European Action Plan for HIV/AIDS 2012–2015

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Abbreviations and acronyms

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral
CTX	co-trimoxazole
ECDC	European Centre for Disease Control and Prevention
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
GMP	good manufacturing practices
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HPV	human papillomavirus
IDU	injecting drug user
ILO	International Labour Organization
MDG	Millennium Development Goal
NGO	nongovernmental organization
NCPI	National Commitments and Policy Instrument
OST	opioid substitution therapy
PMTCT	prevention of mother-to-child transmission
PrEP	pre-exposure prophylaxis
PSM	procurement and supply management
SRH	sexual and reproductive health
STI	sexually transmitted infection
TB	tuberculosis
TRIPS	World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WFP	World Food Programme
WTO	World Trade Organization

Foreword

THE EUROPEAN ACTION PLAN FOR HIV/AIDS 2012–2015 is an urgent call to action to the 53 Member States of the Region to respond to the public health challenge of HIV in Europe.

There is a pressing need for action in Europe to tackle: the rapidly increasing numbers of people becoming infected; the social inequities that mean that socially marginalized and stigmatized citizens are the most vulnerable to HIV; the structural barriers that prevent key populations at higher risk from accessing prevention, treatment and care; the scandalously low coverage with life-saving antiretroviral therapy; the impact on the control of tuberculosis, viral hepatitis and other communicable diseases; and the considerable burdens placed on health systems.

Immediate action is possible in a Region rich in experience of effective policies and programmes. In many central and western European countries, effective programmes have stabilized or prevented epidemics. In the western part of the Region, AIDS cases and AIDS mortality have declined as a result of increased access to treatment. Even in the eastern part, where the epidemic is worst, integration and links between HIV and other health programmes are demonstrating some good results. Mother-to-child transmission of HIV has rapidly decreased through the integration of HIV prevention with maternal and child health services. Further, HIV programming in the Region is showing great potential for strengthening health systems. Laws and regulations have been addressed in many countries, and the power of citizens has been harnessed through civil society organizations and community participation.

The Action Plan is anchored in the guiding principles of: equity in health; community participation; human rights; evidence-informed policies and ethical public health approaches. It is structured around four strategic directions: optimize HIV prevention, diagnosis, treatment and care outcomes; leverage broader health outcomes through HIV responses; build strong and sustainable systems; and reduce vulnerability and remove structural barriers to accessing services (addressing social determinants of health). The Plan puts into action in the WHO European Region both the UNAIDS HIV/AIDS Strategy for 2011–2015 and the WHO Global Health Sector Strategy on HIV/AIDS 2011–2015. It is coherent with the European Commission communication on HIV/AIDS 2009–2013.

The Action Plan was endorsed by 53 European Member States at the WHO Regional Committee for Europe in September 2011 in Baku, Azerbaijan. We therefore have the roadmap and the tools to take up the challenge. We need immediate action now.

Zsuzsanna Jakab
WHO Regional Director for Europe

Introduction

The need for action against HIV in the European Region

HIV REMAINS A MAJOR PUBLIC HEALTH CHALLENGE IN THE WHO EUROPEAN REGION,[1] WHICH HAS IN ITS EASTERN PART THE MOST RAPIDLY GROWING HIV EPIDEMIC IN THE WORLD. Although globally the number of people newly infected with HIV is decreasing, in eastern Europe and central Asia[2] it continues to rise *(1).* The annual rate of newly diagnosed HIV cases was stable in central and western Europe between 2004 and 2009, whereas it increased by two-thirds in eastern Europe and central Asia *(2, 3).* An estimated 2.2 million people in the European Region were living with HIV in 2009, of whom 1.4 million were in eastern Europe and central Asia, three times as many as in 2000. Similarly, while the number of diagnosed AIDS cases and AIDS-related mortality have declined in the Region as a whole *(2),* estimated number of AIDS-related deaths in eastern Europe and central Asia showed a fourfold increase during 2001–2009 *(1).*

HIV FURTHER WIDENS SOCIAL INEQUALITIES. HIV in Europe disproportionally affects populations that are socially marginalized and people whose behaviour is socially stigmatized (such as men who have sex with men) or illegal (such as people who use drugs). Specific key populations at higher risk of HIV exposure and infection are: people who inject drugs and their sexual partners; men who have sex with men, transgender people, sex workers, prisoners and migrants (Box 1) *(2, 4).* The HIV epidemic in Europe remains concentrated in these key populations at higher risk and has not generalized to the broader population. In some eastern European and central Asian countries, over 60% of newly diagnosed HIV infections in 2009 were among people who inject drugs *(2, 3, 5).* The association of sex work and injecting drug use is accelerating the spread of HIV in the Region *(1, 6).* In western and central Europe, men who have sex with men accounted for about half of all newly diagnosed HIV infections in 2009 *(2),* a notable increase over the previous five years *(2, 7)*. Among

BOX 1 Key populations at higher risk

The term "key populations at higher risk" refers to the groups most likely to be exposed to HIV or to transmit it *(7)*.

In the European Region, key populations at higher risk are: people who inject drugs and their sexual partners, men who have sex with men, transgender people, sex workers, prisoners and migrants.

The specific populations will be different in different communities and countries. Each country should define the specific populations that are key to their epidemic and response, depending on the epidemiological and social context.

[1] The WHO European Region comprises 53 Member States: Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom, and Uzbekistan.

[2] The eastern European and central Asian countries of the European Region, as defined in the UNAIDS report *(1)*, are: Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

people whose geographical origin was known, those originating from countries with a generalized epidemic accounted for at least 10% of newly diagnosed infections and about one-third of heterosexually acquired infections in 2009 *(2).*

KEY POPULATIONS AT HIGHER RISK IN EUROPE FACE SPECIFIC STRUCTURAL BARRIERS TO ACCESSING HIV SERVICES, such as criminalization of their behaviour, stigma, discrimination, and rules and regulations within and outside the health care system *(1)*. Services to prevent, diagnose and treat HIV infection are often not accessible to, or do not reach, highly vulnerable and disadvantaged individuals and populations, contributing to increasing health inequalities. In eastern Europe and central Asia, only 11% of all investment in HIV prevention is focused on the key populations at higher risk *(1).* In some countries, effective and evidence-based harm-reduction measures for people who use drugs are not implemented or remain at a small scale or in a pilot phase *(1, 8)*. An estimated one-third of people living with HIV in the European Union and European Economic Area, and up to 60% in some eastern European and central Asian countries, are unaware of having been infected, owing to their limited access to and low uptake of HIV testing and counselling services *(9–12).*

IN THE EUROPEAN REGION, THE SOCIALLY MARGINALIZED KEY POPULATIONS AT HIGHER RISK MOST IN NEED OF TREATMENT ARE THE LEAST LIKELY TO RECEIVE IT *(1).* In many countries of the Region, access to life-saving antiretroviral therapy (ART) is among the lowest in the world. While many countries, especially in the western part of the Region, have ART coverage rates among the best in the world, in the Region's low- and middle-income countries only 19% of adults in need[3] were receiving ART in 2009 *(14).* This is only about half the global average for low- and middle-income countries *(14).* While people who inject drugs account for the majority of people living with HIV in eastern Europe and Central Asia, they account for less than 25% of those receiving ART *(15).*

HIV HAS AN IMPACT ON THE CONTROL AND HEALTH OUTCOMES OF OTHER COMMUNICABLE DISEASES. In Europe, tuberculosis (TB) and end-stage liver disease caused by viral hepatitis C infection are among the leading causes of death among people living with HIV, especially among those who are also drug-dependent *(16, 17)*. HIV is the greatest risk factor for developing tuberculosis, and tuberculosis is responsible for more than a quarter of deaths among people living with HIV *(17).* In eastern Europe and central Asia, the estimated coverage of ART among people with TB/HIV co-infection is lower than that for all those with HIV infection *(14)*. Globally, the highest proportions of multidrug-resistant TB are found in countries of eastern Europe and central Asia *(18)*.

INCREASING NUMBERS OF NEW HIV CASES AND THE ABSENCE OF A CURE FOR HIV IMPOSE A CONSIDERABLE RESOURCE BURDEN ON HEALTH SYSTEMS. In the European Region, where many new HIV cases are diagnosed at a late stage, the costs of treatment and care are higher than in other WHO regions; and with a prolonged survival among people who have access to ART, especially in the western part of the Region, these costs will continue to increase in the foreseeable future *(1, 19).* As the HIV-positive population lives longer and their average age increases, they will have a greater prevalence of noncommunicable diseases, including cancers, neurodegenerative disorders and other chronic conditions, leading to an increased need and demand for complex medical case management, care and end-of-life services *(20)*. In the near future, HIV infection may become one of the most costly chronic diseases in the Region.

MANY PREVENTION, TREATMENT, CARE AND SUPPORT PROGRAMMES IN COUNTRIES IN EASTERN EUROPE AND CENTRAL ASIA ARE HIGHLY DEPENDENT ON EXTERNAL INTERNATIONAL FUNDING. Over dependence on external international funding makes countries vulnerable to changing funding priorities and is unsustainable in the long term *(1).* Of 14 eastern European and central Asian

[3] Based on WHO guidelines 2010 *(13)* (treatment initiation at a CD4+ cell counts of ≤350 cells/mm^3).

countries, five reported that they relied on international funds to finance 50% or more of their total HIV spending in 2009 *(1)*. HIV prevention programmes, in particular, rely on international funding *(1)* and prevention efforts for key populations at higher risk remain seriously underfunded in some eastern European and central Asian countries *(15).*

Seizing opportunities for action in the European Region

Although the HIV epidemic continues to spread at an alarming rate in the European Region and treatment is not keeping pace with new infections, countries in the Region are in a position to radically change the situation by seizing opportunities for action.

There is sufficient scientific evidence, as well as an extensive pool of normative guidance, on all aspects of HIV prevention, treatment and care. Aligning national legislation and policies with internationally recognized standards and ensuring their effective implementation will contribute to a successful response to the HIV epidemic.

There is also sufficient evidence and experience, from projects and interventions throughout the Region, to support effective policies and interventions. In particular, further scaling-up of HIV prevention interventions targeting key populations at higher risk is essential to controlling the epidemic in the Region. In many western European countries, over 75% of people who inject drugs have access to needle and syringe programmes (NSPs) and 60% are receiving opioid substitution therapy (OST) *(21)*. Rates of new infections among people who inject drugs have been falling overall in central and western Europe, largely as a result of harm-reduction services *(1, 2).* The overall number of HIV diagnoses among people who inject drugs declined by 40% from 2004 to 2009 in countries of the European Union and European Economic Area *(2)*. In eastern Europe and central Asia, five of nine countries reported in 2009 that more than 80% of people who injected drugs had used sterile injecting equipment at last injection *(1)*. Evidence-informed prevention strategies need to be more widely adopted to control the growing burden of HIV infection *(1, 22, 23).*

Access to ART is increasing. Although coverage of adults in eastern European and central Asian countries continues to be unsatisfactory, the number of people receiving ART there rose by 34% during 2009 *(14)*. A number of countries, high-income as well as low- and middle-income, have managed to achieve sustainable universal access. Antiretroviral therapy has been shown to be 96% effective in reducing heterosexual transmission in couples where one partner has HIV *(24)*. This is further justification for scaling up access to ART and increasing early HIV diagnosis and treatment. All countries in the WHO European Region offer HIV testing and counselling services, but there are substantial differences in availability, accessibility, affordability and quality *(15)*. In the European Union, the proportion of men who have sex with men with a late HIV diagnosis decreased from 25% in 2000 to 10% in 2006 *(7)*. Best practice models from countries in the Region on expansion of access to HIV testing, treatment and care, particularly for key populations at higher risk, should be shared and used to improve coverage, programmes and policies.

Integration and linkages between HIV and other health programmes have shown encouraging results in the Region. For example, rapid progress has been made in addressing the mother-to-child transmission of HIV, especially by integrating HIV prevention into maternal, newborn, child and adolescent health services. In 2009, 93% of all HIV-positive pregnant women in eastern European and central Asian countries received antiretroviral therapy for prevention of mother-to-child transmission (PMTCT). In comparison, the global average for low- and middle-income countries was 53% *(14)*. In the European Region, where key populations at higher risk face many other health threats, further development of integration models and linkages with other health programmes, such as those dealing with tuberculosis, drug dependence, sexual and reproductive health, maternal, newborn, child and

adolescent health, viral hepatitis and noncommunicable and chronic diseases, will strengthen the overall success of each individual programme.

The costs of commodities and services for HIV prevention, diagnosis, treatment and care have decreased substantially over the past five years, and the possibility of additional price reductions and cost-efficiency savings should be further explored *(1, 15)*. In view of the fiscal constraints facing many countries in the European Region, it is imperative to ensure that available resources are invested appropriately in cost-effective programmes, such as increasing the availability of generic medicines, which are used to a greater extent in other WHO regions. Countries should continue to aim to achieve affordability, increase cost-effectiveness and reduce economic barriers to prevention, diagnosis, treatment and care.

Challenges in health systems have implications for HIV efforts. Reduced political commitment and mobilization of resources, coupled with fragmentation of health systems, absence of common goals and systematic planning, a weak health workforce and poor coordination between services and sectors represent obstacles to programmes addressing HIV *(25–28)*. Conversely, implementation of HIV programmes can potentially strengthen health systems. Engaging countries in an ever-increasing regional focus on health systems strengthening will consequently bring substantial benefits to the HIV response as well as broader health systems benefits.

In the western part of the European Region, alignment of national legislation and policies with internationally recognized standards, progressive enforcement of protective laws and increased efforts to protect the human rights of key populations at higher risk have strengthened the response to the HIV epidemic. In other parts of the Region, some laws and regulations that represented obstacles to an effective response to HIV have been addressed. For example, sexual relations between people of the same sex have been decriminalized in all except two countries in the Region, and laws to address HIV-related discrimination in the workplace and travel restrictions have been revised to protect people living with HIV in many countries. Today, the vast majority of countries in the WHO European Region explicitly address or reflect human rights in their national AIDS strategies *(1)*. Nevertheless, implementing the laws remains a considerable challenge throughout the Region *(1, 15)*. Further enforcement of protective laws across the WHO European Region and increased efforts to protect the human rights of key populations at higher risk will strengthen the response to the HIV epidemic.

The European Region has been at the forefront of forming innovative partnerships with civil society (Box 2) *(29)*, including with communities of key populations at higher risk, people living with HIV and NGOs that advocate for and provide services. Several pan-European networks and organizations have emerged, and the number and size of networks of people living with HIV have increased *(15)*. Civil society is a key actor in the formulation, promotion and delivery of change. Community engagement not only increases the effectiveness and scope of implementation efforts, but also plays an important part in the development of policies and programmes. A truly patient-centred approach to diseases such as HIV and tuberculosis needs to be shaped by the patients. Civil society is being consulted more often in the European Region and its involvement in formulating HIV policy and in decision-making has increased in many countries in the Region *(15)*. Civil society should be consulted and involved in a meaningful way, more often and to a greater degree throughout the Region.

BOX 2 Civil society *(29)*

The term "civil society" refers to the wide array of nongovernmental and not-for-profit organizations that have a presence in public life, expressing the interests and values of their members or others, on the basis of ethical, cultural, political, scientific, religious or philanthropic considerations. Civil society organizations (CSOs) include a wide array of organizations, such as community groups, nongovernmental organizations (NGOs), labour unions, indigenous groups, charitable organizations, faith-based organizations, professional associations and foundations.

Framework for action

THE EUROPEAN ACTION PLAN FOR HIV/AIDS 2012–2015 calls for urgent action by the WHO Regional Office for Europe, the Member States and other stakeholders to address the growing HIV epidemic in the Region. The Action Plan proposes areas of intervention within the framework established by the UNAIDS strategy for 2011–2015 *(30)* and the WHO global health sector strategy on HIV/AIDS for 2011–2015 *(31)*.[4] The Action Plan is based on the four strategic directions of the WHO global strategy, with proposals for implementation that reflect the European context and address the priorities of the Region.

The Action Plan further builds on other relevant global and regional strategies and policies, notably the achievements and experiences of the "3 by 5" initiative *(32)*, the five strategic directions of the WHO HIV/AIDS universal access plan 2006–2010 *(33)*, the United Nations Declaration of Commitment on HIV/AIDS *(34, 35)*, the 2011 Political Declaration on HIV/AIDS *(36)*, and the 2004 Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia *(37).*

The Action Plan also builds on the work already done by the WHO Regional Office for Europe, guided by the far-reaching resolution RC52/R9 on scaling up the HIV response in the Region, which was adopted in 2002 by the fifty-second session of the WHO Regional Committee for Europe *(38).*

The Action Plan takes into consideration the broad global HIV, health and development architecture and existing commitments. It directly supports existing commitments to achieve the Millennium Development Goals (MDGs) (Box 3 and Fig. 1) and is coherent with the European Commission communication on HIV/AIDS 2009–2013 *(39)* and the 2008 Tallinn Charter on Health and Wealth *(40).* The health sector[5] is at the centre of the response to HIV, but it must work with other sectors in order to tackle the social determinants and social inequities that shape the epidemic. The Action Plan emphasizes the need to build stronger intersectoral partnerships for more coherent policy, address social determinants of health, and engage meaningfully with civil society. These actions are also clear priorities of the forthcoming European policy for health – Health 2020 *(41, 42)*.

The Action Plan is guided by evidence and results, and is rooted in ethical public health approaches, as reflected in existing technical guidelines for the HIV response to key populations at higher risk *(43–48)*, as well as clinical protocols, guidelines and strategies *(49–54)*.

The Action Plan is coherent with the priorities and strategies of related programmes and sectors, including: global and regional tuberculosis strategies and TB/HIV collaborative guidelines *(55–60)*; strategies for control of sexually transmitted infections (STIs) *(61)* and for sexual and reproductive health *(62, 63)*; control of hepatitis *(49, 64)*; prevention and control of noncommunicable diseases *(65, 66)*; broader strategies for health system strengthening *(67–70)*; and other related policies and recommendations *(71, 72).*

The Action Plan is anchored in the following guiding principles: equity in health (particularly relevant in the European Region, where key populations at higher risk of HIV infection have the poorest access to health services); community participation; human rights; evidence-informed policies; and ethical public health approaches.

[4] Adopted by consensus by the Sixty-fourth World Health Assembly in May 2011: (http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_R14-en.pdf).

[5] The health sector encompasses organized public and private health services, health ministries, NGOs, community groups and professional associations, as well as institutions that have direct input into the health care system, such as the pharmaceutical industry and teaching institutions *(4, 31).*

Vision and goals

The vision for the European Region is zero new HIV infections, zero AIDS-related deaths and zero discrimination in a world in which people living with HIV are able to live long, healthy lives.

The goals for the European Region are:

1. to halt and begin to reverse the spread of HIV in Europe by 2015;
2. to achieve universal access to comprehensive HIV prevention, treatment, care and support by 2015; and
3. to contribute to the attainment of Millennium Development Goal 6 and other health-related Millennium Development Goals (3, 4, 5 and 8), particularly to halt and begin to reverse the incidence of tuberculosis in Europe.

BOX 3 The Action Plan and the MDGs

The Action Plan contributes to reaching MDGs 3, 4, 5, 6 and 8, and specifically the following MDG targets.

3A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015.

4A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.

5A: Reduce by three quarters the maternal mortality ratio.

5B: Achieve universal access to reproductive health

6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS.

6B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it.

6C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

8E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.

Priorities and actions for Member States

THE EUROPEAN ACTION PLAN FOR HIV/AIDS 2012–2015 is structured around the same four strategic directions for the HIV response as the WHO Global Health Sector Strategy on HIV/AIDS 2011–2015 (Box 4).

These strategic directions are mutually supportive and highly inter-related (Fig. 1). It is essential to address all of them comprehensively if the goals, objectives and targets for the European Region are to be reached.

For each of the four strategic directions, the Action Plan specifies priority areas of intervention that reflect the European context, indicating what should be achieved (objectives and targets) and how (priority actions) in the European Region.

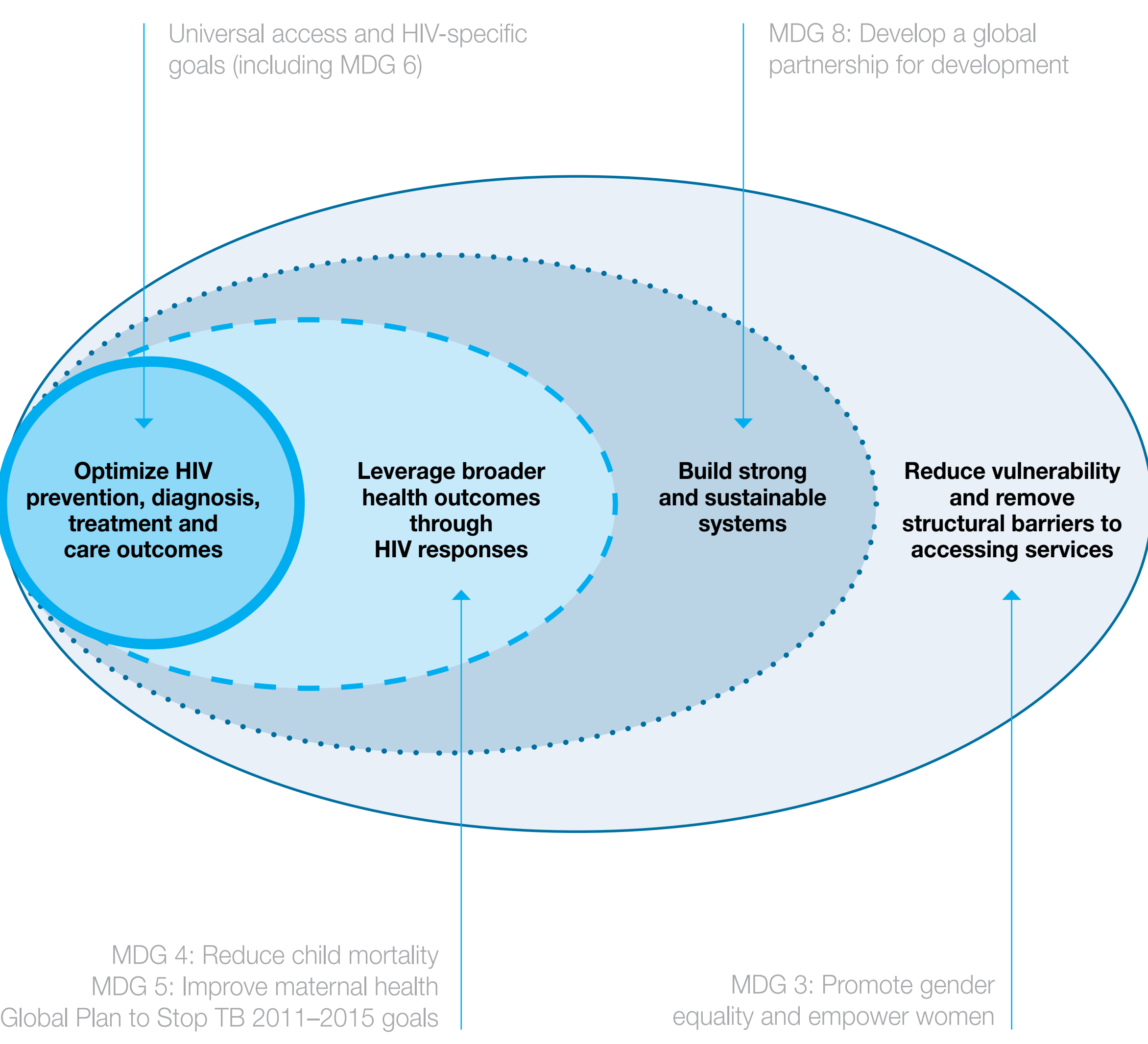
There are 23 priority areas with appropriate actions, focused on key populations at higher risk and services delivered primarily by the health sector. The targeted interventions and actions are those that will have the greatest impact on HIV prevention, treatment, care and support *(73).*

Member States are encouraged to set national objectives and targets in accordance with those proposed in the Action Plan and to adopt areas of intervention and implement priority recommended actions when preparing and revising their national HIV strategies and responses. The proposed targets are indicative and Member States should set their own targets for each intervention, according to the situation in the country. The targets set should be ambitious but realistic, and should allow countries to monitor whether they are having an impact on the epidemic.

BOX 4 Strategic directions

1. Optimize HIV prevention, diagnosis, treatment and care outcomes.
2. Leverage broader health outcomes through HIV responses.
3. Build strong and sustainable systems.
4. Reduce vulnerability and remove structural barriers to accessing services (addressing the social determinants of health).

FIG. 1 **Relationship between strategic directions and existing global goals**[6]



[6] Adapted from the WHO Global Health Sector Strategy on HIV/AIDS 2011–2015 *(31).*

Optimize HIV prevention, diagnosis, treatment and care outcomes

HIV PREVENTION, diagnosis, treatment, care and support services are central to the HIV response. Because the HIV epidemic in the European Region is concentrated in certain key populations at higher risk, the response should focus on these key populations, i.e. people who inject drugs and their sexual partners, men who have sex with men, transgender people, sex workers, prisoners and migrants.

The coverage and quality of HIV prevention, diagnosis, treatment, care and support interventions should be improved. This should be done within the UNAIDS/WHO "prevention revolution" and "treatment 2.0" initiatives *(30, 31),* adapted to the European context. Countries should implement evidence-informed HIV-specific prevention interventions in the key populations at higher risk in which transmission is actually occurring, and scale up efforts to improve access to services for the people that do not currently benefit from HIV programmes.

Optimizing HIV prevention, diagnosis, treatment, care and support outcomes has the following priority areas of intervention.

- **1.1** **HIV testing and counselling:** to reduce the size of the undiagnosed population and the number of late HIV diagnoses, by expanding access to and increasing early uptake of HIV testing and counselling services, especially in key populations at higher risk.
- **1.2** **HIV transmission through injecting drug use:** to prevent new HIV infections in people who use drugs, by implementing the comprehensive harm reduction package of interventions for injecting drug users *(43),* including needle and syringe programmes and opioid substitution therapy.
- **1.3** **Sexual transmission of HIV, particularly in men who have sex with men, in the context of sex work and among migrants:** to prevent sexual transmission of HIV, by implementing behaviour change communication, increasing access to reliable, affordable and high quality condoms and water based lubricants and other specific priority actions.
- **1.4** **Mother-to-child transmission of HIV:** to eliminate the vertical transmission of HIV, by ensuring provider-initiated testing and counselling of pregnant women, antiretroviral therapy for women during pregnancy and postpartum and for newborns, access to safe infant formula and other specific priority actions.
- **1.5** **HIV treatment and care:** to ensure universal access to treatment and care for people living with HIV and to comprehensively address health issues among people living with HIV, including prevention and treatment of co-infections and co-morbidities.
- **1.6** **HIV transmission in health care settings:** to eliminate HIV transmission in health care settings, by implementing comprehensive infection control strategies and procedures including standard precautions, injection and surgical safety, blood safety, safe waste disposal and post-exposure prophylaxis for occupational exposure to HIV.

1.1 HIV testing and counselling

Objective
To reduce the size of the undiagnosed population and the number of late HIV diagnoses, by expanding access to and increasing early uptake of HIV testing and counselling services, especially in key populations at higher risk.
Target for the WHO European Region by 2015
More than 90% of individuals in key populations at higher risk, and more than 95% of pregnant women and exposed infants, will have been tested and know their test result.

Priority actions

1.1.1 Ensure that HIV testing services meet basic ethical standards: voluntary, informed, consent-driven, confidential, and accompanied by adequate pretest information or counselling, and post-test counselling.

1.1.2 Ensure that everyone who is tested for HIV is referred to HIV prevention services and has access to HIV treatment, care and support as needed as soon as possible.

1.1.3 Promote provider-initiated testing and counselling within all settings dealing with tuberculosis, sexually transmitted infections, viral hepatitis, drug dependence, primary health care, and sexual and reproductive health (antenatal, family planning, adolescent sexual and reproductive health centres, childbirth and postpartum services), and in all health care settings for people who have signs and symptoms suggestive of underlying HIV infection, including primary HIV infection.

1.1.4 Provide HIV testing and counselling services in the prison system of equal standards as provided in the civil sector.

1.1.5 Elaborate and implement appropriate HIV testing and counselling policies and service delivery models that meet the needs of key populations at higher risk, including providing tests through outreach services, in locations and conditions convenient to clients (e.g. in prisons and NGO settings).

1.1.6 Promote rapid HIV testing when and where appropriate (in particular for key populations at higher risk and pregnant women presenting at labour with unknown HIV status).

1.1.7 Promote the involvement of non-medical settings and personnel in providing HIV testing and counselling services, including community-based HIV testing and counselling.

1.2 HIV transmission through injecting drug use

Objective
To prevent new infections among people who inject drugs, by implementing a comprehensive harm reduction package of interventions for drug users *(43)*.
Target for the WHO European Region by 2015
To reduce the number of new infections acquired through injecting drugs by 50%.

Priority actions

1.2.1 Implement needle and syringe programmes in all settings where people inject drugs, including prisons and pretrial detention centres.[7]

1.2.2 Provide opioid substitution therapy and other drug-dependence treatment for people who inject opioid-based drugs, including prisoners.[8]

1.2.3 Ensure that people who inject drugs and their partners have access to HIV testing and counselling services.[9]

1.2.4 Ensure that HIV-positive people who inject drugs have access to ART.[10]

1.2.5 Ensure that people who inject drugs have access to services for prevention and treatment of sexually transmitted infections.[11]

1.2.6 Ensure that people who inject drugs and their partners have access to condoms, including through targeted programmes.

1.2.7 Ensure that people who inject drugs have access to PMTCT services.

1.2.8 Provide targeted information, education and communication to people who inject drugs and their partners.

1.2.9 Provide diagnostic, treatment and immunization services for viral hepatitis to people who inject drugs.

1.2.10 Provide services for prevention, diagnosis and treatment of tuberculosis to people who inject drugs.

1.2.11 Ensure that initiatives for people who inject drugs are accompanied by equivalent efforts to provide supportive social, policy and legal environments.

[7] Recommended coverage: more than 60% of people who inject drugs are regularly reached by needle and syringe programmes *(43)*.
[8] Recommended coverage: more than 40% of opioid-dependent people are receiving OST *(43)*.
[9] Recommended coverage: more than 75% of people who inject drugs have been tested for HIV during the past 12 months and received the results *(43)*.
[10] Recommended coverage: more than 75% of HIV-positive injecting drug users for whom ART is indicated are receiving it *(43)*.
[11] Recommended coverage: more than 50% of injecting drug users have been screened for STIs in the past 12 months *(43)*.

1.3 Sexual transmission of HIV

Objective

To prevent sexual transmission of HIV, particularly among men who have sex with men, in the context of sex work and among migrants.

Target for the WHO European Region by 2015

To reduce the number of new HIV infections acquired through sexual transmission by 50%, including among men who have sex with men, in the context of sex work and among migrants.

Priority actions

1.3.1 Provide behaviour change communication, including through targeted information, education and communication, in particular to key populations at higher risk and people living with HIV, and sexual partners of key populations at higher risk and of people living with HIV, including serodiscordant couples and people in prisons and pretrial detention centres.

1.3.2 Employ appropriate communication channels,[12] based on the local context and client preferences, and target venues,[13] using age-, gender-, language- and culture-sensitive approaches.

1.3.3 Implement comprehensive age-appropriate sex/sexuality education.

1.3.4 Ensure that key populations at higher risk have reliable and affordable access to commodities for prevention of HIV transmission, including high-quality condoms (both male and female) and water-based lubricants. These may be sold at subsidized rates or distributed for free in locations where high concentrations of key populations at higher risk are found, including prisons and pretrial detention centres.

1.3.5 Provide post-exposure prophylaxis for people who have been exposed to HIV.

1.3.6 Introduce innovative prevention approaches subject to scientific evidence of effectiveness, e.g. pre-exposure prophylaxis (PrEP) and microbicides.

1.3.7 Introduce earlier start of ARV treatment as a form of combination prevention intervention in serodiscordant heterosexual couples

1.3.8 Scale up access to and uptake of HIV testing and counselling, STI prevention, STI screening, early treatment and care for STIs, and immunization against human papillomavirus (HPV) and hepatitis B virus (HBV), in particular for key populations at higher risk and their sexual partners, and people living with HIV and their sexual partners, including serodiscordant couples, and people in prisons and pretrial detention centres.

[12] Possible channels include personal communication, counselling, social and mass media, internet, mobile phones, printed materials, outreach activities.

[13] Target venues are places where there is an increased likelihood of risk behaviour occurring, e.g. sex venues, parks, motels, truck stops, bus and train stations, harbours, markets and construction sites.

1.4 Mother-to-child transmission of HIV

Objective
To eliminate vertical transmission of HIV.
Target for the WHO European Region by 2015
To reduce the vertical transmission of HIV to <2% in the non-breastfeeding population and <5% in the breastfeeding population.

Priority actions

1.4.1 Revise national PMTCT protocols on the basis of global and regional guidelines.

1.4.2 Ensure provider-initiated HIV testing and counselling of pregnant women, including at labour and delivery, or postpartum.

1.4.3 Provide antiretrovirals during pregnancy, delivery and postpartum, in line with international recommendations.

1.4.4 Administer antiretrovirals to newborns of HIV-positive mothers, in line with international recommendations.

1.4.5 Ensure access to prevention of unintended pregnancies in women living with HIV and access to safe abortion services for women living with HIV in case of unintended pregnancies

1.4.6 Provide access to user-friendly PMTCT services for key populations at higher risk and adolescents.

1.4.7 Establish effective linkages between PMTCT services and HIV treatment and care services.

1.4.8 Ensure access to safe infant formula; where safe infant formula is not available, promote exclusive breastfeeding.

1.4.9 Increase male involvement in PMTCT programmes in order to improve uptake.

1.5 HIV treatment and care

Objective

To ensure universal access to treatment and care for people living with HIV and to comprehensively address their health problems, including preventing and treating co-infections and co-morbidities.

Target for the WHO European Region by 2015

All countries in the Region will have scaled up ART coverage to at least 80% of people in need, including 100% of diagnosed people living with HIV with a CD4 cell count of less than 350 cells/mm^3.

Priority actions

1.5.1 Adapt and approve clinical protocols for treatment of HIV infection and update the protocols regularly in accordance with the European context.

1.5.2 Ensure early enrolment and retention in HIV treatment and care programmes of everyone diagnosed with HIV, with special emphasis on key populations at higher risk.

1.5.3 Ensure appropriate treatment and care for HIV-positive infants and children.

1.5.4 Provide psychological and social support to improve adherence to treatment, ensuring minimal interruptions to, or discontinuation of, ART.

1.5.5 Ensure screening for and treatment of co-infections with tuberculosis, hepatitis B and hepatitis C, as well as other co-morbidities, including metabolic diseases, mental health conditions and malignancies.

1.5.6 Immunize people living with HIV against vaccine-preventable diseases, such as hepatitis B, pneumonia and influenza.

1.5.7 Provide palliative and end-of-life care and support.

1.5.8 Monitor and address development of HIV drug resistance.

1.5.9 Ensure that treatment and care are voluntary, including for prisoners.

1.5.10 Introduce earlier start of ARV treatment as a form of combination prevention intervention in serodiscordant heterosexual couples.

1.6 HIV transmission in health care settings

Objective
To eliminate transmission of HIV in health care settings, using a multidisciplinary approach.
Target for the WHO European Region by 2015
To reduce nosocomial transmission of HIV by 80%.

Priority actions

1.6.1 Promote and coordinate the development of strategies, tools and guidelines to ensure universal access to safe blood and blood products.

1.6.2 Increase voluntary unpaid blood donation and eliminate paid donation.

1.6.3 Strengthen capacities for quality assured screening of all donated blood for HIV.

1.6.4 Increase capacities in patient blood management, improving prevention and integrated care, and reducing the number of unnecessary transfusions.

1.6.5 Develop and implement tools and guidelines to ensure rational and safe use of injections.

1.6.6 Establish and monitor implementation of hazard reduction protocols for invasive diagnostic and therapeutic procedures, haemodialysis and organ transplantation.

1.6.7 Ensure safe disposal of sharps and other blood-contaminated material, and safe and environmentally friendly management of hazardous and infectious waste in health care services.

1.6.8 Strengthen basic infection control precautions in all health care settings.

1.6.9 Identify and eliminate or control exposure hazards in the workplace.

1.6.10 Develop culturally adapted communication, education and training strategies, targeting health care workers, patients and the community, to increase awareness of and reduce safety hazards in health care settings.

1.6.11 Provide post-exposure prophylaxis for people who have been exposed to HIV, in occupational and non-occupational settings.

Leverage broader health outcomes through HIV responses

THE HIV RESPONSE can potentially have a positive impact on other health outcomes. At the same time, integrating programmes and services has the potential to achieve better HIV outcomes. The general principle underlying integration is the promotion of a patient-centred approach through better collaboration and alignment within and between services.

Integration is best seen as a continuum. It may be implemented across different levels, i.e. governance, organization, funding, and service delivery, and between different entities – public, private and nongovernmental (Box 5) *(74–77).*

Integration should be based on models that have been shown to be effective in the European Region, where the key populations at higher risk of HIV exposure and infection face many other health threats. Where full integration is not possible, there should be close linkages, ensuring proper exchange of information, and timely initiation of testing, treatment and other relevant services. Monitoring and evaluation of linkages and integration models, exchange of lessons learnt and best practices should be applied across programmes to leverage health outcomes and strengthen programme management.

Leveraging broader health outcomes through HIV responses has the following priority areas of intervention.

2.1 **Tuberculosis programmes:** to reduce the burden of tuberculosis among people living with HIV, and that of HIV in people with tuberculosis, by implementing collaborative activities and integrating tuberculosis and HIV programmes, especially recognizing the high proportions of multidrug-resistant and extensively drug-resistant tuberculosis in the Region and the high proportions of people who inject drugs, migrants and prisoners who have both diseases.

BOX 5 Definitions of integration of health services

"… the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system." *(75)*

"… a process where disease control activities are functionally merged or tightly coordinated with multifunctional health care delivery." *(76)*

"... the process of bringing together common functions within and between organizations to solve common problems, developing a commitment to shared vision and goals and using common technologies and resources to achieve these goals." *(77)*

2.2 **Drug dependence programmes:** to integrate the comprehensive harm-reduction package of HIV prevention, treatment, care and support interventions (43) and other services into programmes for people who inject drugs, particularly recognizing that most people living with HIV in the eastern part of the European Region are people who inject drugs.

2.3 **Sexual and reproductive health programmes:** to improve sexual and reproductive health and HIV outcomes, by strengthening links between services, especially recognizing: the sexual health needs of men who have sex with men (in the western part of the European Region and increasingly in the eastern part); the sexual and reproductive health needs of women who inject drugs and of the female partners of men who inject drugs, especially in the eastern part of the Region; and the sexual and reproductive health needs of sex workers throughout the Region.

2.4 **Maternal, newborn, child and adolescent health programmes**: to improve maternal (especially for women who inject drugs in the eastern part of the Region), newborn, child and adolescent health and HIV outcomes, by strengthening the links between services.

2.5 **Viral hepatitis programmes:** to reduce the particularly high burden of HIV and viral hepatitis B and C co-infection in Europe (especially among people who inject drugs) by integrating services.

2.6 **Noncommunicable and chronic disease programmes:** to reduce the burden of noncommunicable and chronic diseases among people living with HIV, by improving the links between programmes.

2.1 Tuberculosis programmes

Objective
To reduce the burden of TB/HIV co-infection by implementing collaborative activities and integrating HIV and tuberculosis programmes.
Target for the WHO European Region by 2015
To reduce the number of deaths from tuberculosis among people living with HIV by 50%.

Priority actions

2.1.1 Develop, implement and strengthen joint policies, guidelines and standard operating procedures for prevention and management of HIV/TB co-infection.

2.1.2 Establish functional coordinating committees for tuberculosis, HIV, drug dependence and prison-related health services.

2.1.3 Decrease the tuberculosis burden among people living with HIV by ensuring:
- intensified tuberculosis case-finding and diagnosis among people living with HIV;
- provision of isoniazid preventive therapy to people living with HIV in whom active tuberculosis has been reliably excluded;
- screening for tuberculosis drug resistance and timely initiation of high-quality tuberculosis treatment;
- integrated infection control plans for tuberculosis to minimize transmission in health care and congregate settings, including prisons and pretrial detention centres.

2.1.4 Decrease the burden of HIV among TB patients by providing:
- HIV testing and counselling for all those with confirmed or suspected tuberculosis;
- HIV prevention services (condom provision, screening and treatment for sexually transmitted infections, harm reduction and referral to PMTCT services) for tuberculosis patients, including those living with HIV;
- co-trimoxazole preventive therapy for tuberculosis patients living with HIV;
- HIV treatment, care and support for all tuberculosis patients living with HIV.

2.2 Drug dependence programmes

Objective
To integrate the comprehensive harm-reduction package of HIV prevention, treatment and care interventions (43) and other services into programmes for people who inject drugs.
Target for the WHO European Region by 2015
The majority of Member States will have integrated the comprehensive package of HIV prevention, treatment and care interventions *(43)* and other services into all programmes for people who inject drugs.

Priority actions (see also section 1.2)

2.2.1 Establish coordination at policy level, to ensure that public health concerns are given appropriate consideration in national drug policy and control programmes (public safety and control).

2.2.2 Develop and review policies and adapt clinical guidelines on integrated care for people who use drugs (including people who use amphetamine-type stimulants and cocaine and non-injecting drug users)

2.2.3 Increase access to and promote use of drug dependence treatment (including but not limited to opioid substitution therapy) to prevent HIV, hepatitis C and other infections and to support adherence to treatment of HIV, tuberculosis and other infections.

2.2.4 Ensure that people who use drugs have access to programmes to prevent and manage overdose.

2.2.5 Promote harm-reduction programmes as an entry point to maternal health, reproductive health and sexual health care.

2.3 Sexual and reproductive health programmes

Objective

To improve sexual and reproductive health and HIV outcomes by strengthening linkages between HIV and sexual and reproductive health services.

Target for the WHO European Region by 2015

In the majority of Member States, more than 60% of sexual and reproductive health facilities will have links to, or offer, HIV-related services.

Priority actions

2.3.1 Develop and adopt, or modify, relevant policies, strategic plans and coordination mechanisms, to foster effective links, integration and collaboration between HIV and sexual and reproductive health (SRH) services.

2.3.2 Provide easy, unrestricted, equal access to quality SRH services for people in key populations at higher risk and people living with HIV, and their sexual partners.

2.3.3 Ensure that SRH services are linked to, promote or deliver, as appropriate, HIV-specific and related services including:
- HIV testing and counselling;
- PMTCT and ART services;
- prevention, diagnosis, treatment and care of sexually transmitted infections; and
- promotion of safe sex, counselling on reproductive choices for people living with HIV and their partners, and other positive prevention interventions.

2.3.4 Ensure that HIV-specific services are linked to, promote or deliver, as appropriate, sexual and reproductive health services, including:
- promotion of safe sex;
- access to condoms;
- family planning counselling;
- prevention, diagnosis, treatment and care of sexually transmitted infections;
- cervical cancer screening and management; and
- prevention and management of sexual violence.

2.3.5 Broaden services to reach key populations at higher risk, including through outreach.

2.4 Maternal, newborn, child and adolescent health programmes

Objective

To improve maternal, newborn, child and adolescent health and HIV outcomes by strengthening linkages between services.

Target for the WHO European Region by 2015

In the majority of Member States, more than 60% of facilities offering maternal, newborn, child and adolescent health services will have links to, or offer, HIV-related services.

Priority actions

2.4.1 Develop and adopt, or modify, relevant policies, strategic plans and coordination mechanisms, to foster effective linkages and integration between HIV and maternal, child and adolescent health services, at all levels of health care provision, including primary health care.

2.4.2 Provide easy, unrestricted, equal access to quality maternal, child and adolescent health services for people in key populations at higher risk and people living with HIV, and their sexual partners.

2.4.3 Ensure that maternal, child and adolescent health services are linked to, promote or deliver, as appropriate, HIV-specific and related services, including:
- HIV testing and counselling;
- PMTCT and ART services;
- prevention, diagnosis, treatment and care of sexually transmitted infections; and
- promotion of safe sex, counselling on reproductive choices for people living with HIV and their partners, and other positive prevention interventions.

2.4.4 Ensure that HIV-specific services are linked to, promote or deliver, as appropriate, sexual and reproductive, maternal, child and adolescent health services, including:
- family planning;
- quality antenatal, perinatal and postnatal care;
- newborn and child care; and
- support for infant feeding and immunization.

2.4.5 Broaden services to reach key populations at higher risk, including through outreach.

2.5 Viral hepatitis programmes

Objective
To reduce the particularly high burden of HIV and viral hepatitis co-infection in Europe (especially among people who inject drugs) by integrating services.
Target for the WHO European Region by 2015
To reduce the burden of HIV and viral hepatitis co-infection by 50%.

Priority actions

2.5.1 Revise national clinical guidelines on HIV and viral hepatitis co-infection, in accordance with European recommendations.

2.5.2 Offer HIV testing and counselling to all patients infected with hepatitis C virus (HCV) or hepatitis B virus (HBV).

2.5.3 Provide screening and diagnosis for hepatitis B and C to all people who inject drugs and all people living with HIV.

2.5.4 Provide services for prevention of mother-to-child transmission of HBV to women co-infected with HIV and HBV.

2.5.5 Offer immunization against hepatitis B to key populations at higher risk and their sexual partners, and to people living with HIV and their sexual partners, including serodiscordant couples and people in prison or pretrial detention centres.

2.5.6 Link viral hepatitis services to needle and syringe programmes and drug dependence treatment, particularly opioid substitution therapy for people who inject opioid-based drugs.

2.5.7 Provide access to ART for people co-infected with HIV and HCV or HBV.

2.5.8 Provide treatment for HBV to all people in need co-infected with HIV and HBV.

2.5.9 Provide appropriate treatment and care for HCV to all people in need co-infected with HIV and HCV.

2.6 Noncommunicable and chronic disease programmes

Objective
To reduce the burden of noncommunicable and chronic diseases among people living with HIV, by improving links between programmes.
Target for the WHO European Region by 2015
80% of people living with HIV and with a noncommunicable or chronic disease will receive quality management.[14]

Priority actions

2.6.1 Elaborate national policies and other normative documents to ensure quality management of people with both HIV and a noncommunicable or chronic disease.

2.6.2 Adapt existing programmes to manage non communicable and chronic diseases to address common health complications in people living with HIV, including:

- prevention and treatment of conditions associated with long-term ART and ageing;
- cervical cancer screening and management for women living with HIV;
- cancer management;
- prevention of cardiovascular disease and lifestyle interventions (with regard to smoking, alcohol use, nutrition and exercise).
- integration of palliative care of people living with HIV with services for other chronic diseases.

[14] As defined in the Action plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 (http://www.euro.who.int/__data/assets/pdf_file/0003/147729/RC61_edoc12.pdf).

Build strong and sustainable systems

EFFECTIVE HIV RESPONSES require strong health systems; conversely, health systems can benefit from investment in HIV. The positive effects of HIV programmes on health systems, such as development of human resources, improved procurement management, improved quality assurance mechanisms, strengthened surveillance systems and improved donor coordination, should be actively planned and pursued.

At the country level, key actions are recommended to ensure synergy between national HIV programmes and the development of the health system.

Building strong and sustainable systems has the following priority areas of intervention.

3.1 **Strategic information obtained through surveillance, monitoring and evaluation:** to strengthen HIV/AIDS strategic information systems in the European Region, by continuing to develop comprehensive national plans for HIV surveillance, estimation, monitoring and evaluation, and by ensuring that strategic information, including epidemiological and programme data, financial information and research findings, is analysed and better used at national and regional levels to inform policy decisions and programme planning.

3.2 **Service delivery models:** to ensure that HIV health services meet the needs of service users, including the particular needs of key populations at higher risk in the European Region, who often face many other health threats, stigma and discrimination; this should be achieved through decentralization (where appropriate), integration and other specific activities, including involving civil society organizations in delivering services and providing sustainable support to ensure access, particularly of key populations at higher risk, to HIV prevention, treatment, care and support.

3.3 **Medicines, diagnostics and other commodities:** to ensure that HIV medicines, diagnostics and other commodities are affordable, quality assured and supplied without interruption, by revising legislation (where appropriate) and building capacity and systems for ensuring open, transparent, competitive (when possible) and uninterrupted procurement of medicines, diagnostics and other commodities, monitoring prices of medicines and commodities, and other specific priority actions.

3.4 **Improving quality:** to improve the quality of HIV services, by defining and funding quality improvement systems in national HIV strategies and action plans, promoting participatory quality development in HIV prevention, treatment, care and support and advocating for programmes to be designed in accordance with the expectations of clients, recognizing the particular vulnerabilities of key populations at higher risk in the European Region.

3.5 **Health financing:** to ensure that financing mechanisms allow sustained coverage with HIV interventions that reach target populations as efficiently and equitably as possible, by promoting sustainability, attracting domestic resources, improving the cost-effectiveness of service delivery models, aligning funding mechanisms explicitly to support these, and other specific priority actions.

3.6 **Governance, partnerships, intersectoral action and alignment:** to improve governance, partnerships, intersectoral action and alignment in the HIV response, through a set of specific priority actions.

3.7 **Health workforce:** to strengthen human resource capacity to respond to the HIV epidemic, through a set of specific priority actions.

3.1 Strategic information obtained through surveillance, monitoring and evaluation

Objective

To further strengthen HIV/AIDS strategic information systems.

Target for the WHO European Region by 2015

All Member States will collect, collate, report, analyse and use HIV/AIDS strategic information, using standard data collection and estimation methods and recommended indicators.

Priority actions

3.1.1 Ensure that strategic information systems provide data in a routine, timely, standardized manner, and are consistent in terms of methods, tools and populations surveyed.

3.1.2 Ensure that strategic information, including epidemiological and programme data, financial information and research findings, is analysed and used to inform policy decisions and programme planning.

3.1.3 Develop one comprehensive national HIV monitoring and evaluation plan, as part of the national HIV strategy, including surveillance and estimation, based on WHO/UNAIDS[15] and other appropriate guidance and tools.

3.1.4 Strengthen HIV surveillance systems within the framework of second generation HIV surveillance *(78–80)*, including behavioural and sentinel surveillance and surveillance of co-infections, especially in key populations at higher risk.

3.1.5 Strengthen case-based national reporting systems, including for HIV-related mortality, and ensure high data quality, timeliness and completeness, notably regarding sex, age, CD4 cell count, probable transmission mode and source of infection for heterosexually acquired infections.

3.1.6 Improve routine monitoring and evaluation of the national response to HIV, and of progress towards universal access, including for key populations at higher risk and people with co-infections, based on well defined standardized data collection tools and indicators, with a clear indication of data flow and disaggregation of data by age and sex.

3.1.7 Ensure a functioning patient monitoring system and develop a strategy to prevent and assess HIV drug resistance.[16]

3.1.8 Strengthen operational research and increase research capacity as an important tool to improve programme functioning and to inform policy decisions.

[15] UNAIDS/WHO Working Group on Global HIV/AIDS and STI surveillance, (http://www.who.int/hiv/strategic/surveillance/workinggroup/en/).

[16] See also the European strategic action plan on antibiotic resistance (http://www.euro.who.int/__data/assets/pdf_file/0008/147734/wd14E_AntibioticResistance_111380.pdf).

3.2 Service delivery models

Objective
To ensure that health services meet the needs of service users, recognizing the particular needs of key populations at higher risk.
Target for the WHO European Region by 2015
HIV services in all Member States will meet the eight key characteristics[17] of good service delivery in a well functioning health system.

Priority actions

3.2.1 Provide user-friendly health services that are accessible and acceptable, and that address the needs of service users, including key populations at higher risk.

3.2.2 Encourage meaningful involvement of key populations at higher risk in the design, management, implementation, monitoring and evaluation of programmes (see also section 4.3).

3.2.3 Ensure integration or appropriate linkages between HIV prevention, treatment and care and other essential health services.

3.2.4 Promote decentralization (where appropriate) to lower service delivery levels, ensuring that patients have access to specialized care and are referred to higher service levels when necessary.

3.2.5 Involve civil society and NGOs in service delivery by delegating work and providing sustainable support to ensure access to HIV prevention, treatment, care and support, particularly for key populations at higher risk, and including through community-based outreach models and drop-in centres.

3.2.6 Strengthen collaboration, referral and partnership between all service providers in primary health care, higher-level health care, relevant disease programmes, civil society and community-based services, in order to ensure continuity of treatment and care.

3.2.7 Ensure continuity of treatment and care from the community to prisons and back to the community, and within the prison systems, by ensuring coordination between NGOs, criminal justice systems and health authorities.

3.2.8 Ensure that HIV-positive prisoners receive care, treatment and support equivalent to that available to people living with HIV in the civil sector, including timely initiation of ART.

3.2.9 Ensure that HIV prevention, diagnosis, treatment and care services are free of charge at the point of delivery.

3.2.10 Support approaches that minimize out-of-pocket expenditure, including for HIV services, and assess and address other financial barriers to access.

[17] Comprehensiveness, accessibility, coverage, continuity, quality, person-centreredness, coordination, and accountability and efficiency *(81)*.

3.3 Medicines, diagnostics and other commodities

Objective
To ensure that medicines, diagnostics and other commodities for HIV prevention, treatment and care are affordable, quality assured and supplied without interruption.
Target for the WHO European Region by 2015
All Member States will provide an uninterrupted supply of affordable and quality assured HIV medicines, diagnostics and other commodities.

Priority actions

3.3.1 Revise national legislation, regulations and standards to improve the efficiency and transparency of the medicines registration process, with a special focus on the quality assurance and safety of generic medicines.

3.3.2 Encourage registration of safe and quality assured generic medicines, using mechanisms compliant with Trade-Related Aspects of Intellectual Property Rights (TRIPS)[18], including parallel procurement and compulsory licensing, when necessary, at national and regional levels.

3.3.3 Adopt coordinated drug regulatory regimes at regional and national levels that allow fast-track registration of priority medicines based on prior approval by the WHO Prequalification Programme or by a stringent regulatory authority.

3.3.4 Explore possibilities for local manufacture of antiretroviral drugs in line with good manufacturing practices (GMP), and stimulate the transfer of technology for local manufacture.

3.3.5 Revise national legislation on patents and medicines, to allow the use of flexibilities within TRIPS, as needed, to achieve affordable prices.

3.3.6 Introduce a system to routinely monitor the prices of medicines and commodities, and an appropriate mechanism (such as differential prices, pooled procurement or centralized procurement) to reduce prices to affordable levels.

3.3.7 Revise procurement legislation and the procurement and supply management (PSM) system, in order to ensure an open, transparent, competitive (when possible) and uninterrupted supply of medicines, diagnostics and other commodities to patients.

3.3.8 Strengthen forecasting, stock control (including buffer stocks) and distribution systems and expand procurement planning to cover longer periods of time (e.g. 18 months instead of 12 months), in order to reduce interruptions in supply.

3.3.9 Provide access to medicines and commodities across the entire country to ensure continuity of treatment for people who move from one area to another.

3.3.10 Ensure that legislation and policies allow access to essential medicines, diagnostics and other commodities.

3.3.11 Include HIV-related medicines in the national list of essential medicines.

3.3.12 Scale up drug quality and safety monitoring systems, by introducing or improving systems to monitor use of medicines and adverse drug reactions and their management (pharmacovigilance systems).

[18] The World Trade Organization (WTO) Declaration on the TRIPS agreement and public health adopted in 2001 says that "the TRIPS Agreement does not and should not prevent members from taking measures to protect public health" and reaffirms "the right of WTO members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose", meaning the promotion of access to medicines for all (http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm). This agreement was reemphasized in the Global strategy and plan of action on public health, innovation and intellectual property adopted by the World Health Assembly in 2008 that encourages countries to implement and where necessary to use TRIPS flexibilities to improve access to medicines and provides WHO with a mandate to provide technical support to its Member States in this regard.

3.4 Quality[19] improvement

Objective
To improve the quality of HIV services.
Target for the WHO European Region by 2015
All Member States will have defined and be funding quality improvement systems in national HIV strategies.

Priority actions

3.4.1 Ensure that good practice approaches are included in multilateral and national strategies and action plans.

3.4.2 Improve the effectiveness and standing of quality improvement and quality assurance approaches at national level, by using standardized tools and guidelines.

3.4.3 Ensure that the prevention, treatment and care services of all service providers are of high quality (in terms of scope, completeness, effectiveness, efficiency, safety and user satisfaction).

3.4.4 Promote participatory quality development in HIV prevention, treatment, care and support, and advocate for programmes to be designed to meet the expectations of service users.

[19] Quality health services are "effective, safe, centred on the patient's needs and given in a timely fashion" *(81)*.

3.5 Health financing

Objective
To ensure that financing mechanisms for HIV interventions allow sustained coverage and reach target populations as efficiently and equitably as possible.
Target for the WHO European Region by 2015
All Member States will ensure that domestic financing mechanisms for the HIV response, including funding for civil society, use efficient channels to orient spending to cost-effective priority interventions and promote equity in the delivery of services.

Priority actions

3.5.1 Build commitment among political leaders for sustained financing of HIV programmes.

3.5.2 Ensure that national strategic plans include financial goals and objectives that are linked to programme objectives.

3.5.3 Ensure that financial indicators are included in the monitoring and evaluation framework of national HIV programmes.

3.5.4 Ensure that the different agencies that manage resources for HIV-related services (e.g. drug services, STI programmes, prison health services) either pool their funds or undertake joint planning and budgeting for these services.

3.5.5 Promote sustainability by seeking and attracting domestic resources for HIV prevention, treatment, care and support.

3.5.6 Harmonize and align external funding to support domestic financing mechanisms and to improve national ownership and accountability.

3.5.7 Improve the cost-effectiveness of service delivery models, align financing mechanisms explicitly to support these, and in so doing increase the probability of sustaining adequate levels of coverage with high quality services, including for primary prevention.

3.6 Governance, partnerships, intersectoral action and alignment

Objective
To improve governance, partnerships, intersectoral action and alignment in the HIV response.
Target for the WHO European Region by 2015
All Member States will have integrated HIV into their general development plans.

Priority actions

3.6.1 Ensure that the national HIV strategy is evidence-informed and reflects national priorities and contexts.

3.6.2 Implement HIV programmes that are appropriate to the national situation, adapting them to the local context, while keeping a focus on equity and cost-effectiveness.

3.6.3 Develop national intersectoral strategies and corresponding implementation plans to respond to HIV.[20]

3.6.4 Establish, recognize, strengthen and support national intersectoral HIV coordination structures.

3.6.5 Ensure that HIV-related programming is included in the strategies and plans of the national health sector and other sectors.

3.6.6 Ensure synergy, coherence and balance between the HIV response and other programmes in the national health sector and other sectors.

3.6.7 Review key policies and strategies of other sectors to identify barriers to, and opportunities for, implementing effective HIV responses.

3.6.8 Align and harmonize HIV-related programmes of external development partners to the national intersectoral strategy and related implementation plans.

3.6.9 Forge strategic partnerships between the national authorities and ministries directly responsible for health, other ministries, associations, professional bodies, researchers, academics, civil society, advocacy groups, trade unions, the private sector, and international and global partners, including bilateral and multilateral donors, UNAIDS and its co-sponsoring agencies.

3.6.10 Ensure strong links and follow-up mechanisms between the prison health system and the public health system, and consider transferring control of prison health to the public health authorities.

[20] The following sectors should be included: finance, education, social welfare, child protection, transportation, infrastructure, criminal justice, labour, immigration, development, defence, foreign affairs, civil society, the private sector and the media.

3.7 Health workforce

Objective
To strengthen the human resource capacity available to respond to the HIV epidemic.
Target for the WHO European Region by 2015
All Member States will have adequate human resource capacity to respond to the HIV epidemic.

Priority actions

3.7.1 Ensure that there is sufficient workforce capacity to deliver HIV and related health services.

3.7.2 Ensure high levels of knowledge and skills in the workforce, and address critical deficits in skills through continuous high quality professional training, practice, supervision and evaluation.

3.7.3 Ensure appropriate deployment of the health workforce according to need (e.g. burden of disease, service needs).

3.7.4 Ensure appropriate management and retention of the health workforce, through financial and non-financial incentives (i.e. social recognition, career development, appropriate salary levels).

3.7.5 Align health workforce production with the health needs of the population and health system demand.

3.7.6 Develop strategies to mitigate the impact of health worker migration.

3.7.7 Develop, adopt, implement and monitor workplace policies for all health care workers, including those with a bloodborne infection.

Reduce vulnerability and remove structural barriers to accessing services (addressing the social determinants of health)

AREAS OF INTERVENTION and priority actions within this strategic direction take full account of: the new European policy for health - Health 2020 *(42);* the principle of health in all policies; the protection of human rights and the need to address stigma, discrimination, legal barriers and other key social determinants that shape the HIV epidemic in the European Region (Box 6).

The efforts of Member States and all relevant stakeholders should focus on creating an enabling environment and addressing social determinants of health as an essential step in responding to the HIV epidemic in Europe.

BOX 6 Definitions of structural barriers *(31)*

Structural barriers are systemic barriers (social, cultural and legal) to access faced by key populations that deter them from accessing HIV services and reduce the effectiveness of services. Examples are police harassment and violence towards certain populations and discriminatory policies, practices and attitudes in health services. Structural interventions aim to remove these barriers.

Reducing vulnerability and removing structural barriers to accessing services has the following priority areas of intervention.

4.1 **Laws and regulations related to the HIV response:** to address laws and regulations that present obstacles to effective HIV prevention, treatment, care and support, and to strengthen the enforcement of protective laws and regulations, derived from international and European human rights standards, by implementing specific priority actions.

4.2 **Stigma, discrimination and other human rights abuses that impede the HIV response:** to eliminate stigma, discrimination and other human rights abuses, by establishing and enforcing antidiscrimination and other protective laws, derived from international and European human rights standards, to protect people living with HIV, key populations at higher risk and other affected populations and by implementing other specific priority actions.

4.3 **Strengthening community systems:** to strengthen the involvement of civil society in the HIV response, by increasing the participation of people living with HIV, key populations at higher risk and other civil society groups in national coordination mechanisms for HIV/AIDS and in developing policy, making decisions, coordinating and delivering services (planning, management and implementation), and monitoring and evaluating the implementation of national HIV strategies and plans, and other specific priority actions.

4.4 **Gender and age equity:** to ensure gender and age equity in access to HIV and related health services through a set of specific priority actions.

4.1 Laws and regulations related to the HIV response

Objective

To address laws and regulations that present obstacles to effective HIV prevention, treatment, care and support, and to strengthen the enforcement of protective laws and regulations.[21]

Target for the WHO European Region by 2015

All Member States will have enabling laws and regulations for equal, non-restricted access to effective HIV and related health services, and will enforce them.

Priority actions

4.1.1 Laws should be reviewed and, if necessary, reformed in order to decrease HIV vulnerability, improve access to health services and protect human rights.

4.1.2 A public health approach to managing behaviours that put people at risk of HIV acquisition or transmission should be promoted as an alternative to criminalization.

4.1.3 Remove legal barriers that prevent civil society organizations from delivering evidence-informed interventions and reaching key populations at higher risk.

4.1.4 Ensure that national laws recognize the right to health and do not create barriers to HIV and related health services for undocumented persons, including migrants, asylum seekers and released prisoners.

4.1.5 Specific attention should be paid to HIV-related travel restrictions, employment, homophobia, sex work, drug control laws and criminalization of HIV transmission.

4.1.6 Remove mandatory or compulsory HIV testing and mandatory/compulsory disclosure of HIV status, including for prisoners and migrants.

4.1.7 Legislation should be enacted to uphold non-discrimination in all areas.

4.1.8 Ensure that the reformed laws and regulations are applied, enforced and monitored, including within national strategies.

[21] Derived from international and European human rights standards.

4.2 Stigma, discrimination and other human rights abuses

Objective
To eliminate stigma, discrimination and human rights abuses that impede the HIV response.
Target for the WHO European Region by 2015
All Member States will have eliminated stigma, discrimination and other human rights abuses that impede the HIV response.

Priority actions

4.2.1 Apply specific human rights declarations and legislation in advocating for increased access to and uptake of HIV services.

4.2.2 Monitor HIV-related stigma and discrimination and other human rights abuses, both within and outside the health sector, and document their impact on access to and quality of health services and outcomes.

4.2.3 Establish and enforce policies and practices to eliminate stigma, discrimination and other human rights abuses in health services.

4.2.4 Establish and enforce antidiscrimination and other protective laws, derived from international and European human rights standards, to protect people living with HIV, key populations at higher risk of HIV exposure and infection and other affected populations.

4.2.5 Establish easily accessible dispute resolution procedures for alleged violations of laws that protect against stigma and discrimination, develop legal support mechanisms and increase capacities to provide legal services for enforcement of the laws.

4.2.6 Address the concerns and build the capacity of health staff and other service providers in combating stigma, discrimination and human rights abuses.

4.2.7 Introduce legislation and policies prohibiting stigma and discrimination in the workplace, on the basis of real or perceived HIV status.

4.2.8 Adopt workplace policies to reduce stigma and discrimination in the workplace and abolish compulsory testing as a condition for employment.

4.3 Strengthening community systems[22]

Objective
To strengthen civil society involvement in the HIV response.
Target for the WHO European Region by 2015
Civil society will be fully involved in the HIV response in all Member States.

Priority actions

4.3.1 Ensure that people living with HIV, key populations at higher risk and other civil society groups, together with their networks and organizations, are involved and meaningfully represented in the national HIV response, in particular in:
- HIV coordination mechanisms and other relevant bodies at national and local levels;
- policy development and decision-making processes;
- coordination (planning, management, implementation) of national HIV strategies and plans;
- delivery of HIV and related health services;
- monitoring and evaluation of the national HIV response.

4.3.2 Empower people living with HIV, key populations at higher risk and other civil society groups, together with their networks and organizations, to advocate for their rights and to be involved in the national HIV response, through capacity building, partnerships and sustainable financing.

4.3.3 Promote and support best practice standards for civil society organizations, in relation to accountability, management and operations, on the basis of successful models in the Region.

[22] Community systems strengthening is the enhancement and improvement of a community's ability and capacity to scale up the AIDS response, confront its challenges, and provide services in a conducive and supportive financial, political and legislative environment *(82)*.

4.4 Gender and age equity

Objective
To ensure gender and age equity in access to HIV and related health services.
Target for the WHO European Region by 2015
All Member States will ensure equal access to HIV and related health services for everyone, irrespective of gender or age.

Priority actions

4.4.1 Remove gender and age barriers to HIV and related health services, in particular sexual and reproductive health services.

4.4.2 Collect and analyse data disaggregated by sex and age.

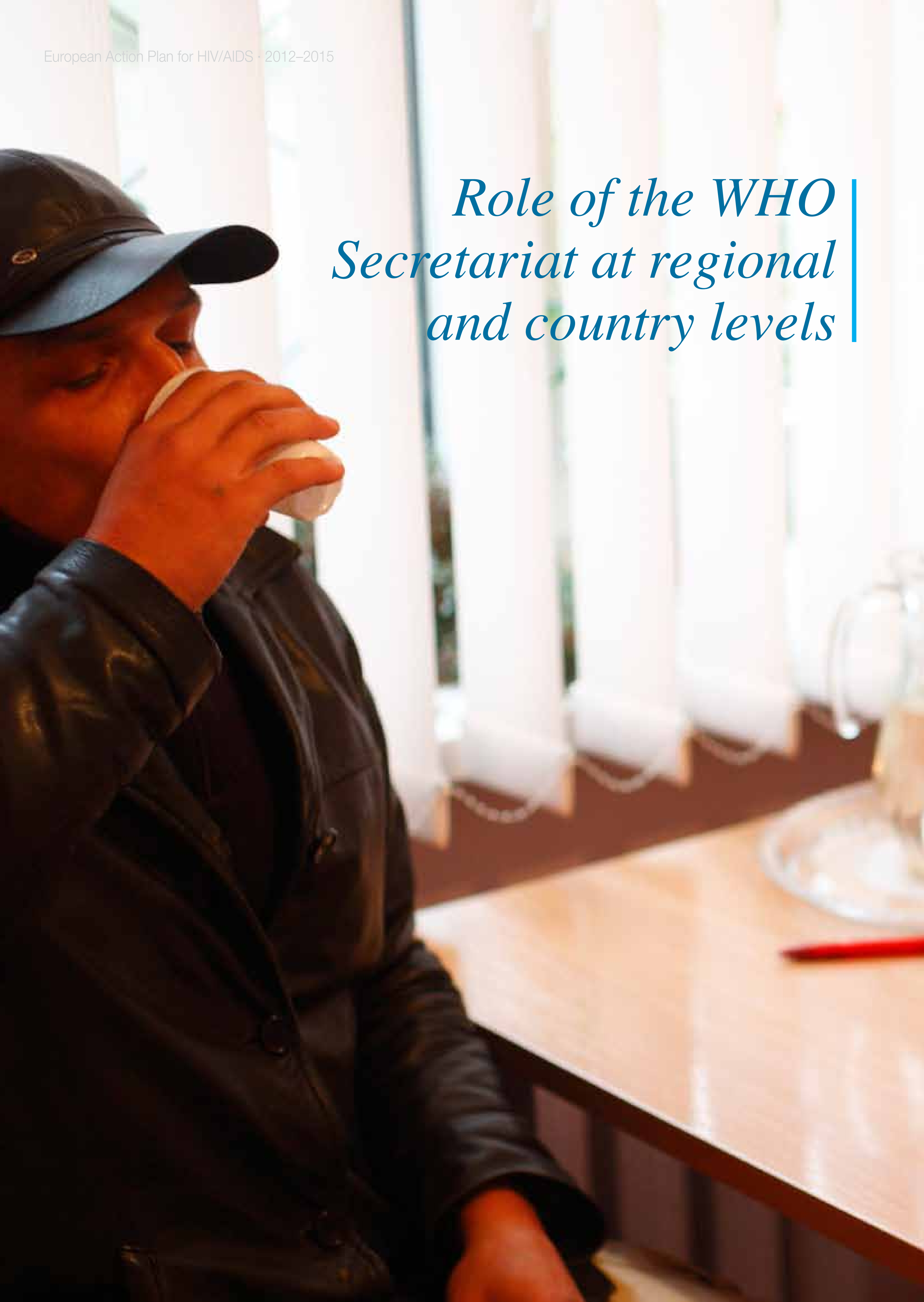
4.4.3 Ensure that services and programmes reach and address the specific needs of women, young people, adolescents and members of key populations at higher risk.

Monitoring and evaluation

PROGRESS IN THE EUROPEAN REGION towards reaching the targets set out in this Action Plan will be assessed regularly. Benchmarking, i.e. comparisons between countries, will also be used to assess performance in achieving targets.

Assessment of progress will be based on data collected through existing reporting processes. No additional data will need to be collected. WHO will continue to work with the UNAIDS secretariat, the United Nations Children's Fund (UNICEF), the European Commission and its specialized agencies, in particular the European Centre for Disease Prevention and Control (ECDC), and other agencies to support countries in the standardized collection of core indicators, as part of harmonized joint WHO, UNAIDS and UNICEF annual reporting processes (United Nations General Assembly Special Session (UNGASS) and Health Sector Response monitoring and reporting). UNAIDS will support a full review of progress towards universal access in June 2016.

Suggested indicators for assessing progress towards the targets and objectives set out in this Action Plan for all areas of intervention are given in Annex 1. All are standardized indicators already included in (or very exceptionally being developed for) existing regional or global monitoring and reporting processes. Additional information is available elsewhere *(83).*



Role of the WHO Secretariat at regional and country levels

THE WHO SECRETARIAT will support countries in implementing the priority actions described in this document, through its six core functions, as set out in the Eleventh General Programme of Work, 2006–2015 (Box 7). The type and intensity of support provided to individual national HIV programmes will depend on specific country needs.

Working in collaboration with the Member States, the WHO Secretariat will take bold and innovative action to challenge conventional approaches to HIV and public health, and take full advantage of opportunities to transform the HIV response.

The focus of WHO's work will be on the areas for which WHO is a convener (HIV treatment, HIV and TB, and – jointly with UNICEF – preventing mother-to-child transmission) or partner in the UNAIDS division of labour (see Annex 2). However, WHO will also contribute to other UNAIDS priority areas and cross-cutting issues, in collaboration with other UNAIDS co-sponsors and the UNAIDS secretariat.

Action Plan costs

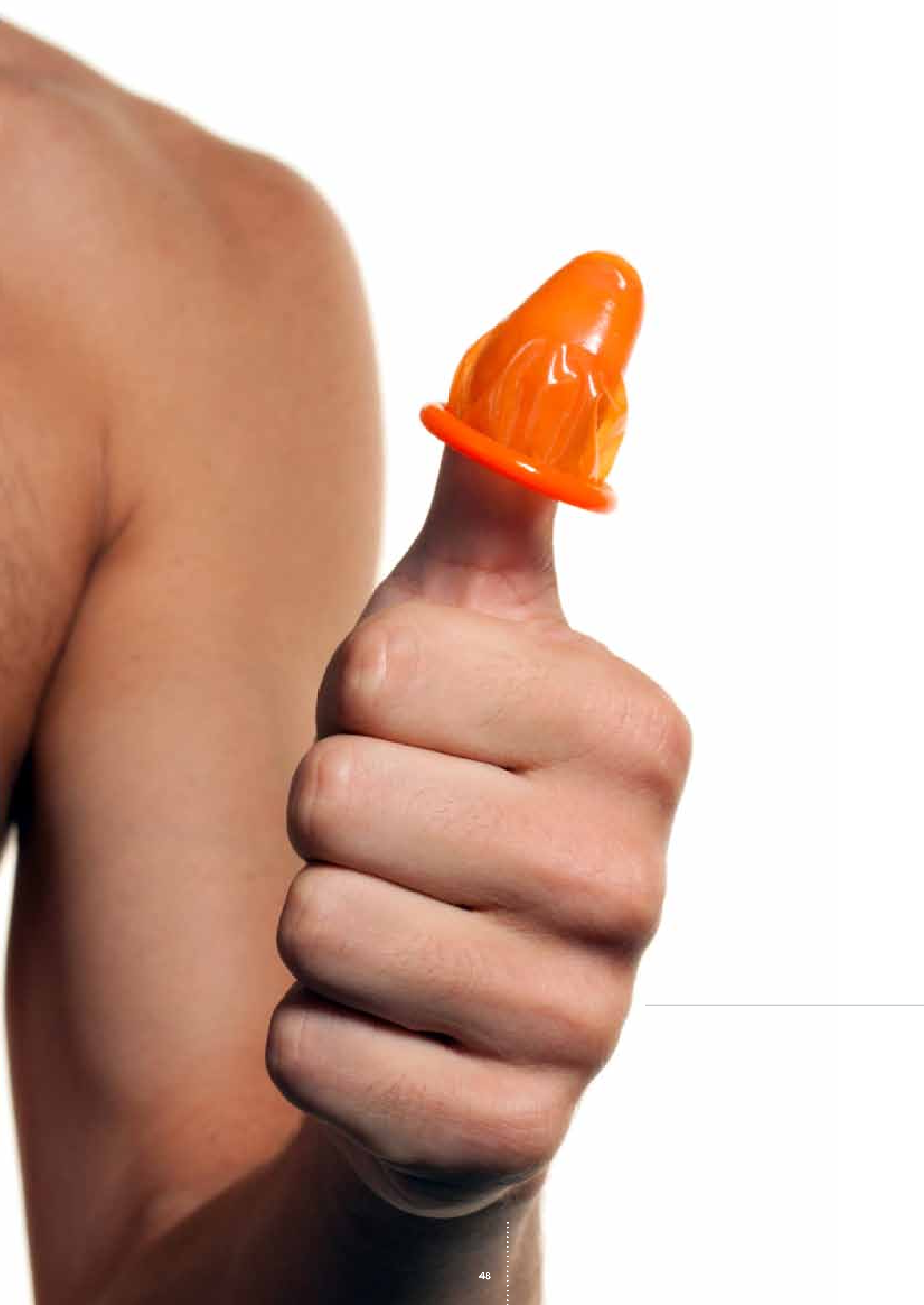
WHO has started to work on a detailed and costed work plan to support all areas of intervention and priority actions described in the Action Plan. The work plan, now in an advanced stage, describes the costs for the first two years (2012–2013) of WHO activities in support of all areas of intervention and priority actions described in the Action Plan.

The estimated cost will be US$ 9 450 000 over the first two years (2012–2013) to support WHO activities in countries and the Regional Office (including staff costs). These costs are within the budget ceilings already approved as part of the overall Regional Office plan for 2012–2013. It is anticipated that costs for the second two years (2014–2015) will be similar.

WHO has begun to estimate the overall costs associated with implementing the Action Plan. The costing of the Action Plan follows the strategic investment framework for HIV/AIDS already developed by WHO, UNAIDS, the Global Fund and other key partners and applied to global costs. The framework suggests that any additional investment would largely be offset by costs savings *(73).* This estimate includes a cost–benefit analysis of suggested key priority actions relevant in the current economic context in the Region. The priority actions will be ranked in accordance with their cost–benefit value. WHO Regional Office for Europe has an agreement with the Global Fund to jointly cost the European Action Plan using the methods described in the global strategic investment framework for HIV/AIDS. Work has started and will be finalized by the end of 2011.

BOX 7 Six core functions of the WHO Secretariat

1. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed.
2. Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge.
3. Setting norms and standards, and promoting and monitoring their implementation.
4. Articulating ethical and evidence-based policy options.
5. Providing technical support, catalysing change, and building sustainable institutional capacity.
6. Monitoring the health situation and assessing health trends.



Action Plan development process

THE WHO REGIONAL OFFICE FOR EUROPE used a fully participatory and inclusive approach to develop the Action Plan. Contributions were elicited from Member States, civil society, donor and development agencies, NGOs, multilateral agencies, UNAIDS and its cosponsors, the European Union and European Commission directorates-general, institutions and bodies (such as the Directorate–General for Health and Consumers, ECDC, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the HIV/AIDS Think Tank), scientific and technical institutions, networks, and leaders and experts in HIV and related programmes and areas.

Representatives of Member States and other stakeholders listed above were invited to review the draft Action Plan. The draft was presented through different mechanisms, including a web-based discussion forum, formal requests for input to the health ministries of the 53 European Region Member States, and various regional policy and scientific meetings. Country representatives, civil society, key experts and partners also considered the draft at a regional consultation organized by the WHO Regional Office for Europe and UNAIDS in Kyiv, Ukraine, in March 2011. The summary of the Action Plan and related resolution were presented to the Standing Committee of the Regional Committee in Geneva in May 2011. Both documents were subsequently approved as working papers for the sixty-first session of the Regional Committee.

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Annex 1
Suggested indicators

SUGGESTED INDICATORS for assessing progress towards the targets and objectives set out in this Action Plan for all priority areas of intervention are given below. All are standardized indicators already included in (or very exceptionally being developed for) existing regional or global monitoring and reporting processes. Additional information is available in the UNAIDS Monitoring and Evaluation Reference Group (MERG) *Indicator standards: Operational guidelines for selecting indicators for the HIV response* and related Indicator Assessment Tool to support country-level development, selection, revision and review of indicators for assessing the HIV response and the UNAIDS HIV Indicator Registry[1]. Whenever possible, data and indicators should be disaggregated by sex and age.

[1] Available at: http://www.globalhivmeinfo.org/AgencySites/MERG%20Resources/MERG%20Indicator%20Standards_Operational%20Guidelines.pdf and http://www.unaids.org/en/resources/presscentre/featurestories/2009/march/20090313propertyrightundp/

AREA 1.1 HIV testing and counselling

Suggested indicators
Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results (UNGASS[2] /WHO UA[3])
Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results (UNGASS/WHO UA)
Number of health facilities that provide HIV testing and counselling services (WHO UA)
Percentage of health facilities providing HIV testing and counselling services that offer rapid testing (WHO UA)
Percentage of HIV infections newly diagnosed with a CD4 cell count less than 350 per µl blood at time of diagnosis (ECDC/WHO[4])
Percentage of pregnant women who were tested for HIV and received their results – during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status (WHO UA)
Percentage of infants born to HIV-infected women receiving a virological test for HIV within two months of birth (WHO UA)

AREA 1.2 HIV transmission through injecting drug use

Suggested indicators
Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected (UNGASS/WHO UA)
Number of HIV infections newly diagnosed in injecting drug users (ECDC/WHO)
Percentage of injecting drug users who are HIV-infected (UNGASS/WHO UA)
Number of needle and syringe programme sites per 1000 injecting drug users (WHO UA)
Number of opioid substitution therapy sites per 1000 injecting drug users (WHO UA)
Number of syringes distributed per person who injects drugs per year by needle and syringe programmes (WHO UA)
Percentage of opioid-dependent people on opioid substitution therapy (WHO UA)
Percentage of injecting drug users reporting the use of a condom at last sexual intercourse (UNGASS/WHO UA)

[2] UNGASS: UNGASS indicator.
[3] WHO UA: indicator from the WHO monitoring and reporting on the Health Sector Response to HIV/AIDS towards Universal Access.
[4] ECDC/WHO: data collected jointly by the European Centre for Disease Prevention and Control and the WHO Regional Office for Europe.

AREA 1.3 Sexual transmission of HIV

Suggested indicators
Number of HIV infections newly diagnosed in men who have sex with men (ECDC/WHO)
Number of HIV infections newly diagnosed in persons infected through heterosexual contact (ECDC/WHO)
Percentage of female and male sex workers reporting the use of a condom with their most recent client (UNGASS/WHO UA)
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (UNGASS/WHO UA)
Percentage of men who have sex with men who are HIV-infected (UNGASS/WHO UA)
Percentage of sex workers who are HIV-infected (UNGASS/WHO UA)
Percentage of sex workers with active syphilis (WHO UA)
Percentage of men who have sex with men with active syphilis (WHO UA)
Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (UNGASS)

AREA 1.4 Mother-to-child transmission of HIV

Suggested indicators
Number of HIV infections newly diagnosed in children infected through mother-to-child transmission (ECDC/WHO)
Percentage of infants born to HIV-infected mothers who are infected (UNGASS)
Percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission (UNGASS/WHO UA)
Percentage of HIV positive pregnant IDU women who received ARVs to reduce the risk of mother-to-child transmission during pregnancy (WHO UA)
Percentage of HIV positive pregnant women who had an elective caesarean section (WHO UA)
Percentage of infants born to HIV-infected women receiving antiretroviral prophylaxis for prevention of mother-to-child transmission (WHO UA)
Percentage of infants born to HIV-infected women started on co-trimoxazole prophylaxis within two months of birth (WHO UA)
Distribution of feeding practices for infants born to HIV-infected women at DTP3 visit (WHO UA)

AREA 1.5 HIV treatment and care

Suggested indicators
Reported number of deaths among AIDS cases (ECDC/WHO)
Estimated number of HIV-related deaths (UNAIDS)
Number of health facilities that offer antiretroviral therapy (WHO UA)
Percentage eligible adults and children currently receiving antiretroviral therapy (UNGASS/WHO UA)
Number of eligible adults and children who newly enrolled on antiretroviral therapy (WHO UA)
Percentage of adults and children with HIV still alive and known to be on treatment 12/24/60 months after initiation of antiretroviral therapy (WHO UA)
Number of adults and children with HIV enrolled in HIV care (WHO UA)
Percentage of HIV-infected children aged 0–14 years who are currently receiving antiretroviral therapy (WHO UA)
Percentage of injecting drug users with HIV still alive and known to be on treatment 12/24/60 months after initiation of antiretroviral therapy (WHO UA)
Percentage of adults and children enrolled in HIV care and eligible for co-trimoxazole (CTX) prophylaxis (according to national guidelines) currently receiving CTX prophylaxis (WHO UA)

AREA 1.6 HIV transmission in health care settings

Suggested indicators
Number of HIV infections newly diagnosed acquired through nosocomial transmission (ECDC/WHO)

AREA 2.1 Tuberculosis programmes

Suggested indicators
Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV (UNGASS/WHO UA)
Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive treatment (WHO UA)
Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit (WHO UA)
Proportion of tuberculosis cases detected and cured under directly observed treatment short course (MDG[5])
Number of tuberculosis deaths among people living with HIV

AREA 2.2 Drug dependence programmes

Suggested indicators
Expert ratings on the level of provision and availability of a number of selected interventions aimed at preventing infectious diseases, including HIV, and reducing overdose risks among prisoners (EMCDDA[6])
Opioid substitution treatment in prisons (EMCDDA)
See also indicators for area 1.2

AREA 2.3 Sexual and reproductive health programmes

Suggested indicators
Number of service delivery points per 500 000 population with trained personnel, laboratory equipment and medicines appropriate for the diagnosis and treatment of bacterial and viral sexually transmitted infections and reproductive tract infections, including HIV/AIDS (WHO RH)[7]
Percentage of family planning service delivery points offering HIV counselling and testing (WHO RH)
Unmet need for family planning (MDG)

[5] MDG: indicator for Millennium Development Goals.
[6] EMCDDA: health and social responses (HSR) indicator (http://www.emcdda.europa.eu/stats10/hsr).
[7] WHO RH: indicator from *Accelerating progress towards attainment of international reproductive health goals. A framework for implementing the WHO Global RH Strategy,* Geneva, World Health Organization, 2006.

AREA 2.4 Maternal, newborn, child and adolescent health programmes

Suggested indicators
Percentage of antenatal care attendees who were positive for syphilis (WHO UA)
Percentage of antenatal care attendees positive for syphilis who received treatment (WHO UA)

AREA 2.5 Viral hepatitis programmes

Suggested indicators
Percentage of adults and children enrolled in HIV care who were screened for hepatitis B (WHO UA)
Percentage of HIV-positive hepatitis B cases eligible for hepatitis B treatment who received treatment for hepatitis B (WHO UA)
Percentage of adults and children enrolled in HIV care who were screened for hepatitis C (WHO UA)
Percentage of HIV-positive hepatitis C cases eligible for hepatitis C treatment who received treatment for hepatitis C (WHO UA)

AREA 2.6 Noncommunicable and chronic disease programmes

Suggested indicators
Number of Member States providing data on noncommunicable and chronic diseases among people living with HIV[8]

AREA 3.1 Strategic information obtained through surveillance, monitoring and evaluation

Suggested indicators
Existence of one national HIV/AIDS monitoring and evaluation plan, including surveillance and estimation (UNGASS/WHO UA)
Number of Member States reporting annually to WHO on the Health Sector Response to HIV/AIDS towards Universal Access
Number of Member States reporting HIV/AIDS surveillance data annually to ECDC/WHO
Existence of an HIV drug resistance prevention and assessment strategy (WHO UA)
Additional indicators in the National Commitments and Policy Instrument (NCPI)[9]

[8] WHO Regional Office for Europe, Division of Noncommunicable Diseases and Health Promotion.

[9] NCPI is part of the core UNGASS indicators (http://www.unaids.org/en/resources/presscentre/featurestories/2009/march/20090331ungass2010/).

AREA 3.2 **Service delivery models**

Suggested indicators
Percentage of health facilities offering HIV services (WHO HS)[10]
Number and distribution of health facilities offering HIV services per 100 000 population (WHO HS)
HIV services readiness score for health facilities (WHO HS)
Number of health facilities that provide HIV testing and counselling services (WHO UA) and distribution per 100 000 population
Number of health facilities that offer antiretroviral therapy (WHO UA) and distribution per 100 000 population

AREA 3.3 **Medicines, diagnostics and other commodities**

Suggested indicators
Percentage of health facilities dispensing antiretrovirals that have experienced a stock-out of at least one required ARV in the last 12 months (WHO UA)
Percentage of antiretroviral batches tested in the past year that met national and international quality control standards (WHO PSM[11])

AREA 3.4 **Quality improvement**

Suggested indicators
Indicators from *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies.* Geneva, World Health Organization, 2010 (WHO HS[12])

AREA 3.5 **Health financing**

Suggested indicators
Domestic and international AIDS spending by categories and financing sources (UNGASS)
General government expenditure on health as a proportion of general government expenditure (WHO HS)
The ratio of household out-of-pocket payments for health to total expenditure on health (WHO HS)

[10] WHO HS: indicator from *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies.* Geneva, World Health Organization, 2010 (http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf).

[11] WHO PSM: indicator from *Harmonized monitoring and evaluation indicators for procurement and supply management systems.* Geneva, World Health Organization, 2001 (http://www.who.int/hiv/pub/amds/monitoring_evaluation/en/index.html).

[12] Available on the World Health Organization web site (http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf).

AREA 3.6 **Governance, partnerships, intersectoral action and alignment**

Suggested indicators
Existence of a national multisectoral strategy to respond to HIV (NCPI)
Integration of HIV into general national development plans (NCPI)
Existence of an officially recognized national multisectoral AIDS coordination body (NCPI)
Additional indicators from the National Commitments and Policy Instrument (NCPI)

AREA 3.7 **Health workforce**

Suggested indicators
Indicators from *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies.* Geneva, World Health Organization, 2010[13]

AREA 4.1 **Laws and regulations related to the HIV response**

Suggested indicators
Existence of laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations (NCPI)
Additional indicators from the National Commitments and Policy Instrument

AREA 4.2 **Stigma, discrimination and other human rights abuses**

Suggested indicators
Existence of non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations (NCPI)
Programmes are in place to reduce HIV-related stigma and discrimination (NCPI)
The promotion and protection of human rights explicitly mentioned in any HIV policy or strategy (NCPI)
Additional indicators from Part B (I) of the National Commitments and Policy Instrument (NCPI)
Indicators from the People Living with HIV Stigma Index (including stigma and discrimination in the health sector)[14]

[13] Available on the World Health Organization web site (http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf).
[14] This index measures the stigma and discrimination experienced by people living with HIV (http://www.stigmaindex.org/9/aims-of-the-index/aims-of-the-index.html).

AREA 4.3 **Strengthening community systems**

Suggested indicators
Percentage of the national HIV budget that was spent on activities implemented by civil society in the past year (NCPI)
Extent to which civil society representatives have been involved in the planning and budgeting process for the national strategic plan on HIV or the most current activity plan (scale 0–5) (NCPI)
Extent to which the services provided by civil society in areas of HIV prevention, treatment, care and support are included in the national AIDS strategy, budget and reports (scale 0–5) (NCPI)
Additional indicators from the National Commitments and Policy Instrument

AREA 4.5 **Gender and age equity**

Suggested indicators
Existence of a national policy to ensure equal access for women and men to HIV prevention, treatment, care and support (NCPI)

Annex 2
UNAIDS division of labour[1]

Division of labour area	Convener(s)	Agency partners
Reduce sexual transmission of HIV	World Bank, UNFPA	UNDP, WHO, World Bank, ILO, UNICEF, UNFPA, UNESCO, UNHCR, WFP
Prevent mothers from dying and babies from becoming infected with HIV	WHO, UNICEF	UNICEF, UNFPA, WFP, WHO
Ensure that people living with HIV receive treatment	WHO	UNDP, UNHCR, WFP, UNICEF, WHO, ILO
Prevent people living with HIV from dying of tuberculosis	WHO	UNICEF, WHO, UNODC, WFP, ILO
Protect drugs users from becoming infected with HIV and ensure access to comprehensive HIV services for people in prisons and other closed settings	UNODC	UNDP, WHO, UNESCO, UNICEF, UNODC, World Bank, UNFPA
Empower men who have sex with men, sex workers and transgender people to protect themselves from HIV infection and to fully access antiretroviral therapy	UNDP, UNFPA	UNDP, UNFPA, World Bank, WHO, UNESCO
Remove punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS	UNDP	UNDP, UNFPA, UNODC, UNHCR, UNESCO, WHO, ILO, UNICEF
Meet the HIV needs of women and girls and stop sexual and gender-based violence	UNDP, UNFPA	UNDP, UNFPA, UNESCO, WFP, UNICEF, WHO, UNHCR, UNODC, ILO
Empower young people to protect themselves from HIV	UNICEF, UNFPA	UNICEF, WFP, UNHCR, WHO, UNESCO, UNFPA, ILO
Enhance social protection for people affected by HIV	UNICEF, World Bank	ILO, WFP, World Bank, UNICEF, UNDP, WHO, UNHCR
Address HIV in humanitarian emergencies	UNHCR, WFP	UNDP, WHO, UNFPA, WFP, UNICEF, UNODC, UNHCR
Integrate food and nutrition within the HIV response	WFP	UNICEF, WHO, WFP, UNHCR
Scale up HIV workplace policies and programmes and mobilize the private sector	ILO	UNESCO, WHO, ILO
Ensure good quality education for a more effective HIV response	UNESCO	UNESCO, WHO, UNICEF, UNFPA, ILO
Support to strategic, prioritized and costed multisectoral national AIDS Plans	World Bank	ILO, UNDP, WFP, UNFPA, UNHCR, World Bank, UNICEF, UNESCO, WHO, UNODC

[1] From: *Getting to zero: 2011–2015 strategy.* Geneva, Joint United Nations Programme on HIV/AIDS, 2010 (http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/JC2034_UNAIDS_Strategy_en.pdf; accessed 6 June 2011).

Annex 3
Resolution EUR/RC61/R8

European action plan for HIV/AIDS 2012–2015

The Regional Committee,

Recalling the Declaration of Commitment on HIV/AIDS adopted by the special session of the United Nations General Assembly in June 2001;

Recalling the Political Declaration on HIV and AIDS adopted by the United Nations General Assembly at the HighLevel Meeting on AIDS in June 2011;

Recalling World Health Assembly resolutions WHA54.10 and WHA55.12 that called for scaling up of the response to HIV/AIDS, and resolutions WHA53.14, WHA56.30, WHA59.12 and WHA59.19, which endorsed a series of strategies that have guided WHO's work on HIV/AIDS;

Considering that the WHO "3 by 5" strategy, launched in 2003, which focused on expanding access to antiretroviral treatment, was developed in the context of the Global Heath Sector Strategy for HIV/AIDS (2003–2007), endorsed by the Fiftysixth World Health Assembly (resolution WHA56.30);

Recalling that in 2006 the United Nations General Assembly adopted the target of universal access to HIV prevention, treatment and care by 2010, and that WHO developed the Universal Access Plan 2006–2010, welcomed by the Fiftyninth World Health Assembly, which has guided WHO's work since then;

Taking account of the Joint United Nations Programme on HIV/AIDS (UNAIDS) HIV/AIDS Strategy for 2011–2015, the Global Health Sector Strategy for HIV/AIDS 2011– 2015 and the European Commission Communication on combating HIV/AIDS in the European Union and neighbouring countries 2009–2013;

Recalling its resolution on scaling up the response to HIV/AIDS in the European Region (EUR/RC52/R9);

Acknowledging Member States' existing commitments to the 2004 Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia and to achieving the Millennium Development Goals;

Concerned that HIV remains an increasingly serious public health challenge in the WHO European Region, with (in its eastern part) the fastest growing epidemic in the world;

Recognizing that HIV in Europe disproportionately affects key populations (people who inject drugs and their sexual partners, men who have sex with men, transgender people, sex workers, prisoners and migrants) who are socially marginalized and whose behaviour is socially stigmatized or illegal;

[1] Available at: http://www.globalhivmeinfo.org/AgencySites/MERG%20Resources/MERG%20Indicator%20Standards_Operational%20Guidelines.pdf and http://www.unaids.org/en/resources/presscentre/featurestories/2009/march/20090313propertyrightundp/

Concerned that key populations most at risk of HIV face structural barriers to accessing HIV prevention, treatment and care services, which further widens social inequalities, and that access to lifesaving antiretroviral therapy in lowand middleincome countries of the Region is among the poorest globally;

Recognizing that HIV impacts the control and health outcomes of other communicable diseases, particularly tuberculosis, and that HIV poses a considerable resource burden on health systems;

Acknowledging the overdependence on external international funding for HIV programmes in some parts of the Region;

Acknowledging that all countries in the Region can seize opportunities for action by using existing evidence and experience derived from successful projects and interventions implemented throughout the Region;

1. ADOPTS the European Action Plan for HIV/AIDS 2012–2015 as a plan for the European Region for the implementation of the Global Health Sector Strategy for HIV/AIDS 20112015 and the UNAIDS 20112015 strategy as adopted by the UNAIDS Programme Coordinating Board (PCB) as well as the resolutions adopted at the World Health Assembly as call for urgent action to the Member States in the European Region to respond to the public health challenge of HIV/AIDS in Europe;

2. RECOMMENDS Member States[1]:
   (a) to reinforce their political commitment and ensure the financial and human resources required to achieve the European goals of halting and beginning to reverse the spread of HIV and achieving universal, equitable access to comprehensive HIV prevention, treatment and care by 2015, in line with Millennium Development Goal 6 and linked with other healthrelated goals (MDGs 3, 4, 5 and 8);
   (b) to ensure that prevention programmes target key populations at higher HIV risk and include a comprehensive harm reduction package of interventions for people who inject drugs and interventions to reduce sexual transmission of HIV in sex workers and men who have sex with men;
   (c) to further develop integration and linkage of HIV programmes with other health programmes, particularly those on tuberculosis, drug dependence, sexual and reproductive health, maternal, child and adolescent health, viral hepatitis and noncommunicable and chronic diseases;
   (d) to increase efforts to strengthen health systems to benefit HIV and the broader public health response, including strong HIV strategic information systems, delivery of services that meet patients' and clients' needs and uninterrupted qualityassured supply of affordable HIV medicines, diagnostics and other commodities;
   (e) to take any necessary action on laws and regulations that present obstacles to effective HIV prevention, treatment and care, and support, and to strengthen the implementation of protective laws and regulations, including those addressing stigma and discrimination, in line with principles of public health and human rights;
   (f) to engage in partnerships, public and private, using a multisectoral approach and to increase the participation of people living with HIV, key populations and civil society actors in policy development, decisionmaking and coordination, service delivery, and monitoring and evaluation of national HIV strategies and plans;

[1] And, where applicable, regional economic integration organizations

3. REQUESTS the Regional Director:
   (a) to actively support the implementation of the Plan in the Region by providing leadership, strategic direction and technical guidance to Member States;

   (b) to engage in global and regional partnerships and to advocate for commitment and resources to strengthen and sustain the response to HIV;

   (c) to identify and facilitate the exchange of best practices and experiences among Member States and to produce evidenceinformed tools for an effective HIV response;

   (d) to monitor and evaluate Member States' progress towards reaching European goals and targets through a harmonized process of data collection, reporting and analysis;

   (e) to report back to the Regional Committee at its sixtyfourth and sixtysixth sessions in 2014 and 2016 on the implementation of the European Action Plan for HIV/AIDS 2012–2015.

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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The primary audience for the European Action Plan for HIV/AIDS 2012–2015 is the national authorities in the WHO European Region responsible for HIV diagnosis, prevention, treatment, care and support, including health ministries and other government bodies responsible for health. The Action Plan is also intended for national authorities and ministries other than those directly responsible for health, including finance, education, social welfare, child protection, transportation, infrastructure, criminal justice, labour, immigration, development, defence, and foreign affairs, as well as associations, professional bodies, researchers, academics, civil society, advocacy groups, trade unions, the private sector, and international and global partners, including bilateral and multilateral donors.

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