



SPECIAL REPORT

Monitoring implementation of the European Commission Communication and Action Plan for combating HIV/AIDS in the European Union and neighbouring countries, 2009–2013

Final report

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

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Acknowledgements

ECDC would like to thank all those who contributed to the report, in particular European Commission staff at the Directorate-General for Health and Consumers and the Directorate-General for Research and Innovation; the Executive Agency for Health and Consumers (EAHC); the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA); the Northern Dimension Partnership in Public Health and Social Well-being (NDPHS); European Union delegations; the members of the EU Think Tank and the Civil Society Forum on HIV/AIDS; the International Organization for Migration (IOM); the World Health Organization (WHO); and UNAIDS.

Disclaimer

This publication was funded by the European Centre for Disease Prevention and Control (ECDC) and solely reflects the views of ECDC. The European Commission cannot be held responsible for any use which may be made of the information or the views contained therein.

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

ISBN 978-92-9193-496-6

doi 10.2900/894

Catalogue number TQ-01-13-466-EN-N

Stockholm, September 2013

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Abbreviations and acronyms

| | |
|----------|---|
| CCM | Country Coordinating Mechanism (Global Fund) |
| CSF | Civil Society Forum |
| DCI | Development Cooperation Instrument |
| DG | Directorate General (European Commission) |
| DG SANCO | Directorate General Health and Consumers |
| EAHC | Executive Agency for Health and Consumers |
| EC | European Commission |
| ECDC | European Centre for Disease Prevention and Control |
| EDCTP | European and Developing Countries Clinical Trial Partnership |
| EMCDDA | European Monitoring Centre for Drugs and Drug Addiction |
| EMIS | European MSM Internet Survey |
| ENP | European Neighbourhood Policy |
| ENPI | European and Neighbourhood Partnership Instrument |
| EU | European Union |
| FP6 | Sixth Framework Programme |
| FP7 | Seventh Framework Programme |
| FRA | Fundamental Rights Agency |
| IDU | Injecting drug user |
| ILO | International Labour Organisation |
| IOM | International Organisation for Migration |
| MDG | Millennium Development Goals |
| MSM | Men who have sex with men |
| M&E | Monitoring and evaluation |
| NDPHS | Northern Dimension Partnership in Public Health and Social Well-being |
| OST | Opioid substitution therapy |
| PLHIV | People living with HIV |
| RFP | Research Framework Programme |
| SGS | Second-generation surveillance |
| STI | Sexually transmitted infection |
| TB | Tuberculosis |
| UNAIDS | United Nations Joint Programme on HIV/AIDS |
| UNFPA | United Nations Population Programme |
| UNGASS | United Nations General Assembly Special Session on HIV/AIDS |
| UNODC | United Nations Office on Drugs and Crime |
| WHO | World Health Organization |

1 Background

1.1 The Communication

The policy priorities of the European Commission (EC) regarding HIV in Europe are contained in a Communication entitled *Combating HIV/AIDS in the European Union and neighbouring countries, 2009–2013*¹. The main objectives are:

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

The Communication highlights key elements of the response to HIV, including political leadership, involvement of civil society and people living with HIV, wider society responsibilities, and universal access to prevention, treatment, care and support. It also highlights priority regions and priority groups and emphasises the improvement of knowledge, including surveillance, monitoring, evaluation and research.

1.2 The Action Plan

Details of around 50 actions intended to implement the Communication are included in an accompanying Action Plan. This plan is structured around six thematic issues:

- Politics, policies and involvement of civil society, wider society and stakeholders
- Prevention
- Priority regions
- Priority groups
- Improving knowledge
- Monitoring and evaluation.

1.3 Building on the previous Communication

The Communication and Action Plan build on previous documents for the period 2006–2009. The current Communication and Action Plan were introduced following an Impact Assessment² of work carried out under the previous Communication and Action Plan. The Impact Assessment described the organisations, stakeholders and funding modalities which had enabled the activities outlined in the first Action Plan to be realised. It highlighted progress and achievements in terms of European Union (EU) policies, health and research programme actions and, in particular, the success of the Action Plan in 'increasing the political commitment of European leaders to keep HIV/AIDS on their agenda and empowering civil society in the European Union'. It also highlighted the need to fully realise political commitments; improve the effectiveness and targeting of prevention strategies and access to treatment; strengthen surveillance; ensure comprehensive reporting of data, address knowledge gaps; and enhance action on neighbourhood policies.

1.4 Monitoring the Communication and Action Plan

The Communication, Action Plan and Impact Assessment all express a clear commitment to monitoring and evaluating the implementation and effects of the activities outlined in the Communication and Action Plan. One challenge faced by the Impact Assessment was that there was no clear and systemic approach to monitoring and evaluating the previous Communication and Action Plan. As a result, it was only possible to describe activities rather than to conduct a more rigorous assessment of results achieved. In February 2010, the European Commission asked the European Centre for Disease Prevention and Control (ECDC) to develop a monitoring and evaluation framework for the current Communication and Action Plan.

¹ Commission of the European Communities. 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*. COM(2009)569. Brussels, 26 October 2009.

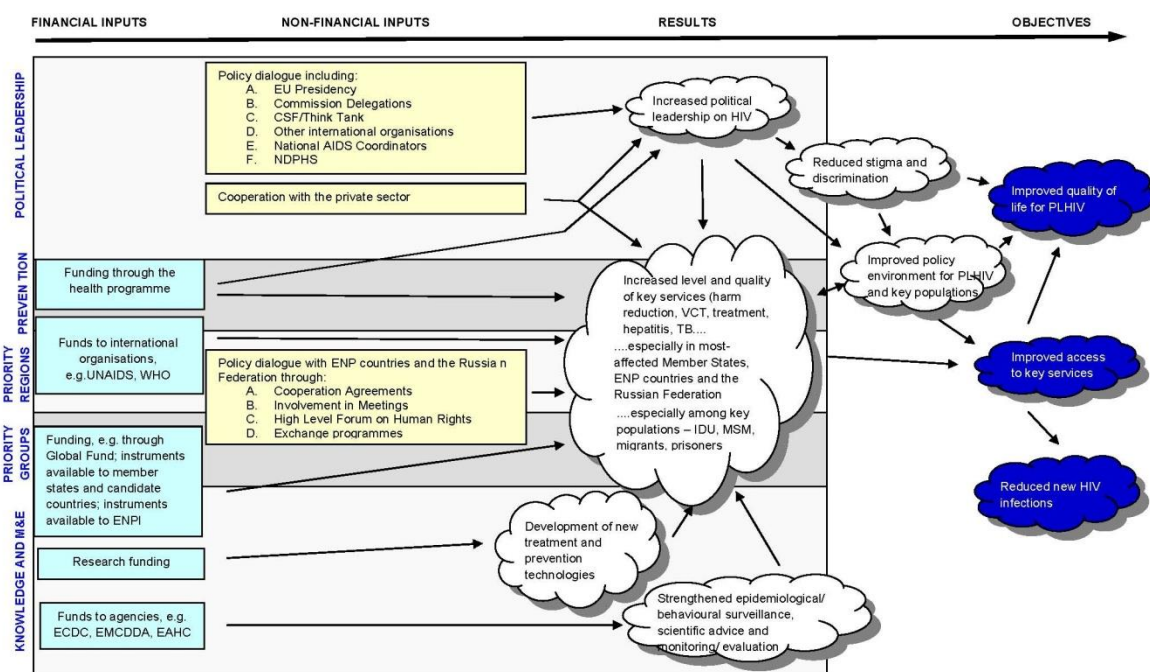
² Commission of the European Communities. Impact Assessment. Accompanying document to the Communication. SEC(2009)1404/2. Brussels, 2009.

1.5 The monitoring and evaluation framework

Through a process of consultation with stakeholders, including the Commission, the Think Tank and the Civil Society Forum, ECDC developed a framework for monitoring and evaluating the Communication and Action Plan (see Figure 1.1). The focus of the framework is on monitoring the added value of European-wide and Commission actions in response to HIV. It does not seek to capture all actions by all those working with HIV in Europe. Rather, it aims to capture the activities of a range of actors, including countries, Commission agencies and services, international agencies and civil society organisations, which result from Commission policies, influence, funding and other actions.

The framework is based on a 'theory of change' which illustrates how the Communication and Action Plan are expected to contribute to achieving the Commission's objectives. This assumes that certain financial and non-financial inputs made available to different actors to support the implementation of the Communication and Action Plan will contribute to certain results. This flow is illustrated by a black arrow at the top of Figure 1.1. Financial inputs in a variety of forms are shown as blue boxes and non-financial inputs are shown as yellow boxes. The results, shown as white clouds, contribute to the ultimate objectives of the Communication and Action Plan, shown as blue clouds. Inputs and results are also mapped against the main thematic issues of the Communication and Action Plan, shown in blue on the left of Figure 1.1.

Figure 1.1: Framework for monitoring the HIV Communication and Action Plan



1.6 Using the framework to monitor the Communication and Action Plan

ECDC supports efforts to monitor the implementation of the Communication and Action Plan using this framework through two processes:

- Monitoring the implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and central Asia provides information on the results achieved by country responses to HIV.
- Monitoring the inputs that relate directly to the Communication and Action Plan and their effect makes it possible to assess how the Plan is contributing to the European region's response to HIV.

Activities related to the first process were published in a special progress report in 2010; a second progress report will be published later this year. This report, which focuses on the second process, reviews the contribution of the Communication and Action Plan. An interim report on the implementation of the Communication and Action Plan was produced in November 2011. A brief analysis of the findings of both processes is included in Section 5.

ECDC developed a series of indicators and related questions intended to collect information on each element of the monitoring and evaluation framework. Each question was directed to one or more organisations. Relevant questions were set out in a questionnaire tailored to each organisation, and these were completed between June

and September 2011. Questionnaires were sent to the European Commission, including some of its Delegations, the Civil Society Forum, members of the Think Tank, ECDC, EMCDDA, EAHC, UNAIDS and WHO Regional Office for Europe. Responses were received from:

- The European Commission, including a specific response from the Directorate-General for Research and Innovation
- Delegations in Belarus, Moldova, Russia and Ukraine
- The CSF – the CSF coordination team submitted a consolidated response based on replies from 14 members³
- Think Tank members from Bulgaria, Denmark, Germany, Moldova, the Netherlands, Norway, Poland, Portugal, Russia, Slovakia, Spain, Sweden and Ukraine
- ECDC
- EMCDDA
- EAHC
- NDPHS
- UNAIDS

A second set of questionnaires was sent to the same organisations in October 2012, with the exception of the members of the Think Tank. Those that had responded to the first questionnaire were sent their previous response and asked to provide an update on progress and actions since October 2011. Those that had not responded were asked to provide information covering the period 2009 to 2012. The second set of questionnaires was also sent to the four countries holding the EU Presidency in 2012 and 2013.

The second questionnaire included three additional questions about the impact of the global financial crisis on the availability of funds for HIV-related work and demand for HIV-related support and how activities are being prioritised in the face of resource constraints. Responses were received from:

- The European Commission
- Denmark (EU Presidency)
- Delegations in Belarus, Moldova, the Russian Federation, and Ukraine
- The CSF (the CSF coordination team submitted a consolidated response)⁴
- ECDC
- EMCDDA
- EAHC
- NDPHS
- IOM
- WHO Regional Office for Europe
- UNAIDS

1.7 Report structure

This report summarises the data collected and presents them on the basis of the framework. Each section of the report starts with a diagram of the framework highlighting the part covered in that section.

- Section 2 describes the financial inputs available for the implementation of the Communication and Action Plan
- Section 3 describes the non-financial inputs available for the implementation of the Communication and Action Plan
- Section 4 considers the effects of these inputs and their contribution towards achieving the results envisaged in the Communication and Action Plan
- Section 5 provides an overview of the links between the effects of the Communication and Action Plan and the results measured through monitoring the Dublin Declaration.
- Section 6 sets out key conclusions and recommendations.

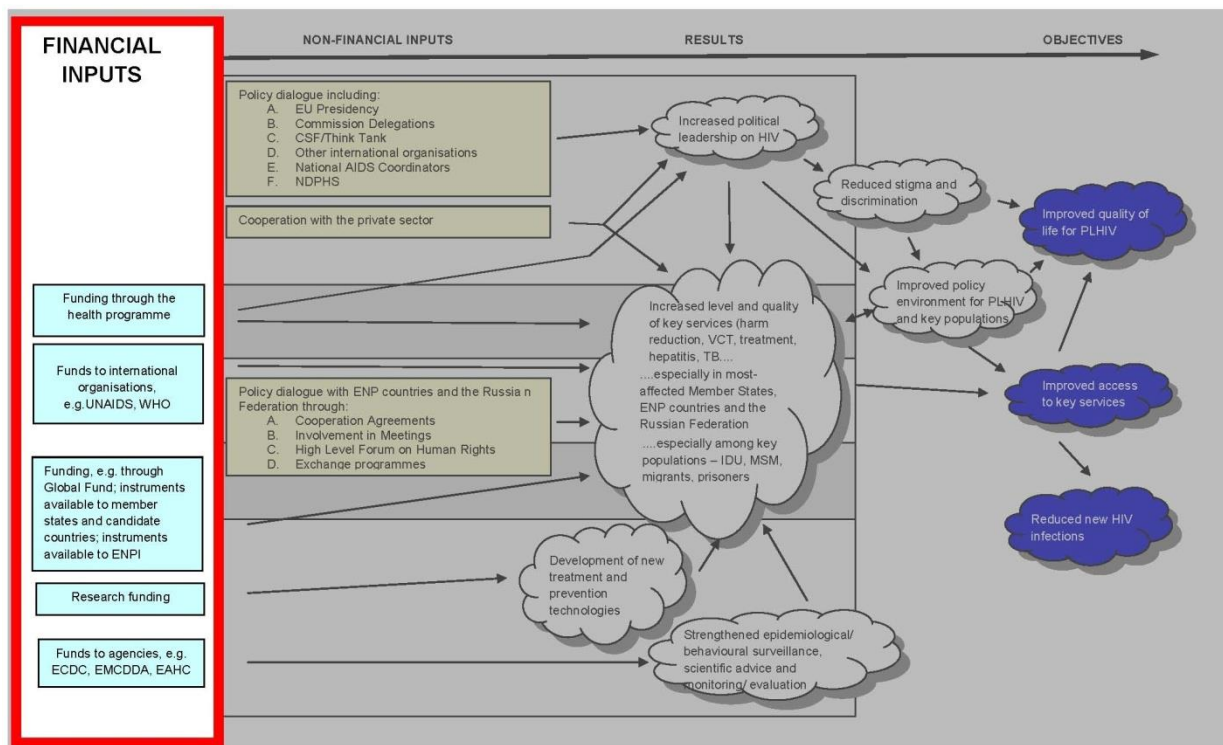
³ Sensoa, Belgium; TAMPEP International Foundation; Swiss AIDS Federation; HIV Nordic, Finland; LILA, Italian League For Fighting AIDS; Soros Foundation, Moldova; AIDS Hilfe Wien, Austria; Dia+Logs, Latvia; All-Ukrainian Network of PLWH; Odyseus, Slovakia; Deutsche Aids Hilfe, Germany; Projecte dels NOMS-Hispanosida; HIV Denmark; GAT, Portugal.

⁴ AIDS Action Europe; Sensoa, Belgium; Deutsche Aids-Hilfe, Germany; HIV Finland; Finnish AIDS Council; LILA, Italian League For Fighting AIDS, Italy; ARAS, Romanian Association against AIDS, Romania; Philanthropy, The Charitable Foundation of the SOC, Serbia; Projecte dels NOMS-Hispanosida, Spain; All-Ukrainian Network of PLWH, Ukraine.

2 Financial inputs

This section focuses on the financial inputs (highlighted by a red box in Figure 2.1) available for implementation of the Communication and Action Plan. As there is no specific financial allocation for this, it draws on information from a number of sources which are discussed here (see Figure 2.1). Approximate annual values from each of these sources are summarised at the end of this section in Table 2.2.

Figure 2.1: Framework for monitoring the HIV Communication and Action Plan: Financial inputs



2.1 Funding to countries

The Global Fund to Fight AIDS, Tuberculosis and Malaria has provided significant levels of financing to counteract HIV in European countries⁵ since its establishment in 2002. During the period 2002–2011, the Global Fund approved the provision of USD 972 million as grants in response to HIV. By 2012, a total of USD 872 million had been disbursed.

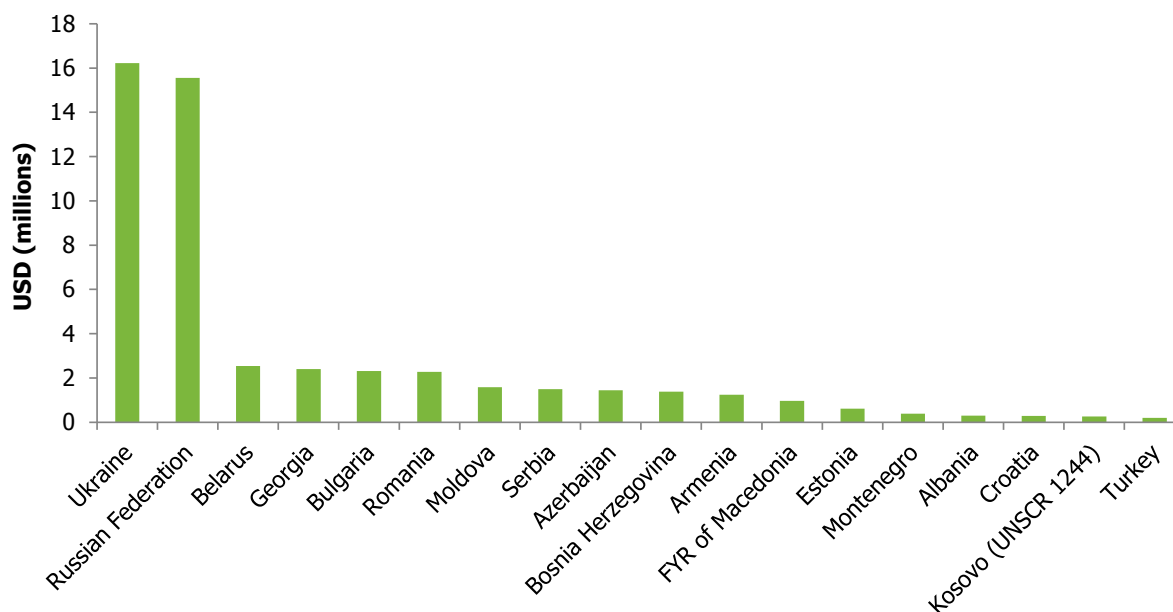
The European Commission has been a major contributor to the Global Fund. From 2002–2012, according to figures from the Global Fund, the Commission provided the Global Fund with USD 1.48 billion, which made it the Fund's sixth largest donor after the United States, France, the United Kingdom, Germany and Japan. Since the Global Fund's formation, 5.9% of the Fund's total finances have been provided by the European Commission. This proportion can be applied to the Global Fund financing to European countries from 2002 to 2012. This means that of the USD 872 million disbursed by the Global Fund during that period, USD 52 million (5.9%) effectively originated from the European Commission.

The USD 52 million provided by the Commission for national responses to HIV in EU and ENP countries and the Russian Federation benefited 18 countries, with the largest amounts going to Ukraine and the Russian Federation through the Global Fund (see Figure 2.2)⁶. In 2012, more than half (51%) of funds disbursed to countries in the region went to Ukraine and, for the first time, the total amount of funds disbursed by the Global Fund to the HIV response in Ukraine exceeded the total disbursed to the HIV response in the Russian Federation. Some examples of programmes supported by this financing are given in Box 2.1.

⁵ For the purpose of this analysis, countries in Europe include those which are within the Global Fund's Europe and Central Asia region which are either EU Member States or European Neighbourhood Policy (ENP) countries. the Russian Federation is also included.

⁶ An estimated, pro rata, annual amount provided by the Commission through the Global Fund is in Table 2.2, Section 2.5.

Figure 2.2: Estimated pro rata amounts of funding provided by the European Commission as a response to HIV in EU and ENP countries and the Russian Federation through the Global Fund: 2002–2012



Box 2.1: Examples of country programmes supported by Global Fund financing

Belarus has received two Global Fund grants worth a total of USD 38.4 million for its national HIV response. The first grant, which runs from 2012–2014, focuses on promoting prevention and treatment of HIV and AIDS. The programme is seeking to boost HIV prevention among injecting drug users (IDUs), men who have sex with men (MSM), women who sell sex, prisoners and young people. In addition, the programme seeks to ensure adequate treatment, care and support for people living with HIV. The second grant, which runs from 2010 to 2016, focuses on promoting universal access to HIV prevention, treatment and care for key affected populations.

Moldova receives Global Fund support for a project entitled 'Scaling-up access to prevention, treatment and care under the national program for prevention and control of HIV/AIDS/STIs 2006–2010 and reducing morbidity, mortality and HIV-related impact on people living with HIV/AIDS, 2010–2014'. The total amount for this grant was USD 9.8 million.

The European Commission's financial support to the Global Fund is part of a broader programme entitled *Investing in People* under the Commission's Development Cooperation Instrument. *Investing in People* has four main areas of focus – health, education, gender equality and other aspects of human and social development^{7,8}. The focus on health includes confronting the main communicable⁹, neglected and emerging diseases.

In addition to the Commission's support for the Global Fund, *Investing in People* has established a EUR 9 million programme to build up the capacity of non-state actors in the area of HIV/AIDS prevention, treatment and care for the European Neighbourhood and Partnership (ENP) countries.

This programme covers seven countries¹⁰. It specifically cites the *Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia* and the *Commission Communication on Combating HIV/AIDS in the European Union and Neighbouring Countries 2009–2013*.

⁷ See European Commission (2010) 2010 Part 2 Action Programme covered by the 2007–2013 strategy paper for the thematic programme *Investing in People* under the Development Cooperation Instrument.

⁸ Several of these funding areas, e.g. education will have indirect effects related to HIV.

⁹ HIV, TB and malaria are mentioned specifically.

¹⁰ Armenia, Azerbaijan, Belarus, Georgia, Moldova, the Russian Federation and Ukraine.

Procurement began in September 2010; supported projects include:

- Strengthening the capacity of non-state actors for HIV testing and counselling of most-at-risk adolescents and young people in Azerbaijan, Belarus, Moldova, and Ukraine (EUR 1 million 2012–2014).
- Broader introduction of effective HIV prevention strategies, targeting populations most at risk in Armenia, Belarus, Georgia, Moldova, Russia, and Ukraine (2012–2014).
- HIV, rights and universal access in Armenia, Azerbaijan, Belarus, Georgia, Moldova, the Russian Federation, and Ukraine (EUR 480 000 2012–2014).
- Strengthening the response of non-state actors to the growing needs of women who use drugs in Armenia, Azerbaijan, Belarus, Georgia, and Moldova (EUR 649 500, 2011–2014).
- Increasing access to HIV prevention, treatment, care and support for HIV-positive prisoners and those released from prison in Belarus (EUR 310 650, 2012–2014).

In addition, it appears that funds from other areas of the *Investing in People* programme are used to support national HIV responses, although this is not tracked systematically. For example, at the CSF in December 2011, a representative of Romanian civil society reported that such funds were being used to finance HIV prevention activities by Romanian NGOs that had previously been funded through a Global Fund grant.

Another of the thematic programmes under the Commission's Development Cooperation Instrument focuses on non-state actors and local authorities. Within this programme, funding is available to support non-state actors in ENP countries and Russia, including EUR 2.15 million in Belarus, EUR 2 million in Russia, EUR 650 000 in Ukraine and EUR 250 000 in Moldova. The EU also funds a number of bilateral EU-Russia projects in the field of public health, including HIV and AIDS. Some of these projects are part of the programme intended to build the capacity of non-state actors in HIV/AIDS prevention, treatment and care in ENP countries (see examples in Box 2.2).

Box 2.2: Examples of bilateral EU-Russia HIV/AIDS projects

- EU-Russia HIV/AIDS projects focus on most-at-risk populations and include support for resource centres working with MSM (approximately EUR 500 000, 2012–2015); HIV prevention for people who inject drugs (EUR 900 000, 2012–2015); and strengthening HIV/STI interventions for sex workers (EUR 400 000, 2011–2013).
- Other projects aim to create a more enabling environment, for example through support to the union of journalists to improve media reporting about most-at-risk populations and people living with HIV (EUR 96 000, 2012–2013); projects also promote the rights of people living with HIV (EUR 225 000, 2012–2014) and of HIV-positive children in St. Petersburg (EUR 675 000, 2010–2013).

Theoretically, structural funds are available for countries to use in their responses to HIV. However, it is unclear if any structural funds have been used directly in relation to HIV.

Similarly, funding through the European Neighbourhood and Partnership Instrument (ENPI)¹¹ can be used to finance responses to HIV. Some examples are given in Box 2.3. ENPI is the main financial mechanism through which assistance is given to European Neighbourhood and Partnership countries and Russia. Almost EUR 12 billion has been allocated to ENPI for 2007–2013. Priorities for ENPI funding include transport; energy; sustainable management of natural resources; border and migration management, the fight against transnational organised crime and customs; people-to-people activities and landmines, explosive remnants of war, small arms and light weapons. In 2011, ENPI also announced funding of EUR 22 million for a new civil society facility¹².

In 2012, the Commission took a decision to support the ENPI East Regional Action Programme, which includes eastern ENP countries and Russia and, specifically, within which EUR 10 million has been allocated for a range of regional sector programmes as part of the multilateral dimension of the Eastern Partnership, Black Sea Synergy and Northern Dimension. Within this, EUR 1 million has been allocated for support to the NDPHS and specific related projects.

¹¹ See http://www.enpi-info.eu/main.php?id_type=2&id=359

¹² See <http://www.enpi-info.eu/eastportal/news/latest/26632/%E2%82%AC22-million-for-new-Civil-Society-Facility-as-EU-steps-up-Neighbourhood-response>

Box 2.3: Examples of HIV and health-related activities supported through ENPI

ENPI includes EUR 46.6 million for health sector support programme in Moldova. The aim of this programme is to improve the health of the population and improve access to, and the efficiency and quality of, essential public health services. Funding to the amount of EUR414 500 is provided for the project 'Strengthening Moldovan civil society organisations in HIV/AIDS prevention and care for women and juvenile prisoners'.

In Russia, the delegation has used ENPI funds to support projects in the social sector tackling HIV. For example, the Commission supported a project entitled 'We Choose a Life – Youth Against HIV/AIDS'. This project was managed by the Baltic Region Healthy Cities Association from 2008 to 2010 and operated in four Russian cities – Cherepovets, Dimitrovgrad, Izhevsk and Stavropol. It was part of the Commission's institution building partnership programmes (IBPP) aimed at giving active support to civil society organisations in Russia.

In addition, the Commission uses ENPI to support an EU Baltic Sea Strategy External Action Programme, valued at EUR 20 million. As part of this programme, in 2011, the Commission launched a call for proposals directed at non-state actors and local authorities in the Baltic Sea region. This EUR 3.5 million grant scheme aims to support cooperation between the EU and Russia by encouraging local stakeholders to address common challenges and opportunities more effectively. One of the priorities of this scheme is to reduce the spread of communicable diseases, including HIV.

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2.2 Funding to agencies of the European Union

Executive Agency for Health and Consumers (EAHC)

The European Health Programme organised by the EHAC includes a focus on supporting responses to HIV in line with the Commission's Communication on HIV/AIDS¹³. The programme allocates funds through its annual work plan to a range of activities including conferences, operating grants and projects.

In 2009–2012, the European Health Programme allocated a total of EUR 9.5 million to HIV-related activities across a range of different thematic areas (see Table 2.1). Based on reports from EAHC, this includes funding for leadership (in particular for international and regional conferences and meetings; see also Box 4.1), civil society, HIV prevention, services for the most affected countries and populations (see also Section 4.2), and for monitoring and evaluation. More details are provided in Figures 2.3 and 2.4.

Overall, the amount of funding for HIV-related activities from the European Health Programme dropped from EUR 6.9 million in 2009–2010 to EUR 2.6 million in 2011–2012.

In 2009–2010, the European Health Programme funded a wide variety of activities, while in 2011–2012, the Programme focus shifted towards leadership, civil society, and monitoring and evaluation. Box 2.4 illustrates some of the HIV activities funded through the European Health Programme.

¹³ Executive Agency for Health and Consumers. Joining together to tackle HIV/AIDS in Europe. DG SANCO: Brussels; 2011.

Table 2.1: European Health Programme: funding for HIV-related activities, 2009–2012, in EUR

| | 2009 | 2010 | 2011 | 2012 | Total |
|---------------------------|---------------------|---------------------|-------------------|---------------------|---------------------|
| Leadership | 449 995.54 | 200 000.00 | 100 000.00 | | 749 995.54 |
| Civil society | 261 927.54 | 250 000.00 | 250 000.00 | 350 581.00 | 1 112 508.54 |
| Prevention | 449 663.00 | | | | 449 663.00 |
| HIV most affected regions | | 694 693.00 | | | 694 693.00 |
| HIV among IDUs | 410 980.15 | | | | 410 980.15 |
| HIV among MSM | | 989 960.00 | | | 989 960.00 |
| HIV among sex workers | 1 243 475.00 | | | | 1 243 475.00 |
| HIV among migrants | 661 385.00 | 792 816.00 | | | 1 454 201.00 |
| HIV among prisoners | 499 976.00 | | | | 499 976.00 |
| Improve knowledge, M&E | | | 412 800.00 | 1 493 180.00 | 1 905 980.00 |
| | 3 977 402.23 | 2 927 469.00 | 762 800.00 | 1 843 761.00 | 9 511 423.23 |

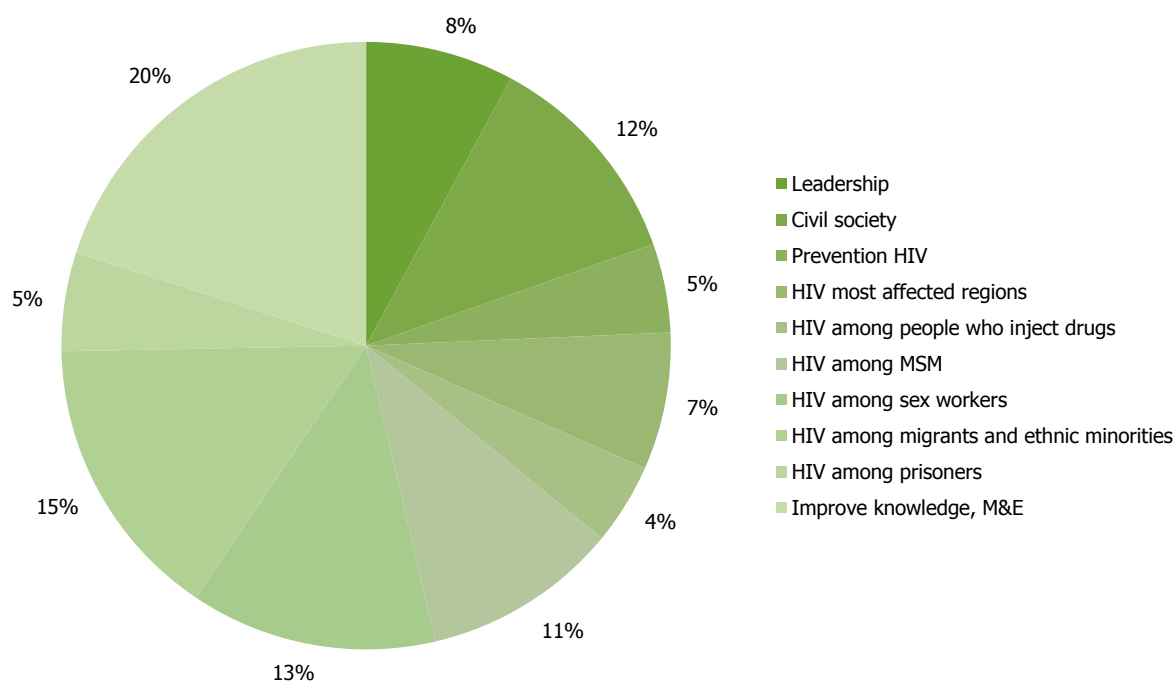
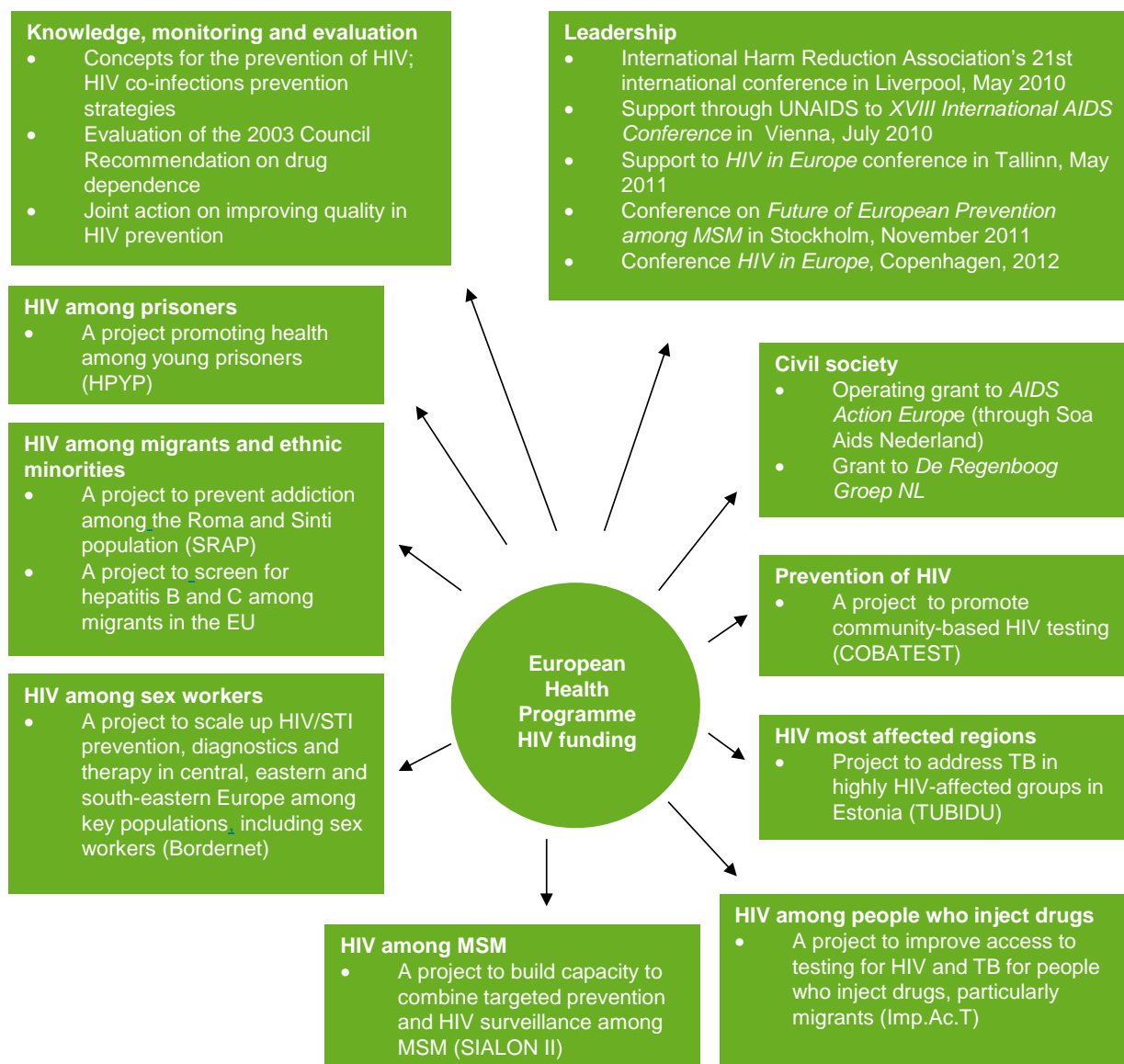
Figure 2.3: Percentage of European Health Programme HIV funding allocated to different topics, 2009–2012

Figure 2.4: Activities supported by European Health Programme HIV funding, 2009–2012

Box 2.4: Examples of HIV-related activities supported through the European Health Programme: 2009–2012

Additional funding went to conferences with a focus on key populations that promoted greater leadership on HIV-related activities, such as the International Harm Reduction Association conference in Liverpool in May 2010 and the Future of European Prevention among MSM (FEMP) conference in Stockholm in November 2011.

Funding for the involvement of civil society and people living with AIDS included support to AIDS Action Europe (through Soa Aids Nederland) to coordinate the CSF (see Section 3.3) and strengthen the contribution of civil society to regional and national HIV policies and responses. In 2013, funding for civil society activities also went to the Correlation Network, which aims to reduce health inequalities; improve access to health and social services for marginalised groups; and enhance prevention, treatment and care for HIV and hepatitis C.

EAHC reports that funding for projects that aim to improve knowledge and monitoring and evaluation also included support for the development of future strategies for the prevention of HIV and HIV co-infections, for the Improving Quality in HIV Prevention (QHP) Joint Action, and for a progress assessment of the 2003 Council Recommendation on prevention and reduction of health-related harm associated with drug dependence in the EU and EU-candidate countries.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

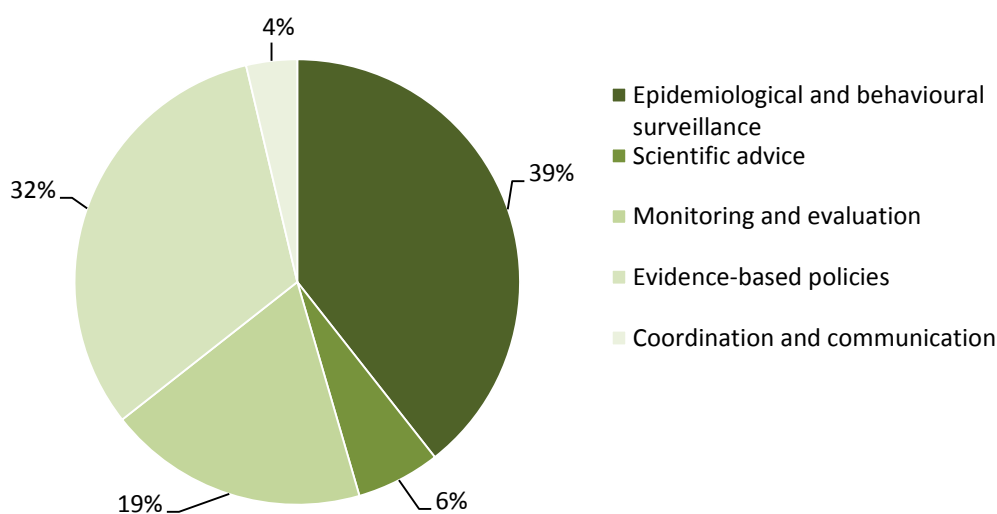
EMCDDA is financed largely through a general subsidy from the European Community¹⁴. In 2010, the EMCDDA budget was almost EUR 16 million, and in 2012 it was approximately EUR 15.6 million¹⁵. EMCDDA reports that its budget does not contain funds earmarked specifically for HIV and, therefore, the Agency is not able to provide figures for the amount of funds used to promote the Commission's Communication and Action Plan. Instead, EMCDDA reports that HIV-related activities are included in the overall budget for the scientific work of EMCDDA and are integral to the monitoring of drug use trends and responses, which is the core mandate of EMCDDA. EMCDDA's HIV-related activities and their effects are discussed further in Section 4 of this report.

European Centre for Disease Prevention and Control (ECDC)

ECDC was established in 2005, achieving full staffing levels in 2011. Core activities include identifying, analysing and communicating current and emerging threats to human health posed by infectious diseases, including HIV/AIDS. The disease programme on sexually transmitted infections, including HIV and blood-borne infections, started in 2006. ECDC carries out HIV-related activities to support the Commission in the areas of surveillance, scientific advice, monitoring and evaluation, evidence-based policies, as well as communication and coordination of scientific activities on HIV/AIDS.

ECDC reports that in the four years from 2009–2012, its estimated budget allocation for HIV projects was EUR 2 960 203. These figures do not include staff time spent on HIV-related activities¹⁶ or support functions, such as facilities, publications, administrative and financial activities and library staff. Figure 2.5 shows the relative allocation of funding to different types of HIV/AIDS projects over this four-year period, with 39% allocated to epidemiological and behavioural surveillance, 32% to evidence-based policies, 19% to monitoring and evaluation, 6% to scientific advice and 4% to coordination and communication. Figure 2.6 briefly summarises examples of the types of activities funded by ECDC in each of these areas. These activities and their effects are discussed in more detail in Section 4 of this report.

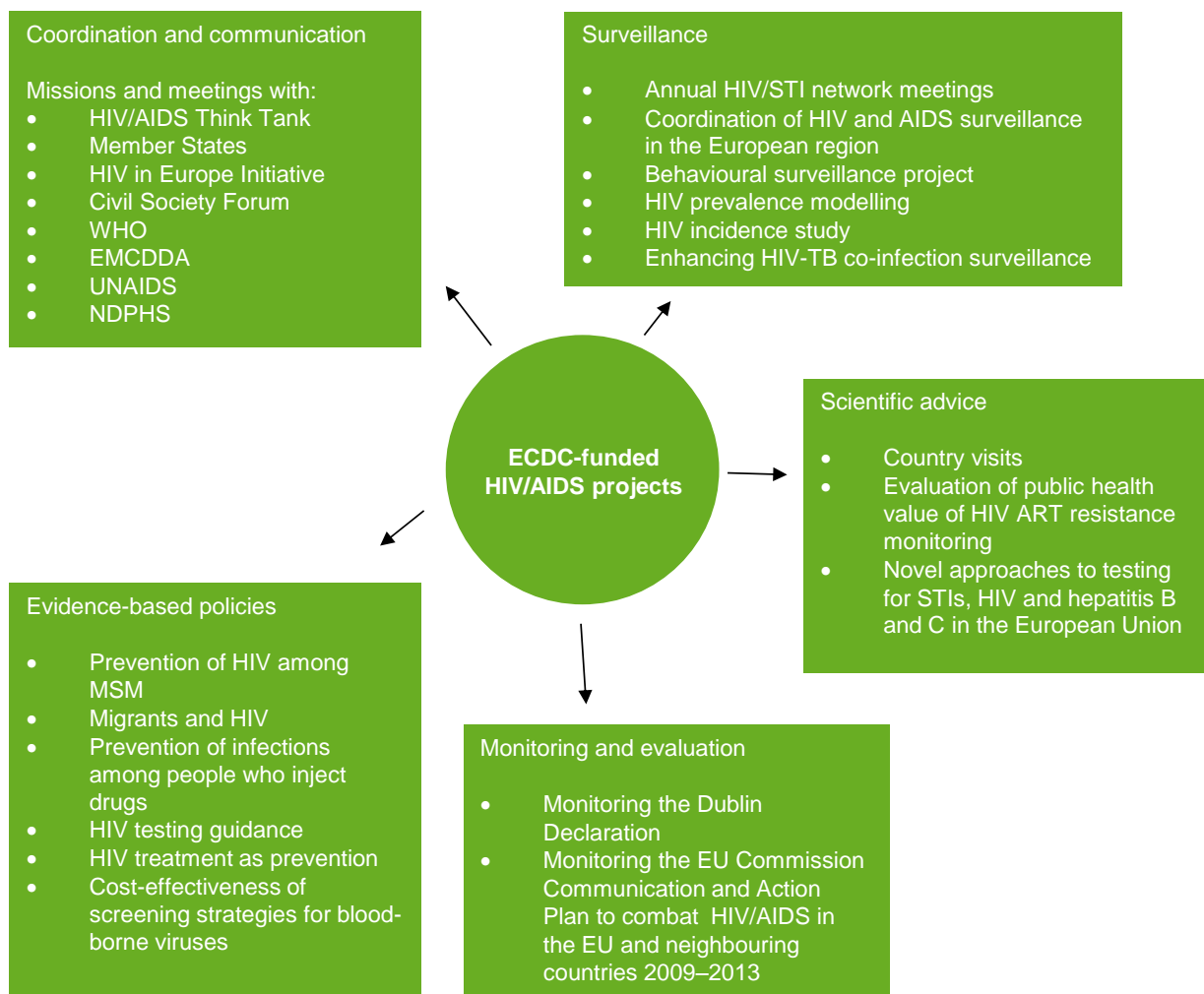
Figure 2.5: Distribution of ECDC budgetary allocations by type of HIV/AIDS project, 2009–2012



¹⁴ In addition, in 2010, the budget contained some funding from other countries, such as Norway and Turkey (see http://www.emcdda.europa.eu/publications/searchresults?action=list&type=PUBLICATIONS&SERIES_PUB=w216); the 2012 budget also included additional funding from Norway, Turkey and Croatia.

¹⁵ Figures from the EMCDDA website

¹⁶ Approximately three full-time equivalents in 2011 and 2.5 in 2012

Figure 2.6: HIV/AIDS activities supported by ECDC funds: 2009–2012

2.3 Funding to key international organisations

In 2010, the Joint United Nations Programme on HIV/AIDS (UNAIDS) reported receiving EUR 400 000 from the European Health Programme to raise awareness of HIV and AIDS in eastern Europe and to support the International AIDS Conference in Vienna in 2010, in particular by funding the participation of civil society representatives. In addition, UNAIDS reported that it received additional funding from the EuropeAid Cooperation Office (AIDCO) Development Cooperation Instrument for its work outside the European Union and in neighbouring countries. According to the UNAIDS report on its income for 2010¹⁷, total contributions from the European Commission amounted to just under USD 1.5 million, which accounted for 0.6% of UNAIDS' total income. This compares to a total of almost USD 150 million received directly from 14 EU Member States¹⁸. UNAIDS reports that no further funding was received from the Commission after October 2011.

IOM reports that the EC is one of its main global donors, providing USD 63.8 million in 2009, USD 73.1 million in 2010, and USD 106.7 million in 2011. Specific funding was provided to the IOM Regional Office for two HIV-related projects, from ECDC for work on improving HIV data comparability in migrant populations in EU/EEA countries (September 2009 to June 2010, see Section 4) and from DG SANCO for the AIDS and Mobility Europe project (July 2009 to July 2011). In addition, IOM has implemented two projects with a total budget of around EUR 1 million, also funded by DG SANCO, which focus on migrant health. IOM has also implemented a programme to improve health services, and awareness of health services, for refugees and asylum seekers in Poland, with funding from

¹⁷ Details of total contributions for 2010 are available from:

http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/20110331_2010DonorTotalContributionTables.pdf

¹⁸ These countries (by size of contribution) were Sweden, the Netherlands, the United Kingdom, Finland, Denmark, Luxembourg, Belgium, Ireland, Germany, Spain, France, Portugal, Austria, and Poland.

the European Refugee Fund. The programme includes workshops for asylum seekers. Workshops address the prevention and treatment of HIV and other communicable diseases and aim to overcome barriers to diagnosis and treatment.

In addition, the European Commission provides direct and indirect funding through a number of different funding schemes to WHO, the United Nations Office on Drugs and Crime (UNODC) and the United Nations Population Fund (UNFPA). For example, the European Health Programme provided EUR 299 109 to WHO between December 2009 and June 2012 to conduct a project aimed at scaling up access to high-quality harm reduction and treatment and care for injecting drug users in the European region. The project focused on harm reduction, HIV treatment, hepatitis C, integrated HIV and TB services, and promoted policy development and training.

2.4 Research funding

The Commission's Communication contains a strong commitment to HIV-related research. The Commission has provided significant levels of funding for HIV-related research through its Research Framework Programmes (FPs). These FPs are the EU's main instrument for funding research in Europe. They are intended to channel European research on HIV into projects ranging from basic science to pre-clinical and early clinical testing of new drugs and therapeutic approaches, microbicides and vaccine candidates, clinical management of HIV-infected individuals, better prevention and improved treatments.

Over the years, FPs facilitated the cooperation between European scientists and research teams and also helped to improve the exchange between industrial and public sector research. Patient organisations and civil society are also members of these partnerships.

The Sixth Framework Programme (2002–2006) provided an EU contribution of EUR 123 million to 41 projects on HIV-related research. The Seventh Framework Programme (FP7, 2007–2013) committed more than EUR 130 million to research on HIV-related therapeutic and preventive approaches. Based on figures provided in 2011, almost all research spending (87%) related to the development of treatment, vaccines and microbicides (see Figures 2.7 and 2.8).

Research projects on therapy included those seeking to develop new antiretrovirals as well as projects looking at how to improve treatment adherence and patient follow-up. A number of research projects also focus on promoting coordination and cooperation among researchers (see Figure 2.8). As part of the Seventh Framework Programme, there was a call for proposals relating to behavioural research in the health field. However, during the evaluation of proposals submitted, no projects addressing HIV were selected for funding.

In response to the global health crisis caused by the three main poverty-related diseases (HIV/AIDS, tuberculosis, and malaria), the European Commission, together with 16 Member States and associated countries, created the European and Developing Countries Clinical Trials Partnership in 2003 (EDCTP, 2003–2015) to bring new drugs and vaccines to patients. From 2003 to 2012, the total amount of EU-funded EDCTP projects was EUR 145 million, of which about EUR 50 million were devoted to HIV-related grants (55 grants total).

Figure 2.7: Distribution of HIV research spending through the European Seventh Framework Programme (2007–2013)

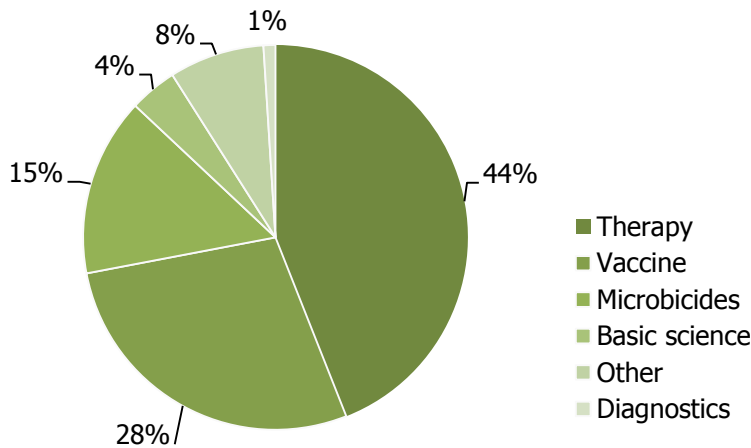
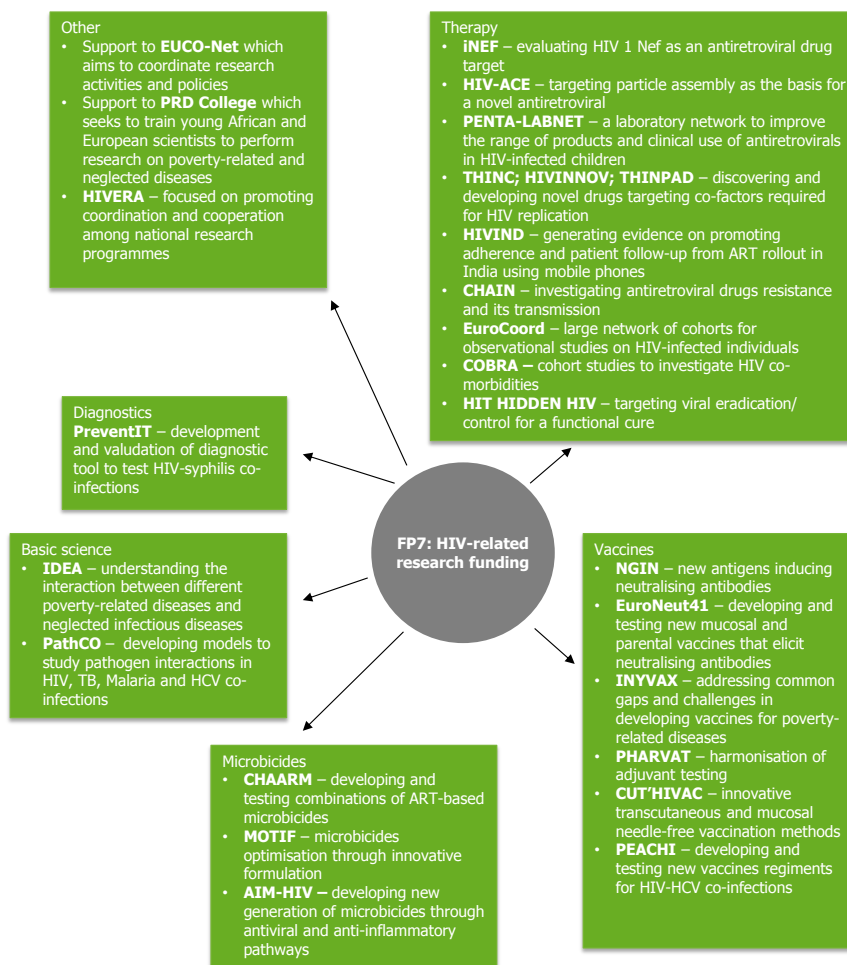


Figure 2.8: HIV-related research projects funded through European Seventh Framework Programme (2007–2013)



2.5 Overall annual financial inputs to support the Communication and Action Plan

Funding has targeted HIV prevention, increasing access to prevention, treatment, care and support, especially in priority regions and for priority groups, research, surveillance and monitoring and evaluation. Table 2.2 shows the approximate financing available on an annual basis to support the Commission's Communication and Action Plan, based on information provided and discussed above. However, these figures should be treated with great caution. They are very approximate and underestimate the actual financial input because accurate information is not available for all funding sources, e.g. structural funds and certain costs, such as staffing, which were not covered in several of the responses. The figures include Commission financing for the activities of the Think Tank and CSF – an approximate annual combined cost of EUR 150 000¹⁹.

Table 2.2: Approximate financing available on an annual basis to support Communication and Action Plan²⁰

| Source | EUR million |
|---|--------------------|
| Funding to countries | |
| Pro rata Commission contribution to the region through Global Fund | 3.6 |
| Investing in People programme to build capacity of non-state actors | 1.4 |
| DCI funds to non-state actors and local authorities | 1.3 |
| Structural funds | no data |
| European Neighbourhood Partnership Instrument | no data |
| | |
| Funding through agencies of the European Union | |
| EAHC Health Programme | 2.4 |
| EMCDDA ²¹ | 0.0 |
| ECDC | 0.7 |
| | |
| Research funding | 24.8 ²² |
| | |
| Other funding | 0.3 |
| | |
| Estimated total | 57.5 ²³ |

2.6 Impact of the financial crisis

There are concerns that the current international financial crisis affecting European countries could be influencing the amount of funding available for national HIV responses. This section reviews data reported on this issue by countries who reported to the Dublin Declaration monitoring process and participated in Think Tank meetings in 2011 and 2012. It also includes information from questionnaire responses on the effect of the financial crisis.

Based on data reported to the Dublin monitoring process, there is evidence that, despite the economic crisis, many countries have continued to increase overall funding for their HIV responses. However, much of this is related to treatment and care. Across the region, more than 95% of all HIV spending goes on treatment and care. This proportion is higher in EU/EEA countries.

Although funding levels for HIV prevention are higher in many countries in 2011 than in 2008, several have seen a decline in funding since 2010. In some countries, such as Kyrgyzstan, Poland and Romania, reductions in funding for HIV prevention are significant. Many countries report that their spending on HIV prevention is increasingly

¹⁹ The Commission also has two full-time professional staff working on HIV within the Directorate General for Health and Consumers, in addition to support staff. Staff in other parts of the Commission also focus on HIV as part of their work.

²⁰ All figures are approximate and rounded to one decimal point.

²¹ EMCDDA reports that its budget does not contain funds specifically earmarked for HIV and, therefore, the agency is not able to provide figures for the amount of funds used to promote the Commission's Communication and Action Plan.

²² Based on average annual FP7 funding for HIV 2007–2013 and average annual EDCTP funds for HIV 2003–2012.

²³ Data on available funds for the implementation of the Communication and Action Plan should be interpreted with caution as there is no standardised way for measuring financial commitments. There are no numbers available from the structural funds and the ENPI. Figures provided by all organisations are estimates.

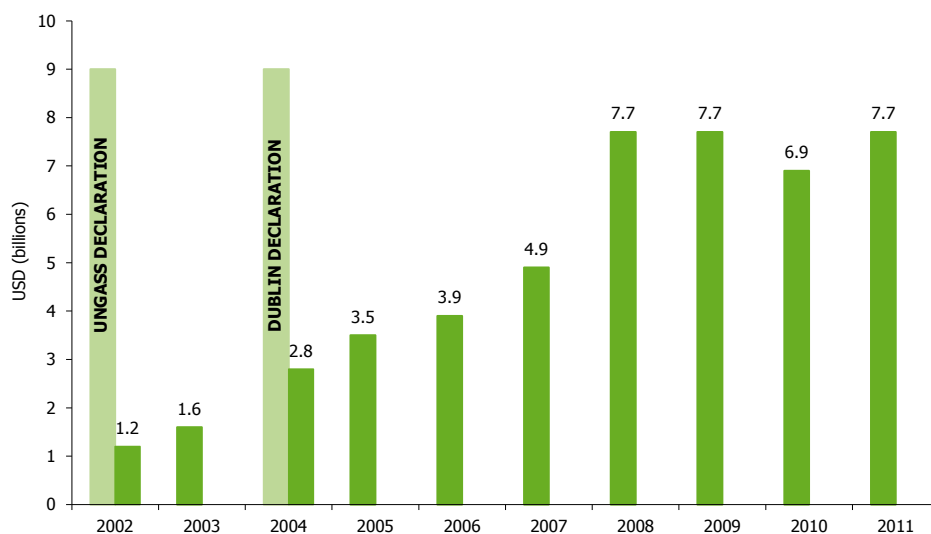
focused on populations most affected by HIV, such as people who inject drugs, sex workers, and men who have sex with men. Often, the underlying reason for this focus is to make programmes more effective. However, in some cases, such as in Estonia, this focus also reflects the need to make spending more efficient in the face of reduced overall funding for HIV prevention activities. It is of concern that some countries, including Latvia, Poland and possibly Ukraine, appear to have reduced their focus on funding programmes for populations most affected by HIV.

Despite the financial crisis, many low- and middle-income countries report that they have increased the level of funding for HIV responses from domestic resources. These include Armenia, the former Yugoslav Republic of Macedonia, Georgia, Kazakhstan, Kyrgyzstan, Moldova, and Tajikistan. However, these countries remain dependent on external funds for their HIV responses, particularly from the Global Fund. Some countries, such as Romania, have experienced HIV outbreaks among people who inject drugs, following the reduced provision of harm reduction services when Global Fund financing ended and replacement funding was not provided from other sources.

The economic crisis has adversely affected European funding for the global HIV response:

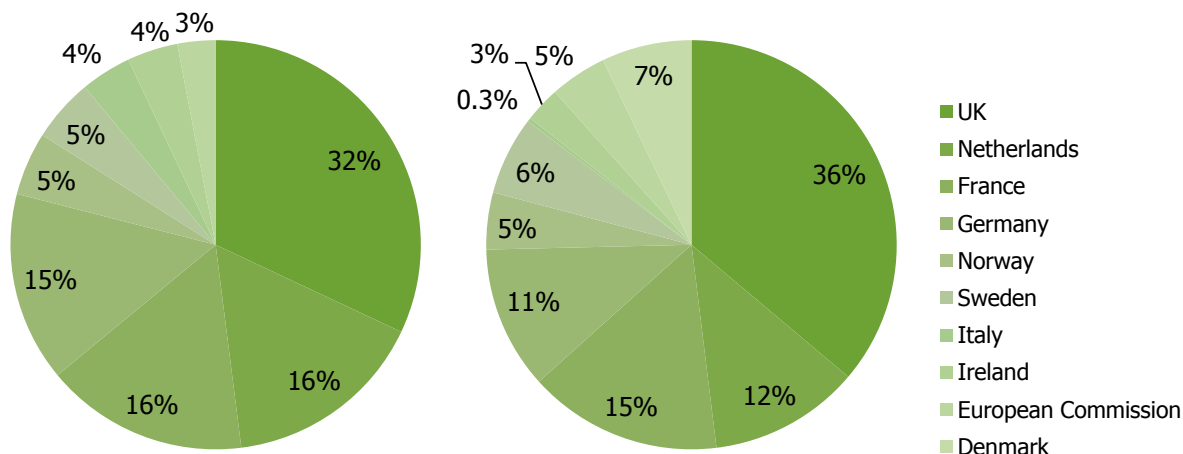
- The overall level of funding has plateaued since 2008 (see Figure 2.9).
- The percentage of international AIDS assistance from Europe fell between 2008 and 2011, largely because of reduced contributions by a number of countries, including France, Germany, Ireland, Italy, the Netherlands, and Norway. However, some countries, e.g. Sweden and the United Kingdom, increased their contributions, as did the European Commission (see Figure 2.10).
- Levels of European funding to the Global Fund declined, largely as a result of decreasing contributions from those countries which were most severely affected by the economic crisis, e.g. Ireland, Italy, and Spain, which made no contributions in 2011 (see Figure 2.11).
- Levels of European funding to UNAIDS declined largely as a result of reduced contributions from some major funders, for example Denmark, Ireland, the Netherlands, and the United Kingdom (see Figure 2.12).

Figure 2.9: International AIDS assistance from donor governments, 2002–2011



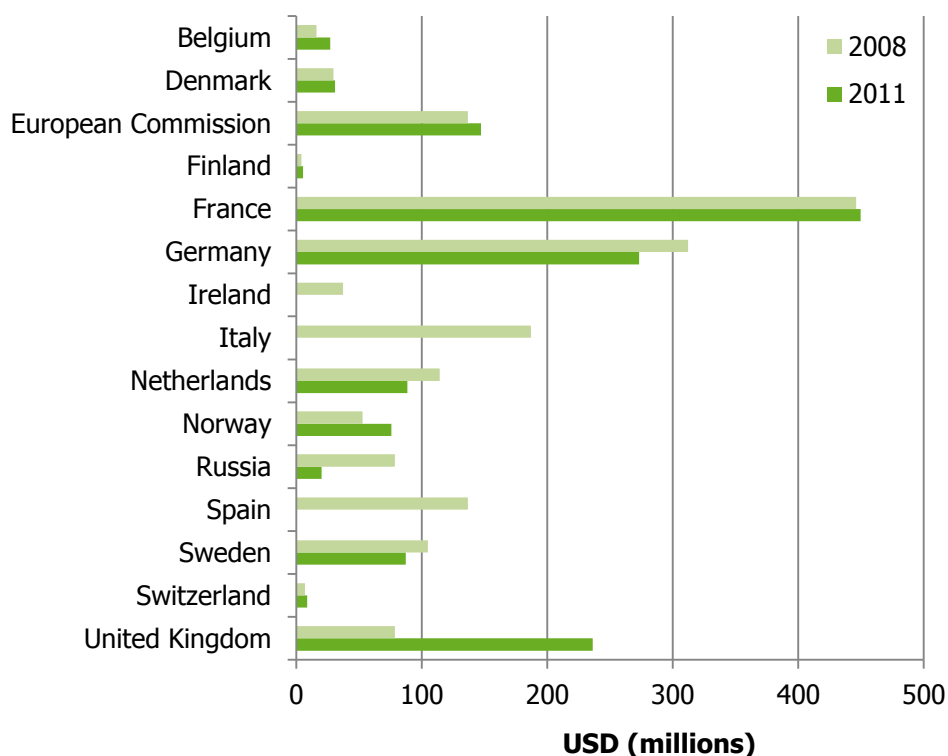
Source: Kaiser Family Foundation and UNAIDS 'Financing the response to AIDS in low- and middle-income countries: international assistance from donor governments in 2011' (July 2012)

Figure 2.10: International AIDS assistance from EU/EEA Member States and the European Commission, proportion of disbursements by source, 2008 and 2011

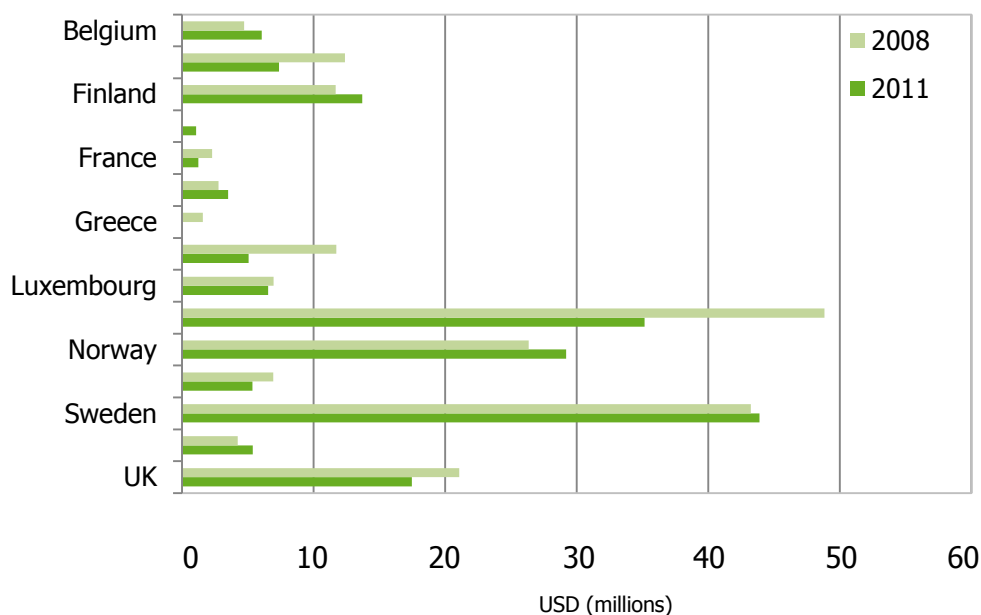


Source: Kaiser Family Foundation and UNAIDS 'Financing the response to AIDS in low- and middle-income countries: international assistance from donor governments in 2011' (July 2012)

Figure 2.11: Contributions to the Global Fund for all three diseases: European countries contributing more than USD 5 million, 2008 and 2011



Source: Global Fund 'List of core pledges and contributions, 2012'

Figure 2.12: Contributions to UNAIDS: selected European countries, 2008 and 2011

Source: UNAIDS 'List of total contributions, 2012'

The Think Tank meeting in December 2012 considered the impact of the financial crisis on national responses to HIV. A number of countries reported that there had been little effect on their funding for national HIV responses:

- In Denmark, spending on HIV prevention has not yet been affected by the financial crisis. This situation is not expected to change in 2013. National NGOs continue to receive state financing of EUR 2 million per year. Municipal funding of HIV prevention amounts to about EUR 0.5 million per year in 2012–2014, which represents a small increase. General harm reduction services to people who inject drugs remain the same. There have been no cuts in regional financing of testing, counselling and treatment.
- In Finland, treatment and care are integrated as part of the overall health system. Prevention is funded at the municipal and national levels. There is some variation year by year, depending on need.
- In Luxembourg, there has been no overall impact. Funding for treatment increased. Prevention campaigns are organised through the ministry and NGOs, and funding has been stable since 2009. However, it has become more difficult to find additional funding, for example for extended testing campaigns. International funding to the Global Fund and UNAIDS has remained unchanged.
- In the Netherlands, there has been no clear effect. 14 000 people receive ART. There are about 1 100 new infections per year, about 700 of which are among MSM. Testing and treatment are provided through the health insurance scheme. The Ministry of Health has been funding a supplementary HIV testing scheme, and the cost of this has risen from EUR 20 million to EUR 30 million. There is no ceiling for this programme but there are concerns about its sustainability. Policy changes on HIV prevention include the discontinuation of specific campaigns on HIV prevention; instead, campaigns now focus on broader lifestyle issues.
- Norway reported no change in funding to their national HIV response.
- Sweden continues to provide an annual grant of around EUR 16 million for HIV preventive work at the national and regional levels. These funds are focused on key populations and support the work of national NGOs (EUR 2.3 million); work in counties and three metropolitan areas (EUR 10.4 million); and different measures at the national level (EUR 3.3 million). Although the level of funding has nominally stayed the same, funding has decreased once adjusted for inflation. It is expected that the level of funding will remain unchanged until at least 2016 when the current HIV strategy expires. ART is currently available to anyone who is legally resident in Sweden. This provision will be extended to those who present 'illegally' in Sweden in 2013. ART costs are covered by health insurance and are estimated at EUR 8 000 to 10 000 per person per year.
- In Switzerland, there has been no change. Spending on HIV prevention has been stable and will remain stable until 2017. There has been a slight increase in contributions to the Global Fund and UNAIDS. Funding for research is stable, and treatment is fully available and funded.

Some countries, such as Austria, commented that although funding had remained stable, demand for services had increased.

Several countries reported that their funding for HIV prevention had been considerably reduced. In some cases, for example France, spending cuts reflect wider cuts in health funding although HIV funding has been less affected

than other areas. However, reduced funding for other areas, such as housing, food, work and mental health also affects people living with HIV (PLHIV), including those on treatment. In Germany, between 2007 and 2010, prevention spending rose from EUR 9.2 million to EUR 13.2 million at the national level. In 2011 spending on prevention decreased to EUR 11.2 million. This amount is expected to remain stable until 2015.

Countries reported reduced spending in a number of areas, including:

- Overall prevention efforts, e.g. in the Russian Federation.
- Prevention activities for the general population and specific groups, for example high school students in France, and sex workers and MSM in Lithuania.
- Anonymous testing in Hungary.
- National prevention campaigns, e.g. in France.
- Initiatives to reduce the cost of antiretroviral medicines, e.g. in France, Italy and the Russian Federation.
- Restrictions in treatment for those with a CD4 count <200–250 cells/mm³, e.g. in Latvia and Lithuania.
- Research, e.g. in France.
- Surveillance, e.g. in Italy and Lithuania.
- NGOs, e.g. in France.
- Restructuring health institutions, e.g. in Lithuania.
- Restrictions in replacing and/or hiring staff; reduced international travel, e.g. in France.

Responses to questionnaires from EU and other agencies paint a mixed picture:

- The EU Delegation in Moldova commented that the financial crisis caused no negative effects on their funding for HIV.
- ECDC expected reductions in 2013 to its HIV-related budget; EMCDDA commented that all EU agencies are expected to reduce budgets and staff.
- IOM commented that it was increasingly difficult to identify matching funds required by Health Programme projects because funding for programmes aimed at non-EU citizens and ethnic minorities has declined. IOM also commented that the financial crisis was exacerbating anti-migrant sentiments, stigma, and populist politics as seen in Spain, Greece, and the Netherlands²⁴, making their work more difficult.
- NDPHS commented that it expected 2013 to be a difficult year because Finland would be concluding its bilateral collaboration with the Russian Federation and EU funds would almost certainly run out before the new round of funding 2014–2020. NDPHS also reported that participation of national governments in international meetings was reduced.
- UNAIDS commented that international financing for HIV has flattened since the onset of the crisis, but domestic spending has increased by 50%.
- WHO noted that funding for HIV-related work had declined significantly, partly as a result of the financial crisis but also because of a shift in priorities in Europe towards non-communicable diseases. As a result, WHO has re-prioritised its work to focus on strategic information, treatment, elimination of mother-to-child transmission and prevention in key populations, in particular people who inject drugs, and towards a more strategic and normative approach, rather than working at a project level.

Several agencies also commented that demand for their services had increased. For example, ECDC reported several requests from Member States to advocate EU-funded, periodic bio-behavioural surveillance among key populations in the EU/EEA, using similar indicators and methodology. Some requests to ECDC and EMCDDA appear to be related to the financial crisis, such as the risk assessment on HIV in Greece and the assessment of outbreaks of HIV among people who inject drugs in Europe²⁵. EMCDDA expressed concern that focusing on acute needs and threats might lead to a reduction of longer-term development programmes. WHO commented that demands for technical assistance were increasing, including those from Western Europe. UNAIDS commented that the financial crisis had resulted in a need to focus resources on priority groups and programmes, and in increased demand for UNAIDS assistance in this area. UNAIDS has itself focused its resources on high impact countries²⁶, which can provide high returns in terms of big reductions in new infections and mortality.

The CSF provided extensive comments on this topic, noting that AIDS Action Europe has experienced reductions and delays in funding. As a result, the organisation has a funding gap for 2013, and there is a risk that the network might have to close down, which would severely affect the Civil Society Forum. Staff efforts are currently focused on fundraising, to the detriment of programme implementation and longer-term strategy.

Civil society respondents from some countries, for example Belgium, commented that there had not yet been any restrictions in budgets for HIV prevention or care. Other countries were less positive:

²⁴ Where interpreting services for migrants were cut.

²⁵ European Centre for Disease Prevention and Control. Risk assessment on HIV in Greece.

Stockholm: ECDC; 2012. <http://ecdc.europa.eu/en/publications/Publications/20121130-Risk-Assessment-HIV-in-Greece.pdf>

²⁶ There are two UNAIDS high impact countries in the region, the Russian Federation and Ukraine.

- In Finland, civil society reported a reduction in municipal funding to HIV prevention and the HIV work of NGOs, although funding for social and health sector organisations comes mainly from the Slot Machine Association; this source of funding has been largely unaffected by the international financial crisis. Nonetheless, securing funding for HIV Nordic's core work is becoming increasingly difficult.
- In Germany, it was reported that the national budget had been cut by around EUR 1 million for 2013. As a result, Deutsche AIDS Hilfe faces a budget cut of EUR 300 000. NGOs in Germany are considering charging training fees.
- In Italy, the financial crisis has affected the availability of funds for HIV-related work. Some interventions have been discontinued or dramatically reduced, for example, harm reduction services in prisons or targeted to people who inject drugs.
- In Serbia, NGOs have been able to implement activities but depend on short-term project funding, e.g. from the EU and Norwegian Church Aid.
- In Spain, civil society organisations reported concerns about reductions in the National AIDS Strategy Secretariat (SPNS) budget, particularly in funds available to regions, which have been cut dramatically, as well as about plans to close the SPNS, which could result in the discontinuation of programmes delivered by NGOs. NGOs are also very concerned by legislation which, in August 2012, revoked healthcare coverage for migrants without residence permit.
- In Ukraine, donor funding has declined due to the international financial crisis. The All-Ukrainian Network of PLHIV, for example, has had to review its programmes and its costs.

A civil society respondent from Romania commented that HIV work in Romania was not affected by the international financial crisis, but that joining the EU resulted in the country being ineligible for Global Fund financing²⁷. Once Global Fund financing ended, most HIV prevention programmes stopped; a few continued with funding from the European Social Fund, but these projects will end in 2013.

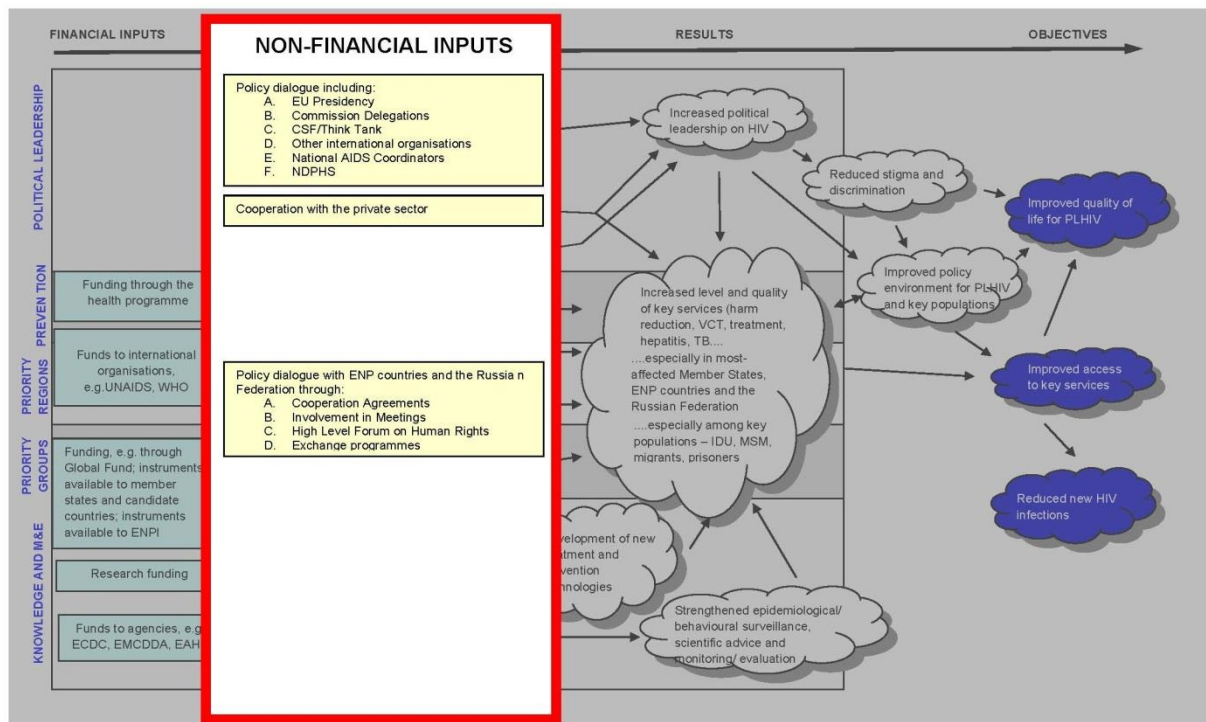
- AIDS Action Europe report increasing demands from member organisations for assistance in identifying new funding sources, particularly in the eastern part of the region, where the Global Fund is phasing out and governments are not stepping in. As a result, effective harm reduction and prevention programmes run by NGOs are at risk. Civil society respondents from some countries also report increasing demand for services. For example:
- In Romania, there has been an increased need for NGO involvement in advocacy campaigns, e.g. over ARV shortages.
- In Serbia, there is an increased demand to meet basic humanitarian needs.

²⁷ In fact, the Global Fund's eligibility criteria were based on a country's income level and not on EU membership per se.

3 Non-financial inputs

This section focuses on the non-financial inputs that support the implementation of the Communication and Action Plan (highlighted by a red box in Figure 3.1). This includes activities through a number of mechanisms including the EU Presidencies, Commission Delegations, the Think Tank and Civil Society Forum, Commission engagement with other international organisations, national AIDS coordinators, Commission involvement in the Northern Dimension Partnership in Public Health and Social Well-being, Commission cooperation with the private sector and various mechanisms for cooperation between the Commission, neighbouring countries and the Russian Federation.

Figure 3.1: Framework for monitoring the HIV Communication and Action Plan: Non-financial inputs



3.1 EU Presidencies

From the second half of 2009 to 2011, EU Presidencies were held by Sweden, Spain, Belgium, Hungary and Poland. These Presidencies gave high priority to health issues²⁸, with Sweden and Spain specifically including an event focused on HIV (see Figure 3.2). Two major conferences were organised during this period, one on HIV testing and care in 2009 under the auspices of the Swedish Presidency and one on HIV and vulnerability under the Spanish Presidency in 2010 (see Box 3.1). During the Polish Presidency to the EU Council, Poland held the Vice-presidency and Presidency to the UNAIDS Programme Coordinating Board (PCB). Using the PCB as a platform, Poland successfully worked on issues such as access to HIV prevention, treatment and care services, co-infections (TB, HBV, HCV), and human rights.

²⁸ Hungary, which assumed the Presidency in January 2011, identified the following priorities: a stronger Europe; growth, jobs and social inclusion; and global engagement.

Box 3.1: Major HIV-related conferences organised under EU Presidencies

Under the auspices of the Swedish Presidency, the HIV in Europe Initiative organised a conference entitled 'Working Together for Optimal Testing and Earlier Care' in Stockholm in November 2009. The conference, which was attended by more than 100 policy makers, health professionals and civil society representatives from 25 countries, addressed issues including late presentation and barriers to the uptake of HIV testing, HIV-related stigma and the criminalisation of HIV transmission. The aim was to increase awareness among the public and policy makers of public health implications resulting from late presentation for care. The conference was also designed to provide an opportunity to share best practices on optimal testing and early care and develop creative solutions to improve early diagnosis and care. Important outcomes of the conference included significant progress towards a consensus on defining late presentation and a list of indicator diseases for HIV – the latter is important since many late presenters may have already been in contact with health services but not had their HIV status diagnosed. There was also a discussion of innovative ways in which to estimate the size of the infected-but-not-yet-diagnosed population in order to develop clear guidance for countries.

Coinciding with the European Year for Combating Poverty and Social Exclusion, the Spanish Presidency identified HIV and health inequalities as a major priority and organised a conference entitled 'Vulnerability and HIV in Europe' in Madrid in April 2010. The conference was organised by the National AIDS Strategy Secretariat of Spain's Directorate-General for Public Health and Foreign Health Affairs. It brought together representatives of organisations and networks from around the EU to share experiences and discuss inequalities, vulnerability to HIV and effective interventions and policies. It focused on key populations at higher risk such as men who have sex with men, people who use drugs, and migrants. The conference concluded that it was important to better address the needs of key populations, to offer comprehensive responses that incorporate social as well as biomedical approaches, and to improve second generation surveillance, early diagnosis of HIV, and HIV prevention. The conference was an important step towards greater EU cooperation and collaboration on programmes to reduce inequalities and factors that increase HIV vulnerability. Moreover, it also called for further action to enhance political leadership, commitment, and coordination of Member States to address the needs of most-at-risk populations through policies, legislative changes and support for sustainable and mainstreamed programmes.

In 2012, EU Presidencies were held by Denmark²⁹ and Cyprus³⁰. Priorities during both presidencies were informed by the global economic crisis and its impact on Europe. However, during the Danish presidency, Copenhagen hosted the HIV in Europe 2012 conference, an important contribution to the problem of late presentation. The European Health Programme contributed EUR 100 000 towards the conference. The keynote speech was given by the Danish acting Minister of Health, who highlighted the Commission's Communication and Action Plan and the importance of early testing and care.

Figure 3.2: Health priorities and HIV activities of EU Presidencies 2009–2012

| | 2009 | 2010 | | 2011 | | 2012 | |
|-------------------|--|---|--|--|---|---|--|
| | Sweden | Spain | Belgium | Hungary | Poland | Denmark | Cyprus |
| Health priorities | <ul style="list-style-type: none"> Ageing Antibiotic resistance Alcohol Communicable disease E-health | <ul style="list-style-type: none"> Public Health Blood Directive Tobacco | <ul style="list-style-type: none"> Health inequality Chronic disease Cancer Social factors of health Health professionals | <ul style="list-style-type: none"> Sustainable health care systems European Disability Strategy EU Framework on National Roma Integration strategies | <ul style="list-style-type: none"> Nutrition Physical activity Childhood respiratory disease Childhood communicable diseases Alzheimer's disease | <ul style="list-style-type: none"> AMR Cross-border health threats Amendment of the Directive on Tobacco | <ul style="list-style-type: none"> Health ageing Legislative proposal on serious cross border threats to health Organ donation and transplantation Pharmacovigilance |
| HIV activities | <ul style="list-style-type: none"> HIV in Europe Conference (not an official Presidency meeting) | <ul style="list-style-type: none"> HIV and vulnerability conference | | | | <ul style="list-style-type: none"> HIV in Europe Conference (not an official Presidency meeting) | |

²⁹ The four priorities for the Danish Presidency were a responsible Europe, a dynamic Europe, a green Europe, and a safe Europe, with an emphasis on economic responsibility, employment, sustainable growth, and security.

³⁰ The Cyprus presidency also gave high priority to economic governance, growth, solidarity and social cohesion, including health, and progress on the EU's development commitments.

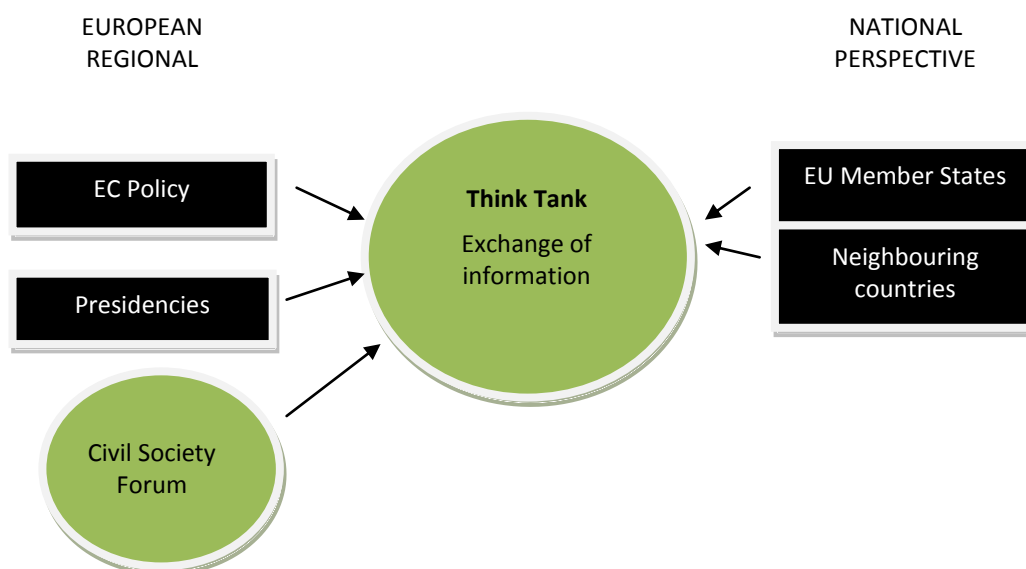
Ireland and Lithuania will hold the EU Presidencies in 2013. The Irish Presidency will give priority to stability, jobs and growth, but will also place particular emphasis on development, humanitarian policy, global hunger and climate change, including the development of the EU's position for the UN Summit in September 2013, which will set the post Millennium Development Goals (MDG) agenda.

3.2 EU Think Tank

The EU's Think Tank on HIV/AIDS, which meets twice a year, was established following the Dublin Conference in 2004. The main purpose of establishing the Think Tank was to support the Commission in developing the first Communication and Action Plan 2006–2009. The Think Tank includes representatives from Member States, EEA and Candidate Countries. Relevant international and regional organisations (including UNAIDS and WHO) and pan-European NGOs represented on the EU CSF are also invited to meetings.

The Think Tank is a forum for exchange of information and coordination of the response to HIV and AIDS in the EU and neighbouring countries and serves as a venue for informal consultation between the Commission, Member States, EEA/EFTA, Candidate Countries and neighbouring countries. Figure 3.3 illustrates how the Think Tank, and the CSF, bring together national and regional perspectives and facilitate exchange on European-wide policy and action and national responses.

Figure 3.3: Consultation, exchange of information and policy dialogue through the EU's HIV/AIDS Think Tank



An analysis of the topics covered at Think Tank meetings shows the diversity of issues and range of policy areas addressed:

- The May 2010 meeting discussed a rights-based approach to HIV in Europe; Global Fund replenishment and the impact of the economic crisis; HIV prevention in MSM and progress in monitoring the Dublin Declaration. The October 2010 meeting covered HIV in prisons; harm reduction among drug users in Spain; the HIV situation in the Russian Federation and WHO plans for improving the effectiveness of HIV prevention through quality assurance and quality improvement practices. The June 2011 meeting discussed NGO funding and the potential impact of the economic crisis on access to treatment, particularly in neighbouring countries; criminalisation of HIV transmission; prison health; updates on research initiatives and new guidelines, and discussion of possible joint action on HIV prevention.
- The December 2011 meeting discussed the HIV situation among people who inject drugs in Greece and Romania; featured presentations from Lithuania and Switzerland; received an update on Health Programme projects, ECDC work and QI/QA for HIV prevention activities. The issue of the impact of the financial crisis on the response to HIV in Europe was discussed.
- The June 2012 meeting received updates on developments in Germany, Greece, Spain and the United Kingdom; presented the Health Programme and Research Framework Programme and the behavioural surveillance project funded by ECDC; discussed issues related to HIV and co-infection with TB and hepatitis B and C; and explored the HIV situation in EU and non-EU countries in eastern Europe.

- The December 2012 meeting received updates on developments in France, Greece, Portugal and Switzerland and on HIV among migrants and people who inject drugs. Various HIV issues and challenges in eastern Europe and neighbouring countries were explored.

Questionnaire respondents report that the Think Tank plays an important role in defining priorities for the HIV response in the EU and neighbouring countries. It also provides an important forum for countries to discuss policy and technical issues, exchange information and experience and ensure that national responses are in line with the rest of Europe. Several respondents highlighted the value of the Think Tank in sharing ideas and experience on HIV prevention policies and programmes.

'The Think Tank is a solid platform to discuss successful approaches to prevention, service delivery for people living with HIV, and monitoring and evaluation.' – Think Tank member, Russian Federation

'Meetings have discussed topics including risk groups, health systems strategies, universal access and improving HIV prevention.' – Think Tank member, Moldova

'Regular updates on international and national developments and projects are an important component of Think Tank meetings... The resulting networking and exchange of policy and practice is a source of inspiration at national level.' – Think Tank member, the Netherlands

To encourage a more intensive exchange of views on certain issues, the Commission has created a 'country representative' forum as part of the Think Tank agenda. This enables country representatives to meet without agency or CSF representatives. The meeting of country representatives in June 2012, for example, discussed ways to reduce the number of late HIV diagnoses and undiagnosed infections, explored the HIV situation in Greece, and discussed international and regional reports.

The Think Tank facilitates dialogue and the flow of information between the Commission, Member States and neighbouring countries. For example, it enables country representatives to give feedback on Commission policies and strategies and provides the Commission with an opportunity to draw attention to emerging issues (e.g. migrants and prisons).

'The Think Tank is also useful for exchanging views on how to implement national policies. Meetings enable countries to share their perspectives and experience on a variety of medical, technical, scientific and legal issues.' – European Commission

In addition, the Think Tank provides a forum for EU Presidencies to consult with country experts and seek information and advice.

Through the Civil Society Forum, the Think Tank allows the perspectives of civil society to be heard and promotes interaction between government and civil society representatives. The Think Tank has promoted the prioritisation of HIV-related issues in EU policies, legislation and agreements. It has also added value to the policy development process at country level by facilitating dialogue between national authorities, civil society and international agencies.

3.3 EU Civil Society Forum

The Communication highlights the important role of civil society and of people living with HIV in combating HIV and AIDS and keeping the issue on the political agenda. The Civil Society Forum (CSF) was established by the Commission in 2005 to ensure civil society involvement in HIV policy development and in a coordinated response. The CSF, which meets twice a year, serves as the interface between European civil society, the Commission and the Think Tank, and plays a critical role in facilitating direct dialogue between civil society and policymakers.

The CSF provided substantial input to the Commission's Communication and Action Plan, helping to ensure that the final documents reflected the concerns of civil society. The CSF has used the Communication and Action Plan as a framework for meetings and for regional and national advocacy. Evaluations of meetings in December 2011 and June 2012 showed the extent to which it informs the work of CSF members. In December 2011, nine of 13 respondents reported that they always or often use the Communication and Action Plan as a framework for their work; two members consulted it sometimes; in June 2012, nine members responded that they use it always or often, seven sometimes, and two never.

Meetings and follow-up action have focused on issues such as HIV prevention, treatment and care for people who inject drugs, men who have sex with men and prisoners, testing guidelines, drugs policies, human rights (see Box 3.3) discrimination in the workplace (see Box 3.4), and funding for NGOs in eastern Europe.

Box 3.2: EU Agency for Fundamental Rights questionnaire

In 2010, the CSF supported the EU Agency for Fundamental Rights (FRA) with the distribution and follow-up of a human rights questionnaire among CSF members. The Agency used the outcomes to prepare a fact sheet on a rights-based approach to HIV in the European Union for the 2010 International AIDS Conference. This represented a follow-up to the European Parliament Resolution dated 6 July 2010, which called on the Commission and the Council to engage the FRA to gather further evidence on the human rights situation of people living with HIV/AIDS and other key populations in Europe.

The CSF is an important venue for sharing information and good practice, stimulating discussion, and developing recommendations and advice, both to improve the quality and impact of civil society programmes and to generate action at European and country level. In addition, it acts as a vital channel for information flow between the Commission and national civil society, and in disseminating information and material to CSF members.

'It has great added value because you can exchange and learn and take back to your country what works in other countries.' – CSF member, Portugal

'Although the epidemic among IDU in the UK is small, we have learned a great deal about this from others which proved relevant in policy debates in the UK.' – CSF member, UK

'I see the CSF as a very good source of information... I also share all the information in Finland at meetings and networks.' – CSF member, Finland

'We were able to contribute to CSF meetings with presentations on Germany's MSM prevention efforts and this was a great opportunity to get feedback from CSF members and to discuss approaches to the MSM community all over Europe' – CSF member, Germany

Box 3.3: ILO Recommendation

In 2010, the CSF communicated the ILO Recommendation concerning HIV and AIDS and the world of work (No. 200) to its members, with suggestions of action they could take at country level to improve the situation for people with HIV in employment. Members were asked to report back about actions and results, so that feedback could be shared with ILO.

The CSF is able to articulate the concerns of European civil society organisations at international and regional level. For example, at the Vienna Conference in 2010, the CSF co-chair was one of the keynote speakers at a Commission-supported satellite meeting on effective policies and measures in Europe to address key populations. The speech elaborated on how current legislation across the European region supports an effective and rights-based response to the epidemic, drawing on the Communication and Action Plan, the ECDC Dublin Declaration report and the EU Charter of Fundamental Rights. During the regional session on Europe at the International AIDS Conference in Washington DC in 2012, one of the Forum's co-chairs made a presentation about the work of the CSF. The co-chairs also participated in EU Health Policy Forum meetings in order to ensure links with broader health policy discussions.

The CSF also provides a forum for civil society to influence the policies and programmes of the Commission and international agencies, such as WHO and UNAIDS, and to reinforce the importance of civil society's contribution to the HIV response at international, regional and national level.

'The CSF gives a voice and provides a coordination platform for European civil society, strengthening advocacy action and democratising decision-making at the European level.' – Think Tank member, Spain

The CSF provides input to the regional plans of international agencies such as UNAIDS and WHO and participates in international and regional advisory bodies. For example, the CSF co-chairs participate in the advisory groups convened by ECDC on HIV testing, infection control among IDU, and the monitoring of the Dublin Declaration. They also worked with ECDC on the development of a civil society questionnaire to monitor the Commission Communication and Action Plan.

The CSF also plays an important role in advising EU Presidencies, the Commission and the Think Tank. For instance, it provided input for the Belgian EU Presidency representative's speech to the Vienna Conference in 2010. A further example, at the October 2010 meeting of the Think Tank, saw CSF reporting on input received from Russian civil society. The CSF has also developed position papers, on drug policy for example, which are shared with the Think

Tank. The drug policy position paper³¹ was also disseminated prior to the High Level Meeting on HIV/AIDS in June 2011 to support national debates on harm reduction policy.

'In my opinion, the CSF has seized the opportunity to participate in implementing and evaluating the response to HIV in the EU and neighbouring countries very well. It is very valuable that there is representation from all regions, that CSF representatives speak with one voice and issues discussed are presented at the Think Tank.' – Think Tank member, Poland

'The CSF has actively contributed to the meetings of the Think Tank.' – Think Tank member, Netherlands

'The CSF is very useful. It provides European civil society with its own platform and has created a strong network of European civil society organisations that goes beyond EU Member States to include Albania, Bosnia Herzegovina, Morocco and the Russian Federation. The CSF has also empowered civil society organisations to be involved in policy implementation and the meetings allow organisations to hear about new ideas and more effective ways of working.' – European Commission

Box 3.4: Evaluation of CSF meetings

The CSF has evaluated the outcomes of meetings in October 2010, June 2011, December 2011 and July 2012.

Key findings from the October 2010 meeting were:

- Meeting organisation by the CSF coordination team and networking opportunities were rated 'very good' by the majority of the respondents (both 57%).
- Exchange of information on actions between the meetings was rated 'good' or 'very good' by a large majority of respondents (86%).
- All members share information from the CSF with their colleagues often (32%) or always (68%). Many also share the information with others at the national or regional level (often: 52%, always: 33%).

Key findings from the June 2011 meeting were:

- Overall the meeting was rated 'good to very good' by the majority of respondents (90%).
- Exchange of information on actions between the meetings was rated 'good' or 'very good' by over two-thirds of respondents (68%).
- 95% indicated that the information is useful for their organisation.
- 62% of members always share the information from the CSF with their colleagues and 32% share it often. Many members also share the information with others at the national or regional level (often: 27%, always: 45%).

Key findings from the December 2011 meeting were:

- Overall the meeting was rated 'very good' (42%) or 'good' (42%), with no participants rating it as 'poor' or 'very poor'.
- Participants were very positive about the CSF as a source of information: 65% rated information provided during the meeting as 'very good', 57% always share the information with colleagues and 54% also share the information at a national or regional level.
- Only 16% of respondents propose topics for CSF meeting agenda. Some noted that the agenda is crowded and wanted more time for discussion and less time on presentations.

Key findings from the July 2012 meeting were:

- Overall the meeting was rated as 'very good' or 'good' by all respondents, and 48% rated the meeting as a very good networking opportunity.
- 50% share information with colleagues and 45% do so at a national or regional level.
- Respondents highlighted the need for more time for discussion.

Key findings from the December 2011 meeting were:

- Overall the meeting was rated 'very good' (42%) or 'good' (42%), with no participants rating it as 'poor' or 'very poor'.
- Participants were very positive about the CSF as a source of information: 65% rated information provided during the meeting as 'very good', 57% always share the information with colleagues, and 54% also share the information at a national or regional level.
- Only 16% of respondents propose topics for the agenda of CSF meetings. Some noted that the agenda is crowded and wanted to reserve more time for discussions and dedicate less time to presentations.

Key findings from the July 2012 meeting were:

- Overall the meeting was rated as 'very good' or 'good' by all respondents and 48% rated the meeting as a very good networking opportunity.
- 50% share information with colleagues and 45% at a national or regional level.
- Respondents highlighted the need for more time for discussion.

In addition to the feedback above, various suggestions were made for improving the CSF, including encouraging more active participation from those members who do not regularly attend meetings, providing additional opportunities for interaction with the Think Tank, increasing the participation of people living with HIV, providing key documentation in Russian, and clarifying expectations about follow-up action by CSF members.

³¹ Putting health and human rights first: EU HIV/AIDS CSF statement on the future drug policies in the EU and beyond, 2011.

3.4 International organisations

In line with the Communication and Action Plan the Commission engages with international organisations to promote HIV/AIDS as a public health and social concern and to keep the issue on the political agenda.

Policy dialogue takes place through the EU Think Tank and the Civil Society Forum, to which UNAIDS, WHO, UNICEF, IOM, UNODC and UNDP are invited. This facilitates debate between EU Member States, neighbouring countries, civil society and international agencies.

The Commission and ECDC have worked closely with UNAIDS to monitor commitments to the 2001 UN General Assembly Special Session on HIV/AIDS (UNGASS) Declaration and the Dublin Declaration reporting in 2010.

The Commission and UNAIDS share strategic information and collaborate on planning and implementing activities. Examples include World AIDS Day activities in 2009 and 2010, planning for the 2010 and 2012 International AIDS Conferences and joint satellite sessions, planning for the 2011 European Conference on HIV/AIDS in Tallinn and for the upcoming high-level conference on AIDS and human rights. The Commission and UNAIDS have also collaborated on actions to respond to recent HIV outbreaks in Greece and Romania.

The Commission and agencies (e.g. ECDC and EMCDDA) provided input for the WHO global health sector strategy on HIV/AIDS 2011–2015 and to the development of the WHO regional action plan on HIV/AIDS 2012–2015. The regional action plan is consistent with the priorities set out in the Commission's Communication and Action Plan. ECDC and WHO have collaborated to improve HIV/AIDS surveillance (see Section 4). EMCDDA has also collaborated with WHO on the EC-funded project to scale up services for drug users, including a WHO workshop for eight Member States on implementation and scale-up of opioid substitution therapy in May 2012.

There has been a close collaborative working relationship between the Commission, IOM, and UNODC, through support to the same projects and to the 'Drug prevention and Information Programme'.

3.5 National AIDS Coordinators

The Commission's Action Plan proposes regular meetings of national AIDS coordinators to share best practices and contribute to policy coherence. The last meeting of national AIDS coordinators took place in Lisbon in October 2007 and was organised under the auspices of the Portuguese EU Presidency. It may be that no further meetings have taken place because other forums, such as the Think Tank, provide sufficient opportunity for dialogue.

3.6 Northern Dimension Partnership in Public Health and Social Well-being

The Northern Dimension Partnership in Public Health and Social Well-being (NDPHS)³² is a partnership involving the Commission, 10 countries (Estonia, Finland, Germany, Iceland, Latvia, Lithuania, Norway, Poland, Russian Federation, Sweden), and eight international organisations (Barents Euro-Arctic Council, Baltic Sea States Sub-Regional Cooperation, Council of the Baltic Sea States, ILO, IOM, Nordic Council of Ministers, UNAIDS, WHO). It aims to promote health and social well-being in Northern Europe by enhancing cooperation, coordination and capacity building.

Reducing the spread of major communicable diseases (including HIV, STI and TB) and preventing non-communicable diseases is one of the NDPHS' two priorities. The NDPHS promotes policy dialogue through annual partnership conferences, and meetings of the Committee of Senior Representatives (CSR), expert groups and task groups. The main side event at the 2013 ministerial PAC will focus on HIV and tuberculosis. The Commission (Directorate-General for Health and Consumers, Directorate-General for Regional Policy and Directorate-General for External Relations) participates in CSR meetings, which are held twice a year, and hosted the CSR meeting in October 2011. CSR meetings include updates from the Chair of the NDPHS HIV/AIDS and Associated Infections Expert Group. As discussed in Section 2.1, the EU funds the NDPHS and its projects.

The HIV/AIDS and Associated Infections Expert Group, which comprises experts from national ministries and agencies, NGOs and the research community, focuses on surveillance, policy development and awareness-raising, as well as prevention and treatment. Its activities include evaluation of the epidemiological situation and national AIDS policies in partner countries, promoting initiatives to prevent HIV and enhancing expert collaboration. The Expert Group was actively involved in organising the European AIDS conference 'HIV in the European Region – Unity and Diversity' in Tallinn in 2011. This included organising sessions on HIV and TB co-infection and on regional collaboration, giving presentations and preparing the concluding note. Members of the Expert Group have also been actively involved in the EMIS MSM survey (see Box 4.4) and are also involved in implementation of the

³² See www.ndphs.org

TUBIDU project (see Box 4.3). The Expert Group was also involved in the H-CUBE project, which studied hepatitis B, hepatitis C and HIV in ten countries.

A review of experience and best practices in integration of social and healthcare services for people with HIV in the Baltic Sea Region, commissioned by the Expert Group and financed by a technical assistance grant linked to the EU Strategy for the Baltic Sea Region, was completed in 2012. Its recommendations are intended to influence national HIV policies. Planning for further activities in the area of integrated health and social care services also took place in 2012.

The Expert Group has supported a joint Norwegian-Russian research project on the governance of HIV prevention in north-west Russia, to improve prevention strategies, and is collaborating with the Barents HIV/AIDS Programme Steering Committee, which implements projects in the Barents Sea Region, covering the Murmansk Region, the Archangelsk Region, Karelia and Komi. It has also supported a range of projects to promote improved services in the Russian Federation, including provision of low threshold services for people who use drugs in the Leningrad Region; collaboration between TB services in the civil and penitentiary systems and AIDS centres to improve prevention and management of co-infection in the Murmansk Region; and training for municipal authorities on the prevention of drug use and rehabilitation of drug users, also in the Murmansk Region.

Together with a range of partners, the Expert Group also organised an NGO forum on HIV and tuberculosis in November 2012 in Russia, which was attended by 80 government and NGO representatives from Russia, Finland, Norway and Sweden. The Forum assessed the HIV and TB situation in Northern Dimension countries, shared best practice and explored the scope for future collaboration to improve prevention of HIV and TB and increase access to comprehensive services for people who inject drugs. The EU is also financing a collaborative project to strengthen HIV and TB prevention and care for people who inject drugs in Kaliningrad Oblast in the Russian Federation (see Box 3.6).

Box 3.5: Developing services to contain the spread of HIV and TB among people who inject drugs in Kaliningrad

Led by the Kaliningrad NGO YLA, in partnership with Monar Association (Poland), Deutsche AIDS-Hilfe (Germany), Ministry of Health of Kaliningrad Oblast, Information Office of the Nordic Council of Ministers in Kaliningrad, National AIDS Centre (Poland) and the Centre for Communicable Diseases and AIDS (Lithuania), this project is financed by the EU programme 'Non-state actors and local authorities in development' for the Baltic Sea Region. The objective is to contribute to preventing the spread of HIV and TB in Kaliningrad Oblast. Specifically, the project will improve provision of services for drug users by promoting cooperation between government medical and social services and NGOs and strengthening the partnership between health officials and NGO activists in Kaliningrad and their counterparts from Germany, Poland and Lithuania. The project will develop services to prevent the spread of HIV and TB among people who inject drugs, including the establishment of low-threshold service points and the improvement of drug treatment.

3.7 Commission Delegations and Cooperation Agreements

The Cooperation Council of the European Commission adopted the EU-Ukraine Association Agenda in November 2009³³. This Agenda replaces the Partnership and Cooperation Agreement which had been in place since 1998, and the related EU/Ukraine Action Plan. In the public health section of the agenda, the parties agree to cooperate in 'preventing and controlling communicable diseases, in particular HIV/AIDS, tuberculosis, sexually transmitted infections, and hepatitis C and B.' The agenda also gives Ukraine the ability to participate 'in EU public health related networks and working parties, such as the annual network meeting on health information and the HIV/AIDS Think Tank.' In May 2011, the Joint Committee at Senior Official's Level of the EU-Ukraine Association Agenda agreed to a list of the EU-Ukraine Association Agenda priorities for 2011–12. The above-mentioned agreement to cooperate on prevention and control of communicable diseases is one of the 90 priorities identified in the list.

The EU Delegation in Ukraine maintains close links with the Ministry of Health and State Services as well as participating in the Global Fund Country Coordinating Mechanism and donor coordination groups. European funding for a range of HIV projects, including for capacity building of teachers and teacher trainers and developing a legal support network, have provided a platform for the Delegation to engage with the education, justice and interior ministries. The Delegation also highlighted the importance for Ukraine of Commission support for regional projects, including advocacy for access to services for vulnerable groups and for access to treatment in ENP

³³ See http://www.eeas.europa.eu/ukraine/docs/2010_eu_ukraine_association_agenda_en.pdf

countries and the Russian Federation, and increasing the capacity of non-state actors to deliver and scale up HIV prevention interventions for most-at-risk populations in the ENPI-East region.

The EU and the Republic of Moldova currently have a Partnership and Cooperation Agreement in place. This Agreement is supplemented by the joint EU-Moldova ENP Action Plan.³⁴ The Action Plan makes specific reference to Moldova's 'participation in dedicated surveillance networks, in particular those collecting data and information on HIV/AIDS, sexually transmitted infections, and hepatitis C and B.' It also refers to the need to 'improve the primary health care system and the prevention of diseases, such as the HIV/AIDS epidemic, notably in rural and deprived communities and within vulnerable groups.' The EU and Moldova are in negotiations to replace the existing Partnership and Cooperation Agreement with an EU-Moldova Association Agreement includes HIV/AIDS as a public health priority. HIV/AIDS and related human rights issues are also a priority in policy dialogue between the EU Delegation and national decision-makers. The Delegation is a member of the Country Coordinating Mechanism.

There has been no cooperation agreement between the EU and the Russian Federation since 2008. At the St. Petersburg summit in May 2003, the EU and Russia agreed to strengthen their cooperation by creating four 'common spaces' within the framework of the Partnership and Cooperation Agreement. In the public health section of the 2010 progress report *EU-Russia Common Economic Space* it was reported that 'the Russian Ministry of Health and Social Development showed an interest in collaborating on communicable diseases (inter alia pandemic influenza, HIV/AIDS), health determinants (alcohol, nutrition, and tobacco), rare diseases and pharmaceuticals.'

The Delegation has not taken any specific actions to promote country leadership on HIV but, following the WHO Euro Ministerial Conference in Moscow in October 2010 and the Memorandum of Understanding for enhanced cooperation between the Commission and WHO Europe, the Delegation has been collaborating with the Office of the WHO Representative in Moscow on health issues, including HIV. The Delegation also facilitates Russian participation in the Think Tank and CSF.

Belarus has no Cooperation Agreement with the EU at present.

3.8 Meetings and exchange programmes

Representatives from Belarus, Moldova, the Russian Federation and Ukraine have standing invitations to participate in Think Tank meetings. The EU Delegation in Moldova, for example, reported that the EC supported the participation of Moldovan representatives in Think Tank meetings in 2011 and 2012. Non-governmental organisations and networks from these countries are invited to participate in the CSF. As noted above, these meetings facilitate information sharing and exchange of experience on the response to HIV. Delegations also highlighted Commission support for two regional meetings in Georgia and Armenia in June and July 2012, which brought together participants from ENPI countries and the Russian Federation involved in a project on the broader introduction of effective HIV prevention strategies targeting populations most at risk.

3.9 High-level conference on HIV/AIDS and human rights

Promoting and protecting human rights is a key commitment in the Communication and Action Plan. In July 2010, the European Parliament adopted a resolution on a rights-based approach to HIV/AIDS³⁵, and, in a resolution in December 2011, called upon Member States to take all necessary action to end discrimination against people living with HIV/AIDS and promote and protect all human rights and fundamental freedoms³⁶. The Communication and Action Plan included a specific commitment to organise a conference on HIV and human rights. This high-level meeting took place in Brussels on 27 and 28 May 2013. The specific objectives of the meeting were to reaffirm the European commitment to promote and protect human rights in the context of HIV by creating enabling and supportive legal environments which also ensure the right to health; assess progress and challenges; review evidence and best practice; and determine next steps for the EU, its Member States, neighbouring countries and civil society in promoting and protecting human rights in the context of HIV.

3.10 Cooperation with the private sector

The main mechanism included the Communication on the Commission's cooperation with the private sector centres on the development of new and improved prevention technologies and treatments for HIV and associated infections (see Section 4.3 of this report). Much of the research funded through the Research Framework Programmes involves close collaboration with the private sector.

³⁴ See http://ec.europa.eu/world/enp/pdf/action_plans/moldova_enp_ap_final_en.pdf

³⁵ [European Parliament resolution of 8 July 2010 on a rights-based approach to the EU's response to HIV/AIDS](#)

³⁶ [European Parliament resolution of 1 December 2011 on the EU response to HIV/AIDS in the EU and neighbouring countries, mid-term review of Commission Communication](#)

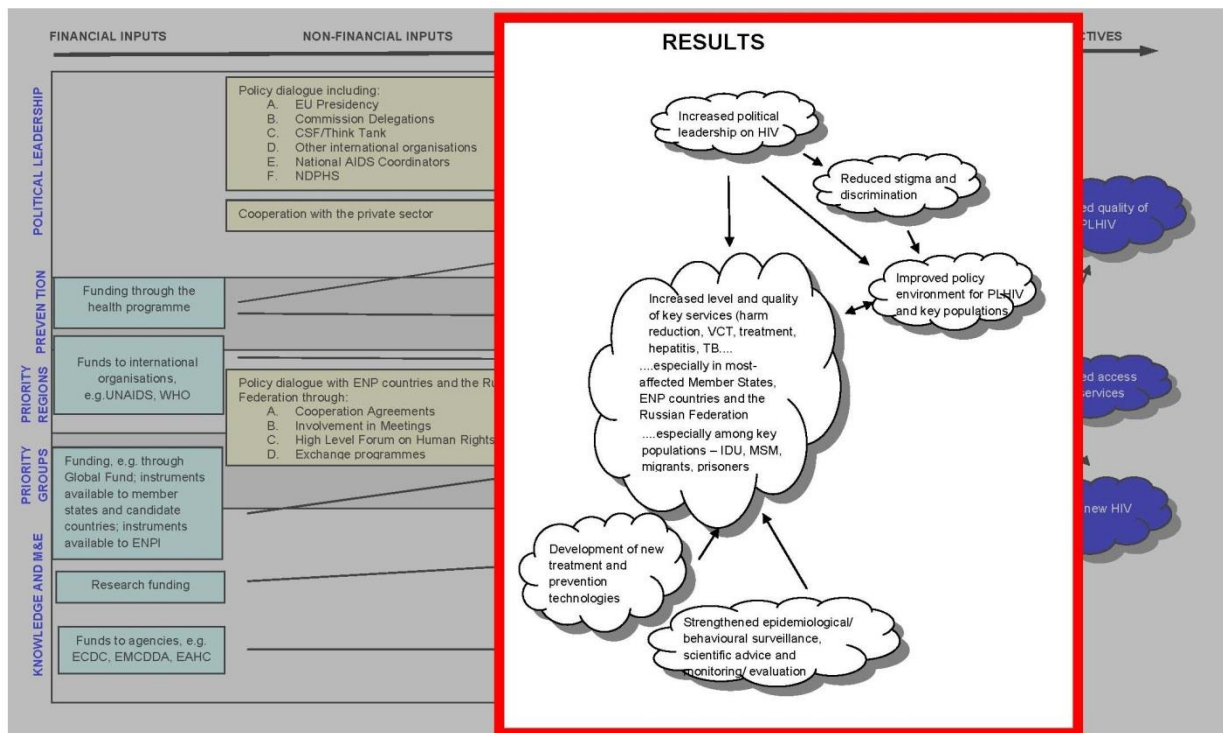
The Commission has also had regular contact and discussions with Gilead Sciences, Inc., the multinational biopharmaceutical company, as well as with EFPIA (European Federation of Pharmaceutical Industries and Associations) and FIPRA (Finsbury International Policy & Regulatory Advisers). The focus of this dialogue has included topics ranging from the pricing of antiretroviral drugs to HIV testing.

Commission support for increased private sector involvement in national HIV responses through funding for specific projects includes a project that aims to strengthen civil society participation in Ukraine for which the Commission provides 67% of funding. Implemented by the All-Ukrainian Network of People Living with HIV/AIDS in July 2011, the project promotes private sector involvement and cooperation with civil society in different regions of the country and has achieved some notable successes. In addition to providing financial support for HIV services for vulnerable groups, private businesses are actively participating in local decision-making through regional HIV/AIDS coordination councils.

4 Effects

This section focuses on the effects of the various inputs available for implementation of the Communication and Action Plan (highlighted by a red box in Figure 4.1). It considers their effects in areas such as political leadership; HIV services; treatment and prevention approaches and technologies; surveillance; monitoring and evaluation; and evidence, scientific advice and dissemination of learning.

Figure 4.1: Framework for monitoring the HIV Communication and Action Plan: effects of inputs



4.1 Political leadership

The Communication clearly states that political leadership is an important asset the European Union can provide in the fight against HIV/AIDS. The Communication also specifically cites the ongoing problem of HIV-related stigma and discrimination in the European Union and neighbouring countries and its impact on the marginalised populations who are most vulnerable and most affected by the epidemic. Most importantly, it recognises the need for political leadership to ensure that the health and rights of these populations are promoted and protected.

Political leadership has the ability to shape the HIV response in a number of different ways and settings. This includes the impact of actions taken by EU Presidencies – although specific effects are difficult to measure. It also includes the outcomes of actions taken by the Think Tank and the CSF and the results of activities funded by the European Health Programme.

Respondents' views on the effects of the Think Tank on political leadership were varied. A number of countries expressed positive views. For example, the response from the Moldova representative suggested that Think Tank action has contributed to HIV being a top public health priority in the country and a permanent topic on the political agenda. The Bulgarian response also suggested that the actions of the Think Tank have kept HIV on the political agenda, while the Slovak Republic indicated that these actions had helped to 'improve' political leadership in the country. Ukraine felt the actions had helped the country to develop a sustainable state response to HIV, including legislative changes and decision-making based on European initiatives and evidence based practices. However, two countries suggested that there had been little impact at national level.

Members of the CSF were also asked about the effects of the Think Tank's actions on political leadership. Although only one civil society representative answered this question, the response was positive:

'We believe that the continued participation of the Portuguese national AIDS coordinator in the Think Tank meetings has contributed to increased political leadership and better national HIV policy development,

actively involving civil society and influenced by the best practices from around Europe, as well as by the EC Communication and Action Plan.’ – CSF member, Portugal

Similarly, there were diverse views about the effects of action taken by the CSF on political leadership, with some respondents suggesting that it has helped to keep HIV on the political agenda in Europe, whereas others suggested that the effects have been more limited. Although the CSF has succeeded in raising a range of issues and concerns, it can only do so much to influence national governments, for example, by urging them to maintain funding for NGOs or improve access to HIV services for undocumented migrants.

The CSF representative from Belgium reported that the Belgian Ministry of Health is developing the first national HIV policy, with the involvement of civil society and people living with HIV. The development process reflects both international monitoring and the opportunity for interaction with representatives from other countries through the Think Tank and the CSF. Engagement at the European level was reported to have contributed to the development of a new national HIV strategy in Finland. In Serbia, initiatives to change the law on criminalisation of HIV transmission and develop a national anti-discrimination plan in Serbia would not have been possible without European support.

The representative from Ukraine noted that in 2011 the *All-Ukrainian Network of People Living with HIV/AIDS* launched an advocacy campaign entitled ‘Let me Live’, which followed the CSF statement on universal access to treatment. It was so successful that ‘the Ukrainian President asked the government to provide 100% funding for the national HIV/AIDS programme’ in 2011 and 2012, including full funding for procurement of medications for people living with HIV. As a result of this, and ongoing advocacy, allocated funds in the state budget for 2012 for procurement of antiretroviral drugs increased by around 64% compared with 2011, increasing the number of people on treatment supported by the state budget from 22 000 in 2011 to 42 000 in 2012. The response from the EU Delegation in Ukraine also suggested that the strong position of the EU and the Commission on human rights and access to health and social services, together with technical support and funding for advocacy by civil society and organisations of people living with HIV, have contributed to the much improved HIV response. The representative from Austria reported that documents published by the Commission or the CSF helped to secure commitment from various stakeholders and provide a useful basis for future work.

According to the Commission’s Executive Agency for Health and Consumers (EAHC), financial support from the European Health Programme for five conferences both demonstrates and resulted in greater leadership on HIV (see Box 4.1).

Box 4.1: Support for conferences strengthens leadership

The International Harm Reduction Association (IHRA)'s 21st International Conference in 2010 provided an opportunity to raise awareness, exchange knowledge, improve advocacy, and increase support and capacity for harm reduction in Europe. The conference also included the launch of the European Harm Reduction Network.

The XVIII International AIDS Conference in 2010 received targeted support – from EAHC via UNAIDS – to strengthen community action and mobilisation through civil society participation in the conference; operate the Global Village organisation; provide scholarships for participants from eastern European Union countries; and provide much-needed translation and interpretation to broaden the reach of the conference. In addition, four satellite sessions were held to improve knowledge sharing and coordination as part of the European response to HIV.

The European AIDS Conference 2011 (HIV in Europe – Unity and Diversity) held in Tallinn, Estonia, represented an opportunity to build the capacity of public health experts to lead the response. The conference had a special focus on vulnerable groups and health systems, particularly in the Baltic region and ENP countries, where HIV is a very serious problem.

The Future of European Prevention among MSM (FEMP 2011). This regional conference was an opportunity to focus discussion and action planning on a population that is central to the HIV response in Europe. A key outcome was a common declaration on HIV/STI prevention among MSM - directed at Member State governments, civil society, and the private sector.

The HIV in Europe conference, held 2012 in Copenhagen, brought together policymakers, experts, and civil society representatives to consider ways to improve timely HIV diagnosis in Europe. The conference helped to increase awareness of the need for action to promote earlier testing and faster access to treatment and care.

IOM notes that it organised, and participated in, conferences and meetings that made an important contribution to political leadership and the policy environment. This would not have been possible without funding from the European Commission. For example, under the framework of the AIDS and Mobility project, IOM organised the conference *With migrants for migrants: HIV prevention for all* on 30 November 2010 at the European Parliament. IOM developed a *Future development report* to operationalise the conference recommendations and guide

implementation of the AIDS and Mobility project. IOM also co-organised a satellite session on responses to HIV and migration in industrialised countries at a meeting on migration and HIV organised by ECDC, CDC, and the Public Health Agency of Canada.

In the Communication and Action Plan, the Commission expressly highlights support for monitoring the implementation of international commitments at country and European levels. The Commission also supports international organisations, for example UNAIDS, in their work to mobilise political leadership in eastern Europe. According to UNAIDS, the Communication and Action Plan has facilitated the EU delegations' political dialogue on HIV/AIDS in many countries, for example the Russian Federation and Ukraine. Participation of government and civil society representatives from ENP countries and the Russian Federation in the Think Tank has increased awareness of the HIV situation, and Commission funding for civil society organisations working on HIV in these countries has played a vital role in strengthening the voice of civil society.

According to UNAIDS, its engagement with the Commission has had two major effects linked to political leadership. Firstly, it has helped maintain the visibility of HIV as an issue in Europe. Secondly, it has kept HIV on the political agenda. More specifically, UNAIDS cites a diverse range of effects from its engagement with the Commission including:

- The participation of senior political leaders in the *XVIII International AIDS Conference*.
- EU statements on World AIDS Days.
- Government support and participation in the regional *HIV in Europe* conference.
- Inter-agency collaboration on the monitoring of the Dublin Declaration.
- Participation of the EU Health Commissioner at the Moscow MDG6 Forum, which played an important role in engaging high-level Russian political leadership.
- Simultaneous and coordinated action in response to HIV outbreaks in Greece and Romania as well as the imprisonment of sex workers in Greece.

UNAIDS also identified a series of challenges related to political leadership, including fully mobilising political leadership in neighbouring countries, particularly for harm reduction programmes in the Russian Federation, and the limited participation of European leaders in the High-Level Meeting on AIDS in June 2011. UNAIDS highlights the need for the Commission to maintain political dialogue, technical collaboration, and support for civil society organisations to maintain the momentum for change in these countries.

'...in the absence of leadership there is a strong risk for a rebound of the epidemic in Europe, as indicated by increasing new infections among men who have sex with men, and a continuous growth in the number of people requiring lifelong sustained treatment, which in some Member States represents a substantive part of the health budget.' – UNAIDS

4.2 HIV services

This section explores the extent to which the Communication and Action Plan has had positive effects on the provision of key services, such as harm reduction programmes, HIV testing and counselling, antiretroviral therapy and services for co-infections such as TB and hepatitis. It focuses on services in the most-affected Member States, neighbourhood countries and the Russian Federation. It also focuses on services in particular settings (e.g. prisons) and for key populations, including men who have sex with men, people who inject drugs, migrants and sex workers.

Support for key services

The Communication is very clear about the need for harm reduction programmes as part of an effective response to HIV. The Global Fund to Fight AIDS, Tuberculosis and Malaria has been very active in financing harm reduction programmes in eastern Europe and central Asia. As a major contributor to the Global Fund, the European Commission has made significant efforts to increase the availability of harm reduction services for people who inject drugs (see Box 4.2). However, there are major concerns about the extent to which countries can sustain these services once Global Fund support ends.

Box 4.2: European Commission pro rata contribution to results achieved through Global Fund financing

Since the formation of the Global Fund, the European Commission has provided more than USD 1.5 billion in financing, accounting for almost 6% of the Fund's total resources. Based on a 2011 review of results in Grant Performance Reports from 19 countries within the region and allocating these results to Commission funds on a pro rata basis, it is estimated that the Commission has supported provision of:

- harm reduction services for over 35 000 people who inject drugs;
- opioid substitution therapy for almost 800 people who inject drugs;
- HIV prevention programmes for over 10 000 sex workers and their clients;
- HIV prevention programmes for over 15 000 men who have sex with men;
- HIV prevention programmes for over 25 000 prisoners;
- almost five million condoms;
- HIV testing and counselling for almost two million people; and
- antiretroviral therapy for over 6 000 people.

HIV testing and counselling services have been supported in a number of ways. For example, the Think Tank representative from Slovakia commented that the involvement of an NGO, Odysseus, in the Civil Society Forum had benefitted their HIV testing and counselling services for people at risk of HIV infection. The European Health Programme has been supporting a project (HIV-COBATEST) focused on community-based HIV testing practices in Europe. This project seeks to promote early HIV diagnosis in Europe by improving the implementation, monitoring and evaluation of community-based counselling and testing practices. Elements of the project include collecting data in many countries on the implementation of community-based HIV testing programmes. It will also explore the likely effect of new rapid, saliva-based HIV tests on community-based HIV testing. It is also developing core indicators to improve monitoring and evaluation of these community-based services.

In 2010, ECDC produced guidelines on HIV testing bringing together evidence of the individual and public health effects of HIV testing. Through its contribution to the Global Fund, the Commission has supported the provision of HIV testing to a large number of people (see Box 4.2)³⁷.

Concern has been raised about the relatively low level of antiretroviral coverage in eastern Europe. In 2011, according to UNAIDS, approximately 23% of people in acute need had access to antiretroviral treatment in eastern Europe. This places the region alongside North Africa as one of those with the lowest coverage globally, with only half of the coverage found in sub-Saharan Africa (37.4%) despite having much larger numbers of people in need.

It is therefore encouraging that the Commission has been able to make a significant contribution to scaling up antiretroviral therapy in eastern Europe through its contribution to the Global Fund (see Box 4.2). Nevertheless, there are still serious concerns about the extent to which some countries will be able to sustain antiretroviral therapy when Global Fund support comes to an end.

ECDC has also been implementing a project to explore new approaches to treatment. This project reviews published scientific literature in order to inform decision-making on prevention efforts.

Meanwhile, the European Health Programme has been supporting a number of projects tackling co-infections, such as TB and hepatitis (see Box 4.3).

³⁷ A very large proportion of those tested are in the Russian Federation. This number includes testing among key populations and the general population, whereas in other countries testing among key populations is reported separately from testing of the general population. Where countries report numbers tested among key populations separately, these numbers have been used.

Box 4.3: Examples of projects within the European Health Programme focused on co-infections

TUBIDU is a project to empower civil society and the public health system to fight the TB epidemic among vulnerable groups, including people who inject drugs. This involves efforts to engage harm reduction service providers and community-based organisations in responding to TB.

The Imp.Ac.T project seeks to improve access to HIV/TB testing for marginalised groups, such as problematic drug users, people who inject drugs and migrant drug users. Approaches include adopting innovative testing strategies, such as HIV and TB rapid testing in low threshold centres. The project has contributed to the development of a standardised reporting system that provides a reliable overview of the HIV and TB epidemics among most-at-risk groups.

The European Health Programme is also establishing EU-HEP-SCREEN which will offer hepatitis B and C screening for migrants in the European Union.

Expansion of services in most-affected regions

Support for the Communication and Action Plan has had a strong focus on the expansion of services in regions and countries most-affected by HIV, such as Ukraine and the Russian Federation. Much of the support from the Global Fund in this region is focused on these two countries, and this is seen in the results achieved (see Box 4.2). This is also reflected in the strategy and actions of other international organisations working with the Commission. For example, UNAIDS reports that its priorities and actions are focused on those regions identified as priority regions in the Communication and Action Plan. The UNAIDS Regional Support Team is based in Moscow and provides support to many countries in the region. The new WHO Europe strategy also has similar regional priorities.

The agenda of the Civil Society Forum is also based on priorities within the Communication and Action Plan and therefore has placed specific emphasis on eastern Europe, (Ukraine and Russia in particular). The European Health Programme also supports projects focused on those EU Member States most affected by HIV, such as the Baltic countries. For example, TUBIDU (see Box 4.3) addresses the TB epidemic among vulnerable groups in the Baltic and the European Union countries in the east of Europe.

Expansion of services for key populations

Support for the Communication and Action Plan has had a strong focus on expanding services for those populations most-affected by HIV.

Box 4.4: Examples of projects within the European Health Programme focused on MSM

- 'The Future of European Prevention among MSM' (FEMP) conference in Stockholm in November 2011.
- The European MSM Internet Survey (EMIS) was conducted among MSM across Europe and attracted over 180 000 respondents from 38 countries.
- SIALON II focuses on building the capacity of NGOs and public health institutions to conduct local surveillance activities among MSM and to use the data gathered to develop appropriate HIV prevention activities for MSM.

Through the Global Fund, the Commission has financed the expansion of services for men who have sex with men (MSM) (see Box 4.2). In addition, the European Health Programme has supported a number of projects with particular emphasis on MSM. These include important international conferences (e.g. FEMP³⁸), major surveys (e.g. EMIS³⁹) and initiatives which aim to link surveillance and targeted prevention (e.g. SIALON II⁴⁰) (see Box 4.4).

ECDC has also focused on action to improve prevention of HIV and STI among MSM. These include a 2009 study on the effectiveness of behavioural and psychosocial HIV/STI prevention activities for MSM in Europe⁴¹ and a

³⁸ See www.femp2011.eu

³⁹ See www.emis-project.eu

⁴⁰ See www.sialon.eu

⁴¹ Effectiveness of behavioural and psychosocial HIV/STI prevention interventions for MSM in Europe. Revised edition, December 2009. ECDC: Stockholm; 2009.

special issue of Eurosurveillance devoted to the issue of HIV and STI among MSM⁴². Other activities supported by ECDC include:

- A seminar in the European Parliament to raise awareness about the high rates of HIV and STI among MSM in Europe.
- An ongoing project to assess the effectiveness of prevention interventions targeting MSM.
- Work to formulate a strategy for promoting sexual health in the context of disease prevention among MSM in Europe.
- Partnership with EMIS (see Box 4.4) to conduct regional analysis of the data collected.
- Contributing to scientific presentations at the FEMP Conference (see Box 4.4)

The Civil Society Forum was reported to have been influential in strengthening the European MSM network, which in turn was considered to have made an impact on addressing the prevention needs of MSM communities across Europe. In addition, the CSF's agenda is based on the Communication and Action Plan and has therefore had a strong focus on most-affected populations, including MSM. Box 4.5 provides an example of the development of new NGO services in Portugal based on priorities expressed in the Communication.

Box 4.5: New and innovative services developed in Portugal reflecting the Communication's emphasis on key vulnerable populations, including MSM

'In light of the Communication's emphasis on key vulnerable populations and following similar initiatives in various European countries, in 2010, GAT opened the first peer-to-peer VCT centre in Portugal (CheckpointLX), specifically targeting the MSM population in Lisbon. To implement this innovative approach in Portugal, advocacy was necessary to adopt changes in the national law in order to allow for community-based HIV testing. Due to the success of the MSM initiative, similar VCT centres are now being programmed, directed specifically at people who inject drugs, sex workers and migrants, according to the latest testing guidelines from ECDC, WHO Europe and EMCDDA.'

Through the Global Fund, the Commission has financed the expansion of services for people who inject drugs (see Box 4.2). In addition, the European Health Programme has supported a number of projects focused on people who inject drugs, including TUBIDU and Imp.Ac.T (see Box 4.3). The Commission's Directorate General for Justice is also funding a number of projects through the European Health Programme and EAHC related to drugs and HIV. These include support for a project entitled 'Connections' launched in 2007 and coordinated by the European Institute of Social Services (EISS) of the University of Kent. The project aims to integrate responses to drugs and infections across the European criminal justice systems. It focuses on the potential for partnerships within the criminal justice systems of the EU Member States to develop responses to drugs and related-infections, particularly HIV/AIDS and hepatitis. The project will facilitate the introduction and promotion of more effective, comprehensive, evidence-based policies and services at national and European level to respond to drugs and infections in prisons and within the wider context of the criminal justice system.

As noted earlier, EAHC has funded a WHO-led regional project to improve access to, and quality of, harm reduction services for people who inject drugs; this includes HIV, TB, and hepatitis C care, as well as opioid substitution therapy. Project activities included literature reviews, qualitative research, and the development of policies and training materials to support the delivery of high-quality services. Following an internal desk review in 2009, ECDC collaborated with EMCDDA to develop a guidance document on the prevention of infections among people who inject drugs⁴³. The CSF has also focused on this population group.

Through the Global Fund, the Commission has financed the expansion of HIV-related services in prisons (see Box 4.2). In addition, the European Health Programme is supporting a project (HPYP) to promote the health of young prisoners by sharing a health promotion toolkit across EU Member States. The toolkit covers issues relating to infectious diseases, sexual health, drug use and mental health. The Think Tank has had discussions related to HIV testing policy in prisons. The CSF's agenda has also had a strong focus on prisoners.

The European Health Programme is supporting a number of projects focused on the health of migrants and ethnic minorities. These include EU-HEP-SCREEN, coordinated by the Erasmus University Medical Center in Rotterdam, which aims to assess, describe and communicate to public health professionals the tools and conditions necessary to implementing successful and cost effective screening programmes for hepatitis B and C among migrants in the

⁴² HIV/AIDS and other STI in men who have sex with men – A continuous challenge for public health. Eurosurveillance Special Edition, Volume 14, Issue 47, December 2009. ECDC, Stockholm.

⁴³ ECDC and EMCDDA. Prevention and control of infectious diseases among people who inject drugs. October 2011. ECDC, Stockholm.

European Union. Another project, SRAP, focuses on preventing addiction among Roma and Sinti communities through participatory community-based interventions, as well as on improving awareness and provision of health and addiction services. The Think Tank and the CSF have also had discussions relating to the health of migrants in Europe.

ECDC has also done significant work in the area of migrant health including the production of a series of five reports covering the epidemiology of HIV and AIDS⁴⁴; access to HIV prevention, treatment and care⁴⁵ and HIV testing and counselling⁴⁶ in migrants; issues relating to infectious diseases, including HIV and migrants⁴⁷; and improving data comparability and definitions of migration used within the EU/EEA⁴⁸.

Through the Global Fund, the Commission has financed the expansion of services for sex workers (see Box 4.2). In addition, the European Health Programme has supported a number of projects for sex workers, including Bordernet⁴⁹, which seeks to scale up HIV and STI prevention, diagnosis and treatment across sectors and borders in central, eastern and south-eastern Europe. The project focuses on a number of key populations affected by HIV, including sex workers, and has collected and published valuable data on sex work, sex work and drug use, and the prevalence of HIV, syphilis and hepatitis among sex workers.

During its vice presidency and presidency to the UNAIDS Programme Coordinating Board in 2011–2012, Poland successfully brought several UNAIDS PCB issues to the attention of neighbouring EU countries, for example HIV prevention, treatment and care services, as well as issues on co-infections (TB, HBV, HCV) and human rights.

4.3 New treatment and prevention technologies and approaches

The Communication states that the Commission encourages long-term public and private investment into research for the development of new and improved prevention technologies and treatments for HIV and associated infections. As discussed in Section 2, the Commission has provided funding for research on HIV and associated infections through its research framework and health programmes. Key findings concerning the effects of Commission-supported actions are summarised below.

Progress in developing new prevention technologies

Commission funding has supported innovative research on HIV prevention (see Box 4.6).

Box 4.6: HIV prevention research

EUROPRISE promoted integrated research on HIV vaccines and microbicides and explored whether combined use of these two technologies can lead to more effective prevention. The network brought together 70 organisations to define new standards for research and pooled data to facilitate research. EUROPRISE partners have been involved in 31 clinical trials and have been instrumental in overcoming the fragmentation of European HIV research on vaccines and microbicides.

Since 2008, EuroNeut-41 has been conducting research for the development of novel vaccine candidates, targeting the cell–HIV fusion mechanisms. After the successful development and pre-clinical testing and selection of two promising candidates, scientists from the consortium are currently testing those two candidates in two Phase I clinical trials (intramuscular and/or nasal administrations). The EuroNeut-41 approach has the potential to complement other methodologies aimed at eliciting a T-cell-mediated immune response to reduce the viral load, if not to prevent HIV infection altogether.

⁴⁴ Migrant health: Epidemiology of HIV and AIDS in migrant communities and ethnic minorities in EU/EEA countries. Technical report. ECDC, Stockholm; 2010.

⁴⁵ Migrant health: Access to HIV prevention, treatment and care for migrant populations in EU/EEA countries. Technical report. ECDC: Stockholm; 2009

⁴⁶ Migrant health: HIV testing and counselling in migrant populations and ethnic minorities in EU/EEA/EFTA Member States. Technical report. ECDC: Stockholm; 2011.

⁴⁷ Migrant health: Background note to the 'ECDC report on migration and infectious diseases in the EU'. Technical report. ECDC: Stockholm; 2011.

⁴⁸ Improving HIV data comparability in migrant populations and ethnic minorities in EU/EEA/EFTA countries: Findings from a literature review and expert panel. Technical report. ECDC: Stockholm; 2011.

⁴⁹ See www.bordernet.eu

Progress in developing new treatments

Commission funding through the Sixth and Seventh Framework Programmes has also supported important research to develop novel HIV drugs and clinical trials of new treatment combinations (see Box 4.7).

Box 4.7: HIV treatment research

The THINC project has taken forward development of a new class of anti-HIV drug, building on research conducted by the TRIhO project under the Sixth Framework Programme. The consortium has worked in partnership with the pharmaceutical company Tibotec and focused on cellular proteins required for HIV replication. The consortium was successful in developing first-in-class drugs against the recently validated target LEDGF/p75 and negotiated with Pfizer in the UK for further development studies and clinical trials after project funding ends.

The NEAT network of excellence is implementing clinical trials for new treatment combinations. NEAT has recently commenced a randomised clinical trial that will enrol more than 800 patients in 15 European countries – a clinical trial of this magnitude is unprecedented in Europe.

Increased research capacity

Commission support has strengthened research capacity both in Europe and in developing countries affected by the HIV epidemic (see Box 4.8).

Box 4.8: Building capacity for research

Under the Sixth Framework Programme, additional funds were committed to the European and Developing Countries Clinical Trials Partnership (EDCTP) to build knowledge, support coordination, build capacity across sub-Saharan Africa, and conduct advanced clinical trials. More than 300 junior and senior African scientists have been trained with EDCTP funds, and the partnership has helped establish important institutions such as the African Vaccine Regulators Forum and the Pan-African Clinical Trial Registry. EDCTP is currently supporting four networks of excellence (EACCR, WANETAM, CANTAM, TESA) that cover four regions in sub-Saharan Africa.

The NEAT network (see Box 4.7 and Box 4.9) is also building capacity to conduct pan-European clinical trials.

The EUROPRISE network established a PhD training programme in HIV prevention technology with over 60 PhD students from China, India and Tanzania (see Box 4.6).

Improved coordination and collaboration

Commission support to a range of initiatives (see Box 4.9) has improved coordination of research in Europe and promoted increased collaboration between European and international researchers and between researchers and industry.

Box 4.9: Research coordination and collaboration

Under the Seventh Framework Programme, the ERA-NET HIVERA project is being funded to improve coordination and integration of national HIV research programmes and activities.

The NEAT network of excellence aims to promote European collaboration in HIV and AIDS clinical research. The network, coordinated by the Istituto Superiore di Sanita in Italy, involves 41 partners and has resulted in collaboration between European researchers on more than 21 clinical trials.

Other examples of research collaboration, described in more detail elsewhere in this report, include EuroSIDA, Eurocoord, the EUROPRISE network, which has established collaboration between European and US researchers and with industry partners such as Novartis and GSK, and the THINC project, which is being implemented by a consortium of 10 European partners and coordinated by Leuven University in Belgium.

4.4 Surveillance

The Commission has asked ECDC to provide data for a more accurate understanding of the HIV epidemic in Europe, including HIV incidence and prevalence, behavioural data, and undiagnosed HIV infections. This highlights the need for second generation and behavioural surveillance and social science research to be intensified to better

understand the dynamics of the epidemic in Europe, in order to inform policy and programming. Key findings concerning the effects of Commission-supported action are summarised below.

Significant improvements in HIV-related epidemiological surveillance in Europe

ECDC has contributed to important progress in biological surveillance of the epidemic in Europe. Surveillance data on HIV and AIDS cases is collected annually and submitted by national HIV/AIDS surveillance contact points in the Member States (WHO European Region) to The European Surveillance system (TESSy). ECDC and the WHO Regional Office for Europe have helped to ensure that a harmonised surveillance system is in place across Europe and that all EU Member States, as well as most non-EU countries, report epidemiological data. Responses indicate that the work of ECDC, in cooperation with Member States and WHO Regional Office for Europe, has contributed to strengthening epidemiological surveillance and surveillance reporting.

ECDC has focused its efforts on supporting countries to improve surveillance systems through country visits, surveillance network meetings and support during surveillance uploading and reporting. This has improved the comprehensiveness and quality of surveillance. ECDC also coordinates the HIV/AIDS expert network. Annual meetings of HIV and STI national contact points from EU and EEA countries have promoted the sharing of experience and information as well as providing an opportunity to update experts on new developments in surveillance, key prevention interventions, and monitoring and evaluation.

Box 4.10: Towards a more accurate picture of HIV prevalence and incidence in Europe

An ECDC project, launched in December 2012, offers a more accurate picture of HIV prevalence in Europe by providing a better estimate of the proportion of people living with HIV who are undiagnosed. The aim is to review available models to estimate HIV prevalence in Europe. A new modelling tool is being developed and piloted in four EU countries.

Another current ECDC project will provide a more accurate picture of HIV incidence in Europe by developing a model to monitor recently acquired infections. The project will improve understanding of transmission patterns and dynamics through better estimation of the proportion of recently infected individuals among all new HIV diagnoses. An epidemiological framework and guidance on implementing this approach in routine HIV surveillance were developed in December 2012.

Collaboration between ECDC and WHO's Regional Office for Europe since January 2008 has resulted in effective coordination of HIV and AIDS surveillance in Europe. ECDC has taken the lead on case-based HIV and AIDS surveillance, data analysis, and report writing; as of December 2012, five joint surveillance reports have been published). Coordination has been strengthened through the HIV/AIDS surveillance network.

In 2012, ECDC started a project to revise HIV/AIDS surveillance. This includes linking HIV and AIDS case reporting, improving the route of transmission variables, and adding more bio-clinical information at time of diagnosis (e.g. CD4 count and viral load); it will be explored whether it is also feasible to collect CD4 count and viral load after diagnosis in order to capture links to HIV treatment. ECDC has also improved the dissemination of surveillance data by publishing scientific articles in the journal *Eurosurveillance* and releasing an annual HIV and AIDS surveillance report.

Initial steps to improve behavioural surveillance

ECDC is supporting projects to enhance behavioural surveillance in Europe. In 2009, ECDC published a technical report, analysing HIV- and STI-related behavioural surveillance programmes in European countries⁵⁰. This information has been used to implement behavioural surveillance, including the development of a set of key indicators. Technical guidance and a toolkit⁵¹ were developed to support Member States. Implementation of behavioural surveillance was piloted in several Member States.

In addition, ECDC organised an expert meeting on the implementation of behavioural surveillance. In 2012, 12 Member States participated in three regional workshops to assess implementation of behavioural surveillance in their countries. A workshop on behavioural surveillance among people living with HIV was held in Paris, where cohort studies of people living with HIV showed how the resulting data can be used to monitor sexual, injecting

⁵⁰ Mapping of HIV/STI behavioural surveillance in Europe. Technical report. September 2009. ECDC, Stockholm.

⁵¹ See www.ecdc.europa.eu

and treatment behaviours. Finally, a framework for behavioural surveillance in Europe was developed and will be published in 2013.

Steps taken to improve HIV-TB co-infection surveillance

Projects supported by ECDC and EAHC are contributing to better surveillance of HIV-TB co-infection, particularly among the most vulnerable population groups (see Box 4.11).

Box 4.11: Developing better surveillance systems to monitor HIV and TB infection

ECDC is supporting a project which aims to improve HIV-TB surveillance by mapping HIV/TB co-infection and related surveillance systems and practices in Europe. The project has conducted a systematic review to determine the burden of co-infection in EU and EEA countries and an online survey of national TB surveillance contact points to assess the burden of co-infection, clinical management of co-infection and current approaches to monitoring HIV co-infection in TB surveillance systems.

A project to improve access to HIV/TB testing for marginalised groups (IMPACT), which commenced in September 2010 with funding from the European Health Programme, will contribute to developing a new accurate, timely and comparable surveillance system for monitoring trends in HIV and TB infection among people who inject drugs, including migrant drug users. The project is expected to result in standardised reporting, thereby providing a more reliable picture of the HIV and TB epidemics among these vulnerable groups at country and European level.

Significant progress in European surveillance among key populations

European Union agencies, such as EMCDDA, and projects funded by the Commission, including through the European Health Programme, have contributed to improved understanding of the impact of the HIV epidemic among the population groups most affected in Europe, in particular people who inject drugs and men who have sex with men.

EMCDDA reports that it provides the EU and its Member States with objective, accurate, comparable information on drugs and drug addiction, including HIV-related information on injecting risk behaviour, HIV incidence and prevalence among people who inject drugs and responses to drug use, which include harm reduction, treatment and HIV prevention measures. Data are published in the annual Statistical Bulletin and the EMCDDA Annual Report on the state of the drugs problem in Europe⁵².

EMCDDA collects data in collaboration with EU Member States, through an EMCDDA focal point in each country and Drug-Related Infectious Diseases (DRID) experts, ECDC and the WHO Regional Office for Europe. Comprehensive data is collected on the availability, provision and coverage of interventions to prevent infections among drug users including, for example, on needle and syringe programmes and the proportion of prisoners receiving opioid substitution therapy. The DRID project has enhanced networking and information exchange between European experts, improved networking, speeded up the exchange of information between European experts, provided technical assistance to strengthen data collection capacity, produced a revised guidance document, and released a tool kit for DRID data collection.

Specific support has also contributed to enhanced surveillance among MSM. UNAIDS, for example, highlighted the significant progress that has been made in this area as a result of innovative activities supported by the Commission. One example is the European MSM Internet Survey (EMIS) project, which has generated valuable behavioural data. Another is the SIALON II project (see Box 4.12).

Box 4.12: Innovative approaches to surveillance among MSM

The SIALON II project, funded through the European Health Programme and implemented in cooperation with WHO and UNAIDS, focuses on the use of innovative surveillance methods among MSM as well as assessment of HIV prevention needs and interventions. The project will develop approaches to epidemiological surveillance that are appropriate to the local context and improve the capacity of public health institutions and MSM NGOs to use innovative methods to collect serological and behavioural data among hard-to-reach MSM.

This is expected to improve issues such as the estimation of HIV and STI incidence, prevalence and undiagnosed infections in the MSM population. The project is also expected to contribute to greater harmonisation of

⁵² See www.emcdda.europa.eu

surveillance methodologies, generate comparable data on epidemiological and behavioural indicators for MSM communities, identify unmet prevention needs and strengthen networking between organisations working on MSM.

4.5 Monitoring and evaluation

The Communication highlights the need for national surveillance systems to be fully compatible with international requirements and for all countries to report regularly on their HIV/AIDS epidemics. Key findings concerning the effects of Commission-supported actions are summarised below.

Monitoring has improved significantly

Country responses suggest that Commission-supported activities, in particular the work of ECDC, have contributed to significant progress in strengthening monitoring. Specifically, ECDC efforts have resulted in a considerably improved reporting on the implementation of the *Dublin Declaration on the partnership to fight HIV/AIDS in Europe and Central Asia*, as well as increased UNGASS reporting.

ECDC has worked closely with UNAIDS and WHO on this and has coordinated a country-led approach through an advisory group that includes representatives from EU Member States and other countries and from the CSF. ECDC held monitoring and evaluation workshops in 2009 and 2012 to support countries' regional and global reporting. The workshops resulted in very high regional response rates both for Dublin and UNGASS reporting. For Dublin reporting in 2010, responses were received from 49 countries. This included responses from 12 countries⁵³ that did not submit returns to UNGASS in 2008. In September 2010, ECDC published an indicator-based progress report⁵⁴ on implementing the Dublin Declaration which describes how countries in the region are responding to the HIV epidemic and identifies clear recommendations for improving and monitoring the response⁵⁵.

For Dublin reporting in 2012, responses were received from 50 countries. Based on an analysis of reported data, ECDC will publish ten topical reports and eight evidence briefs in 2013 (see also Section 5 of this report).

Good progress in developing regionally-relevant indicators and improving monitoring tools

ECDC work is now focusing on improving the usefulness of indicators for regional monitoring. ECDC aims to further harmonise reporting for Dublin monitoring with Global AIDS Response Progress Reporting (which replaced UNGASS reporting).

In 2011, ECDC consulted with EU Member States to reach consensus on a set of regionally specific and harmonised indicators to monitor the HIV response in Europe, including indicators related to migrants, prisoners, ART and late diagnosis, as well as a streamlined approach to reporting to ECDC, UNAIDS and WHO. This set of indicators was used for data collection during the 2012 Dublin/Global AIDS Response Progress and Universal Access reporting round and helped to reduce the reporting burden on countries. ECDC also supported the Commission in hosting a side event on the regionalisation of monitoring the response to HIV at the United Nations High Level Meeting on AIDS in New York in 2011.

EMCDDA has developed a comprehensive set of key indicators and core datasets in cooperation with national focal points and external technical experts. The key indicators, which include monitoring the extent of infectious diseases — primarily HIV, hepatitis C and hepatitis B infection — among people who inject drugs, have become the accepted European standard for drug monitoring and have also been influential internationally. EMCDDA has also taken steps to improve the quality of monitoring tools. For example, EMCDDA organised expert meetings to refine and standardise data collection tools to improve the availability and comparability of data across Europe and provided technical inputs for the review of UNODC's data collection tools. In addition, EMCDDA has produced a comprehensive set of country data sheets (based on information provided by national focal points in 30 countries) on the availability, provision and coverage of interventions to prevent infections among drug users. This includes information on, for example, the estimated number of people receiving drug treatment, the availability of needle and syringe programmes, availability and coverage of opioid substitution therapy, drug-related health policies, and services in prisons. EMCDDA also collaborates with ECDC by sharing data for monitoring the Dublin Declaration.

⁵³ Andorra, Czech Republic, Denmark, Iceland, Italy, Luxembourg, Malta, Norway, Portugal, San Marino, Slovakia, and Turkmenistan.

⁵⁴ Implementing the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2010 progress report. Special report. ECDC: Stockholm; 2010.

⁵⁵ The Vilnius and Bremen Declarations are not actively monitored as the Dublin Declaration encapsulates key commitments. Follow up to Bremen is through the 'Bremen process', which focuses on ensuring fair and affordable prices for antiretroviral drugs.

4.6 Evidence, scientific advice and dissemination of good practice

The Communication emphasises the importance of evidence-based policy and programming, which is supported by accurate data on factors driving the epidemic in Europe and sound research on issues such as clinical management. It also emphasises the importance of scientific advice and the dissemination of learning. Key findings concerning the effects of Commission-supported actions are summarised below.

Operational research, surveys and scientific research have strengthened the evidence base

Commission-supported activities are strengthening the evidence base. For example, operational research (see Box 4.13) will generate evidence to improve the approach to and the cost-effectiveness of HIV testing and screening for HIV, STI, and hepatitis B and C, with particular reference to those population groups most at risk in the European region.

Box 4.13: Examples of operational research

Through the European Health Programme, the HIV COBATEST project, which started in 2010, aims to improve community-based HIV counselling and testing in Europe, in order to promote early HIV diagnosis. The project reviews community-based counselling and testing programmes in order to identify good practices and develop a set of core indicators for related monitoring and evaluation. It also assesses the acceptability, feasibility and impact of introducing rapid oral tests in community-based counselling and testing programmes.

The IMPACT project aims to broaden access to HIV and TB testing, prevention, treatment and care for vulnerable groups including drug users and migrant drug users. The project will raise awareness among health providers of the importance of testing uptake and identify and promote innovative testing strategies for vulnerable groups. To date, the project has developed a protocol for implementing HIV and TB rapid tests in low-threshold facilities, produced a training manual and conducted capacity-building workshops, in particular for the providers of outreach services.

An ECDC project assessed the relevance of novel approaches to testing for HIV, STI and hepatitis B and C in Europe. Based on a review of the literature and of testing technologies used within and outside of healthcare settings, the project will produce a report setting out key findings and implications for public health.

ECDC is also investigating the cost-effectiveness of screening strategies for HIV, hepatitis B and hepatitis C, based on a review of available models and cost-effectiveness estimates. The project will identify the most appropriate models to assess the impact of screening in the European context and develop and test a tool kit for estimating cost-effectiveness.

A project to assess the value to public health of HIV drug resistance monitoring is also being supported by ECDC. To date, the project has assessed the added value of systematically monitoring antiretroviral drug resistance among newly-diagnosed individuals with HIV in EU and EEA countries, and of using the genetic sequence data collected as part of antiretroviral drug resistance monitoring at EU level.

The TUBIDU project is promoting cooperation between harm reduction service providers and community organisations. It is expected to reduce the burden of TB among people living with HIV and people who inject drugs by improving planning, targeting responses, developing guidelines for service delivery and addressing barriers to accessing services.

EU-funded research is generating important evidence which will improve clinical management of HIV and control of HIV drug resistance. The research is exploring ways to improve the clinical management and quality of life for adults and children with HIV and for patients with HIV and other infections such as TB. Research will also improve knowledge on resistance to existing drugs and the prevention and management of drug resistance (see Box 4.14).

Box 4.14: Examples of clinical research funded through the EU Research Framework Programme

EuroSIDA is an observational study following up more than 16 000 people with HIV infection in 32 countries, including all EU Member States. The study has generated valuable data on the impact of antiretroviral drugs on patient outcomes. EuroSIDA has published 130 peer-reviewed publications and influenced patient treatment and related guidelines.

The CASCADE study is following up patients for whom the date of HIV infection can be reasonably well estimated. The study, which has access to data from 20 000 HIV-infected individuals from 26 cohorts in 15 European countries, Australia, Canada and Sub-Saharan African countries, has provided important insight into the course of HIV infection, thereby improving treatment strategies. CASCADE has produced 50 joint, peer-reviewed publications and presentations at international conferences.

The PENTA/ECS study is improving the clinical management and treatment of HIV-infected pregnant women and paediatric infection. Implemented by nine partners, it conducts epidemiological studies of mother-to-child transmission, clinical trials and training, and has published 41 papers in peer-reviewed journals. PENTA guidelines on use of antiretroviral therapy in paediatric infection are widely used and have influenced WHO guidance. The training programme for health workers caring for HIV-infected children has been incorporated into curricula (e.g. Oxford University's Postgraduate Diploma in Paediatric Infectious Disease).

EuroSIDA, CASCADE and PENTA are included in EuroCoord, a network of 24 partners. EuroCoord aims to improve the clinical management and quality of life of people with HIV, as well as to explore differences within sub-groups. It has access to data from over 370 000 HIV patients, one of the largest cohorts in the world, and provides – through prospective and retrospective studies – valuable information on issues such as patient response to therapy, implications of long-term infection and long-term treatment, impact of TB co-infection and management of hepatitis co-infection. The network is also building a harmonised data collection system, known as the HIV Cohorts Exchange Protocol (HICDEP). Finally, EuroCoord also studies migrant populations in Europe and is currently developing a model for estimating the HIV prevalence in different European countries. EuroCoord has a strong base in eastern Europe and neighbouring countries, in particular Ukraine, and works on the prevention of mother-to-child-transmission, optimises paediatric regimens, and conducts studies on HIV co-infections.

CHAIN, is a substantial epidemiological and research project with a particular focus on Eastern Europe and resource-poor regions in Africa heavily affected by the epidemic. CHAIN aims to improve current knowledge on resistance to existing drugs and the prevention and management of drug resistance. The project will develop new laboratory tools to measure drug resistance, improve understanding of the clinical implications of drug resistance, develop strategies for the management of individuals with drug-resistant infection, build scientific and clinical expertise and provide evidence-based recommendations for limiting the emergence and transmission of drug-resistant HIV.

Valuable evidence is also being generated through surveys. As noted earlier in this report, ECDC is a partner in the Commission-funded European MSM Internet Survey (EMIS), conducting regional analysis of data collected with a view to publishing the survey report in 2013 in collaboration with the EMIS consortium.

Evidence is informing policy and programming

Evidence generated is being put into practice, informing policy and programming. For example, ECDC published a technical report and updated guidance on HIV testing in 2010, based on a systematic review of the evidence on the individual and public health effects of HIV testing and consultation with Member States, civil society and disease experts.

ECDC has recently published a report on a comprehensive approach to HIV and STI prevention in the context of sexual health, based on a mapping of policies, programmes and other initiatives relating to the sexual health of key populations in EU and EEA countries. Knowledge gaps identified by the report, together with inputs from an expert meeting, will guide future ECDC work in this area.

EMCDDA and ECDC have developed guidance on the prevention of HIV and other infections among people who inject drugs. The guidance reflects the evidence collected in 2009 by a desk review and a systematic review of the evidence on prevention interventions in this population as well as feedback from a technical consultation. The evidence-based technical reports, guidance, and brief version of the guidance, were published in 2011 and translated into 18 languages in 2012. The translations were well-received by Member States and contributed to the adoption of evidence-based approaches to HIV prevention and harm reduction in the region.

In 2012, ECDC initiated a project to assess the effectiveness of antenatal screening practices for the prevention of mother-to-child transmission of HIV, syphilis, hepatitis B and rubella in the EU/EEA. The project also identifies vulnerable populations and the determinants of vulnerability. Project results will provide input for a guidance document on strengthening antenatal screening, which will be developed in 2014.

Box 4.15: Systematic reviews and scientific papers

EMCDDA has published analyses of trends in injecting drug use in Europe and of prevention policies and interventions (e.g. a monograph on evidence relating to harm reduction published in 2010) as well as technical papers and scientific articles.

In 2009, ECDC published a systematic review of behavioural and psychological HIV and STI prevention interventions for MSM in Europe which identified the characteristics of effective interventions as well as gaps in the evidence base. ECDC also published scientific papers on this topic in a special issue of *Eurosurveillance* and hosted a seminar in the European Parliament to raise awareness on the high rates of HIV and STI transmission among MSM in Europe.

ECDC has published a series of migrant health reports that have made an important contribution to the evidence base for policy and programming and have been widely cited. Topics covered by these reports include improving definitions and data, the epidemiology of HIV and AIDS in migrant and ethnic minority communities, migrant access to HIV prevention, treatment and care services, and HIV counselling and testing among migrants and ethnic minorities. In 2012, ECDC carried out a systematic literature review and a survey of Member States to collect and analyse data on the extent to which sexual transmission of HIV occurs among migrant populations from countries with generalised epidemics after their arrival in the EU/EEA. A report will be published in 2013.

Results of an ECDC project will inform the development of policy guidance on treatment as prevention that is relevant to the European context. Based on a review of the published scientific literature, the project assessed the implications of using antiretroviral treatment to prevent HIV infection at the population level, and to a lesser extent, at the individual level for prevention (and emerging) policies. The findings were published in a report in 2012.

ECDC work to strengthen the evidence base on HIV and STI prevention among MSM has contributed to coordinated EU action. For example, in 2010–2011 a project investigated HIV and STI trends and the effectiveness of prevention interventions among MSM in more detail. The project results, together with a study published in 2009 (see Box 4.15) and a subsequent review of policies and evidence for interventions, has informed the development of an ECDC guidance document on prevention of HIV/STI and hepatitis among MSM in Europe, which will be published in 2013–2014. A parallel project, which started in 2012, will develop a communication strategy and key messages to promote sexual health and prevent infection among MSM in Europe, to be launched in tandem with the prevention guidance.

'Especially in relation to HIV testing, HIV prevention for MSM and HIV prevention among IDU, the knowledge basis established [through activities supported by the Commission] represents a strong platform for further strengthening the implementation of evidence-based policies.' – UNAIDS

ECDC has also done a significant amount of work in the area of migrants and HIV in the EU and on treatment as prevention, in order to inform the development of policy and programming (see Box 4.15).

EU agencies and EU-funded projects are an important source of scientific and technical advice and play a key role in dissemination of learning.

A range of methods is used to provide scientific advice and disseminate learning.

Networks and scientific committees play a key role. Scientific advice has been strengthened by efforts to build networks. Principal investigators and coordinators of EU-funded research projects are represented in scientific committees that advise on research agendas, for example, the Global HIV Vaccine Enterprise 2010 agenda and the 'Towards an HIV Cure' initiative.

Think Tank and CSF meetings have also provided an important forum for sharing and disseminating good practice, according to the majority of respondents who participate in these meetings.

'The regular meetings of the EU Civil Society Forum and Think Tank on HIV/AIDS represent exemplary models of best practice in convening fora where European civil society and governments can exchange information on the situation in EU and neighbouring countries and share experiences of joint projects and other activities – often supported by the EU public health programmes.' – UNAIDS

Scientific advice and technical support is provided to Member States by EU agencies, including through country visits. ECDC provides scientific advice and technical support on infectious diseases to the Commission, European Parliament, European-funded projects and Member States. During the period 2009–2011, ECDC improved systems for initiating and coordinating scientific studies and providing scientific advice. Specific examples of scientific advice to Member States include enhanced microbiological laboratory support and country visits in response to requests from national HIV/STI prevention and control programmes (Estonia in 2010; Romania, Latvia in 2011; Finland in 2012).

In November 2011, at the request of the Commission, ECDC and EMCDDA conducted a study, assessing the risk of HIV outbreaks among people who inject drugs. The risk assessment confirmed reports of HIV outbreaks among this key population in Greece and Romania, and identified a number of other countries at risk. In 2012, the Commission provided support to respond to HIV outbreaks among people who inject drugs in Greece. This included a joint country mission in May 2012, which involved ECDC, EMCDDA, WHO and the EU Fundamental Rights Agency. Further ECDC country missions followed, including meetings with Greek public health officials, clinicians, and civil society organisations, in order to assess the situation and provide evidence-based recommendations for prevention and control. ECDC and EMCDDA also organised two expert meetings on the detection of, and response to, outbreaks of HIV among people who inject drugs (March and October 2012; key participants were Greece, Romania as well as other countries considered as being at risk). In addition, ECDC funded the translation of a joint ECDC–EMCDDA guidance document on prevention of HIV transmission among people who inject drugs; local-language versions were provided for countries at risk of HIV outbreaks. The EU/EEA risk assessment will be periodically updated, and at least one further expert meeting is planned for 2013.

EMCDDA provides EU Member States with scientific advice and technical support on drug issues, including the evaluation of national drug policies, HIV and drug-related studies, and the development of monitoring systems. EMCDDA has also provided technical support to candidate and potential candidate countries on drug monitoring systems and the collection of data on policies and interventions to prevent infectious diseases among drug users.

‘The work of EU institutions, notably ECDC and EMCDDA, have enabled good access to scientific advice and exchange among Member States.’ – UNAIDS

Scientific advice is also provided to other bodies. For example, at the EU level, EMCDDA provides advice on drug policy, to the Horizontal Working Party on Drugs, and EU Presidencies. EMCDDA also made an important contribution to the evaluation of the 2005–2012 EU drugs strategy and its two action plans.

ECDC and the Commission have disseminated policies, guidance and good practice on HIV prevention and treatment through events at the European Parliament. Similarly, the Parliament has been used as a forum to highlight the HIV prevention needs of MSM (2009), to launch the HIV testing guidance (2010) and to hold a seminar on HIV prevention among people who inject drugs (2011). EMCDDA also launches its annual report at the European Parliament.

Scientific advice and information on best policy and practice have also been disseminated through Commission-funded and other international conferences. Commission-funded conferences include the European AIDS Conference in Tallinn in 2011 and the Future of European Prevention among MSM conference in Stockholm in 2011, and the HIV in Europe conference in Copenhagen in 2012. The Tallinn conference facilitated the exchange of knowledge, experience, best practices and research findings in the field of HIV prevention, treatment and care, with a special focus on vulnerable groups and health systems in the Baltic region and ENP countries. The Stockholm conference focused on innovative and evidence-based methods and approaches to scaling up preventive interventions and programmes, as well as promoting networking and the exchange of information. The Copenhagen conference focused on strategies to promote increased and earlier HIV testing, as well as improved access to treatment.

‘The CSF, the Bordernet project and the Tallinn Conference influenced our testing and counselling policies.’
– Civil society respondent, Austria.

The XVIII International AIDS Conference and Harm Reduction International’s 21st International Conference, both of which took place in 2010, provided an opportunity to disseminate information on best practices and share experience. At the latter, the European Harm Reduction Network was launched. In addition, EAHC convenes meetings for EU-funded projects to share information and experience, for example project sessions at the 2011 Tallinn AIDS Conference. At the International AIDS Conference in 2012, ECDC co-hosted, together with the US CDC, the Public Health Agency of Canada and IOM, a special symposium on challenges and promising practices in responses to HIV and migration in western industrialised countries; ECDC scientist held two presentations on migration and HIV at this conference.

The findings of Commission-funded research projects have been widely published in peer-reviewed literature and have influenced international guidelines and practice, as the examples above illustrate. EU agencies such as ECDC and EMCDDA have also provided important scientific advice through the publication of guidelines and technical

reports. EMCDDA, for example, produced papers on trends in injecting drug use in Europe (2010) and on drugs in European prisons (2012).

EMCDDA has established a European 'Best practice portal' to provide policymakers, researchers and programme managers with information on evidence of effective prevention, treatment, harm reduction interventions, national and international standards and guidelines, and evaluated best practice.

AIDS Action Europe, which is funded by the Commission, also disseminates good practice to a wide audience in Europe and central Asia. AIDS Action Europe maintains an online database at www.hivaidsclearinghouse.eu which contains over 1 200 resources and e-mails bimonthly updates to 900 subscribers. Downloads from the site increased from 33 000 in 2009 to 61 000 in 2011. The website has a special CSF section which includes meeting agendas, reports and presentations. The EU-funded AIDS & Mobility database was transferred to the AIDS Action Europe Clearinghouse in 2010. The AIDS Action Europe website at www.aidsactioneurope.org attracted an average of 1 800 visits a month in 2011 (an increase of 37% from 2010), 70% from European countries. Since 2009, AIDS Action Europe has also provided a platform for information exchange on HIV and drugs-related projects funded by the Commission.

'The clearing house of AIDS Action Europe has become a major source of information on HIV and AIDS strategies.' – Civil society respondent, Belgium

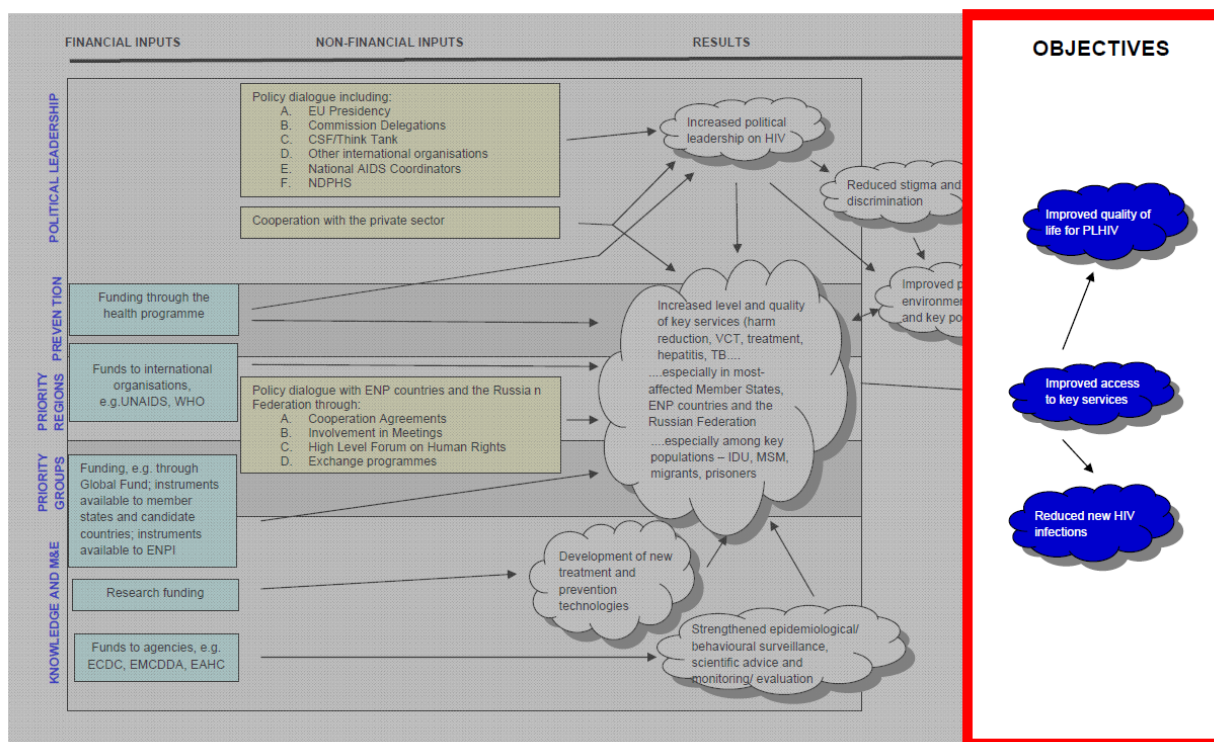
5 Contributions to Europe's response to HIV

This report has considered the financial and non-financial inputs to support the response to HIV in the European region as a result of the Commission's Communication and Action Plan. It has also considered the results and effects of those inputs in terms of increased political leadership on HIV; increased levels and quality of key services; development of new treatment and prevention technologies; strengthened surveillance; improved monitoring and evaluation; and better scientific advice.

But has this resulted in the objectives of the Communication and Action Plan being met? Has the quality of life of people living with HIV improved across the region? Has access to services improved? Has transmission of HIV been reduced?

This section focuses on these issues (see Figure 5.1), drawing mainly on country data reported for the monitoring of the *Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia*⁵⁶.

Figure 5.1: Framework for monitoring the HIV Communication and Action Plan: contributions to objectives

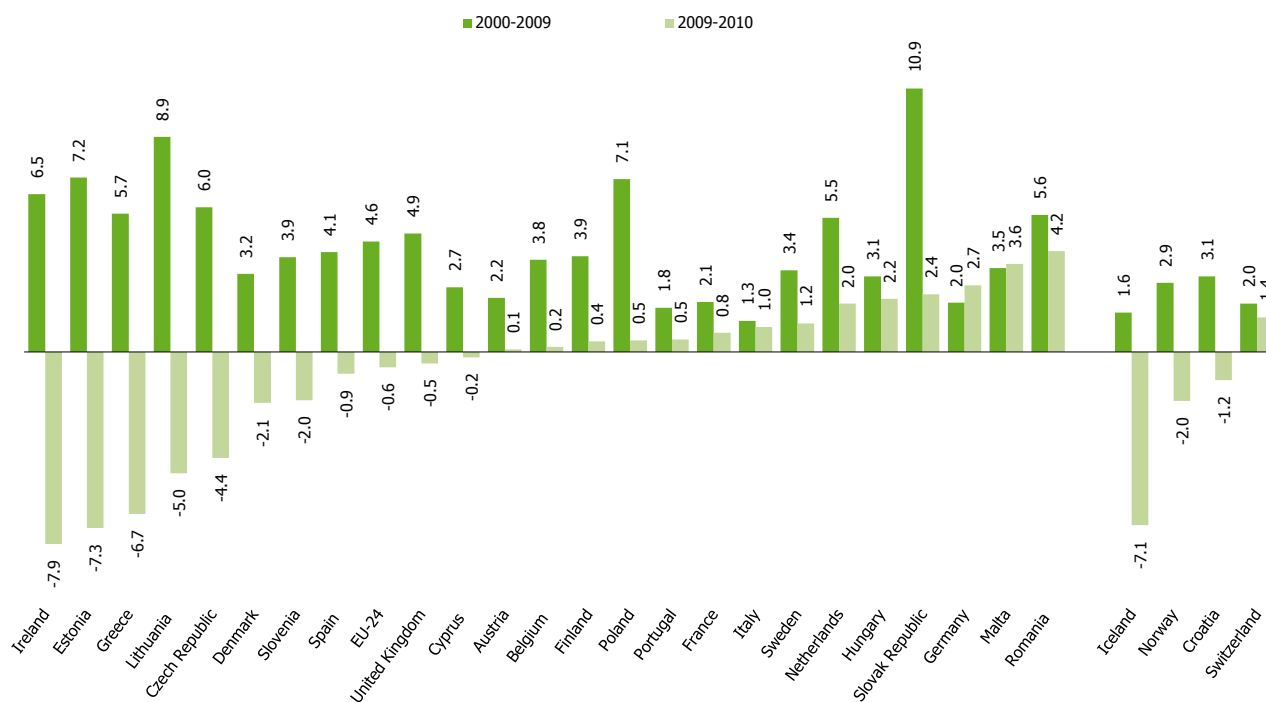


Before attempting to answer the question of whether the objectives of the Communication and Action Plan have been met, it is important to remember the context in which this Communication has been issued. Since 2007, many countries have been impacted negatively by the international financial crisis. Data from OECD and the European Commission show that in 2010 – for the first time since 1975 – the annual average growth rate in health expenditure per capita fell across the European Union⁵⁷. From an annual average growth rate of 4.6% between 2000 and 2009, health spending per person fell by –0.6% in 2010 (see Figure 5.2). So while the Communication and Action Plan aimed to improve access to key services, the input provided by the Communication and Action Plan may have really just allowed countries to sustain (rather than decrease) services because funding for public health/prevention programmes at the Member State level had already been reduced.

⁵⁶ In late 2007, the European Commission requested ECDC to systematically monitor implementation of the Dublin Declaration. ECDC produced its first major report of this work in 2010. In 2012, instead of producing one overall report, information provided by countries was analysed to produce ten topical reports. The topics of these reports are leadership and resources; civil society; people who inject drugs; men who have sex with men; sex workers; migrants; prisoners; treatment, care and support; stigma and discrimination; and combined reporting.

⁵⁷ OECD. Health at a Glance: Europe 2012. OECD Publishing; Paris: 2012. Available from: <http://dx.doi.org/10.1787/9789264183896-en>

Figure 5.2: Annual average growth rate in health expenditure per capita, in real terms, 2000 to 2010 (or nearest year)



Source: OECD Health Data 2012; Eurostat Statistics Database; WHO Global Health Expenditure Database

5.1 Quality of life

No direct data on quality of life for people living with HIV (PLHIV) was reported to the Dublin monitoring process. However, antiretroviral therapy (ART) reduces both mortality and morbidity associated with HIV. Several studies have reported a strong positive association between ART and improved quality of life in different domains among people living with HIV and AIDS, both in developed and developing countries⁵⁸. Data from Dublin reporting in 2010 and 2012 shows that, between the two rounds of reporting, the number of people on ART rose from more than 300 000 to just over 500 000⁵⁹. Particularly high rates of increase were seen in non-EU/EEA countries. For example, in Azerbaijan and Tajikistan, there was more than an eightfold increase in the number of people receiving ART. The Global Fund has made a significant financial contribution to the scaling up of ART in many non-EU/EEA countries. Funding from the European Commission has made an important contribution to this effort (see Box 4.2). In addition, advocacy activities catalysed by the CSF (see 4.1) are considered to have contributed to an increase in domestic funding for ART in some countries, for example in Ukraine.

However, not everyone who needs ART is receiving it. Some people infected with HIV are unaware of their infection. Many others are diagnosed late. Through the Dublin monitoring process and enhanced HIV/AIDS surveillance, ECDC has championed the importance of the issue of late diagnosis and has begun to track it systematically across the region. Between the two rounds of Dublin reporting, the number of countries reporting data on late diagnoses rose from 21 to 38. The proportion of people living with HIV reported to have had a CD4 count at the time of diagnosis rose from half (50%) to over two thirds (68%). The percentage of late diagnoses among those fell slightly from 53% to 46%.

The quality of life of PLHIV is adversely affected by experience of stigma and discrimination. Between the two rounds of Dublin reporting, the proportion of countries reporting that they had programmes to address stigma and discrimination rose from just over half (53%) to more than three quarters (76%). Activities at the European level, e.g. conferences and discussions in the Think Tank and CSF, may have contributed to the development and shaping of some of these programmes. For example, engagement at the European level was reported to have contributed to the development of a national anti-discrimination plan in Serbia (see Section 4.1).

⁵⁸ See <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3418767/>

⁵⁹ In 34 countries reporting in both rounds.

5.2 Access to key services

Data from the Dublin monitoring process provide information how key populations access important HIV-related services. For example:

- People who inject drugs enjoy moderate to good access to programmes that provide sterile injecting equipment in most EU/EEA countries. This is less the case outside the EU/EEA. However, some non-EU/EEA countries report a high coverage with needle and syringe programmes; these include Kazakhstan, Kosovo, Kyrgyzstan, and Uzbekistan.
- Provision of opioid substitution therapy is widespread across the EU/EEA, but this is much less the case outside the EU/EEA. In a number of countries, opioid substitution therapy is not provided at all.
- Comparable data on coverage of prevention programmes for MSM are available from the European MSM Internet Survey (EMIS), which was funded by the Commission. Between the two rounds of Dublin reporting, coverage of HIV prevention programmes for MSM increased in some non-EU/EEA countries, including Armenia, Azerbaijan, Bulgaria and Kazakhstan.
- There was little change between the two rounds of Dublin reporting in rates of HIV testing, programme coverage, or condom use among sex workers.
- In general, HIV-related services are less available in prisons than in the community in most countries of the region. In most, but not all, EU/EEA countries, it is the norm for opioid substitution therapy to be available in prisons. This is much less the case in countries outside the EU/EEA. Countries which reported for the first time that substitution therapy was available in prisons in the second round of the Dublin monitoring process included Armenia, Bulgaria, Greece, Israel and Malta. Overall, only very few countries outside the EU/EEA have sterile injecting equipment available in prisons.

It is likely that the Commission's Communication and Action Plan has contributed in a number of ways to the increased availability of important HIV-related services for key populations. For example, European Commission funding, channelled through the Global Fund, has directly financed expansion of services in some countries (see Box 4.2). Funding through the European Health Programme has made it possible to test innovative approaches of working with key populations (see Figure 2.4). European agencies have provided valuable technical assistance. For example, EMCDDA has championed the provision of HIV services for prisoners and people who inject drugs. ECDC has highlighted the specific needs of previously overlooked key populations, including prisoners and migrants from high-prevalence countries. ECDC warns that migrants may be at particular risk of late HIV diagnosis in many countries and that undocumented migrants often find it difficult to access health services, for example ART.

5.3 New HIV infections

The European Commission finances Europe-wide HIV surveillance and monitoring, implemented by ECDC and in cooperation with WHO.

Data reported for the Dublin monitoring process suggests that HIV prevalence rates among people who inject drugs are stable or declining in several countries. These include Finland, Germany, and Sweden. Ukraine considers the declining HIV prevalence among people who inject drugs to be evidence of the effectiveness of the Ukrainian HIV prevention programmes among people who inject drugs. However, it is of concern that HIV outbreaks were documented among people who inject drugs in two EU countries (Greece and Romania). This illustrates the risk involved in lacking or ineffective HIV prevention programmes for people who inject drugs and, in the case of Romania, the critical need to sustain funding for essential services.

Reported HIV prevalence among MSM is high in many countries in Europe (above 5% in 16 countries). Overall, HIV prevalence among sex workers is low. However, prevalence appears to be increasing in some countries, for example in Lithuania and Ukraine, and tends to be higher in some sex worker subgroups, such as male sex workers and sex workers who also inject drugs.

6 Conclusions and recommendations

This section summarises the main conclusions concerning action taken in response to the Communication and Action Plan. It highlights those areas where there has been good progress and those where action needs to be intensified. It then proposes a number of recommendations, intended to improve both the implementation of the Communication and Action Plan and the monitoring and future evaluation of the Plan.

6.1 Progress

While there is no specific funding for implementation of the Communication and Action Plan, analysis of available information suggests that the level of financial inputs to support the Communication and Action Plan annually is around EUR 57.5 million. Financing is provided through a range of mechanisms and instruments. These include the Global Fund, the ENPI and structural funds, the European Health Programme, the European Framework Programme for research, agencies of the European Union and international organisations. However, information on the amount of funding provided is only available for some mechanisms and instruments and does not capture all financial inputs.

The largest share of estimated total funding is allocated through the European Framework Programme to research. This has contributed to the development of new treatments and prevention technologies, as well as to research to improve clinical management and patient outcomes. There is also evidence of active engagement with the private sector in the area of biomedical research.

The next largest share is represented by funding for country responses through the Global Fund, followed by resources allocated to the European Health Programme. The European Commission has provided significant funding for national responses to HIV in Europe through the Global Fund, with the largest amounts going to the Russian Federation and Ukraine. Funding for national responses to HIV is also available to priority regions through mechanisms including the ENPI and structural funds.

Funding for the European Health Programme through EAHC in 2009 and 2010 has strengthened national responses, focusing on populations most at risk of HIV, including men who have sex with men, people who inject drugs, sex workers, prisoners, migrants and ethnic minorities, with almost two-thirds of funds allocated to projects targeting these groups. In 2011 and 2012, the Programme's HIV funding was reduced, compared with 2009–2010, and showed a stronger focus on leadership, civil society, and monitoring and evaluation.

Support provided in line with the priorities highlighted in the Communication and Action Plan has resulted in a strong focus on expanding targeted prevention services for populations most affected by HIV, including men who have sex with men, sex workers and people who inject drugs, as well as the provision of HIV-related services in prisons.

Commission funding through the Global Fund has supported the scaling up of HIV-related services in the most affected Member States, neighbourhood countries and the Russian Federation. Based on a review of figures in 2011, it was estimated that, through the Global Fund, the Commission has supported provision of harm reduction services to almost 35 000 people who inject drugs and HIV prevention services to over 10 000 sex workers and their clients, over 13 000 men who have sex with men, and over 25 000 prisoners. In addition, it has supported the provision of HIV counselling and testing services for almost two million people and antiretroviral therapy for over 6 000 people.

Commission support has also contributed to the development of better approaches to service delivery to reach the most-at-risk and marginalised populations. The European Health Programme has supported projects that have tested new approaches to service delivery, such as innovative HIV counselling and testing approaches to increase access for vulnerable groups and promote earlier HIV diagnosis. The issue of HIV among migrant populations has received considerable attention, contributing to a better understanding of factors affecting migrant access to prevention, treatment and care services.

The Communication is an important tool for galvanising political leadership. It has helped to ensure that HIV remains on the agenda and has been used by civil society to frame debate at regional and national levels. The Think Tank and the Civil Society Forum are valuable platforms for policy dialogue and exchange of information and experience, as well as for promoting Europe-wide action and effective communication between the Commission, Member States, EEA and Candidate Countries, civil society and international agencies.

Commission financing for international organisations, international and regional conferences and monitoring the implementation of international and regional commitments has helped to keep HIV on the agenda in Europe and to mobilise political leadership, especially in those countries most affected by the epidemic. Collaboration with international agencies such as UNAIDS and WHO has also helped to ensure common approaches and to facilitate regional responses that reflect epidemic priorities.

Civil society involvement has been supported through funding to build the capacity of non-state actors in ENP countries and through Commission support for and engagement with the Civil Society Forum, which plays a critical role in facilitating dialogue between civil society and policy makers. Participation in the Civil Society Forum has enabled civil society organisations to play a more visible role in national policy dialogue in a number of countries.

Funding for agencies such as ECDC and EMCDDA has emphasised improving knowledge, focusing in particular on epidemiological and behavioural surveillance, monitoring and evaluation, and the evidence base for policy and programming. Specific efforts by EMCDDA, ECDC and projects funded by the European Health Programme have contributed to a better understanding of the impact of the HIV epidemic among those population groups most affected, in particular people who inject drugs, men who have sex with men, and migrants from high prevalence countries. ECDC and EMCDDA were quick at responding to HIV outbreaks among people who inject drugs in several countries, for example Greece and Romania.

Support for ECDC has resulted in significant improvements in HIV-related epidemiological surveillance, especially in the comprehensiveness, quality and dissemination of HIV surveillance data. There has also been progress in strengthening surveillance systems to monitor HIV and TB co-infection. In addition, Commission support has given high priority to strengthening regional cooperation, in particular to ensure coordinated approaches to surveillance, monitoring and reporting of data.

HIV monitoring and reporting have also improved. ECDC efforts have significantly enhanced reporting rates, in regard to Dublin Declaration and UNGASS indicators. Progress has been made towards developing a set of regionally specific and harmonised indicators, which will further improve monitoring of the HIV response in Europe and is expected to reduce the reporting burden.

The Commission has also supported efforts to ensure that policy and programming are based on sound research and evidence. Clinical and operational research is generating important evidence on issues such as the cost-effectiveness of screening strategies for HIV and hepatitis, the clinical management of HIV, and the control of HIV drug resistance. Systematic reviews and evidence papers have informed the development of guidance on approaches to HIV prevention among men who have sex with men and people who inject drugs as well as up-to-date guidance on HIV testing and the potential to use HIV treatment as a prevention strategy.

High priority has been given to sharing scientific and clinical expertise. EU agencies and initiatives financed by the Commission are valuable sources of scientific and technical advice to countries. Evidence, guidance and best practices are also disseminated through the European Parliament, scientific networks and committees, international and regional conferences, policy, technical and scientific publications, databases and clearing houses.

6.2 Challenges

However, there are areas of the Communication and Action Plan that have received less attention or where it is more difficult to identify effects (see Annex).

Better information is needed about country use of mechanisms such as the ENPI and structural funds to fund national responses to HIV. There are also concerns about whether some countries that have been receiving funding from the Global Fund will be committed or able to sustain HIV prevention and treatment, once Global Fund support ends. Sustaining HIV programmes requires stronger political leadership from the Commission as well as from national authorities.

In addition, while European support has made an important contribution to improving both the coverage and the quality of services, more needs to be done to achieve universal access. In particular, it is vital to ensure adequate provision of harm reduction, HIV and TB co-infection services and services for specific population groups, including men who have sex with men, prisoners and migrants.

The balance of research funding does not fully reflect the priorities identified in the Action Plan. Research funding has largely been allocated to biomedical research. While this makes sense, as regional research initiatives have inherent comparative advantages, less funding has been provided for social and behavioural research and socio-economic analysis. In addition, considerable support has been provided to strengthen research capacity, networking and collaboration, but the effects are difficult to assess because little evidence is available on the outcomes of this support.

There is scope to improve political leadership in order to ensure that HIV continues to be given both sufficient priority and European development financing. The potential for EU Presidencies to provide political leadership has not been exploited to the full. Some EU Presidencies, in particular those held by Sweden and Spain, have provided leadership on HIV, while others have not addressed this issue at all.

There is a need to intensify policy dialogue with ENP countries, through existing mechanisms such as Commission Delegations, cooperation agreements and memoranda of understanding, meetings and exchange programmes, to increase political leadership and ensure that the health and rights of vulnerable and marginalised groups are addressed.

Support has been provided to civil society organisations, but there are concerns about the reduced availability of funding for NGOs in a number of countries and the impact of the economic downturn on future funding for civil society. Sustained support is critical if civil society is to continue to contribute to national responses. In addition, it is unclear to what extent support has been provided to promote the involvement of people living with HIV or of those population groups most affected by HIV.

There appears to have been limited action to monitor national HIV policies and specific policies and laws concerning HIV-related discrimination. More needs to be done to ensure that appropriate legislative and policy frameworks are in place and to tackle discrimination in relation to both people living with HIV and marginalised population groups.

Commission engagement with the private sector appears to have had limited impact on antiretroviral pricing and treatment coverage or the coverage of HIV-related workplace programmes. Progress in discussions with the pharmaceutical industry about improved access to and availability of antiretroviral treatment across Europe will require increased commitment by Member States.

While efforts are being made to improve and harmonise behavioural surveillance, more needs to be done to strengthen second generation surveillance and to support enhanced surveillance in EU/EEA Member States, and in particular in ENP countries and the Russian Federation.

Finally, it is difficult to measure the impact of efforts to strengthen the evidence base, promote sharing of experience and disseminate guidance (particularly at the national policy and programming level) as there appears to be little systematic follow up of these activities.

6.3 Recommendations

To improve implementation of the Communication and Action Plan:

Strengthen political leadership on critical issues. Specifically:

- The European Commission and Member States should intensify action to ensure that national responses to HIV are adequately financed, including funding for civil society organisations.
- The European Commission should take the lead in initiating dialogue on how countries can sustain HIV prevention programmes as well as HIV treatment and care services in the context of the current economic downturn and declining support from the Global Fund.
- The European Commission, Think Tank and Civil Society Forum should intensify efforts to ensure that EU Presidencies give high priority to HIV and provide effective leadership. One option would be to explore the possibility of organising a high-level meeting on HIV, similar to the one organised in Dublin in 2004 during the Irish EU Presidency.
- The European Commission should develop and implement a strategy for engagement with the private sector, including the promotion of increased commitment by EU Member States to the dialogue on affordable antiretroviral drugs.

Make better use of the range of mechanisms and instruments available to address the needs of priority groups in priority regions. Specifically:

- The European Commission should make better use of policy dialogue, including mechanisms such as cooperation agreements, exchange programmes and meetings, to promote more effective political leadership in the most affected Member States, ENP countries and the Russian Federation, in particular with respect to services for priority populations.
- The European Commission should ensure that its funding through the European Health Programme and other mechanisms targets those populations most-at-risk, with resource allocation clearly based on the epidemiology of the epidemic.
- The European Commission should review the potential to use ENPI and structural funds to complement national financing of country responses that prioritise targeted prevention services and improve treatment coverage for priority groups. This analysis will need to be conducted in partnership with beneficiary countries, which are expected to provide matching funds.

Build on progress to date to ensure access to prevention, treatment and care and to protect the rights of people living with and affected by HIV. Specifically:

- The European Commission and civil society should sustain advocacy and support for universal access to prevention, treatment and care, expansion of harm reduction services, including NSP and substitution treatment programmes, and integration of HIV and TB services in EU Member States, ENP countries and the Russian Federation.
- The European Commission, Member States and civil society should sustain efforts to step up effective HIV prevention strategies for men who have sex with men.

- The European Commission, Member States and civil society should ensure that analytical work on the situation of migrant populations is translated into policies and programmes to ensure that both documented and undocumented migrants can access HIV prevention, treatment and care services.
- The European Commission and ECDC should monitor policy development and implementation.
- The European Commission, Member States and civil society should intensify efforts to tackle discrimination, including the enactment of anti-discrimination laws and the monitoring of discrimination in relation to HIV status.

Strengthen research and surveillance. Specifically:

- The European Commission should take steps to ensure a more balanced allocation of funding for research, by increasing resources for social, behavioural and economic research and stimulating research in these areas.
- The European Commission, ECDC, EMCDDA, academic institutions and civil society should intensify support for improved behavioural surveillance and analysis of risk behaviour.
- ECDC should increase cooperation with ENP countries and the Russian Federation to strengthen surveillance in these countries.

To improve monitoring and evaluation of the Communication and Action Plan:

Improve the quality of information available about financial and non-financial inputs to support implementation of the Communication and Action Plan. Specifically:

- Maintain accurate data on financing provided by the Commission through different mechanisms and instruments to allow financial inputs to be fully captured.
- Maintain accurate data on HIV-related activities undertaken through Commission Delegations, cooperation agreements, meetings and exchange visits.
- Monitor the quality and impact of projects and other activities funded.

Give higher priority to monitoring and evaluation of activities financed by the Commission. Specifically:

- Ensure that Commission-funded programmes and projects include an evaluation component and measure whether or not the desired effects have been achieved.
- Take a systematic approach to monitoring the impact of actions taken to promote political leadership and strengthen networking and collaboration.
- Monitor the impact of scientific and technical advice and dissemination of evidence, guidance and best practices on national policy and programmes.

Annex: Areas of the Action Plan where intensified action is required

| Actions | Responsible | Comments |
|--|---|---|
| Promote HIV as a public health and social concern, keep it on the political agenda. | Commission, Member States, neighbouring countries, civil society, international organisations | Good progress through Think Tank, Civil Society Forum, international and regional conferences and organisations. More could be done by Commission, EU Presidencies and with neighbouring countries. |
| Tackle discrimination related to HIV status. | Commission, Member States and neighbouring countries, civil society | Limited evidence of action or effects. More needs to be done to ensure laws and policies are implemented and monitored. |
| Develop, implement, monitor and evaluate targeted, regional, national and supranational HIV/AIDS policies. | Member States, civil society, ECDC, international organisations | Limited evidence of concerted action to review policy development/implementation or to evaluate policies. |
| Support civil society through funding and legal support at EU and national level. Involve and consult civil society in HIV policy development and implementation. | National authorities, Commission | Support for civil society needs to be sustained, including by Member States, in light of reduced Global Fund support and economic crisis. |
| Intensify cooperation with the private sector – business and media. Work with the pharmaceutical industry to improve access and availability of treatment across Europe. | Industry, national authorities, Commission, civil society | Commitment in the area of biomedical research. More needs to be done to engage Member States in dialogue with the pharmaceutical industry on HIV drug pricing. |
| Strengthen behavioural surveillance to develop measures leading to reduced risk behaviour. In-depth analysis of trends and dynamics in sexual and drug-related risk behaviour. | ECDC, EMCDDA, academia, Commission, civil society | Initial steps taken to improve behavioural surveillance, but efforts need to be stepped up. |
| Eastern European countries, ENP countries and Russian Federation: obtain universal access to voluntary testing, treatment and care. Introduce and implement effective harm reduction measures for HIV prevention. Prevention and integrated HIV, TB and co-infection treatment, in prisons and other settings. | National authorities, civil society, Commission | Good progress, but more needs to be done to achieve universal access and acceptable coverage. |
| ENP countries and Russian Federation: promote cooperation of EU and neighbouring countries on HIV/AIDS. Involvement of neighbouring countries in HIV-related meetings at EU level. | Commission, Member States, ENP countries | Scope to strengthen cooperation through existing mechanisms and instruments. |
| ENP countries and Russian Federation: Strengthen surveillance by stepping up cooperation between ECDC and ENP institutions. | ECDC, surveillance institutions | Although strides have been made, there is scope to strengthen cooperation. |
| Exchange programmes between Member States and neighbouring countries. | Medical associations, industry, Member States, neighbouring countries, civil society | Scope to make better use of exchange programmes. |
| Intensify promotion of safer sex behaviour among MSM. | Civil society, Member States, neighbouring countries, Commission, ECDC | Good progress, but more needs to be done as risk taking behaviour in MSM is increasing, along with the number of HIV infections and other STIs. |
| Intensify VCT (Voluntary Counselling and Testing) and outreach for MARPs (Most At Risk Populations) | Civil society, Member States, neighbouring countries, medical associations, Commission | Good progress, but more needs to be done to build on this. |
| Implement harm reduction for prevention of HIV and drug-dependency | Member States, neighbouring countries, civil society, Commission | Good progress, but more needs to be done to build on this. |
| Targeted prevention measures and access to services and treatment for migrants | Migrant and ethnic minority organisations, national authorities, Commission, civil society | Important analysis carried out. More needs to be done to develop related policies and programmes. |
| Social, and behavioural research and socio-economic analysis. | ECDC, academia, Commission. Member States, civil society. | Limited funding. Greater efforts needed to stimulate research on these aspects of the epidemic in Europe. |