users

There is strong evidence that IDU are particularly affected by HIV in Europe and central Asia. It is also clear that HIV transmission among IDU can be controlled if effective services are provided on a sufficient scale to make a difference. Key measures of scale include the number of needles/syringes distributed per IDU per year and the percentage of IDU receiving opioid substitution therapy (OST). There is a need for all countries to aspire to the high levels of programme coverage that have already been achieved by some.

Of countries with data on HIV prevalence among IDU, almost half (46%) reported high prevalence rates of > 5% (see Figure 14). These are particularly distributed in the eastern and south-western parts of the region. Just over a quarter (27%) of countries reported moderate prevalence rates of 1–5%. These included a number of countries in northern Europe. Countries in south-eastern and central Europe reported low (< 1%) or moderate (1–5%) prevalence among IDU.

Figure 14: HIV prevalence among IDU in Europe and central Asia

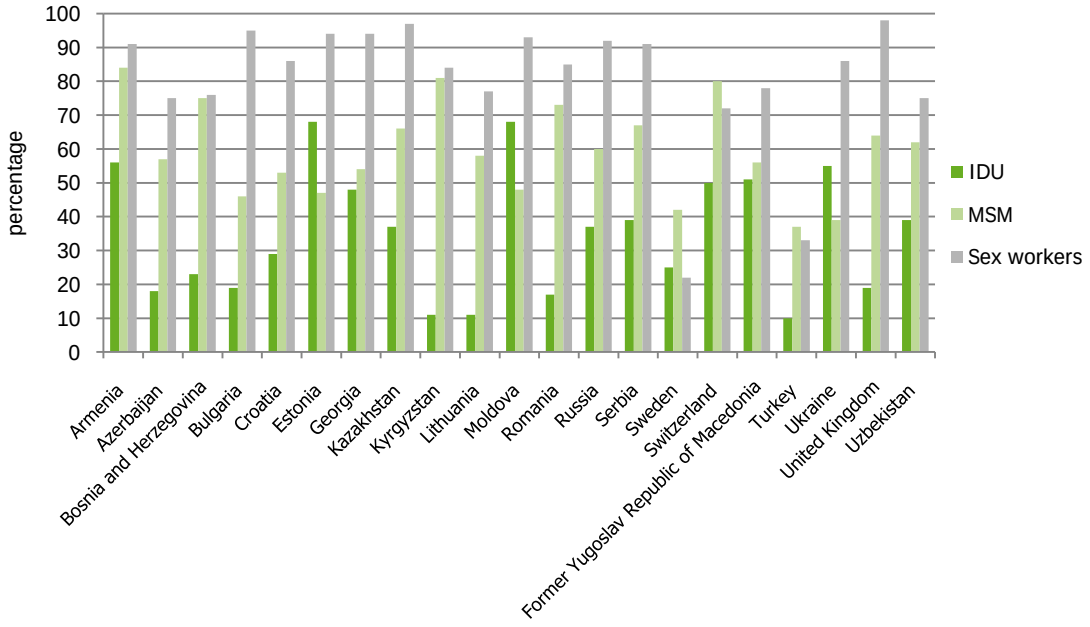


Internationally, it is recognised that HIV-related services targeted towards IDU should include nine elements: needle and syringe programmes; OST and other drug dependence treatment; HIV testing and counselling; ART; prevention and treatment of sexually transmitted infections; condom programmes for IDU and their sexual partners; targeted information, education and communication for IDU and their sexual partners; vaccination, diagnosis and treatment of viral hepatitis; and prevention, diagnosis and treatment of tuberculosis.

Fifteen countries reported coverage of OST. Of these, almost all (87%) were EU/EFTA countries. Most of these (77%) reported coverage above 30%. The three exceptions were Estonia (5%), Hungary (20%) and Lithuania (15%). The two non-EU/EFTA countries reporting coverage of OST, Azerbaijan and Bosnia and Herzegovina, also reported low coverage levels. Ten countries reported the number of needles/syringes distributed per IDU per year. Most (70%) of those were EU/EFTA countries and all of these reported coverage levels exceeding 100 needles/syringes per IDU per year. Of the three non-EU/EFTA countries reporting figures, Croatia reported needle distribution above this level but Azerbaijan and Bosnia and Herzegovina reported lower levels.

Among countries that reported quantitative data, almost two thirds (64%) reported rates of condom use of 50% or less among IDU. These rates of reported condom use are lower than for other key populations. For example, among 21 countries with data on condom use among IDU, MSM and sex workers, the mean reported rates were 35% for IDU, 59% for MSM and 81% for sex workers (see Figure 15). Countries reported a wide variety of data on the injecting behaviour of IDU. The United Kingdom reported data over a nine-year period which shows a decline in sharing injecting equipment in England and Wales. This is strong evidence that effective programmes, e.g. needles/syringe programmes, on a large scale can be effective in influencing the HIV-related risk behaviour of IDU.

Figure 15: Comparison of rates of reported condom use among IDU, MSM and sex workers



In conclusion, ECDC has identified the following issues that need further action:

- There is a need for all countries of the region to scale up the provision of HIV programmes for IDU to levels currently recommended by WHO[6]. In particular, this should include ensuring the provision of sterile injecting equipment, such as needles and syringes, at a sufficient level, i.e. greater than 200 needles/syringes per IDU per year[7]. It should also include ensuring that OST is provided to a high proportion (at least 30–40%) of opioid-using IDU.
- There is a need to improve the rate of adoption of systematic estimation of the size of IDU populations using the methodology recommended by the EMCDDA.
- There is a need to improve the coverage and representativeness of HIV prevalence estimation studies in the countries of the region.
- Access to ART and HIV voluntary counselling and testing among IDU needs to be improved, both in community settings and attached to addiction and other health services.
- There is a need for HIV prevention programmes among IDU to ensure adequate focus on preventing sexual transmission of HIV, including the provision of condoms and promotion of their use by IDU and their sexual partners.
- There is a need to replace the current composite UNGASS indicator for measuring HIV programme coverage among IDU with more relevant indicators such as the number of needles/syringes distributed per IDU; the proportion of IDU receiving OST; and the proportion of HIV-positive IDU receiving ART.

[6] WHO, UNODC and UNAIDS. Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users; 2009.

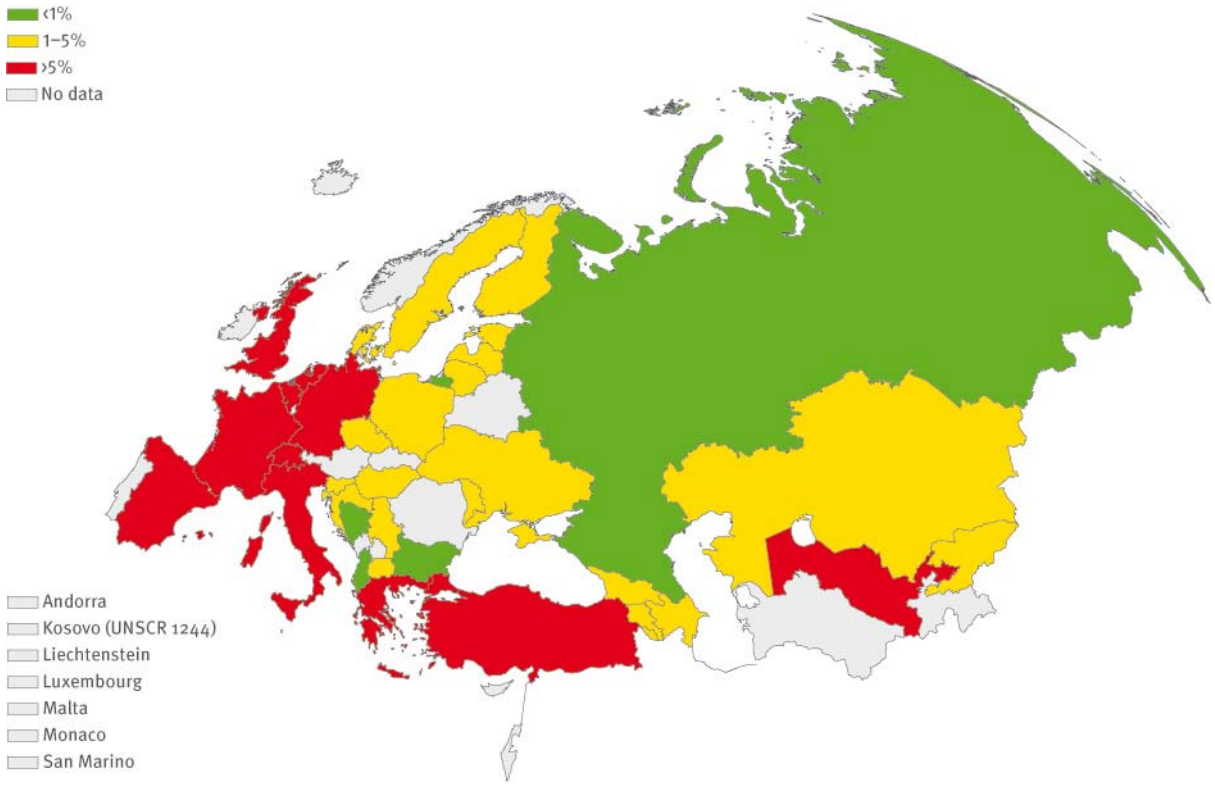
[7] Mathers BM, Degenhardt L, Ali H, Wiessing L, Hickman M, Mattick RP, et al; 2009 Reference Group to the UN on HIV and Injecting Drug Use. HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. Lancet. 2010 Mar 20;375(9719):1014-28. Epub 2010 Feb 26.

2.3 Men who have sex with men

Of countries with data on HIV prevalence among MSM, only four reported rates of < 1%. In countries in the west of the region, rates were mostly high (> 5%). In the centre and east, most countries reported moderate rates (1–5%), although both Turkey and Uzbekistan reported high prevalence rates (See Figure 16). Additional data from some countries suggests increasing HIV infection among MSM.

While it is well known that MSM have been particularly affected by HIV in certain countries, particularly in the west of the region, there is also evidence that they are more affected than previously recognised in other parts of the region. In some countries, there are concerns that self-reported MSM transmission may be under-reported because of social and cultural norms concerning sex between men.

Figure 16: Reported HIV prevalence among MSM in Europe and central Asia

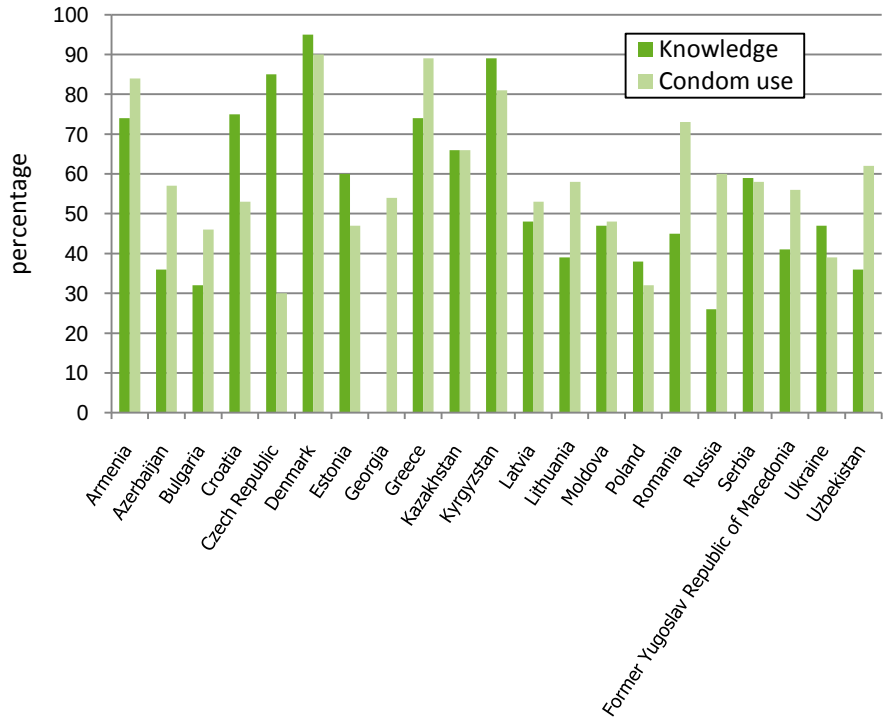


Although there are widely differing approaches to measuring coverage of HIV prevention programmes among MSM in Europe and central Asia, coverage remains low in many countries. There is evidence from some countries (e.g. Azerbaijan, Serbia, Sweden, United Kingdom and Uzbekistan) of higher coverage among older MSM, MSM in large cities, more educated MSM and men who consider themselves homosexual rather than bisexual. As a result, particular groups of MSM (the young, those outside capital cities, those who are less well educated and those who identify themselves as bisexual) are less likely to be reached by HIV programmes.

There is a considerable variation in reported rates of HIV testing among MSM in the region, ranging from less than 1% in Poland to 70% in Kyrgyzstan. Fourteen countries reported HIV testing rates of less than 30%, 15 reported rates of between 30% and 60% and four reported rates above 60% (Belgium, Italy, Kyrgyzstan and the Netherlands).

Similarly, there is considerable variation in reported rates of HIV-related knowledge and condom use and the comparison (see Figure 17) shows no obvious pattern.

Figure 17: Comparison of HIV-related knowledge and condom use among MSM reported by selected countries in Europe and central Asia



Rates of unprotected anal sex remain unacceptably high among some MSM. In several countries, around one third of MSM (27–40%) reported having unprotected anal sex, particularly with casual partners. There is some evidence that unprotected anal sex is more common among particular groups of MSM, including younger men, less well educated men, men without a steady partner, men who seek partners on the internet and men who used drugs before sex. Although there are concerns that rising rates of unprotected anal sex may be driving increased rates of HIV transmission among MSM in some countries, evidence from Germany did not indicate declining safer sex practices among MSM. Further research into these issues is currently ongoing through the European MSM Internet Survey.

In conclusion, ECDC has identified the following issues that need further action:

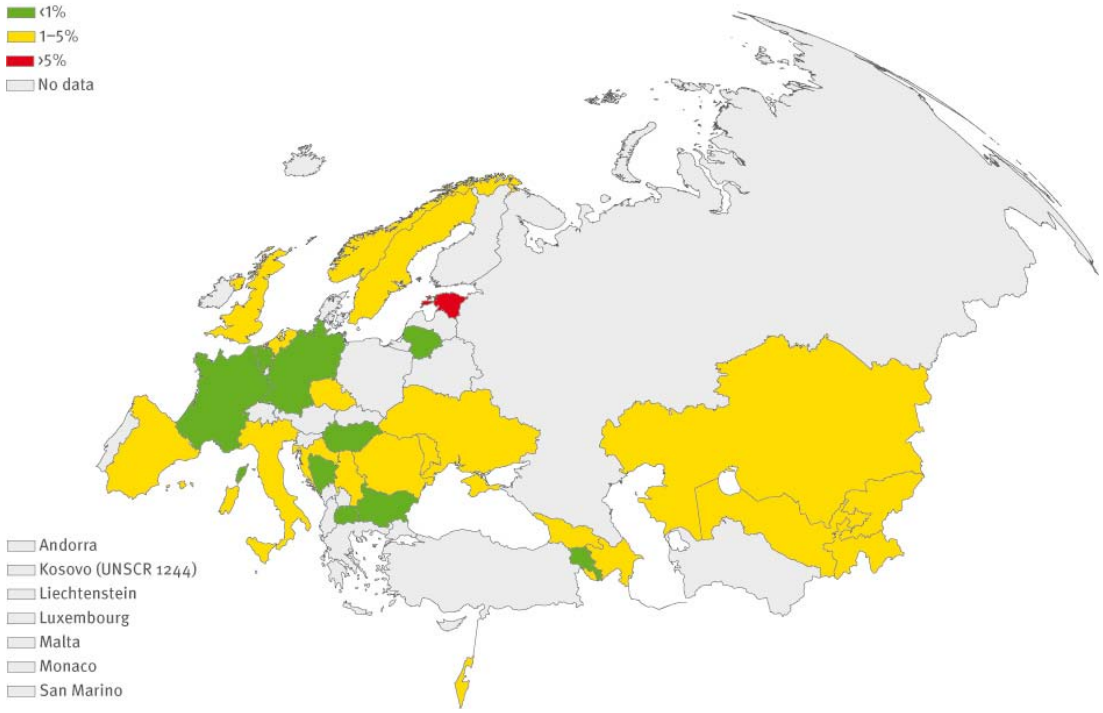
- The need for all countries of the region to recognise the continued risk of HIV transmission among MSM and to demonstrate the political leadership to respond appropriately, e.g. by addressing discriminatory policies and legislation, and providing appropriate and accessible services. Reports of rising rates of HIV infection among MSM in many countries of the region are a cause of great concern requiring urgent and determined action.
- There is a need to improve region-wide data collection and analysis of trends on specific risks and risk perception in MSM communities through development of behavioural surveillance programmes.
- There is a need for data collection and programme responses to recognise that MSM are a heterogeneous group and that some MSM are more vulnerable to HIV infection and less likely to be reached by HIV prevention programmes than others.
- There is a need to review the relevance of current indicators. For example, if knowledge indicators are to be used, they need to be more specific for MSM. Greater clarity is needed on how to measure coverage of HIV prevention programmes for MSM. Indicators of HIV testing and counselling may need to be tailored to specific policy environments. For example, it makes sense to enquire about testing in the last year if the aim is to test each MSM once per year. A focus on measuring reported condom use is highly appropriate given concerns that unprotected anal sex is still one of the major determinants of HIV transmission among MSM in the region. Disaggregated data about condom use with different types of partner and with regards to HIV status may be of particular value.

2.4 Sex workers

Although sex work has been demonstrated to be a key driver of the HIV epidemic in some parts of the world, this does not seem to be the case in Europe and central Asia. In almost all countries of the region, HIV prevalence rates among sex workers are < 5% and some countries have formally decided that sex workers are no longer a priority in their national response to HIV. The fact that reported HIV prevalence among sex workers exceeds 1% in 14 countries is, however, of concern (see Figure 18).

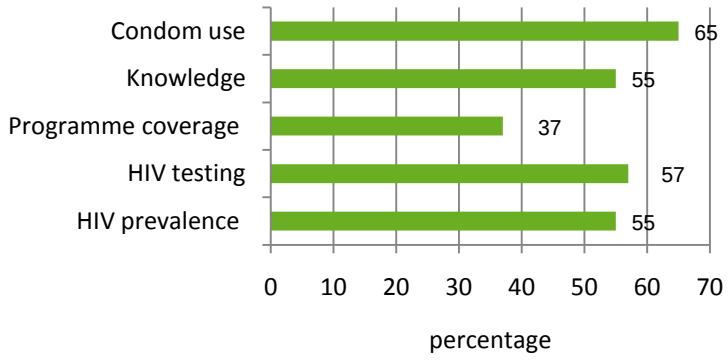
Reported data also suggest that HIV prevalence is higher among specific sub-groups of sex workers, including sex workers who inject drugs, male and transgender sex workers, street sex workers and sex workers from countries with generalised HIV epidemics. For example, the Netherlands reported data showing that prevalence among sex workers who inject drugs and transgender sex workers was as high as 20% in some settings, compared with 3% or less among female sex workers who did not inject drugs. Israel and the United Kingdom reported data showing higher prevalence among male sex workers than among female sex workers, and Norway attributed the recent increase in prevalence to an increase of sex workers from countries with generalised epidemics.

Figure 18: Reported HIV prevalence among sex workers in Europe and central Asia



However, prevalence data for these specific groups of sex workers are very limited. Likewise, there are limited data on prevalence among young sex workers, who are often considered to be more vulnerable than older sex workers. Only two countries, Kyrgyzstan and Uzbekistan, reported data disaggregated by age. Data availability was better for condom use by sex workers (65%) than for other indicators, such as programme coverage (see Figure 19).

Figure 19: Percentage of countries reporting data on indicators relating to sex workers



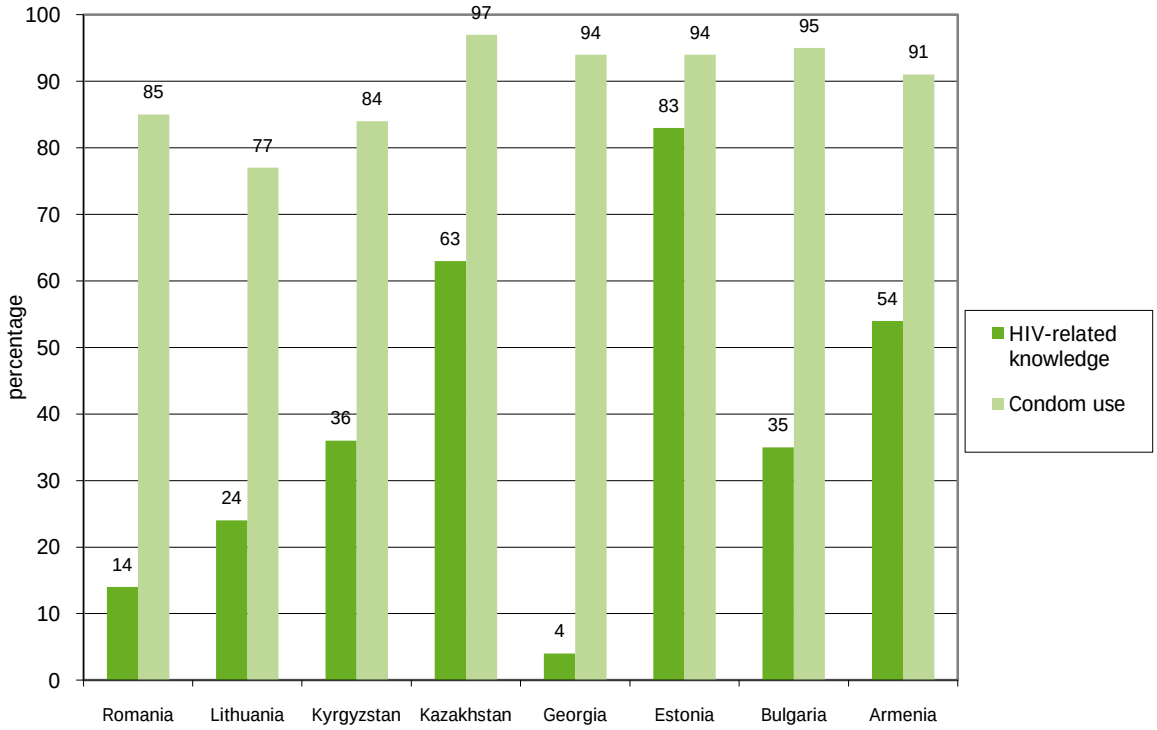
There is no shared understanding of how programme coverage should be measured. The UNGASS indicator is a composite indicator that reflects very limited services, specifically whether a sex worker knows where to go for an HIV test and has been given condoms in the last 12 months. The lack of clarity over method and a perceived lack of relevance may be factors in the relatively low proportion of countries in the region reporting data on this indicator. Similarly, only 55% of countries reported data on HIV-related knowledge, which again suggests that this indicator is not considered to be particularly relevant or useful.

However, based on reported data, coverage of HIV prevention programmes for sex workers varies considerably between countries. The evidence presented suggests that coverage is inadequate in a number of countries, including those where there is known to be an overlap between sex work and injecting drug use. Less is known about coverage among specific sub-groups of sex workers that may be at higher risk of HIV infection.

Similarly, reported data on HIV-related knowledge, condom use and HIV testing suggest that there are wide variations between countries in the extent to which sex workers have accurate knowledge about HIV transmission and prevention, use condoms consistently and have been tested for HIV. In most cases, reported data relate to female sex workers and less is known with respect to these indicators for male sex workers, transgender sex workers or other sub-groups of sex workers.

The disparity between HIV-related knowledge and condom use (see Figure 20) suggests that knowledge may not be a particularly reliable determinant of behaviour or that the indicator for knowledge does not measure relevant knowledge. Other factors, such as a supportive legal and working environment where condom use is considered to be the norm, may also be more significant in influencing condom use. The data provided suggest that more marginalised sex workers, for example street sex workers and those who also inject drugs, are less likely to use condoms consistently with clients. Further research is required to identify the factors that support or limit safe practices.

Figure 20: Levels of HIV-related knowledge and condom use among sex workers reported by selected countries in Europe and central Asia



In addition, UNGASS indicators do not address some issues that may be of particular relevance in the region, including the diversity of the sex industry, the links between sex work and injecting drug use, the links between sex work and human trafficking (see Section 3.1), and male and transgender sex workers.

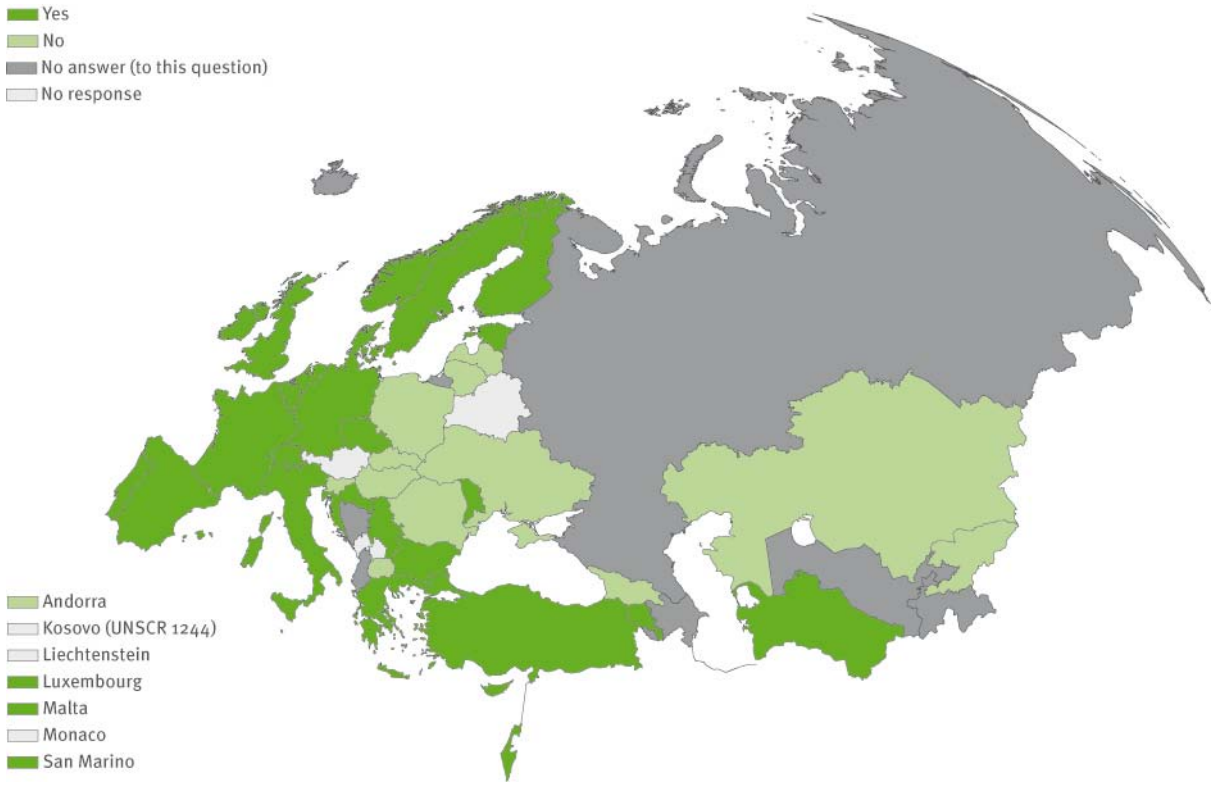
In conclusion, ECDC has identified the following issues that need further action:

- Although sex work *per se* may not be a major driver of HIV transmission in most countries of the region, there is a need to identify and work for improved prevention with those sub-groups of sex workers who may be at elevated risk of HIV. This is likely to include sex workers who also inject drugs, male and transgender sex workers, street sex workers, young sex workers and sex workers from countries with generalised HIV epidemics.
- There is a need for all countries to ensure high coverage of programmes for sex workers, particularly those who are most vulnerable to HIV infection. In many countries of the region, this will include sex workers who inject drugs.
- There is a need for countries to review the relevance of current indicators to measure HIV-related knowledge among sex workers and to identify indicators to measure programme coverage that are appropriate to the regional context, including indicators that are flexible enough to take account of the diverse nature of sex work and sex workers. It may be worth focusing efforts on those indicators which countries appear to consider most relevant, such as the rate of reported condom use.

2.5 Migrants

Issues relating to HIV and migrants are important for the countries of Europe and central Asia. Fifty-nine per cent of the countries responding, regarded migrants as an important sub-population in their national response to HIV and almost three quarters (72%) of responding EU/EFTA countries did so (see Figure 21).

Figure 21: Map showing the extent to which countries identify migrants as an important sub-population in the national response to HIV and AIDS



Although the definitions of the term 'migrants' vary considerably across the region, there is strong evidence that migrants from countries with generalised HIV epidemics are disproportionately affected by HIV in many EU/EFTA countries. But there is no compelling evidence that other migrant groups, independent of risk factors such as injecting drug use, are particularly affected by HIV in the region. A number of countries, such as the Czech Republic, Estonia and the United Kingdom reported that a particular ethnic group and/or group of migrants were disproportionately affected by HIV, but this is more likely to reflect injecting drug use (see Section 2.2) than ethnicity or migration *per se*.

This chapter presents the rich and varied data that countries have available relating to migrants and HIV. Much of this is qualitative in nature. Relatively few countries have robust, quantitative data available, apart from figures derived from HIV and AIDS case reporting. For example, only six countries reported data on rates of HIV testing among migrants. Of these, only three (France, the Netherlands and the United Kingdom) reported rates of HIV testing among migrants from countries with generalised HIV epidemics. Eight countries reported quantitative data related to the access of migrants to ART. Only four countries reported data on the HIV-related knowledge and behaviour of migrant populations. However, none of these corresponded fully to the standard indicators used by UNAIDS for UNGASS reporting related to other key populations.

Several countries reported barriers and obstacles to delivering HIV-related services to migrants. The most commonly reported obstacles included language barriers (16 countries), cultural differences (10), issues relating to fear, stigma and discrimination (6), religious differences (4) and lack of services in the locations where migrants lived (3).

Countries reported particular challenges in providing services to undocumented migrants. For example, some countries provide health services through insurance schemes. By definition, undocumented migrants do not usually belong to such schemes. In other countries, undocumented migrants are afraid of using health services for fear of being detected and removed from the country.

In general, most countries report that their laws and policies are based on the principle of providing services equitably to all in need of them. However, some countries reported having restrictions on entry and residence for people living with HIV. In other countries, some categories of migrants may not benefit from the social security system in place in the country. Some ethnic minorities in some countries may lack access to health insurance cover because they do not have a permanent address.

Although a few countries, for example, Italy and Portugal, make a clear commitment to provide ART to undocumented migrants who need it, most countries do not do this. In some countries, the extent to which a person is eligible for services is explicitly linked to their immigration status.

In conclusion, ECDC has identified the following issues that need further action:

- Although it is entirely appropriate for countries to define migrants in a way that is appropriate to their context, there is a need for selected standard definitions of categories of migrants in relation to HIV in Europe. There is a strong argument for one of these categories to be someone born in a country with a generalised HIV epidemic.
- There is a need for EU/EFTA countries to develop and expand programmes for migrants from countries with generalised HIV epidemics. There is also a need to develop ways of monitoring whether these programmes are being delivered on a sufficient scale.
- There is a need to ensure that programmes focused on other key populations, for example, sex workers, MSM and IDU, provide equitable access to services, including to those born in other countries or having a particular nationality or ethnicity, regardless of legal status. In some contexts, ensuring equitable access may require additional resources for specific services targeting migrants within these key populations.
- There is a need to develop a standard set of HIV indicators for inclusion in a regional European monitoring and evaluation system.

2.6 Prisoners

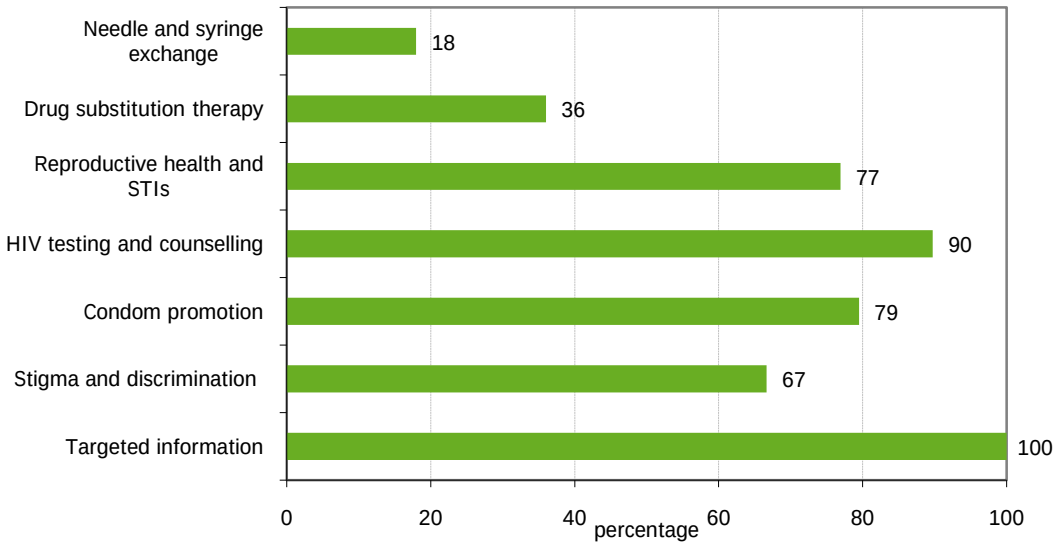
Prisons are an important environment for the response to HIV in the countries of Europe and central Asia. Injecting drug users are particularly at risk of HIV infection and frequently spend time in the prison system. Within the prison system, there are risks of HIV transmission through sharing contaminated injecting equipment and unprotected sex. Just under half (47%) of all reporting countries provided quantitative data for HIV prevalence among prisoners. Reported HIV prevalence varied from 0% (Czech Republic and Croatia) to 14.5% (Ukraine). Although the vast majority of prisoners in countries of the region are male, some countries have collected and provided disaggregated data for HIV prevalence by sex. In some countries, such as Kyrgyzstan and the United Kingdom, HIV prevalence among women prisoners was higher than among men. Rates of HIV prevalence among prisoners are high, particularly when disaggregated to show rates for those who inject drugs and those who do not, e.g. in Kazakhstan.

Almost all (92%) responding countries provided some information about the HIV policy environment in prisons in their country. Of these:

- almost all (84%) reported that their country's multi-sectoral strategy/action framework addressed prisons; and
- almost three quarters (73%) reported that they have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services, including prison staff.

In addition, most countries reported having a policy and/or strategy to promote information, education and communication and other preventive health interventions for prisoners. Figure 22 shows the percentage of country strategies/policies with particular elements.

Figure 22: Percentage of countries with a policy and/or strategy to promote information, education and communication and other preventive health interventions for prisoners that includes particular elements



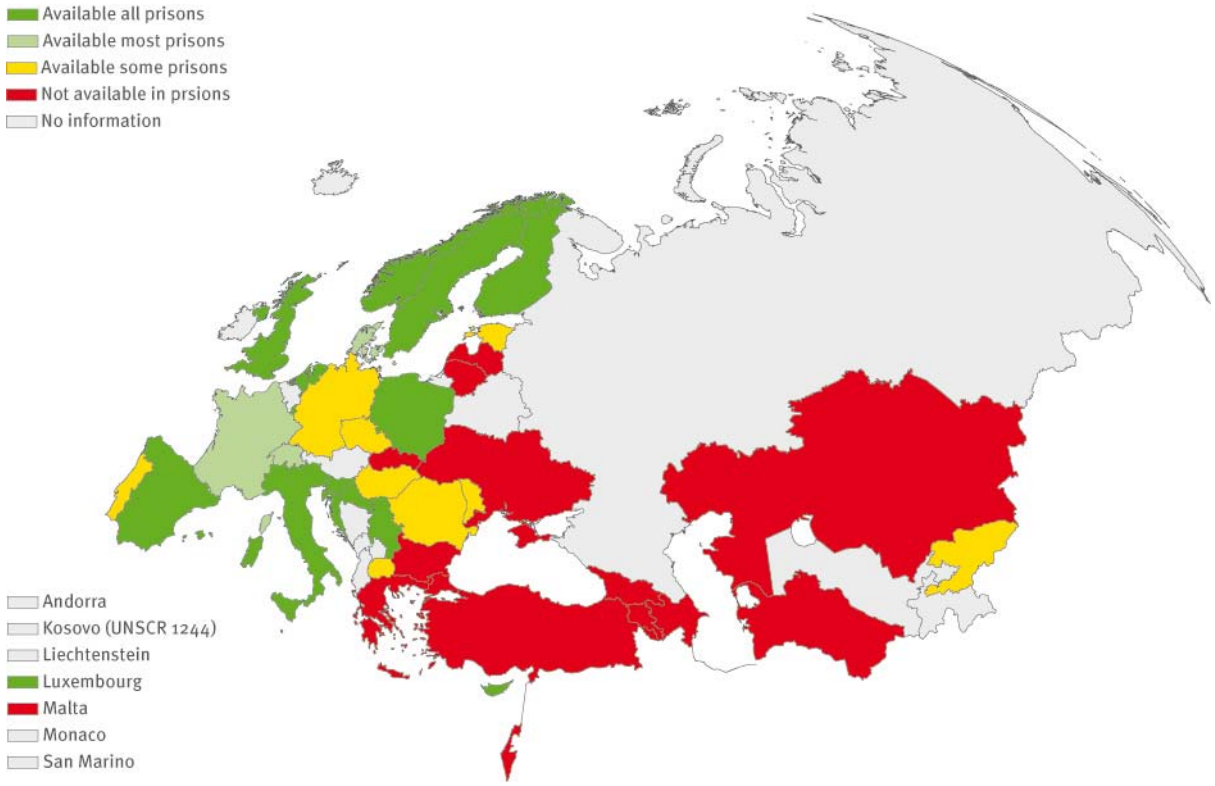
All policies and strategies are reported to include targeted information on risk reduction and HIV education. Almost all (90%) include HIV testing and counselling. More than three quarters include condom promotion (79%) and reproductive health, including sexually transmitted infection (STI) prevention and treatment (77%). Two thirds (67%) refer to stigma and discrimination reduction. Worryingly, only just over one third (36%) report drug substitution therapy and less than one fifth (18%) report needle and syringe exchange.

Less than half (44%) of countries providing information on this issue indicated that their country has non-discrimination laws or regulations that specify protection for prisoners, and 40% report that the country has laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for prisoners. For example, of the 40 countries providing information on whether or not they conduct mandatory HIV testing in prisons, 34 said they did not and six confirmed that mandatory testing in prisons was part of their national policies.

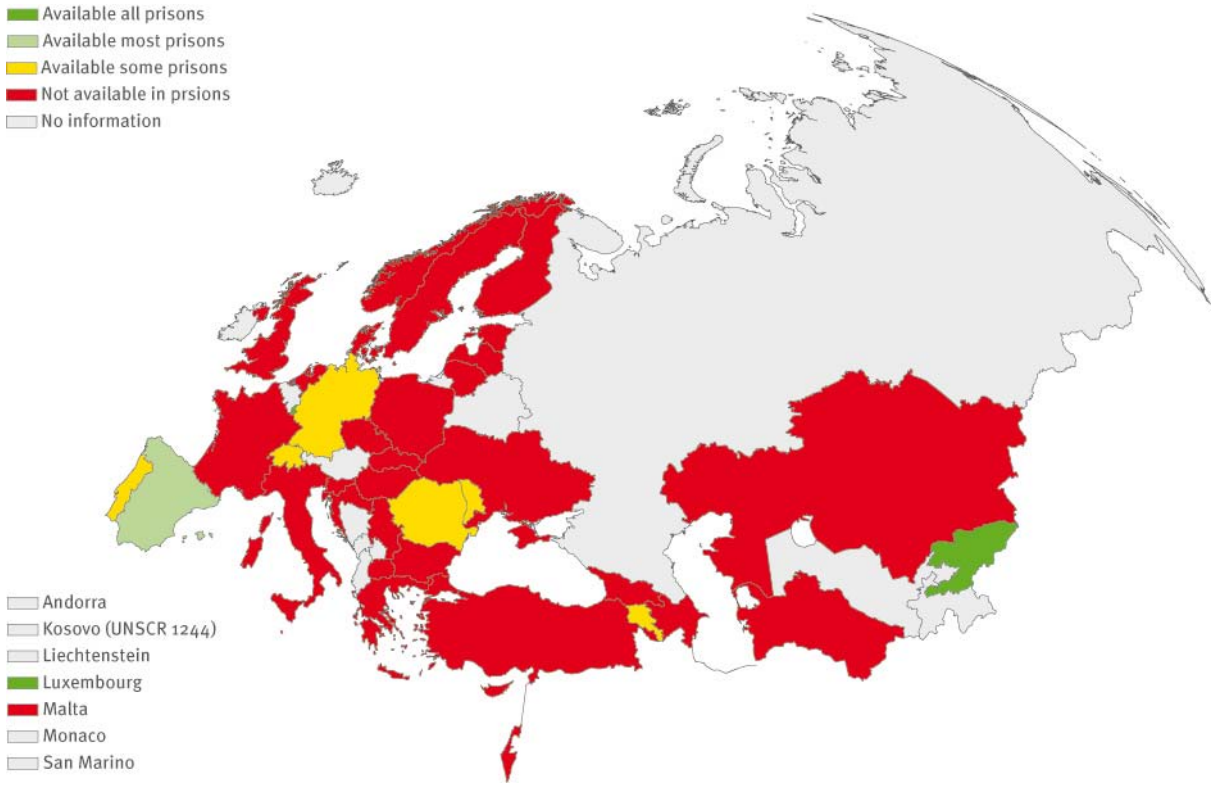
It is critical that equivalent HIV services are provided for IDU in prisons as in the community. International agencies have proposed that these services should, as a minimum, include nine elements (see Section 2.2). However, it is clear that some of these services are more available in prisons than others. For example, all countries report providing targeted HIV information to prisons, yet far fewer provide key services, such as drug substitution therapy and needle/syringe programmes (see Figure 23).

Figure 23: Maps showing the extent to which opioid substitution therapy and needle/syringe programmes are reported to be available in prisons in Europe and central Asia

Opioid substitution therapy



Needle/syringe programmes



EU/EFTA countries are clearly taking the lead in providing OST in prisons. Almost three quarters (71%) of EU/EFTA countries report providing OST in at least some of their prisons. But only just over a quarter (29%) of non-EU/EFTA countries do so. The picture is less clear for needle/syringe programmes. Only nine countries reported that needle and syringe programmes are available in any of their prisons. Only three countries reported providing such programmes in all or most of their prisons (Kyrgyzstan, Luxembourg and Spain). Forty countries provided information on whether or not they conduct mandatory testing in prisons. Most do not but it is of concern that six do report carrying out such testing.

In conclusion, ECDC has identified the following issues that need further action:

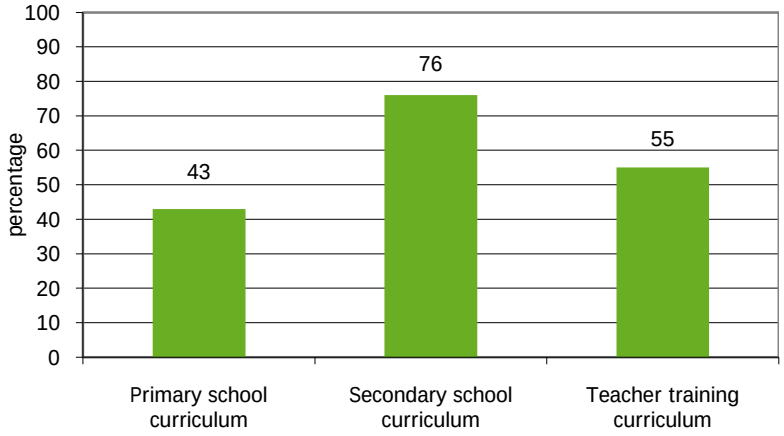
- There is a need for essential HIV prevention programmes to be as available in prisons as they are in community settings. In particular, this should include harm reduction services for IDU, such as OST and provision of sterile injecting equipment and condoms.
- There is also a need to ensure equivalence in access to HIV treatment and care services in prison and community settings, including access to TB diagnosis and treatment.
- There is an opportunity for countries not currently providing drug substitution therapy in their prisons to emulate EU/EFTA countries that do provide this service.
- There is an opportunity for countries not currently providing sterile injecting equipment to IDU in their prisons to emulate the few countries that are demonstrating leadership in this area.
- There is a need for all countries in Europe and central Asia to recognise that mandatory HIV testing in prison settings violates the widely accepted principle of self-determination in the area of health, and cannot be justified from a public health perspective. Routine offering of HIV testing in prison settings with appropriate provision of test information may provide better acceptance and result in attachment to the health system.

2.7 Promotion of sexual health among young people

Globally, 40% of new HIV infections occur in the 15–24 year age group. Consequently, young people are often described as a high risk or vulnerable population. However, in Europe and central Asia, the extent to which young people should be considered a 'risk group' that is more vulnerable to HIV is an issue about which there are widely differing views.

There is consensus that young people should be taught about HIV as part of a programme of sexual and reproductive health education in schools. Almost all countries (84%) have a policy or strategy to promote HIV-related reproductive and sexual health education for young people. However, although more than three quarters (76%) of countries include HIV education in the secondary school curriculum, fewer countries report that HIV education is included in the teacher training curriculum (55%) or that HIV education is included in the primary school curriculum (43%) (see Figure 24).

Figure 24: Percentage of countries reporting that HIV education is part of the primary school, secondary school and teacher training curricula



However, not all young people are equally at risk of HIV infection. There is a need for better data on, and more tailored programmes for, sub-groups of young people who may be at elevated HIV risk, such as young people who inject drugs or engage in sex work, young people in prisons and young men who have sex with men.

In conclusion, ECDC has identified the following issues that need further action:

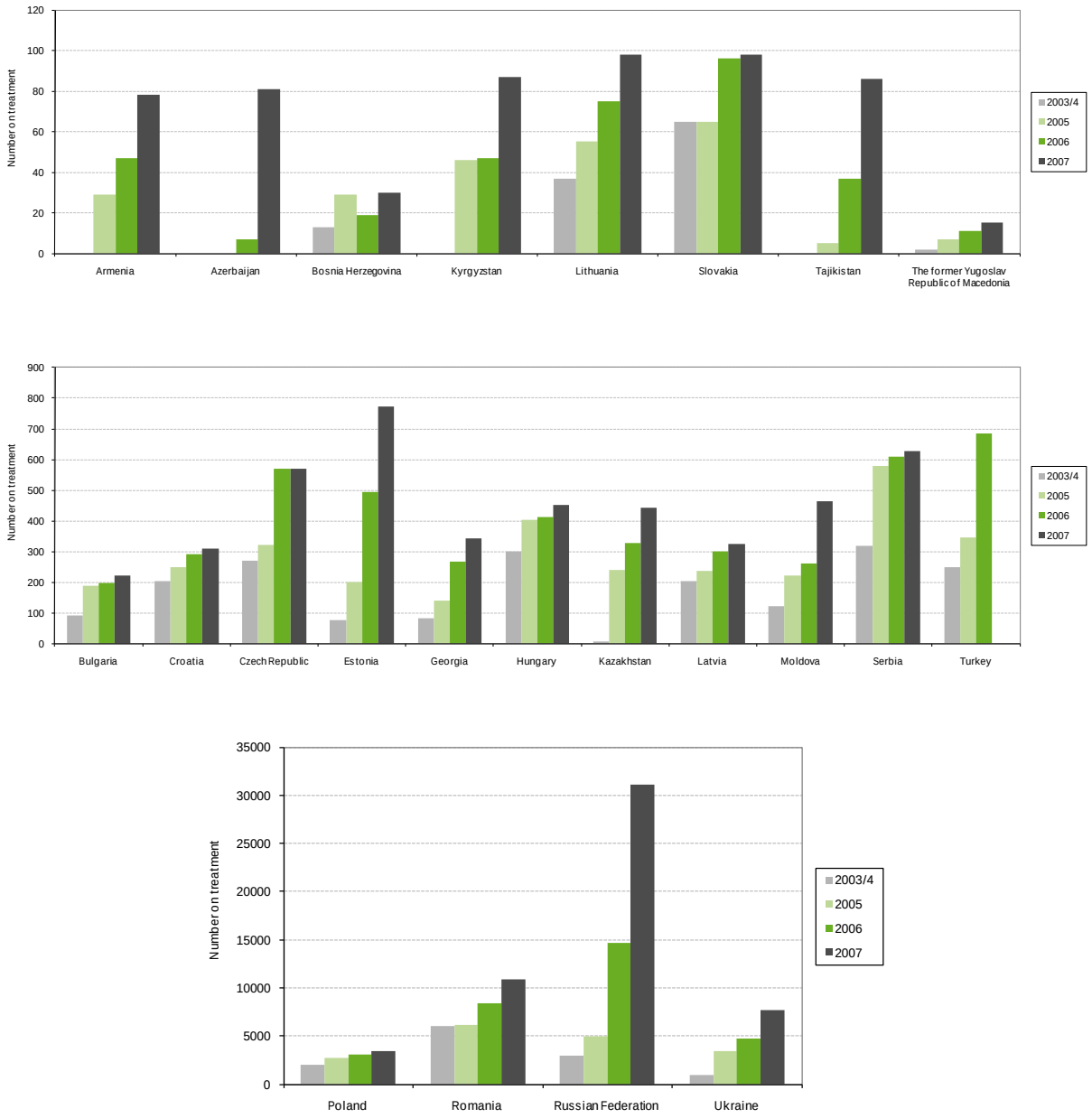
- There is a need to recognise that young people are not a homogeneous group in terms of HIV risk in the region. More data is needed on the heterogeneity of this risk. Service provision needs to be focused on those young people particularly at risk of HIV infection, such as young IDU, young sexual partners of IDU, young sex workers, young MSM, young migrants from high prevalence regions and young people in correctional and prison settings.
- There is a need for countries of Europe and central Asia to provide high quality sexual and reproductive health education, with integrated HIV/STI risk information, to their young people. Overall, there is a need for this to be provided in more countries' schools and for this to be included in curricula used to train teachers.

3 LIVING WITH HIV

3.1 Treatment and care

There have been significant increases in the numbers of PLHIV receiving ART in countries of Europe and central Asia since 2004 (see Figure 25). Some countries, where numbers on treatment were low, such as Estonia, Russia and Ukraine, have made good progress although they were starting from a very low level and there are still concerns that not all those who need treatment receive it promptly.

Figure 25: Trend data for ART in selected countries of Europe and central Asia



The main issue regarding prompt delivery of treatment to those who need it is not related to providing treatment to those who are known to need it. Most countries in Europe and central Asia report high levels of ART coverage for those known to be HIV positive. Rather the issue is the extent to which PLHIV in the region who need treatment are unaware of their HIV status, i.e. they have not been diagnosed. Although data on late diagnosis are limited, ECDC has been tracking CD4 counts at the time of diagnosis through its HIV case surveillance system since

2007 (see Figures 26, 27). This shows that of more than 10 000 people diagnosed in 2008 and having a CD4 count at the time of diagnosis, more than half had CD4 counts below 350 cells/mm^3 when diagnosed[8]. This finding is of great concern. It means that large numbers of people are not receiving ART promptly because of late diagnosis of their HIV status.

Figure 26: Percentage of new diagnoses with CD4 count at time of diagnosis, 2008

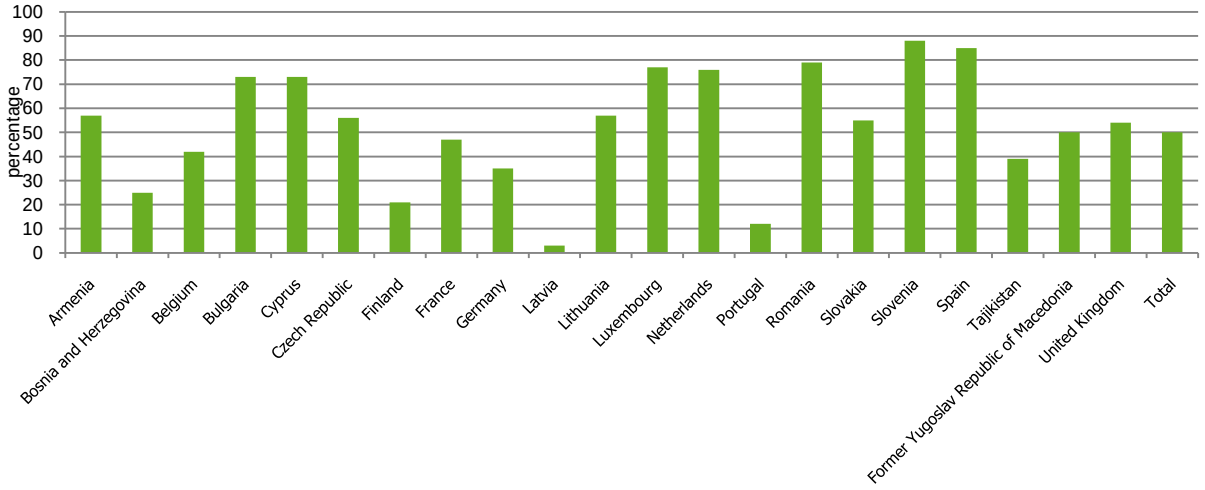
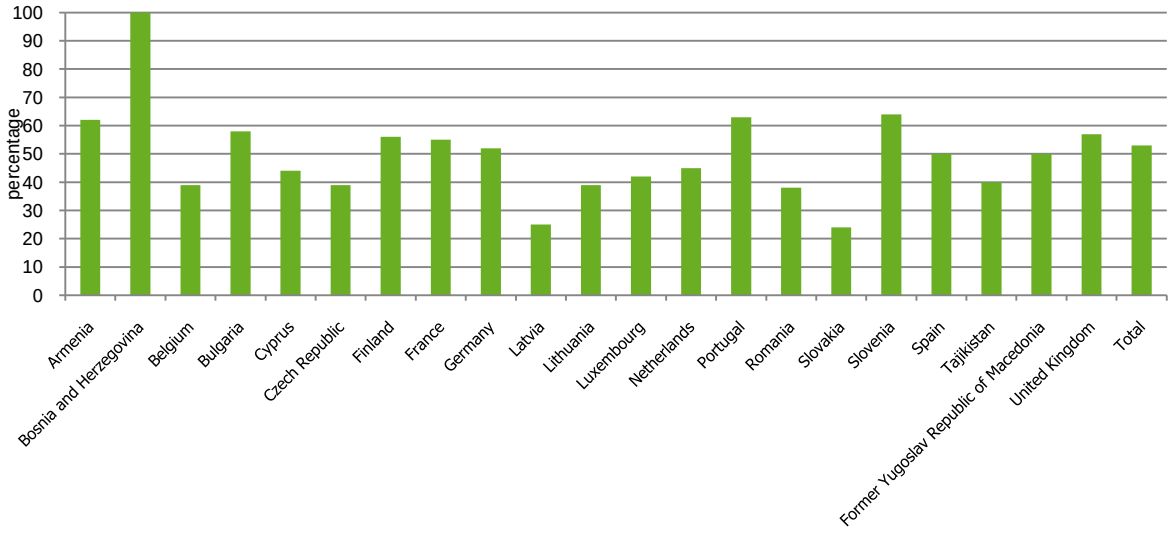


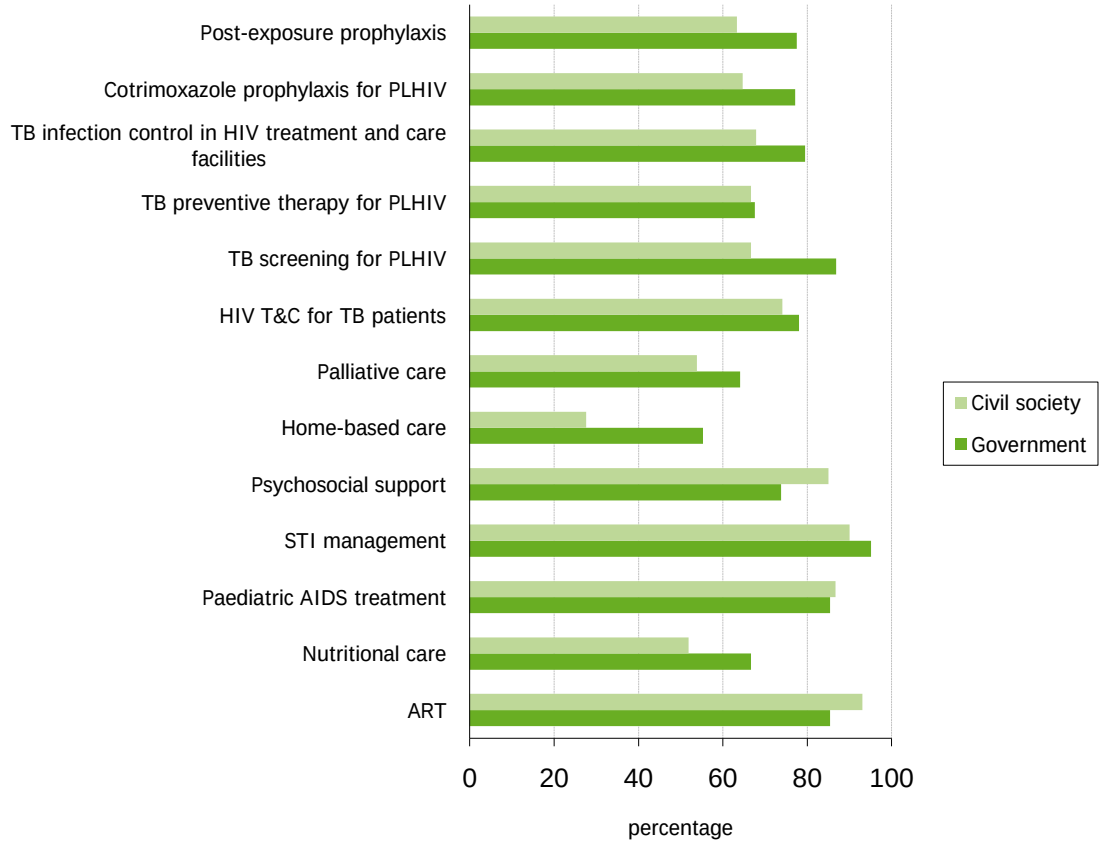
Figure 27: Percentage of those with a CD4 count at time of diagnosis with a CD4 count < 350



People living with HIV need a range of services, not just ART. Perceptions about the availability of key services vary both between countries and between different stakeholders in the same country. Some services, such as ART, including paediatric AIDS treatment and STI management, are perceived by government and civil society respondents to be widely available, while others, such as home-based care, are considered to be less widely available (see Figure 28).

[8] European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS data collection 2009.

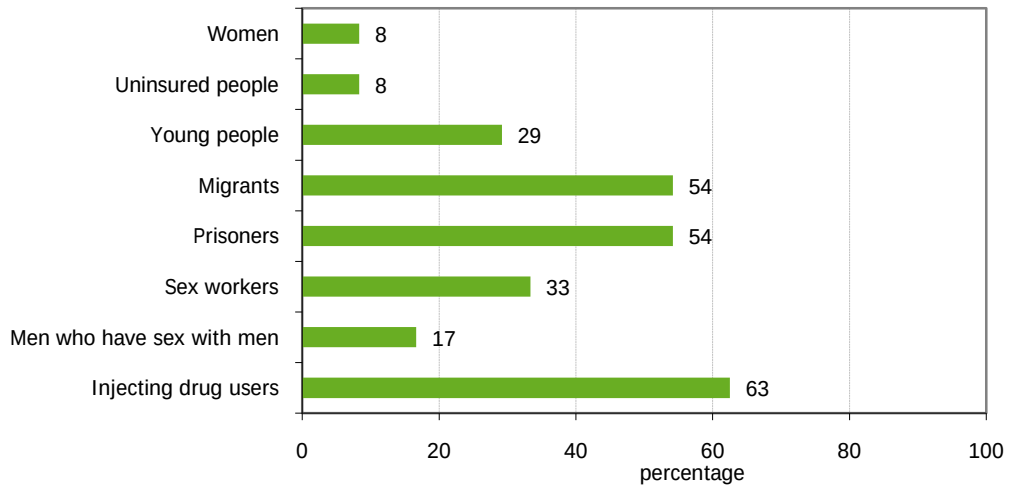
Figure 28: Percentage of respondents agreeing that the majority in need have access to a specific service



Almost all (94%) countries responding indicated that they have a policy or strategy to promote comprehensive HIV treatment, care and support. Of countries with a policy or strategy, more than three quarters (80%) report that it specifically addresses barriers facing women and most-at-risk populations (78%).

Almost half (49%) of the countries responding reported that the country has laws, regulations or policies that present obstacles to effective HIV treatment, care and support for particular populations. Figure 29 shows the extent to which specific sub-populations face legal, regulatory and policy obstacles in accessing HIV treatment, care and support. Almost two thirds (63%) of countries with such obstacles identified them for IDU and more than half (54%) for prisoners and migrants.

Figure 29: Percentage of countries reporting legal, regulatory and policy barriers for specified populations to access HIV treatment, care and support (n=24)



With regards to prevention of mother-to-child transmission of HIV, several countries asserted that such services are provided to all women who need them. Most countries follow the same strategy of offering HIV testing to all pregnant women and then offering a range of services for women who test positive and their infants. Less than half (45%) of reporting countries provided information on either the number of infants infected with HIV as a result of mother-to-child transmission or the rate of mother-to-child transmission. Some countries, such as Estonia, the Netherlands, Poland, Ukraine and the United Kingdom, presented evidence that the rate of infection through this route has declined. In Poland, this decline was from 23% in 1989 to < 1% and in Ukraine from 27.8% in 2001 to 7.1% in 2006. Other countries commented that remaining infections through mother-to-child transmission largely occur among particular sub-populations such as migrants and IDU. Although the numbers of infections occurring through this route are very low, the fact that some countries still experience easily preventable mother-to-child transmission must be considered unacceptable and a failure of the healthcare systems.

In conclusion, ECDC has identified the following issues that need further action:

- There is a need for countries of Europe and central Asia to focus on addressing the critical issue of late diagnosis of HIV infection as this is resulting in delays in starting ART for a significant number of PLHIV. This could include rigorously tracking the proportion of PLHIV with late diagnosis, i.e. a CD4 count < 350 at the time of diagnosis and introducing measures aimed at reducing the proportion of PLHIV who receive a late HIV diagnosis.
- There is a need for countries of Europe and central Asia to address the obstacles faced by some populations in accessing ART. These include, in particular, IDU, prisoners and migrants.
- Although data on the issue are not completely clear, the fact that some countries still experience easily preventable mother-to-child transmission, albeit limited, cannot be considered acceptable in the region. There is a need for some countries to review their procedures and practices to identify specific client-oriented solutions to ensure prevention of such cases in the near future.

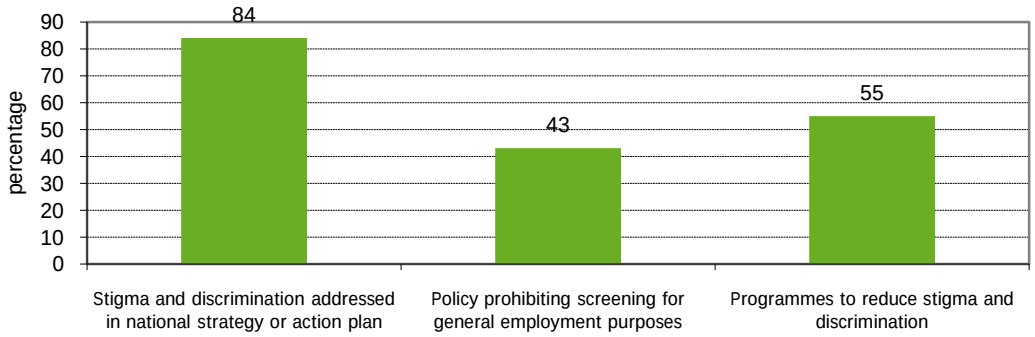
3.2 Stigma and discrimination

Only just over a third (39%) of countries were able to provide quantitative or qualitative data about attitudes towards people living with HIV. Although the picture is mixed, it appears that there are high rates of discriminatory attitudes/low rates of accepting attitudes in some countries and low rates of discriminatory attitudes/high rates of accepting attitudes in others. Nevertheless, there are a significant number of people in all countries who support highly discriminatory measures towards PLHIV.

Overall, people appear more likely to express accepting attitudes towards PLHIV within their immediate circle of family and friends, rather than PLHIV encountered in workplaces or schools. Broadly speaking, it appears that more accepting attitudes are held by younger people, women, more educated people and those living in urban areas. There is some evidence to suggest that stigma and discrimination are associated with negative views about particular population groups such as IDU, MSM, sex workers and migrants rather than only about PLHIV *per se*.

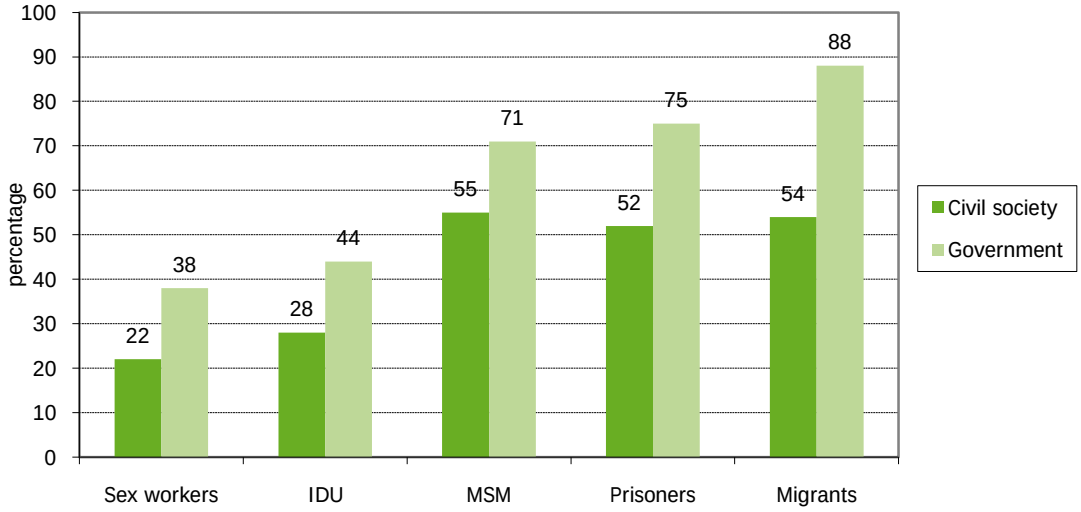
In general, countries report that appropriate policies are in place to address HIV-related stigma and discrimination. However, it is less clear how well these are implemented. For example, almost all countries (84%) report that stigma and discrimination are addressed in national HIV strategies but this is not consistently reflected in policies and programmes (see Figure 30). Less than half of countries (43%) have a policy prohibiting screening for general employment purposes and only just over just over half (55%) have programmes in place to reduce HIV-related stigma and discrimination.

Figure 30: Percentage of countries reporting that stigma and discrimination are addressed in strategy, policy and programmes



The same pattern is seen with non-discrimination laws and regulations. Around half of the countries report general non-discrimination laws that guarantee the rights of all citizens or non-discrimination laws or regulations that specify protections for most-at-risk or other vulnerable sub-populations. MSM, prisoners and migrants are more likely to be covered by non-discrimination laws or regulations than IDU or sex workers (see Figure 31). Overall, civil society respondents are less likely to consider that these laws and regulations exist than government respondents. Fewer countries report mechanisms to ensure laws are implemented or to address cases of discrimination or human rights violations. And while more than half of countries report non-discrimination laws and regulations that specify protection for PLHIV, again this is only backed up by mechanisms to address cases of discrimination experienced by PLHIV in a third of countries. These findings highlight a gap between the protection of human rights on paper and actual practice.

Figure 31: Percentage of government and civil society respondents reporting the existence of non-discrimination laws and regulations covering specific populations



In conclusion, ECDC has identified the following issues that need further action:

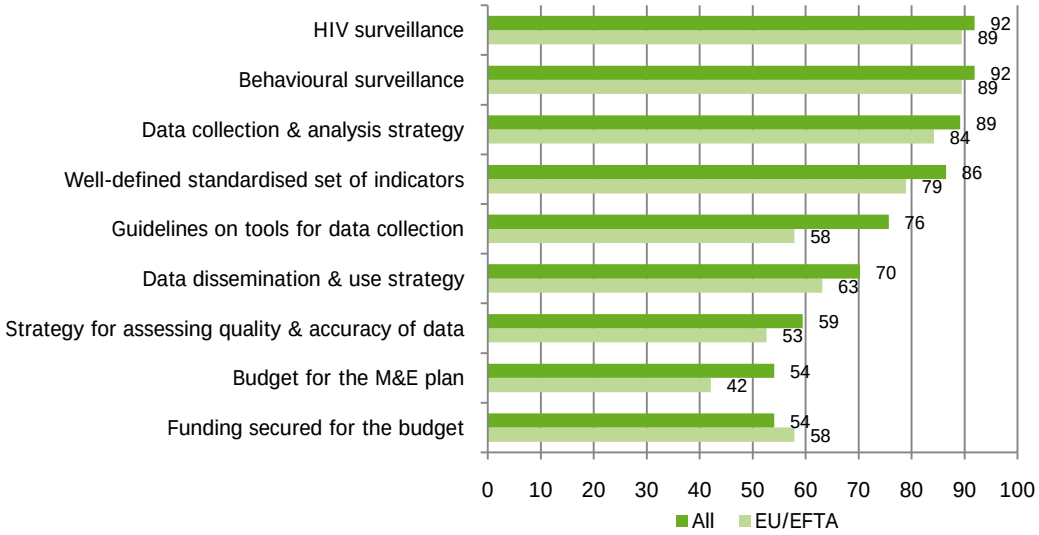
- There is a need for countries to continue and expand efforts to address HIV-related stigma and discrimination. In particular, there is a need to ensure that mechanisms exist to address stigma and discrimination when they occur, and that these mechanisms are well used.
- It is useful for countries to track the existence of both accepting and discriminatory attitudes among the population through periodic surveys. However, it is essential that the questions used are relevant to the countries of the region. It would also be useful if questions were extended to include stigma and discrimination experienced by marginalised populations who are also particularly affected by HIV, in addition to stigma and discrimination experienced by PLHIV.
- The European Commission could consider charging the European Union Agency for Fundamental Rights to conduct thorough research and analysis on the issue of HIV-related discrimination in Europe.

4 MONITORING AND EVALUATION

4.1 Political leadership: monitoring and evaluation

Almost all countries of Europe and central Asia report having structures and systems in place for monitoring their national responses to HIV. For example, 85% of countries report that they have or are developing a national monitoring and evaluation plan. However, some elements of these plans are better developed than others. For example, while almost all countries have systems for HIV and behavioural surveillance, far fewer have a strategy for assessing the quality and accuracy of data or a budget for the M&E plan (see Figure 32).

Figure 32: Percentage of responses from all countries and EU/EFTA countries on whether the HIV/AIDS M&E plan includes specific elements



There are concerns that the requirements of a national M&E system, as defined by international agencies and encapsulated in the third of the 'Three Ones' principles[9], may be too rigid and prescriptive for countries in Europe and central Asia. For example, it is unclear how relevant the third 'One' (one agreed country-level M&E system) is for countries with highly decentralised federal structures. While data are needed to understand the HIV epidemic and ensure that the response is appropriate for the particular drivers of the national epidemic, countries are able to ensure such data is collected using a variety of systems and structures.

Collecting data on the epidemic and the response in a country is not the main problem. A rich plethora of data are available in the countries of Europe and central Asia. The main problem is that that information is not used consistently to guide national responses to HIV. For example, many countries have strong evidence that HIV transmission is concentrated among particular sub-populations, such as IDU and MSM. Despite this, some countries have been reluctant to focus the national HIV response on evidence-based programmes for these populations. In some cases this is due to negative political and public opinion towards these populations and programmes. However, it is essential that national HIV responses focus on sub-populations that are particularly affected by HIV in order to prevent further transmission and to provide appropriate treatment, care and support for those living with HIV.

In conclusion, ECDC has identified the following issues that need further action:

- There is a need to ensure that monitoring and evaluation data is analysed and used to ensure that national responses to HIV are appropriate to the nature of the HIV epidemic in any particular country.
- Countries need to ensure that they have appropriate systems and adequate human and financial resources to monitor and evaluate the national HIV response. However, M&E needs to be country-driven and the systems used for these activities may vary according to the country context.
- There is a need to review and revise the questions used to assess the adequacy of monitoring and evaluation of HIV responses. This may involve a shift away from a normative focus on the third 'One', one agreed country-level monitoring and evaluation system, to an approach that focuses more on whether countries have the information they need about their epidemic and their response, and how that information is used.

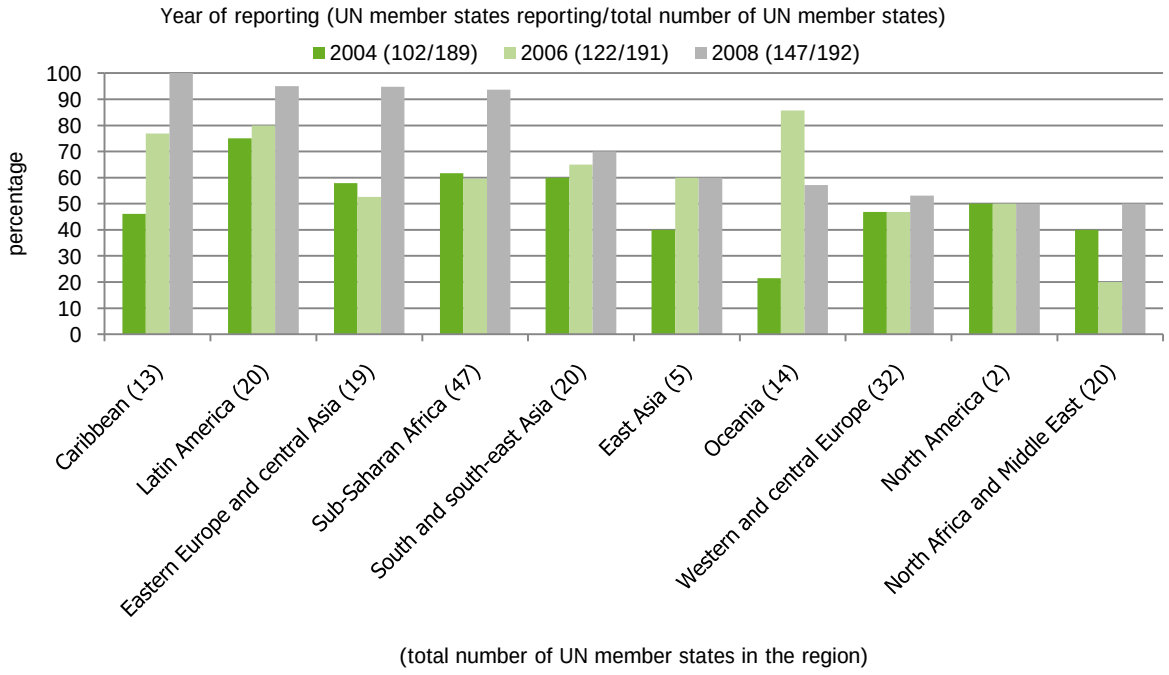
[9] UNAIDS. "Three Ones" key principles. Conference paper 1. Washington Consultation 25.04.04. Available from http://data.unaids.org/UNA-docs/Three-Ones_KeyPrinciples_en.pdf

4.2 UNGASS reporting in Europe and central Asia

In 2001, a United Nations General Assembly Special Session (UNGASS) agreed a Declaration of Commitment on HIV and AIDS. Following that, UNAIDS introduced a system of 'UNGASS reporting' focused on the implementation of the Declaration of Commitment based on progress reported by UN member states, against a number of agreed indicators. Reporting takes place every two years. To date, there have been four rounds of UNGASS reporting – in 2004, 2006, 2008 and 2010.

According to UNAIDS, the rate of reporting on UNGASS by countries in Europe and central Asia to 2008 had been lower than in other regions. Within the region, the rate of reporting had been higher in eastern Europe and central Asia than in western Europe (see Figure 33).

Figure 33: UNGASS reporting rates, by region, 2004–08



Source: UNAIDS presentation to advisory group

This relatively low rate of reporting to date, particularly among EU/EFTA countries, reflects a number of concerns about the UNGASS process. Firstly, the overall process of UNGASS reporting is seen as donor-driven, which makes it appear more relevant to developing countries than to developed ones. Secondly, some of the topic areas covered by UNGASS indicators, e.g. orphans and vulnerable children, are seen as more relevant to the generalised epidemics in eastern and southern Africa than the concentrated epidemics of Europe and central Asia. Thirdly, some populations of particular interest to the region, e.g. migrants (see Section 2.5) and prisoners (see Section 2.6) are currently largely overlooked by UNGASS reporting. Finally, a number of specific UNGASS indicators are not seen to be relevant in the region because the thematic area is monitored in a different way or because the monitoring is not considered essential or cost-effective for the specific country context.

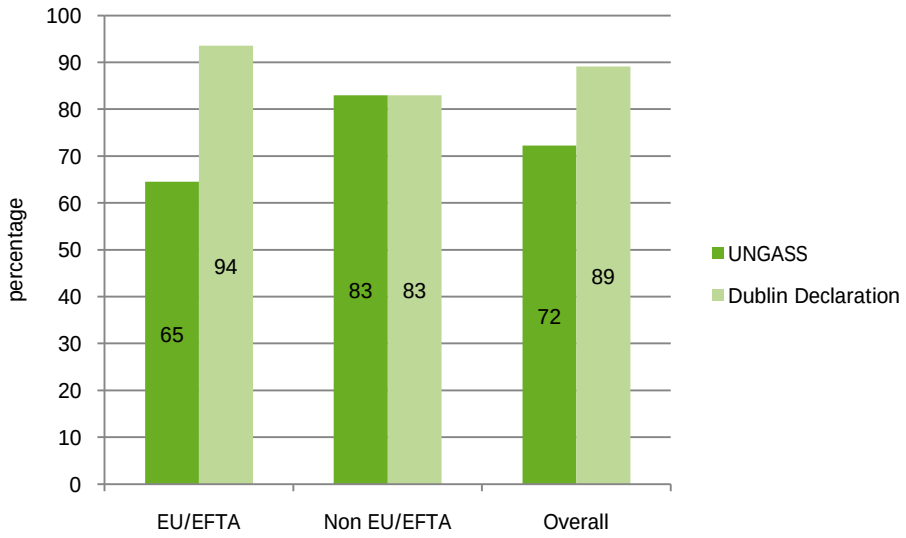
If developed countries are going to report on UNGASS, there is a need to make a stronger case for the benefits of improved international and regional reporting. Tangible benefits such as shared learning, inter-country benchmarking and regional analysis of issues that affect multiple countries are much more compelling reasons to report than the argument that countries are obliged to report as signatories to the UNGASS Declaration.

In addition, the benefits need to be proportional to the reporting burden on countries. This burden could be significantly reduced if countries were asked to report data in a more regular and coordinated manner. A good example of this would be the introduction of a single reporting framework and schedule for reporting on the UNGASS Declaration, the Dublin Declaration and the WHO/UNICEF/UNAIDS annual global report on the scale-up of priority health sector interventions for HIV prevention, treatment, care and support.

This current process of reporting on progress towards implementing the Dublin Declaration has shown that if these concerns are addressed and countries are approached through a trusted regional body, such as ECDC, high response rates can be achieved (see Figure 34). Overall response rates were higher (89%) for the Dublin

Declaration process than for UNGASS 2008 (72%). This difference was due entirely to an increased response rate among EU/EFTA countries.

Figure 34: Percentage of countries responding to UNGASS 2008 and the Dublin Declaration 2009/10



In conclusion, ECDC has identified the following issues that need further action:

- There is a pressing need to adopt a regional approach to UNGASS reporting. There are a number of compelling reasons to make this shift:
  - Harmonised indicators that are more epidemic- and region-specific. Harmonising indicators should also mean there are fewer of them which would reduce the reporting burden for countries.
  - The ability to identify and provide countries with clearly defined benefits of reporting, e.g. shared learning, inter-country benchmarking and regional analysis of issues that affect multiple countries.
  - The ability of international bodies such as ECDC and WHO Regional Office for Europe to provide enhanced support for the reporting process.
  - Higher response rates from countries in the region.
- There is an urgent need to combine the multiple reporting mechanisms currently being used by international organisations, including UNGASS, into one exercise. The various international stakeholders could then extract the data from the consolidated process to use in their different reports. Conducting a single exercise would make it a more routine activity for countries, which is likely to make it easier to manage internally and easier to support externally, e.g. through ECDC. Clarity is needed on what data need to be reported and how often.

5 Conclusions

Specific conclusions for each thematic area have been included at the end of each section. This chapter focuses on the main overall conclusions emerging from the review, particularly those that cut across a number of thematic areas.

1 There is evidence of **strong political commitment** (Section 1.1) for the response to HIV in European and central Asian countries. However, this commitment is not seen uniformly across all countries and is not well reflected by international indicators of political commitment that focus on the existence of a national HIV strategic framework and a multi-sectoral, national AIDS coordinating body. Rather, it is seen in those countries that have demonstrated the political leadership needed to address HIV effectively among those populations most affected by the epidemic. For example, this includes:
- focusing HIV prevention spending on those populations most affected by HIV (see Section 1.3);
- ensuring that effective programmes, such as harm reduction services for IDU (see Section 2.2), are provided on a sufficient scale;
- ensuring a supportive legal and policy environment for work among key populations like MSM (see Section 2.3); and
- ensuring that essential HIV prevention services are available, including in prison settings (see Section 2.6).

2 The role of **civil society** (Section 1.2) in responses to HIV is recognised across countries of Europe and central Asia. Civil society organisations are involved in strategic planning processes in many countries of the region, and civil society considers that the environment in which they operate improved between 2005 and 2007. However, civil society organisations still face considerable challenges in ensuring sustainable funding for their activities. In addition, although reviews like this often consider the views of civil society organisations on the support provided to them by government, there appears to have been less focus on critical review of the activities of civil society organisations by government and other stakeholders.

3 Since 2004, the countries of Europe have provided **considerable financial support** (Section 1.3) for the global response to HIV. This is seen in bilateral funding to national HIV responses and in support of key international institutions, such as the Global Fund to Fight AIDS, TB and Malaria and UNAIDS. However, this funding support needs to be sustained and there is a need for all countries to show the same level of commitment to this as has, to date, been shown by a rather small number of EU and EFTA countries.

4 There is evidence that many countries in Europe and central Asia have appropriately focused their HIV responses on **key populations** affected by the epidemic. However, this focus is not seen clearly in all countries. Injecting drug users (Section 2.2) remain vulnerable to HIV infection across the region. There is evidence of rising rates of HIV infection among MSM (Section 2.3) in many countries, not only in the western part of the region. Any focus on key populations needs to acknowledge that there are overlapping vulnerabilities, e.g. for IDU in prisons and for migrant sex workers. There are also subsets of key populations who may be particularly vulnerable to HIV infection and are less likely to access HIV services. Examples include bisexual men and young IDU.

5 **Migrants from countries with generalised HIV epidemics** (Section 2.5) have been identified as a key population affected by HIV in EU/EFTA countries. This group is not well recognised in international HIV monitoring and reporting systems. There is an opportunity for countries of the region and regional institutions to provide leadership in monitoring responses for this population. One particular area of concern is ensuring that migrants, including those who are undocumented, gain access to ART promptly when they need it.

6 **Prisoners** (Section 2.6) have been identified as another key population affected by HIV in countries of Europe and central Asia. Again, this group is not well recognised in international HIV monitoring and reporting systems. There is a need for essential prevention services, particularly for IDU, to be as available in prison settings as in community settings. EU/EFTA countries have provided leadership on this for OST but progress in providing sterile injecting equipment in prisons has, to date, been limited to very few countries.

7 Since 2004, there has been **an increase in the number of PLHIV receiving ART** (Section 3.1) in some countries of the region. However, these increases took place from a very low base in those countries. Obstacles to treatment still exist for key populations in many countries of the region, particularly for IDU, migrants and prisoners.

8 There is also evidence from many countries of the region that rates of **late diagnosis of HIV infection** remain unacceptably high with many PLHIV presenting with CD4 counts < 350 cells/mm^3 at the time of diagnosis. This is a significant issue because these people are starting treatment later than medically advised. Evidence shows that late diagnosis leading to later introduction of treatment results in higher rates of AIDS-related illness and death.

9 This review demonstrates that countries of Europe and central Asia have **large quantities of data available** concerning their responses to HIV. Analyses of these data provide a rich picture of the nature and diversity of responses to HIV in the region. However, the degree to which this is used to focus national responses on populations most affected by HIV varies markedly across Europe and central Asia.

10 The value of **international reporting on HIV responses** is recognised in the countries of Europe and central Asia. This review shows that high response rates are possible when countries are approached with relevant indicators by a trusted regional organisation and in a way that takes account of previously submitted data. Lessons can be learned for UNGASS reporting and other international reporting processes. It should be possible to introduce a single data collection process which could satisfy all current international reporting requirements, e.g. monitoring the UNGASS and Dublin Declarations and monitoring the progress towards achieving universal access in the health sector. There are strong aspirations from countries that the reporting burden must be reduced by streamlining the current multiple processes into one.