SPECIAL REPORT

Thematic report: HIV treatment, care and support

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

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

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.

ECDC is grateful to members of the advisory group who provided input in many different ways. The group was chaired by Teymur Noori (ECDC). Members included Tobias Alfvén (UNAIDS), Yusuf Azad (Civil Society Forum), Henrique Barros (Portugal), Olivia Castillo (Spain), Nikos Dedes (Civil Society Forum), Frida Hansdotter (Sweden), Tomás Hernández Fernández (Spain), Vasileia Konte (Greece), Ulrich Laukamm-Josten (WHO Regional Office for Europe), Arild Johan Myrberg (Norway), Aidan O'Hora (Ireland), Klaudia Palczak (EMCDDA), Jasmina Pavlic (Croatia), Ines Perea (Germany), Wolfgang Philipp (European Commission), Brian Rice (United Kingdom), Luciano Ruggia (Switzerland), Kristi Rüütel (Estonia), Vladimir Shoukhov (Russian Federation), Danijela Simic (Serbia), Olga Varetska (Ukraine), Ursula von Reuden (Germany), Michelle Sherlock-Williams (UNAIDS RST/ECD), Iwona Wawer (Poland) and Tsvetana Yakimova (Bulgaria). Other ECDC staff who participated in the advisory group included Anastasia Pharris, Giedrius Likatavicius, Mika Salminen and Marita van de Laar. Dagmar Hedrich, André Noor and Paul Griffiths at the EMCDDA also provided valuable support.

Thanks are due to those who attended the monitoring and evaluation workshop in Lisbon in January 2012 that was part of this process. In addition to the advisory group, these were representatives from the following countries: Zulfiya Abdurakhimova (Uzbekistan), Esmira Almammadova (Azerbaijan), Roland Bani (Albania), Dominique van Beckhoven (Belgium), Larisa Bochkova (Ukraine), Henrikki Brummer-Korvenkontio (Finland), Tatiana Cotelnic-Harea (Moldova), Šerifa Godinjak (Bosnia and Herzegovina), Peter Grech (Malta), Samvel Grigoryan (Armenia), Aikul Ismailova (Kyrgyzstan), Irena Klavs (Slovenia), Jean-Paul Klein (Austria), Šarlote Konova (Latvia), Rima Krupenkaite (Lithuania), Ulrich Marcus (Germany), Vladimir Mikik (Former Yugoslav Republic of Macedonia), Maja Milanović (Montenegro), Katarina Mitić (Serbia), Zohar Mor (Israel), Patrizia Parodi (Italy), Mioara Predescu (Romania), Izet Sadiku (Kosovo), Jean-Claude Schmit (Luxembourg), Caroline Semaille (France), Švetlana Sergeenko (Belarus), Alijon Soliev (Tajikistan), Džamila Stehlíková (Czech Republic), Jumamurat Suhanguliyev (Turkmenistan), Dora Tonté (Hungary), Peter Truska (Slovakia), Maria Tsereteli (Georgia), Maaike van Veen (Netherlands), Alia Yeliazarieva (Kazakhstan), and Canan Yilmaz (Turkey). Additional invited experts were: Ruy Burgos Filho (Ministry of Health, Brazil), Valerie Delpech (HPA, UK), Eleanora Gvozdeva (UNAIDS) and Lev Zohrabyan (UNAIDS). Thanks are also due to Alessandra Bo, Paul Griffiths, Dagmar Hedrich, Ilze Jekabsone, Cecile Martel, André Noor, Klaudia Palczak, Roland Smith, Julian Vicente and Lucas Wiessing from EMCDDA and Piotr Kramarz, Victoria Markevich and Susanne Freudenberg from ECDC. Particular thanks are also due to the Ministry of Health in Portugal and EMCDDA for hosting the monitoring and evaluation workshop.

Suggested citation: European Centre for Disease Prevention and Control. Thematic report: HIV treatment, care and support. Monitoring implantation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2012 progress report. Stockholm: ECDC; 2013.

Stockholm, May 2013

ISBN 978-92-9193-470-6

doi 10.2900/82793

Catalogue number TQ-03-13-145-EN-N

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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 (EMCDDA)
EU/EFTA	European Union/European Free Trade Association
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
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organization

Executive summary

Key messages

Most countries in Europe and Central Asia, particularly in the EU/EEA, have a strong focus on delivering treatment, care and support for people living with HIV, including, in particular, providing antiretroviral therapy (ART) to those who need it.

The number of people receiving antiretroviral therapy in countries across the region has increased considerably since the last round of Dublin reporting two years ago. The rate of increase has been particularly high in non-EU/EFTA countries. For example, between the two rounds of Dublin reporting, the number of people reported to be receiving ART in Azerbaijan and Tajikistan increased more than eight-fold.

Overall, across the countries, most people (>85%) diagnosed with HIV who are known to need treatment receive it. However, this is not the case in some non-EU/EFTA countries including Azerbaijan, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan, Ukraine and Uzbekistan.

Overall rates of late diagnosis of HIV remain high across the region. Almost half of those being diagnosed with HIV are already in need of treatment (CD4 <350). As a result, many people who need ART are not receiving it because they have not yet been diagnosed with HIV infection. More countries are tracking and reporting data on this indicator since the previous round of Dublin reporting. In addition, the proportion of people diagnosed with HIV who received a CD4 count at the time of diagnosis rose from 50% in the previous round of reporting to 68% this time. However, almost one third of people newly diagnosed with HIV infection are not receiving a CD4 count within the first three months of diagnosis.

Almost all countries seek to provide people living with HIV with a comprehensive range of HIV treatment and care services. In general, most such services are reported to have good availability across most countries.

Non-governmental organisations (NGOs) are recognised as playing a vital role in providing care and support services for people living with HIV in many countries.

Many countries recognise that key populations have difficulty in accessing HIV treatment services. There are particular issues facing undocumented migrants. Laws, regulations and policies are reported as being obstacles to HIV services in non-EU/EFTA countries more than in EU/EFTA countries. EU/EFTA countries, however, are more likely to recognise the difficulties marginalised and vulnerable populations have in accessing HIV, treatment and care services.

Many countries recognise the role of treatment as prevention. However, there is a lack of clarity over what this means. Relatively few countries have adopted clear guidance for using ART for preventive purposes outside of the confines of established practice, such as post-exposure prophylaxis.

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 of 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 organisations in August 2008. In late 2007, the European Commission requested that ECDC monitor the Dublin Declaration on a more systematic basis. The first country-driven, indicator-based progress report was published in 2010. The objective was to harmonise indicators with existing monitoring frameworks, notably 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[i], 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.

[i] 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

Method

All 55 countries were requested to submit data regarding their national responses to HIV (see Annex 5 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.

Globally, ART coverage is calculated by dividing the number of people receiving treatment by the estimated number of people needing treatment. This denominator can be estimated by using software, such as Spectrum (provided by UNAIDS). This tool 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.'
- 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 the second is 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 Global AIDS Response Progress 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 (see Annex 1). In some cases, countries reported both. In Kyrgyzstan and Poland, 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 Global AIDS Response Progress 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 who 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 (See Annexes 3 and 4). In general, when reporting on rates of late HIV diagnosis, this is done using the number of those having CD4 counts at the time of diagnosis as a 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 are a few questions within the National Commitment and Policies Instrument (NCPI) and the European supplement to the NCPI related to treatment, care and support. The European supplement to NCPI also contained a few specific questions related to the use of HIV treatment as prevention. Qualitative material from this and other sources has been included in this report on an illustrative basis.

Respondents were offered the opportunity to submit any additional data that they wished to. A number of countries did so, particularly through their narrative reports.

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. As mentioned earlier, extreme caution is needed in comparing figures for ART coverage in this report with those reported by UNAIDS or WHO. Because of methodological differences, these are unlikely to be comparable.

Providing treatment for people living with HIV

This chapter is focused on the issue of providing treatment for people living with HIV, particularly the need to increase the scale and coverage of treatment services across countries.

This report is divided into five main parts. The first part considers issues relating to the provision of antiretroviral therapy (ART) to people living with HIV in Europe and Central Asia. The second part considers other elements of care and support. The third part then addresses issues of late diagnosis. The fourth part considers issues relating to providing treatment, care and support to key affected populations. The fifth part reviews issues relating to treatment as prevention. The report then draws a number of conclusions, considers progress since the last round of Dublin reporting and presents a number of issues identified by ECDC for further action.

Box 1. HIV treatment in EU/EFTA countries

The number of people receiving ART in EU/EFTA countries rose between the two rounds of Dublin reporting. Nineteen EU/EFTA countries presented figures to both rounds of Dublin reporting on the number of people receiving ART. In these countries, numbers receiving treatment rose 27% from 285 693 to 364 222. The number of people receiving treatment in France rose from 102 000 in 2008 to 111 000 in 2010. Some EU/EFTA countries did see dramatic rises in the number of people receiving ART over this period. For example, numbers almost trebled in both Estonia and Lithuania. They did treble in Finland where the number of people receiving treatment rose from 450 in 2006 to 1 550 in 2010.

People who are diagnosed with HIV and require antiretroviral therapy receive it in EU/EFTA countries. In general, in EU/EFTA countries reporting data, more than 85% of those diagnosed with HIV and known to need ART receive it. Some countries, e.g. Bulgaria and Latvia reported that they had decentralised the provision of ART in order to improve access.

However, rates of late diagnosis are high in EU/EFTA countries. Approximately half of all those diagnosed with HIV already require ART at the time of diagnosis.

EU/EFTA countries face a number of challenges in providing HIV treatment care and support to those who need it. Challenges identified include:

- financing the increasing number of people requiring ART, e.g. in Bulgaria, Estonia, Portugal, Romania, Sweden and the UK
- expanding ART to all those with a CD4 count <350, e.g. in Latvia
- limited availability of HIV specialists, e.g. in Lithuania
- interruptions in antiretroviral drug supplies, e.g. in the Czech Republic
- difficulties in decentralising ART provision and support services in some countries, e.g. Italy, Latvia, Romania, Slovenia and Sweden
- ensuring professional quality of services, e.g. in Lithuania
- improving retention/adherence of those on ART, e.g. in Latvia, Lithuania, Portugal and Romania
- emerging drug resistance, e.g. in Germany and Lithuania
- need for advanced clinical services in some countries, e.g. organ transplantation in Italy and Spain

Overall, EU/EFTA countries provide a wide range of treatment care and support services for people living with HIV (see Figure 1).

Members of vulnerable and marginalised populations in EU/EFTA countries find it more difficult to access HIV treatment, care and support than members of the general population. In EU/EFTA countries, this was reported to be the case by civil society respondents in almost all countries (88%) and by government respondents in almost two thirds (64%). These rates were higher than in non-EU/EFTA countries. However, this does not appear to be particularly due to 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, such obstacles were reported to be the case by civil society respondents in more than half the countries (57%) and by government respondents in just less than one third (31%). These rates were lower than for non-EU/EFTA countries.

Antiretroviral therapy is reported to be available to undocumented migrants in less than half of the EU/EFTA countries responding to the question - 44% of government and 29% of civil society respondents from EU/EFTA countries answering the question reported that ART is available for undocumented migrants in their country. The figure was over half (54%) for both government and civil society respondents in non-EU/EFTA countries (see Figure 9). EU/EFTA countries that report they do provide ART for undocumented migrants are clustered in the south-west of the region (see Figure 10) whereas those that report they do not are clustered in the north, centre and east.

Delivering antiretroviral therapy in countries across the region

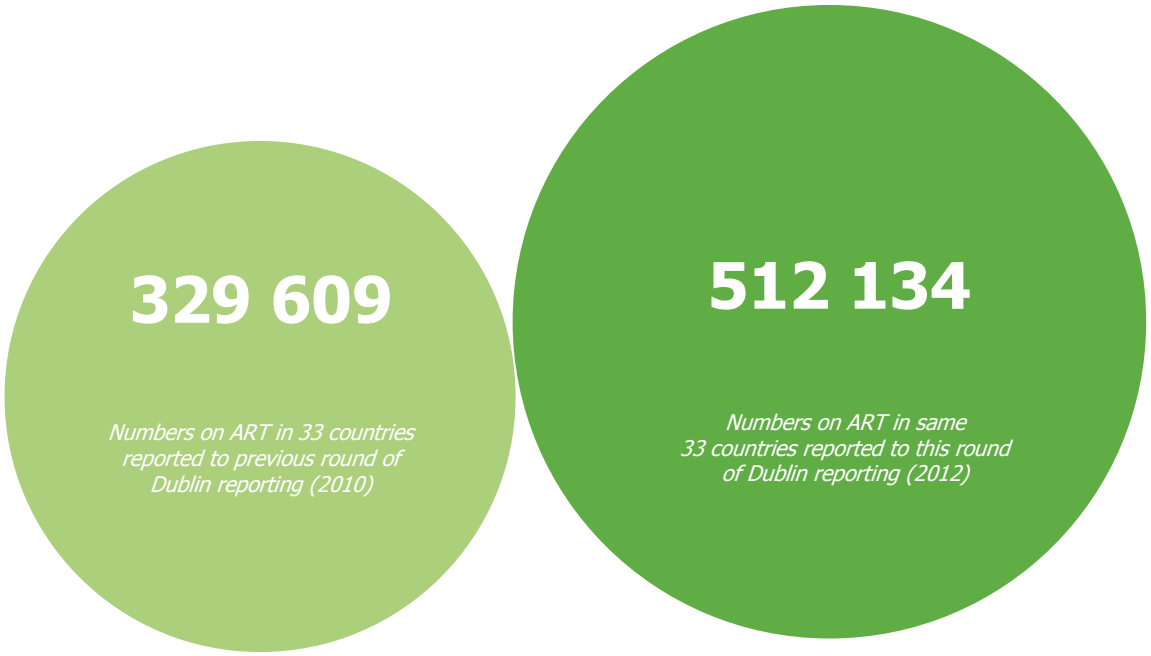
Most countries have policies, laws or regulations recommending antiretroviral therapy for people living with HIV

In almost all countries, government (91%) and civil society (90%) respondents reported that they have a policy, law or regulation recommending ART for people living with HIV. In seven countries[i], this was reported not to be the case by at least one of the government or civil society respondents.

The number of people living with HIV receiving antiretroviral therapy has increased considerably since the last round of Dublin reporting

Data regarding the number of people receiving ART was available for 33 countries in both rounds of Dublin reporting (See Annex 1). Figures in this round of reporting were from the period 2009 to 2011 and in the previous round of reporting from 2006 to 2009. In the previous round of reporting, there were more than 300 000 people receiving ART in these 33 countries. In this round of reporting, this number had risen to over 500 000 (see Figure 1) [ii].

Figure 1. Numbers of people living with HIV reported to be receiving antiretroviral therapy in two rounds of Dublin reporting*



**Data for 33 countries with data available for both rounds of reporting.*

Of the 33 countries with data available for both rounds of reporting, 19 are members of the EU/EFTA (see Box 1 for further analysis). The majority of those on treatment within these 33 countries are in EU/EFTA countries. However, this percentage fell between the two rounds of reporting (from 87% to 72%). These figures may not be representative of the region as a whole as data were not available in both rounds of reporting for some large countries, for example, Italy.

[i] Czech Republic, Estonia, Finland, Malta, Norway, Slovakia and the UK. In commenting on this point, the Estonian government respondent explained that 'we do have several documents (policies and regulations) recommending ART (national strategy, treatment guidance). We do not have any law recommending treatment, but this is the case with any other health issue and treatment, too.'

[ii] Caution is needed in interpreting these data. They are included mainly to demonstrate the rising burden of HIV treatment being faced by countries. Clearly, it is positive that more people with HIV who need treatment receive it. However, as HIV is a preventable condition, it is of concern that the need for treatment is rising in many countries because HIV transmission is continuing.

In the countries for which data are available, the rate of increase was much higher in non-EU/EFTA countries as compared to those in the EU/EFTA. Overall, the number of people receiving ART, in the 19 EU/EFTA countries for which data are available, rose 27% between the two reporting periods. However, the number more than trebled in the 15 non-EU/EFTA countries over the same period. In some countries, for example, Azerbaijan and Tajikistan, there was more than an eight-fold increase in the number of people receiving ART between these two periods. In Russia, the number receiving treatment rose from 31 094 in 2007 to 103 001 in 2011 and, in Ukraine, 7 657 in 2007 to 26 730 in 2010. The rates of increase were much more modest in most EU/EFTA countries, most likely because most people known to need treatment in EU/EFTA countries are already on treatment. For example, the number of people receiving treatment in France rose 9% from 102 000 in 2008 to 111 000 in 2010. Some EU/EFTA countries did see dramatic rises in the number of people receiving ART over this period. For example, numbers almost trebled in both Estonia and Lithuania. They did treble in Finland where the number of people receiving treatment rose from 450 in 2006 to 1 550 in 2010.

These data are important because they show the increasing treatment burden being imposed by HIV on countries. In addition, the challenge for all countries of providing treatment to all in need is likely to increase given the movement of international guidelines toward earlier antiretroviral treatment.

People who are diagnosed with HIV and require antiretroviral therapy receive it, particularly in EU/EFTA countries

As explained in the methods section, this report uses a specific, regional approach to monitoring the coverage of ART. It is important to note that coverage figures reported in this sub-section are for those diagnosed with HIV and known to need treatment. As a result, these figures are not comparable with coverage figures produced by WHO which uses different methods based on estimates of the number of people living with HIV in a country needing treatment. These figures need to be considered alongside the figures for late diagnosis presented later in this report.

In general, reported rates of ART coverage among those diagnosed with HIV and known to need treatment are high in countries. In 29 countries with available data, reported coverage was more than 85% in most of them (81%). This means that people who are diagnosed with HIV and considered to be in need of treatment are receiving it in most countries. However, seven countries reported figures below this level. All these countries (Azerbaijan, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan, Ukraine and Uzbekistan) are outside the EU/EFTA.

Several countries reported ART coverage data disaggregated by sex (20) and by age (18) (see Annex 2). Although there was no difference in coverage between the sexes in eight countries, nor by age (<15; >15) in four countries, where differences did occur, coverage was higher among women than men in almost all countries (92%) and among those under 15 as compared to those over 15 (100%). The biggest differences were seen in Kazakhstan, Kyrgyzstan, Moldova, Tajikistan, Ukraine and Uzbekistan.

Overall, provision of treatment, care and support across the region is considered good by both government and civil society

Respondents were asked to rank their country's efforts to implement HIV treatment, care and support programmes in 2011 on a scale of 0 to 10. The mean score allocated by government respondents was 8.2 and 7.2 by civil society respondents.

Scores from government respondents ranged from five in the former Yugoslav Republic of Macedonia to ten in Croatia, Greece and Iceland. Scores from civil society respondents ranged from one in Lithuania to ten in Poland. Scores allocated by civil society were higher than those assigned by government in Belgium, Luxembourg, the Netherlands and Poland.

Countries are scaling up antiretroviral therapy in a variety of different ways

Countries provided examples of mechanisms they have used to scale up the provision of ART. For example, in Albania, ART is provided through both inpatient and outpatient facilities. In Armenia, ART is also provided through mobile medical teams. In Kyrgyzstan, multidisciplinary teams have been established to scale up treatment provision. Serbia stressed the importance of promoting cooperation between treatment centres, organisations of people living with HIV, and governmental institutions as a means of promoting treatment scale-up. In Ukraine, ART is provided not only in AIDS centres but also in TB dispensaries and district hospitals. More details of ways in which ART is delivered in individual countries are presented in Table 1.

Table 1. Providing antiretroviral therapy to people living with HIV in Europe and Central Asia: country examples

Country	Comments
Albania	ART was first provided in 2004. An outpatient clinic for people living with HIV was opened with Global Fund support in 2007. Services are provided on the basis of guidelines developed by the Infectious Disease Department and Service and the Albanian Infectious Diseases Association.
Armenia	ART was first provided free-of-charge in 2005. Mobile medical teams provide HIV treatment, care and support to people living in provinces outside of Yerevan. ART is available within the prison system in Armenia.
Austria	ART has resulted in a reduction in mortality among people living with HIV from around 40 per 100 person-years in 1992 to less than five currently. ART is provided through a network of seven HIV treatment centres. It is financed through health insurance which covers almost the entire population.
Bosnia and Herzegovina	HIV treatment and care are provided free of charge to people living with HIV. Costs of ART are covered from the health insurance fund. ART is available in three centres in Sarajevo, Tuzla and Banja Luka.
Bulgaria	ART and treatment monitoring are available free-of-charge, funded through the Ministry of Health budget. New treatment and treatment monitoring guidelines were approved in 2010. More than 90% of those starting ART are reported to be continuing it 12 months later.
Croatia	ART was first provided in 1998. The provision of ART remains centralised at the University Hospital for Infectious Diseases in Zagreb. The cost of ART and treatment monitoring is covered from health insurance which is universal.
Czech Republic	ART is provided through a network of seven clinical AIDS centres. The majority of resources to cover treatment-related expenses are reported to come from health insurance.
Estonia	Health services related to HIV are provided in infectious disease departments of hospitals in Tallinn, Narva, Kohtla-Järva and Tartu. Services are available in prisons through contracts with hospitals. Services are provided free-of-charge. ART is financed by the Ministry of Social Affairs.
Finland	Treatment and care are available free-of-charge for those eligible for Finnish social security benefits. HIV treatment and care are provided by regional health districts as part of specialised medical care in central hospitals and university hospitals.
the former Yugoslav Republic of Macedonia	ART was first provided in 2006. The provision of ART remains centralised at the Clinic for Infectious Diseases (CID) in Skopje. CID has been improved through establishing a new HIV inpatient department and through provision of monitoring equipment.
Georgia	ART is provided through the National AIDS Centre and three affiliated regional facilities. Services are provided free-of-charge, financed through the national programme and Global Fund. Steps are currently being taken to adjust the ART initiation criteria in Georgia (from CD4 <200 to CD4 <350).
Germany	Easy access to HIV testing, counselling, treatment and care constitutes one of the pillars of the HV/AIDS strategy. ART is financed through health insurance which covers the entire population, except for undocumented migrants.
Greece	For insured persons, treatment costs are covered by health insurance. All drugs are provided through the public hospital pharmacy system with a central procurement and registry. For Greek citizens who are uninsured, the costs are covered by social welfare or hospital budgets. EU citizens and legal-resident citizens of other countries should be covered by their own insurance. Third country nationals are provided with ART free of charge when this is not available in the country of origin. According to a recent circular ART is free of charge for everyone in need, in case of an emergency and until stabilization of clinical status. ART is provided through specialized centres for treatment, care and support.
Latvia	ART is only available for asymptomatic people living with HIV with a CD4 < 200. By, 2009, ART was available in two cities – Riga and Jelgava. By the end of 2011, ART was available in ten cities in Latvia although take-up of decentralised treatment services has been slow.
Lithuania	ART has been available to all who need it since 1998. ART is provided free-of-charge through an agreement between the Health Insurance Fund and the Ministry of Health.
Moldova	ART was first provided in 2002. Since 2011, ART provision has been decentralised to include Balti and Cahul, and the left bank of the Nistru River in Tiraspol and Ribnita. Financial support for ART has been received from both the World Bank and the Global Fund.

Country	Comments
Montenegro	Since 2009, ART has been available through the health insurance fund. Steps have been taken to improve the laboratory monitoring of people living with HIV. ART is provided in line with European AIDS Clinical Society Guidelines.
The Netherlands	There is a principle that everyone should receive appropriate health care. ART is legally regulated to ensure quality and is provided through a network of 25 HIV treatment centres, including two specialised in paediatric treatment. Costs are covered by health insurance which is obligatory for residents.
Poland	ART is provided free-of-charge. Since 2006, data concerning people on ART have been stored on a central database. ART is available for those within the prison system.
Romania	ART was first introduced in 1996. Since then, the number of people receiving ART increased through an increased budgetary allocation and reduced prices/donations from pharmaceutical companies. In 2008, ART procurement was decentralised to county level.
Serbia	Until 2008, ART was available only at the Institute for Infectious Diseases in the Clinical Centre of Serbia, in Belgrade. Since then, it has been decentralised to Novi Sad, Nis and Kragujevac. ART provision is funded through health insurance. Provision is based on national guidelines adopted in 2011.
Slovakia	ART is provided to people living with HIV across the country through three centres in Bratislava, Banská Bystrica and Košice.
Sweden	ART is available to all people legally present in the country. Costs are covered through health insurance. Treatment is provided to all pregnant women with HIV, all people living with HIV with TB and asymptomatic people with HIV with a CD4 < 350. All patients are monitored in the InfCareHIV register.
Ukraine	Large-scale ART provision was launched in 2004 with Global Fund support. By 2008, ART had been scaled-up to all 27 regions of the country. At the start of 2012, most (83%) of people on ART were financed from the state budget with the remainder being financed by the Global Fund.
United Kingdom	HIV treatment and care services are provided through the National Health Service. In 2011, for the first time, the Health Protection Agency published figures for key quality of care indicators.

Countries highlighted achievements and challenges relating to ART scale-up in a number of areas:

- *Initiatives to increase HIV testing* Belgium reported increased testing among key populations. Kazakhstan reported introduction of rapid HIV testing for pregnant women. Several countries, including Georgia and Spain, recognised the need to improve the early diagnosis of HIV. Latvia reported challenges in the greater use of rapid HIV tests. Civil society in Lithuania reported the lack of post-test counselling for people testing positive.
- *Financing antiretroviral therapy* Countries reporting that they had ensured an adequate budget for ART included Bulgaria, Kazakhstan, Romania and Ukraine. Countries noting that ART provision had been supported through Global Fund financing included Albania, Armenia and Ukraine. Countries reporting making cost efficiency savings on antiretroviral drugs (ARVs) included Latvia and Ukraine. Countries highlighting that some HIV treatment and care services are provided free-of-charge included Bosnia and Herzegovina, Bulgaria, Finland and Germany. Some countries expressed concern about the sustainability of ART provision. These countries included Armenia, Bulgaria, Estonia, Kyrgyzstan, Poland, Portugal, Romania, Sweden and Tajikistan. Specific concerns included the current financial climate, the increasing numbers of people needing treatment and particular issues regarding the continuation of Global Fund financing. Ukraine reported specific challenges with regard to financing treatment of opportunistic infections.
- *Clinical guidelines and protocols* Countries reporting updated guidelines/protocols included Belarus, Greece and Moldova. Some countries, e.g. Switzerland and the UK reported producing guidelines/statements related to ART and onward transmission of HIV. Some countries, e.g. Georgia and Latvia expressed concerns about their ability to provide treatment to all asymptomatic people living with HIV with CD4 <350. Spain indicated that they plan to develop new protocols of care, treatment and monitoring for people living with HIV. Concern was expressed about the lack of a case management protocol in Moldova.
- *Staff capacity* Countries reporting training and staff capacity-building included Azerbaijan, Belarus and Kazakhstan. Ukraine reported training staff in prisons. Sweden reported training staff on how to discuss sexuality with clients. Some countries expressed concern about the number of infectious disease/HIV specialists available, e.g. in Belarus and Lithuania. Moldova expressed concern about underdeveloped human resources. Civil society reported problematic attitudes among some health staff in Lithuania.
- *Continuity of supplies of drugs and commodities* Significant achievements were reported in this area in Albania, Azerbaijan, Belarus, Bulgaria and Latvia. In Bulgaria, this involved establishing an operational reserve of ARV drugs. The government was reported to have taken responsibility for ARV procurement in the former Yugoslav Republic of Macedonia. However, the country recognised the lack of an integrated system for planning, procurement and distribution of ARVs and diagnostic tests. Serbia reported that there had been a reduction in interruptions of drug supply. However, concerns were also raised about restrictive prescribing practices in Serbia, e.g. only proving patients with one month's supply of medicines. Several countries expressed concern about their ability to continue to provide an uninterrupted supply of drugs and other commodities. These countries included Armenia, Belarus, Czech Republic, Serbia and Ukraine. Romania recognised its need to establish a more coordinated approach to ARV purchasing. Procurement processes in Ukraine were reported to be complicated and bureaucratic.
- *The number and type of antiretroviral drugs available* Countries reporting that they had expanded the number of available ARVs included Azerbaijan, Belarus and Romania. Bulgaria noted that they were ensuring up-to-date antiretroviral treatment. The Czech Republic reported making most ARVs available on the national market. Latvia reported that ARVs are now included on their national reimbursement list. Bosnia and Herzegovina expressed concern about their ability to introduce new drugs as recommended by WHO. Concern was expressed that the range of available ARVs was inadequate in Kazakhstan and that not all ARVs are covered by the health insurance fund in Serbia. Tajikistan expressed concern about quality assurance procedures for ARVs in the country.

- *Decentralisation of treatment services* Countries reporting this included Azerbaijan, Bulgaria, Latvia, Moldova and Serbia. Portugal reported a reduction in regional inequalities. The Czech Republic reported a good referral system for people living with HIV. However, some countries, e.g. Azerbaijan, commented that services are not available in some parts of the country. There are particular challenges in providing services in some parts of some countries, e.g. on the left bank of the Dniester river in Moldova. Italy reported the need to eliminate differences between northern, central and southern areas of the country. Slovenia reported challenges in decentralising services to Maribor. Sweden reported that support to people living with HIV is inconsistent across the country. Ukraine reported that treatment services are less accessible in remote areas. Specific concerns were expressed from Romania about the effects of decentralising procurement of ARVs including increasing costs, significant distribution problems and treatment interruptions. As a result, a decision was taken to restart centralised procurement but this has been delayed because of the financial crisis. In Latvia, the number of people using the decentralised services has been low. Reasons for this include limited knowledge of the change among people living with HIV and concerns over standards of confidentiality in the decentralised services.
- *Quality of services* Civil society reported concerns about confidentiality in Lithuania. The condition of some clinical facilities in Serbia was reported to be poor.
- *Laboratory services* Azerbaijan and Tajikistan reported strengthening their laboratory services. Concern was expressed about the ability to sustain CD4, PCR and HIV-resistance testing in Serbia. Ukraine reported that laboratory services for monitoring of people living with HIV are insufficient.
- *ART adherence/retention* Several countries expressed concern about the need to improve ART adherence, including Kazakhstan, Latvia, Lithuania, Portugal, Romania and Ukraine.
- *Addressing HIV treatment resistance* Countries that developed guidelines for monitoring HIV resistance included Belarus and Georgia. Moldova reported developing infrastructure for testing HIV resistance. Austria reported that the probability of developing ART resistance had reduced. Countries reporting the need to address problems relating to drug resistance included Armenia, Belarus, Germany and Lithuania.
- *Specific additional clinical services* Italy reported concluding a trial on transplants for people living with HIV. Both Italy and Spain expressed the need to expand access to organ transplantation for people living with HIV. Spain reported producing guidelines on reconstructive surgery for facial lipodystrophy. Germany reported the need to address more issues related to chronic HIV infection. Spain reported the need to facilitate greater access to assisted reproduction for people living with HIV. Austria expressed concern about relatively high rates of mental illness, osteoporosis, diabetes and cardiovascular disease among people living with HIV.
- *Access for women and children* Moldova reported improving the accessibility and quality of prophylactic ART for HIV-positive pregnant women and opening a paediatric ward in the ARV treatment institution but noted with concern that ART coverage among children remained lower than among adults. Serbia reported provision of ART to children. Ukraine noted that ART coverage among children needing treatment was now almost 100%. Spain reported the challenge of adapting ART to children's needs. Italy recognised the need to pay more attention to gender issues related to ART provision.
- *Management of co-infections* Kazakhstan reported improved prevention of opportunistic infections. Germany reported providing medication for co-infection. Georgia reported making progress in addressing the burden of HIV–hepatitis C co-infection. Belarus and Kazakhstan reported improved collaboration between HIV and TB services. Estonia reported on providing opioid substitution therapy and TB treatment together. Bulgaria reported improved access to management of TB–HIV co-infection. Serbia recognised the need to improve its approach to HIV–TB co-infection including strengthening TB infection control in HIV treatment centres. Austria expressed concern about increasing syphilis co-infection among homosexual men. Estonia and Ukraine reported the challenges they face in seeking to provide combined treatment options for people with multiple treatment needs.
- *Treatment monitoring* Sweden reported the use of nationwide software (InfCare HIV) to provide support from a university hospital to smaller clinics on issues such as low treatment coverage and low treatment success. The UK reported that use of outcome quality indicators demonstrated the high quality of care available.
- *Coordination/integration of services* Kazakhstan reported strengthening inter-agency collaboration and Spain reported improving coordination between health and social services.

Some civil society respondents expressed scepticism about whether or not services were being scaled up. The civil society respondent from Portugal commented that there is a risk that the current financial crisis may affect the country's ability to scale up treatment. From Sweden, the civil society respondent commented that they did not perceive that services were being scaled up as support is very limited outside the major cities.

Some countries, e.g. Luxembourg, Slovenia and the UK, commented that their treatment services are already 'at scale'. The government respondent from Slovenia commented that 'there is no need for scaling up HIV treatment

services because universal access to high quality clinical treatment and care, that is free for patients, is ensured to everyone diagnosed with HIV and in contact with health services. The costs are reimbursed through mandatory health insurance. Psychological support for people living with HIV/AIDS has also been scaled up'. However, the civil society respondent from Slovenia commented that there was a need to scale up psychosocial support for people living with HIV. The UK commented that the main priority is early testing and diagnosis.

Other elements of care and support

Most countries strive to deliver a comprehensive package of HIV treatment, care and support services

In almost all (98%) countries that responded to this question, government respondents reported that they had identified the essential elements of a comprehensive package of HIV treatment, care and support services. However, in six countries – Cyprus, Finland, Lithuania, Serbia, Slovakia and Slovenia – the civil society respondent reported that this was not the case. Examples of specific elements identified are presented in Box 2. The material in Box 2 is illustrative in nature and is not intended to be an exhaustive or definitive list of what constitutes a comprehensive package of HIV treatment, care and support services.

Box 2. Reported examples of elements of a comprehensive package of HIV treatment, care and support services:

- Creating a positive environment for people living with HIV free of stigma and discrimination in which they can continue to work (Albania).
- Delivering medical services confidentially and with the consent of the individual (Albania).
- Ensuring a safe place in which to receive health services (Albania).
- Delivering key elements of medical services, including HIV diagnosis, laboratory monitoring, prevention and treatment of opportunistic infections and medical follow up (Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, the former Yugoslav Republic of Macedonia, Georgia, Kazakhstan, Moldova, Poland, Portugal, Tajikistan, Ukraine and the UK.)
- Monitoring and detection of ARV resistance (Georgia).
- Paediatric AIDS treatment and care (Kazakhstan, Poland, Romania and Tajikistan).
- Financing antiretroviral therapy and providing it free-of-charge (Belarus, Bosnia and Herzegovina, Bulgaria, the Czech Republic, Finland, Kazakhstan, Moldova, Romania, Slovenia, Tajikistan and Ukraine). In Slovakia, HIV testing is provided free-of-charge.
- Treatment of lipoatrophy in Spain.
- Access to assisted reproduction for people living with HIV in Spain.
- Access to organ transplants (Italy and Spain).
- Providing elements of care and support including psychosocial and financial support (Albania, Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, the former Yugoslav Republic of Macedonia, France, Italy, Luxembourg, Poland, Romania, Serbia, Tajikistan and Ukraine). One key focus of care and support is adherence support (Azerbaijan, Belarus, Italy, Poland and Ukraine). In Moldova, this includes community-based support and peer-to-peer care. In Azerbaijan and Serbia, this includes legal support. In Spain, this involves strengthening institutions that offer support to people living with HIV. In Croatia, Romania and Tajikistan, this also includes providing support to family members. In Romania, some people living with HIV may receive a disability allowance depending on the severity of their disease.
- Ensuring the quality of services provided (France, Germany and the UK).
- Ensuring health workers receive the training required (Armenia and Azerbaijan).
- Ensuring that services are accessible to those who need them. In many countries, this has involved decentralising antiretroviral services (Bulgaria, Latvia, Lithuania and Serbia). However, in some countries (Croatia), ART is still provided in only one central hospital.
- Ensuring services cater for particular populations (prisoners in Armenia), undocumented migrants in Germany and people who inject drugs in Kyrgyzstan
- Developing links with other relevant health services, particularly those offering drug treatment (Armenia, Belarus and Estonia), and treatment of other infectious diseases, such as TB, hepatitis and STIs (Armenia, Bulgaria, the Czech Republic, Georgia, Italy, Moldova, Switzerland and Tajikistan).
- Ensuring there is a mechanism to deal with complaints (Albania).
- Using the internet to provide information to patients (Georgia).

Most countries succeed in providing many different elements of treatment, care and support services

Respondents were asked the extent to which they agreed or disagreed with statements regarding the availability of treatment-related services in their country. In general, more than three quarters of respondents, both government and civil society, agreed that a wide range of services were available to all who need them in their country (see Figure 2). These services included ART overall and its specific availability for TB patients, children and women post-delivery and for use as post-exposure prophylaxis (PEP) in both occupational and non-occupational settings. They also included other services including early infant diagnosis; cotrimoxazole prophylaxis for people living with HIV; psychosocial support; STI management; treatment of common HIV-related infections and various services related to HIV and TB. In general, the most available of these services was PEP in occupational settings.

Overall, government responses were more positive than those for civil society except in the cases of paediatric AIDS treatment and provision of psychosocial support for people living with HIV.

There were three services which were considered less available in the countries. Treatment, care and support in the workplace may be less relevant for this region than for others as treatment is provided in healthcare settings and not in workplace settings. Just under two thirds (63%) of government respondents and just over half (52%) of civil society respondents agreed or strongly agreed with the statement that the majority of people living with HIV in the country who need nutritional care receive it. There was a marked difference in this finding between EU/EFTA and non-EU/EFTA countries. More than three quarters (77%) of government respondents from EU/EFTA countries that responded agreed or strongly agreed with this statement. However, this was the case in just over one third (38%) of non-EU/EFTA countries (see Table 2 and Figures 3 and 4).

Figure 2. Percentage of responding countries that agree or strongly agree that the majority of people in the country who need the following services have access to them: Government and civil society respondents

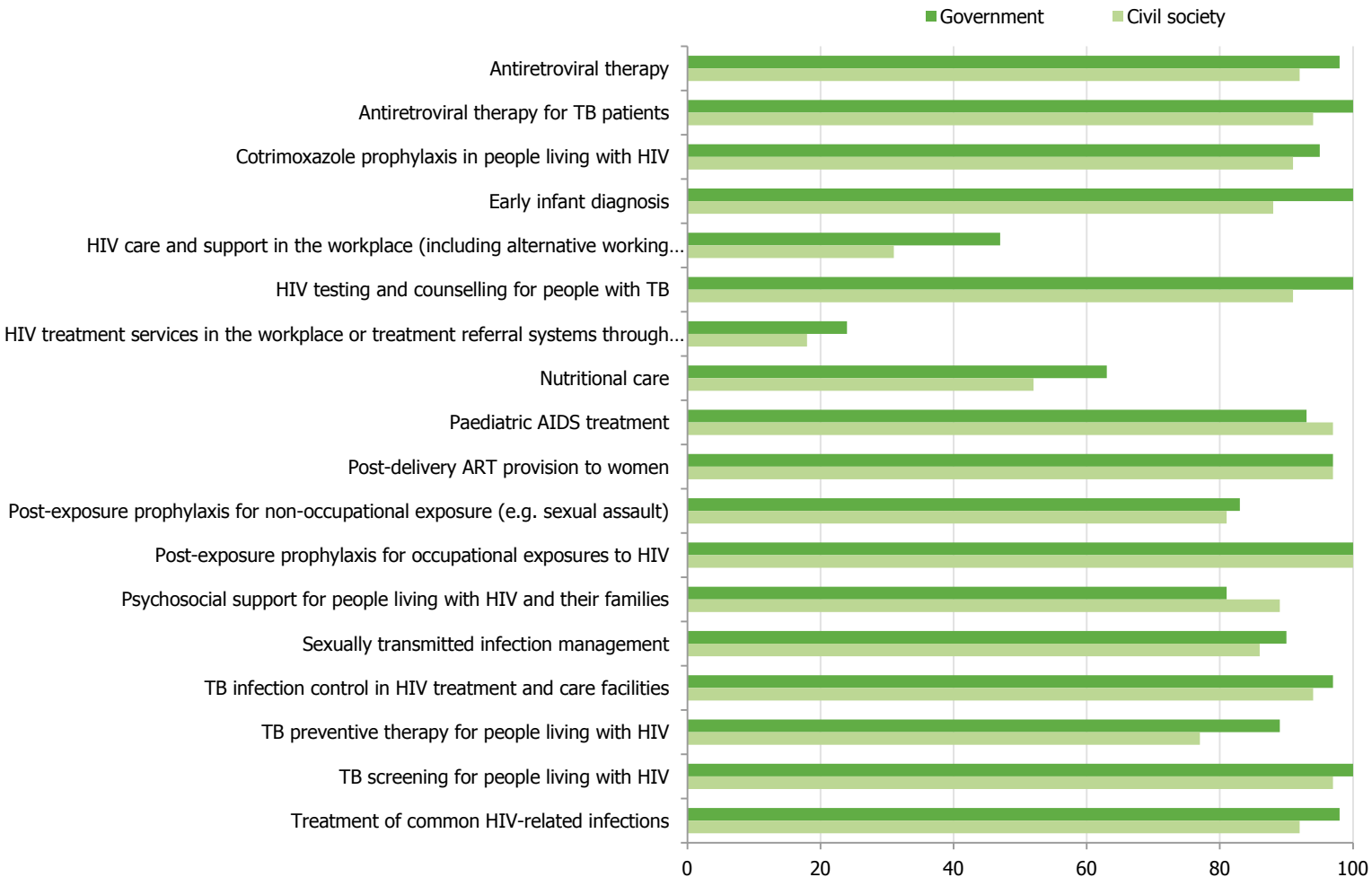
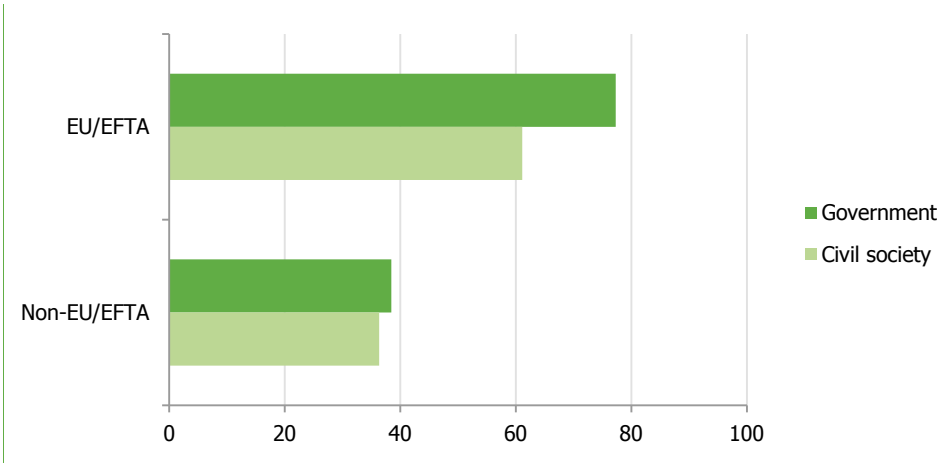


Table 2. Countries in which at least one respondent was neutral, disagreed or strongly disagreed that nutritional care was accessible to the majority of people living with HIV who needed it

EU/EFTA			Non-EU/EFTA		
Country	Government	Civil society	Country	Government	Civil society
Bulgaria	Neutral	N/A	Albania	Neutral	Disagree
Czech Republic	Neutral	Strongly agree	Bosnia and Herzegovina		
Estonia	Disagree		the former Yugoslav Republic of Macedonia		
Greece			Georgia	Strongly agree	Disagree
Latvia	N/A		Kyrgyzstan		
Lithuania	Neutral	Disagree	Moldova	Neutral	Agree
Portugal	Neutral		Serbia	Agree	Disagree
Romania	Agree	Disagree	Tajikistan	Disagree	
Slovenia	Agree	Disagree	Ukraine	Disagree	Disagree

Figure 3. Percentages of respondents that agreed or strongly agreed that nutritional care was accessible to the majority of people living with HIV who needed it: Comparison of EU/EFTA with non-EU/EFTA countries



NGOs play an important role in providing care and support services in many countries

In several countries, care and support services are provided by NGOs. For example, in Belarus, services provided by NGOs include palliative care, support groups, programmes for children and families of people living with HIV, support programmes for people who inject drugs and support for people living with HIV in prisons. In Bulgaria, psychological and social support for people living with HIV is provided through NGOs in Sofia, Varna and Plovdiv. In Croatia, an NGO provides support services to people living with HIV in the same hospital where they are treated. In Serbia, support has been given to establishing a new organisation of people living with HIV that is able to offer care and support programmes. In Ukraine, care and support services are implemented exclusively by NGOs.

Some countries expressed concern about over-reliance on NGOs for these services, including Italy, Moldova, Portugal and Ukraine. A few countries, however, expressed the desire to involve NGOs more in HIV responses.

Countries have made significant achievements in providing care and support for people living with HIV but also face challenges in this area

Countries highlighted achievements and challenges relating to a number of areas of care and support:

- *Decentralisation of services* Ukraine reported improved access to care and support services in its regions. Finland reported the need to guarantee care and support for people living with HIV in different parts of the country where the number of HIV-positive people and nursing resources are not matched. Bosnia and Herzegovina reported wishing to provide improved socioeconomic support to people living with HIV through decentralised services.
- *Coordination between civil society and the public sector* this was reported to have improved in Kyrgyzstan.
- *Involvement of people living with HIV* including through expanded networks of people living with HIV in Slovakia and Tajikistan such as the establishment of networks for women in Tajikistan. This also included scaling up positive prevention in Portugal and the recognition of the need to do this in Slovenia. Azerbaijan expressed the need to involve people living with HIV more. Civil society in Spain expressed the need to make information about drugs and clinical trials more available for people living with HIV.
- *Palliative care services* these were reported to have expanded in Azerbaijan. Belarus reported having trained people living with HIV, their relatives and volunteers in palliative care. Moldova reported development of a regulation on the organisation of palliative care for people living with HIV.
- *Psychological and social support services for people living with HIV* these were reported to have expanded in Belarus, Bulgaria, Bosnia and Herzegovina, Croatia, Romania, Serbia, Slovenia and Ukraine. Both Lithuania and Spain reported wanting to improve psychosocial support for people living with HIV. Lithuania reported a lack of support for family members. Serbia identified the need for more nutritional care. Italy reported the need for home care assistance for patients with chronic HIV. Spain reported the need for greater protection of the employment rights of people with HIV.

Addressing late HIV diagnosis across the region

Rates of late diagnosis remain high across the region

In the previous round of Dublin reporting, data were available on CD4 count at time of diagnosis for 21 countries. Of these, 20 also reported data in this round, however no data were reported for Lithuania. In addition, a further 18 countries reported data for this indicator (see Annex 3 and Table 3).

Table 3. Key indicators related to late HIV diagnosis over two rounds of Dublin reporting

	Dublin reporting 2010	Dublin reporting 2012
Number of countries reporting data on late diagnosis	21	38
Percentage of new HIV infections with CD 4 count at time of diagnosis	50%	68%
Percentage of all new HIV diagnoses with a CD4 count <350 at time of diagnosis	26%	35%
Percentage of new HIV diagnoses with a CD4 count available at time of diagnosis with a CD4 count <350 at time of diagnosis	53%	46%

Please note that not all data sets from all countries contained all data points. As a result, the data sets used to calculate the figures presented vary by indicator and are therefore not directly comparable.

Overall, countries reported that a higher percentage (68%) of people newly-diagnosed with HIV received a CD4 count at the time of diagnosis than was reported in the last round of Dublin reporting (50%) (see Table 3). This was also the case in three quarters (75%) of countries reporting data for this indicator in both rounds of Dublin reporting (see Table 4). Bulgaria, Cyprus, the former Yugoslav Republic of Macedonia, Portugal and Spain, did not report an increase in the rate of CD4 testing at time of diagnosis. In some of these cases, e.g. Spain, the rate of CD4 testing at time of diagnosis was and remained high. Countries reporting rates of CD4 testing at the time of diagnosis above 80% included the Czech Republic, Denmark, Kazakhstan, Luxembourg, Malta, Slovenia, Spain and the UK. The UK commented that one of the quality of care indicators now being reported by the public health authorities is the proportion of adult HIV patients receiving a CD4 count within three months of diagnosis. Countries reporting rates of CD4 testing at the time of diagnosis below 20% included Montenegro and Portugal.

In general, it might be expected that, if more people have a CD4 count taken at the time of diagnosis, more people would be found to have low CD4 count at this time and the percentage of all new diagnoses with a low CD4 count at the time of diagnosis would rise. This was the case in almost two thirds (65%) of the countries reporting data on this indicator to both rounds of Dublin reporting (see Table 3). Countries in this category were Armenia, Bosnia and Herzegovina, Belgium, Finland, France, Germany, Latvia, Luxembourg, Netherlands, Romania, Slovakia, Tajikistan and the UK. The Czech Republic and Slovenia had a rise in the proportion of people receiving a CD4 count at the time of diagnosis but no rise in the proportion of people with low CD4 count at the time of diagnosis. Possible explanations for this are either that CD4 count had previously been carried out on all those with low CD4 count or the rate of late diagnosis may be falling in these countries. Overall, the rate of late diagnosis as a proportion of all new HIV diagnoses rose between the time of the last round of Dublin reporting (26%) and the current round of reporting (35%). Rates of late diagnosis as a proportion of all new HIV diagnoses varied from 7% in Portugal to 100% in Malta. However, the key factor in determining this is the proportion of people newly diagnosed with HIV receiving a CD4 count at the time of diagnosis.

Table 4. Trends in indicators related to late HIV diagnosis in countries who reported in first round of Dublin reporting

	% of new diagnoses with CD4 count available	% of those with available CD4 count with late diagnosis	% of all new diagnoses with late diagnosis
Armenia	↑	↓	↑
Bosnia and Herzegovina	↑	-	↑
Belgium	↑	-	↑
Bulgaria	↓	↓	↓
Cyprus	↓	↑	↓
Czech Republic	↑	↓	-
Finland	↑	↓	↑
the former Yugoslav Republic of Macedonia	↓	-	↓
France	↑	↓	↑
Germany	↑	↑	↑
Latvia	↑	↑	↑
Lithuania	No follow up data		
Luxembourg	↑	↓	↑
Netherlands	↑	↑	↑
Portugal	-	-	-
Romania	↑	-	↑
Slovakia	↑	↑	↑
Slovenia	↑	↓	↓
Spain	↓	↓	↓
Tajikistan	↑	↑	↑
United Kingdom	↑	↓	↑

↑ denotes an increase between two rounds of reporting; - denotes no change; ↓ denotes a decrease: colour coding – green for positive changes, red for negative changes and amber for no change

Conversely, it might be expected that, if more people have a CD4 count taken at the time of diagnosis, the proportion of those with a low CD4 count at that time would fall. This would be the case if CD4 testing was previously triggered by evidence of more advanced disease. This pattern was seen in more than one third (35%) of the countries reporting data on this indicator to both rounds of Dublin reporting (see Table 3). Countries in this category were Armenia, Czech Republic, Finland, France, Luxembourg, Slovenia and the UK[i]. Bulgaria and Spain had a fall in this proportion despite a fall in the proportion of those having a CD4 count available at the time of diagnosis. This may suggest that the rate of late diagnosis may be falling in these countries.

Overall, the rate of late diagnosis among those who had a CD4 count at the time of diagnosis fell from the time of the last round of Dublin reporting (53%) to the current round of reporting (46%) (see Table 3). Rates of late diagnosis among those with CD4 count available at the time of diagnosis varied from 20% in Kazakhstan to 100% in Bosnia and Herzegovina, Malta and Montenegro. High rates may be due to countries only providing CD4 counts to those with suspected late disease at the time of diagnosis. But, in countries where rates of CD4 testing among people newly-diagnosed with HIV are high, e.g. Malta, this probably does reflect high rates of late diagnosis in the country. More details of late diagnosis in some countries are presented in Box 3.

[i] In the case of the UK, it appears that almost all people with a new HIV diagnosis have a CD4 count at the time of diagnosis. However, there have been some problems in some locations with reporting this data. It is considered that the distribution of late diagnoses is the same among those locations that do report and those that do not. As a result, the fall in the rate of late diagnosis among those with a CD4 count at the time of diagnosis probably reflects a real reduction in the rate of late diagnosis among those newly-diagnosed with HIV infection.

Several countries reported rates of late diagnosis among all those newly-diagnosed with HIV, by sex (36 countries) and by age (36 countries) (see Annex 4). There was no difference or inconsistent difference in coverage between the sexes in eight countries and by age (<15; >15) in 14 countries. Where differences related to sex occurred, these differences were often slight and varied between countries with just over half (57%) reporting higher rates of late diagnosis among women than among men. In almost three quarters (73%) of countries with a difference in rates of late diagnosis between age groups, the rate of late diagnosis was higher among those aged over 15 than those aged under 15. In some of the six countries showing the reverse picture, the numbers of those under 15 were very small (1–3). Countries which showed this pattern among a larger number of children included Belarus, Georgia, Kazakhstan and Kyrgyzstan.

Box 3. Late presentation for HIV diagnosis and care: country examples

In Austria, distinction is made between late (CD4 <350) and advanced diagnosis (CD4 <200). Among 3 061 new HIV infections diagnosed between 2001 and 2010, 50.2% were classified as late and 30.0% as advanced. Increased risk of late and advanced diagnosis was found among those infected heterosexually and among those originating from high-prevalence countries. No change in the rate of late or advanced diagnosis was reported over time.

In Germany*, data from the national surveillance database for 2001 to 2010 show that almost half (49.5%) of 22 925 eligible patients were found to have a CD4 count <350 cells/ at the time of diagnosis. Between 1999 and 2010, more than half (58.1%) of 6 897 treatment-naive patients in the ClinSurv cohort study were found to have a CD4 count <350 cells/ mm^3 at the time of diagnosis. Late presentation was associated with older age (median 42 vs 39 years for early presenters and was more likely among migrants and heterosexuals than among men who have sex with men. The probability of late presentation among men who have sex with men declined between 1999 and 2010. However, the authors conclude that, in Germany, the numbers of late presenters for HIV diagnosis and care remain high. The probability of late presentation for HIV diagnosis seems to be particularly high for migrants. Late presentation for care seems to be an additional problem after HIV diagnosis.

In the UK, in 2010, a total of 3 300 adults were diagnosed at a late stage of infection, equivalent to just over half of all people diagnosed that year. The rate of late diagnosis was reported to have declined from 59% in 2001 to 50% in 2010. This was reported to be due to the UK's approach of routinely offering HIV testing to all those attending sexual health clinics and for antenatal care. Nevertheless, most of those being diagnosed late have had previous contact with healthcare professionals who, if they had been aware of the latest information on HIV, including common presenting conditions, could have made the HIV diagnosis much earlier.

**Zoufaly A, An der Heiden M, Marcus U, Hoffmann C, Stellbrink H.J, Voss L, et al. (2012) Late Presentation for HIV Diagnosis and Care in Germany HIV Medicine 13, 172–181*

Although some caution is needed in interpreting late diagnosis data[i], rates of late diagnosis remain very high across countries. Almost half of those people newly-diagnosed with HIV infection already require treatment at the time of diagnosis. As a result, it is clear that there are many people across countries in Europe and Central Asia who are HIV-infected and require antiretroviral therapy but are not yet receiving it as they have not yet been diagnosed. This is of great concern and requires further attention from policy makers and programmatic level decision makers alike.

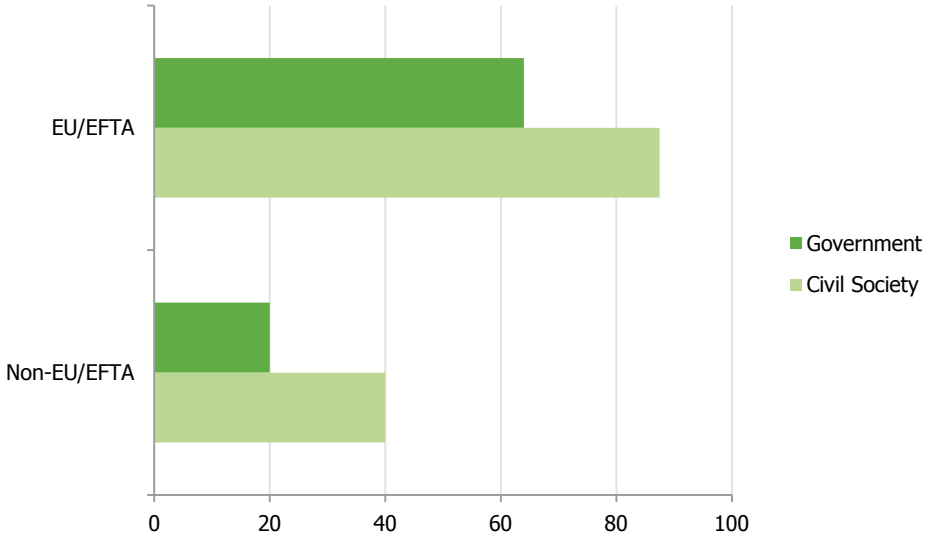
[i] Particular caution is needed in interpreting late diagnosis data where they are expressed using the number of people with a CD4 count available at the time of diagnosis as the denominator because results will depend on policy for CD4 testing at the time of diagnosis. For example, apparent 'rates of late diagnosis' would be expected to be higher using this method in a setting where CD4 testing was only carried out at time of diagnosis on symptomatic patients compared to a setting where CD4 testing was carried out on everyone. In their response on this topic, Germany noted that rates of late diagnosis will fluctuate depending on the stage of an epidemic and rates of HIV incidence. For example, in a new HIV epidemic, rates of late diagnosis would be low. The same would be expected to be true in cases of an outbreak, i.e. high HIV incidence. Conversely, as HIV incidence falls, the proportion of late diagnoses would be expected to rise if HIV testing policy and practice remained unchanged.

Providing treatment, care and support to key affected populations

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

Respondents were asked if there are vulnerable or marginalised populations who have more difficulty accessing HIV treatment, care and support services. In EU/EFTA countries, this was reported to be the case by civil society respondents in almost all countries (88%) and by government respondents in almost two thirds (64%). 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 4). 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 some countries than in others. 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 4. Percentage of responding countries recognising that vulnerable and marginalised populations find it more difficult to access HIV treatment, care and support



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 the 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 (38%) (see Figure 5). Particular groups identified as facing such obstacles in many countries included people living with HIV, migrants, people who inject drugs, prisoners and sex workers (see Figure 6).

Figure 5. Percentage of 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

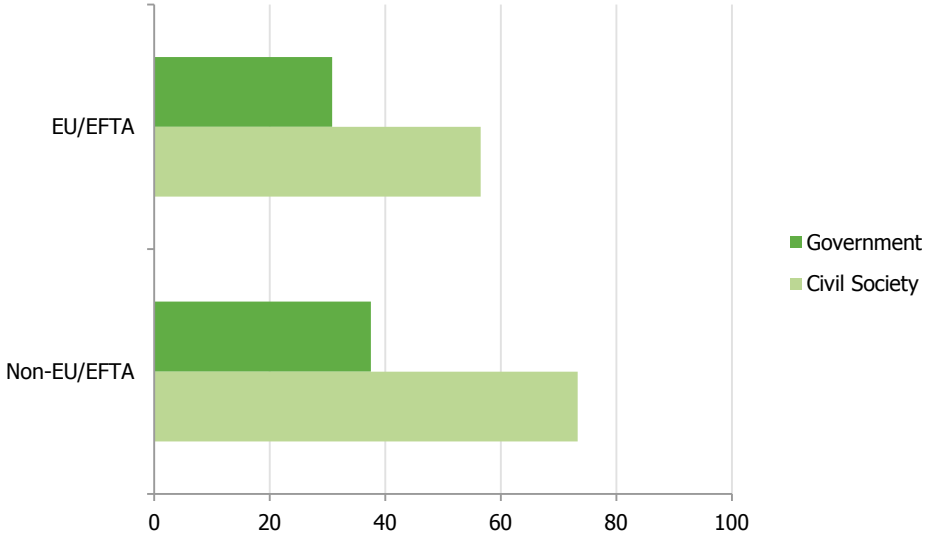
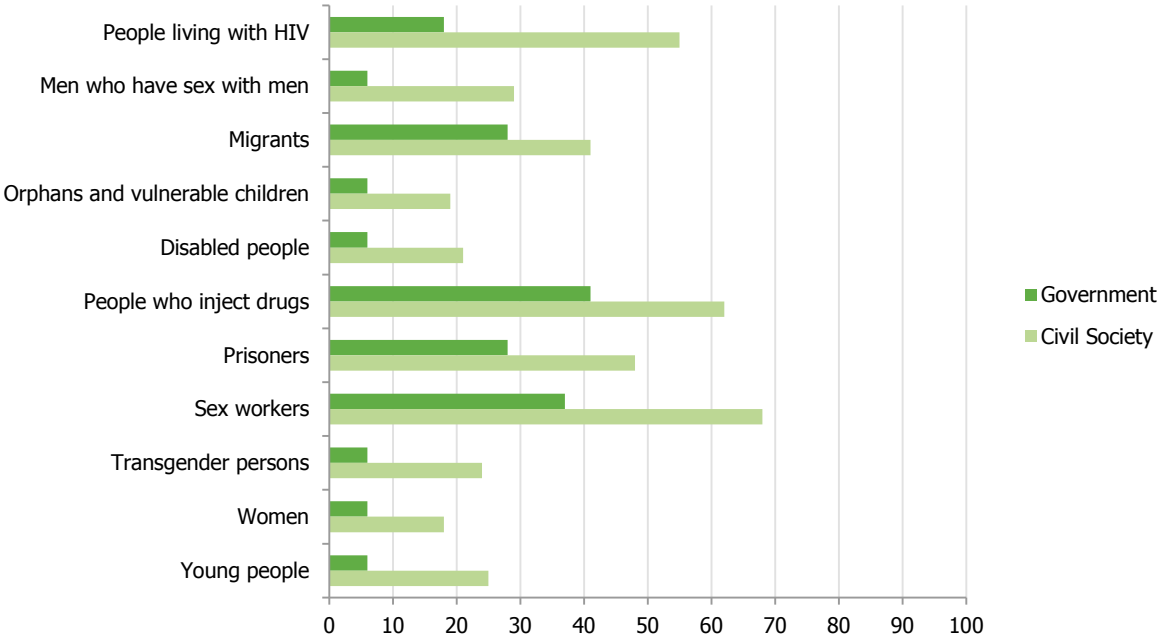


Figure 6. Percentage of countries reporting that there are laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support by specific key populations and vulnerable groups



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. These populations included:

Key populations at increased risk of HIV infection overall e.g. 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, e.g. in Azerbaijan. 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 that they did focus their efforts to provide treatment on these populations included Spain and Tajikistan.

Migrants e.g. 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, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, the UK and Ukraine. 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 UK; asylum seekers in Israel and the 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 the 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 the delivery of HIV programmes. Changes in legislation in France have affected the health of sex workers as sex workers have moved location, 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 some countries reported particular efforts to promote treatment and care among men who have sex with men, e.g. in Spain. For example, France reported developing a brochure focused on gay men living with HIV.

Those in places of detention These 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 the 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.

People lacking health insurance In Estonia, the main barriers to HIV services are reported to be unrelated to risk behaviour or membership of a vulnerable group. Rather, they relate more specifically to the employment/social status and access to health insurance. Uninsured people currently comprise around 6% of the population, consisting mainly of low-income men who either are long-term unemployed or work in the informal sector. Around 30–50% of people who inject drugs in Estonia are uninsured. Those lacking health insurance in Belgium, Germany, Greece, Israel and Slovakia also have difficulty accessing treatment as well as people lacking documents in Bulgaria.

Those who are socially marginalised e.g. in Luxembourg, those with difficult socioeconomic status in Bulgaria; those who are homeless in Italy, Norway, Slovakia and Spain; people with low income in Ukraine; disabled people in state-run institutions in Ukraine; and victims of violence in Ukraine.

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 people who inject drugs, men who have sex with men, migrants and transgender persons.

Children in Serbia and Ukraine; and teenagers in Ukraine. In Croatia, there is a regulation which prohibits HIV testing in minors without the consent of their parents. In the former Yugoslav Republic of Macedonia, similar regulations restrict provision of services to those under the age of 16 without the consent of their parents.

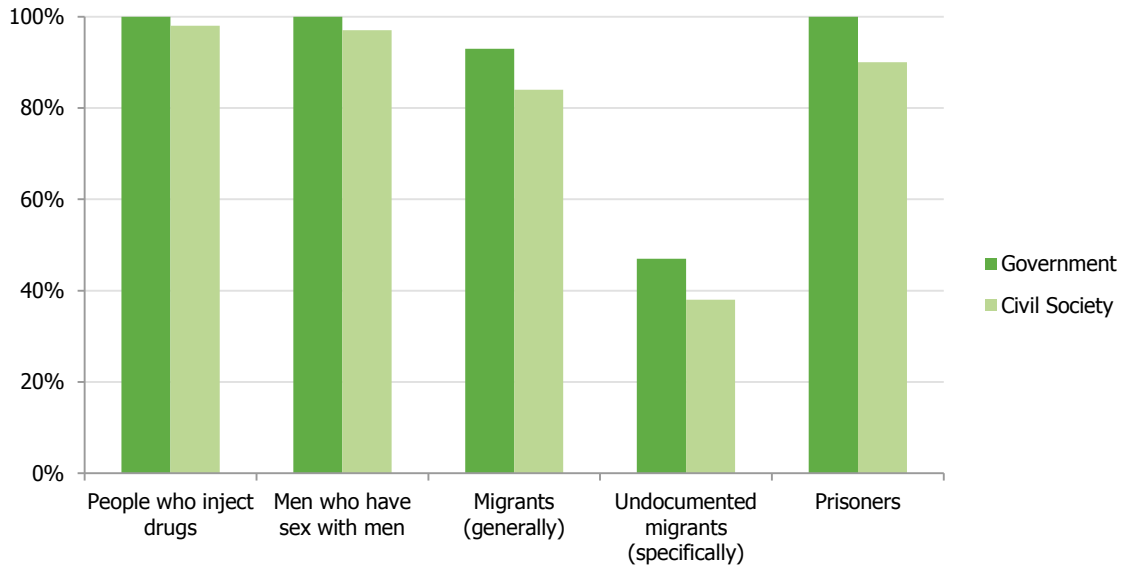
There is some evidence that these difficulties and obstacles may reduce antiretroviral therapy coverage and increase rates of late diagnosis among some key affected subpopulations

For example, there is evidence from Kyrgyzstan that ART coverage among people who inject drugs may be lower than among other people. Similarly, there is evidence that rates of late diagnosis may be higher than among other members of the population in:

- people who inject drugs in Armenia, Belgium, France, Italy and the Netherlands
- migrants in Belgium, Germany, Italy, the Netherlands and the UK (see Box 3)
- men who have sex with men in Latvia.

Nevertheless, most respondents from both government and civil society concluded that ART is readily available for people who inject drugs, men who have sex with men, migrants (in general) and prisoners (see Figure 7). However, this was only the case for undocumented migrants in less than half (47%) the responding countries according to government respondents and only just over one third (38%) of responding countries according to civil society respondents.

Figure 7. Percentage of responding countries reporting that antiretroviral therapy is readily available for key populations



The proportion of EU/EFTA countries reporting that ART is available for undocumented migrants was lower than for non-EU/EFTA countries. In the case of EU/EFTA countries, 44% of government and 29% of civil society respondents answering the question reported that ART is available for undocumented migrants in their country. The figure was over half (54%) for both government and civil society respondents in non-EU/EFTA countries (see Figure 8).

Figure 8. Percentage of responding countries reporting that antiretroviral therapy is available for undocumented migrants

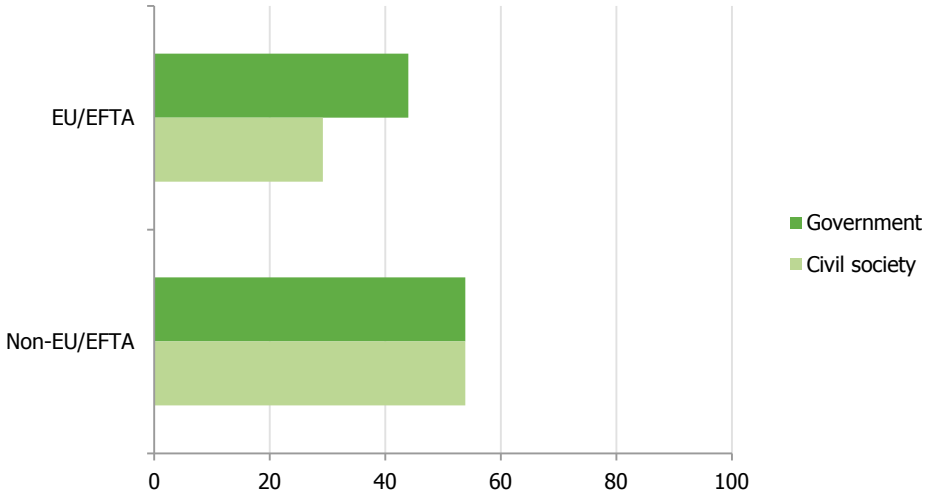
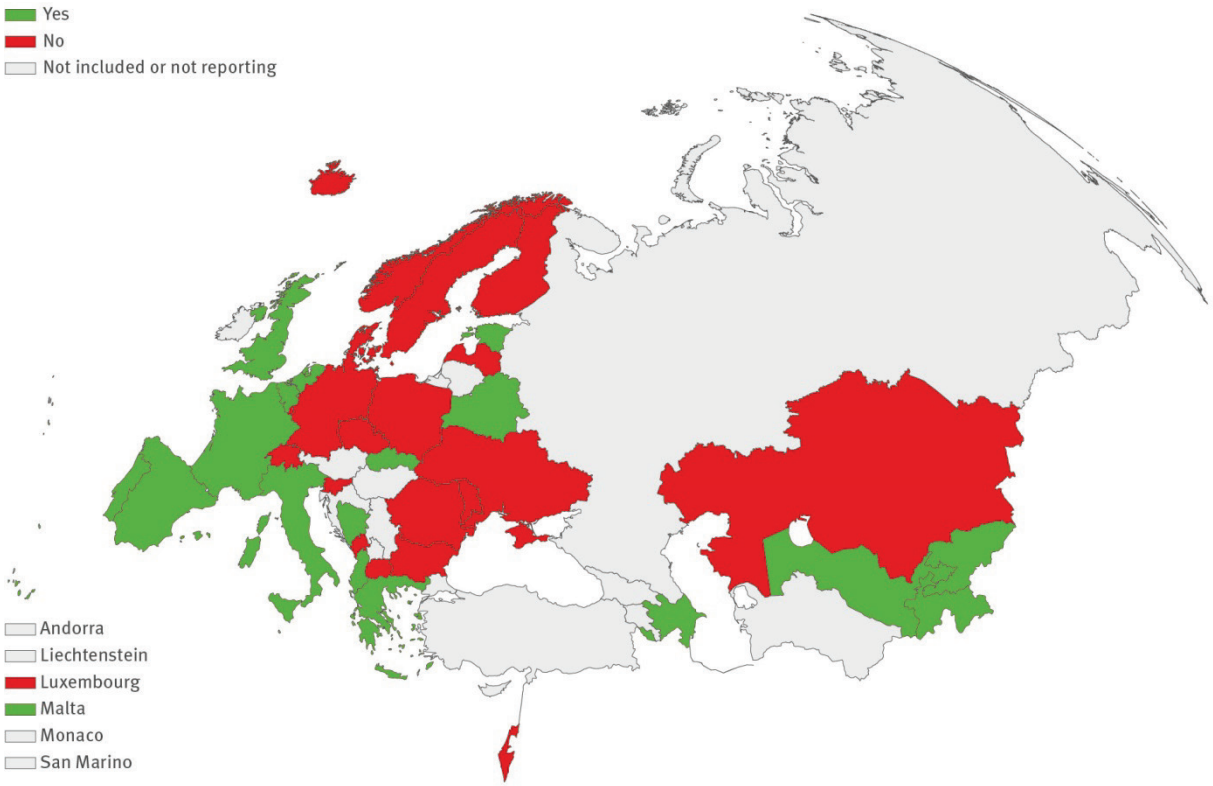


Figure 9 shows the countries which reported that ART is available/unavailable for undocumented migrants[i].

Figure 9. Countries reporting that antiretroviral therapy is available/unavailable for undocumented migrants



[i] Where government and civil society respondents expressed the same opinion this opinion was used. Also, where either respondent expressed an opinion and the other sector did not respond, the response given was used. In five cases, divergent views were expressed between civil society and government respondents. In four cases (Greece, Kyrgyzstan, Slovakia and the UK), the government respondent expressed the view that ART is available for undocumented migrants while the civil society respondent expressed the contrary view. The situation was reversed in Moldova.

Countries reported a number of reasons why ART is not available for undocumented migrants. Many of these reasons relate to how ART for undocumented migrants should be financed, e.g. in Germany and Israel. Although several respondents assumed that undocumented migrants would not be able to access ART unless it was provided free of charge, two countries – the Netherlands and the UK – distinguished between availability of treatment and who was expected to pay for it. In the case of the UK[i], the government respondent commented that 'a small number of overseas visitors are currently excluded from free HIV treatment but in practice there is no evidence treatment is refused although it may be chargeable.' In the case of the Netherlands, the civil society respondent commented that 'persons who are illegally present in the Netherlands have to pay their own healthcare expenses. They are not covered by the Health Insurance Act. If undocumented persons can prove that they are not able to pay for the cost of medical care, then the healthcare provider can claim part of his costs from a special national budget.'

Countries reported a variety of reasons why undocumented migrants are unable to receive antiretroviral therapy free of charge:

- In many countries, this is because ART is provided on the basis of health insurance and most undocumented migrants are uninsured. This is the case in the Czech Republic, Finland, Hungary, Israel, Montenegro, Poland and Slovakia. In Israel, women are able to receive ART while pregnant and for six months afterwards irrespective of whether or not they have health insurance. In Switzerland, undocumented migrants are reportedly able to have health insurance but, in most cases, are unable to afford the premiums.
- In some countries, e.g. Denmark and Luxembourg, ART is provided on the basis of being eligible for social security. In Denmark, this is linked to permanent residence and in Luxembourg this requires a fixed address.
- In some countries, e.g. Georgia, Romania and Ukraine, ART is provided on the basis of citizenship. In Romania, this is assessed on the basis of identity papers.
- In some countries, e.g. Bulgaria and Latvia, ART provision requires some form of registration with HIV services.

Other reasons why undocumented migrants may not access ART include difficulties in reaching them as they are a marginalised group, (Switzerland). In Slovakia, there are no specific services focused on undocumented migrants. In Spain, it is reported that undocumented migrants are reluctant to access health services for fear that their immigration status will become known to the police.

In some countries, e.g. Sweden and the UK, it is reported that ART may be provided free of charge informally to undocumented migrants by individual doctors despite rules or restrictions which should prevent this.

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 UK; 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 person 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. The Swedish civil society respondent commented that migrants face particular problems in accessing HIV services outside the main urban centres.

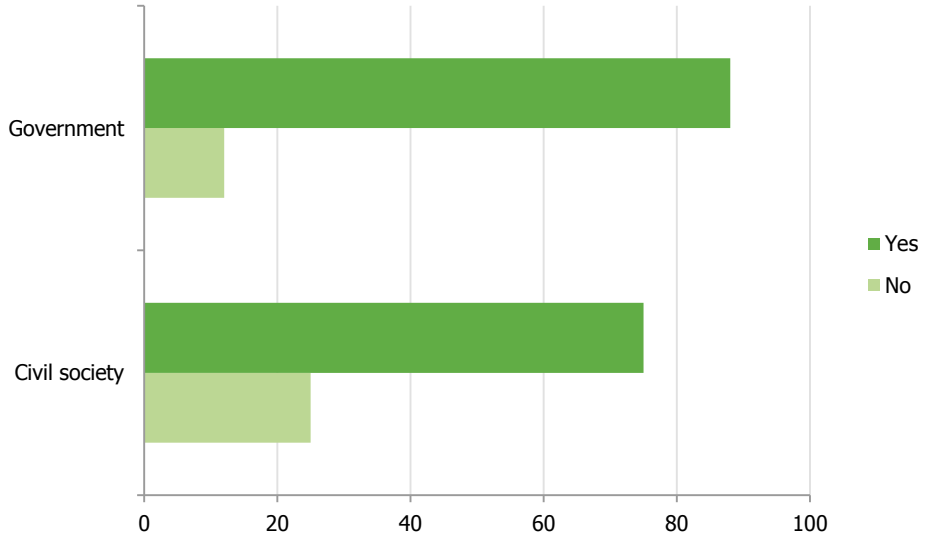
[i] The United Kingdom also reported that from October 2012, the practice of charging people with no 'leave to remain' for HIV treatment will be stopped.

Treatment as prevention

Most countries consider treatment as prevention as part of their HIV prevention efforts

Almost all (88%) government and three quarters (75%) of civil society respondents considered treatment as prevention to be part of national HIV prevention efforts (see Figure 10).

Figure 10. Percentage of government and civil society respondents reporting that treatment as prevention is part of prevention efforts

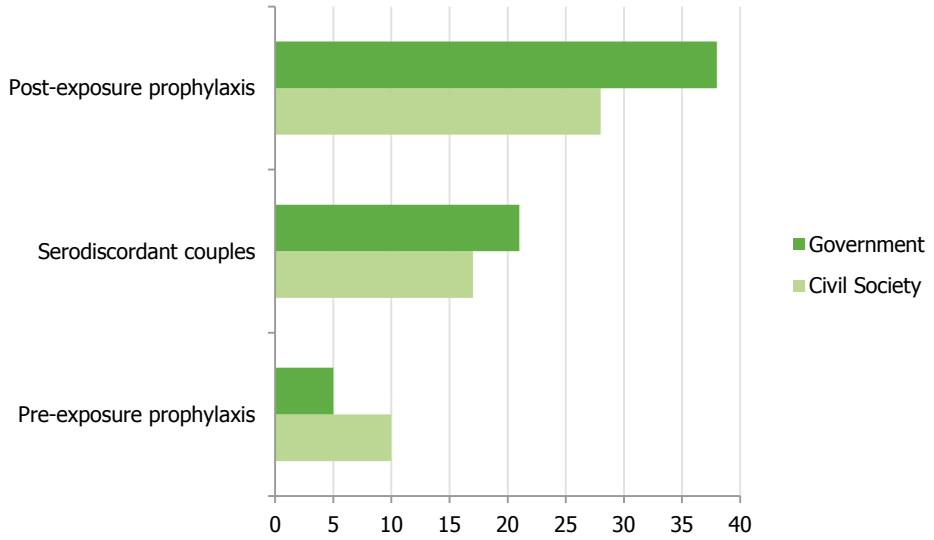


A number of countries commented that there was, however, no formal policy, programme or strategy in place, although there was reported to be great interest in the topic. In Albania, the government respondent commented that there was no policy, programme or strategy in place regarding treatment as prevention. The civil society respondent commented that there is a policy on post-exposure prophylaxis (PEP). In Finland, the government respondent reported that treatment as prevention is being considered. The civil society respondent commented that there is a general understanding that this is an effective approach to prevention. In Ireland, the civil society respondent commented that there had been discussions about treatment as prevention among civil society organisations but not in national level structures. In Italy, the government respondent commented that there is an ongoing debate in the scientific community on treatment as prevention but PEP for occupational exposure is available at the discretion of individual physicians. In Slovakia, the civil society representative reported limited awareness of treatment as prevention as an approach. In Ukraine, the civil society representative reported that there is no clear-cut state policy on the issue. Currently, most ART in Ukraine is reported to be prescribed for late-stage disease so the focus is more on 'life extension' than on prevention.

Countries conceive treatment as prevention in different ways and as consisting of different elements

Different countries appear to understand treatment as prevention in different ways. Government respondents from 38 countries and civil society respondents from 28 considered PEP to be part of their approach to treatment as prevention. The numbers were lower for work with serodiscordant couples and pre-exposure prophylaxis (PreP) (see Figure 11). Government respondents in three countries (Iceland, Romania and Uzbekistan) and civil society respondents in seven countries (Bulgaria, Estonia[i], Iceland, Romania, the UK, Ukraine and Uzbekistan) reported that all three approaches to treatment as prevention were available in their country.

Figure 11. Number of government and civil society respondents reporting different elements as part of treatment as prevention



Specific issues were raised by a number of countries related to treatment as prevention.

- Denmark recognises the overall value of HIV treatment in lowering community viral load and thus contributing to HIV prevention but not on the individual level.
- Some countries made specific comments about PEP. For example, costs of both occupational and non-occupational PEP can be reimbursed in Belgium. Both occupational and non-occupational PEP are available in Estonia, Slovenia and Ukraine. In Hungary, PEP is reported to be available for occupational exposure only. In Latvia, both PEP and pre-exposure prophylaxis (PrEP) are reported to be available according to clinical guidelines.
- Azerbaijan commented that ART is viewed as a method of HIV prevention in harm reduction programmes among vulnerable populations.
- In Georgia, ART is available for serodiscordant couples only when they wish to have a child in order to prevent transmission to the child. Efforts were made a few years ago to advocate for PrEP but this was not possible because of lack of funding. In Hungary, treatment is reported to be available to serodiscordant couples on an individual basis. In Malta, treatment as prevention is given to the positive partner of a serodiscordant couple before there is the need to start treatment according to CD4 count. In Switzerland, efforts are focused on serodiscordant couples because of evidence that 30% of infected men and 60% of infected women became infected in a stable partnership.
- Since July 2010, France adopted a policy which allowed ART to be started when the CD4 count was <500 or if there is a wish to reduce the risk of HIV transmission. Similarly, in Germany, since May 2012, an explicit desire to reduce infectiousness has been considered a valid reason for starting ART. In 2012, guidelines published by the British HIV Association were revised with a specific recommendation that doctors discuss antiretroviral treatment as prevention with all patients with HIV, and that it should be offered to those who want to protect their partners from the risk of HIV infection – even if they have no immediate clinical need for treatment themselves.

[i] In commenting on the report, the Estonian government respondent questioned the accuracy of this response as the country does not yet have official guidelines on PrEP. Although some people may receive 'what we call' PrEP in Estonia, it is not yet common practice.

Conclusions

Most countries have a strong focus on delivering treatment, care and support for people living with HIV, including, in particular, providing ART to those who have been diagnosed with HIV and are known to need ART. Overall, efforts are considered good by both government and civil society respondents in most countries.

The number of people receiving ART in countries has increased considerably since the last round of Dublin reporting two years ago. The rate of increase has been particularly high in non-EU/EFTA countries. For example, between the two rounds of Dublin reporting, the number of people reported to be receiving ART in Azerbaijan and Tajikistan increased more than eight-fold and in Russia a three-fold increase.

As total spending on HIV continues to increase in most countries, largely as a result of the costs of an increasing number of people receiving ART, there are concerns less funding will be available for prevention services targeted to those most at risk. In addition, the challenge for all countries of providing treatment to all in need is likely to increase given the movement of international guidelines toward earlier antiretroviral treatment.

Overall, across countries, most people (>85%) diagnosed with HIV who are known to need treatment receive it. However, this is not the case in some non-EU/EFTA countries that provided data to ECDC, including Azerbaijan, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan, Ukraine and Uzbekistan. With respect to Russia, no figure on how many people are in need of treatment was provided. For this reason, it is not possible to provide an ART coverage number for Russia.

In addition, almost all countries seek to provide people living with HIV with a comprehensive range of HIV treatment and care services. In general, most such services are reported to have good availability. However, nutrition care appears to be less available in non-EU/EFTA countries than in EU/EFTA countries. NGOs are recognised as playing a vital role in providing care and support services for people living with HIV in many countries.

However, overall rates of late diagnosis of HIV remain high across the region. Almost half of those being diagnosed with HIV are already in need of treatment (CD4 <350). This means that a substantial number of people who need ART are not receiving it because their HIV infection has not yet been diagnosed. More countries are tracking and reporting data on this indicator than for the previous round of Dublin reporting. In addition, the proportion of people diagnosed with HIV who received a CD4 count at the time of diagnosis rose from 50% in the previous round of reporting to 68% in this round.

Many countries recognise that key affected populations, such as migrants, people who inject drugs, prisoners and sex workers, have difficulty in accessing HIV treatment services. There are particular difficulties relating to undocumented migrants accessing HIV treatment and care. Although laws, regulations and policies are reported as being obstacles to HIV services in non-EU/EFTA countries more than in EU/EFTA countries, EU/EFTA countries are more likely to recognise the difficulties marginalised and vulnerable populations have in accessing HIV, treatment and care services. In many countries, the difficulties faced by key affected populations relate more to their social marginalisation, e.g. lacking health insurance, than the HIV risk behaviour of a particular sub-population.

Most countries now recognise treatment as prevention as part of their country's prevention efforts. However, there is no clear, shared definition of what constitutes treatment as prevention. Relatively few countries have taken explicit steps to promote use of antiretroviral medicines for preventive purposes before treatment is indicated on the basis of CD4 count. Countries which have done so include France, Germany and the UK.

In 2010, the ECDC report on monitoring the implementation of the Dublin Declaration identified a number of key issues needing further action. Progress on addressing these is summarised here:

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 for countries in Europe and Central Asia to focus on addressing the critical issue of late diagnosis of HIV infection as this is resulting in delays in starting ART for a significant number of PLWHA. This could include rigorously tracking the proportion of PLWHA with late diagnosis, i.e. a CD4 count < 350 cells/mm^3 at the time of diagnosis and introducing measures aimed at reducing the proportion of PLHIV with late HIV diagnosis..	Limited progress / Good progress	More countries are tracking and reporting data on late diagnosis and there is evidence that the proportion of people with CD4 count at the time of diagnosis is increasing. But rates of late diagnosis remain very high with almost half of those diagnosed with HIV already needing treatment by time of diagnosis.
There is a need for countries of Europe and central Asia to address the obstacles faced by some populations in accessing ART. These include, in particular, PWID, prisoners and migrants.	Limited progress / Good progress	Many countries have reported measures they are taking to address the obstacles faced by key affected populations in accessing ART. However, obstacles and difficulties still exist in many countries particularly for undocumented migrants.

Issues needing further action

There remains a need for countries in Europe and Central Asia to:

- continue to scale up the provision of ART to ensure that everyone who needs this is able to receive it.
- focus on addressing the critical issue of late diagnosis of HIV infection as this is resulting in delays in starting ART for a significant number of people living with HIV. This needs to include introducing measures aimed at earlier HIV diagnoses.
- ensure that everyone diagnosed with an HIV infection in the region should have a CD4 count performed within three months of HIV diagnosis.
- address the obstacles and difficulties faced by some populations in accessing ART. These include, in particular, people who inject drugs, prisoners and migrants, particularly undocumented migrants.

Annex 1. Reported coverage of ART in Europe and Central Asia

Country	Dublin reporting 2010				Dublin reporting 2012			
	Year	Number	Coverage	Comment	Year	Number	Coverage	Comment
Albania[a]	2007	74	N/A	50 in 2004; 45 in 2006	2011	161	N/A	
Andorra				No data				No data
Armenia	2007	78	9%[b]	0% in 2003; 29 in 2005 [6(4-8%)]; 47 in 2006 [8(5-12%)]	2011	330	N/A	
Austria				No data			100%	Date source: GARP reporting 2012: Country narrative report
Azerbaijan	2007	81[c]	14(6-24)%[d]	0% in 2003; 7 in 2006 [1%]	2011	707	63%	
Belarus				No data	2011	3223	95%	
Belgium	2006	6450	67(39->95)% [d]	94% in 2003	2009	1787	87%	ART status is estimated once per year on 31 December of each year. In the cells below, denominator is the number of "eligible" patients based on first CD4 count (<350) made in 2009. Numerator is the number of these patients receiving ART at end 2009. These results do not include patients that initiated ART before 2009 and had CD4 above 350 in 2009. The total number of patients on ART at end 2009 (regardless of CD4 count value) is estimated at 8690 patients (=78.7% of HIV-infected patients in medical follow-up).
Bosnia Herzegovina	2007	30	100%[e]	13 [10%] in 2003; 29 in 2005; 19 in 2006	2011	63	100%	
Bulgaria	2007	221	N/A	90(45%) in 2004; 187 in 2005; 196 in 2006	2010	383	89%	Men who have sex with men have been reported by the transmission category at the time of HIV diagnosis People who inject drugs have been reported by their injecting status at time of entry into treatment, i.e. current IDUs. Respectively all other people have been reported as non-IDUs. Number of people diagnosed with HIV infection who are eligible for ART is represented as the number of adults and children enrolled in HIV care who need antiretroviral therapy based on immunological or virological criteria. Reasons for not starting ARV treatment vary but do not include unavailability of ARV drugs. Provision of ARV in Bulgaria is universal for all who need it regardless of their health and social insurance status, since it is covered by the Ministry of Health budget. Reported number of people diagnosed with HIV infection who are eligible for ART refers to people with CD4 count <350 registered for HIV care.
Croatia	2007[f]	310[g]	N/A	204 [>95%] in 2003; 247 in 2005; 291[h] in 2006	2011	561	100%	The system of HIV care in Croatia is centralised, hence all HIV infected patients are treated at the HIV/AIDS center at University Hospital for Infectious Diseases in Zagreb. All HIV infected patients who want to take ART can receive it.
Cyprus	2009	178	N/A[i]	151[a] [98%] in June 2007	2011	223		Denominator given as 53.
Czech Republic	2009	c550	N/A[j]	570[a] [56(30–>95)%] end 2007; 270 [34(18–57)%] in 2004; 322 [37(19–62)%] in 2005; 570 [60(32–>95)%] in 2006	2011	921	95%	

Country	Dublin reporting 2010				Dublin reporting 2012			
	Year	Number	Coverage	Comment	Year	Number	Coverage	Comment
Denmark	2009	3000	94%[k]	4000 known to be living with HIV				These data are not collected by or referred to the national authorities, but privately owned and not finished for 2010.
Estonia	2007	772	38(19-81%) [d]	76 [12(4–33)%] in 2004; 201 in 2005 [19(7–48]%); 495 in 2006[33(15–76)%]	2011	2156		All people who need ART can get it and it is free of charge. Estimated number of people diagnosed with HIV infection who need ART and who receive it is 50%. In Estonia there were 2,156 people who received ART at the end of 2011.
Finland	2006	450	54% [d]	95% in 2003	2010	1550	95%	
The former Yugoslav Republic of Macedonia [a]	2007	15	N/A	2 [20%] in 2003; 7 in 2005; 11 in 2006	2009	45	97%	
France				No data	Estimates for France 2008-2010 2008 2009 2010 Estimated number of patients under care* 102000 107000 111000 % women 33 33 33 Age (med and IQR) 44 (38–51) 45 (39–52) 46(39–52) Transmission group % MSM 34 34 34 % IVDU 12 11 11 % Heterosexual 45 46 46 HCV % unknown 23 20 20 % neg 71 74 74 % pos 6 6 6 AgHBs % unknown 25 22 23 % neg 75 78 77 % pos 0 0 0 % AIDS stage 25 25 24 CD4 cell count (med and IQR) cells /mm3 495 (348-677) 520 (370-704) 530 (378-715) Plasma HIV-1 RNA (med and IQR) copies/ml <50 (<50–92) <50 (<50–54) <50 (<50–<50) % with cART 86 87 87 Duration of cART (among those with cART) Med and IQR 8.0 (3.7–10.9) 8.4 (3.8–11.8) 8.7 (3.9–12.6) Nature of cART % 2 NRTIs+1 PI±r 41 41 38 % 2 NRTIs+1 NNRTI 24 25 26 % 3 NRTIs 4 3 2 % regimen including Raltegravir 6 10 13 % of patients with at least 6 months of cART who have VL<50 copies/ml 83 85 87 % of new patients presenting with an advanced HIV disease (AIDS and/or CD4 cell count < 200/mm3) 30 29 29 Source FHDH ANRS CO4 *based on the number of patients with complete reimbursement scheme for HIV infection with social security source Points de repère CNAM.			
Georgia	2007[l]	334[m]	72%[n]	83 in 2003 [8%]; 140 in 2005 [>95%]; 267 in 2006 [69%]	2011	1122	98%	Source: Infectious Diseases, AIDS and Clinical Immunology Research Center, AIDS Health Information System. In 2011 Georgia started implementation of 2010 WHO treatment initiation recommendation (CD4 count <350 cells/mm3) according to the respective adaption guidelines. Based on the careful assessment of feasibility and sustainability, CD4 eligibility threshold was set to <250 as the first step towards full implementation. New guidelines will be fully implemented in 2012. Consequently denominator A is based on currently available guidelines, while denominator B is based on eligibility criteria of CD4 count <350 cells/mm3 as requested by UNAIDS. Given that Georgia has not yet implemented new eligibility criteria the first method should be used for assessing treatment coverage in the country, which demonstrates that Georgia continues to provide universal access to ART. Distinguishing between current and former drug users was not possible at this point, therefore total number of persons who were infected through IDU is provided for this indicator – on therapy.
Germany	2006	27000	N/A	95% in 2003	2010	8780	97%	Data reported are based on an open cohort study representing approximately 20% of HIV patients under medical care in Germany. Tertiary and secondary care providers are slightly overrepresented compared to primary care providers in this cohort. Of course, data refer only to patients already receiving medical care. The proportion of patients diagnosed with HIV, under medical care, and receiving antiretroviral treatment may be higher than for patients not included in the cohort study, since patients diagnosed with HIV but not yet eligible for ART (n=719) may be underrepresented in the study sites.
Greece	2008	4233	N/A	3426 [a] in 2006	2011	5600	100%	
Hungary	2007	452	22(13-38)% [d]	300 [20(11–33)%] in 2004; 402 [24(13–39)% in 2005; 412 [22(13–37)%] in 2006	2010	692	99%	

Country	Dublin reporting 2010				Dublin reporting 2012			
	Year	Number	Coverage	Comment	Year	Number	Coverage	Comment
Iceland				No data				No data
Ireland				No data				No data
Israel	2006	2431	64%[o]					Out of all HIV positive people who are Israeli citizens, roughly 70% are currently under ARV treatment.
Italy				No data	2010	c65 000		Only data for ART sold and consumed are available. The file attached is named AIFA. During 2010, 41931690 antiretroviral drugs for HIV were used. The consumption shows an increase of 9% in respect to 2009. It is estimated that about 65 000 people are under ART treatment.
Kazakhstan	2007	442	41%[p]	7 [<1(<1–5)%] in 2004; 240 [23(12–62)%] in 2005; 326 [23(13–39)%] in 2006	2011	1830	83%	Kazakhstan has provided ART since 2005. The current treatment protocol is based on two main criteria – CD4 count and the clinical stage of the disease. Level of viral load is a sub-criterion. The decision to start ART is based on the results of 2 separate measurements of CD4, with an interval of at least 7 days. ART is recommended for all adults and adolescents in clinical stages 3 and 4 and those in stages 1 and 2 with a CD4 <350. The treatment registration and patient monitoring systems do not provide a breakdown of all the requested categories to fill indicator 4.1b. Given that the Republic of Kazakhstan has a concentrated HIV epidemic, Spectrum gives inflated figures for the estimated number of people needing treatment. As a result, Kazakhstan does not use the estimated number but uses official statistics instead.
Kosovo[q]				No data	2010	14	100%	
Kyrgyzstan	2007	87	25%[r]	46 in 2005; 47 [23%] in 2006	2011	510	31%	This percentage coverage is based on a total of 1 645 people estimated to need treatment. As a percentage of those diagnosed and known to need treatment (776) the coverage is 66%.
Latvia	2007	323	15(9-22%) [d]	202 [25(9–38)%] in 2004; 235 [19(9–29)%] in 2005; 301 [18(10–27)%] in 2006	2011	560		
Liechtenstein				No data				No data
Lithuania	2007	98	75%[s]	37 [55%] in 2003; 55 in 2005; 75 [h] in 2006 [79%]	2011	266		In 2011 HIV treatment was provided to 266 HIV infected persons (53 females with average age 39,5 and 173 males with average age 43,3), of them 87 (38,5 %) were IDUs, 81 (35,8%) got infected during heterosexual intercourse, 39 (17,3%) - during homosexual intercourse, 18 (9,7%) - unknown mode of transmission and 1 - MTC. Data source: National Center for Communicable diseases and AIDS under MOH, 2012.
Luxembourg	2009	354	N/A[t]	312 [a] in 2006				Luxembourg offers treatment for free to all people with HIV who need treatment following international treatment guidelines. If some people are not treated it is because of a personal decision to refuse treatment. Treatment is also available under the same conditions to subgroups like prisoners, migrants and IVDU, whether on OST or not.
Malta	2008	91	N/A[u]	65 [a] in 2007				No data

Country	Dublin reporting 2010				Dublin reporting 2012			
	Year	Number	Coverage	Comment	Year	Number	Coverage	Comment
Moldova	2007	464	54%[v]	120 [8%] in 2003 [8%] 222 in 2005; 262 [48%] in 2006	2011	1666	82%	The number of people known to need treatment in Moldova is 2 030. Based on an estimation of the number of people needing treatment in the country, coverage is estimated to be 29%. According to the National Protocol, followed in all medical institutions that initiate ARV treatment, undertake clinical monitoring and dispense ARV drugs, the immunologic criteria for enrolment in treatment in the reporting period have been CD4 <350 and RNA HIV>100000. The clinical monitoring provides for quarterly CD4 and viral RNA testing for those that were initiated on treatment and for twice per year CD4 and viral RNA testing for those not yet on ARV treatment. In accordance with Guidelines on construction of core indicators for monitoring the 2011 Political Declaration on HIV/AIDS (UNAIDS 2011) the denominator is generated by estimating the number of people with HIV infection requiring ARV therapy. For the latest estimates produced in March 2011, the tool Spectrum version 4.47 was used.
Monaco				No data				No data
Montenegro				No data	2011	42	100%	Percentage of those diagnosed and known to need treatment.
Netherlands	2007	7919	61(36->95%) [d]	>95% in 2003	2010	11780	100%	
Norway				No data				No data
Poland	2007	3382	77%[w]	2000 [35(20–59)%] in 2004; 2707 [39(22–66)%] in 2005; 3072 [38(21–64)%] in 2006	2011	5606	86%	This percentage coverage is based on a total of 6 500 people estimated to need treatment. As a percentage of those diagnosed and known to need treatment (5 606) the coverage is 100%.
Portugal	2009	14000	N/A	60% diagnosed with <350 CD4 (35% < 200)	2011	15022	100%	These figures are from 26/39 hospitals. As a result, numbers are not complete. Portugal reports that number of people receiving treatment rose at least 30% since 2009.
Romania	2007	6500	101%[x]	6000 [82(70–>95)%] in 2004; 6116 [77(66–>95)%] in 2005; 6790 [81(69–>95)%] in 2006	2011	7536	96%	Figures provided are 7536 for numerator and 7887 for denominator. % is 95.5% but is given as 99.5%
Russia	2007	31094	93%[y]	3000 [4(2–7)%] in 2004; 5000 [5(2–7)%] in 2005 and 14681 [10(6–15)%] in 2006	2011	103001		Figures supplied by Russian member of advisory board based on an official presentation by the Ministry of Health dated September 2012
San Marino				No data				No data
Serbia	2007	628	17(8-30)% [d]	317 [11(6–19)%] in 2004; 580 [19(9–32)%] in 2005; 608 [18(9–31)%] in 2006	2011	995	99%	Data on PLHIV who were on ART as of November 2011 is reported by Republic Health Insurance Fund (RHIF). Denominator (A) is the best estimate provided by clinicians who treat PLHIV based on diagnosed PLHIV. Denominator (B) is less relevant for our country because the estimates provided by Spectrum is considered to be overestimated the number of eligible PLHIV in need for ART due the fact that we are the country with low HIV prevalence and knowing that the ART is free of charge (in total covered by RHIF) and available for all eligible diagnosed PLHIV. Also, we notified decreasing mortality rate in the last 15 years (0,4 per 100.000 population in 2011 versus 1,2 per 100.000 population in 1996) or since 1997 when the HAART is available in Republic of Serbia.

Country	Dublin reporting 2010				Dublin reporting 2012			
	Year	Number	Coverage	Comment	Year	Number	Coverage	Comment
Slovakia	2007	98	N/A	65 [95%] in 2003; 65 in 2005; 96 in 2006	2011	153	87%	
Slovenia	2007	157	N/A	147 in 2006				No data
Spain	2006	77500	N/A	92% in 2003	2011	92697		The total number of people taking HAART in Spain in 2011 has been estimated to be 92697 using data from antiretroviral drugs expenses. In Spain HAART is available free of charge for all HIV patients who are eligible for treatment, including irregular migrants.
Sweden	2006	2800	74%(n)	95% in 2003	2011	5016	99%	Data is collected from InfCareHIV- a medical decision support and quality register for the Swedish HIV care monitoring all HIV patients in Sweden. All patients eligible for ART receive treatment. The few patients (about 50 patients) who do not receive treatment according to recommendations either do not want treatment or have other medical reasons for not receiving ART. Mainly these patients are IDUs.
Switzerland				No data				In Switzerland, between 23'000 and 29'000 people live with HIV. ART is fully available and paid by the general health insurance (obligatory for all legal residents). We do not collect systematic data on indicators listed here. We have recommendations on when to start a therapy, but finally it's the therapist in agreement with the patient who decides. About 10'000 people are enrolled in the Swiss HIV Cohort Study, which collect comprehensive data and produces excellent research: http://www.shcs.ch
Tajikistan	2007	86	109%(z)	0 in 2003; 5 [<1(<1–7)%] in 2005; 37 [4(2–10)%] in 2006	2011	769	81%	Numerator data reflects those who received ART by 2011 disaggregated by sex, age, risk group, and whether or not the person is a prisoner. Denominator data was obtained from the registration of laboratory monitoring. The second denominator (4085) was obtained from Spectrum.
Turkey	2009	700	N/A	250 (a) in 2004; 344 in 2005; 685 in 2006				No data
Turkmenistan				No data				No data
Ukraine	2007	7657	35%(za)	1000 [2(2–3)%] in 2004; 3450 [5(4–7)%] in 2005; 4777 [6(5-8)%] in 2006	2010	26720	70%	To calculate the indicator there was used a data from the temporary statistical accounting and reporting forms for monitoring of HIV-infection/AIDS treatment № 56 (Table 1000) "Report on the ART provision for HIV-infected and AIDS patients by 01.01.2012" of Ministry of Health of Ukraine. To calculate the indicator of the number of patients that has been taken on ART during the year the form № 57 "Reports on adults and children who started ART in a cohort treated during 6, 12, 24 and 36 months for January-December 2010" of Ministry of Health of Ukraine was used. Information is provided for the year 2010 as the information on the number of patients on ART in 2011 according to the reporting deadlines will be available only after July 20, 2012.
United Kingdom	2006	35000	>95%(n)	92% in 2003	2010	56071	82%	Data refer to reporting period: Jan-Dec 2010 Numerator is total number of HIV diagnosed persons seen for HIV care and receiving ART. Denominator is total number of HIV diagnosed persons seen for HIV care and for whom ART status was available. UK guidelines recommend treatment is initiated when CD4 count<350 therefore we would never expect the below percentage to reach 100% in the UK. The percentage of people diagnosed with HIV and who have CD4 counts <350 and who are on treatment is 87%.
Uzbekistan	2009	2536(zb)	N/A	259 (a) [30(12–66)%] in 2006; 319 [24(9–51)%] in 2007(zc)	2011	3832	72%	ART provided to those with CD4 <200

[a] UNGASS 2008
[b] Based on country-reported figure of those in need of treatment of 860. UNAIDS estimated that the number of people needing treatment was 660 (<500–1000) resulting in a coverage of 12(8–17)%.
[c] In commenting on this report, Azerbaijan stated 'at the end of 2007 the number of people who actually took ART shall be at 81 (as indicated in draft) as well 59.
[d] Based on UNAIDS denominator figures
[e] Based on country-reported figure of those in need of treatment of 30.
[f] June
[g] Projected 322 by end 2007
[h] UNAIDS figures
[i] The total number of people living with HIV who are currently alive and have ever had a CD4 count < 350 is 118. The total number of people living with HIV diagnosed in the last year who had a CD4 count<350 at the time diagnosis is 15. The estimated number of people living with HIV is 260.
[j] Every patient who has indications for treatment and health insurance is reported to receive optimal treatment. Total of around 950 people living with HIV.
[k] Based on supplied figure of 3200 people needing treatment
[l] November
[m] Projected 343 by end 2007
[n] Based on country-reported figure of those in need of treatment of 476.
[o] Percentage as reported to UNAIDS
[p] Based on country-reported figure of those in need of treatment of 1 078. UNAIDS estimated that the number of people needing treatment was 1 900 (1 200–3 200) resulting in a coverage of 23 (14–36)%.
[q] 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
[r] Based on country-reported figure of those in need of treatment of 345. UNAIDS estimated that the number of people needing treatment was 610 (<500–1 100) resulting in a coverage of 14 (1–26)%.
[s] Based on country-reported figure of those in need of treatment of 131. UNAIDS estimated that the number of people needing treatment was 550 (<500–1 200) resulting in a coverage of 18 (8–31)%.
[t] As of 28.10.09, the number of people living with HIV was 509. Of these, those who are currently alive and have ever had a CD4 count < 350 was 284. The total number of people living with HIV diagnosed in the last year who had a CD4 count<350 at the time diagnosis was 11.
[u] Approximately 132 enrolled in HIV care
[v] Based on country-reported figure of those in need of treatment of 856. UNAIDS estimated that the number of people needing treatment was 800 (540-1 100) resulting in a coverage of 58 (43–86)%.
[w] Based on country-reported figure of those in need of treatment of 4 390. UNAIDS estimated that the number of people needing treatment was 9 300 (5 500-17 000) resulting in a coverage of 36 (20–82)%.
[x] Based on country-reported figure of those in need of treatment of 6 418. UNAIDS estimated that the number of people needing treatment was 8 900 (5 400-10 000) resulting in a coverage of 73 (62–>95)%.
[y] Based on country-reported figure of those in need of treatment of 33 365. UNAIDS estimated that the number of people needing treatment was 190 000 (120 000-300 000) resulting in a coverage of 16 (10–25)%.
[z] Based on country-reported figure of those in need of treatment of 79. UNAIDS estimated that the number of people needing treatment was 1 300 (750-2 400) resulting in a coverage of 6 (4–11)%.
[za] Based on country-reported figure of those in need of treatment of 21 770. UNAIDS estimated that the number of people needing treatment was 91 000 (69 000-120 000) resulting in a coverage of 8 (7–11)%.
[zb] Cumulative total inclusive of PMTCT and PEP
[zc] Figures supplied by WHO

Annex 2. Reported coverage of ART disaggregated for different populations: Europe and Central Asia

Country	Year	Males			Females			Sex unknown			<15			>15			Age unknown			MSM			PWID			Former IDU			Non-IDU			OST recipient			Non-OST recipient			Migrants HPC			Prisoners		
		N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%
AL	2011	113			48						14			147																												
AD		No data																																									
AM	2011	216			114						11			319						4			113																		16		
AT		No data																																									
AZ	2011	550	889	62	157	241	65				15	15	100	692	1115	62				8	10	80	419	567	74	84			288			30			677						192	238	81
BY	2011	1806	1915	94	1417	1463	97				139	139	100	3084	3239	95																										
BE	2009	1141			646						2			1785						363			34																				
BA	2011	50	50	100	13	13	100				1	1	100	62	62	100				19	19	100	3	3	100																		
BG	2010	265			118			0			6			377			0			31			43						340			25			358						11		
HR	2011	476		100	85		100				6		100	555		100				270		100	17		100																3		100
CY		No data																																									
CZ	2011	771	817	94	150	153	98				3	3	100	918	967	95																										
DK		No data																																									
EE		No data																																									
FI	2010	1200		95	350		95				14		100			95				500		98	150		90															350		90			90
MK	2009	36	26	100	9	10	90	0		0	0		0	45	46	97	0	0		20	20	100	0		0	0			1			1			0			0		0	0		0
FR		No data																																									
GE	2011	785	803	98	337	347	97	0	0	0	35	35	100	1087	1115	97	0	0	0	32	32	100	564	574	98	564			526			40			486			3	3	100	69	69	100
DE	2010	7012	7269	98	1768	1822	97							8777	9086	97	1	1	100	4530	4692	97	626	651	96													1097	1121	98			
GR		No data																																									
HU	2010	595	600	99	94	11[a]	99	0	0	0	8	8	100	684	694	99	0	0	0	667	677	99	6	6	100													11	11	100			
IS		No data																																									
IE		No data																																									
IL		No data																																									
IT		No data																																									
KZ	2011	1027	1379	74	556	570	97	247	247	100	247	247	100	1583	1949	81																									294	355	82
XK	2010	11	11	100	3	3	100	0		0	0		0	14	14	100	0		0	1	1	100	0		0	0		0	0		0							0		0	0		0
KG	2011	316	524	60	194	252	77				170	186	91	340	590	58				1			143	323	44				197			19			124						86	87	99

Country	Year	Males			Females			Sex unknown			<15			>15			Age unknown			MSM			PWID			Former IDU			Non-IDU			OST recipient			Non-OST recipient			Migrants HPC			Prisoners		
		N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%
LV	2011	382			178						25			535			59			248																					40		
LI		No data																																									
LT	2011	173			53															18			87																				
LU		No data																																									
MT		No data																																									
MD[b]	2011	866	3682	24	765	2001	38	0		0	52	108	48	1614	5575	29	0		0	15			494						1172											135		
MC		No data																																									
ME		No data																																									
NL	2010	9380	9380	100	2400	2400	100				68	68	100	11712	11712	100				6859	6859	100	303	303	100																	
NO		No data																																									
PL	2011							0	0	0	130	130	100	5476	5476	100	0	0	0													264			5342								100
PT	2011	10264	10264	100	4601	4601	100				157	157	100																													
RO	2011	3935	4133	95	3601	3754	96				189	194	97	7347	7693	96																										
RU		No data																																									
SM		No data																																									
RS		No data																																									
SK	2011	123			30						0			153																	2			151			1			1		
SI		No data																																									
ES		No data																																									
SE	2011	2608	2633	99	2408	2433	99				101	101	100	4915	4965	99																										
CH		No data																																									
TJ	2011	472	615	77	297	332	90	0	0	0	56	62	90	713	885	81	0	0	0	3	3	100	469	566	83	0			300			43			426			0	0	0	84	96	88
TR		No data																																									
TM		No data																																									
UA	2010	13809	19923	69	12911	18307	71				2268	2406	94	24452	35824	68																										
GB	2010	37194	45665	81	18877	23018	82							55457	67829	82				23745	29566	80	1295	1557	83																	
UA	2011	1662	2412	69	2170	2899	75				1794	2390	75	2038	2921	70																										

[a] This figure appears to be incorrect. If the denominator figures given for total (702) and men (600) are correct, this figure would be 102. But, the numerator figures for men (595) and women (94) do not total the combined numerator figures (692).

[b] Denominators estimated using Spectrum

Annex 3. Data on CD4 count/late diagnosis at time of HIV diagnosis: Europe and Central Asia

Country	Dublin reporting 2010 (2008 data)						Dublin reporting 2012						
	No. new HIV diagnoses	CD4 counts available		CD4 counts <350			Year of data	No. new HIV diagnoses	CD4 counts available		CD4 counts <350		
		No.	%	No.	% of available CD4 counts	% of new HIV diagnoses			No.	%	No.	% of available CD4 counts	% of new HIV diagnoses
Albania	No data							No data					
Andorra	No data							No data					
Armenia	136	77	57	48	62	35	2010*	148*	114*	77*	69*	61*	47*
							2011	182			62		34
Austria	No data							No data					
Azerbaijan	No data						2010*	459*	187*	41*	107*	57*	23*
							2011	548	280	51	183	65	33
Belarus	No data						2011	1196			248		21
Belgium	1079	456	42	178	39	17	2010	1196	620	52	240	39	20
Bosnia and Herzegovina	8	2	25	2	100	25	2010*	6*	4*	67*	4*	100*	67*
							2011	34			13		38
Bulgaria	122	89	73	52	58	43	2010	163	116	71	52	45	32
Croatia	No data						2011	72			49		68
Cyprus	37	27	73	12	44	32	2010*	41*	22*	54*	10*	46*	24*
Czech Republic	148	83	56	32	39	22	2010	180*	158	88*	40	25	22*
Denmark	No data						2010	242			137		57
							2010*	275*	230*	84*	129*	56*	47*
Estonia	No data												30[a]
Finland	154	32	21	18	56	12	2010	187	142	76	70	49	37
							2010*	190*	88*	46*	46*	52*	24*
The former Yugoslav Republic of Macedonia	4	2	50	1	50	25	2010*	5*	2*	40*	1*	50*	20*
							2010/11	17			8		47
France	4068	1923	47[b]	1051	55	26	2010*	3952*	2284*	58*[c]	1182*	52*	30*
Georgia	No data						2011	424			193		46
Germany	2806	969	35	507	52	18	2010[d]	2918	1087	37	571	53	20
Greece	No data							No data					

Country	Dublin reporting 2010 (2008 data)						Dublin reporting 2012						
	No. new HIV diagnoses	CD4 counts available		CD4 counts <350			Year of data	No. new HIV diagnoses	CD4 counts available		CD4 counts <350		
		No.	%	No.	% of available CD4 counts	% of new HIV diagnoses			No.	%	No.	% of available CD4 counts	% of new HIV diagnoses
Hungary	No data						2010	113			51		45
Iceland	No data							No data					
Ireland	No data							No data					
Israel	No data						2010*(e)	430*	288*	67*	151*	52*	35*
Italy	No data						2010*(f)	2884*	2067*	72*	1101*	53*	38*
Kazakhstan	No data						2011	2006	1998(g)	99.6	408	20	20
Kosovo	No data							No data					
Kyrgyzstan	No data						2011	599			29		5
Latvia	358	12	3	3	25	1	2010*	274*	157*	57*	89*	57*	33*
Liechtenstein	No data							No data					
Lithuania	95	54	57	21	39	22		No data(h)					
Luxembourg	47	36	77	15	42	32	2010*	44*	31*	71*	16*	52*	36*
							2011	44	44	100	17	39	39
Malta	No data						2010*	17*	17*	100*	17*	100*	100*
Moldova	No data						2011	721	491	68	228	46	32
Monaco	No data							No data					
Montenegro(i)	No data						2010*	14*	2*	14*	2*	100*	14*
							2010/11	23			8		35
Netherlands	1367	1027	76	465	45	34	2010*	995*	850*	85*	422*	50*	42*
													56
Norway	No data							No data					
Poland	No data							No data					
Portugal	1124	131	12	82	63	7	2010*	952*	110*	12*	69*	63*	7*
Romania	179	142	79	54	38	30	2010*	152*	136*	90*	52*	38*	34*
							2011	619			478		77
Russian Federation	No data							No data					
San Marino	No data							No data					
Serbia	No data						2011	127	68	54	40	59	32
Slovakia	53	29	55	7	24	13	2010*	28*	22*	79*	6*	27*	21*
Slovenia	48	42	88	27	64	56	2010	35	33*	94*	17	52*	49

Country	Dublin reporting 2010 (2008 data)						Dublin reporting 2012						
	No. new HIV diagnoses	CD4 counts available		CD4 counts <350			Year of data	No. new HIV diagnoses	CD4 counts available		CD4 counts <350		
		No.	%	No.	% of available CD4 counts	% of new HIV diagnoses			No.	%	No.	% of available CD4 counts	% of new HIV diagnoses
Spain	1583	1345	85	666	50	42	2010[j]	2907	2447*	84*	1111	45*	38
Sweden	No data						2011[k]	312			181		58
Switzerland	No data							No data					
Tajikistan	331	129	39	52	40	16	2010*	1004*	517*	52*	294*	57*	29*
							2011	989	648	66	182	28	18
Turkey	No data							No data					
Turkmenistan	No data							No data					
Ukraine	No data						2011	21177			8467[l]		40
United Kingdom	7298	3910	54	2241	57	31	2010*	6654*	5501*	83*	2703*	49*	41*
							2010[m]		5486		2721	50	
Uzbekistan	No data						2011	3584			1114[n]		31

Numbers from ECDC datasheets

[a] Estimation

[b] In reviewing this report, France commented that this figure should be 42%

[c] In reviewing this report, France commented that we estimate the missing values (for example CD4 count) through a multiple imputation method, in which the distribution of the observed data is used to estimate plausible values for the missing observations. The information is then available for all cases.

[d] Methodological concerns: comparison across countries and across mode of transmission is highly problematic due to important interactions between proportion of late presentation and incidence of new infections. E.g., for people who inject drugs and migrants from high prevalence countries declining numbers of newly diagnosed infections are observed in recent years. The decline is particularly observed in younger age groups. This could mean that due to declining incidence (IDU), resp. more restrictive immigration rules the number of newly infected individuals in these two groups is declining, leaving a pool of ageing, undiagnosed infections with a consequently increasing proportion of late diagnosis (however, also a declining incidence - at least among IDU), primarily due to declining incidence. Data is for HIV cases diagnosed and reported to TESSy for the period 1st January-31st December 2010. In total, 2918 verified newly diagnosed HIV infections had been reported in 2010. For 1087 of these reports a CD4 value at diagnosis has been reported. It remains unknown whether reports with missing CD4 data have the same CD4 distribution as reports for which a CD4 cell count has been reported. In a model in which we imputed missing values the proportion of late presentation (CD4<350) among patients aged 25+ was in 2010: 47% among MSM, 56% among migrants from high prevalence regions, and 58% among patients with heterosexual transmission risk.

[e] According to country report – in 2011, among HIV positive Israeli citizens born in Israel an estimated 3-4% are considered to be "late diagnosis".

[f] About 30% of HIV diagnosis is done in people in an advanced stage of disease (CD4 <200/mmc and/or pathologies associated with AIDS). Almost 60% of AIDS diagnosis is done in people with a late recognition of HIV infection.

[g] At the moment, this figure is not part of the routinely-collected administrative statistics, but it is expected that it will be from 2013 onwards, with the introduction of electronic registration and tracking of HIV cases in Kazakhstan. So, data was collected through a written request from the National AIDS Centre to regional and city AIDS centres. The number of primary HIV cases in the reporting period assessed for the start of ARV treatment (CD4 and / or other criteria of the national protocol) was1998.

[h] There were 153 new HIV cases in 2010, 5,8% HIV cases were diagnosed in late stage of HIV infection; in 2011 respectively 166 HIV cases and 4,8% in late HIV diagnosis. Data source: National Center for Communicable Diseases and AIDS under MOH, 2012.

[i] Since 2007, CD4 testing and HIV PCR have been available in National Referent Laboratory in Institute of Public Health. Since then, every person who is diagnosed as HIV+ and examined by infectious disease specialist in Clinical Centre of Montenegro (this is the only health care facility where complete diagnosis and therapy is available), at the time of diagnosis perform CD4 testing and viral load. Therefore, CD4 count is not available only to those with suspected late disease, but for all HIV+ persons at the time of diagnosis.

[j] Data arising from the New HIV Diagnoses Information System (SINIVIH). Current SINIVIH coverage is 71% of the total Spanish Population. Data pertaining to the WHOLE year 2010. More detailed information available at: http://www.msssi.gob.es/ciudadanos/enfLesiones/enfTransmisibles/sida/vigilancia/InformeVIHSida_Junio_2011.pdf

[k] Data from InfCareHIV- a medical decision support and quality register for the Swedish HIV care monitoring all HIV patients in Sweden. Other studies including patients diagnosed between 2009-2010 (A high occurrence of late presenters and missed HIV diagnosis in clinical care in Sweden, J Brännström et al available online: http://www.jiasociety.org/content/pdf/1758-2652-13-S4-P169.pdf) describes late presenters per transmission route. The study included 100 patients. 69% were late presenters (CD4 <350); 70% were immigrants from non-European countries. 57% of these had lived > 1 year in Sweden. This group also had the highest overall risk of being diagnosed late (37/45, 82%) followed by IDU's (3/5, 60%), heterosexuals from the EU (7/12, 58%) and MSM (14/28, 50%).

[l] To calculate the indicator there was the data from Table 4000 form № - HIV/AIDS "Report on people with conditions and diseases caused by human immunodeficiency virus (HIV)", 2011 used. In 2011, 21 177 people are taken for supervision during the year with newly diagnosed HIV infection (regardless of stage of infection), including 4 391 4,076 people with common (prevalent) HIV-infection and 4 076 people with AIDS in Ukraine. That is, 8 467 people in total in the late stage of HIV infection.

[m] Data includes individuals 15 years of age and over at diagnosis, who have a CD4 count available and <350 mm/L within 91 days of diagnosis. Data is not collected for individuals under the age of 15. Data is not available for migrants from high prevalence countries, sex workers or prisoners.

[n] Late diagnosis in Uzbekistan appears to be defined as CD4 <200.

Annex 4. Data on CD4 count <350 at time of HIV diagnosis/late diagnosis disaggregated for different populations: Europe and Central Asia

Country	Year	Males			Females			<15			>15			MSM			PWID			Migrants HPC			Sex workers			Prisoners		
		N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%
AL		No data																										
AD		No data																										
AM[a]	2010*	47	97	49	22	51	43	1	4	25	68	144	47	0	0	0	24	48	50	0	0	0						
	2011	46	115	40	16	67	24	1	2	50	61	180	34	1	4	25	21	41	51				0	4	0	3	12	25
AT		No data																										
AZ[b]	2010*	74	364	20	33	95	35	2	11	18	105	448	23	4	6	67	42	253	17	0	0	0						
	2011	127	410	31	56	138	41	2	10	20	181	538	34		5		90	316	29							19	154	12
BY	2011	102	621	16	146	575	25	19	23	83	229	1173	20															
BE[c]	2010	145	792	18	95	401	24	0	13	0	240	1183	20	68	386	18	6	13	46	108	326	33						
BA[d]	2010*	4	6	67	0	0	0	0	0	0	4	6	67	2	4	50	0	0	0	0	0	0						
	2011	10	30	33	3	4	75				13	34	38	6	15	40		2										
BG[e]	2010	42	132	32	10	31	32	0	4	0	52	159	33	9	32	28	9	56	16	0	1	0	1	3	33	5	30	16
HR	2011	44	62	71	5	10	50	1	1	100	48	71	68	30	44	68	2	4	50	0	0		0	0		0	0	
CY[f]	2010*	7	34	21	3	7	43	0	0	0	10	41	24	5	22	23	0	0	0	1	4	25						
CZ[g]	2010*	34	159	21	6	21	29	0	0	0	40	180	22	23	128	18	1	5	20	3	4	75						
DK[h]	2010													52	107	49	5	10	50	61	111	55						
	2010*	93	201	46	36	74	49	2	3	67	127	272	47	52	112	46	2	8	25	37	68	54						
EE		No data																										
FI[i]	2010[j]	51	103	50	19	39	49	0	1	0	70	141	50	22	41	54	2	7	29	35	59	60						
	2010*	34	133	26	12	57	21	0	1	0	46	189	24	14	46	30	3	9	33	7	39	18						
MK[k]	2010*	1	5	20	0	0	0	0	0	0	1	5	20	1	5	20	0	0	0	0	0	0						
	2010/11	7	16	44	1	1	100				8	17	47	4	12	33										0		
FR[l]	2010*	802	2655	30	380	1297	29	4	28	14	1178	3924	30	322	1036	31	43	90	48	140	863	16						
GE	2011	141	300	47	52	124	42	3	6	50	190	418	46	6	25	24	93	189	49	3	6	50	0	2	0	9	16	56
DE[j, m]	2010	482	2471*	20	88	436*	20	0	21*	0	571	2897*	20	310	1684*	18	19	93*	20	58	293*	20						
GR		No data																										

Country	Year	Males			Females			<15			>15			MSM			PWID			Migrants HPC			Sex workers			Prisoners		
		N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%
HU	2010	44	102	43	7	11	64	0		0	51	113	45	40	98	41	1	1	100	2	2	100	0		0	2	2	100
IS		No data																										
IE		No data																										
IL[n]	2010*	96	292	33	55	138	40	1	7	14	150	423	36	45	148	30	12	42	29	59	144	41						
IT[o]	2010*	792	2139	37	307	743	41	0	9	0	1101	2875	38	314	914	34	65	131	50	144	310	47						
KZ	2011	255	1200	21	126	806	16	8	15	53	395	1991	20	3	12	25	200	710	28	2	41	5	1	17	6	31	301	10
XK		No data																										
KG	2011	15	417	4	14	182	8	7	57	12	22	542	4	0	2	0	5	362	1				0	6	0	0	191	0
LV[p]	2010*	56	170	33	33	104	32	0	4	0	89	270	33	10	18	56	25	86	29	0	0	0						
LI		No data																										
LT		No data																										
LU[q]	2010*	13	30	43	3	14	21	0	0	0	16	44	36	10	21	48	0	1	0	1	12	8						
	2011	11	32	34	6	12	50	0		0	17	44	39	10	24	42	0		0	5	9	56						
MT[r]	2010	15	15	100	2	2	100	0	0	0	17	17	100	5	5	100				6	6	100						
MD	2011	129	376	34	99	345	29	1	15	7	227	706	32	0	5	0	17	64	27							0	13	0
MC		No data																										
ME[s]	2010*	2	14	14	0	0	0	0	0	0	2	14	14	2	12	17	0	0	0	0	0	0						
	2010/11	8	22	36	0	1	0	0		0	8	23	35	6	16	38			0			0			0			0
NL[t]	2010*	357	855	42	65	140	46	0	8	0	422	987	43	244	651	37	3	6	50	91	168	54						
	2010															40												
NO		No data																										
PL		No data																										
PT[u]	2010*	49	673	7	20	279	7	0	8	0	69	944	7	8	210	4	6	116	5	14	171	8						
RO[v]	2010*	35	94	37	17	58	29	1	11	9	51	141	36	7	25	28	0	2	0	0	0	0						
	2011	314	421	75	164	198	83	19	19	100	459	600	77															
RU		No data																										
SM		No data																										
RS	2011	38	110	35	2	17	12	0	1	0	40	126	32	24	66	36	0	9	0									
SK[x]	2010*	6	25	24	0	3	0	0	0	0	6	28	21	4	21	19	1	2	50	0	0	0						
SI[y]	2010	15	31	48	2	4	50	0*	0*	0*	17	35	49	12	28	43	0*	0*	0*	3	3	100						

Country	Year	Males			Females			<15			>15			MSM			PWID			Migrants HPC			Sex workers			Prisoners		
		N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%	N	D	%
ES[z]	2010	895	2386	38	216	521	42	3[za]	11	27	1108[zb]	2894	38	434	1339	32	75	171	44	111	233	48						
SE	2011	81	158	51	100	154	65	0	4	0	181	308	59															
CH		No data																										
TJ[zc]	2010*	226	808	28	68	196	35	3	17	18	291	987	30	0	0	0	165	528	31	0	0	0						
	2011	124	707	18	58	282	21	30	53	57	152	936	16	3	5	60	59	423	14				5	8	63	24	153	16
TR		No data																										
TM		No data																										
UA		No data																										
GB[zd]	2010*	1749	4506	39	954	2147	44	4	61	7	2699	6593	41	921	2702	34	53	141	38	1123	2053	55						
	2010[ze]	1758	3815	46	963	1671	58				2721	5486	50	941	2440	39	32	111	29									
UZ	2011	643	1878	34	471	1706	28				325	869	37	789	2715	29												

* *Numbers from ECDC datasheets*

[a] *In 2010, rates of CD4 among new HIV diagnoses – males 75% (73); females 80% (41); <15 100% (4); >15 76% (110); and people who inject drugs 75% (36). Among 10 people with unknown route of infection, CD4 count at time of diagnosis was available for 4 (40%). Rate of late diagnosis among those was 40% overall but 100% of those with a CD4 count at time of diagnosis.*

[b] *In 2010, rates of CD4 among new HIV diagnoses – males 34% (125); females 65% (62); <15 82% (9); >15 40% (178); MSM 83% (5); and people who inject drugs 28% (70). Among 68 people with unknown route of infection, CD4 count at time of diagnosis was available for 12 (18%). Rate of late diagnosis among those was 9% overall but 50% of those with a CD4 count at time of diagnosis.*

[c] *Rates of CD4 among new HIV diagnoses – males 55% (438); females 45% (182); <15 0% (0); >15 52% (620); MSM 73% (282); people who inject drugs 62% (8); and migrants 63% (207). Among 350 people with unknown route of infection, CD4 count at time of diagnosis was available for 26 (7%). Rate of late diagnosis among those was 3% overall but 46% of those with a CD4 count at time of diagnosis.*

[d] *In 2010, rates of CD4 among new HIV diagnoses – males 67%(4); >15 67% (4); and MSM 50% (2).*

[e] *In 2010, rates of CD4 among new HIV diagnoses – males 70% (92); females 77% (24); <15 75% (3); >15 71% (115); MSM 88% (28); people who inject drugs 41% (23) and migrants 100% (1).*

[f] *In 2010, rates of CD4 among new HIV diagnoses – males 50% (17); females 71% (5); >15 54% (22); MSM 50% (11); and migrants 25% (1). Among 3 people with unknown route of infection, CD4 count at time of diagnosis was available for 1 (33%). Rate of late diagnosis among those was 33% overall but 100% of those with a CD4 count at time of diagnosis.*

[g] *In 2010, rates of CD4 among new HIV diagnoses – males 91% (144); females 67% (14); >15 88% (158); MSM 94% (120); people who inject drugs 60% (3); and migrants 100% (4). Among 9 people with unknown route of infection, CD4 count at time of diagnosis was available for 5 (56%). Rate of late diagnosis among those was 22% overall but 40% of those with a CD4 count at time of diagnosis.*

[h] *In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 85% (171); females 80% (59);<15 100% (3); >15 84% (227); MSM 92% (103); people who inject drugs 50% (4); and migrants 77% (52).*

[i] *In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 50% (67); females 37% (21);<15 100% (1); >15 46% (87); MSM 59% (27); people who inject drugs 66% (6); and migrants 33% (13). Among 41 people with unknown route of infection, CD4 count at time of diagnosis was available for 8(20%). Rate of late diagnosis among those was 10% overall but 50% of those with a CD4 count at time of diagnosis.*

[j] *Data is for those with known CD4 count only*

[k] *In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 40% (2); >15 40% (2); and MSM 40% (2).*

[l] *In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 60% (1584); females 54% (700);<15 50% (14); >15 58% (2270); MSM 83% (856); people who inject drugs 81% (73); and migrants 24% (209). Among 1376 people with unknown route of infection, CD4 count at time of diagnosis was available for 209(15%). Rate of late diagnosis among those was 10% overall but 67% of those with a CD4 count at time of diagnosis.*

[m] In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 38% (937); females 34% (147);<15 43% (9); >15 37% (1078); MSM 41% (685); people who inject drugs 34% (32); and migrants 31% (90). Among 436 people with unknown route of infection, CD4 count at time of diagnosis was available for 115(26%). Rate of late diagnosis among those was 20% overall but 77% of those with a CD4 count at time of diagnosis.

[n] In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 69% (201); females 63% (87);<15 14% (1); >15 67% (285); MSM 78% (116); people who inject drugs 67% (28); and migrants 58% (83). Among 19 people with unknown route of infection, CD4 count at time of diagnosis was available for 4(21%). Rate of late diagnosis among those was 16% overall but 75% of those with a CD4 count at time of diagnosis.

[o] In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 71% (1520); females 73% (545);<15 44% (4); >15 72% (2063); MSM 76% (696); people who inject drugs 78% (102); and migrants 71% (219). Among 346 people with unknown route of infection, CD4 count at time of diagnosis was available for 166(48%). Rate of late diagnosis among those was 26% overall but 55% of those with a CD4 count at time of diagnosis.

[p] In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 52% (89); females 65% (68);<15 0% (0); >15 58% (157); MSM 89% (16); and people who inject drugs 41% (35). Among 35 people with unknown route of infection, CD4 count at time of diagnosis was available for 13(37%). Rate of late diagnosis among those was 20% overall but 54% of those with a CD4 count at time of diagnosis.

[q] In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 77% (23); females 57% (8); >15 71% (31); MSM 81% (17); and people who inject drugs 0% (0).

[r] In 2010, based on data from an ECDC country sheet, among 2 people with unknown route of infection, CD4 count at time of diagnosis was available for both. Rate of late diagnosis among those was 100%.

[s] In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 14% (2); >15 14% (2); and MSM 17% (2).

[t] In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 86% (736); females 81% (114);<15 88% (7); >15 85% (843); MSM 87% (567); and people who inject drugs 100% (6). Among 48 people with unknown route of infection, CD4 count at time of diagnosis was available for 38(79%). Rate of late diagnosis among those was 63% overall but 79% of those with a CD4 count at time of diagnosis.

[u] In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 12% (79); females 11% (31);<15 0% (0); >15 12% (110); MSM 12% (26); people who inject drugs 7% (8); and migrants 10%(17). Among 30 people with unknown route of infection, CD4 count at time of diagnosis was available for none of them.

[v] In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 90% (85); females 88% (51);<15 100% (11); >15 89% (125); MSM 100% (25); and people who inject drugs 100% (2). Among 35 people with unknown route of infection, CD4 count at time of diagnosis was available for 30(86%). Rate of late diagnosis among those was 49% overall but 57% of those with a CD4 count at time of diagnosis.

[x] In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 84% (21); females 33% (1); >15 79% (22); MSM 86% (18); and people who inject drugs 50% (1).One person with unknown route of infection did not have a CD4 count available.

[y] In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 94% (29); females 100% (4); >15 94% (33); MSM 93% (26); and migrants 100% (3).

[z] In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 84% (2006); females 85% (441);<15 69% (9); >15 84% (2438); MSM 89% (1193); people who inject drugs 77% (132) and migrants 79%(174). Among 396 people with unknown route of infection, CD4 count at time of diagnosis was available for 245(62%). Rate of late diagnosis among those was 31% overall but 49% of those with a CD4 count at time of diagnosis.

[za] Figures in ECDC fact sheet n=2 and d=9 differ from those reported through GARP reporting process.

[zb] 1109 in ECDC fact sheet

[zc] In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 48% (384); females 68% (133);<15 18% (3); >15 51% (503); and people who inject drugs 50% (265). Among 212 people with unknown route of infection, CD4 count at time of diagnosis was available for 78(37%). Rate of late diagnosis among those was 20% overall but 54% of those with a CD4 count at time of diagnosis.

[zd] In 2010, based on data from an ECDC country sheet, rates of CD4 among new HIV diagnoses – males 85% (3813); females 79% (1688);<15 26% (16); >15 83% (5485); people who inject drugs 82% (115); and migrants 89% (1820). Among 652 people with unknown route of infection, CD4 count at time of diagnosis was available for 291(45%). Rate of late diagnosis among those was 24% overall but 53% of those with a CD4 count at time of diagnosis.

[ze] In these figures, reported by country, the denominator includes only those who had a CD4 count.

Annex 5. 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		