SPECIAL REPORT

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

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Abbreviations

AHPN	African HIV Policy Network (UK)
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
AZN	Azerbaijani manats
BME	Black and minority ethnic
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHF	Swiss francs
CRC	Convention on the Rights of the Child
DHS	Demographic and health survey
DKR	Danish krone
EC	European Commission
ECDC	European Centre for Disease Prevention and Control
EEK	Estonian kroon
EFTA	European Free Trade Association
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EMIS	European MSM Internet Study
EU	European Union
EUR	Euro
GBP	Pound sterling
GDP	Gross domestic product
GESIDA	AIDS Study Group of the Spanish Society of Infectious Diseases
GNI	Gross national income
GNP+	Global Network of People Living with HIV
GP	General practitioner
GUM	Genitourinary medicine
HAART	Highly active antiretroviral therapy
HBSC	Health behaviour in school-aged children
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HPA	Health Protection Agency (UK)
HUF	Hungarian forint
HRK	Croatian kuna
IBBS	Integrated bio-behavioural surveillance
ICRW	International Centre for Research on Women
IDU	Injecting drug user(s)
IEC	Information, education and communication
IOM	International Organization for Migration
IPPF	International Planned Parenthood Federation
IPU	Inter-Parliamentary Union

IVF	In-vitro fertilisation
KZT	Kazakh tenge
LTHSC	Low threshold health service centres
M&E	Monitoring and evaluation
MDR	Multidrug resistant
MICS	Multiple indicator cluster survey
MOH	Ministry of Health
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
NAHIP	National African HIV Prevention Programme (UK)
NASA	National AIDS Spending Assessment
NCPI	National Composite Policy Index
NEP	Needle exchange programme
NGO	Non-governmental organisation
NHA	National health account
NHS	National Health Service (UK)
NOK	Norwegian krone
PEP	Post-exposure prophylaxis
PLHIV	Person/people living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
R&D	Research and development
RELIS	National Drug Monitoring System (Luxembourg)
SEK	Swedish krona
SHM	HIV Monitoring Foundation (Netherlands)
STI	Sexually transmitted infection
T&C	Testing and counselling
TB	Tuberculosis
UK	United Kingdom
UNAIDS	Joint UN Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNITAID	International facility for the purchase of drugs against HIV/AIDS, malaria and tuberculosis
UNODC	United Nations Office on Drugs and Crime
UNSCR	United Nations Security Council Resolution
USAID	United States Agency for International Development
USD	US dollar
USSR	Union of Soviet Socialist Republics
VCT	Voluntary counselling and testing
WHO	World Health Organization

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Executive summary

In February 2004, representatives of European and central Asian countries met in Dublin and issued a declaration (see Annex 1) focused on accelerating the implementation of the Declaration of Commitment that countries made at the UN General Assembly Special Session (UNGASS) on HIV/AIDS in 2001.

So, what progress has been made? That is the focus of this report. It seeks to document achievements, 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, in general, and the report issued by the WHO Regional Office for Europe and UNAIDS in 2008, in particular. Tailored questionnaires (see Annex 2) were sent to 55 countries and responses were received from 49 (see Annex 3).

Political leadership and partnership (Chapter 1)

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) at sufficient scale
- the extent to which countries have tackled difficult but essential policy issues related to marginalised and most-at-risk populations, such as the provision of harm reduction programmes for IDU in prison settings (see Section 2.6) and access to services for migrants from countries with generalised HIV epidemics (see Section 2.5)

In general, there is strong evidence that civil society is widely-recognised as a key player in the response to HIV across the region and that it is heavily involved in that response. For example, almost all countries (98%) reported involving civil society to some extent in developing their strategic framework. In line with the findings from the first progress report on the Dublin Declaration, 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 (see Figure 10). Formal involvement of the private sector in HIV responses appears to be much 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 Figure 11). Doing this more would not only ensure better value for money but promises to produce a more effective response overall. Although financing for national HIV responses in the region is coming increasingly from domestic sources, there is a pressing need for ongoing financial support for HIV responses in low- and middle-income countries of the region (Figure 12). Establishing sustainable mechanisms for providing this financial support needs to be a priority for all countries in the region.

There has been a dramatic increase in funds available for the global response to HIV since the Dublin Declaration (see Figure 13). Prior to the declaration, in 2002, resources available for the global response to HIV were USD 1.2 billion These rose more than sixfold to USD 7.7 billion in 2008. This increase has been driven by the United States and some 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 (EU) Member States, European Free Trade Association (EFTA) countries and the European Commission (see Figure 14). Given the current global financial crisis and competing priorities for funding, it is important that countries of the region meet the challenge to maintain and further increase these levels of funding and to ensure that funding is used most effectively.

Prevention (Chapter 2)

There is strong evidence that certain key populations are particularly affected by HIV in Europe and central Asia. The ongoing challenge is to ensure that these populations have access to the necessary HIV prevention services at sufficient scale. The first progress report on the Dublin Declaration stated the importance of intensifying and scaling up targeted HIV efforts to reduce inequities and this issue continues to be relevant in the region.

It is well-known that injecting drug users (see Section 2.2) are particularly vulnerable to HIV infection and this is certainly the case across the region (see Figure 24). 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. 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 also 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 27), but there is also evidence that they are more affected than previously recognised in other parts of the region. This evidence supports the findings of the first progress report that there is a hidden HIV epidemic among MSM. In some countries, infection rates among this group continue to rise. However, the reasons for this are unclear and may vary from country to country. Further evidence on these reasons is needed and should be provided by the ongoing European MSM Internet Study (EMIS). 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. 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 of the region (see Figure 29). 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 sex workers' knowledge.

Migrants (see Section 2.5) from countries with generalised HIV epidemics are especially affected by HIV. Although some countries are concerned about other groups of migrants, there is little convincing 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 to the provision of treatment and care (see Section 3.1). There are particular issues, in many countries, relating to the access of undocumented migrants to essential services, such as antiretroviral therapy (ART).

Prisoners (see Section 2.6), especially those who inject drugs, are also highly vulnerable to HIV infection in the region. Although there is a recognised need for prisons and the community to have the same HIV services available, 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 36), but this approach has not been taken up in many other countries of the region. This leadership has not been so consistent regarding the provision of sterile injecting equipment in prisons (see Figure 37).

The extent to which young people (Section 2.7) are particularly vulnerable to HIV infection in countries of the region proved to be a contentious issue for this review. Clearly, young people can not be considered a homogeneous group in terms of HIV risk. Nevertheless, 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, it is of concern that 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 (Chapter 3)

All countries with trend data available reported an increase in the number of people on ART (see Figure 40) since the Dublin Declaration was adopted. However, there are concerns that many of these countries started from a very low level of treatment provision and whether or not all those who need treatment receive it promptly. 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, e.g. with a CD4 of < 350 cells/mm^3. 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. ECDC data for 2008 shows that in 21 countries that reported data for CD4 count at time of diagnosis, more than half of those who had a CD4 count had a CD4 count of less than 350 cells/mm^3 when diagnosed (see Figure 42 and Table 43). These figures are of great concern because they indicate that a significant number of people in the region are starting 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 45). There is also strong evidence of residual stigmatisation and discriminatory attitudes in countries of the region and the extent to which available mechanisms to combat stigma and discrimination are used is unclear. This situation has not improved significantly since the first progress report on the Dublin Declaration.

Monitoring the Dublin Declaration (Chapter 4)

One of the commitments of the Dublin Declaration was to monitor its implementation. The European Commission gave this responsibility to ECDC. This report is the product of a process initiated by ECDC to fulfil that responsibility. It is based on the contributions of a wide range of individuals and organisations (see Acknowledgements). In particular, the data in the report has been contributed by the 49 countries that participated in this review.

Two of the principles followed during this review were to use existing data and indicators wherever possible and to ensure that indicators being tracked were relevant to the context of European and central Asian countries. At times, there were tensions 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 who 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. This review concludes that higher response rates for UNGASS reporting from countries of the region would be achieved if:

- the indicators were more relevant for the region;
- the benefits of international reporting were more clearly articulated;
- reporting burden on countries was reduced by having one coordinated international reporting process

Moving speedily to address these issues emerged as an urgent concern of the countries of the region that participated in this review. ECDC is committed to play a leading role in such a regional process.

Introduction and background

HIV is a political priority for the European Union and countries of Europe and central Asia. This is reflected in a number of declarations during the past decade. These include the 2004 Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia, the 2004 Vilnius Declaration on Measures to Strengthen Responses to HIV/AIDS in the European Union and in Neighbouring Countries, and the 2007 Bremen Declaration on Responsibility and Partnership – Together Against HIV/AIDS. These declarations, and international declarations such as the UNGASS Declarations of Commitment in 2001 and 2006, embody the commitment of countries to act on HIV and AIDS and to reach specific targets, such as ensuring universal access to HIV prevention, treatment, care and support.

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 and neighbouring countries, and the Action Plan for 2006–2009. An impact assessment in 2009 assessed progress against that Action Plan.

The Commission has recently issued a follow-up Communication and accompanying Action Plan for the period 2009–2013. The objectives set out in the Communication are to reduce new HIV infections; to improve access to prevention, treatment, care and support; and to improve the quality of life of people living with, affected by or most vulnerable to HIV and AIDS in the European Union and neighbouring countries. The Communication emphasises the importance of political leadership; involvement of civil society and people living with HIV; human rights; and universal access to services. The Action Plan focuses on political commitment and the involvement of a wide range of stakeholders; HIV prevention; action targeting priority regions and populations; improving research and surveillance; and monitoring and evaluation. ECDC monitors the implementation of the Communication and Action Plan and will ensure a coordinated approach to HIV monitoring in Europe by harmonising with other monitoring initiatives, such as those of UNAIDS, WHO and EMCDDA.

The Dublin Declaration

Against the background of the global emergency of HIV and AIDS, representatives of governments from Europe and central Asia met at a conference 'Breaking the Barriers – Partnership to fight HIV/AIDS in Europe and central Asia' in Dublin on 23-24 February 2004. The outcome of that conference, the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia, embodied countries' commitments in a set of 33 actions (see Annex 1 for the full text).

Monitoring the Dublin Declaration

Specifically, action 33 of the declaration calls on the European Union (EU) and others to monitor progress in implementing the Dublin Declaration:

'*We commit ourselves to closely monitor and evaluate the implementation of the actions outlined in this Declaration, along with those of the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS, and call upon the European Union and other relevant regional institutions and organisations, in partnership with the Joint United Nations Programme on HIV/AIDS, to establish adequate forums and mechanisms including the involvement of civil society and people living with HIV/AIDS to assess progress at regional level every second year, beginning in 2006.*'

With funding provided by the German Ministry of Health in 2007, the WHO Regional Office for Europe, UNAIDS and civil society published the first progress report—'Progress on Implementing the Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia'—in August 2008.

At the end of 2007, the European Commission (EC) requested the European Centre for Disease Prevention and Control (ECDC) to develop a framework to monitor the Dublin Declaration on a systematic basis and to produce a second progress report. At the EC Think Tank on HIV and AIDS meeting in April 2008, ECDC presented a proposed monitoring framework. In February 2009, ECDC established an advisory group consisting of 10 country representatives and a number of key stakeholders to support the development of a report on the monitoring of progress in implementing the actions set out in the Dublin Declaration (see Method).

The objective of ECDC was to produce a country-driven, indicator-based progress report, harmonising indicators with existing monitoring frameworks, most notably UNGASS and EMCDDA indicators, and with the EU Communication Action Plan on HIV/AIDS, using existing data and focusing on reporting that is relevant to the European and central Asian context, in order to minimise the additional reporting burden for countries.

The purpose of this second report is to monitor progress in implementing the Dublin Declaration, in particular, reporting on the extent to which countries have met the commitments made in 2004. In addition, this report is expected to help fill gaps in the 2008 UNGASS data, to provide information on data quality and reporting issues in Europe and central Asia to inform the upcoming UNGASS review, and to improve UNGASS reporting in the region.

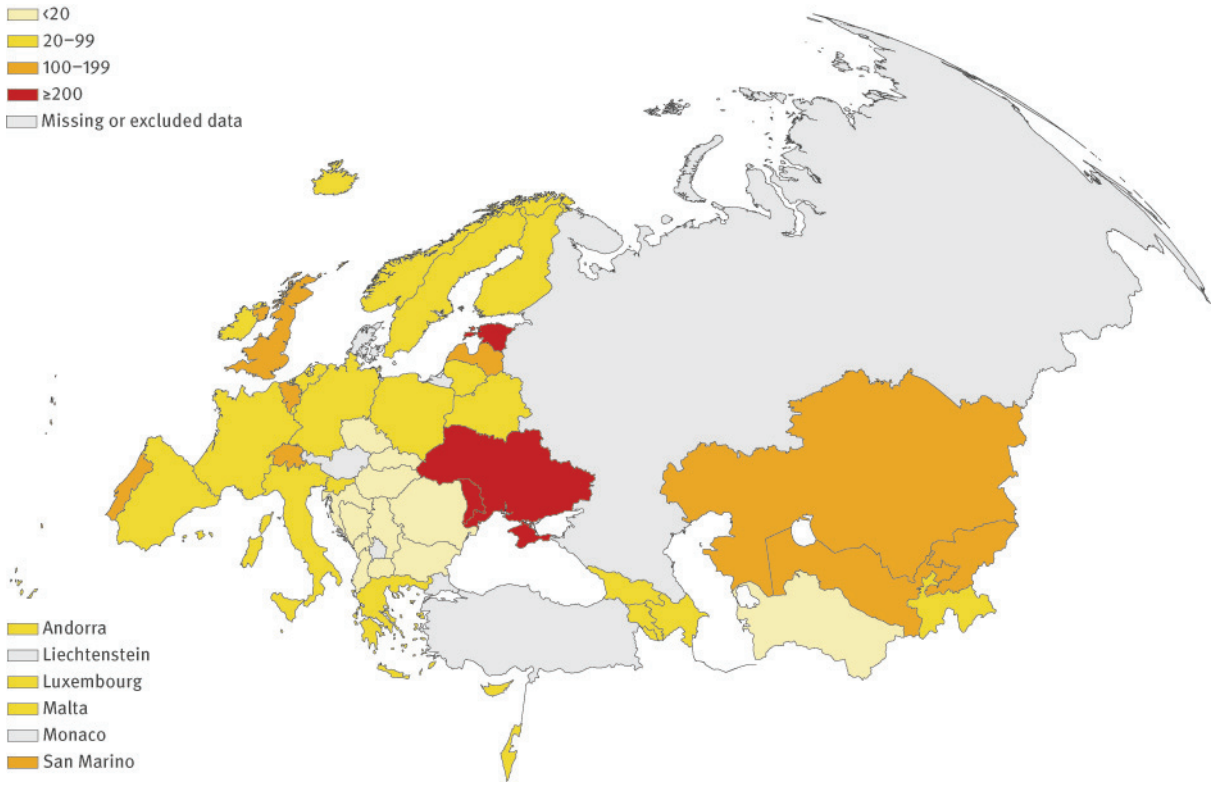
Overview of the HIV epidemic in the region[1]

HIV cases and AIDS cases

HIV infection remains a significant 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 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.

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 2008, 51 600 newly diagnosed cases of HIV infection were reported by 49 countries in Europe and Central Asia[2]. 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[3], 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[4]. 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.

Modes of transmission and epidemic trends

Among the 47 countries reporting consistently for the period 2004–2008, the number of heterosexually acquired cases increased by 16%, the number of HIV diagnoses among men who have sex with men increased by 22% and the number of HIV diagnoses among injecting drug users increased by 19%. However, as discussed below, the predominant mode of transmission varies by country and geographical area, reflecting the diversity of the epidemiology of HIV in the region.

[1] This section is based largely on the report ECDC/WHO Regional Office for Europe. HIV/AIDS Surveillance in Europe 2008.

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

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

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

In EU/EEA countries, the highest proportion of the total number of HIV cases were diagnosed in MSM. Among 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.

Conclusions

HIV infection remains of major public health importance in Europe, with evidence of increasing transmission of HIV in several European countries. Overall, despite incomplete reporting, the number of newly diagnosed cases of HIV infection reported for 2008 has increased, while the number of diagnosed AIDS cases has continued to decline in the WHO European Region, except in the East, where the number of AIDS cases has increased.

Interventions to control the epidemic should be evidence-based and adapted to the country and geographical area. From the surveillance data available it is reasonable to recommend the following:

- For the countries in the East[5]: interventions to control HIV among injecting drug users, including harm reduction programmes, should be the cornerstone of HIV prevention strategies. Measures should also be strengthened to prevent heterosexual transmission targeted at those with high-risk partners.
- For the countries in the Centre[6]: prevention should be adapted to each country's circumstances in order to limit the epidemic to its current low level. However, as the epidemic among men who have sex with men is increasing, interventions to control HIV in this group should be strengthened as a priority.
- For the countries in the West[7]: interventions to control HIV among men who have sex with men should be the cornerstone of HIV prevention strategies, including innovative programmes for this group. Interventions for prevention, treatment and care must be adapted to reach migrant populations.

[5] Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan.

[6] Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Hungary, the Former Yugoslav Republic of Macedonia, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia, Turkey.

[7] Andorra, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, Portugal, San Marino, Spain, Sweden, Switzerland, United Kingdom.

Method

This review took place between November 2008 and June 2010. The work has been based on four key principles:

- Building on previous work, in particular the work done for the first report by WHO and UNAIDS in 2008.
- Ensuring that indicators are streamlined and simplified so that information produced is useful and readily available.
- Ensuring that indicators are relevant to the European and central Asian regional context.
- Ensuring that data collection is harmonised with other monitoring exercises.

There were some tensions between the third and fourth principles, particularly regarding the extent to which the process should be based on existing UNGASS indicators.

ECDC established an advisory group specifically for the purposes of guiding this project forward. This group consisted mainly of country representatives[8], but also included several representatives from civil society and international/regional agencies. The advisory group met four times during the course of the project.

In consultation with the advisory group, ECDC developed a framework for the implementation of the project (see Annex 4). This followed the approach of the previous WHO/UNAIDS report of focusing on three thematic areas: leadership and partnership, prevention, and living with HIV. It also identified a number of subthemes within these main themes. A total of 38 indicators were identified for inclusion in the project. These were divided into three categories, based on the typology used for UNGASS indicators. These were:

- indicators of commitment and action;
- programmatic indicators;
- indicators of knowledge, behaviour, outcome and impact.

Of these, 23 (61%) were existing UNGASS indicators. Three[9] were slight modifications of existing UNGASS indicators. Three[10] were based on UNGASS indicators but involved some additions. Nine[11] other indicators were also included. A number of indicators were based on the UNGASS National Composite Policy Index (NCPI). These indicators were based on the version of NCPI being used in 2010. In keeping with NCPI, there were some questions to be answered by government and some to be answered by civil society. Finally, a detailed description of each of the indicators to be tracked was developed.

The basic principle followed in collecting data for these indicators was to use data reported from countries. There were very few exceptions, for example, data related to national contributions to international AIDS spending was collected from other sources.

An interactive PDF questionnaire was developed covering all questions. However, a distinctive feature of the method was that questionnaires were tailored for each country so that they were only asked to supply data for indicators where they had not previously submitted this to either UNAIDS or EMCDDA. Specifically:

- EMCDDA provided relevant data from their database. Where a country had provided data for a particular indicator, this indicator was omitted from their tailored questionnaire.

[8] Countries represented were Bulgaria, Estonia, Germany, Italy, Portugal, Spain, Sweden, Ukraine and the United Kingdom. For more details of the advisory group, see Acknowledgements.

[9] The indicator on national HIV spending focused on spending on HIV prevention only. The indicator on coverage of programmes for IDU did not only focus on the UNGASS indicator but included measures proposed by others, particularly EMCDDA and the WHO/UNODC/UNAIDS 'target-setting' guide. The indicator of rates of mother-to-child transmission focused on measurement of actual rates rather than the modelled data used by the UNGASS indicator.

[10] The qualitative assessment of civil society involvement included an additional question specifically requested by civil society representatives on the advisory group. The qualitative assessment of HIV-related policy environment in prisons included four additional questions about the availability of free condoms, opioid substitution therapy and needle/syringe programmes in prisons and the practice of mandatory HIV testing in prisons. The indicator on rates of coverage of ART asked countries to provide four pieces of additional information: the total number of adults and children currently receiving ART; the total number of people living with HIV who are currently alive and have ever had a CD4 count < 350 cells/mm^3; the total number of people living with HIV diagnosed in the last year who had a CD4 count < 350 cells/mm^3 at the time of diagnosis; and the estimated number of people living with HIV in the country.

[11] Six questions related to migrants. One of these used questions similar to those used within the UNGASS NCPI. The other five were based on UNGASS indicators used for other key populations, i.e. IDU, sex workers and MSM. One question related to national contributions to international spending, one to HIV prevalence among prisoners and one to an assessment of accepting attitudes towards people living with HIV. This latter indicator is included in UNAIDS Guidance and Specifications for Additional Recommended Indicators.

- Where a country had submitted a response to NCPI in 2008, all questions based on NCPI were then omitted from their tailored questionnaire[12]. Time and resource constraints meant that it was not possible to analyse the completeness of countries' 2008 NCPI responses prior to administering the questionnaire. This meant that if a country that submitted a response to NCPI in 2008 did not answer a particular question, they were not asked this question again.
- Where a question was included in NCPI 2010 but not in NCPI 2008, this was not asked of those countries that had submitted responses to NCPI in 2008. It was included in the generic questionnaire and in tailored questionnaires for those countries that did not respond to NCPI in 2008.
- Data related to other UNGASS indicators was collected from the UNAIDS report on the global AIDS epidemic[13]. Where a country had provided data for a particular indicator, this indicator was omitted from their tailored questionnaire.
- This process was managed through the use of an Excel-based customisation guide developed for this purpose.

In addition, countries were not restricted to supplying information of a particular type. If they did not have information available for a particular indicator, they were encouraged to submit any data they had that was relevant to the issue being measured. Similarly, no rigid timeframe was imposed on countries. Rather, they were requested to supply their most recent data[14].

A training and orientation workshop was held in Stockholm on 16–18 June 2009. This was attended by representatives from 33 European and central Asian countries. It was conducted in English with Russian translation. Following the provision of background information, the monitoring framework and questionnaire were presented to participants. Based on discussion at the workshop, it was decided that all responses would be made in English but a Russian translation of the entire questionnaire would be made available to Russian-speaking countries. However, these countries agreed to submit their responses in English in their tailored questionnaire, which would be supplied in English.

Following the workshop, tailored questionnaires were sent to 55 countries[15]. Responses were received from 49 countries[16]. This included responses from 12 countries[17] that did not submit returns to UNGASS in 2008 (see Section 4.2).

Data was entered into a secure Filemaker Pro database developed expressly for this purpose. Data from the questionnaires was exported electronically from the PDF form to the database[18]. UNGASS and EMCDDA data were entered manually. In order to enter data from 2008 version of NCPI, a 'crosswalk' had to be developed matching questions in the 2008 version of NCPI with questions in the questionnaire. In cases where there had been changes in NCPI from 2008 and 2010, a decision was made as to whether data was comparable or not. Where such data has been used in the report, this issue is clearly flagged in a footnote.

Based on feedback from countries and in consultation with the advisory group, the ECDC has identified a number of positive and negative features of the reporting process. Overall, countries appreciated the comprehensive nature of the questionnaire, e.g. inclusion of migrants and prisoners, and the fact that the process included previously reported data, e.g. UNGASS and EMCDDA.

However, while some countries reported positively on civil society inputs, others had challenges in getting responses from civil society. Some countries commented that the process had led them to realise that more information was available than they had expected, and others noted that the questionnaire had highlighted gaps in available information, especially about certain populations. Specific concerns were raised by some countries about the relevance of questions on migrants from countries with generalised epidemics.

The advisory group noted that:

[12] Two indicators—qualitative assessment of involvement of civil society and qualitative assessment of HIV-related policy environment in prisons—contained questions from NCPI and some additional questions. These questions were sent to all countries regardless of whether they had submitted a response to NCPI in 2008.

[13] In finalising the report, each country was given the opportunity to comment on the data in the report. In a few cases, countries questioned or disagreed with EMCDDA or UNGASS data. In these cases, the EMCDDA/UNGASS data was retained and the country comments/concerns noted as a footnote.

[14] Tables in this report attempt to explain which date countries' data refer to. However, there may be some inconsistencies between date of collection period and date of reporting.

[15] The 53 countries in the WHO European Region plus Kosovo under UN Security Council Resolution 1244 and Liechtenstein. These include 31 EU/EFTA countries and 22 others.

[16] No response was received from Austria, Belarus, Kosovo (under UNSCR 1244), Liechtenstein, Monaco and Montenegro.

[17] Andorra, Czech Republic, Denmark, Iceland, Italy, Luxembourg, Malta, Norway, Portugal, San Marino, Slovakia and Turkmenistan.

[18] In a small number of cases, e.g. Turkmenistan and Uzbekistan, countries submitted a Word version of the questionnaire. In these cases, data was exported manually to the database.

- the process of bringing together institutions and country representatives in the advisory group and at the workshop had been positive and useful;
- the questionnaire was well designed and the way it was tailored for each country was helpful;
- the questionnaire promoted the involvement of a range of colleagues and stakeholders, including from other government departments and civil society, although some countries experienced difficulties in getting responses from civil society;
- more guidance on the level of detail required in responses would have been helpful, especially for countries that have a significant amount of data available. Guidance on what data can be used, e.g. data from small-scale research studies, would also have been helpful;
- the process helped to identify gaps in data and to promote discussion about how to address this;
- the process provided UNAIDS with insights into the challenges of UNGASS reporting for countries in the region and will help to improve the next round of UNGASS reporting.

This final report is structured around the monitoring framework developed for the project. It also includes an introduction and sections related to monitoring and evaluation. The various sections of the report have been drafted with input from the advisory group. Each country that responded has been given opportunity to review and validate the data presented on behalf of their country.

Limitations

The review of the findings has been performed with an aim of providing as complete and reliable overview as possible. While efforts were made to ensure a sufficient level of data quality, several factors contribute to limitations in the conclusions that can be drawn based on the reported information. The results of this review should therefore be considered in the light of these limitations.

Data comparability is addressed within the monitoring process by the use of the standardised indicators. While these have been designed with an aim of both capturing and describing the relevant information of the issue measured, compromises due to data availability and comparability cannot be completely avoided. ECDC remains aware of the fact that for some of the indicators, especially the economic and resource indicators (Financial Resources for National Responses to HIV and AIDS) serious limitations remain in the ability to capture the full societal response of many countries in the region. In many cases, it is likely that reported figures underestimate the role of integrated services and preventive measures in sectors outside the health services. Another indicator for which interpretation is challenging is treatment coverage, particularly ART coverage, as the reported indicator relies on accurate estimates of individuals in need of treatment, which may not be available or systematically used. These limitations are important to bear in mind if comparisons between countries are made based on the data presented here within.

Bias in the reported data cannot be completely avoided in the reporting process, as methods for primary data collection vary both between countries (and regions within countries) and over time, even if the indicators derived from them would not change. Most data collection relies on existing internal monitoring systems that are designed out of country needs. It is likely that both systematic and random biases exist in many of the response indicators due to the different systems and lack of a common agreed protocol for primary information collection. In a short term perspective, the introduction of a common protocol for primary data collection is realistic only for a very limited number of subject areas in the monitoring process (such as HIV and AIDS surveillance data).

Correctness of the data reported is addressed through guidelines defining the specifications for deriving the indicator data in the reporting countries. While the guidelines are intended to be clear, understandable and unambiguous, the monitoring process was not designed to capture sporadic or even systematic misunderstandings in the way the primary country data was collected and indicators derived, except for answering direct questions posed by the reporting countries.

Completeness of the reported data varies. In calculations of the overall proportion of reporting countries in the region, all countries responding to the reporting request with data have been included. While this may slightly overestimate the response rate to all areas of the monitoring process, most countries that reported responded to a substantial proportion of the indicators. This will, however, have an impact on some of the analyses and conclusions presented in the report.

Reliability and validity of data presented in the report is directly dependent on the reporting parties, as the ECDC has no possibility to systematically verify provided information from secondary sources, but relies on the countries to report accurate data and information. In the review process, an effort has been made to identify potential technical mistakes within the reported information and countries were asked to verify identified anomalies. However, if the information provided does not reflect reality, this would not be possible to be addressed within the reporting process. The inclusion of both governments and civil society in the monitoring process is intended to improve the representativeness and completeness of the process, but is dependent on the level of involvement of both parties.

While the data provided through the monitoring process is likely to contain some errors and biases, the presentation of the information in a systematic report provides ample opportunity for independent benchmarking of the data and its quality for the readership.

1 Leadership and partnership

1.1 Political leadership – planning and coordination

1.1.1 Introduction

Political leadership is widely recognised by the international community as an essential component of an efficient and effective response to HIV and AIDS. In 1999, UNAIDS and the Inter-Parliamentary Union (IPU) published the *Handbook for Legislators on HIV/AIDS, Law and Human Rights*. The underlying theme of this publication was the importance of political leadership to the effectiveness of the HIV response.

The Dublin Declaration includes several key statements that are specifically relevant to political leadership and consistent with the themes in the UNAIDS and IPU handbook. These include promoting strong and accountable leadership at the level of heads of state, encouraging strong leadership by civil society and the private sector, and establishing and reinforcing national HIV/AIDS partnership forums.

Political leadership was also an important consideration behind the international community's endorsement of the Three Ones principles in 2004 (see Box 1). While these principles were originally intended to coordinate the role of donor agencies and reduce the reporting burden in developing countries, they have been widely used to measure the organisation, efficiency and effectiveness of national responses. The National Composite Policy Index (NCPI), which is a key component of UNGASS reporting, includes sections that address each of the principles.

This section is based on data from NCPI questions focused on the first two of the Three Ones principles and is structured around two topic areas, i.e. strategic planning and political support. In addition, Section 4.1 considers questions relating to the third principle.

Given the challenges of measuring strategic planning and political support, proxies are used to determine the level of commitment. The proxy for strategic planning focuses on the existence of a strategic framework and the role of civil society in developing it. The proxy for political support focuses on the existence of an officially recognised national multisectoral AIDS management and/or coordination body.

Box 1: The Three Ones Principles

- One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners.
- One National AIDS Coordinating Authority with a broad-based multisectoral mandate.
- One agreed country-level monitoring and evaluation system.

1.1.2 Strategic planning

Almost all (92%[19]) countries reported the existence of a strategic framework[20] for their response to HIV. Almost all of these frameworks (91%[21]) were based on a needs assessment and include a clear statement of goals. Just over three quarters (76%[22]) include operational and monitoring and evaluation (M&E) plans. However, less than three quarters (71%[23]) of these frameworks have identified funding sources and less than two thirds (62%[24]) are costed (see Figure 2). These findings indicate that strategic frameworks have not been translated into operational plans, M&E plans and budgets in some countries.

All but one of the responding countries (98%[25]) had involved civil society in the development of their strategic framework. Over three quarters (76%[26]) had fully involved civil society in the development of their strategic

[19] 45/49. Andorra, Belgium and the Netherlands reported that they do not have such a strategic framework. Iceland did not respond to the question. Albania answered 'No' to the initial question about the existence of a strategic framework, but provided answers to most of the follow-up questions. Consequently, Albania has been treated as having a strategic framework and its answers to the follow-up questions are factored into the analysis of the responses.

[20] A screening question about the existence of a strategic framework, followed by a series of detailed questions if the respondent answered 'Yes' to the screening question, was used in the questionnaire. This approach is identical to the one used for UNGASS reporting.

[21] 41/45.

[22] 34/45.

[23] 33/45.

[24] 28/45.

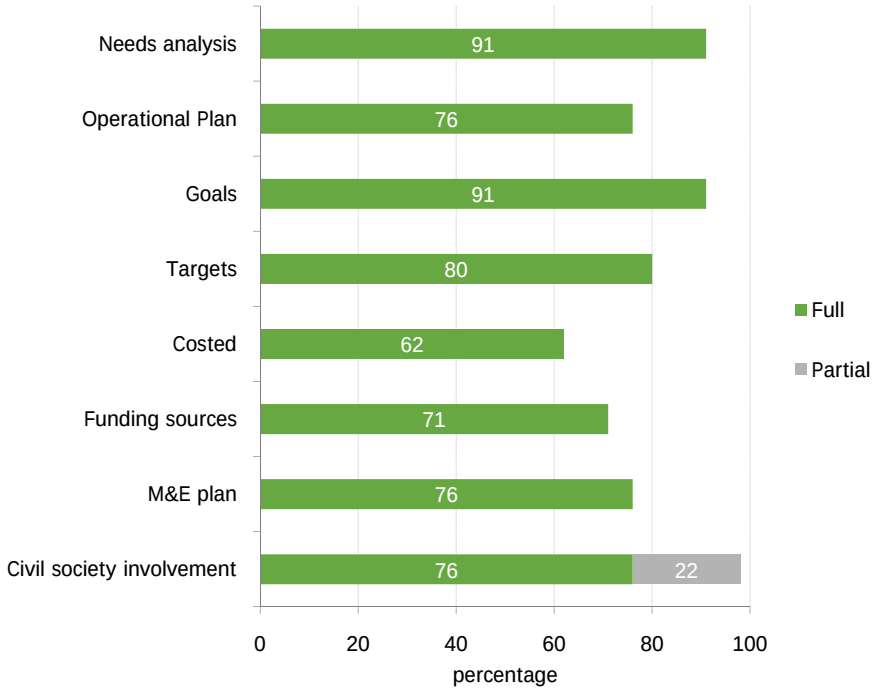
[25] 44/45.

[26] 34/45.

framework and 22% had partially involved civil society in this process[27] (see Figure 2). The high rate of involvement of civil society in the development of strategic plans is positive. Other aspects of civil society involvement are considered elsewhere in this report (see Sections 1.2 and 4.1).

Almost all (80%) countries with a strategic framework report having had such a framework for more than five years. Since the Dublin Declaration was agreed in 2004, an additional eight countries report having developed a strategic framework[28,29].

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



1.1.3 Political support

Almost all (84[30]) countries indicated that they have an officially recognised national multisectoral AIDS management and/or coordination body[31,32]. Almost all (82%[33]) countries have had a management and/or coordination body for more than five years. Across the region, an additional nine countries report having formed a management and/or coordination body since the Dublin Declaration in 2004[34].

Among the countries reporting that they do not have a coordination body, several provided specific comments about the reasons for this. For example, Cyprus reported having a National AIDS Committee that has similar

[27] The questionnaire asked if countries fully or partially involved civil society. The corresponding question for 2008 NCPI reporting asked countries if civil society was actively or moderately involved. For the purposes of this report, actively is considered to correlate to fully and moderately is considered to correlate to partially.

[28] Bosnia and Herzegovina, Czech Republic, France, Greece, San Marino, Serbia, Sweden and Ukraine.

[29] The Former Yugoslav Republic of Macedonia did not respond to the question about the number of years that the country has had a strategic framework.

[30] 41/49. Albania and Andorra answered 'No' to the screening question, but did provide answers to some of the follow-up questions and their answers were factored into the analysis of the responses. Consequently, they have been treated as having such a body.

[31] The questionnaire used the existence of an officially recognised national multisectoral AIDS management and/or coordination body as a proxy for political support for the HIV response. Specifically, countries were asked a screening question about the existence of such a body. If they answered 'Yes' to this question, they were directed to a series of additional questions to collect more information. This is identical to the approach used for UNGASS reporting.

[32] Of the remaining eight countries, seven—Belgium, Cyprus, Czech Republic, France, Greece, Netherlands and San Marino—reported not having a management and/or coordination body, and Iceland did not provide any information.

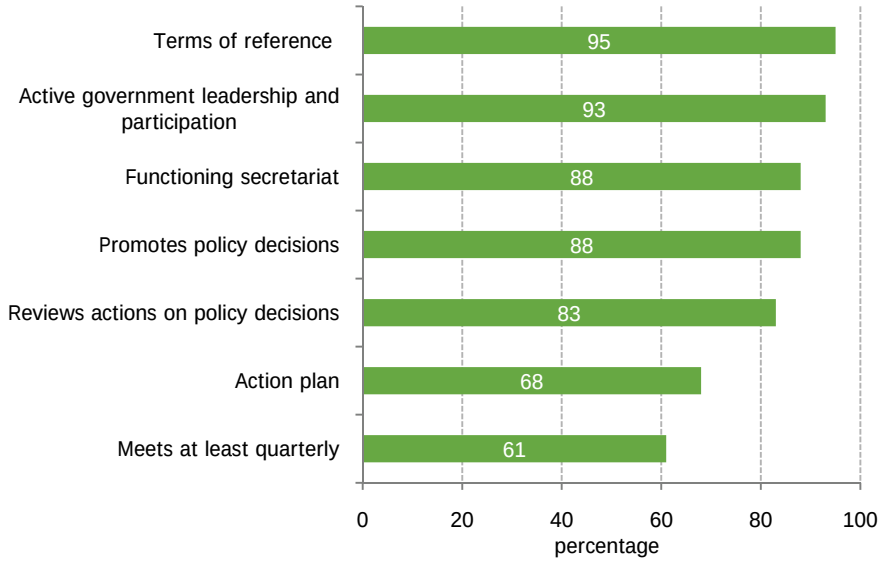
[33] 32/41.

[34] Azerbaijan, Hungary, Kazakhstan, Lithuania, Norway, Russia, Sweden, Tajikistan and Ukraine. In addition, Slovenia reported re-establishing their body in 2007. It had originally been established in 1985.

features and functions[35]. France reported that it does have a management and/or coordination body but that it is restricted to the health sector. The Czech Republic reported that it had a multisectoral coordination body until 2007 when it was disbanded because of limited participation by non-health sectors.

As shown in Figure 3, almost all countries reported that their management and/or coordination body has terms of reference (95%[36]), active government leadership and participation (93%[37]) and a functioning secretariat (88%[38]) and that it promotes policy decisions (88%[39]) and reviews actions on policy decisions (83%[40]). However, just over two thirds reported that the management and/or coordination body has an action plan (68%[41]) and less than two thirds reported that meetings are held at least every quarter (61%[42]). This raises questions about the extent to which these bodies function in practice in some countries.

Figure 3: Percentage of countries reporting a management and/or coordination body that meets key criteria related to governance and operations[43]



The questionnaire asked specifically about membership aspects of the management and/or coordination body. Nearly all (93%[44]) countries with this type of body report that it has a defined membership (see Figure 4).

The high proportion of countries that include people living with HIV (PLHIV) in their management and/or coordination body (83%[45] in all countries and 91%[46] in EU/EFTA countries) is encouraging. Similarly, a high proportion of countries reported that the management and/or coordination body involves civil society (83%[47] in all countries and 82%[48] in EU/EFTA countries). In contrast, the proportion of such bodies that involve the private sector (29%[49] in all countries and 23%[50] in EU/EFTA countries) is low. It may be useful to collect more specific information about the reasons for this in the future.

[35] Cyprus did not provide any additional information on their National AIDS Committee so there is no analysis of its operations included in this report.

[36] 39/41.

[37] 38/41.

[38] 36/41.

[39] 36/41.

[40] 34/41.

[41] 28/41.

[42] 25/41.

[43] Data presented in Figures 3 and 7 reflect responses to two different NCPI questions; however, in many countries the bodies referred to in these two questions could be or are one and the same.

[44] 38/41.

[45] 34/41.

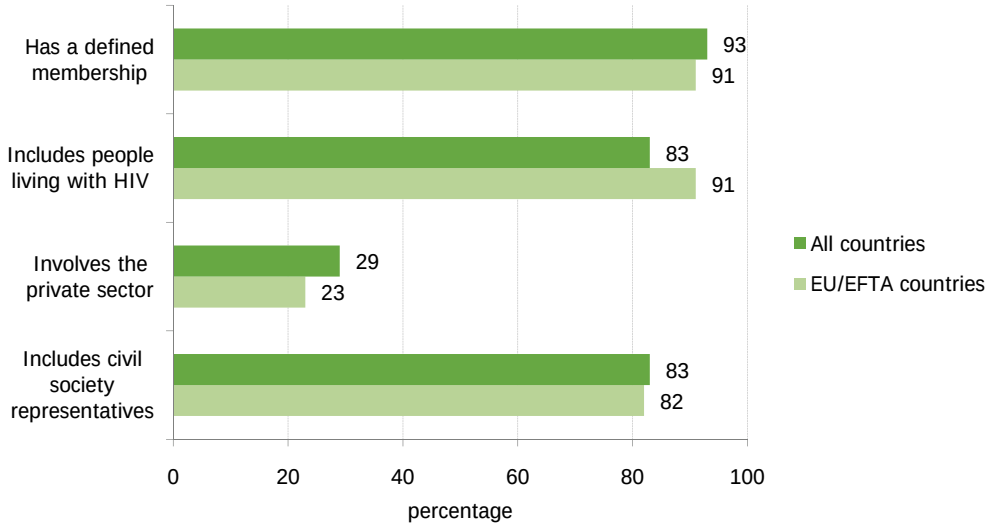
[46] 20/22.

[47] 34/41.

[48] 18/22.

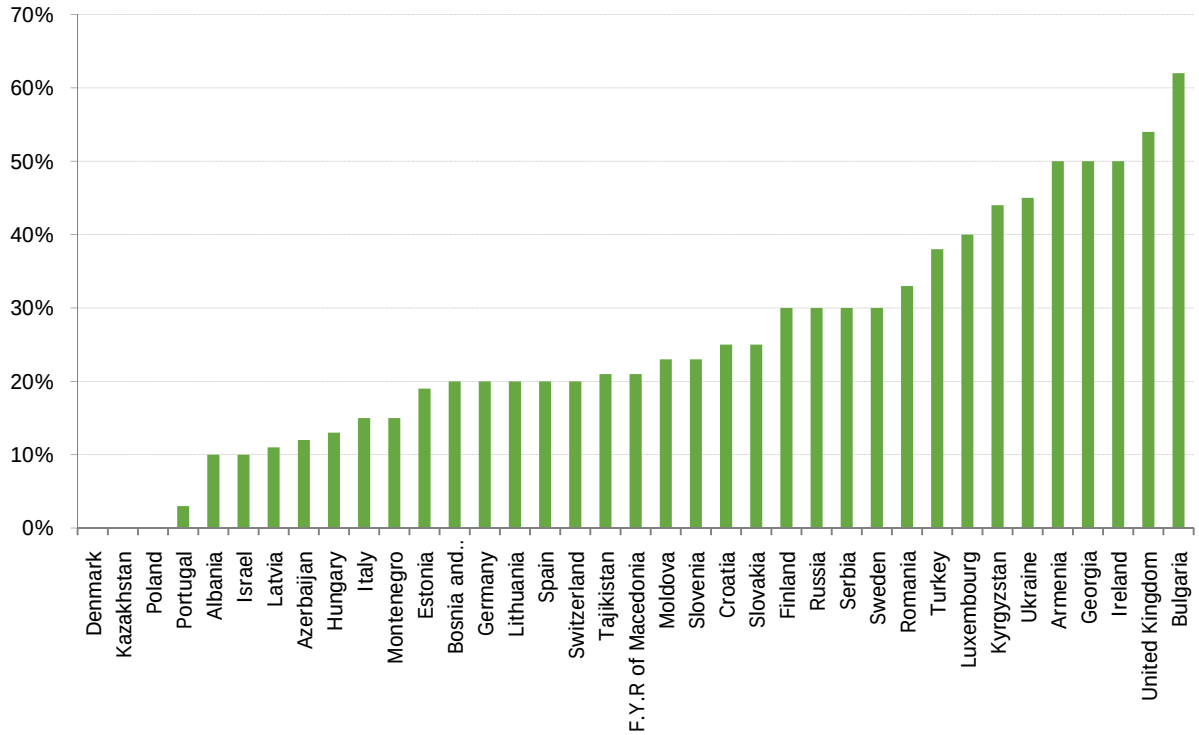
[49] 12/41.

Figure 4: Percentage of respondents with a management and/or coordination body that meets key criteria related to membership



The percentage of the membership of the management and/or coordination body represented by civil society ranged from zero, in Denmark, Kazakhstan and Poland, to 62% in Bulgaria (see Figure 5). More than a third (39%[51]) of countries reported that more than one quarter of representatives on the body are from civil society. Five countries (12%[52]), Armenia, Bulgaria, Georgia, Ireland and the United Kingdom, reported civil society representation of 50% or more. In addition, 85%[53] of countries responding, including 100% of EU/EFTA countries, reported that the body provides opportunities for civil society to influence decision making.

Figure 5: Percentage of civil society membership on the AIDS management and/or coordination body



[50] 5/22.

[51] 16/41.

[52] 5/41.

[53] 38/41.

1.1.4 Conclusions

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 in the region have strategic frameworks and management and/or coordination bodies. This number has increased since the adoption of the Dublin Declaration in 2004. These frameworks are largely well constructed, built around needs analyses and incorporating goals and targets. Management and/or coordination bodies in most countries have sound governance arrangements, inclusive membership and are engaged in policy matters.

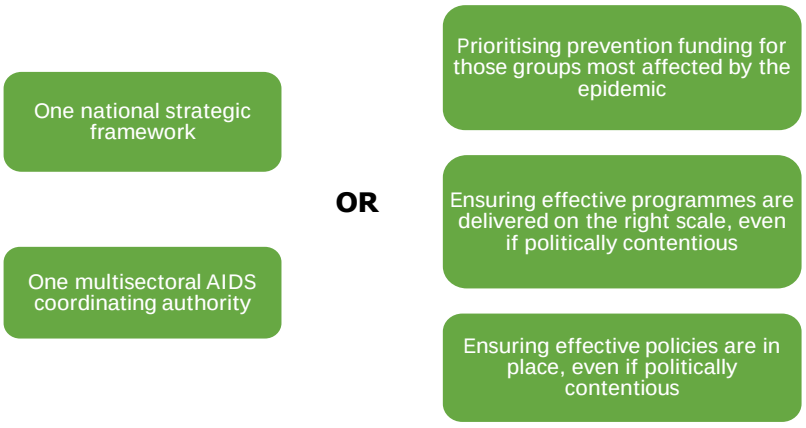
However, although almost all countries have strategic frameworks, there are concerns about how effectively these are implemented in practice, given that fewer have operational plans or a costed framework. If these frameworks do not clearly affect implementation of the national HIV response, they risk being merely symbolic documents. Similarly, although almost all countries have an officially-recognised national multisectoral AIDS management and/or coordination body, fewer have an action plan or meet quarterly, raising concerns about whether these bodies have practical value or are largely symbolic in nature. Some countries have either decided to disband their multisectoral body, e.g. Czech Republic, or have a body focused on health rather than HIV specifically, e.g. France.

The biggest question though is about the relevance of these proxy measures of political leadership for the region (see Figure 6). 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 across 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 subpopulations that are most affected by HIV in a country (see Section1.3);
- 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; and
- the extent to which countries are providing 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 6: What is political leadership?



In conclusion, the ECDC has identified the following issues needing 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 at sufficient scale and these populations have access to treatment, care and support as well as to effective prevention services (see Sections 2.2 to 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 Section2.6); 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

1.2.1 Introduction

The international community values the role of civil society in responses to HIV. Many national governments, bilateral donors and multilateral agencies have recognised the wide range of knowledge, skills and experience that civil society brings to those responses. There have been many initiatives to harness the capacity of civil society organisations. However, there are also likely to be opportunities to engage with civil society more efficiently, more effectively and more broadly.

However, there is no single, standard definition of civil society. In some cases, the definition of civil society includes the private or commercial sector (see Box 2), and in some cases it does not. In recent years, the private sector has become increasingly involved with the HIV response. However, when compared with civil society, its role continues to be relatively minor, often focusing on awareness raising and resource mobilisation. The operational role of the private sector in the response is generally limited[54].

Box 2: UNAIDS definition of civil society

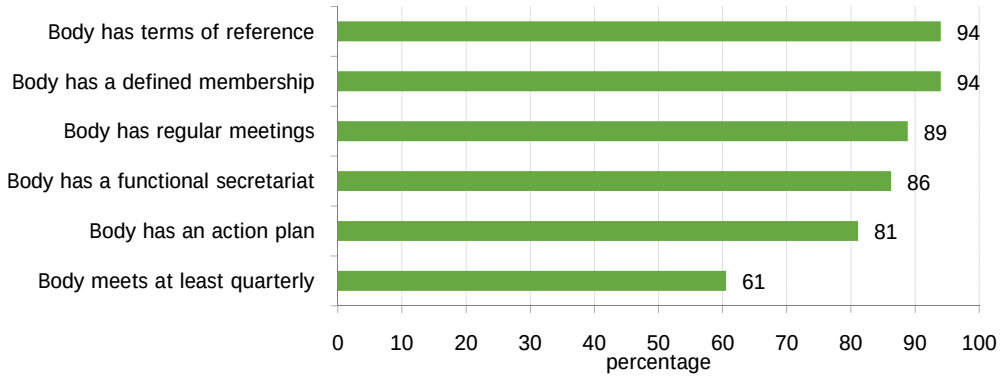
UNAIDS defines civil society broadly to include AIDS service organisations, groups of people living with HIV and AIDS, youth organisations, women's organisations, business, trades unions, professional and scientific organisations, sports organisations, international development NGOs, and a wide spectrum of religious and faith-based organisations, both globally and at country level.

This section looks at responses from countries on the role of civil society in the response to HIV. The findings are based on responses to a series of detailed questions. These questions are almost exclusively based on questions contained within the UNGASS NCPI[55]. The questions were separated into two sections. In the first section, national governments were asked 20 questions about a range of issues, including the involvement and role of civil society in national bodies. In the second section, representatives from civil society were asked 13 questions, including about the role of different risk populations, people living with HIV and civil society more broadly in the response.

1.2.2 Organisational structures

Issues relating to civil society involvement in national multisectoral AIDS management/coordination bodies are covered in Section 1.1. More than three quarters (78%[56]) of countries reported that they have a national AIDS body that promotes interaction between government, PLHIV, civil society and the private sector. Figure 7 presents data on the membership, governance and operation of this body. Relatively few (60%) of these bodies have an action plan. The scope to actively and effectively promote interaction among key stakeholders may be limited without an action plan.

Figure 7: Percentage of countries reporting on key criteria for a national AIDS body that promotes interaction between government, people living with HIV, civil society and the private sector[57]



[54] Initially, it was intended that this chapter would focus on all types of non-state actors, both civil society and private sector. However, so little data was collected for the private sector that it was decided to focus on civil society only.

[55] One additional question was added and was asked of both government and civil society. This question was added specifically at the request of Civil Society Forum representatives on the project's advisory group and asked to what extent the involvement of civil society has made a difference.

[56] 38/49.

[57] Data presented in Figures 4.2 and 5.1 reflect responses to two different NCPI questions; however, in many countries the bodies referred to in these two questions could be or are one and the same.

Just over one third (36%[58]) of countries reported having civil society participation in an M&E committee or working group. A slightly higher proportion (43%[59]) reported that the national M&E plan was developed in consultation with civil society, including people living with HIV (see Section 4.1 on M&E).

Civil society respondents from few (16%[60]) countries indicated that civil society and people living with HIV are represented on the ethical review committee. Almost half (49%[61]) said these constituencies do not serve on the committee. Around a third (35%[62]) of countries did not answer this question.

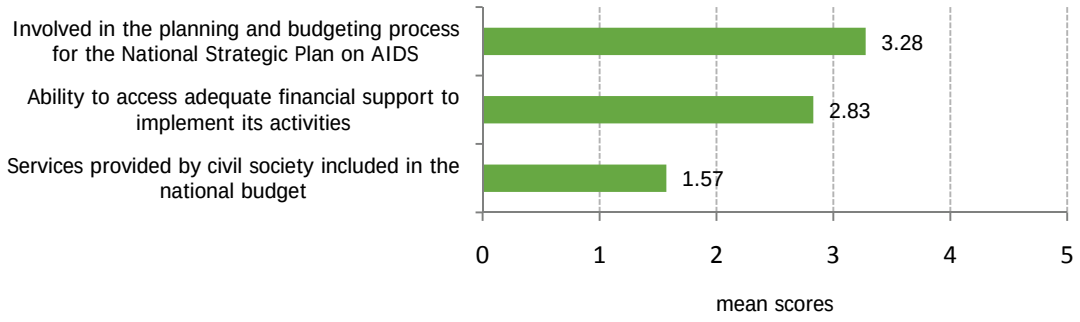
Overall, the link between civil society and key organisational structures appears to be strong, particularly with management/coordination bodies. However, rates of participation by civil society in other structures, e.g. M&E and ethical review committees, are lower. It is not clear the reason for this or if this is an issue of concern for civil society.

1.2.3 Working relationship between civil society and government

The degree to which civil society is involved in developing strategic frameworks for the HIV response is documented in Section 1.1 (see Figure 2). In addition, 31 countries reported on the percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year. The amounts ranged from 0% to 100%[63].

Civil society was asked three different questions related to financial matters (see Figure 8) and gave higher mean scores to its involvement in the planning and budgeting process for the National Strategic Plan (mean 3.28, median 3) than to their ability to access adequate resources (mean 2.83, median 3). The lowest score was given to civil society's ability to get the costs of services it provides included in the national budget (mean 1.57, median 2). It appears that civil society is relatively satisfied with its involvement in national financial planning processes but less satisfied with their ability to access financial resources. Using the same 0–5 scale, civil society ranked the extent to which it is able to access adequate technical support to implement its HIV activities. The mean score was 2.90 (median 3), which is broadly similar to the mean score for the comparable question on financial support.

Figure 8: Mean scores on questions assessing the extent to which civil society has a role in financial matters of the national response to HIV[64]



Countries responded to five questions focused on the specific relationship between the AIDS management/ coordination body and civil society organisations (see Figure 9). Among those countries with these bodies, the provision of information to civil society organisations is high (87%) but the provision of technical guidance/materials is lower (73%). Similarly, while coordination is relatively high (83%), capacity building is much lower (58%). Less than a quarter (24%) of governments reported procuring and distributing commodities, including supplies such as condoms, for civil society organisations. Reasons for this variation are unclear and may vary from country to country. For example, this may reflect the limited role of civil society in some countries in direct delivery of services. It appears that the relationship between government and civil society is primarily focused on a few key activities, such as the provision of information, rather than capacity building or distribution of commodities.

[58] 18/49.

[59] 21/49.

[60] 8/49.

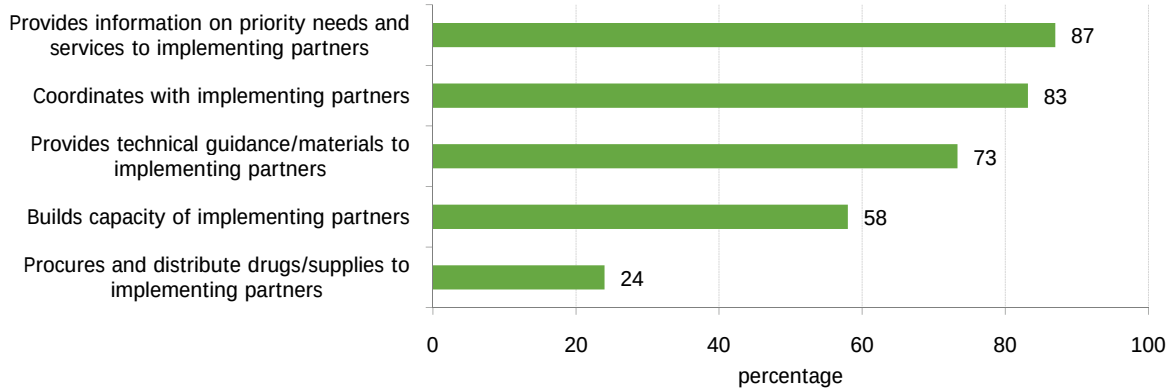
[61] 24/49.

[62] 17/49.

[63] Data is not included as the figures are not directly comparable.

[64] Questions were answered by civil society. All questions used a 0–5 scale, where 0 is lowest and 5 is highest.

Figure 9: Percentage of positive responses by government showing support from AIDS management/coordination bodies for civil society organisations



1.2.4 Inclusiveness and diversity

Civil society reported that a variety of key populations are included by government in HIV policy design and programme implementation. Examples included injecting drug users (see Section 2.2.), men who have sex with men (see Section 2.3), sex workers (see Section 2.4), migrants from high prevalence countries (see Section 2.5) and prisoners (see Section 2.6). Almost two thirds (65%[65]) of countries were reported to involve these populations in policy design and programme implementation. Nine countries[66] were not considered to involve these populations and eight[67] did not respond to this question.

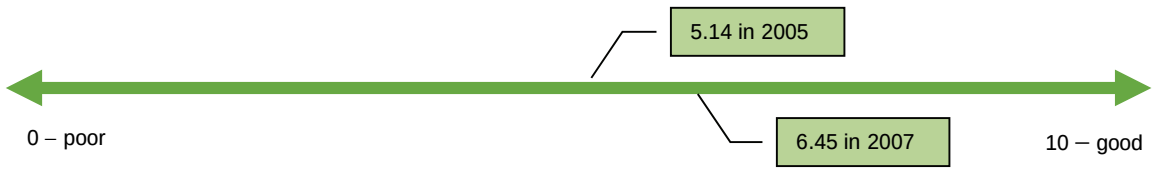
Civil society was also asked a question about the extent that civil society representation in HIV-related efforts inclusive of its diversity. This question also used the same 0–5 scale mentioned above to measure this. The mean score for this question was 3.38 (median 3). Countries scoring highly (5) on this measure included Croatia, Germany and Switzerland.

1.2.5 Outcomes of the relationship between civil society and government

The questionnaire captured a range of data from civil society and government on the outcomes of their relationship. Of those countries with a national multisectoral AIDS management/coordination body, almost all (88%[68]) governments reported that the body provided opportunities for civil society to influence decision making. Civil society respondents gave a mean score of 3.24 (median 3)[69] to a question regarding their ability to strengthen political commitment of top leaders and national policy formulation. High scoring (5) countries were Denmark, Germany, Sweden and Uzbekistan.

Civil society representatives were also asked to rank the extent that 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 (median 5) in 2005 to 6.45 (median 6) in 2007 (see Figure 10). This mirrors the finding in the first progress report on the Dublin Declaration that civil society is being engaged more broadly in the HIV response.

Figure 10: Civil society rating of efforts to increase civil society participation between 2005 and 2007



Governments in 39 countries responded to an open question about the extent to which civil society has made a difference in the response (see Box 3). Many countries cited the ability of civil society to work with marginalised and most-at-risk populations. They recognised the expanding role of NGOs in the response and civil society's ability

[65] 32/49.

[66] Bosnia and Herzegovina, Estonia, Greece, Ireland, Italy, Romania, Russia, Slovakia and Uzbekistan.

[67] Albania, Andorra, Azerbaijan, Belgium, Iceland, Israel, Malta and San Marino.

[68] 40/45.

[69] Using a 0–5 scale, where 0 is lowest and 5 is highest.

to deliver prevention, care and treatment services and were appreciative of the sector's participation in planning, resource mobilisation and M&E.

Box 3: Government comments about the role of civil society in the HIV response

Cyprus	'The involvement of civil society opens the doors to high risk groups that are not easily reachable by the government.'
Denmark	'Danish NGOs have played a major part in information, teaching and counselling programmes involving HIV prevention'.
France	'NGOs implement … most of the prevention strategies and provide feedback to the national level'.
Greece	'Civil society plays "an active role in the field of advocacy"'.
Germany	'The involvement of the civil society provides us with 'important feedback about our HIV/AIDS strategy'.
Kyrgyzstan	'Civil society contributes to "creating a supportive environment, reducing stigma and discrimination"'.
Norway	'The involvement of civil society has … made a difference in: a) implementation of policies, especially related to vulnerable groups; b) development of policies; [and] c) development of knowledge and information'.
Poland	'Without the involvement of NGOs, many prevention activities wouldn't be possible … civil society [organisations] are [the] best representatives for PLWHIV as well as for vulnerable populations'.
Portugal	'Civil society provides "a better assurance of non-discrimination"'.
Romania	'Civil society organisations participate in "the national response to HIV/AIDS at all levels: policy design, coordination, implementation, monitoring and evaluation"'.
Spain	'NGOs are particularly good at "defending the interests of the affected ones, being alert on the emergent needs, answering with agility, reaching the most inaccessible and contributing to the comprehension of the epidemic with the knowledge from inside'".
Sweden	'Civil society organisations play a major role in giving [most vulnerable] groups access to prevention, treatment and social support'.
Switzerland	'A good implementation of prevention and support policies would not be possible without [the] active participation of … civil society'".
United Kingdom	'UK health departments routinely engage with civil society in developing HIV and related national policy and in changes to how HIV services are delivered'".
Ukraine	'Civil society organisations "have also contributed greatly to the preparation of changes to the law on social services, the law on social order and introduction of licensing for organisations providing social services"'.

Civil society representatives in 34 countries also submitted comments to an open question about the extent to which their sector has made a difference in the response (see Box 4). Themes identified in their comments included the ability of civil society organisations to more easily work with marginalised and most-at-risk populations and broad involvement in prevention, care and treatment initiatives. In addition, civil society respondents expressed concerns about the constraints faced by civil society. For example, there were multiple references to the issue of limited funding, including the inability of NGOs to access government funds and reliance on international support for their efforts.

Box 4: Civil society comments about their role in the HIV response

Armenia	'Civil society is involved in [the] development, implementation and oversight of the National AIDS Programme'.
Belgium	'Since 2007, the involvement of the Flemish Gay Movement in lobbying and prevention activities has increased, leading to a stronger sense of urgency both with gay men and policy makers'.
Bosnia and Herzegovina	'We see NGOs and other civil society members becoming partners of the government and strong voices [for the] vulnerable and marginalised'.
Croatia	'Civil society is the biggest implementer of … HIV/AIDS prevention, working with different beneficiaries all across Croatia, making the national AIDS response participatory, multisectoral and innovative'
Estonia	'In late 2007 after the end of the Global Fund programme, thanks to the active participation of civil society organisations and PLHIV representatives, funding of HIV prevention, treatment and care programmes was continued at full scale and in 2008 funding was higher than in previous years'.
Finland	'Civil society has influenced national policy making and the actions of people and organisations across Finland who have the greatest impact on the lives of people living with HIV'.
Georgia	'Civil society plays a major role on care and support of HIV positives and family members'.
Hungary	'Without the operation of NGOs hardly any prevention work would be carried out in the country'.
Ireland	'Civil society brings issues to the table which reflect the lives of people with HIV beyond their medical selves, proposes a more strategic response to HIV on a regular basis, highlights the possible impact on people with HIV of particular policies (for example, partner notification) and helps to broaden the discussions in general to include the different target group's perspectives'.
Moldova	'Even if the role of NGOs in [the] HIV national response is recognised, there is no mechanism in place to contract NGOs using national public money'.
Netherlands	'The involvement of civil society has made a difference … by stimulating the exchange of expertise among professionals in the Netherlands and among AIDS NGOs in Europe'.
Romania	'All preventive and supportive activities and interventions targeting vulnerable populations were initiated by the civil society with international financial support'.
Switzerland	'The involvement of the Swiss AIDS Federation in different initiatives such as the Swiss National Programme on HIV and AIDS, UNGASS Reports, Monitoring Reports on the Dublin Declaration has [ensured] that the voice of civil society could be heard and find its ways in important documents'.

1.2.6 Conclusions

Data presented in this chapter provides 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 government (see Box 3) and civil society respondents (see Box 4) provided a range of examples of the value added by civil society organisations to national HIV responses. Civil society reports greater efforts to increase civil society involvement from 2005 to 2007.

But there are some common limitations across countries of the region. Limited access to financial and technical support seriously constrains civil society capacity to contribute fully to the response. Civil society organisations find it difficult to get their activities included in national budgets in many countries. 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 used by NCPI in UNGASS 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, the ECDC has identified the following issues needing 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 to most-at-risk populations.
- There is a pressing need for adequate and sustainable financial support to the work of civil society. Access to financial support is critical to effective participation by civil society in the national response to HIV. Sustainable funding strategies will inevitably include government subcontracting/granting 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

1.3.1 Introduction

Internationally, it is recognised that how a country spends financial resources in responding to HIV, and where those resources come from, can provide an indication of a country's commitment to its HIV response. As a result, UNAIDS has recommended tracking countries' domestic and international AIDS spending by categories and financing sources as one of the core UNGASS indicators. There are various mechanisms for tracking financial resources, including National AIDS Spending Assessments (NASA), AIDS sub-accounts of National Health Accounts (NHA) and ad hoc Resource Flow Surveys. However, questions have been raised by European countries about the value and feasibility of tracking this information. In particular, there are concerns that:

- tracking finances centrally in countries with highly decentralised systems may not be practical or politically acceptable;
- tracking spending on HIV and AIDS in countries with integrated health systems may not be feasible[70];
- the methods are more suited to non-EU countries that have programmatic responses to HIV which is not the way that a modern and developed comprehensive system works;
- relatively high costs of antiretroviral drugs and medical services may distort figures derived from such an exercise;
- such data is not currently routinely tracked by EU countries, indicating that there is no felt need for this information by countries.

Consequently, for the purpose of this exercise, it was decided to assess the extent to which countries had data available on their spending on HIV prevention, including the sources of this funding and the extent to which this spending was focused on populations most affected by the epidemic.

In addition, countries of Europe and central Asia made a specific commitment in the Dublin Declaration to provide increased financial resources to scale up HIV-related services in the most affected countries internationally. This chapter also reviews evidence of the extent to which this has happened[71].

1.3.2 Financial resources for national responses to HIV and AIDS

More than three quarters (76%[72]) of countries responding were able to provide some quantitative data relating to their expenditure on HIV prevention. Of these, almost half (46%[73]) had provided relevant information to the 2008 UNGASS reporting process[74]. More than two thirds (68%[75]) provided additional information[76].

A number of countries provided qualitative information on the difficulties they faced in providing this information. These included:

- Integration of many HIV-related services into other activities making identification of HIV-specific funding difficult, for example, in Finland, Slovenia, Sweden, Turkey and the United Kingdom. In Serbia, figures are available for health spending from National Health Accounts, but disaggregated figures for HIV are not available.
- Lack of available information on decentralised spending, for example, in Sweden and the United Kingdom, and by cantons, cities and NGOs in Switzerland.
- The effort needed to collect the data would outweigh the benefits gained, for example, in Slovenia and the United Kingdom.
- Only having access to government figures and not those spent by the private sector, for example, in Israel.
- Delays in approving government budgets.

[70] Although this concern applies, to some extent, to all countries and detailed instructions provided by UNAIDS on the interpretation of this indicator clearly explain how spending on broader health systems related to HIV can be captured.

[71] Figures both for spending on HIV prevention and on funding for the global HIV response are presented in this chapter in US dollars (USD), both for ease of comparison and because data on international HIV financing is tracked in USD.

[72] 37/49. The countries that were unable to provide quantitative data on this question were: Andorra, Finland, Iceland, Ireland, Italy, Lithuania, Serbia, Slovakia, Slovenia, Turkey, Turkmenistan and Uzbekistan. Uzbekistan indicated that they had provided relevant information in an attachment. However, this attachment did not appear to be received by the team. In commenting on the report, Serbia explained that data on HIV/AIDS annual spending at national level is available from the Ministry of Health and Republic Health Insurance Fund and was reported in the UNGASS 2008 narrative country report.

[73] 17/37. This included five EU/EFTA countries: Bulgaria, Latvia, Poland, Romania and Switzerland.

[74] Albania, Armenia, Azerbaijan, Bulgaria, Croatia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Moldova, Poland, Romania, Russia, Switzerland, Tajikistan, the Former Yugoslav Republic of Macedonia and Ukraine.

[75] 25/37.

[76] This included five countries that had reported to UNGASS: Azerbaijan, Croatia, Kazakhstan, Romania and Switzerland.

Table 1 presents data on HIV prevention expenditure as reported to UNGASS 2008 by 36 countries of Europe and central Asia[77]. A great deal of caution is needed in interpreting data in this table because of variations in method between countries. This is particularly true of data reported outside of the UNGASS process[78]. Most issues relate to which services are included as HIV prevention[79]. Examples include:

- inclusion or exclusion of costs of ART, care and support[80];
- inclusion or exclusion of broad services for sexual and reproductive health (some countries, e.g. Denmark, included these while others, e.g. Norway, excluded them);
- inclusion or exclusion of drug prevention services (for example, Norway specifically excluded these).

Perhaps the biggest issue relates to the inclusion or exclusion of costs of ensuring blood safety[81]. Some countries, e.g. Denmark, Greece and Moldova, included all their costs of ensuring blood safety as HIV prevention, whereas others either included some of the costs, e.g. Estonia, or none, e.g. the United Kingdom.

Reported expenditure ranged from USD 0.024 million in San Marino to USD 61.749 million in Russia[82]. When adjusted for population, per person expenditure on HIV prevention ranged from USD 0.06 in Malta to USD 5.81 in Luxembourg[83]. Countries with low levels of reported HIV prevention expenditure per person included Azerbaijan, Bosnia and Herzegovina, Cyprus and Malta. Countries with high levels of reported HIV prevention expenditure per person included Denmark, Estonia, Greece, Kyrgyzstan, Luxembourg, Moldova, Sweden and the former Yugoslav Republic of Macedonia. The median expenditure per person on HIV prevention is just USD 0.54. The proportion of total AIDS expenditure on HIV prevention ranged from 7% in Romania to 82% in Kyrgyzstan. The extent to which countries' prevention expenditure was focused on specific populations—IDU, sex workers and MSM[84]—varied from 1% in Kazakhstan to 97% in the Czech Republic.

[77] It includes figures reported by 16 countries to UNGASS 2008. Although Albania reported on total AIDS spending to UNGASS 2008, it did not provide specific information for spend on HIV prevention. Figures reported to UNGASS 2008 were for various years from 2005 to 2007.

[78] Instructions on how to compile a National AIDS Spending Assessment contains very clear guidance on how to classify different types of expenditure. It also explains how to capture decentralised spending and expenditure on HIV that is integrated with other services. Some EU countries, e.g. Estonia and Luxembourg, reported figures based on processes that are very similar to NASA. In the case of Luxembourg, this was a study on public expenditures in the drugs field.

[79] According to NASA, the following activities are considered HIV prevention: communication for social and behaviour change; community mobilisation; voluntary counselling and testing; risk reduction programmes for vulnerable and accessible populations; prevention(youth in school); prevention(youth out of school); prevention of transmission aimed at PLHIV; prevention programmes for sex workers and their clients; programmes for MSM; harm reduction programmes for IDU; prevention programmes in the workplace; condom social marketing; public and commercial sector male condom provision; public and commercial sector female condom provision; microbicides; prevention, diagnosis and treatment of STI; PMTCT; male circumcision; blood safety; safe medical injections; universal precautions; post-exposure prophylaxis; and two categories of other.

[80] NASA does not include these costs under prevention. Where these could be identified, they were excluded.

[81] According to NASA guidelines, these should be included in HIV prevention.

[82] Greece reported a figure equivalent to USD 208.571 million. However, this included a very large amount for blood safety. If this is excluded, the figure is still high at USD 57.103 million.

[83] For the purpose of comparability, Greece's reported spending on blood safety was excluded from this figure (see Table 1). If this is not done, the value is USD 19.45.

[84] The four that did not report this data in UNGASS 2008 were Azerbaijan, Romania, Russia and Switzerland. In some cases, e.g. Switzerland, some data on this issue was reported as part of this Dublin Declaration monitoring process (see Annex 5). However, it was not possible to integrate this with data submitted to UNGASS 2008 as it was unclear if the data was directly comparable.

Table 1: Data on HIV prevention expenditure as reported by countries[85]

Country	Expenditure (USD millions)[86]	Year[87]	% of total AIDS spending	% spent on IDU, sex workers and MSM	Population[88]	Per person spend on HIV prevention (USD)
Armenia*	1.296	2007	52	12	2 968 586	0.44
Azerbaijan[89]*	0.851	2007	38	N/A	8 177 717	0.10
Belgium	4.581[90]	2009	N/A	13[91]	10 403 951	0.44
Bosnia and Herzegovina	0.395[92]	N/A	N/A	3[93]	4 590 310	0.09
Bulgaria[94]*	2.877	2007	43	21	7 262 675	0.40
Croatia*	3.743	2006	44	14	4 491 543	0.83
Cyprus	0.063[95]	2009	N/A	N/A	792 604	0.08
Czech Republic	0.833[96]	2007/8[97]	N/A	97[98]	10 220 911	0.81
Denmark	13.724[99]	2008	N/A	N/A	5 484 723	2.50
Estonia	6.444[100]	2008	33	36[101]	1 307 605	4.93
Former Yugoslav Republic of Macedonia*	2.939	2005	81	70	2 061 315	1.43
France	55.117[102]	N/A	N/A	N/A	64 057 790	0.86
Georgia*	2.563	2006	49	40	4 630 841	0.55

[85] For countries marked with * data is that reported to UNGASS 2008.

[86] See footnote 71 for explanation as to why figures are presented in USD. Figures have been converted from the currency in which data was provided using the exchange rate for 30 June of the year in question using www.xe.com. Where countries did not provide the year of their data, 30 June 2008 has been used. Where countries provided budget data for 2010, the current rate as of 24 May 2010 was used. Where countries provided data for a period spanning two years, e.g. 2007–8, the rate as of 31 December of the first year was used.

[87] Where countries indicated the year for which data was supplied, this is given. Where no information was provided, this is indicated as N/A. In some cases, countries provided data for different years. This is indicated by the symbol '/' between the relevant years. In others, they supplied data for a financial year spanning two calendar years. This is indicated by the symbol '–'.

[88] Data from UN Census Bureau as of October 2008.

[89] Additional data supplied (see Annex 5).

[90] EUR3.661 million. Includes EUR3.181 million for sexual health. Not all this is expended on HIV prevention.

[91] Based on assuming that spend on syringe exchange programmes focuses on IDU and spend on sexual health is not specifically targeted to key populations.

[92] Figures are national contribution only. Figures were supplied for ART drugs and human resources but these have been excluded. The largest amount is for human resources for counselling and testing services. These are integrated services, i.e. they do not provide HIV counselling and testing only. For this reason, one fifth (20%) of the cost has been taken as HIV-related.

[93] Based on assuming that spend on bio-behavioural survey among MSM and sex workers focuses on key populations and spend on counselling and testing services is not specifically targeted.

[94] Also provided information for 2005 and 2006.

[95] EUR50 000. Excludes medical care and ART.

[96] This figure represents EUR333 000 from the national HIV/AIDS budget (excluding funds for infrastructure investment and medical care of uninsured PLHIV) and EUR5 million from the drug prevention budget for harm reduction activities. Funds for blood safety, provider-initiated HIV testing, HIV testing of pregnant women and STI diagnostics are excluded.

[97] Figures for harm reduction from 2007. Figures for national HIV/AIDS budget from 2008.

[98] Based on assuming that expenditure on harm reduction among IDU, Lighthouse activities, NGO work among gay minority and sex workers is focused on key populations and that expenditure on HIV testing and counselling, HIV prevention for the general population and NGO work among Roma populations and youth-at-risk is not focused on these groups. See also footnote 96 for items excluded from figures.

[99] DKR65 million. This includes funding for the National Board of Health, NGOs and safe blood supply.

[100] Based on detailed spreadsheet provided. Figures for psychosocial support, healthcare services for PLHIV, M&E and coordination excluded.

[101] Based on assuming that expenditure on services for IDU, sex workers, MSM and prisoners is focused on key populations and that expenditure on services for general population and young people and counselling and testing, blood safety and PMTCT are not focused on key populations.

[102] EUR35 million.

Country	Expenditure (USD millions)[86]	Year[87]	% of total AIDS spending	% spent on IDU, sex workers and MSM	Population[88]	Per person spend on HIV prevention (USD)
Germany	35.328[103]	2009	N/A	N/A[104]	82 369 548	0.43
Greece	208.571[105]	2007/8	N/A	N/A	10 722 816	5.35[106]
Hungary	2.565[107]	2008[108]	N/A	N/A	9 930 915	0.26
Israel	3.750[109]	N/A	N/A	N/A	7 112 359	0.53
Kazakhstan[89]*	3.392	2007	19	1	15 340 533	0.22
Kyrgyzstan*	6.469	2006	82	9	5 356 869	1.21
Latvia[110]*	0.996	2007	17	34	2 245 423	0.44
Luxembourg	2.825[111]	2008	N/A	N/A	486 006	5.81
Malta	0.025[112]	N/A	N/A	N/A	403 532	0.06
Moldova*	6.292	2007	77	5	4 324 450	1.45
Netherlands	13.482[113]	2010[114]	N/A	N/A	16 645 313	0.81
Norway	3.262[115]	2009	N/A	N/A	4 644 457	0.70
Poland*	4.400	2007	10	65	38 500 696	0.11
Portugal	5.868[116]	N/A	N/A	N/A	10 676 910	0.55
Romania[89]*	5.239	2006	7	N/A	22 246 862	0.24
Russia*	61.749	2006	20	N/A	140 702 094	0.44
San Marino	0.024[117]	2007	N/A	N/A	31 006[118]	0.79

[103] EUR25.2 million. Includes funding from the National German Government and from 16 states. Does not include funding from local government.

[104] EUR5 million of the national funding goes to German AIDS Help for prevention activities among most-at-risk populations. Information about use of other funds not provided.

[105] EUR137.7 million. This is based on EUR200 000 for school education in 2008, EUR100 million for blood safety (year not specified) and EUR37.5 million for campaigns and NGO programmes in 2008.

[106] For the purpose of comparability, Greece's reported spending on blood safety has been excluded from this figure. If this is not done, the value is USD 19.45.

[107] HUF 383.424 million. Includes funds for blood safety, youth programmes, training in HIV prevention for doctors, Sziget festival event, work of NGOs, anonymous HIV testing and counselling and World AIDS Day programme.

[108] Total figures also provided for 2004–7.

[109] Based on rough estimates. Includes costs of testing and counselling, advertising and education and two STI walk-in clinics in Haifa and Tel Aviv. Figures exclude costs of AIDS clinic and ART. Figures are for government only and exclude any contribution from private providers.

[110] Preliminary figures.

[111] EUR1.794 million. Includes provision of drug injection material, staff and operational cost of National Aids Prevention and Counselling Centre, National AIDS Plan, Reimbursement of prescription substitution drugs and medical counselling costs, campaigns and condoms. The figures are indicative and do not cover all costs, e.g. prevention in schools.

[112] EUR16 000. This is the AIDS fund administered by the Department of Health Promotion and Disease Prevention. Most of the budget is spent on TV and radio, adverts in magazines and in public places.

[113] EUR10.7 million. This is the funding by the national government for primary HIV/STI prevention in 2010. These funds for primary prevention through civil society organisations include funding for STI AIDS Netherlands for primary prevention and education among ethnic minorities, youth and sex workers; for Schorer Foundation for primary prevention and behavioural monitoring among MSM; for HIV Association for prevention and advocacy among people living with HIV; and for Rutgers Nisso Group for research and prevention related to sexual health of youth and the general population.

[114] Figures provided by RIVM.

[115] NOK21 million. This is the national budget allocated to HIV prevention activities and includes information, communication and research projects, activities targeting sex workers and MSM, funding to PLHIV, activities targeting youth and young adults, activities targeting migrants and funding for condoms and lubricants. It excludes the budget for HIV surveillance and information activities administered by the National Institute for Public Health. It also does not include national funding for sexual health or activities funded under the prevention of drug abuse.

[116] EUR3.726 million. This includes funding for the civil society funding programme and media campaigns.

[117] EUR18 000 for HIV testing.

[118] Figures from World Bank, 2008.

Country	Expenditure (USD millions)[86]	Year[87]	% of total AIDS spending	% spent on IDU, sex workers and MSM	Population[88]	Per person spend on HIV prevention (USD)
Spain	19.473[119]	2009	N/A	N/A	40 491 051	0.48
Sweden	24.897[120]	2008	N/A	N/A	9 045 389	2.75
Switzerland[89,121]*	5.747	2006	31	N/A	7 581 520	0.76
Tajikistan*	2.509	2006	48	11	7 211 884	0.35
Ukraine*	17.067	2006	31	43	45 994 287	0.37
United Kingdom	36.538[122]	2008-9	N/A	N/A	60 943 912	0.60

Figure 11 compares countries' per person expenditure on HIV prevention with their degree of focus on specific populations, namely IDU, sex workers and MSM. Four patterns can be identified:

- Low per person expenditure on HIV prevention and low degree of focus on IDU, sex workers and MSM, for example, in Kazakhstan.
- High per person expenditure on HIV prevention and low degree of focus on IDUs, sex workers and MSM, for example, in Moldova[123].
- Low per person expenditure on HIV prevention and high degree of focus on IDU, sex workers and MSM, for example, in Poland.
- High per person expenditure on HIV prevention and high degree of focus on IDU, sex workers and MSM, for example, in the Czech Republic, Estonia and the former Yugoslav Republic of Macedonia.

[119] EUR13.89 million. This consists of transfers to regional governments according to the population and number of registered AIDS cases in each region, activities related to the HIV response, grants to institutions for the prevention and control of HIV and coordination. A specific grant to GESIDA for research was reported but has been excluded.

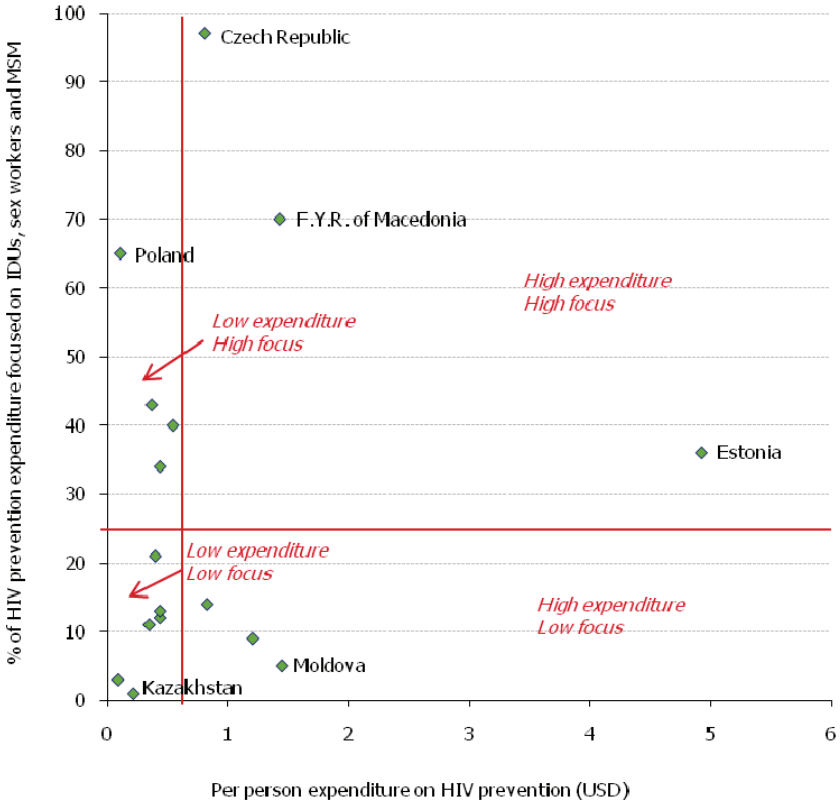
[120] SEK 150 million. This figure is for a yearly government grant distributed by the National Board of Health and Welfare. It includes funds for regional authorities, municipalities, national NGOs and research and development projects. It excludes funding from regional governments and municipalities. These are the major funding sources for the national response to HIV in Sweden. It also excludes funding for national surveillance and health communication activities.

[121] Central spend only.

[122] GBP 25 million. This is based on figures in a spreadsheet provided by the UK. It excludes spending on social protection. It includes spending on programmes for MSM, microbicides and other prevention activities. It excludes the majority of the UK's HIV prevention expenditure, e.g. for blood screening, condom social marketing, harm minimisation for IDU and HIV testing and counselling, which is provided through the National Health Service.

[123] In reviewing this report, Moldova commented that it had been difficult to disaggregate expenditure to capture the benefit for key populations. As a result, some expenditure that benefited these key populations may not have been fully captured resulting in a lower apparent focus of spending on these populations.

Figure 11: 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



Three countries[124] provided trend data for more than one year (see example in Box 5). Few countries reported trend data for their financial data. One exception was Hungary who documented that the national budget for HIV prevention[125] had fallen from HUF 91 million in 2004 to HUF 57 million in 2006 and HUF 43 million in 2008.

Box 5: Expenditure on HIV prevention: examples of trend data

According to the 2008 UNGASS report, total spending on HIV prevention in **Ukraine** rose from USD 7.442 million in 2005 to USD 17.067 million in 2006. As a result, the percentage of total AIDS spending on HIV prevention rose from 19% in 2005 to 31% in 2006. In 2006, more than half (51%) was from domestic resources as compared to 43% in 2005.

In **Hungary**, the national budget for HIV prevention (excluding blood safety) fell from HUF 91 million in 2004 to HUF 57 million in 2006 and HUF 43 million in 2008.

Table 2 shows the source of funds for the national HIV response in 17 countries that responded to UNGASS in 2008. The proportion of funds provided from domestic resources ranged from 6% in Tajikistan to 100% in Poland and Switzerland.

Although it has been suggested that the percentage of funds from domestic resources can be used to assess political commitment to the response, Figure 12 shows that the degree to which a country funds its HIV response from domestic resources is largely related to its wealth. It is not surprising that countries with the lowest GNI per capita, for example, Tajikistan, Kyrgyzstan and Georgia, provided the lowest proportion of their HIV funding from domestic resources, or that countries with higher GNI per capita, for example, Latvia and Poland, provided the highest proportion of their HIV funding from domestic resources. However, there are some outliers. Croatia has the highest GNI per capita of the responding countries[126] but, in 2006, provided only three quarters of its funding for HIV from domestic resources[127]. Conversely, Azerbaijan had relatively low GNI per capita but, in 2007, reported providing two thirds of the funding to its response to HIV from domestic resources.

[124] Bulgaria (three years), Hungary (five years) and Ukraine (two years).

[125] Excluding funding for blood safety.

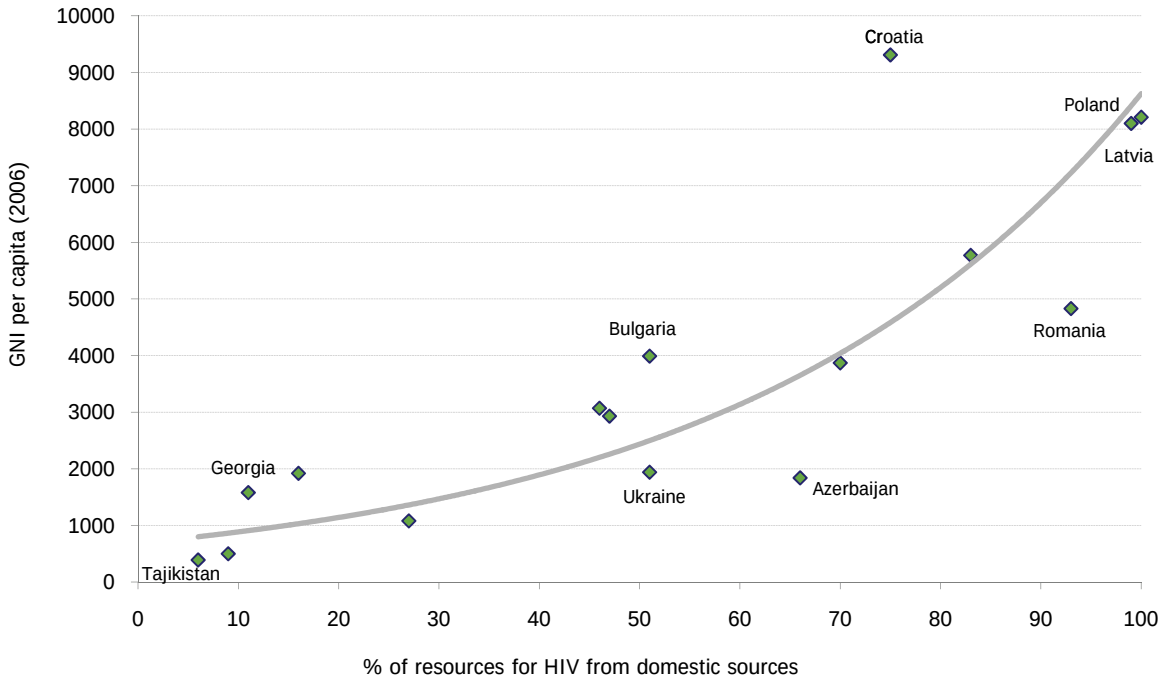
[126] Apart from Switzerland.

[127] As a result of the Global Fund grant it was receiving at that time.

Table 2: Source of funds for national response to HIV as reported by countries to UNGASS 2008

Country	Year	Source of funds (%)				
		Domestic	Bilaterals	Global Fund	UN/multilaterals	Other international
Albania	2005	47	0	0	0	53
Armenia	2007	16	7	56	21	0
Azerbaijan	2007	66	0	34	0	0
Bulgaria	2007	51	0	43	6	0
Croatia	2006	75	0	23	2	1
Georgia	2006	11	19	57	13	0
Former Yugoslav Republic of Macedonia	2005	46	0	37	13	3
Kazakhstan	2007	70	1	27	1	1
Kyrgyzstan	2006	9	9	39	44	0
Latvia	2007	99	0	0	0	1
Moldova	2007	27	19	17	32	5
Poland	2007	100	0	0	0	0
Romania	2006	93	0	5	1	0
Russia	2006	83	0	12	0.3	5
Switzerland	2006	100	0	0	0	0
Tajikistan	2006	6	19	37	20	19
Ukraine	2006	51	8	36	3	2

Figure 12: A comparison of percentage of resources for the national HIV response from domestic resources compared to GNI per capita among European and central Asian countries reporting to UNGASS 2008[128]



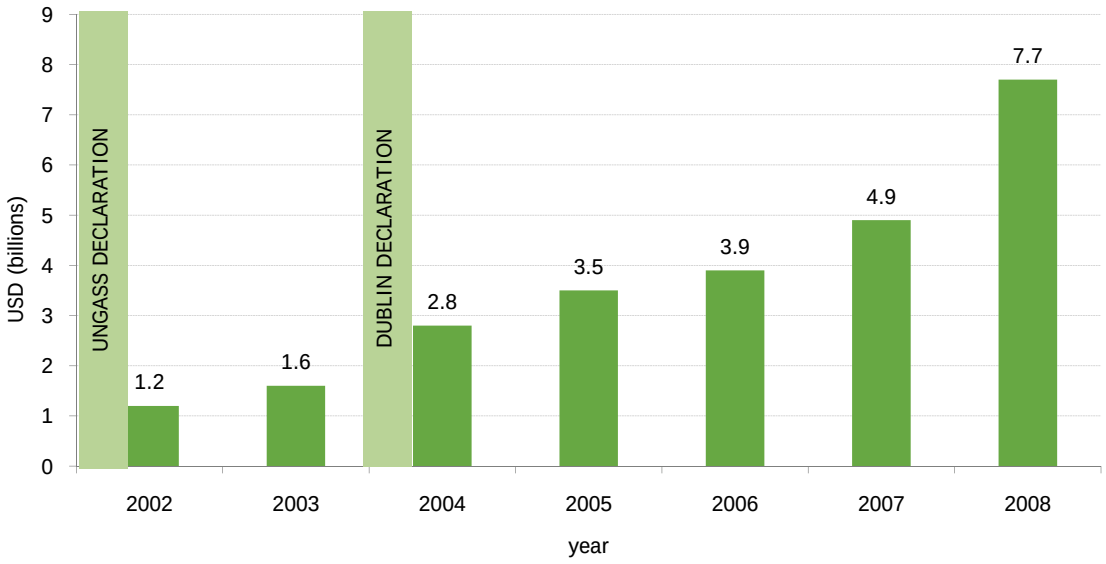
[128] Excluding Switzerland – GNI per capita in 2006 of USD 58 050.

Figures in Table 2 provide evidence that bilateral donors, UN and multilateral agencies are not significant providers of financial resources for HIV responses in the region, with the exception of a few countries, namely Georgia, Moldova and Tajikistan for bilateral agencies and Georgia, Kyrgyzstan, Moldova, Tajikistan and the former Yugoslav Republic of Macedonia for UN/multilateral agencies. Conversely, the figures provide evidence that the Global Fund to Fight AIDS, TB and Malaria (Global Fund) is a major funder of responses to HIV in some countries of the region. For example, in the years for which data was reported, the Global Fund was providing more than one third of the funding to national AIDS responses in eight[129] of the countries reporting to UNGASS 2008. Serbia also commented on the importance of Global Fund financing for their national response to HIV.

1.3.3 Financial resources from the countries of Europe and central Asia to HIV-related services in the most affected countries internationally

Since the UNGASS Declaration of Commitment in 2001, there has been an increase in disbursements from donor countries as international AIDS assistance (see Figure 13). These increased more than sixfold from USD 1.2 billion in 2002 to USD 7.7 billion in 2008. This increase gained further impetus and accelerated after the adoption of the Dublin Declaration in 2004[130].

Figure 13: International AIDS assistance: Trends in G8/EC and other donor government assistance: 2002–2008: disbursements



Source: Kates et al, 2009

This increase has been driven by a relatively small number of donor governments, including several EU Member States. In 2008, 40%[131] of all disbursements for international AIDS assistance from donor countries came from EU Member States, EFTA countries and the EC (see Figure 14). This amounted to more than USD 3 billion, which was more than the total of international AIDS assistance from all donor countries in 2004, the year of the Dublin Declaration.

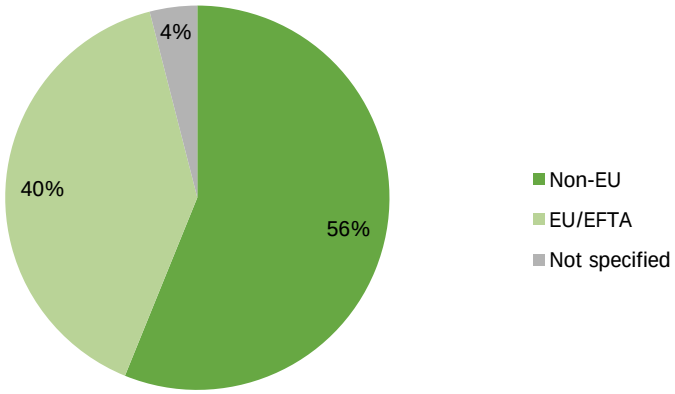
Figure 15 shows where the disbursements came from within the EU and EFTA. Almost one third (31%) came from one EU Member State, the United Kingdom, and over three quarters (79%) came from four Member States: France, Germany, the Netherlands and the United Kingdom. Other significant donors included Norway, Sweden, Italy, Ireland and the EC.

[129] Armenia, Azerbaijan, Bulgaria, Georgia, Kyrgyzstan, Tajikistan, the Former Yugoslav Republic of Macedonia and Ukraine.

[130] This is the case even if the value reported in 2008 is considered an outlier and the trend is plotted through the values reported for 2006 and 2007.

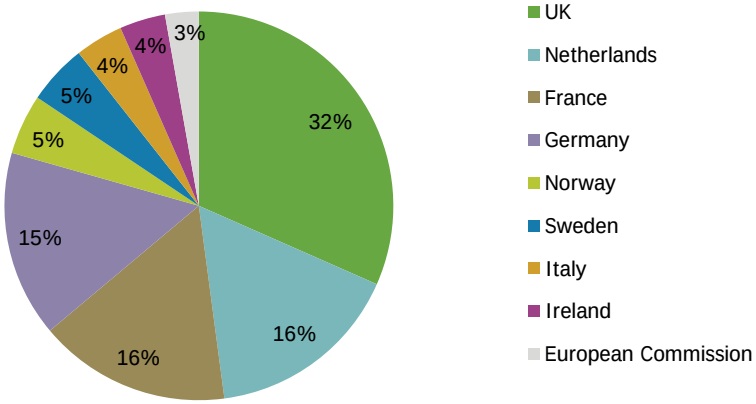
[131] The largest single donor was the USA, accounting for 51% of all disbursements of international AIDS assistance from donor countries. Australia, Canada and Japan accounted for 4.9% of all disbursements. Other unspecified governments accounted for a further 4% of disbursements. It is likely that EU Member States constitute at least part of that amount.

Figure 14: Proportion of disbursements in 2008 for international AIDS assistance from different sources



Source: Kates et al, 2009.

Figure 15: Proportion of disbursements in 2008 for international AIDS assistance from EU Member States, EFTA countries and the European Commission, by source



Source: Kates et al, 2009.

However, the ability of countries to contribute to the international response to HIV varies enormously. This has led to the concept of 'fair share' of international funding[132]. Table 3 presents data on two proposed approaches to 'fair share'.

- The first approach compares a country's funding for the international response to HIV with its share of world GDP. Some European countries, for example, the Netherlands and the United Kingdom have higher shares of funding for the international response than their shares of world GDP.
- The second approach compares the amount of money (in USD) disbursed for the international response to HIV per USD 1 million of GDP. Some European countries, for example, the Netherlands, the United Kingdom, Ireland, Norway and Sweden have very high rates.

[132] However, there is no agreed approach to determining how 'fair share' should be calculated and the concept has gained more support among civil society than among governments.

Table 3: Two different approaches to assessing 'fair share' of donor funding for the international response to HIV

	Assessing fair share 1		Assessing fair share 2
Country	**Share of world GDP (2008)**	**Share of all resources for HIV/AIDS (2008)**	**Disbursements for AIDS per USD 1 million GDP (2008)**
Non-EU (for comparison)			
Australia	1.7	0.6	84.4
Canada	2.5	0.4	38.9
Japan	8.1	0.1	4.3
United States	23.5	22.2	242.5
EU			
France	4.7	0.4	23.3
Germany	6.0	1.8	78.3
Ireland	0.5	0.6	328.5
Italy	3.8	0.1	3.8
Netherlands	1.4	2.8	496.1
Norway	0.8	0.7	226.4
Sweden	0.8	0.6	180.2
United Kingdom	4.4	5.7	332.9

Source: Kates et al, 2009

Almost three quarters (USD 5.7 billion – 74%) of donors' disbursements for international AIDS assistance in 2008 were considered bilateral in nature. Most of the remainder (USD 1.7 billion – 22%) was paid through the Global Fund. The degree to which European countries channel their funds through bilateral[133] means or through the Global Fund differs greatly. For example, the United Kingdom is reported to have provided 92% of its international AIDS assistance in 2008 bilaterally, whereas Italy and France provided, respectively, 93% and 86% of their international AIDS assistance in 2008 through the Global Fund[134].

European countries have been significant funders of the Global Fund since its formation in 2001 (see Figure 16). HIV-related contributions from Europe[135] rose from USD 297 million in 2001/2 and USD 274 million in 2003 to USD 935 million in 2007 and exceeded USD 1 billion[136] in 2008. These contributions accounted for just over half of all contributions from countries[137] in 2001/2 (54%) and 2003 (51%). But they accounted for 60% of all contributions from countries in both 2007 and 2008.

The majority of these contributions come from EU Member States. For example, in 2008, EU Member States provided 84.3% of all European HIV-related contributions to the Global Fund. Member States making the largest contributions included France, Germany and Italy (see Figure 17). Almost 8% came from the EC, 4.5% from Russia and 3.4% from EFTA countries. Russia has contributed to the Global Fund since its inception in 2001. Its HIV-related contributions increased more than eightfold from USD 6.1 million in 2006 to USD 52.3 million in 2007 and USD 47.8 million in 2008.

[133] The definition of bilateral used by Kates et al differs from that used by donors. For example, they included 'earmarked multilateral' funding, e.g. to UNAIDS, as bilateral.

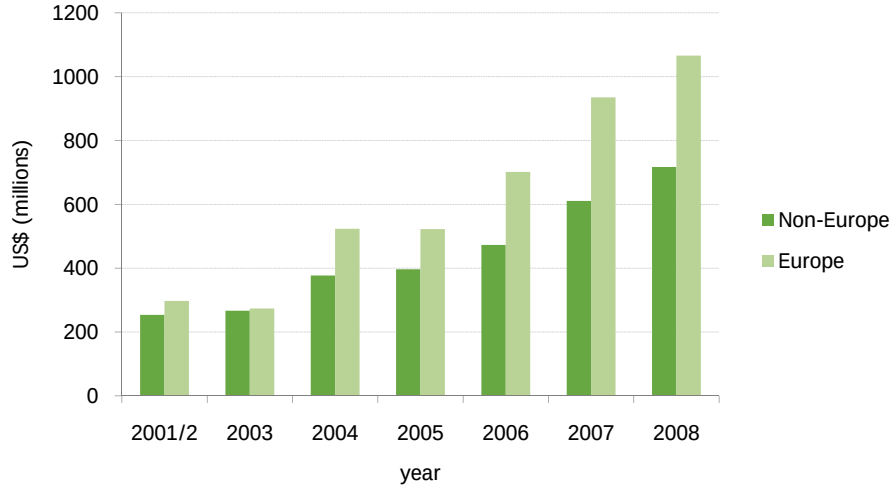
[134] And UNITAID.

[135] These include contributions of EU Member States, the European Commission, EFTA countries and Russia.

[136] USD 1 066 million.

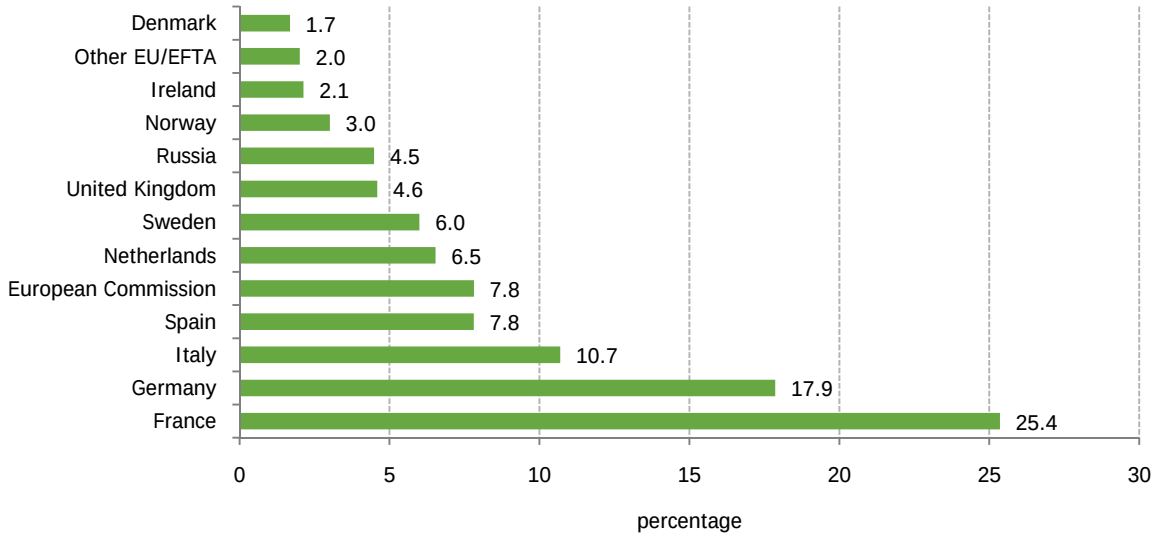
[137] Most of the Global Fund's income comes from countries. In 2008, countries contributions accounted for 94% of total contributions to the Global Fund.

Figure 16: HIV-related[138] contributions by countries to the Global Fund by origin, 2001–8



Source: Global Fund, 2009.

Figure 17: Percentage of European HIV-related[139] contributions to the Global Fund by origin, 2008



Source: Global Fund, 2009.

In addition, Europe has been a significant funder of the Joint UN Programme on AIDS (UNAIDS) (see Figure 18). In 2008, 83% of all country contributions to UNAIDS came from Europe. Most (69%) were from countries of the EU but 12% were from EFTA countries[140] and 1% from other European countries[141].

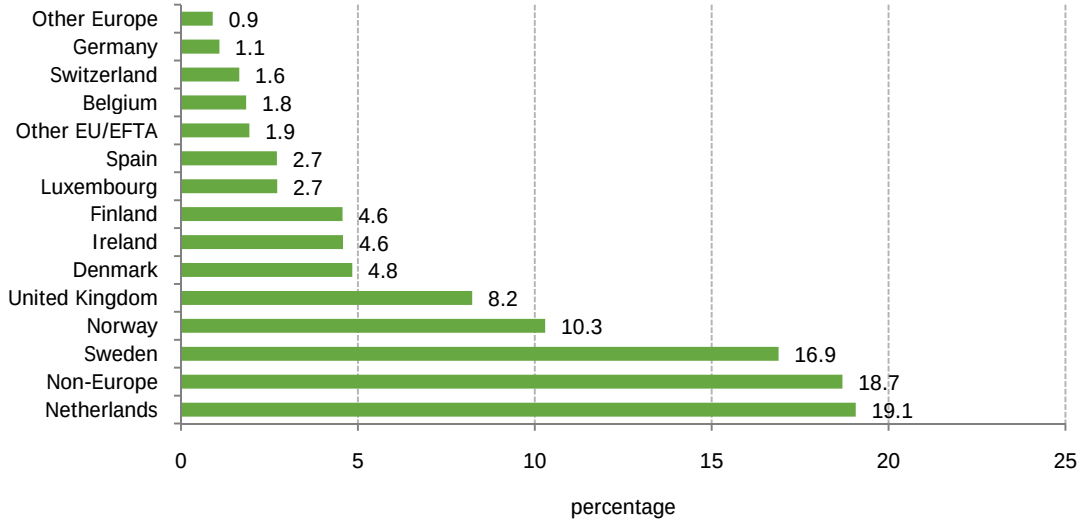
[138] 61% of total.

[139] 61% of total.

[140] Norway contributed US$26.4m and Switzerland US$4.2m. Liechtenstein also contributed.

[141] Russia, Turkey, Monaco and Andorra.

Figure 18: Percentage of total country contributions to UNAIDS by origin, 2008



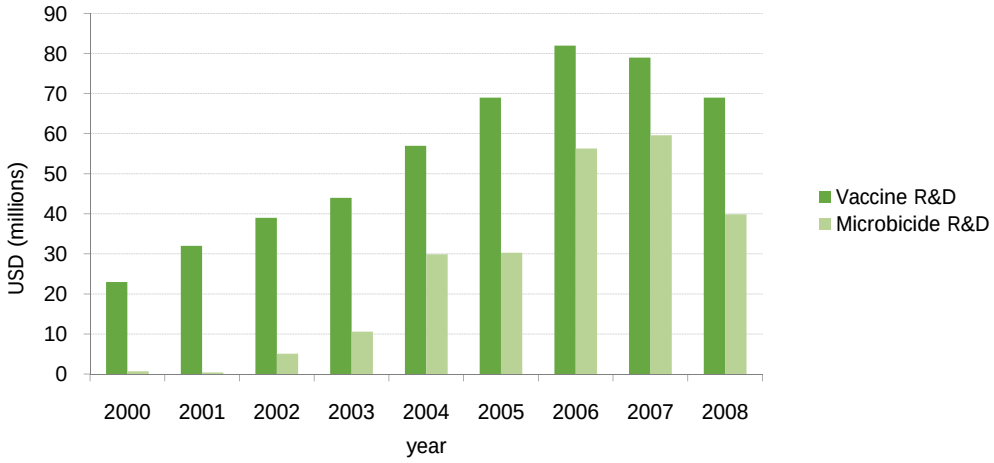
Source: UNAIDS, 2009.

Finally, Europe[142] has been a significant funder of vaccine and microbicide research and development (see Figure 19). From 2000 to 2006, European funding for vaccine research and development rose from USD 23 million to USD 82 million. In 2006, European funding accounted for 11% of all country funding for vaccine research and development. Similarly, from 2000 to 2007, European funding for microbicide research and development rose from USD 0.7 million to USD 59.6 million. In 2007, European funding accounted for 29% of all country funding for microbicide research and development.

However, from 2006 to 2008, European funding for vaccine research and development fell from USD 82 million to USD 69 million. In 2008, European funding accounted for 10% of all country funding for vaccine research and development. From 2007 to 2008, European funding for microbicide research and development fell from USD 59.6 million to USD 39.9 million. In 2008, European funding accounted for 19% of all country funding for microbicide research and development.

Suggested reasons for the reductions in European funding for vaccine and microbicide research and development since 2006/7 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[143]. On balance, the latter explanation seems the most plausible.

Figure 19: European funding to vaccine and microbicide research and development, 2000–2008



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

[142] Based on definition of European funding used by the HIV Vaccines and Microbicides Resource Tracking Working Group.

[143] A number of trials released results in 2007 and 2008 that were considered disappointing.

1.3.4 Conclusions

Most countries of Europe and Central Asia track some financial data related to their spending on the national response to HIV, in general, and for prevention of HIV, in particular. However, it is difficult to analyse such data unless standardised in some way. Useful standardised indicators might include:

- Expenditure on HIV prevention per person of population (see Table 1 and Figure 11). This might give some evidence of the degree of a country's overall commitment to responding to HIV.
- Percentage of HIV prevention expenditure focused on key populations (see Table 1 and Figure 11). In Europe and central Asia, it would be expected that this percentage would be high. Again this would demonstrate the degree of commitment to an appropriate response to HIV[144].
- Proportion of funding for the response to HIV from domestic resources as compared to GNI per capita (see Table 2 and Figure 12).

International funding for responses to HIV and AIDS increased more than sixfold from USD 1.2 billion in 2002 to USD 7.7 billion in 2008 (see Figure 13). The overall trajectory of this increased from 2004, following the Dublin Declaration. Some EU Member States and EFTA countries have been instrumental in driving this process. These countries include France, Germany, Ireland, the Netherlands, Norway, Sweden and the United Kingdom. In 2008, total disbursements for the international response to AIDS from EU Member States, EFTA countries and the EC exceeded USD 1 billion and accounted for 40% of all donor disbursements for the international response to HIV (see Figure 14).

The Global Fund is a significant funder of responses to HIV in low- and middle-income countries in Europe and central Asia. For example, in the year for which data was provided, the Global Fund provided more than one third of the funds for national responses to HIV in at least eight countries of the region. European countries have been significant funders of the Global Fund since its formation in 2001 (see Figure 16). HIV-related contributions from Europe rose to exceed USD 1 billion in 2008. This constituted 60% of all contributions from countries.

Europe is also a significant funder of UNAIDS, the Joint UN Programme on HIV/AIDS. In 2008, 83% of all country contributions to UNAIDS came from Europe. Of these, 83% were from EU Member States. Europe is a significant funder of vaccine and microbicide research and development although this declined slightly from 2006–2007 reflecting an adjustment in scientific priorities away from certain approaches.

In conclusion, the ECDC has identified the following issues needing 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 to ensure 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 efficient savings, i.e. services being delivered at a lower overall cost.
- There is a need for 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 to 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 asked include whether such research should continue to be funded and whether funding should be reoriented or further scaled back.

[144] Focusing in this way might allow a country to reduce expenditure on HIV prevention per person of population, reflecting efficiency gains rather than a reduction in commitment to respond to HIV.

2 Prevention

2.1 HIV prevention: an overview

2.1.1 Introduction

The Dublin Declaration takes a strong position on prevention of HIV, stating that prevention 'must be the mainstay of the subnational, 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.

Similarly, there is an equally strong commitment among the global community to prevent new HIV infections. For example, Michel Sidibé, Executive Director of UNAIDS, called for a 'prevention revolution' to dramatically decrease the number of new infections. Also, the current ECDC multi-annual work plan includes as a key activity 'to have evaluated and produced a number of scientific guidance documents on key prevention strategies including Chlamydia control, HIV testing, screening of migrants, partner notification'. As access to treatment continues to be scaled up, there is a parallel push to improve the effectiveness of prevention efforts.

This section sets the scene for consideration of prevention issues in this report. It is followed by a series of sections looking at HIV prevention among specific populations, including IDU (Section 2.2), MSM (Section 2.3), sex workers (Section 2.4), migrants (Section 2.5) and prisoners (Section 2.6).

The chapter is based on responses from both governments[145] and civil society[146] to a range of questions on HIV prevention. These questions are based on those from the UNGASS NCPI. Responses are structured around a number of themes including policies and strategies, prevention needs, access to prevention and implementation challenges/achievements.

2.1.2 Policies and strategies

The questionnaire included a series of questions related to prevention policies and strategies. All of the questions were directed to government[147]. Topics covered include policy, legal and regulatory obstacles to effective prevention; policies and strategies related to interventions for most-at-risk populations, e.g. injecting drug users, men who have sex with men, sex workers and prisoners; and policy/strategy-related achievements and challenges.

Of those countries responding to the specific question, more than half (54%[148]) reported having laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support[149] for most-at-risk populations or other vulnerable subpopulations[150]. Country examples are presented in Box 6. The populations most commonly affected by these obstacles are IDU, prisoners and migrants (see Figure 20).

145 Governments were asked 12 questions, and 48/49 countries responded to one or more of these questions. Iceland did not respond to any of these questions.

146 Civil society organisations were asked six questions, and 43/49 countries responded to one or more of these questions. Andorra, Belgium, Iceland, Israel, Malta and San Marino did not provide answers to any of these questions.

147 See footnote 150.

148 25/46.

149 This same question was asked in our questionnaire in the section on treatment (see Section 3.1).

150 Our questionnaire directed this question to government respondents whereas NCPI in UNGASS 2008 addressed this question to civil society. Almost three quarters (72% [21/29]) of those responding to NCPI in 2008 identified these obstacles in their country. However, less than a quarter (24% [4/17]]) identified these obstacles in their country in their responses to this questionnaire. It is unlikely that this reflects actual differences between countries but differences in the extent to which obstacles are identified by government and civil society respondents. In UNGASS 2010, this question is being asked of both civil society and government respondents.

Box 6: Country comments about the legal, regulatory and policy obstacles facing most-at-risk populations

Denmark 'Penalty if HIV positive people have unsafe sex. Debate about this [is] scaring people away from testing'.

Estonia 'Estonia's system for paying for healthcare services may present obstacles to most-at-risk populations regarding healthcare services which are not directly related to HIV treatment and care'.

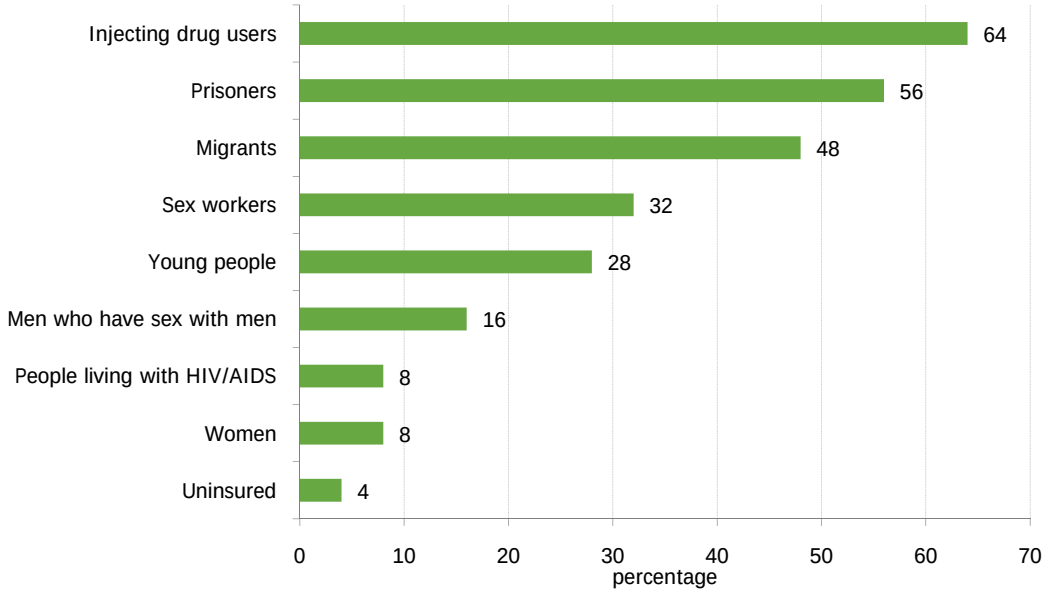
Israel 'Undocumented immigrants do not have access to routine CD4 and viral load testing, neither to HAART'.

Norway 'The General Civil Penal Code section 155 has the purpose of protecting society against the spread of communicable diseases that are hazardous to public health. This provision imposes penalties on those who have good reason to believe that they are infected and who wilfully or negligently transmit that infection or expose someone to the risk of becoming infected'.

Nearly all countries (92%[151]) reported having a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk or other vulnerable subpopulations. However, when asked about the key elements of the policy or strategy related to specific risk populations, the percentages varied widely (see Figure 20).

- The four population groups were injecting drug users, men who have sex with men, sex workers and prisoners.
- The seven elements were: targeted information on risk reduction and HIV education; stigma and discrimination reduction; condom promotion; HIV testing and counselling; reproductive health, including STI prevention and treatment; drug substitution therapy; and needle and syringe exchange[152].

Figure 20: Percentage of countries reporting legal, regulatory and policy barriers for specified populations to access HIV prevention, treatment, care and support (n=25)[153]



Overall, almost all (> 80%) countries' policies and strategies include targeted information on risk reduction/HIV education and HIV testing and counselling for each population. Almost all (> 80%) include condom promotion for IDU, sex workers and MSM but only three quarters (75%) include condom promotion for prisoners. Although almost all (82%) countries include stigma and discrimination reduction for MSM in their policies and strategies, this falls to three quarters (75%) for IDU and less than two thirds for sex workers (64%) and prisoners (61%). Similarly, although almost all (82%) countries include reproductive health for sex workers, this falls to around three quarters for IDU (75%) and MSM (77%) and just over two thirds for prisoners (68%). Although almost all

[151] 44/48.

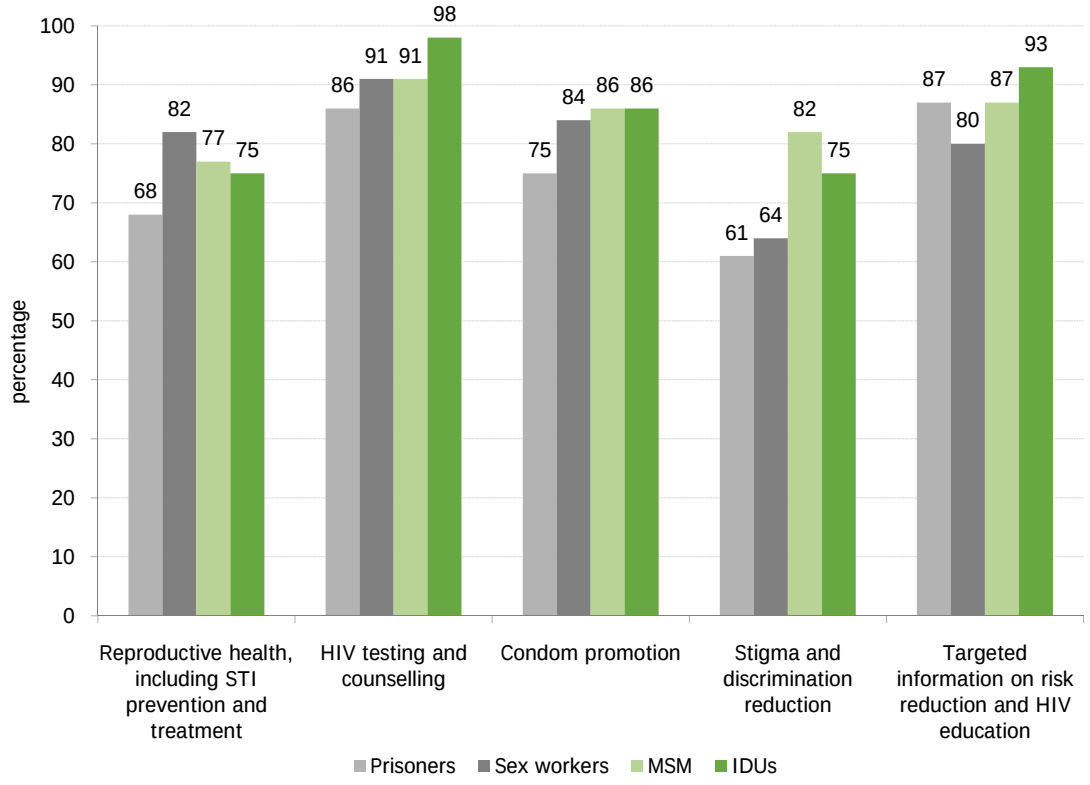
[152] The last two categories are not shown in Figure 21.

[153] See Figure 43 and related footnote.

countries have policies and strategies that include provision of opioid substitution therapy (84%) and needle and syringe exchange (91%) for IDU, only just over one third (34%) have policies and strategies that include provision of opioid substitution therapy for prisoners and only one quarter (25%) have policies and strategies that include needle and syringe exchange for prisoners.

In general, the findings suggest that almost all countries recognise the importance of key populations in responses to HIV and demonstrate this by including these populations, and interventions for them, in the country's policies and strategies. However, policies or strategies that could be considered politically more acceptable, e.g. provision of information, tend to score higher across the four populations than those that are more challenging, e.g. efforts to reduce stigma and discrimination for all four subpopulations or harm reduction services for prisoners.

Figure 21: Percentage of countries[154] reporting a policy or strategy that includes the following elements for each of the listed subpopulations



In addition to reporting on individual elements of policy and/or strategy for specific risk populations, governments were also asked to rate their country's overall policy efforts in support of HIV prevention. Using a rating scale from 0–10, with 10 being best, the ratings ranged from 3–10[155]. The mean rating across all respondents was 7.36 (median 8). Overall, it appears that governments consider that their policies for HIV prevention are relatively strong[156].

A number of countries provided additional comments on key achievements (see Box 7) and remaining challenges (see Box 8) in the HIV prevention policy arena in the last two years[157]. Although some of the achievements cited by countries are outside of the prevention policy arena, they provide a wide-ranging and useful perspective on prevention efforts in these countries.

[154] The denominator used is the number of countries supplying a response to a particular question. For most questions, this ranged from 32–44. The only exceptions were questions relating to opioid substitution therapy and needle and syringe exchange for populations other than IDU. For these questions, 15–22 countries responded.

[155] The only country scoring 10 was Uzbekistan. Ten countries scored nine: Armenia, Denmark, Germany, Poland, Russia, Serbia, Spain, Switzerland, the Former Yugoslav Republic of Macedonia and Turkey.

[156] The NCPI question on prevention policy environment is addressed to government only. There are similar questions relating to implementation of prevention policy that are addressed to both government and civil society.

[157] These questions were included in NCPI 2010 but not NCPI 2008. Consequently, these questions were only addressed to those countries that did not submit responses to NCPI in 2008.

Box 7: Government comments about key achievements in the policy arena in the last two years

Czech Republic	'Passage of a resolution in July 2008—National Programme for HIV/AIDS in the Czech Republic for 2008–2012—which governs the national response'.
Denmark	'National campaigns about discrimination against people living with HIV'.
France	'Expanded work on prevention for migrant populations; healthcare for people living with HIV'.
Ireland	'Development of a new HIV and AIDS Education and Prevention Plan 2008–2012'.
Israel	'Focus on susceptible populations, including men who have sex with men, injecting drug users and immigrants'.
Italy	'Campaign to encourage HIV testing; launch of a National AIDS helpline that provides anonymous and free telephone counselling in accordance with proven methods of telephone counselling'.
Luxembourg	'Needle and syringe exchange in prisons; mobile services for hard-to-reach populations, including rapid testing for HIV and HCV'.
Norway	'Increased involvement of people living with HIV, especially men who have sex with men in HIV prevention work; increased focus in the health services on improved comprehensive treatment programmes, based on good teamwork; improved understanding of immigrants' knowledge and attitudes about HIV/AIDS and strengthened HIV prevention measures targeting this population'.
Portugal	'HIV testing and counselling programme for injecting drug users; needle and syringe exchange for prisoners; reformulation of the needle and syringe exchange kit; creation of the Civil Society Forum; conduct code for non-discrimination related to labour and employment; general use of rapid tests'.
Serbia	'An update to the National Programme on HIV/AIDS Prevention (2009–2012) was agreed by the government in 2009'.
Turkmenistan	'Launch of a "communication centre" for injecting drug users that focuses on prevention activities; launch of a series of youth centres focusing on HIV prevention'.

Box 8: Government comments about remaining challenges in the policy arena

Cyprus	'Motivate wider civil society involvement'.
Czech Republic	'Strengthen policies and programmes focusing on men who have sex with men in response to the dramatic increase of HIV in this population'.
Denmark	'Prevention for prisoners'.
France	'Prevention among men who have sex with men; more attention on overseas departements (e.g. French Guyana); screen more of the population for HIV infection'.
Ireland	'Integrate HIV and AIDS with sexual health, wellbeing and reproductive health'.
Luxembourg	'Maintain high standards during the current economic crisis'.
Israel	'Improve access to care for undocumented immigrants; improve outreach activities for sex workers and men who have sex with men; secondary prevention among infected individuals'.
Malta	'Finalise the Sexual Health Policy and activate the plan; turning knowledge into behaviour change, especially among youth'.
Norway	'Rising rate of infections among men who have sex with men; ongoing issues of stigma and discrimination facing people living with HIV; weak prevention measures for ethnic minority groups; lack of needle exchange in prisons; increasingly difficult to do prevention with sex workers because of a recent ban on the purchase of sexual services'.
Portugal	'Increase the rate of condom use; stigma and discrimination facing people living with HIV; providing better services to vulnerable populations to ensure more early diagnosis of HIV'.
Serbia	'Financial constraints; need for additional resources to support specific programmes, including staff and technical assistance'.

2.1.3 Prevention needs

Both government and civil society were asked the same questions about specific needs for HIV prevention programmes[158]. The initial question simply asked whether the country had identified specific needs. If government or civil society answered 'yes' to the initial question, they were asked two follow-up questions. First, they were asked to provide a brief summary identifying specific needs in priority order. Second, they were asked how the specific needs were determined. If government or civil society answered 'No' to the initial question, they were asked how HIV prevention programmes were being scaled up.

A total of 17 countries answered the initial question[159]. Governments responded from 16 of these countries. Civil society responded from 13 of them. Almost all governments (88%[160]) and civil society respondents (85%[161]) affirmed identifying specific needs for HIV prevention programmes.

There was a wide range of responses to the follow-up questions about identifying specific needs in priority order and explaining how the specific needs were determined. There were recurring comments around the importance of working with key risk populations, e.g. MSM and IDU; the need to strengthen and/or expand prevention efforts; HIV testing and counselling; and stigma and discrimination. There was less information on how the needs were determined but the responses included epidemiological data, stakeholder fora, expert consultations, needs assessments, international guidelines and common sense. Several countries, e.g. Ireland and Norway, provided comprehensive responses to these questions (see Box 9).

[158] These questions were included in NCPI 2010 but not NCPI 2008. Consequently, these questions were only addressed to those countries that did not submit responses to NCPI in 2008.

[159] Albania, Andorra, Cyprus, Czech Republic, Denmark, Estonia, France, Ireland, Israel, Italy, Luxembourg, Norway, Portugal, San Marino, Slovakia, Turkmenistan and Uzbekistan. Albania's response was from civil society only. Andorra, France, Israel and San Marino responded from government only.

[160] 14/16. The two countries that answered 'no' were Andorra and Turkmenistan.

[161] 11/13. The two countries that answered 'no' were Portugal and Turkmenistan. In all cases, except one (Portugal), responses from government and civil society were concordant.

Box 9: Country examples of results of and methods for assessing HIV prevention needs

Ireland

Priorities identified by government included building leadership and strengthening necessary infrastructure; addressing broader determinants; preventing new infections; addressing stigma and discrimination; monitoring and evaluation; and international commitments. Priorities identified by civil society were those included in an HIV prevention action plan based on a range of specific needs of target populations such as women, young people, MSM, drug users, sex workers, migrants and prisoners. This is structured under a number of headings including education and awareness raising, target group specific interventions (such as improved access to condoms, resources targeting primary care and mental health providers to increase their knowledge of the health and social needs of MSM, early intervention and service access for non-IDU to prevent injecting drug use developing) increasing testing and screening, research and capacity building and linkages to relevant policy frameworks.

These needs were identified through:

- a national consultation day held with key stakeholders in November 2006, with approximately 60 representatives of statutory and civil society organisations and groups involved in the area of HIV and AIDS education and prevention;
- commissioning the National University of Ireland, Galway, to provide a review of international publications and policy developments; the current situation in Ireland in terms of epidemiology, trends and structures; and evidence of best practice in HIV and AIDS prevention and education;
- an overview of progress on the implementation of the 19 recommendations in the National Aids Strategy Committee's "AIDS 2000" report, to establish the current situation and identify key gaps;
- questionnaires sent to relevant agencies and individuals and collated;
- services mapped and gaps identified; and
- multisectoral involvement in devising an action plan.

Norway

Priorities identified by government included improved holistic approach to treatment and follow-up of people living with HIV in the healthcare services; establishing training and follow-up programmes for children, adolescents and young adults living with HIV; strengthening HIV preventive measures targeting MSM with the aim of changing risky behaviour; improving early detection of HIV: testing, surveys, diagnostics and counselling; supporting targeted preventive measures aimed at groups that are especially at risk for HIV, with a special focus on immigrants and groups of women; improving access to free condoms and lubricants for youth, young adults and vulnerable groups; and improving research on the prevention and treatment of HIV and monitoring and evaluation of prevalence, risk factors and effects of measures. Civil society highlighted the increase in new HIV cases among MSM and migrant communities, and noted that special attention is now paid to these two groups.

Needs were identified through:

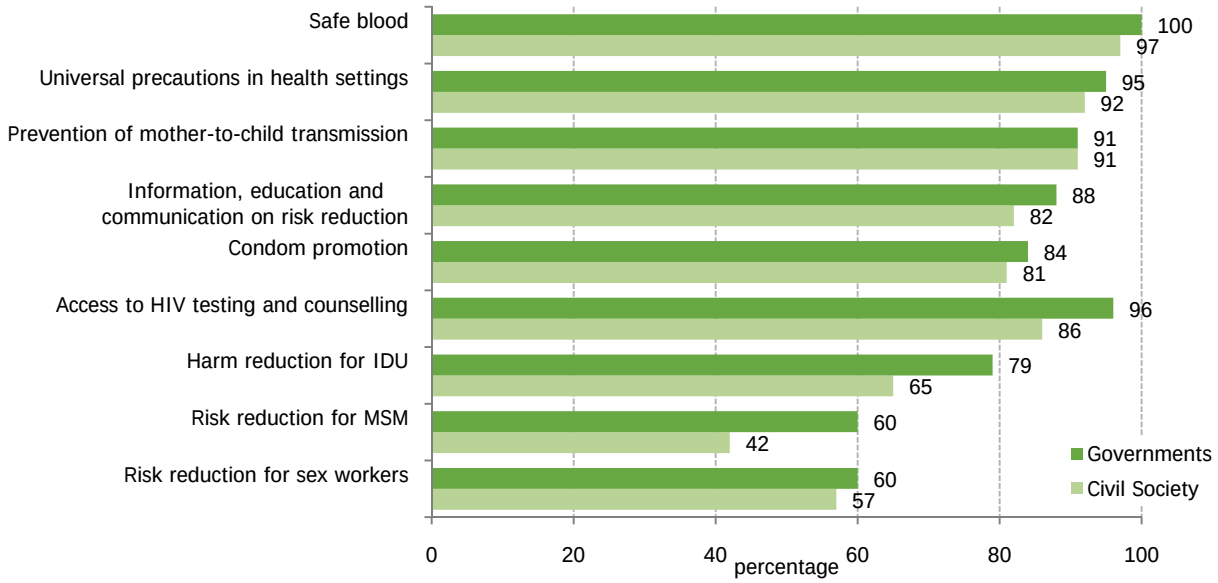
- living with HIV in Norway, a 2009 study on living conditions among people living with HIV in Norway;
- experience-based knowledge from healthcare services and NGOs;
- Norwegian and international research on HIV prevention among MSM;
- international research;
- evaluation of the National HIV/STI Strategic Plan from 2002–2008;
- international knowledge review on measures to increase the use of condoms among boys and young men;
- evaluation of the Norwegian Directorate of Health national free condom scheme; and
- statistics on new cases of HIV infection from the Institute of Public Health.

2.1.4 Access to prevention services

Government and civil society were asked if the majority of the people in need[162] in the country have access to the following prevention services: safe blood; universal precautions in healthcare settings; PMTCT; information, education and communication (IEC) on risk reduction; condom promotion; HIV testing and counselling; harm reduction for injecting drug users; risk reduction for men who have sex with men; and risk reduction for sex workers (see Figure 22).

[162] This was the wording of the questionnaire based on NCPI 2010. The wording in NCPI 2008 was different and focused on districts rather than people.

Figure 22: Percentage of countries[163] reporting that particular prevention services are available to the majority of those in need, government and civil society responses



Almost all (> 80%) countries considered that a range of prevention services are available to the majority of people in need. These include access to safe blood; universal precautions in healthcare settings; PMTCT; IEC on risk reduction; condom promotion; and access to HIV testing and counselling. The figures are lower for harm/risk reduction services for key populations, such as IDU, MSM and sex workers. Overall, the assessments by government and civil society were similar. However, there was a difference in relation to perceived availability of risk reduction programmes for men who have sex with men.

These findings are in keeping with the policy findings presented earlier, i.e. that interventions that could be considered politically more acceptable, e.g. provision of safe blood are more likely to be implemented than those that are more challenging, e.g. harm reduction services for prisoners. However, these findings also show differences between availability of policies relating to particular services and actual provision of those services. For example, almost all (84%) countries reported that their policies include provision of harm reduction services for IDU yet only just over three quarters (79%) of governments and less than two third of civil society respondents (65%) consider that these services are available to the majority of those who need them in their countries (see Figure 22).

2.1.5 Implementation: achievements and challenges

Governments and civil society were asked the same three questions about achievements and challenges. The first question asked them to rate the country's efforts in implementation of HIV prevention programmes. The following two questions[164] gave governments and civil society an opportunity to identify what have been the key achievements in the last two years and what are the remaining challenges.

Nearly all governments (94%[165]) and civil society respondents (84%[166]) answered the first question. Using a rating scale from 0–10 with 10 being best, the ratings ranged from a 0–10[167]. The mean rating from governments was 7.4 (median 8) compared to 6.1 (median 6) from civil society (see Figure 23).

[163] The denominator used is the number of countries supplying a response to a particular question. For government responses, this ranged from 42 to 45. For civil society responses, this varied from 33 to 37.

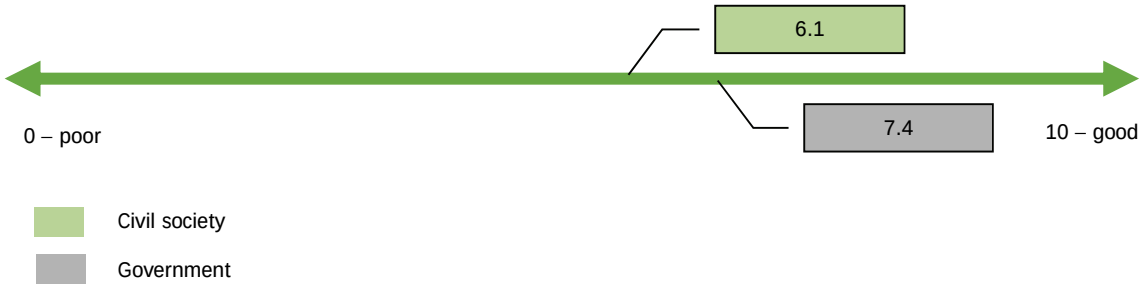
[164] These two questions were included in NCPI 2010 but not NCPI 2008. Consequently, these questions were only addressed to those countries that did not submit responses to NCPI in 2008.

[165] 46/49.

[166] 41/49.

[167] Both government and civil society ranked this as 10 in Uzbekistan. Nine governments ranked this as nine. These were (corresponding scores from civil society in brackets): Bosnia and Herzegovina (6), Bulgaria (8), Denmark (8), Germany (8), Romania (8), Switzerland (9), the Former Yugoslav Republic of Macedonia (8), Turkey (7) and United Kingdom (6). Only Switzerland received a score of nine from civil society.

Figure 23: Mean ratings of implementation of prevention response, government and civil society responses



Governments and civil society from a number of countries provided responses to questions on key achievements (Box 10) and remaining challenges (Box 11) [168]. Comments covered a range of topics relevant to country responses. Overall, the comments provided by both constituencies reinforced the focus on key risk populations and access to services cited in responses to other prevention-related questions.

Box 10: Key achievements in prevention over the last two years, country examples

Government

Cyprus	'Civil society organisations have been motivated to increase and widen their efforts'.
Denmark	'National campaigns against discrimination of HIV positive people'.
Estonia	'Harm reduction services for injecting drug users have been scaled up considerably. The geographical coverage of the services has improved, and the number of people attending the services and the number of syringes distributed have constantly increased'.
France	'Prevention charter with gay shops, bars and saunas to provide condoms at their premises'.
Israel	'Focusing on susceptible populations, such as MSM, IDU and immigrants'.
Luxembourg	'Needle and syringe exchange in prisons'.
Portugal	'Clear increase in condom use and HIV test uptake'.
San Marino	'No HIV transmitted through blood transfusion or in hospital'.

Civil society

Cyprus	'Civil society organisations committed to the cause have been motivated to increase and widen their efforts'.
Czech Republic	'The outreach programme for prevention among MSM in Prague'.
Estonia	'Harm reduction programmes have been very successful; coverage has increased year by year'.
Luxembourg	'Harm reduction, including needle and syringe exchange in prisons'.
Slovakia	'Harm reduction services survived even with a lack of funding; however, one out of seven closed down'.

[168] These two questions were included in NCPI 2010 but not NCPI 2008. Consequently, these questions were only addressed to those countries that did not submit responses to NCPI in 2008.

Box 11: Remaining challenges in prevention, country examples

Government

Czech Republic	'Prevention of HIV/AIDS among MSM and other groups at risk'.
Denmark	'See to the prevention needs of prisoners'.
Estonia	'1) Integration of harm reduction, health and social care services for IDU and other groups; linking the services with the prison and detention system. 2) Ensuring an appropriate range of easily accessible services for IDU and their sexual partners (for example appropriate injecting-related equipment, other than needles and syringes; sexual health services; HIV and hepatitis testing in all syringe exchange programs) and improving the geographical coverage of services. 3) Providing sexual health and other HIV prevention services for PLHIV. 4) Providing IEC and promoting condom use among MSM. 5) Implementing school-based sexual health programs all across the country and developing special programmes for out-of-school youth. 6) Providing adequate IEC and harm reduction services in all prisons and arrest houses. 7) Providing HIV prevention services for sex workers in other regions besides the capital city.'
France	'Increase testing for HIV among MSM, migrants and drug users'.
Israel	'Improving access to care for undocumented immigrants'.
Malta	'Targeting risk groups more specifically; e.g. sex workers and MSM'.
Norway	'Ensure good access to testing and counselling for groups that find the health systems relatively inaccessible or poorly adapted to their personal situation.'
Slovakia	'To gain further financial means from the private sector to cover more specific programmes for HIV/AIDS prevention'.

Civil society

Czech Republic	'Poor coordination and insufficient cooperation between HIV programmes, groups and experts with drug prevention programmes'.
Denmark	'People living with HIV who are unidentified and undiagnosed; more testing and counselling'.
Estonia	'Services for MSM and sex workers are limited'.
Ireland	'Finding the resources and leadership to implement the action plan in a recession'.
Italy	'Post-test counselling is practically absent if the HIV test is negative'.
Luxembourg	'Migrants, especially undocumented ones'.

2.1.6 Conclusions

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 (see Figure 23). In general, countries recognise the importance of providing prevention services to key populations. However, it is of concern that 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 20). 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.

Second, it is of concern that policies/strategies that are more likely to be politically acceptable, e.g. 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, e.g. provision of

safe blood, are more likely to be implemented than those that are more challenging, e.g. harm reduction services for prisoners (see Figure 22).

These issues are explored in more detail in the chapters that follow focused on specific populations—injecting drug users (Section 2.2), MSM (Section 2.3), sex workers (Section 2.4), migrants (Section 2.5) and prisoners (Section 2.6).

In conclusion, ECDC has identified the following issues needing 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 Introduction and background) 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 at 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

2.2.1 Introduction

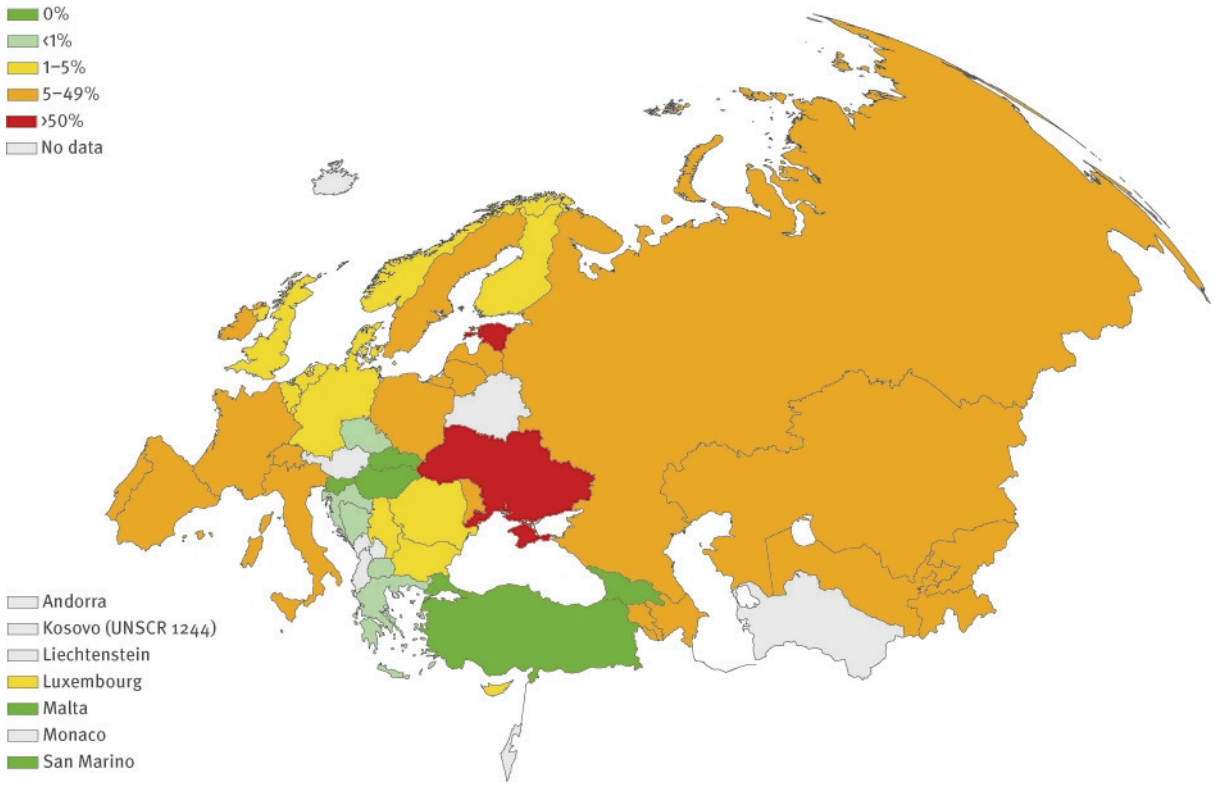
Injecting drug use has been recognised as a major driver of HIV epidemics across Europe and central Asia. Many countries have documented high rates of HIV prevalence among injecting drug users (IDU). However, there is evidence that the role of injecting drug use in national epidemics has declined in some countries in the western part of the region. Reasons for this appear to include changes in drug-taking behaviour as a result of the introduction of effective harm reduction programmes. Nevertheless, it appears that injecting drug use remains a major driver of HIV epidemics in many countries, particularly in the eastern part of the region, where these programmes have been implemented more slowly.

This section explores these issues. It is structured around relevant UNGASS indicators and EMCDDA measures. It starts by considering countries' HIV prevalence data. It then looks at rates of HIV testing among IDU and various ways of measuring programme coverage. It concludes by considering HIV-related knowledge of IDU, and reported use of condoms and sterile injecting equipment by IDU.

2.2.2 HIV prevalence in injecting drug users

Almost all (90%[169]) countries provided some quantitative information on HIV prevalence among IDU (see Figure 24 and Table 4)[170]. One country[171] reported that data on this indicator is not available[172].

Figure 24: HIV prevalence among IDU in Europe and central Asia[173]



[169] 44/49, including San Marino, who reported that there are no IDU affected by HIV. Israel reported that it was not possible to report prevalence as the number of IDU is not known, but that in recent years approximately 15% of newly notified HIV cases, around 50 cases annually, are of IDU. Other countries, e.g. Croatia and Turkey, also report the proportion of new HIV cases reported to be acquired through injecting drug use.

[170] Countries were asked to respond to a question in line with UNGASS designed to measure the percentage of IDU who are HIV infected (disaggregated by age and sex). Types of data varied including results from diagnostic testing, surveillance studies and self-reported status. Dates of data varied from 2003 to 2008 (see Table 4). Given differences in data sources and dates, comparisons should be made with caution.

[171] Andorra.

[172] Albania, Iceland and Turkmenistan did not provide any information in response to this question.

[173] Where prevalence data is available for countries as a range, the top end of the range has been used.

Almost half (46%[174]) of the countries reported high prevalence rates of > 5%. These are particularly distributed in the eastern[175] and south-western[176] parts of the region. Just over a quarter (27%[177]) of countries reported moderate prevalence rates of 1–5%. These included a number of countries in northern Europe[178]. Countries of south-eastern and central Europe reported low[179] or moderate[180] prevalence among IDU. Three countries[181] reported prevalence data disaggregated by age. In each case, this showed higher prevalence rates among older IDU. Some countries reported on geographic variations in prevalence rates within the country[182] and some countries commented on trends in their data over time[183].

Table 4: HIV prevalence among IDU in Europe and central Asia

Country	HIV prevalence [184]	Year	Comment
Armenia	6.8%	2007	Source: UNGASS 2008
Azerbaijan	13%	2003	Source: UNGASS 2008
Belgium	3.7%	2007	Among 54 IDU in the Flemish community. In 2006, 2.9% of 68 IDU in the Flemish community and 5.7% of 336 in Antwerp. Data based on diagnostic testing at 11 drug treatment centres/low-threshold services. Source: EMCDDA
Bosnia and Herzegovina	0.1%	2006	Source: UNGASS 2008
Bulgaria	3.4%	2006	Source: UNGASS 2008. Other evidence: 0% among 613 IDU (based on diagnostic testing in national study of six prisons); 0.8% of 487 in 2006 and 1.5% of 676 in 2007 in five sites in Sofia (drug treatment centres, needle exchanges, low-threshold services, HIV testing centres). Source: EMCDDA
Croatia	0.6%	2006	Source: UNGASS 2008. Other evidence: 2008 study states that IDU account for 8.2% of reported HIV cases, with prevalence among IDU stable at around 1% for last 20 years. Source: Croatian National Institute of Public Health 2008. Studies in 2006 and 2007 (including specific prevalence studies in prisons nationally and in various locations in Rijeka, Split and Zagreb) reported 0% prevalence; one specific prevalence study conducted on the streets in Zagreb, Rijeka, Split, Zadar, Slavonski Brod, Osijek and Dubrovnik found prevalence of 0.6% among 323 IDU. Source: EMCDDA
Cyprus	0–2%	2007	Two studies in 2007: 0% of 102 (based on diagnostic testing in 18 drug treatment centres) and 2% of 252 (based on self-reported test results in 32 drug treatment centres). Figure for 2006 was 0% of 96 in two studies using the same method. Source: EMCDDA

[174] 20/44.

[175] E.g. Armenia, Azerbaijan, Estonia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Poland, Russia, Tajikistan, Ukraine and Uzbekistan.

[176] E.g. France, Ireland, Italy, Spain and Switzerland.

[177] 12/44.

[178] E.g. Belgium, Finland, Germany, Luxembourg, Netherlands, Norway and the United Kingdom.

[179] Hungary, Malta, Slovakia, Slovenia and Turkey reported no HIV among IDU. Bosnia and Herzegovina, Czech Republic, Croatia, Greece and the Former Yugoslav Republic of Macedonia reported rates of < 1%.

[180] Bulgaria, Cyprus, Romania and Serbia reported rates of 1–5%.

[181] Kyrgyzstan, Moldova and Uzbekistan. Moldova also disaggregated HIV prevalence by sex. Levels of prevalence were similar in males and females.

[182] For example, Belgium reported higher prevalence in Antwerp than in other parts of the country. Estonia reported higher prevalence rates in Kohtla-Jarve than in the capital, Tallinn. Serbia reported higher prevalence in Belgrade than in Novi Sad.

[183] For example, Czech Republic commented that HIV prevalence rates among IDU had remained below 1% from 1996. Germany commented that HIV prevalence among IDU had remained stable in recent years.

[184] Latest available figure.

Country	HIV prevalence [184]	Year	Comment
Czech Republic	0.2%	2007	Based on diagnostic testing, 0% of 412, 0% of 728 and 0.1% of 994 in 2006 in three national studies (data from 11 drug treatment centres and low-threshold services; data from drug treatment centres, needle exchanges, GPs, STI clinics, other hospitals or clinics, prisons and HIV testing centres; data from 36 needle exchanges and low-threshold centres). In 2007, 0.2% of 1 376 (second method) and 0.2% of 609 (third method). Source: EMCDDA. Other evidence: 0.07% (1 of 1 363 IDU tested at National Reference Laboratory on AIDS) Prague; 0.13% (1 of 762 tested by harm reduction programmes); 0.64% (15 of 2 332, based on self-reported HIV status by IDU on TDI register). Prevalence of HIV among IDU has remained below 1% between 1996 and 2008.
Denmark	2.1%	2006	Of 188 nationally; data based on a specific prevalence study using unlinked anonymous testing among overdose deaths in five sites. Source: EMCDDA
Estonia	62.1%	2005	Source: UNGASS 2008. Other evidence: 56.6% of 325 in Tallinn in 2007, based on street-based, respondent-driven sampling; 54.3% of 350 in Tallinn and 89.9% of 99 in Kohtla-Jarve in 2005, based on diagnostic testing in one low-threshold service. Source: EMCDDA
Finland	1.4%	2007	Source: UNGASS 2008. Other evidence: 0.2% in 1 486 IDU in 2006 (based on diagnostic testing in 21 needle exchange sites) and 0.2% of 1 316 IDU in 2006 and 0.1% of 1 363 in 2007 (based on diagnostic testing in 29 prisons). Also in 2007, 0.6% of 1 560 IDU (based on diagnostic testing in seven needle exchanges in Helsinki, Espoo, Vantaa and Tampere); 1.3% of 722 in prevalence study conducted in 10 needle exchanges in Helsinki, Vantaa, Espoo, Turku, Tampere, Lahti, Hämeenlinna, Kuopio, Forssa and Lohja.
Former Yugoslav Republic of Macedonia	0.8%	2006	Source: UNGASS 2008
France	5.1–8%	2006	Two studies in five cities in 2006: 5.1% in 356 (based on self-reported test results in needle exchanges, low-threshold services and on the streets) and 8% of 342 IDU (based on specific prevalence study using unlinked anonymous testing in needle exchanges, low-threshold services and on the streets). Source: EMCDDA[185].
Georgia	0%	2006	Source: UNGASS 2008
Germany	3.4%	2007	HIV prevalence among IDU nationally 3.4% of 1 394 in 2007, 2.9% of 1 296 in 2006 and 5.3% of 1 326 in 2005 (based on diagnostic testing of overdose deaths)[186]. Different studies show that HIV prevalence in IDU has remained stable in recent years. Source: EMCDDA
Greece	0.7%	2006	Source: UNGASS 2009. Other evidence: national prevalence of 0.3% of 761 and 0.7% of 1 259 in 2006 (based on diagnostic testing in 18 drug treatment centres and low-threshold services, and in 19 drug treatment centres, low-threshold services, public health laboratories and other hospitals); prevalence subnationally, based on diagnostic testing in various locations, ranged from 0% to 1.9% (in Crete). Source: EMCDDA
Hungary	0%	2006	Source: UNGASS 2008. Other evidence: 0% in two samples of 69 and 300 in 2006 (based on diagnostic testing at four public health laboratories, and on a specific prevalence study conducted in 15 drug treatment centres and needle exchanges[187]); 0% of 567 in 2007 using the second method. Source: EMCDDA

[185] In commenting on the report, France stated that HIV prevalence was found to be 8% in IDU in 2004 in Coquelicot Survey. This study is being repeated in 2010 by the Institut de veille sanitaire.

[186] In Germany, data on clinical staging and CD4 cell count at time of HIV diagnosis suggest that IDU and MSM are the two groups with the earliest HIV diagnosis. Study results from HIV incidence testing March 2008–February 2009 reveal 37% of recent HIV infections (< 6 months) in newly HIV-diagnosed IDU.

[187] IDU status not known; prevalence in IDU is likely to be underestimated.

Country	HIV prevalence [184]	Year	Comment
Ireland	12.5%	2003	Prevalence among 64 IDU in Dublin (based on specific prevalence in study conducted at one drug treatment centre). Source: EMCDDA. In Ireland it is estimated that approximately one in 10 IDU has HIV.
Italy	11.9%	2007	Prevalence in IDU nationally 11.9% of 67 776 (12.1% of 67 300 in 2006) based on diagnostic testing in 515 drug treatment centres[188]. Source: EMCDDA. Other evidence: 19% of 1 917 IDU surveyed in 205 and 2007. Source: Regine at al, SISMEC Conference 2009
Kazakhstan	7.4%	2006	Source: UNGASS 2008
Kyrgyzstan	0–8.3%	2008	< 25 years: male 4.9%, female 0%; > 25 years male 7.8%, female 8.3%. Source: Epidemiological surveillance 2008
Latvia	22.5%	2007	Source: UNGASS 2008. Other evidence: Prevalence nationally in 2003 6.6% of 987 and 9.7% of 93 in two studies (the first based on diagnostic testing in drug treatment centres and other hospitals and clinics, the second on diagnostic testing in drug treatment centres) and 22% of 205 in Riga and Tukums (specific prevalence study conducted in needle exchange programmes and on the streets). Source: EMCDDA
Lithuania	9.7%	2007	Source: UNGASS 2008. Other evidence: Most recent national study in 2003 found prevalence of 2.4% in 1 112 IDU (based on diagnostic testing in drug treatment centres, needle exchanges and other hospitals and clinics). Prevalence in 2006 in Vilnius was 1.9% of 799, 9.7% of 320 and 0.6% of 522 in three studies (based on diagnostic testing in 15 HIV testing centres, a specific prevalence study in one needle exchange and one HIV testing centre, and on diagnostic testing in one needle exchange/low-threshold service); prevalence in Alytus was 1.3% of 78 (based on diagnostic testing in one needle exchange/low-threshold service) and in Klaipeda 3.6% of 56 (no methodological information available). Source: EMCDDA
Luxembourg	3.5%	2007	Prevalence nationally 3.5% of 250 in 2007, 2.8% of 254 in 2006 (based on self-reported test results at eight drug treatment centres). Source: EMCDDA
Malta	0%	2006	0% of 175 (based on diagnostic testing at one drug treatment centre). Source: EMCDDA
Moldova	17.5%	2007	Source: UNGASS 2008
Netherlands	1.8%	2007	Prevalence of 1.8% in 56 IDU in Amsterdam in 2007 (based on diagnostic testing in five drug treatment centres); 9.5% of 452 IDU in Rotterdam in 2002 (based on a specific prevalence study conducted in drug treatment centres and on the streets). Source: EMCDDA
Norway	2.9%	2007	National data based on specific prevalence studies in 14 drug treatment centres found prevalence of 3.2% of 3 349 in 2006 and 2.9% of 3 669 in 2007. Data from Oslo based on specific prevalence studies in 10 needle exchanges and low-threshold services found prevalence of 1.3% of 228 in 2006 and 0% of 222 in 2007. Source: EMCDDA
Poland	11.4%	2007	Prevalence nationally 8.9% of 910 in 2006 and 11.4% of 1 064 in 2007 (based on diagnostic testing in public health laboratories and HIV testing centres). Specific prevalence study in 2004 in eight drug treatment centres, low-threshold services and prisons found prevalence 2.4% of 82 in Warminsko-Mazurskie, 31.5% of 178 in Wroclaw, 29.5% of 88 in Lubuskie. Source: EMCDDA
Portugal	9.1–19.9%	2007	10.9% of 1 520 in 2006 and 9.1% of 1 845 in 2007 (based on diagnostic testing in 78 outpatient drug treatment centres); 20.2% of 946 in 2006 and 19.9% of 933 in 2007 (based on diagnostic testing in 156 drug-free drug treatment centres); 16.1% of 4 128 in 2006 and 15.6% of 4 232 in 2007 (based on diagnostic testing in 73 inpatient therapeutic communities). Source: EMCDDA

[188] IDU status not known; prevalence in IDU is likely to be underestimated.

Country	HIV prevalence [184]	Year	Comment
Romania	1.6%	2007	Prevalence in IDU in Bucharest 1.4% of 138 in 2006, 1.6% of 304 in 2007 (based on diagnostic testing in two drug treatment centres); 0.8% of 121 in 2007 (diagnostic testing in one drug treatment centre). Source: EMCDDA
Russia	10.3%	2006	Source: UNGASS 2008
Serbia	0.3–4.7%	2008	Unadjusted prevalence 4.7% Belgrade, 0.3% Novi Sad, 1.6% Nis (sample size 320 per city). Source: Ministry of Health/Integrated Bio-Behavioural Survey (IBBS) conducted as a part of second generation HIV surveillance
Slovakia	0%	2007	0% of 88 in 2007 and 0% of 79 in 2006 in Bratislava (based on diagnostic testing in one treatment centre). Data not collected using EMCDDA or UNGASS method. There are estimated to be between 3 000 and 12 000 IDU in Slovakia; 4 HIV-positive IDU were identified in 2007 and 2008. Source: EMCDDA
Slovenia	0%	2007	Source: UNGASS 2008. Other evidence: Nationally 0% of 263 in 2006, 0% of 287 in 2007 (based on diagnostic testing in 18 drug treatment centres); also 0% in Ljubljana and Koper in 2006 and 2007 (based on specific prevalence studies using unlinked anonymous testing from three sites—drug treatment centres, needle exchanges and low-threshold centres; sample size 162 in 2006, 174 in 2007). Source: EMCDDA
Spain	36.4–39.7%	2006	Prevalence in two national studies 36.4% of 9 068 (based on diagnostic testing in 497 drug treatment centres) and 39.7% of 1 194 (based on self-reported results in 66 prisons). Source: EMCDDA. Other evidence: 17.8% in 2005. Source: UNGASS 2008. HIV prevalence among IDU attending an STI clinics network was 16% in 2007 (n=185) and 19.5% in 2008 (n=159). Source: EpiVIH study
Sweden	5.1%	2007	Source: UNGASS 2008. Other evidence: HIV prevalence of 1.3% of 152 in 2006, 0% of 129 in 2007 (based on a combination of diagnostic testing and specific prevalence studies in two prisons in Gothenburg); 6.1% of 375 in 2006 and 8.4% of 345 in 2007 (based on specific prevalence studies in six sites in Stockholm including prisons, drug treatment centres and other hospitals and clinics); and 5.4% of 203 in 2007 (based on diagnostic testing in 207 sites in low-threshold centres and on the street in Stockholm county). Source: EMCDDA
Switzerland	10.9%	2006	Source: UNGASS 2008
Tajikistan	23.5%	2006	Source: UNGASS 2008
Turkey	0%	2004	0% of 38 (based on diagnostic testing in drug treatment centres)[189]. Source: EMCDDA
Ukraine	61.2%	2006	Source: UNGASS 2008
United Kingdom	0.5–1.8%	2007	England and Wales: 1.3% of 3 075 in 2006, 1.1% of 3 415 in 2007 (based on specific prevalence studies using unlinked anonymous testing at 58 sites including drug treatment centres, needle exchanges, low-threshold services and primary care providers). Disaggregated data available for London and outside London. Scotland: 0.8% of 2 142 in 2006, 0.5% of 2 098 in 2007 (based on diagnostic testing conducted at 15 public health laboratories). Specific data available for Dundee, Edinburgh and Glasgow. Northern Ireland: 1.8% of 164 in 2006, 1.8% of 165 in 2007 (based on specific prevalence studies using unlinked anonymous testing at drug treatment centres, needle exchanges, low-threshold services and primary care providers).
Uzbekistan	12.9%	2007	Male IDU 12.5%, female IDU 15.6%; < 25 years 10.9%, > 25 years 13.1%. Source: DHS 2007. Other evidence: 17.9% in 2005. Source: UNGASS 2008

[189] Turkey commented that an estimated 3.95% of reported HIV cases are in IDU, of which 91.72% were male and 8.27% female.

2.2.3 HIV testing in injecting drug users

Four fifths of countries (80%[190]) provided some quantitative data on HIV testing among IDU (see Table 5)[191]. Five countries[192] reported that data is not available[193,194].

As with data on HIV prevalence, evidence on HIV testing in this population was drawn from a wide range of sources, including different types of surveys. In some cases, questions used varied from the standard UNGASS question. For example, some surveys asked whether an IDU had ever been tested for HIV or whether they had been tested during a different timeframe from the 12 months used by the UNGASS indicator. This raises the issue of how often countries consider IDU should be tested for HIV and the factors that might usefully determine an appropriate frequency of testing[195]. Not all countries provided data about whether or not IDU knew their test result.

There is considerable variation in reported rates of HIV testing in IDU in the region, ranging from < 1% in Poland to 84% in Luxembourg and Sweden. Eleven countries reported HIV testing rates of less than 30%, 14 countries rates of between 30% and 60% and 11 countries rates of more than 60%[196]. Broadly speaking, higher rates of HIV testing in IDU were reported by EU/EFTA countries[197] and from countries with higher HIV prevalence among IDU.

Azerbaijan and Uzbekistan provided data disaggregated by age and sex that showed little difference in testing rates between IDU aged under or over 25 years old but higher rates of HIV testing among female IDU. Greece reported that male IDU and those aged 25–34 years were more likely to report having been tested for HIV than female IDU or those aged over 34 years. Data from France showed higher rates of testing in female IDU and IDU aged over 25 years.

A few countries provided data on whether IDU who had been tested for HIV knew their test result. While 100% of those tested in Sweden reported knowing the result, the proportion was lower in Bulgaria (82%), Czech Republic (72%) and Latvia (80%), and varied in Greece, depending on the treatment centre.

Table 5: HIV testing among IDU in Europe and central Asia

Country	HIV testing	Year	Comment
Armenia	23%	2007	Compared with 21% in 2005. Source: UNGASS 2008
Azerbaijan	4.9%	2007/8	Age < 25, 5%; age > 25, 4.9%; male IDU 4.6%; female IDU 15.4%. Source: Epidemiological surveillance 2007/8
Belgium	32–62%	2007/8	Flemish community: 62% of 200 IDU tested in last two years (data from syringe exchange programme). Source: Windelinckx 2008. French-speaking community: 32% of 618 tested in last year, 65% ever tested. Source: Survey 2007. Results are not representative of all the IDU in each community. No data disaggregated by age and sex.
Bosnia and Herzegovina	53%	2007	Male IDU. Source: 2008 UNGASS
Bulgaria	38%	2006	Source: 2008 UNGASS. Other evidence: 75.3% of 146 in Sofia in 2007 reported having had an HIV test, 61.6% reported knowing the result. Source: EMCDDA
Croatia	40%	Not stated	Of newly registered opiate users on treatment (based on annual laboratory reports of routine surveillance system). Other evidence: 25% of 239 respondents never tested. Source: Kosanovic et al 2006. 18.5% of 193 never tested for HIV in a 2008 study.
Cyprus		2009	28 IDU tested for HIV in 2009.

[190] 39/49.

[191] Countries were asked to respond to a question in line with the UNGASS indicator designed to measure the percentage of IDU who have had an HIV test in the last 12 months and know the results (disaggregated by age and sex).

[192] Andorra, Denmark, Iceland, Norway and Slovenia.

[193] Denmark and Slovenia commented that data on this indicator is not collected at national level.

[194] Albania, San Marino and Turkmenistan provided no information in response to this question. Israel and Slovakia referred to data provided relating to HIV prevalence but did not provide specific data on HIV testing among IDU.

[195] EMCDDA DRID testing guidelines (see Bibliography) suggest at least annual testing for IDU, and more frequent testing depending on risk behaviour.

[196] Cyprus and Finland provided data on numbers of IDU tested; Ireland provided data on numbers of cases diagnosed.

[197] Mean rates reported were 48.3% for EU/EFTA countries and 28.2% for others.

Country	HIV testing	Year	Comment
Czech Republic	40.4%	2008	56% (3 205 of 5 766) had had an HIV test, 40.4% (2 332 of 5 766) knew the results. Source: Stuničková, 2009. Other evidence: 51% of 783 clients in all seven low-threshold centres in Prague surveyed in May 2008 had had an HIV test in the last 12 months and knew the results. Source: Sejvl, 2008. 33.5% of 758 in a national survey in 2003 reported having a test in the last 12 months. Source: EMCDDA
Estonia	62%	2007	Source: UNGASS 2008
Finland	1 560	2007	1 560 IDU tested in Low-threshold Health Service Centres (LTHSC) (9 positive). HIV tests are available for IDU on substitution or maintenance therapy. In 2007 in prisons, 1 363 inmates took a voluntary HIV test (1 positive); the total number of IDU in prisons is unknown.
Former Yugoslav Republic of Macedonia	44%	2007	Compared with 32% in 2005. Source: UNGASS 2008
France	60.7%	2008	Male IDU 54.6%; female IDU 60.4%; > 25, 60.8%; < 25, 55%. Source: Enacaarud Study, OFDT
Georgia	9%	2007	Compared with 6% in 2005. Source: UNGASS 2008
Germany	40%	Not stated	HIV surveillance system shows at least 40% of IDU newly diagnosed with HIV had a previous negative test result. There is no national data collection on HIV testing in IDU, but a national survey of IDU under substitution therapy being conducted will provide data about this group of IDU in 2010[198].
Greece	22.5–58.4%	2006	Proportion of IDU who approached treatment services tested for HIV and who knew the test result depended on the treatment centre. In other settings, HIV tested IDU are mainly male (50.1%) compared with female (8.3 %). Higher proportion of IDU aged 25–34 tested than those aged > 34. Source: EMCDDA. No data yet for 2008.
Hungary	8%	2007	Source: UNGASS 2008. In commenting on the report, Hungary clarified that 567 of an estimated 3 940 IDU were tested for HIV, i.e. 14.4%[199]
Ireland			See Box 12.
Italy	28%	2005/7	Percentage tested in last 12 months in survey of 1 917 IDU conducted in 2005 and 2007. Source: Camoni et al 2009
Kazakhstan	42%	2007	Source: UNGASS 2008
Kyrgyzstan	34%	2007	Source: UNGASS 2008
Latvia	68%	2008	Percentage of 221, 281 and 372 IDU in 13 sites in 2006, 13 sites in 2007 and six sites in 2008 respectively, reporting having had an HIV test: 68% in 2006, 86% in 2007, 85% in 2008; percentage knowing their test result was 58% in 2006, 53% in 2007, 68% in 2008. Questions included: 'Have you ever been tested for HIV? When did you test for HIV the last time? What were the results of the last HIV test?' All respondents with an answer missing excluded from the calculations. Source: EMCDDA. Other evidence: 61% in 2007.Source: UNGASS 2008
Lithuania	64%	2007	Source: UNGASS 2008. Other evidence: 100% of 174 IDU in Klaipeda in 2005 and 100% of 320 IDU in Vilnius in 2006 reported having had an HIV test.
Luxembourg	84.1%	2006	84.1% of 164 in a national survey in 2006 (77.5% of 165 in 2005) reported having had an HIV test in the last 5 months. Source: EMCDDA
Malta	1 085	2008	1 085 IDU tested (1 HIV positive; the rate of HIV infection in IDU is very low).
Moldova	34%	2007	Source: UNGASS 2008
Netherlands	72%	2003	Latest data. Percentage of IDU in Rotterdam ever tested for HIV. Source: de Boer et al 2004. No national data; surveys conducted in various cities 1994–2003.

[198] In Germany, the total number of 'problematic drug users' (includes non-opioid users and non-injectors) is estimated at 170 000–200 000; 70 000 opioid users/injectors are in oral substitution treatment.

[199] This method is based on programmatic data and differs from the survey-based approach proposed for UNGASS. It also does not consider whether or not the person knows the result.

Country	HIV testing	Year	Comment
Poland	< 1%	2007	Source: UNGASS 2008. Other evidence: In 2005, 22% of 76 IDU in Lubelskie, 17% of 176 in Wroclaw and 11% of 73 in Warminsko-Mazurskie reported having had an HIV test. Source: EMCDDA
Portugal	> 60%	Not stated	No data source. Other data, date not stated, reports that 24 000 IDU have been tested for HIV.
Romania	16%	2007	Compared with 36% in 2005. Method not harmonised with UNGASS 2008 guidelines. Source: UNGASS 2008. Other evidence: 51.7% of 64 IDU in Bucharest in 2008 reported having had an HIV test. Source: EMCDDA
Russia	46%	2007	Source: UNGASS 2008
Serbia	15–32%	2008	Unadjusted HIV testing rate 32% Belgrade, 15% Novi Sad, 20% Nis (sample size 320 per city). Source: Ministry of Health/Integrated Bio-Behavioural Survey (IBBS) conducted as a part of second generation HIV surveillance
Spain	68%	2007	Data collection started before 2005. Method not harmonised with UNAIDS 2008 guidelines. Source: UNGASS 2008
Sweden	84%[200]	2007	Method not harmonised with UNAIDS 2008 guidelines. Source: UNGASS 2008. Other evidence: IDU reporting having had an HIV test 40% in 2006, 2007 and 2008; percentage tested who knew the result 40% in 2006 and 2007, 10% in 2008. Samples in Stockholm of 395 in 2005, 375 in 2006, 342 in 2007. In 2007, 30% of 128 IDU in Gothenburg and 30% of 204 IDU in Stockholm county reported having been tested; of those tested, 100% in Gothenburg and 30% in Stockholm county knew their results. Source: EMCDDA
Switzerland	60%	2007	Source: UNGASS 2008
Tajikistan	24%	2007	Source: UNGASS 2008
Turkey	8%	2007	Source: UNGASS 2008
Ukraine	29%	2007	Compared with 27% in 2005. Source: UNGASS 2008
United Kingdom	57.3–79.9%	2006/7	Combined 2006–2007 data from annual survey of IDU: 68.6% in England had ever had an HIV test (3 928 of 5 727); 57.3% in Wales (280 of 489); 79.9% in Northern Ireland (247 of 309). In 2008, 28% of IDU (863 of 3 087) reported never having had an HIV test. Source: HPA Unlinked Anonymous Prevalence Monitoring Programme
Uzbekistan	18%	2007	Source: UNGASS 2008. Other evidence: In surveillance September–November 2007, 19.3% of 3 743 IDU (male 17.6%; female 30.5%; age < 25, 15.8%; age > 25, 19.6%) had been tested in last 12 months and knew the result.

Box 12: HIV cases associated with injecting drug use in Ireland

According to the most recent report of the Health Protection Surveillance Centre, at the end of 2008 there were 5 186 diagnosed HIV cases in Ireland, of whom 1 417 (27%) were probably infected through injecting drug use. There has been a decline in new cases among IDU since 2000, when 83 new cases were diagnosed. Between 2001 and 2008 the number of new cases each year was 38, 50, 49, 71, 66, 57, 54 and 36 respectively. Of the 36 new cases reported in 2008, 27 were male and 9 female. Data provided on opiate using behaviours suggests a decline in injecting. Of the 3 575 cases who entered treatment and reported opiates as their main problem substance in 2007, 40% injected, 52% smoked it and 5% consumed it orally. Between 2003 and 2007, decreasing proportions of cases reported that injecting was their primary route of administration, while correspondingly higher proportions reported smoking opiates.

2.2.4 HIV programme coverage for injecting drug users

The issue of how to measure coverage programmes for injecting drug users has been much debated. The UNGASS indicator is based on those who know where to receive an HIV test and have received condoms and sterile needles and syringes in the last year. Criticisms of this indicator include its composite nature, that it overlooks key services, such as substitution therapy and that it accepts very low levels of service as coverage.

[200] In reviewing this report, Sweden expressed concerns about the accuracy and origins of this data.

Consequently, a range of other indicators have been used. EMCDDA tracks syringes distributed per IDU per year and percentage of opioid injectors on opioid substitution therapy (OST)[201]. A recent WHO/UNODC/UNAIDS 'target setting' guide recommended a range of measures including the proportion of IDU regularly reached by needle and syringe programmes, the number of syringes distributed per IDU per year and the proportion of IDU in opioid substitution therapy[202]. The Reference Group to the UN on HIV and injecting drug use recently published an article in *The Lancet* that tracked:

- number of needle/syringes distributed per IDU per year;
- number of recipients of opioid substitution therapy per 100 IDU; and
- number of IDU receiving antiretroviral therapy per 100 HIV positive IDU (see Section 3.1).

Countries were advised about the various indicators being used by different bodies to track coverage of HIV programmes among IDU, and were asked to submit available data. Data was also collected from country submissions to UNGASS and EMCDDA.

Almost all (82%[203]) countries provided some data on the extent of their HIV prevention programmes for IDU. Of these, eight (20%) provided qualitative data and/or some quantitative measure of service provision. Most (80%) provided coverage figures but used a wide range of measures including reporting to UNGASS (12), the percentage of IDU in OST (15) and the number of syringes distributed per IDU (10)[204] (see Table 6).

Table 6: Coverage of HIV programmes for IDU in Europe and central Asia

Country	HIV programme coverage			Estimated number of IDU	Year	Comment
	As per UNGASS indicator	% of IDU receiving OST[205]	Number of syringes distributed IDU/year			
Armenia	54%				2007	Source: UNGASS 2008
Azerbaijan		1.25%	15[206]–23		2008	Percentage of IDU receiving OST. Number of IDU covered by needle and syringe programmes: 13 810. Number of syringes distributed: 315 144.
Belgium					2007	Distributed 600 000 syringes to 17 000 contacts. Number of unique individuals not tracked because of concerns for anonymity.
Bosnia and Herzegovina		10%	43	7 000[207]	2008	15.2% in harm reduction; 10% on methadone therapy. 436 reached through outreach needle exchange; 628 drop-in centres (harm reduction needle exchange programmes); 106 drop-in (prevention programme); 703 on methadone substitution therapy; 46 459 syringes distributed.
Bulgaria	47%				2006	Source: UNGASS 2008

[201] EMCDDA uses Problem Opioid User (POU) as the target group for OST.

[202] The guide recommends a comprehensive package of nine HIV prevention, treatment and care interventions for IDU: needle and syringe programmes; opioid substitution therapy; HIV testing and counselling; ART; STI prevention and treatment; condom programmes for IDU and their sexual partners; targeted IEC programmes for IDU and their sexual partners; vaccination, diagnosis and treatment of viral hepatitis; prevention, diagnosis and treatment of TB.

[203] 40/49.

[204] Additional data is available at the EMCDDA website.

[205] EMCDDA coverage data refers to POU not IDU. See www.emcdda.europa.eu/stats09/hsr, Table HSR-3.

[206] Mean number of sterile needles in last four weeks.

[207] EMCDDA estimate of IDU population.

Country	HIV programme coverage			Estimated number of IDU	Year	Comment
	As per UNGASS indicator	% of IDU receiving OST[205]	Number of syringes distributed IDU/year			
Croatia			56[208]–150[209]		2008	Coverage is measured through monthly reports from five NGOs implementing harm reduction programmes on the number of clients, number of needles and syringes and educational material distributed. In 2008, these five NGOs served a total of 4 590 clients and distributed a total of 38 423 condoms, 687 530 needles and 256 096 syringes as well as 13 963 educational materials.
Czech Republic			200	31 200	2008	In 2008, 4.6 million syringes distributed through needle exchange programmes for 22 300 clients (2.5 times increase compared with 2003) and 1.5 million through pharmacies. National survey of 712 IDU in 2003 reported mean of 80 sterile syringes from needle exchange programmes and pharmacies in the last month.
Estonia		5%	175	13 800[210]	2008	Proportion on methadone treatment 5% (proportion who mainly inject opioids on methadone treatment 7%). Visited syringe exchange in last four weeks: 64% in Tallinn, 75% in Kohtla-Järve (regions with the most IDU). Proportion whose main source of syringes in last four weeks was syringe exchange 48% in Tallinn, 65% in Kohtla-Järve. Proportion visiting syringe exchange at least once in three months 66–76%; visiting at least twice in three months 40–46%. Sources: RDS study 2007; methadone treatment data; syringe exchange data in the second quarter of 2008.
Finland			222	14 500–19 100	2007	IDU in Finland inject mostly amphetamines and buprenophine. Health promotion and harm reduction services reach approximately 60% of IDU nationally, a higher proportion in Helsinki. There are more than 30 LTHSCs; services are available in most towns with a population > 50 000. In addition, services are provided by mobile LTHSC units. In 2007, LTHSCs reached 12 624 clients and distributed > 2.6 million syringes. Pharmacies sold > 600 000 syringes, mostly to IDU. Number of syringes distributed/IDU/year was between 20 and 310 (average 222).
Former Yugoslav Republic of Macedonia						Preventive activities for IDU include harm reduction and needle exchange (HR/NE) implemented by NGOs, and harm reduction and drug substitution (HR/DS) implemented by health care facilities. There are 15 HR/NE sites covering 5 438 clients and 10 HR/DS centres providing services to 2 575 clients. Both programmes, in addition to providing sterile injecting equipment and methadone, offer medical, legal and social assistance, psychosocial support and distribute condoms and IEC materials.
France		71%			2004	Percentage of primary opioid IDU who received OST in the last six months according to a national survey. Source: EMCDDA from Coquelicot Survey, Institut de veille sanitaire

[208] Syringes.

[209] Needles.

[210] 2005 estimate age 15–44 years.

Country	HIV programme coverage			Estimated number of IDU	Year	Comment
	As per UNGASS indicator	% of IDU receiving OST[205]	Number of syringes distributed IDU/year			
Georgia	17%				2007	Source: UNGASS 2008. Male IDU.
Germany					2007	Data is only available for use of syringe vending machines. In 2007, 500 000 packages were sold via 120 of the 170 vending machines. No data is available on how many IDU are reached by needle and syringe programmes, but the harm reduction system is well developed and most IDU are reached by the existing programmes.
Greece		58.8%			2006	Percentage of 944 IDU receiving OST nationally (52.6% of 886 in 2005). 2006 figures for regions range from 24% in Central Macedonia to 100% in Central Greece, Crete and Thessaly. Source: EMCDDA
Hungary		20.4%	76	3 940	2008	18 organisations operated needle exchange programmes, four in Budapest. In 2007, the number of opiate users in treatment decreased by 7.4% from the previous year, and the number of heroin users, including injecting users, among patients receiving treatment also decreased. In recent years the total number treated for opiate use is about 2 000 to 2 500.In 2008, 802 IDU received OST. The estimated number of IDU is 3 940.
Ireland		31–91%			Not stated	54% of opiate users known to services in 2006. Data provided for percentage of known opiate users/injectors in OST disaggregated by age, sex and place of residence. Ireland: male age 15–24 42%, 25–34 82%, 35–64 87%; female age 15–24 64%, 25–34 85%, 35–64 88%. Proportions lower outside Dublin than in Dublin for males and females in all age groups (lowest proportion is 31% in males aged 15–24 outside Dublin, highest is 91% in males and females aged 35–64 in Dublin), perhaps reflecting more recent spread of opiate use and of methadone treatment services outside Dublin.
Israel						Needle exchange centres in five cities, run by social workers and ex-IDU, provide information about safe injecting and safe sex, distribute sterile needles and syringes and condoms, and offer social and health care. Clinics treated 1 700 IDU in 2008 and distributed 25 000 condoms and 100 000 syringes, mainly in Tel Aviv.
Italy		39%			2000	Proportion receiving OST 53.1% of 2 024 in 1998, 51% of 6 194 in 1999 and 39% of 972 in 2000 in national surveys; 48% of 882 in 1998, 45% of 1 159 in 1999 and 32% of 351 in 2000 in Piemonte. IDU asked if they had received at least one dose of methadone maintenance treatment in the last month. Source: EMCDDA
Kazakhstan	44%				2007	Source: UNGASS 2008. Method not harmonised with UNGASS 2008 guidelines.
Kyrgyzstan	78%				2007	Source: UNGASS 2008. Method not harmonised with UNGASS 2008 guidelines.
Latvia	47%				2007	Source: UNGASS 2008

Country	HIV programme coverage			Estimated number of IDU	Year	Comment
	As per UNGASS indicator	% of IDU receiving OST[205]	Number of syringes distributed IDU/year			
Lithuania		15%			2006	Percentage of 320 primary opioid IDU surveyed in Vilnius who received opioid maintenance. Source: EMCDDA
Luxembourg		60%	175	1 480	2008	Percentage of IDU in OST in 2008. Number of syringes distributed in 2008: 259 607. Estimated IDU population.
Malta						Syringe distribution is available to all IDU from government pharmacies. All IDU have access to HIV testing and counselling. If positive, they are referred for care and treatment. Condoms are widely available from pharmacies, supermarkets and dispensing machines.
Moldova	89%				2007	Source: UNGASS 2008. This figure is based on a survey among beneficiaries of harm reduction programmes and is not representative of all IDU in Moldova.
Netherlands						Data on the number of needles/syringes distributed to IDU is only available for Amsterdam and Rotterdam. The number of needles/syringes distributed has declined over recent years, although there was an unexplained increased in 2008, when 184 800 were distributed in Amsterdam and 260 000 in Rotterdam. There are no data on the number of IDU in these cities (estimated number of problem drug users [PDU] including IDU will be available in 2010). The most recent data is for 2001: 33 500 PDU (range 24 000–48 000). The number of injectors among PDU is unclear, although in 2007 9% of opiate clients in addiction care were known to be injectors and, in 2004, 20% of participants in the Amsterdam Cohort Studies among drug users had injected drugs in the last year. Based on this, there were an estimated 3 100 injectors (range 2 200–4 300) in 2005.
Norway		43–60%		8 400–11 700	2007	5 058 IDU in OST in 2007. An estimated 3.3 million syringes distributed annually (does not include all municipalities with syringe distribution programmes). Limited data on HIV programme coverage for IDU.
Poland						In 2008, the National Bureau for Drug Prevention commissioned 15 harm reduction programmes for drug users, implemented in nine cities in venues attended by users who are not motivated to take up treatment. Needle exchange data shows that 254 053 needles and 261 249 syringes were distributed annually (126 435 needles and 148 584 syringes were returned.
Portugal					2008	Data for the number of syringes exchanged is as follows: 2 845 031 in 2005, 2 591 150 in 2006, 2 313 180 in 2007 and 2 449 351 in 2008.

Country	HIV programme coverage			Estimated number of IDU	Year	Comment
	As per UNGASS indicator	% of IDU receiving OST[205]	Number of syringes distributed IDU/year			
Romania		62.9%			2008	Proportion of 105 IDU in Bucharest who reported being included in a substitution programme in last 12 months. Mean of 2 400 syringes based on number received at a single visit multiplied by 30 days in survey of 125 IDU in Bucharest. Source: EMCDDA. Other evidence: Programme monitoring data shows 4 434 IDU reached by drop in and outreach services in 2007, 451 091 syringes distributed during the first three quarters of 2007. Source: UNGASS Country Progress Report 2008
Russia	24%				2007	Source: UNGASS 2008
Serbia					2008	Estimated proportion of population covered with HIV programme 12% Belgrade, < 1% Novi Sad, 8% Nis (sample size 320 per city). Source: Ministry of Health/Integrated Bio-Behavioural Survey (IBBS) conducted as a part of second generation HIV surveillance
Spain		41.9%	140	20 000	2007	Percentage of IDU from Itinere Project in methadone maintenance treatment in last 12 months. Of heroin injectors admitted to any drug treatment in 2003-2004 36.7% in methadone maintenance treatment in last 12 months. Estimated number of syringes distributed: 2.8 million. Among young street-recruited heroin injectors surveyed in 2001–2003, 98.1% in Barcelona, 92.6% in Madrid had obtained some free sterile syringes in the last 12 months, 44.6% in Barcelona, 32.1% in Madrid had obtained all sterile syringes free. Sources: Ramirez et al 2007, Bravo et al 2008
Sweden	27%	30–60%			2007	Source: UNGASS 2008. Other evidence: In 2006, 50% of 104 in Stockholm and, in 2007, 50% of 102 in Stockholm, 30% of 20 in Gothenburg, 60% of 64 in Stockholm county reported ever having received opioid maintenance (For Stockholm county, only those receiving maintenance in the previous year). In 2007, 130 IDU in Stockholm county reported mean of 14 sterile needles in the last four weeks[211]. Source: EMCDDA The Swedish Prison Programme (SHP) is a collaboration between the National Board of Health and Welfare, County Councils, Karolinska Institute and the Prison and Probation Service. Initially run as a project but now part of the prison structure, SHP monitors HIV prevalence, incidence and risk behaviours for HIV and hepatitis transmission among IDU and offers VCT services to detainees. An estimated 80% of the 25 000–30 000 IDU in Sweden pass through the prison and probation system within a three year period. During 2002–2008, 2 000 IDU participated in VCT—46 new infections detected—and interviews on risk behaviour. Regular VCT in prison contributes to the high coverage of HIV testing among IDU in Sweden and possibly helps to keep HIV prevalence relatively low among this group.

[211] In commenting on the report, Sweden explained that in 2007, the Malmo county NEP reported a mean of approximately 8 sterile needles in the last four weeks.

Country	HIV programme coverage			Estimated number of IDU	Year	Comment
	As per UNGASS indicator	% of IDU receiving OST[205]	Number of syringes distributed IDU/year			
Switzerland					Not stated	Estimated coverage of syringe distribution (47% in IDU injecting twice a day, up to 100% in those injecting once a day). Access to low-threshold facilities not quantified but believed to be very high. Access to ART close to 100%.
Tajikistan	25%				2007	Source: UNGASS 2008
Turkey	22–30%				2007	Male IDU 22%, female IDU 30%. Source: UNGASS 2008
Ukraine	46%				2007	Source: UNGASS 2008
United Kingdom		71.8%	85 in last four weeks[212]		2005	Percentage of 440 IDU in Glasgow prescribed methadone in the last six months (79% of 421 received methadone maintenance or methadone detoxification treatment in 2004). Source: EMCDDA
Uzbekistan					2007	Based on epidemiological surveys, prevention programmes reached 40.2% of IDU. Male IDU 38.4%; female IDU 52.3%; < 25 years 31.1%; > 25 years 41.2%. Source: DHS 2007

Five countries[213] reported they had no data and four did not specifically respond to the question[214].

Several countries commented on reasons why they had difficulty in collecting and supplying coverage data. Some, e.g. Belgium, provide services on an anonymous basis meaning that it is not possible to know the number of individuals receiving a service. Germany faces similar problems because it supplies syringes through vending machines. Although Italy used to collect this data, they do not do so any longer because it is not considered useful. Some countries, e.g. the Netherlands, only have data available for particular cities and not the whole country.

Although the UNGASS indicator provides a single figure for programme coverage, it is difficult to understand what this means particularly when some countries' figures were not based precisely on the UNGASS method[215].

Most (87%[216]) of the countries reporting coverage of opioid substitution therapy were EU/EFTA countries. Most of these (77%) reported coverage levels above 30%. The three exceptions are Estonia (5%), Hungary (20%) and Lithuania (15%). The two non-EU/EFTA countries reporting coverage of opioid substitution therapy, Azerbaijan and Bosnia and Herzegovina, also reported low coverage levels.

Similarly, most (70%[217]) of the countries providing figures for the number of needles/syringes distributed per IDU per year were EU/EFTA countries[218]. Of these, all except one[219] 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.

[212] Mean number of new and unused needles over the last four weeks, based on response to the question 'How many new and unused needles obtained from a needle exchange or pharmacy in an average week during the last six months', this figure was multiplied by four. From survey of 439 IDU in Glasgow in 2005.

[213] Andorra, Cyprus, Denmark, Slovakia and Slovenia.

[214] Albania, Iceland, San Marino and Turkmenistan.

[215] For example, in commenting on the report, Moldova explained that their results were based on a survey conducted among beneficiaries of harm reduction programmes. These results are not representative of all IDU in Moldova and are not comparable with other countries.

[216] 13/15.

[217] 7/10.

[218] Most countries use as the denominator the number of IDU receiving programme services. Some, e.g. Luxembourg, use the estimated total number of IDU in the country.

[219] Hungary.

A few countries provided data disaggregated by sex[220]. Programme coverage is reported to be higher among female IDU than male in some countries, e.g. Ireland[221], Turkey and Uzbekistan. In addition, coverage of services is higher in older IDU in some countries, e.g. Ireland and Uzbekistan. Several countries, e.g. Finland, Ireland and Serbia, provided evidence that programme coverage is higher in their capital city than elsewhere. In Spain, programme coverage was slightly higher in Barcelona than Madrid.

Few countries reported trend data and patterns are mixed. Czech Republic reported that the number of syringes distributed had increased 2.5 times from 2003 to 2008. However, both Netherlands and Portugal reported declining numbers. Similarly, Greece reported an increase in the number of people receiving opioid substitution therapy whereas the number fell in Hungary. Elsewhere in this review (see Section 2.1, Box 10), both government and civil society respondents identified expanded harm reduction services for IDU as a key prevention achievement in Estonia.

Switzerland commented on access to antiretroviral therapy among IDU (see Section 3.1) and Sweden commented on services for IDU in prison (Section 2.6).

2.2.5 HIV-related knowledge of injecting drug users

Less than half (43%[222]) of countries reported data on HIV-related knowledge of IDU[223,224] (see Table 7). Twenty-four countries[225] reported that data is not available, largely because the indicator is not considered particularly relevant. This is because:

- studies show good levels of knowledge among IDU, e.g. in Finland;
- harm reduction programmes have proved very effective, e.g. in Switzerland; and
- countries collect other data about IDU. For example, the United Kingdom focuses its data collection on risk and protective behaviours rather than on knowledge. Belgium collects data on unsafe injecting practices.

Some countries that do not have national statistics on knowledge of IDU do have results from local surveys. For example, Hungary reported observations based on a pilot programme in 2008, which included comparison of an intervention aiming to change IDU knowledge about HIV and HCV and their behaviour with standard counselling. Multiple use of injecting equipment reduced among the intervention group compared with the control group, with 69% of IDU in the first group reporting single use of sterile equipment.

In some cases, e.g. Croatia and Luxembourg, where countries did report data on knowledge, they used questions relating specifically to injecting risk rather than the more generic UNGASS questions. In others, the precise questions were not specified. Where countries used single questions or questions that differed from those specified in UNGASS, the results are not comparable. Sweden reported data for IDU in prisons.

Among countries that reported data, reported rates of HIV-related knowledge of IDU ranged from 22% in Bosnia and Herzegovina to 90% in France. Just over half (53%) of the countries reported levels of knowledge below 50%. Of the six EU/EFTA countries reporting data, two thirds (66%) had levels of knowledge above 50% whereas this figure was only 40% for the 15 non-EU/EFTA countries. There is some evidence of higher levels of knowledge among IDU in countries with high HIV prevalence.

Some countries, e.g. Bosnia and Herzegovina and Georgia, reported data for male IDU only. Azerbaijan and Uzbekistan reported data disaggregated by age and sex. Both reported slightly higher levels of knowledge among female than male IDU. There was little reported difference in knowledge between those aged under and over 25. Five countries[226] had data available for more than one year. In each case, this showed increasing levels of knowledge.

[220] Bosnia and Herzegovina commented that they had done this since 2008. Georgia stated that their data was for males only.

[221] For young age group.

[222] 21/49. Sweden reported data on HIV-related knowledge among prisoners in the Stockholm region (from the SHP, which primarily targets IDU). Of 392 prisoners, 48%, answered all questions correctly (35% aged under 25 years, 56% aged over 25 years; 47% males and 65% of females).

[223] Countries were asked to respond to a question, in line with UNGASS, designed to measure the percentage of IDU—disaggregated by age and sex—who can correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission.

[224] Albania, Iceland, San Marino and Turkmenistan provided no information in response to this question.

[225] Andorra, Belgium, Cyprus, Czech Republic, Denmark, Finland, Germany, Greece, Hungary, Ireland, Israel, Italy, Lithuania, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Switzerland, Turkey and the United Kingdom.

[226] Armenia, Moldova, Romania, the Former Yugoslav Republic of Macedonia and Ukraine.

Table 7: HIV-related knowledge of IDU in Europe and central Asia[223]

Country	HIV-related knowledge	Year	Comment
Armenia	68%	2007	Compared with 60% in 2005. Source: UNGASS 2008
Azerbaijan	32.7%	2007/8	Age < 25 34.4%, age > 25 32.3%; male IDU 32.6%, female IDU 38.5%. Source: Epidemiological surveillance 2007–2008
Bosnia and Herzegovina	22%	2007	Male IDU. Source: UNGASS 2008
Bulgaria	29%	2006	Source: UNGASS 2008
Croatia	85%	2008	85% of 193 IDU respondents knew that condoms can prevent transmission of HIV (19.4% thought they could recognise a person who has a sexually transmitted disease, while 33.7% did not know), 84% knew where they could get new unused needles and syringes. Source: Croatian National Institute of Public Health. In a 2006 study, 85% of 239 respondents knew that one can get infected with HIV by using a needle or syringe that has already been used; a high proportion knew that consistent condom use can protect against HIV. Source: Kosanovic et al 2006
Estonia	75%	2007	Method not harmonised with UNGASS guidelines. Source: UNGASS 2008
Former Yugoslav Republic of Macedonia	34%	2007	Compared with 27% in 2005. Source: UNGASS 2008
France	90%	2004	Specific data on all UNGASS questions not collected but Coquelicot-2004, a national study, found 90% of IDU had good knowledge of HIV modes of transmission. Specifically, 99% of IDU respondents knew that condoms can prevent transmission of HIV and 82% knew that a person cannot get HIV from a mosquito bite.
Georgia	41%	2007	Male IDU. Compared with 36% of IDU in 2005. Source: UNGASS 2008
Kazakhstan	63%	2007	Source: UNGASS 2008
Kyrgyzstan	64%	2007	Source: UNGASS 2008
Latvia	45%	2007	Source: UNGASS 2008
Luxembourg	11–58.4%	2007	In a 2007 survey of 354 IDU, most effective strategies to prevent HIV and HCV reported were: use of condoms during sex (58.4%), selection of sexual partners (52.8%), stop or reduce syringe exchange with other users (43.5%), stop or reduce injecting drugs (11%). Source: Origer and Removille, 2007. In a 2007 survey of 161 IDU, 38% of males and 30.4% of females reported the need for more information on HIV transmission. Source: Cocsit 2007
Moldova	64%	2007	Compared with 37% in 2005. Source: UNGASS 2008. This figure is based on a survey among beneficiaries of harm reduction programmes and is not representative of all IDU in Moldova.
Romania	30%	2007	Compared with 18% in 2005. Source: UNGASS 2008. Reflects overall score for answers to all questions; 84% knew about condom use.
Russia	46%	2007	Source: UNGASS 2008
Serbia	53–64%	2008	Unadjusted rate 64% Belgrade, 58% Novi Sad, 53% Nis (sample size 320 per city). Source: Ministry of Health/Integrated Bio-Behavioural Survey (IBBS) conducted as a part of second generation HIV surveillance
Sweden	48%		Data on HIV-related knowledge among prisoners in the Stockholm region (from the SHP, which primarily targets IDU). Of 392 prisoners, 48%, answered all questions correctly (35% aged under 25 years, 56% aged over 25 years; 47% males and 65% of females).
Tajikistan	46%	2007	Source: UNGASS 2008
Ukraine	47%	2007	Compared with 21% in 2005. Source: UNGASS 2008
Uzbekistan	32.3%	2007	Age <25 26.8%, age >25 32.9%; male IDU 31.3%, female IDU 39%. Source: DHS 2007

2.2.6 Condom use by injecting drug users

More than two thirds (69%[227]) of countries provided some evidence about condom use by IDU[228] (see Table 8). Ten countries[229] reported that data on this indicator is not collected[230]. There was some variation in the question asked by those who provided quantitative data. Many countries[231] asked about condom use at last sex but some[232] asked about whether condoms had ever/never been used and some[233] asked about the consistency of condom use.

Rates of reported condom use ranged from 2% in the Czech Republic to 68% in Estonia and Moldova[234]. Among countries that reported quantitative data, almost two thirds (64%[235]) reported condom use rates of 50% or less among IDU. Only nine countries[236] reported condom use rates of 50% or above in this subpopulation.

These rates of reported condom use are lower than for other key populations. 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.

Croatia, Finland, the Netherlands and Spain reported data showing that IDU are less likely to use condoms with regular partners than with casual partners. In Croatia, those reporting that they did not use a condom with regular partners included those who reported sharing injecting equipment.

Bosnia and Herzegovina and Georgia reported data for male IDU only. Luxembourg and Romania reported similar rates of condom use for male and female IDU. Uzbekistan reported higher rates of condom use among female IDU. Romania and Uzbekistan presented age-disaggregated data that showed slightly higher condom use in the younger age group.

Table 8: Condom use by IDU in Europe and central Asia[237]

Country	Condom use	Year	Comment
Armenia	56%	2007	Results of biological and behavioural surveillance, which was conducted in 2007 between October and November. Source: UNGASS 2008
Azerbaijan	18%	2007	Data collection started prior to 2005. Source: UNGASS 2008
Bosnia and Herzegovina	23%	2007	Male IDU. Source: UNGASS 2008
Bulgaria	19%	2006	Source: UNGASS 2008. Other evidence: 42.5% of 146 IDU surveyed in Sofia in 2007 reported condom use at last intercourse. Source: EMCDDA
Croatia	29.2%	2008	In a 2008 survey of 193 IDU, only 29.2% used a condom at last intercourse (76.6% have used condoms at some time, 21.4% never used condoms, 2.1% did not reply). Other evidence: A 2006 survey of 239 respondents showed inadequate rate of condom use by IDU within a stable relationship or with casual partners, although use is somewhat higher with casual partners or by IDU with a large number of sexual partners—35% of those who report sharing injecting equipment have a regular sexual partner who does not use drugs, and 70% of them do not, or only rarely, use condoms. Source: Kosanovic et al 2006
Cyprus		Not stated	According to infectious disease indicators in a sample of 36 persons, 9 of them report using a condom and 160 not using a condom. The others report no sexual intercourse.

[227] 34/49.

[228] Countries were asked to respond to a question in line with the UNGASS indicator designed to measure the percentage of IDU—disaggregated by age and sex—who report using a condom during last sexual intercourse.

[229] Andorra, Belgium, Denmark, Ireland, Italy, Malta, Norway, Portugal, Slovakia and Slovenia.

[230] Albania, Iceland, San Marino and Turkmenistan provided no information in response to this question. Although Israel provided data, this consisted of quantitative data of a programmatic nature.

[231] E.g. Bulgaria, France, Latvia and Lithuania.

[232] E.g. Czech Republic, Croatia and the United Kingdom.

[233] E.g. Czech Republic, Finland, France, Germany, Hungary, Spain and the United Kingdom.

[234] This figure is based on a survey among beneficiaries of harm reduction programmes and is not representative of all IDU in Moldova.

[235] 21/33.

[236] Armenia, Estonia, France, Luxembourg (female), Moldova, Spain (with casual partners), Switzerland, the Former Yugoslav Republic of Macedonia and Ukraine.

[237] For UNGASS 2008 data: report date 2007, but data collection can vary from 2005 to 2007.

Country	Condom use	Year	Comment
Czech Republic	2%	2003	Ever reported condom use in national survey of 100 IDU in 2003. Source: EMCDDA. Other evidence: 75.2% of IDU surveyed in HCV prevalence study 2002–2003 always or mostly have sexual intercourse without a condom.
Estonia	68%	2007	Source: UNGASS 2008
Finland	15–35%	2007	In survey of 734 LTHSC clients in 2007, 15% reported always using a condom for sex with a regular partner and 35% for sex with a casual partner during the last six months. In 2007, LTHSCs distributed 45 073 condoms to IDU.
Former Yugoslav Republic of Macedonia	51%	2007	Source: UNGASS 2008
France	53%	2004	53% of IDU reported always using a condom for sex in the last six months with a regular partner and 53% used a condom at last intercourse with a casual partner. Source: Coquelicot Survey 2004
Georgia	48%	2007	Male IDU. Source: UNGASS 2008
Germany	42%		Data is available for 1 615 IDU under substitution therapy from the Cobra Study. Of these, 58% reported that they do not use condoms on a regular basis
Greece	48%	2007	Source: UNGASS 2008
Hungary			Data is available from a survey conducted as part of a pilot HIV and HCV programme implemented by the Hungarian Scientific Academy and a drug centre. Among a sample of 87 IDU interviewed (80% male, 20% female; 25% aged 19–25, 24% 26–30, 32% 31–35 and 18% > 35 years old), the average length of drug use was more than 11 years. The programme included education about sexual risk behaviours. Interviews with IDU found that prior to the programme, they used condoms every other time they had sex; after the programme they reported using condoms every time they had sex.
Kazakhstan	37%	2007	Source: UNGASS 2008
Kyrgyzstan	11%	2007	Source: UNGASS 2008
Latvia	48%	2008	48% of 497 IDU in 2008, 45% of 483 in 2007. In 2008, sampling was conducted in six sites and in 2007 in 13 sites. Questions asked about sex in the last 30 days, number of partners, condom use during last intercourse. Source: EMCDDA. Other evidence: 38% in 2007. Source: UNGASS 2008
Lithuania	11.3%	2006	According to data submitted to EMCDDA, 11.3% of a sample of 320 IDU in Vilnius in 2006 reported using a condom at last intercourse.
Luxembourg	48–50%	2009	48% male IDU reported condom use during sexual intercourse, 50% female IDU reported asking male partners to use a condom in 2008. Source: RELIS 2009
Moldova	68%	2007	Source: UNGASS 2008. This figure is based on a survey among beneficiaries of harm reduction programmes and is not representative of all IDU in Moldova.
Netherlands			National data is not available on condom use among IDU, although several regional behavioural surveys were conducted between 1994 and 2003 in different cities. The latest data, from 2003, suggests that not using condoms is most common with steady partners (76–96%), then with casual partners (39-73%) and finally, least common with clients (13–50%).
Poland			No detailed data is collected on this issue. However, the National Bureau for Drug Prevention reports that, in 2008, it distributed 41 241 condoms to drug users who do not want to take up treatment, and estimates that 80% of these condoms reached IDU.
Romania	17%	2009	Percentage of IDU reporting use of condoms with regular and non-regular partners the last time they had sex (male 17%; female 18%; < 25 years 22%, > 25 years 15%). Source: UNODC Behavioural Surveillance Survey among Injecting Drug Users from Bucharest, Romania 2009
Russia	37%	2007	Source: UNGASS 2008

Country	Condom use	Year	Comment
Serbia	29–39%	2008	Unadjusted HIV testing rate 29% Belgrade, 30% Novi Sad, 39% Nis (sample size 320 per city). Source: Ministry of Health/Integrated Bio-Behavioural Survey (IBBS) conducted as a part of second generation HIV surveillance
Spain	17.6–59.3%	2003/4	Among IDU admitted to drug treatment in 2003–2004, 59.3% used condoms consistently in the last 12 months in vaginal/anal intercourse with casual partners and 17.6% with regular partners. Source: Unpublished data
Sweden	25%	2007	Method not harmonised with UNGASS 2008 guidelines. Source: UNGASS 2008
Switzerland	50%	2007	Method not harmonised with UNGASS 2008 guidelines. Source: UNGASS 2008
Tajikistan	36%	2007	Source: UNGASS 2008
Turkey	10%	2007	Source: UNGASS 2008
Ukraine	55%	2007	Source: UNGASS 2008
United Kingdom	19%	2006	19% (170/907) of IDU who had more than one sexual partner in the last year reported always using a condom; 33% (300/907) had never used a condom. Annual Survey of IDU asks how many sexual partners (male and female) IDU have had and if they always, sometimes or never used condoms in the past year.
Uzbekistan	39%	2007	Male IDU 32.8%, female IDU 54.1%; age < 25 41.1%, aged > 25 35.3%. Source: UNGASS 2008

2.2.7 Use of sterile injecting equipment

Almost three quarters (71%[238]) of countries reported some quantitative data on use of sterile injecting equipment and/or on sharing needles, syringes or other injecting equipment (see Table 9)[239]. Nine countries[240] reported that data is not available[241,242].

There was a great deal of variation in the questions asked. Some countries asked about the use of sterile equipment while others asked about sharing or not sharing of injecting equipment. The time period covered varied greatly. Although the UNGASS indicator focuses on behaviour during the last time drugs were injected, some countries asked about behaviour in the last month[243], last six months[244], last year[245] or ever[246].

There was also variation in questions concerning whether they focused on all injecting equipment or just part of it, e.g. needles and/or syringes. Data from Estonia and Germany shows higher rates of sharing when questions include all injecting equipment and not only needles and syringes. Spain provided specific data for sharing of spoons and injecting water.

Rates of reported use of sterile injecting equipment vary considerably, ranging from 10% in Turkey to 96% in Moldova[247]. Eight countries reported rates of use of sterile injecting equipment of 90% or more, while 10 countries reported rates of 40% or less. Reported rates of sharing injecting equipment ranged from 4% in a study in Germany to 90% in a study in Sweden.

Some countries also asked more detailed questions about injecting behaviour. For example, questions in Spain distinguished between giving and receiving equipment in sharing behaviour. Croatia presented data that showed most sharing occurs among close friends and relatives, and that most of those who share equipment know where to get sterile equipment. Germany presented data on injecting and sharing behaviour among those receiving opioid

[238] 35/49.

[239] Countries were asked to respond to a question in line with the UNGASS indicator designed to measure the percentage of IDU—disaggregated by age and sex—who report using sterile injecting equipment the last time they injected drugs.

[240] Andorra, Denmark, Hungary, Malta, Netherlands, Norway, Portugal, Slovakia and Slovenia. The Netherlands commented that there is no recent data, as the last behavioural survey among drug users was conducted in 2003.

[241] Albania, Iceland, San Marino and Turkmenistan provided no information in response to this question.

[242] Israel reported data on the number of syringes distributed (see Table 9).

[243] E.g. Belgium, Croatia, Finland, France, Luxembourg and the United Kingdom.

[244] E.g. Italy, Latvia, Luxembourg, Scotland and Spain.

[245] E.g. Croatia, Czech Republic and Romania.

[246] E.g. Croatia, Czech Republic, Greece, Ireland, Luxembourg and Sweden.

[247] This figure is based on a survey among beneficiaries of harm reduction programmes and is not representative of all IDU in Moldova.

substitution therapy. This showed that 12–17% of those on such treatment still inject drugs. Of these, between a quarter and a third report sharing injecting equipment.

Finland and Uzbekistan reported data disaggregated by age. The former showed that sharing equipment was more likely to be reported in those aged 20–24 years and declined in older age groups, while the latter showed little difference in reported use of sterile equipment between those aged under and over 25 years. Georgia reported data for male IDU only. Data disaggregated by sex reported by Luxembourg and Uzbekistan did not reveal any clear patterns.

A few countries reported data for more than one year. The United Kingdom reported data over a nine year period (see Figure 25) which shows a decline in sharing of injecting equipment in England and Wales.

Figure 25: Rates of reported sharing behaviour among IDU in last 28 days, England and Wales, 1998–2006

Table 9: Use of sterile injecting equipment by IDU in Europe and central Asia[248]

Country	Use of sterile injecting equipment	Sharing injecting equipment	Year	Comment
Armenia	95%		2007	Source: UNGASS 2008
Azerbaijan	34%		2007/8	Source: UNGASS 2008
Belgium		20.6%	2006	Of 174 IDU in Antwerp who reported sharing needles, syringes or other injecting equipment in the last month. Source: EMCDDA
Bosnia and Herzegovina	25%		2007	Source: UNGASS 2008
Bulgaria	25%		2006	Source: UNGASS 2008. Country specific methodology for indicator calculation: cross-tabulation of five questions to take into account borrowing and lending practices.

[248] For UNGASS 2008 data: report date 2007, but data collection can vary from 2005 to 2007.

Country	Use of sterile injecting equipment	Sharing injecting equipment	Year	Comment
Croatia		42%	2008	2008 survey of 193 IDU: 38 injected drugs in the last month, of whom 16 (42%) shared equipment; 37.6% reported never sharing injecting equipment; and 83.6% had not shared equipment in the last year. Other evidence: 2006 survey of 239 IDU: 32.6% reported sharing in the last year, 37% within the last month; most with close friends or partner; two thirds of respondents who reported sharing knew where they could obtain clean needles and syringes. Source: Kosanovic et al 2006
Czech Republic	36%		2008	Of IDU seeking treatment who reported using sterile injecting equipment during the last 12 months.
		78.9%	2003	Of 750 IDU in national survey who reported ever sharing needles, syringes or other injecting equipment. Source: EMCDDA
Cyprus	58%		2009	21 of a sample of 36 reported using sterile injecting equipment.
Estonia	65–94%		2007	Proportion of IDU who did not share injecting equipment in the last four weeks: 65% in Tallinn, 79% in Kohtla-Järve; proportion of IDU who did not share syringes/needles in last four weeks: 82% in Tallinn, 94% in Kohtla-Järve. Source: RDS study 2007
Finland		14–40%	2007	Of 734 LTHSC clients sharing needles in last month: < 20 years 28%; 20–24 40%; 30–34 19%; 35–39 18%; 40–44 12 %; > 44 years 14%.
Former Yugoslav Republic of Macedonia	73%		2007	Source: UNGASS 2008
France		38%	2004	Percentage of IDU in national survey who reported sharing needles, syringes or other injecting equipment in the last month. Source: EMCDDA from Coquelicot Survey, Institut de veille sanitaire.
Georgia	93%		2007	Male IDU. Source: UNGASS 2008
Germany		4–14%	Not stated	Survey of 517 IDU found that 45% use their own syringes, 14% share equipment with others and 10% share syringes with others. Source: ZIS-Hamburg. Another study, of 1 615 IDU under substitution therapy found that 4% (under buprenorphine) and 5% (under methadone) share needles with others when they inject drugs; 12% (under buprenorphine) and 17% (under methadone) still inject drugs. More data is needed but resources are limited.
Greece	67%		2007	Source: UNGASS 2008
		55.4–77.1%	2005/6	Data from national surveys in 2005 and 2006. The first set found that 77.1% of 890 IDU reported ever sharing needles, syringes or other injecting equipment in 2005; 70.1% of 1 027 in 2006. The second set found that 57.8% of 676 IDU reported ever sharing needles, syringes or other injecting equipment in 2005; 55.4% of 745 in 2006. Data is also available for specific regions of Greece.
Ireland	34%	66%	2007	66% of IDU entering treatment had ever shared injecting equipment and 34% never shared.

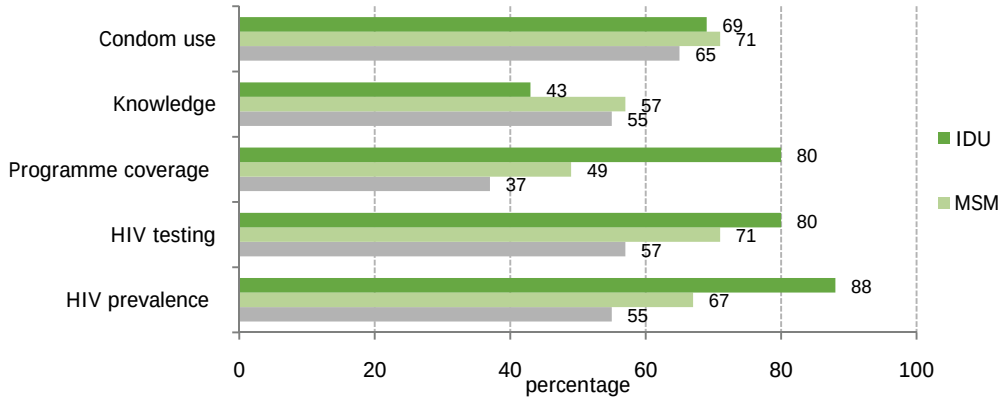
Country	Use of sterile injecting equipment	Sharing injecting equipment	Year	Comment
Italy		23%	2000	National surveys found that 18.6% of 2 001 IDU in 1998, 19.6% of 6 193 in 1999, 23% of 918 in 2000 reported sharing needles, syringes or injecting equipment in the last six months. Surveys in Piemonte showed that 20% of 862 IDU in 1998, 19% of 1 145 in 1999, 20% of 287 in 2000 reported sharing needles, syringes or injecting equipment in the last six months. Source: EMCDDA
Kazakhstan	59%		2007	Source: UNGASS 2008
Kyrgyzstan	77%		2007	Source: UNGASS 2008
Latvia	90%		2007	Source: UNGASS 2008
		57%	2008	IDU reporting sharing needles, syringes or other injecting equipment in the last six months: 28.1% of 551 in 2006 (13 sample sites), 44% of 582 in 2007 (six sites), 57% of 627 in 2008 (six sites). Source: EMCDDA
Lithuania		38.1%	2006	Percentage of 320 IDU in Vilnius who reported sharing needles, syringes or other injecting equipment. Source: EMCDDA
Luxembourg		19–81%	2008	Sharing injecting equipment in the last month reported by 30% male IDU, 42% female IDU; 81% male, 67% female sharing reported sporadic sharing, 19% males, 23% females reported always sharing. Source RELIS 2008. Other evidence: 36.7% of male and female IDU reported sharing equipment in the last six months. Source: Origer and Removille 2007. National surveys: 30.1% of 206 in 2005, 29.4% of 221 in 2006 reported sharing needles or syringes. Source: EMCDDA
Moldova	96%		2007	Source: UNGASS 2008. This figure is based on a survey among beneficiaries of harm reduction programmes and is not representative of all IDU in Moldova.
Poland		8%-16%	2005	16% of 172 IDU in Wroclaw and 8% of 76 in Warminsko-Mazurskie reported sharing of needles or syringes. Source: EMCDDA.
Romania	28%		2007	Data collection started prior to 2007. Source: UNGASS 2008
		78.9%	2008	Of 327 IDU in Bucharest reporting sharing needles, syringes or other injecting equipment in the last 12 months. Source: EMCDDA
Russia	82%		2007	Source: UNGASS 2008
Serbia	76–80%	15–38%	2008	Use of sterile equipment: 80% Belgrade, 76% Novi Sad, 78% Nis. Reports of sharing in last month: 15% in Belgrade, 23% in Nis and 38% in Novi Sad (sample size 320 per city). Source: Ministry of Health/Integrated Bio-Behavioural Survey (IBBS) conducted as a part of second generation HIV surveillance

Country	Use of sterile injecting equipment	Sharing injecting equipment	Year	Comment
Spain		20.9–23.3%	2006	Of 296 IDU: 20.9% gave others a needle/syringe already used, 23.3% accepted a needle/syringe already used, 69.2% shared filter/spoon/cleaning water in the last six months. Source: CEESCAT 2008. Other evidence: Of 604 heroin injectors admitted to outpatient drug treatment in 2003–2004: 22.7% gave others a needle/syringe already used, 19% accepted a needle/syringe already used, 11.6% took a diluted drug from a syringe already used, 14.1% back/front loading during last 12 months. Source: Ramirez et al 2007
Sweden	38%		2007	Source: UNGASS 2008
		90%	2007	Of 102 IDU in Stockholm county who reported ever sharing needles, syringes or other injecting equipment. Source: EMCDDA
Switzerland	94%		2007	Method not harmonised with UNGASS 2008 guidelines. Source: UNGASS 2008
Tajikistan	32%		2007	Source: UNGASS 2008
Turkey	10%		2007	Source: UNGASS 2008
Ukraine	84%		2007	Source: UNGASS 2008
United Kingdom		35–49%	2006	Percentage of IDU reporting sharing needles, syringes or other injecting equipment in the last 28 days in 2006: England and Wales 49% of 1 875; London 49% of 265 in 2006; Northern Ireland 35% of 43; Outside London, England and Wales 49% of 1 610. Percentage of IDU reporting sharing needles, syringes or other injecting equipment in the last six months in 2005: Glasgow 38.2% of 437.
Uzbekistan	23%		2007	Source: UNGASS 2008. Other evidence: Use of sterile syringe last time injected: male 83.4%; female 86.1%; < 25 years 81.3%; > 25 years 84%.

2.2.8 Conclusions

In general, countries have more data available regarding their response to HIV among IDU than among other key populations, such as MSM and sex workers (see Figure 26). This is particularly true for HIV prevalence, rates of HIV testing and measures of programme coverage. It is not true for measures of HIV-related knowledge reflecting the perceived lack of relevance of questions for the UNGASS knowledge indicators to countries of Europe and central Asia.

Figure 26: Percentage of countries reporting data on specific topics for particular key populations



Different patterns of HIV prevalence among IDU are seen across Europe and central Asia (see Figure 24). In general, rates are high in countries in the eastern part of the region and in south-western Europe. Rates are moderately high in countries of northern Europe and are low to moderate in countries of central and south-eastern Europe. However, this does not mean that IDU are not at risk of HIV infection in countries that currently have lower HIV prevalence among IDU. Given the proximity of countries with higher rates of HIV prevalence among IDU, the movement of people between countries and the risk of HIV transmission through sharing injecting equipment, the potential for HIV spread among IDU remains high.

Almost all reporting countries were able to provide data on the extent of their HIV programmes for IDU. However, data on the coverage of key services, e.g. the number of needles and syringes distributed per IDU and the proportion of IDU receiving opioid substitution therapy was available for relatively few countries, mostly EU/EFTA countries. Although many countries are achieving high levels of programme coverage according to these indicators, there are a considerable number that still have low levels of coverage of these key services.

In addition, rates of reported condom use are much lower than for other key populations. Twenty-one countries provided data on condom use among sex workers, MSM and IDU, which showed that rates of reported condom use averaged 81% among sex workers, 59% among MSM and 35% among IDU. This is of particular concern in countries with high HIV prevalence among IDU because of the risk of transmitting HIV to non-injecting sexual partners of IDU.

In conclusion, ECDC has identified the following issues needing 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[249]. 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[250]. It should also include ensuring that opioid substitution treatment 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 injecting drug user populations using the methodology recommended by 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 through 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 opioid substitution therapy; and the proportion of HIV-positive IDU receiving ART.

[249] WHO et al, 2009.

[250] See Mathers et al, 2010.

2.3 Men who have sex with men

2.3.1 Introduction

Sex between men is thought to account for between 5% and 10% of HIV infections globally, but there is considerable regional variation. For example, sex between men is a predominant mode of HIV transmission in North America, Western Europe and Latin America. However, men who have sex with men (MSM) are vulnerable to HIV in all regions, and high prevalence among this subpopulation has been reported in countries as diverse as India, Jamaica, Kenya and Thailand.

In Europe and central Asia, 19% of new HIV infections (8 920 cases) diagnosed in 2008 were among MSM and the number of HIV diagnoses among MSM increased by 22% between 2004 and 2008. However, the significance of sex between men as a mode of transmission and the extent to which MSM are vulnerable to HIV may differ within the region. While MSM have been identified as particularly vulnerable to HIV in countries in the western part of the region, less is known about the situation in other countries.

ECDC reports that sex between men was the predominant mode of HIV transmission in EU/EEA[251] countries in 2008, with the highest proportion (40%) of newly diagnosed cases reported among MSM. Between 2004 and 2008, the number of reported cases among MSM in EU/EFTA countries increased by 19%. In some countries, this rising trend had started earlier. The explanation for these rises is unclear. Although this is widely attributed to a rise in sexual risk behaviour, in particular unprotected anal sex, among some MSM, this explanation is disputed by others (see Box 13).

In contrast to the high figures in EU/EEA countries, in Eastern Europe and central Asia, according to UNAIDS, less than 1% of newly-registered HIV cases in 2008 were attributed to unprotected sex between men. However, studies cited in the UNAIDS 2008 report on the global epidemic found HIV prevalence among MSM in three countries in Eastern Europe and central Asia to be between 5–11%. Some consider that HIV transmission among MSM is underestimated, due to underreporting in countries where men are unwilling or unable to reveal that they have sex with other men.

The topics covered in this chapter reflect the UNGASS questions. Countries were asked to provide data in response to a set of questions intended to assess HIV prevalence among MSM, HIV testing in MSM, HIV programme coverage for MSM, levels of HIV-related knowledge and rates of condom use among MSM.

2.3.2 HIV prevalence in men who have sex with men

Quantitative data on HIV among MSM (see Table 10) was provided by almost three quarters of countries (73%[252])[253,254]. Eight countries reported that data on this indicator was not available[255]. Reasons given included lack of nationally representative data, lack of a denominator and data being collected on different indicators. For example, Luxembourg, Poland and Israel noted that it was not possible to report on this indicator because there is no data on the denominator, i.e. the size of the MSM population, to calculate prevalence rates. Germany commented that it is difficult to estimate the number of MSM in a country. One difficulty is that there is a difference between men who define themselves as homosexual and other men who also have sex with men, but do not consider themselves homosexual. Norway reported the number of MSM diagnosed with HIV, while Poland and Turkey reported the percentage of MSM among reported cases. Portugal reported that a data collection process is underway.

Figure 27 shows HIV prevalence among MSM based on data provided by countries. Reported prevalence ranged from 0% in Bulgaria to 12% in France. Four countries[256] reported HIV prevalence of less than 1%, 19[257] prevalence of between 1% and 5%, and 10 countries[258] prevalence of more than 5%. Countries reporting the highest prevalence in MSM were all, with the exception of Turkey and Uzbekistan, EU/EFTA countries. This may reflect the actual situation or more accurate and complete reporting in some countries. In some countries, self-reported MSM transmission may be underreported because of social and cultural norms concerning sex between

[251] No data from Austria, Denmark and Liechtenstein.

[252] 36/49.

[253] Countries were asked to respond to a question, in line with the UNGASS indicator, designed to measure the percentage of MSM who are HIV infected (disaggregated by age).

[254] Iceland, Ireland, San Marino, Tajikistan and Turkmenistan did not provide any information in response to this question.

[255] Andorra, Cyprus, Israel, Luxembourg, Malta, Portugal, Romania and Slovakia.

[256] Albania, Bosnia and Herzegovina, Bulgaria and Russia.

[257] Armenia, Azerbaijan, Croatia, Czech Republic, Denmark, Estonia, Finland, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Serbia, Slovenia, Sweden, Ukraine and the Former Yugoslav Republic of Macedonia.

[258] Belgium, France, Germany, Greece, Italy, Netherlands, Spain, Switzerland, United Kingdom and Uzbekistan.

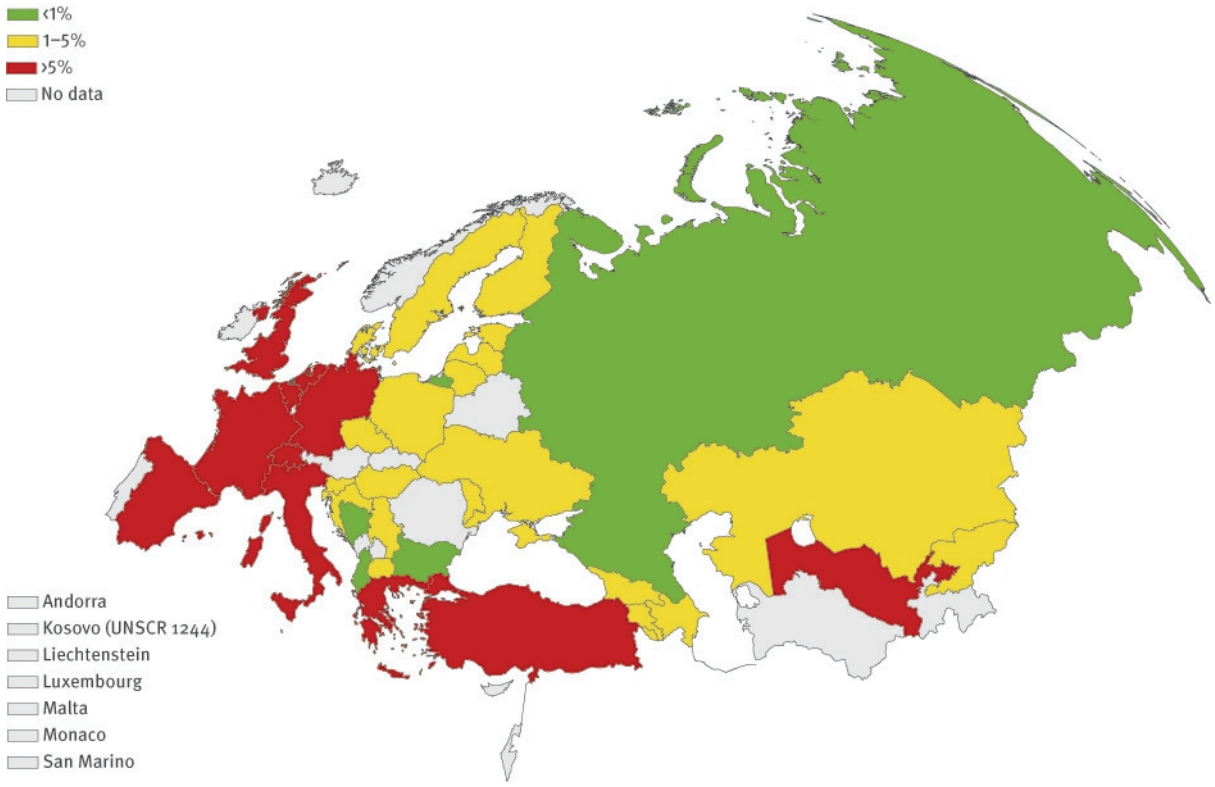
men. In such contexts, it may result in transmission being classified as heterosexual or through injecting drug use because the person does not feel able to report having had sex with another man.

UNAIDS' Policy Brief on HIV and Sex between Men concludes that 'Experience shows that recognition of the rights of people with different sexual identities, both in law and practice, combined with sufficient, scaled-up HIV programming to address HIV and health needs are necessary and complementary components for successful response. Countries may choose to prioritise one or the other component but both have to fall into place to effectively deal with the epidemic as it relates to sex between men... Discrimination prevents men who have sex with men from disclosing their sexual orientations, or reporting for HIV services. Consequently their vulnerability to infection is increased, and national data do not reflect the size of the HIV epidemic that is linked to same-sex behaviour involving men.'

Five countries, France, Hungary, Kyrgyzstan, Latvia and Uzbekistan, reported prevalence data disaggregated by age[259]. With the exception of Latvia, this showed higher prevalence among MSM aged over 25 years than among those aged under 25. Sweden also commented that prevalence is higher in older men.

Data from Serbia, Sweden and the United Kingdom indicates that HIV prevalence is higher in MSM in larger metropolitan areas than in smaller cities or the country overall.

Figure 27: Reported HIV prevalence among MSM in Europe and central Asia



[259] In commenting on this report, Spain explained that they also provided this disaggregated data. It appears that this was available in the country narrative report but this was not included in the UNAIDS aggregated report or in Spain's summary of its indicators.

Table 10: HIV prevalence among MSM in Europe and central Asia

Country	HIV prevalence	Year	Comment
Albania	0.8%	2005	Source: UNGASS 2008
Armenia	2%	2007	Source: UNGASS 2008
Azerbaijan	1%	2007/8	Source: Epidemiological surveillance 2007-2008
Belgium	5–11%	2004/9	Data from the Flemish community: 5.6% in online survey of 1 793 respondents 2006–2009; 5% in outreach testing among 137 MSM in a sauna and a fetishist club in Flanders March–July 2008. Source: Van den Berghe. A study of HIV prevalence in MSM in Flanders is being conducted. Data from the French-speaking community: 84% had ever had an HIV test (11% HIV positive, 75% HIV negative, 14% status unknown) in survey of 942 respondents though self-administered questionnaire 2004-2005.
Bosnia and Herzegovina	0.7%	Not stated	Source: Bio-Behavioural Surveillance
Bulgaria	0%	2006	Source: UNGASS 2008
Croatia	3%	2006	Source: UNGASS 2008
Czech Republic	2–3%	Not stated	Estimated figure based on behavioural studies and one large VCT centre in Prague where around 700 MSM are tested for HIV each year.
Denmark	< 5%	Not stated	Estimate based on national surveillance data.
Estonia	1.7%	2007	Source: UNGASS 2008
Finland	4.5%	2007	Source: UNGASS 2008
Former Yugoslav Republic of Macedonia	2.8%	2006	Source: UNGASS 2008
France	12%	2009	MSM who had ever had an HIV test (age under 25: 2%; age over 25: 15%) from self-administered questionnaire to 19 048 users of website Net Gay Baromètre. No 2007 data available.
Georgia	3.6%	2007	Compared with 4.3% in 2005. Source: UNGASS 2008
Germany	10.7%	2007	Source: UNGASS 2008
Greece	6.5%	Not stated	Based on Estimation and Projection Package (EPP) HCDCP (ΚΕΕΛΠΝΟ)[260]
Hungary	2.7%	Not stated	Age 20–24: 2%(1/49); 30–34: 4.8%(3/63); 35–39: 8.5% (4/47) based on project data that is not nationally representative.
Italy	11.6%	2008	Survey among 4 690 MSM 2008. Other evidence: 4.6%, 2005. Source: Survey of 405 MSM
Kazakhstan	1%	2006	Source: UNGASS 2008
Kyrgyzstan	0–2.6%	2008	Age < 25: 0%; age > 25: 2.6%. Source: Epidemiological surveillance 2008
Latvia	4%	2008	10/252 – age < 25: 4.8%; age > 25: 3.4%. Source: Survey 2008
Lithuania	1.2%[261]	2007	Source: UNGASS 2008
Moldova	4.8%	2007	Source: UNGASS 2008
Netherlands	6%	2009	Estimated prevalence. Source: RIVM 2009. Other evidence: 12% self-reported prevalence. Source: Schorer Monitor 2008
Norway			Total of 1 278 MSM diagnosed with HIV, 92 diagnosed in 2008 and 77 in 2007.

[260] http://www.keel.org.gr/keelpno/2009/id951/epp.pdf

[261] Lithuania reports HIV incidence in MSM in 2007 of 1.2%, i.e. new cases diagnosed, rather than prevalence.

Country	HIV prevalence	Year	Comment
Poland	4%	2008	Percentage of new HIV infections where sex between men was the route of transmission, based on 36 of total of 809 new infections, but transmission route is unknown in over 80% of infections registered. VCT centre data shows 48% of newly diagnosed HIV infections in 2008 were related to homosexual or bisexual contacts (42% in 2007 and 45% in 2006), but data is not nationally representative.
Russia	0.9%	2006	Source: UNGASS 2008
Serbia	2.4–6.1%	2008	6.1% Belgrade, 2.4% Novi Sad[262] in survey of sample of MSM age 15-59, 250 in Belgrade, 250 in Novi Sad. Source: Ministry of Health/Integrated Bio-Behavioural Survey (IBBS) conducted as a part of second generation HIV surveillance
Slovenia	2.1%	2006	Source: UNGASS 2008. Other evidence: Between 1999 and 2008, HIV prevalence among male clients of STI clinics tested for syphilis (a substantial proportion of whom are MSM) increased from 0% to 3.4%.
Spain	9.2%	2007	Source: UNGASS 2008
Sweden	3%	2008	3% HIV positive; 80% HIV negative; 10% unsure of status in MSM survey March 2008. Prevalence rises to 10% in middle-aged self-identified homosexual men in metropolitan areas.
Switzerland	8.1%	2007	Source: UNGASS 2008
Turkey	8.6%	Not stated	Percentage of MSM among reported HIV cases, based on patient information
Ukraine	4.4%	2007	Source: UNGASS 2008
United Kingdom	5.3%	2007	8.5% in London; 3.7% elsewhere in England and Wales, estimated prevalence (diagnosed and undiagnosed) in MSM age 15–44. The HPA uses Multi-parameter Evidence Synthesis to estimate overall prevalence of HIV. Source: Sexually transmitted infections and men who have sex with men in the UK 2008 Report.
Uzbekistan	6.2%	2007	Age under 25: 1.6%; age over 25: 14.1%. Source: DHS 2007. Other evidence: 10.8% 2005. Source: UNGASS 2008

Additional data from some countries suggests increasing HIV infection among MSM:

- In the Netherlands, the proportion of new HIV cases accounted for by MSM began to increase in 2003, reaching 68.9% in 2008, and homosexual contact was the reported mode of transmission for 7 779 (70%) of the 11 115 men diagnosed with HIV-1.
- Norway reported that, despite prevention efforts, HIV infection in MSM has increased since 2003.
- Israel reported that, in the past decade, the number of HIV cases notified in MSM has increased and MSM now represent 43% of all men living with HIV in the country.
- Slovenia reported that among 48 newly diagnosed HIV cases reported in 2008, 34 were in MSM. Between 1999 and 2008, the annual reported rate of HIV diagnoses in MSM rose from 7.1 to 46.8 per million men aged 15–64 years. The burden of HIV among MSM in Slovenia is disproportionately high and increasing fast, and the overall increase in newly diagnosed HIV cases during recent years has been due almost exclusively to the increase in diagnoses in MSM.

Possible reasons for rises in HIV among MSM are explored in Box 13.

[262] Unadjusted prevalence.

Box 13: What is the cause of rising HIV prevalence among some MSM in some countries of Europe and central Asia?

Although it is widely assumed that rising HIV prevalence among MSM is indicative of a rise in sexual risk behaviour, i.e. unprotected anal intercourse and/or 'condom fatigue', data from **Germany** indicates that this is not the case. The authors conclude, 'taken together, a pronounced and generalisable erosion of safer sex practices over the last 17 years is not supported by our data… It should be emphasised that this also applies to young respondents. Although frequently stated otherwise, an erosion of safer sex practices among young German MSM cannot be observed'. Other possible explanations for rising HIV prevalence among MSM in Germany include:

- Increased numbers of MSM taking HIV tests because of the availability of treatment. In Germany, it is estimated that up to 50% of 'new' diagnoses are actually detecting 'old' infections acquired several years ago.
- Rising rates of other STIs increase the risk of HIV transmission with every sexual contact.
- Reduced rates of death among PLHIV mean that the chances of having sex with a person with HIV are rising. However, the effects of starting ART earlier on HIV transmission risk may counteract this effect.
- Some young MSM starting to have earlier anal intercourse.
- Greater openness about reporting sex with another man because of changing social context.

Further qualitative data on these issues is to be collected through the current European MSM Internet Survey.

2.3.3 HIV testing in men who have sex with men

Three quarters of countries (75%[263]) provided some quantitative data on HIV testing among MSM (see Table 11)[264]. Eight countries[265] reported that data is not available on this indicator[266].

As with data on HIV prevalence, data on HIV testing in MSM was drawn from diverse sources. Countries differ in the period over which they track HIV testing. Some reported for the last 12 months, as recommended for UNGASS reporting. Others, such as Croatia, Denmark, Italy and Norway, reported on MSM ever tested for HIV; Denmark also reported on testing within the last 16 months.

There is a considerable variation in reported rates of HIV testing in 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 rates of between 30% and 60% and four rates above 60%[267].

Azerbaijan, France, Latvia, the Netherlands, Sweden and Uzbekistan, reported data on HIV testing among MSM disaggregated by age. In Latvia, Sweden and Uzbekistan, a higher proportion of those aged over 25 years had been tested for HIV. Data from the Netherlands also showed that older men were more likely to have been tested for HIV. In Azerbaijan and France rates of HIV testing were similar across age groups.

Data from the Netherlands was disaggregated by location and according to whether MSM identify as homosexual or bisexual (see Box 14). This data shows that MSM who live in cities were more likely to have been tested for HIV and that rates of testing were higher in homosexual than in bisexual men. Data reported by Ireland also shows a similar picture, with lower testing rates among MSM living outside cities and men who have sex both with men and with women.

Few countries provided trend data. Of those that did, most showed similar testing rates between years. Exceptions included Slovenia and the former Yugoslav Republic of Macedonia, which showed increases in testing rates among MSM between 2005 and 2007[268].

Several countries highlighted the issue of MSM who have not been tested for HIV. Sweden reported that as of 1 July 2009, a total of 4 898 people were living with HIV in Sweden, of whom 1 518 (31%) were MSM, but noted that an estimated further 300 MSM are living with undiagnosed HIV. Latvia reported that a small proportion of MSM did not know where to go for an HIV test, while the United Kingdom reported that over half of those who had not been tested did not perceive themselves to be at risk of HIV.

[263] 37/49.

[264] Albania, Iceland, San Marino and Turkmenistan provided no information in response to this question.

[265] Andorra, Cyprus, Hungary, Israel, Luxembourg, Malta, Portugal and Slovakia.

[266] Countries were asked to respond to a question, in line with the UNGASS indicator, designed to measure the percentage of MSM who have had an HIV test in the last 12 months and know the results (disaggregated by age).

[267] Belgium, Italy, Kyrgyzstan and the Netherlands.

[268] Data reported by Armenia showed a decrease in HIV testing rates.

Table 11: HIV testing among MSM in Europe and central Asia

Country	HIV testing	Year	Comment
Armenia	5%	2007	Compared with 42% in 2005. Source: UNGASS 2008
Azerbaijan	13%	2007	Age under 25: 14%; age over 25: 12.3%. Source: Epidemiological surveillance 2007–2008
Belgium	62%	2007	Data collection period not defined. Source: UNGASS 2008
Bosnia and Herzegovina	10%	2007	Data collection period started before 2005. Method not harmonised with UNAIDS 2008 guidelines. Source: UNGASS 2008
Bulgaria	29%	2006	Source: UNGASS 2008
Croatia	47%	2006	25.3% tested for HIV several times; 21.4% tested for HIV once; 53.1% never been tested in study of 1 127 MSM. Source: Radic et al 2006. Other evidence: 51.9% had never had an HIV test in study among 360 MSM in Zagreb to investigate the prevalence of HIV, other sexually transmitted infections and sexual risk behaviours. Source: Bozicevik et al, 2006
Czech Republic	45–50%	Not stated	60% ever tested for HIV; 45–50% within the last 12 months. No data source provided.
Denmark	55%	2009	77% ever tested for HIV; 55% within the last 16 months. Source: Survey 2009
Estonia	27%	2007	Method not harmonised with UNAIDS 2008 guidelines. UNGASS 2008
Former Yugoslav Republic of Macedonia	56%	2007	Compared with 7% in 2005. Source: UNGASS 2008
France	45%	2009	Tested for HIV in the last 12 months (age <25: 46%; age >25: 45%) from self-administered questionnaire to 19 048 users of gay website Net Gay Baromètre. No 2007 data available
Finland			No recent data on HIV testing among MSM. Only the gender of people tested for HIV is recorded, although clients are asked about possible route of transmission. In 2008, 317 people tested by the Finnish AIDS Council reported homosexual contact as a potential transmission route, and 7 were HIV positive. As of September 2009, 199 who reported homosexual contact as a potential transmission route had been tested, of whom 3 were HIV positive.
Georgia	30%	2007	Compared with 27% in 2005. Data collection started before 2005. Source: UNGASS 2008
Germany	18%	2007	Source: UNGASS 2008
Greece	39%	2007	Source: UNGASS 2008
Ireland	50%	2005/6	50% of respondents had not been tested for HIV. Of those testing, 5% (2% of respondents) were HIV positive. Source: Real Lives 2. See also Box 14.
Italy	69%	2005	Ever tested for HIV. No data available on HIV testing in the last 12 months. Source: Survey Modidi 2005[269]
Kazakhstan	38%	2007	Source: UNGASS 2008
Kyrgyzstan	70%	2007	Source: UNGASS 2008
Latvia	23%	2008	58 out of 252 tested in last 12 months (age < 25: 47.2% (27); age > 25: 52.6% (30). Out of MSM aged < 25 years 27 (26.0%) and aged > 25 years 30 (20.5%) were tested for HIV in last 12 months. 2/252 (0.8%) said they did not know where to go for an HIV test. Source: Anonymous cross-sectional questionnaire and testing for HIV, Hepatitis B and syphilis in 252 MSM recruited in sites in Riga (gay night clubs, AIDS counselling service, NGO premises).
Lithuania	28%	2007	Source: UNGASS 2008
Moldova	38%	2007	Source: UNGASS 2008
Netherlands	66%	2008	Percentage of 5 603 respondents ever tested for HIV. See also Box 14.

[269] www.modidi.net

Country	HIV testing	Year	Comment
Norway	56%	Not stated	Recent internet survey: 74.7% of 1 418 respondents had had a test (of whom 56% tested in the last 12 months; 1.6% did not know the result; 1.8% were still waiting for the result), 22.5% had never had an HIV test.
Poland	< 1%	2007	Source: UNGASS 2008
Romania	47%	2007	Source: UNGASS 2008
Russia	32%	2007	Source: UNGASS 2008
Serbia	53%	2005	Source: UNGASS 2008 from Ministry of Health/Integrated Bio-Behavioural Survey (IBBS) conducted as a part of second generation HIV surveillance
Slovenia	38%	2008	Compared with 29% in 2003. Sentinel population of MSM in Ljubljana.
Spain	49%	2007	Data reporting period not specified. Source: UNGASS 2008
Sweden	41%	2007	Source: UNGASS 2008. Other evidence: 75% tested for HIV at least once (0–19: 27%; 20–24: 60%; 25–49: > 80%); > 50% tested in the last 12 months; > 90% over 25, 74% under 19 knew where to go for an HIV test. Source: MSM Survey 2008
Switzerland	31%	2007	Source: UNGASS 2008
Tajikistan	29%	2007	Source: UNGASS 2008
Turkey	31%	2007	Source: UNGASS 2008
Ukraine	28%	2007	Compared with 25% in 2005. Source: MoH Ukraine
United Kingdom	17%	2007	Data collection started before 2005. Source: UNGASS 2008. Other evidence: 10% of MSM had never had an HIV test, of whom 56% did not perceive themselves to be at risk.
Uzbekistan	25%	2007	Source: UNGASS 2008. Other evidence: 30.3% tested for HIV in last 12 months (age < 25: 21.4%; age > 25: 41.5%). Source: Surveillance in 211 MSM in Tashkent Sept–Nov 2007

Box 14: Data on HIV testing among MSM in Ireland and the Netherlands

Ireland reported that undiagnosed HIV in MSM was higher among men not living in or near Dublin or Cork. Notably two thirds of men aged under 24 years and 62% of men who had sex with both men and women have never been tested for HIV.

In the **Netherlands**, a national annual cross-sectional behavioural survey (Schorer Monitors) is conducted among MSM via the internet. The number of respondents was 4 194 in 2006, 3 691 in 2007 and 5 603 in 2008. Responses show that the percentage ever tested for HIV increased from 60% in 2006 to 63% in 2007 and 66% in 2008. The percentage ever tested in the last six months also increased, from 30% in 2006 to 32% in 2007 and 39% in 2008. Data for 2008 showed the following differences: 69% of homosexual men ever tested compared with 45% of bisexual men; 45% of MSM aged under 26 ever tested compared with 73% of those aged over 26; and 71% of MSM living in cities compared with 58% of those living in smaller communities.

2.3.4 HIV programme coverage for men who have sex with men

Over half of countries (53%[270]) reported that there is some quantitative data (either percentage or number reached[271]) on HIV prevention programmes for MSM[272,273] (see Table 12)[274]. Six countries provided qualitative data (see Box 15).

Twelve countries[275] reported that data is not available. Some, for example, Latvia, have no data because they report having no programmes specifically targeting MSM, while others, for example, Georgia, track coverage through the impact of programmes on other indicators such as HIV prevalence. Other countries that measure programme coverage also look at the effects of programmes. For example, Germany and the Netherlands track intended condom use.

A number of countries take a different approach to measuring programme coverage from that used for UNGASS reporting. These include:

- Exposure to HIV campaigns and information measured through frequency of visits to gay venues, use of internet sites, exposure to printed information and other information-seeking behaviour, for example, in Belgium, Germany, the Netherlands, Sweden and the United Kingdom.
- Attendance at specialised health facilities, for example in Ireland.
- Distribution of free condoms and/or lubricants, for example, in Croatia and the United Kingdom, and possession of condoms, for example, in Germany and the Netherlands.

Reported rates of HIV programme coverage for MSM in the region range from 7% in Serbia to 90% in Sweden. Nine countries reported coverage of 50% or less.

Four countries (Azerbaijan, Sweden, United Kingdom and Uzbekistan) reported some coverage data disaggregated by age. Data from Azerbaijan, United Kingdom and Uzbekistan showed slightly higher coverage in older age groups. Data from Sweden showed that younger MSM were more likely to access information from the internet and more likely to have received condoms.

Serbia reported higher coverage among MSM in the capital city than in another city surveyed.

Data from Sweden on intended condom use showed lower intentions to use condoms in future among less educated MSM and bisexual men, which may indicate the extent to which these subgroups of MSM are reached with HIV programmes.

Table 12: Coverage of HIV prevention programmes for MSM in Europe and central Asia

Country	HIV programme coverage	Year	Comment
Armenia	10%	2007	Source: UNGASS 2008
Azerbaijan	22%	2007/8	Age < 25: 14%; age > 25: 28.1%. Source: Epidemiological surveillance 2007–2008
Belgium			Sensoa runs campaigns for MSM, distributing posters to gay venues and parties and providing information though gay websites. An estimated 60% of Flemish gay men visit gay venues at least once every three months and over 90% of MSM use the internet to contact other MSM. Sensoa's information website is visited by 700 users each day.

[270] 26/49.

[271] Bosnia and Herzegovina, Hungary, Ireland and the Former Yugoslav Republic of Macedonia provided data on numbers of MSM reached.

[272] Countries were asked to respond to a question designed to assess the coverage of HIV programmes for MSM (disaggregated by age). The UNGASS indicator is based on knowing where to get an HIV test and having received a condom in the last 12 months. Countries were encouraged to provide alternate coverage data if they had it.

[273] Albania, Iceland, San Marino, Tajikistan and Turkmenistan provided no information in response to this question.

[274] Croatia did not provide specific data but reported that HIV programme coverage is measured through monthly reports from an NGO that works with MSM in Zagreb and the east of the country. These reports track the number of clients and of condoms and educational materials distributed, as well as advice provided though a dedicated phone line and the NGO internet site. France reported that data was collected in 2004 through Enquête Presse Gay but did not provide this data.

[275] Andorra, Cyprus, Denmark, Georgia, Italy, Latvia, Luxembourg, Malta, Norway, Portugal, Slovakia and Slovenia.

Country	HIV programme coverage	Year	Comment
Bosnia and Herzegovina	1 075	2008	Number of MSM reached by HIV prevention programmes. Not possible to provide figure for percentage covered as size of MSM population unknown; NGO estimation is that there are 13 500 MSM in the country.
Bulgaria	30%	2006	Source: UNGASS 2008
Estonia	56%	2007	Source: UNGASS 2008
Former Yugoslav Republic of Macedonia	2 067	2005/9	Preventive activities include peer education, counselling, outreach, distribution of educational materials, condoms and lubricants, and a gay information telephone helpline. Since 2005, when the programme began, 2 067 MSM have been reached in the capital city and one other town.
Germany	54%	2007	Percentage of 8 170 MSM surveyed who reported that they had actively sought HIV-specific information or counselling during the previous 12 months from public institutions or NGOs involved in HIV prevention. Evidence also suggests that the first nationwide HIV prevention campaign targeting MSM, conducted by the NGO Deutsche Aidshilfe e.V, which started in October 2008 and uses a wide range of communication channels including the internet, mass media, outreach and counselling, has increased discussion of HIV prevention in the MSM community and the community press.
Greece	19%	2007	Source: UNGASS 2008
Hungary	388	2008/9	MSM involved in the MSM project coordinated by the National Centre for Epidemiology November 2008 and February 2009.
Ireland	10 000	2006/7	HIV prevention and sexual health interventions for gay and bisexual men are carried out by NGOs, statutory health services and gay community services, and many of these are involved with or support the All Ireland Gay Health Network (GHN). The specialised statutory service, the Gay Men's Health Service (GMHS) in Dublin runs an STI clinic which sees men from across the country and in 2006 and 2007 received over 10 000 visits and conducted 2 200 HIV tests, diagnosing 40 HIV cases. GHN has produced and distributed information leaflets on safer sex, HIV and PEP, conducted information campaigns on syphilis awareness and testing and worked with young services and NGOs to develop information targeting younger and bisexual men. State funding has been made available to translate material into other languages, in response to inward migration—more than a third of new attendees at the GMHS were born outside Ireland—and material on the GHN website is published in nine languages.
Kazakhstan	48%	2007	Method not harmonised with UNGASS 2008 guidelines. Source: UNGASS 2008
Kyrgyzstan	77%	2007	Method not harmonised with UNGASS 2008 guidelines. Source: UNGASS 2008
Lithuania	40%	2007	Source: UNGASS 2008
Moldova	86%	2007	Source: UNGASS 2008. This figure is based on a survey among beneficiaries of harm reduction programmes and is not representative of all MSM in Moldova.
Netherlands	73%	2008	Based on Schorer Monitor, a cross-sectional national behavioural survey among MSM conducted via the internet of 5 603 respondents: 73% were familiar with one or more gay health websites, HIV prevention campaigns and materials; 29% were familiar with PEP; 85% were very likely or definitely planning to use condoms during the next six months. With respect to the latter, less educated respondents had significantly lower intentions to use condoms than more highly-educated respondents, and bisexual men had significantly lower intentions than gay men.
Romania	59%	2007	Source: UNGASS 2008

Country	HIV programme coverage	Year	Comment
Russia	17%	2007	Source: UNGASS 2008
Serbia	7–13%	2008	13% Belgrade and 7% Novi Sad in survey of sample of MSM age 15-59, 250 in Belgrade, 250 in Novi Sad. Source: Ministry of Health/Integrated Bio-Behavioural Survey (IBBS) conducted as a part of second generation HIV surveillance
Sweden	57–90%	Not stated	The focus is on how and to what extent MSM access information, about HIV, STI, safer sex and other sexual health issues, and condoms. Over 65% had accessed information from the internet at least once and 48% had read printed information during the last 12 months. Younger men accessed information more frequently from internet sites than older men; printed information was used far less by all age groups. More than 90% of MSM aged over 25 knew where to go for an HIV test (74% in those aged under 19) and 57% had received free condoms during the previous 12 months (> 70% in MSM aged under 19).
Turkey	19%	2007	Source: UNGASS 2008
Ukraine	50%	2007	Source: UNGASS 2008
United Kingdom	85%		87.5% of MSM had seen an advertisement about HIV or safer sex in the past 12 months (age: < 20: 59%, 20–29: 64.2%, 30–39: 67.2%, 40–49: 66.9%, 50+: 64.7%) and 84.4% had received a free condom and lubricant pack in the past 12 months (age in past month: < 20 66.4%, 20–29 60.4%, 30–39 61.4%, 40–49 59.3%, 50+ 55.9%). Of 16 267 MSM interviewed, 24.8% had attended an STI clinic in the last year. Based on a range of studies, e.g. the Gym Study, Gay Men's Sex Survey, Sexual Health Survey of Gay Men and Sigma Survey in a range of settings, e.g. community, GUM clinics and web based, which monitor prevention activities among MSM.
Uzbekistan	81.5%	2007	Age < 25: 77.8%; age > 25: 86.2%. Source: DHS 2007

As noted above, six countries provided qualitative data about programmes for MSM (Box 15). These encompass information dissemination through outreach, peer education and the internet, HIV counselling and testing, and distribution of condoms. In most countries these services are delivered by NGOs.

Box 15: Examples of programmes and services for MSM

In the **Czech Republic**, the National AIDS Programme supports internet websites for MSM, other sites provide information, and leaflets and booklets on HIV/STI prevention for the MSM community are distributed. The Czech AIDS Help Society, an NGO, conducts an outreach programme in gay clubs in Prague, and HIV prevention work is also carried out by two rural gay clubs, in southern Bohemia and Moravia.

In **Finland**, there is no data on programme coverage, but most activity is carried out by the Finnish Aids Council, the main NGO doing preventive work for MSM. The Council produces and distributes information, conducts outreach work and uses the internet. Other NGOs such as the A-clinic Foundation, Red Cross, Helsinki Deaconess Institute and HIV Finland also implement activities. HIV prevention for MSM has not yet been fully integrated into multisectoral public health, social welfare and education programmes at national, regional and municipal levels. STI clinics play a role in health promotion for MSM, but are not always able to address the whole spectrum of MSM specific health issues.

In **Israel**, there are few interventions targeting MSM. Most are implemented by NGOs, with government funding, and include distribution of condoms, lubricants, pamphlets and booklets, HIV testing in gay venues, a telephone information hotline and electronic outreach through gay-related sites.

In **Poland**, programmes for MSM run by NGOs include comprehensive awareness-raising campaigns, peer education and outreach work on the streets and at parties, use of the internet, and positive prevention for MSM living with HIV. In **Spain**, data is not collected on this issue, but all regions have targeted prevention programmes for MSM and there are also programmes working through the internet.

In **Switzerland**, HIV programme coverage among MSM is not known, although most MSM know where to go for an HIV test—there are two specific MSM Checkpoints in Geneva and Zurich—and condoms are widely available in venues such as gay saunas and clubs. However, in response to the increase in HIV infection among MSM in recent years, HIV prevention efforts are being stepped up. To ensure that policies and programmes are evidence-based, a regular behavioural surveillance survey called GaySurvey is conducted every two years. The last survey was conducted in 2009. The results will be published in mid-2010.

2.3.5 HIV-related knowledge of men who have sex with men

Almost two thirds (63%[276]) of countries reported some quantitative data about HIV-related knowledge of MSM (see Table 13 and Box 16)[277,278]. Thirteen countries[279] reported that data is not available, in almost all cases because this information is not collected[280].

Germany commented that the UNGASS indicator for HIV-related knowledge of MSM is not relevant, as more than 98% of respondents to MSM behaviour surveys have good general knowledge about the most important modes of sexual transmission of HIV. A number of countries take a different approach to measuring HIV-related knowledge from that used for UNGASS reporting. Some of these are described in Box 16. For example:

- Belgium, Germany and Sweden assess knowledge of the risks of different sexual practices, for example, insertive or receptive anal sex;
- the Netherlands assesses knowledge among different subgroups of MSM, for example, gay and bisexual men;
- Norway and the United Kingdom assess knowledge about the effects of ART on HIV infectivity and on MSM concerns about risk of HIV infection.

In the approach taken by the Netherlands, participants are asked to rate their own knowledge on particular topics rather than assessing their responses to particular questions. Switzerland uses a similar approach. The Swedish approach focuses on risk assessment and behaviour as proxies of knowledge, and allows for different degrees of risk rather than simple 'Yes' or 'No' answers.

[276] 31/49.

[277] Countries were asked to respond to a question, in line with UNGASS, designed to measure the percentage of MSM—disaggregated by age—who can correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission.

[278] France reported that no 2007 data are available and that data was collected in 2004 through Enquête Presse Gay, but did not provide this data. Bosnia and Herzegovina referred to data from bio-behavioural surveillance of a sample of 224 MSM but this data was not provided.

[279] Andorra, Cyprus, Finland, Hungary, Israel, Italy, Luxembourg, Malta, Portugal, Slovakia, Slovenia, Spain and Turkey.

[280] Albania, Iceland, San Marino, Tajikistan and Turkmenistan provided no information in response to this question.

Reported HIV-related knowledge of MSM varies considerably, ranging from 0% in Georgia to 98% in Germany. However, rates of reported knowledge will be higher when based on correct responses to a single question rather than correct answers to all five UNGASS questions.

HIV-related knowledge was higher in those aged over 25 in Kyrgyzstan, Latvia and Uzbekistan, and higher in those aged under 25 in Azerbaijan. Data from the Netherlands shows that men younger than 26 years reported lower levels of knowledge. Lithuania's UNGASS country progress report 2008 comments that there was no difference in knowledge between those aged under and over 25. Sweden also reported no differences in knowledge between different age groups, although younger men highlighted the need for more information on certain topics.

Data from the Netherlands shows that bisexual men, less educated men and men from smaller communities reported lower levels of knowledge. Serbia also reported better knowledge among MSM in the capital city than in another smaller city.

Kyrgyzstan, Moldova and the Former Yugoslav Republic of Macedonia reported trend data showing increases in knowledge between 2005 and 2007.

Table 13: HIV-related knowledge of MSM in Europe and central Asia

Country	HIV-related knowledge	Year	Comment
Armenia	74%	2007	Compared with 54% in 2005. Source: UNGASS 2008
Azerbaijan	35.8%	2007/8	Age < 25: 59.4%; age > 25: 20.4%. Source: Epidemiological surveillance 2007-2008
Belgium			See Box 16.
Bulgaria	32%	2006	Source: UNGASS 2008
Croatia	75.4%	2006	Proportion of sample survey of 1 127 MSM who knew that using a condom protects against HIV infection. Source: Radic et al 2006
Czech Republic	85%	Not stated	85% of respondents agreed that condom can decrease the risk of HIV transmission.
Denmark	95%	2006	Percentage answering correctly about HIV-related knowledge in 2006 survey.
Estonia	60%	2007	Method not harmonised with UNGASS 2008 guidelines. Source: UNGASS 2008
Former Yugoslav Republic of Macedonia	41%	2007	Compared with 34% in 2005. Source: UNGASS 2008
Georgia	0%	2007	Data collection started prior to 2005. Source: UNGASS 2008
Germany	88–99%	Not stated	In survey of 7 000 that included 119 MSM (Public Awareness of AIDS in Germany), questions similar to UNGASS were included. 88% of MSM gave the correct answer to the question 'are there externally visible signs that allow non-medical people to recognise whether someone is HIV positive or is this not externally recognisable?' and 99% gave the correct answer to the question 'can HIV be transmitted if you have unprotected sex, i.e. without a condom, with an unknown partner?' However, the level of knowledge declines if more detailed and specific questions are asked, e.g. about risk of HIV transmission through unprotected oral intercourse or unprotected insertive anal intercourse with or without ejaculation.
Greece	74%	2007	Source: UNGASS 2008
Ireland	56.2–92.7%	2003	Proportion of respondents who agreed that they already knew in survey which presented six true statements and asked respondents how many they already knew ranged from 56.2% to 92.7%, depending on the question.
Kazakhstan	66%	2007	Source: UNGASS 2008
Kyrgyzstan	89%	2007	Compared with 7% in 2005. Source: UNGASS 2008. Other evidence: age < 25: 52.2%; age > 25: 65.8%. Source: Epidemiological surveillance 2008

Country	HIV-related knowledge	Year	Comment
Latvia	48%	2008	121 out of 252 MSM gave correct answers to all five questions. Of those, 44 (36.4%) were < 25 years old and 77 (63.6%) > 25 years old. Source: UNGASS 2008. Out of all MSM aged < 25 years and > 25 years, 44 (42.3%) and 77 (52.7%), respectively, gave correct answers to all five questions. Source MSM questionnaire 2008
Lithuania	39%	2007	No difference between those aged under and over 25. Source: UNGASS 2008
Moldova	47%	2007	Compared with 38% in 2005. Source: UNGASS 2008. This figure is based on a survey among beneficiaries of harm reduction programmes and is not representative of all MSM in Moldova.
Netherlands			See Box 16.
Norway			See Box 16.
Poland	38–99%	2004	Knowledge of HIV in the MSM population is as good as or better than in the general population. Research on MSM conducted for the National AIDS Centre reported the following: 99% of respondents gave the correct answer to a question about sharing syringes with an HIV-positive person; 55% said that it is impossible to prevent HIV infection through sexual abstinence; 38% said it is impossible to prevent HIV infection if you have only one uninfected and faithful partner; 81% thinks that their level of knowledge about HIV prevention methods is good or very good.
Romania	45%	2007	Source: UNGASS 2008
Russia	26%	2007	Source: UNGASS 2008
Serbia	59–66%	2008	66% Belgrade and 59% Novi Sad in survey of sample of MSM age 15–59, 250 in Belgrade and 250 in Novi Sad Source: Ministry of Health/Integrated Bio-Behavioural Survey (IBBS) conducted as a part of second generation HIV surveillance
Switzerland			See Box 16.
Ukraine	47%	2007	Compared with 49% in 2005. Source: UNGASS 2008
United Kingdom			See Box 16.
Uzbekistan	35.5%	2007	Age under 25: 34.2%; age over 25: 37.2%. Source: DHS 2007

Box 16: Examples of different approaches to measuring HIV-related knowledge in MSM

In **Belgium**, a survey of 942 MSM in the French community in 2004–2005 using a self-administered questionnaire reported the following responses to questions:

	Yes	No	Don't know
Is HIV transmitted by deep kiss?	7%	85%	8%
Is HIV transmitted by mutual masturbation?	2%,	95%	3%
Is HIV transmitted by fellatio? Being the one sucking	62%	17%	21%
Is HIV transmitted by fellatio? Being the one sucked	43%	39%	18%
Is HIV transmitted by insertive anal sex?	97%	1%	2%
Is HIV transmitted by receptive anal sex?	100%		

In the **Netherlands**, Schorer Monitor 2008 asked HIV-negative and never-tested respondents to indicate their HIV knowledge on a five point scale (1= very little, 5= very much). Respondents knew most of the risks of unprotected anal sex with ejaculation (4.3) and oral sex (3.8), but knew least about treatment of HIV infection with combination therapy (2.8) and living with HIV and AIDS (2.7). Men younger than 26 years, bisexual men, less educated men and men from smaller communities reported significantly less knowledge.

In **Norway**, a survey of 2 573 MSM asked whether they agreed or disagreed with the following statement: 'Now that HIV medicines have improved, I do not to the same extent as before need to worry about being infected with HIV'. 88% totally disagreed or disagreed a little and 7% totally agreed or agreed a little.

In **Sweden**, the 2008 MSM Survey reported on actual practice, risk assessment and risk reduction strategies as measures of HIV-related knowledge. Regarding receiving oral sex without ejaculation (no sperm in mouth) around half of respondent considered this a 'very small risk', 'small risk' or 'neither small' nor 'big risk', with no big differences between age groups. Insertive anal intercourse without a condom was generally perceived as posing a 'big' or 'very big' risk, but less risky than unprotected receptive anal intercourse with no ejaculation. Generally, younger men expressed a need for more knowledge regarding HAART, HIV, STI, PEP and how to disclose one's HIV status.

In **Switzerland**, an evaluation of an MSM prevention campaign found that about half of those questioned consider themselves well informed about HIV risks, but a sixth considered themselves to be poorly informed.

In the **United Kingdom** data is available from a number of behavioural surveys for MSM on HIV. The Gym Survey found that 69% of MSM disagree that they are less worried about HIV infection now that treatments have improved, 58% of MSM disagree that new drug therapies make people with HIV less infectious.

2.3.6 Condom use by men who have sex with men

Almost three quarters (71%[281]) of countries provided some data about condom use (see Table 14)[282]. Nine countries[283] reported that data on this indicator is not collected[284]. Again, some countries take a different approach from that used for UNGASS reporting to measure condom use by MSM, including questions about:

- unprotected anal sex, for example, in Belgium, France, the Netherlands, Norway and the United Kingdom;
- condom use with steady and casual sex partners, for example, in Belgium, the Netherlands and Spain, and with partners met in different settings, for example, in Spain;
- consistency of condom use, for example, in Belgium, Ireland and the United Kingdom.

[281] 35/49.

[282] Countries were asked to respond to a question in line with the UNGASS indicator designed to measure the percentage of MSM who report using a condom the last time they had anal sex with a male partner.

[283] Andorra, Cyprus, Finland, Israel, Italy, Luxembourg, Malta, Portugal and Slovakia. The Finnish AIDS Council provides free condoms and lubricants at MSM venues in Helsinki and four other cities as well as at events.

[284] Albania, Iceland, San Marino, Tajikistan and Turkmenistan provided no information in response to this question.

Some countries, such as Belgium, France, the Netherlands, Norway, Sweden and the United Kingdom asked about the occurrence of unprotected anal sex within a specific time period, which varied from three months to one year.

Condom use by MSM, based on data reported in line with the relevant UNGASS indicator, ranges from 30% in the Czech Republic to 90% in Denmark. Sixteen of the countries included in Table 14 reported condom use rates of between 30% and 60% and 12 rates of 60% or higher.

Age-disaggregated data reported by Azerbaijan, Latvia and Uzbekistan showed higher condom use by MSM aged over 25 than aged under 25. Data from Sweden also showed higher condom use among older MSM.

Data on unprotected anal sex, although not directly comparable, shows a consistent proportion of MSM reporting unprotected anal sex, mostly with casual partners, for example, Belgium 39.2%, France 40%, Hungary 35.6%, Netherlands 33%, Norway[285] 37% and the United Kingdom 37%. A lower proportion in Sweden (27%) reported unprotected anal sex.

The Netherlands noted that unprotected anal sex with casual partners was reported by a higher proportion of younger men, less educated men, men without a steady partner, men who seek partners on the internet and men who used drugs before sex.

Data from Belgium and Spain showed that reported condom use was higher with casual than with steady partners. Data from Bosnia and Herzegovina showed the opposite. Spain also reported data showing that unprotected sex with partners met online was associated with having more than 20 sexual partners, using drugs in association with sex, being HIV positive and having had an STI in the previous year.

Data reported by the Netherlands on condom use with steady partners, depending on the HIV status of both partners, showed that reported condom use was higher between partners when one was HIV positive and one was HIV negative or of unknown HIV status[286].

Among countries that reported trend data, Armenia, Georgia, Kyrgyzstan, Russia and the former Yugoslav Republic of Macedonia showed increases in condom use between 2005 and 2007. Moldova, Slovenia and Ukraine reported a decline in condom use.

Table 14: Condom use by MSM in Europe and central Asia[287]

Country	Condom use	Year	Comment
Armenia	84%	2007	Compared with 30% in 2005. Source: UNGASS 2008
Azerbaijan	57.4%	2007/8	Age < 25: 47.6%; age > 25: 65.4%. Source: Epidemiological surveillance 2007–2008
Belgium	31–72%	2004/5	A survey of 942 MSM in the French-speaking community using a self-administered questionnaire reported responses to the question 'did you use condoms with your partners for anal sex during the last 12 months?' With casual partners (n=558): always 72%, often 17%,rarely 5%, never 6%; with stable partners (n=553): always 31%, often 11%, rarely 15%, never 43%. In a survey of sexual risk behaviour among MSM in the Flemish community in 2008, 39.2% of respondents reported at least one instance of unprotected anal intercourse in the past year.
Bosnia and Herzegovina	57–75%	Not stated	Sample size: 224 from four urban areas. 75% of respondents reported having used a condom when having anal sexual intercourse with their steady partner, while 57% reported having used a condom with a casual partner. No data source given.
Bulgaria	46%	2006	Source: UNGASS 2008
Croatia	53%	2007	Source: UNGASS 2008
Czech Republic	30%	Not stated	30% used a condom during the last anal intercourse. No data source given.
Denmark	90%	2009	Source: Survey 2009
Estonia	47%	2007	Source: UNGASS 2008

[285] Norway commented that the increased syphilis rate among MSM in the last three years may be an indicator of condom use.

[286] The Dublin Declaration questionnaire did not include a question about serostatus, but this is recognised to be an important issue and a European study (EMIS), which is currently being implemented, will collect data on this. More information on this study can be found on this web address: www.emis-project.eu.

[287] For UNGASS 2008 data: report date 2007, but data collection can vary from 2005 to 2007.

Country	Condom use	Year	Comment
Former Yugoslav Republic of Macedonia	56%	2007	Compared with 29% in 2005. Source: UNGASS 2008
France	60%	2009	In response to a self-administered questionnaire responded by 19 048 users of the gay website Net Gay Baromètre in 2009, 40% of MSM reported unprotected anal intercourse with casual partners during the last 12 months; no difference was found by age.
Georgia	54%	2005	Source: UNGASS 2008. Other evidence: 62% in BSS conducted in MSM in late 2007.
Germany	58%	2007	Source: UNGASS 2008
Greece	89%	2007	Source: UNGASS 2008
Hungary	53.6%	2008/9	The question asked was 'have you used a condom during anal sexual intercourse since your last screening?' 53.6 % of clients responded 'Yes', 35.6% reported that they had not used any kind of protection since their last screening. It was the first screening for 23 (5.9%) respondents, 19 (4.9%) did not answer the question. Source: National Centre for Epidemiology – 2009 pilot programme.
Ireland	37.8%	2005/6	Of 854 men who had anal sex with at least one male partner in the last year, 37.8% had always used condoms, 36.1% sometimes used condoms, and 8% never used condoms. This suggests that 44% had some unprotected anal intercourse, a similar finding to the 2000 survey which found that 42.6% of men who had a male partner had had unprotected anal sex in the previous year. Source: Real Lives 2 2005–2006
Kazakhstan	66%	2007	Source: UNGASS 2008
Kyrgyzstan	81%	2007	Compared with 68% in 2005. Source: UNGASS 2008
Latvia	52.8%	2008	UNGASS indicators were not included in the questionnaire used in MSM research in 2008. Questions asked included: 'have you used a condom during last sex (anal or vaginal sex not specified)?' and 'how often during the last 12 months have you had anal sex with a male partner?' The percentage who had used a condom during last sex was 49.2% (124/252). The proportion who had used a condom for anal sex with a male partner during the last 12 months was 52.8% (124/235). Of those who had used a condom during last sex: 48 (38.7%) were < 25 years old and 76 (61.3%) > 25 years old. Of all MSM who had anal sex during the last 12 months: 48 (49.5%) aged < 25 years and 76 (55.9%) aged > 25 years had used a condom during last sex. Source: MSM questionnaire 2008.
Lithuania	58%	2007	Compared with 55% in 2004. Source: UNGASS 2008
Moldova	48%	2007	Compared with 63% in 2005. This figure is based on a survey among beneficiaries of harm reduction programmes and is not representative of all MSM in Moldova.
Netherlands			See Box 17.
Norway	63%	Not stated	65% of 2 431 MSM respondents had had sex with an anonymous or unknown partner in the last six months. Of these, 37% reported having unprotected anal sex.
Poland	32%	2007	Data collection started prior to 2005. Method not harmonised with UNAIDS 2008 guidelines. Source: UNGASS 2008
Romania	73%	2007	Source: UNGASS 2008
Russia	60%	2007	Compared with 39% in 2005. Source: UNGASS 2008
Serbia	58–67%	2008	67% in Belgrade and 58% in Novi Sad in survey of sample of MSM age 15-59 (250 in Belgrade, 250 in Novi Sad). Source: Ministry of Health/Integrated Bio-Behavioural Survey (IBBS) conducted as a part of second generation HIV surveillance

Country	Condom use	Year	Comment
Slovenia	75%	2007	Method not harmonised with UNAIDS 2008 guidelines. Source: UNGASS 2008. Other evidence: Proportion among sentinel population of MSM in Ljubljana reporting condom use at last anal sex decreased from 81% in 2004 to 66% in 2008. Source: Klavs et al 2009
Spain			See Box 17.
Sweden	42%	2007	Method not harmonised with UNAIDS 2008 guidelines. Source: UNGASS 2008. Overall 27% of respondents in the 2008 MSM Survey reported that they had unprotected anal intercourse at the latest sexual encounter, 30% in those aged 15–25 years. This does not provide information about the timeframe during which the encounter took place or whether it was with a regular or casual partner, but gives a general picture of condom use. There were no significant differences in condom use for penetrative or receiving intercourse.
Switzerland	80%	2007	Source: UNGASS 2008
Turkey	37%	2007	Source: UNGASS 2008
Ukraine	39%	2007	Compared with 72% in 2005. Source: UNGASS 2008
United Kingdom	64%	2005	The Gym Survey found that 37% of MSM had unprotected anal intercourse in the past three months and 64% of MSM had protective anal intercourse in the past three months. The Gay Men's Sex Survey in 2006 found that among MSM who had insertive anal intercourse in the last year, 83.3% had used a condom for sex at least once and 56.2% had not used a condom for sex at least once. Among MSM who had receptive anal intercourse in the last year, 84.1% had used a condom at least once and 57.4% had not used a condom at least once.
Uzbekistan	62.4%	2007	Age under 25: 60%; age over 25: 65.2%. Source: DHS 2007. Other evidence: 61%. Source: UNGASS 2008

Box 17: Condom use by MSM

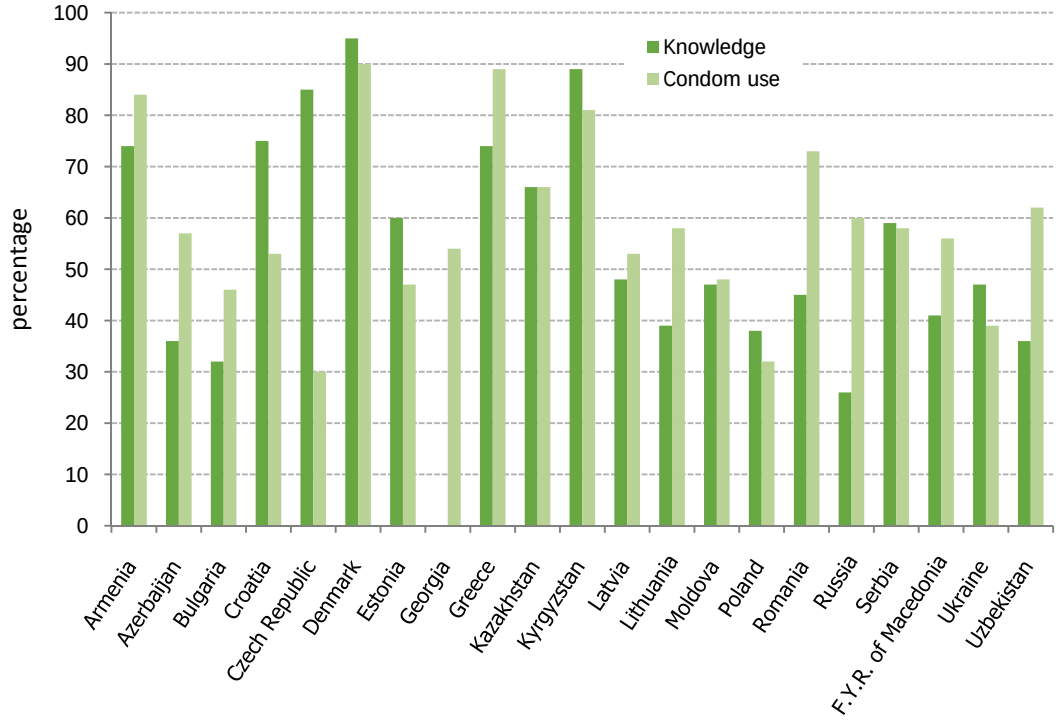
In the **Netherlands**, Schorer Monitor 2008 asked MSM about condom use with steady and casual partners. With steady partners: 64%, where both are HIV-negative or never-tested, reported unprotected anal sex; 31% of those where one partner was HIV negative or never-tested and one HIV-positive reported unprotected anal sex; and 70% of those where both were HIV-positive reported unprotected anal sex. With casual partners (73% of the respondents reported casual partners): 33% had one or more incidents of unprotected anal sex in the previous six months. Unprotected anal sex was reported by a higher proportion of younger men (37%), men without a steady partner (36%), less educated men (37%), men who seek partners on the internet (35%), men who have partners in 'darkrooms' (41%) and in men who used drugs before sex (39%).

With respect to intended condom use, 85% were very likely or definitely planning to use condoms during the next six months. Less educated respondents had significantly lower intentions to use condoms than more highly-educated respondents, and bisexual men had significantly lower intentions than gay men.

In **Spain**, the 2006 STOP SIDA study surveyed MSM over a month via the internet (n=1 240) and in gay venues (n=804). The prevalence of unprotected anal sex was similar in the two samples, but a higher proportion of those surveyed online had unprotected anal sex with partners met online, had intentionally practiced unprotected sex, used drugs when they practised unprotected sex, had had an STI in the previous year, or did not know their HIV status. Unprotected sex with partners met online was associated with having more than 20 sexual partners, using drugs in association with sex, being HIV-positive and having had an STI in the previous year. Other data shows that 39.6% of men surveyed in 2006 always used condoms for anal intercourse with a steady partner in the last year, 65.4% always used condoms with casual partners.

Comparison of HIV-related knowledge and condom use (see Figure 28) shows no obvious pattern.

Figure 28: Comparison of HIV-related knowledge and condom use among MSM



2.3.7 Conclusions

The evidence in this chapter confirms that MSM are at high risk of HIV infection in countries of Europe and central Asia. Although HIV prevalence rates are highest in the western part of the region, there is evidence to suggest that MSM are at significant risk of HIV transmission throughout the region and that level of risk may have been underestimated in many countries to date. Of 33 countries providing data on HIV prevalence among MSM, all but four (88%) reported rates above 1%. Nineteen countries reported prevalence of between 1% and 5% and 10 reported prevalence of more than 5% (see Figure 27).

Reported coverage with HIV prevention programmes for MSM varies considerably. However, countries measure coverage in different ways. Some countries, for example, Georgia, do not track programme coverage as such but focus on the effects of programmes on condom use intentions and HIV prevalence rates. This review provides evidence that particular subgroups of MSM are more likely to be reached with HIV programmes than others. For example, there may be higher coverage in capital cities, among older men, among more educated men and among men who identify themselves as homosexual rather than bisexual.

Similarly, reported data on HIV testing, HIV-related knowledge and condom use show wide variations between countries. Higher testing rates were reported for the same subgroups of MSM as for programme coverage. Countries varied in whether they asked MSM if they had ever been tested for HIV or had been tested in the last year. This raises the issue of how often countries consider MSM should be tested for HIV and the factors that might usefully determine an appropriate frequency of testing.

The relevance of the UNGASS indicator for measuring knowledge was also questioned by some countries. Several countries considered the UNGASS questions far too simplistic and generic for use among well-informed MSM populations. For example, Germany noted that more than 98% of respondents to MSM behaviour surveys have good general knowledge about the most important modes of sexual transmission of HIV, but that knowledge declines when more detailed questions are asked. This is confirmed by data from other countries such as Belgium, the Netherlands, Sweden and the United Kingdom. These countries also reported good levels of knowledge of sexual transmission of HIV but poorer knowledge when questions were asked about more specific sexual practices. However, relatively low scores on HIV-related knowledge were reported by some countries. One explanation for this is the design of the UNGASS indicator, where respondents have to answer all questions correctly.

A number of countries reported data showing that condom use is higher with casual partners than with steady partners. However, reported data also shows that one third or more of MSM report having had unprotected anal

sex, mostly with casual partners. Data from the Netherlands also indicates that the HIV status of steady partners influences rates of condom use with these partners.

A number of countries also reported data showing an increase in reported HIV cases among MSM. The extent to which this is linked to a rise in sexual risk behaviour, in particular unprotected anal sex, is unclear. Data from Slovenia suggests that there has been a recent increase in unsafe sexual behaviour among some MSM. Spain suggested that a proportion of MSM actively seek unprotected sex. The Netherlands provided data showing that unprotected anal sex with casual partners was reported by a higher proportion of younger men, men without a steady partner, less educated men, men who seek partners on the internet and men who used drugs before sex. Data from Germany, though, (see Box 13) did not provide evidence of declining safer sex practices among MSM. Other reasons for rising HIV prevalence among MSM in Germany were suggested which might be relevant to other countries. Further research into these issues is currently ongoing through the European MSM Internet Survey.

Available data about HIV testing, programme coverage and condom use among different subgroups of MSM is also limited. No country provided data on sex between men among men from migrant populations for example. Apart from data reported in supporting material submitted by Croatia (see Box 18), no country provided data on use of lubricants. Only Croatia, Ireland and the Netherlands provided data on men who have sex with both men and with women.

Box 18: Risks for HIV infection among Croatian men who have sex with men

Research was conducted in 2006 among MSM in gay venues and through an internet survey to provide insights into risk behaviour. While the median number of partners was one for oral and two for anal intercourse during the last year, some men reported up to 70 partners for oral and up to 100 for anal sex during the last year. Evidence of unsafe sexual behaviour included the fact that 40% had not used a condom during last anal sex, for reasons that included 'it was not necessary' and 'I do not like sex with a condom'. Only 64% had used a lubricant and around half of these had used unsuitable products. Around one third of respondents had had sex with women in the last 12 months and only 20% had consistently used a condom. The findings highlighted the need for further behavioural research including to identify which subgroups of MSM use drugs, given the proportion of respondents reporting drug use prior to sex and the link between drug use and unprotected sex, to identify characteristics that relate to higher numbers of sexual partners, and to explore other aspects of risk behaviour in more depth.

In conclusion, ECDC has identified the following issues needing 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

2.4.1 Introduction

Sex work is seen as a key driver of the HIV epidemic globally, since in many regions the majority of HIV infections are sexually transmitted and the risk of HIV transmission is high in contexts where sex workers have multiple partners and are unable to negotiate or insist on condom use. In addition, in Europe and central Asia, countries have very different policies towards sex work. In some, selling and buying sexual services is largely legalised. In others, selling sex, organising sex work or buying sex are criminalised to differing extents. This clearly has implications for risk of HIV transmission. Other factors affecting vulnerability of those involved in sex work include trafficking of persons for sex work, sex work associated with poverty and addiction and sex work by minors. Nevertheless, there are questions about the extent to which sex work per se is linked to HIV transmission in Europe and central Asia. Some countries in the region, such as the United Kingdom, do not consider sex workers to be especially at risk of HIV. Some available evidence suggests that the overlap between sex work and other risk behaviours, such as injecting drug use (see Section 2.2) and sex between men (see Section 2.3), may be more critical than unprotected sex in the context of sex work (see Box 19).

Box 19: Overlap between sex work and injecting drug use

Evidence cited by UNAIDS in the 2009 AIDS Epidemic Update indicates that more than 30% of sex workers in Russia have injected drugs. Surveys among sex workers in Romania confirm the overlap between sex work and injecting drug use. Romania's 2008 UNGASS country progress report cites a national survey of sex workers and risk behaviours in 2005, which found that more than 11% of sex workers injected drugs and almost 40% of these shared injecting equipment.

The topics covered in this chapter reflect the UNGASS questions[288]. These questions focus on HIV prevalence among sex workers, HIV testing and HIV-related knowledge among sex workers, HIV programme coverage for sex workers and use of condoms by sex workers, and are reflected in the structure of this chapter[289]. The UNGASS questions do not specifically address issues that may be important with respect to HIV in the region including the links between sex work and injecting drug use and between sex work and human trafficking (see Section 2.5), and issues affecting male and transgender sex workers.

2.4.2 HIV prevalence in sex workers

More than half (59%[290]) of countries provided some quantitative information on HIV prevalence among sex workers (see Figure 29 and Table 15)[291]. Fourteen countries reported that data on this indicator is not available[292,293]. Reasons included:

- Lack of data to provide a denominator. For example, Poland reported that there is no data on the total number of sex workers in the country.
- The indicator is not considered relevant as prevalence among sex workers is low. For example, Switzerland commented that prevalence among sex workers is very low with exceptions among subgroups of sex workers, for example, those who inject drugs and those from sub-Saharan Africa and Eastern Europe. Greece also commented that the indicator is not relevant as there is mandatory testing of legal sex workers and none have been found to be HIV positive[294].

Some countries—for example, France, Hungary and Romania—reported that data is available but this may not be nationally representative. Some countries—for example, France and Portugal—commented that national surveys are planned.

Countries collect prevalence data through epidemiological and bio-behavioural surveillance surveys, specific surveys among sex workers, case reporting through sentinel surveillance, and clinic and project data.

[288] The issue of STI, both among sex workers and MSM, was raised by the advisory group although a decision was taken by the group not to include a question on STI in the Dublin Declaration questionnaire because of the lack of harmonised indicators in the region.

[289] The specific UNGASS question is described in each of the relevant sections of the section.

[290] 29/49.

[291] Countries were asked to respond to a question in line with UNGASS designed to measure the percentage of sex workers who are HIV infected (disaggregated by age and sex).

[292] Andorra, Cyprus, Denmark, Finland, Latvia, Luxembourg, Malta, Slovenia, Slovakia, Turkey and Switzerland commented that data is not collected. Cyprus noted that data is not available as sex work is illegal.

[293] Albania, Iceland, Ireland, Russia, San Marino and Turkmenistan did not provide any information.

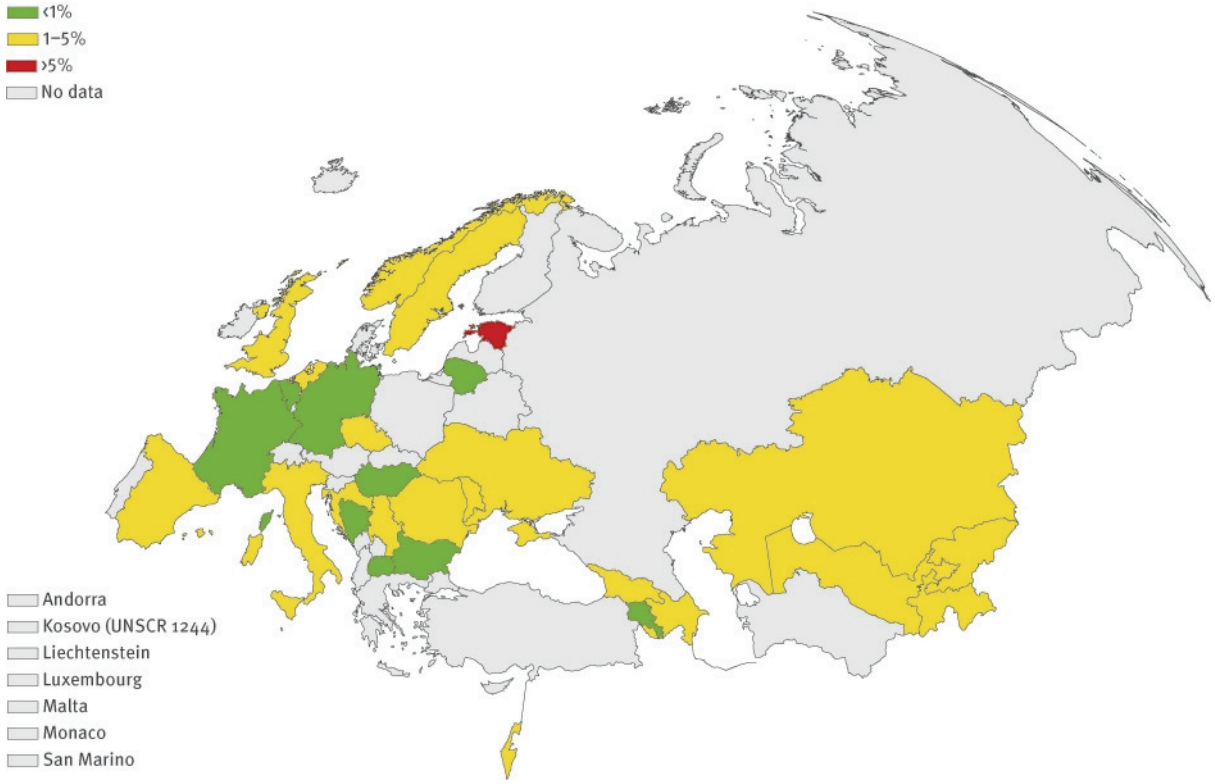
[294] Greece also commented that there is no data on HIV prevalence among illegal sex workers.

Reported prevalence in sex workers ranged from 0% (Bosnia and Herzegovina, France, Hungary[295], Lithuania and the Former Yugoslav Republic of Macedonia) to 7.7% (Estonia). Five countries reported prevalence of 0%[296], five reported prevalence of between 0% and less than 1%, 18 reported prevalence of between 1% and 5% and one prevalence of more than 5%. Overall, in countries with available data, the reported HIV prevalence among sex workers tends to be low (< 1%) or moderate (1–5%) (see Figure 29).

Some countries, for example, Israel, the Netherlands, Serbia and the United Kingdom reported data on prevalence among male sex workers[297]. The Netherlands, reported data on prevalence among transgender sex workers[298]. Data reported suggests that prevalence is higher in these subgroups of sex workers than in female sex workers.

Some countries, for example, Kyrgyzstan and Uzbekistan reported prevalence data disaggregated by age. Both countries showed higher prevalence among female sex workers aged over 25 years.

Figure 29: Reported HIV prevalence among sex workers in Europe and central Asia



Evidence provided, for example, by the Netherlands (see Box 20), Norway, Serbia, Spain and the United Kingdom, suggests that HIV prevalence may be higher among specific subgroups of sex workers, such as sex workers who are also drug users, male and transgender sex workers, street sex workers and sex workers from countries with generalised HIV epidemics. Evidence reported by Georgia shows higher prevalence among sex workers in the capital city than in smaller urban centres.

[295] This was a survey in a pilot programme among 500 people who considered themselves sex workers. It is not nationally representative.

[296] In addition, Serbia reported an HIV prevalence of 0% among female sex workers.

[297] In commenting on the report, Spain explained that they had provided the following data in their 2008 UNGASS country report. The HIV prevalence among male sex workers was 18.7% in 2007 and 24.1% in 2008. Among transgender sex workers, the HIV prevalence was between 27–28% in both years.

[298] UNGASS reports specifically on prevalence among female sex workers.

Table 15: HIV prevalence among sex workers in Europe and central Asia

Country	HIV prevalence	Year	Comment
Armenia	0.4%	2007	Female sex workers. Source: UNGASS 2008
Azerbaijan	1.7%	2007/8	Age under 25: 0%; age over 25: 2%. Sample of 300 sex workers (53 under 25; 247 over 25). Source: Epidemiological surveillance 2007/8
Belgium	0.3%	2008	Three HIV positive of 1 016 tested in survey among sex workers in Antwerp in 2008. Other evidence: one HIV positive of 988 tested in Antwerp in 2007. Routine data collection through hepatitis B campaign for sex workers: one HIV positive of 142 tested in Brussels in 2007; 9 HIV positive of 1 502 in Wallonia between 1998–2007.
Bosnia and Herzegovina	0%	Not stated	Zero of 138 tested were HIV positive in a sample of sex workers; 28.8% had been tested for HIV before; 81% were aware of test results. Source: Bio-Behavioural Surveillance
Bulgaria	0.2%	2006	Female sex workers. Source: UNGASS 2008
Croatia	1.4%	2006	Female sex workers. Source: UNGASS 2008
Czech Republic	> 1%	Not stated	HIV prevalence among sex workers is very low. Over 17 years, 7 000 were tested regularly; 16 were HIV positive. Source: NGO Bliss without Risk
Estonia	7.7%	2006	Female sex workers. Source: UNGASS 2008
Former Yugoslav Republic of Macedonia	0%	2006	Source: UNGASS 2008
France	0%	2008	Data from a survey among Chinese sex workers in Paris in December 2008 (none of the 46 women tested were HIV positive). A pilot national survey planned in 2010 will collect data on HIV prevalence in sex workers.
Georgia	1.44%	2008	Source: BSS. Other evidence: Female sex workers 0.6% 2006. Source: UNGASS 2008. 1.1% in 2006 BSS among street-based female sex workers in Tbilisi and those attending facilities in Batumi; 280 women were tested (160 in Tbilisi and 120 in Batumi); prevalence was higher in Tbilisi (1.88%) than in Batumi (0.83%).
Germany	0.1–0.2%	Not stated	Estimated figure for female sex workers; data on number tested for HIV not available. Source: Case reporting within the STD Sentinel Surveillance System
Hungary	0%[295]	2006	500 sex workers tested. Source: MOH screening bus pilot programme
Israel	1.25%	2002–8	10 of 571 female sex workers tested were HIV positive.
	5.6%		Three of 54 male sex workers.
Italy	2.5%	2001	Of 121 sex workers. Other evidence: 1.6% of 558 sex workers (1999); 1.8% of 110 sex workers (1998); 1.8% of 109 sex workers (1998); 6% of 102 sex workers (1998). Sources: Beltrame; D'Antuono; Smacchia; Prestileo; Verster
Kazakhstan	1.4%	2006	Female sex workers. Source: UNGASS 2008
Kyrgyzstan	1.1–3.1%	2008	Age under 25 and over 25. Source: Epidemiological surveillance 2008
Lithuania	0%	2007	Female sex workers. Source: UNGASS 2008
Moldova	2.9%	2007	Female sex workers. Source: UNGASS 2008
Netherlands			See Box 20.
Norway	1%	2008	Seven female, one male HIV positive of 746 tested at the only Oslo clinic specifically for sex workers. Exact data not available but infection rates are low. At the same clinic in 2007, 0.5% tested HIV positive; rise in 2008 attributed to increase in sex workers from countries with generalised epidemic.
Romania	1%	2009	204 street sex workers in Bucharest; no prevalence data for other sex workers. Source: Behavioural Sero-Surveillance Survey

Country	HIV prevalence	Year	Comment
Serbia	2.2%	2008	139 indoor and street sex workers aged 15+ in Belgrade. However, the HIV prevalence was 0% among surveyed 85 female sex worker, and out of 54 tested male sex workers, three persons were HIV positive (5.6%) of whom two were transgender. Source: Ministry of Health/Integrated Bio-Behavioural Survey (IBBS) conducted as a part of second generation HIV surveillance
Spain	2.2%	2005	Source: UNGASS 2008. 1.4% among 2 167 female sex workers and 16.7% among 144 male sex workers.
Sweden	2.2%	2006/7	Of 979 clients interviewed by the Swedish Prison Project in 2006–2007, 46 reported that they had sold sex, of whom 45 were tested for HIV and one female (2.2%) was confirmed as HIV positive. Data from Stockholm region only.
Tajikistan	3.7%	2006	Source: UNGASS 2008
Ukraine	4%	2006	Source: UNGASS 2008
United Kingdom	5%	2006	Six of 120 female sex workers contacted by a mobile HIV/STI clinic at a London sex worker outreach project. Source: Creighton S, Tariq S, Perry G, 2008. Other evidence: 1.5% (3/200) (1996–2002) of female sex workers registered at a London GUM clinic. Source: Ward H et al, 2004. 9% (59/636) (1994–1996) of male sex workers attending a London GUM clinic. Source: Sethi et al, 2006
Uzbekistan	2.2%	2007	Age under 25: 1.8%; age over 25: 2.6%. Source: DHS 2007. Other evidence: 4.7% in 2005. Source: UNGASS 2008

Box 20: Data on HIV prevalence among sex workers in the Netherlands

Data from a range of sources indicate that HIV prevalence may be higher among specific subgroups of sex workers:

- Prevalence rates in the Amsterdam HIV Survey 2003–2004 were: 3% in heterosexual sex workers, 17% in transgender sex workers and 11% in sex workers who were also IDU.
- Prevalence rates in the Rotterdam HIV Survey 2002–2003 were: 12% in street sex workers and 2% in sex workers in brothels and clubs. The survey was conducted among 109 sex workers (93 women, 15 transgender and one male), 37% of Latin American origin.
- Prevalence rates in the Hague HIV Survey 2005 were: 20% in transgender sex workers and 22% in sex workers who were also IDU. Survey of 201 sex workers (167 not IDU, 9 IDU, 25 transgender), 24% of Dutch origin.
- A cross-sectional survey of 557 sex workers in three cities (2002–2005) found prevalence rate of 5.7% overall, with prevalence of 1.5% in female, 13.6% in IDU and 18.8% in transgender sex workers.

2.4.3 HIV testing in sex workers

More than half (59%[299]) of countries provided quantitative data on HIV testing in sex workers (see Table 16)[300]. Fourteen countries[301] reported that data is not available[302]. Of these, Germany reported that, although data on HIV-positive test results among sex workers is available from the STD Sentinel Surveillance System there is no data on the number of sex workers tested for HIV.

As with data on HIV prevalence among sex workers, evidence on HIV testing in this population is drawn from a wide range of sources. However, it is not always nationally representative. Countries also differ in what is documented with respect to HIV testing in sex workers. Some countries, such as Belgium and the United Kingdom, report data on whether sex workers have ever been tested, which gives higher figures than reports on testing in

[299] 29/49.

[300] Countries were asked to respond to a question in line with the UNGASS indicator designed to measure the percentage of sex workers who have had an HIV test in the last 12 months and know the results (disaggregated by age and sex).

[301] Andorra, Cyprus, Denmark, Finland, Germany, Hungary, Israel, Italy, Latvia, Luxembourg, Malta, Portugal, Slovakia and Slovenia.

[302] Albania, Croatia, Iceland, Ireland, San Marino and Turkmenistan provided no information.

the past year. Some, such as the Czech Republic, report on testing in the past year in line with the UNGASS indicator, while others, such as Greece, report on more frequent testing.

There is a wide variation in the frequency of HIV testing among sex workers. Greece reported that HIV testing every 15 days is mandatory for legal sex workers, while the Netherlands reported that the standard protocol is for sex workers to take an HIV test annually.

There is a considerable variation in reported rates of HIV testing in sex workers, ranging from 5.7% in Azerbaijan to 100% in Greece[303]. Four countries reported testing rates of less than 30%, 15 countries between 30% and 60% and 10 countries more than 60%. However, differences may reflect the methodological issues highlighted above rather than actual differences in testing rates.

Almost all countries reported data on HIV testing in female sex workers, with the exception of Switzerland, which provided data only on testing in male sex workers. No country provided data disaggregated by sex, although Belgium and the Czech Republic refer to male sex workers among sex workers who have been tested.

Two countries, Azerbaijan and Uzbekistan, reported data on HIV testing among sex workers disaggregated by age. Both showed higher rates of testing among sex workers aged over 25.

While most countries did not provide data on trends over time, data reported by Georgia, Turkey and Ukraine showed that rates of testing among sex workers increased between 2005 and 2007[304].

Several countries reported data on HIV testing among specific subgroups of sex workers, for example, male sex workers in Switzerland, ethnic minority and migrant sex workers in France, and indoor and street sex workers in Serbia.

Table 16: HIV testing among sex workers in Europe and central Asia

Country	HIV testing	Year	Comment
Armenia	18%	2007	Compared with 33% in 2005. Source: UNGASS 2008
Azerbaijan	5.7%	2007/8	Age under 25: 3.8%; age over 25: 6.1% in sample of 300 sex workers (53 under 25; 247 over 25). Source: Epidemiological surveillance 2007/8
Belgium	93.8%	2007	Of 1 965 sex workers in the French-speaking community who had ever had a test. Other evidence: the Flemish government works with two NGOs: GhaPro saw 1 057 sex workers in 2008 and did 1 016 HIV tests (3 positive); Pasop saw 677 sex workers in 2007 and did 439 HIV tests (none positive). High turnover of sex workers means not all get tested. Both NGOs see more female than male sex workers.
Bosnia and Herzegovina	96%	2007	Method not harmonised with UNGASS 2008 guidelines. Source: 2008 UNGASS
Bulgaria	53%	2006	Source: 2008 UNGASS
Czech Republic	33%	Not stated	Of an estimated 10 000 sex workers, a third are estimated to have had an HIV test in the last year. The NGO Bliss without Risk tested 1 742 sex workers during a 12-month period, one of whom, a young male, tested positive.
Estonia	52%	2007	Source: 2008 UNGASS
Former Yugoslav Republic of Macedonia	47%	2007	Compared with 67% in 2005. Source: UNGASS 2008
France	35%	2007	Survey of 93 Chinese sex workers in Paris tested in last 12 months. Data only available from studies in cities; a pilot national study in 2010 will provide data on this indicator. Other evidence: 81% of migrant sex workers in Lyon and Toulouse tested in last 12 months in 2004.
Georgia	33%	2007	Compared with 24% in 2005. Source: 2008 UNGASS
Greece	100%		HIV testing every 15 days mandatory for sex workers.
Kazakhstan	70%	2007	Source: 2008 UNGASS
Kyrgyzstan	53%	2007	Source: 2008 UNGASS

[303] HIV testing is mandatory for legal sex workers in Greece.

[304] Data reported by Armenia and the Former Yugoslav Republic of Macedonia showed a decrease in HIV testing rates. Data reported by Romania showed rates were fairly stable.

Country	HIV testing	Year	Comment
Lithuania	50%	2007	Source: 2008 UNGASS
Moldova	31%	2007	Source: 2008 UNGASS
Netherlands	82%		Ever been tested for HIV in anonymous unlinked HIV surveys in sex workers.
Norway	47%	2008	No exact data available. The Oslo harm reduction centre for sex workers did 746 HIV tests in 1 585 clients in 2008 (most female and 79% foreign born). Sex workers get tested frequently. Total number of sex workers in 2008 was 3 246.
Poland	64%	Not stated	Detailed data on this indicator is not available. A study conducted for the National AIDS Centre found that 64% of sex workers had had at least one HIV test.
Romania	35%	2007	Compared with 36% in 2005. Source: UNGASS 2008
Russia	61%	2007	Source: UNGASS 2008
Serbia	45%	2008	139 indoor and street sex workers aged > 15 in Belgrade. Source: Ministry of Health/Integrated Bio-Behavioural Survey (IBBS) conducted as a part of second generation HIV surveillance
Spain	67%	2007	Method not harmonised with UNAIDS 2008 guidelines. Source: UNGASS 2008
Sweden	34%	2007	Method not harmonised with UNAIDS 2008 guidelines. Source: UNGASS 2008
Switzerland	38%	2007	Male sex workers. Source: UNGASS 2008
Tajikistan	29%	2007	Source: UNGASS 2008
Turkey	97%	2007	Compared with 26% in 2005. Source: UNGASS 2008
Ukraine	46%	2007	Compared with 32% in 2005. Source: UNGASS 2008
United Kingdom	70%	1998	48/69 of female sex workers had had an HIV test. Source: Pickton et al, 1998. Other evidence: 68% (59/68) of female sex workers had had an HIV test 1994. Source: Morrison and McGee, 1995
Uzbekistan	19%	2007	Source: UNGASS 2008. Other evidence: 27.9% (age under 25: 24.6%; age over 25: 30.7%) 2007. Source: Surveillance in 2 493 sex workers

2.4.4 HIV programme coverage for sex workers

Just over a third of countries (37%[305]) provided some quantitative data on HIV programme coverage for sex workers, either the percentage or number reached (see Table 17)[306]. Some of the 13 countries[307] reporting that data is not available gave reasons for this[308]. For example, in Germany, data is not collected because HIV prevalence in sex workers has been low. However, there are plans to conduct small surveys on a regular basis among sex workers in future. Latvia reported that there are no HIV programmes targeting sex workers.

Again, the evidence provided by countries was drawn from diverse sources. Reported rates of HIV programme coverage for sex workers in the region vary considerably, from 6% in Azerbaijan to 96% in Moldova[309] and Uzbekistan. Seven of the 18 countries reported coverage of 60% or above and seven reported coverage of below 60%[310].

[305] 18/49.

[306] Countries were asked to respond to a question designed to assess the coverage of HIV programmes for sex workers (disaggregated by age and sex). The relevant UNGASS indicator relates to having received a condom is the past year and knowing where to get an HIV test.

[307] Andorra, Cyprus, Denmark, Estonia, Germany, Georgia, Italy, Latvia, Luxembourg, Malta, Portugal, Slovakia and Slovenia.

[308] Albania, Belgium, France, Iceland, Ireland, San Marino and Turkmenistan provided no information.

[309] The survey in Moldova was conducted in beneficiaries of HIV prevention programmes only. This is likely to explain the apparent high coverage in Moldova. The results are not representative of all sex workers in Moldova.

[310] Four countries (Bosnia and Herzegovina, Croatia, Hungary and Romania) provided data on numbers of sex workers reached by specific programmes, which ranged from 135 to 5 558.

The majority of countries reported programme coverage data for female sex workers. No country reported coverage data for male sex workers, although Hungary provided data on the number of male sex workers reached by an outreach HIV prevention programme.

Two countries, Azerbaijan and Uzbekistan, reported data on HIV programme coverage for sex workers disaggregated by age, which showed slightly higher coverage in those aged over 25 years.

Table 17: Coverage of HIV programmes for sex workers in Europe and central Asia

Country	HIV Programme Coverage	Year	Comment
Armenia	41%	2007	Female sex workers. Source: UNGASS 2008
Azerbaijan	6%	2007/8	Sample of 300 sex workers, age under 25: 3.8%; age over 25: 6.5%. Source: Epidemiological surveillance 2007–2008
Bosnia and Herzegovina	208	2008	Number of female sex workers reached by prevention programmes. Not possible to report percentage covered as size of sex worker population unknown; NGO estimate is 3 500 sex workers.
Bulgaria	77%	2006	Source: UNGASS 2008
Croatia	135	2008	303 reached in 2007.Coverage monitored through monthly reports from two NGOs implementing programmes for sex workers through drop-in centres and outreach, in Zagreb and in Split, which track the number of sex workers and of condoms and educational materials distributed. Source: NGO reports 2008, 2007
Hungary	500	2006	467 female, 33 male sex workers reached January–June 2006. No nationally representative data. Source: MOH screening bus pilot programme
Kazakhstan	71%	2007	Method not harmonised with UNGASS 2008 guidelines. Source: UNGASS 2008
Kyrgyzstan	89%	2007	Method not harmonised with UNGASS 2008 guidelines. Source: UNGASS 2008
Lithuania	43%	2007	Female sex workers. Source: UNGASS 2008
Moldova	96%	2007	Female sex workers. Source: UNGASS 2008. This figure is based on a survey among beneficiaries of harm reduction programmes and is not representative of all sex workers in Moldova.
Romania	5 558 sex workers	2007/9	Number reached by outreach teams July 2007–June 2009. HIV prevention programme targets female street sex workers in nine of 42 counties. Coverage data for the programme, in line with the UNGASS indicator, will be available at the end of 2009.
Russia	39%	2007	Source: UNGASS 2008
Serbia	32%	2008	139 indoor and street sex workers aged > 15 in Belgrade. Source: Ministry of Health/Integrated Bio-Behavioural Survey (IBBS) conducted as a part of second generation HIV surveillance
Sweden	50%	2007	Method not harmonised with UNGASS 2008 guidelines. Source: UNGASS 2008
Tajikistan	60%	2007	Female sex workers. Source: UNGASS 2008
Turkey	42%	2007	Source: UNGASS 2008
Ukraine	69%	2007	Source: UNGASS 2008
Uzbekistan	95.8%	2007	Age under 25: 94.2%; age over 25: 97.2%. Source: DHS 2007

Eleven countries provided qualitative information about programmes for sex workers (see Box 21). These programme examples can be categorised according to:

- The type of services provided, which include dissemination of information about HIV and STI, available services, rights and legal issues, HIV counselling and testing, STI screening and treatment, condom distribution, and social care and support. Some of the programmes cited focus on HIV prevention, for example in the Netherlands and the United Kingdom, while others offer a more comprehensive range of services, for example, in the Czech Republic and the former Yugoslav Republic of Macedonia. Others have a particular focus on rights and legal issues, for example, in Finland and Greece.
- The target group for services, for example, programmes targeting migrant sex workers in Greece and

Norway, sex workers who inject drugs in Greece, male and transgender sex workers in Spain and young sex workers in the United Kingdom.

- The way in which services are delivered. Services are provided by both NGOs and government. For example, NGOs provide services through static centres and outreach activities in the Czech Republic, Finland and Poland. Government provides services through public health services such as STI clinics in Israel and the United Kingdom[311] and through collaboration between local health and social services in the Netherlands.

Box 21: Examples of programmes and services for sex workers

In the **Czech Republic**, several NGOs, which receive support from the National AIDS Programme, work with female sex workers e.g. Jana in Domazlice, Ulice in Plzen, Kotec in Karlovy Vary and Charity in Znojmo. The largest, Bliss without Risk, runs two centres, in Brno and Prague, seven outreach teams covering 10 regions of the country and mobile services in areas where sex workers are concentrated. These NGOs offer HIV testing and STI screening, information, counselling, condoms and social support. One NGO provides similar services to male sex workers.

In **Finland**, the NGO Pro-tukipiste runs social and healthcare services, including outreach services, in Helsinki and Tampere, promotes rights of sex workers and provides information and education on sex work issues. The NGO does not have a specific HIV programme for sex workers, as HIV prevention is included in STI prevention work.

In **Greece**, TAMPEP, an EC-funded project, addresses the needs of migrant sex workers, providing information about HIV and STI, services for sex workers and legal issues relating to sex work and migrants, also via a website. The project monitors sex workers' knowledge about HIV transmission, drug use, HIV testing sites and rights, and collaborates with government and non-government agencies on advocacy for the rights of sex workers and issues such as trafficking. Other NGOs also provide services, e.g. New Life, which conducts outreach programmes and distributes information, and KETHEA, which provides support for sex workers who also inject drugs.

In **Israel**, the Ministry of Health runs a walk-in STI clinic for sex workers and a mobile unit that visits sex trade venues. Medical, nursing and social care services are provided by a community worker, who is a former sex worker, nurse, physician, social worker and volunteers. Condoms, HIV/STI counselling, testing and treatment are free of charge.

In the **Netherlands**, STI AIDS Netherlands (SANL), a national programme, aims at promoting a safe, healthy working environment and informing sex workers about HIV prevention. SANL provides information via the internet, leaflets, brochures, outreach and peer education; promotes national standards through training; and has developed an outreach protocol that is used by social workers and Municipal Health Services. Print materials are produced in 13 languages and the website indeprostitutie.nl has information in Dutch, English and Spanish. Activities are also undertaken, e.g. via the Hepatitis B vaccination campaign. However, sex workers are highly mobile, so it likely that not all are reached.

In **Norway**, HIV programmes are universal but, in practice, not equally accessible to all. Coverage for Norwegian sex workers is good, but reaching the growing number of migrant sex workers, who face language and cultural barriers, is more difficult. Most cities and large towns have centres or NGOs providing services for sex workers; some operate low-threshold clinics, which take a proactive approach, visiting sex workers to offer information, contraceptives, legal and health support. Men who sell sex have access to HIV preventive measures targeting men who have sex with men.

In **Poland**, coverage of HIV programmes for sex workers is not monitored, but a number of NGOs provide services for female sex workers, e.g. TADA works with sex workers in three cities, PARASOL with sex workers in Cracow, and SKA with populations engaged in risk behaviours, including sex workers, in Warsaw.

In **Spain**, data is not collected about coverage, but all regions have targeted HIV prevention programmes for female, male and transgender sex workers. Similarly, in **Switzerland**, coverage data is not collected, but there are many HIV prevention and harm reduction initiatives, at canton and local level, addressing sex workers.

In the **former Yugoslav Republic of Macedonia**, the HIV prevention programme, implemented by NGOs, includes peer education, counselling, outreach and drop-in centres for sex workers in three cities. Services include distribution of condoms, lubricants and educational material, medical, social and legal assistance, support groups and educational workshops, and a place where sex workers can have a meal, take a shower and do their laundry.

In the **United Kingdom**, there were 124 HIV prevention services for sex workers in 2001[312], most aimed at younger sex workers and provided by GUM clinics. Although sex workers are no longer a general priority for HIV prevention work, many sex worker projects continue to provide HIV counselling, testing and support. The numbers of sex workers and of contacts between projects and sex workers is not known.

[311] GUM clinics

[312] Source: Cooper K, Kilvington J, Day S, Ziersch A, Ward H. (2001) HIV prevention and sexual health services for sex workers in the UK. Health Education Journal 60(1):26–34.

2.4.5 HIV-related knowledge of sex workers

Just over half (55%[313]) of countries reported some evidence about HIV-related knowledge of sex workers[314]. Twenty-four countries provided quantitative data (see Table 18) and three provided qualitative information (see Box 22). Sixteen countries[315] reported that data are not available[316]. For example, France reported that no national study has been conducted for several years and this indicator is not explored in local studies.

HIV-related knowledge of female sex workers varies considerably between countries, ranging from 4% in Georgia to 83% in Estonia. The proportion of sex workers who can correctly identify ways of preventing sexual transmission of HIV and reject misconceptions about transmission was below 50% in 15 of the 24 countries that provided quantitative data. However, reported rates of knowledge are higher for individual questions than for the UNGASS indicator, where the overall score depends on answering several questions correctly.

There are differences in levels of knowledge between countries; for example, knowledge is higher in Belgium, the Czech Republic, Estonia, Poland and the United Kingdom than in Georgia, Lithuania, Romania, Serbia, Turkey and Uzbekistan.

Countries reported data on HIV-related knowledge of female sex workers. No country reported data on knowledge among male sex workers. Azerbaijan, Kyrgyzstan and Uzbekistan reported data disaggregated by age.

Table 18: HIV-related knowledge of sex workers in Europe and central Asia

Country	HIV-related knowledge	Year	Comment
Armenia	54%	2007	Female sex workers. Compared with 49% in 2005. Source: UNGASS 2008
Azerbaijan	43.5%	2007/8	Age under 25: 34.2%; age over 25: 45.3% in sample of 300 sex workers. Source: Epidemiological surveillance 2007–2008
Belgium	68.4–96.9%	2007	96.9% knew the risk of HIV transmission through vaginal sex; 88.1% knew the risk of HIV transmission through fellatio with ejaculation; 68.4% knew the risk of HIV transmission through fellatio without ejaculation; 87.6% knew the risk of HIV transmission through anal intercourse. Source: Survey of 193 sex workers in the French-speaking community
Bosnia and Herzegovina		Not stated	Sample of 146 sex workers. Source: Bio-Behavioural Surveillance
Bulgaria	35%	2006	Female sex workers. Source: UNGASS 2008
Croatia	37% (Zagreb) 43% (Split)		Correctly answered six questions about modes of HIV transmission and ways to prevent transmission. One study of female sex workers in Zagreb (n=65) and Split (n=89). 24.5% (Zagreb), 12.4% (Split) did not know the correct answer when asked if a person who looks healthy can have HIV; 16.9% in Split when asked if HIV can be transmitted by needle sharing. Formal education positively associated with HIV knowledge. Source: Stulhofer et al 2009
Czech Republic	90%	Not stated	Female sex workers. While 90% have correct knowledge about HIV and STI, 30% think that a healthy-looking person cannot have HIV.
Estonia	83%	2007	Female sex workers. Method not harmonised with UNGASS 2008 guidelines. Source: UNGASS 2008
Former Yugoslav Republic of Macedonia	47%	2007	Compared with 10% in 2005. Source: UNGASS 2008
Georgia	4%	2007	Female sex workers. Compared with 1% in 2005. Source: UNGASS 2008
Kazakhstan	63%	2007	Female sex workers. Source: UNGASS 2008

[313] 27/49.

[314] Countries were asked to respond to a question, in line with UNGASS, designed to measure the percentage of sex workers—disaggregated by age and sex—who can correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission.

[315] Andorra, Cyprus, Denmark, Finland, France, Germany, Hungary, Italy, Latvia, Luxembourg, Malta, Portugal, Slovakia, Slovenia, Spain and Switzerland.

[316] Albania, Iceland, Ireland, Israel, San Marino and Turkmenistan provided no information.

Country	HIV-related knowledge	Year	Comment
Kyrgyzstan	36%	2007	Female sex workers. Compared with 1% in 2005. Source: UNGASS 2008. Other evidence: age under 25: 38.4%; age over 25: 49.7%. Source: Epidemiological surveillance 2008
Lithuania	24%	2007	Female sex workers. Source: UNGASS 2008
Moldova	58%	2007	Female sex workers. Compared with 35% in 2005. Source: UNGASS 2008. This figure is based on a survey among beneficiaries of harm reduction programmes and is not representative of all sex workers in Moldova.
Poland	27–97%	2003	68% said only having one faithful and healthy sexual partner can protect against AIDS; 27% you can get infected by being bitten by a mosquito; 97% you can get infected by using a needle after someone else; 96% knew about MTCT. Data only available for female sex workers. Source: Izdebski Z, 2003
Romania	14%	2007	Female sex workers. Compared with 14% in 2005. Source: UNGASS 2008
Russia	36%	2007	Source: UNGASS 2008
Serbia	15%	2008	Sample of 139 indoor and street sex workers aged > 15 in Belgrade. Source: Ministry of Health/Integrated Bio-Behavioural Survey (IBBS) conducted as a part of second generation HIV surveillance
Sweden	46%	2007	Source: UNGASS 2008
Tajikistan	41%	2007	Female sex workers. Source: UNGASS 2008
Turkey	22%	2005	
Ukraine	48%	2007	Female sex workers. Compared with 80% in 2005. Source: UNGASS 2008
United Kingdom	> 80–> 90%	2006/7	> 80% correct response to whether a person could be infected with HIV by sitting on toilet seats, eating food prepared by a PLHIV, or kissing someone with HIV; > 90% agreed HIV can be prevented by consistent condom use in survey of 156 female sex workers in Greater Manchester. Source: Yin Z, 2009.
Uzbekistan	27%	2007	Age under 25: 24.3%; age over 25: 29.2%. Source: DHS 2007

Box 22: HIV-related knowledge of sex workers

In **Greece**, information is only available from the TAMPEP questionnaire sent to government and non-government organisations working with sex workers. A summary of data from four NGOs shows that the knowledge of Greek and legal sex workers about HIV is good. Data is not available on the HIV knowledge of migrant and illegal sex workers. More studies of sex work, given the issues of migration and trafficking in Greece, are required.

In the **Netherlands**, an evaluation of the brochures 'Safe Sex' and 'A–Z' showed that sex workers' knowledge about prevention of HIV, STI and pregnancy was high. However, the HIV surveys in Rotterdam, The Hague and Amsterdam, found higher condom failure among street sex workers, including transgender sex workers. In response, SANL developed an instruction leaflet for sex workers on appropriate condom usage.

In **Norway**, high rates of condom use among Norwegian, African and Asian sex workers indicate sound knowledge of HIV transmission and prevention (see also Box 23).

2.4.6 Condom use by sex workers

Almost two thirds (65%[317]) of countries reported some data about condom use by sex workers[318]. This was more than reported on other indicators relating to sex workers. Twenty-eight countries provided quantitative data (see Table 19) and four provided qualitative information (see Box 23). Eleven countries[319] reported that data on this indicator is not available[320]. Data reported differs between countries. While some countries reported in line with the UNGASS indicator, i.e. condom use at last sex, others, for example, Belgium, the Netherlands, Spain and the United Kingdom, reported on consistent condom use.

Condom use by female sex workers, based on data reported on the relevant UNGASS indicator, ranges from 20% in Sweden to 97% in Kazakhstan. With the exception of Sweden (22%), Turkey (33%) and Poland (46%), all countries reported condom use rates by sex workers of 70% or above.

Relatively few countries reported on condom use by male sex workers—Armenia, Hungary, Spain, Sweden, Switzerland and the former Yugoslav Republic of Macedonia—or by transgender sex workers—Italy, the Netherlands and Spain.

Azerbaijan and Uzbekistan provided data disaggregated by age, which showed relatively little difference in rates of condom use between sex workers aged under and over 25 years.

Data provided by Belgium, Bosnia and Herzegovina, Hungary, Spain and the United Kingdom suggests that female sex workers are less likely to use condoms with clients for oral sex than for vaginal or anal sex. Data from Hungary, the Netherlands, Spain and the United Kingdom show lower rates of consistent condom use with regular partners than with clients. Data reported by the Netherlands show lower rates of condom use by sex workers who also inject drugs. This is supported by qualitative information reported by the Czech Republic.

The Czech Republic commented on the impact of the economic crisis and the potential for competition for clients to increase pressure on sex workers to have unprotected sex. Norway also highlighted client demand for unprotected sex and the increased vulnerability of some sex workers in a legal environment that now criminalises the purchase of sex.

Table 19: Condom use by sex workers in Europe and central Asia[321]

Country	Condom use	Year	Comment
Armenia	91%	2007	Female sex workers. Compared with 89% by female sex workers in 2005. Source: UNGASS 2008
Azerbaijan	74.7%	2007/8	Female sex workers. Age under 25: 79.2%; age over 25: 73.7%. Source: Epidemiological surveillance 2007–2008
Belgium	59–98%	2008	33/38 sex workers who had anal sex always used a condom; 64/109 who had oral sex always used a condom; 93/95 who had vaginal sex always used a condom in survey of 119 sex workers on use of condoms conducted by GhaPro. This type of survey is no longer used because of the difficulty of evaluating whether the answer is right.
Bosnia and Herzegovina	36.2–75.7%	Not stated	36.2% reported using a condom during the last oral sex; 75.7% reported using a condom during the last vaginal sex; 58.2% reported using a condom during the last anal sex in sample of 146 sex workers. Source: Bio-Behavioural Surveillance
Bulgaria	95%	2006	Female sex workers. Source: UNGASS 2008
Croatia	86%	2007	Data collection started before 2005. Source: UNGASS 2008
Estonia	94%	2007	Female sex workers. Source: UNGASS 2008
Former Yugoslav Republic of Macedonia	78%	2007	93% male; 75% female. Compared with 86% (88% male; 84% female) in 2005. Source: UNGASS 2008
Georgia	94%	2007	Female sex workers. Compared with 95% in 2005. Source: UNGASS 2008

[317] 32/49.

[318] Countries were asked to respond to a question in line with the UNGASS indicator designed to measure the percentage of sex workers—disaggregated by age and sex—who report using a condom with their most recent client.

[319] Andorra, Cyprus, Denmark, Finland, France, Latvia, Luxembourg, Malta, Portugal, Slovakia and Slovenia.

[320] In addition, Albania, Iceland, Ireland, Israel, San Marino and Turkmenistan provided no information.

[321] For UNGASS 2008 data: report date 2007, but data collection can vary from 2005 to 2007.

Country	Condom use	Year	Comment
Hungary	16–90%	2006	Condom use by 500 sex workers (467 female, 33 male) reached January–June 2006: vaginal sex: use/not use 451/21; anal sex: use/not use 451/35; oral sex: use/not use 290/196; private life: use/not use 82/404. National data not collected and there are no available, representative data on condom use by sex workers. Source: MOH screening bus pilot programme 2006
Italy	97% (female) 38% (transgender)	1998	Reported condom use in the last week in survey of 102 female and 40 transgender sex workers 1998. Source: Verster et al 2001
Kazakhstan	97%	2007	Female sex workers. Source: UNGASS 2008
Kyrgyzstan	84%	2007	Female sex workers. Compared with 81% in 2005. Source: UNGASS 2008
Lithuania	77%	2007	Female sex workers. Source: UNGASS 2008
Moldova	93%	2007	Female sex workers. Compared with 98% in 2005. Source: UNGASS 2008. This figure is based on a survey among beneficiaries of harm reduction programmes and is not representative of all sex workers in Moldova.
Netherlands	11–81%	2008	Always use condoms with clients: 81%; always use condoms with a steady partner: 11%; in cross-sectional study among 557 female and transgender sex workers in three cities. Transgender sex workers and sex workers who inject drugs use condoms less frequently. Source: Van Veen et al 2008
Poland	46%	2007	Female sex workers. Figures reflect data collection that started before 2005. Source: UNGASS 2008
Romania	85%	2007	Female sex workers. Compared with 85% in 2005. Source: UNGASS 2008
Russia	92%	2007	Female sex workers. Compared with 77% in 2005. Source: UNGASS 2008
Serbia	91%	2008	Sample of 139 indoor and street sex workers aged 15+ in Belgrade. Source: Ministry of Health/Integrated Bio-Behavioural Survey (IBBS) conducted as a part of second generation HIV surveillance
Spain	12.4–95.5% (female) 10.4–100% (transgender) 97% (male)	Not stated	Female sex workers: 95.5% consistent condom use in vaginal sex and 87.2% consistent use in anal sex with clients; 12.4% consistent condom use with regular partners. Transgender sex workers: 100% consistent condom use in anal sex (insertive and receptive penetration) and 77.2% consistent condom use in oral sex with clients; 29.5% consistent condom use in insertive penetration, 30.6% in receptive penetration and 10.4% in oral sex with regular partners. Male sex workers: 97% consistent condom use in anal sex with clients.
Sweden	22%	2007	100% male; 20% female. Source: UNGASS 2008
Switzerland	72%	2007	Male sex workers. Source: UNGASS 2008
Tajikistan	75%	2007	Female sex workers. Source: UNGASS 2008
Turkey	33%	2005	Source: UNGASS 2008
Ukraine	86%	2007	Female sex workers. Compared with 80% in 2005. Source: UNGASS 2008
United Kingdom	44-98%	1996/2002	98% reported consistent use of condoms for vaginal sex, 66% for oral sex, 94% for anal sex with clients; and 44% for sex with non-commercial partners in study of female sex workers registering at a London GUM clinic 1996–2002. Source: Ward et al, 2004
Uzbekistan	74.8%	2007	Age under 25: 77%; age over 25: 73%. Source: DHS 2007 Other evidence: 65%. Source: UNGASS 2008

Box 23: Condom use among sex workers

In the **Czech Republic**, use of condoms by sex workers with clients is generally very high (although sex workers who inject drugs are less likely to use condoms consistently), but very low with regular partners. The economic crisis has reduced the number of clients and competition for clients may result in some sex workers agreeing to unprotected sex—93% report that clients have requested unprotected sex and 50% have been asked regularly for unprotected sex.

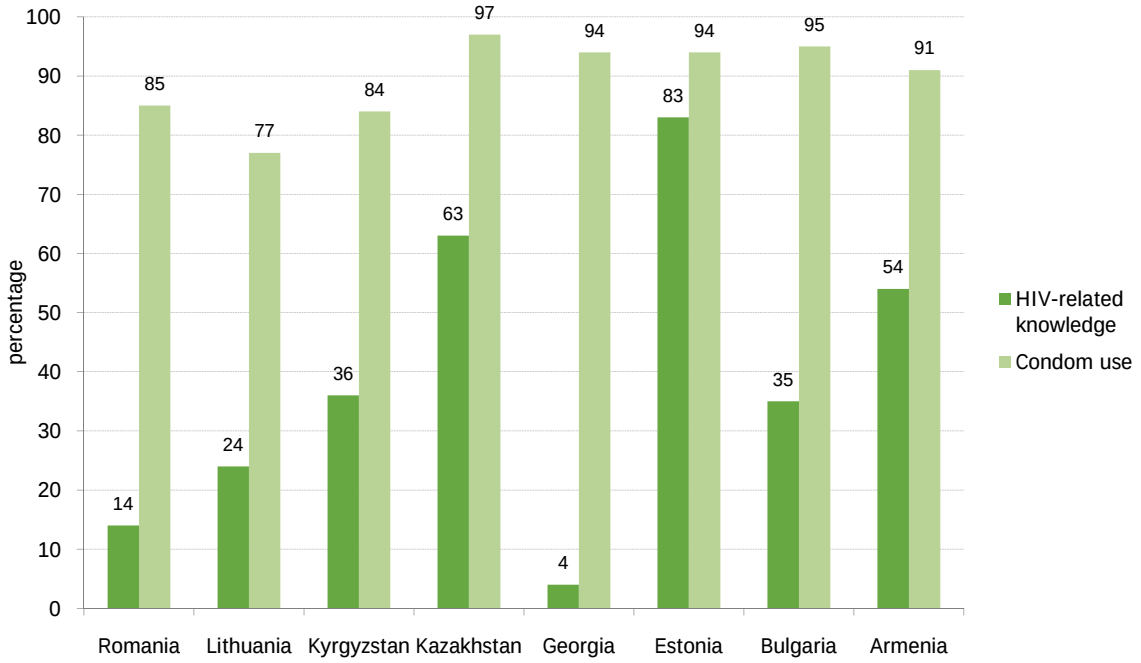
In **Germany**, it is assumed that a high proportion of sex workers use condoms consistently with clients, although data is not currently collected. However, there is evidence that knowledge about HIV and STI among female sex workers in brothels and clubs has decreased significantly in recent years and that competition in the sex trade has resulted in a decrease in condom use. To address this, Deutsche AIDS-Hilfe started a pilot programme in 2008 to provide on-site training for female sex workers.

In **Greece**, NGO responses to the TAMPEP questionnaire—the only information available—indicate high rates of condom use by legal national and migrant sex workers.

In **Norway**, rates of condom use with clients are high, the incidence of Chlamydia is lower among sex workers than among the general population, and rates of hepatitis B and C have declined. Anecdotal reports suggest that the implications of non-use of condoms are not fully understood. One misconception, particularly among African sex workers, is that two condoms are better than one. Social workers report that sex worker attitudes towards safe sex and condom use may differ with respect to clients, regular customers and partners, with less consistent use with regular customers and partners. Some sex workers report that clients offer to pay more for sex without a condom. Although no evidence is available, some sex workers, particularly African women, are thought to be having unprotected sex due to increased vulnerability in negotiation following the introduction of the General Civil Penal Code in 2009, which criminalises the purchase of sex.

Reported data (Figure 30) shows that there is little correlation between reported levels of HIV-related knowledge, which are relatively low, and reported rates of condom use with clients, which are generally high[322]

Figure 30: Levels of HIV-related knowledge and condom use among sex workers reported by countries in Europe and central Asia



2.4.7 Conclusions

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

[322] Figure 29 includes examples of countries that provided data on both indicators. The only exception to this pattern was Sweden, where reported knowledge was higher than the reported rate of condom use.

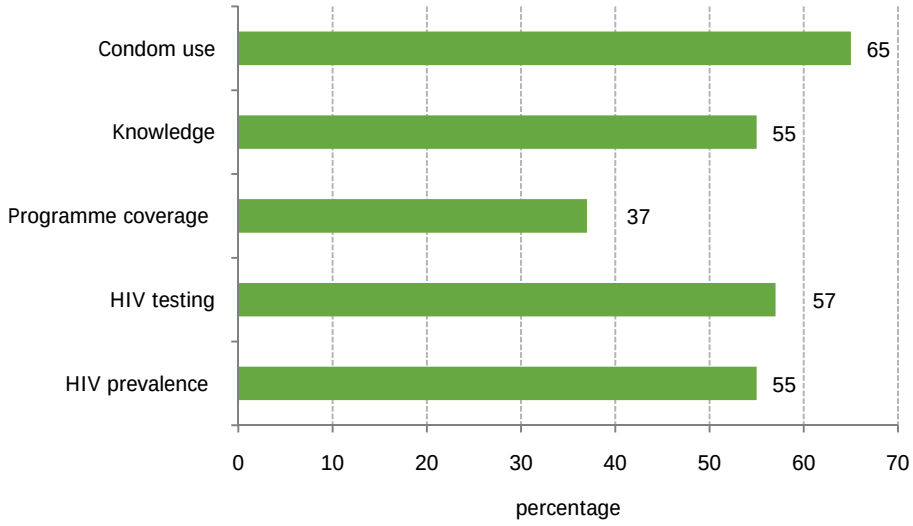
priority in their national response to HIV. The fact that reported HIV prevalence in sex workers exceeds 1% in 14 countries is, however, of concern.

Reported data also suggests that HIV prevalence is higher among specific subgroups 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 in 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 in sex workers from countries with generalised epidemics.

However, data about prevalence in these specific groups of sex workers is very limited. Likewise, there is limited data about 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 31).

Figure 31: 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, HIV prevention programme coverage 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 an overlap between sex work and injecting drug use. Less is known about coverage among specific subgroups 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 relates to female sex workers and less is known with respect to these indicators in male sex workers, transgender sex workers or other subgroups of sex workers.

The disparity between HIV-related knowledge and condom use (see Figure 30) 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 suggests 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.

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 2.5), and male and transgender sex workers.

In conclusion, ECDC has identified the following issues needing 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 subgroups 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 rapidly changing 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

2.5.1 Introduction

The links between migration and HIV are complex and contested. It has been argued that people moving from countries with high HIV prevalence can result in HIV transmission in countries with lower prevalence. This has sometimes led to migrants being blamed and stigmatised for bringing HIV to a country. It has also been argued that migrants and mobile populations may be more vulnerable to HIV transmission because of behaviours adopted and more limited access to services than host populations. Issues relating to access to services are not only relevant with respect to prevention but also for critical treatment, care and support for migrants and mobile populations living with HIV.

International monitoring systems, such as that used by UNAIDS to monitor the implementation of the UNGASS Declaration of Commitment, do not have indicators focused on migrants. As a result, this review developed its own questions and indicators based on UNGASS indicators and NCPI questions used for other subpopulations.

This section explores the extent to which countries consider migrants to be an important subpopulation with respect to HIV. It considers different terminology and definitions regarding migrants, before reviewing available data on the size of migrant populations in different countries. It then reviews evidence provided by countries of the extent to which different populations of migrants are particularly affected by HIV and considers issues relating to availability of HIV-related services for migrants. It concludes by considering how HIV responses for migrants are monitored.

2.5.2 Importance of migrants in responses to HIV

Of 49 countries responding, 29 (59%) indicated that migrants are considered an important subpopulation in the national response to HIV (see Figure 32). This represents almost three quarters (72%[323]) of EU/EFTA countries that responded but under half (40%[324]) of other countries[325]. Within the EU/EFTA, countries in the central and eastern part of the region were less likely to consider migrants an important subpopulation in the national response to HIV[326] than those in the western part.

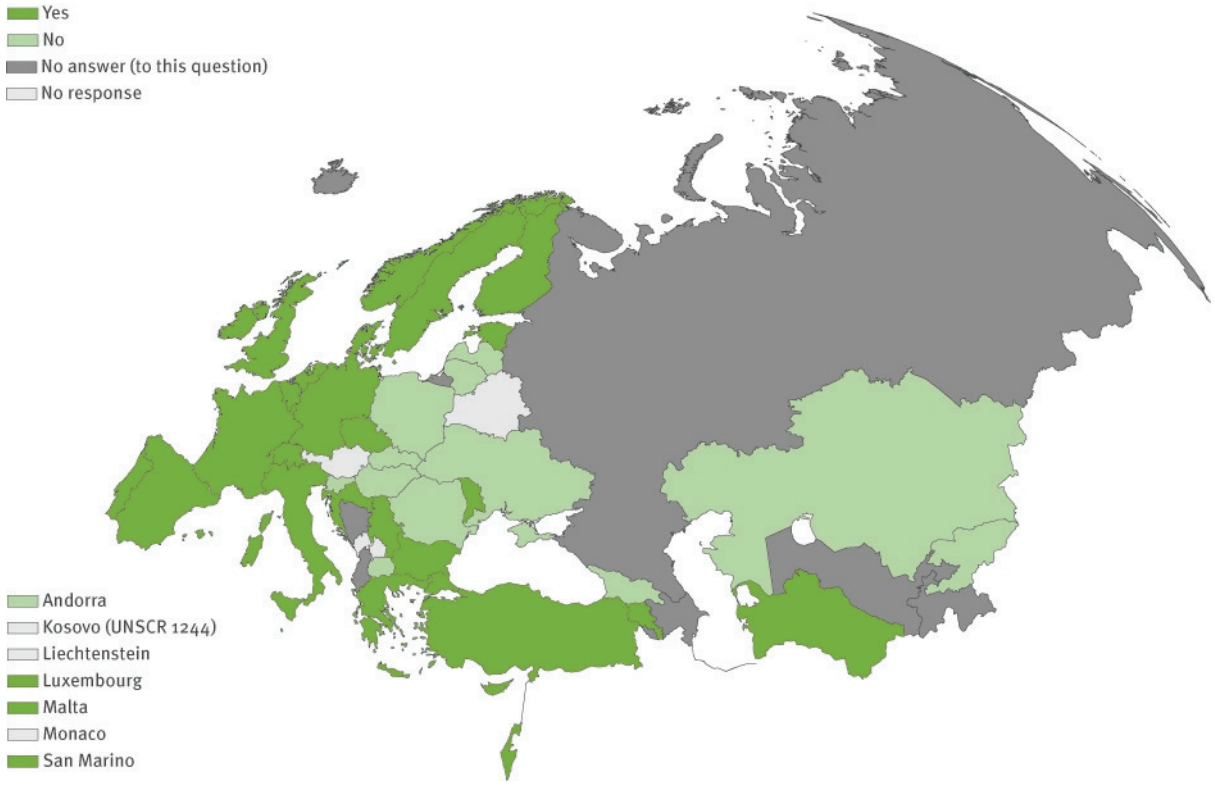
[323] 21/29.

[324] 8/20.

[325] Non-EU/EFTA countries that consider migrants an important subpopulation in the national response to HIV are Armenia, Croatia, Israel, Moldova, San Marino, Serbia, Turkey and Turkmenistan.

[326] EU/EFTA countries that do not consider migrants an important subpopulation in the national response to HIV are Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia. Iceland did not respond to this question.

Figure 32: Map showing the extent to which countries identify migrants as an important subpopulation in the national response to HIV and AIDS



Almost half (47%[327]) of the countries responding reported that the term 'migrant' was used to identify a specific subpopulation in the national response to HIV (see Table 20). Of the 29 countries that identified migrants as an important subpopulation in their national response to HIV, almost two thirds (62%[328]) used the term 'migrant' to identify a specific subpopulation in their national response. However, over one third (38%[329]) did not. Almost three quarters (73%[330]) of these countries used other terms[331]. Surprisingly, a quarter[332] (25%[333]) of countries that did not report migrants as an important subpopulation in their national response to HIV still used the term 'migrant' to identify a subpopulation in their national response. Almost half (47%[334]) of countries responding reported using a term other than 'migrant' in relation to the same population.

Table 20: Correlation between the perceived importance of migrants in the national response to HIV and the use of the term 'migrant' to identify a specific subpopulation in that response

		Is the term 'migrant' used to identify a specific subpopulation in the national response to HIV?	
		Yes	**No**
Are migrants an important subpopulation in the national response to HIV?	**Yes**	18	11
	No	5	15

[327] 23/49.

[328] 18/29.

[329] 11/29. Turkmenistan did not respond to this question.

[330] 8/11.

[331] Three countries (Belgium, San Marino and Turkmenistan) that identified migrants as an important subpopulation in their national response to HIV did not answer the question about whether they used the term 'migrant' to identify a subpopulation within their national response to HIV. In commenting on the report, Belgium clarified that they use the terms 'migrant' and 'sub-Saharan migrant'.

[332] Five countries, namely Kazakhstan, Lithuania, Poland, Romania and the Former Yugoslav Republic of Macedonia.

[333] 5/20.

[334] 23/49.

2.5.3 Terminology and definitions

Country responses show that the term 'migrant' is used quite loosely and that range of other terms are used to refer to the same group(s) of people. Some countries, for example, Malta, commented that they did not use the term 'migrant' because it is considered too 'loose'. Terms used in country responses included:

- **Foreigners or foreign citizens**, including those with permanent or long-term residence and those with work/study permits. In some cases, countries refer to people 'originating' from other countries. In the case of some EU Member States, for example Greece, nationals of other Member States are excluded from the category of migrants. In some countries, for example Ukraine, people without citizenship were identified.
- **Immigrants**, who can be first or second generation[335]. Such people may have immigrated to the host country for a variety of reasons, including work or study.
- **Emigrants**, i.e. those leaving the country. Although countries of Western Europe are mainly focused on migrants, in terms of those coming to the country, other countries, such as Croatia and Moldova, are more focused on their own citizens migrating to other countries.
- **Mobile populations**, including truck drivers, merchant navy sailors, migrant workers and soldiers on international peacekeeping missions.
- **Ethnic minorities**, including the Russian-speaking minority in Estonia (see Box 24) and the Roma population in Serbia and other countries.

Box 24: Ethnic Russians in Estonia

Estonia has two main ethnic/linguistic communities. Ethnic Estonians comprise 69% of the population and ethnic Russians, 26%. In 1991, following independence from the USSR, Estonia decided that only those who were citizens of Estonia prior to 1940, and their descendants, would automatically be recognised as Estonian citizens. This meant that a large number of Russian-speakers living in Estonia in 1991 did not automatically qualify for citizenship, even if they had been born in Estonia, as they or their families could not claim to have been citizens before 1940.

Ethnic Russians are not considered 'migrants' as such, although they or their parents did 'migrate' from other parts of the Soviet Union when that was administered as a single country. Estonia does not collect data on nationality/ethnicity in its HIV routine surveillance. However, this information is included in research studies and the language in which interviews are conducted is routinely recorded.

In addition, there are specific terms that are applied to specific subgroups of migrants including:

- asylum seekers and asylum grantees;
- refugees and displaced people;
- internally-displaced people[336];
- foreigners in detention centres and prisons;
- people reunited with family members;
- undocumented or illegal migrants;
- women victims of trafficking and transnational sex workers.

In several cases, countries focus on migrants from regions with high levels of HIV prevalence, such as some countries of sub-Saharan Africa, south-east Asia and the Caribbean.

When asked how they define migrants, countries report widely-divergent definitions depending on their context[337]. Four key elements form part of those definitions:

- **Who?** Countries variously define migrants according to their place of origin, place of birth or citizenship.
- **Where?** Although most countries consider migrants to be people originating from other countries who have come to their country, several countries[338] consider their own citizens to be migrants if they spend considerable time abroad[339].

[335] For example, in Denmark, a first generation immigrant is defined as someone living in Denmark but born in another country. A second generation immigrant is someone born in Denmark but whose parents were both born outside Denmark.

[336] Reported by both Serbia and the Former Yugoslav Republic of Macedonia.

[337] Some countries referred to United Nations (Poland) and International Organization for Migration (IOM) (Romania) definitions of migration. However, IOM reports that no universally accepted definition of migration exists (IOM, 2008). IOM's own definition focuses strongly on voluntary migrants as opposed to refugees or asylum seekers.

[338] Some countries, e.g. Armenia, Croatia, and Kyrgyzstan only focus on this group as migrants. Others, e.g. Bulgaria, Ireland, Kazakhstan, and Moldova consider this group in addition to other groups of migrants.

[339] Three months for Armenia and one month for Moldova.

- **What?** In some cases, countries' definitions of migrants include an element of behaviour, such as 'settling' or 'developing significant social ties'. In others, the term migrant embraces populations that move or are mobile within a particular country[340]. In some cases[341], migrants are considered to be those who have moved voluntarily to a country, as opposed to those who have been subject to an external compelling factor, such as refugees and asylum seekers. However, many countries regard refugees and asylum seekers as a specific subset of migrants.
- **When?** Some countries have definitions of migrants that include a minimum time period, to exclude tourists and other visitors. For example, Armenia and Moldova consider someone a migrant if they have been out of the country for a specified period[339] in the last three years. Croatia considers migrants to be those who have moved permanently[342] to another country. Luxembourg excludes foreigners who 'migrate' to work daily. Poland and Portugal count those permanent residents[343]/citizens[344] of other countries residing in the country for more than a specified period[345].

Precise definitions may vary within a country depending on what the definition is being used for (see Box 25).

Box 25: Definitions of migrants vary according to purpose

In **France**, migrants are defined for demographic purposes as those born 'as foreigners' in a foreign country, i.e. those born to French parents outside France would not be considered migrants. However, for the purpose of HIV surveillance, migrants are defined only by the country of birth.

In **Germany**, migrants are defined for the purpose of HIV surveillance as people originating from countries other than Germany. However, for HIV prevention work migrants are considered to be both first and second generation immigrants.

2.5.4 Size of migrant populations

Almost two thirds (65%[346]) of countries[347] responding reported that they had figures available for the size of their migrant populations (see Table 21). Almost all (83%[348]) countries that reported that migrants were an important subpopulation in the national response to HIV reported having figures available for the size of their migrant populations[349]. In addition, over a third of countries (40%[350]) that did not report that migrants were an important subpopulation in the national response to HIV reported having figures available for the size of their migrant populations[351].

Table 21: Correlation between the perceived importance of migrants in the national response to HIV and the availability of data on the size of the migrant population

		Is data available on the total number of migrants in your country?	
		Yes	**No**
Are migrants an important subpopulation in the national response to HIV?	**Yes**	24	5
	No	8	12

[340] However, this is considered problematic by some countries, e.g. Serbia, because migration of communities which may be considered 'mobile', e.g. the ethnic Roma population, is at a very low level.

[341] E.g. IOM, 2008 and the Former Yugoslav Republic of Macedonia.

[342] Defined as at least one year.

[343] Poland.

[344] Portugal.

[345] Two months for Poland and one month for Portugal.

[346] 32/49.

[347] All of these, apart from Kyrgyzstan and San Marino, provided figures (see Table 22).

[348] 24/29.

[349] The five countries who did not report having figures available for the size of their migrant population are Armenia, Cyprus, Serbia, Turkey and Turkmenistan.

[350] 8/20.

[351] The eight countries who reported having figures available for the size of their migrant population are Hungary, Kyrgyzstan, Latvia, Poland, Romania, Slovenia, the Former Yugoslav Republic of Macedonia and Ukraine.

Table 22 shows figures for the size of migrant populations reported by countries. Of those reporting, almost all (83%[352]) reported cumulative figures for their total migrant[353] population, i.e. the number of migrants living in the country at a particular time. Three countries[354] reported the annual inflow of all migrants and three countries[355] reported only on particular groups of migrants. Although figures are not directly comparable and cannot be aggregated across the region, it is clear that these numbers represent a large population, particularly in the large countries of Western Europe, such as France and Germany. In most cases, figures exclude undocumented migrants, although in some countries, e.g. the Czech Republic, these have been estimated.

In addition, many countries disaggregate their data regarding migrants by sex (24 countries), country of origin[356] (23) and age (22). Other disaggregated data collected in some countries includes legal status, other demographics[357], education level, the situation in host country[358], the reason for application and the last country of previous residence.

Table 22: Reported number of migrants in European and central Asian countries

Country	Number	Cum	Inflow	Comment
Countries reporting cumulative figures for all migrants[359]				
Belgium	97 1448	✓		Non-Belgians in 2008
Bulgaria	55 684	✓	✓[360]	2006 figures for foreigners as permanent residents
Croatia	30 000	✓		2009 figures for immigrants. Also figures for seafarers, construction workers and truck drivers
Czech Republic	438 000	✓		2008 figures. 4% of population. Estimated 50 000–200 000 undocumented migrants
Denmark	450 000	✓		Estimated 8% of population
Estonia		✓		26% of population were ethnic Russians[361,362] in 2008
Finland	143 256	✓		2008 figures[363]
France	4 959 000	✓		2005 figures. 8.1% of total population
Germany	15 411 000	✓		People with a migrant background living in Germany—total population: 82 257 000
Greece	563 625	✓		Legal migrants
Hungary	216 084	✓		2009 figures. Number of immigrants, persons with permanent residence permit and staying longer than three months. This number includes: third country nationals, EU nationals, refugees and beneficiaries of subsidiary protection
Ireland	420 000	✓		Foreign nationals
Italy	3 891 295	✓		Out of population of 60 045 068
Latvia	33 055	✓		Permanent residents at end 2007[364]. Also figures for temporary residents and for end 2006

[352] 24/29.

[353] Although this term was defined differently between countries.

[354] Luxembourg, Moldova and the United Kingdom.

[355] Israel reported on work immigrants. Malta reported on asylum seekers. The Former Yugoslav Republic of Macedonia reported on asylum seekers and internally-displaced people.

[356] Or in some cases country of birth or citizenship.

[357] Such as marital status.

[358] Such as region of residence, economic activity.

[359] Note that definitions used vary from country to country so figures are not directly comparable.

[360] Bulgaria also provided figures for the annual inflow of migrants into the country.

[361] Where countries reported percentages only, it would be possible to calculate the absolute number from population statistics. However, as these tables contain only data reported by countries, this has not been done. Similarly, percentages are only given where they have been supplied by countries.

[362] It should be noted that ethnic Russians are not considered migrants in Estonia – see Box 24.

[363] 2007: 132 708.

[364] Over three quarters of these (78%) are from Russia.

Country	Number	Cum	Inflow	Comment
Netherlands	approx. 3 100 000	✓		2007 figures. 1.7 million are non-Western, mainly from Suriname and Dutch Antilles.
Norway	508 000	✓		Includes immigrants and people with migrant background
Poland	15 300	?	?[365]	Increasing inflow of illegal migrants but no data available on numbers
Portugal	approx. 500 000	✓		4% of Portuguese population
Romania	133 441	✓		Legally registered migrants
Slovenia		✓		At the end of 2006, 2.7% of people had the status of foreigners, while 11.3% of the population had been born abroad[361]
Spain		✓		2008 figures, 11.4% of population[361]
Sweden	1 200 000	✓		1.2 million of 9 million inhabitants born outside Sweden. In addition, 3% of the population have two parents born abroad and 6% have one parent born abroad
Switzerland		✓		21% of population does not have Swiss passport[361]
Ukraine	160 000	✓		Permanent residents in Ukraine
Countries reporting annual inflow figures for all migrants				
Luxembourg	16 675		✓	2007 figures. Also figures for emigration
Moldova	13 973		✓	Also figures for emigrants, national truck drivers and trafficked women
United Kingdom	577 000		✓	2007 figures
Countries reporting figures for particular subgroups of migrants				
Former Yugoslav Republic of Macedonia	1 670	?	?[365]	Asylum seekers from Bosnia and Kosovo. Also figures for internally displaced people
Israel	150 000	✓		Work immigrants. In addition, about 35% of the Israeli population was born elsewhere
Malta	3 489	✓		Asylum seekers in open and closed centres

2.5.5 Evidence that migrants are particularly affected by HIV

Countries were asked to provide evidence of the extent to which migrants are disproportionately affected by HIV in their countries. Responses are presented in Table 23.

Seventeen countries[366] provided evidence that migrants from countries with generalised HIV epidemics are disproportionately affected by HIV in their countries[367],[368] (see Table 23/Figure 33). Although this evidence takes a variety of forms, it provides compelling evidence that migrants from countries with generalised HIV epidemics are disproportionately affected by HIV, especially in the western parts of Europe.

Two countries, the Czech Republic and the United Kingdom, presented evidence that people from other European countries[369] are disproportionately affected by HIV (See Table 23/Figure 33). Estonia also presented evidence that ethnic Russians are disproportionately affected by HIV. However, this evidence relates specifically to IDU[370] so it can be concluded that this issue is more related to injecting drug use than migration. For example, there is no

[365] In some country reports, it was unclear whether figures were cumulative or the annual inflow.

[366] In addition, Turkey provided some comments regarding unregistered sex workers but did not provide quantitative or qualitative evidence that these are more affected by HIV.

[367] Of these, all but two (Malta and Switzerland) provided quantitative data.

[368] These tally quite closely with countries reporting that migrants are considered an important subpopulation in the national response to HIV (see Figure 32). Of countries reporting that migrants were considered an important subpopulation in the national response to HIV, a few reported having no data (e.g. Ireland) or no evidence (e.g. Portugal, Turkmenistan) on whether migrants were disproportionately affected by HIV.

[369] This includes ethnic Russians in Estonia.

[370] At least in the case of Estonia and the United Kingdom.

evidence that people from a particular European country who do not inject drugs are disproportionately affected by HIV in another country[371].

Croatia reported that more than half of all documented HIV infections had occurred outside the country, particularly among seamen. Moldova reported that the HIV prevalence of national migrants leaving the country was lower than those returning (see Table 23/Figure 33). Although the data from Moldova might be evidence of these migrants becoming infected with HIV while outside the country, an alternative explanation might be differences in testing practice[372].

Finally, no country presented any evidence that any particular mobile population, for example, the Roma population, was disproportionately affected by HIV in their country.

Table 23: Evidence that HIV disproportionately affects migrants in Europe and central Asia

Country	Evidence
Countries presenting evidence that migrants from countries with generalised epidemics are disproportionately affected by HIV	
Belgium	From the beginning of the epidemic to 2007, 60.1% of 14 804 PLHIV with known nationality were non-Belgian. From 2005–2007, 70% of 1 350 non-Belgians with reported nationality were from sub-Saharan Africa.
Denmark	The rate of HIV infection among immigrants (1 in 400) is higher than in ethnic Danes (1 in 1 250).
Finland	In 2007, foreign citizens accounted for 30% of newly-diagnosed PLHIV and, in 2008, for 42%. Foreign citizens accounted for 2.5% of the population in 2007 and 2.6% in 2008.
France	In 2008, 48% of newly-diagnosed PLHIV were born outside France. The percentage was higher for women (75%) than men (35%). Rate of new diagnoses was 6/100 000 in the population born in France, 62/100 000 in the population born outside France and 372/100 000 in the population born in sub-Saharan Africa.
Germany	People from high-prevalence regions count for 0.3% of the population but about 13% of HIV diagnoses.
Greece	Of 2 118 people infected through heterosexual contact, 35.2% were persons who lived in or originate from countries with a generalised epidemic.
Israel	People originating from 'endemic' countries, particularly Ethiopia, represent 50% of all PLHIV.
Italy	In 2007, the HIV incidence[373] among migrants was 11 times higher than among Italians.
Luxembourg	In 2008, 21 of 68 newly-diagnosed PLHIV originated from sub-Saharan Africa.
Malta	The majority of new HIV cases are recorded among migrants from areas of high HIV prevalence.
Netherlands	Women from sub-Saharan Africa (456) constituted 60% of all newly-diagnosed women with HIV in 2008.
Norway	Of all infections reported, around one third have migrant backgrounds. In 2008, there were 139 newly-diagnosed cases in people infected prior to arriving in Norway (92 women and 47 men). 108 originated from Africa, most from East Africa. Thai women, entering Norway through marriage with Norwegian men, accounted for 14 new cases in 2008.
Spain	For the period 2000–2007, the number of new HIV diagnoses among migrants rose from 57 to 201. As a percentage of total new HIV diagnoses, this rose from 24% to 43%.
Sweden	New diagnoses per year—approximately 120 among migrants and 59 among non-migrants.
Switzerland	Yes, for those originating from sub-Saharan Africa.
United Kingdom	Sentinel surveillance among GUM clinic attenders showed HIV prevalence of 2.4% in heterosexuals born in sub-Saharan Africa compared to 0.2% in those born in the UK. Among women giving birth, HIV prevalence was 0.05% for women born in the UK, 0.53% for those born in Central America and the Caribbean and 2.4% for those born in sub-Saharan Africa.

[371] In their comments on the report, Spain explained that MSM from Latin America and Western Europe are particularly affected by HIV in Spain.

[372] For example, if those leaving are tested as part of getting entry visas while those returning only are tested if they suspect they might have been at risk. In a scenario like this, the groups would not be comparable.

[373] Based on HIV case reporting.

Country	Evidence
Countries presenting evidence that people from other European countries[369] are disproportionately affected by HIV[374]	
Czech Republic	Foreigners, especially those from Eastern Europe, account for 21% of PLHIV.
Estonia	One third of the general population is Russian-speaking, yet Russian speakers account for 75% of IDU. HIV prevalence among IDU is high (48–60%). Although ethnicity of newly-diagnosed PLHIV is not recorded, 89% of newly-diagnosed PLHIV were counselled in Russian.
United Kingdom	In 2007, 61% of IDU diagnosed with HIV were from outside the UK, particularly Southern and Eastern Europe.
Countries presenting evidence that nationals leaving the country are disproportionately affected by HIV	
Croatia	54% of documented HIV infections occurred abroad.
Moldova	In 2007, the proportion of those leaving the country and having an HIV test that were HIV positive was 0.09%. Of those returning who had an HIV test, the proportion positive was 1.4%.

Figure 33: Map showing the extent to which countries provided evidence that migrants are disproportionately affected by HIV

2.5.6 Services for migrants

Programme examples

Many countries reported a range of examples of HIV-related programmes focused on migrants and ethnic minorities. Selected examples are featured in Box 26. Some countries commented on the provision of services for migrants in their responses on other thematic issues. For example, France and Norway identified expanded work with migrant populations as a key achievement of their prevention activities (see Section 2.1, Box 7).

There are also good examples of migrant communities being involved in policy/programme responses in a number of countries:

- In 2007, in **Bulgaria**, a series of nine round tables included one on issues relating to migrants and mobile

[374] The United Kingdom presented evidence that migrants from generalised epidemics and IDU from other parts of Europe are disproportionately affected by HIV. The former group is much larger so the United Kingdom has been allocated to that group in Figure 33.

populations. This involved governmental institutions, NGOs working with migrants and representatives of foreign diaspora. This collaboration is continuing under the new National Programme for Prevention and Control of HIV and STI (2008–2015).

- In **Germany**, migrants are involved in the civil society/NGO sector, in planning prevention activities in their communities and in designing prevention material. They also act as expert volunteers and paid consultants at national and local level in a range of capacities, for example, as counsellors.
- In **Italy**, migrants are involved in the Girasole Project and the Italian National Focal Point of the AIDS and Mobility Project.
- In the **Netherlands**, Municipal Health Councils often work with the target groups concerned, including on baseline surveys and needs assessments. There are also consultative forums where professionals/intermediaries meet with immigrant groups to discuss relevant issues. Examples are the Ethnic Minorities Annual conference, the annual members' meeting of the HIV Association, and The National Consultative Meeting.
- In **Norway**, a number of HIV preventive projects targeting migrants are run by, for and with migrants by NGOs or municipalities. The projects are given financial support from the government.
- In the **United Kingdom**, the African HIV Policy Network (AHPN) is an alliance of African community-based organisations working for fair policies for PLHIV. The Naz Project is a community-based organisation providing sexual health and HIV services to targeted black and minority ethnic (BME) communities in London. The Chief Medical Officer's Expert Advisory Group on AIDS and the Sexual Health and HIV Independent Advisory Group include NGOs representing HIV-affected migrant communities.

More details of involvement of migrants in HIV programmes in some countries are provided in Box 26.

Box 26: Examples of HIV programmes for migrants in Europe and Central Asia

In **Belgium**, Sensoa, the Flemish community centre for sexual health and HIV has developed a project targeting asylum seekers and newcomers to the country. This project operates in collaboration with the Flemish integration and reception centres. The project provides tailored education on sexual health and HIV, including a specific educational package (Idriss packs – see ECDC, 2009, Annex 6). It also trains staff at reception centres and teachers at integration centres.

In **Bulgaria**, the National Programme for Prevention and Control of HIV and STIs provides a number of interventions targeting migrants including informational materials tailored to the needs of migrants; low-threshold outreach HIV/STI prevention activities; distribution of condoms and provision of mobile counselling and testing services. Services, designed for the most-at-risk groups of migrant sex workers, IDU, Roma and MSM are provided in close cooperation with NGOs and representatives of the groups.

Croatia has been running a capacity building programme on HIV and AIDS among migrant workers aimed at preventing the spread of HIV and other STI. This includes provision of education materials and training opportunities. The programme was started with Global Fund finance and is now supported by the Croatian government.

The **Czech Republic** provides specific programmes for migrant sex workers and migrant drug users. In **Denmark**, information, counselling and health checks are available at checkpoints and immigrant health clinics.

In **Finland**, the AIDS Council has a Multicultural HIV Programme that aims to reduce HIV infections among people with an immigrant background; improve the competence of social and health care professionals to meet and provide services for HIV positive immigrants; and develop new models for peer support and preventive work with immigrants. Most of the NGO Pro-tukipiste's clientele are foreigners. The organisation provides material and services in several languages. The Red Cross provides support to asylum seekers, including provision of information about HIV and HIV testing.

In **Germany**, there are a range of HIV programmes for migrants from different regions, including sub-Saharan Africa and Eastern Europe (ProMig and GEMO). There are also programmes for migrant IDU and sex workers and a programme to strengthen the involvement of migrants in HIV prevention with immigrant communities.

In **Greece**, a number of NGOs (PRAKSIS, Medecins du Monde, Center for Life) and the Ministry of Health and Social Solidarity work with migrants, including those who are undocumented.

In **Italy**, in 2007, the Ministry of Health ran an AIDS campaign in seven different languages. A programme entitled Communities HIV/AIDS Educators has been trialled in 2008-2009. This aims to increase the capacity of migrants' associations to prevent HIV among migrants. It has an innovative approach which places migrants' associations at the centre of HIV prevention initiatives targeting migrant communities.

In the **Netherlands**, HIV prevention programmes are particularly well-developed in four large cities but there are also health programmes for migrants in most municipalities. There is also a patient-oriented organisation, The HIV Association, that does care and prevention work among those already living with HIV. Also, there are civil society organisations of immigrants that support PLHIV and carry out prevention programmes for their target population.

In **Norway**, the government funds NGOs for ethnic minority groups and projects run by municipalities targeting migrant populations. In **Portugal**, the AIDS programme funds NGO-designed and implemented programmes.

In **Switzerland**, the Afrimedia project aims to inform and educate sub-Saharan African migrants about HIV/AIDS, especially through the work of trained cultural mediators. It seeks to promote solidarity within the target group and to support self-help initiatives. The project is implemented in the cantons of Geneva, Vaud and Zurich and is currently being extended to other cantons.

In the **United Kingdom**, the Department of Health funds the National African HIV Prevention Programme (NAHIP), which focuses on HIV prevention among Africans living in the United Kingdom. NAHIP have developed Christian and Muslim Faith toolkits and have collaborated on an action plan to summarise the central issues for planning sexual HIV prevention interventions targeting Africans living in England. The African HIV Policy Network published an audit of HIV Information Materials Targeted at African People living in England in 2002.

Specific services

Of 49 countries reporting, 19 (39%) reported having data on the uptake of HIV testing among migrants. In most cases, this was qualitative[375] in nature. Table 24 shows quantitative data reported by eight countries[376].

Table 24: Quantitative data on HIV testing among migrants

Country	Evidence
Countries presenting data on testing rates	
Estonia	In 2008, 11% of those aged 16–64 reported being tested for HIV in the last 12 months. Rates were higher among Russian speakers[362] (14%) than among Estonian speakers (9%). In 2007, 25% of youth aged 19–29 reported ever having been tested for HIV. Again, rates were higher among Russian speakers (38%) than among Estonian speakers (20%).
France	Based on two studies[377], 69% and 65% of the black African population report ever being tested for HIV.
Moldova	In 2007, 18.8% of national truck drivers had had an HIV test in the past 12 months and knew the results, 73% knew where they could go to get an HIV test and 38.4% had ever had an HIV test. In 2006, 19.2% of emigrants had been tested in the past 12 months and knew the results. 31.9% had ever been tested.
Netherlands	In 2005, a study in The Hague found that rates of reporting ever having an HIV test were 44%, 34% and 35% among Antillean, Surinamese and Ghanaian migrants respectively. In 2006, a national survey showed that 51% of Surinamese/Antillean men were ever tested for HIV, compared to 33% of autochthonous men. For women these figures were 57% and 36%, respectively
Serbia	In a survey of 380 Roma aged 15–24, 1.6% reported being tested for HIV in the last 12 months and knew the test result.
United Kingdom[378]	Mayisha II, a survey of sexual attitudes and lifestyles of 1 359 black Africans (aged 16 and over) recruited in community settings in London, Luton and the West Midlands was undertaken in 2004. 49% (316/643) of women and 57% (397/695) men had never had an HIV test. 47% (302/643) of women and 38% (261/695) of men had had a HIV test in the past five years and 4% (25/643) of women and 5% (37/695) of men had last had a test more than five years ago.

[375] Three countries (Lithuania, Portugal and Sweden) reported that they had data but did not provide further information. Two countries (Bulgaria and the Former Yugoslav Republic of Macedonia) reported that they monitor ethnicity/nationality/ country of origin of those undergoing HIV testing. Israel commented that all immigrants from Ethiopia are tested for HIV. Two countries (Kazakhstan and Kyrgyzstan) provided information on HIV testing policy among migrants.

[376] In addition, two countries (Hungary and Latvia) reported numbers of imported HIV cases in response to this question. Switzerland reported the total number of HIV tests conducted annually in the country (over 300 000).

[377] One conducted in 2004 among the population tested in all free anonymous centres and one conducted in 2005 in the black African population living in the Paris area.

[378] The United Kingdom also commented that unlinked anonymous surveillance of those attending genitourinary medicine services and antenatal care collects data on country of birth and uptake of HIV testing.

Country	Evidence
Countries presenting data on number of tests	
Romania	In 2008, 1 179 HIV tests for Romanian labour migrants were performed on their return to the country. Of these, three were positive.
Ukraine	In 2006, 6 639 migrants were tested for HIV. Of these, 22 (0.33%) were positive. In 2007, 6 811 migrants were tested for HIV. Of these, 25 (0.37%) were positive. In 2008, 6 986 migrants were tested for HIV. Of these, 25 (0.36%) were positive.

Of 49 countries reporting, 20 (41%) reported having data on access to antiretroviral therapy (ART) among migrants (see Table 25)[379]. Of these, nine[380] referred to their policies relating to ART for migrants. A further four simply stated that they had such data[381]. Seven countries[382] provided quantitative data, which took three main forms:

- three countries[383] reported the proportion of migrants receiving ART compared to all those receiving ART in the country;
- three countries[384] reported the proportion of migrants receiving ART compared to all migrants known to be HIV positive; and
- two countries[385] reported the number of migrants receiving ART.

Table 25: Migrants' access to antiretroviral therapy (ART)

Country	Evidence
Bulgaria	Free HIV diagnosis and treatment is provided through the budget of the Ministry of Health for all Bulgarian citizens and foreigners. Anyone included in the National HIV Register that meets criteria for initiation of ART according to national treatment guidelines receives free-of-charge ART, regardless of their health/social insurance status.
Croatia	Treatment of HIV patients is centralised in one University Hospital. All data is maintained at that hospital.
Czech Republic	Asylum seekers have the same access to ART as Czech citizens. Non-documented immigrants with HIV, mostly from Ukraine, are treated by committed doctors who prescribe ART and assist immigrants with the paperwork needed to gain access to health coverage.
Denmark	Everybody regardless of ethnicity has access to ART, apart from illegal immigrants.
Estonia	Data is not available for all PLHIV in care. Based on a 2008 convenience sample of 450 PLHIV from three major infectious diseases clinics (Tallinn, Kohtla-Järve and Narva), in which half of the participants were on ART, 10% were ethnic Estonians, 86% were ethnic Russians and 4% representatives of other nationalities.
Germany	Migrants from countries with generalised HIV epidemics constitute between 10% and 20% of HIV patients in an open clinical cohort study that covers around one quarter of HIV patients under care.[386] Initiation of treatment occurs at lower mean CD4 levels in migrants compared with other affected groups, and loss to follow-up is more common.
Greece	At the end of 2008, of 1 459 HIV-positive migrants, 728 had been prescribed ART. Of these, 292 were from sub-Saharan Africa and 73 from Eastern Europe.

[379] In addition, in response to this question, Italy reported the percentage of migrants who were unaware of being HIV positive before an AIDS diagnosis.

[380] Bulgaria, Croatia, Czech Republic, Denmark, Israel, Lithuania, Luxembourg, Norway and Switzerland.

[381] Malta, Netherlands, Slovakia and the United Kingdom.

[382] Estonia, Germany, Greece, Latvia, Moldova, Spain and Sweden.

[383] Estonia, Germany and Spain – but see footnote 362.

[384] Greece, Spain and Sweden. Spain also reported the proportion of migrants receiving ART compared to all those receiving ART in the country.

[385] Latvia and Moldova. In the case of Latvia it was zero, and in the case of Moldova, it was one.

[386] It is recognised that migrants are likely to be slightly overrepresented in this cohort compared to HIV patients cared for in private practice.

Country	Evidence
Israel	Jewish immigrants have free and immediate access to medical services and treatment in the same way as all citizens. Documented immigrants are medically insured, but usually the insurers prefer to fly them back to their country of origin rather than paying for their treatment in Israel. Undocumented immigrants are generally not entitled to treatment, but only to free counselling and testing. Exceptions are pregnant women and children born in Israel to HIV-positive mothers. Even if they are undocumented immigrants, they are insured and have access to therapy.
Latvia	ART in Latvia is centralised and provided by one hospital, the Infectology Centre of Latvia. There are no cases of ART provided for migrants in the reporting period.
Lithuania	ART is supplied only through a specialised medical institution. Currently, everyone who needs ART receives it.
Luxembourg	There is no limitation for access but no denominator for calculations.
Malta	ART is only dispensed from one centre in Malta, so records are accessible from this centre.
Moldova	Emigrants and national truck drivers have the same access to ART as other nationals. There is also legal provision for access to prevention, social assistance, treatment of opportunistic infections and ART for immigrants, emigrants, refugees and asylum seekers infected and affected by HIV. However, only one foreigner was ever registered entering in ART in the prison system. There were two cases in the last five years where foreign pregnant women were provided antiretroviral prophylactic treatment.
Netherlands	Data is collected from all HIV cases registered into care by the HIV Monitoring Foundation (SHM).
Norway	Access to ART is included in general healthcare services. It is therefore assumed that access to ART is close to universal among legal migrants. It is, however, unclear whether illegal migrants have proper access to ART, especially given their lack of access to health services. The Communicable Disease Control Act gives all people residing in Norway the right to free HIV testing, counselling and treatment. Thus, illegal immigrants by law have the right to access ART.
Slovakia	There is information on access to ART among the general population and it is possible to identify if the treatment is given to a Slovak citizen or to a migrant.
Spain	According to an annual prevalence-day survey performed in public hospitals, 10% of attending patients were migrants in 2008 (trends from 4% in 2001 to 10% in 2008). For the period 2001–2008, 70% of these migrants were on ART.
Sweden	All diagnosed HIV positive have access to ART. All immigrants, i.e. those born abroad and residing in Sweden, who need treatment, receive it. Approximately 80% of the known HIV-infected 'immigrant' cohort currently receives treatment.
Switzerland	All immigrants with valid legal status are required to subscribe to medical insurance, like all Swiss citizens. With medical insurance, everybody enjoys full access to ART. Problems exist for illegal, non-declared immigrants.
United Kingdom	Any HIV-infected individual legally living in the UK is eligible for HIV-related care and treatment from National Health Service clinics. This includes refugees and asylum seekers. The Health Protection Agency collects data on ethnicity and country of birth among newly-diagnosed individuals and those accessing HIV care. Data indicates high ART uptake across all ethnicities.

A few countries commented on difficulties in monitoring migrants' access to ART:

- Luxembourg expressed concerns about what should be used as the denominator for calculating access.
- Germany commented that migrants tended to start ART with lower CD4 counts[387] and be more often lost to follow-up than non-migrants.
- The United Kingdom commented that there are higher rates of late presentation among HIV-positive Africans than among other groups.

Barriers and obstacles

Several countries reported barriers and obstacles in delivering HIV-related services to migrants. In some countries this was based on a formal assessment[388].

[387] An indicator of late diagnosis.

[388] For example, in 2007, Bulgaria conducted a rapid qualitative assessment of the availability of information and migrants' knowledge on the ways of transmission and prevention of HIV/TB, and the provision of and access to HIV/TB services. The United Kingdom and the Netherlands included references to published material, e.g. Burns and Fenton, 2006 and Weatherburn et al, 2003 for the United Kingdom, and Shiripinda and van Eerdewijk, 2008 for the Netherlands.

The most commonly-reported was language barriers (16 countries). Other commonly-reported obstacles included cultural differences (10), issues relating to fear, stigma and discrimination (6), religious differences, for example, related to the acceptability of male doctors dealing with female patients (4) and lack of services in the locations where migrants lived in the host country (3).

Countries reported particular challenges in providing services to undocumented migrants. For example, some countries[389] 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.

Laws and policies

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[390] reported having restrictions on entry and residence for PLHIV. In other countries, some categories of migrants[391] may not benefit from the social security system in place in the country. Some ethnic minorities[392] 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.

2.5.7 Monitoring responses for migrants

Countries reported a range of methods for monitoring their response to HIV and AIDS among migrants. In some cases, these were incorporated into the national HIV monitoring and evaluation system[393] and/or linked into broader processes for monitoring the situation of migrants in a country[394]. In some cases, countries collect data relating to migrants from their monitoring of programmatic data[395]. Several countries reported having conducted situational analyses[396], surveys[397], evaluations[398], special studies[399] or research[400] relating to HIV among migrants. In addition, some countries[401] have constituted particular groups to review the response to HIV among migrants.

A number of countries reported on indicators they use to track the response to HIV among migrants in their country. These reports are summarised in Annex 6.

There may be some advantages in having standardised indicators relating to migrants which are tracked in EU/EFTA countries. Potential indicators for this purpose are shaded green in Annex 6. In order for these to have maximal use, it would be helpful to have a shared definition of migrant. For this purpose, it is proposed that this be someone born in a country with a generalised epidemic[402]. The following might be considered for inclusion as standard indicators for monitoring the response to HIV among migrants in EU/EFTA countries:

- Number of migrants from countries with generalised HIV epidemics living in the country at a given time.
- Percentage of HIV positive migrants from countries with generalised HIV epidemics diagnosed/registered per year of all new HIV positive diagnoses/registrations[403].
- Percentage of migrants from countries with generalised HIV epidemics who have been tested for HIV in the last twelve months and know the results.

[389] E.g. Germany and Switzerland.

[390] E.g. Kazakhstan and Moldova.

[391] E.g. temporary residents in Finland.

[392] E.g. the Roma population in Serbia

[393] E.g. Bulgaria and Moldova.

[394] E.g. Bulgaria.

[395] E.g. Croatia and Serbia.

[396] E.g. Bulgaria.

[397] E.g. Czech Republic, Serbia and Switzerland.

[398] E.g. Norway and Switzerland.

[399] E.g. Croatia and the United Kingdom.

[400] E.g. Norway.

[401] E.g. in 2007, Bulgaria held a round table meeting on migrants and Germany formed an interdisciplinary working group on migrants.

[402] If ECDC proposes to monitor these indicators, it would be essential to establish and maintain a list of those countries that it considers to meet this criterion.

[403] Compared to ratio of number of migrants from countries with generalised HIV epidemics to total population.

- Percentage of migrants from countries with generalised HIV epidemics receiving ART of all those receiving ART[404].
- Percentage of migrants from countries with generalised HIV epidemics diagnosed with HIV at late clinical stage of all migrants from countries with generalised HIV epidemics diagnosed with HIV.
- Percentage of migrants from countries with generalised HIV epidemics reporting condom use during last high risk sex.
- Prevalence of HIV infection among migrants from countries with generalised HIV epidemics.

Countries collect data for indicators in different ways and from a variety of sources. Many have systems of HIV and AIDS case reporting. In some cases, these operate at a national level[405], while in others they are decentralised to municipal or state level. Data is also collected from a variety of programmatic sources, including services operated by NGOs, voluntary counselling and testing services, laboratory services and STI clinics. Many countries conduct behavioural surveys among migrants, and in some countries, these surveys form part of a second generation surveillance system. In some countries, some data[406] is available from administrative statistics collected by government ministries responsible for working with migrants.

Finally, countries were asked if they had data relating to migrants for the standard UNGASS indicators that are applied to other most-at-risk populations[407].

Six countries reported data on the rates of HIV testing among migrants (see Table 24). France, the Netherlands and the United Kingdom had conducted surveys among migrants from countries with generalised epidemics and were able to report the percentage that had ever had an HIV test. In addition, the United Kingdom was able to disaggregate those who had had an HIV test in the last five years and those who had last been tested more than five years previously. No country reported data for migrants from generalised epidemics in the precise UNGASS format, i.e. the percentage that received an HIV test in the last 12 months and knew the results.

Estonia, Moldova and Serbia reported data on the rates of HIV testing among other groups—ethnic Russians in Estonia[362], truck drivers and emigrants in Moldova and the Roma population in Serbia. Both Moldova[408] and Serbia reported data in the precise UNGASS format. Estonia reported both the percentage who had been ever tested and those who had been tested in the last 12 months[409].

No country was able to report quantitative data on the percentage of migrants reached with HIV prevention programmes[410]. However, several countries[411] expressed interest in getting further information on how this might be done. The United Kingdom did provide some quantitative information related to numbers of migrants reached through a particular campaign and this is summarised in Box 27[412].

Four countries (France, Italy, the Netherlands and the United Kingdom) reported having survey data on migrants' knowledge about HIV transmission prevention and reported condom use (see Table 26f). In addition, three countries[413] reported that they were planning such surveys[414]. None of the countries reported data for these topics in the precise UNGASS format[415].

[404] Compared to percentage of HIV-positive migrants from countries with generalised HIV epidemics diagnosed/registered per year of all new HIV-positive diagnoses/registrations.

[405] E.g. a national HIV register.

[406] Particularly on numbers of migrants.

[407] These are: HIV testing in most-at-risk populations (UNGASS 8); most-at-risk prevention programmes (UNGASS 9); most-at-risk populations knowledge about HIV transmission prevention (UNGASS 14), condom use during higher-risk sex (analogous to UNGASS 17–20); and most-at-risk populations reduction in HIV prevalence (UNGASS 23).

[408] Moldova also reported the percentage of those ever tested.

[409] But did not inform if the question included whether or not the respondent knew their result.

[410] Hungary commented that it could not collect this kind of data because of data protection rules.

[411] E.g. Germany, Italy and Switzerland.

[412] Croatia provided similar data for the activities of its capacity building programme among migrant workers in 2007 and 2008. This included, in 2008, training 84 seafarers/engineers; providing counselling for 2 119 seafarers, 350 truck drivers and 353 construction workers; providing 254 medical check-ups for people travelling abroad; distributing 1 000 leaflets, 500 brochures, 20 posters, 5 copies of an educational film, 13 manuals and 1 000 condoms.

[413] Czech Republic, Sweden and Switzerland.

[414] In addition, some countries provided qualitative information on migrants' knowledge about HIV prevention, e.g. Belgium and Bulgaria.

[415] The UNGASS knowledge indicator requires correct answers to each of five specified questions. The first three of these 'should not' be altered but the other two 'may be replaced by the most common misconceptions' in the country. The UNGASS condom use indicator requires information about condom use during last sex among those who report having sex with more than one sexual partner in the last 12 months.

Box 27: Measuring the number of migrants reached with an HIV prevention programme: an example from the United Kingdom

Between May 2007 and February 2008, the National African HIV Prevention (NAHIP) Programme conducted just under 500 health promotion activities through the Do It Right Campaign. Nearly 13 000 people were contacted in over 927 venues and a total of 1 527 hours of health promotion activity delivered. There were 19 191 posters and 20 012 booklets distributed in numerous sites across England.

Table 26: Countries reporting migrants' knowledge about HIV transmission prevention and reported condom use

Country	Data on migrants' knowledge about HIV transmission prevention	Data on migrants' condom use
France	Data is available from a 2005 survey conducted among the black African population living in the Paris area. A new survey is planned but has not yet been conducted.	In the 2005 KABP survey, data was collected on condom use during first sexual intercourse and in the last 12 months.
Italy	A socio-behavioural survey was conducted among 1 492 migrants in 2006 in conjunction with IOM. Sample size: 1 492 migrants in Italy. Multivariate analyses showed that those reporting higher risk sexual behaviour had a lower level of HIV knowledge than those who did not report this risk behaviour.	The 2006 survey showed that 22% of the sample reported having had sex with occasional partners and 14% with sex workers. Of these, 51% reported 'always used a condom' with an occasional partner and 61% with sex workers. Among the reasons for not using condoms is the reduction of pleasure. Migrants less familiar with the Italian language are more likely to be engaged in sexual risk behaviour.
Netherlands	Some information was collected in bio-behavioural surveys conducted in 2005 among Surinamese, Antillean, Ghanaian and Cape Verdean populations[416]. About 95% of the participants reported that they knew that HIV could be transmitted by contact with blood. However, 29–42% also reported that HIV could be transmitted by mosquitoes and about 25% thought that French kissing might transmit HIV.	The same survey showed that 12% of Surinamese, Antillean and Ghanaian migrants reported consistent condom use with steady partners in the past six months. This figure was higher with casual partners: Surinamese 46%, Antillean 53% and Ghanaian 50%. Data from STI clinic attendees in 2007 showed that reported condom use during last sex was 32% among Africans, 26% among Antilleans, 25% among Surinamese, 44% among Latin Americans and 27% among Dutch.
United Kingdom	In the BASS Line survey, conducted in 2007 to assess the HIV prevention needs of African people in England, 93% of individuals identified that HIV can be passed to a partner during sexual intercourse and 71% reported that they could use a condom with a sexual partner. 92% knew that HIV was not passed on through shaking hands and touching people.	In the Mayisha II survey (see Table 24), 79% of individuals listed prevention of HIV/STI infection as a main reason for condom use. 49% (253/518) of women and 57% (347/605) of men reported using a condom the last time they had sex. In the BASS Line survey, 27.1% of women and 32.5% of men reported always using a condom for sex in the past 12 months. 21.7% of women and 20.7% of men reported never using a condom for sex in the past 12 months.

In reporting HIV prevalence among migrants, several countries[417] reported data from their HIV case reporting systems (see Table 23)[418]. In order to turn these figures into prevalence data, a denominator is required. This could be the number of migrants tested or the total number of migrants[419] in the country[420]. Moldova used the former method, reporting that 0.13% of immigrants who entered the country and had an HIV test were found to

[416] Results in Dutch only.

[417] E.g. Belgium, Netherlands, Norway, Sweden, Switzerland and the United Kingdom. In addition, Cyprus reported that it had diagnosed 117 HIV-positive migrants from countries with generalised epidemics between 1996 and 2007.

[418] In addition, some countries provided qualitative data. For example, Denmark commented that HIV prevalence rates were similar to published rates in the country of origin. Germany commented that relatively few migrants came to Germany from high prevalence countries.

[419] Of a specified type.

[420] The former method will give lower values than the latter.

be positive[421]. The United Kingdom uses the latter method. In 2008, the diagnosed HIV prevalence in the United Kingdom was 3.9%[422] among black Africans, 0.4%[423] among the black Caribbean population and 0.09%[424] among the white population. Both these methods only measure diagnosed HIV prevalence. Where rates of non-diagnosis or late diagnosis are high, they will significantly underestimate actual HIV prevalence. However, they do provide prevalence data without having to conduct special studies.

Some countries also reported HIV prevalence rates among migrants based on different kinds of surveillance. Both Italy and Spain reported data from a surveillance system based in STI clinics[425]. In Italy, HIV prevalence among migrants from sub-Saharan Africa with STI is reported to be 9.1%. In Spain[426], HIV prevalence among migrants from sub-Saharan Africa attending STI clinics was 2.4% in 2007 and 2.2% between 2000 and 2007[427].

The United Kingdom reported data from HIV testing among pregnant women. This showed HIV prevalence to be 2.5%[428] among women born in sub-Saharan Africa[429], 0.5%[430] among women born in the Caribbean and Central America and less than 0.1% among UK-born women.

The Netherlands has conducted bio-behavioural surveillance among the Surinamese, Antillean, Ghanaian and Cape Verdean populations. The combined data of three surveys showed HIV prevalence to be 0.4% among Surinamese, 0.4% among Antilleans, 1.1% among Ghanaians and 1.3% among Cape Verdeans.

2.5.8 Conclusions

Issues relating to HIV and migrants are important for the countries of Europe and Central Asia. 59% of the countries responding regarded migrants as an important subpopulation in their national response to HIV. Almost three quarters (72%) of responding EU/EFTA countries regarded migrants an important subpopulation in their national response to HIV (see Figure 32).

But, 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 (see Table 23 and Figure 33). 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 than ethnicity or migration per se.

This section 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 (see Table 24). Eight countries reported quantitative data related to the access of migrants to antiretroviral therapy. In three cases, this related to the total number of people on antiretroviral therapy in the country and, in three cases, to the total number of migrants with HIV (see Table 25). Only four countries reported data on the HIV-related knowledge and behaviour of migrant populations.

No country reported rates of migrants from countries with generalised epidemics reporting an HIV test in the last 12 months and knowing the result. No country reported rates of coverage of HIV programmes for migrants,

[421] In addition, the Czech Republic reported that HIV prevalence among the Ukrainian population was 0.03%. In the absence of detail about method, it is assumed that this is based on the number of positive HIV tests as a proportion of those people tested.

[422] 18 719/500 600 – numerator is number of individuals aged 15–64 with diagnosed HIV and denominator is 2006 population aged 15–59.

[423] 1 538/395 800 – numerator is number of individuals aged 15–64 with diagnosed HIV and denominator is 2006 population aged 15–59.

[424] 24 368/27 058 700 – numerator is number of individuals aged 15–64 with diagnosed HIV and denominator is 2006 population aged 15–59.

[425] In a country where all HIV diagnoses are made in STI clinics, this system would be analogous to the case-reporting system described earlier.

[426] Based on data, from 2000–2007, from the EPI-VIH Network, which consists of 19 HIV/STI clinics located in 18 Spanish cities.

[427] In 2007, the rates were higher among new testers (3.1%) than repeat testers (1.6%). Rates also varied by region from 6.2% for sub-Saharan Africa, 3.5% for Latin America and 2.2% for Northern Africa (new testers). In commenting on the report, Spain explained that, overall, the HIV prevalence among migrants from sub-Saharan Africa attending these STI clinics was 3.5% in 2007 and 4.3% between 2000 and 2008.

[428] 558/22 718.

[429] Rates were reported to be higher in sub-Saharan-born women living outside London (3.1%) than in London (2.3%).

[430] 12/2333.

although several countries expressed interest in knowing how to do this. Although four countries reported survey data on migrants' HIV-related knowledge and reported condom use, none of these corresponded fully to the standard indicators used by UNAIDS for UNGASS reporting related to other key populations.

In conclusion, ECDC has identified the following issues needing 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 need to develop ways of monitoring whether these programmes are being delivered at 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

2.6.1 Introduction

Prisons[431] are significant for the response to HIV in the countries of Europe and central Asia. Populations more affected by HIV, such as injecting drug users, often spend time within a country's prison system. Risks of HIV transmission exist in prisons through sharing of contaminated injecting equipment and through unprotected sex. As a result, national responses to HIV need to include prison systems. In principle, prison systems need to provide HIV services equivalent to those available in the community, in particular for IDU, including information and education, particularly through peers; needle and syringe programmes; drug dependence treatment, in particular opioid substitution therapy; provision of condoms; voluntary HIV testing and counselling; diagnosis and treatment of STIs; and antiretroviral treatment[432]. Needle and syringe programmes and opioid substitution therapies have proven effective at reducing HIV risk behaviours in a wide range of prison environments, without resulting in negative consequences for the health of prison staff or prisoners. Despite this, global monitoring processes have not yet had a significant focus on prisons and prisoners. For example, there are no prison-related indicators within the overall UNGASS monitoring process[433].

This section focuses on two major areas. First, it explores the extent to which countries have data available on HIV prevalence among prisoners. Second, it maps the HIV policy environment in prisons in Europe and central Asia, largely using data based on questions in the UNGASS National Composite Policy Index (NCPI)[434]. It concludes with brief consideration of some country programme examples.

2.6.2 HIV prevalence in prisons

Just under half (47%[435]) of all reporting countries presented quantitative data for HIV prevalence among prisoners (See Table 27). The figure was higher among reporting EU/EFTA countries (52%[436]) than among others (40%[437]). In addition, three countries reported on numbers of people living with HIV[438] in prisons and/or those receiving antiretroviral therapy[439]. One country[440] reported that it had conducted surveys of HIV prevalence among prisoners but did not report the data. Two countries[441] reported that they are planning such surveys.

Countries collected prevalence data in two main ways. Ten countries conducted some kind of survey[442]. Eight used data from diagnostic/clinical testing[443]. In one country[444], HIV prevalence data was derived from mandatory testing of all prisoners. Four countries[445] did not specify their method.

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[431] In this section, the term 'prisons' is used to denote all places of detention and the term 'prisoner' is used to describe all who are held in such places. It includes both adults and juveniles, those who are awaiting trial, those who have been convicted and those who are subject to other conditions of security. It is recognised that different terms are used for different places of detention in different countries. Although the term does not formally cover persons detained for reasons relating to immigration or refugee status, those detained without charge, and those sentenced to compulsory treatment and rehabilitation centres as they exist in some countries, nonetheless most of the considerations in this report apply to them as well.

[432] The WHO/UNODC/UNAIDS technical guide on target setting for universal access to HIV prevention, treatment and care for IDU recommends a comprehensive package of nine interventions: needle and syringe programmes; opioid substitution therapy; HIV testing and counselling; ART; STI prevention and treatment; condom programmes for IDU and their sexual partners; targeted IEC programmes for IDU and their sexual partners; vaccination, diagnosis and treatment of viral hepatitis; and prevention, diagnosis and treatment of TB.

[433] Although the National Composite Policy Index includes some questions related to prisons.

[434] One issue with NCPI is that although it asked about the availability of drug substitution therapy and needle exchange services, it stated that they were not applicable for prisoners. As a result, some countries did not answer these questions in relation to prisoners in their responses to NCPI. Consequently, we asked all countries questions about their provision of free condoms, opioid substitution therapy and sterile injecting equipment in prisons. We also asked all countries about mandatory HIV testing in prisons.

[435] 23/49.

[436] 15/29.

[437] 8/20.

[438] Luxembourg and Poland.

[439] Greece and Poland.

[440] The Former Yugoslav Republic of Macedonia.

[441] France and the Netherlands.

[442] In most cases, this involved HIV testing to determine HIV status, although in Belgium they relied on self-reported HIV status.

[443] In two countries, Hungary and Italy, this was part of a screening programme.

[444] Israel.

[445] Lithuania, Portugal, Spain and Switzerland.

Reported HIV prevalence varied from 0% (Czech Republic and Croatia) to 14.5% (Ukraine). Data from Kazakhstan provided evidence that prisoners are a heterogeneous group. Rates of HIV prevalence were four times higher among those who were hepatitis C positive than among those who were not. This implies a link between HIV infection in prisons and injecting drug use, which is probably valid in other countries of the region.

Although the vast majority of prisoners in countries of the region are male, some countries[446] 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.

Table 27: HIV prevalence in prisons in countries of Europe and central Asia

Country	HIV prevalence	Year	Method							Comment
			Bio-survey[447]	SR survey[448]	Diagnostic	Clinical	Screening	Mandatory	Not stated	
Azerbaijan	2.9%	2007/8	✓							29/1 000 in epidemiological surveillance[449].
Belgium	1.5%	2006		✓						Of 902 prisoners, 269 reported having had an HIV test. Of these, 82.1% reported being negative; 16.4% did not know the result or did not answer; 1.5% reported being positive.
Bulgaria	0.5%	2007	✓							Data from 2006 available through the national system for second generation HIV sentinel surveillance. Integrated bio-behavioural surveillance has been conducted in 13 prisons in Sofia, Burgas, Pelven, Stara Zagora and Plodvid. Convenience sample using annual, cross-sectional, venue-based survey. In 2006, 0 of 600 positive. In 2007, 4 of 754 positive. Disaggregated data by age and sex available.
Croatia	0%	2003–9			✓					No such studies conducted in Croatia yet. However, through the prison VCT centre no positive cases yet from 1 078 tests conducted.
Czech Republic	0%	2009			✓[450]					0 of around 100, mainly IDU.
Estonia	1.8%	2007			✓[451]					This data relates to new HIV diagnoses among prisoners. In 2007, there were 63 new diagnoses in prisons. These accounted for 10% of all new diagnoses and represented 1.8% of all prisoners. Of these, 92% were male.
Georgia	1.0%	2009	✓							Using Global Fund money, a survey was conducted in 2009 among 210 prisoners in three prisons in Tbilisi and Kutaisi.
Germany	0.8%	2006/7	✓							1 582 offered testing. 1 515 accepted.
Greece	N/A	2008				✓				20 prisoners on antiretroviral therapy
Hungary	< 0.1%	2008					✓			As part of a health promotion and counselling programme, 4 800 prisoners, out of total of 15 000, took part in the screening programme. One person was found to be HIV positive.
Israel	0.3%	Not stated						✓		All new prisoners are tested for HIV upon incarceration. Of around 30 000 prisoners in Israel, 85 were HIV infected (~0.3%).
Italy	2.5%	2009					✓			In 2009, the total prison population was 65 000. Of these, 35% were screened for HIV. HIV prevalence was 2.5%. But, a study in 2005 found 7.5% of 973 prisoners to be positive.
Kazakhstan	2.4%	2008	✓							Annual sentinel surveillance among 4 470 prisoners found an HIV prevalence of 2.4% and a hepatitis C prevalence of 43%. HIV prevalence among those with hepatitis C is four times higher than among those without hepatitis C.

[446] E.g. Kyrgyzstan, Romania and the United Kingdom (see Table 27). Georgia also collected data from a women's prison (see Box 28).

[447] Involving selection of a representative sample of prisoners and HIV testing.

[448] Self-reporting survey involving selection of a representative sample of prisoners and self-reporting of HIV status.

[449] It has been assumed that this was a survey sample rather than diagnostic testing or testing of all prisoners.

[450] Voluntary testing offered by an NGO during prevention activities.

[451] Diagnosis of new HIV cases.

Country	HIV prevalence	Year	Method							Comment
			Bio-survey[447]	SR survey[448]	Diagnostic	Clinical	Screening	Mandatory	Not stated	
Kyrgyzstan	Figures disagg. by age/sex	2008	✓							Data from epidemiological surveillance for 2008 – under 25 men:25%; under 25 women: 33%; over 25 men: 46.4%; over 25 women: 69.2%.
Latvia	9%[452]	2008			✓[453]					On 1 January 2008, there were 621 people with HIV and 103[454] with AIDS in prisons, out of total number of prisoners of 6 873. On 1 January 2007, there were 570 people with HIV and 97 with AIDS in prisons, out of total number of prisoners of 6 548.
Lithuania	2.1%[452]	2008							✓	12/570.
Luxembourg	N/A	2008			✓					In 2008, 12 prisoners tested positive , but of those 10 had been tested before.
Moldova	4.2%	2007	✓							Integrated bio-behavioural survey using probability sampling and a two-stage cluster sampling design. Two categories of prisons were used: those with syringe exchange points and those without. Transdniestrian penitentiaries were not involved. Data disaggregated by age available.
Poland	N/A	2008			✓					In 2008, 3 965 prisoners were tested for HIV. Number of people living with HIV was 281; new cases, 88. As of September 2009, there were 211 prisoners on antiretroviral therapy.
Portugal	7.3%	2008							✓	
Romania	2.1%	2007	✓							Data disaggregated by age and sex available.
Spain	7.8%	2008							✓	Trends: from 22.4% in 1995 to 8.6% in 2007.
Sweden	4.3%	2006/7			✓[455]					979 interviews and tested. 969 tested for HIV and 42 positive. Stockholm only.
Switzerland	1–2.4%	2001–5							✓	A study conducted in the prison of the French-speaking side of Switzerland.
Ukraine	14.5%	2008			✓					In 2008, 20 502 prisoners were tested for HIV. Of these, 2 975 were positive. Figures were 2 700 of 21 068 in 2007 and 2 979 of 21 385 in 2006.
United Kingdom	0.3% men and 1% women	1997/8	✓							

2.6.3 HIV policy environment in prisons

Almost all (92%[456]) of responding countries provided some information about the HIV policy environment in prisons in their country[457]. Of these:

- almost all (84%[458]) reported that their country's multisectoral strategy/action framework addressed prisons;
- almost three quarters (73%[459]) reported that they have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services, including prison staff.

In addition, almost all (87%[460]) reported that they have a policy and/or strategy to promote information, education and communication and other preventive health interventions for prisoners. Figure 34 shows the percentage of country strategies/policies with particular elements.

[452] Calculated from numbers provided as of 1 January 2008.

[453] Cumulative number of those ever diagnosed.

[454] For prevalence rate, it is assumed that this number is a subset of those with HIV.

[455] Swedish Prison Project focused on IDU.

[456] 45/49.

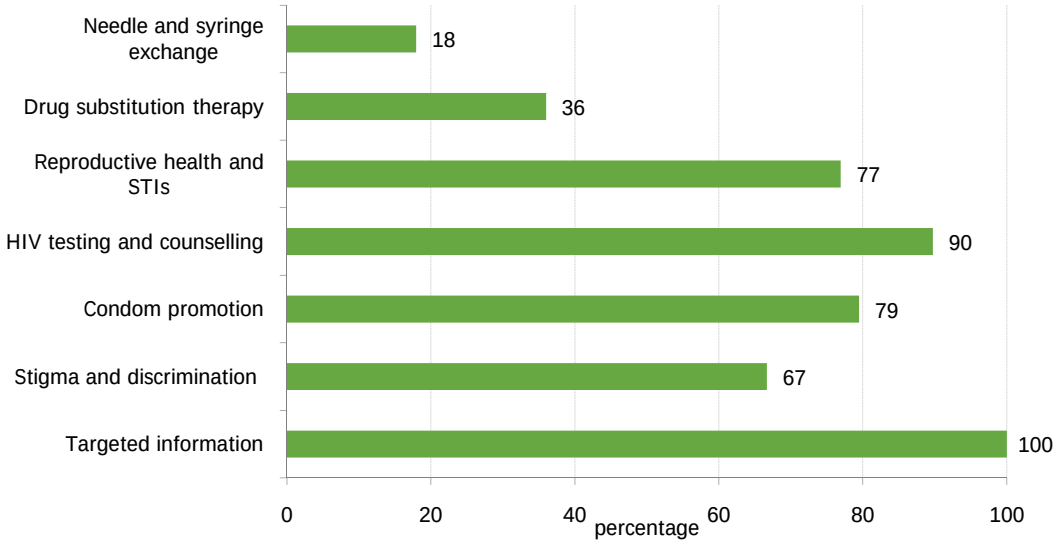
[457] The four that did not were Albania, Iceland, San Marino and Uzbekistan.

[458] 38/45.

[459] 33/45.

[460] 39/45.

Figure 34: 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 (100%) policies and strategies are reported to include targeted information on risk reduction and HIV education. Almost all (90%[461]) include HIV testing and counselling. More than three quarters include condom promotion (79%[462]) and reproductive health, including STI prevention and treatment (77%[463]). Two thirds (67%[464]) refer to stigma and discrimination reduction. Only just over one third (36%[465]) report referring to drug substitution therapy and less than one fifth (18%[466]) report referring to needle and syringe exchange[467].

Less than half (44%[468]) of countries providing information on this issue indicated that their country has non-discrimination laws or regulations that specify protection for prisoners, and 40%[469] report that the country has laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for prisoners.

Forty countries provided information on whether or not they conduct mandatory testing in prisons[470]. Most (85%[471]) do not. The six that report that they do mandatory HIV testing in prisons were Cyprus, Germany, Israel, Kazakhstan, Malta and Turkmenistan.

Almost two thirds (64%[472]) of countries providing information on this issue reported that free condoms were available in at least some prisons (see Figure 35). Of these, 59%[473] reported providing them in all prisons, 17%[474] in most prisons and 24%[475] in some prisons.

[461] 35/39.

[462] 31/39.

[463] 30/39.

[464] 26/39.

[465] 14/39.

[466] 7/39.

[467] It is possible that these last two categories are under-reported in responses to the UNGASS NCPI as the instructions indicated that these interventions were only applicable to IDU and were not applicable to prisoners.

[468] 20/45.

[469] 18/45.

[470] In a policy brief and a technical paper on HIV testing and counselling in prisons and other closed settings, both published in 2009, UNODC, UNAIDS and WHO state that mandatory or compulsory HIV testing of prisoners violates ethical principles and the basic rights of consent, privacy and bodily integrity and cannot be justified from a public health perspective.

[471] 34/40.

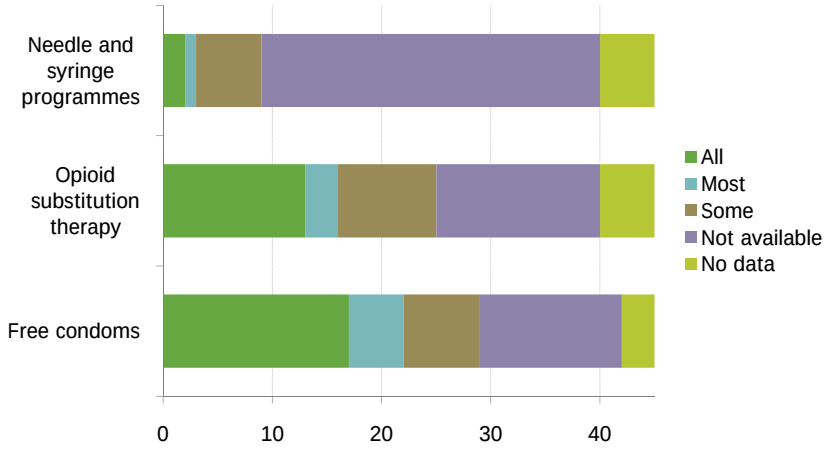
[472] 29/45.

[473] 17/29.

[474] 5/29.

[475] 7/29.

Figure 35: Number of countries with identified services available in all, most or some prisons



Over half (56%[476]) of countries providing information on this issue reported that opioid substitution therapy was available in at least some prisons (see Figure 35). This was the case for almost three quarters (71%[477]) of EU/EFTA countries but just over a quarter (29%[478]) of other countries (see Figure 36).

Of countries with opioid substitution therapy available in at least some prisons, 52%[479] reported providing it in all prisons, 12%[480] in most prisons and 36%[481] in some prisons. The countries reporting that opioid substitution therapy is available in all their prisons included Croatia, Cyprus[482], Finland, Italy, Luxembourg, the Netherlands, Norway, Poland, Serbia, Slovenia, Spain, Sweden and the United Kingdom (see figure 36). All these countries but two[483] are EU/EFTA countries. Of EU/EFTA countries, only six[484] report that opioid substitution therapy is not available in their prisons[485]. Conversely, only five[486] non-EU/EFTA countries reported that drug substitution therapy is available in any of their prisons.

[476] 25/45.

[477] 20/28.

[478] 5/17.

[479] 13/25.

[480] 3/25.

[481] 9/25.

[482] But the answer conflicted with another one elsewhere in the questionnaire.

[483] Croatia and Serbia.

[484] Bulgaria, Greece, Latvia, Lithuania, Malta and Slovakia.

[485] Austria, Belgium, Iceland, Ireland and Liechtenstein did not provide information.

[486] Croatia and Serbia reported that opioid substitution therapy is available in all prisons. Kyrgyzstan, Moldova and the Former Yugoslav Republic of Macedonia reported that opioid substitution therapy is available in some prisons.

Figure 36: Map showing the extent to which opioid substitution therapy is reported to be available in prisons in Europe and central Asia[487]

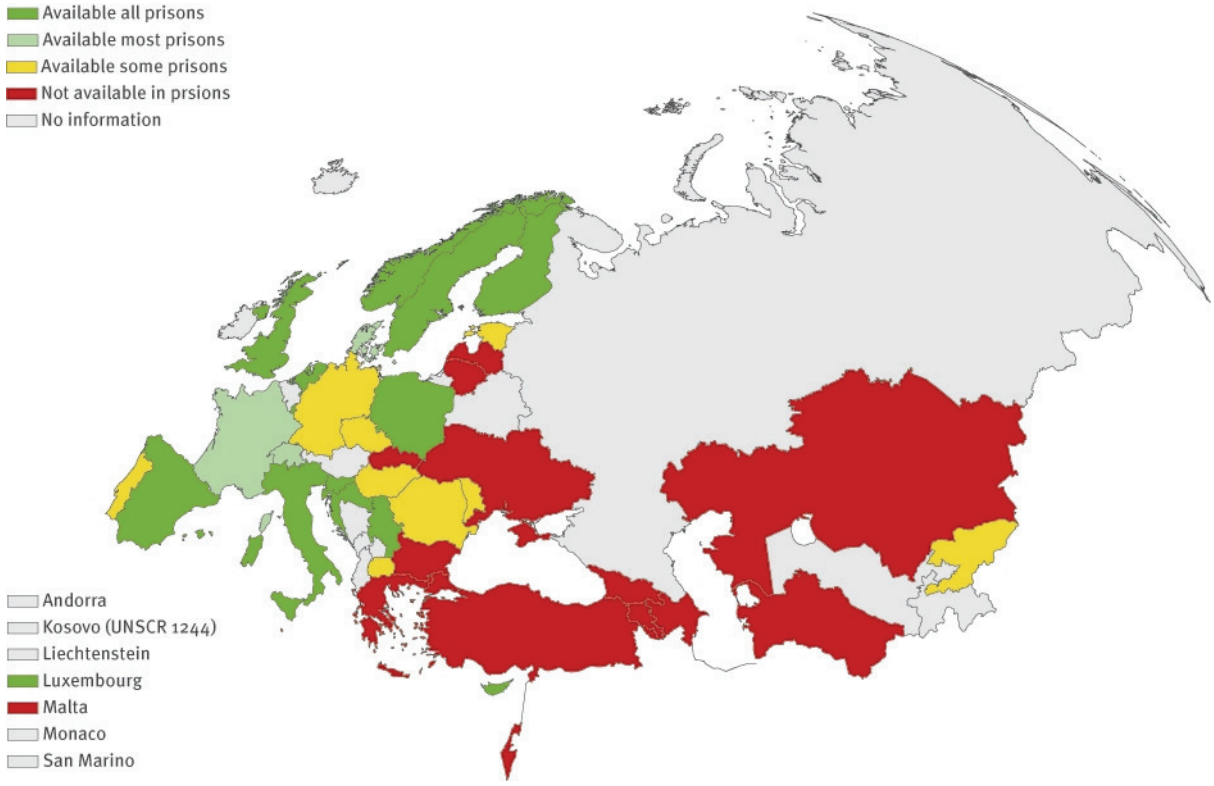
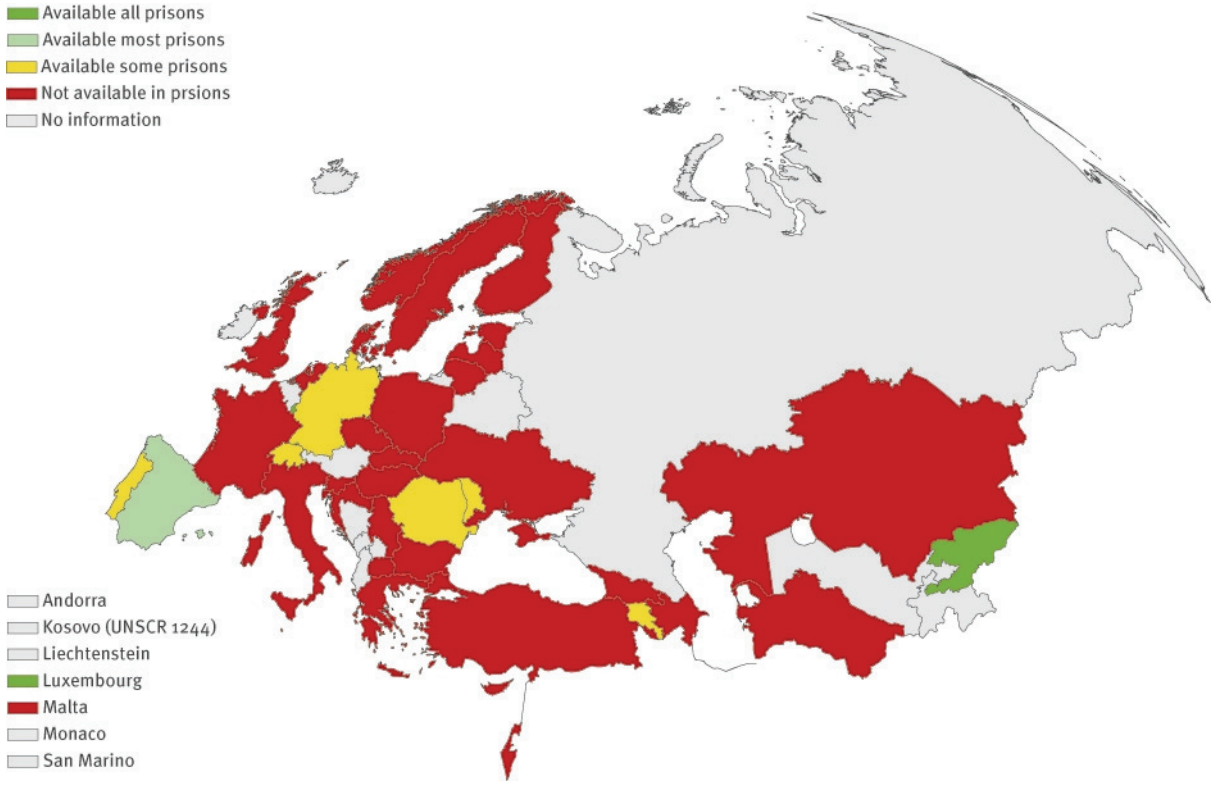


Figure 37: Map showing the extent to which needle and syringe programmes are reported to be available in prisons in Europe and central Asia



[487] EMCDDA also has data available on the extent to which OST and needle and syringe programmes are available in prisons but uses different categories to rate availability from those used in Figures 36 and 37.

Only nine (20%[488]) countries reported that needle and syringe programmes are available in their prisons. This was six (21%[489]) EU/EFTA countries and three (18%[490]) others. Two[491] reported that they are available in all prisons, one[492] in most, and six[493] in some (see Figure 37). Luxembourg and Portugal identified the provision of needle and syringe exchange in prisons as one of their most significant prevention achievements (see Section 2.1, Boxes 7 and 10).

Some countries, e.g. Denmark, commented, in other parts of this review (see Section 2.1, Box 8), that providing services for prisoners was one of the biggest prevention challenges faced by the country.

2.6.4 Programme examples

Box 28 contains brief descriptive examples of responses to HIV in prisons in two countries.

Box 28: Examples of responses to HIV in prisons

Spain has 79 prisons with over 40 000 prisoners. Up to half of those in prison have a history of injecting drug use. In 2000, HIV prevalence among prisoners was found to be 16.4%. HIV prevention programmes in prisons, including HIV counselling, education, bleach, condoms, methadone, were started between 1990 and 1993. The first pilot Needle and Syringe Exchange Programme (NEP) in a prison began in 1997 in Bilbao and other prisons have followed since then. The mode of provision of sterile injecting material is through hand to hand distribution, respecting the confidentiality of the users and allowing the possession of one syringe per inmate. All prisoners are eligible. To acquire the first syringe and needle, the prisoner requests one anti-AIDS kit, containing a syringe, needle, swabs and water for injection, from the NEP team. Further anti-AIDS kits are obtained by exchanging the used needle and syringe. NEP teams involve prison health professionals and NGOs.

With financial support from the Global Fund and USAID, **Georgia** has been able to expand counselling and testing services within prisons. Bio-behavioural surveillance among prisoners was conducted for the first time in 2009. From three prisons, including one women's prison and a juvenile colony, 210 prisoners participated. HIV prevalence was found to be 1%. However, efforts to introduce harm reduction programmes are reported to have 'not been adequate'. In addition, closer monitoring of counselling and testing in prisons was thought to be needed to ensure that services are voluntary and confidential and avoid violating prisoners' rights.

2.6.5 Conclusions

Prisons are a significant environment for the response to HIV in countries of Europe and central Asia. In many of these countries, injecting drug users have been 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 of contaminated injecting equipment and unprotected sex. Prevalence data from prisons provide evidence of the extent to which HIV is affecting prisoners in some countries, particularly when disaggregated to show rates for those who inject drugs and those who do not.

In principle, the same services should be available to prisoners as to other citizens but the evidence presented in this chapter shows that prisoners do not have equal access to services, in particular key elements of a comprehensive package of interventions for IDU.

Opioid substitution therapy is a critical service for those who inject opioid drugs, not only to prevent HIV transmission but also to allow opioid users to adhere to antiretroviral therapy. But, this service is reported to be available in only just over half of those countries that provided data relating to prisons (see Figure 35). EU/EFTA countries are taking the lead in providing opioid substitution therapy in prisons (see Figure 36). Almost three quarters of EU/EFTA countries report providing opioid substitution therapy in at least some of their prisons. But, only just over a quarter of non-EU/EFTA countries report providing opioid substitution therapy in at least some of their prisons.

Disappointingly, needle and syringe programmes are reported to be available in prisons in nine countries only, i.e. one in five of those providing data relating to prisons. The difference between EU/EFTA countries and others is less marked than for opioid substitution therapy. Countries that report providing these services are: Armenia, Germany, Kyrgyzstan, Luxembourg, Moldova, Romania, Portugal, Spain and Switzerland. These countries could be considered as examples of good practice from which other countries of the region could learn.

[488] 9/45.

[489] 6/28.

[490] 3/17.

[491] Kyrgyzstan and Luxembourg.

[492] Spain.

[493] Armenia, Germany, Moldova, Portugal, Romania and Switzerland.

There are serious gaps in coverage of key services, in particular opioid substitution therapy and needle and syringe programmes, in prisons in many countries in the region. These key services are not included in national policies and strategies for prison settings to the same extent as other services, such as the provision of information, testing and counselling (see Figure 34). More needs to be done to increase access to these key services, including changes in policy and provision of training for prison staff.

In conclusion, ECDC has identified the following issues needing 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 opioid substitution therapy 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 tuberculosis 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 ethical principles 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

2.7.1 Introduction

Globally, 40% of new HIV infections occur in the 15–24 year age group and, consequently, youth are often described as a high risk or vulnerable population. In Europe and central Asia, the extent to which young people[494] should be considered a 'risk group' or more vulnerable to HIV is an issue about which there are widely differing views.

According to surveillance data submitted to the ECDC, 11% of newly diagnosed cases of HIV infection in the EU in 2006 were in those aged 15–24 and 13% of newly diagnosed cases in EU/EFTA countries in 2008 were in this age group. However, available data suggests that HIV infection in young people in the region is associated with the predominant modes of transmission rather than age per se. In Georgia, for example, HIV infection in the 15–24 year age group is largely associated with risk factors such as injecting drug use. The situation is similar in other countries where young people account for a high proportion of PLHIV. A study of street youth aged 15–19 in Saint Petersburg in Russia found that 37% were infected with HIV and that positive HIV status was strongly associated with injecting drugs and sharing needles.

Countries were asked to provide data in response to a set of questions intended to assess approaches to promoting the sexual and reproductive health of young people and the HIV-related knowledge of young people. The policy questions used were drawn from NCPI and the knowledge indicator used is both an UNGASS and an MDG indicator.

This chapter covers country responses concerning policies and strategies to promote HIV-related sexual and reproductive health education for young people, inclusion of HIV education in primary school, secondary school and teacher training curricula, access to school-based HIV education, access to HIV prevention services for out-of school youth[495], and HIV-related knowledge of young people[496].

2.7.2 Policy environment

Almost all countries (84%[497]) reported that they have a policy or strategy promoting HIV-related sexual and reproductive health education for young people, while four (8%)[498] reported that they do not[499].

Less than half of countries have an HIV education strategy specifically for out-of-school young people. Twenty countries (41%) reported that there is a specific strategy for this group of young people and 24 (49%) reported that there is not[500].

This is perhaps not surprising since the concept of young people out-of-school[501] is perhaps less relevant in Europe and central Asia than in other regions.

2.7.3 HIV education in schools

Countries were asked to provide data about whether or not HIV education is included in primary and secondary school curricula and in the teacher training curriculum (see Figure 38).

HIV education is more likely to be part of the curriculum at secondary school than at primary school[502]. More than

[494] The UN defines adolescents as aged 10–19 years, young people as 10–24 years and youth as 15–24 years.

[495] Questions in the Dublin Declaration questionnaire were based on 2010 NCPI questions which differ from NCPI 2008 questions. Specifically, Q7 and Q8 in the questionnaire asked about whether all had access to school-based education or out-of-school prevention programmes rather than whether services were available in 'all', 'most' or 'some' districts.

[496] The specific question countries were asked to respond to is in line with the UNGASS indicator: the percentage of young people aged 15–24 who can correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

[497] 41/49.

[498] Bosnia and Herzegovina, Malta, Slovakia and the Former Yugoslav Republic of Macedonia.

[499] Albania, Iceland, San Marino and Uzbekistan did not provide any information in response to this question.

[500] Albania, Iceland, San Marino, Sweden and Uzebekistan did not provide any information in response to this question.

[501] There is no clear definition of out-of-school young people. The term out-of-school youth is used most frequently, although youth are defined as those aged between 15–24 years, a period that extends beyond school age. Definitions cover a range of groups including those who have dropped out of school, those who have never attended school and those participating in non-formal education, and a distinction is sometimes also made between 'mainstream' out-of-school youth, e.g. those who are married or working and 'marginalised' out-of-school youth, like street children, adolescent sex workers and child soldiers.

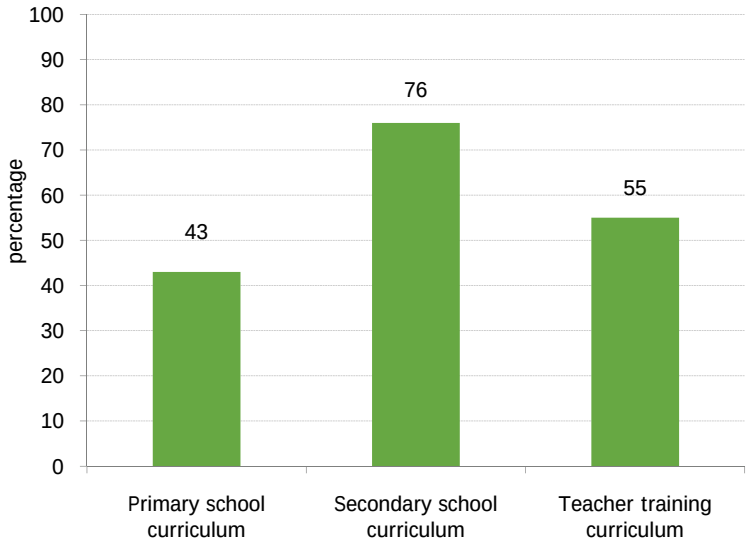
[502] This is consistent with global figures, based on UNGASS reporting, which showed 89% of countries include HIV education in secondary school curricula but only 65% address HIV education in primary schools.

three quarters of countries (76%[503]) reported that HIV education is part of the curriculum in secondary schools. In eight countries[504] (16%), HIV education is not part of the secondary school curriculum[505]. HIV education is part of the primary school curriculum in less than half (43%[506]) of countries, with slightly more (45%[507]) reporting that HIV education is not included in the curriculum at this level[508].

Somewhat surprisingly, given the high proportion of countries that include HIV education in the secondary school curriculum, only just over half (55%[509]) reported that HIV education is part of the teacher training curriculum. Seventeen countries (37%) reported that HIV education is not part of teacher training[510].

Almost all countries (86%[511]) report that the same provision is made for young women and young men in national strategy or policy promoting HIV education and in school curricula. Three countries reported that this was not the case[512,513].

Figure 38: Percentage of countries reporting that HIV education is part of the primary school, secondary school and teacher training curricula



Qualitative information about HIV education in schools from a selection of countries (see Box 29), shows that there are also differences in the way in which countries include HIV education in the curriculum and the extent to which HIV education is compulsory or optional.

[503] 37/49.

[504] Bosnia and Herzegovina, Bulgaria, Denmark, Georgia, Italy, Kyrgyzstan, Malta and Slovenia.

[505] Albania, Iceland, San Marino and Uzbekistan did not provide any information in response to this question.

[506] 21/49.

[507] 22/49.

[508] Albania, Azerbaijan, Iceland, San Marino, Switzerland and Uzbekistan did not provide any information in response to this question.

[509] 27/49.

[510] Albania, Iceland, Netherlands, San Marino and Uzbekistan provided no information in response to this question.

[511] 42/49.

[512] Bosnia and Herzegovina, Malta and Slovakia.

[513] Albania, Iceland, San Marino and Uzbekistan did not provide any information in response to this question.

Box 29: HIV education in schools

In **Lithuania**, youth education on HIV is considered a priority. Various programmes have been launched including the Life Skills Development Programme and the Programme on Preparation for Family and Sexuality Education. HIV/AIDS issues are integrated into biology, moral education and informal education curricula. Lithuania has also implemented a national project, involving collaboration between the health and education ministries, to inform young people about HIV, involve them in prevention activities, improve awareness of the consequences of high-risk behaviour and form positive attitudes towards PLHIV—school teams created posters, leaflets and videos about HIV/AIDS.

In **Romania**, HIV education is included in the health education curriculum promoted as an optional course at all levels of mandatory education—primary and secondary—and specific training programmes are being developed for teachers. In 2006, the national health education programme covered 64% of schools.

In **Sweden**, sexual and relationship education is compulsory in schools and young people are generally well informed about these issues. Sex education begins in primary school and, as children advance to secondary school they receive age-appropriate information about contraception, STI and HIV. In response to a survey, 22% of male students and 33% of female students aged 16–17 answered that they 'very' or 'fairly often' receive information about HIV in school. However, with almost 100% access to the internet, 59% of young men and 72% of young women say that the internet has been a source of information about HIV for them. In addition, since 1987, HIV prevention efforts have targeted four identified risk groups, including adolescents.

The NCPI questions focus specifically on HIV education. However, given that many countries in the region deliver HIV education in the context of sex education, as illustrated by the response from Sweden (see Box 29), questions that address the inclusion of HIV within sexual and reproductive health education would perhaps be of greater relevance in Europe and central Asia.

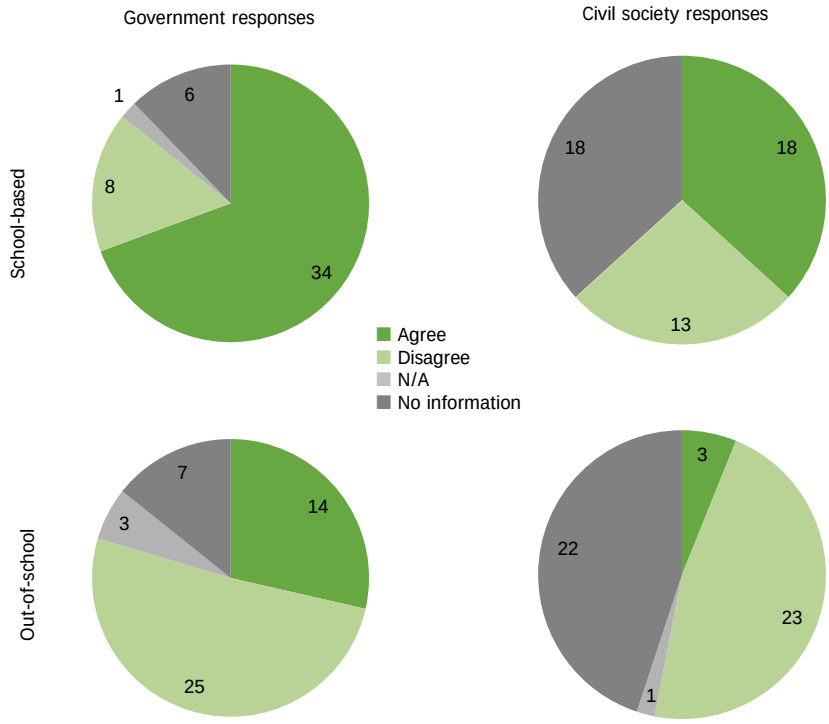
Overall, less than one third (31%[514]) of countries reported that there is both a policy to promote HIV-related education for young people and that HIV education is included in the primary, secondary and teacher training curricula.

2.7.4 Access to HIV education and prevention

Government and civil society respondents were more likely to agree that the majority in need have access to school-based HIV education than to HIV prevention for out-of school youth (see Figure 39). There were differences between government and civil society perspectives. Civil society respondents were less likely than government respondents to agree that the majority of young people have access to HIV education, both school-based and out-of-school. No information was provided by either government or civil society respondents in a relatively high proportion of countries (see Figure 39).

[514] Czech Republic, Finland, Germany, Greece, Hungary, Ireland, Latvia, Lithuania, Norway, Poland, Portugal, Romania, Serbia, Spain and Ukraine.

Figure 39: Country responses on the extent to which the majority of young people have access to school-based and out-of-school HIV education (n=49)



A number of countries provided qualitative information about HIV education and prevention programmes for young people, including out-of-school youth. Two examples are included in Box 30.

Box 30: HIV prevention programmes for young people

In **Georgia**, the Global Fund supported STI/HIV Prevention Project, implemented since 2004 by the Georgia Children's Federation, a local NGO, includes development of life skills curricula for schools and teachers, promotion of peer education and awareness raising among youth, and the establishment of youth-friendly VCT centres in five cities. The programme also conducted a survey in 2005 among youth aged 18–24 to assess HIV awareness and attitudes. Another programme, the joint UNFPA-EU Reproductive Health Initiative for Youth in the South Caucasus launched in 2006, has provided education on sexual and reproductive health and rights to more than 28 000 young people and opened 20 youth-friendly centres offering information, counselling and HIV testing to young people.

In **Hungary**, the A-HA! Sex Education Programme was launched in 2002 by the Hungarian Preventive Scientific Society of Obstetrics and Gynaecology in response to evidence that around 50% of secondary school students were sexually active and 90% of young people did not use any contraception during their first sexual experience. The programme uses a range of methods to reach young people including educational seminars run by public health nurses and gynaecologists in secondary schools and senior years of primary schools, publications, games and an interactive website. Between 2002 and 2007 the number of abortions among young people aged under 19 decreased by 19%.

2.7.5 HIV-related knowledge of young people

Of the 49 countries that responded, 36 provided data through the ECDC questionnaire, six reported that data on this indicator is not available[515], three referred to other sources of data[516] and four provided no information[517].

[515] Hungary, Luxembourg, Malta, San Marino, Slovakia and Slovenia.

[516] Italy provided article references (included in the bibliography) and Iceland and Portugal referred to the Health Behaviour in School-aged Children (HBSC) study, a WHO EURO collaborative cross-national study.

[517] Andorra, France, Ireland, Israel and Turkmenistan.

Among those reporting that data is not available, Hungary commented that the latest information stems from HBSC research in 2007, and questions did not concern HIV knowledge specifically, but there are plans to research this area in 2010, and San Marino plans to collect data for the first time in 2009–2010 through HBSC research.

Sweden highlighted challenges in collection of comprehensive data, suggesting that new data collection methods will be required in future, as response rates to postal surveys are decreasing. In a forthcoming study of youth knowledge, attitudes and behaviours, a mixed mode design will be used to allow comparison between data collected by traditional postal survey and data collected through a web survey with a self-selected sample.

Thirty-five countries (71%) reported some quantitative data about the HIV-related knowledge of young people (see Annex 7)[518,519]. Countries drew on a range of data sources to provide evidence about the HIV-related knowledge of young people. These included:

- General population surveys, for example in Belgium, Germany, Norway, Spain and the United Kingdom, and including the Multiple Indicator Cluster Survey in Albania, Azerbaijan and Uzbekistan, and the Demographic and Health Survey in Armenia.
- Specific surveys among young people, for example, in Denmark, Netherlands, Poland, Romania and Switzerland, and studies such as the Health Behaviour in School-aged Children study in Belgium and the Czech Republic.

The relevance of the UNGASS indicator was questioned by Sweden's response, which noted that it is hard to translate the five questions into the Swedish context and that the indicator is therefore not considered to be particularly useful. Relevance may also be an issue for other countries, since several used other questions to assess young people's knowledge about HIV[520].

While comparison is difficult because of differences in the questions used to assess knowledge, levels of knowledge among young people appear to be considerably higher in some countries[521] in the region than in others[522].

Responses depend on the nature of the question asked. So, for example, with respect to the five UNGASS questions, the evidence provided shows that awareness that HIV can be transmitted through sex without a condom and sharing injecting equipment is high, but is lower with respect to mother-to-child transmission, and a significant minority do not reject misconceptions about transmission through mosquito bites or sharing utensils with a PLHIV. Consequently scores for comprehensive knowledge[523] are relatively low—21 of 22 countries had scores below 50%—as this is based on giving the correct answer to all five questions. Data provided by Spain highlights this point. While 96% knew that using a condom is an effective measure to prevent sexual transmission of HIV, 17% thought that HIV could be transmitted by mosquito bite and 8% by drinking from the same glass as an infected person.

Even in countries where knowledge levels of young people are high with respect to the main modes of HIV transmission and methods of HIV prevention, knowledge in other areas is less comprehensive. For example, in the Netherlands, where young people have high levels of knowledge about HIV transmission and prevention, awareness that the presence of an STI can increase the risk of HIV infection was lower. Similarly, in Belgium, a high proportion of young people responded correctly to questions about HIV transmission through unprotected sex, sharing injecting equipment and mother-to-child transmission, but only around half could correctly identify inefficient methods of protection[524].

Data provided by the Netherlands reported knowledge in young people disaggregated by those who had no sexual experience, those who had casual sexual partners and those who were in a steady relationship. Broadly speaking, knowledge was better among those who reported sexual activity than those who had no sexual experience, and better among those in a steady relationship than those with casual sexual partners.

Some countries reported differences in levels of knowledge between young men and young women. In most countries where a difference was reported, young women tended to be better informed than young men. The difference was especially marked in countries such as Croatia, Estonia, Romania and the Former Yugoslav Republic

[518] 16 (33%) countries provided data disaggregated by sex, three (6%) provided data for young women only, two (4%) provided overall data but no data disaggregated by sex. No country provided data disaggregated by age 15–19 and 20–24 years. Data in some cases related to different age groups from the 15–24 year age group used for the UNGASS indicator. For example, data provided by Germany related to those aged 16–24 years, by the Netherlands to those aged 15–35 years and by Spain to those aged 18–29 years.

[519] One country, the Czech Republic, reported qualitative information.

[520] Nine countries provided other evidence about young people's knowledge.

[521] For example, Belgium, Denmark, Germany, Finland, Netherlands, Norway, Spain, Sweden and the United Kingdom.

[522] For example, Albania, Azerbaijan, Cyprus, Georgia, Latvia, Kazakhstan and Tajikistan.

[523] Based on answers to the questions used for the UNGASS indicator.

[524] Use birth control pill; choose healthy-looking partners; withdraw before ejaculation; wash after having sex.

of Macedonia. Only in Armenia and Greece were young men reported to have higher levels of knowledge than young women.

Some countries also provided evidence suggesting that there have been positive changes in knowledge among young people, for example, Albania, Armenia, Azerbaijan, Kyrgyzstan, Moldova, Tajikistan and Uzbekistan. In many cases these improvements have been modest.

2.7.6 Conclusions

In Europe and Central Asia, the extent to which young people are affected by HIV varies. Clearly, not all young people are equally at risk of HIV infection across the region. However, some young people are particularly at risk of HIV infection such as young and adolescent MSM, young sex workers and young people who inject drugs. The majority of countries that responded have a policy or strategy to promote HIV-related reproductive and sexual health education for young people (82%) and include HIV education in the secondary school curriculum (76%). But, 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%).

It is critical that young people are taught about sexual and reproductive health, As a result, integrated sexual and reproductive health and HIV education needs to be provided through schools in countries of the region. There are examples of good practice in the region from which other countries could learn.

As all young people are not equally at risk of HIV infection, there is a need for better understanding of which young people are at particular risk in which context. There is a pressing need for effective policies and programmes to prevent HIV transmission among the most vulnerable groups of young people.

In conclusion, ECDC has identified the following issues needing 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 form 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. In many countries, 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

3.1.1 Introduction

This chapter looks at issues of critical importance to people living with HIV, namely the provision of antiretroviral therapy and associated care and support services. This includes co-management of HIV and tuberculosis (TB) and the provision of antiretroviral drugs to HIV-positive women to prevent mother-to-child transmission of HIV.

The chapter is strongly based on indicators recommended by UNAIDS for monitoring progress in implementing the UNGASS Declaration of Commitment and considers the limitations of these for some of these topics in Europe and central Asia.

The chapter looks at trends in the numbers of people receiving antiretroviral therapy (ART) in countries of Europe and central Asia and what this means in terms of 'coverage', that is the extent to which all people who need treatment receive it. In addition to this quantitative data, this review also considers stakeholder perception of coverage of key services, the overall policy environment for provision of treatment, care and support services, how countries assess needs for treatment care and support, and what countries consider to be their major achievements and remaining challenges in these areas.

It then briefly considers the issue of co-management of HIV and TB before closing with a review of the use of antiretroviral drugs for the prevention of mother-to-child transmission (PMTCT) of HIV. It focuses on the number of women receiving this service in countries of Europe and central Asia, what this represents in terms of coverage of those needing the service and the outcome of this, in terms of rates of mother-to-child transmission of HIV.

3.1.2 Coverage of antiretroviral therapy (ART)

Almost all (82%[525]) countries responding to the review provided information on the number of people living with HIV receiving ART (see Table 28).

Several countries have reported data[526] over a number of years meaning that trends can be plotted (see Figure 40). Such graphs show increases in all countries. In some cases, for example, Estonia, Russia and Ukraine, the number of people on treatment increased up to 10-fold between 2003–2004 and 2007. This may reflect rising need as a result of a fairly recent epidemic. However, the rise did occur from an initial low base. There is a wide variation in numbers of people on ART in reporting countries. One quarter (25%[527]) report less than 100 people on treatment with almost two thirds (65%[528]) having less than 1 000 people on treatment. Of the 14 countries reporting more than 1 000 people on treatment, five[529] report more than 10 000 on treatment. In some cases, for example the Czech Republic and Turkey, figures are estimations. Some countries explained why they were unable to track these figures[530].

Table 28: Reported coverage of ART in Europe and central Asia

Country	Year	Number	Coverage	Comment
Albania[531]	2007	74	N/A	50 in 2004; 45 in 2006.
Armenia[531]	2007	78	9%[532]	0% in 2003; 29 in 2005 [6(4–8%)]; 47 in 2006 [8(5–12%)].
Azerbaijan[531]	2007	81	14(6–24)%[533]	0% in 2003; 7 in 2006 [1%].

[525] 40/49. Countries that did not provide data were Andorra, France, Iceland, Ireland, Italy, Norway, San Marino, Switzerland and Turkmenistan. In commenting on the draft report, France explained that, in 2008, 88% of those receiving care for HIV infection received ART.

[526] To UNAIDS for UNGASS monitoring.

[527] 10/40.

[528] 26/40.

[529] Germany, Portugal, Russia, Spain and the United Kingdom.

[530] For example, San Marino residents are provided free HIV and AIDS treatment and care in Italy. This means that San Marino does not have data on how many residents are receiving ART.

[531] UNGASS 2008.

[532] Based on country-reported figure of those in need of treatment of 860. UNAIDS estimated that the number of people needing treatment was 660 (< 500–1 000) resulting in a coverage of 12 (8–17)%.

[533] Based on UNAIDS denominator figures for low-level epidemics, UNAIDS estimates have very wide ranges of confidence, resulting in high levels of uncertainty of coverage estimates based on using these estimates as denominator.

Country	Year	Number	Coverage	Comment
Belgium[531]	2006	6 450	67(39–>95)%[533]	94% in 2003. These figures reported to UNGASS differ from those reported by the country of 5 788/6 177 = 94%. For the figures reported by the country, the denominator is the sum of those on ART and those PLHIV with a CD4 below 350 cells/mm^3 but not on treatment.
Bosnia and Herzegovina[531]	2007	30	100%[533]	13 [10%] in 2003; 29 in 2005; 19 in 2006.
Bulgaria[531]	2007	221	N/A	90(45%[534]) in 2004; 187 in 2005; 196 in 2006.
Croatia[531]	2007[535]	310[536]	N/A	204 [> 95%] in 2003; 247 in 2005; 291[537] in 2006.
Cyprus	2009	178	N/A[538]	151[531] [98%] in June 2007.
Czech Republic	2009	circa 550	N/A[539]	570[531] [56(30–>95)%] end 2007; 270 [34(18–57)%] in 2004; 322 [37(19–62)%] in 2005; 570 [60(32–>95)%] in 2006.
Denmark	2009	3 000	94%[540]	4 000 known to be living with HIV.
Estonia[531]	2007	772	38(19–81%)[533]	76 [12(4–33)%] in 2004; 201 in 2005 [19(7–48]%); 495 in 2006[33(15–76)%].
Finland[531]	2006	450	54%[533,541]	95% in 2003.
Former Yugoslav Republic of Macedonia[531]	2007	15	N/A	2 [20%] in 2003; 7 in 2005; 11 in 2006.
Georgia[531]	2007[542]	334[543]	72%[544]	83 in 2003 [8%]; 140 in 2005 [>95%]; 267 in 2006 [69%].
Germany[531]	2006	27 000	N/A	95% in 2003.
Greece	2008	4 233	N/A	3 426[531] in 2006.
Hungary[531]	2007	452	22(13–38)%[533]	300 [20(11–33)%] in 2004; 402 [24(13–39)% in 2005; 412 [22(13–37)%] in 2006.
Israel[531]	2006	2 431	64%[545]	
Kazakhstan[531]	2007	442	41%[546]	7 [< 1(< 1–5)%] in 2004; 240 [23(12–62)%] in 2005; 326 [23(13–39)%] in 2006.
Kyrgyzstan[531]	2007	87	25%[547]	46 in 2005; 47 [23%] in 2006.

[534] In reviewing this report, Bulgaria questioned the origin of this figure. It is reported by UNAIDS in their Report on the Global AIDS Epidemic 2008.

[535] June.

[536] Projected 322 by end 2007.

[537] UNAIDS figures.

[538] The total number of people living with HIV who are currently alive and have ever had a CD4 count < 350 cells/mm^3 is 118. The total number of people living with HIV diagnosed in the last year who had a CD4 count < 350 cells/mm^3 at the time diagnosis is 15. The estimated number of people living with HIV is 260.

[539] Every patient who has indications for treatment and health insurance is reported to receive optimal treatment. Total of around 950 people living with HIV.

[540] Based on supplied figure of 3 200 people needing treatment.

[541] This figure does not appear to be accepted in Finland. A much higher estimate of 95% coverage was submitted to UNGASS in 2010.

[542] November.

[543] Projected 343 by end 2007.

[544] Based on country-reported figure of those in need of treatment of 476.

[545] Percentage as reported to UNAIDS.

[546] Based on country-reported figure of those in need of treatment of 1 078. UNAIDS estimated that the number of people needing treatment was 1 900 (1 200–3 200) resulting in a coverage of 23(14–36)%.

[547] Based on country-reported figure of those in need of treatment of 345. UNAIDS estimated that the number of people needing treatment was 610 (< 500–1 100) resulting in a coverage of 14(1–26)%.

Country	Year	Number	Coverage	Comment
Latvia[531]	2007	323	15(9–22%)[533]	202 [25(9–38)%] in 2004; 235 [19(9–29)%] in 2005; 301 [18(10–27)%] in 2006.
Lithuania[531]	2007	98	75%[548]	37 [55%] in 2003; 55 in 2005; 75[537] in 2006 [79%].
Luxembourg	2009	354	N/A[549]	312[531] in 2006.
Malta	2008	91	N/A[550]	65[531] in 2007.
Moldova[531]	2007	464	54%[551]	120 [8%] in 2003 [8%] 222 in 2005; 262 [48%] in 2006.
Netherlands[531]	2007	7 919	61(36–> 95%)[533]	> 95% in 2003.
Poland[531]	2007	3 382	77%[552]	2000 [35(20–59)%] in 2004; 2707 [39(22–66)%] in 2005; 3072 [38(21–64)%] in 2006.
Portugal	2009	14 000	N/A	60% diagnosed with < 350 cells/mm^3 CD4 (35% < 200).
Romania[531]	2007	6 500	101%[553]	6 000 [82(70–> 95)%] in 2004; 6 116 [77(66–> 95)%] in 2005; 6 790 [81(69–> 95)%] in 2006.
Russia[531]	2007	31 094	93%[554]	3 000 [4(2–7)%] in 2004; 5 000 [5(2–7)%] in 2005 and 14 681 [10(6–15)%] in 2006.
Serbia[531]	2007	628	17(8–30)%[533]	317 [11(6–19)%] in 2004; 580 [19(9–32)%] in 2005; 608 [18(9–31)%] in 2006.
Slovakia[531]	2007	98	N/A	65 [95%] in 2003; 65 in 2005; 96 in 2006.
Slovenia[531]	2007	157	N/A	147 in 2006.
Spain[531]	2006	77 500	N/A	92% in 2003.
Sweden[531]	2006	2 800	74%[545]	95% in 2003.
Tajikistan[531]	2007	86	109%[555]	0 in 2003; 5 [< 1(< 1–7)%] in 2005; 37 [4(2–10)%] in 2006.
Turkey	2009	circa 700	N/A	250[531] in 2004; 344 in 2005; 685 in 2006.
Ukraine[531]	2007	7 657	35%[556]	1 000 [2(2–3)%] in 2004; 3450 [5(4–7)%] in 2005; 4777 [6(5–8)%] in 2006.
United Kingdom[531]	2006	35 000	> 95%[545]	92% in 2003.
Uzbekistan	2009	2 536[557]	N/A	259[531] [30(12–66)%] in 2006; 319 [24(9–51)%] in 2007[558].

[548] Based on country-reported figure of those in need of treatment of 131. UNAIDS estimated that the number of people needing treatment was 550 (< 500–1 200) resulting in a coverage of 18(8–31)%.

[549] As of 28 October 2009, the number of people living with HIV was 509. Of these, those who were alive and have ever had a CD4 count < 350 cells/mm^3 were 284. The total number of people living with HIV diagnosed in the last year who had a CD4 count< 350 cells/mm^3 at the time diagnosis was 11.

[550] Approximately 132 enrolled in HIV care.

[551] Based on country-reported figure of those in need of treatment of 856. UNAIDS estimated that the number of people needing treatment was 800 (540–1 100) resulting in a coverage of 58(43–86)%.

[552] Based on country-reported figure of those in need of treatment of 4 390. UNAIDS estimated that the number of people needing treatment was 9 300 (5 500–17 000) resulting in a coverage of 36(20–82)%.

[553] Based on country-reported figure of those in need of treatment of 6 418. UNAIDS estimated that the number of people needing treatment was 8 900 (5 400–10 000) resulting in a coverage of 73(62–> 95)%.

[554] Based on country-reported figure of those in need of treatment of 33 365. UNAIDS estimated that the number of people needing treatment was 190 000 (120 000–300 000) resulting in a coverage of 16(10–25)%.

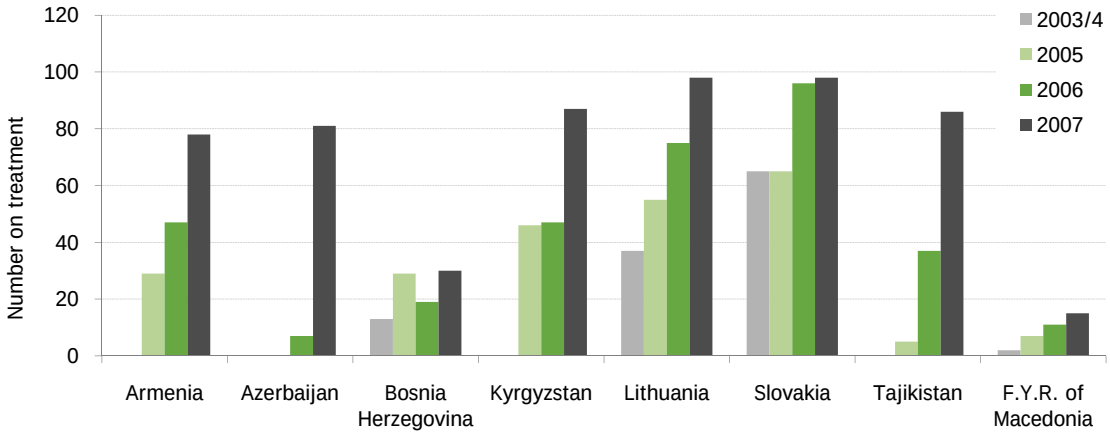
[555] Based on country-reported figure of those in need of treatment of 79. UNAIDS estimated that the number of people needing treatment was 1 300 (750–2 400) resulting in a coverage of 6(4–11)%.

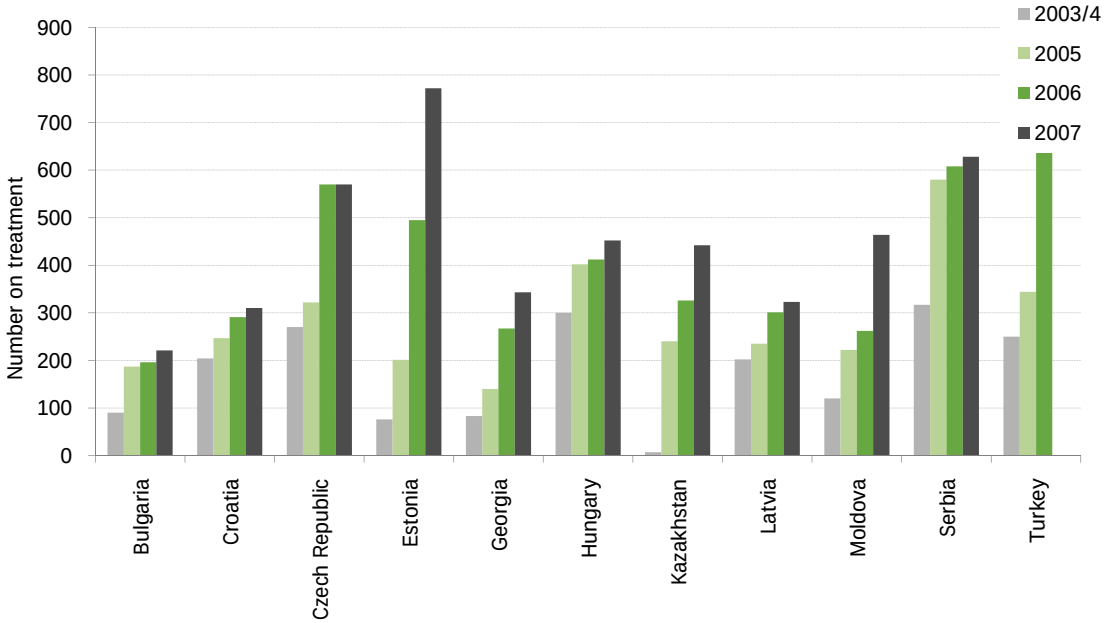
[556] Based on country-reported figure of those in need of treatment of 21 770. UNAIDS estimated that the number of people needing treatment was 91 000 (69 000–120 000) resulting in a coverage of 8(7–11)%.

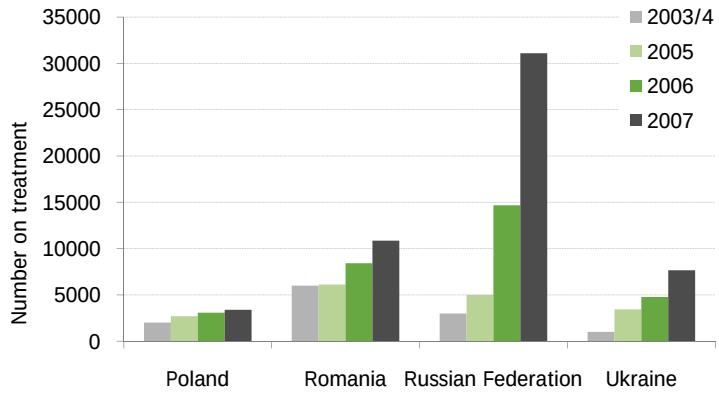
[557] Cumulative total inclusive of PMTCT and PEP.

[558] Figures supplied by WHO.

Figure 40: Trend data for ART in selected countries[559] of Europe and central Asia[560]







[559] Countries selected on the basis of having absolute figures available of those on treatment for two or more years.

[560] Note different scale for three graphs. First graph shows countries with < 100 people on ART. Second graph shows countries with < 1 000 people on ART. Third graph shows countries with > 1 000 people on ART.

It is important to know not only the number of people receiving ART, but also the proportion of those who need it that receive it, i.e. the coverage. Coverage figures were available for 60%[561] of those countries with figures for number of people on ART (see Table 28).

In some cases, differing figures for coverage were provided for a particular country from different sources. As this report is based on country-reported data, priority has been given to coverage figures reported by countries. However, the alternative figures are also provided. The reasons behind the different coverage estimates are important and are explained in detail in the next subsection.

3.1.3 Measuring ART coverage: different approaches

Most countries have a clinical protocol that defines those who need ART. This may be based on particular clinical indications, such as an AIDS-defining illness, or a CD4 count below a certain level[562]. As a result, many countries argue that those who need treatment are those who are known to be HIV positive and meet these criteria.

However, this approach overlooks those who would meet the criteria but are not yet aware of this, for example, if they have not yet been tested for HIV or have not had a CD4 count. In some countries, the numbers of these are significant.

For this reason, UNAIDS and other international organisations recommend that ART coverage should be calculated as a percentage of all those in a country with advanced HIV infection[563]. This figure is estimated using modelling software, such as Spectrum[564]. Given this difference in approach between countries and international organisations, such as UNAIDS, it is not surprising that widely differing coverage figures have been generated in some cases (see Table 29).

Table 29: Difference in ART coverage figures, country reports and UNAIDS estimates

Country	No. on ART	Country figures		UNAIDS figures[565]	
		No. need ART	Coverage	No. need ART	Coverage
Bosnia and Herzegovina	30	30	100%	N/A	N/A
Kazakhstan	442	1 078	41%	1 900	23%
Lithuania	98	131	75%	550	18%
Moldova	464	856	54%	800	58%
Poland	3 382	4 390	77%	9 300	36%
Romania	6 500	6 418	101%	8 900	73%
Russia	31 094	33 365	93%	190 000	16%
Tajikistan	86	79	109%	1 300	7%
Ukraine	7 657	21 770	35%	91 000	8%

In some cases, for example, Moldova, the coverage figures generated by the country are broadly similar to those generated by UNAIDS. This is because the country has adopted the same or similar method as used by UNAIDS. In other cases, there are very significant differences in estimated need and coverage—for example in Russia, where the country estimates that 33 365 people need treatment, whereas UNAIDS estimates are over five time higher.

However, European countries have raised concerns about the relevance of modelling methods used by UNAIDS to estimate the number of PLHIV needing ART. This issue was discussed extensively in the advisory group established for this review. Some countries question the value of measuring ART coverage at all in countries where medical services are universally available[566]. Particular concerns were expressed about the UNAIDS estimates of people

[561] 24/40.

[562] Previously, many countries recommended ART for asymptomatic people with a CD4 count below 200 cells/mm^3. Currently, many countries are adopting a higher threshold of 350 cells/mm^3.

[563] This is the approach used for the UNGASS indicator on ART.

[564] It should be noted that the UNAIDS' models are applicable to low- and middle-income countries only. There are also concerns that the assumptions that the software is based on are only valid for relatively high prevalence situations. The results given for many countries with low level or concentrated epidemics in Europe and central Asia may be unreliable or have very wide uncertainty ranges.

[565] In addition, UNAIDS also provided a range.

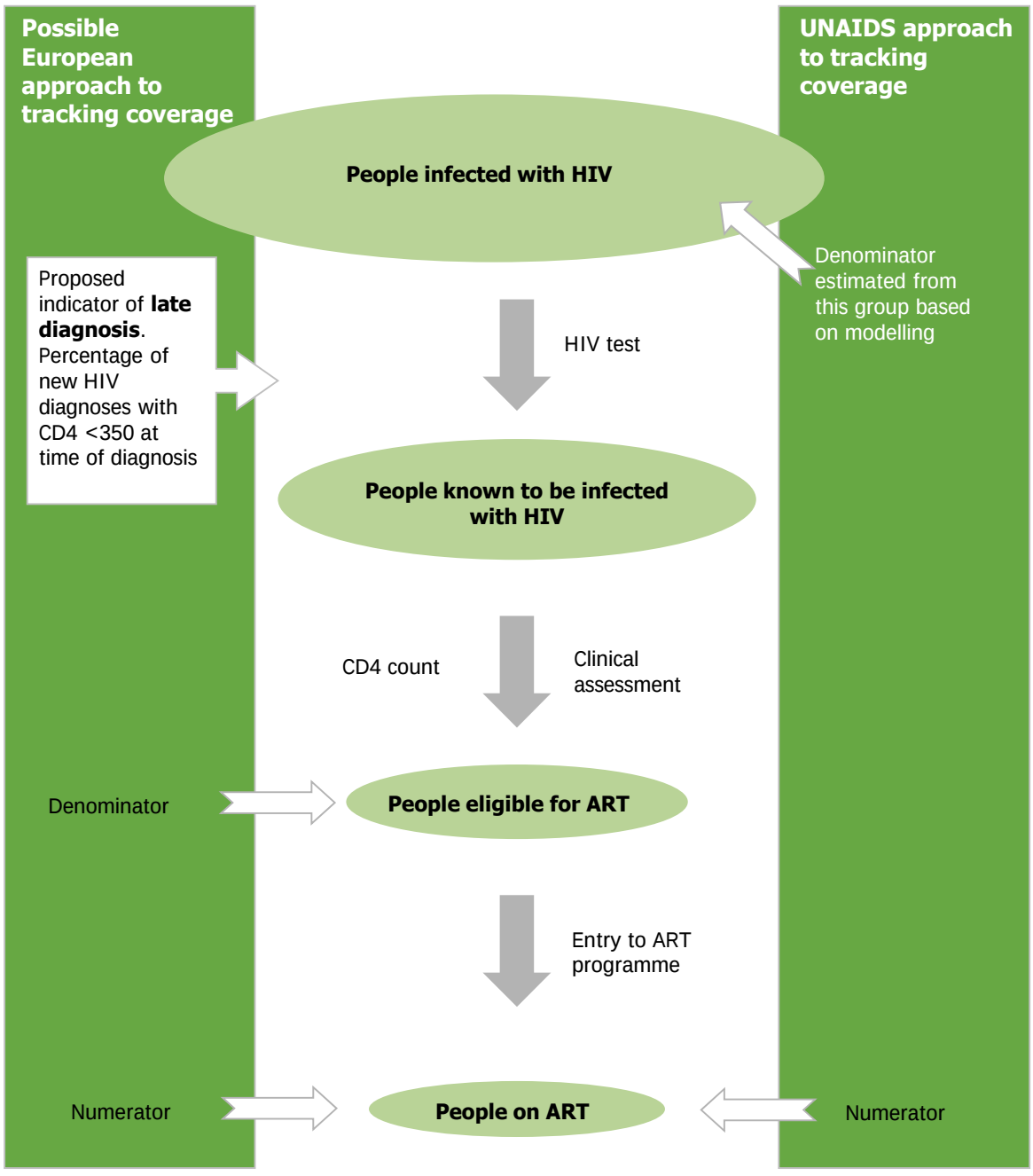
[566] Several countries commented to this effect in their response to their review. Broadly, this was the view that there is no need to measure who is getting treatment because everyone who needed it receives it. Countries expressing this view included the Czech Republic, Ireland, Norway and Switzerland. In some cases, there were some qualifying statements, e.g. regarding health

needing ART. These were felt to be of limited relevance to Europe and to confuse two issues, namely access to treatment and late diagnosis of HIV infection.

The advisory group proposed that access to ART could be better measured using a combination of two indicators (see Figure 41):

- an indicator of late diagnosis – % of new HIV diagnoses with a CD4 count less than 350 cells/mm^3 at time of diagnosis[567]; and
- an indicator of ART coverage – % of those who have ever had a CD4 count less than 350 cells/mm^3 that are on ART.

Figure 41: Alternative approaches to tracking ART coverage



insurance in the Czech Republic. However, these are essentially statements of policy. Evidence presented, e.g. on rates of late diagnosis (see Table 30) raises questions about whether all people living with HIV with indications for ART are receiving it promptly even in countries where ART is, in principle, available to all.

[567] In commenting on the report, Spain suggested that there needs to be a defined timeframe within which a CD4 count needs to be performed to be considered 'at time of diagnosis.'

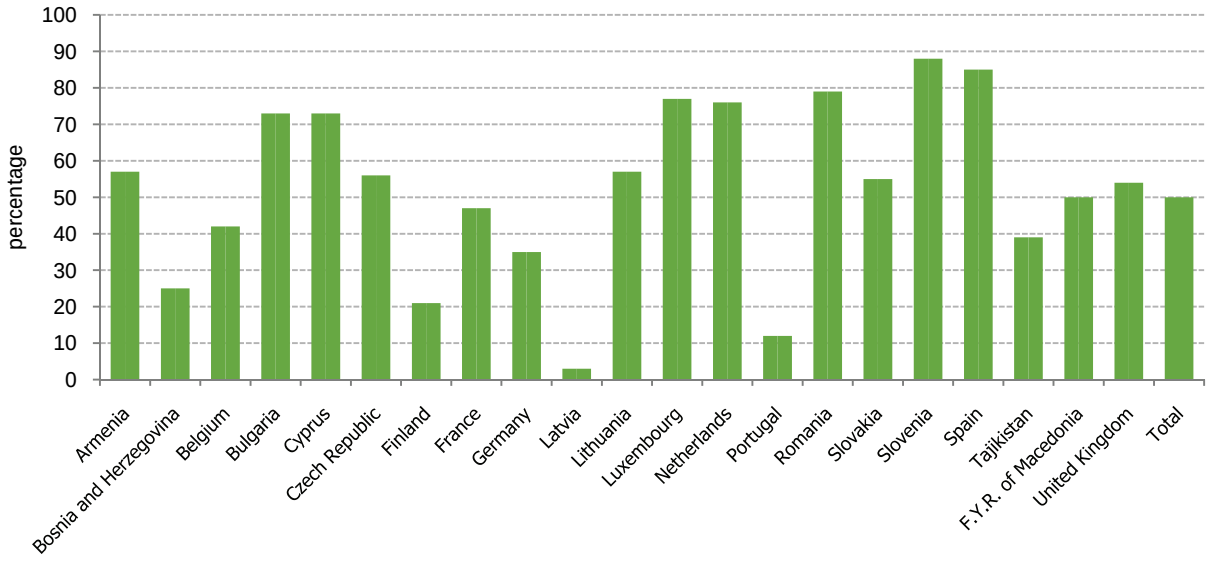
ECDC and WHO collect surveillance data from countries[568] of Europe and central Asia based on HIV and AIDS case reporting. This review examined the availability of data for the relevant indicators within ECDC databases.

Data on CD4 count at the time of diagnosis has been included in ECDC HIV surveillance systems from 2007. Twenty-one countries reported on CD4 count at the time of diagnosis in 2008 (see Figure 42 and Table 30). The extent to which CD4 counts were available at the time of HIV diagnosis in 2008 was highly variable from 3[569]-88[570]%[571]. Overall, in the countries reporting, half (50%) of those diagnosed with HIV had a CD4 count reported at the time of diagnosis.

Rates of late diagnosis were 26–53% overall[572]. More than half of those who had a CD4 count at the time of diagnosis in reporting countries had a CD4 count of less than 350 cells/mm^3. These figures are of concern because these people would be starting ART later than recommended. They effectively lower ART coverage figures if measured using the UNAIDS method.

ECDC's surveillance of HIV infection and AIDS is based on the model transferred from the earlier EuroHIV project, where HIV and AIDS cases were kept in different, unlinked data sets. ECDC has as its long-term goal to improve European HIV/AIDS surveillance by combining the two stages of the disease into a single dataset. This would reduce reporting burden and enable more sophisticated analysis of reported data, including coverage of ART at different disease stages, as defined both by CD4 data and/or AIDS diagnosis.

Figure 42: Percentage of new diagnoses with CD4 count at time of diagnosis, 2008



Source: ECDC

[568] ECDC supplied data for 44 countries from its AIDS database and for 47 countries from its HIV database. Austria is included in the AIDS database but not for HIV. Andorra, Iceland, Kazakhstan and Ukraine are included in the HIV database but not for AIDS. Kosovo UNSCR 1244, Liechtenstein, Monaco, Russia, San Marino and Turkmenistan are not included in either of these ECDC databases. Data from Italy is included in both databases but this was not supplied for the purpose of this review.

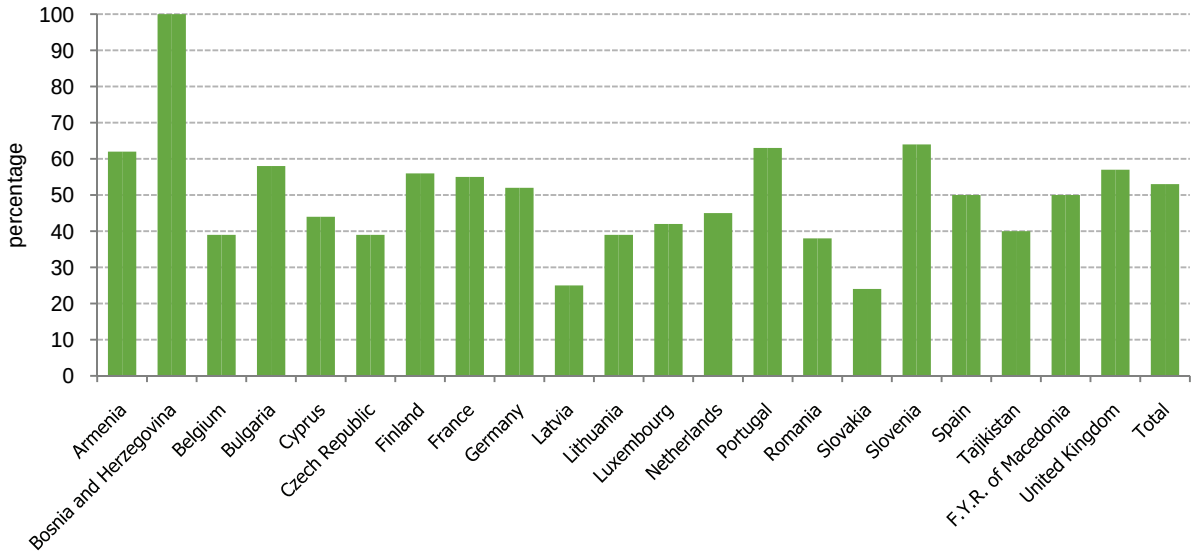
[569] Latvia.

[570] Slovenia.

[571] 13 countries achieved CD4 count rates of 50% or higher. Slovenia and Spain achieved rates of over 80%. More than one third (37%) of all reported CD4 counts at the time of diagnosis came from one country, the United Kingdom.

[572] Depending on whether the denominator used is the number of CD4 counts performed or the number of new HIV diagnoses. The former is likely to overestimate rates of late diagnoses particularly where CD4 counts are performed purposively, e.g. on the basis of symptoms. The latter approach is likely to underestimate late diagnoses.

Figure 43: Percentage of those with a CD4 count at time of diagnosis with a CD4 count < 350 cells/mm^3, 2008



Source: ECDC

Table 30: ECDC data on CD4 counts at time of HIV diagnosis, 2008

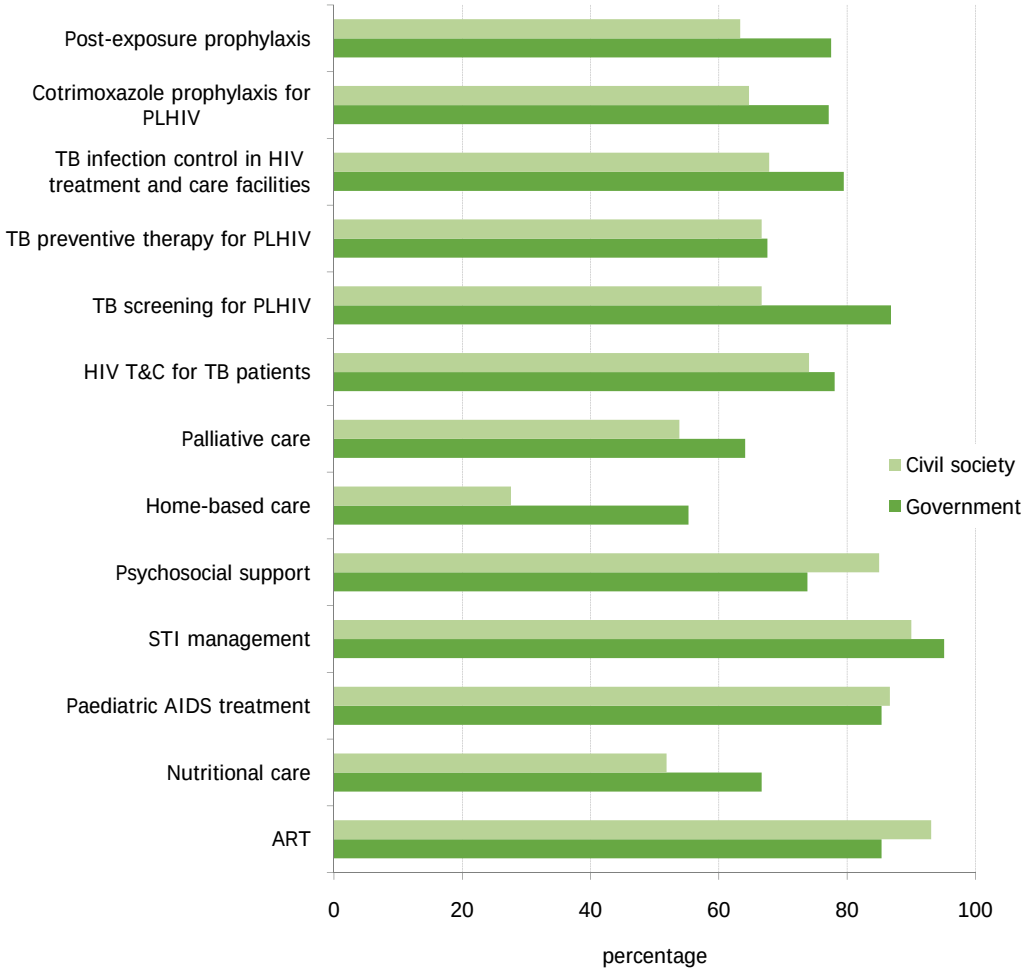
Country	No. new HIV diagnoses	CD4 counts available		CD4 count < 350		
		No.	%	No.	% of available CD4 counts	% of new HIV diagnoses
Armenia	136	77	57	48	62	35
Bosnia and Herzegovina	8	2	25	2	100	25
Belgium	1 079	456	42	178	39	17
Bulgaria	122	89	73	52	58	43
Cyprus	37	27	73	12	44	32
Czech Republic	148	83	56	32	39	22
Finland	154	32	21	18	56	12
Former Yugoslav Republic of Macedonia	4	2	50	1	50	25
France	4 068	1 923	47[573]	1 051	55	26
Germany	2 806	969	35	507	52	18
Latvia	358	12	3	3	25	1
Lithuania	95	54	57	21	39	22
Luxembourg	47	36	77	15	42	32
Netherlands	1 367	1 027	76	465	45	34
Portugal	1 124	131	12	82	63	7
Romania	179	142	79	54	38	30
Slovakia	53	29	55	7	24	13
Slovenia	48	42	88	27	64	56
Spain	1 583	1 345	85	666	50	42
Tajikistan	331	129	39	52	40	16
United Kingdom	7 298	3 910	54	2 241	57	31
Total	**21 045**	**10 517**	**50**	**5 562**	**53**	**26**

[573] In reviewing this report, France commented that this figure should be 42%.

3.1.4 Perceptions of access to treatment, care and support services

Government and civil society respondents were asked to comment on the extent to which the majority of people[574] in need of particular services have access to them. Figure 44 shows the percentage of respondents[575] agreeing with this statement for specific services. Services considered to be widely available[576] include ART, paediatric AIDS treatment, STI management, psychosocial support for PLHIV and their families[577] and TB screening for PLHIV[578,579]. Services which are considered less widely available[580] include home-based care, nutritional care[577] and palliative care[577,581].

Figure 44: Percentage of respondents[582] agreeing that the majority in need have access to a specific service



[574] This was the wording of the questionnaire based on NCPI 2010. The wording in NCPI 2008 was different and focused on districts rather than people.

[575] Who expressed an opinion. In general, this was higher for government respondents (n between 35 and 42) than for civil society respondents (n between 26 and 30).

[576] > 80% of respondents agree with statement.

[577] Civil society only.

[578] Government only.

[579] In most cases, government assessment is more optimistic than civil society. There are a few exceptions, e.g. psychosocial support. One explanation could be that civil society is the main provider of these services so assesses them more favourably.

[580] < 60% respondents agree with statement.

[581] And treatment of common HIV-related infections.

[582] Who expressed an opinion.

3.1.5 Policy environment for providing HIV-related treatment, care and support

Almost all (94%[583]) 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%[584]) report that it specifically addresses barriers facing women and most-at-risk populations (78%[585])[586,587].

Almost half[588] (49%[589]) of countries responding reported that the country has laws, regulations or policies that present obstacles to effective HIV treatment, care and support[590] for particular populations. Figure 45 shows the extent to which specific subpopulations 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[591].

Some of these issues are interlinked. For example, the Czech Republic explained that migrants may face difficulties in accessing services if they lack health insurance. Box 31 presents other reasons from other countries.

Box 31: Reasons for difficulties in accessing HIV treatment, care and support services

In **Ireland**, individuals in all groups appear to have difficulties accessing social support due to stigma-related fears.

In **Norway**, migrants often lack knowledge about their rights and how systems work. There may also be communication problems. Prisoners face more general problems relating to proper healthcare. NGOs express concern that HIV treatment, care and support services are too clinical and do not take a sufficiently holistic approach.

In **Slovakia**, people living with HIV have significant problems in accessing general medical services, such as dental and gynaecological care because they are obliged to reveal their status to health workers who may discriminate against them by being reluctant to provide them with the health services they require.

The majority of those who responded[592] reported that their country had identified specific needs for HIV treatment, care and support services. For example, Estonia conducted an initial needs assessment in 2005 and has conducted an annual review of the epidemiological situation and progress of the national response since then. Other countries, for example, Uzbekistan, report basing their assessment of need on results from epidemiological surveillance. Some countries, for example, Slovakia, have established a consultative body, to review needs, that draws together experts and civil society representatives. Norwegian NGOs commented positively on the involvement of civil society in the process of assessing needs. They also pointed out the value of specific research into the needs of PLHIV. In

[583] 46/49. Two countries (Albania and Iceland) did not respond to this question. Andorra indicated that it did not have a policy or strategy on this issue.

[584] 37/46.

[585] 36/46.

[586] Our questionnaire asked about women and most-at-risk populations separately. NCPI in UNGASS 2008 reporting asked about these populations in one question.

[587] San Marino did not provide information for either of these populations and Switzerland did not provide information for most-at-risk populations. The eight countries reporting that their policy/strategy on treatment, care and support does not address barriers facing women and most-at-risk populations were Cyprus, Denmark, Germany, Greece, Ireland, Italy, Kyrgyzstan and Romania.

[588] Our questionnaire directed this question to government respondents whereas NCPI in UNGASS 2008 addressed this question to civil society. Almost three quarters (72% [21/29]) of those responding to NCPI in 2008 identified these obstacles in their country. However, less than one fifth (18% [3/17]) identified these obstacles in their country in their responses to this questionnaire. It is unlikely that this reflects actual differences between countries but differences in the extent to which obstacles are identified by government and civil society respondents. In UNGASS 2010, this question is being asked of both civil society and government respondents.

[589] 24/49. 22 reported that they had no such obstacles. Three did not respond.

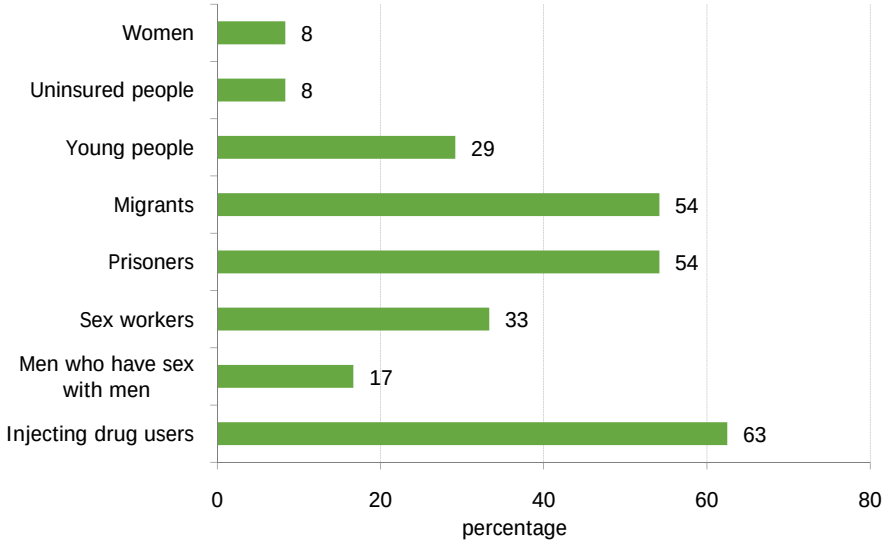
[590] Although our questionnaire asked only about treatment, care and support, the question in NCPI also included reference to prevention. This same question was included in the section of our questionnaire on prevention (see Section 2.1).

[591] Some other groups were identified as having more difficulty in accessing HIV treatment, care and support services. These included trafficked women in Denmark and homeless people in Italy.

[592] 10/17 (59%) of government respondents and 9/11 (82%) of civil society respondents. The numbers responding to this question were low because the question in our questionnaire was based on NCPI 2010 and was not directly comparable to the question in NCPI 2008, which was focused on districts. For this reason, NCPI data could not be used for this question.

other countries, for example, Ireland, civil society expressed concern that their organisations and PLHIV had not been involved in initial assessments of need, although this situation has now changed.

Figure 45: Percentage of countries reporting legal, regulatory and policy barriers for specified populations to access HIV treatment, care and support (n=24)[593]



Assessments identified a range of needs in different countries including:

- The need for a range of **specific services** including clinical management[594]; counselling; nursing; psychological support; home care[595]; 'therapeutic coordination apartments'[596]; community workers to support particular ethnic groups[597]; life skills training for PLHIV[598]; positive prevention[599]; post-exposure prophylaxis[600]; support services[601]; and STI diagnostics and treatment[602].
- Issues relating to the **mode of service delivery** including development of specialised services in infectious disease clinics[603]; collaboration with NGOs[603]; greater use of GPs and better links between GPs and specialised services[604]; and the need for detailed implementation plans for the national strategy[605].
- Appropriate **financing mechanisms** including reimbursement systems[606]; free services for 'risk' groups[607]; and issues relating to health insurance not covering everyone needing services[608].
- Protection of **legal rights**, for example of people living with HIV[609].

[593] The NCPI has a single question that asks about barriers to accessing HIV prevention, treatment, care and support (see Section 2.1, Figure 20). Countries that had not answered the NCPI question were asked a separate question in the Dublin Declaration, which used similar but slightly different wording to the NCPI and so produced slightly different data–shown in Figure 44–but the findings are essentially much the same.

[594] Including detailed treatment protocols (e.g. in Denmark).

[595] E.g. in Finland.

[596] Finland.

[597] Israel.

[598] Norway.

[599] Including IEC materials and condoms in Portugal.

[600] E.g. in Czech Republic and Portugal.

[601] E.g. in Cyprus.

[602] E.g. in Czech Republic.

[603] Czech Republic.

[604] Norway.

[605] Estonia.

[606] Finland and Turkmenistan.

[607] Slovakia.

[608] E.g. undocumented migrants in Czech Republic.

[609] E.g. in Italy.

- Needs of **particular populations** including 'hard to reach' groups[610]; TB services for PLHIV from Africa[611]; and undocumented migrants[612].
- The value of links to **other countries** particularly for smaller countries that may not be able to provide all required services[613]

Governments and civil society[614] were asked to rate the country's efforts in implementation of HIV treatment, care and support programmes using a numerical score from 0–10. Mean score was 7.65[615] (median 8) for government responses and 6.97[616] (median 8) for civil society responses. Countries with low scores[617] were two[618] for government responses and six[619] for civil society responses. Countries with high scores[620] were six[621] for government responses and eight[622] for civil society responses.

3.1.6 Major achievements and remaining challenges[623]

Government and civil society respondents identified achievements in a wide variety of areas including:

- The development of new **overall policies and strategies**, for example the new National HIV Strategy 2010–2014 in Norway. The Italian government highlighted the continuity of their strategic framework, although NGOs thought it needed updating. Ireland reported conducting a knowledge, attitudes and behaviour study among the general population and using that to develop an HIV and AIDS Education and Prevention Plan.
- Many countries highlighted achievements in providing **ART and related clinical services**. Specific achievements included the value of ART in reducing viral loads[624]; improved treatment protocols[625]; increasing ART coverage[626]; decentralisation of services[627] and provision of treatment free of charge[628].
- Improving **laboratory services**, such as the introduction of resistance testing in Cyprus.
- Improving services to **prevent mother-to-child transmission of HIV**, such as the provision of infant formula to HIV-positive pregnant women in Israel and Uzbekistan.
- Provision of a range of **other services** including IVF therapy for PLHIV in Israel; voluntary counselling and testing, HIV surveillance, improved access to healthcare and research in Italy; improved blood safety in Slovakia; counselling, nursing and psychological support in Cyprus; and reconstruction of the Lighthouse in Czech Republic.
- Better **services for specific groups** including migrants[629] (see Section 2.5), MSM[630] (see Section 2.3) and IDU[631] (see Section 2.2).

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[610] E.g. in Luxembourg.

[611] E.g. in Norway.

[612] E.g. in Czech Republic.

[613] E.g. San Marino and Italy.

[614] It was decided not to use civil society responses to this question in our questionnaire as there was an error in wording referring to prevention rather than treatment, care and support.

[615] N=17.

[616] N=29.

[617] Five or less.

[618] Estonia (5) and Andorra (3).

[619] Turkey (5), Ukraine (5), Greece (3), Serbia (3), Lithuania (2) and Hungary (0).

[620] Nine or 10.

[621] Uzbekistan (10), Denmark (9), France (9), Luxembourg (9), Malta (9) and Slovakia (9).

[622] Armenia (9), Croatia (9), Georgia (9), Germany (9), Poland (9), Slovenia (9), the Former Yugoslav Republic of Macedonia (9) and the United Kingdom (9).

[623] These questions were asked in our questionnaire. However, they were based on NCPI 2010 and were not asked in NCPI 2008.

[624] Reported by France.

[625] Denmark commented on the change in treatment threshold from a CD4 count of 200 cells/mm^3 to 350 cells/ mm^3 and the availability of first-line drugs with fewer side effects.

[626] E.g. in Estonia, Malta, Portugal.

[627] E.g. in Estonia.

[628] E.g. in Estonia, Israel and San Marino. Slovakia commented on the achievement of providing ART free of charge even to those without health insurance.

[629] E.g. in Luxembourg. Norway reported introducing guidelines for services for refugees and asylum seekers.

[630] Including better voluntary counselling and testing in Norway and targeted resources for MSM, including a gay men's health clinic, in Ireland.

[631] E.g. expanded harm reduction services in Slovakia.

- Increasing **involvement of NGOs**, including, in Denmark, supporting civil society to conduct prevention activities among MSM, migrants and PLHIV and, in Estonia, involving patient organisations in visiting hospitals to provide counselling services.

In addition, respondents identified a wide range of areas where challenges remained, including:

- **Policies and strategies**, for example, the need for a new sexual health strategy in Ireland.
- The need for **better coordination of services**, including between primary care providers and specialists in Norway, between San Marino's health system and Italian specialists and among the different providers of opioid substitution therapy, TB treatment, ART and counselling in Estonia.
- The need for adequate **financial**[632] **and human resources**[633].
- The need to address negative **attitudes among service providers**. In Estonia, it was highlighted that some infectious disease specialists remain unwilling to treat PLHIV who are IDU, because of the stigma associated with injecting drug use and perceptions about IDU motivation and adherence to treatment.
- Some countries commented on **low adherence to ART** among some patients[634].
- The need for high **quality treatment and care**. For example, Italy has developed and implemented national standards of care.
- Several countries commented on issues relating to **ART coverage**, i.e. ART being provided to all those who need it. The biggest issue relates to late/non-diagnosis[635]. Other issues include lack of services for uninsured persons[636] and lack of suitable services for particular groups, such as IDU[637].
- Respondents identified a wide range of **other services** that are needed. These included support programmes in Cyprus; training in life skills in Norway; psychosocial, nutritional and home care services in Portugal; case management and specific counselling in Estonia[638]; a need to respond to new emergencies and needs in Italy; care and support beyond ART in Slovakia; and home care in Italy.
- The need for better and expanded services for **specific populations** including 'hard-to-reach' populations[639], the most vulnerable[640], migrants[641], MSM[642] and IDU[643]. Denmark commented on the challenge of keeping HIV at the 'top of the mind' among the main target groups.
- Estonia commented on the need for better **monitoring** of the response and for more research into key issues, such as treatment outcomes and emergence of antiretroviral resistance.

It is perhaps surprising that issues relating to second-line drug treatment and resistance did not emerge as challenges through this process.

3.1.7 TB and HIV

Overall, 31 countries (63%) provided some quantitative and/or qualitative data about TB and HIV co-management or co-infection, 11 countries[644] reported that data on this indicator is not collected and seven did not provide any information[645]. Reasons given for lack of data on this indicator include:

- Data is **not considered relevant or useful** in the country context. For example, Cyprus reported that there is only one case of co-infection, and Switzerland has, as yet, no cases of HIV/TB co-infection.
- **Data protection** – for example, in Germany, matching of TB and HIV reports is not possible due to data protection regulations.
- Data is **not available** – for example, San Marino residents are provided free HIV treatment and care in facilities in Italy.

[632] Including funding for the new AIDS strategy in Norway. Slovakia commented on general financial constraints and Ireland on the need to match resources and political leadership to the commitment to undertake the work on the ground.

[633] The issue of rising workloads was highlighted in Malta.

[634] E.g. Denmark, Israel.

[635] E.g. in Denmark, Estonia, France, Norway, Portugal.

[636] E.g. in Israel.

[637] Estonia referred to the need for better follow-up of injecting drug users.

[638] Civil society respondents from Estonia also commented that there were too many support groups for people living with HIV.

[639] Luxembourg.

[640] Italy.

[641] Czech Republic commented on undocumented migrants with no health insurance. Italy highlighted the need for more research among migrants. Malta commented on challenges communicating with migrants and the cultural and social differences that exist. Norway referred to immigrants and refugees.

[642] Norway commented on the challenges of changing sexual behaviour among MSM.

[643] Estonia reported the need for more support services for injecting drug users.

[644] Cyprus, Denmark, France, Germany, Greece, Ireland, Luxembourg, Norway, San Marino, Turkey and Switzerland.

[645] Albania, Andorra, Bosnia and Herzegovina, Iceland, Turkmenistan, Ukraine and Uzbekistan.

- Lack of data on the **denominator** – for example, Serbia reported that calculating coverage was not possible due to lack of data on the estimated number of incident TB cases in people living with HIV.

Twenty-two countries provided quantitative data on treatment for both HIV and TB (see Table 31). All, apart from Belgium and the United Kingdom[646], reported on numbers of cases of TB and HIV co-infection receiving treatment for both infections. Sixteen countries[647] provided data on treatment coverage. Although most countries measured coverage in terms of estimated number of people needing treatment for both HIV and TB, Hungary measured coverage in terms of total number of people treated for TB. The United Kingdom reported results of a study of rates of TB incidence among a cohort of people living with HIV.

Numbers of people treated for both HIV and TB vary markedly between countries, ranging from 0 in Finland and Slovenia[648] to 463 in Russia. Reported coverage also varies markedly from less than 5% in Azerbaijan to over 90% in Belgium, Croatia, the former Yugoslav Republic of Macedonia and the United Kingdom[649].

Additional quantitative information provided included data on TB and HIV co-infection from eight countries (see Table 32). Data reported included:

- number of cases of TB and HIV co-infection (column A);
- prevalence/incidence of TB among PLHIV or people with AIDS (column B);
- prevalence of HIV among TB cases (column C).

Several countries provided qualitative data on the approach taken to identifying and managing TB and HIV co-infection. These included examples of routine TB screening of HIV patients and integrated management of patients who have both HIV and TB (see Box 32). Provision of integrated care is more challenging in contexts with highly vertical systems for delivery of HIV and TB services, and this is reflected in the low co-management coverage reported by some countries in the region.

Table 31: Quantitative data on treatment for both HIV and TB

Country	Number treated	Coverage	Comment
Armenia	15	59%	Figures for 2007 reported in 2008 UNGASS report. Denominator figures provided by WHO.
Azerbaijan	3	4%	Figures for 2007 reported in 2008 UNGASS report.
Belgium		100%	Except where CD4 levels require initiation of ART first, in order to limit the number of drugs taken at the same time.
Bulgaria	32		Figures for 2007 reported in 2008 UNGASS report.
Croatia	3	100%	Figures for 2007 reported in 2008 UNGASS report .
Finland	0		Figures for 2007 reported in 2008 UNGASS report. According to HIV statistics for 2007 and 2008, there were 6 and 7 TB cases, respectively, in PLHIV. People with HIV and TB receive treatment for both, with the exception of those whose CD4 count is high and do not need ART. TB drugs and ART are free for those eligible for social security benefits.
Former Yugoslav Republic of Macedonia	2	100%	Figures for 2007. Since 2005, seven patients have been diagnosed with TB and HIV co-infection (2 in 2005, 2 in 2007 and 2 in 2008).
Georgia	34	71%	Figures for 2007 reported in 2008 UNGASS report.
Hungary	7		< 1% of all TB cases reported in 2007.
Kazakhstan	76	33%	Figures for 2007 reported in 2008 UNGASS report.
Kyrgyzstan	31		Adults receiving ART who started TB treatment in 2008 (29 men, 2 women).
Latvia	27	57%	Figures for 2007 reported in 2008 UNGASS report.
Lithuania	5	38%	Figures for 2007 reported in 2008 UNGASS report.
Moldova	23	10%	Figures for 2007 reported in 2008 UNGASS report.

[646] Who provided treatment coverage figures only. The UK reported that 741 (2.7%) of HIV-positive adults experienced one or more episodes of TB between 1996 and 2006.

[647] Including seven EU/EFTA countries.

[648] In commenting on the report, Slovenia explained that the reason for this was that there is no TB/HIV co-infection in Slovenia.

[649] Comparability is a challenge because countries use different approaches to measure co-management and some report data for specific regions or treatment centres rather than national data.

Country	Number treated	Coverage	Comment
Netherlands	16	89%	As of June 2009, all 18 people co-infected with HIV and TB registered in one HIV treatment centre were being treated for TB, of whom 16 had ever been on ART.
Poland	70	176%	Figures for 2007 reported in 2008 UNGASS report. Estimated denominator supplied by WHO.
Russia	463	39%	Figures supplied for four oblasts only: Ulyanovskaya, Saratovskaya, Tverskaya and Altayskiy kray.
Serbia	6		2008 figures. 16 in 2007. All notified cases of co-infection are treated for both, in line with the national treatment protocol. Currently not possible to provide estimated number of incident TB cases for denominator.
Slovenia	0		Figures for 2007 reported in 2008 UNGASS report. All diagnosed cases have access to both treatments.
Tajikistan	6	8%	Figures for 2007 reported in 2008 UNGASS report.
Turkey	47		Figures for 2007 reported in 2008 UNGASS report.
United Kingdom		>90%	The UK Collaborative HIV Cohort (UKCHIC) study found that 2.7% (741/27 868) of HIV-positive adults experienced one or more episodes of TB between 1996 and 2006 (incidence rate of 3.28 events/1 000 person-years). HIV-related treatment is free for legal residents under the NHS and UK residents are entitled to free TB treatment (this includes Visitors to the UK under the NHS Charges to Overseas Visitors Regulations 1989). As a result, uptake of HIV and TB treatment in co-infected individuals is very high.

Table 32: Quantitative evidence concerning TB and HIV co-infection

Country	A[650]	B[651]	C[652]	Evidence
Estonia	✓		✓	According to the National TB Registry, the first HIV-infected TB patient was diagnosed in 1997. By end 2008, 218 people with HIV and TB were diagnosed. In 2008 the proportion of HIV-infected people among all TB cases was 9.4%.
Germany		✓	✓	Among reported AIDS cases, currently between 10–15% are reported with TB or atypical mycobacteria. Based on a study among TB patients conducted in 2006, the proportion with HIV co-infection was estimated at 4.3%.
Italy		✓		Data from the National AIDS Registry show that 8.8% of AIDS cases have TB as an AIDS-defining disease.
Portugal			✓	In 2007, 40% of TB cases were tested for HIV and prevalence of HIV among TB cases was around 25%.
Romania[653]		✓	✓	Of the 24 786 TB patients registered in 2008, 6 419 were tested for HIV and 202 tested HIV positive. Of 9 372 patients living with HIV followed in 2008, 142 developed TB.
Slovakia		✓		In 2007 and 2008 there was no reported TB diagnosis in any HIV-positive patient.
Spain	✓	✓	✓	In 2008, almost one third of newly-diagnosed AIDS cases had TB as their first AIDS-defining illness (340/1 166). A study in 2000–2003 identified latent TB in 17% of 1 242 PLHIV. In 2008, HIV infection was identified in 6% of 8 214 TB cases.
Sweden	✓			During 2007–2008, 100 cases were detected[654]. All were aged 25 years or older and 38% were women.

[650] Number of cases of TB and HIV co-infection.

[651] Prevalence of TB among people living with HIV.

[652] Prevalence of HIV among TB cases.

[653] Romania's 2008 UNGASS Progress Report notes that HIV testing with consent is routinely performed for all people diagnosed with TB but the number of cases of co-infection is low. In 2006, 60 PLHIV (44 males and 16 females) received TB treatment and in 2007 185 PLHIV (101 males and 74 females) received TB treatment.

[654] Extrapolated from Gothenburg and Stockholm regions.

Box 32: Examples of integrated management of patients with HIV and TB

In the **Czech Republic**, all patients with HIV and TB are treated for both infections. In **Estonia**, all patients suspected of having TB are offered an HIV test. HIV-infected TB patients are treated together by infectious diseases and TB specialists. ART for TB and HIV cases is decided individually for each patient.

In **Israel**, AIDS centres are expected to test their patients for TB and TB patients should be offered HIV testing. The national database for HIV and TB patients is routinely cross-matched to verify notifications. Local health departments do likewise. In **Malta**, all HIV patients are tested for TB and referred for treatment as necessary. There is one Infectious Disease Unit that cares for all HIV patients and one physician that cares for TB patients at the general hospital, so communication between them is good and there is follow-up of all patients referred.

In **Slovakia**, there is co-management of TB and HIV. HIV-positive patients are offered TB testing and TB patients are offered HIV testing. In **Spain**, diagnosis of both HIV and TB is free of charge. HIV treatment is provided free of charge for all patients, including foreigners, by the Spanish National Health System. TB treatment is provided free of charge for all patients while they stay in the hospital. Outside hospital, treatment is free for retired people but other patients have to pay 10% of the cost, to a maximum of EUR2.64. While patients with TB who are HIV negative are managed by a pulmonary specialist, co-infected patients are treated by the same physician, generally an HIV specialist, in collaboration with a pulmonary specialist if needed, for example, if the patient has MDR TB. Within the prison system, routine follow-up is managed by primary care physicians, but HIV specialists are consulted about HIV treatment.

In **the former Yugoslav Republic of Macedonia**, there are synergies between HIV and TB activities in programmes implemented by the Ministry of Health with Global Fund support. Voluntary HIV counselling and testing is provided for TB patients who are hospitalised at the Institute for Lung Diseases and Tuberculosis and efforts are underway to provide outreach counselling and testing to populations most at risk for both HIV and TB, for example, IDU, sex workers, MSM, and prisoners.

3.1.8 Prevention of mother-to-child transmission using antiretroviral drugs

More than half (55%[655]) of responding countries provided information on the number of HIV-positive women receiving antiretroviral drugs to prevent mother-to-child transmission (PMTCT) of HIV (see Table 33).

There is a wide variation in numbers of women receiving antiretroviral drugs for PMTCT. More than three quarters (78%[656]) report less than 100 women receiving antiretrovirals for PMTCT. Almost all (89%[657]) reported having less than 1 000 women receiving antiretrovirals for PMTCT. Only three countries[658] reported more than 1 000 women receiving antiretrovirals for PMTCT. Some countries[659] explained that they could not provide this information because they do not collect data centrally.

[655] 27/49.

[656] 21/27.

[657] 24/27.

[658] Russia, Ukraine and United Kingdom.

[659] E.g. Estonia, Ireland. San Marino does not provide this information because citizens are treated in Italy.

Table 33: Reported coverage of antiretrovirals for PMTCT in Europe and central Asia

Country	Year	Number[660]	Coverage	Comment
Armenia	2007	6	100%[661]	3 in 2003; 5 (16–38%) in 2006[662].
Azerbaijan[662]	2007	6	4–17%[663]	1 (< 1–4%) in 2006.
Bosnia and Herzegovina[662]	2007	0	0%[664]	0 (0%) in 2006.
Bulgaria	2008	2	N/A	1 in 2006; 1 in 2007[662].
Croatia[662]	2007	2	67%[665]	3 (> 95%) in 2006.
Cyprus	N/A	10	N/A	
Czech Republic[662]	2006	15	84–> 95%	
Georgia[662]	2007	22	88%[666]	7 (47–> 95%) in 2004; 15 (7–21%) in 2005; 15 (40–> 95%).
Germany[662]	2006	225	40–> 95%	80% in 2005.
Greece[662]	2007	21	100%[667]	18 (14–45%) in 2006.
Hungary[662]	2007	1	100%[668]	0 (0%) in 2006.
Kazakhstan[662]	2007	126	60%[669]	37 (19–66%) in 2004; 47 (16–69%) in 2005; 80 (23–> 95%) in 2006.
Kyrgyzstan[662]	2007	3	2%[670]	9 (8–27%) in 2006.
Latvia[662]	2007	37	97%[671]	37 (34–78%) in 2006.
Lithuania[662]	2007	9	90%[672]	1 (3–13%) in 2004; 2 (6–25%) in 2006.
Moldova[662]	2007	73	85%[673]	31 (56–> 95%) in 2004; 32 in 2005; 62 (50–> 95%) in 2006.
Poland	2008	70	N/A	62 (26–87%) in 2006; 63 (100%[674]) in 2007[662].
Romania[662]	2007	68	97%[675]	21 (6–11%) in 2004; < 1% in 2005; 75 (23–45%) in 2006.
Russia[662]	2007	6 419	59–> 95%[676]	5 601 (55–> 95%) in 2004; 5 709 (54–> 95%) in 2005; 6 224 (57–> 95%) in 2006.
Serbia[662]	2006	2	100%[677]	5 (4–15%) in 2004; 6 (5–17%) in 2005.
Slovakia	2008	4	N/A	2 in 2007.
Spain	2008	N/A	> 90%	Data from cohort of mother and children with HIV infection in Madrid Region (FIPSE Project).

[660] Of HIV-positive women receiving antiretrovirals for PMTCT.

[661] Country-reported figures. UNAIDS estimated coverage at 19–45%.

[662] UNGASS 2008.

[663] UNAIDS figures.

[664] Country reported one woman needing antiretrovirals for PMTCT.

[665] Country-reported figures.

[666] Based on country estimates of 25 women needing this treatment, but UNAIDS estimated that coverage was 41–> 95%.

[667] Based on country estimates of 21 women needing this treatment, but UNAIDS estimated that coverage was 16–69%.

[668] Based on country estimates of 1 woman needing this treatment, but UNAIDS estimated that coverage was 2–8%.

[669] Based on country estimates of 210 women needing this treatment, but UNAIDS estimated that coverage was 2–8%.

[670] Based on country estimates of 197 women needing this treatment, but UNAIDS estimated that coverage was 30–> 95%.

[671] Based on country estimates of 38 women needing this treatment, but UNAIDS estimated that coverage was 27–> 95%.

[672] Based on country estimates of 10 women needing this treatment, but UNAIDS estimated that coverage was 33–75%.

[673] Based on country estimates of 86 women needing this treatment, but UNAIDS estimated that coverage was 51–> 95%.

[674] Based on country estimates of 63 women needing this treatment, but UNAIDS estimated that coverage was 26–85%.

[675] Based on country estimates of 70 women needing this treatment, but UNAIDS estimated that coverage was 22–42%.

[676] UNAIDS figures.

[677] Country figures reported to this review. This coverage figure does not relate to 2006. UNAIDS estimated the coverage as 2–6% at that time.

Country	Year	Number[660]	Coverage	Comment
Sweden[662],[678]	2007	31[679]	100%[680]	31 (21–66%) in 2006.
Tajikistan[662]	2007	9	2%[681]	4 (1–7%) in 2005; 4 (1–6%) in 2006.
Turkey[662]	2006	4	> 95%	
Ukraine[662]	2007	3 046	93%[682]	2 817 (53–91%) in 2004; 2 168 (36–63%) in 2005; 2 517 (40–69%) in 2006
United Kingdom[662]	2006[683]	1 065	> 95%[684]	
Uzbekistan	2009[685]	508	N/A	3–19% in 2006; 95 (11–68%) in 2007[662].

For most (82%[686]) of the countries reporting the numbers of HIV-positive women receiving antiretroviral drugs to prevent mother-to-child transmission of HIV, coverage data was also available (see Table 33). However, there were marked differences between coverage figures provided by countries compared to those provided by UNAIDS[687]. These differences largely reflect different approaches to measuring the denominator, i.e. those in need of antiretrovirals for PMTCT. These issues are similar to those relating to ART for PLHIV in general, which are discussed in detail earlier in this section.

Several countries[688] asserted that PMTCT services are provided to all women who need them. Most countries[689] follow the same strategy of offering HIV testing to all pregnant women and then offering a range of services[690] to women who test positive and their infants[691]. This strategy means that in most countries a large number of women are tested in order to detect a very small number who are HIV positive[692]. One country, Slovenia, with low levels of HIV infection commented that it had not adopted this approach. Some countries[693] specified that they provide PMTCT services free of charge to all. Some countries have recognised that this strategy is not as effective for some groups of women as for others, for example, migrants[694]. In some countries, for example, the Netherlands, most children infected with HIV were infected in their country of origin.

[678] Stockholm only.

[679] Projected figure based on actual of 23 from January to September.

[680] Based on country estimates of 31 women needing this treatment. But, UNAIDS estimated that coverage was 21–63%. In commenting on the report, Sweden strongly contested the UNAIDS figures arguing that there had only been two documented cases of mother-to-child transmission of HIV in Sweden in the last 10 years. One was in an immigrant and one was in a person with treatment failure.

[681] Based on country estimates of 438 women needing this treatment, but UNAIDS estimated that coverage was 2–11%.

[682] Based on country estimates of 3 293 women needing this treatment, but, UNAIDS estimated that coverage was 45–79%.

[683] 2006 values used because 2007 figures included two widely divergent figures of 48 and 1 066.

[684] In 2007, the country estimated that 487 women needed this treatment, but UNAIDS estimated that coverage was 76–> 95% in 2006.

[685] First nine months.

[686] 22/27. The five that did not were Bulgaria, Cyprus, Poland, Slovakia and Uzbekistan. One country, Spain, provided information on the coverage of PMTCT services without supplying absolute numbers of those receiving services.

[687] For example, five countries (Armenia, Greece, Hungary, Serbia, Sweden) reported PMTCT coverage figures of 100% although UNAIDS reported much lower figures. Serbia commented that it is difficult to estimate the number of HIV-positive pregnant women needing PMTCT services in a country with a low level epidemic and without antenatal surveillance data.

[688] E.g. Belgium, Czech Republic, Denmark, Finland, Georgia, Ireland, Israel, Malta, Netherlands, Norway, Poland, Serbia, Spain, Switzerland and Uzbekistan

[689] The Czech Republic reported that they have mandatory testing of all pregnant women. The Netherlands specified that they use an opt out approach.

[690] In some countries, e.g. the Czech Republic, Serbia and Ukraine, this includes delivery by caesarean section. However, the United Kingdom presented evidence that transmission rates were the same for babies delivered by caesarean section or vaginal delivery from women on antiretroviral therapy. In Israel and Serbia, this includes provision of free formula to HIV-positive mothers. Georgia provided detailed information on their antiretroviral regimens and how they were now starting these earlier in pregnancy. Ukraine commented that they were shifting away from single drug regimens, e.g. nevirapine only.

[691] Including follow-up HIV testing.

[692] For example, Georgia tested 44 000 pregnant women for HIV in 2008. A total of 24 HIV-positive women were detected but 10 of these were already known to be HIV positive before they became pregnant. Georgia argues that this approach is important because of the feminisation of the epidemic globally and that the country is not immune from this trend.

[693] E.g. Estonia, France, Georgia, Israel and Spain. In the case of Georgia, antiretroviral drugs for PMTCT are provided by the Global Fund. San Marino citizens receive free treatment in Italy.

[694] Belgium and Norway both specified that PMTCT coverage was around 100% in legal inhabitants.

Less than half (45%[695]) of reporting countries provided information on either the number of infants[696] infected with HIV as a result of mother-to-child transmission or the rate[697] of mother-to-child transmission (see Table 34). Overall, the numbers of infections occurring through this route are very low. For example:

- New infections occurring as a result of mother-to-child transmission accounted for only 0.4% of new HIV cases in Estonia from 1988 to 2007 and 0.2% in Spain from 2003 to 2007[698].
- In Sweden, there have only been two cases of mother-to-child transmission in 10 years. One of these was among an immigrant and the other was among someone who experienced treatment failure.
- Several countries, for example, Norway and Slovenia reported that they had had no cases of mother-to-child transmission to children born in the country for a number of years.
- One country, the former Yugoslav Republic of Macedonia, reported that it had not yet had any case of an HIV-infected pregnant woman.
- Reported rates of mother-to-child transmission were 0 in 5 countries[699], < 2% in three countries[700], 2–5% in seven countries[701] and > 5% in four countries[702,703].

Table 34: Reported rates of mother to child transmission of HIV in Europe and central Asia

Country	Year	Numerator[704]	Denominator[705]	Rate[706]	Comments
Armenia	2007	1	16	6.25%	Three children unknown HIV status.
Azerbaijan	2008	5	N/A	N/A	
Belgium	2007	5	169[707]	2.96%	
Bulgaria	2007	0	3	0%	
Cyprus	N/A	0	7[708]	0%[708]	
Czech Republic	N/A	4[709]	103	3.88%	
Estonia	2007	N/A	N/A	2.2%	Compares to 25/467 (5.4%) for years 2000 to 2007.
Finland	2008	0	N/A	0%	Same for 2007.
France	2007	N/A	N/A	1%	ANRS French perinatal cohort. From 2001 to 2007, the rate was 1.1% [0.8–1.4].
Georgia	2008	0	22[710]	0%[710]	From 1989 to October 2009, there were registered 103 HIV-positive women and 110 pregnancies. 89 delivered babies, of which 3 (3.37%) were positive.

[695] 22/49.

[696] 15 countries provided this information for a specific year or an annual figure. Of these, Azerbaijan, Norway and Serbia did not provide rate information. In addition, some other countries provided information on numbers infected over several years. These countries included Croatia, Cyprus and Luxembourg.

[697] 19 countries provided this information for a specific year or an annual figure. Of these, Estonia, France, Italy, Kazakhstan, Poland, Romania and Ukraine provided rates only without actual numbers. The United Kingdom provided rates over a number of years.

[698] In commenting on this report, Spain explained that transmission in these cases occurred outside Spain.

[699] Bulgaria, Cyprus, Finland, Georgia and Slovakia.

[700] France, Poland and Portugal.

[701] Belgium, Czech Republic, Estonia, Germany, Italy, Kazakhstan and Romania.

[702] Armenia, Greece, Latvia and Ukraine.

[703] In most cases, countries reported mother-to-child transmission rates using the number of children born to HIV-positive women as the denominator. Denmark (1.5) and Israel (9) report rates of children born with HIV per 100 000 live births.

[704] Number of infected infants born.

[705] Number of infants with known HIV status born to HIV-positive women.

[706] Of mother-to-child transmission.

[707] Children of less than 15 months born to HIV-positive women and followed up in 2007.

[708] But a further three results pending.

[709] The Czech Republic reports that 'in all cases pregnant women refused the preventive programme through their own fault.'

[710] An additional one HIV-positive mother had an abortion and one child born to an HIV-positive mother was lost to follow-up. Georgia reports a mother-to-child transmission rate of 4.3% based on the assumption that the child lost to follow-up was HIV positive. Cumulatively, 3/89 children born to HIV-positive mothers have been HIV-infected, i.e. 3.4%.

Country	Year	Numerator[704]	Denominator[705]	Rate[706]	Comments
Germany	n/a	10–15	300–400[711]	2.50–5.00%	
Greece	2008	1	14	7.14%	
Italy	2008	N/A	N/A	< 3%	From national surveillance system.
Kazakhstan	2008	N/A	N/A	4.2%	3% among those receiving ART and 13% among those who do not.
Latvia	2007 2008	11	126	8.7%	Figures for a two year period.
Norway	2008	4	N/A	N/A	All four infants born outside Norway.
Poland	N/A	N/A	N/A	< 1%	Reduced from 23% in 1989.
Portugal	N/A	< 5	circa 300	1.67%	
Romania	2008	N/A	163[712]	2%	
Serbia	2008	1	N/A	N/A	Also one in 2007 .
Slovakia	2008	0	4	0%	Since 1985, 15 children born to HIV-positive mothers. None were HIV positive.
Ukraine	2006	N/A	N/A	7.1%	27.8% in 2001; 8.2%[713] in 2004.

Some countries, such as Estonia, 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 subpopulations[714,715] such as migrants[716] and IDU[717].

All countries reporting on rates of mother-to-child transmission used observed data based on HIV testing of infants and not modelled data as proposed by UNAIDS. Moldova expressed concern that UNAIDS did not publish figures for rates of mother-to-child transmission in 2008 although countries understood that rates were to be calculated centrally by UNAIDS and so did not report on this indicator.

3.1.9 Conclusions

There has been an increase in the overall number of PLHIV receiving ART in the region since 2004 (see Figure 40). 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.

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 (see Figure 41). 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 is limited, ECDC has been tracking CD4 counts at the time of diagnosis through its HIV case surveillance system since 2007 (see Table 30 and Figure 42). 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

[711] Country estimate.

[712] 177 positive tests. Estimates of 200 HIV-positive pregnant women.

[713] Country data. Data in the 2004 UNGASS report gave the figure as 15.8%.

[714] In many countries, HIV infection itself is concentrated among the same populations.

[715] In Germany, most infections occurred among women not offered HIV testing during pregnancy. In the Netherlands, the one case of mother-to-child transmission in 2005 occurred in a child born to a woman who tested HIV negative in pregnancy. It is assumed that she must have been infected with HIV during pregnancy.

[716] Israel mentions those from endemic countries. Norway noted that there were four infants infected with HIV through mother-to-child transmission in 2008; all were born outside Norway. Norway has had no recorded case of mother-to-child transmission among a child born in Norway since 2000. In Sweden, in 2006 and 2007, a total of 30 children were reported to be infected through mother-to-child transmission. Of these, 28 were infected prior to arrival in Sweden, the majority from Africa. Only one case of transmission was reported where the person resided in Sweden. An additional case occurred from a person residing in Sweden but where the transmission took place outside of Sweden. Switzerland notes that most of its cases of mother-to-child transmission occur in migrants.

[717] Israel.

diagnosed. 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.

In addition, perceptions of availability of key services vary. For example, some services, such as ART, 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 43).

Also, some subpopulations are considered to face particular obstacles to accessing ART. These include IDU, migrants and prisoners (see Figure 43). Women among these populations are also those most likely to give birth to HIV-infected children having 'slipped through the net' of PMTCT services. Although the numbers requiring treatment for both TB and HIV in countries of the region are relatively low, useful lessons could be learned from those countries that have effectively integrated treatment for these patients.

In conclusion, ECDC has identified the following issues needing 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 cells/mm^3 at the time of diagnosis and introducing measures aimed at reducing the proportion of PLHIV with 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 is not completely clear, the fact that still some countries 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

3.2.1 Introduction

Stigma is the consequence of factors including lack of understanding of HIV, misconceptions about how HIV is transmitted, irresponsible media reporting and prejudice and fear associated with behaviours such as sex work, drug use and sex between men. Stigma can result in discrimination and other violations of the human rights of people who engage in these behaviours and of PLHIV.

HIV-related stigma and discrimination can prevent governments from taking appropriate action to address HIV and deter individuals from seeking HIV testing, disclosing their HIV status, seeking and adhering to treatment and taking action to protect others from infection. Reducing stigma and discrimination is therefore critical to successful responses to the HIV epidemic.

With respect to Europe and central Asia, a review of the literature conducted by ICRW cited a study in France that identified HIV-related employment discrimination and a study in the United Kingdom that found an association between perceived stigma and treatment adherence. Other evidence, from UNGASS country progress reports, also indicates that stigma and discrimination are issues in the region.

This chapter summarises country responses regarding attitudes towards PLHIV and the policy and legal environment relating to stigma and discrimination. Our approach was based on UNGASS indicators, drawing on material from NCPI questions and an 'additional recommended' indicator focused on measuring accepting attitudes towards PLHIV (see Box 33). Box 33 also contains information about another approach being used to measure stigma experienced by PLHIV.

Box 33: Approaches to measuring HIV-related stigma

UNAIDS has proposed a number of **additional recommended indicators** to supplement UNGASS reporting. One of these (#14) focuses on stigma and discrimination. It uses as a numerator the number of women and men aged 15–49 who report accepting attitudes towards people living with HIV and as a denominator all respondents aged 15–49 who have heard of HIV. Measured using population-based survey tools such as the DHS, respondents who have heard of HIV are asked a series of questions including whether they would be willing to care for a family member with HIV who is sick, would be willing to buy vegetables from an HIV-positive shopkeeper or food seller, think a female HIV-positive teacher should be allowed to continue teaching, and would want the HIV status of a family member to remain secret.

The **PLHIV Stigma Index**, which measures and documents stigma experienced by PLHIV, aims to increase understanding of how stigma and discrimination is experienced by PLHIV and to use this evidence to inform policy and programmes. The Index is being used by more than 20 countries in Asia, Africa, Latin America and the Pacific and was launched in the United Kingdom in 2009. The United Kingdom is the first country in Europe to implement this approach.

3.2.2 Attitudes towards people living with HIV

Only just over a third of countries (39%[718]) provided some quantitative or qualitative data on accepting attitudes towards PLHIV in their country, 17 (35%) reported that no data was available or collected on this indicator[719] and 13 (27%) provided no information[720].

Some countries provided reasons why data was not available. Finland, Slovakia and Switzerland reported that no studies or surveys of attitudes towards PLHIV have been conducted. Portugal noted that scientifically sound data is not available. Bulgaria reported that no data is available because there has been no DHS, but a general population survey is planned and results are expected to be available for UNGASS reporting in 2010.

Countries that reported drew on data sources ranging from national surveys to small-scale surveys and studies. These included:

- Health, behavioural surveillance and other population-based surveys, such as the DHS, for example, in Armenia, Azerbaijan, Belgium, Denmark, Germany, Romania, Serbia and Spain.

[718] 19/49.

[719] Andorra, Cyprus, Finland, Georgia, Greece, Hungary, Italy, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Poland, Portugal, Slovakia, Slovenia and Switzerland.

[720] 12 countries provided no information. They are Albania, Bosnia and Herzegovina, Croatia, Iceland, Ireland, Russia, San Marino, Tajikistan, the Former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Uzbekistan. In addition, Israel did provide some information but this was not considered directly relevant to the questions asked.

- Specific knowledge and attitudes surveys, for example, in the Netherlands, Norway, Spain, Sweden and the United Kingdom; sociological studies in the Czech Republic and Kazakhstan; and use of general population survey in Moldova.

Seven countries[721] reported data broadly in line with the UNGASS indicator. Others, for example, Belgium, Denmark, France, Germany, Norway and Spain, used different questions to assess accepting attitudes, which are perhaps more relevant to the regional context than the UNGASS questions,. These included, for example, questions about attitudes towards working with an HIV-positive colleague, allowing a child to attend school with HIV-positive children or to be cared for by a PLHIV. Questions used by countries broadly fall into three categories:

- questions about personal discriminatory attitudes, for example, in the Czech Republic and Norway;
- questions about personal accepting attitudes, for example, in Denmark, France and Germany; and
- questions about the prevailing attitudes of others, for example, in the Netherlands and the United Kingdom.

Evidence provided by countries (see Annex 8) shows that responses vary by country and depend on the precise questions asked.

The percentage of people with accepting attitudes towards PLHIV varies considerably between countries. Although the picture is mixed, it appears that there are high rates of discriminatory attitudes/low rates of accepting attitudes in some countries, such as Armenia, Belgium, Czech Republic, Kazakhstan, Romania and Serbia, and low rates of discriminatory attitudes/high rates of accepting attitudes in others, such as Denmark, France, Germany, Sweden and the United Kingdom.

A few countries reported trend data. For example, Kazakhstan showed a modest improvement in reported accepting attitudes from 1.2% in 2006 to 8.3% in 2008.

Based on the UNGASS questions, the extent of accepting attitudes differs depending on the specific question. For example, responses are generally more positive about caring for a family member with HIV than buying vegetables from an HIV-positive shopkeeper or allowing an HIV-positive teacher to continue to teach. For example, in Azerbaijan, around 50% of women in all age groups would be willing to care for a family member with HIV, but only 20% would be willing to buy vegetables from an HIV-positive shopkeeper or would allow an HIV-positive teacher to work. A similar pattern was reported in Ukraine.

When accepting attitudes are based on 'correct' answers to several questions, this reduces the score. So, for example, few countries reported high levels of accepting attitudes across all UNGASS questions—the proportion expressing accepting attitudes across all questions ranged from less than 1% in Armenia to around 20% in Serbia.

Even in countries where attitudes are generally more accepting, responses to specific questions about PLHIV in the workplace and in schools suggest that a relatively high proportion of the population has negative attitudes. For example, around 30% of respondents in countries such as Spain, Sweden and the United Kingdom would avoid contact or feel uncomfortable working with a colleague with HIV, and a similar proportion in Norway would not accept an HIV-positive person looking after their child.

In some countries, for example, the Czech Republic, Kazakhstan, Norway and Spain, a significant minority expressed support for discriminatory measures such as isolating PLHIV, preventing PLHIV from working in professions such as medicine, teaching or catering, and enforcing disclosure of HIV status in the workplace.

Responses to questions designed to assess prejudice towards PLHIV, for example, in the Netherlands, Spain and the United Kingdom, suggest that the view that PLHIV are to blame for their infection is not uncommon.

The evidence provided also highlights factors that appear to influence accepting attitudes towards PLHIV:

- Age – Several countries reported data disaggregated by age. In some, for example, Belgium, there was evidence of more discriminatory attitudes in older age groups.
- Sex – Several countries reported data disaggregated by sex. Some countries, for example, Azerbaijan and Germany, showed more accepting attitudes among women than men. Romania, however, was an exception to this pattern, with more accepting attitudes reported among men.
- Education – Several countries, for example, Azerbaijan, Belgium, Moldova, Sweden and Ukraine, reported an increase in accepting attitudes with increasing educational level.
- Location – Several countries reported data disaggregated by urban or rural location. In some, for example, Ukraine, there was evidence of more accepting attitudes in urban areas.

In addition to stigma and discrimination specifically associated with HIV status, reported data suggests that stigma and discrimination may be associated with negative views about particular population groups such as IDU, MSM, sex workers and migrants rather than about PLHIV per se. Ireland's response, for example, noted that drug users, sex workers, prisoners and migrants suffer discrimination as a result of societal attitudes and not specifically related to their HIV status.

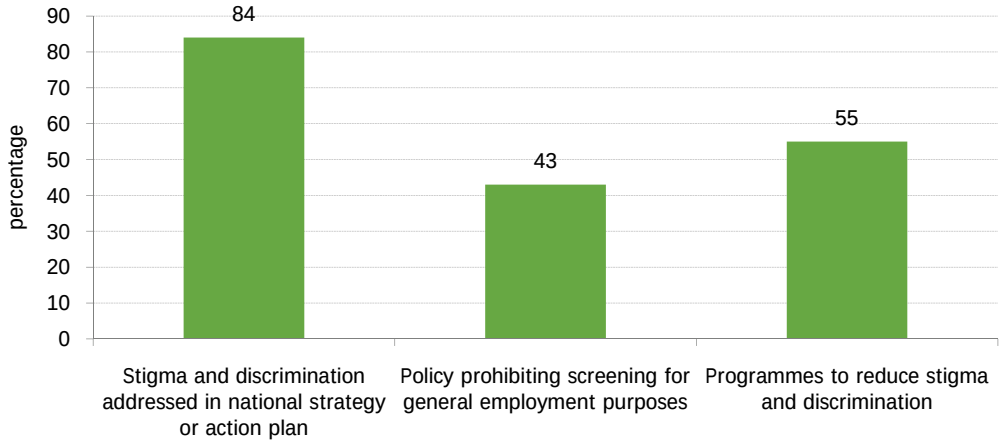
[721] Armenia, Azerbaijan, Estonia, Moldova, Romania, Serbia and Ukraine.

3.2.3 Policy and legal environment

Tackling stigma and discrimination, and addressing negative attitudes towards PLHIV, requires a supportive policy and legal environment and initiatives to reduce stigma and discrimination. Countries were asked to respond to questions about national strategy, policy and programmes.

Almost all countries (84%[722]) reported that stigma and discrimination is addressed in their national multisectoral strategy or action framework. Two countries[723] reported that it is not addressed in these documents[724]. Fewer countries have translated national strategies or action frameworks into related policies and programmes (see Figure 46).

Figure 46: Percentage of countries reporting that stigma and discrimination is addressed in strategy, policy and programmes



Less than half of countries (43%) reported the existence of a policy prohibiting screening for general employment purposes. More than half of countries (55%) reported that there are programmes in place to reduce HIV-related stigma and discrimination[725], but almost a quarter (22%) reported that there are no such programmes[726]. Examples cited include a project in schools in Slovakia, 'Game to tackle AIDS', which encourages students to accept PLHIV.

The inclusion of stigma and discrimination in strategies or action frameworks is also not consistently reflected in non-discrimination laws or regulations. Fewer countries reported the existence of legal frameworks that protect most-at-risk or other vulnerable subpopulations from discrimination than reported that stigma and discrimination is addressed in their national multisectoral strategy or action framework[727]. Government responses concerning the existence of non-discrimination laws or regulations were received from 13 countries[728] and civil society responses from 37 countries[729,730]. Of these, government responses from eight countries and civil society responses from 25 countries reported that their country has non-discrimination laws or regulations that protect most-at-risk or other vulnerable populations[731].

[722] 41/49.

[723] Andorra, San Marino.

[724] No information was provided by five countries: Albania, Azerbaijan, Iceland, Netherlands and Uzbekistan.

[725] This question was only addressed to civil society respondents.

[726] 12 countries provided no information about programmes to reduce HIV-related stigma and discrimination.

[727] Bosnia and Herzegovina noted that development of a legal framework to protect the human rights of PLHIV is one of the goals in its HIV/AIDS strategic framework.

[728] France did not answer this question but did provide information about non-discrimination laws covering the five specific subpopulations (see Figure 47)

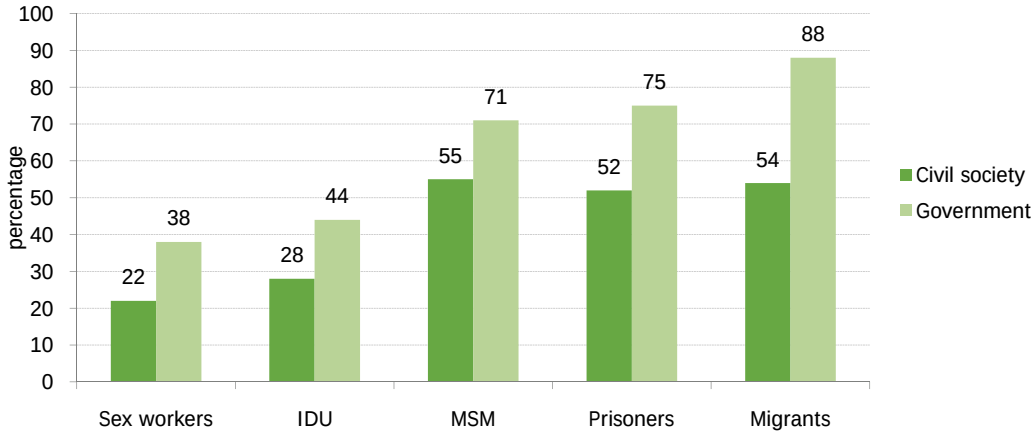
[729] Although this question was directed to both government and civil society in the Dublin Declaration questionnaire, it was only asked of civil society respondents in 2008 UNGASS reporting; the lower government response rate reflects where UNGASS 2008 data has been used and the question was, therefore, not asked of government respondents.

[730] Government and civil society responses about whether there are non-discrimination laws or regulations that specify protections for most-at-risk or other vulnerable subpopulations differed in Ireland, Norway and Slovakia

[731] Of the five countries (government responses) that report having no legal framework, three are small—Andorra, San Marino and Luxembourg—so caution should be exercised in comparing government and civil society responses to this question.

Countries were also asked whether these laws and regulations cover specific populations. Government and civil society responses were consistent in suggesting that migrants, prisoners and MSM are more likely to be covered by non-discrimination laws and regulations than IDU or sex workers. More than half of countries reported laws and regulations covering migrants, prisoners and MSM, while less than half reported laws and regulations covering IDU and sex workers. Overall, civil society respondents were less likely than government respondents to consider that non-discriminatory laws and regulations existed to protect particular subpopulations (see Figure 47).

Figure 47: Percentage of government and civil society respondents reporting the existence of non-discrimination laws and regulations covering specific populations



Based on civil society responses, only six countries (Denmark, Portugal, Kazakhstan, Kyrgyzstan, Romania and Spain) have laws and regulations that cover all five of these subpopulations.

Civil society respondents were also asked about laws or regulations that protect PLHIV against discrimination. Respondents in 28 countries (57%) reported that there are non-discrimination laws and regulations that specify protection for PLHIV and nine (18%) that there are no such laws or regulations[732].

Qualitative data provided by 28 countries (see Annex 9) shows that:

- Most countries either include non-discrimination in the constitution[733] or have general anti-discrimination or equality laws that guarantee the rights of all citizens but do not specify protection for particular population groups[734].
- Several countries highlighted the role of international or European human rights conventions in guaranteeing the human rights of all citizens, for example, Bosnia and Herzegovina, Bulgaria and Georgia.
- Some countries highlighted legislation that protects against discrimination in specific arenas, for example, the workplace in Denmark, healthcare settings in Greece and Serbia and housing in Norway. Other countries cited legislation that protects against discrimination for specific populations, for example, ethnic minorities in Finland and sexual minorities in the Czech Republic.
- Relatively few countries provided information about non-discrimination legislation that provides specific protection for PLHIV. Armenia, Moldova, Russia, Tajikistan and Ukraine mentioned AIDS laws, although only Armenia and Ukraine reported that these make provisions for the rights of PLHIV.

Countries (government and civil society respondents) were asked about mechanisms to ensure that non-discrimination laws are implemented and a separate question (civil respondents only) about specific mechanisms to record, document and address cases of discrimination experienced by PLHIV, most-at-risk and other vulnerable subpopulations.

Twenty five (41%) countries[735] provided information about mechanisms to ensure laws are implemented[736] (see examples in Table 35). Two countries[737] reported that there are no mechanisms in place and 22 countries did not

[732] 12 countries provided no information about laws or regulations protecting PLHIV.

[733] For example, Bosnia and Herzegovina, Bulgaria, Finland, Hungary, Kazakhstan, Kyrgyzstan, Moldova, Netherlands, Poland, Romania, Serbia, Slovenia and Spain.

[734] For example, the Czech Republic, Ireland, Latvia, Norway, Serbia and the United Kingdom.

[735] Armenia, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Finland, Georgia, Germany, Greece, Hungary, Ireland, Kazakhstan, Kyrgyzstan, Latvia, Moldova, Norway, Romania, Russia, Serbia, Sweden, Switzerland, Tajikistan, Ukraine, United Kingdom.

[736] This question was addressed to both government and civil society respondents.

[737] Poland, Portugal.

provide any information[738]. Sixteen countries (33%) reported the existence of mechanisms to record, document and address cases of discrimination experienced by PLHIV, most-at-risk and other vulnerable subpopulations, while 20 (41%) reported that there are no mechanisms in place for this[739].

Table 35: Examples of mechanisms to enforce laws and to address discrimination

Country	Evidence
Armenia	The Directorate of Public Prosecutions monitors the implementation of existing laws. Civil society organisations and individuals can alert the Directorate of human rights violations and also have the right to apply to the Constitutional Court in cases where provisions in the Constitution have been violated.
Bosnia and Herzegovina	The Ombuds monitors implementation of the law and protects human rights.
Bulgaria	There is a commission for protection against discrimination. Individuals also have recourse to the Ombudsman.
Croatia	Implementation of laws is ensured through the Ministry of Justice and Ministry of Internal Affairs. The Complaints Commissioner acts in cases of discrimination.
Georgia	The CCM and the Ombudsman's office monitor implementation of laws regarding PLHIV and most-at-risk populations.
Germany	There are various mechanisms including the Anti-Discrimination Office of the Federal Government; Equality of Treatment Commissioners at commune, state and federal level; commissioners for patients and the disabled; and, in one state, an Ombudsperson for people in prison.
Greece	The Ombudsman monitors the implementation of the principle of equal treatment in the public sector. The newly established Commission of Equal Treatment plays a similar role in cases outside the public sector. The Ombudsman mediates in cases of violation and refers cases that cannot be resolved to the appropriate authorities. The law also provides for the establishment of the Equal Treatment Service of the Ministry of Justice to examine complaints in relation to violation of the equal treatment principle.
Kazakhstan	Legal defence in cases of discrimination relating to HIV is provided under the auspices of the general system of defence of citizens' rights. Any person who thinks he or she has suffered discrimination may petition the court according to standard procedure. In accordance with Article 13 of the Constitution 'every person has a right to the legal defence of his rights and freedoms' and 'every person has a right to receive qualified legal assistance. In cases provided for by law, legal assistance is provided free of charge'.
Kyrgyzstan	There are institutions that provide free legal assistance for individuals from vulnerable populations, including representation in court and legal defence.
Latvia	The Ombudsman, established in 2007, and the Parliamentary Human Rights Committee.
Moldova	Disputes are settled by ministries through departments for petitions or specialised committees or, if necessary, through the courts. There is also the Human Rights Centre (Centre of Parliamentarian Lawyers or Ombudsman), as well as NGOs that deal with human rights such as CREDO.
Norway	The Equality and Anti-discrimination Ombud, established in 2006, promotes equal opportunity, upholds the law, and fights discrimination based on gender, ethnic origin, sexual orientation, religion, disability and age. The Parliamentary Ombudsman supervises public administration agencies and responds to complaints from citizens concerning maladministration or injustice that apply to government, municipal or county administrations. The Ombudsman may also address issues on his own initiative.
Romania	Mechanisms are harmonised with EU standards. Access is facilitated by institutions such as the National Council for Combating Discrimination and civil society organisations. Citizens whose rights have been infringed can file a complaint with the National Council, which has the powers and instruments to decide if the case is one of discrimination and provides legal support for action.
Russia	All citizens can use common complaint procedures in cases where the actions or decisions of state organs violate their rights; there are no separate anti-discrimination provisions or mechanisms for vulnerable groups.

[738] Andorra, Albania, Azerbaijan, Belgium, Cyprus, Estonia, France, Iceland, Israel, Italy, Lithuania, Luxembourg, Malta, Netherlands, San Marino, Slovakia, Slovenia, Spain, the Former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Uzbekistan.

[739] 13 countries did not provide any information in response to this question.

Country	Evidence
Serbia	The Ombudsman's Office has recently been established and standard laws and operational mechanisms are in place.
Sweden	The government and parliament ensure that laws are implemented. Different ombudsman authorities include the Ombudsman against Ethnic Discrimination, the Equal Opportunities Ombudsman, the Disability Ombudsman, the Children's Ombudsman and the Ombudsman against Discrimination on grounds of Sexual Orientation. These comment on proposed amendments to current legislation and also have the authority to call attention to shortcomings in the law and to recommend improvements.
Switzerland	There is the Federal Office for Gender Equality, which aims to raise awareness but does not take up individual cases, and the Ministry of Interior's Service for Combating Racism. Switzerland has set up a system to track and report discrimination. Twice a year AHS, the main Swiss HIV/AIDS NGO, provides an in-depth report to the Swiss National AIDS Commission on discrimination encountered by PLHIV.
Tajikistan	Legal defence through the court system is provided in cases of discrimination and violation of legislation
United Kingdom	The Equalities and Human Rights Commission oversees implementation of all equalities-related and human rights legislation. The European Convention for Human Rights is now embedded in UK law through the Human Rights Act, which theoretically provides protection for PLHIV from marginalised groups. However, the interpretation of human rights is not uniform amongst law makers.
Ukraine	Rights' violations can be settled through pretrial procedures or in court. Other mechanisms cited include appeals to the Ombudsman or to the European Court of Human Rights, advocacy and human rights NGOs, provision of free legal assistance, use of successful precedents regarding the most typical cases of human rights violations of vulnerable groups and of respective clarifications of the Plenary Session of the Supreme Court of Ukraine, although there are still no clarifications on cases of HIV-related human rights violations.

Country responses to both questions show that:

- Ombudsperson's offices are the most frequently reported mechanism, for example in Georgia, Greece, Latvia, Norway, Moldova, Serbia and Sweden. Some, such as Sweden, have multiple ombudsmen covering different areas.
- Several countries have specific institutions, for example, the Complaints Commissioner in Croatia, Federal Government Anti-Discrimination Office in Germany, National Council for Combating Discrimination in Romania, and Equalities and the Human Rights Commission in the United Kingdom.
- Croatia, Greece, Latvia and Moldova highlighted the role of parliament, government ministries and committees. Other countries cited specific national bodies, for example, the Global Fund Country Coordinating Mechanism in Georgia.
- Armenia, Kazakhstan, Kyrgyzstan and Tajikistan cited the legal system as the main mechanism for redress. The availability of free legal assistance was also noted by Kazakhstan, Kyrgyzstan and Ukraine.
- Several countries, for example, Armenia, Moldova and Ukraine, also highlighted the role of civil society organisations.

Overall, only 11 countries[740] report both that stigma and discrimination is addressed in national strategy, policy and programmes and the existence of non-discrimination laws of regulations that protect most-at-risk populations and PLHIV. Few countries commented on the degree to which laws are actually implemented and this could perhaps be an area of focus for future reporting.

Some countries commented on issues relating to stigma and discrimination in responses on other issues in the review. For example, Denmark highlighted a campaign on discrimination against PLHIV as a key achievement in its prevention efforts (see Section 2.1, Box 7).

3.2.4 Conclusions

This chapter presents data that countries reported concerning the prevalence of accepting attitudes among the general population towards PLHIV and the policy and legal environment with respect to HIV-related stigma and discrimination.

Only just over a third of countries were able to provide some quantitative or qualitative data about attitudes towards PLHIV. The percentage of people with accepting attitudes towards PLHIV varies considerably between

[740] Czech Republic, Georgia, Germany, Kazakhstan, Kyrgyzstan, Lithuania, Moldova, Poland, Romania, Spain and Turkey.

countries. Although the picture is mixed, it appears that there are high rates of discriminatory attitudes/low rates of accepting attitudes in some countries, such as Armenia, Belgium, Czech Republic, Kazakhstan, Romania and Serbia, and low rates of discriminatory attitudes/high rates of accepting attitudes in others, such as Denmark, France, Germany, Sweden and the United Kingdom. But, even in countries where attitudes are broadly positive, a significant minority appear to hold discriminatory views about PLHIV.

Responses depended on the precise question asked, with more accepting attitudes expressed towards PLHIV in people's immediate circle of family and friends than towards PLHIV in settings outside the personal environment, such as in workplaces or schools. The data also indicates that, broadly speaking, more accepting attitudes tend to be expressed by women, people living in urban areas and those with higher levels of education.

While the UNGASS questions elicit some useful data, their relevance to the region is questioned. Some countries have used different questions and approaches to assess attitudes towards PLHIV. In addition, the UNGASS focus on HIV-related stigma and discrimination means that it is not possible to assess the extent to which stigma and discrimination are associated with negative attitudes towards specific population such as MSM, IDU or sex workers rather than towards HIV.

Almost all (84%) countries report that stigma and discrimination is addressed in national strategies or action frameworks for HIV and AIDS. However, this is not consistently reflected in policies and programmes (see Figure 46). Less than half of countries have a policy prohibiting screening for general employment purposes and only just over just over half have programmes in place to reduce HIV-related stigma and discrimination.

The same pattern is seen with non-discrimination laws and regulations. Around half of 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 subpopulations. MSM, prisoners and migrants are more likely to be covered by non-discrimination laws or regulations than IDU or sex workers. 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 mirror those of the first progress report on the Dublin Declaration, which identified a gap between protection of human rights on paper and actual practice.

In conclusion, ECDC has identified the following issues needing 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 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 EU 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

4.1.1 Introduction

Over the past few years, the international community has encouraged countries to strengthen their monitoring and evaluation (M&E) programmes related to the HIV and AIDS response. The focus of efforts to improve M&E has been on developing countries or countries receiving external funding for their HIV response. This focus is in line with the third of the Three Ones Principles discussed in Section1.1: one agreed country-level monitoring and evaluation system (see Box 1). However, improved M&E is also an issue across Europe and central Asia.

The Dublin Declaration makes several references to M&E, including the importance of effective surveillance systems to monitor the epidemic, risk behaviours and vulnerability to HIV; the importance of a role for civil society and PLHIV in monitoring the response; and monitoring best practices for prevention, treatment and care, particularly for persons at the highest risk of and most vulnerable to infection.

This chapter looks at M&E aspects of the national response to HIV and AIDS. The findings are based on a series of 24 questions answered by national governments about their M&E efforts. These questions are all based on UNGASS NCPI. The responses include NCPI data submitted by countries in the 2008 round of UNGASS reporting as well as data collected directly from countries for this review of activities related to the Dublin Declaration.

Countries responding to the Dublin questionnaire were asked an initial screening question: 'does the country have one national HIV/AIDS M&E plan?' If they answered 'Yes' to this question, they were directed to answer 24 detailed questions on M&E. These questions covered eight topic areas: 1) the national M&E plan; 2) an M&E unit or department; 3) an M&E committee or working group; 4) a national M&E database; 5) a health information system; 6) an annual M&E report; 7) data use; and 8) M&E training. A total of 48 countries answered the screening question[741]. Of these respondents, 54%[742] answered 'Yes'; 31%[743] answered 'In progress'; and 15%[744] answered 'No'[745].

4.1.2 M&E plan

Data was collected for nine questions about the national M&E plan. Thirty-seven countries (77%[746]), including 19 EU/EFTA countries (68%[747]), provided data for at least one of these questions. The percentage of EU/EFTA countries answering positively to these questions was, in many cases, slightly lower than the percentage of all countries (see Figure 48).

Almost all countries reported having systems for HIV and behavioural surveillance (92%), data collection and analysis (89%) and a well-defined standardised set of indicators (86%). However, only just over half (59%) reported having a system for assessing quality and accuracy of data. Overall, more than three quarters (76%) of countries reported that their plans include guidelines on tools for data collection but this figure was only just over half (58%) for EU/EFTA countries.

[741] Iceland did not respond to the screening question.

[742] 26/48.

[743] 15/48.

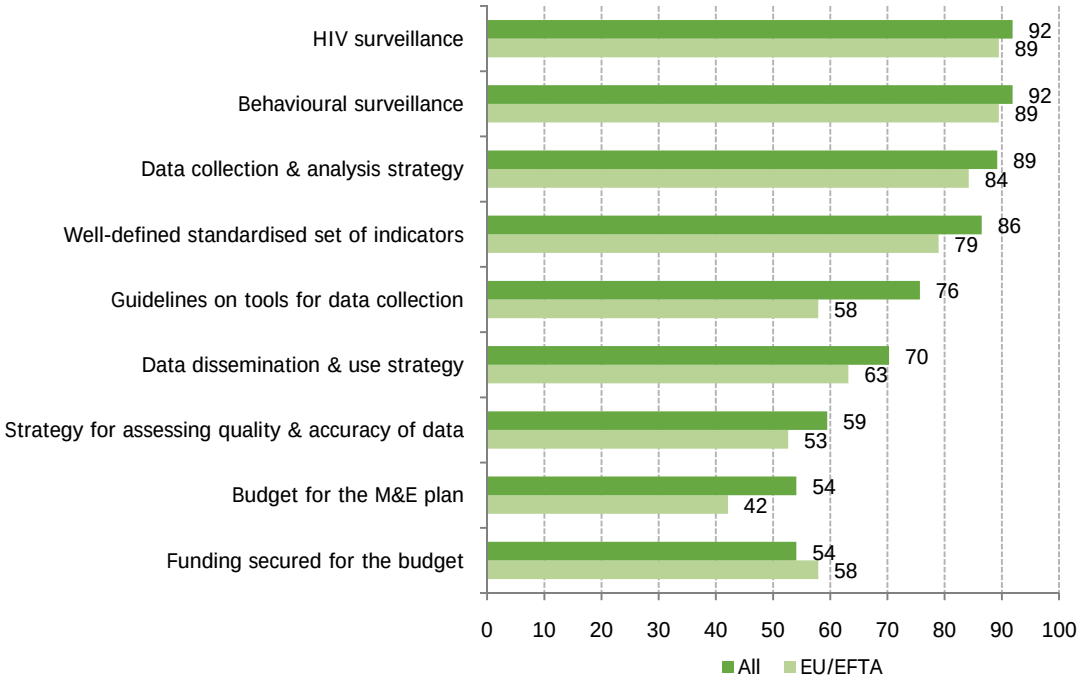
[744] 7/48.

[745] Bosnia and Herzegovina, Denmark, France, Georgia, Ireland, Latvia and the Netherlands.

[746] 37/48.

[747] 19/28.

Figure 48: Percentage of responses from all countries and EU/EFTA countries on whether the HIV/AIDS M&E plan includes specific elements



Just over half (54%) of countries reported having a budget for the M&E plan and secured funding for that budget. Although the proportion of EU/EFTA countries (42%) was lower, the proportion that reported they had secured funding (58%) was higher. An additional 10 countries[748] reported that a budget was 'in progress'. Two countries[749] reported having secured funding for M&E despite reporting not having an M&E budget.

Overall, the percentage of countries with a budget for their M&E plan is low and even lower among EU/EFTA countries. Given the importance of data for decision making, it would be reasonable to assume that countries reporting that they have an M&E plan would also report that this plan has a budget and funding.

In the section of the questionnaire related to civil society participation (see Section 1.2), 21 countries reported that the national M&E plan was developed in consultation with civil society, including PLHIV. Given that 26 countries report having M&E plans and a further 15 report that these are under development, and in view of the specific reference in the Dublin Declaration to the role of civil society and PLHIV in monitoring the response, the low percentage of countries including these stakeholders in the development of the M&E plan is notable.

4.1.3 M&E unit or department

The questionnaire included three questions on the existence, staffing and operations of HIV/AIDS M&E units or departments in countries. Of countries providing some data on their M&E plan, almost three quarters (73%[750]) of countries reported having a functional M&E unit or department. Almost all (84%[751]) EU/EFTA countries reported having such a unit/department. A further seven countries reported that the development of such a unit/department was 'in progress'.

The data reported raises questions about how countries conduct HIV-related M&E activities. One possibility is that these activities are done in other units or departments rather than in a dedicated HIV M&E unit.

The second question asked about the number of permanent staff working in the M&E unit or department. Twenty-five countries (68%[752]) reported on this question, with the number of permanent staff ranging from 0 to 29 (see Table 36). Without more detailed information from countries, it is difficult to determine how well this question

[748] Andorra, Armenia, Bulgaria, Greece, Hungary, Kazakhstan, Poland, Portugal, the Former Yugoslav Republic of Macedonia, Ukraine.

[749] Finland, Italy.

[750] 27/37.

[751] 16/19.

[752] 25/37.

captures actual staffing. For example, different interpretations of 'permanent' may have had an impact on responses.

Table 36: Country data on the number of permanent staff working in the M&E unit or department

Country	Number of permanent staff in the M&E unit or department	Country	Number of permanent staff in the M&E unit or department
Andorra	1	Moldova	4
Bosnia	6	Netherlands	7
Bulgaria	3	Poland	1
Croatia	2	Portugal	1
Czech Republic	2	Romania	5
Estonia	2.5	Russia	6
Germany	6	Serbia	2
Hungary	2	Spain	7
Israel	2	Sweden	2
Kazakhstan	4	Switzerland	5
Kyrgyzstan	29	Tajikistan	0
Lithuania	4	Uzbekistan	5
Luxembourg	1		

The third question related to mechanisms to ensure that all major implementing partners submit M&E data or reports to the M&E unit or department for review and consideration in the country's national reports. Of countries providing some data on their M&E plan, more than half (59%[753]) reported having mechanisms in place. This figure was over two thirds (68%[754]) of EU/EFTA countries.

4.1.4 M&E committee or working group

The questionnaire also included three questions related to the existence and operation of an M&E committee or working group. Of countries providing some data on their M&E plan, nearly two thirds (62%[755]) reported having this type of committee or a working group that meets to coordinate M&E activities. Just over half (58%[756]) of EU/EFTA countries reported that they have a committee or working group.

Among the countries that reported having an M&E committee or working group, more than half (61%[757]) reported that the group meets regularly. However, only just over a third (35%[758]) reported that it had met in the last year.

In the section of the questionnaire related to civil society participation (see Section 1.2), 18 countries reported civil society participation, including PLHIV, on the M&E committee or working group.

Overall, relatively few countries report having an M&E committee or working group. Of those that have such a group/committee, a substantial number do not meet regularly or have not met in the last year. However, it is not clear if stakeholders in countries believe an M&E committee or working group is necessary or beneficial. It is possible that this type of a group may be more appropriate in countries with generalised epidemics where there is a broader range of stakeholders and issues relating to monitoring and evaluation.

4.1.5 National database

The questionnaire included two questions about a central national database for information on the HIV response. Of countries providing some data on their M&E plan, more than two thirds (68%[759]) of countries reported that the M&E unit or department manages a central national database. Although the percentage of positive responses is relatively low, there may be reasons for this. For example countries may have a central national database that is not managed by the M&E unit or department or they may have decentralised data systems.

[753] 22/37.

[754] 13/19.

[755] 23/37.

[756] 11/19.

[757] 14/23.

[758] 8/23.

[759] 25/37.

Nearly three quarters (72%[760]) of countries with a database managed by the M&E unit or department reported that it includes information about the content, target populations and geographical coverage of programmatic activities, as well as implementing organisations.

4.1.6 Health information system

This section of the questionnaire also included two general questions about a functional Health Information System. Of countries providing some data on their M&E plan, almost all (84%[761]) reported that there is a functional system at national level. However, less than two thirds (62%[762]) reported a functional system at subnational level.

4.1.7 Annual M&E report

Countries were asked whether they produce an annual M&E report on HIV. Of countries providing some data on their M&E plan, nearly three quarters (73%[763]) reported that they publish an M&E report on HIV at least once a year and that this report includes HIV surveillance data. Among EU/EFTA countries, the percentage was higher (84%[764]).

4.1.8 Data use

Countries were also asked about data use. Specifically, they were asked to rate on a scale of 1–5 the extent to which M&E data is used in planning and implementation. Of countries providing some data on their M&E plan, almost all (86%[765]) responded. High-scoring (5) countries included Italy, Romania and Uzbekistan. Scores ranged from 1 to 5 and the mean score was 3.5 (median 4). This suggests that countries are using M&E data for decision making, but that there is room for improvement both in the number of countries using data and the extent to which they use it.

4.1.9 M&E training

Lastly, the questionnaire included three questions about training in M&E in the last year. Of countries providing some data on their M&E plan, less than half (41%[766]) reported that M&E training was conducted at the national level in the last year, less than a quarter (24%[767]) reported M&E training at the subnational level and less than a third (32%[768]) included civil society in M&E training in the last year. Reported M&E training was particularly low in EU/EFTA countries. Among EU/EFTA countries, only 21%[769] conducted M&E training at the national level and 16%[770] at the subnational level, and only 11%[771] included civil society in M&E training.

Across the region, relatively few countries reported conducting M&E training. However, it is not possible to determine the reason for this or whether the lack of training is an impediment to effective M&E at the country level. Although the figures suggest low involvement of civil society in M&E training, it appears that most countries do involve civil society in M&E training when it is provided.

4.1.10 Conclusion

The value placed on M&E in the region is underscored by reports from 85% of countries that they have or are developing a national M&E plan. In addition, of countries that provided information on their M&E plan, 92% report that they have or are developing a functional M&E unit or department, 92% report their M&E plans include both HIV and behavioural surveillance and 89% report that their plans include a data collection and analysis strategy (see Figure 48). However, there are several areas where scores for M&E indicators in the region are relatively low. For example, only just over half of countries report having a strategy for assessing the quality and accuracy of data (59%) or a budget and secured funding for their M&E plan (54%).

[760] 18/25.

[761] 31/37.

[762] 23/37.

[763] 27/37.

[764] 16/19.

[765] 32/37.

[766] 15/37.

[767] 9/37.

[768] 12/37.

[769] 4/19.

[770] 3/19.

[771] 2/19.

Although EU/EFTA countries are slightly less likely to have some of the elements of an M&E system in place than other countries (see Figure 48), they are more likely to have access to adequate funding, an HIV M&E unit and an annual HIV M&E report than other countries.

However, it is unclear the extent to which these questions, based on assessing the extent of implementation of the third of the 'Three Ones' principles gives an accurate picture of the adequacy of HIV-related M&E in countries of the region. More relevant issues may be whether countries have the information they need to understand their HIV epidemics and respond appropriately. Based on this review, it does appear that most countries of the region have this information. The key question is the extent to which this information is used to shape national responses to HIV.

In conclusion, ECDC has identified the following issues needing 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.

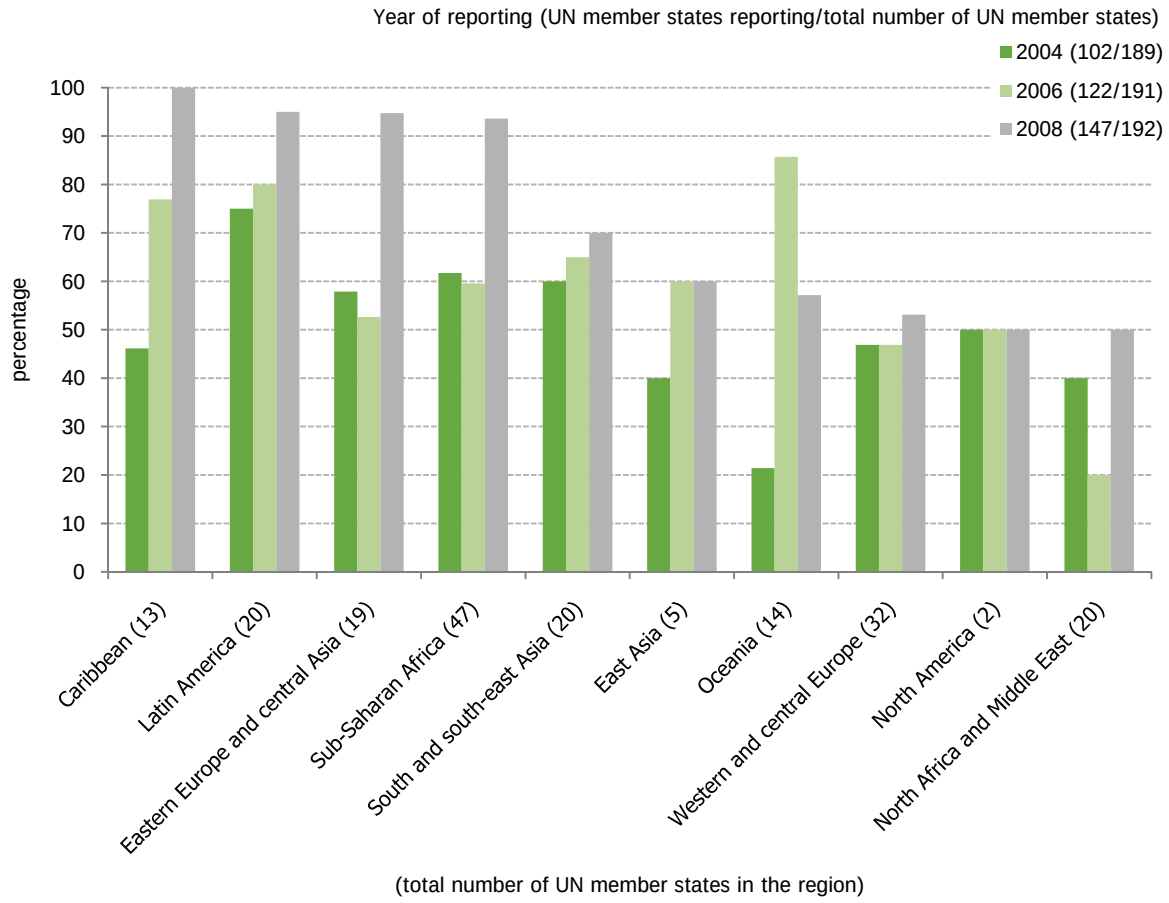
4.2 UNGASS reporting in Europe and central Asia

4.2.1 Introduction

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 tracking progress in implementation of that 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 three rounds of UNGASS reporting: in 2004, 2006 and 2008.

According to UNAIDS, the rate of reporting on UNGASS by countries in Europe and central Asia has been lower than in other regions around the world. Within the region, the rate of reporting has been higher in eastern Europe and central Asia than in western Europe (see Figure 49).

Figure 49: Regional UNGASS reporting rates, 2004–2008



Source: UNAIDS presentation to advisory group.

This chapter first examines response rates for reporting for both UNGASS and the Dublin Declaration. It then looks at key issues raised by countries about UNGASS reporting during the workshop on monitoring the Dublin Declaration held in June 2009 (see Method) and in follow-up discussions. It is clear that countries in the region generally feel that almost all UNGASS topic areas and many specific indicators are relevant to their situations, particularly those related to most-at-risk populations. However, there are a number of concerns, including that some topics and indicators are less relevant, including those related to orphans and vulnerable children and the general population.

4.2.2 Response rates

Almost three quarters (72%[772]) of countries asked to report on the Dublin Declaration in 2009–2010 submitted an UNGASS report in 2008 (see Table 37). However, the quality and completeness of these UNGASS reports varies

[772] 39/54.

widely. For example, four countries in the region[773] submitted reports without the National Composite Policy Index, which provides a range of useful qualitative data on country responses.

Table 37: Countries in Europe and central Asia that reported on UNGASS in 2008

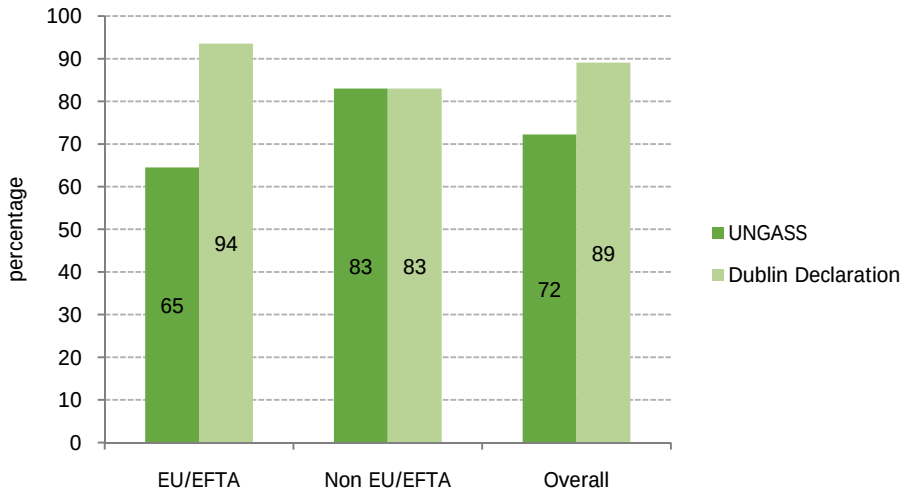
Albania	Georgia	Poland
Armenia	Germany	Romania
Azerbaijan	Greece	Russia
Belarus	Hungary	Serbia
Belgium	Ireland	Slovenia
Bosnia and Herzegovina	Israel	Spain
Bulgaria	Kazakhstan	Sweden
Croatia	Kyrgyzstan	Switzerland
Cyprus	Latvia	Tajikistan
Estonia	Lithuania	Turkey
Finland	Moldova	Ukraine
Former Yugoslav Republic of Macedonia	Montenegro	United Kingdom
France	Netherlands	Uzbekistan

Fifteen countries did not report on UNGASS in 2008 (see Table 38). Of these, 12[774] did report on the Dublin Declaration in 2009–2010 (see Method). Figure 50 shows the percentage of countries that reported to the two processes, overall and broken down to show EU/EFTA countries and others. Overall response rates were higher (89%) for the Dublin declaration process than for UNGASS 2008 (72%). This difference was particularly marked for EU/EFTA countries.

Table 38: Countries in Europe and central Asia that did not report on UNGASS in 2008

Andorra	Italy	Norway
Austria	Liechtenstein	Portugal
Czech Republic	Luxembourg	San Marino
Denmark	Malta	Slovakia
Iceland	Monaco	Turkmenistan

Figure 50: Percentage of countries responding to UNGASS 2008 and the Dublin Declaration 2009–2010



[773] Albania, Estonia, France and Ireland.

[774] The countries that did not report to either process were Austria, Liechtenstein and Monaco.

4.2.3 Regional relevance

The most important issue for countries was the perceived relevance of UNGASS reporting in Europe and central Asia. In general, concerns relating to this issue were divided into three groups.

First, the overall process of UNGASS reporting is seen as donor-driven (e.g. bilateral programmes, the Global Fund for AIDS, TB and Malaria and the World Bank), which makes it appear more relevant to developing countries than to developed ones. If developed countries are going to report on UNGASS, there is a need to make a stronger case about the benefits of improved international and regional reporting. Tangible benefits such as shared learning, intercountry benchmarking and regional analysis of issues that affect multiple countries are much more compelling reasons to report than the argument that they are obliged to report as signatories to the UNGASS Declaration.

There are parallel concerns that the UNGASS approach is system-oriented rather than being problem-focused, which is the primary approach for most national programmes in the region. While a system-orientated approach is relevant in many developing countries, it is far less relevant in developed ones.

Second, some of the topic areas covered by the UNGASS indicator set are seen as more relevant to the generalised epidemics in eastern and southern Africa than the concentrated epidemics in Europe and central Asia. The example cited most frequently is the area of orphans and vulnerable children. Opinions on the relevance of other areas, e.g. PMTCT and HIV prevention among young people, vary from country to country, depending on their epidemic, their response and their political climate. In general, there is a consensus that almost all of the thematic areas covered by UNGASS reporting are relevant to countries in Europe and central Asia. However, there are areas of particular relevance to Europe and central Asia that are not currently covered by UNGASS reporting. The most prominent gaps are around migrants and prisoners. The existence of these gaps reinforces the perception in the region that UNGASS reporting is more relevant in developing countries with generalised epidemics.

Third, a number of specific UNGASS indicators are not seen as relevant in the region and reporting on these is viewed as adding to the workload of staff responsible for reporting. The lack of relevance may be because the thematic area is monitored in a different way or because the monitoring is not considered essential and/or cost effective for the specific country context. For example, there are concerns that UNGASS is too focused on indicators that use data from special surveys rather than from routine surveillance and/or service delivery statistics, which are key sources of data in Europe. Indicators that monitor HIV prevalence among specific subpopulations are seen as particularly problematic, given concerns about the measurement tools and the methods of measurement.

In addition, some countries object strongly to the denominator proposed by UNAIDS to measure ART coverage. Rather than estimating the number of PLHIV in need of treatment, they prefer to use the number of people known to be in need of treatment[775] as the denominator (see Section 3.1).

There are similar concerns about relevance of component parts of specific indicators. For example, some countries would prefer the NCPI to have more questions that allow for broader answers as opposed to very restrictive 'yes/no' responses. In addition, multiple countries have concerns that the upper age limit of 49 for many UNGASS indicators is not relevant in the region.

4.2.4 Use of country data

Some countries are concerned that the consolidated UNGASS report produced by UNAIDS uses data from sources other than the countries' own data. There were specific concerns that it is not always clear when alternative data is used or how it compares with the countries' own data.

4.2.5 Limited standardisation, harmonisation and/or coordination

In recent years, there has been a sharp increase in international efforts to standardise, harmonise and/or coordinate around key indicators used to monitor the HIV response. This effort has largely focused around donor-funded programmes in developing countries. For example, the Global Fund for AIDS, TB and Malaria has included a number of UNGASS indicators in its Monitoring and Evaluation Toolkit for grantees. However, in Europe and central Asia, there has been relatively little standardisation, harmonisation and/or coordination of indicators or questions, e.g. the questions used in behavioural surveillance[776].

Although countries in the region have developed their own systems for monitoring their national responses, there is strong demand among them for ECDC and other international agencies to explore opportunities to standardise, harmonise and/or coordinate this monitoring in Europe and central Asia. However, an issue to consider is the trade

[775] Those who have had a positive HIV test and a CD4 cell count of < 350 cells/mm^3.

[776] In September 2009, ECDC published Mapping of HIV/STI behavioural surveillance in Europe. This report was an important step in understanding existing surveillance mechanisms in EU/EFTA countries and could be used as the basis for standardisation, harmonisation and coordination in the future. An electronic version of the report can be downloaded from the ECDC website: www.ecdc.europa.eu.

off between standardisation and flexibility. As the process of this progress review of the Dublin Declaration has highlighted, allowing countries to report the data that they have provides a richer and wider range of information than would have been the case with a more rigid approach.

There is a parallel interest in standardising, harmonising and/or coordinating reporting in the region. For example, in 2010, countries in the region have been asked to report on the UNGASS Declaration (due 31 March 2010); submit data for the WHO/UNICEF/UNAIDS annual global report on the scale-up of priority health sector interventions for HIV prevention, treatment, care and support (due 31 March 2010); and submit extensive surveillance data for the 2010 AIDS Epidemic Update (due 9 April 2010). In addition, countries noted that there is a similar UNGASS reporting process for issues relating to drug use, and that they are expected to report both to UNODC and to EMCDDA.

It would reduce the reporting burden considerably if multiple reporting mechanisms could be combined into one regular exercise—whether this is annual or biennial would depend on what is to be reported on and how frequently this is measured—particularly if combined with an overall reduction in the number of indicators and/or questions.

4.2.6 Limited capacity

Currently, countries in Europe and central Asia have limited human and financial resources for regional and international monitoring and reporting. It is difficult for countries to allocate the required resources to these processes while the perceived benefits remain unclear.

In addition, countries believe ECDC could play an important role in enhancing their M&E capacity. For example, ECDC could:

- develop minimum standards and guidelines on integration of surveillance and M&E systems;
- facilitate an agreement on regional indicators and data collection methods;
- organise meetings for countries to share knowledge, experience and good practice; and
- provide technical support and training.

4.2.7 Practical issues

There are also a number of practical/logistical problems with UNGASS reporting. For example, very few countries are reporting using the UNAIDS Country Response Information System (CRIS). In addition, experience with electronic forms for UNGASS reporting has been poor with countries having problems doing simple tasks such as saving partially completed forms, making changes and printing forms.

4.2.8 Conclusions

Although UNGASS reporting has been consistently lower in Europe and central Asia than in other regions, the process to monitor the Dublin Declaration has significantly increased the percentage of countries providing data on their HIV response.

Countries have a wide range of concerns about UNGASS reporting. The most important issue is relevance in Europe and central Asia. There is a concern that UNGASS is largely a donor-driven process, which makes it more relevant in developing countries than in developed ones. Countries also question the relevance of specific topic areas as well as specific indicators included in UNGASS monitoring. In addition, there are concerns about gaps in UNGASS topic areas and indicators that are highly relevant in the region, e.g. migrants from countries with generalised epidemics (Section 2.5) and prisoners (Section 2.6).

There is also concern about the lack of standardisation, harmonisation and/or coordination in international reporting processes. Multiple requests for data from international organisations (e.g. UNGASS, health sector response and AIDS Epidemic Update) are a significant burden on countries, most of which have limited human and financial resources available to monitor the epidemic and the response and to report on this.

In conclusion, ECDC has identified the following issues needing 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 fewer indicators, which would reduce the reporting burden for countries.
  - The ability to identify and provide clearly defined benefits to countries for reporting, e.g. shared learning, intercountry benchmarking and regional analysis of issues that affect multiple countries.
  - 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 needs to be reported and how often.

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 multisectoral, 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.

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Annex 1: Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia

Against the background of the global emergency of the HIV/AIDS epidemic with 40 million people worldwide living with HIV/AIDS, 90 per cent in developing countries and 75 per cent in Sub-Saharan Africa, representatives of States and Governments from Europe and Central Asia, together with invited observers, met in Dublin, Ireland, from 23 to 24 February 2004, for the Conference "Breaking the Barriers – Partnership to fight HIV/AIDS in Europe and Central Asia" and made the following declaration:

Recognising that poverty, underdevelopment and illiteracy are among the principal contributing factors to the spread of HIV/AIDS, and noting with grave concern that HIV/AIDS is compounding poverty and is now reversing or impeding development in many countries;

Emphasising the importance of sustained, pro-poor economic growth through poverty-reduction policies, programmes and strategies for the success of the fight against HIV/AIDS;

Recognising that the promotion of equality between women and men, girls and boys and respecting the right to reproductive and sexual health, and access to sexuality education, information and health services as well as openness about sexuality, are fundamental factors in the fight against the pandemic;

Reaffirming the Declaration of Commitment on HIV/AIDS adopted by the UN General Assembly Special Session on HIV/AIDS on 27 June 2001;

Reaffirming the development goals as contained in the Millennium Declaration adopted by the United Nations General Assembly at its fifty-fifth session in September 2000, and in the Road Map towards the implementation of the United Nations Millennium Declaration, and other international development goals and targets;

Reaffirming the Programme of Action of the International Conference on Population and Development (Cairo, 1994) and key actions for the further implementation of the Programme of Action of the International Conference on Population and Development adopted by the twenty-first special session of the United Nations General Assembly in July 1999;

Reaffirming the Beijing Platform for Action (Beijing, 1995) and the further actions and initiatives to implement the Beijing Declaration and the Platform for Action adopted at the twenty-third special session of the United Nations General Assembly in June 2000;

Expressing profound concern that in the European and Central Asian region at least 2.1 million of our people are now living with HIV/AIDS;

Noting with serious concern the particularly rapid escalation of the epidemic among young people in Eastern Europe, where HIV prevalence in the adult population is reaching critical levels in a number of countries and also the significant potential for the rapid spread of HIV in South-Eastern Europe and Central Asia;

Also noting with serious concern the resurgence of HIV/AIDS prevalence in Western Europe, including HIV resistant to anti-retroviral therapy, where the disease remains a potent threat to our young people;

Emphasising that the most seriously affected countries, mainly in southern Africa, are facing collapse in one or more sectors of society, and agreeing that the HIV/AIDS epidemic threatens to become a crisis of unprecedented proportions in our region, undermining public health, development, social cohesion, national security and political stability in many of our countries;

Agreeing that we must act collectively to tackle this crisis through a deepening of coordination, cooperation and partnership within and between our countries and are encouraged by proposals made at the Conference to strengthen the capacity of the European Union to fight effectively against the spread of HIV/AIDS;

Confirming that the respect, protection and promotion of human rights is fundamental to preventing transmission of HIV, reducing vulnerability to infection and dealing with the impact of HIV/AIDS;

Acknowledging that the prevention of HIV infection, through the promotion of safer and responsible sexual behaviour and practices, including through condom use, must be the mainstay of the sub-national, national, regional and international response to the epidemic and that prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic;

Recognising that in our region persons at the highest risk of and most vulnerable to HIV/AIDS infection include drug injectors and their sexual partners, men who have sex with men, sexworkers, trafficked women, prisoners and ethnic minorities and migrant populations which have close links to high prevalence countries;

Stressing that without urgent action, HIV/AIDS will continue to move into the general population;

Recognising that women and girls are particularly vulnerable to HIV infection;

Recognising that a focus on the role of men and boys in combating HIV/AIDS and in the promotion of gender equality will benefit everyone and society as a whole, and that engaging men and boys as partners will encourage them to take responsibility for their sexual behaviour and to respect the rights of women and girls;

Recognising that in order to be able to tackle the HIV/AIDS crisis, we need strong basic health care systems and services to ensure universal and equitable access to HIV/AIDS prevention, treatment and care;

Recognising that success in the fight against HIV/AIDS is linked to the fight against other sexually transmittable infections and the fight against tuberculosis;

Emphasising that while young people are vulnerable, they themselves are key actors and agents of change in the fight against HIV/AIDS and are a major resource for the response at national and regional levels;

Acknowledging that the principle of greater involvement of people living with or affected by HIV/AIDS is critical to ethical and effective national responses to the epidemic;

Recognising that investment in research and development for more effective therapeutic and preventive tools, such as microbicides and vaccines, will be essential to securing the long-term success of HIV and AIDS responses;

We have agreed on the following actions to accelerate the implementation of the Declaration of Commitment on HIV/AIDS;

Leadership

1. Promote strong and accountable leadership at the level of our Heads of State and Government to protect our people from this threat to their future, and promote human rights and tackle stigma and ensure access to education, information and services for all those in need;

2. Encourage and facilitate strong leadership by civil society and the private sector in our countries in contributing to the achievement of the goals and targets of the Declaration of Commitment;

3. Accelerate the implementation of the provisions of the Declaration of Commitment relating to orphans and girls and boys infected and affected by HIV/AIDS777;

4. Establish and reinforce national HIV/AIDS partnership forums including meaningful participation of civil society, and particularly of people living with HIV/AIDS and their advocates, to design, review, monitor and report progress in the fight against the disease, and to take timely and determined action to identify and address barriers to implementation;

5. In 2004-2005, promote the active involvement of the institutions of the European Union, and other relevant institutions and organisations such as the Commonwealth of Independent States, the Council of Europe, the Organisation for Security and Cooperation in Europe and the Regional Committee of the World Health Organisation, in partnership with UNAIDS through its co-sponsoring agencies and its Secretariat, in our common effort to strengthen coordination and cooperation;

6. Make the fight against HIV/AIDS in Europe and Central Asia a regular item on the agendas of our regional institutions and organisations;

7. Provide increased and results-based financial and technical resources to scale up access to prevention, care and sustained treatment, including effective low cost treatment such as generics, in the most affected countries with the greatest needs through national and regional allocations as well as from the Global Fund to Fight AIDS, TB and Malaria, the European Union, new public and private partnerships, multilateral and bilateral financing mechanisms;

Prevention

8. Reinvigorate our efforts to ensure the target of the Declaration of Commitment[778] that, by 2005, at least 90 percent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to

[777] Declaration of Commitment of the UN General Assembly S

reduce their vulnerability to HIV infection, in dialogue with young persons, parents, families, educators and health-care providers;

9. By 2010, ensure through the scaling up of programmes that 80% of the persons at the highest risk of and most vulnerable to HIV/AIDS are covered by a wide range of prevention programmes providing access to information, services and prevention commodities and identifying and addressing factors that make these groups and communities particularly vulnerable to HIV infection and promote and protect their health, and intensify cross border, sub-regional and regional technical collaboration and sharing of best practices through the EU and regional organisations in the prevention of HIV transmission among vulnerable groups;

10. Scale up access for injecting drug users to prevention, drug dependence treatment and harm reduction services through promoting, enabling and strengthening the widespread introduction of prevention, drug dependence treatment and harm reduction programmes[779] (e.g. needle and syringe programmes, bleach and condom distribution, voluntary HIV counselling and testing, substitution drug therapy, STI diagnosis and treatment) in line with national policies;

11. Ensure that HIV positive women and expectant mothers should have access to high quality maternal and reproductive health care services in order to prevent mother to child-transmission;

12. By 2010, eliminate[780] HIV infection among infants in Europe and Central Asia;

13. Ensure men, women and adolescents to have universal and equitable access to and promote the use of a comprehensive range of high quality, safe, accessible, affordable and reliable reproductive and sexual health care services, supplies and information including access to preventive methods such as male and female condoms, voluntary testing, counseling and follow-up;

14. By 2005, to develop national and regional strategies and programmes to increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, and reduce their vulnerability to HIV/AIDS;

15. By 2005, to develop national and regional strategies ensuring that all men and women in uniformed services, including armed forces and civil defence forces, have access to information, services and prevention commodities to reduce risk-taking behaviour and encourage safe behaviour, and urge the European Union, NATO and other regional and international security institutions in partnership with UNAIDS to lead such efforts;

16. Control the incidence and prevalence of sexually-transmitted infections, particularly amongst those at the highest risk of and most vulnerable to HIV/AIDS, through increased public awareness of their role in HIV transmission, improved and more accessible services for prompt diagnosis and efficient treatment;

17. Fund, improve, and harmonise surveillance systems, in line with international standards, to track and monitor the epidemic, risk behaviours and vulnerability to HIV/AIDS;

18. Request the Global Commission on International Migration to take into account in its work the threat of exposure to HIV/AIDS particularly to migrant women and unaccompanied and orphaned children;

19. Increase commitment to research and development for new technologies that better meet the prevention needs of people living with or most vulnerable to HIV transmission including increasing public sector investment in vaccines and microbicides to prevent HIV infection;

Living with HIV/AIDS

20. Combat stigma and discrimination of people living with HIV/AIDS in Europe and Central Asia, including through a critical review and monitoring of existing legislation, policies and practices with the objective of promoting the effective enjoyment of all human rights for people living with HIV/AIDS and members of affected communities;

21. By 2005, provide universal access to effective, affordable and equitable prevention, treatment and care including safe anti-retroviral treatment to people living with HIV/AIDS in the countries in our region[781] where access to such treatment is currently less than universal, including through the technical support of the UN through the global initiative led by the World Health Organisation and UNAIDS to ensure 3 million people globally are on anti-retroviral treatment by 2005 (“3 by 5”). The goal of providing effective anti-retroviral treatment must be conducted in a poverty-focused manner, equitable, and to those people who are at the highest risk of and most vulnerable to HIV/AIDS;

[779] The WHO recommends that at least 60% of injecting drug users have access to drug dependence treatment and harm reduction programmes in order to have an impact on the epidemic among this group.

[780] Elimination is defined as less than 2% of all new infections are acquired by an infant from his or her infected mother.

[781] The treatment gap in the region is estimated by the WHO to be at least 100 000 people in 2003.

22. Ensure early implementation of the WTO Decision of 30 August 2003 on the implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health;

23. Increase access to non-discriminatory palliative care, counseling, psychosocial support, housing assistance, and other relevant social services for people living with HIV/AIDS;

24. Invest in public research and development for the development of affordable and easier to use therapeutics and diagnostics to support expanded treatment access and improve the quality of life of people living with HIV;

25. Monitor best practices on and take concrete steps to exchange information on service delivery for prevention, treatment and care, particularly for persons at the highest risk of and most vulnerable to HIV/AIDS infection;

Partnership

26. Strengthen coordination, cooperation and partnership among the countries of Europe and Central Asia, as well as with their trans-Atlantic and other development partners, to scale up local capacity to fight the epidemic and mitigate its consequences in the most affected countries with the greatest needs, and in countries with a high risk of a major epidemic;

27. Involve civil society and faith-based organizations, as well as people living with HIV/AIDS and persons at the highest risk of and most vulnerable to HIV/AIDS infection in the development and implementation of national HIV/AIDS prevention and care strategies and financing plans, including through participation in national partnership forums;

28. Work with leaders from the private sector in fighting HIV/AIDS through workplace education programmes, employee non-discrimination policies, provision of treatment, counseling, care, and support services, and through engagement with policy makers on the local, national and regional levels;

29. Involve the national and international pharmaceutical industry in a public-private partnership including with relevant international organisations such as the World Health Organisation in helping to tackle the epidemic along all points of the drug supply chain – from manufacturing to pricing to distribution;

30. Ensure effective coordination between donors, multilateral organisations, civil society and Governments in the effective delivery of assistance to the countries most in need of support in the implementation of their national HIV/AIDS strategies, based on ongoing processes on simplification and harmonization particularly the UNAIDS guiding principles;[782]

31. Establish sustainable partnerships with the media, recognising the critical role that it plays in influencing attitudes and behaviour and in providing HIV/AIDS related information;

32. Support stronger regional cooperation and networking among people living with HIV/AIDS and civil society organisations in Europe and Central Asia, and call upon the Joint United Nations Programme on HIV/AIDS in partnership with the European Union, existing civil society networks and other regional partner institutions to assist, facilitate and coordinate such collaboration;

Follow-up

33. We commit ourselves to closely monitor and evaluate the implementation of the actions outlined in this Declaration, along with those of the Declaration of Commitment of the United Nations General Assembly Session on HIV/AIDS, and call upon the European Union and other relevant regional institutions and organisations, in partnership with the Joint United Nations Programme on HIV/AIDS, to establish adequate forums and mechanisms including the involvement of civil society and people living with HIV/AIDS to assess progress at regional level every second year, beginning in 2006.

24 February 2004

[782] These are: that there should be one agreed national HIV/AIDS Action Framework that drives alignment of all partners., one national AIDS authority with a broad-based multisectoral mandate, and one agreed country-level monitoring and evaluation system.

Annex 2: Questionnaire

A questionnaire based on the 38 indicators in the Monitoring Framework for the Dublin Declaration were sent to 55 countries. It was put together in a PDF form in order to make the completion of the questionnaire as easy and accurate as possible. It included two types of indicators: 1) those that use a series of specific questions to collect data following the model of the UNGASS National Composite Policy Indicator (NCPI); and 2) those that rely on survey or programmatic data, including, for example, indicators drawn from existing international sets.

A model of this questionnaire can be found at ECDC's website:
http://ecdc.europa.eu/en/healthtopics/Documents/1009_questionnaire_to_monitor_Dublin_Declaration.pdf

Annex 3: List of countries

Table 39: Countries that responded to the Dublin Declaration questionnaire

Albania	Andorra	Armenia	Azerbaijan	Belgium*
Bosnia and Herzegovina	Bulgaria*	Croatia	Cyprus*	Czech Republic*
Denmark*	Estonia*	Finland*	Former Yugoslav Republic of Macedonia	France*
Germany*	Georgia	Greece*	Hungary*	Iceland**
Ireland*	Israel	Italy*	Kazakhstan	Kyrgyzstan
Latvia*	Lithuania*	Luxembourg*	Malta*	Moldova
Netherlands*	Norway**	Poland*	Portugal*	Romania*
Russia	San Marino	Serbia	Slovakia*	Slovenia*
Spain*	Sweden*	Switzerland**	Tajikistan	Turkey
Turkmenistan	Ukraine	United Kingdom*	Uzbekistan	

** EU countries*
*** EFTA countries*

The following countries were also invited to respond:

Austria*

Belarus

Kosovo (UNSCR 1244)

Liechtenstein**

Monaco

Montenegro

Annex 4: Monitoring framework

The project's proposed monitoring framework is presented in Figure 51. This is structured around three main thematic areas:

- leadership and partnership;
- prevention;
- living with HIV.

These three areas are drawn directly from the Dublin Declaration. Leadership and partnership have been combined into a single area as they were in the previous WHO/UNAIDS report.

The framework shows the proposed indicators to be used in this work. Each indicator has been assigned a number. In figure 51, indicators shown in **light green** correspond to indicators within the UNGASS set, whereas those that are not within the UNGASS set are shown in **light grey**. For indicators shown in **dark grey** some information would be available from indicators within the UNGASS set but other questions are proposed. Indicators in **lime green** are modifications of UNGASS indicators.

A summary table of all proposed indicators is presented in Figure 51 .More details of each proposed indicator are presented in Table 40. The framework groups indicators into three types, based on the typology used in the UNAIDS *Guidelines on construction of core indicators for monitoring the Declaration of Commitment on HIV/AIDS*. These are:

- indicators of commitment and action;
- programmatic indicators;
- indicators of knowledge, behaviour, outcome and impact.

Figure 51: Proposed indicators for monitoring the Dublin Declaration

Colour coding of indicators:

- Available from UNGASS
- Modified UNGASS
- Some information available from UNGASS but additional information needed
- Non-UNGASS

			Commitment and action	Programmatic	Knowledge, behaviour, outcome and impact
Leadership and partnership		Political leadership	MDD1		
		Civil society and private sector	MDD2		
		Financial resources	MDD3		
			MDD4		
Prevention	Targeted at those most at risk	IDU	MDD5	MDD6	MDD8-11
				MDD7	
		MSM		MDD12-13	MDD14–16
		Sex workers		MDD17-18	MDD19–21
		Migrants from countries with generalised epidemics	MDD22	MDD23-24	MDD25–27
		Prisoners	MDD28		MDD29
	PSH	Young people	MDD30		MDD31
Living with HIV		Treatment and care	MDD32	MDD33	MDD35
				MDD34	
		TB/HIV		MDD36	
		Stigma and discrimination	MDD37		MDD38

Table 40: Themes and indicators (same colour coding of Figure 51)

Themes	Indicator
Theme 1: Leadership and partnership	MDD1: Qualitative assessment of political leadership
	MDD2: Qualitative assessment of involvement of civil society and the private sector
	MDD3: National spending on HIV prevention
	MDD4: national contributions to international AIDS spending
Theme 2: Prevention	
Theme 2.1: Prevention among most-at-risk populations	MDD5: Qualitative assessment of prevention response
	MDD6: Rates of HIV testing among IDU
	MDD7: Rates of coverage of HIV programmes among IDU
	MDD8: HIV-related knowledge of IDU

	MDD9: Condom use among IDU
	MDD10: Use of sterile injecting equipment among IDU
	MDD11: HIV prevalence among IDU
	MDD12: Rates of HIV testing among MSM
	MDD13: Rates of coverage of HIV programmes among MSM
	MDD14: HIV-related knowledge of MSM
	MDD15: Condom use among MSM
	MDD16: HIV prevalence among MSM
	MDD17: Rates of HIV testing among sex workers
	MDD18: Rates of coverage of HIV programmes among sex workers
	MDD19: HIV-related knowledge of sex workers
	MDD20: Condom use among sex workers
	MDD21: HIV prevalence among sex workers
	MDD22: Qualitative assessment of issues relating to HIV and 'migrants'
	MDD23: Rates of HIV testing among migrants from countries with generalised epidemics
	MDD24: Rates of coverage of HIV programmes among migrants from countries with generalised epidemics
	MDD25: HIV-related knowledge of migrants from countries with generalised epidemics
	MDD26: Condom use among migrants from countries with generalised epidemics
	MDD27: HIV prevalence among migrants from countries with generalised epidemics
	MDD28: Qualitative assessment of HIV-related policy environment in prisons
	MDD29: HIV prevalence among prisoners
Theme 2.2: Promotion of sexual health	MDD30: Qualitative assessment of measures to promote sexual and reproductive health among young people
	MDD31: HIV-related knowledge of young people
Theme 3: Living with HIV	MDD32: Qualitative assessment of treatment, care and support
	MDD33: Rates of coverage of antiretroviral therapy
	MDD34: Rates of coverage of PMTCT
	MDD35: Rates of MTCT
	MDD36: Co-management of TB and HIV
	MDD37: Qualitative assessment of policy environment related to stigma and discrimination
	MDD38: Assessment of accepting attitudes towards people living with HIV

Annex 5: Additional data provided by countries on HIV prevention expenditure

Table 41: Additional data on HIV prevention expenditure

Country	Data provided
Azerbaijan	In 2008, the Global Fund provided USD 536 680 for HIV prevention including youth programmes (USD 140 071), focused programmes among most-at-risk populations (USD 347 091) and condom social marketing (USD 49 518). In addition, the Ministry of Health provided AZN 954 404[783], including AZN 901 454 to the Azerbaijan AIDS Control Centre and AZN 52 950 to the Haematology and Transfusion Scientific Research Institute. The Ministry of Youth and Sport also provided AZN 70 349.
Belgium	The Flemish government already spent EUR 3 181 000 on sexual health in 2009. HIV prevention is one of the most important themes within sexual health. An additional EUR 480 000 was spent on syringe exchange programmes at the local level.
Bosnia and Herzegovina	The country's national contribution was considered to be USD 371 250 for VCT centres[784], USD 10 000 for Public Health Institutes' contribution to bio-behavioural studies among MSM and sex workers, USD 14 000 for HIV tests in VCT centres and USD 903 082 on antiretroviral drugs and treatment-related human resources.
Croatia	All healthcare in Croatia, including responses to infectious diseases, such as AIDS, is funded by the state through the Health Insurance Fund. All national AIDS spending is from the state budget. No Global Fund money is currently received by Croatia. In 2005 and 2006, the total budget for treatment, diagnostics and preventive activities regarding HIV in Croatia was HRK 45.1 million[785] and HRK 49.6 million respectively.
Cyprus	An HIV prevention campaign is included in the annual budget of the Ministry of Health through the AIDS Fund that was set up in 1992 according to specific legislation. The amount spent in 2008 on prevention was EUR 50 000[786,787]. This does not include the amount spent on medical care and antiretroviral therapies.
Czech Republic	There is a national HIV budget which was around EUR 600 000 in 2008. Of this, around EUR 200 000 was spent on infrastructure[788] investments. The remainder was spent on other preventive and medical activities, including EUR 93 000 for HIV testing and counselling, EUR 67 000 for medical care of uninsured persons[789] with HIV, EUR 55 000 for Lighthouse activities[790], EUR 80 000 for HIV prevention for the general population[791], including prevention among young people, about EUR 67 000 through NGOs for HIV prevention in certain population groups[792]. The cost of AIDS treatment and other activities, e.g. blood safety, provider-initiated HIV testing, HIV testing of pregnant women and STI diagnostics are not covered from this budget, but from health insurance. In addition, harm reduction among injecting drug users is financed from another part of the national budget for drug prevention. In 2007, more than EUR 5 million was spent on harm reduction.
Denmark	In 2008, financial resources for all HIV activities, including other sexually transmitted diseases were DKR 3 million[793] through the National Board of Health, DKR 22 million to NGOs[794] and DKR 40 million for a clean blood supply.

[783] At the time of writing AZN 1 was approximately USD 1.25.

[784] 20% of human resource costs based on proportion of time spent dealing with HIV.

[785] In December 2005, HRK 1 was worth approximately USD 0.16.

[786] Based on a population of 792 604, this would be a per person expenditure on HIV prevention of approximately USD 0.08.

[787] Euro amounts have been converted to USD using a rate of EUR 1 to USD 1.27.

[788] The complete reconstruction of Prague Lighthouse.

[789] Including undocumented migrants.

[790] Comprehensive HIV/AIDS services to all individuals in need.

[791] Including prevention among young people.

[792] That is EUR 37 000 for 'gay minority', EUR 25 000 for sex workers, EUR 1 500 for the Roma population and EUR 3 500 for youth at risk.

[793] At the end of 2008, DKR 1 was approximately USD 0.19.

[794] DKR 17 million through the National Board of Health and DKR 5 million from municipalities.

Country	Data provided
Estonia	The total spending on HIV, in 2008, exceeded EEK 196 million[795]. The majority of the resources were provided by the Ministry of Social Affairs (95%). The subcategory with the largest financing was healthcare services for PLHIV (62% of the total). The second largest was harm reduction services for IDU (13%)[796].
France	Around EUR 35 million[797].
Germany	In 2008, the National German Government spent EUR 12.2 million on HIV prevention. In 2009, the figure was EUR 13.2 million[798]. Of this, around EUR 5 million goes to German AIDS Help, the biggest German NGO, for prevention activities for most-at-risk groups. In addition, the 16 states fund HIV prevention on a regional level with an overall budget of approximately EUR 12 million[799]. Figures for local funding of local AIDS Help organisations and blood safety are not available.
Greece	In 2008, there was EUR 200 000 for school education. In 2007, there was EUR 37 500 000 for campaigns and NGO programmes from the Ministry of Health. Every year, there is EUR 100 million for blood safety.
Hungary	From 2004 to 2008, the country spent HUF 340 million[800] annually on blood safety. In addition, the country reported HUF 91.15 million in 2004, HUF 94.77 million in 2005, HUF 57 million in 2006 and HUF 53.3 million in 2007. There was HUF 5 million for doctors, HUF 1.4 million for Sziget festival, HUF 15 million for NGOs, HUF 10 million for anonymous testing and counselling, and HUF 2 million for World AIDS Day programme.
Israel	Governmental funds include annual budgets of approximately USD 2.9 million for HIV testing and counselling, USD 350 000 for advertising and education and USD 500 000 for two STI walk-in clinics in Tel Aviv and Haifa. Other funds are spent by hospitals and insurers to pay for medical and nursing staff at the AIDS clinics and for antiretroviral therapy.
Kazakhstan	Expenditure on HIV/AIDS from the state budget in 2008 was KZT 197.1 million[801]. This included KZT 30.048 million on population-level HIV prevention, KZT 35.11 million on harm reduction, KZT 83.406 million to maintain VCT facilities, KZT 43.294 million on PMTCT and KZT 5.242 million for the prevention of opportunistic infections. In addition, international organisations spent around KZT 364.1 million in 2008 on HIV prevention. This included KZT 97.3 million on population-level HIV prevention, KZT 104.015 million on harm reduction, KZT 20 million on training professionals to provide preventive services to the general population and vulnerable groups, and KZT 135 million for the prevention of sexual transmission of HIV.
Luxembourg	Public spending analysis divides 'labelled' and 'non-labelled' expenditures. According to a recent study of public expenditure in the drugs field[802], the state budget for 2008 provided as 'labelled' expenses EUR 510 000[803] for provision of drug injecting material, EUR 752 670 for the staff and operational costs of the National AIDS Prevention and Counselling Centre, and EUR 68 000 for the National AIDS Plan. In addition, there were non-labelled expenses for prescription of substitution drugs and medical counselling costs of EUR 370 489. These figures do not include funds for campaigns and condoms. Expenses for campaigns were EUR 50 000 in 2007, EUR 68 000 in 2008 and EUR 66 000 in 2009.
Malta	An AIDS fund is available and is administered by the Department of Health Promotion & Disease Prevention. It has an annual budget of EUR 16 000. Most of this budget is spent on advertising on TV and radio, in magazines and in public places.

[795] At the end of 2008, EEK 1 was approximately USD 0.09.

[796] In Estonia all ministries implementing activities in the framework of National HIV and AIDS Strategy report their spending to the Ministry of Social Affairs. Some local municipalities and county governments also implement HIV prevention projects and activities that are not officially part of the national strategy. They are not required to report their spending.

[797] Based on a population of 64 057 790, this would be a per person expenditure on HIV prevention of approximately USD 0.70.

[798] As 2009 had not been completed at the time of this report, it is assumed that this is a budget figure.

[799] In 2008, this would give total, documented HIV prevention funds of EUR 24.2 million. Based on a population of 823 669 548, this would be a per person expenditure on HIV prevention of approximately USD 0.37.

[800] At the end of 2008, HUF 1 was approximately USD 0.005.

[801] Figures also supplied in USD at the rate of USD 1 = KZT 120.

[802] Conducted by Alain Origer in 2009.

[803] For the purpose of this report, EUR 1 = USD 1.27.

Country	Data provided
Netherlands	Funding by the national government for primary HIV/STI prevention in 2010 is approximately EUR 10 700 000[803]. These funds for primary prevention through civil society organisations include funding for STI AIDS Netherlands for primary prevention and education among ethnic minorities, youth and sex workers; for Schorer Foundation for primary prevention and behavioural monitoring among MSM; for HIV Association for prevention and advocacy among people living with HIV; and for Rutgers Nisso Group for research and prevention related to sexual health of youth and the general population.
Norway	In 2009, the national budget allocated to HIV prevention activities was NOK 21 million[804]. This excludes the budget for HIV surveillance and information activities administered by the National Institute of Public Health. Of this, there was NOK 2.8 million for information, communication and research projects; NOK 1.2 million for activities targeting sex workers; NOK 7 million for activities targeting MSM; NOK 5.6 million for people living with HIV; NOK 1.5 million for activities targeting youth/young adults; NOK 0.9 million to activities targeting immigrants; and NOK 2 million to condoms and lubricants. However, this overview gives a very rough estimate of how much is spent on each target group, and is limited to the national budget specifically dealing with HIV. In addition, the Norwegian HIV preventive work is closely coordinated with work on sexual health, including prevention of Chlamydia and unwanted pregnancies and abortion. In 2009, the budget for this was NOK 25 million. Also, a substantial amount of funding for measures targeting sex workers and MSM were financed from the budget allocated to prevention of drug abuse.
Portugal	Civil society funding programme: EUR 3 260 667; and media campaigns: EUR 465 477.
Romania	The estimated total cost of the national HIV/AIDS programme in 2008 was EUR 82.4m. This does not include the costs of hospitalisation for people living with HIV. Of this total, an estimated EUR 6.2 million was allocated for prevention, of which EUR 4.2 million was coming from sources other than national budget. An estimated EUR 57.5 million was allocated for procurement of antiretrovirals and other drugs used in the HIV/AIDS treatment programme. Of this, EUR 50.8 million was from Insurance House and the remainder from pharmaceutical companies.
San Marino	It is not currently possible to provide disaggregated data. In public health facilities workers are provide with gloves, needles, syringes etc. There are extensive guidelines on hospital safety, especially for blood transfusions, testing etc. In 2007, 5 812 patients were HIV tested, with 6 783 tests and an expenditure of EUR 18 000.
Spain	In 2009, transfers to the regional government according to the population and the AIDS cases registered in each region for all kinds of expenses amounted to EUR 4.3 million. Other costs included EUR 4.4 million for activities related to the fight against AIDS; EUR 3.7 million to support institutions' programmes of prevention and control of AIDS; EUR 1.4 million for coordination and the development of the multisectoral plan to fight AIDS; and EUR 77 000 for the Spanish Society of Infectious Diseases and Clinical Microbiology (GESIDA) for research on AIDS.
Sweden	The regional governments and municipalities carry the major responsibility for working with HIV/AIDS, including for prevention, treatment, support, blood screening and condom distribution. However, given that this work is integrated into their general health approach, it is hard to assess how much of their respective budget is actually spent on HIV, AIDS and STI. In addition to this regional and local work, the National Board of Health and Welfare distributes a yearly governmental grant. This is intended as an extra measure from the government to boost the national response to HIV, AIDS and other STI. Of the SEK 150 million[805] granted in 2008, SEK 95 million went to the regional authorities and municipalities; SEK 20 million to NGOs working at the national level; and approximately SEK 6 million went to targeted research and development projects. Additional funding is spent on development of national surveillance systems for certain risk-groups and health communication activities, etc.

[804] Figures also supplied in Euro at the rate of EUR 1 = NOK 8.4. For USD rate see footnote 806.

[805] At the end of 2008, SEK 1 was approximately USD 0.127.

Country	Data provided
Switzerland	Prevention among the general population in 2008 included CHF 2 million[806] for the HIV/AIDS-Campagne Love Life Stop AIDS; CHF 100 000 for information material on HIV; CHF 550 000 for PLANeS, an organisation for sexual and reproductive health; and CHF 350 000 for KOMPEZ for prevention in schools. Also prevention in target groups in 2008 included CHF 800 000 for work with MSM; CHF 300 000 for work with migrants; CHF 250 000 for work with female sex workers; CHF 25 000 for work with injecting drug users and CHF 100 000 for Project BIG.
United Kingdom	The vast majority of prevention activity[807] is delivered by the National Health Service (NHS) at a local level as part of routine healthcare services. Expenditure is not separately identified. The Department of Health funds NGOs for national health promotion programmes for groups most at risk of HIV and a national HIV helpline provided by the Terrence Higgins Trust. Total expenditure from 2007/08 was approximately GBP 2.4 million[808]. Additionally, for 2009/10, the department is investing GBP 750 000 in eight national HIV pilot projects looking at HIV testing in routine healthcare and community settings.

[806] Equivalent USD figures provided at the rate of CHF 1 = USD 1.

[807] Blood screening, condom social marketing, harm minimisation for IDU, HIV counselling and testing, etc.

[808] At the end of 2008, GBP 1 was approximately USD 1.46.

Annex 6: Indicators used by countries to monitor their response to HIV among migrants

Table 42: Indicators used by countries to monitor their responses to HIV among migrants (potential standardised indicators are shaded gray)

Indicator	General comments[809]	Specific comments	Examples of countries reporting data for this indicator
Number of migrants			
Number of migrants living in a country at a particular time	Useful as a denominator. However, this needs to be the specific population disproportionately affected by HIV. For most of western Europe, this is migrants from countries with generalised HIV epidemics.	The total number living in a country at a particular time is a more useful denominator than the annual inflow. The figure reported is likely to be documented migrants only, although the number of undocumented migrants might be estimated.	See Table 22
Number of migrants entering a country annually			
Evidence that migrants disproportionately affected by HIV			
Number of HIV-positive migrants diagnosed/registered cumulatively/per year	These figures are available in many countries from their case reporting systems. But, they may not reflect true rates of HIV infection in countries where rates of late diagnosis/non-diagnosis are high.	In order to understand these figures, it is helpful to relate the number of HIV-positive migrants diagnosed during a given period to the total number of HIV-positive diagnoses during that same period. This can then be compared to the ratio of migrants to total population of the country.	See Table 23
Percentage of HIV-positive migrants diagnosed/registered cumulatively/per year of all new HIV positive diagnoses/registrations			
Number of new AIDS cases among migrants	AIDS registrations are likely to be of less value than HIV diagnoses.	N/A	N/A
Percentage of AIDS cases among migrants of all new AIDS cases		N/A	N/A
Percentage of HIV-positive migrants detected by surveillance among those attending STI clinics	Few countries have this type of surveillance system.	Although such surveillance may be of use for detecting early rises in HIV infections, it may be of limited value in comparing HIV infection rates among different groups unless they have similar health-seeking behaviour for suspected STI.	The United Kingdom reports having a system of this type.
Percentage of HIV-positive migrants detected by surveillance among those attending antenatal clinics	Few countries have this type of surveillance system.	In countries with low level or concentrated epidemics, rates of infection among pregnant women are too low to justify this type of surveillance.	The United Kingdom reports having a system of this type.

[809] A key issue is how migrants are defined in a particular country. This issue is discussed in Subsection 2.5.3.

Indicator	General comments[809]	Specific comments	Examples of countries reporting data for this indicator
HIV testing			
Number of migrants tested for HIV	Increased rates of testing for HIV among target populations is likely to reduce delayed entry into treatment and may contribute to HIV prevention efforts. However, there are risks of expending resources inefficiently if testing is not appropriately targeted and there are risks related to human rights if testing becomes obligatory and insufficient attention is paid to safeguarding human rights.	Establishing the number of migrants tested is potentially a useful measure of programmatic outputs. Can be obtained from programmatic data.	Croatia, Romania, Ukraine (see Table 24)
Percentage of migrants tested for HIV (and knowing the results)		Potentially useful indicator of coverage of key intervention. Probably requires a special survey but can be obtained from accurate programmatic data if denominator known.	France, Netherlands and the United Kingdom for migrants from countries with generalised epidemics. Estonia, Moldova and Serbia for other 'migrant' groups[810] (see Table 24)
Access to ART			
Number of HIV-positive migrants receiving medical care/follow-up	Some measure of this would be helpful as there are concerns that migrants, particularly those who are undocumented, may not have access to ART. Many countries reported data on migrants' access to ART (see Table 25).	It is unclear precisely how this would be defined or monitored, or what it adds to figures based on rates of diagnosis.	N/A
Number of HIV-positive migrants receiving ART		The problem with tracking the number of HIV-positive migrants receiving ART relates to what the denominator should be. Using the UNGASS modelled figure is not relevant for high income countries. Combining this indicator with a measure of late diagnosis could be an appropriate solution.	Greece, Italy, Spain and Sweden (see Table 25)
Proportion of migrants diagnosed with HIV at late clinical stage of all migrants diagnosed with HIV			France, Germany and the United Kingdom commented on the importance of late diagnosis among migrants
Outcome measures			
HIV-related knowledge of migrants	There are concerns that knowledge-based indicators are poor proxies for change in behaviour and reduction of HIV transmission.	If a survey is being conducted to ask about sexual behaviour, it is easy to include questions about knowledge.	France, Italy, Netherlands and the United Kingdom (see Table 26)
Condom use by migrants during last high-risk sex	This is a key indicator but requires a special survey to collect data.	In some cases, the precise questions asked differ from this indicator.	
Percentage of migrants reporting sex before age of 15	Unclear if age of sexual debut is strongly linked to HIV transmission independent of condom use. Has strong moral overtones.		Serbia tracks this indicator among the Roma population

[810] For Estonia, this is ethnic Russians; for Moldova, national truck drivers and emigrants; and for Serbia members of the Roma population.

Indicator	General comments[809]	Specific comments	Examples of countries reporting data for this indicator
Other			
Number of migrants tested for syphilis	A wide range of other indicators were suggested by different countries.		Suggested by Bulgaria
Number and percentage of sex workers who have worked/plan to work abroad			Suggested by Bulgaria
Number and percentage of MSM who have been abroad			Suggested by Bulgaria
Number of migrants contacted for HIV prevention services through outreach activities			Suggested by Bulgaria; example from the United Kingdom
Percentage of migrants contacted for HIV prevention services through outreach activities of all people contacted			Suggested by Bulgaria
Number of migrants reached with preventive services			Suggested by Croatia
Number of educational workshops among migrants			Suggested by Croatia. Also suggested number of leaflets produced and distributed; number of delivered lectures; presentations of film
Proportion of B subtypes among newly-diagnosed migrants			Suggested by France
Number of migrants consulting in counselling centres			Suggested by Germany
Number of migrants involved in community-based prevention action			Suggested by Germany
Number of STI among migrants			Suggested by Netherlands
Percentage of young Roma reached by HIV prevention programmes			Suggested by Serbia

Annex 7: Evidence concerning HIV-related knowledge of young people

Table 43: Evidence concerning HIV-related knowledge of young people

Country	All	M	F	Year	Comment
Albania			6%	2005	Compared with < 1% in 2003. UNGASS data 2008
Armenia	36%	42%	34%	2007	Compared with 15% of young men and 23% of young women in DHS 2005. UNGASS data 2008
Azerbaijan		5%	6%	2006	Compared with 2% in 2003. UNGASS data 2008
Belgium				2006	Percentage of 15–18 year-olds who agree/disagree with the following statements about how HIV can be transmitted (data from HBSC): • Using injecting equipment used by a person who has HIV: 92.3%/3.3%; • Sex without a condom with a person who looks healthy and is not sick 75%/16.5%; • Sex without a condom with a person who has HIV 95.5%/2.3%; • Mother-to-child transmission 74.2%/10.7%. Also in the Belgian National Health Survey 2004: Correct identification of non-infective contacts[811] among 15–24 year-olds: 28%; Correct identification of all inefficient methods of protection[812] among 15–24 year olds: 53%.
Bosnia and Herzegovina			44%	2006	Compared with 48% in MICS 2005. UNGASS data 2008
Bulgaria	19%	18%	21%	2006	UNGASS data 2008
Croatia	20%	16%	25%	2006	UNGASS data 2008
Cyprus	10%	10%	11%	2007	UNGASS data 2008
Czech Republic					Based on HBSC, HIV-related knowledge of young people is reported to be 'satisfactory'.
Denmark				2006	Based on survey data, 98% of young men and women aged 15–24 reported knowing that condoms could prevent HIV.
Estonia	32%	28%	37%	2007	UNGASS data 2008
Finland	85%				UNGASS data 2008
Former Yugoslav Republic of Macedonia	22%	19%	26%	2007	UNGASS data 2008. Compared to 27% of young women in MICS 2005
France					A KABP survey on HIV/AIDS has been performed regularly in general population (18–65) for several years (1992, 1994, 1998, 2001, 2004), and is ongoing in 2010. Data on HIV-related knowledge is available for young people (18–24) and by sex. 'Do you think that HIV can be transmitted in such circumstances?' by piercing or tattoo (65.7% of 18–29), sharing the razor of a PLHIV (60.8% in 18–29), by dental care (31.9% of 18–29), by acupuncture (33.8% of 18–29), kissing a PLHIV on the mouth, by saliva, shaking hands with a PLHIV, sitting in a toilet (for 16.2% of young people), sharing the glass of a PLHIV, giving blood, by mosquito bite (for 22.6% of young people).
Georgia	4%			2005	UNGASS data 2008

[811] Sitting on a toilet; sharing someone's glass; kissing someone on the mouth; by mosquito bite; giving blood (in Belgium).

[812] Use birth control pill; choose healthy-looking partners; withdraw before ejaculation; wash after having sex.

Country	All	M	F	Year	Comment
Germany				2008	Correct answers to following questions (data from Behavioural Representative Survey): • 'Is there a danger of being infected with AIDS': – if you share a workplace with someone infected with AIDS? Female age 16–19: 98%; female age 20–24: 97%; male age 16–19: 95%; male age 20–24: 96%; – if you have unprotected sex (without a condom) with an unknown partner? Female age 16–19: 100%; female age 20–24: 100%; male age 16–19: 100%; male age 20–24: 99%; – if you shake hands with a person with AIDS? Female age 16–19: 99%; female age 20–24: 98%; male age 16–19: 98%; male age 20–24: 97%; – when lovers kiss? Female age 16–19: 90%; female age 20–24: 86%; male age 16–19: 88%; male age 20–24: 88%; • Are there externally visible signs when someone is HIV positive? Female age 16–19: 85%; female age 20–24: 88%; male age 16–19: 84%; male age 20–24: 85%.
Greece	25%	27%	23%	2007	UNGASS data 2008
Kazakhstan	19%	18%	20%	2007	UNGASS data 2008. Compared with 22% of young women in MICS 2006
Kyrgyzstan	32%	30%	33%	2006	UNGASS data 2008. Compared with 20% of young women in MICS 2006
Latvia	3%	3%	3%	2007	Respondents who gave correct answers to all five questions. Source: UNGASS data 2008
Lithuania					Percentage aged 15–24 giving correct responses: • Can the risk of HIV transmission be reduced by having sex with only one faithful partner? 49.8%; • Can the risk of HIV transmission be reduced by using condoms? 74%; • Can a healthy looking person have HIV? 76.5%; • Can a person get HIV from kissing? 44.8% • Can a person get HIV by sharing a meal with someone who is infected? 43.4%. No overall figure given; data provided as responses to five UNGASS indicator questions. UNGASS 2008
Moldova	26%	26%	27%	2007	UNGASS data 2008. Compared with 19% of young women in 2003.
Netherlands				2007	Age group: 15–35 years divided into three groups: A no sexual experience; B casual sex partners; C steady relationship. Correct answers to questions (data from Safe Sex Monitor): • Meaning of word STI? A 82%, B 88%, C 92%; • Most common STI in the Netherlands? A 20%, B 32%, C 35%; • Knowledge of different STI/HIV? A 55%, B 63%, C 69%; • Consequences of Chlamydia? A 26%, B 41%, C 40%; • Do you have physical complaints if you have an STI? A 69%, B 85%, C 85%; • If you are infected with an STI, do you have more chance of getting HIV? A 19%, B 22%, C 20%; • Which protects best against pregnancy (pill, condom, both)? A 30%, B 36%, C 41%; • Does the pill protect against STI? A 94%, B 96%, C 98%; • Risk perception (chance of HIV on scale 1–5): New sex partner, no condom: A 3.32, B 3.17, C 3.15. In general, level of knowledge of STI and HIV is reasonably high, increases with age and is higher in girls than in boys.

Country	All	M	F	Year	Comment
Norway				2007	Knowledge and Attitudes population-based survey covering 1 002 people, of whom 156 were aged 15–24. Results from age group 15–24 years: • 100% of male respondents and 98.7% of female respondents believe that one can become HIV infected by having sex without a condom; • 17.7%/57% of male respondents and 23.7%/60.5% of female respondents agree/disagree that one can become HIV infected by kissing a PLHIV on the mouth; • 11.4%/64.6% of male respondents and 17.1%/67.1% of female respondents agree/disagree that one can become HIV infected by drinking from the same glass as a PLHIV; • 50% of male respondents and 31% of female respondents assess their knowledge to be poor, at the same time 77% of respondents report having received information at school/through educational institutions; 60.4% of male respondents and 63.7% of female respondents agree that a PLHIV is obligated to inform their employer and colleagues about their HIV status in Norway.
Poland				2007	Data from research into level of knowledge and attitudes in lower secondary schools pupils regarding HIV/AIDS. Research findings: • 89% of young people say that people can get infected through sexual contacts with many partners; • 43% say people can get infected through sexual contacts with one, healthy, faithful partner; • 90% say people can get infected using the same needles and syringes by drug addicts; • 50% say people can get infected in the following situations: shaking hands, hugging, kissing; • 50% say people can get infected having a tattoo and piercing; • 30% say people can get infected by being bitten by a mosquito or other insects and animals; • 51% say people can get infected during a stay in hospital; • 64% say people can get infected during blood transfusion.
Romania				2006	9.2% of respondents (12.5% of young women and 5.8% of young men) know two methods to prevent HIV infection: 34.7% of respondents (39.8% of young women and 29.4% of young men) correctly reject the three misconceptions. Correct answer to questions: • Can a person get HIV by sharing food with someone who is infected? 70% (young women 73.4%; young men 67.7%); • Can a healthy-looking person have HIV? 59% (young women 60%; young men 58%); • Can a person get HIV from mosquito bites? 67% (young women 72.5%; young men 61.2%); • Can a person reduce the risk of getting HIV by using a condom every time they have sex? 82% (young women 80.2%; young men 84.8%); • Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? 9.7% (young women 12.5%; young men 6.8%). Almost 100% of young people have heard about HIV/AIDS; 82.5% recognise condoms as an HIV prevention method but only 9.7% point out faithfulness as prevention. Based on survey data in Romania CRIS Report.
Russia	34%	33%	35%	2007	UNGASS data 2008
Serbia	20%	20%	21%	2006	UNGASS data 2008. Compared with 42% of young women in MICS 2006.

Country	All	M	F	Year	Comment
Spain				2003	Among those aged 18–29 surveyed, the percentage who: • can correctly identify correctly all modes of HIV transmission: 13.1 % (men 12.1%; women 14.1 %); • know that use of the male condom is an effective measure to prevent sexual transmission of HIV: 96.1% (men 96.5%; women 95.6%); • think that HIV can be transmitted by mosquito bite: 17.2% (men 18%; women 16.3%); • think that HIV can be transmitted by drinking from the same glass as an infected person: 8.3% (men 8.8%; women 7.7%). Based on data from Heath and Sexual Habits Survey conducted among general population aged 18–49, sample 10 980 of whom 4 135 were aged 18–29.
Sweden				2007	In age group 15–24: 94% assess their risk of getting infected with HIV as 'moderate' to 'very low; 94% knew where they could get tested. In age group 16–19: 82 (93%) answered 'yes absolutely' or 'yes probably' when asked if a healthy-looking person can carry and transmit HIV; 28 (34%) answered 'yes absolutely' or 'yes probably' when asked if HIV can be transmitted through mosquito bites; 11(19%) answered 'yes absolutely' or 'yes probably' when asked if transmission is possible by using the same plate as an infected person. Data from National Board of Health and Welfare study.
Switzerland				2004–8	According to a survey, 75% of young people consider themselves 'well informed'.
Tajikistan	11%	11%	11%	2007	UNGASS data 2008. Compared to 3% of young women in MICS 2006
Turkey	37%	35%	39%	2007	UNGASS data 2008
Ukraine	40%	39%	42%	2007	UNGASS data 2008. Compared to 43% of young men and 42% of young women in DHS 2007.
United Kingdom				2007	Among 16–24 year-olds asked to identify from a list how HIV could be transmitted: • 85% identified transmitted through sex without a condom between a man and a woman; • 73% transmitted through sex without a condom between two men; • 71% identified blood transfusion; • 75% sharing a syringe when injecting drugs; • 16% breastfeeding mother to her child. Data from survey of Public Attitudes towards HIV conducted among 1 981 adults aged 16 and over in 210 sampling points in Great Britain, of whom 238 were aged 16–24 years.
Uzbekistan			31%	2006	UNGASS data 2008. Compared with 3% in 2003.

Annex 8: Evidence concerning attitudes towards people living with HIV

Table 44: Evidence concerning attitudes towards PLHIV

Country	% showing		Year	Comments
	Discriminatory attitudes	Accepting attitudes		
Armenia		0.3–1.8%	2005	Percentage expressing accepting attitudes on all four questions (DHS data): • Women: age 15–19: 1%; age 20–24: 1.8%; age 25–49: 1.4%; • Men: age 15–19: 0.9%; 20–24: 0.3%; 25–49: 0.6%.
Azerbaijan		5–56%	2006	Percentage willing to care for a family member with HIV (DHS data): • Women: age 15–19: 46.8%; age 20–24: 55.5%; 25–29: 52.5%; 30–39: 49.8%; • Men: age 15–19: 21.9%; 20–24: 23.1%; 25–29: 28.9%; 30–39: 24.2%. Percentage who would buy vegetables from a shopkeeper with HIV: • Women: age 15–19: 21%; age 20–24: 20.4%; 25–29: 22.7%; 30–39: 19.3%; • Men: age 15–19: 9.3%; 20–24: 9.4%; 25–29: 6.9%; 30–39: 5.1%. Percentage who say a female teachers with HIV who is not sick should be allowed to continue teaching: • Women: age 15–19: 19.3%; age 20–24: 19.6%; 25–29: 21.9%; 30–39: 17.1%; • Men: age 15–19: 11.9%; 20–24: 9.8%; 25–29: 7.8%; 30–39: 7.7%. Rural residents expressed more accepting attitudes on the first indicator, urban on the second and third. More accepting attitudes associated with higher educational levels for all indicators in women and men.
Belgium	69%		2004	National prevalence of discriminatory attitudes towards PLHIV remained stable between 1997 and 2004, but decreased in Brussels from 66% to 59%. In 2004, 69% of those interviewed reported one or several discriminatory attitudes towards PLHIV, with no differences between men and women (62% among those aged 15–24). The proportion with discriminatory attitudes increased with age, reaching 89% in those aged 75 or older. Attitudes are associated with educational level (84% with basic or no education reported discriminatory attitudes; 69% educated to 18 years; 59% with higher education) and place of residence (65% in cities reported discriminatory attitudes; 73% in suburban areas; 68% in rural areas). Questions asked were: Would you share a meal with someone infected with HIV? Would you leave your children with someone infected with HIV? Do you agree that a boss is entitled to dismiss someone with AIDS? Do you agree that, if a colleague has HIV, you should be warned even without his or her consent? Data from National Health Questionnaire.
Czech Republic	50–70%		2008	50–70% of respondents think PLHIV should not work as a cook, physician, etc. Data from sociological study.

<table>
<tr><th rowspan="2">Country</th><th colspan="2">% showing</th><th rowspan="2">Year</th><th rowspan="2">Comments</th></tr>
<tr><th>Discriminatory attitudes</th><th>Accepting attitudes</th></tr>
<tr><td>Denmark</td><td>1–4%</td><td></td><td>2008</td><td>In response to question ‘How would you react if you found out that your colleague, schoolmate or a child in your child/grandchild´s kindergarten had HIV?’ Avoid any contact: 4%; forbid my child/grandchild to play with that child: 2%; that person/child can no longer come to work/school/kindergarten: 1%.</td></tr>
<tr><td>Estonia</td><td></td><td>23–54%</td><td>2008</td><td>Proportion of people aged 16–64 who would agree to work with a PLHIV: Fully agree: 23%; rather agree: 31% (2008). Proportion of people aged 16–29 who have accepting attitudes towards PLHIV (based on five questions): 40% (2007).</td></tr>
<tr><td>Germany</td><td></td><td>71–97%</td><td>2008</td><td>Percentage with accepting attitudes in response to the following questions (data from Behavioural Representative Survey):
• ‘Would you personally help to look after people infected with AIDS or would you not help?’
– Women: age 16–19: 88%; age 20–24: 86%; 25–49: 83%;
– Men: age 16–19: 72%; 20–24: 71%; 25–49: 73%;
– Educational level: low: 77%; medium: 80%; high: 77%.
• ‘Would you consider it right or not right to ensure that all people with AIDS come into contact with no one – except medical personnel and relatives?’
– Women: age 16–19: 94%; 20–24: 97%; 25–49: 97%;
– Men: age 16–19: 91%; 20–24: 96%; 25–49: 95%;
– Educational level: low: 91%; medium: 97%; high: 98%.</td></tr>
<tr><td>Kazakhstan</td><td></td><td>8.3%</td><td>2008</td><td>Percentage of people accepting PLHIV increased from 1.2% in 2006, to 4.3% in 2007 and to 8.3% in 2008. There is significant stigma and discrimination against PLHIV. Only 50.4% of respondents in 2007 and 55.8% in 2008 did not agree with the statement that HIV-infected people should be isolated from society. Most would limit the interaction of children with a man who is HIV positive. Discriminatory attitudes are not dependent on HIV knowledge or socio-demographic characteristics. Data from sociological study.</td></tr>
<tr><td>Moldova</td><td></td><td>0–4.7%[813]</td><td>N/A</td><td>Percentage expressing accepting attitudes (data from GPS 2008):
<table><tr><td></td><td>All</td><td>Males</td><td>Females</td></tr><tr><td>15-19</td><td>2.8%(13/470)</td><td>3.5%(8/231)</td><td>2.1%(5/239)</td></tr><tr><td>20-24</td><td>2.9%(15/517)</td><td>2.7%(7/260)</td><td>3.1%(8/257)</td></tr><tr><td>25-49</td><td>2.7%(52/1918)</td><td>3.7%(35/940)</td><td>1.7%(17/978)</td></tr><tr><td>Total</td><td>2.8%(80/2905)</td><td>2.4%(35/1431)</td><td>2.0%(30/1474)</td></tr><tr><td>Education:</td><td></td><td></td><td></td></tr><tr><td>None</td><td>0%(0/1)</td><td>–</td><td>0%(0/1)</td></tr><tr><td>Primary</td><td>0%(0/10)</td><td>0%(0/7)</td><td>0%(0/3)</td></tr><tr><td>Secondary</td><td>2.9%(60/2092)</td><td>4.7%(35/744)</td><td>2.5%(25/1019)</td></tr><tr><td>Higher</td><td>2.4%(19/2905)</td><td>4.1%(14/344)</td><td>0.7%(5/727)</td></tr></table></td></tr>
</table>

[813] It has been assumed that data provided is percentage expressing accepting attitudes. The data provided refers to method but does not specify questions or indicators used.

Country	% showing		Year	Comments
	Discriminatory attitudes	Accepting attitudes		
Netherlands			2009	Concerning knowledge of HIV transmission: almost all respondents were aware of the fact that HIV cannot be transmitted by shaking hands. One in six thought that contact sports with a lot of sweating may involve risks for HIV transmission. Two in five thought that French kissing might be risky. Majority of participants reported that the Dutch population in general has prejudices against PLHIV. However, they also reported that they themselves do not hold prejudices. Older participants, those with less education and those who denounce homosexual behaviour as unnatural are more likely to have misconceptions about risk of HIV transmission and to hold prejudiced views. Data from study on HIV and Stigmatisation.
Norway	8–64%	34–97%	2008	Percentage who agree that PLHIV should be obliged to inform their employer and their colleagues about their HIV status: • Women: age 15–24: 63.7%; age 25–39: 56.3%; 40–59: 53.9%; • Men: age 15–24: 60.4%; age 25–39: 53.5%; 40–59: 57.6%. Percentage who agree that employees with HIV must accept that their employers change their job responsibilities out of consideration for other employees in the workplace: • Women: age 15–24: 44.7%; age 25–39: 55.5%; 40–59: 45.7%; • Men: age 15–24: 62.6%; age 25–39: 50.4%; 40–59: 47.3%. Percentage who would avoid close contact with a colleague or schoolmate who told that he/she was HIV positive: • Women: age 15–24: 26.3%; age 25–39: 7.5%; 40–59: 7.9%; • Men: age 15–24: 35%; age 25–39: 12.2%; 40–59: 15.2%. While around 97% of women and men agree that PLHIV should have the same opportunity to participate in schooling, training and work as everyone else and 69% of women and 62% of men agree that a PLHIV can have parental responsibility, only 34% would accept an infected person looking after their own child and a similar proportion think that an HIV-infected person should not work as a physician or nurse. Responses indicate that people are willing to accept relatively significant restrictions in the rights of PLHIV in the workplace. There is a positive correlation between educational level and attitudes. Data from HIV in Norway: Knowledge and Attitudes.
Romania		11–24%	2008	Women who have heard about HIV and have positive attitudes on the four questions: 12.7% (15–19: 12%; 20–24: 11.3%; 25–29: 12.4%; 30–34: 11.1%; 35–39: 13.9%; 40–44: 16.3%). Men who have heard about HIV and have positive attitudes on the four questions: 21.2% (15–19: 17.5%; 20–24: 20.9%; 25–29: 22.7%; 30–34: 21.4%; 35–39: 24%; 40–44: 20.9%). Data from Reproductive Health Survey.
Serbia		19–20%	2006	Percentage expressing accepting attitudes towards PLHIV: • Women and men aged 20-34: 20%; • Women and men aged 35-49: 19%. Numerator: number of respondents aged 20–49 stating that an HIV-infected teacher who is not sick should be allowed to continue teaching in school and that they would buy the food from HIV-infected shopkeeper. Denominator: number of respondents of both sexes aged 20–49 included in survey. Data from National Health Survey.

Country	% showing		Year	Comments
	Discriminatory attitudes	Accepting attitudes		
Spain	7–59%		2008	Based on responses from a 1 607 sample aged 16–80: • 58.8% would feel uncomfortable sending their son to a school where another student has HIV infection or AIDS; • 30.8% would feel uncomfortable working in an office if a colleague has HIV infection or AIDS; • 44.5% would feel uncomfortable if a shop assistant has HIV infection or AIDS; • 20% think that the law, in some places, should enforced segregation between PLHIV and people who are not infected; • 18.1% think that the identity of PLHIV should be divulged so other people can avoid them; • 6.9% think that PLHIV are guilty or responsible for their infection; • 18.8% would not have any relationship with a person with HIV or AIDS; • 12.3% would feel embarrassed if someone in their family was infected. Data from Survey of Beliefs and Attitudes of the Spanish Population towards People with HIV. Also in a survey of health and sexual habits in 2003, a third of respondents would not work or study in the same place as a person infected with HIV or who has AIDS.
Sweden	2.6–20%	58–81%	2007	Questionnaire responses from 3 011(1 263 men and 1 748 women) to the question 'would you avoid contact if you found out that a work colleague or schoolmate was infected with HIV?' While the majority replied that they would 'absolutely not' or 'probably not', 26% of men and 20% of women replied 'yes, absolutely' or 'yes, probably'. Accepting attitudes were highest among those with university education (81%), and higher in those with secondary education (68%) than in those who only had primary education (58%). Data from HIV and AIDS in Sweden: Knowledge, Attitudes and Practice among the General Population.
Ukraine		8–76%	2007	Percentage willing to care for a family member with HIV: • Women: age 15–19: 67.6%; age 20–24: 69.2%; 25–29: 73.1%; 30–39: 76%; • Men: age 15–19: 65.8%; 20–24: 75.5%; 25–29: 71.8%; 30–39: 72.6%. Percentage who would buy vegetables from a shopkeeper with HIV: • Women: age 15–19: 16.3%; age 20–24: 24.4%; 25–29: 25.8%; 30–39: 22.7%; • Men: age 15–19: 10%; 20–24: 12.1%; 25–29: 7.9%; 30–39: 12%. Percentage who say a female teachers with HIV who is not sick should be allowed to continue teaching: • Women: age 15–19: 39.7%; age 20–24: 43.8%; 25–29: 42.3%; 30–39: 40.7%; • Men: age 15–19: 25.1%; 20–24: 35.7%; 25–29: 29.6%; 30–39: 32.3%. Urban residents expressed more accepting attitudes than rural residents and more accepting attitudes were associated with higher educational levels across all three indicators in both women and men.

Country	% showing		Year	Comments
	Discriminatory attitudes	Accepting attitudes		
United Kingdom	48%	70–74%	2007	In a survey of 1 981 adults (aged 16+) interviewed at 210 different sampling points in Great Britain: • 69% agreed with the statement 'There is still a great deal of stigma in the UK today around HIV and AIDS'; • 71% agreed that 'More needs to be done to tackle prejudice against people living with HIV in the UK'; • 48% agreed that 'People who become infected with HIV through unprotected sex only have themselves to blame'; • 74% said that discovering a relative had HIV would not damage their relationship with them and 67% stated the same with respect to a neighbour; • 70% of people said they would feel comfortable working with a colleague with HIV. People appear to be more supportive of those living with HIV when the issue is considered on personal terms. Stigma and discrimination are more prevalent among older age groups and those with lower education. Data from survey Public Attitudes towards HIV.

Annex 9: Evidence concerning non-discrimination laws and regulations

Box 34: Non-discrimination laws and regulations

In **Armenia**, Article 14 of the Law on HIV makes provisions for the rights and obligations of HIV-infected individuals and their family members. Under this law, HIV-positive individuals have the right to:

- receive the results of laboratory testing in written form;
- non-discriminatory attitudes;
- demand confidentiality (except in cases stipulated by current legislation);
- continue working (except in cases stipulated by the government);
- be provided with counselling, including information about HIV prevention methods.

In **Bosnia and Herzegovina**, the Constitution guarantees the human rights of all citizens. Legislation protects citizens from discrimination on any basis, including HIV status, but there are no specific laws that directly address protection of PLHIV against discrimination. Bosnia and Herzegovina is a signatory to the international convention on the protection of human rights.

In **Bulgaria**, the Constitution guarantees the protection of human rights of all citizens. Relevant laws and regulations include: Law for Protection against Discrimination, Law on Health, Law for Asylum and Refugees, Ministry of Health Ordinance Number 47 of 2009 on HIV testing. Universal Declaration of Human Rights and Convention for the Protection of Human Rights cited.

In the **Czech Republic**, the Anti-Discrimination Act, through which the Czech Republic will adopt European law, covers discrimination on grounds of race, ethnicity, age, health, disability and sexual orientation. Rights are also protected through the Constitution and the Charter of Fundamental Rights and Freedoms. Under healthcare laws, it is incumbent on all PLHIV to undergo treatment.

In **Denmark**, relevant laws include the Criminal Law, laws prohibiting discrimination in the workplace and on grounds of race or other characteristics.

In **Finland**, the Constitution provides a comprehensive equality framework. Separate laws protect the rights of specific populations such as ethnic minorities.

In **Georgia**, relevant laws include the Law on HIV/AIDS, Law on Patient's Rights. There are no laws to protect the rights of specific populations. International declarations on the human rights of PLHIV cited.

In **Greece** there are no specific laws addressing discrimination against PLHIV. PLHIV fall under general provisions of laws protecting patient rights. Greece has adopted a Law on Implementation of the Principle of Equal Treatment between Persons Irrespective of Racial or Ethnic Origin, Religious or Other Convictions, Disability, Age or Sexual Orientation. Ratification of CEDAW and CRC cited.

In **Hungary**, the Constitution guarantees the right of everybody living in Hungary 'to the highest possible level of physical and mental health' and to social security in the event of ill health and disability.

In **Ireland**, equality legislation can be used to protect people from discrimination. This has been successfully used very recently in a case brought by a PLHIV. There is also a law relating to offences against the person which could be used against PLHIV who pass on HIV, although this has not been used to date.

In **Israel**, regulations distributed by governmental agencies set norms to ensure that vulnerable populations are not discriminated against.

In **Latvia**, protection of the rights of PLHIV is part of general non-discrimination legislation. There are no specific provisions for HIV/AIDS. Ratification of relevant international legislation cited.

In **Kazakhstan**, in accordance with Article 14 of the Constitution 'no person may be subject to any type of discrimination on the basis of origin; social, occupational, or property status; sex; race; nationality; language; religious affiliation; convictions; place of residence; or any other circumstance'. Relevant laws include: Law on the Prevention of the AIDS Disease, Law on the Protection of the Health of the Population, Law on Labour, Law on Reproductive Rights of Citizens and Guarantees to Protect Them, Law on Residential Relationships, Law on Education.

In **Kyrgyzstan**, non-discrimination is included in the Constitution and covered in the Law on HIV/AIDS. Articles on sodomy and prostitution have been removed and Article 246 (the unlawful preparation, acquisition, possession or transportation of narcotic substances or psychotropic substances without the intent to sell) has been decriminalised.

In **Moldova**, the Constitution provides for equality of rights and free access to justice. Article 16 states that 'All citizens are equal before the law and the public authorities, without any discrimination as to race, nationality, ethnic origin, language, religion, sex, political choice, personal property or social origin'. Article 20 states that 'Every citizen has the right to obtain effective protection from competent courts of jurisdiction against actions infringing on his/her legitimate rights, freedoms and interests' and 'No law may restrict the access to justice'. Relevant laws include the Law on Prevention of HIV/AIDS, Law on the Rights and Responsibilities of Patients and Law on Health Protection.

In the **Netherlands**, the Constitution prohibits discrimination towards any group in any way.

In **Norway**, relevant laws include the Gender Equality Act and the Discrimination Act. Regulations on equal treatment are provided in the Labour Environment Act and on anti-discrimination in housing legislation.

In **Poland**, there is no specific regulation protecting PLHIV from discrimination, but more general provisions can be applied including the Constitution and, with respect to employment issues, the Labour Code, which includes anti-discrimination measures in line with EU policy. International law is also applied in Poland.

In **Romania**, non-discrimination is included in the Constitution and in specific laws including the law regarding HIV/AIDS prevention and protection for PLHIV, law regarding the prevention and punishment of all forms of discrimination, and law regarding the protection of disabled persons.

In **Russia**, the AIDS law was developed in accordance with international principles of HIV prevention and protects the rights of HIV-positive people.

In **Serbia**, non-discrimination is included in the Constitution, the Law on Health Protection and the Law on the Prohibition of Discrimination.

In **Spain**, non-discrimination is included in the Constitution, Article 14, and covered in specific laws, for example, the Labour Act, Article 17, and Penal Code, Article 314.

In **Slovakia**, non-discrimination laws do not refer to specific populations, but cover sexual orientation and disability.

In **Slovenia**, Article 14 of the Constitution ensures that 'everyone has equal human rights and basic freedom irrespective of nationality, ethnicity, gender, language, religious affiliation, political and other beliefs, economical status, birth, education, social status or any other personal circumstance'.

In **Switzerland**, the Constitution protects all citizens equally. Specific laws include: Disability Discrimination Law but this only applies to the public sector i.e. where there is a legal relationship between the state as employer and an HIV-positive person as employee (there is no specific anti-discrimination law for the private sector). Regulations within other laws, e.g. Labour or Data Protection Law, provide some protection against discrimination, e.g. dismissal on grounds of illness or HIV status.

In **Tajikistan**, various laws and regulations guarantee equal rights for men and women and the rights of prisoners. Other relevant laws include the Law on HIV and AIDS and the Law on Migration. The programme for developing the health of young people, implemented via a Decree of the Government, includes defence of the rights of youth in the provision of HIV services.

In **Ukraine**, legislation does not include regulations on discrimination concerning PLHIV, but the Law on Prevention of AIDS and Social Protection of the Population (1991) guarantees PLHIV rights in certain areas. Revisions to this Law were introduced in 1998 and 2001. Normative and administrative documents of sector ministries and institutions include regulations that protect the rights of PLHIV.

In the **United Kingdom**, the Disability Discrimination Act (2005) provides protection for PLHIV in employment, provision of goods, services, housing and education. Other relevant legislation includes the Human Rights Act. The government is committed to enacting the Single Equality Act, which will bring clarity and consistency to discrimination law and address the 'multiple discrimination' experienced by many PLHIV. The UK does not protect people from discrimination through association with, or assumption of, HIV.