SPECIAL REPORT

Background and methods

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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See Annex 1 for further acknowledgements

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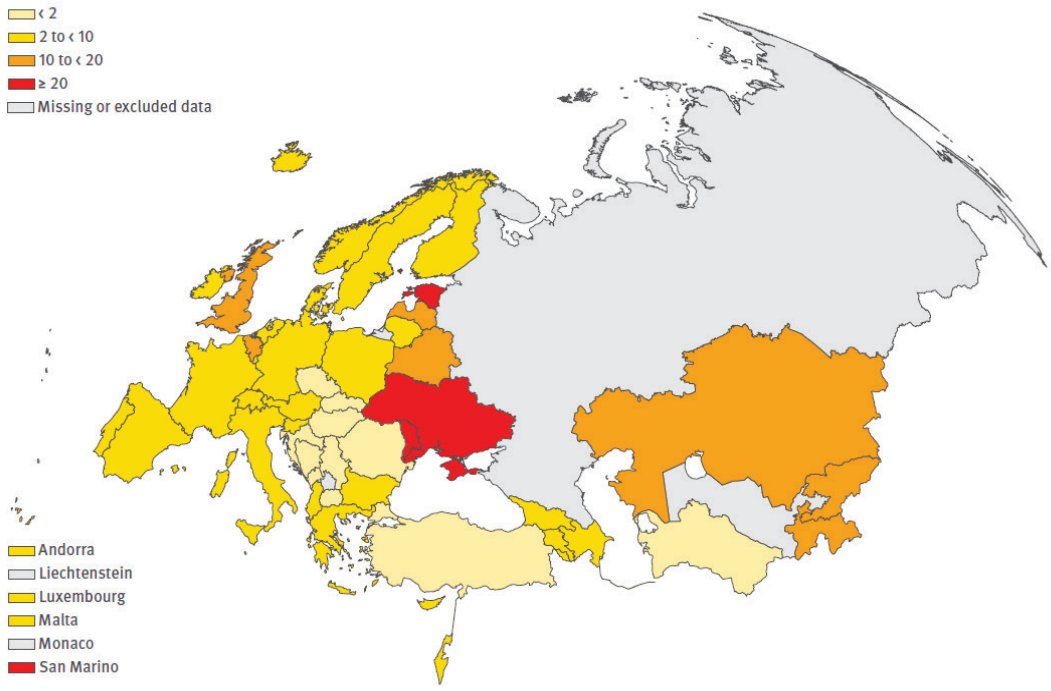
Abbreviations

ART	Antiretroviral therapy
ECDC	European Centre for Disease Prevention and Control
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU/EEA	European Union/European Economic Area
EU/EFTA	European Union/European Free Trade Association
GARP	Global AIDS Response Progress
MSM	Men who have sex with men
NCPI	National Commitments and Policies Instruments
NGO	Non-governmental organisation
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
UNICEF	United Nations Children's Fund
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organization

1. HIV in Europe and Central Asia

HIV infection is of major public health importance in Europe. In 2011, 53 974 HIV diagnoses were reported by 50 of the 53 countries in the WHO European Region[i], of which 28 038 were reported by the countries in the European Union and European Economic Area (EU/EEA)[ii]. The surveillance data suggest that HIV transmission continues in many countries, with an overall rate of 7.6 diagnoses per 100 000 population for the WHO European Region and 5.7 in the EU/EEA. The main transmission mode varies by geographical area[iii], illustrating the wide diversity in the epidemiology of HIV in Europe; heterosexual transmission is the main mode of transmission in the entire WHO European Region and sexual transmission among men who have sex with men (MSM) is the most common mode in the EU/EEA.

Figure 1. HIV infections per 100 000 population, reported for 2011



Source: European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2011. Stockholm: European Centre for Disease Prevention and Control; 2012.

[i] ECDC and WHO Regional Office for Europe jointly coordinate HIV/AIDS surveillance in the 53 countries that constitutes the WHO European Region. For the Dublin Declaration on Partnership to fight HIV/AIDS, 55 countries are committed to report progress. In addition to the 53 countries that make up the WHO European Region, Kosovo and Liechtenstein make up the 55 countries.

[ii] European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2011. Stockholm: European Centre for Disease Prevention and Control; 2012.

[iii] *The WHO European Region comprises:

The West, 23 countries: Andorra, Austria (EU), Belgium (EU), Denmark (EU), Finland (EU), France (EU), Germany (EU), Greece (EU), Iceland (EFTA), Ireland (EU), Israel, Italy (EU), Luxembourg (EU), Malta (EU), Monaco, the Netherlands (EU), Norway (EFTA), Portugal (EU), San Marino, Spain (EU), Sweden (EU), Switzerland (EFTA), United Kingdom (EU).

The Centre, 15 countries: Albania, Bosnia and Herzegovina, Bulgaria (EU), Croatia, Cyprus (EU), Czech Republic (EU), Hungary (EU), the Former Yugoslav Republic of Macedonia, Montenegro, Poland (EU), Romania (EU), Serbia, Slovakia (EU), Slovenia (EU), Turkey.

The East, 15 countries: Armenia, Azerbaijan, Belarus, Estonia (EU), Georgia, Kazakhstan, Kyrgyzstan, Latvia (EU), Lithuania (EU), Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine, Uzbekistan.

Since the beginning of the HIV epidemic, a total of almost 780 000 HIV cases have been reported to the WHO Regional Office for Europe and ECDC. Eleven percent of HIV diagnoses in 2011 were reported among 15–24-year-olds and the male-to-female ratio (M/F) was 2.0. Most frequently, reported cases were due to heterosexual transmission (46%), although the picture is more heterogeneous at sub-regional level, illustrating the wide diversity in the epidemiology of HIV in Europe. Twenty per cent of the HIV cases were diagnosed in people who inject drugs (PWID) and 22% in MSM. One per cent of the new infections were due to mother-to-child transmission (MTCT) and other transmission modes (nosocomial infection, transfusion or use of other blood products); for 12% of cases the transmission mode was reported as unknown.

In the West, sexual transmission between men remains the main transmission mode, followed by heterosexual transmission, together accounting for almost 80% of all HIV cases in 2011. In the Centre, levels of HIV remain low and stable, although there is evidence of increasing sexual transmission between men in several countries. In 2011 there was a marked increase in the number of HIV diagnoses in PWID compared with 2010, due to an outbreak in Romania. In the East, the number of HIV diagnoses has continued to increase. Heterosexual contacts, followed by PWID, are reported to be the dominant modes of transmission. PWID-related heterosexual transmission is known to be of significant importance, but the proportion of independent versus PWID-related heterosexual transmission is unknown as information on the probable source of infection is missing for the majority of cases. In 2011 there was a marked increase in the number of HIV cases among PWID compared with 2010, due to outbreaks in Greece and Romania.

The rate of HIV diagnoses per 100 000 population increased by 15% between 2004 and 2011, from 6.6 (42 189 cases) to 7.6 in 2011 (53 974 cases) among the 50 countries that reported consistently. Trends by transmission mode show a consistent increase as well: the number of cases due to heterosexual transmission increased by 25%; among MSM by 27%; among PWID by 15% and the number of cases due to MTCT has increased by 42%.

In 2011, 28 countries in the WHO European Region provided information on CD4 cell count at the time of diagnosis for 16 539 (31%) cases in 2011. Half of these cases were reported as late presenters (CD4 cell count <350/mm^3), including 29% of cases with advanced HIV infection (CD4 <200/mm^3).

In 2011, 10 923 cases of AIDS were reported by 49 countries. Among the 49 countries, which all reported consistently, the overall number of reported AIDS cases declined from 12 940 cases (1.9 per 100 000 population) in 2004 to 10 923 cases (1.5 per 100 000 population) in 2011. However, the number of AIDS cases in eastern Europe is increasing with no sign of stabilising.

Conclusions

Surveillance results indicate that the number of people living with HIV in Europe is increasing and that HIV is highly concentrated in key populations, such as MSM, PWID, and people originating from high-endemic countries, mainly Sub-Saharan Africa. The most recent increase of HIV among PWID indicated that even low numbers in the EU/EEA and WHO west European region can rapidly evolve into an outbreak when public health interventions are insufficient. Although the number of countries conducting enhanced HIV surveillance and reporting surveillance data at the European level has gradually increased over time, the overall picture is still incomplete; in 2011, 50 of the 53 countries submitted their data. Data quality and completeness of such key variables as transmission mode and CD4 cell count at time of diagnosis are still to be improved in many countries. This is of utmost importance to be able to monitor the HIV epidemic and the response to HIV, in particular the access to and uptake of HIV testing services. The relatively high proportion of late diagnoses in many countries indicates a delay in HIV testing and many people are already eligible for treatment when they are diagnosed. The high and increasing number of AIDS cases, particularly in the East, is indicative of low treatment coverage, delayed initiation of life-saving HIV treatment and late HIV diagnosis.

2. Commitments to combat HIV/AIDS in Europe

Regional commitments

HIV is a political priority for the European Union and the countries of Europe and Central Asia. This is reflected in a number of declarations adopted during the past decade. These include the 2004 'Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia', the 2004 'Vilnius Declaration on Measures to Strengthen Responses to HIV/AIDS in the European Union and in Neighbouring Countries[i]', and the 2007 'Bremen Declaration on Responsibility and Partnership – Together Against HIV/AIDS'[ii]. These declarations, and others such as the UNGASS 'Declarations of Commitment in 2001 and 2006' and the 2011 Political Declaration[iii], embody the commitment of countries to act on HIV and AIDS and to reach specific targets, including ensuring universal access to HIV prevention, treatment, care and support.

The high priority given to HIV is also reflected in European Commission policies and plans, including the Communications on Combating HIV/AIDS in the European Union and Neighbouring Countries and related Action Plans for 2006–2009 and 2009–2013. The objectives set out in the 2009–2013 Communication are to:

- reduce new HIV infections across all European countries by 2013
- improve access to prevention, treatment, care and support
- improve the quality of life of people living with, affected by, or most vulnerable to, HIV and AIDS in the European Union and neighbouring countries.

The Communication emphasises the importance of political leadership, involvement of civil society and people living with HIV, human rights, and universal access to services. The action plan focuses on: political commitment and the involvement of a wide range of stakeholders; HIV prevention; action targeting priority regions and populations; improving research and surveillance; and monitoring and evaluation.

In 2012 ECDC published the interim report on implementation of the EU Communication and Action Plan[iv]. This interim report aims to capture the activities of a range of actors including: Commission agencies and services; international agencies; and the activities of civil society organisations which result from Commission policies; influence, funding and other actions. In 2013 ECDC will publish the final report on implementation of the EU Communication and Action Plan[v].

The Dublin Declaration

Representatives of governments from Europe and Central Asia met at a conference 'Breaking the Barriers – Partnership to fight HIV/AIDS in Europe and Central Asia' in Dublin on 23–24 February 2004. The outcome of this conference, the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia, embodied countries' commitments in a set of 33 actions (see Annex 2). Action 33 of the declaration calls on the European Union and others to monitor progress in implementing the Dublin Declaration:

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

[i] Vilnius Declaration on Measures to Strengthen Responses to HIV/AIDS in the European Union and in Neighbouring Countries. Available at: http://ec.europa.eu/health/ph_threats/com/aids/docs/ev_20040916_rd03_en.pdf

[ii] Bremen Declaration on Responsibility and Partnership – Together Against HIV/AIDS. 2007. Available at: http://ec.europa.eu/health/ph_threats/com/aids/docs/bremen_declaration_en.pdf

[iii] Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS. UNAIDS 2011. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_un_a-res-65-277_en.pdf

[iv] European Centre for Disease Prevention and Control. Monitoring implementation of the European Commission Communication and Action Plan for combating HIV/AIDS in the EU and neighbouring countries, 2009–2013. Stockholm: ECDC; 2012.

[v] 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

Monitoring the Dublin Declaration

With funding from the German Ministry of Health, the WHO Regional Office for Europe, UNAIDS and civil society organisations published a one-off progress report – 'Progress on Implementing the Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia' – in August 2008.

At the end of 2007, the European Commission requested that ECDC develop a framework to monitor the Dublin Declaration on a more systematic basis. In April 2008, ECDC presented a proposed monitoring framework to the European Commission think tank on HIV and AIDS. The objective was to produce a country-driven, indicator-based progress report, harmonising indicators with existing monitoring frameworks, notably UNGASS and European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) indicators, and with the EU Communication and Action Plan, 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 November 2008, ECDC initiated the process of monitoring the Dublin Declaration with guidance from an Advisory Group comprising representatives from national governments, civil society, EMCDDA, UNAIDS and WHO. Data collection and analysis took place between November 2008 and June 2010. The progress report produced by ECDC in 2010[i] reported on progress in implementing the Dublin Declaration and the extent to which countries had met the commitments made in 2004. In addition, it addressed gaps in 2008 the UNGASS data, provided information on data quality and reporting issues in Europe and Central Asia to inform the UNGASS review, and helped to improve UNGASS reporting in the region. The report was based on four principles:

- building on existing monitoring processes (i.e. UNGASS)
- ensuring that indicators are streamlined and simplified so that information produced is useful and readily available
- ensuring that indicators are relevant to the regional context
- ensuring that data collection is harmonised with other monitoring exercises

A total of 38 indicators were included. Of these, 23 were existing UNGASS indicators, three were slight modifications of existing UNGASS indicators and three were based on UNGASS indicators but involved some additions. Nine other indicators were also included. A number of indicators were based on the 2010 UNGASS National Composite Policy Index (NCPI), with some questions answered by government and some by civil society. The 2010 data collection exercise used a questionnaire that was tailored to each country so that they were only asked to report data for indicators where this had not been previously submitted to either UNAIDS or EMCDDA.

[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.

3. Methods

The 2010 Dublin progress report highlighted the need for a regional approach to reporting, based on indicators that are relevant to the region, and to reduce the burden on countries by combining multiple reporting mechanisms. In response, ECDC, UNAIDS and WHO and UNICEF took steps to harmonise reporting processes. For the 2012 reporting round, Dublin reporting was harmonised with Global AIDS Response Progress (GARP) reporting (formerly known as UNGASS reporting). Between 1 January 2012 and 31 March 2012, countries submitted their responses through UNAIDS using a joint online reporting tool. This tool included all indicators for GARP, Dublin and Health Sector Response reporting, and made clear which indicators were to be used by which agency for the purposes of their own reporting. Countries also had the option to state that a topic or indicator is not relevant.

For Dublin Declaration reporting, countries were requested by ECDC to report on a set of 24 regionally relevant indicators and measures that were agreed with the Advisory Group. These included 18 GARP indicators and measures, including the UNAIDS National Commitments and Policy Instrument (NCPI)[i], five indicators of relevance to the region not covered by GARP reporting – three relating to migrants from countries with generalised epidemics, one relating to prisoners and one to late diagnosis of HIV – and a European Supplement to the NCPI[ii].

The main purpose of the NCPI is to collect qualitative data that are not captured by the online reporting tool. For Dublin reporting, ECDC augmented the online reporting tool with a European supplement to the UNAIDS NCPI, which addressed issues of specific relevance in Europe and Central Asia, including questions on migrants and treatment as prevention, as well as focused questions for government and civil society respondents on political leadership, the role of civil society and stigma and discrimination.

ECDC hosted a workshop 25–27 January 2012 in Lisbon, in collaboration with the Portuguese Ministry of Health and EMCDDA, which was attended by representatives from 48 countries in the Europe and Central Asia region, the European Commission, EMCDDA, UNAIDS, WHO and civil society, and other monitoring and evaluation experts. The workshop updated countries on global and regional reporting processes, focusing on GARP, Dublin Declaration and Health Sector Response reporting, and the harmonised regional reporting system to be used in 2012. It provided participants with technical guidance on use of the joint online reporting tool, including practical sessions to enable country representatives to practice using the tool, and with the European supplement to the NCPI. The supplement was also available to download from the UNAIDS online reporting tool.

Responses were received from 51 of 55 countries (93%)[iii] (see Annex 3). This response rate was slightly higher than for 2010. In 2010, countries were not restricted to supplying information of a particular type. If they did not have information available for a particular indicator, they were encouraged to submit any data they had that were relevant to the issue being measured. However, harmonisation with the GARP reporting process in 2012 did not provide this flexibility, as there was no scope to attach files to the online reporting tool. Countries were requested to send additional reports and studies separately to UNAIDS or ECDC but few took this opportunity.

In 2012, instead of producing one overall report, information provided by countries has been used to produce 10 thematic reports. In addition to this background report, these reports cover the following topics: leadership and resources, civil society, people who inject drugs, men who have sex with men, sex workers, migrants, prisoners, treatment care and support, stigma and discrimination, and combined reporting.

In addition to the thematic reports, seven evidence briefs will be published covering the following subjects: leadership and resources, civil society, treatment, people who inject drugs, men who have sex with men, migrants and prisoners. An eighth evidence brief will be produced, summarising the whole series.

The 2012 thematic reports are based on the same principles as the 2010 report and draw primarily on:

- data reported by countries through UNAIDS for regionally relevant GARP indicators
- data submitted by countries in response to the UNAIDS NCPI
- data submitted by countries to the European supplement to the NCPI
- additional data and information submitted by countries in narrative reports to UNAIDS and in response to the European supplement to the NCPI.

[i] For GARP reporting, three new indicators were added and five were modified. Of these, the new indicator on distribution of syringes to people who inject drugs and the modified indicator for preventing mother-to-child transmission and the modified NCPI were included in the Dublin reporting set. Indicators that were deleted from GARP reporting included the previous PWID prevention coverage indicator and those related to blood safety, knowledge of prevention of HIV transmission among most-at-risk populations and life-skills-based HIV education in schools

[ii] Prior to the 2012 round of reporting, NCPI stood for National Composite Policy Index. As part of the revisions to the UNAIDS biennial reporting process, the name was changed to National Commitments and Policy Instrument.

[iii] Countries that did not respond were Liechtenstein, San Marino, Turkey and Turkmenistan.

GARP and UNAIDS NCPI data, and country narrative reports, were accessed from the UNAIDS database. Data and additional information from the European NCPI supplement, which were submitted separately to ECDC, was entered into a secure Filemaker Pro database developed expressly for this purpose.

Data from additional sources were also used where countries agreed to their use. A key principle of Dublin reporting is that ECDC does not request countries to provide data that have already been reported. The thematic reports therefore drew on the following sources of data already reported by countries:

- data reported to ECDC on late diagnosis
- data reported to EMCDDA on people who inject drugs, for example, on the proportion of problem opiate users receiving substitution therapy in the community and in prison settings
- data on HIV prevention programme coverage for MSM from responses to the 2010 European MSM Internet Survey (EMIS)[i].

Countries were provided with country data sheets by ECDC and EMCDDA and asked to decide whether to enter these data into the online reporting tool or to use other data for GARP and Dublin reporting. Late diagnosis data reported to ECDC were included in the thematic report on treatment and care for countries that reported on and/or agreed to the use of these data. Data reported to EMCDDA were included in the thematic reports on people who inject drugs and prisoners for countries that reported on and/or agreed to the use of these data.

The Advisory Group agreed that 2012 Dublin Declaration reporting would draw on EMIS programme coverage data, where this was available and countries agreed to their use. The survey collected data from 38 countries[ii] in 2010. Since EMIS is not official country data, the NCPI European supplement included a specific question asking countries if EMIS data could be used. European MSM Internet Survey data were included in the thematic report on MSM for the 25 countries[iii] that agreed.

Additional data sources were also used to analyse international funding provided by countries for the thematic report on HIV and AIDS financing.

Each thematic report presents the main findings, discusses key issues, assesses progress since 2010 and provides a summary of issues for future action. As appropriate, data reported by countries in both 2012 and 2010 are included and developments and trends between the two reporting rounds are highlighted. The thematic reports were reviewed by the Advisory Group and, in addition, all countries that reported in 2012 were given the opportunity to review and validate the data presented for their country.

[i] EMIS 2010: The European Men-Who-Have-Sex-With-Men Internet Survey. Findings from 38 countries. European Centre for Disease Prevention and Control. www.ecdc.europa.eu

ii Austria, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, the former Yugoslav Republic of Macedonia, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Moldova, the Netherlands, Norway, Poland, Portugal, Romania, Russia, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, Ukraine and the United Kingdom.

[iii] Belarus, Belgium, Bosnia and Herzegovina, the Czech Republic, Denmark, Estonia, Finland, the former Yugoslav Republic of Macedonia, France, Germany, Greece, Latvia, Lithuania, Luxembourg, Moldova, the Netherlands, Norway, Poland, Portugal, Slovakia, Spain, Sweden, Switzerland, Ukraine and the United Kingdom. Moldova requested that both EMIS and GARP data be included.

4. Limitations

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

Data comparability is addressed within the monitoring process by the use of the standardised indicators. While these have been designed to capture and describe the relevant information on the issue measured, compromises due to data availability and comparability cannot be completely avoided. ECDC remains aware that for some of the indicators, especially the economic and resource indicators (Financial Resources for National Responses to HIV and AIDS), serious limitations remain in the ability to capture the full societal response of many countries. In many cases, it is likely that reported figures underestimate the role of integrated services and preventive measures in sectors outside the health services.

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

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

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

Reliability and validity of data presented in the report are directly dependent on the reporting parties, as ECDC has no possibility to systematically verify provided information from secondary sources, but relies on the countries to report accurate data and information. In the review process, an effort has been made to identify potential technical mistakes within the reported information and countries were asked to verify identified anomalies. The inclusion of both governments and civil society in the monitoring process is intended to improve the representativeness and completeness of the process, but is dependent on the level of involvement of both parties.

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

The information below is a collation of the information related to the specific limitations provided in each of the topical reports.

Leadership and resources

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

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.

Countries were also requested to submit financial data using the national funding matrix developed by UNAIDS[ii]. 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.

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. However, several European countries and institutions continue to question the usefulness and relevance of the UNAIDS funding matrix. In particular, there are concerns that:

- tracking finances centrally in countries with highly decentralised systems may not be practical or politically acceptable
- tracking spending on HIV and AIDS in countries with integrated health systems may not be feasible
- 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
- such data are not currently routinely tracked by EU countries, indicating that countries do not perceive a need for this information.

Nevertheless, no credible alternative has yet been developed or presented.

All the financial data are self-reported by countries. It is extremely likely that there are variations, both between countries and within countries over time, related to the specific expenditures that are included and how they are classified. Therefore, extreme caution should be exercised in making comparisons between countries and within countries over time.

Data related to countries' contribution to international HIV financing is, as in the previous round of Dublin reporting, taken from data published from other sources[iii].

[i] Prior to the 2012 round of reporting, the acronym NCPI stood for National Composite Policy Index. As part of the revisions to the UNAIDS biennial reporting process, the name was changed to National Commitments and Policy Instrument.

[ii] UNAIDS. Global AIDS Response Progress Reporting 2012. Available at: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/JC2215_Global_AIDS_Response_Progress_Reporting_en.pdf

[iii] In particular, this includes an annual assessment of global HIV spending published by Kaiser Family Foundation and UNAIDS, and details of funding received by the Global Fund and UNAIDS as published in their websites.

People who inject drugs

Countries were asked to report on a number of global indicators related to PWID. These included HIV prevalence among PWID and measures of rates of HIV testing, condom use and use of sterile injecting equipment.

One challenge facing HIV prevention programmes for PWID is how to measure their coverage and scale. Previously, UNAIDS recommended a composite UNGASS indicator which measured whether a person had received a condom and injecting equipment in the last year plus whether or not they knew where to get an HIV test. Since the last round of Dublin reporting, this indicator has been reviewed and removed from the set of indicators now being used for Global AIDS Response Progress reporting. It has been replaced by an indicator which measures the number of syringes distributed by needle and syringe programmes per year per person who injects drugs, an indicator that has been agreed upon by EU Member States and collected by the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA). Such a change has long been advocated by the advisory group overseeing the Dublin reporting process. However, other relevant coverage indicators proposed by the group and currently tracked in Europe, such as the EMCDDA indicator on the proportion of problem opiate users receiving substitution therapy, have not yet been incorporated into the indicator set for Global AIDS Response Progress reporting.

The EMCDDA also produced country data sheets for a total of 29 countries. These sheets drew on data held by EMCDDA based on reports submitted by its network of national focal points (Reitox). These sheets included data on the following activities among PWID: numbers of syringes distributed; reported condom use; safe injecting practices; rates of HIV testing among; HIV prevalence among; and scale of opioid substitution therapy (OST). Data from these sheets has been included in this report.

In the European supplement to NCPI, countries were invited to submit information not yet reported to EMCDDA or UNAIDS and to submit any additional information considered relevant. A number of countries did so, particularly through their narrative reports.

One challenge faced in a report of this nature is that there is no easy way of tracking HIV incidence among PWID. HIV prevalence is used to provide some insight into the extent of ongoing HIV transmission among PWID in the region. However, it has limitations because it is not only affected by the number of people acquiring an HIV infection but also by other factors such as increased survival of people living with HIV. Other proxies of HIV incidence among PWID have been proposed, such as the number of diagnoses of HIV among PWID and/or HIV prevalence among young people (<25 years) who inject drugs. However, each of these proxies of HIV incidence has its own limitations. The number of reported cases is only a reasonable proxy of HIV incidence if rates of diagnosis are high, if diagnosis occurs promptly, and if under-reporting and reporting delays are limited. HIV prevalence among young people can be used as a proxy for HIV incidence if it can be assumed that young people are a reasonable proxy for new injectors. This is not the case in all countries. HIV prevalence among new injectors would be a better proxy of HIV incidence but few countries have such data.

There is a great deal of variation over the type of data reported between and within countries. Surveys may have been conducted in different ways and/or in different locations. Countries may have used different methods to calculate data for the same indicator. Countries may have used different ways to calculate the population sizes used as denominators, e.g. to calculate the number of syringes distributed per person who injects drugs. In addition, there may be variation in what countries include in the numerator for this indicator, e.g. whether or not syringes sold and/or distributed for free through pharmacies are included in numbers reported by countries. Because of this, caution should be exercised in making comparisons between countries or within a country over time.

In addition to free or subsidised provision through needle and syringe programmes, syringes are also available for sale from pharmacies, which impacts on coverage of need for clean syringes. Although the number of syringes distributed annually per person who injects drugs is a useful measure, it does not provide, in isolation, a full picture of HIV prevention service coverage for PWID.

There are difficulties in interpreting data on rates of HIV testing among PWID. This is partly because it is unclear, in general, how frequent HIV testing should be among PWID. In addition, there are specific issues in countries with very high rates of HIV prevalence among PWID, e.g. in Estonia. For people who know their HIV status, there is no need to repeat the HIV test. As a result, overall rates of HIV testing among PWID may be low although testing rates may be much higher among those who previously tested negative or those who have not been tested before.

Men who have sex with men

Data on HIV prevalence among MSM are based on country reports to UNAIDS on the Global AIDS Response Progress (GARP) indicator. Data sources were diverse and included integrated bio-behavioural surveys (IBBS) and behavioural surveys, sentinel surveillance, facility data, and, for 12 countries, data from the 2010 EMIS survey. Some countries noted that data reported were not nationally representative, mostly because of small sample size.

Countries highlighted the value of the EMIS data but also commented on the limitations of the methodology, in particular that data are based on self-reporting by a self-selected sample of MSM and that HIV-positive men may be over-represented in the sample. In addition, for example, Spain noted that limited internet access – 43% of Spanish households do not have internet access – may mean that rural, low-income and migrant MSM are under-represented. The survey also recruited MSM through gay websites, which are typically used for seeking sexual partners, so users of these sites may have different characteristics from MSM who do not use them. Norway also commented that EMIS was not representative of all MSM; 'most of the respondents were less than 35 years of age and lived in larger cities, some regions were over-represented while others were under-represented, and very few MSM originating from countries outside Europe participated in the survey.'

A comparison of reported data from the 30 countries that reported in both 2010 and 2012 indicates that prevalence among MSM has increased in the majority of these countries. There are two important caveats. First, prevalence would be expected to increase, even if the incidence of new infections is low, as access to ART increases and MSM with HIV live longer. Second, differences in data sources mean that comparisons between the two reporting rounds should be interpreted with caution. This applies in particular to reported prevalence rates in 2012 that are based on EMIS data.

The GARP reporting indicator for HIV testing relates to the percentage of MSM who have had an HIV test in the last 12 months and who know the result. One of the limitations of this indicator is the 12-month timeframe. In addition, some countries commented that MSM who engage in high-risk sexual behaviour may be tested for HIV more frequently. A number of countries use different measures. For example, collecting data on whether or not MSM have ever been tested for HIV rather than on testing in the last 12 months.

Data on HIV prevention programme coverage for MSM have been collected through previous rounds of UNGASS reporting using a composite indicator. This indicator reflects limited services: it considers someone to be covered by a prevention programme if he has received condoms in the last year and knows where to get an HIV test. Although acknowledged to be inadequate, this indicator was retained by UNAIDS for 2012 GARP reporting in the absence of agreement about a better way of measuring coverage of HIV prevention interventions for MSM.

However, countries have questioned the relevance of the indicator in the European region and, consequently, the value of the data. The ECDC Advisory Group therefore agreed that the 2012 Dublin Declaration reporting round would draw on programme coverage data from EMIS, where this was available and countries agreed to their use. Although EMIS data have not been officially accepted as an alternative to the GARP indicator, the survey collected data from more than 180 000 respondents in 38 countries[i] in 2010 and provides a comprehensive data set. EMIS considered:

- HIV-negative MSM to be covered by HIV prevention programmes if they were 'very confident' or 'quite confident' to get an HIV test and had been reached by MSM-specific HIV prevention in the last 12 months and had refrained from having unprotected anal sex in the last 12 months because of non-availability of condoms.
- HIV-positive MSM to be covered by HIV prevention programmes if they had monitored their HIV infection in the last six months and had been reached by MSM-specific HIV prevention in the last 12 months and had refrained from having unprotected anal sex in the last 12 months because of non-availability of condoms.

[i] Austria, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, the former Yugoslav Republic of Macedonia, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Moldova, the Netherlands, Norway, Poland, Portugal, Romania, Russia, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, Ukraine and the United Kingdom.

In the European supplement to the NCPI, government respondents were asked if they agreed to ECDC using EMIS data for their country in the 2012 Dublin Declaration progress report. EMIS data have therefore been included in this report for the 26 countries[i] that agreed. Three of the five countries covered by EMIS that declined[ii], Bulgaria, Romania and Serbia, stated that they preferred to report national data, as they are more representative of the MSM population[iii]. Data on programme coverage are therefore based on EMIS, where countries agreed that these data could be used for Dublin Declaration reporting in 2012, and GARP reporting to UNAIDS by countries that were not covered by EMIS and countries that did not consent to use of EMIS data.

Sex workers

More countries reported data on HIV prevalence among male sex workers in 2012 than in 2010. Reported data show high rates of HIV prevalence among male sex workers. However, it is important to note that sample sizes were small; most of these countries commented that reported data are not nationally representative.

Differences in rates of condom use by female and male sex workers should be interpreted with caution, given the differences in sample sizes and data collection methods used for male and female sex workers.

Migrants

In general, international reporting processes, such as GARP reporting, have had relatively little focus on migrants as a key population affected by HIV. There are a few questions within the NCPI in which migrants and mobile populations are considered as one of a number of key affected populations. In addition, a number of region-specific indicators were introduced into the UNAIDS reporting tool for GARP reporting. These included three indicators related to migrants: HIV prevalence among migrants; rates of condom use; and HIV testing among migrants from high prevalence countries. Overall, availability of data for these indicators was very limited. In addition, countries were asked to report disaggregated data for migrants in relation to coverage of antiretroviral therapy and late diagnosis.

A number of questions related to migrants were included in the European supplement to NCPI. These questions were asked of both government and civil society respondents. Respondents were offered the opportunity to submit additional data and a number of countries did so, particularly through their narrative reports.

A major challenge faced in dealing with this particular population is that there is no shared definition of the term 'migrant' in countries. In addition, countries use a wide range of other terms. Some of these terms, e.g. 'immigrant' and 'foreign citizen', appear to be used interchangeably with the term 'migrant' in some countries. However, in other countries, there are clear distinctions between these terms. Other terms appear to be used to describe a sub-set of migrants, e.g. 'refugee' and 'asylum seeker'. Because of this, and because of the nature of available data, extreme caution should be exercised in making comparisons between countries or generalising results beyond the area studied.

Overall, the amount of data provided when countries are asked to report against standardised indicators is lower than when more open questions are asked. One argument in favour of standard indicators is that they aid data comparison. However, it is unclear whether this is possible for the countries reporting HIV prevalence, for example, because of differences in sampling method and sample size, even with standard indicators.

[i] Belarus, Belgium, Bosnia and Herzegovina, the Czech Republic, Denmark, Estonia, Finland, the former Yugoslav Republic of Macedonia, France, Germany, Greece, Ireland, Latvia, Lithuania, Luxembourg, Moldova, the Netherlands, Norway, Poland, Portugal, Slovakia, Spain, Sweden, Switzerland, Ukraine and the United Kingdom. Moldova requested that both EMIS and GARP data be included.

[ii] Bulgaria, Italy, Romania, Serbia and Slovenia responded 'No'. Malta did not agree or disagree, commenting that EMIS data are the only data available but are not likely to be representative as only a small number of MSM responded. The remaining countries either did not report or did not respond to the question.

[iii] Of these countries, only Bulgaria actually reported data.

Prisoners

In general, international reporting processes, such as GARP, have had relatively little focus on prisoners as a key population affected by HIV or prisons as a setting in which HIV transmission may occur and in which HIV services need to be provided. There are a few questions within the NCPI in which prisoners are considered as one of a number of key affected populations and others in which prisons are considered as a special setting for HIV service provision. Countries were asked to respond to these questions.

In addition, a number of region-specific indicators were introduced into the UNAIDS reporting tool for GARP reporting. These included one indicator related to HIV prevalence among prisoners. Countries were asked to report data on this indicator. In addition, countries were asked to report disaggregated data for prisoners in relation to coverage of antiretroviral therapy and late diagnosis.

A number of questions related to prisons were included in the European supplement to NCPI. These questions were asked of both government and civil society respondents. They focused on the availability of key services in prisons, such as: provision of free condoms; needle and syringe programmes; OST and testing and treatment for hepatitis C. The question about hepatitis C was included for the first time in this round of Dublin reporting because of the high prevalence of hepatitis C among people who inject drugs in the region and the perception that availability of services for testing and treatment of hepatitis C in the region is limited. In addition, countries were, as in the previous round, asked about the practice of mandatory HIV testing in prisons.

The European Monitoring Centre for Drugs and Drug Addiction also produced country data sheets for a total of 29 countries. These sheets drew on data held by the EMCDDA based on reports submitted by its network of national focal points (Reitox) and included some data relevant to prisons and prisoners, including the availability of key services in prisons, such as: provision of free condoms; needle and syringe programmes; OST and testing and treatment for hepatitis C. The data sheets also provided information about the practice of mandatory HIV testing in prisons[i].

Figures for HIV prevalence in prisons need to be interpreted with caution as they come from a variety of different sources. In some cases, they include those already known to be HIV positive before entering prison and in other cases they are excluded. This makes a big difference to the values reported and presented. For example, in 2011, 1.1% of those tested in Estonian prisons were found to have previously undetected HIV infections, while the overall prevalence in Estonian prisons was estimated at 16%.

Challenges faced in dealing with this particular population include difficulties in deciding how to quantify availability of key services in prisons. Attempts were made through the advisory group overseeing the Dublin reporting process to identify ways to measure coverage of HIV prevention programmes of relevance to prisons, such as those used for tracking services for people who inject drugs outside prison. However, it was not possible to do this, so this report has retained the focus of the previous report, namely tracking government and civil society perceptions of the policy environment in prisons in countries. The European Monitoring Centre for Drugs and Drug Addiction does, however, have some data on the scale of HIV prevention programmes in prisons, e.g. the proportion of all prisoners receiving OST, and these have been used where available. An underlying problem is the limited availability of quantitative data relating to the level of HIV services in prisons. A key problem for tracking the scale of OST in prisons is that, in many prison settings, the number of problem opioid users within a country's prison system is unknown. Consequently, EMCDDA tracks data for the proportion of a country's prison population receiving OST in a number of countries[ii].

[i] The European supplement to the NCPI is not yet fully aligned with the EMCDDA on data related to prisons. In particular, the supplement asks countries to classify availability of services as – not available; available in some prisons; available in most prisons; available in all prisons. EMCDDA asks countries to classify availability as not available; rare; limited; extensive or full. The EMCDDA classification is more meaningful and should be used for any subsequent rounds of Dublin reporting.

[ii] These data are based on the country sheets provided by EMCDDA for the Dublin reporting process. More up to date information is available at: http://www.emcdda.europa.eu/stats12/hsrfig4

Treatment, care and support

Countries were asked to report data on the provision of antiretroviral therapy (ART) to people living with HIV. Globally, ART coverage is calculated by dividing the number of people receiving treatment by the estimated number of people needing treatment. This denominator is estimated using software, such as Spectrum, and includes both those who have been diagnosed with HIV infection and those not yet diagnosed. However, countries, in general, and members of the Dublin advisory group, in particular, have expressed concern and dissatisfaction with this approach because:

- The Spectrum models apply only to low- and middle-income countries. As most of the countries of Europe and Central Asia are high-income countries, this model is not particularly relevant for this region. This is particularly the case for EU/EFTA countries.
- Many countries dispute the accuracy of the denominator for countries with HIV epidemics concentrated among particular sub-populations. For example, in their response to this round of Dublin reporting, Kazakhstan expressed the view that 'Spectrum gives inflated figures for the estimated number of people needing treatment' and Serbia stated that 'the estimates provided by Spectrum is considered to be overestimated.' The respondent from Estonia commented, 'As far as I have understood and had experience in working with Spectrum, the problems are related more to the type of epidemic (generalised vs concentrated), treatment availability and the fact that Spectrum does not take into account the injecting drug use patterns, and not so much about a country being high or low income.'
- It is considered to conflate two quite distinct issues which require different policy and programmatic responses. The first is providing ART to all those who are known to need it and identifying all those who need treatment. Conflating these issues into one can create the incorrect impression that the main problem in the region is providing ART to all those who are known to need it when, in fact, the main problem is identifying all those who need treatment.

For these reasons, the Dublin monitoring process has not followed the global approach to tracking ART coverage. Rather, this issue is tracked using two indicators. The first is the number of people receiving ART divided by the number of people diagnosed with HIV and known to need ART. The second is the percentage of people who already need treatment at the time of HIV diagnosis, i.e. those with late HIV diagnosis.

This approach means that extreme caution needs to be exercised in comparing coverage figures reported or discussed here with those reported based on Spectrum estimations, e.g. by UNAIDS and WHO. There is a serious risk of superficial analysis creating the impression that the Dublin monitoring process produces a more positive view of 'ART coverage' than those using Spectrum estimations. This is not the case. Both methods highlight the problem of people infected with HIV who already need treatment. One approach estimates this number and includes them as part of the denominator for ART coverage calculations. The other measures this number by tracking rates of late diagnosis.

Given that countries were reporting concurrently through the same process to GARP reporting and Dublin monitoring, all countries were invited to submit data for both denominators. The number of people diagnosed with HIV and known to require treatment was referred to as 'denominator A' and the number of people estimated to be in need of ART was referred to as 'denominator B'. Overall, countries preferred to report denominator A, and mostly, this is the figure that has been used in this report. In some cases, countries reported both. In a very small number of cases, the coverage figure reported by the country is based on denominator B.

A number of region-specific indicators were introduced into the UNAIDS reporting tool for GARP reporting. These included the indicator related to late HIV diagnosis. Countries were asked to report data on this indicator. A number of countries already report this data to ECDC. ECDC made this data available in the form of country data sheets for a total of 26 countries. Data from these sheets were based on surveillance data for 2010 and have been included in this report. In general, when reporting on rates of late diagnosis, this is done using the number of those having CD4 counts at the time of diagnosis as denominator. However, this may create a misleading picture if the proportion of new diagnoses having a CD4 count at the time of diagnosis varies between countries and within a country over time. For this reason, this report also includes data relating to the total number of new HIV diagnoses as well as the number having a CD4 count at the time of diagnosis.

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. Caution is also needed in comparing figures for ART coverage in this report with those reported elsewhere, because of methodological differences.

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Jean-Claude Schmit (Centre of Public Health Research CRP-Sante), Robert Hemmer (Infectious Disease Specialist, former President National AIDS Committee), Danielle Hansen-Koening (Director of Health, Ministry of Health), Vic Arendt (President National AIDS Committee), Alain Origer (National Focal Point, OEDT), Henri Goedertz (Patient Support Organisation).

Malta

Jackie Maistre Melillo (Department of Health Promotion and Disease Prevention, Ministry for Health, the Elderly and Community Care), Charles Mallia Azzopardi (Mater Dei Hospital), Tonio Piscopo (Mater Dei Hospital) and Daniela Mallia (Mater Dei Hospital).

Moldova

Oleg Barba (Ministry of Health), Tatiana Cotelnic-Harea (National Centre of Health Management, Ministry of Health), Stefan Gheorghita (National Centre of Public Health), Svetlana Plamadeala (CCM Secretariat), Vitalie Slobozian (Soros Foundation), Gabriela Ionascu (UNAIDS), Alexandrina Iovita (UNAIDS), Svetlana Doltu (Department of Penitentiary Institutions, Ministry of Justice), Svetlana Popovici (Dermatology and Communicable Diseases Hospital), Alexandru Goncear (Tiraspol AIDS Center) and other public institutions, NGO and development partners.

Montenegro

Alma Cicic (Institute of Public Health), Boban Mugosa (Institute of Public Health), Aleksandra Marjanovic (Ministry of health), Brankica Dupanovic (Infectious Disease Specialist) and Miso Pejkovic (NGO CAZAS).

Netherlands

Silke David (National Institute for Public Health and the Environment, Centre for Infectious Disease Control), Eline op de Coul (National Institute for Public Health and the Environment, Centre for Infectious Disease Control) and Cor Blom (Soa Aids Nederland).

Norway

Rolf Angeltvedt (Gay & Lesbian Health Norway), Arne Walderhaug (HivNorway), Elise Klouman (Norwegian Institute of Public Health), Liv Jessen (Prosenteret), Odd Hordvin (Norwegian Institute for Alcohol and Drug Research), Monica Djupvik (Norwegian Agency for Development Cooperation), Anne Skjelmerud (Norwegian Agency for Development Cooperation), Ida Erstad (Norwegian Directorate of Health), Arild Johan Myrberg (Norwegian Directorate of Health) and Hedda Bie (Norwegian Directorate of Health).

Poland

Iwona Wawer (National AIDS Centre) and Wojtek Tomczyński (Sieć Plus).

Portugal

Antonio Diniz (Directorate-General of Health), Joana Bettencourt (Directorate-General of Health) and Teresa de Melo (Directorate-General of Health).

Romania

Mariana Mardarescu (National Institute for Infectious Diseases "Prof. Dr. Matei Bals"), Adrian-Streinu Cercel (National Institute for Infectious Diseases "Prof. Dr. Matei Bals") Marieta Iancu (National Institute for Infectious Diseases "Prof. Dr. Matei Bals"), Mioara Predescu (National Institute for Infectious Diseases "Prof. Dr. Matei Bals"), Eugenia Apolzan (UNICEF Romania).

Russia

Marina P. Shevireva (Department of health protection and sanitary-epidemiological human well-being, Ministry of Health), Alexandr Goliusov (Department of health protection and sanitary-epidemiological human well-being, Ministry of Health), Vadim Pokrovsky (Federal Centre for HIV/AIDS Prevention), Nikolay Briko (I.M.Sechenov First Moscow State Medical University) and Vladimir S. Shoukhov (A.I.Evdokimov Moscow State University of Medicine and Dentistry).

Serbia

Danijela Simic (Institute of Public Health of Serbia, National HIV/AIDS Office), Katarina Mitic (Ministry of Health, Global Fund HIV Project Implementation Unit), Sladjana Baros (Institute of Public Health of Serbia, National HIV/AIDS Office), Farida Bassioni Stamenic (Ministry of Health, Global Fund HIV Project Implementation Unit), Mijodrag Andjelkovic (Ministry of Justice), Pavle Demel (NGO Youth of JAZAS, Global Fund HIV Project Implementation Team), Miljana Grbic (UN Theme Group on HIV/AIDS), Milos Stojanovic (UNODC) and the Union of Organizations in Serbia which provide care and support to PLHIV.

Slovakia

Peter Truska (Public Health Authority), Ján Mikas (Public Health Authority),

Helena Hudecová (Public Health Authority), Alexandra Žampachová (Public Health Authority), Imrich Šteliar (National Drug Monitoring Centre) and Katarína Jírešova (Civil Association Odyseus).

Slovenia

Irena Klavs (National Institute of Public Health), Tanja Kustec (National Institute of Public Health), Zdenka Kastelic (National Institute of Public Health), Evita Leskovšek (National Institute of Public Health), Janez Tomažič (Infectious Disease Hospital, University Medical Centre Ljubljana), Mario Poljak (Institute of Microbiology and Imunology, Medical School, University of Ljubljana), Miran Šolinc (SKUC), and Miha Lobnik (LEGEBITRA).

Spain

Olivia Castillo Soria, Mercedes Díez Ruíz-Navarro, Rosa Polo Rodríguez, Rosa Polo Rodríguez, Montserrat Neira León, Ana Koerting de Castro, Ángela M. Tapia Raya, Raúl Soriano Ocón, César Garriga Fuentes, Fernando Alonso Sánchez, Silvia Galindo Carretero, Sonia Velasco Tarrero (Ministry of Health, Social Services and Equality), Asúnción Díaz Franco, Jesús Oliva Domínguez (Carlos III Health Institute), Olga Muñoz Castejón (Sub-Directorate of Prison Health), Francisco Rábago Lucerna (Spanish Drug Strategy), Percy Fernández-Dávila (Stop Sida) and Julio Gómez Caballero (Advisory Committee NGOs).

Sweden

Frida Hansdotter (Swedish Institute for Communicable Disease Control) and Peter Månehall, (HIV-Sweden).

Switzerland

Luciano Ruggia (Federal Office of Public Health).

Tajikistan

Murodali Ruziev and Alijon Soliev (Republican AIDS prevention center)

Ukraine

Olga Varetska (ICF International HIV/AIDS Alliance in Ukraine), Natalya Nizova (SI "Ukrainian Center for Disease Control"), Yevgeniy Shyder (SI "Ukrainian Center for Disease Control"), Olga Gvozdetska (All-Ukrainian Network of PLWH).

United Kingdom

Brian Rice (Health Protection Agency), Valerie Delpech (Health Protection Agency), Melvina Woode Owusu (Health Protection Agency), Alison Brown (Health Protection Agency), Sara Croxford (Health Protection Agency), Sarika Desai (Health Protection Agency), Kay Orton (Department of Health), Jabulani Chwaula (African HIV Policy Network), Yusuf Azad (National AIDS Trust), Joe Murray (National AIDS Trust), Lisa Power (Terrence Higgins Trust), Guy Slade (Terrence Higgins Trust) and Victoria Sheard (Terrence Higgins Trust).

Uzbekistan

Authors: Nurmat Atabekov and Zulfiya Abdurakhimova; researchers: Shukhrat Umarkhodjayev, Djamshid Zakirov, Dilbar Urunova, Khabibullo Ashurov, Mokhigul Shodibekova and Dildora Mustafayeva.

Annex 2. Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia

Against the background of the global emergency of the HIV/AIDS epidemic with 40 million people worldwide living with HIV/AIDS, 90 per cent in developing countries and 75 per cent in Sub-Saharan Africa, representatives of States and Governments from Europe and Central Asia, together with invited observers, met in Dublin, Ireland, from 23 to 24 February 2004, for the Conference "Breaking the Barriers – Partnership to fight HIV/AIDS in Europe and Central Asia" and made the following declaration:

Recognising that poverty, underdevelopment and illiteracy are among the principal contributing factors to the spread of HIV/AIDS, and noting with grave concern that HIV/AIDS is compounding poverty and is now reversing or impeding development in many countries;

Emphasising the importance of sustained, pro-poor economic growth through poverty-reduction policies, programmes and strategies for the success of the fight against HIV/AIDS;

Recognising that the promotion of equality between women and men, girls and boys and respecting the right to reproductive and sexual health, and access to sexuality education, information and health services as well as openness about sexuality, are fundamental factors in the fight against the pandemic;

Reaffirming the Declaration of Commitment on HIV/AIDS adopted by the UN General Assembly Special Session on HIV/AIDS on 27 June 2001;

Reaffirming the development goals as contained in the Millennium Declaration adopted by the United Nations General Assembly at its fifty-fifth session in September 2000, and in the Road Map towards the implementation of the United Nations Millennium Declaration, and other international development goals and targets;

Reaffirming the Programme of Action of the International Conference on Population and Development (Cairo, 1994) and key actions for the further implementation of the Programme of Action of the International Conference on Population and Development adopted by the twenty-first special session of the United Nations General Assembly in July 1999;

Reaffirming the Beijing Platform for Action (Beijing, 1995) and the further actions and initiatives to implement the Beijing Declaration and the Platform for Action adopted at the twenty-third special session of the United Nations General Assembly in June 2000;

Expressing profound concern that in the European and Central Asian region at least 2.1 million of our people are now living with HIV/AIDS;

Noting with serious concern the particularly rapid escalation of the epidemic among young people in Eastern Europe, where HIV prevalence in the adult population is reaching critical levels in a number of countries and also the significant potential for the rapid spread of HIV in South-Eastern Europe and Central Asia;

Also noting with serious concern the resurgence of HIV/AIDS prevalence in Western Europe, including HIV resistant to anti-retroviral therapy, where the disease remains a potent threat to our young people;

Emphasising that the most seriously affected countries, mainly in southern Africa, are facing collapse in one or more sectors of society, and agreeing that the HIV/AIDS epidemic threatens to become a crisis of unprecedented proportions in our region, undermining public health, development, social cohesion, national security and political stability in many of our countries;

Agreeing that we must act collectively to tackle this crisis through a deepening of coordination, cooperation and partnership within and between our countries and are encouraged by proposals made at the Conference to strengthen the capacity of the European Union to fight effectively against the spread of HIV/AIDS;

Confirming that the respect, protection and promotion of human rights is fundamental to preventing transmission of HIV, reducing vulnerability to infection and dealing with the impact of HIV/AIDS;

Acknowledging that the prevention of HIV infection, through the promotion of safer and responsible sexual behaviour and practices, including through condom use, must be the mainstay of the sub-national, national, regional and international response to the epidemic and that prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic;

Recognising that in our region persons at the highest risk of and most vulnerable to HIV/AIDS infection include drug injectors and their sexual partners, men who have sex with men, sex workers, trafficked women, prisoners and ethnic minorities and migrant populations which have close links to high prevalence countries;

Stressing that without urgent action, HIV/AIDS will continue to move into the general population;

Recognising that women and girls are particularly vulnerable to HIV infection;

Recognising that a focus on the role of men and boys in combating HIV/AIDS and in the promotion of gender equality will benefit everyone and society as a whole, and that engaging men and boys as partners will encourage them to take responsibility for their sexual behaviour and to respect the rights of women and girls;

Recognising that in order to be able to tackle the HIV/AIDS crisis, we need strong basic health care systems and services to ensure universal and equitable access to HIV/AIDS prevention, treatment and care;

Recognising that success in the fight against HIV/AIDS is linked to the fight against other sexually transmittable infections and the fight against tuberculosis;

Emphasising that while young people are vulnerable, they themselves are key actors and agents of change in the fight against HIV/AIDS and are a major resource for the response at national and regional levels;

Acknowledging that the principle of greater involvement of people living with or affected by HIV/AIDS is critical to ethical and effective national responses to the epidemic;

Recognising that investment in research and development for more effective therapeutic and preventive tools, such as microbicides and vaccines, will be essential to securing the long-term success of HIV and AIDS responses;

We have agreed on the following actions to accelerate the implementation of the Declaration of Commitment on HIV/AIDS.

Leadership

1. Promote strong and accountable leadership at the level of our Heads of State and Government to protect our people from this threat to their future, and promote human rights and tackle stigma and ensure access to education, information and services for all those in need;
2. Encourage and facilitate strong leadership by civil society and the private sector in our countries in contributing to the achievement of the goals and targets of the Declaration of Commitment;
3. Accelerate the implementation of the provisions of the Declaration of Commitment relating to orphans and girls and boys infected and affected by HIV/AIDSi;
4. Establish and reinforce national HIV/AIDS partnership forums including meaningful participation of civil society, and particularly of people living with HIV/AIDS and their advocates, to design, review, monitor and report progress in the fight against the disease, and to take timely and determined action to identify and address barriers to implementation;
5. In 2004-2005, promote the active involvement of the institutions of the European Union, and other relevant institutions and organisations such as the Commonwealth of Independent States, the Council of Europe, the Organisation for Security and Cooperation in Europe and the Regional Committee of the World Health Organisation, in partnership with UNAIDS through its co-sponsoring agencies and its Secretariat, in our common effort to strengthen coordination and cooperation;
6. Make the fight against HIV/AIDS in Europe and Central Asia a regular item on the agendas of our regional institutions and organisations;
7. Provide increased and results-based financial and technical resources to scale up access to prevention, care and sustained treatment, including effective low cost treatment such as generics, in the most affected countries with the greatest needs through national and regional allocations as well as from the Global Fund to Fight AIDS, TB and Malaria, the European Union, new public and private partnerships, multilateral and bilateral financing mechanisms.

[i] Declaration of Commitment of HIV/ANDS. United Nations General Assembly Special Session on HIV/AIDS June 25-27, 2001. http://www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub03/aidsdeclaration_en.pdf

Prevention

8. Reinvigorate our efforts to ensure the target of the Declaration of Commitment[i] that, by 2005, at least 90 percent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection, in dialogue with young persons, parents, families, educators and health-care providers;

9. By 2010, ensure through the scaling up of programmes that 80% of the persons at the highest risk of and most vulnerable to HIV/AIDS are covered by a wide range of prevention programmes providing access to information, services and prevention commodities and identifying and addressing factors that make these groups and communities particularly vulnerable to HIV infection and promote and protect their health, and intensify cross border, sub-regional and regional technical collaboration and sharing of best practices through the EU and regional organisations in the prevention of HIV transmission among vulnerable groups;

10. Scale up access for injecting drug users to prevention, drug dependence treatment and harm reduction services through promoting, enabling and strengthening the widespread introduction of prevention, drug dependence treatment and harm reduction programmes[ii] (e.g. needle and syringe programmes, bleach and condom distribution, voluntary HIV counselling and testing, substitution drug therapy, STI diagnosis and treatment) in line with national policies;

11. Ensure that HIV positive women and expectant mothers should have access to high quality maternal and reproductive health care services in order to prevent mother to child-transmission;

12. By 2010, eliminate[iii] HIV infection among infants in Europe and Central Asia;

13. Ensure men, women and adolescents to have universal and equitable access to and promote the use of a comprehensive range of high quality, safe, accessible, affordable and reliable reproductive and sexual health care services, supplies and information including access to preventive methods such as male and female condoms, voluntary testing, counseling and follow-up;

14. By 2005, to develop national and regional strategies and programmes to increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, and reduce their vulnerability to HIV/AIDS;

15. By 2005, to develop national and regional strategies ensuring that all men and women in uniformed services, including armed forces and civil defence forces, have access to information, services and prevention commodities to reduce risk-taking behaviour and encourage safe behaviour, and urge the European Union, NATO and other regional and international security institutions in partnership with UNAIDS to lead such efforts;

16. Control the incidence and prevalence of sexually-transmitted infections, particularly amongst those at the highest risk of and most vulnerable to HIV/AIDS, through increased public awareness of their role in HIV transmission, improved and more accessible services for prompt diagnosis and efficient treatment;

17. Fund, improve, and harmonise surveillance systems, in line with international standards, to track and monitor the epidemic, risk behaviours and vulnerability to HIV/AIDS;

18. Request the Global Commission on International Migration to take into account in its work the threat of exposure to HIV/AIDS particularly to migrant women and unaccompanied and orphaned children;

19. Increase commitment to research and development for new technologies that better meet the prevention needs of people living with or most vulnerable to HIV transmission including increasing public sector investment in vaccines and microbicides to prevent HIV infection.

[ii] The WHO recommends that at least 60% of injecting drug users have access to drug dependence treatment and harm reduction programmes in order to have an impact on the epidemic among this group.

[iii] Elimination is defined as less than 2% of all new infections are acquired by an infant from his or her infected mother.

Living with HIV/AIDS

20. Combat stigma and discrimination of people living with HIV/AIDS in Europe and Central Asia, including through a critical review and monitoring of existing legislation, policies and practices with the objective of promoting the effective enjoyment of all human rights for people living with HIV/AIDS and members of affected communities;

21. By 2005, provide universal access to effective, affordable and equitable prevention, treatment and care including safe anti-retroviral treatment to people living with HIV/AIDS in the countries in our region[i] where access to such treatment is currently less than universal, including through the technical support of the UN through the global initiative led by the World Health Organisation and UNAIDS to ensure 3 million people globally are on anti-retroviral treatment by 2005 ("3 by 5"). The goal of providing effective anti-retroviral treatment must be conducted in a poverty-focused manner, equitable, and to those people who are at the highest risk of and most vulnerable to HIV/AIDS;

22. Ensure early implementation of the WTO Decision of 30 August 2003 on the implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health;

23. Increase access to non-discriminatory palliative care, counseling, psychosocial support, housing assistance, and other relevant social services for people living with HIV/AIDS;

24. Invest in public research and development for the development of affordable and easier to use therapeutics and diagnostics to support expanded treatment access and improve the quality of life of people living with HIV;

25. Monitor best practices on and take concrete steps to exchange information on service delivery for prevention, treatment and care, particularly for persons at the highest risk of and most vulnerable to HIV/AIDS infection.

Partnership

26. Strengthen coordination, cooperation and partnership among the countries of Europe and Central Asia, as well as with their trans-Atlantic and other development partners, to scale up local capacity to fight the epidemic and mitigate its consequences in the most affected countries with the greatest needs, and in countries with a high risk of a major epidemic;

27. Involve civil society and faith-based organizations, as well as people living with HIV/AIDS and persons at the highest risk of and most vulnerable to HIV/AIDS infection in the development and implementation of national HIV/AIDS prevention and care strategies and financing plans, including through participation in national partnership forums;

28. Work with leaders from the private sector in fighting HIV/AIDS through workplace education programmes, employee non-discrimination policies, provision of treatment, counseling, care, and support services, and through engagement with policy makers on the local, national and regional levels;

29. Involve the national and international pharmaceutical industry in a public-private partnership including with relevant international organisations such as the World Health Organisation in helping to tackle the epidemic along all points of the drug supply chain – from manufacturing to pricing to distribution;

30. Ensure effective coordination between donors, multilateral organisations, civil society and Governments in the effective delivery of assistance to the countries most in need of support in the implementation of their national HIV/AIDS strategies, based on ongoing processes on simplification and harmonization particularly the UNAIDS guiding principles;[ii]

31. Establish sustainable partnerships with the media, recognising the critical role that it plays in influencing attitudes and behaviour and in providing HIV/AIDS related information;

32. Support stronger regional cooperation and networking among people living with HIV/AIDS and civil society organisations in Europe and Central Asia, and call upon the Joint United Nations Programme on HIV/AIDS in partnership with the European Union, existing civil society networks and other regional partner institutions to assist, facilitate and coordinate such collaboration.

[i] The treatment gap in the region is estimated by the WHO to be at least 100 000 people in 2003.

[ii] These are: that there should be one agreed national HIV/AIDS Action Framework that drives alignment of all partners., one national AIDS authority with a broad-based multisectoral mandate, and one agreed country-level monitoring and evaluation system.

Follow-up

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

24 February 2004

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		