SPECIAL REPORT

Thematic report: Leadership and resources in the HIV response

Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2012 progress

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This report of the European Centre for Disease Prevention and Control (ECDC) was coordinated by Teymur Noori and Anastasia Pharris (ECDC), Programme for sexually transmitted infections, including HIV/AIDS and blood-borne infections.

This report is one in a series of thematic reports based on information submitted by reporting countries in 2012 on monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS. Other reports in the series can be found on the ECDC website at: http://www.ecdc.europa.eu/ under the health topic HIV/AIDS.

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Contents

Abbreviations

ART	Antiretroviral therapy
ECDC	European Centre for Disease Prevention and Control
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)
EU/EFTA	European Union/European Free Trade Association
GDP	Gross domestic product
GNI	Gross national income
MSM	Men who have sex with men
NCPI	National Commitments and Policies Instruments
OST	Opioid substitution therapy
PLWHA	People living with HIV/AIDS
PWID	People who inject drugs
TB	Tuberculosis
UNAIDS	Joint United Nations programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Executive summary

Key messages

Leadership

Most countries report that relevant and effective policies which demonstrate political leadership are in place. However, this is not the case in all countries and there are areas of concern in a number of others. Most countries report their HIV prevention spending is prioritised toward those populations most affected by the epidemic, particularly people who inject drugs (PWID) and men who have sex with men (MSM).

Most countries report that relevant and effective HIV programmes are being delivered at the scale required to provide significant coverage. Antiretroviral therapy (ART) is reported to be readily available to most key populations in most countries. The clear exception is the more limited availability of ART for undocumented migrant populations. Many countries recognise that vulnerable and marginalised populations find it more difficult to access HIV treatment, care and support.

On balance, political leadership on HIV is reasonably strong in Europe and Central Asia. However, comments submitted by many respondents clearly indicate that gaps in leadership continue to exist in countries across the region. Given the concentrated nature of the epidemic in Europe and Central Asia where HIV primarily affects specific, marginalised populations, the need for strong, focused leadership is more important than ever.

Resources

It is useful to understand the level and nature of funding for national HIV responses as this provides information about what resources are available, how these are being affected by external factors, such as the economic situation and how funds are being used in the response. Most countries have some financial data available but not all believe it is useful or feasible to track this. In general, countries with lower gross national income (GNI) track this data more than those with higher GNI.

The UNAIDS funding matrix is a tool which allows countries to report how funds are being spent on the national HIV response and the source of those funds. However, several European countries question the usefulness and relevance of the UNAIDS funding matrix, and as a result, not many countries, especially in the western parts of the region, provide financial spending data through the UNAIDS funding matrix. Despite the economic crisis, many countries have continued to increase funding for their HIV responses. However, much of this is treatment-related. Across the region, more than 95% of all HIV spending goes on treatment and care. This proportion is higher in EU/EFTA countries.

Although funding levels for HIV prevention were higher in many countries in 2011 than in 2008, several have seen a decline in funding levels since 2010. In some countries, such as Kyrgyzstan, Poland and Romania, the reductions in funding for HIV prevention are very large. Many countries report a greater focus of their HIV spending on key populations most affected by HIV, such as PWID, sex workers and MSM In many cases, this appears to have been done to make programmes more effective. However, in some cases, e.g. in Estonia, this has been done to make spending more efficient when faced with reduced funding for HIV prevention activities.

However, it is of concern that some countries appear to have reduced their focus on funding programmes for key populations most affected by HIV. These countries include Latvia, Poland and Ukraine. Many low- and middle income-countries have increased the level of funding of their HIV responses from domestic resources. These include Armenia, the former Yugoslav Republic of Macedonia, Georgia, Kazakhstan, Kyrgyzstan, Moldova and Tajikistan. However, these countries remain dependant on external funds for effective HIV responses, particularly from the Global Fund to fight AIDS, Tuberculosis and Malaria (The Global Fund).

Some countries, e.g. Romania, have experienced HIV outbreaks among PWID when levels of harm reduction services declined when the Global Fund financing ended and funding was not provided from other sources, e.g. from local or national government or from within the European Union.

The economic crisis has adversely affected international funding for the global HIV response. In particular:

- The overall level of funding has plateaued since 2008.
- The percentage of international AIDS assistance from Europe fell between 2008 and 2011 largely due to reduced contributions by a number of countries including France, Germany, Ireland, Italy, the Netherlands and Norway. However, some countries, such as Sweden and the United Kingdom maintained or increased their contributions, as did the European Commission.
- Levels of European funding to the Global Fund declined, largely as a result of those countries most severely affected by the economic crisis, e.g. Ireland, Italy and Spain, making no contributions in 2011
- Levels of European funding to UNAIDS declined largely as a result of reduced contributions from some major funders including Denmark, Ireland, the Netherlands and the United Kingdom.

Background

The Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia, adopted in 2004, was the first in a series of regional declarations, which emphasise HIV as an important political priority for the countries of Europe and Central Asia.

Monitoring the progress in implementing this declaration began in 2007 with financial support from the German Ministry of Health. This resulted in the publication of a first progress report by the WHO Regional Office for Europe, UNAIDS and civil society in August 2008. In late 2007, the European Commission requested ECDC to monitor the Dublin Declaration on a more systematic basis. The first country-driven, indicator-based progress report was published in 2010[i]. The objective was to harmonise indicators with existing monitoring frameworks, notably the United Nations General Assembly Special Session (UNGASS) and European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) indicators, and with the EU Communication and Action Plan[ii], using existing data and focusing on reporting that was relevant in the European and Central Asian context, to minimise the reporting burden for countries. In 2012, instead of producing one overall report, information provided by countries has been analysed to produce ten thematic reports.

Method

All 55 countries were requested to submit data regarding their national responses to HIV (see Annex 3 for a list of the 55 countries). For this round of reporting, the process was further harmonised with Global AIDS Response Progress Reporting (formerly known as UNGASS reporting). As a result, countries submitted most of their responses through a joint online reporting tool hosted by UNAIDS. Responses were received from 51 of 55 countries (93%). This response rate was slightly higher than for 2010. More details of methods used are available in the Background and Methods report.

The two primary instruments for collecting data regarding political leadership in the region were the UNAIDS National Commitments and Policy Instrument (NCPI) and the ECDC European Supplement to the NCPI. Both instruments include a series of questions for both government and civil society respondents.

Countries were also requested to submit financial data using the national funding matrix developed by UNAIDS[iii]. This involves countries identifying the amount of funds spent on particular categories of HIV spending and the source of those funds. If countries were unable to report their HIV spending using the funding matrix, they were invited to submit summary and more detailed information through the European supplement to the NCPI. If countries were not submitting any financial data, they were asked to explain why. All the financial data is self-reported by countries. It is extremely likely that there are variations, both between countries and within countries over time, regarding what specific expenditures are included and how these are classified. Therefore, extreme caution should be exercised in making comparisons between and within countries over time.

Data related to countries' contribution to international HIV financing are, as in the previous round of Dublin reporting, taken from data published by the Kaiser Family Foundation and UNAIDS, and details of funding received by the Global Fund to fight AIDS, Tuberculosis and Malaria (the Global Fund) and UNAIDS as published on their websites.

[i] European Centre for Disease Prevention and Control. Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2010 progress report. Stockholm: ECDC; 2010. Available here: http://ecdc.europa.eu/en/publications/publications/1009_spr_dublin_declaration_progress_report.pdf

[ii] Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee, and the Committee of the regions. Combating HIV/AIDS in the European Union and neighbouring countries, 2009–2013. Available here: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0569:FIN:EN:PDF

[iii] UNAIDS. Global AIDS Response Progress Reporting 2012. Available here: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/JC2215_Global_AIDS_Response_Progress_Reporting_en.pdf pp96–103

Introduction

The combination of political leadership and financial resources is the essential underpinning of an effective HIV response. The issues that leaders choose to prioritise, the actions they take to support those priorities and the level of resources committed to key programmes and activities provide valuable insights on a country's commitment to its HIV response.

In this round of reporting, government and civil society provided data in response to a series of questions about issues that are closely linked to political leadership, including questions about policies related to populations and/or interventions that may lack widespread political support in the country; about the prioritisation of prevention funding towards populations most affected by HIV; about delivering programmes at scale, even if they are not politically popular; and about the coverage of antiretroviral therapy for key populations.

Countries were also asked to provide detailed financial data on their HIV responses. Given the importance of this information, UNAIDS includes tracking a country's spending on the response as one of the core indicators in its Global AIDS Response Progress Reporting. While the feasibility and value of tracking financial resources continues to be questioned in some European countries, most countries did submit some data on this topic.

This report is divided into two main parts. Part 1 focuses on leadership issues and part 2 focuses on resource issues. The resource section of the report is further divided into two subsections: part 2a considers financial resources available to national responses to HIV in Europe and Central Asia; part 2b considers financial resources contributed by European countries to the international HIV response. The report then draws a number of conclusions, considers progress since the last round of Dublin reporting and presents a brief list of issues identified for further action.

Part 1. Leadership

There is a clear consensus globally and in Europe and Central Asia, on the importance of political leadership to the HIV response. However, there is less agreement on how to define and measure that leadership.

Between 2006 and 2010, the primary tool for defining and measuring political leadership was the National Composite Policy Index, which was part of the UNGASS monitoring process done by UNAIDS. The NCPI included a series of questions for government respondents on different proxy measures for leadership. For example, there are questions about whether senior government officials 'speak publically and favourably about HIV efforts in major domestic forums at least twice a year'; whether the country has a national multisectoral HIV coordination body; and whether reviews of national policies and laws have been performed to determine their consistency with national HIV control policies.

In addition to the specific section on political leadership, there were questions on strategic plans in a section of The National Composite Policy Index on strategic planning that were also seen as proxy measures for leadership. Examples of these questions include: has the country developed a national multisectoral strategy to respond to HIV? Does the multisectoral strategy include an operational plan? Does the multisectoral strategy or operational plan include clear targets or milestones?

In the 2010 progress report on the Dublin Declaration, questions were raised about the effectiveness of these types of proxy measures in assessing leadership. Specifically, the progress report stated:

> 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.

The 2010 progress report also made the following conclusion:

> 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;
> – 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;
> – the extent to which countries have tackled difficult but essential policy issues, such as the provision of harm reduction programmes for PWID in prison settings; and
> – the extent to which countries are providing ART coverage for key populations, particularly PWID, migrants and prisoners.'

For the 2012 round of UNAIDS international reporting, the renamed National Commitments and Policy Instrument (NCPI) included a section on political support and leadership for government respondents, which was largely the same as the political support section in the three previous rounds of international reporting. The revised NCPI also added a single question for civil society respondents about the government's efforts to involve people living with HIV and AIDS (PLWHA), key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation.

It is important to note that responses to the questions in the UNAIDS NCPI were reviewed during the analysis of data submitted by countries during this round of reporting. However, they did not provide significant insight into the state of political leadership on HIV in countries. Consequently, these data are not referenced in this report.

For the 2012 round of reporting on the Dublin Declaration, ECDC developed a focused set of questions on the topic of political leadership in line with the conclusion cited above. These questions were included in the European supplement to the NCPI and the same questions on political leadership were asked of both government and civil society, which enabled comparison of responses from the different constituencies.

The questions addressed the extent to which:

- relevant and effective policies are in place to prevent and respond to HIV
- HIV prevention funding is prioritised towards those key populations that are most affected by HIV
- essential programmes are delivered at scale, even if they lack widespread political support
- countries are providing ART coverage for key populations, specifically people who inject drugs, men who have sex with men, migrants and prisoners.

Findings

Most countries report that relevant and effective policies that demonstrate political leadership in responses to HIV are in place.

Almost all government and civil society respondents reported that relevant and effective policies that demonstrate political leadership in the response to HIV are in place. However, the positive response was higher among government (95%) respondents than among civil society (83%). The governments of Kyrgyzstan and Finland as well as civil society in Finland, Greece, Hungary, Italy, Slovakia, Spain and Ukraine reported that effective policies were not in place. Finland was the only country where both government and civil society reported that effective policies were not in place.

Many of the descriptions provided by respondents about policies that demonstrate political leadership were about standard policy instruments such as national strategies or action plans. While the existence of these types of policy instruments can be useful, they do not necessarily require or imply the leadership needed to ensure appropriate steps are taken, or the necessary funds are available, to deal with the realities of an epidemic that primarily affects marginalised populations in the region.

Nevertheless, respondents from several countries did highlight specific policies linked to political leadership (see Table 1). In addition, respondents from other countries provided insights on areas of concern (see Table 2).

Table 1. Comments from respondents on policies linked to political leadership

Country	Comments
Albania	In July 2008, the country passed a law addressing critical legal aspects of HIV, including 'discrimination, the right to keeping one's job, information consent, confidentiality, free access to information and treatment, the establishment of "safe places where affected people have access to life saving treatment, and a complaints mechanism.' In February 2010, the country also approved an anti-discrimination law, 'which protects the citizens from a number of forms of discrimination, including on the grounds of sexual orientation and gender identity.'
Armenia	'HIV/AIDS has been removed from the list of the diseases that prohibits persons who are infected from entry into Armenia; prohibition for PLHIV to hold positions in the diplomatic and the police service systems has been repealed; HIV/AIDS has been removed from the list of diseases that deny a person the right to adopt children, or accept children into his/her family for bringing them up and assuming guardianship.'
Germany	The national strategy includes specific activities that require strong political leadership such as harm reduction in prisons and ART for undocumented migrants.
Luxembourg	The national strategy and action plan allows for activities such as opioid substitution and needle exchange programmes in different regions and also in prison settings. In addition, it allows for mobile units to do prevention work among key populations (e.g. MSM, migrants and sex workers), including HIV and hepatitis B and C testing.
Spain	Policies are in place to provide free HIV testing, needle and syringe programmes and universal and free access to ART for all citizens. In addition, Spain has an extensive HIV programme in prisons, including free condoms, opioid substitution therapy and needle exchange.
United Kingdom	The policy environment enables activities such as 'targeted prevention for those groups at increased risk of HIV, harm minimisation interventions for injecting drug users, antenatal HIV testing and robust monitoring and surveillance systems.'

Table 2. Comments from respondents on areas of concern

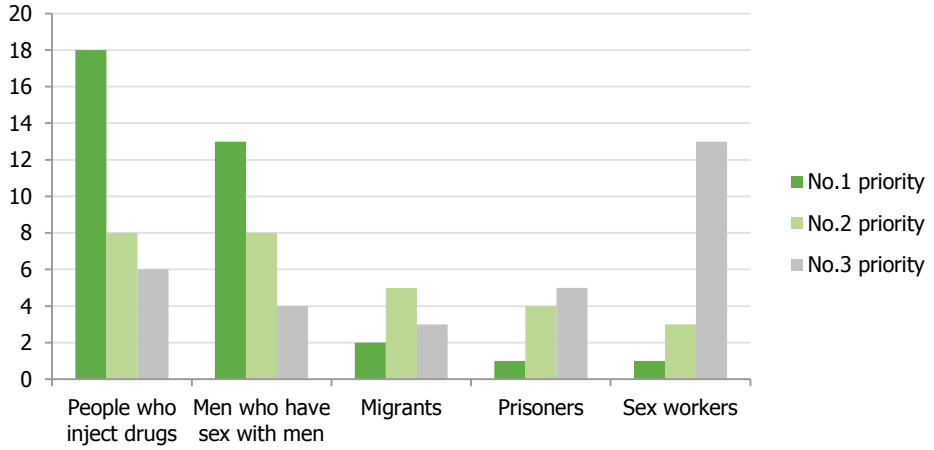
Country	Comments
Belgium	'Political leadership is lacking to develop a consistent national policy, encompassing both federal and regional matters, on HIV prevention in Belgium.'
Czech Republic	'HIV has no priority among politicians, there is almost no interest [in] HIV issues outside the health sector.'
Hungary	Free condom distribution to men who have sex with men has limited political support 'due to political homophobia'.
Lithuania	The country's national programme and action plan do not correspond to the epidemiology. The main concerns are: 'the key most at risk target groups are not distinguished, MSM/TG and CSW are not included at all; the roles and responsibilities of the main actors for national response to HIV are not clearly indicated; the expansion of services for risk groups is not planned; most activities focus on primary prevention in the general public while the epidemics is clearly concentrated in two key populations - IDUs and in prisons; the use of rapid HIV tests is not promoted; there is no consensus on free of charge testing of the risk groups; condom use programmes are not promoted; patient organizations and NGOs are not involved in the service provision and deliver services only with the support of international donors; suggestions from NGOs regarding the HIV programme are not taken into consideration; NGOs are not listed as programme implementers.'
Romania	Over the past two years, the commitment to most-at-risk populations has declined and 'most of the interventions developed under the GFATM grant reduced their scale.' Only two out of seven NGOs delivering harm reduction services were operating in 2012.
Spain	Political leadership involves promotion of citizen participation, but it does not happen.

Most countries report their HIV prevention spending is prioritised for those populations most affected by the epidemic.

A majority of government and civil society respondents reported that their country's prevention funding was prioritised for those key populations most affected by the epidemic, particularly for PWID and MSM. However, there was a gap between the perspectives of government and civil society. Eighty-six per cent of government respondents felt that funding was prioritised, but only 73% of civil society respondents felt that was the case. In four countries – Italy, Kyrgyzstan, Romania and Slovakia – government and civil society respondents agreed that prevention funding is not prioritised for these populations. In addition, governments in Malta and Poland as well as civil society in Azerbaijan, Finland, Greece, Lithuania, Sweden and Ukraine also reported that funding was not prioritised for these key populations.

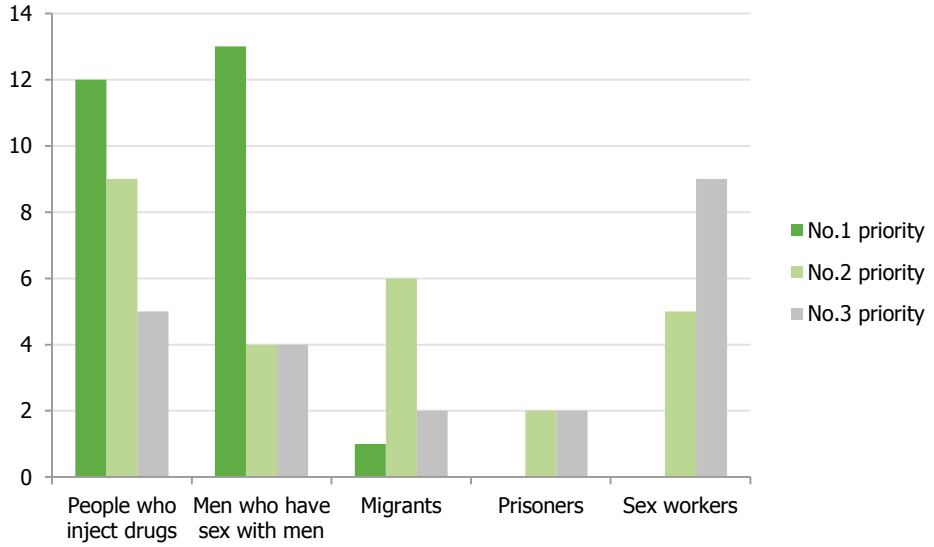
Government and civil society respondents provided their perspectives on the prioritisation of different subpopulations in their countries. As Figures 1 and 2 show, PWID and MSM were seen as the greatest priority for prevention funding by the largest number of respondents. A complete list of the rankings by government and civil society respondents is available in Annex 1.

Figure 1. Prevention funding prioritised by population by number of government respondents



Government respondents from Switzerland and the United Kingdom identified multiple populations as their number one priority. Switzerland identified people who inject drugs, men who have sex with men, migrants, prisoners and sex workers as their number one priority; the United Kingdom identified people who inject drugs, men who have sex with men, migrants and pregnant women as their number one priority.

Figure 2. Prevention funding prioritised by population by number of civil society respondents



Seven government respondents identified other populations as being their number one priority: Georgia – pregnant women; Israel – migrants from Ethiopia and tuberculosis cases; Moldova – general population, including young people; Sweden – youths and young adults; Ukraine – PLWHA; United Kingdom – pregnant women (see note below figure 1); and Uzbekistan – total population. Three civil society respondents also identified other populations as being their number one priority: Belarus – youth; Moldova[i] – general population, including young people; and Serbia – PLWHA

From a financial perspective, many countries have increased their spending on HIV prevention among key populations, primarily for PWID, MSM and sex workers. For example, in countries providing data on spending on HIV prevention among these key populations, spending rose in 72% of them. And while prevention spending on key populations has declined in a small number of countries reporting (Latvia, Poland, Portugal and Ukraine), there are also countries that have increased their per capita spending on prevention and sharpened their focus on key populations (Armenia, Azerbaijan, Georgia, Kazakhstan, Moldova and Tajikistan).

However, it is important to note that financial data is only available from a minority of countries so it provides only a partial picture of the situation. It is also unclear how far commitments by countries to programmes for key populations will be affected by possible financial constraints in the future; consequently, it will be important to continue monitoring both political leadership and the commitment of resources to HIV-related programmes for key populations. (See page 18 of this report for additional information on funding for HIV prevention for key populations.)

Most countries report that relevant and effective HIV programmes are being delivered at scale.

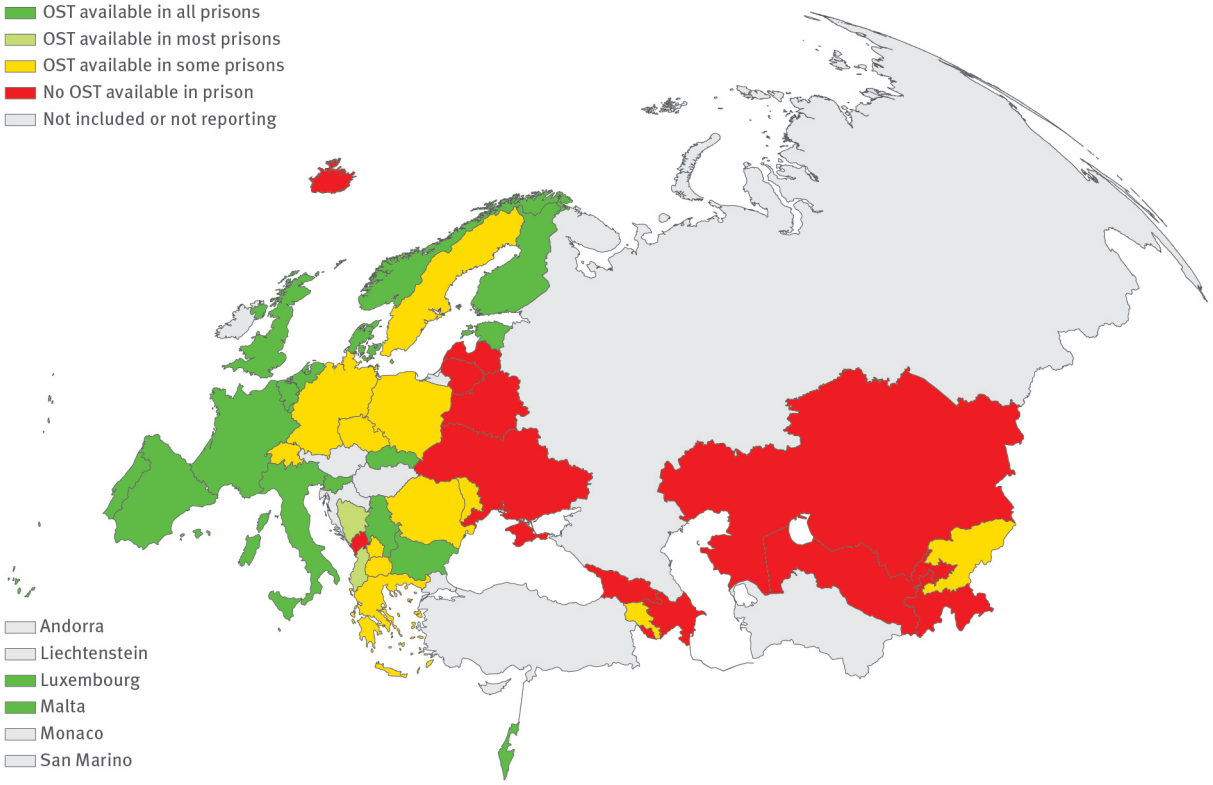
A majority of government and civil society respondents report that programmes are being delivered at a sufficient scale to provide significant coverage. However, as was the case with the prioritisation of prevention spending, there is gap between the perspectives of government and civil society. Eighty-six per cent of government respondents felt programmes are delivered at a sufficient scale, but only 70% of civil society respondents felt that was the case. In four countries – Armenia, Latvia, Lithuania and Romania– government and civil society respondents agreed that programmes are not delivered at the scale required to provide significant coverage. In addition, governments in Italy and Poland and civil society in Azerbaijan, Finland, Greece, Hungary, Ireland, Kyrgyzstan, Slovakia and Sweden also reported that programmes are not being delivered at a sufficient scale.

Opioid substitution treatment in prison settings

Although OST is available in at least some prisons in almost all (84%) EU/EFTA countries, it is much less widely available in countries outside the EU/EFTA (see Figure 3). Only 10 (42%) of these countries have reported providing this service. Opioid substitution therapy is not available in Azerbaijan, Georgia, Kazakhstan, Tajikistan, Turkmenistan, Ukraine or Uzbekistan. No report on the situation in the Russia has been received. It is also reported that substitution therapy is not available in prisons in Montenegro or Turkey.

i Moldova intends to approve amendments to its National HIV/AIDS programme 2011–2015; the amended draft refocuses priorities on key populations at risk and their sexual partners, particularly on people who inject drugs.

Figure 3. Reported availability of opioid substitution therapy in prisons in Europe and Central Asia



This map shows responses from both government and civil society. In most (26) cases, these responses were the same so the map reflects both responses. In some cases, e.g. Belgium, Czech Republic, France, Israel, Kosovo (UNSCR 1244), Malta, Norway, Slovenia and Switzerland, there was a response from government but no response from civil society. In these cases, the map reflects the government response. In Hungary, there was a response from civil society but no response from government. In this case, the map reflects the civil society response. In Bosnia and Herzegovina, there was only a partial response from government but a fuller response from civil society. In this case, the full response was used. In Hungary, the only response was partial (yes). In this case, it was assumed that this was 'yes in at least some prisons'. In cases where conflicting responses were given by government and civil society respondents, the government response was used. The countries affected by this were Bulgaria, Finland, Greece, Italy, Portugal, Slovakia and the UK. The responses depicted in this map do not distinguish whether opioid substitution therapy can be initiated in prison or is only available to those on OST prior to imprisonment. However, this information is available and is discussed in the narrative.

Box 1. Delivering programmes at scale: success in Bulgaria, challenges in Finland

Bulgaria

The implementation of the National Programme for Prevention and Control of HIV and STIs (2008–2015), and especially the programme 'Prevention and Control of HIV/AIDS', financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria, led to a 70% increase in the annual number of HIV tests performed among the groups most-at-risk between 2007 and 2010. Furthermore, the provision of services for voluntary and anonymous HIV counselling and testing proved to be five times more efficient in HIV case finding - more than 60% of the newly diagnosed HIV infections were found through VCT [voluntary counselling and testing] and NGOs implementing HIV prevention programmes. Biological data on the low levels of HIV prevalence among the key populations, and the levelling HIV prevalence among IDUs, as well as the positive trends in behaviour change further evidence the effect of scaled-up coverage with services."

Finland

There has been reluctance in the past towards identifying sexual minorities in need of targeted prevention services due to the fear of stigma and discrimination, especially if attention would be brought to higher disease burden in these subpopulations. As a consequence, prevention needs are not particularly highlighted, disease burden is not costed, and in times of financial constraints, easily get ignored or de-prioritised. The national association for Lesbian, Gay, Bisexual and Transgender people (LGBT) is weak and has little resources for preventive work. Furthermore, on the municipal level there is a real lack of expertise in skilled personnel capable of designing and executing preventive services for MSM, which are generally not seen as a priority group. While Finnish sexual and reproductive and health services are relatively well developed, they address issues of the sexual majority and little specific work is done for MSM prevention in particular. School health education addresses minority sexuality fairly comprehensively, but fails to describe MSM HIV risks.'

Many respondents cited increased/increasing availability and access to services as well as the engagement of civil society in the delivery of services as evidence that coverage of relevant and effective programmes is either in place or improving. However, there was a wide range of concerns among respondents about programmes that have limited political support:

- the illegality of sex work and drug use in Albania and Montenegro makes it difficult to implement prevention programmes for people engaged in those behaviours
- problems implementing programmes for MSM were identified by the Czech Republic, Estonia, Portugal and Romania
- Kazakhstan and Ukraine reported that substitution therapy for PWID has little support
- several countries – Iceland, Germany, Macedonia, Portugal, Serbia and Ukraine – cited needle exchange in prisons as problematic and needle exchange programmes more generally do not have widespread political support in Hungary or Sweden.

Box 2. Prevention programmes in prisons

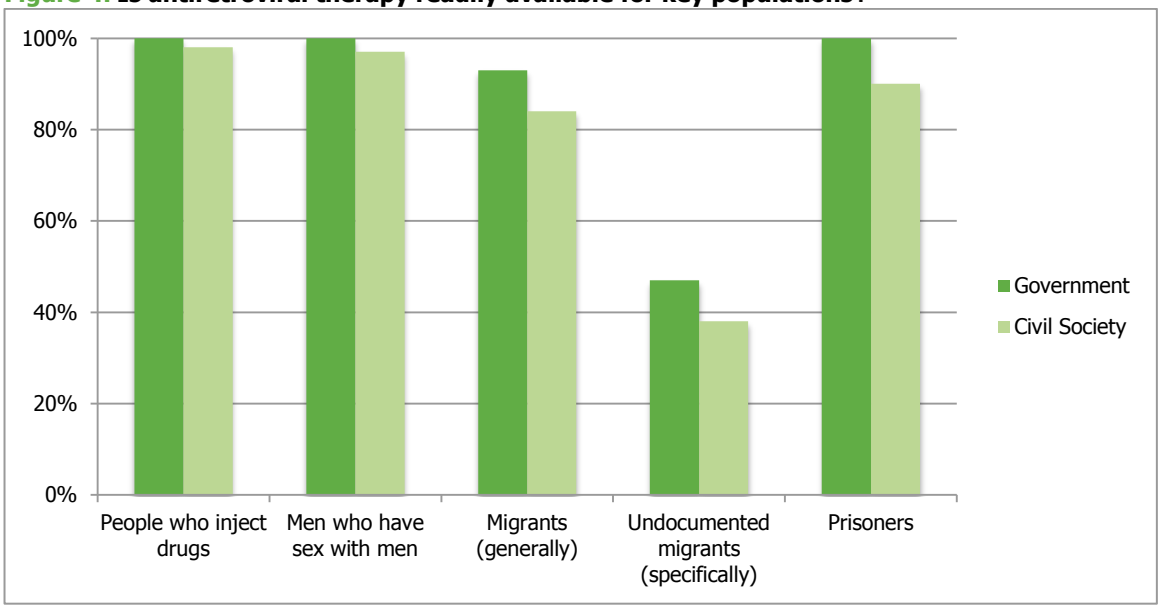
A number of countries are demonstrating good political leadership by providing key prevention services in prisons. For example:

- Opioid substitution therapy is available in prisons in 22 EU/EFTA countries.
- Needle exchange in prison settings is available in 10 countries in Europe and Central Asia: Armenia, the Czech Republic, Kyrgyzstan, Luxembourg, Moldova, Romania, Slovakia, Spain, Switzerland and Tajikistan.
- Luxembourg, Slovakia and Spain report that needle exchange is available in all prisons in their country.
- Six countries – Luxembourg, Moldova, Romania, Slovakia, Spain and Switzerland – report that condoms, OST, needle exchange and hepatitis C testing are all available in at least some prisons in their country.

Antiretroviral therapy is reported to be readily available to most key populations in most countries. The clear exception is the more limited availability of ART for undocumented migrant populations.

One important act of political leadership is to ensure the availability of ART for key populations with HIV (i.e. PWID, MSM, migrants (generally), undocumented migrants (specifically) and prisoners).

Figure 4. Is antiretroviral therapy readily available for key populations?



Most respondents reported that ART was readily available for four of the five populations specified: People who inject drugs, MSM, migrants (generally) and prisoners. In fact, 100% of government respondents reported ART was readily available for PWID, MSM and prisoners. While the figures were lower among civil society respondents for these same populations, they were still high (>80%). However, the response rate fell for both categories of migrants. This was particularly true for undocumented migrants, where only 47% of government respondents and 38% of civil society respondents felt it was readily available (see Figure 4). Reasons for this situation are included in Table 3.

Table 3. Reasons why antiretroviral therapy is not available for undocumented migrants

Country	Comments
Bulgaria	'A person living with HIV needs to be included in the national HIV registry in order to receive free-of-charge ARV treatment covered by the budget of the Ministry of Health.'
Czech Republic	'Undocumented migrants are not insured.'
Denmark	'By law, long time treatment administered by hospitals requires permanent residence/national health care/social security.'
Finland	'Complete access to the public healthcare system without private insurance coverage is dependent on legal long-term residence status or subject to bilateral and/or multilateral agreements between state[s].'
Georgia	'Based on the HIV/AIDS State Law, free ARV treatment is accessible to citizens of Georgia. Decision of availability of ART to migrants [is] decided on a case-by-case basis.
Germany	'There is no funding mechanism available. A lot of discussion is going on [around] different models of financing treatment and care for undocumented migrants and migrants without health insurance.'
Israel	"ARV provision is covered as part the National Health Insurance Act to all Israeli citizens only. Among undocumented migrants, only pregnant women receive ART free of charge during pregnancy+ 6 months.'
Montenegro	'Undocumented migrants are not covered by national health insurance.'
Sweden	'Undocumented migrants in Sweden cannot access HIV treatment for free. However, in practice most patients in need of HIV treatment are offered free treatment regardless of migration status'.
Switzerland	'Undocumented migrants are often difficult to reach and on the margins of the health system'.

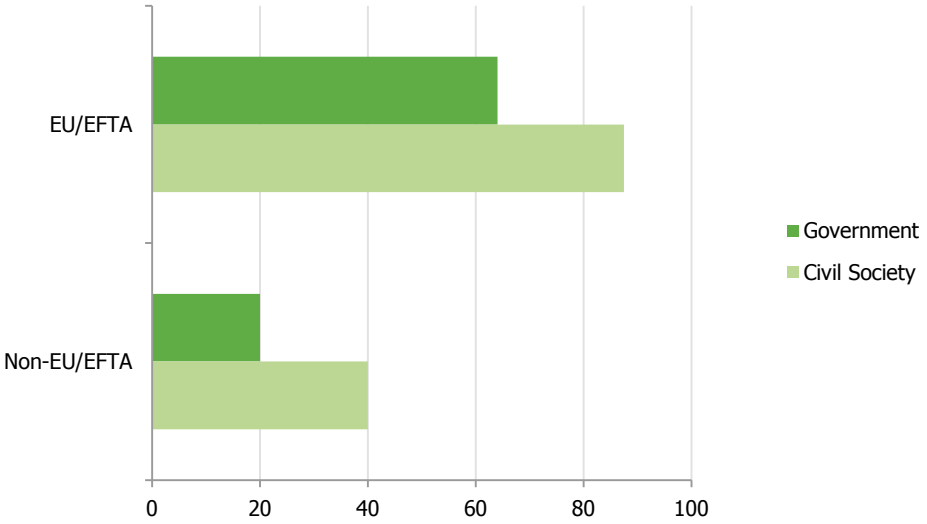
Only 33% of government respondents and 28% of civil society respondents reported that ART was readily available for all five populations. Government and civil society respondents agreed in only eight countries that ART was available to all five populations (Albania, Belgium, Bosnia, Estonia, the Netherlands, Portugal, Spain and Tajikistan), which is less than 20% of all respondents.

Many countries recognise that vulnerable and marginalised populations find it more difficult to access HIV treatment, care and support.

Data collected on access to treatment, care and support as part of the Dublin reporting process provided additional insights into the situation in the region. While government and civil society respondents reported that access to treatment by key populations tends to be readily available (see above), they reported separately on the difficulty that vulnerable and marginalised populations have in accessing HIV treatment, care and support. This corollary data suggests that despite improving circumstances for key populations affected by HIV, the need for strong political leadership continues in the region.

In EU/EFTA countries, civil society respondents in almost all countries (88%) and government respondents in almost two thirds (64%) reported that it was more difficult for vulnerable and marginalised populations to access these services. However, in non-EU/EFTA countries, this was reported to be the case by civil society respondents in less than half the countries (40%) and by government respondents in one fifth (20%) (see Figure 5). It could be that these reports reflect the actual situation but it seems more likely that the difficulties are recognised more fully by civil society and government respondents in EU/EFTA countries than in other countries. Countries in which both government and civil society reported that vulnerable and marginalised populations did not find it more difficult to access HIV treatment, care and support included Albania, Armenia, Bosnia and Herzegovina, the former Yugoslav Republic of Macedonia, Georgia, Kazakhstan, Latvia, Moldova, Montenegro, Poland, Slovenia and Uzbekistan.

Figure 5. Percentage of responding countries recognising that vulnerable and marginalised populations find it more difficult to access HIV treatment, care and support in countries across the region



Respondents were also asked if their country has laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups. In EU/EFTA countries, this was reported to be the case by civil society respondents in more than half of countries (57%) and by government respondents in just less than one third (31%). However, in non-EU/EFTA countries, this was reported to be the case by civil society respondents in almost three quarters of the countries (73%) and by government respondents in just over one third of countries (38%) (see Figure 8). Particular groups identified as facing such obstacles in more countries included PLWHA, migrants, PWID, prisoners and sex workers (see Figure 7).

Figure 6. Percentage of responding countries reporting that there are laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups overall

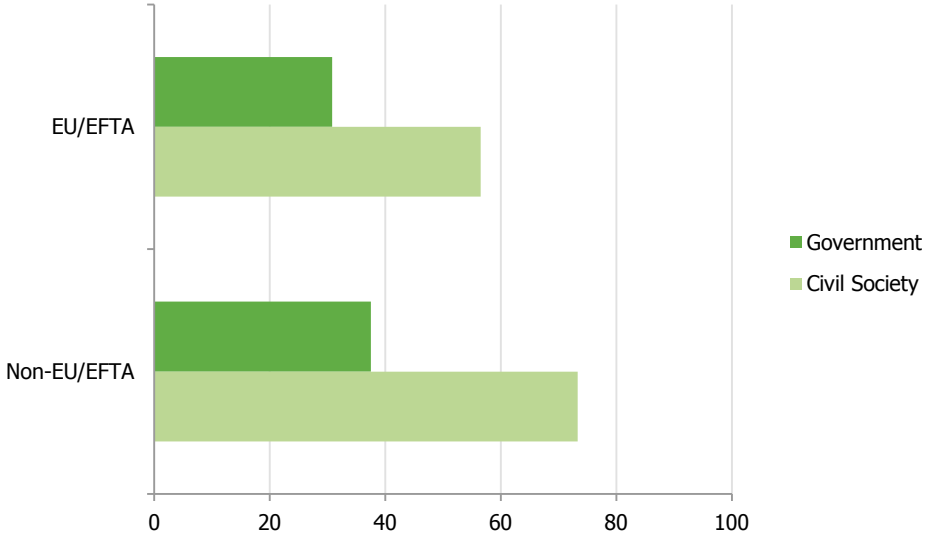
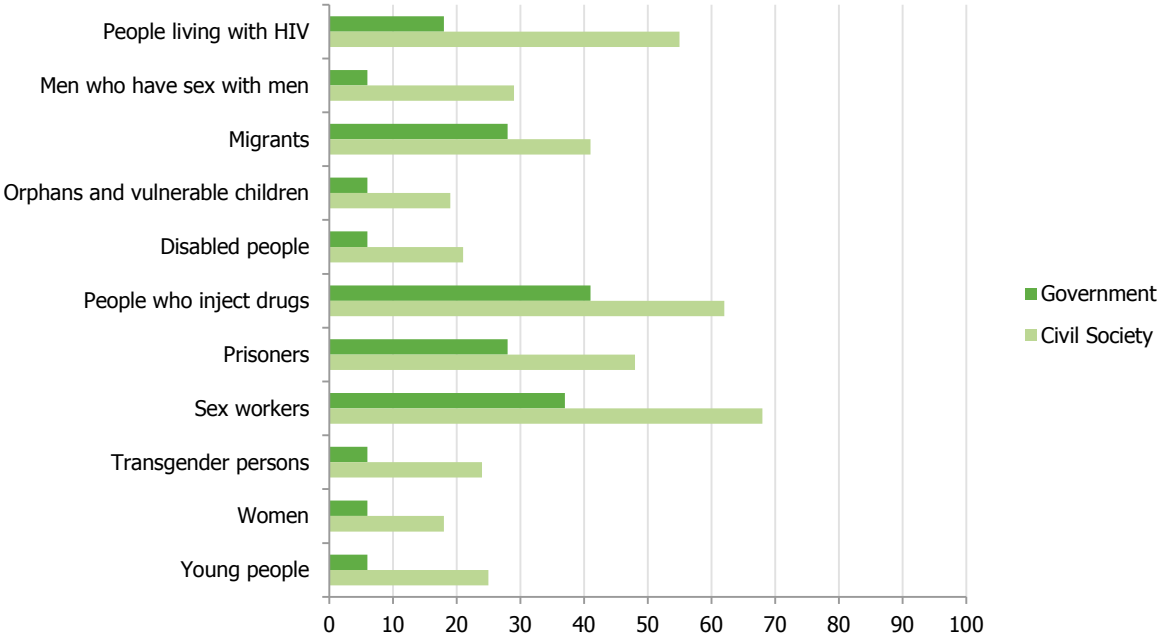


Figure 7. Percentage of responding countries reporting that there are laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for specific key populations and vulnerable groups



A wide range of populations were identified as facing difficulties in accessing HIV treatment, care and support. In many cases, countries reported efforts to provide specific programmes for these populations. In the context of political leadership, reported data on key populations included:

Key populations at increased risk of HIV infection overall, for example in Bulgaria and Ukraine. Portugal commented on the challenge of providing correct testing and referral to members of key affected populations. Some countries reported challenges in encouraging people in key affected populations to attend medical institutions. Latvia reported challenges in motivating people to visit an infectious diseases doctor when they have a positive HIV test. Estonia and Georgia reported the challenge of expanding and focusing their HIV testing on key affected populations. Countries which reported focusing their efforts to provide treatment on these populations included Spain and Tajikistan.

Migrants in Finland, Luxembourg, Spain and Switzerland, particularly those who are undocumented in Belgium, the Czech Republic, Denmark, Finland, France, Germany, Greece, Israel, Italy, Kyrgyzstan, Luxembourg, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, Ukraine and the United Kingdom. Other groups of migrants who are reported to face difficulties accessing services include older male migrants in Denmark; migrant sex workers in France and Switzerland; migrant transsexuals in France; migrants from high prevalence countries in Germany and Sweden; non-nationals in Italy; those from African communities in the United Kingdom; asylum seekers in Israel and Netherlands; migrant workers in Kazakhstan; undocumented children who have never been in the asylum process in Sweden and trafficked women in Denmark and Israel. In Belarus, foreign citizens and stateless persons can be subjected to compulsory medical examination if they are suspected of having a 'dangerous disease'. Finland reported that it was using the same criteria for HIV treatment among refugees and asylum seekers as among citizens.

People who inject drugs in Belarus, Estonia, Greece, Iceland, Italy, Lithuania, Portugal, Romania, Slovakia, Spain, Tajikistan and Ukraine. In some countries, e.g. Armenia, Belarus, Croatia, Georgia and Ukraine, the criminalisation of drug use and drug possession is seen as an obstacle to delivery of HIV programmes. The requirement for drug users to be officially registered is reported as an obstacle to delivering services in Lithuania. Azerbaijan, Moldova and Ukraine commented on the positive value of substitution therapy in supporting people who inject drugs receiving ART. Estonia reported providing ART as directly observed treatment for those on substitution therapy. Countries reporting challenges in delivering OST at scale included Romania and Ukraine. Ukraine commented specifically on the lack of social support for people receiving OST.

Sex workers in Greece, Iceland, Portugal, Slovakia, Spain and Ukraine; male sex workers in Switzerland. In some countries, e.g. Albania, Belarus, Croatia, Lithuania, Romania and Serbia, the criminalisation of sex work is seen as an obstacle to delivery of HIV programmes. Changes in legislation in France have affected the health of sex workers because sex workers have moved location, have become more isolated and engage in more hidden activities. In the Netherlands, there are fears that the intended compulsory registration of sex workers will result in more operating 'underground'.

Men who have sex with men in Spain. Some countries reported particular efforts to promote treatment and care among men who have sex with men. For example, France reported developing a brochure focused on gay men living with HIV and Switzerland reported publishing one on better sexual health. Although its main focus is prevention, Switzerland has also taken a very proactive approach with its integrated campaign – 'Break the Chain' – focusing on men who have sex with men.

People in places of detention: Differences were largely reported by civil society respondents in Belarus, Greece, Lithuania, Serbia and Ukraine. In some countries, e.g. Croatia and Spain, the existence of a separate health system for prisons was identified as an obstacle to delivery of HIV programmes. In Lithuania, there was reported to be poor coordination of ART between prison and community settings. In Georgia, the attitudes of prison authorities were identified as an obstacle to service delivery. Ukraine reported that the number of people receiving ART had increased in prisons and that the management of opportunistic infections had improved. The country also reported that a decision had been taken to allow continuation of OST in prisons for those receiving this prior to imprisonment. However, it was also reported that there is a lack of adequate funding for prison health and HIV services in Ukraine. Azerbaijan reported that people living with HIV in prisons were receiving ART. Belarus reported that they provide support to people living with HIV when they leave prison.

Regional variations in Azerbaijan, Hungary and Sweden. These differences were largely reported by civil society respondents. For example, the respondent from Sweden reported that it was more difficult to access HIV treatment, care and support services outside the main urban centres, particularly for PWID, MSM, migrants and transgender persons.

Part 2. Resources

Internationally, it is recognised that the way 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. UNAIDS recommends tracking countries' AIDS spending as one of the core indicators for Global AIDS Response Progress Reporting.

However, some European countries continue to question the feasibility and value of tracking this information in the region. In particular, there are concerns that:

- tracking spending on HIV and AIDS in countries with integrated health systems may not be feasible
- the methods are more suited to non-EU countries that have programmatic responses to HIV
- relatively high costs of antiretroviral drugs and medical services may distort figures derived from such an exercise.

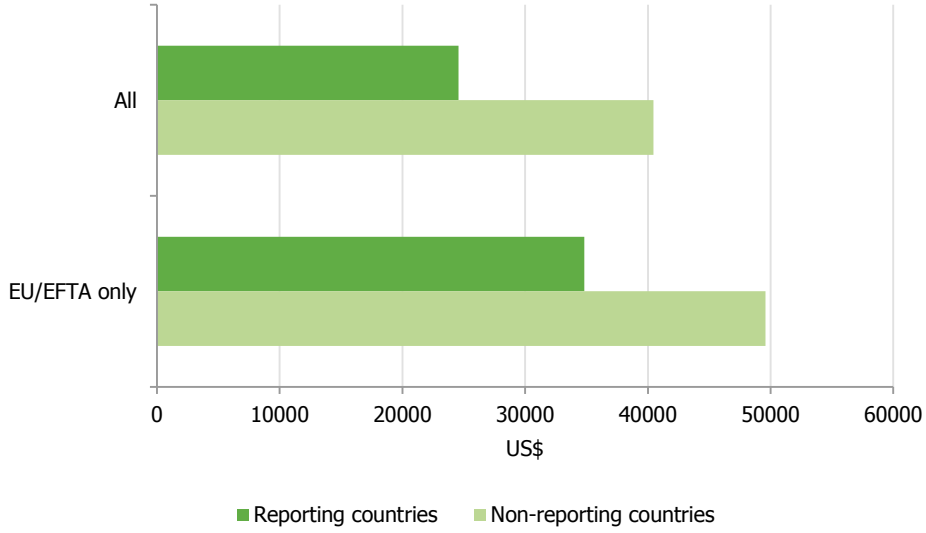
Nevertheless, in the two rounds of monitoring implementation of the Dublin Declaration that have been conducted to date, most countries (40/55; 73%) in the region submitted some data related to this indicator. More than three quarters (77%) of EU/EFTA countries submitted some financial data, compared with two thirds (66%) of non-EU/EFTA countries (see box 3 below). Twenty one countries submitted data using the UNAIDS national funding matrix template in this round of reporting. This included 10 EU countries (see below). Countries with decentralised governments and integrated systems of health delivery, e.g. Spain and Switzerland, were among those reporting financial data.

Box 3. HIV-related financial resources in EU/EFTA countries

- Overall, EU/EFTA countries do have financial data related to their HIV responses and are able to report this when asked. Over two rounds of Dublin reporting, more than three quarters (77%) of EU/EFTA countries submitted some financial data on their HIV response, as compared with two thirds (66%) of non-EU/EFTA countries.
- Ten EU/EFTA countries were able to report financial data using the UNAIDS funding matrix. In the current round of Dublin reporting, 10 EU/EFTA countries used this matrix, including Belgium, Italy, Portugal, Spain and Switzerland.
- However, higher income countries are less likely to track and report HIV-related financial data than those with lower incomes (see Figure 10). All four middle-income EU countries (see Annex 2) submitted financial data to the Dublin reporting process. The seven EU/EFTA countries that did not submit financial data to the Dublin reporting process were all high-income countries.
- In EU/EFTA countries, the proportion of HIV spending on treatment is extremely high (see Table 3). For example, in 2011, the proportion of HIV spending on treatment in the eight countries reporting was 98.3%, compared with 64.2% in seven non-EU/EFTA countries.
- Some middle-income EU countries have depended on external financing, particularly from the Global Fund, to finance their HIV prevention activities, particularly among key affected populations. For example, Bulgaria continues to finance much of its HIV prevention activities from Global Fund financing. Romania has reported severe problems financing its HIV prevention activities among key populations, including people who inject drugs, since its Global Fund financing ended. This resulted in reduction in levels of key services, such as needle and syringe programmes (see Table 4). This is considered to have been a major factor in the current HIV outbreak among people who inject drugs in Romania. Civil society organisations from other middle-income EU countries, such as Latvia and Lithuania, report significant difficulties in accessing finances for their HIV prevention activities among key populations.
- Currently, there is no specific EU-level instrument to provide HIV funding to such countries. The main mechanism for such funding has been through the Global Fund. However, the Global Fund has been facing pressures, e.g. from some donors, to prioritise its funding towards lowest income countries, e.g. in Africa, rather than financing responses in middle-income countries. Where middle-income countries have failed to secure funding from the Global Fund, e.g. Latvia, Lithuania and Romania, they have found it very difficult to find other sources of financing. Such difficulties may also be beginning to affect high-income EU countries that are particularly affected by the current financial crisis and that are experiencing HIV outbreaks among key populations, e.g. Greece.
- EU/EFTA countries have been among the most significant funders of the international response to HIV. For example, in 2008, EU Member States, EFTA countries and the European Commission contributed more than US$ 3 billion to the international response to HIV. EU/EFTA countries remain among the most significant funders of the international AIDS response when compared with GDP (see Figure 15).
- However, the total amount of financing to the international HIV response provided by EU/EFTA countries declined between 2008 and 2011. Although total funding to the international HIV response remained constant during that period (see Figure 12?[maybe fig 12?]), the percentage provided by EU/EFTA countries declined from 40% to 35% (see Figure 13).
- In particular, European contributions to the Global Fund declined between 2008 and 2011 (see Figure 166[or maybe fig 16?]). This was largely because some EU countries particularly affected by the financial crisis, e.g. Ireland, Italy and Spain were unable to make any financial contribution in 2011 (see Figure 17[or fig 17?]).
- In addition, European financial contributions to UNAIDS declined in the same period (see Figure 18). However, this was largely due to reduced level of contributions from a small number of large donors, including Denmark, Ireland, the Netherlands and the United Kingdom (see Figure 19).

Overall, countries reporting on their spending on their national response to HIV had lower gross national income (GNI) per capita than those that did not. This was also the case for EU/EFTA countries specifically (see Figure 10). All four middle-income EU countries submitted financial data to the Dublin reporting process. The seven EU/EFTA countries that did not submit financial data to the Dublin reporting process were all high-income countries (see box 3).

Figure 10. Mean GNI per capita of countries that did and did not report financial data related to their national HIV responses in either of the two rounds of Dublin reporting



Although data from several countries and a large amount of explanatory material would be lost if reporting relied on the UNAIDS template only, it is clear that it is feasible for countries to estimate and report their national HIV spending. The UNAIDS funding matrix is a relatively straightforward and flexible economics tool which allows financial data, collected in a range of ways, to be reported. To date, no alternative to the funding matrix has been proposed to collect financial data in a systematic and comparable way.

In particular, the UNAIDS funding matrix can be used to track spending on HIV regardless of the type of health system:

- Decentralised systems – it allows financial data to be collected from all organisations and bodies that either finance or implement HIV responses. In most countries, this would involve collecting data from both central and local government structures.
- Integrated health systems – although it is easier to identify the level of funding for HIV when this is provided in an earmarked or 'vertical' manner, this only accounts for a proportion of HIV funding in most countries. For example, in most countries of the world, HIV treatment is provided through an integrated health system in which health workers who treat people living with HIV also treat people with other health conditions. In such situations, the human resource costs of treating HIV need to be estimated based on the total cost of human resources for healthcare and the estimated proportion of human resources' time spent on HIV-related treatment. This is fairly standard practice in health economics. Data generated in this way can be included in the UNAIDS funding matrix.

Clearly, it is feasible for countries to track this indicator and to do so using the UNAIDS funding matrix. However, some countries still do not track this indicator, presumably because they do not see the value of investing the resources needed to do so. This report argues that tracking spending on HIV is of value for a number of reasons:

- It provides evidence of the extent to which the global financial crisis is affecting national responses to HIV. Although many countries argue that funding for HIV is declining, it is not particularly credible to make these arguments in descriptive/narrative terms without some form of financial analysis.
- It shows where funding is being focused and prioritised in particular countries.
- It ensures that responses to HIV are transparent and accountable, not only to a country's government, but also to a country's citizens and civil society organisations.

Part 2a. Financial resources for national responses to HIV

Overall spending on HIV continues to rise in many countries.

Trend data for overall HIV spending are available for 14 countries across two rounds of Dublin reporting (see Annex 2). In most of these (11; 79%), overall HIV spending rose between the periods 2005–08 and 2009–11. In seven countries – Azerbaijan, Bulgaria, the former Yugoslav Republic of Macedonia, Kazakhstan, Moldova, Poland and Ukraine – overall HIV spending rose consistently. In some cases, the rise in spending was considerable, for example, in Azerbaijan, where spending rose from an estimated EUR 7m in 2007 to more than EUR 10m in 2011. In Armenia, Georgia and Tajikistan there was a considerable rise between the two reporting periods but a smaller decline between 2010 and 2011. In Estonia and Latvia HIV spending was relatively static across the two reporting periods. In Kyrgyzstan and Romania overall HIV spending declined considerably between the two periods (see Annex 2).

Most of the costs of responding to HIV relate to treatment, particularly in EU/EFTA countries.

Total spending on HIV continues to increase in most countries. This is largely as a result of the costs of an increasing number of people receiving ART. Total costs of providing treatment are much higher than for HIV prevention services, particularly in EU/EFTA countries (see Table 4).

Table 4. Reported spending on national HIV responses in 2011 in 15 countries*

	Total	Prevention	Percentage
All countries (15)	1 642	59	3.6
EU/EFTA countries (8)	1 551	27	1.7
Non-EU/EFTA countries (7)	91	32	35.8

**All figures in millions of Euro.*

Spending on HIV prevention declined in some countries, particularly between 2010 and 2011.

Trend data for HIV prevention spending are available for 18 countries across two rounds of Dublin reporting (see Annex 2). In most of these (12; 66%), spending on HIV prevention rose between the periods 2005–08 and 2009-11. In Azerbaijan, the former Yugoslav Republic of Macedonia, Kazakhstan and Spain, spending on HIV prevention rose consistently. In six countries – Armenia, Bulgaria, the Czech Republic, Georgia, Portugal and Tajikistan – there was a rise between the two reporting periods but a smaller decline between 2010 and 2011. In Latvia, rates of HIV prevention spending fluctuated widely year on year. In Moldova, Switzerland and Ukraine, HIV spending was relatively static across the two reporting periods. In Estonia, Kyrgyzstan, Poland and Romania, HIV prevention spending declined. In the cases of Kyrgyzstan, Poland and Romania, this decline was very considerable. For example, in Poland, reported spending on HIV prevention fell from more than €3m in 2007 to just over €1m in 2011 (see Annex 2).

Evidence of increased spending on HIV prevention for people who inject drugs, men who have sex with men and sex workers.

In countries responding, almost all government respondents (86%) and almost three quarters of civil society respondents (73%) considered that their country's HIV prevention response was focused on key affected populations. This was not, however, the case for government respondents in Italy, Kyrgyzstan, Malta, Poland, Romania and Slovakia and for civil society respondents in Azerbaijan, Finland, Greece, Israel, Italy, Kyrgyzstan, Lithuania, Romania, Slovakia, Sweden and Ukraine.

Trend data for HIV prevention spending among these key populations are available for 13 countries across two rounds of Dublin reporting (see Annex 2). In addition, five countries reported data for two or more years in this round of reporting. In most of these 18 countries (13; 72%), spending on HIV prevention among these key populations rose. In eight countries – Armenia, Azerbaijan, Belarus, the former Yugoslav Republic of Macedonia, Kazakhstan, Moldova, Romania and Uzbekistan – spending on HIV prevention among these key populations rose consistently. In seven of these countries, this increase involved focusing a higher percentage of HIV spending on these populations. In the former Yugoslav Republic of Macedonia, the percentage of HIV prevention spending focused on these key populations fell slightly, from 70% to 65%, but remained at a very high level.

In five countries – Bulgaria, the Czech Republic, Georgia, Kyrgyzstan and Tajikistan – there was a rise between the two reporting periods with a smaller decline between 2010 and 2011. In four cases, this trend reflects the country's spending on HIV prevention overall. In the case of Kyrgyzstan, the spending on HIV prevention for these key populations was preserved, at a level of around €500,000, by increasing the percentage of HIV prevention spending focused on them from 9% in 2006 to 53% in 2011.

In Estonia HIV prevention spending among these key populations was relatively static between 2008 and 2010 at around €1.4m. This was possible despite a decline in spending on HIV prevention over that period because the percentage of HIV prevention funds spent on these key populations rose from 36 to 43% (see Annex 2).

Evidence of decreased spending on HIV prevention for key populations.

In four countries – Latvia, Poland, Portugal and Ukraine – HIV prevention spending among these key populations declined. In the cases of both Latvia and Poland, this decline was very considerable. In both these countries, and in Ukraine, the percentage of HIV prevention funding focused on these key populations fell (see Annex 2).

Several countries increased both their per capita spending on HIV prevention and their focus on key populations.

Trend data for the two rounds of Dublin reporting for both per capita spending on HIV prevention and percentage of HIV prevention spending focused on key populations were available for 14 countries. In seven of these – Armenia, Azerbaijan, Bulgaria, Georgia, Kazakhstan, Moldova and Tajikistan – both per capita spending on HIV prevention and percentage of HIV prevention spending focused on key populations increased. Figures reported for the Czech Republic showed that per capita spending on HIV prevention increased while still maintaining a high degree of focus on key populations. Estonia and Kyrgyzstan reported a reduction in per capita spending on HIV prevention combined with an increased focus on key populations. In the case of Estonia, overall per capita spending on HIV prevention remains high but in Kyrgyzstan this has fallen to very low levels. In the former Yugoslav Republic of Macedonia, Latvia, Poland and Ukraine the reported focus on key populations declined. In the former Yugoslav Republic of Macedonia, the degree of focus on key populations remained at a high level and the level of per capita spending on HIV prevention rose. However, in both Latvia and Poland, the reported percentage of spending on key populations fell greatly. In Poland, this was associated with a marked decline in per capita spending on HIV prevention.

Low- and middle-income countries are funding more of their HIV responses from domestic public resources.

Trend data over the two rounds of Dublin reporting were available for 13 countries regarding the proportion of their national HIV response funded from domestic public resources (see Table 5). In Latvia, Poland and Romania more than 90% of funding for the national response came from domestic public resources in both rounds of reporting. Seven low- or middle-income countries – Armenia, the former Yugoslav Republic of Macedonia, Georgia, Kazakhstan, Kyrgyzstan, Moldova and Tajikistan – increased the proportion of their national HIV response funded from domestic public resources. In Bulgaria and Ukraine the proportion remained static. In Azerbaijan, the proportion fluctuated considerably year on year.

Table 5. Proportion of funding as a percentage for the national HIV response from domestic public resources

	2005–08	2009	2010	2011
Armenia	16	-	39	37
Azerbaijan	66	-	83	59
Bulgaria	51	52	43	51
Former Yugoslav Republic of Macedonia	46	51	51	-
Georgia	11	31	34	32
Kazakhstan	70	-	-	81
Kyrgyzstan	9	12	13	25
Latvia	99	95	97	98
Moldova	27	47	42	37
Poland	100	99	100	100
Romania	93	95	94	93
Tajikistan	6	-	11	15
Ukraine	51	58	52	-

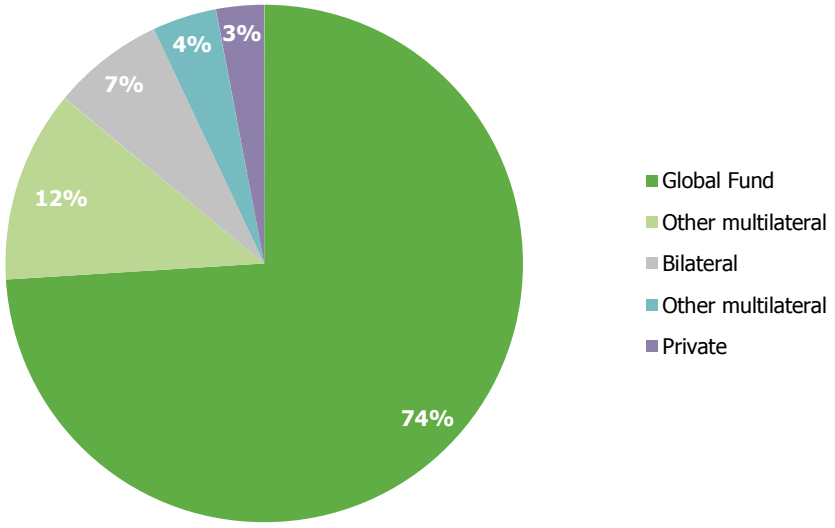
National HIV responses in several countries remain dependant on external resources, particularly from the Global Fund.

In total, 16 countries reported receiving a total of €176.7m for their national HIV responses from external sources between 2009 and 2011. These figures are incomplete as not all countries reported for each year. Almost three quarters (74%) of reported external resources came from the Global Fund (see Figure 11).

The number of countries eligible to receive Global Fund financing for their HIV response is relatively small and is declining. A number of European countries, e.g. Estonia and Romania, which have received Global Fund financing for their HIV responses in the past were not eligible to receive further financing in the Global Fund's most recent funding rounds because of their relatively high income levels. In the case of Romania, this is reported to have resulted in a funding gap, which led to reduced levels of HIV prevention services. This is considered to have been a major factor in the current outbreak of HIV among PWID in the country (see box below.

Other reported sources of funds included other multilateral sources, particularly UN agencies, and bilateral agencies. However, bilateral aid is provided to relatively few countries, such as Georgia, Kyrgyzstan, Tajikistan and Ukraine. Funds from private sources remain extremely limited. Countries did not report receiving financing for their HIV responses from the European Commission. There is, as yet, no specific financial mechanism through which countries could receive such financing.

Figure 11. Reported sources of funding for national HIV responses other than domestic public resources, 2009–11



Reported consequences of failing to sustain funding for the HIV response in Romania following the cessation of financing from the Global Fund

Between 2004 and 2010, Romania received almost US$40m in financing for its national HIV response in two grants from the Global Fund. However, funding has not been maintained since those grants ended, leading to a reduction in HIV prevention services as reported in the Romanian narrative report to UNAIDS in 2012 as part of Global AIDS Response Progress Reporting.

> Funding prevention interventions for vulnerable populations is not ensured after the closure of Global Fund projects in mid-2010. Government at national and local level, despite repeated commitments, has not yet identified the resources and the adequate mechanisms to ensure sustainable, adequate funding. NGOs, despite their proven capacity and results, are still not benefiting from subcontracts from public funds for public health interventions.
>
> Prevention programmes such as prevention of transmission among young people, prevention of mother to child transmission, and prevention activities among uniformed services and prisoners which were developed or extended in the framework of the Global Fund Round 2 programme (2004–2008), which significantly scaled up and became national, restrained dramatically, after the end of the projects, in December 2008. The concern about the sustainability of these programmes, which were supposed to be taken over by the different ministries, turned into a reality. Adequate funding, and continuous training of personnel were diminished.
>
> Other interventions, like prevention among vulnerable groups and the Roma population, developed in the framework of the Global Fund Round 6 programme (2007–2010) and the United Nations Office on Drugs and Crime (UNODC) five year programme, diminished in 2010, and especially in 2011, due to lack of funding. For instance, the programme concerning prevention of HIV infection among Roma young people, run by Save the Children Romania, during the first eight months of 2010 covered more than 4 400 people in three counties of Romania, but the need is much higher. At the end of 2011, less than 30% of the population of drug users in Bucharest had access to needle exchange services (including needle and syringe exchange) and less than 10% to substitution treatment. Services for drug users are limited and hardly accessible even if an NGO opened a new substitution centre in 2011.

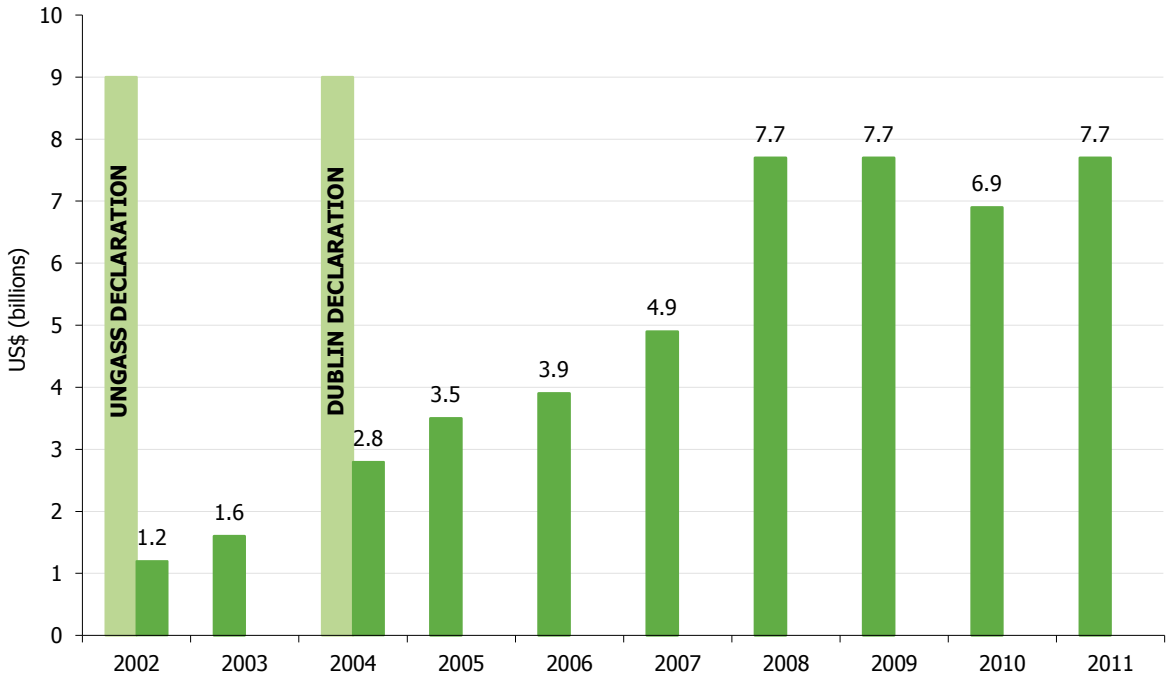
The underlying problem appears to be that although harm reduction services are mentioned as components of the draft National AIDS Strategy for 2012–16, these services remain controversial. They are 'acutely debated and disputed in the political as in the mass media.' This has implications for funding. 'Despite advocacy efforts, neither the Ministry of Health nor any of the municipalities of Bucharest did undertake any support for the needle exchange projects. Needle exchange programmes sustained through the Global Fund and UN agencies (United Nations Children's Fund and UNODC) diminished in 2011 at the

Part 2b. Financial resources from the countries of Europe and central Asia to the international HIV response

Although international AIDS assistance rose dramatically between 2002 and 2008, it plateaued in the following years.

As reported in the previous round of Dublin reporting, international AIDS assistance rose dramatically from USD1.2billionin 2002 to US$7.7bn in 2008. However, largely as a result of the global financial crisis, it has remained at that level since (see Figure 12).

Figure 12. International AIDS assistance from donor governments: 2002–11



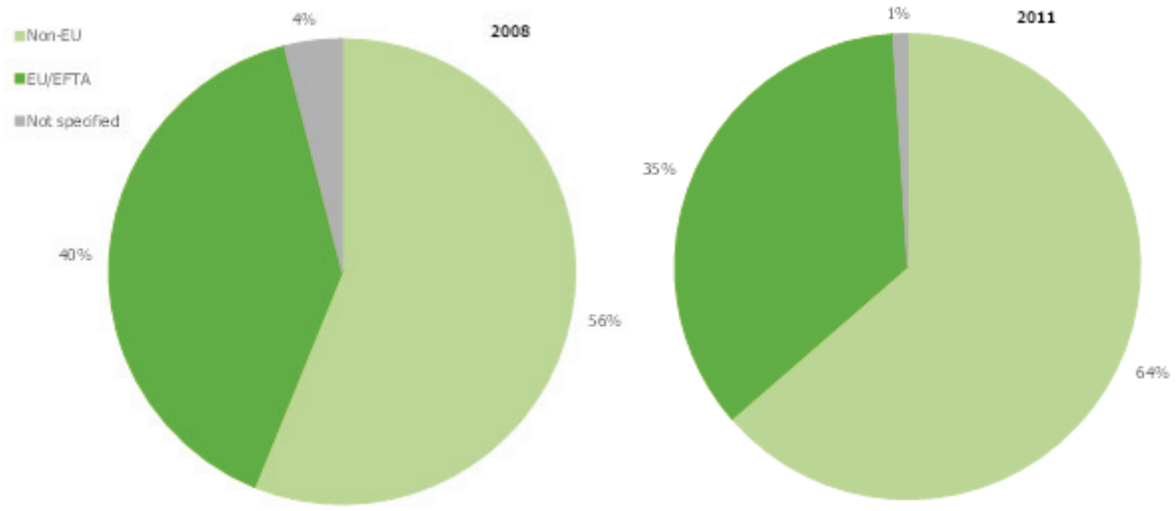
Source: Kaiser Family Foundation and UNAIDS Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2011, July 2012

The proportion of international AIDS assistance provided from Europe[i] reduced between 2008 and 2011.

In 2008, 40% of all international AIDS assistance originated from EU/EFTA countries and the European Commission. By 2011, this proportion had fallen to 35% (see Figure 13). As the total level of international financing remained constant during this period, this reduction in the proportion represented an actual decline in levels of funding from Europe. During this period, funding from Europe as international AIDS assistance declined by US$350m.

[i] Europe as defined by the Kaiser Family Foundation

Figure 13. Proportion of international AIDS assistance from different sources, 2008 and 2011

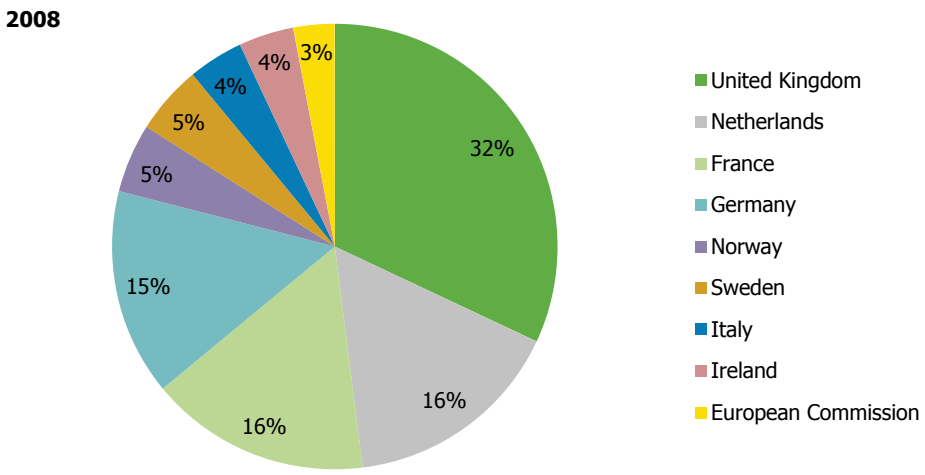


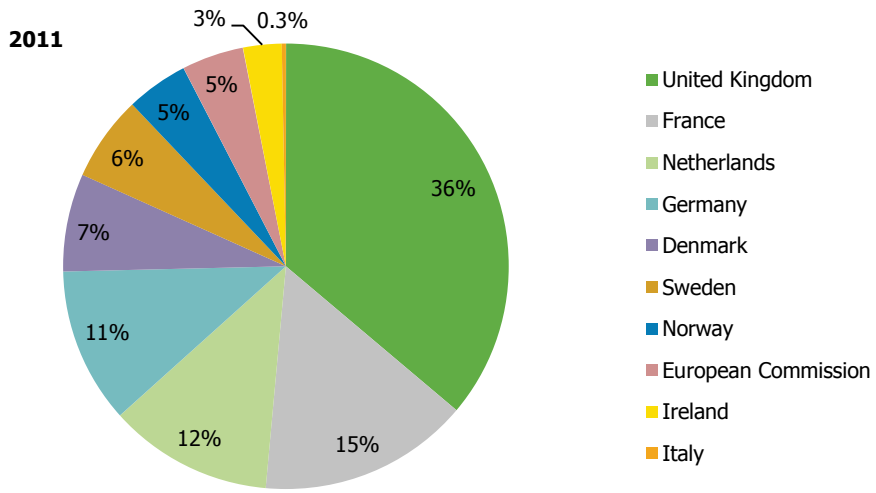
Source: Kaiser Family Foundation and UNAIDS Financing the Response to AIDS in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2011, July 2012

Many of the large European funders of international AIDS assistance reduced their contribution between 2008 and 2011.

Between 2008 and 2011, several European countries reduced the amount of funding they provided for international AIDS assistance. These included France, Germany, Ireland, Italy, the Netherlands and Norway. The amount provided by the United Kingdom remained largely unchanged. There were small increases in the amounts provided by Sweden and the European Commission. Figure 14 shows the proportion of disbursements for international AIDS Assistance from EU Member States, EFTA countries and the European Commission in 2008 and 2011.

Figure 14. Proportion of disbursements for international AIDS assistance from EU Member States, EFTA countries and the European Commission, by source, 2008 and 2011



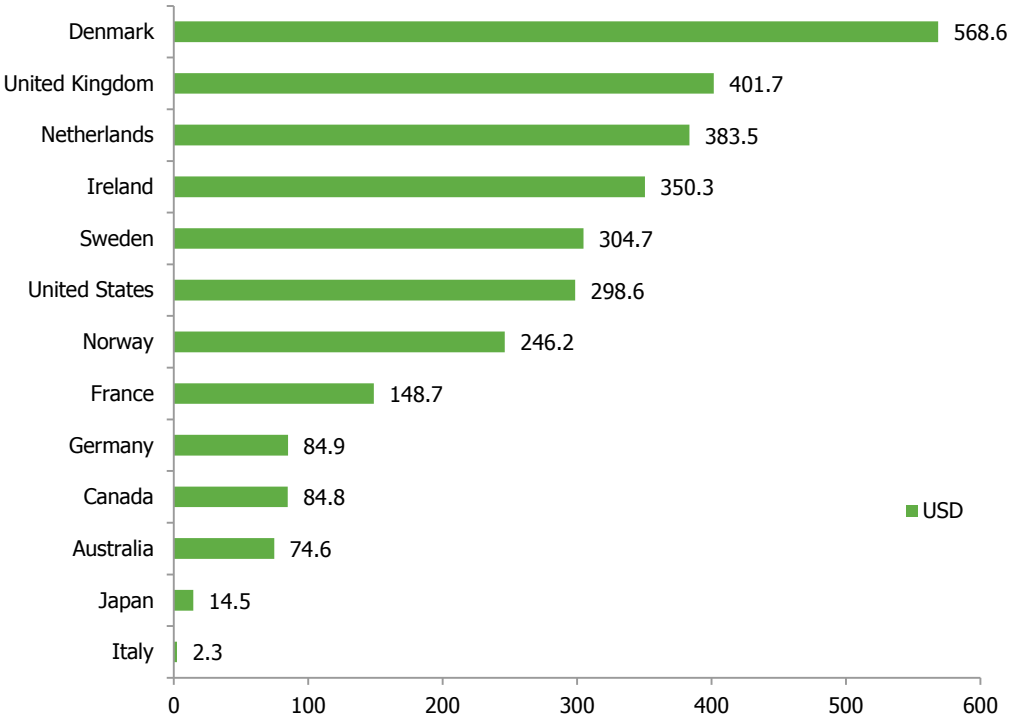


Source: Kaiser Family Foundation and UNAIDS Financing the Response to AIDS in low- and middle-income countries: International Assistance from Donor Governments in 2011, July 2012

European countries remain the largest funders of the international AIDS response when compared to GDP.

European countries continue to rank among the countries that provide the highest levels of international AIDS assistance when compared to GDP (see Figure 15).

Figure 15. Disbursements for international AIDS assistance per US$1m of GDP, 2011

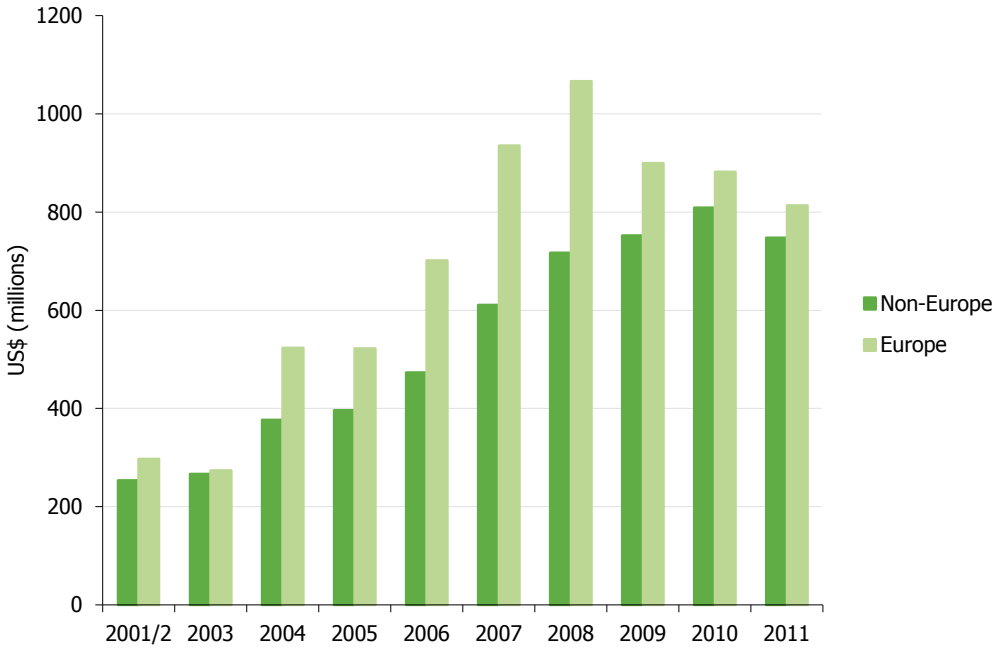


Source: Kaiser Family Foundation and UNAIDS Financing the Response to AIDS in low- and middle-income countries: International Assistance from Donor Governments in 2011, July 2012

European HIV-related contributions to the Global Fund have declined since 2008.

The Global Fund has been a significant funder of HIV responses internationally. European countries have provided significant levels of funding to the Global Fund. For example, from 2001/2 to 2008 European HIV-related contributions to the Global Fund rose from US$297m to more than US$1bn. However, they have been declining steadily since then to US$814m in 2011 (see Figure 16)

Figure 16. HIV-related contributions by countries to the Global Fund by origin, 2001–11

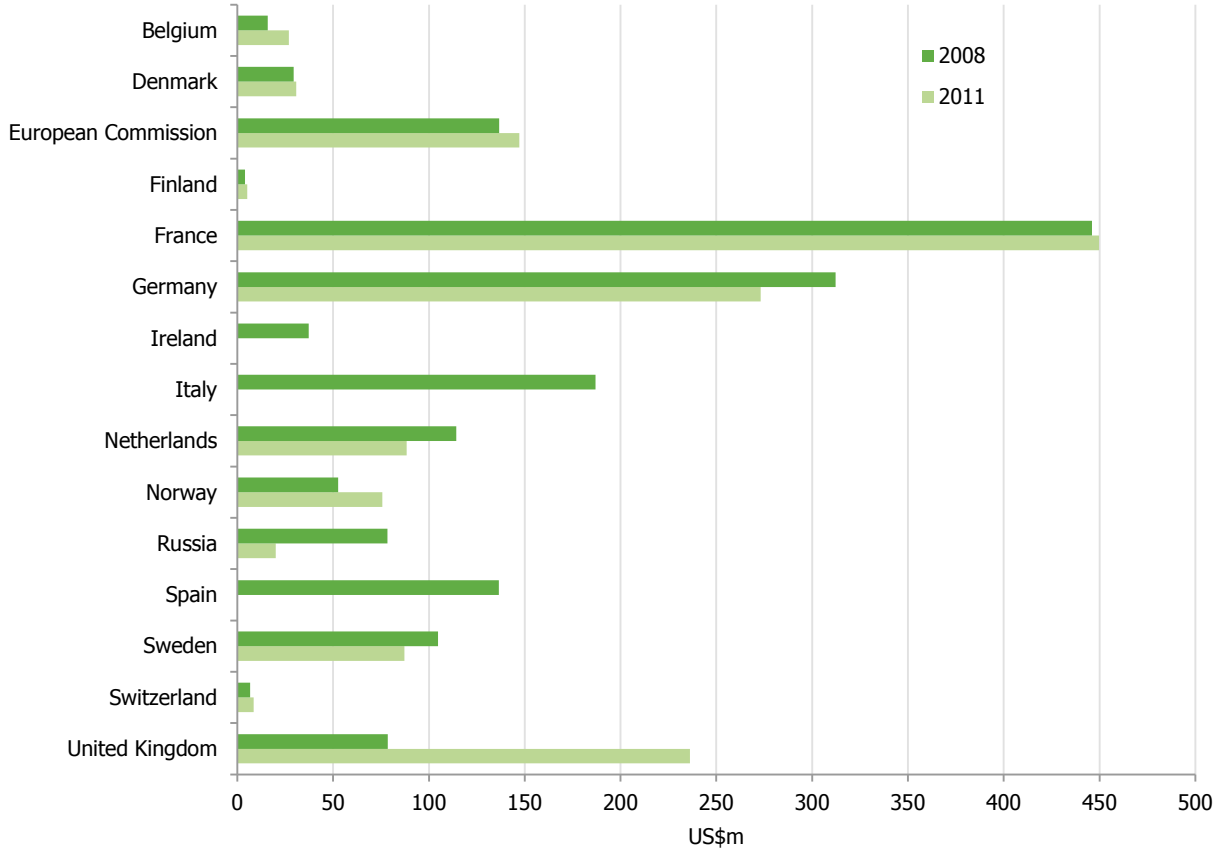


Source: Global Fund List of Core Pledges and Contributions, 2012

Reductions in European contributions to the Global Fund from 2008 to 2011 are largely due to some countries not making any contribution in 2011.

Figure 17 shows contributions to the Global Fund (in total, not just for HIV) in 2008 and 2011 for all European countries contributing more than US$5m in either of those years. Ireland, Italy and Spain, who contributed a total of more than US$360m in 2008 made no contributions in 2011. Contributions were also reduced from Germany, the Netherlands, Russia and Sweden. A number of countries – Belgium, Denmark, Finland, France, Norway, Switzerland and the United Kingdom – increased their contributions, as did the European Commission. In the case of the United Kingdom, this increase was very considerable from US$78.5m in 2008 to US$236.2m in 2011.

Figure 17. Contributions to the Global Fund for TB, HIV and Malaria from European countries contributing more than US$5m, 2008 and 2011

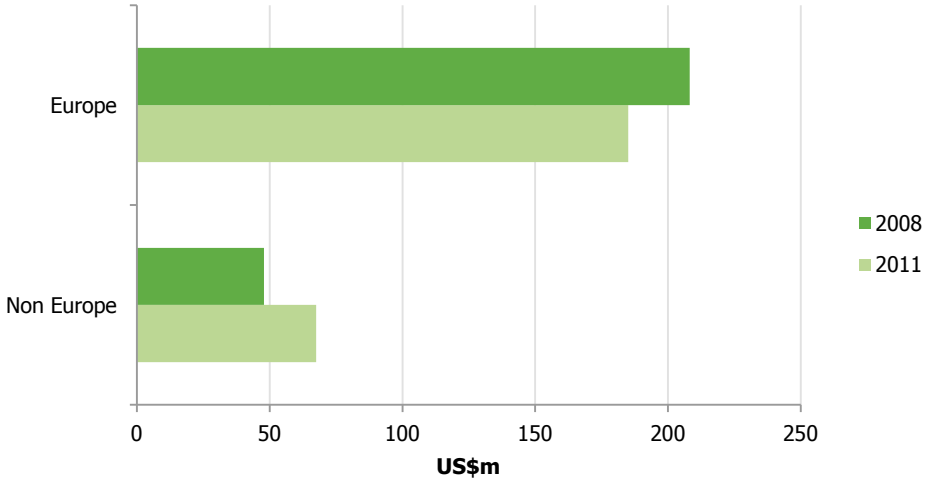


Source: Global Fund List of Core Pledges and Contributions, 2012

Contributions from European countries to UNAIDS declined between 2008 and 2011.

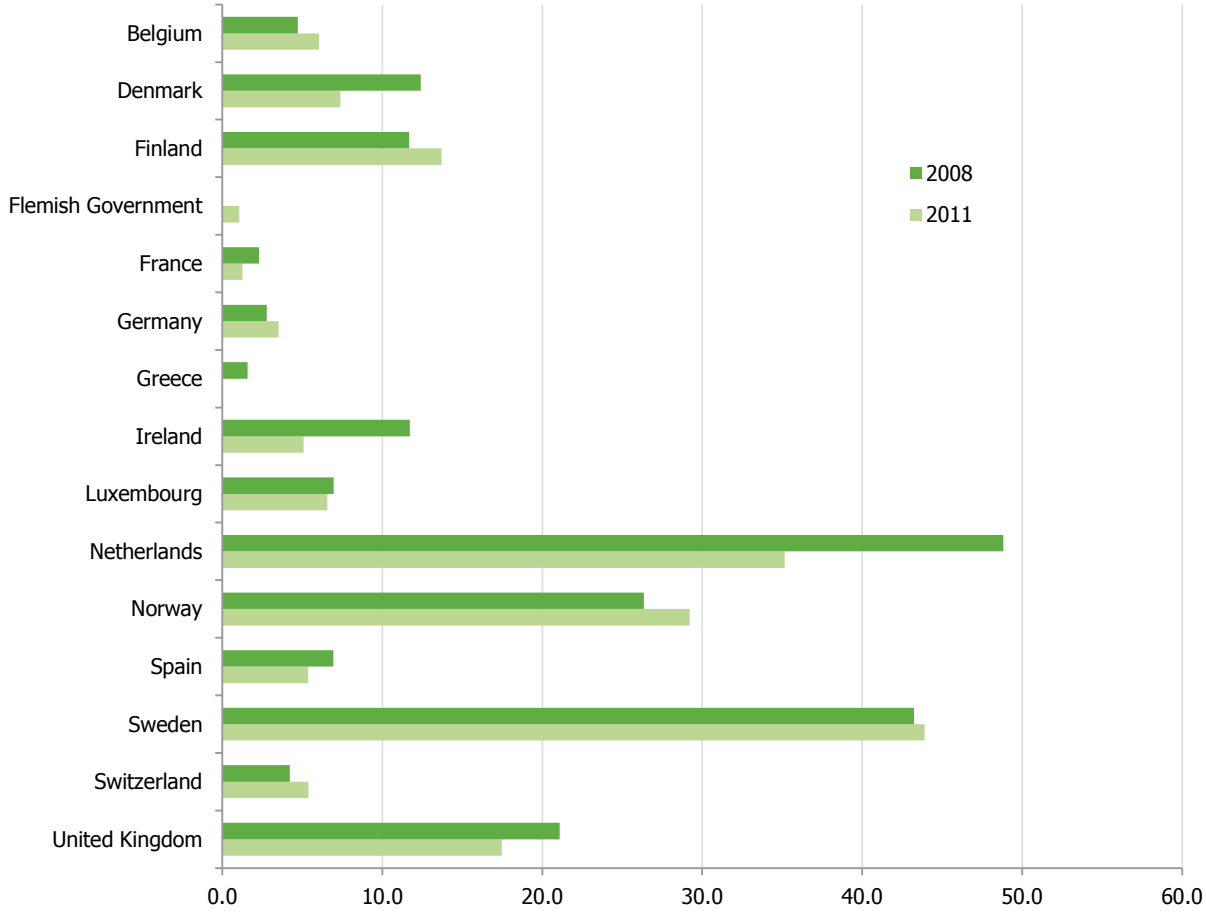
Total country contributions to UNAIDS in 2011 were US$252m, compared with US$256m in 2008. However, the proportion received from European countries declined from 81% in 2008 to 73% in 2011 (see Figure 18). This reduction was largely due to smaller contributions from a number of large donors, including Denmark, Ireland, the Netherlands and the United Kingdom (see Figure 19).

Figure 18. Contributions to UNAIDS by source, 2008 and 2011



Source: UNAIDS List of Total Contributions, 2012

Figure 19. Contributions to UNAIDS from selected European countries, 2008 and 2011



Source: UNAIDS List of Total Contributions, 2012

Conclusions

In general, countries report prioritising their response around key populations, particularly for PWID, MSM and sex workers. However, countries also report that key populations continue to face significant obstacles in accessing HIV treatment, care and support. It is possible this discrepancy is due to a desirability bias in responses to direct questions about political leadership. For example, the responses to leadership questions about the prioritisation of prevention spending and the availability of ART for key populations were more positive than corresponding data provided in response to questions about treatment, care and support.

The low priority assigned to activities for migrant populations raises questions about the current boundaries of political leadership. With migrants – especially irregular migrants – typically being seen as outside of mainstream society, the inclination and/or ability of political leaders to act on their behalf poses challenges in some countries. However, these challenges must be addressed if countries are going to reduce the impact of HIV among migrant populations.

While there are different challenges associated with political leadership and HIV programmes for prisoners (e.g. legal and regulatory barriers to the provision of services in prisons), the need for strong and effective leadership in this area is great. Fortunately, there are countries that are doing good work in prisons and other countries can learn from their experience.

While there is a prevailing sentiment among all respondents that political leadership is relevant and effective, the gap between the perspectives of government and civil society is notable in some cases. For example, 86% of government respondents felt programmes – including those that lack widespread political support – were providing significant coverage compared with only 70% of civil society respondents. Overall, government rates political leadership higher than civil society, given its interest in providing that leadership. However, the perspective of civil society is a vital and valid counterpoint to that of government.

The use of directly comparable questions on political leadership for government and civil society respondents in the European supplement to the NCPI were more relevant for tracking leadership regionally than those used historically to track leadership globally. However, the question about 'relevant and effective policies' was not sufficiently focused on policies related to key populations. In past rounds of international reporting, countries have been asked more broadly about the existence of documents such as national strategies, action plans and treatment guidelines as a measure of their leadership and that is generally how they responded to this policy question in the Supplement. In the future, questions on policy should be more focused on teasing out specific actions and/or concerns about the policy environment that are directly relevant to leadership in the region.

On balance, political leadership on HIV is reasonably strong in Europe and Central Asia. However, comments submitted by many respondents on the different issues clearly indicate that significant gaps in leadership continue to exist in countries across Europe and Central Asia. Given the concentrated nature of the epidemic in the region, where HIV primarily affects specific key populations, the need for strong, focused leadership is more important than ever.

From a resource perspective, this report demonstrates that it is both useful and feasible for countries to track and report their levels of spending on their response to HIV. Financial data is essential for countries to understand and to demonstrate in a credible manner how the current economic climate is affecting responses to HIV.

Most countries have some financial data available. This is particularly the case for EU/EFTA countries. Countries with decentralised and/or integrated health systems, such as Spain and Switzerland, are able to report data on their spending on their response to HIV. In general, countries with a lower gross national income are more likely to track and report spending on their national HIV response than those countries with a higher gross national income (see Figure 10).

The UNAIDS funding matrix is a relatively simple and flexible economics tool which allows countries to report how funds are being spent on the national HIV response and the source of those funds. The matrix can be used to track both earmarked and integrated HIV financing although the latter requires a relatively simple economics analysis to identify the proportion of integrated funding and services relevant to HIV. The matrix can also be used in decentralised health systems as it allows services and funding from all types of organisations to be tracked and analysed. This includes not only different levels of government but also non-governmental and international organisations. However, several European countries and institutions continue to question the usefulness and relevance of the UNAIDS funding matrix. Nevertheless, no credible alternative has yet been developed or presented.

Despite the economic crisis, many countries have continued to increase funding for their HIV responses. Much of this appears to be related to care and treatment. Across the region, particularly in EU/EFTA countries, the cost of providing care and treatment accounts for more than 95% of all HIV spending (see Table 3).

For this reason, investment in effective HIV prevention makes sound economic sense because the funds needed to prevent HIV transmission are much lower than those needed to treat HIV infection once it has occurred. Effective HIV prevention forms an essential part of the new HIV investment framework proposed by UNAIDS and others in 2011[i].

Although funding levels for HIV prevention were higher in many countries in 2011 than in 2008, several have seen a decline in funding levels, particularly since 2010. In some countries, such as Kyrgyzstan, Poland and Romania, the reductions in funding for HIV prevention are significant.

Many countries report a greater focus of their HIV spending on key populations most affected by HIV, such as PWID, sex workers and MSM. Such countries include Armenia, Azerbaijan, Bulgaria, Georgia, Kazakhstan, Moldova and Tajikistan. In many cases, this appears to have been done to make programmes more effective. However, in some cases, e.g. in Estonia, this has been done to make spending more efficient when faced with reduced funding for HIV prevention activities overall.

However, it is of concern that some countries appear to have reduced their focus on funding programmes for key populations most affected by HIV. These countries include Latvia and Poland, and possibly Ukraine.

Many low- and middle-income countries have increased the level of funding for their HIV responses from domestic resources. These include Armenia, the former Yugoslav Republic of Macedonia, Georgia, Kazakhstan, Kyrgyzstan, Moldova and Tajikistan. However, these countries remain dependant on external funds for effective HIV responses, particularly from the Global Fund. Some countries, e.g. Romania, have experienced HIV outbreaks among PWID when levels of harm reduction services declined after Global Fund financing ended and funding was not provided from other sources, e.g. from local/national government or from within the European Union.

The economic crisis has adversely affected international funding for the global HIV response. This has had a particular effect so that:

- The overall level of funding has plateaued since 2008.
- The percentage of international AIDS assistance from Europe fell between 2008 and 2011 largely because of reduced contributions by a number of countries including France, Germany, Ireland, Italy, the Netherlands and Norway. However, some countries, such as Sweden and the United Kingdom maintained or increased their contributions, as did the European Commission.
- Levels of European funding to the Global Fund declined, largely as a result of those countries most severely affected by the economic crisis, e.g. Ireland, Italy and Spain, making no contributions in 2011. A number of other countries also reduced their contributions to the Global Fund including Germany, the Netherlands, Russia and Sweden. A few countries did increase their contributions to the Global Fund, particularly the United Kingdom.
- Levels of European funding to UNAIDS declined largely as a result of reduced contributions from some major funders including Denmark, Ireland, the Netherlands and the United Kingdom.

[i] Schwartländer B, Stover J, Hallett T, Atun R, Avila C, Gouws E et al. Towards an improved investment approach for an effective response to HIV/AIDS. The Lancet. 11 June 2011 (Vol. 377, Issue 9782, Pages 2031–2041). Available at: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)60702-2/abstract

Issue identified as needing further action in previous report	Progress Shading indicates amount of progress since last reporting round; ranked from limited to good.	Comment
Historical measures of political leadership should be replaced with others that are more relevant to the region and more focused on appropriate responses to concentrated HIV epidemics.	Limited progress / Good progress	The European Supplement to the NCPI, which was produced and fielded by ECDC, shifted to a new set of measures to assess political leadership in the context of the epidemic in the region. The data produced by these measures was more relevant and more useful; however, there were still limitations with the questions related to policy and leadership.
Countries need strong political leadership, which is closely linked to the realities of their HIV epidemic. They need to clearly demonstrate the political courage to focus the response on populations most affected by HIV.	Limited progress	In general, countries are demonstrating political leadership by focusing the response on populations most affected by HIV. However, there are significant gaps in both leadership and the response, including programmes for migrant populations and prisoners.
Leadership also includes the ability to translate plans and structures into practical actions.	Limited progress	For the most part, countries appear to be focused on implementation. As mentioned above, there are, however, significant gaps in the response in many countries. Gaps that need strong and courageous leadership if they are going to be addressed.
There is a need for countries to increase funding for their responses to HIV from domestic resources. However, there is an on-going need for external financial support for responses to HIV in low- and middle-income countries. 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.	Limited progress	Many countries have made progress on increasing the level of domestic resources available for their national HIV responses, see Table 5. The Global Fund continues to provide considerable levels of funding to countries. No progress was reported on developing a regional strategy for sustainable funding of the response to HIV.
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.	Limited progress	There are examples of many countries that report focusing finances more on programmes for key populations most affected by HIV. In most countries, this has required more resources although there are a few examples, e.g. Estonia where overall cost of HIV prevention activities has been reduced. However, it is of concern that a few countries appear to be focusing less on HIV prevention among key populations.
There is a need for European and Central Asian countries 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.	Limited progress	No specific progress on this. The UNAIDS approach using a national funding matrix was retained for this round of Dublin reporting.

Issue identified as needing further action in previous report	Progress Shading indicates amount of progress since last reporting round; ranked from limited to good.	Comment
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.	Limited progress	Overall, the economic crisis affecting Europe means that gains made in this area are being lost.
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.	Limited progress	It is unclear if such a review has been conducted. European funding for vaccine and microbicide research continues to decline. However, research in other areas is being supported. The Dublin advisory group considers that microbicide and vaccine research should no longer be highlighted as the only specific area of research to be monitored. Data on this have therefore not been included in this report.

Issues needing further action

LEADERSHIP

- Countries need to ensure the provision and coverage of HIV-related services for key populations who are most affected by the epidemic is a programmatic and financial priority. These populations, including people who inject drugs, men who have sex with men, regular and irregular migrants from high-endemic countries, sex workers and prisoners, should have good access to HIV-related prevention, treatment, care and support services. Services include but are not limited to testing, early diagnosis, antiretroviral therapy, needle exchange and opioid substitution therapy.
- There is an ongoing need for leaders in government and civil society to tackle difficult but essential policy issues, such as the provision of harm reduction programmes in prison settings for people who inject drugs and access to antiretroviral therapy for undocumented migrants.
- Measures used to monitor political leadership and the policy environment should be refined to ensure they capture more specific actions and/or concerns related to key populations and programmes providing services for them.
- The definition and measures of political leadership should be expanded to explicitly include roles for both government and civil society. In the current paradigm, there is an underlying presumption that government provides the political leadership and civil society simply confirms what is being done as opposed to both sectors having important roles in providing political leadership.
- If the UNAIDS National Commitments and Policy Instrument is going to continue to be a part of international monitoring and reporting, it should be tailored to the specific needs of European and Central Asian countries to improve its relevance and reduce the reporting burden; conversely, it should be replaced with the European Supplement to the NCPI.

RESOURCES

- It is essential, especially in times of reduced public health spending, that all countries tailor their HIV prevention programmes to focus on those key populations that are at increased risk of HIV transmission. Providing effective HIV prevention services to these populations will be both more effective and more efficient in preventing HIV transmission than less-targeted and less-focused HIV prevention programmes for the general population.
- In the current economic crisis, there is need to ensure value for money in national HIV responses, e.g. by reducing costs of treatment. Small savings in the costs of treatment would ensure that the relatively modest amounts required for effective HIV prevention are available
- A clear strategy is needed to ensure the sustainability of future financing for national responses to HIV in Europe and Central Asia. This could include the European Union providing a financial mechanism to support HIV responses in low- and middle-income countries, rather than relying on the Global Fund to do this.
- There is a need to assess the declining levels of European funding to the global HIV response and its key institutions, such as the Global Fund.
- There remains 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 UNAIDS funding matrix to identify what changes, if any, would make it more applicable for the regional context.

Annex 1. Prevention funding

Beneficiary populations ranked in priority order by government and civil society respondents

Country	People who inject drugs		Men who have sex with men		Migrants		Prisoners		Sex workers		Other (1)		Other (2)	
	G	CS	G	CS	G	CS	G	CS	G	CS	G	CS	G	CS
Albania	1	1	3	3	-	-	4	4	5	5	2[a]	2[a]	-	-
Armenia	1	1	2	2	5	5	4	4	3	3	-	-	-	-
Azerbaijan [b]	1	-	4	-	5	-	2	-	3	-	-	-	-	-
Belarus	1	2	5	4	-	-	6	5	4	3	3[c]	1[d]	2[d]	1
Belgium	-	1	1	1	2	2	-	-	3	3	4[e]	4[e]	-	-
Bosnia and Herzegovina [f]	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Bulgaria	1	1	2	2	7	6	3	5	5	3	4[g]	4[a]	6[h]	7[i]
Czech Republic	2	2	1	1	5	5	4	4	3	3	-	-	-	-
Denmark	2	3	1	1	3	2	-	-	-	-	-	-	-	-
Estonia	1	1	4	4	-	-	2	2	3	3	-	-	-	-
Finland [b]	1	-	3	-	4	-	5	-	4	-	2[d]	-	4[e]	-
France	3	-	1	-	2	-	4	-	5	-	6[i]	-	-	-
Georgia	2	1	5	3	-	-	3	4	4	3	1[j]	5[k]	-	-
Germany	2	2	1	1	4	3	5	5	3	4	-	-	-	-
Greece[b]	2	-	1	-	3	-	5	-	4	-	-	-	-	-
Hungary	-	3	-	1	-	-	-	-	-	2	-	1	-	-
Iceland	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Ireland	-	2	-	1	-	-	-	-	-	-	-	3[l]	-	4[m]
Israel [b]	3	-	2	-	4	-	5	-	-	-	1[n]	-	1[o]	-
Italy[p]	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Kazakhstan	1	-	4	-	-	-	2	-	3	-	5[e]	-	6[i]	-
Kosovo*	1	-	3	-	5	-	4	-	2	-	-	-	-	-
Kyrgyzstan	1	-	4	-	5	-	2	-	3	-	-	-	-	-
Latvia	1	1	-	-	-	-	-	-	-	-	-	-	-	-
Lithuania[q]	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Luxembourg	1	1	2	2	3	2	4	2	5	2	-	2[d]	-	-
Macedonia	2	2	1	1	-	-	4	3	3	4	5[e]	5[e]	6[r]	6[r]
Malta[s]	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Moldova[t]	2	2	4	5	-	6	5	4	3	3	1[r]	1[r]	-	-
Montenegro	3	3	1	1	6	6	5	5	2	2	4[u]	4[u]	-	-
Netherlands	3	3	1	1	2	2	-	-	4	4	5[e]	5[e,d]	-	-
Norway	3	-	1	-	2	-	3	-	3	-	-	-	-	-
Poland[s]	-	1	-	-	-	-	-	-	-	-	-	2[d]	-	3[e]
Portugal	1	1	2	3	4	5	3	6	5	4	-	2[j]	-	-
Romania[p]	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Serbia	1	2	2	1	-	-	4	4	3	2	5[d]	3[k,a,v]	-	1[e]
Slovakia[p]	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Slovenia	2	2	1	1	-	-	4	4	-	-	3[d]	3[d]	-	-
Spain	1	1	2	2	4	3	5	5	3	4	6[e]	1[m]	7[k]	-
Sweden[b]	5	-	2	-	4	-	7	-	6	-	1[d]	-	3[e]	-
Switzerland	1	4	1	1	1	2	1	5	1	3	-	-	-	-
Tajikistan	1	1	3	3	5	5	4	4	2	2	-	6[j]	-	-
Ukraine[b]	-	-	-	-	-	-	-	-	-	-	1[e]	-	-	-
United Kingdom	1	3	1	1	1	2	-	-	-	-	1[j]	-	-	-
Uzbekistan	3	2	6	5	2	1	4	3	5	4	1[w]	-	-	-

**This designation is without prejudice to positions on status, and is in line with UNSCR 1244 and the ICJ Opinion on the Kosovo Declaration of Independence.*
G: Government; CS: Civil society
(a) Roma population
(b) Civil society reported prevention funding was not prioritised by most-affected population
(c) Working in enterprises
(d) Youth
(e) PWLHA
(f) Government and civil society respondents reported that all listed populations were at risk
(g) Roma population at risk
(h) Young people at risk
(i) French overseas areas
(j) Pregnant women
(k) Most at-risk adolescents
(l) Others
(m) Not specified
(n) Migrants from Ethiopia
(o) Tuberculosis cases
(p) Government and civil society reported prevention funding was not prioritised by most-affected population
(q) The government response identified 'drug users living with HIV/AIDS.' However, the population was not ranked; civil society reported prevention funding was not prioritised by most-affected population.
(r) Youth and general population
(s) Government reported prevention funding was not prioritised by most-affected population; civil society did not report
(t) Moldova intends to approve amendments to its National HIV/AIDS programme 2011–2015; the amended draft re-focuses priorities on key populations at risk and their sexual partners, particularly on people who inject drugs.
(u) Sailors
(v) Vulnerable children
(w) Total population

Annex 2. Data on HIV expenditure (EUR)

Country	Income level [a]	Overall HIV spending (€m)				HIV prevention spending (€m)				% HIV prevention spending on key populations				Population		Per capita spending on HIV prevention (€)			
		DD1	2009	2010	2011	DD1	2009	2010	2011	DD1	2009	2010	2011	DD1	DD2	DD1	2009	2010	2011
Albania	LM	-	-	-	-	-	-	-	-	-	-	-	-		2 831 741	-	-	-	-
Andorra	H	-	-	-	-	-	-	-	-	-	-	-	-		78 115	-	-	-	-
Armenia	LM	1.8	-	4.1	3.8	1.0	-	2.4	2.3	12	-	21	31	2 968 586	3 275 700	0.32	-	0.73	0.71
Austria	H	-	-	-	-	-	-	-	-	-	-	-	-		8 452 835	-	-	-	-
Azerbaijan	UM	1.7	-	6.7	10.0	0.6	-	3.7	4.3	-	-	3	18	8 177 717	9 235 100	0.08	-	0.41	0.47
Belarus	UM	-	-	16.3	16.4	-	-	10.6	8.5	-	-	16	22		9 457 500	-	-	1.12	0.89
Belgium	H	-	96.7	110.0	-	3.3[b]	5.3	5.3	-	13	-	-	-	10 403 951	10 839 905	0.31	0.49	0.49	-
Bosnia and Herzegovina	UM	-	-	-	-	0.3	-	-	-	3	-	-	-	4 590 310	3 868 621	0.05	-	-	-
Bulgaria	UM	4.9	7.9	8.0	9.1	2.1	4.3	3.4	3.6	21	18	32	28	7 262 675	7 364 570	0.29	0.59	0.46	0.48
Croatia	H	-	-	-	-	2.9	-	-	-	14	-	-	-	4 491 543	4 290 612	0.65	-	-	-
Czech Republic	H	-	51.2[c]	-	-	0.6	-	7.0	7.0	97	-	97	97	10 220 911	10 507 566	0.06	-	0.67	0.67
Cyprus	H	-	-	-	-	0.0	-	-	-	-	-	-	-	792 604	838 897	0.06	-	-	-
Denmark	H	-	-	-	-	8.7	-	-	-	-	-	-	-	5 484 723	5 584 758	1.59	-	-	-
Estonia	H	12.4	-	12.3	-	4.1	-	3.4	-	36	-	43	-	1 307 605	1 294 236	3.13	-	2.59	-
Finland	H	-	-	-	-	-	-	-	-	-	-	-	-		5 417 410	-	-	-	-
the former Yugoslav Republic of Macedonia	UM	3.0	3.5	3.7	-	2.4	2.8	2.8	-	70	63	65	-	2 061 315	2 059 794	1.18	1.34	1.37	-
France	H	-	-	-	-	35.0	-	-	-	-	-	-	-	64 057 790	65 350 000	0.55	-	-	-
Georgia	LM	4.1	7.8	10.4	9.9	2.0	3.6	5.9	5.4	40	57	60	60	4 630 841	4 497 600	0.43	0.81	1.31	1.21
Germany	H	-	-	-	-	25.2	-	-	-	-	-	-	-	82 369 548	81 859 000	0.31	-	-	-
Greece	H	-	-	-	-	9.5[d]	-	-	-	-	-	-	-	10 722 816	10 787 690	13.32	-	-	-
Hungary	H	-	-	-	-	1.6	-	-	-	-	-	-	-	9 930 915	9 957 731	0.16	-	-	-
Iceland	H	-	-	-	-	-	-	-	-	-	-	-	-		320 060	-	-	-	-
Ireland	H	-	-	-	-	-	-	-	-	-	-	-	-		4 588 252	-	-	-	-
Israel	H	-	-	-	-	2.4	-	-	-	-	-	-	-	7 112 359	7 890 600	0.33	-	-	-
Italy	H	-	-	-	668.2	-	-	-	0.2	-	-	-	0		60 820 787	-	-	-	-
Kazakhstan	UM	13.2	-	-	23.8	2.5	-	-	4.9	1	-	-	45	15 340 533	16 793 000	0.16	-	-	0.29
Kosovo	LM	-	-	-	-	-	-	-	-	-	-	-	-		1 739 825	-	-	-	-
Kyrgyzstan	L	6.2	8.7	9.1	3.9	5.1	4.0	4.0	0.9	9	45	41	53	5 356 869	5 477 600	0.94	0.72	0.74	0.17
Latvia	UM	4.3	4.8	4.3	4.9	0.7	1.6	1.0	1.6	34	1	5	0	2 245 423	2 070 371	0.33	0.75	0.48	0.77
Liechtenstein	H	-	-	-	-	-	-	-	-	-	-	-	-		36 476	-	-	-	-
Lithuania	UM	-	-	-	2.8	-	-	-	0.3	-	-	-	15		3 182 800	-	-	-	0.09

Country	Income level [a]	Overall HIV spending (€m)				HIV prevention spending (€m)				% HIV prevention spending on key populations				Population		Per capita spending on HIV prevention (€)			
		DD1	2009	2010	2011	DD1	2009	2010	2011	DD1	2009	2010	2011	DD1	DD2	DD1	2009	2010	2011
Luxembourg	H	-	-	-	-	1.8	-	-	-	-	-	-	-	486 006	511 800	3.69	-	-	-
Malta	UM	-	-	-	-	0.0	-	-	-	-	-	-	-	403 532	417 617	0.04	-	-	-
Moldova	LM	6.0	7.6	8.6	9.7	4.6	4.4	4.2	4.4	5	10	17	18	4 324 450	3 559 500	1.07	1.24	1.17	1.24
Monaco	H	-	-	-	-	-	-	-	-	-	-	-	-		35 000	-	-	-	-
Montenegro	UM	-	-	-	-	-	-	-	-	-	-	-	-		626 029	-	-	-	-
Netherlands	H	-	-	-	-	11.0	-	-	-	-	-	-	-	16 645 313	16 740 554	-	-	-	-
Norway	H	-	-	-	-	2.3	-	-	-	-	-	-	-	4 644 457	5 029 600	0.50	-	-	-
Poland	H	32.5	34.1	49.0	55.3	3.2	2.1	1.2	1.1	65	5	0	0	38 500 696	38 511 824	0.08	0.05	0.03	0.03
Portugal	H	-	7.5	137.7	150.6	3.7	5.5	5.5	4.0	-	47	52	47	10 676 910	10 561 614	0.35	0.52	0.52	0.38
Romania	UM	58.6	20.0	15.6	19.3	4.1	0.8	1.2	1.7	-	14	38	36	22 246 862	19 042 936	0.18	0.04	0.06	0.09
Russia	UM	-	-	-	-	48.3	-	-	-	-	-	-	-	140 702 094	127 550 000	0.34	-	-	-
San Marino	H	-	-	-	-	0.0	-	-	-	-	-	-	-	31 006	32 380	0.57	-	-	-
Serbia	UM	-	-	-	-	-	-	-	-	-	-	-	-		7 120 666	-	-	-	-
Slovakia	H	-	-	-	-	-	-	-	-	-	-	-	-		5 445 324	-	-	-	-
Slovenia	H	-	-	-	-	-	-	-	-	-	-	-	-		2 057 780	-	-	-	-
Spain	H	-	-	-	645.8	13.9	-	-	16.0	-	-	-	0	40 491 051	46 163 116	0.34	-	-	0.35
Sweden	H	-	-	-	-	15.8	-	-	-	-	-	-	-	9 045 389	9 507 324	1.75	-	-	-
Switzerland	H	-	-	-	-	4.5	-	-	4.8	-	-	-	28	7 581 520	7 952 600	0.59	-	-	0.60
Tajikistan	L	4.1	-	12.4	10.4	2.0	-	5.5	3.8	11	-	35	37	7 211 884	7 800 000	0.27	-	0.71	0.49
Turkey	UM	-	-	-	-	-	-	-	-	-	-	-	-		74 724 269	-	-	-	-
Turkmenistan	UM	-	-	-	-	-	-	-	-	-	-	-	-		5 170 000	-	-	-	-
Ukraine	LM	43.1	47.1	59.5	-	13.4	10.8	13.2	-	43	30	30	-	45 994 287	45 565 909	0.29	0.24	0.29	-
United Kingdom	H	-	-	-	-	26.2	-	-	-	-	-	-	-	60 943 912	62 262 000	0.43	-	-	-
Uzbekistan	LM	-	-	9.5	12.5	-	-	2.6	3.3	-	-	3	32		29 123 400	-	-	0.09	0.11

There is a great deal of variation over the type of data reported between and within countries. Because of this, extreme caution should be exercised in making comparisons between countries or within a country over time.

Figures from the first round of Dublin reporting were presented in US$m. These have been converted to €m at the following exchange rates: 2005 – 1 210; 2006 – 1 278; 2007 – 1 354; 2008 – 1 575; 2009 – 1402; 2010 – 1 229; 2007/8 – 1 460; 2008/9 – 1 392.

DD1: Dublin Declaration report 1

(a) As classified by the World Bank – L = Low; LM = Lower middle; UM = Upper middle; H = High.

(b) Belgium provided different spending figures for 2009 in the two rounds of Dublin reporting. Therefore, Belgium's figures were not included in the trend analysis

(c) Approximately

(d) Greece updated DD1 (2007-2008) figures in 2012

Annex 3. Countries included in Dublin Declaration monitoring

Nr	Country	Nr	Country	Nr	Country
1	Albania	20	Greece	39	Poland
2	Andorra	21	Hungary	40	Portugal
3	Armenia	22	Iceland	41	Romania
4	Austria	23	Ireland	42	Russian Federation
5	Azerbaijan	24	Israel	43	San Marino
6	Belarus	25	Italy	44	Serbia
7	Belgium	26	Kazakhstan	45	Slovak Republic
8	Bosnia and Herzegovina	27	Kosovo	46	Slovenia
9	Bulgaria	28	Kyrgyzstan	47	Spain
10	Croatia	29	Latvia	48	Sweden
11	Cyprus	30	Liechtenstein	49	Switzerland
12	Czech Republic	31	Lithuania	50	Tajikistan
13	Denmark	32	Luxembourg	51	Turkey
14	Estonia	33	Malta	52	Turkmenistan
15	Finland	34	Moldova	53	Ukraine
16	the former Yugoslav Republic of Macedonia	35	Monaco	54	United Kingdom
17	France	36	Montenegro	55	Uzbekistan
18	Georgia	37	Netherlands		
19	Germany	38	Norway		