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Progress on implementing the Dublin Declaration

on Partnership to Fight HIV/AIDS in Europe and Central Asia

POLICY BRIEF

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This policy brief was written by Jeffrey V. Lazarus and Misha Hoekstra, based on the UNAIDS/WHO publication "Progress on Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia", edited by Srdan Matic, Jeffrey V. Lazarus, Stine Nielsen, Ulrich Laukamm-Josten. Available at www.euro.who.int/aids

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Beyond the promises of Dublin

When the Member States of the WHO European Region signed the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia in February 2004, they could not have known what a historic document it would become. Fully two years before the rest of the international community, the European Region made a visionary call in this Declaration for "universal access to effective, affordable and equitable prevention, treatment and care". Now, four years after the Declaration signing, this initial progress report takes stock of the situation in the Region by discussing which indicators can best help us to understand current efforts to combat HIV, how to interpret the most recent data collected for these indicators and how to improve HIV efforts.

The European Region is now experiencing the fastest rate of growth of HIV prevalence in any region of the world. Against the background of this worsening HIV epidemic and, in many countries, struggling health systems to address the emerging public health and societal challenges *(1)*, the representatives of Governments from Europe and central Asia met in Dublin, Ireland, on 23–24 February 2004 for the conference "Breaking the Barriers – Partnership to fight HIV/AIDS in Europe and Central Asia" to explore these challenges and to develop a response to them. The conference culminated in a declaration to more effectively tackle in Europe and Central Asia the HIV epidemic and its consequences. The "Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia" recognised the principal factors contributing to the spread of HIV/AIDS, reaffirmed the Declaration of Commitment on HIV/AIDS adopted by the UN General Assembly Special Session (UNGASS) on HIV/AIDS on 27 June 2001 and subsequent international commitments and agreed 33 points of action to "…accelerate the implementation of the Declaration of Commitments on HIV/AIDS".

Under the auspices of the Joint United Nations Programme on HIV/AIDS (UNAIDS), the WHO Regional Office for Europe and its partners have prepared this report on the progress made in implementing the Dublin Declaration since it was signed in early 2004. In accordance with Action 33 of the Declaration, this progress report seeks to help the Member States of the Region to "closely monitor and evaluate the implementation" of its actions.

The report draws on continuing monitoring efforts conducted by the United Nations, its agencies, the European Union (EU) and various national bodies in the Region, in accordance with global efforts to harmonize and streamline monitoring and evaluation activities. It comprises 15 thematic chapters followed by 9 country profiles. This effort is timely in that in 2005, the Group of Eight (G8) and the United Nations made similar commitments *(2)*, in 2006, the United Nations member states agreed to work towards "universal access to comprehensive prevention programmes, treatment, care and support" by 2010 *(3)* and in 2007 the German EU Presidency held the conference "Responsibility and Partnership:

Together Against HIV/AIDS," again highlighting the gravity of the situation in Europe and calling for renewed action *(4,5)*.

In reviewing the thematic chapters, several broad imperatives for HIV efforts in the European Region have emerged. They include the need to:

- simplify data collection on HIV and other sexually transmitted infections, ensuring that the collected information is useful and relevant for individual countries while avoiding overlap and reducing the burden of reporting placed on the Member States;
- ensure that the information collected is accessible and available to other agencies and the general public;
- establish greater accountability;
- amend legal and regulatory frameworks to enable them to better address HIV-related stigma, exclusion and discrimination;
- intensify, scale up and improve the targeting of HIV efforts to reduce inequities;
- work for greater harmonization of the highest standards of prevention and treatment programmes and policies;
- expand the use of internationally recognized evidence-based interventions;
- strengthen cooperation between countries on such efforts;
- increase civil society and private sector involvement; and
- retain strong European political leadership and accountability for the Dublin Declaration, the Millennium Development Goals and the universal access goals.

The following section summarizes the report's key findings and recommendations for each thematic area. It should be kept in mind that these summary statements are broad generalizations that will rarely apply to all 53 countries in the WHO European Region. More detailed information about the countries can be found in the full report at www.euro.who.int/aids. The particular Dublin actions listed for each chapter may be consulted in Appendix 1.

Key findings and recommendations: leadership and partnership

Chapter 1. Political leadership *(Actions 1, 3, 5, 6, 22, 26 and 30)*

Relevance. The largely unchecked growth of HIV in the first decades of the epidemic was due in great part to widespread denial among decision- and policy-makers. An effective HIV response requires political vision and leadership, especially since the groups at greatest risk for HIV tend to be disproportionately marginalized by society and their activities often criminalized by the state.

Key findings

- National and international political leadership on HIV has been significantly strengthened in the European Region.
- National leaders are increasingly speaking out on HIV.
- Financial resource constraints have eased in many countries.
- Regional institutions are now addressing HIV regularly and cross-border partnerships are stronger, though gaps persist.
- Civil society is being consulted more at the country and European levels.
- Political leadership challenges now often lie in implementation rather than in making policy or allocating money. The worst implementation gaps lie in carrying out structural reforms to health systems, instituting harm-reduction programmes and confronting other injecting drug user (IDU) issues.

Key recommendations

- Progress and accountability on HIV commitments need to be consistently monitored and evaluated.
- The EU should strive for greater inclusion in its response to HIV of countries and subregions beyond its borders and neighbourhood programmes – as should the Commonwealth of Independent States CIS) Coordination Council on HIV/AIDS.
- National and local leaders must redouble their efforts to implement every Dublin action and live up to each commitment. That means speaking out frequently about HIV, ensuring policy is evidence- and rights-based, and establishing coordination and management structures in accordance with the UNAIDS Three Ones principles (6).
- All countries should prepare timely, comprehensive UNGASS reports. A regional synthesis of reports from the Europe Region would be an invaluable supplement.
- Policy- and decision-makers should make concerted efforts to protect the rights of people living with HIV (PLHIV) or at high risk for it, to reach out to risk populations and to plan for future HIV resource increases to match the long-term growth of the epidemic (see specific recommendations below).

Chapter 2. Civil society and other nongovernment stakeholders *(Actions 2, 4, 27 and 32)*

Relevance. Civil society (particularly community-based groups representing people living with or at risk for HIV) has long played a pioneering role in responding to HIV. Yet many governments have been slow to utilize their invaluable resources or recognize the right of affected communities to help shape the response.

The resources and outreach opportunities of the private sector are similarly underutilized.

Key findings

- Government commitments to greater involvement of civil society have yet to be translated to pervasive action. Government efforts to increase involvement have been patchy, incremental and uncoordinated.
- There *has* been a marked increase in civil society involvement in HIV policy- and decision-making in most countries – but it has been largely driven by civil society itself.
- Global, regional and subregional networks of PLHIV and risk group members have increased dramatically in number and size.
- There exist few systematic data on the participation of civil society, PLHIV or risk group members in the HIV response. Some of the best such data sources remain largely inaccessible to the public.
- While the Code of Good Practice for NGOs Responding to HIV/AIDS *(7)* has encouraged accountability and responsible action in civil society, no corresponding mechanism exists for private businesses engaged in HIV-related philanthropy and customer and community outreach.

Key recommendations

- Governmental bodies need to proactively involve civil society, PLHIV, risk group members and the private sector in shaping and implementing the national response to HIV.
- UNAIDS should post UNGASS shadow reports on its web site and make its country office date more widely available.
- The Code of Good Practice for NGOs Responding to HIV/AIDS should be more widely promoted and adopted.
- The Global Business Coalition should be urged to develop a version of the NGO Code for firms engaged in HIV-related philanthropy and outreach, including implementation and accountability mechanisms.

Chapter 3. Resources in eastern Europe *(Actions 1, 7, 8, 9, 13, 17 and 29)*

Relevance. Roughly 2 million people in eastern Europe (the 15 former Soviet republics) live with HIV, while HIV incidence there has soared 20-fold in less than a decade. The area includes the fastest-growing HIV epidemics in the world, driven chiefly by injecting drug use. Meanwhile, some of its countries experienced severe economic downturns and turmoil after achieving independence, leading to increased income disparity.

European populations are increasingly mobile, and HIV recognizes no national boundaries. Accordingly, the Dublin Declaration commits all European Region nations to act collectively in addressing HIV – which means ensuring eastern Europe has adequate resources to fight HIV effectively.

Key findings

- Estimated HIV resource needs for eastern Europe have risen from US$ 900 million in 2006 to US$ 1.5 billion in 2008, with more than 70% for prevention.
- International donors have increased contributions to HIV efforts in the 12 CIS states from US$ 12 million in 2003 to an estimated US$ 60 million in 2006, including a sharp increase in 2005 from the Global Fund to Fight AIDS, Tuberculosis and Malaria.
- Domestic HIV funding has doubled in the same period, to US$ 60 million in 2006 for CIS countries except for the Russian Federation.
- In the Russian Federation, domestic funding has risen even more dramatically, to US$ 320 million in federal allocations in 2007, in addition to large commitments to reimburse the Global Fund and to develop an HIV vaccine. However, prevention efforts for risk populations remain seriously underfunded.
- Out-of-pocket expenditures, which affect the poor disproportionately, have also increased in the CIS, now averaging almost 50% of all HIV spending.

Key recommendations

- Despite large increases in international and domestic HIV funding, the gap between available resources and need continues to grow – as does the area's epidemic.
- Domestic and international contributions to the HIV response in eastern Europe need to increase substantially.
- Allocations should be more closely matched to need. In particular, there is a desperate need for eastern European governments to expand evidence-based prevention efforts targeting IDUs dramatically.
- Governments and donors should seek for ways to reduce out-of-pocket expenditures for those least able to pay.
- Better measures to determine the national funding requirements for a comprehensive response to HIV need to be developed in the near future.
- Accurate, detailed HIV spending assessments need to be conducted nationally and subnationally to facilitate more efficient allocation of funds.

- Allocations also need to be aligned with current scientific findings and determination of best practice, following e.g. UNAIDS prevention guidelines *(8)*, WHO clinical protocols *(9)* or nationally tested interventions.

Key findings and recommendations: prevention

Chapter 4. Injecting drug use *(Actions 9, 10, 21 and 33)*

Relevance. Injecting drug use is the primary driver of HIV epidemics in eastern European and central Asian countries. Injecting drug users continue to contribute to HIV epidemics in many western European countries. Despite overwhelming scientific evidence about the effectiveness of targeted "harm-reduction" efforts, including opioid substitution therapy and needle and syringe exchange programmes, in drastically reducing HIV transmission, some countries persist in persecuting IDUs and ignoring their prevention and care needs.

Key findings

- In western Europe and the EU, countries have demonstrated the political will to scale up access to opioid substitution therapy (OST) and needle and syringe programmes (NSPs). Progress in some of the new EU countries, notably the Baltic countries, is less than in the rest of the EU, but still substantial.
- The rest of eastern Europe shows far less progress, including five countries without OST and others where OST is only provided on a pilot basis. Even in Ukraine, where a concerted effort has been made to introduce OST, coverage remains poor.
- NSPs have adequate coverage in most of western Europe except in prisons, where it is rarely available.
- While access to highly active antiretroviral therapy (HAART) has improved across the European Region, discriminatory practices continue to prevent IDUs from accessing and adhering to it.
- United Nations agencies support harm reduction and have prepared a technical guide to facilitate national development of a framework, indicators and targets for monitoring progress on HIV interventions targeting IDUs *(10,11)*.

Key recommendations

- Countries should make focused efforts to scale up IDU access to OST and other harm-reduction services and to HIV treatment.
- Where injecting drug use contributes significantly to HIV epidemics, or where IDUs are at risk of HIV, the government should use the United Nations technical guide *(10)* to determine the national mix and coverage levels of the nine interventions in the Comprehensive Package for prevention, treatment and care of HIV in injecting drug users
- Countries need to set national targets that ultimately aim at providing full access to indicated HIV prevention, treatment and care interventions for all IDUs. Suggested coverage targets are for NSPs to reach at least 60% of all IDUs, and for OST to reach at

least 40% of opioid-dependent IDUs.
- Countries should utilize pharmacies in making NSPs and sterile injecting equipment widely available.
- Armenia, Kazakhstan, the Russian Federation, Tajikistan and Turkmenistan are urged to introduce OST promptly.
- Countries should massively scale up IDU access to HAART, using OST to improve access and adherence.
- Countries should use the United Nations technical guide to set ambitious but achievable national targets for scaling up IDU access to HIV prevention, treatment and care. They should also harmonize the ways they measure progress on scaling up with other countries in the Region.
- Countries should collect data on OST and HAART, and on current IDUs receiving HAART.

Chapter 5. Prevention in vulnerable populations and risk groups *(Actions 9, 13, 25 and 27)*

Relevance Risk groups are defined by behaviours that put members at risk for HIV. In western Europe, the HIV epidemic is especially concentrated among men who have sex with men (MSM), and in eastern Europe, among IDUs. Because risk groups tend to be marginalized and often driven underground, targeting them for prevention poses special challenges.

Vulnerable populations are defined by external circumstances that reduce members' ability to avoid HIV infection, such as poverty, incarceration and war, that often render them similarly invisible and likewise demand targeted interventions. Migrants and certain ethnic minorities are at high risk for HIV, as are prisoners throughout the Region.

Key findings
- Although sex workers are the risk group most likely to respond positively to prevention programmes, many national policies and laws aimed at sex workers continue to place them at heightened risk for HIV. Sex workers who are also MSM, migrants or IDUs are especially in need of targeted interventions.
- In central and eastern Europe, data on MSM continue to be minimal in comparison to other risk groups. Recent evidence suggests that in eastern European countries with a major HIV epidemic among IDUs, there is also a hidden epidemic among MSM.
- Same-sex relations have now been decriminalized in all nations of the Region except for Turkmenistan and Uzbekistan. Recent decriminalization has often been driven by intense external pressure, and in many countries MSM still face stigmatization, persecution and harassment, much of it sanctioned by the state.

- Following recent EU expansions, there has been a large-scale temporary influx of young sexually active migrants from central to western Europe. There is great concern that these migrants will bring HIV back to their home countries, where prevalence rates are now quite low. Migrants continue to face barriers in accessing medical and social services, while the monitoring of migration and HIV in the Region is lacking.

For key findings on IDU, gender, youth and prisoner issues, see the sections on chapters 4, 6, 8 and 15, respectively.

Key recommendations

National governments should:

- ensure that national HIV policies and strategies draw attention to those who are members of more than one vulnerable population or risk group;
- audit existing legislation and regulations for obstacles to the development and utilization of HIV prevention programmes for vulnerable populations and risk groups – and then remove the obstacles;
- implement a national policy to guarantee vulnerable populations and risk groups equitable access to HIV prevention and care;
- incorporate comprehensive surveillance systems into their national HIV policies and strategies to identify and support vulnerable populations and risk groups;
- ensure that national HIV prevention programmes satisfy the standards set out in the UNAIDS guidelines for intensifying prevention efforts *(8)*;
- ensure that the national HIV strategy and related frameworks specifically mention the need to protect vulnerable populations and risk groups from violence;
- take steps to counter the stigma experienced by vulnerable populations and risk groups, including any stigma they may experience from health care providers;
- outline these targets and undertakings in programme guidance documents, and align national data collection surveys with them to monitor progress; and
- provide, in partnership with civil society organizations, a wide range of HIV prevention programmes targeting all major vulnerable populations and risk groups.

Chapter 6. Gender equity *(Actions 13, 14, 20 and 21)*

Relevance. Women and men have different needs and abilities. Moreover, they have been and continue to be treated very differently by government, society and health services in ways that do not address these natural differences and are thus patently inequitable. For maximum effectiveness – and justice – HIV efforts need to strive for equity while recognizing essential gender differences.

Key findings

- Statistics on HIV prevalence and access to HIV prevention, treatment and care are still very rarely disaggregated by sex, making it nearly impossible to monitor progress on gender equity – and thus to *make* progress on it.
- Men still comprise the overwhelming majority of new HIV infections in the European Region, but official rates of newly reported cases indicate a slightly growing percentage of female PLHIV (36% in 2004 and 39% in 2006).
- While injecting drug use and sex between men continue to be the primary drivers of the European epidemic, many countries have observed an increase in reports of heterosexual transmission. Yet very few of these countries have developed or implemented prevention programmes aimed at women, specifically at the migrant women who are most in need of it.
- No data on HIV and transgender individuals are available.
- Sexual transmission of HIV from male IDUs to their female partners is helping drive the European epidemic, though partners of risk group members are very rarely targeted by prevention programmes.
- What has sometimes been termed "the feminization of HIV" does not apply to the European Region at this time.

Key recommendations

- HIV monitoring bodies should request – and countries should gather – surveillance statistics disaggregated by sex.
- Countries need to report the steps they are taking in combating HIV to target men and women respectively, and to measure the effectiveness of these efforts.
- Prevention programmes need to be developed to target the sexual partners of IDUs, migrants and prisoners, and the female partners of MSM.
- Countries need to identify obstacles to gender-equitable prevention and care – and dismantle them. Such barriers may include the location, hours, staffing and programming of services; unconsciously restrictive laws and policies; and gender-related violence.

Chapter 7. Mother-to-child transmission of HIV (MTCT), and children living with HIV *(Actions 11, 12 and 14)*

Relevance. In the absence of preventive interventions, an infant born to and breastfed by an HIV-positive woman has a one-in-three chance of contracting HIV. Appropriate interventions – timely antiretroviral treatment, caesarean deliveries and safe alternatives to breastfeeding – can reduce MTCT to nearly zero.

Dublin Action 11 commits the Region to eliminating MTCT – defined as reducing transmission to less than 2% – by 2010. With a concerted effort, this goal is clearly achievable.

A comprehensive approach to paediatric HIV also requires addressing HIV incidence among women of childbearing age (especially in eastern Europe, where more new cases are being reported for this cohort), diagnosing HIV in children early and improving the treatment of paediatric HIV.

Key findings

- Significant progress has been made in eliminating MTCT in most countries.
- In 2005, the 23 countries of western Europe reported only 167 cases of MTCT.
- Many eastern European countries have rapidly scaled up their MTCT prevention programmes, though challenges remain, including improving service quality.
- Data quality is poor for several eastern European countries but indicates that in the countries most affected by HIV, MTCT has been reduced to about 10% or below.
- Though the European Region is home to only 1% of the world's children living with HIV, there is still cause for grave concern. In the most-affected countries of eastern Europe, the number of paediatric HIV deaths has risen steadily. One contributing factor is health system failures.
- Overall, however, access to treatment has increased substantially for children living with HIV.
- Children living with or affected by HIV require greater social support and legal protection in many countries.

Key recommendations

- Countries should seek to implement the "Four Ps", the programmatic goals of the *Unite for Children, Unite against AIDS* initiative:
  - Prevent mother-to-child transmission of HIV
  - Provide paediatric treatment
  - Prevent infection among adolescents and young people
  - Protect and support children affected by HIV and AIDS *(12)*.

Specifically:

- National policies and protocols for MTCT and paediatric HIV need to be updated to reflect the latest scientific evidence.
- Eastern European countries need to mobilize national and subnational resources for MTCT prevention programmes in order to reduce dependence on external funding. Such resources should be adequate to ensure uninterrupted supplies of HIV tests, antiretroviral drugs, drugs for prophylaxis and treatment of opportunistic infections, and supplies of modern contraceptive methods, including condoms.
- Countries need to strengthen their institutional capacity for addressing paediatric HIV, including upgrading the quality of medical and psychosocial support services (see Chapter 12 for further recommendations on this issue).
- Countries need to systematically monitor and evaluate the progress in their efforts related to PMTCT and paediatric HIV.
- Health systems should integrate PMTCT programmes with existing maternal and child health and reproductive health services, including family planning services.
- Special efforts need to be made to target MTCT in women who represent the most vulnerable populations and engage in risky behaviour. Several measures should be undertaken to provide a protective environment for children affected by HIV, including providing legal protection and monitoring of their rights, and ensuring that national policies favour adoption and foster care over institutionalization.
- Countries need to make sure that eliminating HIV among infants and young children is a priority in their national HIV strategies.

Chapter 8. Youth *(Actions 3, 8, 13)*

Relevance. The youth of any nation – defined as being age 15 to 24 (and termed "young people" in the Dublin Declaration) – are its immediate future. It is morally incumbent upon society to give them the tools to avoid and, when necessary, learn to live with HIV. Moreover, educating youth about HIV is one of the best long-term strategies to combat the epidemic by helping them resist risk behaviours at a formative age, by reducing HIV-related stigma and discrimination and by improving health-seeking behaviour. Although antiretroviral therapy can make HIV a chronic rather than fatal disease, it is expensive, and the longer life expectancy of infected youth makes prevention efforts targeting them more cost-effective than ever.

Key findings

- In 2005, the percentage of newly diagnosed cases found in youth was 31% in eastern Europe, 21% in central Europe and 10% in western Europe and declined to 27%, 17% and 10%, in 2006, respectively.
- In eastern Europe, which accounted for more than two thirds of the Region's new HIV

infections in 2005, the rate of new cases reported among youth is falling.
- Females made up 27% of new HIV infections reported among eastern European youth in 1999–2002, and 53% in 2003–2005.
- In the worst affected areas, the drivers of HIV infection in youth are rooted in unemployment, social breakdown and the absence of a positive outlook.
- Data collection for major indicators on youth behaviour and the effectiveness of HIV education and prevention efforts targeting them remain weak globally and throughout the European Region, especially in eastern and central Europe.
- Early exposure to sexuality education is not associated with an earlier age of sexual debut; the promotion of safe sex is most effective if it begins in primary school, before debut.
- While sexuality education has been shown to be a cost-effective prevention strategy when of high quality, it continues to be marked by quality and consistency problems across the Region.
- While countries in the Region have all committed themselves to international declarations and action frameworks that support effective action on youth and HIV, these commitments have rarely been translated into a correspondingly supportive national legal environment.

Key recommendations
- Policy-makers and service providers should approach youth development with a foundation of respect, understanding and openness.
- Youth–adult partnerships and youth participation should be key elements of HIV prevention programming.
- Efforts targeting youth at risk for HIV, including those who are MSM, IDUs or sex workers, should be prioritized, and the individuals treated with respect.
- Governments (through the ministries of health and education, or their equivalent) should support comprehensive sexuality and reproductive health education and take steps to ensure its quality.
- The health sector should prioritize the development of youth-friendly services, including sexual and reproductive health services.
- Governmental bodies need to prioritize long-term monitoring and the collection of age-disaggregated data, using the age brackets of 10–14, 15–19 and 20–24 years.
- International donors should ensure adequate attention to HIV youth programming, with an emphasis on harm reduction (condoms, opioid substitution therapy, etc.) and educational interventions.

Chapter 9. HIV in the workplace *(Actions 2, 15 and 28)*

Relevance. Most PLHIV are in their economically productive prime, and HIV is responsible for a great deal of lost productivity in the European Region due to not only sickness, but also to the stigma and discrimination that its PLHIV suffer. Despite widespread social security coverage, employers must bear a large number of the direct and indirect costs of HIV. Small businesses and workers in the informal economy are hit particularly hard.

Conversely, because of its substantial resources and ubiquity, the "world of work" offers unique opportunities for combating HIV by providing a gateway for universal access to prevention, treatment and care; targeting everyday stigma and discrimination; and reintegrating PLHIV who are receiving antiretroviral treatment into the workplace.

Key findings

- Several European countries have revised laws to address HIV-related discrimination in the workplace.
- A variety of national and individual initiatives have been undertaken to institute workplace prevention and education programmes.
- In several countries, the government and civil society are jointly implementing programmes to (re)integrate PLHIV into the labour market.
- The International Labour Organization (ILO) has been using Decent Work Country Programmes to accelerate implementation of the *Code of Practice on HIV/AIDS and the World of Work (13)*, which addresses workplace issues including prevention, PLHIV support and care, and stigma and discrimination.
- The ILO is developing a new international labour standard on HIV to strengthen and speed up the workplace response for economic sectors ranging from forestry to tourism to public services.
- The UNAIDS Secretariat and several cosponsoring agencies have been working with 18 central and eastern European countries to develop and implement programmes addressing HIV in the armed forces.
- Migrant and mobile workers continue to be especially vulnerable to HIV infection – and consistently underserved by HIV services.

Key recommendations

- Employers and trade unions should work together to implement Article 27 of the Bremen Declaration on Responsibility and Partnership *(4)*, including its call to establish non-discriminatory policies for PLHIV and risk groups in the workplace, provide information on HIV to employees and, in accordance with the ILO Code of Practice on HIV/AIDS *(13)*, guarantee access to HIV prevention, testing, treatment and care.
- Governments should ensure that national laws prohibit HIV-related discrimination in hiring and in the workplace.
- Governments should include a world of work strategy in national HIV plans and promote

HIV prevention programmes in all workplaces.
- Workers' organizations should promote workplace HIV policies in line with the Code of Practice, including collective agreement provisions.
- Workers' organizations should support the formation of associations for young people and for migrant workers.
- Civil society and trade unions should collaborate to monitor cases of stigma and discrimination suffered by PLHIV in the workplace.
- Civil society and trade unions should educate PLHIV about their workplace rights.

Chapter 10. Sexually transmitted infections (STIs) *(Action 16)*

Relevance. Many acute STIs increase the risk of HIV infection and transmission. STI prevention is not only an important HIV prevention measure, but also a key health goal in itself. Conversely, PLHIV are at higher risk for STIs and can experience severer STI symptoms than HIV-negative people. With their shorter incubation periods and similar modes of transmission, certain STIs can serve as indicators of potential HIV infection, and a good reason for health care providers to offer a patient an HIV test.

Key findings

- There is widespread variation in the composition and quality of national STI surveillance systems in the European Region. Relatively weak systems and a lack of consistency in case definitions greatly limit the recognition of regional trends and the comparability of data.
- Syphilis incidence increased from low levels to a peak in 2003–2004 in most western European countries, mirroring HIV trends; in central Europe the trends are mixed, but also mirrors the trends in new HIV cases reported. Gonorrhoea trends resemble HIV trends for both subregions, being concentrated among MSM and heterosexuals with many partners.
- In eastern Europe, the much higher syphilis rates have fallen but do not follow HIV trends, since HIV there is largely driven by injecting drug use. Gonorrhoea incidence there has also declined.

Key recommendations

- As part of second-generation HIV surveillance, national STI surveillance systems need to be strengthened and harmonized throughout the Region *(14)*.
- Governments should use high-quality STI surveillance and evidence-based approaches to integrate prevention and treatment services for HIV and STIs.
- A regional mechanism should be considered for systematically collating, assessing and monitoring the extent to which national health systems address STI and HIV control.
- STI efforts should be guided by both the UNAIDS public health approach *(15)* and the WHO global STI strategy *(16)*.
- Safer sex behaviour needs to be encouraged throughout the Region with proven

interventions – particularly condoms – and by addressing the factors underlying risky sexual behaviours, including socioeconomic factors such as poverty and the use of alcohol and other recreational drugs.

- Proven methods should be used to encourage:
  - people to seek health care for sexual health problems;
  - the integration STI and HIV control into primary care and other health care services, where relevant;
  - the provision of specific STI services that target risk groups;
  - the provision of comprehensive case management; and
  - the detection of asymptomatic and symptomatic STIs earlier.

Chapter 11. Research and new technologies *(Actions 19 and 24)*

Relevance. The last 15 years have seen remarkable advances in HIV therapy, but effective treatment remains expensive, adherence difficult and side-effects often debilitating. Diagnostic technology could be more accurate and easier to use. And, while generally efficacious, existing interventions do not meet all the prevention needs of PLHIV or members of risk groups. Such shortcomings can only be addressed by dedicated investment in research and development (R&D).

Key findings

- Data on HIV-related R&D remain sparse, inconsistent and irregularly collected. What does exist focuses on funding commitments rather than actual expenditures.
- The EU has made a concerted and successful effort to improve coordination, cooperation and competitiveness among European researchers, e.g. by introducing the European Research Area, utilizing Framework Programmes for Research and Technological Development (FPs) and setting up the European and Developing Countries Clinical Trials Partnership (EDCTP).
- While the European Commission increased funding for R&D on new HIV technologies in Framework Programme 7 (2007–2013), its decision to hold the public health budget at the same level as the previous budget was a disappointing setback for HIV research, which is often linked to public health activities.
- More than 80% of HIV vaccine and microbicide R&D is funded by the public sector. Yet though the European Region is the wealthiest of the six WHO regions, it funds just 10% of the world's public sector investment in HIV vaccine R&D and 21% of global microbicide R&D.
- While support for vaccine R&D has been growing, the global investment of US$ 760 million falls short of the estimated US$ 1.2 billion needed to drive development forward at an optimal pace.
- The private sector, especially the pharmaceutical industry, continues to be very active in

developing HIV treatments but reluctant to invest in other areas of HIV R&D, such as vaccines, microbicides and social science research, which are considered to have uncertain outcomes and poor commercial prospects.
- While many western European governments have abandoned certain types of HIV research as infeasible to undertake nationally, they have begun to provide substantial grants to international private–public product development partnerships (PDPs).
- Most central and eastern European countries, which struggle to fund HIV prevention and treatment programmes adequately, provide minimal or no funding for HIV research, though the Russian Federation is a recent exception.
- There is an EU funding gap for social and behavioural research (due to inflexible participation rules) and international PDPs.

Key recommendations
- Data needs to be collected at the European Region level about public, philanthropic and private funding of HIV-related research.

The European Commission should:
- increase resources for research efforts;
- include social science in its definition of HIV-related research eligible for funding;
- increase its public health budget and encourage HIV projects to incorporate a research component;
- increase the flexibility of contracting arrangements for FP7 grants to allow outsourcing approaches and responsive product-focused research;
- support global research efforts as outlined in *FP7 Cooperation Work Programme 2007–2008: health (17)*; and
- establish and maintain R&D capacity-building efforts in the countries that most need it.

National governments should:
- if EU members, satisfy all financial commitments to the EDCTP;
- increase the national budget for HIV-related research, as committed to in signing the Dublin Declaration, using as a possible guideline the Sydney Declaration, which calls for 10% of national HIV spending to be allocated to HIV research *(18)*;
- explore partnerships whereby western European countries test HIV technologies in eastern Europe;
- increase support for international HIV research efforts, e.g. international PDPs and social science research; and
- improve national coordination of research funding.

Key findings and recommendations: living with HIV

Chapter 12. Treatment and care *(Actions 13, 21, 23 and 25)*

Relevance. The introduction of HAART in 1995–1996 to western Europe represented a major turning point in the response to HIV. It turned a mortal disease into a manageable chronic infection, so that a person infected with HIV at 25 can now expect to enjoy another 35 years of quality life. Where access to HAART has been made widely available, affordable and equitable – an admittedly difficult achievement – it has resulted in dramatic declines in HIV-related morbidity, mortality, infectivity and risk of onward transmission, with correspondingly substantial economic and demographic benefits.

Key findings

- HAART coverage for the European Region rose from 282 000 people in mid-2004 to 435 000 by December 2007, when it was estimated as "very good" (>75%) in 38 of the 53 Member States. For central and eastern Europe, where the need is greatest, coverage went from 16 000 to 55 000 in the same period – a substantial scale-up, but still far short of need.
- From mid-2004 to the end of 2006, reported HIV cases in the Region rose from 774 000 to 1 025 000, and reported AIDS cases from 285 000 to 328 000.
- HAART coverage for women and particularly children is high.
- In eastern Europe and Poland, IDUs represented about 80% of all reported HIV cases, but only 39% of HAART recipients at the end of 2006. While this percentage represents major progress in IDU access to HAART, such access remains greatly restricted and inequitable in the area. IDU coverage is poor because overall HAART coverage is low in countries where most PLHIV are IDUs, and because health care providers often discriminate against infected IDUs.
- Access to OST, which greatly increases IDUs' treatment adherence, is minimal in much of central and eastern Europe.
- In most of central and western Europe, ARV drugs for the first-line regimen cost average about US$ 10 000 annually. Significant price reductions have been achieved in eastern Europe, falling to as low as US$ 300–400 in Ukraine.
- While the cost of ARV drugs remains prohibitive in many countries, they are offset by substantial reductions in treatment costs for opportunistic infections and other HIV-related conditions.
- The reported number of tuberculosis (TB)/HIV coinfections remains low in the Region – 6800 in 2005 – but that may be attributable to a lack of coordinated surveillance. Multidrug-resistant TB prevalence is especially high in eastern Europe.

- Liver disease is replacing AIDS as one of the most common cause of death among PLHIV in Europe, indicating an urgent need to address hepatitis B and C coinfection in the Region.
- The tracking and managing of pharmacovigilance and antiretroviral resistance in PLHIV, in order to ensure safety and efficacy, have emerged as major – and expensive – clinical challenges.
- In 2007, the WHO Regional Office for Europe, in collaboration with experts from around the world, developed a key set of 13 clinical protocols on HIV treatment and care *(9)*.

Key recommendations

- Countries should continue to strive towards the goal of providing universal access to HIV treatment by 2010 *(19)*.
- Countries should ensure the same access and treatment standards for all, regardless of gender, age, sexual orientation, substance use, imprisonment or migratory status. A special effort should be made to remove obstacles to treatment of IDUs and other vulnerable populations such as migrants.
- Health care services for PLHIV should comprehensively address their needs, including prevention and treatment of comorbidities, age- and behaviour- related health issues.
- Universal HIV treatment access should be supplemented by the coordinated efforts of experienced care teams, including social workers, linked to sustainable, publicly funded community services providing nursing and home-based care.
- Accurate, detailed, regularly updated databases are needed to track antiretroviral treatment, HIV resistance, major HIV coinfections and risk behaviours.

Chapter 13. Stigma, discrimination and human rights *(Actions 1, 20 and 31)*

Relevance. The Dublin Declaration observes that respecting, protecting and promoting human rights is "fundamental to preventing transmission of HIV, reducing vulnerability to infection and dealing with the impact of HIV/AIDS". It also commits European nations to combating HIV-related stigma and discrimination.

Human rights are germane to nearly every aspect of the HIV response. The various Dublin actions reinforce national commitments to honour and protect numerous rights, including the right to life, the right to the highest attainable level of health, the right to an adequate standard of living, the right to social protection and the various rights of children.

The stigma and discrimination experienced by PLHIV and members of risk groups and vulnerable populations critically affect not only individual quality of life, but also access to prevention, treatment and care. Prevailing levels of stigma and discrimination also help determine how well a country will fulfil – or not fulfil – its Dublin commitments.

Key findings

- Few of the 53 countries in the European Region have adopted an approach to stigma, discrimination and human rights that complies with their Dublin Declaration commitments.
- Only 4 of 28 European governments surveyed had conducted the "critical review … of existing legislation, policies and legislation" promised in Action 20, to audit "existing legislation, policies and practices" for their promotion and protection of the rights of PLHIV and affected communities.
- While most European countries have laws in place to protect the rights of PLHIV, there is a broad lack of protection for the communities most affected by HIV, most notably prisoners, IDUs and sex workers, but also ethnic minorities, disabled people and MSM.
- Moreover, experience has shown that it is immensely difficult to take advantage of rights protections that do exist, and a massive gulf yawns between protection on the books and practices on the ground. The UNGASS shadow reports provide some of the clearest depictions of this gap between rhetoric and reality *(20)*.
- In many countries, citizens are unable to seek redress for violations of their rights, particularly their economic, social and cultural rights.
- An April 2007 survey of 36 European Region countries found that 22 lacked legal aid; 20 did not provide confidentiality in legal proceedings; 19 did not have lawyers and judges with appropriate training in HIV issues; and in the legal systems of about half, institutional discrimination against groups such as drug users, PLHIV, sex workers, MSM and migrants was present.
- At least 35 countries in the European Region have a national human rights commission or ombudsperson.
- The lack of HIV data that is disaggregated by e.g. gender, transmission route, age, nationality, etc. makes it nearly impossible to monitor progress on stigma and discrimination effectively, to identify the needs of particular groups or to assess the effectiveness of targeted interventions.

Key recommendations

- Future monitoring of progress on the Dublin Declaration should take an approach based on human rights and qualitatively assess country responses to indicators that directly address human rights issues.
- Outcome indicators for HIV services should be disaggregrated wherever possible and appropriate by sex, age, ethnicity, socioeconomic status, urban/rural situation and risk group membership.

Countries need to:

- critically review their legislation, policies and practices for how well they promote the enjoyment of all rights by PLHIV and members of affected communities – and amend them where needed;
- establish a human rights commission or ombudsperson if they do not already have one;
- take steps to ensure that laws and policies providing human rights protections are

honoured in practice, including by educating the public about them in and out of schools; and
- make sure that their residents can seek confidential redress for rights violations, and that the neediest can obtain free legal assistance to do so.

Chapter 14. Testing and counselling *(Actions 10 and 13)*

Relevance. Scaling up the availability of and equal access to acceptable, affordable, safe, reliable testing and counselling (T&C) services for all in need is an essential prerequisite for moving towards achieving universal access to prevention, treatment, care and support services. PLHIV who do not know they are infected cannot take advantage of HIV treatment, care and support services, which can greatly improve their health and quality of life. Moreover, PLHIV who are aware of their status are likelier to avoid risky behaviour that can infect others. T&C services should be voluntary and informed consent and confidentiality should be clearly observed, recognizing the patient's right to refuse to be tested. Further, counselling is a crucial part of HIV testing and an essential preventive intervention.

Key findings
- All European countries offer HIV testing and counselling services, but there persist significant variations in their availability, accessibility, affordability and quality in the Region.
- Data on HIV testing coverage especially for major groups being at risk and vulnerable to HIV is spotty throughout the Region.
- While the number of HIV tests performed in some central and eastern European nations rose significantly from 2001 to 2005, it remained steady in western Europe during the same period. An increased number of tests performed does not necessarily lead to increased coverage.
- Access to T&C services for vulnerable populations and those at risk remains limited in many countries.
- Mandatory, imposed testing still takes place in a number of countries across the Region.
- The fear of stigma and discrimination experienced by PLHIV in many parts of the Region limits access and discourages testing.
- Access to quality counselling remains an issue of concern.
- CIS countries have made significant progress in accelerating access to HIV testing and counselling, but access remains far from universal.
- Positive experiences in a number of countries should be shared in order to improve testing programmes and policies.
- Other major unresolved issues include T&C services for minors, a supportive environment for scaling up T&C, capacity-building needs; sustainability and monitoring and evaluation.

Key recommendations

- The national response to meeting T&C needs should be further transformed from an episodic, one-time approach to a strategic long-term national commitment based on evidence and human rights approaches, national needs and opportunities.
- Further harmonization of policies and practices across the region is required, including reaching consensus on a set of T&C-related indicators for effective monitoring and evaluation is needed.
- There should be changes in national legislation, policies and strategies in order to promote evidence-based policies and practices and an enabling environment.
- Prevention from stigma, discrimination and violence has to be ensured, and disclosure issues should be addressed in the context of protecting human rights.
- There should be further promotion of the centrality of the "3 Cs" principle (confidentiality, counselling and informed consent).
- Ensure multisectoral collaboration, including civil society involvement, in policy, strategy development and service delivery.
- Promote T&C-related capacity-building and best practice and experience sharing across the Region.
- Create and promote national guidance on pre- and post-test counselling.
- Reach consensus in countries and develop guidance on home testing.
- Support operational research addressing current T&C needs in the Region.

Chapter 15. HIV in prisons *(Actions 9 and 21; also 8, 10, 11, 13, 20 and 23)*

Relevance. People in prison have the same right to health as people in the outside community. When it comes to infectious diseases, the health of the two groups is intertwined, and safeguarding the health and lives of prisoners helps protect the health and lives of everyone outside. HIV rates are higher inside prisons than outside in much of the European Region, and ineffective prevention and treatment programmes can concentrate risk behaviours and effectively turn prisons into incubators for the virus.

Dublin Action 9 commits European governments to making comprehensive HIV prevention programmes accessible to 80% of all prisoners by 2010.

Key findings

- The coverage and quality of HIV prevention, treatment and care in European prisons is far lower than what is needed, than the coverage and quality levels found in the outside community and than what countries have promised to provide by signing the Dublin Declaration.
- A 2004 review of available data suggests that prison populations in central Europe have a lower prevalence of HIV than the general population, while prisons in much of eastern

Europe have much higher prevalence rates than outside, particularly in the countries hardest hit by HIV. The picture in western Europe is mixed.

- Many prisoners inject drugs in European prisons, often acquiring the habit in prison and often sharing needles. In 2002, drug use was more common among female prisoners in the EU than male prisoners.
- In 2006, the United Nations Office on Drugs and Crime (UNODC), WHO and UNAIDS jointly issued a national framework document laying out the actions needed to implement a comprehensive response to HIV in prisons *(21)*. It prescribes the expansion of HAART in prison and endorses needle and syringe exchanges, substitution therapy and condom provision there, while opposing mandatory HIV testing for prisoners.
- While 24 of 25 EU member states had needle exchange programmes in the community in early 2007, only 3 had such programmes in prisons.
- The incarceration of people for non-violent drug offences – which in most cases is properly a health rather than a penal issue – unnecessarily crowds prisons and introduces a major risk behaviour, increasing the transmission rates for HIV and its two most significant coinfections, TB and hepatitis, and stretching resources.

Key recommendations

- European governments must act promptly to honour their commitments to providing prison populations with universal access to HIV services.
- National and regional progress on Action 9 should be carefully monitored and widely publicized.
- Governments should significantly reduce the use of criminal penalties and incarceration as a response to non-violent drug offences.
- There should be greater involvement of NGOs in HIV surveillance and prevention within prison systems *(22)*.
- The international community should provide financial, technical and professional assistance to states in economic transition to ensure their ability to meet their commitments to providing HIV programmes in prisons.
- Evidence-based HIV interventions should be introduced to prisons to provide them with the same levels of prevention and treatment coverage and quality as the outside community. Such interventions include voluntary counselling and testing, substitution therapy, needle exchange programmes, access to condoms and lubricants, and HAART.

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Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Leadership

1. Promote strong and accountable leadership at the level of our Heads of State and Government to protect our people from this threat to their future, and promote human rights and tackle stigma and ensure access to education, information and services for all those in need;

2. Encourage and facilitate strong leadership by civil society and the private sector in our countries in contributing to the achievement of the goals and targets of the Declaration of Commitment;

3. Accelerate the implementation of the provisions of the Declaration of Commitment relating to orphans and girls and boys infected and affected by HIV/AIDS[1];

4. Establish and reinforce national HIV/AIDS partnership forums including meaningful participation of civil society, and particularly of people living with HIV/AIDS and their advocates, to design, review, monitor and report progress in the fight against the disease, and to take timely and determined action to identify and address barriers to implementation;

5. In 2004-2005, promote the active involvement of the institutions of the European Union, and other relevant institutions and organisations such as the Commonwealth of Independent States, the Council of Europe, the Organisation for Security and Cooperation in Europe and the Regional Committee of the World Health Organisation, in partnership with UNAIDS through its co-sponsoring agencies and its Secretariat, in our common effort to strengthen coordination and cooperation;

6. Make the fight against HIV/AIDS in Europe and Central Asia a regular item on the agendas of our regional institutions and organisations;

7. Provide increased and results-based financial and technical resources to scale up access to prevention, care and sustained treatment, including effective low cost treatment such as generics, in the most affected countries with the greatest needs through national and regional allocations as well as from the Global Fund to Fight AIDS, TB and Malaria, the European Union, new public and private partnerships, multilateral and bilateral financing mechanisms;

Prevention

8. Reinvigorate our efforts to ensure the target of the Declaration of Commitment[2] that, by 2005, at least 90 percent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection, in dialogue with young persons, parents, families, educators and health-care providers;

9. By 2010, ensure through the scaling up of programmes that 80% of the persons at the highest risk of and most vulnerable to HIV/AIDS are covered by a wide range of prevention programmes providing access to information, services and prevention commodities and identifying and addressing factors that make these groups and

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[1] Declaration of Commitment of the UN General Assembly Special Session on HIV/AIDS, paragraphs 65-67

[2] Declaration of Commitment of the UN General Assembly Special Session on HIV/AIDS, target 53, page 21.

communities particularly vulnerable to HIV infection and promote and protect their health, and intensify cross border, sub-regional and regional technical collaboration and sharing of best practices through the EU and regional organisations in the prevention of HIV transmission among vulnerable groups;

10. Scale up access for injecting drug users to prevention, drug dependence treatment and harm reduction services through promoting, enabling and strengthening the widespread introduction of prevention, drug dependence treatment and harm reduction programmes[3] (e.g. needle and syringe programmes, bleach and condom distribution, voluntary HIV counselling and testing, substitution drug therapy, STI diagnosis and treatment) in line with national policies;

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

12. By 2010, eliminate[4] HIV infection among infants in Europe and Central Asia;

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

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

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

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

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

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

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

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

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

Living with HIV/AIDS

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

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

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

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

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

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

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

Partnership

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

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

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

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

30. Ensure effective coordination between donors, multilateral organisations, civil society and Governments in the effective delivery of assistance to the countries most in need of support in the implementation of their national HIV/AIDS strategies, based on ongoing processes on simplification and harmonization particularly the UNAIDS guiding principles;[6]

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

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

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

Follow-up

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

24 February 2004

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