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Executive Summary

For almost two decades European countries have been active to address prevention for and care of HIV infection. Nevertheless, the recent surveillance data show an increase in the rate of new HIV infections in the EU. Parts of Europe have the fastest rate of new HIV/AIDS cases in the world. Unlike most other deadly illnesses, HIV's prime target is young people and those in working-age which may cause concerns in the years to come as the disease burden translates not only into long-term increases in healthcare expenditure, but also into heavy social costs ranging from sick leave, replacement at work and lower productivity to early retirement. It seems the time has come for health to be put at the centre of EU policy making.

There are an estimated 740 000 people living with HIV or AIDS in western and central Europe in 2006, and 1.7 million in the neighbouring countries of eastern Europe and Central Asia. The proportion of undiagnosed HIV infections is estimated to be as high as 30% in the European Union (EU), and likely to be higher in neighbouring countries. The availability of data is still not optimal and some European countries need to put more efforts in surveillance systems and reporting. The share of infections acquired by heterosexual transmission increases and young people and women are becoming more vulnerable.

As there is currently no vaccine or cure for HIV/AIDS, prevention plays the most significant role in the efforts to fight spread of the epidemic. The EU needs to continue investing in measures such as awareness-raising campaigns on healthy lifestyles, screening and education. Prevention programs have to be primarily targeted towards young people (including minority and vulnerable groups). European countries have different approaches toward HIV/AIDS issue. Some have included public health actions to address HIV/AIDS in their general health strategies and development plans – Portugal, Finland, Ireland, others have elaborated specific strategies for HIV/AIDS prevention and treatment activities – UK, Estonia, Spain, Hungary, Cyprus, Bulgaria, Romania, etc. Countries where high prevalence rates are reported in the recent years seem to be active in tackling the problem by elaborating strategies/plans to cope with HIV epidemic.

The actions taken by the European governments to expand activities in order to fight with the further expansion of HIV/AIDS epidemic is to show that a political will exists and collaborative approaches are considered. The quick review of the strategies and plans makes it clear that principles of solidarity, equity and quality are emphasised by the policy makers. However, more research is needed to estimate how many of the prepared plans are still in operation, and how effective are these plans in achieving the overall goal for eliminating HIV infections among population. It proves to be difficult to find comprehensive data base containing HIV/AIDS prevention strategies in EU. It is therefore recommendable the European Centre for Disease Prevention and Control (ECDC) to establish a database of the national strategies for HIV/AIDS prevention and care. A comprehensive and regularly maintained and up-to-date data base describing the HIV/AIDS strategies may facilitate promoting best practices among the EU member states.

I. Introduction

Good health is among the basic capabilities that gives value to human life (Sen, 1999).¹ Kofi Annan (2000)² stressed that good health consistently ranked as the number one desire of people around the world. For individuals and families, good health brings the capacity for personal development and economic security, it is the basis for job productivity, the capacity to learn and grow intellectually, physically, and emotionally. Good health is a critical input into poverty reduction, economic growth, and a long-term economic development at the scale of whole societies (Sachs, 2001).³

At the start of the 21st century, HIV/AIDS remains a communicable disease of major public health importance in Europe (Hamers and Downs, 2004).⁴ Human immunodeficiency virus (HIV) is a retrovirus that causes Acquired Immune Deficiency Syndrome (AIDS), a condition in which the immune system begins to fail, leading to life-threatening infections.⁵ HIV is found in the blood and other body fluids (particularly semen, vaginal secretions, and breast milk) of persons infected with the virus.⁶ The main identified transmission routes for HIV are: sexual; blood or blood products and mother-to-child transmission. HIV/AIDS is incurable and remains complex because it is asymptomatic for 7-10 years after infection and many people who are infected with HIV develop no symptoms and may spread the disease unknowingly.

The number of infected people (on global scale and in Europe) is increasing and the epidemic represents a challenge in terms of public health, political ideology and human rights (Quah, 2006).⁷ Unlike most other illnesses, HIV's prime target is young people and those in working-age. The disease burden translates not only into long-term increases in healthcare expenditure, but also into heavy social costs ranging from sick leave, replacement at work and lower productivity to early retirement (EC, 2003).⁸ Notwithstanding, HIV/AIDS may have a potential negative impact on overall economy, on companies, on affected individual and households, etc. as it is an expensive illness to treat, and caring costs are high (Alleyne and Cohen, 2002).⁹ HIV may also have social implications as rights of HIV infected individuals are not always protected in European countries (Matic et al., eds., 2006).^{10 11}

Currently there is no vaccine or cure for HIV/AIDS however, an Antiretroviral Treatment (ARV), known as post-exposure prophylaxis is believed to reduce the risk of infection if begun directly after exposure.

¹ Sen, A. (1999), *Development as freedom*. Anchor Books, Random House, Inc.

² Annan, K. (2000), *UN Secretary General's Millennium Report*. New York: United Nations

³ Sachs J. (2001), *Macroeconomics and health: Investing in health for Economic development*, Commission on Macroeconomics and health, WHO.

⁴ Hamers F., and Downs A. (2004) *The changing face of the HIV epidemic in western Europe: what are the implications for public health policies?* *Lancet* 2004; 364: 83-94

⁵ <http://en.wikipedia.org/wiki/HIV>

⁶ <http://www.engenderhealth.org/wh/inf/dhiv.html#what>; HIV Infection and AIDS

⁷ Quah, S. (2006), *Public image and governance of epidemics: Comparing HIV/AIDS and SARS*, Health policy, articles in press, Science direct, Elsevier.

⁸ EC (2003), *The Social situation in the EU 2003*, European Commission

⁹ Alleyne G. and Cohen D. (2002) *Health, Economic Growth, and Poverty Reduction. The Report of Working Group 1 of the Commission on Macroeconomics and Health*, WHO, <http://www.emro.who.int/cbi/pdf/PovertyReduction.pdf>

¹⁰ For example the insurance providers (with the exception of the Netherlands) refuse coverage due to increased risk of early mortality that an HIV infection allegedly implies and without such forms of insurance (primarily life insurance), it is extremely difficult or costly for individuals to obtain bank credit, mortgage guarantees and other such statements of financial solvency that are essential to acquire property or set up an independent business (Matic, et al., eds., 2006)

¹¹ Matic, S., Lazarus J. and Donoghoe, M. eds. (2006), *HIV/AIDS in Europe Moving from death sentence to chronic disease management*. WHO

The introduction of ARV¹² in the late 1990s in Europe allows patients to live longer with HIV and thus transforms the disease from an acute viral infection with an almost universally fatal outcome into an infectious disease with chronic epidemiological pattern (WHO, 2005).¹³

This might require increases in health spending and higher demand for long term care which could mean cuts in investment in other growth-enhancing areas. An increase in HIV/AIDS infections may cause a shock to the health sector as demand for medical care will be increased resulting in possible difficulties with the access to medical care and raise in expenditures (Over, 2004).¹⁴ Indeed, the health sector¹⁵ must play the lead role in coordinating the response to the epidemic at national and local levels (WHO, 2006).¹⁶

HIV is the infectious disease that plays the crucial role of placing health high on the international political agenda and in creating an understanding of how health is directly related to poverty and international security. Moreover, HIV/AIDS is recognized as a global emergency and therefore demands the attention of all public sectors (Matic et al., eds., 2006)¹⁷ and systematic actions promoting effective improvement of populations health by using genuinely all available measures in all policy fields (Stahl et al., eds., 2006).¹⁸

¹² Antiretroviral drugs inhibit the replication of HIV. When antiretroviral drugs are given in combination, HIV replication and immune deterioration can be delayed, and survival and quality of life improved; <http://www.who.int/hiv/topics/arv/en/>

¹³ WHO (2005) What is the impact of HIV on families? WHO Regional Office for Europe's Health Evidence Network (HEN); <http://www.euro.who.int/document/e87762.pdf>

¹⁴ Over, M. (2004) Coping with the impact of AIDS in Health and development. Why investing in health is critical for achieving economic development goals. A compilation of articles from F&D, IMF;

¹⁵ In the Global Health Sector Strategy on HIV/AIDS 2003–2007 WHO defines health sector as “wide-ranging and encompassing organized public and private health services (including those for health promotion, disease prevention, diagnosis, treatment and care); health ministries; nongovernmental organizations; community groups; and professional associations; as well as institutions that directly input into the health-care system (e.g. the pharmaceutical industry, and teaching institutions).”

¹⁶ WHO (2006), Towards universal access by 2010: How WHO is working with countries to scale-up HIV prevention, treatment, care and support, www.who.int/hiv

¹⁷ Matic, S., Lazarus J. and Donoghoe, M. eds. (2006), HIV/AIDS in Europe Moving from death sentence to chronic disease management. WHO

¹⁸ Stahl, T., et al (eds) (2006) Health in all policies. Prospects and potentials. Ministry of Social affairs and Health. Finland; <http://www.euro.who.int/document/E89260.pdf>

II. Recent epidemic trends

Globally the number of people living with HIV increased in every region in the world in the past years. In 2006 a total of 39.5 million people are living with HIV (2.6 million more than in 2004) and the number of new infections rose to 4.3 million (400.000 more than in 2004). In the EU neighbouring countries of Eastern Europe and Central Asia (former Soviet Union except the Baltic States) there are 1.7 million HIV infected people (WHO, 2006).¹⁹ A total of 51.984 new HIV diagnoses were reported in 2005 of which nearly 90% were reported from the Russian Federation and Ukraine²⁰ (EUROHIV, 2006).²¹

In Western and Central Europe 740.000 people are living with HIV or AIDS (in 2006). The cumulative number of HIV infections in EU (25) as reported by 31 December 2005 was 231.662.²² For a couple of years in Western Europe the rate of new HIV diagnoses nearly doubled - from 42 cases per million population in 1998 to 74 per million in 2006. According to the latest epidemiological data collected by the EuroHIV surveillance network²³ the number of new HIV diagnoses reported in the EU²⁴ in 2005 was 23.620 (68.7 per million population) (see Annex 1) (EUROHIV, 2006).²⁵ The proportion of undiagnosed HIV infections is estimated to be as high as 30% in the European Union.

The highest rates in new HIV diagnoses in 2005 were reported in Estonia (467 cases per million) and Portugal (251 cases per million), and the lowest rates were reported in the Czech Republic (9 cases per million) and Slovakia (4 cases per million). Rates between 100 and 200 new diagnoses of HIV infection per million population were reported also by Belgium (102.3), Luxemburg (135.5) and the United Kingdom (148.3) (Annex 2) (Hamers F. et al, 2006).²⁶ Although one can observe high level of infection in the Baltic countries in the last couple of years there has been a steady decrease in the number of new HIV diagnoses in Latvia (from 231.4 cases per million population in 2002 to 129.6 in 2005), Lithuania (from 114.5 in 2002 to 35 in 2005) and Estonia (from 666.8 in 2002 to 467.0 in 2005). However, among the 19 EU countries²⁷ that have consistently reported HIV data since 1998, the rate of newly diagnosed cases of HIV infection for the period 1998-2005 has nearly doubled, from 32.0 per million in 1998 (8,630 cases) to 61.3 (16,585 cases) in 2005. Rates of HIV infection have more than doubled in Cyprus, Czech Republic, Estonia, Ireland, Lithuania, Slovenia and the United Kingdom.

Steady decrease in the number of AIDS cases diagnosed in recent years in the EU²⁸ is reported – 6.415 cases in 2005 (16.1 per million population) comparing to 9.850 cases in 1998 (25.2 per million population). The highest rates were reported in Portugal (834 cases, 79.5 per million), Latvia (85 cases, 37.0 per million), Spain (1.549 cases, 36.0 per million) and Italy (1.475 cases, 25.4 per million).

¹⁹ WHO (2006) Global facts and figures, December;

http://www.who.int/hiv/mediacentre/20061121_EPI_FS_GlobalFacts_en.pdf

²⁰ The cumulative total number of HIV infections in Russia in 2005 is about 330 000 and in Ukraine about 78 000 people.

²¹ EuroHIV (2006), HIV/AIDS Surveillance in Europe. End-year report 2005. Saint-Maurice: Institut de veille sanitaire; No. 73. http://www.eurohiv.org/reports/report_73/pdf/report_eurohiv_73.pdf

²² More detailed data on the single countries can be found on page 243 in Matic, et al., eds., 2006 - HIV/AIDS in Europe Moving from death sentence to chronic disease management, WHO - <http://www.euro.who.int/>

²³ <http://www.eurohiv.org>

²⁴ excluding France, Italy and Spain

²⁵ EuroHIV (2006), HIV/AIDS Surveillance in Europe. End-year report 2005. Saint-Maurice: Institut de veille sanitaire; No. 73. http://www.eurohiv.org/reports/report_73/pdf/report_eurohiv_73.pdf

²⁶ Hamers F. et al (2006), HIV/AIDS in Europe: trends and EU-wide priorities; <http://www.eurosurveillance.org/ew/2006/061123.asp>

²⁷ France (since 2003), Greece (1999), Luxemburg (1999) , Malta (2004), Netherlands (2002), Spain (1999)

²⁸ 23 EU countries - no data for Cyprus and France

However for the period 1998-2005 Spain reported the largest decrease of AIDS cases from 91.4 per million in 1998 to 36.0 in 2005 while Latvia experienced the opposite trend – increase in cases in a rate from 5 per million in 1998 to 37 per million in 2005 (EUROHIV, 2006).²⁹

The two newcomers to the European Union - Bulgaria and Romania – are also affected by HIV and AIDS infections. In 2006 in Bulgaria 677 HIV - positive individuals were registered at the Ministry of Health (National AIDS committee, 2006).³⁰ In Romania in 2005 cumulative number of 6.433 HIV infections were reported (the rate of new cases had decreased since 1999 from 16.4 per million to 9.4 per million in 2005). In Romania the AIDS cases are reported to be 9.825 (cumulative number in 2005) and the incidence rate decreased significantly since 1998 (37.4) to reach the level of 12.4 in 2005 EUROHIV, 2006).³¹

In the EU the HIV case reporting system is still incomplete (UNADIS/WHO, 2006).³² For example in 2005, national HIV data were not reported for Italy and Spain (EuroHIV, 2006).³³ According to experts' estimations Italy and Spain are considered as two of the highly affected western European countries and yet HIV cases reporting system is still not introduced (Matic et al, eds., 2006).³⁴ Although most of the EU countries have already established or substantially modified their national HIV reporting systems (e.g. Greece in 1999, Portugal in 2000, Netherlands in 2002 and France in 2003) some delays between diagnosis and reporting of HIV cases or incomplete information³⁵ can be observed (EUROHIV, 2006).³⁶

Transmission of HIV is affected by individual and population practices and also by the contexts in which these practices occur. Changing economic and social environment provide some explanation as to why HIV/AIDS epidemics are more severe in some parts of Europe than in others. Contributing factors include: changes in drug trafficking routes and associated increases in drug injection, economic downturns, poor influence on the health determinants, failing health care systems and public health policies (Figure 1). The socio economic situation in a particular country determines to a large extend the most predominant mode of transmission (Matic et al, eds., 2006).³⁷

²⁹ EuroHIV (2006), HIV/AIDS Surveillance in Europe. End-year report 2005. Saint-Maurice: Institut de veille sanitaire No. 73.; http://www.eurohiv.org/reports/report_73/pdf/report_eurohiv_73.pdf

³⁰ National AIDS committee (2006); <http://www.ncaids.government.bg/>

³¹ EuroHIV (2006). HIV/AIDS Surveillance in Europe. End-year report 2005. Saint-Maurice: Institut de veille sanitaire; No. 73.; http://www.eurohiv.org/reports/report_73/pdf/report_eurohiv_73.pdf

³² UNAIDS/WHO (2006). AIDS epidemic update. Geneva: December 2006; http://data.unaids.org/pub/EpiReport/2006/2006_EpiUpdate_en.pdf

³³ EuroHIV (2006). HIV/AIDS surveillance in Europe: end-year report 2005, No 73. Institut de Veille Sanitaire. Saint-Maurice. Available at <http://www.eurohiv.org/>

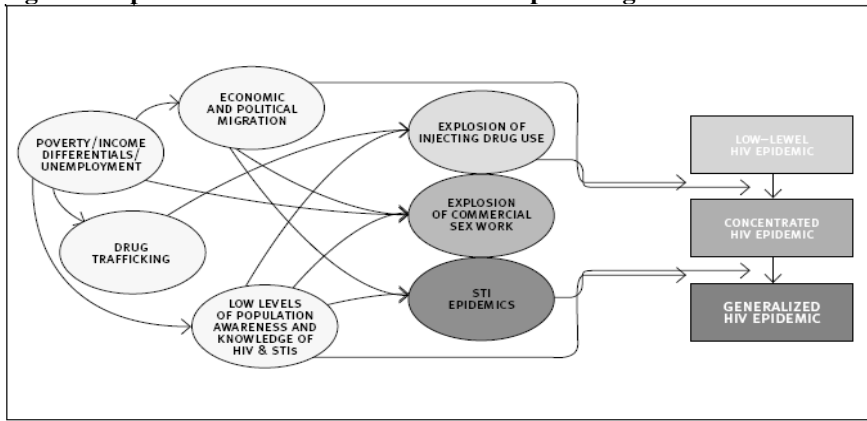
³⁴ Matic, S., Lazarus J. and Donoghoe, M. eds. (2006), HIV/AIDS in Europe Moving from death sentence to chronic disease management. WHO

³⁵ e.g. Estonia and Austria do not report HIV transmission group

³⁶ EuroHIV (2006), HIV/AIDS Surveillance in Europe. End-year report 2005. Saint-Maurice: Institut de veille sanitaire, No. 73.; http://www.eurohiv.org/reports/report_73/pdf/report_eurohiv_73.pdf

³⁷ Matic, S., Lazarus J. and Donoghoe, M. eds. (2006), HIV/AIDS in Europe Moving from death sentence to chronic disease management. WHO

Figure 1: Epidemic drivers of HIV in the European Region



*STIs: sexually transmitted infections

Source: Matic, S. et al, eds. (2006)

The predominant mode of HIV transmission in the EU³⁸ countries for the period 1998-2005 is reported to be by heterosexual contact (Figure 2). Latvia, Luxembourg, United Kingdom, Ireland and Czech Republic³⁹ have reported a threefold increase in the number of cases among this transmission group. The number of HIV reports among homo/bisexual men has also increased in this period. Statistics and studies among specific populations of men who have sex with men show HIV prevalence of 10%–20% in Western European countries. This mode of infection predominates in Czech Republic, Hungary and Slovenia. For four years (2001-2005) the number of HIV diagnoses in this population group increased in the Netherlands, Portugal, Belgium and Germany while in the Nordic countries the epidemic remains small and stable overall (increase is reported in Sweden).

One has to recognise the opposite trend regarding the transmission of HIV among injecting drug users. A decrease in the number of newly diagnosed cases of HIV among injecting drug users has been reported (from 1.067 in 1998 to 820 in 2005)⁴⁰ showing the effectiveness of harm reduction programs⁴¹ introduced in a number of EU countries in reducing HIV infections among injecting drug users (IDUs).⁴² Harm reduction programs have been associated with a decrease in injecting drug use, use of contaminated needles and syringes and HIV infections among IDUs in Spain, Portugal and the Netherlands (UNAIDS/WHO, 2006).⁴³

³⁸ Excluding: France, Greece, Luxemburg, Malta, Netherlands, Spain, Austria and Estonia

³⁹ Latvia - from 14 cases in 1998 to 94 in 2005, Luxembourg - from 9 to 39, United Kingdom - from 1.119 to 4.750, Ireland - from 41 to 159 and Czech Republic - from 9 to 28.

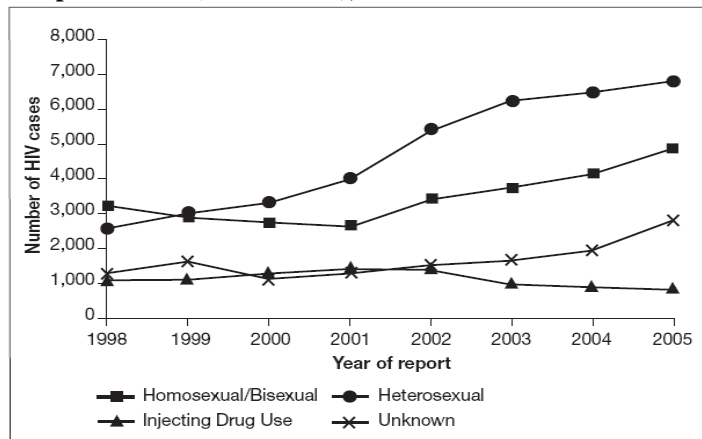
⁴⁰ data not available for this period for Estonia, Italy, Spain and Portugal, where major epidemics among injecting drug users have been reported in the recent past.

⁴¹ Harm reduction is a pragmatic and humanistic approach to diminishing the individual and social harms associated with drug use, especially the risk of HIV infection. Needle exchanges and replacement therapy treatment are the two of the most effective interventions to reduce drug-related harm.

⁴² http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/articles/what_20010101

⁴³ UNAIDS/WHO (2006), AIDS epidemic update. Geneva: December 2006; http://data.unaids.org/pub/EpiReport/2006/2006_EpiUpdate_en.pdf

Figure 2: Number of newly diagnosed cases of HIV infection by transmission group and year of report, European Union (17 countries), 1998-2005



Source: EuroHIV, 2006

To sum up, the epidemic in the EU is characterised by a continuing increase in newly diagnosed cases of HIV infection acquired mainly by heterosexual transmission. A growing proportion of cases originate from foreign countries with generalised HIV epidemics (rising from 24% in 1997 to 45% in 2004) (EUROHIV, 2006).⁴⁴ In the 12 countries with available information, two-thirds of all heterosexually acquired HIV infections diagnosed during 1997–2002 were in people from countries with generalised HIV epidemics.⁴⁵

Surveillance data show that most HIV infections diagnosed in migrants were probably acquired in their country of origin (Hamers and Downs, 2004).⁴⁶

Young people are becoming more vulnerable and appear to move to the centre of the epidemic in the European region (incl. Eastern European countries – Russia, Ukraine, etc.) where more than 80% of those living with HIV are under 30 years of age. 12% of newly diagnosed HIV infections in the EU in 2005 were reported in young people (15 to 24 years old) (EUROHIV, 2006).⁴⁷ Young people have become highly vulnerable to HIV infection in the wake of the rapid social change, economic hardship and increased insecurity. They face challenges such as poverty, unemployment (at levels three times higher than of the adult population) and falling rates of enrolment and completion of secondary schooling. High rates of trafficking of drugs and human beings also increase their vulnerability. In Eastern Europe and Central Asia an estimated 70% of newly reported infections are related to IDUs and most of these who inject drugs are very young, sometimes even under the age of 15, e.g. up to 25% of IDUs are estimated to be less than 20 years of age (UNAIDS, 2005).⁴⁸ Women are also becoming more vulnerable and the proportion of newly diagnosed HIV infections in females in the EU countries is increasing (34% in 2005). The same trend is observed in the two newcomers to the EU - Romania and Bulgaria.

⁴⁴ EuroHIV (2006), HIV/AIDS Surveillance in Europe. End-year report 2005. Saint-Maurice: Institut de veille sanitaire; No. 73.; http://www.eurohiv.org/reports/report_73/pdf/report_eurohiv_73.pdf

⁴⁵ In UK, three-quarters of heterosexual infections diagnosed in 2002 were probably acquired in Africa. In Germany, the number of new HIV diagnoses increased in 2002 among heterosexuals originating from countries with generalised HIV epidemics. In Sweden, more than 80% of reported HIV infections acquired through heterosexual contact were probably acquired abroad. In Denmark, immigrants accounted for 37% of all HIV infections diagnosed in 2002. In Belgium, 73% of HIV infections diagnosed in heterosexually infected people were mostly in African people

⁴⁶ Hamers, F., and Downs, A. (2004), The changing face of the HIV epidemic in western Europe: what are the implications for public health policies?, Review, Lancet 2004; 364: 83–94; www.thelancet.com Vol 364 July 3, 2004

⁴⁷ EuroHIV (2006), HIV/AIDS Surveillance in Europe. End-year report 2005. Saint-Maurice: Institut de veille sanitaire; No. 73.; http://www.eurohiv.org/reports/report_73/pdf/report_eurohiv_73.pdf

⁴⁸ UNAIDS (2005) At great risk of HIV/AIDS: Young people in Eastern Europe and Central Asia. Ministerial meeting on “Urgent response to the HIV/AIDS epidemics in the commonwealth of Independent states”. Moscow.

III. Are there reasons for concern?

Several facts observed in the EU may cause concerns regarding the spread of the HIV. Firstly, the statistical data for the whole region is not complete⁴⁹ despite of the fact that various systems have been set up to monitor HIV prevalence among specific subpopulations in different countries (Hamers and Downs, 2003).⁵⁰ This means that HIV cases might be underreported and the actual scope of the problem to be unknown.

Secondly, in most western European countries one can observe a steady decline in unsafe injecting practices and HIV prevalence among injecting drug users that occurred throughout the 1990s, reflecting success in past prevention interventions. However, HIV prevalence among drug injectors varies greatly both between and within countries and has remained high in some countries and regions. In Eastern part of Europe in late 1990s, there was a sharp increase in the number of IDUs and in some regions intravenous drug use is spreading at an alarming rate in the age group 15-24.

Thirdly, a significant proportion of young people become sexually active before the age of 15 and they are at high risk of contracting HIV because, once they become sexually active, they often have several, usually consecutive, short term sexual relationship and do not consistently use condoms. Furthermore, young people often have insufficient information and understanding about HIV/AIDS (UNAIDS, 2004).⁵¹ Since the young people become highly vulnerable group a special attention is needed to ensure their awareness for the risks and consequences of HIV infection.

Fourthly, as already indicated by the available data the HIV epidemic fuelled by heterosexual transmission is emerging and its expansion will depend on the size of so-called bridge populations that link high-risk groups with the general population. Moreover, HIV situation in the EU is increasingly influenced by international travel and migration which underlines the need for a global and the European-wide approach for HIV prevention and control. Migrants from countries with generalised HIV epidemics, particularly sub-Saharan Africa, account for a disproportionate and increasing share of HIV infections in Western Europe. Although not often, the reason for migration is connected with seeking HIV treatment.⁵² Increasing numbers of migrant commercial sex workers who have come to the EU from Eastern Europe and neighbouring countries where HIV is spreading rapidly since 1996 is also a matter of concern.

The recent increase in HIV in the EU countries raises important concerns about the vulnerability of overall population and in particular of some strata of the population, e.g. migrants, homosexual and bisexual men, commercial sex workers, IDUs, etc. Most immediate response has to be directed toward young people and women who become more vulnerable. As the epidemic has matured, patterns of HIV transmission have changed and new populations have become affected, with an increasing proportion of people infected through unprotected heterosexual intercourse.

⁴⁹ aggregate data on HIV prevalence in various populations are compiled in the European HIV Prevalence Database

⁵⁰ Hamers, F. and Downs, A. (2003), HIV in central and eastern Europe, *The Lancet Review*, published online February 18, 2003; <http://image.thelancet.com/extras/02art6024web.pdf>

⁵¹ UNAIDS (2004) National AIDS programmes, A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people.; http://www.who.int/child-adolescent-health/publications/ADH/ISBN_92_4_159257_5.htm

⁵² In France, in a study among 280 HIV-infected African people seen in the hospitals of the Paris area, health care was the reason for migrating to France for 27% of those who migrated since 1999, compared with 2% of those who arrived earlier.

Notwithstanding actions are required in the presence of the alarming facts, weakening government commitment and waning or ineffective prevention efforts (WHO, 2005).⁵³ The EU needs to continue investing in measures such as awareness-raising campaigns on healthy lifestyles, screening and legislation (Byrne, 2004).⁵⁴

⁵³ WHO (2005), HIV/AIDS in Europe: Overview. Fact sheet EURO/14/05, Copenhagen, 28 November 2005.

⁵⁴ Byrne, D. (2004), Enabling Good Health for all A reflection process for a new EU Health Strategy; http://ec.europa.eu/health/ph_overview/Documents/byrne_reflection_en.pdf

IV. Prevention – the key stone for effective and sustainable actions

Prevention approaches can work as long as they are grounded on evidence based strategies, carefully tailored to the social and economic settings in which they are implemented and to the state of national HIV/AIDS epidemics. A comprehensive approach that supports social and individual rights, involves communities and is developed on the basis of their cultural values has been found to be effective when combined with the promotion of consistent condom use, voluntary testing and counselling for HIV, and delayed sexual initiation. Level of social and economic development, cultural factors such as gender equality or access to education and health care are all known to be important factors for the successful implementation of prevention initiatives. The promotion of human rights, combined with behavioural change programmes is also important. Lessons learnt from various settings and communities show that the use of any chosen prevention measure requires that people not only have the proper knowledge but also the ability to apply it (WHO, 2004).⁵⁵

In the European countries the public health approach for HIV/AIDS is adopted, which addresses the health needs of a population, emphasising along with the individual needs also the collective health status of the people. A public health approach involves a collaborative effort by all parts of the health sector, working to ensure the well-being of society through comprehensive prevention, treatment, care and support. It is based upon the principles of simplification, standardization, decentralization, equity and patient and community participation (WHO, 2006).⁵⁶

European countries have not been passive in front of the HIV/AIDS challenges. The late 1980s and early 1990s marked a significant scale-up of specific prevention efforts in Western Europe. The extensive prevention programmes set up in that period had a strong impact in altering behaviours that put people at risk for HIV infection, particularly among high-risk communities. They included extensive public information and awareness campaigns and safer sex promotion efforts. Among the targeted interventions, the most prominent (and most effective) were harm-reduction initiatives to prevent the spread of HIV through injecting drug use, which was one of primary modes of transmission in the western European countries at a time (e.g. France, Italy, Portugal, Spain and the UK). Adopted regulations and legislative requirements for blood products and systematic screening of blood donations since 1985 virtually eliminated the risk of HIV transmission through blood transfusion.⁵⁷ In the 1990s, large-scale voluntary HIV testing of pregnant women followed by antiretroviral treatment of those found to be seropositive, and other interventions to reduce the risk of vertical transmission (mother-to-child), were implemented. The rate of vertical transmission in Europe fell from 15.5% (1994) to 2.6% (after 1998) (Hamers and Downs, 2004).⁵⁸

The positive trends to constrain HIV epidemic in Western Europe suddenly started to change for the worse five years ago. What has been called “treatment optimism” and “prevention fatigue” has – together with declines in prevention funding and in the dramatic nature and frequency of prevention campaigns – contributed to an increase in unsafe behaviour and consequently to growing numbers of new HIV infections (Matic et al, eds., 2006).⁵⁹

⁵⁵ WHO (2004), The world Health report 2004. Changing History. WHO. <http://www.who.int/whr/2004/en/index.html>

⁵⁶ WHO (2006) Towards universal access by 2010: How WHO is working with countries to scale-up HIV prevention, treatment, care and support, www.who.int/hiv

⁵⁷ For more information see the web page of DG SANCO, European commission; http://ec.europa.eu/health/ph_threats/human_substance/keydo_blood_en.htm

⁵⁸ Hamers, F., and Downs, A. (2004), The changing face of the HIV epidemic in western Europe: what are the implications for public health policies?, *Review, Lancet* 2004; 364: 83–94; www.thelancet.com Vol 364 July 3, 2004

⁵⁹ Matic, S., Lazarus J. and Donoghoe, M. eds. (2006), HIV/AIDS in Europe Moving from death sentence to chronic disease management. WHO

Therefore, one has to realize that HIV treatment and prevention have to be recognized as equally important (the attention to HIV/AIDS treatment has caused some neglect of HIV prevention) and supportive of each other and their synergies are to be harnessed (UNAIDS, 2005).⁶⁰

Since these negative trends in HIV development have been recognized in the EU the attempts have been made so that the debate on HIV/AIDS related issues is pushed up to the political agenda. It has been estimated that the implementation of a comprehensive HIV prevention package could avert more than 50% of the number of new infections expected to occur between 2002 and 2010 (Stover et al., 2002).⁶¹ Yet, the HIV/AIDS epidemic can only be reversed if effective HIV prevention measures are intensified in scale and scope (UNAIDS 2005).⁶² A number of targets for HIV prevention have been established by governments in the 2001 United Nations General Assembly Special Session Declaration of Commitment on HIV/AIDS⁶³ that have laid the foundations on which to build global momentum to intensifying HIV prevention (Annex 3) (UNAIDS, 2005).⁶⁴ It is not within the scope of this paper to evaluate whether all proposed actions have been completed by the years defined in the declaration. Most important however is that governments achieved commitment to put back HIV/AIDS prevention as a priority in the health policy agenda and to be consistent in their actions so that sustainability of the process to combat spread of the epidemic is guaranteed.

Lately, the EU and its institutions have consistently reaffirmed their commitments to combat HIV and AIDS. The national governments have committed their support through high-level declarations in Dublin⁶⁵ and Vilnius in 2004.⁶⁶ After the endorsement by all UN member states of the Declaration of commitment on HIV/AIDS in 2001 the European Commission also has initiated actions by adopting a strategic plan to combat HIV/AIDS within the EU and in the neighbouring countries⁶⁷, by commissioning a special issue of Eurobarometer on AIDS⁶⁸ and involving itself in some awareness campaigns.⁶⁹ The European Centre for Disease Prevention (ECDC) has been established in 2004 to collect information and indicate measures to combat communicable diseases in the EU.⁷⁰

⁶⁰ UNAIDS (2005), Intensifying HIV prevention: a UNAIDS policy position paper. Joint United Nations Programme on HIV/AIDS

⁶¹ Stover J, Walker N, Garnett GP, et al. (2002) Can we reverse the HIV/AIDS pandemic with an expanded response? *Lancet*, 360 (9326): 73-77 (as quoted by UNAIDS, 2005, Intensifying HIV prevention: a UNAIDS policy position paper. Joint United Nations Programme on HIV/AIDS)

⁶² UNAIDS (2005), Intensifying HIV prevention: a UNAIDS policy position paper. Joint United Nations Programme on HIV/AIDS

⁶³ Declaration of Commitment on HIV/AIDS—United Nations General Assembly Special Session on HIV/AIDS. New York, United Nations, 2001

⁶⁴ UNAIDS (2005), Intensifying HIV prevention: a UNAIDS policy position paper. Joint United Nations Programme on HIV/AIDS

⁶⁵ Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia. Dublin: Irish EU Presidency 2004 Website; 24 February 2004; http://www.eu2004.ie/templates/meeting.asp?sNavlocator=5,13&list_id=25

⁶⁶ Vilnius Declaration on Measures to Strengthen Responses to HIV/AIDS in the European Union and in Neighbouring Countries. Vilnius, 17 September 2004; http://europa.eu.int/comm/health/ph_threats/com/aids/docs/ev_20040916_rd03_en.pdf

⁶⁷ EC (2005), Communication from the Commission to the Council and the European Parliament on combating HIV/AIDS within the EU and in the neighbouring countries, 2006-2009. (COM (2005) 654 final), Brussels. http://eur-lex.europa.eu/smartapi/cgi/sga_doc?smartapi!celexapi!prod!CELEXnumdoc&lg=en&numdoc=52005DC0654&model=guichett

⁶⁸ European commission (2006) Special Eurobarometer 240 / Wave 64.1 and 64.3 – TNS Opinion & Social; http://ec.europa.eu/health/ph_publication/eb_aids_en.pdf

⁶⁹ "Night of the HIV/AIDS TV Commercials", Brussels (30 November 2006) - the main aim is to raise awareness among youth about HIV/AIDS in Europe and safer sex.

⁷⁰ http://www.ecdc.eu.int/About_ECDC.html

Experts in the field of HIV prevention⁷¹ have identified priorities requiring a European - wide HIV prevention approach:⁷² a) increasing voluntary HIV testing; b) scaling up HIV prevention and care; and c) tackling risky behaviour in high risk groups (e.g. men having sex with men, migrants and commercial sex workers, etc.).

This short list of actions is just a fraction of the emerging needs to mobilize an intensification of HIV prevention aiming at arresting the spread of HIV infections. The governance of HIV/AIDS prevention needs to address the public image of the disease and the impact of such an image has upon efforts to mobilize the community in the prevention efforts (Quah, 2006).⁷³ Health authorities need to widespread accurate, clear and consistent information on the nature of the disease and modes of transmission, high levels of political commitment and civil society engagement have to be accompanied by increased funding by governments and most likely innovative approaches toward prevention and care has to be created. Moreover, effective prevention programmes have to be aimed at young people in order to educate them in responsible and safe sexual behaviour.

Success in HIV prevention requires a series of sustained, specific, concrete and robust actions based on a number of over-arching principles: a) promotion, protection and respect of human rights including gender equality; b) differentiation and local adaptation to the relevant epidemiological, economic, social and cultural contexts; c) comprehensiveness in scope by using the full range of policy and programmatic interventions known to be effective; and d) community participation. Besides, HIV prevention actions must be evidence-informed and at a coverage, scale and intensity that is enough to make a critical difference. Last, but not least HIV prevention is for life and therefore, both delivery of existing interventions as well as research and development of new technologies require a long-term and sustained effort, recognizing that results will only be seen over the longer-term and need to be maintained. In addition, HIV prevention programs have to be continuously reinforced to meet the needs of new generations (UNAIDS 2005).⁷⁴ The experience of numerous European countries applying more liberal policies that respect individual human and civil rights and rely on the effectiveness of health promotion efforts and voluntary behavioural change has shown to be highly effective, while also maintaining the dignity of individuals at risk for or living with HIV and minimizing the stigmatization and discrimination they experience without sacrificing individual or collective rights (WHO, 2006).⁷⁵

In a recently published WHO report⁷⁶ a model of essential package of integrated health sector interventions for HIV prevention, treatment, care and support is proposed as guidelines to countries to adapt it based on local needs and environment (see Annex 4) (WHO, 2006). Preventive measures are discussed for different settings – health facility, community levels and nation-wide activities.

⁷¹ The ECDC organised workshop on HIV prevention (2-3 October 2006, Stockholm) and brought together national surveillance and prevention experts from the 25 EU countries plus Bulgaria, Iceland, Norway, Romania and Switzerland, as well as representatives from the European Commission, WHO, UNAIDS, European Monitoring Centre for Drugs and Drug Addiction, United States Centers for Disease Control and Prevention, and civil society

⁷² <http://www.eurosurveillance.org/ew/2006/061123.asp#1>

⁷³ Quah, S. (2006), Public image and governance of epidemics: Comparing HIV/AIDS and SARS, Health policy, articles in press, Science direct, Elsevier.

⁷⁴ UNAIDS (2005), Intensifying HIV prevention: a UNAIDS policy position paper. Joint United Nations Programme on HIV/AIDS

⁷⁵ WHO (2006), Towards universal access by 2010: How WHO is working with countries to scale-up HIV prevention, treatment, care and support, www.who.int/hiv

⁷⁶ WHO (2006), Towards universal access by 2010: How WHO is working with countries to scale-up HIV prevention, treatment, care and support, www.who.int/hiv

Important additional opportunities for an intensification of HIV prevention also arise from forging links with other programs and services, for example through workplace programs, trade unions, community groups, women's and young people's organizations and groups of people living with HIV (UNAIDS, 2005).⁷⁷

As part of prevention efforts, an encouragement of screening practices for HIV may contribute to reduce of disease burden. There is wide variation of screening practice in Europe. In most of the EU countries screening for HIV is mainly targeted at vulnerable social groups. More and more countries though adopt compulsory regulations for screening for donors of blood, organs, sperm and milk. HIV screening programmes are also offered to all pregnant women in Finland and France, although it is not compulsory.

In most of the new Member states screening becomes compulsory for certain groups of population. For example, in the Czech Republic HIV screening is compulsory for donors of blood, organs or any biological material, and for pregnant women; in Estonia it is compulsory during pregnancy, on entering the military service and for prisoners; in Latvia, the target population includes pregnant women, individuals to be recruited for military service, those involved in the national armed forces and international peace maintenance, and prisoners; in Slovenia, HIV screening is performed on pregnant women, patients with a newly established diagnosis of syphilis, and on all donors of blood or organs (see Annex 5 for more details on screening regulations in EU countries) (Holland et al., 2006).⁷⁸

⁷⁷ UNAIDS (2005), Intensifying HIV prevention: a UNAIDS policy position paper. Joint United Nations Programme on HIV/AIDS

⁷⁸ Holland W., Stewart S. and Masseria C, (2006) Policy Brief: Screening in Europe, World Health Organization, 2006, on behalf of the European Observatory on Health Systems and Policies.

V. HIV prevention strategies in the EU

Countries have different approaches toward HIV/AIDS issue. Some have included public health actions to address HIV/AIDS in their general health strategies and development plans; others have elaborated specific strategies for HIV/AIDS prevention and treatment activities. Some EU countries have both – national health strategies and separate action plans or specific strategies regarding HIV/AIDS. Countries where high prevalence rates are reported in the recent years seem to be active in tackling the problem, e.g. United Kingdom, Portugal, Estonia, Spain, Bulgaria, Romania. Examples of the different approaches are listed below.

V.1 General health strategies⁷⁹

Portugal

A National Health Plan has been adopted in 2004 for the period 2004-2010⁸⁰ where AIDS is one of the priorities for actions. The National plan foresees strong support for the development of a curriculum for health promotion and education, incl. issues related to HIV/AIDS. A commission responsible for the fight against HIV/AIDS developed an HIV prevention project for schools (5-18 years of age), in partnership with the ministry of education. Other initiatives include a theatre play that addresses HIV prevention and related issues, such as relationships and gender roles. HIV/AIDS is one of the priority areas emphasised also in the Strategic guidelines for the Implementation of the National Health Plan (phase II – 2004 -2006) for which resource distribution and investment is also foreseen. Priority targets specified for AIDS are presented in Table 1.⁸¹

Table 1: Priority targets for communicable diseases

Indicator	Present situation	Projection for 2010	Target for 2010
Rate of standardized mortality from AIDS before 65 years/ 100.000 individuals	10.3 (data for 2001)	9.2	7

In June 2005, when the High-Commissariat for Health was created, AIDS programme has been one of the four areas considered as particularly important. The program has the following objectives: a) to promote a multi-sector approach, where prevention is prioritized and integrated with treatment and care efforts aiming to reduce infection risks and to promote quality of life of people with HIV; b) to improve the quality of epidemiological information, by applying indicators that describe risk extensions; c) to promote priority interventions in specific population groups; and d) to ensure that the activities developed in the different health levels and structures, as well as those promoted by civil society, are integrated in a consistent way, so as to make the best use of resources and minimize negative impacts.

⁷⁹ HIV is part of the general health strategies

⁸⁰ The plan has 3 stages - stage I corresponds to the definition of the Plan's structure and its general goals, as well as specific strategy guidelines and priority targets. This stage was over by the end of the first quarter of 2004. Stage II runs between 2004 and 2006 and corresponds to the "launching" of the Plan and to the activation of its structures and the follow-up process. Stage III goes up to 2010, will involve monitoring the accomplishment of the Plan by duly appointed entities.

⁸¹ <http://www.dgs.pt/default.aspx>

Special attention is paid to promote information campaigns for changing population's attitudes and behaviour.⁸² Portugal's national plan combines 10 goals to be attained in 2006, for example to: implement a second generation epidemiological surveillance system; increase by 30% the number of people who know the correct methods of HIV prevention; reduce by 50% the mother-to-child transmission; guarantee universal access to HIV/AIDS treatment, in accordance with international recommendations; increase by 70% the number of health centres that have multidisciplinary teams for HIV/AIDS; participate in the creation of HIV prevention programs in prisons; develop legislation that guarantees and promotes the rights of people living with HIV/AIDS, etc.

Finland

The Government adopted in May 2001 a Resolution on the Health 2015 public health programme outlining targets for Finland's health policy for the next fifteen years. The main focus is placed on the health promotion including HIV/AIDS promotion activities.⁸³

Ireland

The National Health Promotion Strategy 2000-2005⁸⁴ aims to decrease the percentage of the population engaging in behaviours which risk HIV transmission. Strategic objective of the Strategy is to promote sexual health and safer sexual practices among the population and particularly the young people. This is foreseen to be achieved by educational programmes, convenience advertising campaigns which for example target entertainment venues with posters in male and female toilets, targeted campaigns, information leaflets, training for health professionals, support for the implementation of the report of the National Aids Strategy Group, collaboration with voluntary organisations, and participation in European HIV/AIDS Prevention Networks.⁸⁵

V.2 Specific HIV/AIDS strategies

United Kingdom

UK is one of the countries where a special national HIV strategy has been adopted. The Department of Health (UK)⁸⁶ has published the first national Strategy for sexual health and HIV in 2001 addressing the problem of rising prevalence of sexually transmitted infections (STIs) and HIV. In 2002 the implementation action plan with proposed interventions has been published. An expert advisory group on AIDS has been created as part of Department of Health's advisory body. The Strategy aims to reduce: a) the transmission of HIV and the prevalence of undiagnosed HIV; b) unintended pregnancy rates; c) the stigma associated with HIV; and d) to improve health and social care for people living with HIV. The strategy emphasizes on better prevention by means of national information campaigns, promotion of evidence-based prevention, setting clear targets and new reporting guidelines for local HIV prevention and elaboration of a national target for reducing the number of newly acquired HIV infections.

⁸² Statement by H.E. Mr. João Salgueiro, ambassador extraordinary and plenipotentiary and permanent representative of Portugal to the United Nations, to the 38th session of the commission on population and development (Agenda item 5: General debate on national experience in population matters: population, development and HIV/AIDS, with particular emphasis on poverty), New York, 5 April 2005; <http://www.un.int/portugal/59ungacpd.htm>

⁸³ http://www.terveys2015.fi/esite_eng.pdf

⁸⁴ <http://www.dohc.ie/publications/pdf/hpstrat.pdf?direct=1>

⁸⁵ http://www.healthpromotion.ie/health_promotion_strategy/

⁸⁶ http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4003133&chk=iTv%2BN

Moreover, the strategy foresees actions toward a) developing managed networks for HIV and sexual health services, with a broader role for those working in primary care settings and with providers collaborating to plan services jointly so that they deliver a more comprehensive service to patients; b) evaluating the benefits of more integrated sexual health services, including pilots of one-stop clinics; c) developing primary care youth services and primary care teams with a special interest in sexual health; d) setting up standards for the treatment, support and social care of people living with HIV; e) prioritising future research to improve the evidence base of good practice in sexual health and HIV; f) addressing the training and development needs of the workforce across the whole range of sexual health and HIV services and g) increasing in the offer of testing for HIV and setting a target to reduce the number of undiagnosed infections, thereby ensuring earlier access to treatment for those infected and limiting further transmission of the virus.

Hungary

In 2003 the so called “Johan Béla National Programme for the decade of health”⁸⁷ has been approved by the parliament⁸⁸ and adopted by the government. With respect to HIV/AIDS the goal is to reduce the number of new infections and to improve the rate of diagnosed cases of infection. The defined objectives are: a) to prevent new HIV infection, maintain a low incidence of infection, and reduce AIDS morbidity by 20% and mortality by 25%; b) to design the forms and contents of primary prevention programs and to fit programs for young people into the school health education curriculum and into drug-prevention programs; c) to design special prevention programs for groups that have a high risk of infection; d) to design a grant scheme and to establish a grant fund to finance the above programs; and e) to increase the effectiveness of HIV diagnosis, principally among persons with high-risk behaviours. On 1 December 2004, the National AIDS Control Strategy was promulgated enhancing awareness raising programs and particular attention has been paid to programs that aimed at improving young persons’ sexual culture, disseminating and promoting safe sexual behaviours and preventing HIV infection. Involvement of civil society has been strongly encouraged.

The National AIDS Committee is responsible for putting together proposals for annual action plans. The activities fall into 3 main fields: prevention, targeted screening and education. Prevention is seen as teaching family life information in the schools as part of health education, assisting young people to evolve values and personalities that lead to responsible sexual behaviour and drug avoidance. Specific preventive programmes are to be designed for high-risk communities, with the active participation of organisations and members from these communities (homosexual men, commercial sex workers, IDUs, etc.). Regular information to the public on how to prevent HIV infection and how AIDS as a disease has changed is also seen as part of preventive efforts as well as creation of a welfare network and reinforcing the existing one to offer support to socially vulnerable HIV/AIDS patients. Screening foresees to increase the number of voluntary testing based on informed consent among high-risk groups as well as re-introduction of anonymous HIV testing combined with counselling. The action plan aims at enforcing the legally regulated regular mandatory health examinations of commercial sex workers and monitoring of the implementation of work related HIV exposure of health service workers and preventive treatment following exposure to the virus. Building information on HIV/AIDS into medical specialist training and colleague courses is part of educational efforts. Regular continuing education for family practitioners and primary care paediatricians as well as for doctors and dentists who may potentially treat HIV patients is foreseen.

⁸⁷ http://www.eum.hu/index.php?akt_menu=3538

⁸⁸ Parliamentary Decision 46/2003

Poland

The HIV/AIDS Programme to curb the spread of epidemic has started in 1995.⁸⁹ The program has specified the following objectives: a) lobbying for the rights, care of and support to people living with HIV (PLWHA); b) support to non-governmental organizations dealing with HIV/AIDS and drug use; c) identifying and popularizing effective methods of fighting HIV through international and regional cooperation and development of local and cross-border projects; d) dissemination of knowledge and international standards on HIV prevention and popularizing of good practices, etc. The activities foreseen in the program include: publications, training, social campaigns (e.g. “run for life”, photo exhibitions, etc.) and popularizing of knowledge on conferences, seminars and meetings.

Estonia

A number of state financed national programmes for AIDS Prevention in Estonia run since 1992 and are coordinated by the Ministry of Social Affairs as well as the Global Fund programme for Estonia (2003-2007), e.g. a) the National HIV/AIDS Prevention Programme (1992-1996); b) the National Programme on Prevention of HIV/AIDS and other sexually transmitted diseases (1997- 2001); c) the National HIV/AIDS Prevention Programme (2002-2006); d) the Global Fund to Fight AIDS, Tuberculosis and Malaria, Estonian Programme (2003-2007) and e) the National HIV/AIDS Prevention Strategy (2006-2015). The goal of the HIV/AIDS prevention in Estonia is to achieve constant decrease in the HIV infection. The key activities in HIV/AIDS prevention in Estonia are: a) preventive work among the general population, especially among young people; b) preventive work among risk groups; c) care and support for HIV-infected people; d) maintaining the capacity of the health care system to deal with HIV. The National Institute for Health Development⁹⁰ coordinates HIV/AIDS prevention under the Ministry of Social Affairs in partnership with the Ministries of Internal Affairs, Education, Justice and Defence. The Institute is responsible for the monitoring and evaluation of all prevention activities and develops minimum standards for partner organizations

The general objective of the newly elaborated Estonian National HIV and AIDS strategy for 2006-2015⁹¹ is to achieve a permanent decline in the spread of HIV (Table 2). The strategy outlines the following priorities: a) immediate implementation of harm reduction measures among injecting drug users where the HIV epidemic is concentrated; b) a special focus on young people in the risk groups and their partners because over 80% of newly registered HIV-positives are less than 30 years old; c) ensuring the availability of health services and care for HIV infected people.

Table 2: Targets for continual decrease in the spread of the HIV infection

Indicator	Year 2004 (base indicator)	Year 2009	Year 2015
New HIV cases per 100,000 people	55	30	20
Share of pregnant women infected with HIV among all pregnant women	0.5%	<1%	<1%

⁸⁹ http://www.undp.org.pl/hiv-aids_en/temat_opis.php

⁹⁰ <http://www.tai.ee/?id=4043>

⁹¹ Order No 771 of the Government of the Republic of Estonia “Approval of the national HIV and AIDS strategy for 2006-2015 and establishment of the HIV and AIDS Committee of the Government of the Republic”, 2005

The strategy document specifies also the principles and measures to be used to evaluate the achievement of these objectives.

The strategy document also describes the functions of a national AIDS coordinating authority, the roles and responsibilities between the parties involved and the country-level monitoring and evaluation system based on the “Three ones”⁹² principle. Action plan with detailed description of strategic objectives, sub objectives, financial means and indicators for fulfilment for each year during the period of the strategy is also approved by the government.

Spain

In Spain several initiatives have been undertaken regarding HIV/AIDS prevention.⁹³ In 1997 a plan for mobilizing multi-sectorial efforts for the period 1997-2000 was adopted followed by its evaluation. In 2001 HIV Infection and AIDS plan (2001-2005) has been elaborated and adopted by the government.⁹⁴ The plan has specified three global objectives: a) to prevent new infections; b) to reduce the negative personal and social impact of the epidemic; and c) to mobilize and coordinate efforts against HIV/AIDS epidemic. Prevention efforts are directed both toward general population and specific risk groups – adolescence and youth, IDUs, men having sex with men, commercial sex workers, prisoners, women, immigrants, etc. Preventive actions are specified according to specificities of the different settings. Indicators⁹⁵ for the plan have been approved in 2003 and a follow up has been elaborated in 2006.

Denmark

A key principle of Denmark’s HIV/AIDS policy is that prevention should be carried out without compulsory measures and, if necessary, on the basis of anonymity. The main elements of the AIDS prevention programme, involving close collaboration between the National Board of Health, counties, municipalities and private organizations such as the Danish Organization for Gays and Lesbians, include general information campaigns on safe sex, psychosocial assistance to those who are HIV positive and information targeted at specific risk groups. National responsibility for the prevention of drug abuse lies with the National Board of Health, which develops information and educational materials and carries out national campaigns. However, local activity is considered to be more effective and the state therefore provides some financial support for local initiatives carried out by health, social and educational authorities, as well as by private organizations. The National Board of Health runs training programmes for key local people involved in activities tackling drug abuse. Recently two key documents have been adopted - a framework plan for HIV prevention (2002-2005)⁹⁶ and Health throughout life - targets and strategies for public health policy of the Government of Denmark (2002–2010)⁹⁷.

⁹²“Three Ones” principles aims to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management:

- a) one agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners;
- b) one National AIDS Coordinating Authority, with a broad-based multisectoral mandate;
- c) one agreed country level Monitoring and Evaluation System;

http://www.unaids.org/en/Coordination/Initiatives/three_ones.asp

⁹³ <http://www.msc.es/en/ciudadanos/enfLesiones/enfTransmisibles/sida/planesEstrat/home.htm>

⁹⁴ http://www.msc.es/en/ciudadanos/enfLesiones/enfTransmisibles/sida/docs/vih_infection.pdf

⁹⁵ http://www.msc.es/en/ciudadanos/enfLesiones/enfTransmisibles/sida/planesEstrat/indicadores2006_3.pdf

⁹⁶ http://www.sst.dk/faglige_omr/sundhed/AIDS/rammplan_forebyggelse_hiv-aids.pdf

⁹⁷ <http://www.folkesundhed.dk/media/healthythroughoutlife.pdf>

Cyprus

AIDS has constituted a basic priority for the authorities of the Republic of Cyprus and a National AIDS Programme has been implemented since 1986 through a series of strategic plans. The latest HIV/AIDS Strategic Plan (2004 – 2008)⁹⁸ adopted by the Ministry of health⁹⁹ has the following general aims: a) to make a situation analysis with regard to HIV/AIDS; b) to describe the response to the epidemic so far; and c) to propose a strategic framework for future action.

The strategies of the plan are formulated according to the following objectives: prevention of sexual and perinatal transmission of HIV, transmission through blood and blood products, tissue and organ transplants, and skin piercing procedures; reduction of harm related to drug use; provision of health care based on the latest international standards in counselling, clinical management, laboratory testing; human rights' protection and reduction of the personal and social impact of HIV-infection.

Bulgaria

The "Prevention and Control of HIV/AIDS" program¹⁰⁰ is run by the Ministry of Health with the financial support of the Global Fund against AIDS, Tuberculosis and Malaria. The implementation of the program is controlled by the members of the National AIDS committee at the Council of Minister.¹⁰¹ The overall goal of the programme is to keep low level of HIV prevalence through reducing risky behaviours in the vulnerable groups and ensuring access to quality medical care for HIV/AIDS infected people. The program aims at raising experts' knowledge and abilities and institutional engagement. The Programme interventions are targeted at intravenous drug users, commercial sex workers, Roma community, people living with HIV/AIDS, young people. Objectives of the Program include: a) development of infrastructure and training of the personnel for HIV/AIDS prevention; b) establishment of a national surveillance system on HIV/AIDS; b) preventive activities among risk groups (IDUs, commercial sex workers, Roma community (age group 12-25)); c) decreasing risky sexual behaviours among young people; and d) appropriate and accessible treatment and care for HIV infected people. The programme is implemented in 19 municipalities around the country. Priorities for the next years (2006-2008) include: a) maintaining the preventive focus of the program to the most vulnerable groups; b) extending the coverage of key services through the increase the number of outreach workers and the number of mobile medical units; c) strengthening the national standards and good practices for HIV/AIDS prevention and d) encouraging active participation of both the government and the civil society.

Romania

In 2001 HIV/AIDS was declared a public health priority and a National Plan for Universal Access to HIV/AIDS Treatment and Care was launched. In 2004 a new national HIV/AIDS Strategy (2004-2007) has been elaborated and approved by the government.¹⁰² The strategy proposes three major intervention areas: prevention, access to treatment and surveillance. The main goal formulated for the prevention efforts is to maintain the HIV incidence in 2007 at the 2002 level. Young people and high risk groups (IDUs, commercial sex workers, Roma communities etc.) are put in the centre of preventive activities which include condom use promotion, school education, prevention in the military units, etc.

⁹⁸ [http://www.moh.gov.cy/MOH/moh.nsf/All/1A78A986B4980B1BC2256E440034268C/\\$file/stratplan.pdf?OpenElement](http://www.moh.gov.cy/MOH/moh.nsf/All/1A78A986B4980B1BC2256E440034268C/$file/stratplan.pdf?OpenElement)

⁹⁹ <http://www.moh.gov.cy/MOH/moh.nsf/All/294EED8B7F4B8907C2256E440031A2AB?OpenDocument>

¹⁰⁰ <http://www.aidsprogram.bg/web/hiv-aids/home.nsf/0/92B3B225DBF0BDEF0C22571C3002E74C8?OpenDocument>

¹⁰¹ <http://www.ncaids.government.bg/>

¹⁰² Government of Romania (2004) National Strategy for surveillance, control and prevention of HIV/AIDS cases:2004-2007. Bucharest, <http://www.undp.ro/aids/>

Access to treatment, care and psycho-social support services for people infected, affected or groups vulnerable to HIV/AIDS is another major area of activities specified in the strategy. Development and maintaining of efficient surveillance systems for HIV/AIDS and associated risk factors is foreseen in order to provide timely information regarding the epidemic and the determinants of its evolution and to allow development of appropriate programmes and interventions. A national coordination mechanism shall facilitate the implementation, monitoring and evaluation of the strategy.

To sum up, the above listed examples are by no means exhaustive but used as examples of the EU countries' actions taken to emphasise the importance of HIV/AIDS issues and the attempts of the governments to undertake steps to prioritise the preventive measures. It is difficult to find a comprehensive data base containing HIV/AIDS prevention strategies in EU.

For this document, the web pages of EU Member states' ministries of health have been searched. Yet in most cases there were few documents in English or other than the local language which in some ways has constrained the overall conclusions regarding the availability of information. Moreover in some EU countries health policy is performed on regional/commune level (e.g. Belgium) and federal states have no competence and information on ongoing activities (e.g. information campaigns).

The actions taken by the European governments to expand activities in order to fight with the further development of HIV/AIDS epidemic is to show that a political will exists and collaborative approaches are considered. The quick review of the strategies and plans makes it clear that principles of solidarity, equity and quality are emphasised by the policy makers. However, more research is needed to estimate how many of the prepared plans are still in operation, how effectively they are implemented and what is their impact in achieving the overall goal for eliminating HIV infections among population. Just as the HIV/AIDS epidemic is changing constantly, so should the national strategies to be responsive and to anticipate the changes (UNAIDS, 2005).¹⁰³ It is therefore recommendable the European Centre for Disease Prevention and Control (ECDC) to establish a database of the national strategies for HIV/AIDS prevention and care. A comprehensive and regularly maintained and up-to-date data base of the HIV/AIDS strategies may be used by EU governments to check their own plans against the current developments in the other member states. Availability of such type of information may facilitate promoting of the best practices.

¹⁰³ UNAIDS (2005), Intensifying HIV prevention: a UNAIDS policy position paper. Joint United Nations Programme on HIV/AIDS

VI. How are we informed about HIV/AIDS?

One of the basic principles for HIV effective prevention is the availability of information and awareness both among general population and high risk groups. Government, non-government organisations, business organisations, schools, media, health care providers, etc. have to work in collaboration to assure good dissemination of proper and accurate information of HIV risks and possible attitudes to avoid the spread of the infection. The special issue of Eurobarometer on HIV/AIDS prevention (2006)¹⁰⁴ shows that, as compared to 4 years ago people are less well informed and almost half of all EU-citizens do not fully understand how HIV/AIDS can be passed on. This trend is even more prevalent among younger citizens. Only about half of the population is adapting its sexual behaviour as regards taking precautions and 88% of respondents acknowledged the need for EU-wide information initiatives. This indicates that there is a vital need for more and better information and communication in this area, specifically targeting the young.¹⁰⁵ Notwithstanding, European countries have been performing information activities and have been active in awareness campaigns. Although, in most of the cases the campaigns are related to events exclusively devoted to 1 December – the World AIDS day, some general and specific campaigns have been organized separately in order to increase knowledge on HIV/AIDS among population.

United Kingdom

The UK HIV/AIDS strategy underlines the importance of the information to the public and points out that the information on sexual health is often uncoordinated or poorly targeted and doesn't make enough use of new media and technology. Particular attention is paid to the young people because they often lack accurate sexual health information so that actions giving them better information are encouraged, e.g. Teenage Pregnancy Strategy, Sure Start Plus, the Healthy Schools initiative and the Department for Education and Skills' revised Sex and Relationship Education Guidance are important documents to help and expand young people's knowledge of and understanding of sexual health and relationships. In particular the schools guidance makes sure that secondary schools provide young people with information about different types of contraception, safe sex and how they can access local sources for further advice and treatment. Information to specific groups is also envisaged in the strategy as some groups need targeted sexual health information and HIV prevention because they are at higher risk and are particularly vulnerable. Therefore, information strategies need to be developed to respond to the specific information and prevention needs of local populations and assess the needs of young people, minority ethnic groups, homo and bisexual men, injecting drug users, adults and children living with HIV, commercial sex workers, and people in prisons and youth offending establishments.

Better information contributes to the efforts to tackle the stigma associated with HIV. This issue has been identified in the National Strategy for Sexual Health and HIV in 2001 and a commitment to publish an HIV stigma action plan was made in the strategy's implementation action plan in 2002. Stigma and discrimination have featured explicitly in a wide range of guidance, recommended standards and good practice for those working in the HIV field, including the Recommended Standards for National Health Service HIV services. The National AIDS Trust¹⁰⁶ had organized campaigns ('Are you HIV prejudiced?') and more recently has developed resources for health workers and employers.

¹⁰⁴ http://ec.europa.eu/health/ph_publication/eb_aids_en.pdf

¹⁰⁵ Questions and answers on EU action on fighting HIV/AIDS;

<http://europa.eu/rapid/pressReleasesAction.do?reference=MEMO/06/428&format=HTML&aged=0&language=EN>

¹⁰⁶ <http://www.nat.org.uk/>

HIV related stigma and discrimination Action plan has been published in 2005¹⁰⁷ outlining the main actions and key responsible agencies and deadlines for implementing the activities.

Another stream of information has been directed toward health professionals, e.g. recommended standards for NHS HIV services¹⁰⁸ have been developed with the aim of enabling people with HIV to access the same quality of care wherever they live. The care pathway for people with HIV provides a framework for the standards, and focuses on patient-centred care. Effective Sexual Health Promotion Toolkit¹⁰⁹ has been developed in response to the first national strategy for sexual health and HIV and the implementation action plan has been published by the Department of Health in June 2002. It represents a wide range of interests and views within sexual health and health promotion and HIV prevention and provides a range of practical, usable tools which can be adapted to particular work settings, client groups and service users.

Public awareness campaigns have been initiated to increase awareness of the risk of HIV transmission. For example, "Don't play the sex lottery - use a condom" (2002)¹¹⁰ was directed toward 18 - 30 year old by highlighting the importance of practicing safe sex in order to prevent HIV infection. Another campaign for the use of condoms and counselling services is promoted by department of health by specially created web page¹¹¹ where information on protection, infections and hot phone lines is available. The National AIDS trust¹¹² has elaborated a number of information materials for specific target groups: children and young people, adults and risk groups as well as for specific days – 1 of December (World AIDS day), etc.

Ireland

Attention is paid to sexually active people with the goal safer sexual practices to be promoted. The aim is to be achieved by means of support for the implementation of Relationships and Sexuality Education, participation in the implementation of the Report of the National Aids Strategy Committee, development of 'Knowledge is Power' – HIV/AIDS Education Pack for exploring the issue with young people, convenience Advertising Campaign. World AIDS Day Campaign, production of AIDS Education Video, development of Information leaflets, etc. Emphasis is put on Sexual Health Convenience Advertising Campaign pointing out that sexuality is an integral part of being human and healthy sexual relationships can contribute to an overall sense of well-being, however, unsafe sexual practice may lead to HIV infection.

Hungary

A teaching package was created on topics of education for family life, safe sex and HIV/AIDS for 15-16 years old, taking into account the needs of this age-group and applying modern educational principles. In July 2005, the first part of a pilot program related to education for family life was completed, which contributed to developing the system of values and personality of young persons, as well as to evolve responsible sexual and drug-avoiding behaviours. A pilot program targeted at 11-17 old people was elaborated by 'Sexual Education Foundation of Priority Public Interest' and supported by the Public Health Program.

¹⁰⁷http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4123992&chk=0UjEtg

¹⁰⁸http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4106272&chk=A6bmj4

¹⁰⁹http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SexualHealth/SexualHealthGeneralInformation/SexualHealthGeneralArticle/fs/en?CONTENT_ID=4002168&chk=pmmyeN

¹¹⁰http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4025977&chk=QjXvaQ

¹¹¹ <http://www.condomessentialwear.co.uk/>

¹¹² http://shop.nat.org.uk/lg_catalogue_for_web.pdf

A multimedia CD-ROM entitled 'Love, sex and what you should know' was published as a teaching material using interactive tools to promote awareness amongst young people. In addition to the CD, a student textbook and a teacher's manual have been also published under the title 'Private life and health awareness'. A pilot activity to train educators was also launched in 5 regions with the involvement of teachers, health visitors and peer educators.

A number of prevention programs for high risk communities were completed with the active involvement of NGOs and individual members of the relevant communities. In January 2006 a HIV/AIDS screening bus has been put into operation targeted at the commercial sex workers. Attached to the anonymous HIV screening stations of the National Public Health and Medical Officer's Service, an anonymous AIDS counselling service has been established, with the task of providing information on continuing care facilities, the necessary lifestyle changes and providing psychological support to those attending the screening and those screened out. Screening capacities, laboratory background and care for HIV/AIDS cases are available in appropriate volume in the country. In 2005 the Public Health Government Commissioner's Office organized programs in Budapest to commemorate the World AIDS Day - 1 December, with the title 'Ignorance means risk', when first and foremost, the importance of actions for prevention has been stressed.

Poland

Information materials have been elaborated in Polish and distributed among population: "Drugs and drug addiction in Polish law" (2004); "Preventing HIV/AIDS and sexually transmitted diseases – workbook for students, handbook for teachers and handbook for educational programme makers" (2004); "HIV/AIDS - Human Rights at the workplace" (2004).

During the last couple of years several campaigns have been organized in Poland:

Race for life (2003) in Warsaw - the aim of the race was to promote healthy life style and knowledge about HIV/AIDS by disseminating information materials about HIV and its social and psychological consequences as well as about testing and prevention.

686 candles (2004) in Warsaw and Lublin – as part of the worldwide AIDS Memorial Day. The AIDS Memorial Day is designed to show support for those living with HIV/AIDS, raise awareness of HIV/AIDS, and mobilize community involvement in the fight against HIV/AIDS. Additionally in Lublin a photo exhibition "Positive Lives" was opened.

'Safer with knowledge' - contest for teachers - conducted to broaden knowledge about HIV/AIDS, as well as to strengthen positive approach towards people who are infected.

Country-wide HIV testing campaign for women (2005) - aimed at all women, with particular attention to future mothers, by informing them about the need to take HIV tests, especially when planning pregnancy. The campaign aimed to give incentives to doctors and nurses to guide their patients (especially pregnant women) to HIV testing points.

Denmark

Publications (Focus on Life)¹¹³ explaining the nature of HIV/AIDS, the means of transmission and preventive measures have been disseminated. The confederation of Danish Industries published a leaflet “Handling of HIV/AIDS in the workplace” containing information on risks and situation assessment, information and prevention programs, addresses for counselling, advices and care programs¹¹⁴ and emphasising the need for more involvement of the business companies in the overall efforts to increase awareness about HIV/AIDS.

Romania

Several initiatives have been organized to increase awareness among population:

“All About HIV/AIDS” (2001) – dissemination through internet¹¹⁵ of information and confidential advice to young people about HIV/AIDS in order to enhance the understanding of HIV/AIDS amongst young people (15-25 years of age).

HIV/AIDS Prevention Among Vulnerable Groups - aimed at involving a large number of partners in the design and overall development of the HIV/AIDS Strategic Plan for Romania, developing best practices as well as increasing the capacity of different partners to respond.

Continuing medical education on HIV/AIDS for healthcare workers (distance learning modules - through internet, CD-ROM and printed version) (2002) - with particular emphasis on prevention and care of HIV infected people. HIV/AIDS related counselling and information has become part of basic healthcare services. The learning modules cover the following subjects: counselling (pre- and post-testing); preventing transmission and health education for teenagers (a healthcare worker’s guide).

Multi-media information campaign in schools and high-schools, on HIV/AIDS and related issues (2002) – the initiative addressed the need for promoting health education on HIV/AIDS and related issues, as part of the regular curricula in schools. A multi-media kit has been produced in order to be used by teachers in health education classes in schools and high schools.

National HIV/AIDS Anti-discrimination Campaign (2005 – 2006) - addressing the major stigma and discrimination issues related to HIV/AIDS and increasing awareness about HIV/AIDS issues among the general population and specific communities.

Austria

In spearheading best practices several Austrian pilot projects have been found to be highly successful: “First Love” – which has been run in a hospital, offering young people counselling and information on contraception and protection against HIV/AIDS. An internet and e-mail service has been created to provide anonymous counselling and information with regard to all issues of contraception, family planning and relationship problems.¹¹⁶ .

The Annual Life Ball organized in Vienna aims to raise funds to support people living with HIV/AIDS.¹¹⁷ Several organizations¹¹⁸ provide information and counselling.¹¹⁹

¹¹³ http://www.sst.dk/publ/Publ2005/CFH/Hiv_engelsk/engelsk.pdf

¹¹⁴ <http://www.di.dk/english/Shop/Productpage/?productid=2676>

¹¹⁵ www.sexdex.ro

¹¹⁶ UN (1999) Statement by Mr. Martin Bartenstein Austrian Federal Minister of Environment Youth and Family Affairs, 21st Special Session of the General Assembly, Permanent Mission of Austria to the United Nations. New York, 30 June 1999, <http://www.un.org/popin/unpopcom/32ndsess/gass/state/austria.pdf>

¹¹⁷ http://www.lifeball.org/lifeball/show_content.php?hid=14&language=en

The examples presented above do not pretend to be exhaustive. A number of informational materials have been also elaborated in other EU countries in the local languages. National authorities (ministries of health or national centres of public health) have been collaborating with educational institutions and non-government sectors as well as with media to provide up-to-date and reliable information on HIV issues, to produce leaflets, manuals, and to create frameworks for awareness campaigns and continuous educational practices and policies.

During the last couple of years HIV awareness campaigns have been organized in many EU countries and the civil society has been largely involved in this process. Yet, it is recommendable the ECDC to create a data base of best practices with respect to methodologies, organisation, scale and scope of the awareness campaigns performed in the EU countries and of existing educational modules on HIV/AIDS topic.

¹¹⁸ Die AIDS-Hilfen - Austrian AIDS Support Groups (www.aidshilfen.at); Aidshilfe Kärnten - Regional AIDS organization (www.hiv.at); Adshilfe Vorarlberg - Provides a meeting place for HIV-positive people, financial help for people with HIV and a low income, and social, legal and financial counselling (www.aidshilfe-vorarlberg.at), etc.

¹¹⁹ <http://www.thebody.com/hotlines/>

VII. What to do next?

There are a number of both humanitarian and economic¹²⁰ arguments on taking actions to prevent HIV/AIDS epidemics as no cure has yet been found. Indeed, the choices that countries make depend on political, social, and moral considerations (Squire, 2004).¹²¹ Governments can play an important role in prohibiting discrimination against HIV infected persons in health care settings and in the work place and most importantly in emphasising and enhancing prevention efforts through vigorous, effective interventions aimed at providing accurate and clear information in order to change the behaviour of those most likely to contract and spread infection (Over, 2004).¹²² The World Bank Research Report “Confronting AIDS: Public Priorities in a Global Epidemic”¹²³ highlights three strategies to reduce risky behaviour: providing information, lowering the costs of safer behaviour, and raising the costs of risky behaviour. Knowledge is the most important factor to support changes. Awareness of the nature of the problem, mode of transmission and possible ways to avoid risks is a necessary prerequisite in the public policy attempts to cope with the problem. The most visionary approach to the epidemic is to provide universal access to HIV/AIDS prevention, treatment, and care and support services.¹²⁴

The EU and its Member states should continue to stress evidence - based approaches to HIV control, such as condom use and comprehensive harm reduction programs. In accordance to the principles articulated by the European Commission, the various European strategies need to be harmonized (EC, 2005).¹²⁵ Aligning HIV/AIDS control strategies will facilitate cooperation and improve efficacy (Liljestrand and Lazarus, 2006).¹²⁶ Exchanging experiences between stake holders within and between countries can be mutually beneficial. For that reason the first step is creation of data base containing EU member states’ strategies to fight HIV/AIDS and examples of awareness campaigns performed in the countries. Adequate funding of the government’s plans should be secured in order to guarantee sustainability of efforts.

The representatives of states and governments from Europe and Central Asia have outlined 12 commitments for prevention in the Dublin declaration on Partnership to fight HIV/AIDS in Europe and Central Asia.¹²⁷ Based on the listed examples of HIV/AIDS strategies elaborated by EU countries one can conclude that efforts have been made to achieve these targets. Yet, information is not complete for all EU countries to evaluate whether these goals have been achieved. Seemingly some EU countries have faced delays in completing the commitments.

¹²⁰ The issues of externalities, public goods and redistribution have to be taken into consideration.

¹²¹ Squire, L. (2004) Confronting AIDS in Health and development. Why investing in health is critical for achieving economic development goals. A compilation of articles from F&D, IMF; <http://www.imf.org/external/pubs/ft/health/eng/hdwi/hdwi.pdf>

¹²² Over, M. (2004) Coping with the impact of AIDS in Health and development. Why investing in health is critical for achieving economic development goals. A compilation of articles from F&D, IMF; <http://www.imf.org/external/pubs/ft/health/eng/hdwi/hdwi.pdf>

¹²³ World Bank (1997), Confronting AIDS: Public Priorities in a Global Epidemic, Policy Research Report, New York: Oxford University Press for the World Bank; <http://www.worldbank.org/aids-econ/>

¹²⁴ http://data.unaids.org/pub/InformationNote/2006/20060324_HLM_GA_A60737_en.pdf

¹²⁵ EC (2005) Communication from the Commission to the Council and the European Parliament on combating HIV/AIDS within the European Union and in the neighbouring countries, 2006-2009; http://eur-lex.europa.eu/LexUriServ/site/en/com/2005/com2005_0654en01.pdf

¹²⁶ Liljestrand, J. and Lazarus J. (2006), HIV/AIDS – a global threat that medicine alone can not cure, in Mellbourn A eds., Health and conflict prevention, Madariaga European Foundation.

¹²⁷ http://ec.europa.eu/health/ph_threats/com/aids/docs/dublin_decl.pdf

Back in 2004 (“Vilnius Declaration” on Measures to Strengthen Responses to HIV/AIDS in the European Union and in Neighbouring Countries¹²⁸) the European commission called upon partnership to ensure coordination and cooperation of the response to HIV/AIDS in the European Union and in its neighbouring countries, in order to minimise duplication of efforts and maximise synergies as well as to support and facilitate the mobilization, promotion and support of cross border, sub-regional and regional technical collaboration and sharing of best practices in HIV prevention.

Facing the challenges of increasing HIV prevalence rates, EU member states and the neighbouring countries may consider enhancing the scope of their by sharing experiences from best practices. These efforts can be coordinated by the European Centre for Disease Prevention and Control.

In order to face HIV challenges EU member states may consider taking actions to:

Place HIV/AIDS prevention among the priorities for public health actions.

Create comprehensive and up-to-date data base of available government programs, strategies, plans of actions and initiatives for HIV prevention and care in order to make best practices available to stake holders within and between EU countries

Perform comprehensive evaluation of the government programs on HIV/AIDS prevention based on preliminary defined indicators and criteria for success. (The National AIDS Programmes - A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people can be used as a reference point¹²⁹).

Incorporate health and sex education into school curricula (if this is not already done) and encourage development of modules for peer education.

Plan future awareness campaigns based on the knowledge of best practices, focused on the most affected regions and vulnerable population groups.

Establish a framework for regular awareness campaigns (at European, national and local levels) targeted both at general population and at specific groups, e.g. youth, minorities, high risk groups and working population.

Encourage multi-sectoral approach in HIV prevention activities by promoting extensive involvement of non-government institutions (public private partnerships), educational institutions, media and business companies.

¹²⁸ http://ec.europa.eu/health/ph_threats/com/aids/docs/ev_20040916_rd03_en.pdf

¹²⁹ http://www.who.int/child-adolescent-health/New_Publications/ADH/ISBN_92_4_159257_5.pdf

VIII. List of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral Treatment
CSWs	Commercial Sex Workers
EC	European Commission
ECDC	European Centre for Disease Prevention and Control
EU	European Union
HIV	Human Immunodeficiency Virus
IDUs	Injecting Drug Users
MSM	Men who have Sex with Men
NGOs	Non-Government Organisations
PLWHA	People Living With HIV
STI	Sexually Transmitted Infections
TB	Tuberculosis
UK	United Kingdom
WHO	World Health Organisation

IX. References

Alleyne G. and Cohen D. (2002) Health, Economic Growth, and Poverty Reduction. The Report of Working Group 1 of the Commission on Macroeconomics and Health, WHO, http://www.emro.who.int/cbi/pdf/PovertyReduction.pdf
Annan, K. (2000), UN Secretary General's Millennium Report. New York: United Nations
Byrne, D. (2004), Enabling Good Health for all A reflection process for a new EU Health Strategy; http://ec.europa.eu/health/ph_overview/Documents/byrne_reflection_en.pdf
Declaration of Commitment on HIV/AIDS—United Nations General Assembly Special Session on HIV/AIDS. New York, United Nations, 2001
Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia. Dublin: Irish EU Presidency 2004 Website; 24 February 2004; http://www.eu2004.ie/templates/meeting.asp?sNavlocator=5,13&list_id=25
EC (2003), The Social situation in the EU 2003, European Commission
EC (2005) Communication from the Commission to the Council and the European Parliament on combating HIV/AIDS within the European Union and in the neighbouring countries, 2006-2009; http://eur-lex.europa.eu/LexUriServ/site/en/com/2005/com2005_0654en01.pdf
EC (2005), Communication from the Commission to the Council and the European Parliament on combating HIV/AIDS within the European Union and in the neighbouring countries, 2006-2009. (COM (2005) 654 final), Brussels. http://eur-lex.europa.eu/smartapi/cgi/sga_doc?smartapi!celexapi!prod!CELEXnumdoc&lg=en&numdoc=52005DC0654&model=guichett
EuroHIV (2006), HIV/AIDS Surveillance in Europe. End-year report 2005. Saint-Maurice: Institut de veille sanitaire; No. 73. http://www.eurohiv.org/reports/report_73/pdf/report_eurohiv_73.pdf
European commission (2006) Special Eurobarometer 240 / Wave 64.1 and 64.3 – TNS Opinion & Social; http://ec.europa.eu/health/ph_publication/eb_aids_en.pdf
Government of Romania (2004) National Strategy for surveillance, control and prevention of HIV/AIDS cases:2004-2007. Bucharest, http://www.undp.ro/aids/
Hamers F. et al (2006), HIV/AIDS in Europe: trends and EU-wide priorities. http://www.eurosurveillance.org/ew/2006/061123.asp
Hamers F., and Downs A. (2004) The changing face of the HIV epidemic in western Europe: what are the implications for public health policies? Lancet 2004; 364: 83–94
Hamers, F. and Downs, A. (2003), HIV in central and eastern Europe, The Lancet Review, published online February 18, 2003; http://image.thelancet.com/extras/02art6024web.pdf
Holland W., Stewart S. and Masseria C, (2006) Policy Brief: Screening in Europe, World Health Organization, 2006, on behalf of the European Observatory on Health Systems and Policies. http://data.unaids.org/pub/InformationNote/2006/20060324_HLM_GA_A60737_en.pdf
http://ec.europa.eu/health/ph_publication/eb_aids_en.pdf
http://ec.europa.eu/health/ph_threats/com/aids/docs/dublin_decl.pdf
http://ec.europa.eu/health/ph_threats/com/aids/docs/ev_20040916_rd03_en.pdf
http://ec.europa.eu/health/ph_threats/human_substance/keydo_blood_en.htm
http://en.wikipedia.org/wiki/HIV
http://shop.nat.org.uk/lg_catalogue_for_web.pdf
http://www.aidsprogram.bg/web/hiv-aids/home.nsf/0/92B3B225DBF0BDEF0C22571C3002E74C8?OpenDocument
http://www.condomessentialwear.co.uk/
http://www.dgs.pt/default.aspx
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SexualHealth/SexualHealthGeneralInformation/SexualHealthGeneralArticle/fs/en?CONTENT_ID=4002168&chk=pmmyeN
http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4025977&chk=QjXvaQ
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4003133&chk=iTv%2BN
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4123992&chk=0UjEtg
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4106272&chk=A6bmj4
http://www.di.dk/english/Shop/Productpage/?productid=2676
http://www.dohc.ie/publications/pdf/hpstrat.pdf?direct=1
http://www.ecdc.eu.int/About_ECDC.html
http://www.engenderhealth.org/wh/inf/dhiv.html#what; HIV Infection and AIDS
http://www.eum.hu/index.php?akt_menu=3538
http://www.euro.who.int/

http://www.eurohiv.org
http://www.eurosurveillance.org/ew/2006/061123.asp#1
http://www.folkesundhed.dk/media/healthythroughoutlife.pdf
http://www.healthpromotion.ie/health_promotion_strategy/
http://www.lifeball.org/lifeball/show_content.php?hid=14&language=en
http://www.moh.gov.cy/MOH/moh.nsf/All/1A78A986B4980B1BC2256E440034268C/\$file/stratplan.pdf?OpenElement
http://www.moh.gov.cy/MOH/moh.nsf/All/294EED8B7F4B8907C2256E440031A2AB?OpenDocument
http://www.msc.es/en/ciudadanos/enfLesiones/enfTransmisibles/sida/planesEstrat/home.htm
http://www.msc.es/en/ciudadanos/enfLesiones/enfTransmisibles/sida/docs/vih_infection.pdf
http://www.msc.es/en/ciudadanos/enfLesiones/enfTransmisibles/sida/planesEstrat/indicadores2006_3.pdf
http://www.nat.org.uk/
http://www.ncaids.government.bg/
http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/articles/what_20010101
http://www.sst.dk/faglige_omr/sundhed/AIDS/rammplan_forebyggelse_hiv-aids.pdf
http://www.sst.dk/publ/Publ2005/CFF/Hiv_engelsk/engelsk.pdf
http://www.tai.ee/?id=4043
http://www.terveys2015.fi/esite_eng.pdf
http://www.thebody.com/hotlines/
http://www.un.int/portugal/59ungacpd.htm
http://www.unaids.org/en/Coordination/Initiatives/three_ones.asp
http://www.undp.org.pl/hiv-aids_en/temat_opis.php
http://www.who.int/child-adolescent-health/New_Publications/ADH/ISBN_92_4_159257_5.pdf
http://www.who.int/hiv/topics/arv/en/
Liljestrand, J. and Lazarus J. (2006), HIV/AIDS – a global threat that medicine alone can not cure, in Mellbourn A eds., Health and conflict prevention, Madariaga European Foundation.
Matic, S., Lazarus J. and Donoghoe, M. eds. (2006), HIV/AIDS in Europe Moving from death sentence to chronic disease management. WHO
National AIDS committee (2006); http://www.ncaids.government.bg/
Order No 771 of the Government of the Republic of Estonia “Approval of the national HIV and AIDS strategy for 2006-2015 and establishment of the HIV and AIDS Committee of the Government of the Republic”, 2005
Over, M. (2004) Coping with the impact of AIDS in Health and development. Why investing in health is critical for achieving economic development goals. A compilation of articles from F&D, IMF; http://www.imf.org/external/pubs/ft/health/eng/hdwi/hdwi.pdf
Quah, S. (2006), Public image and governance of epidemics: Comparing HIV/AIDS and SARS, Health policy, articles in press, Science direct, Elsevier.
Questions and answers on EU action on fighting HIV/AIDS; http://europa.eu/rapid/pressReleasesAction.do?reference=MEMO/06/428&format=HTML&aged=0&language=EN
Sachs J. (2001), Macroeconomics and health: Investing in health for Economic development, Commission on Macroeconomics and health, WHO.
Sen, A. (1999), Development as freedom. Anchor Books, Random House, Inc.
Squire, L. (2004) Confronting AIDS in Health and development. Why investing in health is critical for achieving economic development goals. A compilation of articles from F&D, IMF; http://www.imf.org/external/pubs/ft/health/eng/hdwi/hdwi.pdf
Stahl, T., et al (eds) (2006) Health in all policies. Prospects and potentials. Ministry of Social affairs and Health. Finland; http://www.euro.who.int/document/E89260.pdf
Stover J, Walker N, Garnett GP, et al. (2002) Can we reverse the HIV/AIDS pandemic with an expanded response? Lancet, 360 (9326): 73-77 (as quoted by UNAIDS, 2005, Intensifying HIV prevention: a UNAIDS policy position paper. Joint United Nations Programme on HIV/AIDS)
UN (1999) Statement by Mr. Martin Bartenstein Austrian Federal Minister of Environment Youth and Family Affairs, 21st Special Session of the General Assembly, Permanent Mission of Austria to the United Nations. New York, 30 June 1999, http://www.un.org/popin/unpopcom/32ndsess/gass/state/austria.pdf
UNAIDS (2004) National AIDS programmes, A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people.; http://www.who.int/child-adolescent-health/publications/ADH/ISBN_92_4_159257_5.htm
UNAIDS (2005) At great risk of HIV/AIDS: Young people in Eastern Europe and Central Asia. Ministerial meeting on “Urgent response to the HIV/AIDS epidemics in the commonwealth of Independent states”. Moscow.
UNAIDS (2005), Intensifying HIV prevention: a UNAIDS policy position paper. Joint United Nations Programme on HIV/AIDS
UNAIDS/WHO (2006), AIDS epidemic update. Geneva: December 2006; http://data.unaids.org/pub/EpiReport/2006/2006_EpiUpdate_en.pdf

Vilnius Declaration on Measures to Strengthen Responses to HIV/AIDS in the European Union and in Neighbouring Countries. Vilnius, 17 September 2004. http://europa.eu.int/comm/health/ph_threats/com/aids/docs/ev_20040916_rd03_en.pdf
WHO (2004), The world Health report 2004. Changing History. WHO. http://www.who.int/whr/2004/en/index.html
WHO (2005) What is the impact of HIV on families? WHO Regional Office for Europe's Health Evidence Network (HEN); http://www.euro.who.int/document/e87762.pdf
WHO (2005), HIV/AIDS in Europe: Overview. Fact sheet EURO/14/05, Copenhagen, 28 November 2005.
WHO (2006) Global facts and figures, December; http://www.who.int/hiv/mediacentre/20061121_EPI_FS_GlobalFacts_en.pdf
WHO (2006) Towards universal access by 2010: How WHO is working with countries to scale-up HIV prevention, treatment, care and support, www.who.int/hiv
World Bank (1997), Confronting AIDS: Public Priorities in a Global Epidemic, Policy Research Report, New York: Oxford University Press for the World Bank; http://www.worldbank.org/aids-econ/
www.eurosurveillance.org
www.sexdex.ro

X. Annexes

Annex 1: HIV/AIDS cases and incidence rates per million population in the European Region¹³⁰

HIV infections newly diagnosed and rates by country and year of report (1998-2005), and cumulative totals, WHO European Region, data reported by 31 December 2005			AIDS cases and incidence rates per million population by country and year of diagnosis (1998-2005) adjusted for reporting delays*, and cumulative totals, WHO European Region, data reported by 31 December 2005		
Cumulative total reported*	Geographic area		Cumulative total reported †	Geographic area	
N	Country		N	Country	
West			West		
41	Andorra †		1	Andorra ‡	
3,270	EU Austria		2,468	EU Austria	
17,869	EU Belgium		3,511	EU Belgium	
4,521	EU Denmark		2,573	EU Denmark	
1,887	EU Finland		422	EU Finland	
11,952 ‡	EU France ‡		60,212 §	EU France	
26,333	EU Germany		24,335	EU Germany	
7,718	EU Greece §		2,669	EU Greece	
184	Iceland		57	Iceland	
4,082	EU Ireland		876	EU Ireland	
4,662	Israel		1,035	Israel	
6,979	EU Italy		56,076	EU Italy	
715	EU Luxembourg ¶		185	EU Luxembourg	
36	EU Malta **		61	EU Malta	
-	Monaco ††		40	Monaco	
11,610	EU Netherlands ††		6,845	EU Netherlands	
2,755 §§	Norway		813	Norway	
28,370	EU Portugal		12,702	EU Portugal	
53	San Marino		19	San Marino	
-	EU Spain ¶¶		72,099	EU Spain	
7,099	EU Sweden		2,033	EU Sweden	
28,606	Switzerland		8,251	Switzerland	
76,850	EU United Kingdom		21,898	EU United Kingdom	
245,592	Total West		279,181	Total West	
Centre			Centre		
179	Albania		57	Albania	
116	Bosnia & Herzegovina		83	Bosnia & Herzegovina	
598	Bulgaria		164	Bulgaria	
538	Croatia		234	Croatia	
484	EU Cyprus ***		-	EU Cyprus ¶	
827	EU Czech Republic		196	EU Czech Republic	
1,285	EU Hungary		505	EU Hungary	
82	Macedonia, F.Y.R.		63	Macedonia, F.Y.R.	
9,801	EU Poland		1,725	EU Poland	
6,433	Romania		9,825	Romania	
2,079	Serbia & Montenegro †††		1,334	Serbia & Montenegro **	
158	EU Slovakia		40	EU Slovakia	
281	EU Slovenia		125	EU Slovenia	
2,254	Turkey		588	Turkey	
25,115	Total Centre		14,939	Total Centre	
East			East		
363	Armenia		105	Armenia	
928	Azerbaijan		166	Azerbaijan	
7,014	Belarus		303	Belarus	
5,063	EU Estonia		100	EU Estonia	
880	Georgia		383	Georgia	
5,657	Kazakhstan		332	Kazakhstan	
822	Kyrgyzstan		18	Kyrgyzstan	
3,332	EU Latvia		394	EU Latvia	
1,100	EU Lithuania		96	EU Lithuania	
2,838	Moldova, Republic of		220	Moldova, Republic of	
329,980	Russian Federation †††		451 ††	Russian Federation	
506	Tajikistan		1	Tajikistan	
2	Turkmenistan		1	Turkmenistan	
77,801	Ukraine †††		8,614 ††	Ukraine	
7,810	Uzbekistan		70	Uzbekistan	
444,096	Total East		11,254	Total East	
231,622 Total European Union (EU)			272,146 Total European Union (EU)		
714,803 Total WHO European Region			305,374 Total WHO European Region		

¹³⁰ EuroHIV (2006), HIV/AIDS Surveillance in Europe. End-year report 2005. Saint-Maurice: Institut de veille sanitaire; No. 73.; http://www.eurohiv.org/reports/report_73/pdf/report_eurohiv_73.pdf

Annex 2: Newly diagnosed HIV infections in 2005 and rates per million population by country, European Union (25), reported by 31 December 2005¹³¹

Country	Year reporting started	2005	
		n	Rate (per million population)
Austria	1998	453	55.3
Belgium	1986	1066	102.3
Cyprus *	1986	43	51.5
Czech Republic	1985	90	8.8
Denmark	1990	285	52.5
Estonia	1988	621	467.0
Finland	1986	137	26.1
France †	2003	3165	–
Germany	1993	2451	29.6
Greece §	1999	560	50.4
Hungary	1985	110	10.9
Ireland	1985	318	76.7
Italy ‡	1985	–	–
Latvia	1987	299	129.6
Lithuania	1988	120	35.0
Luxembourg	1999	63	135.5
Malta	2004	19	47.3
Netherlands	2002	1216	74.6
Poland	1985	652	16.9
Portugal	1983	2635	251.1
Slovakia	1985	21	3.9
Slovenia	1986	36	18.3
Spain ‡	1999	–	–
Sweden	1985	392	43.4
United Kingdom	1984	8868	148.3
Total European Union (EU)		23 620	
* 40% cases were non residents			
† 2005 data from January-June			
‡ No national data available but HIV reporting exists in some regions			

¹³¹ www.eurosurveillance.org

Annex 3: Targets for HIV prevention (extracts from UN Declaration of Commitment on HIV/AIDS)¹³²

- By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010, and to intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys (Para 47);
- By 2005, ensure: that a wide range of prevention programmes that take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections (Para 52);
- By 2005, reduce the proportion of infants infected by HIV by 20 per cent, and by 50 per cent by 2010, by ensuring that 80 per cent of pregnant women accessing antenatal care have information, counselling and other HIV prevention services available to them, increasing the availability of and providing access for HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV-infected women, including voluntary counselling and testing, access to treatment, especially antiretroviral therapy, and, where appropriate, breast-milk substitutes and the provision of a continuum of care (Para 54);
- By 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic (Para 58);
- By 2003, develop and by 2005 implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS, including by providing appropriate counselling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance (Para 65).

¹³² Declaration of Commitment on HIV/AIDS—United Nations General Assembly Special Session on HIV/AIDS. New York, United Nations, 2001

Annex 4: The Model Essential Package of integrated health sector interventions for HIV prevention, treatment, care and support¹³³

Health facility-based interventions

- Information and education on preventing HIV transmission
- HIV testing and counselling, including:
 - Provider-initiated testing and counselling
 - Infant testing and diagnosis
 - Family testing and counselling
- Prevention of mother-to-child transmission of HIV, including:
 - Information and counselling on preventing HIV transmission
 - Family planning for pregnant women living with HIV/AIDS
 - Use of antiretroviral drugs to prevent HIV transmission from mother to child
 - Infant feeding counselling
 - HIV treatment and care for infected mothers, infants and other family members
- Prevention of sexual transmission, including:
 - STI detection and management
 - Safer sex and risk reduction counselling
 - Condom promotion and provision
 - Special interventions for commercial sex workers, men who have sex with men and adolescents
- Harm reduction for injecting drug users, including:
 - Risk reduction information and education
 - Sterile needle and syringe provision and exchange
 - Opioid substitution therapy
 - Hepatitis B vaccination
- Prevention of transmission in health-care settings, including:
 - Safe blood
 - Universal precautions and safe medical waste management
 - Safe injections
 - Post-exposure prophylaxis
- Prevention services for people living with HIV/AIDS
- Clinical management of people living with HIV/AIDS, including
 - Co-trimoxazole prophylaxis
 - Management of opportunistic infections and comorbidities (including mental health and hepatitis)
 - TB-HIV co-management
 - Palliative care (symptom management and end-of-life care)
 - Nutritional support
 - Antiretroviral therapy
 - Specific focus on care and treatment for health workers

Community-based interventions

- HIV testing and counselling, including:
 - Voluntary HIV counselling and testing
 - Home-based testing and counselling, for partners and, in high HIV prevalence settings, for Know Your Status campaigns
- Community-based prevention, including:
 - Prevention information and education
 - Prevention interventions for vulnerable and most-at-risk populations
 - Prevention for people living with HIV/AIDS
- HIV/AIDS treatment and care, including:
 - Treatment preparedness for both HIV and TB
 - Treatment support for antiretroviral therapy, TB treatment and prophylaxis
 - Psychosocial support
 - Home-based palliative care
 - Home delivery of drug refills

¹³³ WHO (2006), Towards universal access by 2010: How WHO is working with countries to scale-up HIV prevention, treatment, care and support, www.who.int/hiv

- Peer support groups

Interventions delivered through outreach to most-at-risk populations (in partnership with other sectors)

- HIV testing and counselling, including
 - Outreach HIV testing and counselling, including use of HIV rapid tests
 - Referral from outreach to HIV testing and counselling services
- HIV prevention outreach to most at-risk populations, including commercial sex workers, drug users, men who have sex with men, young people and mobile populations, including:
 - Peer-based information and education
 - Condom promotion and programming, including 100% condom promotion campaigns
 - Provision and exchange of sterile needles and syringes
 - Targeted STI and sexual and reproductive health services, particularly for vulnerable girls and women
 - Referral to specific prevention services
- HIV/AIDS treatment and care
 - Integration of treatment support for antiretroviral therapy, TB treatment and prophylaxis in outreach services

National measures needed to support service delivery

Advocacy and leadership, including:

- Policies, laws and regulations that support HIV and STI programmes
- Measures to counter discrimination and stigmatization of people living with HIV/AIDS and most-at-risk populations
- Mobilizing communities, NGOs, people living with HIV/AIDS, most-at-risk groups and the business sector
- National strategic planning and programme management
 - National strategic and operational plans incorporating priority health sector interventions
 - National protocols and standards for service delivery
 - National targets for each major intervention area
- Procurement and supply management, including:
 - Updated national essential medicines lists and efficient drug registration systems
 - Secure and functional procurement and supply management systems for HIV medicines, diagnostics and other commodities
- Laboratory services, including:
 - HIV diagnosis and treatment monitoring
 - Diagnosis of TB and other opportunistic infections
 - HIV screening of blood and blood products
- Human resources, including:
 - National human resource plan
 - Health-worker training
 - Health-worker retention schemes and career development
- Sustained financing
 - Costed national HIV plans
 - Resource mobilization, accountability and reporting mechanisms
- HIV and STI strategic information systems, including:
 - National HIV, STI and behavioural surveillance
 - Population HIV drug resistance surveillance and pharmacovigilance monitoring
 - National HIV monitoring and evaluation system and programmes
 - Operational research

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Austria: There is no national policy on screening for HIV. Some 1.2 million people in Austria have an HIV test done every year, 500 000 of them when making a blood donation. For prevention of HIV infection, general information brochures ensure continuity in the dissemination of basic information about this disease. Target-group-specific publications and campaigns are addressed to certain age groups (e.g. young people) or people who indulge in certain forms of high-risk behaviour (people who frequently change sexual partners, sex tourists, commercial sex workers and their customers). The duty of the Federal Minister of Health to implement measures to educate people about HIV and the prevention of HIV infection is embedded in the Austrian AIDS Act, 1985. In addition to its central information activities, the health department supports the regional AIDS help institutions and a number of self-help institutions. The continuous information and consultation activities of the AIDS help institutions range from carrying out anonymous HIV antibody tests and associated advisory talks, right up to the psychological care of HIV-positive people and those with full-blown AIDS. The Federal Ministry for Health and Women publishes statistics on incidence and deaths, differentiated by risk groups and provinces, on a monthly basis.

Belgium: In Belgium there are seven AIDS-reference centres with eight reference laboratories, recognized and financed by the federal government. One of their tasks is to implement confirmation tests on sera found positive at a detection test. Since only these seven reference centres are qualified to run these tests, the recording gives a complete picture of the total number of persons with HIV. The reference centres also try to collect basic epidemiological facts. For this a standardized form is sent to every doctor who diagnoses HIV, requesting information on sex, age, nationality, possible manner of contagion and clinical stage at the point of diagnosis. This registration is financed by the federal state and data are analysed by the Scientific Institute of Public Health.

Denmark: Screening for HIV is opportunistic. Tests are available, and free of charge, at every GP surgery and at larger hospitals throughout the country, where anonymous testing and counselling are available. Information about the testing options is promoted in high-risk populations, especially among the homosexual population. Finland Screening for HIV for pregnant women was started in 1993. Except for pregnant women, the screening system for HIV is opportunistic. The National Public Health Institute maintains an HIV laboratory, which follows, predicts and tries to prevent new HIV cases. In the period 1980–2003, 1625 HIV cases were identified in Finland. The Finnish municipalities, which organize and finance maternity clinic services, organize the screening programme for HIV for pregnant women.

France: HIV screening is systematic and compulsory for blood, organ, sperm or milk donors. It is systematically suggested in prenuptial and prenatal examinations and often to people undergoing surgical procedures. If someone wishes to benefit from HIV screening, there are two possibilities: 1. Attendance at special centres (Consultations de Dépistage Anonyme et Gratuit: CDAG), where tests are free and anonymous. There is at least one centre per "department". 2. Consultation with a GP or specialist, who will prescribe an HIV test. The test is performed in a laboratory and fully reimbursed.

Germany: There is no national policy on screening for HIV. Case-finding for HIV infections is paid for by statutory health insurance in the presence of indicative complaints or symptoms. Screening is encouraged in pregnancy and recommended in "risk groups" by professional guidelines but is subject to the decision of the physician and patient ("opportunistic"). With regard to HIV there is a national policy not to encourage testing, but to focus on practical protection messages (condoms, risk-prone situations, negotiation skills, as well as solidarity with those affected). Many other countries use both voluntary counselling and testing strategies. The German and Dutch public education systems, for example, encourage voluntary counselling and are silent about testing to try to avoid a reduction in safe behaviour.

¹³⁴ Holland W., Stewart S. and Masseria C., (2006) Policy Brief: Screening in Europe, World Health Organization, 2006, on behalf of the European Observatory on Health Systems and Policies.

For the same reason, testing was even proactively discouraged among homosexuals in the early and mid-1990s. In general, written education materials are provided and balance testing is recommended if long-term partners want a child or want to choose another contraceptive. There is extensive information about test validity, test characteristics, the window period and recommendations for support and future behaviour.

HIV was never defined as “sexually-transmittable infections” (STIs) in a legal sense since this would have meant until 1999 that legal options to perform compulsory testing and treatment could have been applied to “non-compliant” STI patients under treatment or to “promiscuous people suspected of spreading the disease”. The Infectious Diseases Act of 2000 abolished the 1956 compulsory regulations for all STIs, which, in practice, had rarely been applied.

Greece: In Greece several policies have been implemented to control, monitor and prevent the HIV epidemic. The Hellenic Centre for Infectious Disease Control (KEEL) is responsible for HIV/AIDS case reporting and has established a reliable monitoring network of nine AIDS Laboratories Reference Centres and 17 HIV/AIDS clinics in public and private hospitals. AIDS case reporting was implemented in Greece in 1984. It is anonymous, confidential and mandatory by law A1/6122/19-9-1986.

The first two characters of the name as well as the patient’s date of birth are used as personal identifiers to prevent duplication. The reporting of HIV cases was initially implemented in Greece in 1998. It is anonymous, confidential and mandatory by law B1/5295/7-8-1998. The new surveillance system for monitoring HIV infection was implemented at European level in January 1999. KEEL is responsible for collecting and monitoring data on HIV and other infectious diseases. Reporting is obligatory and all hospitals and health centres are obliged to report treated cases. KEEL presents the collected information every six months. A pre-specified standard format is used in order to ensure homogeneity of the reported data. According to the “Half-Year” edition of KEEL (30 June 2004), the number of HIV positive persons (including AIDS cases) reported in Greece over the first half of 2004, was estimated to be 6923 cases, and around 221 were new HIV infections. The percentage of men reporting HIV infection was on average 4 times higher than that of women. Data on newly diagnosed HIV infections should be interpreted with caution because they may not represent incidence and because they depend heavily on varying patterns of HIV testing and reporting.

Ireland: The Department of Health and Children introduced a policy of voluntary antenatal HIV screening in Ireland in April 1999. As part of this programme, HIV screening is offered to all women who attend for antenatal services.

Italy: Recently, the Ministry of Health has established a National Commission for HIV (“Commissione Nazionale per la lotta contro l’AIDS”) which is intended to devise educational and preventive strategies and to promote continuing education for doctors in the field of infectious diseases. The commission will also monitor the spread of HIV both at national and international level, with particular emphasis on high-risk categories. It will promote and monitor research in HIV and audit the level of care provided for HIV patients. Moreover, the commission will update guidelines for certain types of treatment and verify DGRs tariffs for infectious diseases.

Netherlands: There is no national screening programme for HIV. However: all pregnant women can undergo an HIV test as part of antenatal and postnatal screening; the local public health agencies (GGDs) are in charge of HIV testing of specific risk groups. The GGDs have set up voluntary HIV screening for men and women in high-risk groups (homosexuals, drug addicts, commercial sex workers).

Portugal: Screening is opportunistic. Notification of HIV became compulsory in 2004. Drugs for AIDS patients are fully reimbursed by the state; patients are exempted from user charges in the NHS; but HIV-positive patients pay for drugs outside hospital. There are guidelines for testing pregnant women, with the aim of improving detection and early treatment.

Spain: Responsibility for AIDS is shared between the central government and the Autonomous Communities, although the Ministry of Health is the key sponsor of the National Plan Against AIDS (the first one was approved in 1997, and was followed by a new one in 2001). A multisectoral approach (community participation, coordination of central/regional/local administration, interdisciplinary approach), strategies of proven effectiveness and equity (human rights, tolerance and solidarity; equal opportunities and non-discrimination; reduction of vulnerability) are some of the principles governing the New Plan (2001–2005). Action in this area is directed towards better knowledge and analysis of the reality of the epidemic; the development of prevention programmes (information campaigns, needle exchange, prevention of sexual transmission, methadone substitution programmes); training and support programmes for health care staff; recommendations on treatment; screening, etc. Recently, AIDS patients were included in the group which pays a reduced charge for medicines. The HIV tests can be carried out in Spain free of charge and confidentially throughout the National Health System.

Since 1983 there has been a National HIV Registry and since the end of the 1980s all Autonomous Communities have had their own Regional HIV Registry. HIV surveillance consists of periodic surveys aimed at representative groups of the general population as well as target population groups as defined in the HIV Infection and AIDS Multisectoral Plan 2001–2005 (adolescents and young people, intravenous drug users, commercial sex workers, homosexuals, women, prisoners, immigrants and ethnic minorities).

Sweden: National strategies for the entire area of health and sexuality are presently lacking and will be developed by the National Institute of Public Health. In addition, work has been initiated on establishing an action plan for the prevention of unwanted pregnancies. This is based on preventive work carried out under provisions of the Communicable Diseases Act, the Health and Medical Services Act and the public health policy of the National Institute of Public Health with respect to HIV and STIs, as well as within the framework of various regional/local programmes. Currently, screening for HIV is opportunistic with pregnant women being offered tests, as are those displaying risk behaviours.

UK - HIV testing is offered to women in early pregnancy. Testing is compulsory for blood and organ donors.

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Cyprus: None

Czech Republic: Screening for HIV is very complex with a set of legal instruments controlling HIV screening. There is obligatory screening in cases included in specific rules. Voluntary screening is accessible for anyone who wants it (in certain circumstances admitted by law it can be anonymous). Screening is compulsory for donors of blood, organs or any biological material, and for pregnant women. Any such screening is paid for by health insurance. Some foreign countries require HIV testing before entry and in such cases the cost of the test is the responsibility of the individual concerned.

Estonia - HIV testing is compulsory during pregnancy, when entering military service, and for prisoners.

Hungary: Opportunistic screening for HIV is also available. Targeted screening for HIV infection is a subprogramme of the NPHP. Increasing voluntary testing based on informed consent among high-risk groups and re-introducing anonymous HIV testing combined with counselling are planned. Enforcing the legally regulated mandatory health examination (including HIV testing) of sexual workers is also among the actions planned in the sub-programme “Preventing AIDS” of the NPHP. Screening tests are paid for by the National Insurance Fund (NIF) if they are carried out in accredited institutions.

Latvia: Programme for Limiting the Spread of HIV/AIDS in Latvia 2003–2007 (previously HIV/AIDS spread control strategy in Latvia 1999–2003). Priorities are: HIV prevention among injecting drug users; treatment and support for people living with HIV and AIDS; HIV infection spread control among young people.

Two major projects support the control of HIV infection: coordinated support for young people's health in Latvia; and uniform secondary prevention building for intravenous drug users. AIDS Prevention Centre: epidemiological monitoring and prevention measures. Liaises with the European AIDS Monitoring Centre and adheres to the requirements of UNAIDS and the European Union and is integrated into EuroHIV programme. Target groups for screening: HIV infected persons and AIDS patients; pregnant women; military recruits; those involved in the national armed forces and international peace maintenance.

Lithuania: There is a national policy on HIV screening. Tests are performed on people with clinical AIDS symptoms, people from high-risk groups and on pregnant women. Tests are financed by the state sickness fund.

Malta: Opportunistic screening for HIV is offered within the public health service. It is usually carried out through the antenatal for gynaecology clinics or through the genito-urinary clinic. Pre- and post-test counselling is also given as part of the service.

Poland: Health and social problems related to HIV/AIDS necessitated the establishment of an institution at national level to identify problems, propose solutions and coordinate different activities. Such an institution was established in 1992 as a part of the office of National Sanitary Inspection. In 2000, the national offices for the coordination of AIDS prevention became the National Centre for AIDS.

This institution is directly subordinate to the Ministry of Health and plays the main role in: shaping the state policy on HIV/AIDS prevention and treatment, analysing the epidemiological situation in this field, and information and training activities. Its main current task is coordinating work on the implementation of the National Programme for HIV Prevention and Care for People Living with HIV/AIDS. The National Centre for AIDS is also the contact point for nongovernmental organizations (NGOs), which are offered support and financial help, experience, education, professional advice and consultation. Help and support is offered also to individuals living with HIV/AIDS, to ensure prevention and education in this area. Screening for HPV virus is available for women living with HIV. An HIV-positive woman has the same right to become a mother as any other woman.² If a woman in this situation consciously decides to become a mother, she is under the care of the Institute of Mother and Child for the whole pregnancy and has an access to antiretroviral (ARV) treatment for vertical infections. There exists a pilot programme of test-tube insemination with clean sperm.

Slovakia: Slovakia has a national policy on screening for HIV. There is a National HIV register, but there is currently no targeting of at-risk groups. All costs are paid by the health insurance companies.

Slovenia: There is a national policy of screening for HIV. HIV is screened for routinely in all pregnant women, in all patients with a newly established diagnosis of syphilis and in all those donating blood and other tissues (both since 1986). It is possible to test for HIV anonymously or openly at several points and there is voluntary inclusion testing for high-risk groups. Furthermore, HIV testing is offered upon informed consent to drug addicts in centres across the country.

Accession countries

Bulgaria: A National Programme for Prevention and Control of HIV and other sexually transmitted diseases (2001–2007) has been in place since 2001. It is not opportunistic. The main objectives, broadly defined, of this programme are: to establish the basis for a steady process of eradicating the factors that contribute to the spread of HIV, paying special attention to the vulnerable groups of the population; to ensure a tolerant and supportive social environment and access to health care for those suffering from HIV or sexually transmitted diseases; to reduce the risk of transmitting HIV and other blood-borne infections by introducing good medical practices and standards according to the directives of WHO and the European Council. The programme is not uniform throughout the country. Nineteen of the 27 municipalities contain the highest percentages of the target population: 90% of the intravenous drug addicts; 67% of the commercial sex workers; 50% of the gypsy minority; and 67% of young people (66% of those in secondary education and 82% of those in university education).

The programme classifies the municipalities in three groups: 1. six municipalities with higher risk exposure, where the programme cover all four vulnerable groups in the population (intravenous drug addicts, commercial sex workers, the gypsy minority, and young people); 2. three municipalities where the programme covers three of the four vulnerable groups (intravenous drug addicts, commercial sex workers, and young people); 3. ten municipalities where the programme covers only one of the four vulnerable groups. The programme is financed by the Global Fund to fight AIDS, TB and malaria. The financial contribution received from the Fund amounts to US\$ 6 894 270 for the period 2003–2005. However, most of the tests for detection of HIV or other sexually transmitted diseases are paid directly by the patients. There is one ONG that provides HIV tests free of charge.

Romania: Testing for HIV is voluntary with the guarantee of confidentiality. Pregnant women, patients with STIs and TB patients have easy access to HIV testing and counselling. The National Strategy on HIV/AIDS 2004–2007 develops further the initiatives from the previous strategy of 2000–2003 and aims to make HIV testing and counselling available to defined vulnerable populations such as commercial sex workers, prisoners, street children, institutionalized children, travelling communities and so on.

Annex 6: HIV/AIDS Country profiles¹³⁵

Austria (pop. 8 117 754) - By the end of 2004, Austria had reported a cumulative total of 9154 HIV cases; 2394 had developed AIDS, and of this latter group 1384 had died. For the year 2004, the country reported 470 new HIV cases, 85 new AIDS cases and 22 AIDS deaths. Of the reported people living with HIV/AIDS (PLWHA), 78.9% are men and 48.2% live in the capital, Vienna. There are an estimated 12 000–15 000 PLWHA in the country. The main modes of transmission are men having sex with men, 41.2%; sharing injecting equipment, 9.8%; heterosexual transmission, 21.6%; blood transfusions, 6.2%; and vertical (mother-to-child) transmission, 1.25%. HIV testing is mandatory for all blood/plasma and organ donors, as well as for commercial sex workers. There is no national register for HIV cases. More than 1.2 million people are tested annually for HIV, including 0.5 million blood donors. Several HIV surveys have been conducted among IDUs and prisoners. Prevalence among Viennese IDUs increased from 13% in 1986 to 27% in 1990. In Innsbruck, IDU prevalence reached 44% in the period 1985–1990. Prevalence in prisons is estimated at 0.5–1.3%, five times higher than in the general population. The understanding of new HIV infections in Austria is limited due to a lack psychosocial research in the fields of sexual and preventive behaviour. The most recent study on men who have sex with men (MSM), for example, is from the pre-ARV era. As of 1 July 2005, 1628 patients were on treatment at the five HIV centres in Austria. Including the patients cared for by general practitioners, there are an estimated total of 2000 people on treatment.

Belgium (pop. 10 376 132) - By the end of 2004, there had been 16 781 cumulative HIV cases reported in Belgium, of which 3341 had developed AIDS, including 1736 people who had died. In all, 65% of the HIV cases had a known mode of transmission, including 6% through injecting drug use. For the year 2004 alone, 984 new HIV cases, 87 new AIDS cases and 18 AIDS deaths were reported. Among the reported HIV cases, 62% have been male. The largest numbers of HIV-positive people are aged 30–34 (men) and 25–29 (women). Among Belgian nationals, 67.2% of the infected men reported having acquired HIV by having had sex with a man and 5.1% through injecting drug use. Heterosexual transmission accounted for 25% of the cases. For women of Belgian nationality, heterosexual transmission was cited in 77.8% of the known cases. Among non-Belgian men and women the majority of cases are heterosexual (62% and 86% respectively). Whilst AIDS incidence has continued to decline among Belgians, incidence among non-Belgians has remained relatively stable or slightly increasing, particularly for non-residents who were diagnosed shortly after arriving in the country. Since 1997, the majority of new AIDS cases have been among non-Belgians, especially those from countries with generalized HIV/AIDS epidemics. Annual incidence of new HIV cases has been relatively stable, with peaks in 1987 (928 cases), 1992 (977 cases) and most recently 2003 (1048 cases). The recent increases are particularly noteworthy. Following a steady decline in the number of new cases between 1992 and 1997, there was a 50% increase in the number of new cases between 1997 and 2003, and the number of new cases reported for the year 2003 is the highest since reporting began. It is estimated that 8072 HIV/AIDS patients received medical care for their condition in 2004; they include approximately 6000 receiving ARV.

Bulgaria (pop. 7 823 557) - By the end of 2004, Bulgaria had reported a cumulative total of 515 HIV cases, including 145 diagnosed as AIDS. The annual number of newly reported HIV infections grew from 15–20 in the early 1990s to 40–60 in the past three years. Among the HIV cases reported from 1986 through 2004 that had a known mode of transmission, more than 91% had been transmitted through sexual intercourse, 4.1% through injecting drug use, 3.7% through blood transfusion (last registered in 1996) and 1.0% through vertical transmission. The dominant mode of sexual transmission is heterosexual, at 85%, with the other 15% being due to sex between men. Sixty-nine per cent of Bulgaria's reported HIV cases are male, while 71% of them fall in the age range of 20–39 years. The largest numbers of cases have been registered in four major cities, Sofia (163), Varna (39), Bourgas (72) and Plovdiv (40).

¹³⁵ Matic, S., Lazarus J. and Donoghoe, M. eds. (2006), HIV/AIDS in Europe Moving from death sentence to chronic disease management. WHO

An initial round of second-generation sentinel surveillance surveys among three risk groups – IDUs, commercial sex workers (CSWs) and the Roma people – was conducted in late 2004 in five major cities: Sofia (the capital), Varna, Bourgas, Plovdiv and Pleven. HIV prevalence in the three groups was 0.59% among IDUs, 0.73% among CSWs and 0.30% among the Roma population. Although the data indicate that prevalence among these risk groups is still low, their vulnerability appears to be high. Surveillance data show that 63.9% of IDUs, 13.4% of the Roma and 8.7% of CSWs are seropositive for hepatitis C, while the syphilis prevalence among the three groups is 2.4%, 6.7% and 21.5%, respectively.

Access to antiretroviral treatment in Bulgaria is now universal, and 154 people were on ARV at the end of 2004. Though antiretrovirals were previously available only in Sofia, decentralization was successfully initiated in the beginning of 2005, and by the end of the year, three infectious diseases hospitals in the country provide ARV.

Cyprus (pop. 720 568) - Between 1986 and the end of 2004, there were 441 cases of HIV/AIDS reported in Cyprus: 261 among permanent residents and 180 among visitors. By the end of 2004, 224 cases had developed AIDS, and 77 AIDS patients had died. Among the permanent residents with HIV, 235 were Cypriots and 26 non-Cypriots. The annual incidence has been relatively low and stable, with small peaks in 1994 and 1999.

Surveillance in certain population groups (e.g. inpatients, pregnant women, army conscripts and blood donors) indicates very low or zero prevalence rates. It is estimated that the true prevalence in the adult population is less than 0.1% and that fewer than 400 people with HIV currently live in Cyprus. Twenty-five new cases of HIV and 2 new cases of AIDS were reported in 2004. Four fifths of known HIV cases were aged 20–44 at the time of diagnosis, while 3% were younger than 20. The mean age at HIV diagnosis is 31.8 years and 36.5 years for AIDS. The main mode of transmission is sexual intercourse: 46.4% of all cases were infected heterosexually and 45.6% through MSM. The remaining cases include 1.1% who reported having injected drugs, 3% who were infected abroad through blood and blood products before 1987, 0.4% representing one child who was infected perinatally and 3.3% for whom the mode of transmission is not known. Factors that may have a negative impact on the future course of the epidemic include: the increasing proportion of them who are testing positive; intense population movements to and from Cyprus and across the dividing line; the steady increase in the trafficking and use of drugs; the increasing number of seropositive women from abroad who come to live in Cyprus. The persistence of traditional social and family values may be considered a protective factor that should be further reinforced. The information presented here concerns the Greek part of Cyprus, due to an absence of reliable information concerning the rest of the island. Unofficial sources indicate that low prevalence and similar protection and risk factors are common to both parts of the island. Efforts are being made by the Ministry of Health of Cyprus, through collaboration with Turkish Cypriot NGOs, to establish common strategies against HIV/AIDS. There were 126 people on ARV at the end of 2004.

Czech Republic (pop. 10 201 651) - By the end of 2004, authorities had reported a cumulative total of 737 HIV cases among Czech nationals. These reports include 186 patients who developed AIDS, 109 of whom died. In addition, 216 foreigners, mostly from eastern Europe, also tested HIV positive – i.e. almost one quarter of all reported HIV cases were among foreign citizens. Seventy-six new HIV cases and 12 AIDS cases were recorded in the Czech Republic in 2004, the former being the highest annual incidence since reporting began in 1985. In the Czech Republic, HIV is most often transmitted sexually (in more than 84% of HIV cases). Transmission between MSM accounts for more than half of all cases (52%), and about 79% of PLWHA are male. HIV-positive mothers have given birth to 57 children, and mother-to-child HIV transmission was recorded in 3 of these children. Among the cumulative total of HIV cases with a known route of transmission, 4.7% have been infected through injecting drug use. By 2004, this figure rose to 8.8% of the new cases registered for the year. Almost two thirds of all HIV infections are in residents of the capital, Prague, and its immediate vicinity. Viewed from a long-term perspective, the HIV/AIDS situation in the Czech Republic may be considered as relatively favourable, and incidence is stable. In 2004, 836 601 HIV tests were performed, of which 514 523 were among blood donors. A total of 297 people were receiving ARV at the end of 2004 (88.2% male).

Denmark (pop. 5 387 174) - By the end of 2004, Danish authorities had reported a cumulative total of 4266 HIV cases, including 2536 AIDS cases, of which 1938 had had fatal outcomes. For the year 2004 alone, 303 new HIV cases, 57 AIDS cases and 14 AIDS deaths were reported. Denmark introduced an anonymous HIV case-reporting system in August 1990. The data collected include information on risk behaviour, previous testing and results, and nationality. The number of HIV tests conducted is reported monthly. No routine screening programmes exist except for blood donors. Over the past 10 years, the level of HIV incidence has been stable, whereas the number of new AIDS cases has declined since the mid-1990s. Among Danish nationals, the transmission is primarily between MSM, whereas for foreigners the transmission is primarily heterosexual. Ten per cent of cases with known transmission routes are due to injecting drug use. Out of the 303 new HIV infections in 2004, 194 were among Danish nationals, of whom 176 were male and 18 female. Among the 176 new HIV cases in Danish males, 70% were among MSM, 23% people who contracted HIV heterosexually, 5% IDUs and 2% those classified as others. Of the 18 new HIV cases in Danish females, 16 were transmitted through heterosexual contact and 1 by injecting drug behaviour. The number of new cases among MSM in 2004 was the highest since 1991.

The number of Danish syphilis cases reported increased dramatically from an annual incidence of 30–50 cases in 1994–2002, to 151 cases in 2004, most of them among MSM in Copenhagen. ARV is universally available in Denmark. Around 3000 patients are receiving treatment. Data from Greenland, an autonomous territory of Denmark, are not included in the data above. By the end of 2004, Greenland had reported cumulative totals of 137 HIV cases, 48 AIDS cases and 48 AIDS deaths. Sixty-five HIV/AIDS patients on the island received medical treatment for their condition in 2004, with 49 receiving ARV.

Estonia (pop. 1 353 558) - By the end of 2004, Estonia had reported a cumulative total of 4442 HIV cases; it had also reported that 70 of these cases had developed AIDS, of which 36 had died. For the year 2004 alone, the republic reported 743 new HIV cases, 27 new AIDS cases and 6 AIDS deaths. Estonia has the second highest estimated prevalence of HIV, over 1% of the adult population, in Europe. Seventy-three per cent of Estonian PLWHA are male. The estimated number of IDUs in Estonia is 12 000–15 000. The annual opiate use prevalence rate of 1.2% of the adult population is among the highest in the world. Preventive measures (e.g. the exchange of needles and methadone substitution programmes) since 2003 have covered less than 10–20% of those who needed it. HIV prevalence among IDUs is estimated at between 6.2% and 41%. The majority of all HIV infections are among IDUs and their sexual partners. Most infections are reported from IDUs in Kohtla-Järve, Narva and Tallinn among Russian-speaking Estonians. Many HIV infections – 22% of all new cases in 2004 – are among prisoners. While the HIV incidence rate in Estonia (1071 per million population in 2001, 661 per million in 2002) is the highest in the WHO European Region, the epidemic remains concentrated in Russian-speaking drug injectors in specific geographic areas. HIV testing is mandatory among blood donors and prisoners.

HIV surveillance is carried out through screening and through a national HIV case-reporting system. The incidence of syphilis cases increased dramatically from less than 10/100 000 in 1982–1990 to 76/100 000 in 1997, declining in 2001 to 21/100 000. The number of patients on ARV increased from 47 in 2003 to 174 in August 2005.

Finland (pop. 5 213 013) - By the end of 2004, Finland had reported a cumulative total of 1753 HIV cases; 397 of them had developed AIDS, including 257 who had died. In the year 2004, there were reported 128 new HIV cases, 19 new AIDS cases and 8 AIDS deaths. Seventy-five per cent of Finnish PLWHA are men. Foreigners contribute 26% of all reported HIV cases. Of the cases with a reported mode of transmission (1540), the majority are heterosexual (40%) or MSM cases (38%), while 19% are IDUs. The majority of heterosexual cases (60%) are individuals from countries with generalized HIV epidemics, with an additional 7% people who have sexual partners from this group. The annual incidence of Finnish HIV cases has been relatively low and stable, with a small peak in 1992 when 93 new cases were reported, declining to 69 cases in 1996. From 1996 to 2000 the annual incidence increased rapidly, cresting in 2000 with 145 newly reported cases. This rise was in part a result of an outbreak among IDUs that peaked in 1999 with 86 cases (60% of all HIV cases reported that year). Since 1999, the number of IDU cases has been declining, while new cases among MSM have been increasing slightly. Approximately 1000 people currently receive ARV in Finland.

France (pop. 60 144 000) - France has the most PLWHA and the second highest estimated prevalence of HIV (after Spain), in terms of absolute numbers, in the European Union. It only started mandatory HIV case reporting in March 2003, so analysis of the French HIV epidemic over a longer period of time is not possible. From March 2003 until 31 December 2004, the authorities reported a total of 6302 new HIV cases. From the beginning of the epidemic through December 2004, they reported 59 495 AIDS cases and 34 098 AIDS deaths. Underreporting is estimated to be 15% for AIDS cases and 20% for AIDS deaths. In 2003–2004, 58% of new HIV cases were male. Among those cases with a known mode of transmission, 27% were caused by men having sex with men, 69% by heterosexual contact and 3% through injecting drug use. The majority (51%) of women infected through heterosexual transmission came from sub-Saharan Africa. In all, 24% of the cumulative AIDS total since the beginning of the epidemic have been among IDUs. An estimated 110 000 IDUs are currently on opioid substitution treatment. In the new AIDS cases reported during the same two years, 69% were male. Among those with a known mode of transmission, 24% were through sex between men, 61% through heterosexual contact and 13% through injecting drug use. The decrease in the percentage of AIDS cases in drug users, which must be compared to the low proportion of IDUs in the HIV diagnoses for 2003–2004, confirms the reduction of HIV transmission in this population. Among HIV-positive IDUs, a large proportion was screened early, long before acquiring AIDS. The number of AIDS cases among French nationals decreased by 41% from 1999 to 2004, while it increased by 20% among immigrants, most notably those from sub-Saharan Africa or Haiti.

In conjunction with the institution of a mandatory reporting system for HIV, virological surveillance of recent infections (defined as less than 6 months old) was set up to contribute another measure of HIV incidence. Determination of infection recency was possible for 4353 patients (70% of the new diagnoses) in the 2003–2004 period. The proportion of recent infections among the new diagnoses in 2003 was 30.9%. More than half (51%) of new diagnoses for MSM are recent infections and nearly one quarter for those infected through heterosexual contact. This higher proportion in MSM is consistent with the increase in incidence of sexually transmitted infections observed among French MSM in recent years. But differences in proportion must be weighed carefully since they depend highly on screening practices, and because MSM test for HIV more frequently than other risk groups, the probability of their being screened shortly after infection is correspondingly higher. According to a standardized national self-reporting study of gay men's behaviour, the number of reported acts of unprotected anal intercourse in the previous year doubled between 1997 and 2004 among both seropositive and seronegative men. Thirteen per cent of the respondents reported being HIV-positive and another 17% being of unknown HIV status; 86% reported having been tested for HIV at least once in their lifetime. In addition, 10% of the respondents reported contracting an STI other than HIV in the past 12 months: 30% of them had gonorrhoea and 20% syphilis, an increase of 100% and 300%, respectively, since 1997. Consistent with this self-reported syphilis prevalence of 2.0%, a syphilis prevalence survey in 2002 recorded one of 2.6% among MSM, about 10 times higher than among heterosexuals. The same study found a prevalence of 8.9% among all PLWHA, regardless of sexual orientation. Out of an estimated 85 000 patients seen for HIV/AIDS treatment in 2004, more than 53 000 were on ARV.

Germany (pop. 82 476 000) - By the end of 2004, Germany had reported a cumulative total of approximately 67 500 HIV infections, including 23 546 cases of AIDS. Adjusting the figures for underreporting estimates, the actual number of AIDS cases is approximately 28 000, of whom 23 500 have already died. Currently, some 200–300 people die annually from AIDS. In the year 2004 alone, the country reported 1979 new HIV cases. Each year there are about 10–20 HIV infections in children, substantially less than 1% of all new infections. In the first half of 2005, Germany noted a 20% increase in newly reported HIV infections, most of it among MSM infected domestically. The estimated number of newly diagnosed AIDS cases during 2004 was 359, though it likely exceeded 800. Germany estimated that at the end of 2004 there were around 44 000 PLWHA in the country. More than half of all infections (55%) are in MSM, a rate that has been on the rise since 2001. Syphilis rates have also increased among MSM in recent years. About 20% of all HIV infections are found in immigrants from high-prevalence countries. An additional 15% are heterosexually transmitted. The number and percentage of infected IDUs decreased in the 1990s, but the numbers have since stabilized, with IDUs accounting for about 8% of all infections. In Germany, HIV testing is systematic among blood donors and recommended for pregnant women, who have an estimated coverage rate of 50–80%. Laboratories (since 1987) and clinicians (since 1998) anonymously report newly diagnosed HIV cases to a national database.

Since 1993, HIV laboratory reports have differentiated between newly diagnosed infections and already diagnosed patients. From 1993 through 2004, the number of newly diagnosed HIV infections reported was 23 055. Clinician reports are available for more than 90% of the new cases since 1998 and contain a name-based code to allow detection of duplicate reports. HIV prevalence is low in the general population, particularly outside metropolitan areas. In Berlin, one of the five German cities with the highest AIDS prevalence, pregnant women have an HIV prevalence of less than 0.1%. Since the early 1990s, HIV prevalence has decreased among IDUs entering drug treatment centres. As in other western European countries, prevalence among non-IDU commercial sex workers is similar to that found in general population. ARV is universally available in Germany, and 65–70% of all PLWHA are currently receiving it.

Greece (pop. 11 023 532) - By the end of 2004, Greek authorities had reported a cumulative total of 7134 HIV cases; they included 2515 people who developed AIDS, of whom 1417 had died. For the year 2004 itself, the authorities reported 434 new HIV cases, 72 new AIDS cases and 25 AIDS deaths. The route of transmission was unknown in 47.1% of HIV cases reported in the first half of 2004. This high percentage is due to the fact that many reports are based only on laboratory surveillance. Men who have sex with men accounted for 30.3% and heterosexual transmission 19.5% during that period. The majority of cases were in the 25–44 age group, with 30–34 year olds the most affected group. Sexual transmission accounts for the vast majority of all HIV cases reported with a known route of transmission over the years: 45.6% of the overall total are found in MSM, 20.1% in heterosexually infected individuals and 4% in IDUs. As of June 2004, men accounted for 86% of all HIV infections to date. Heterosexual contact is the only transmission mode in which women account for the majority of cases. Most of the heterosexual cases reported in 2002–2003 (45%) are from countries with generalized HIV epidemics.

The annual incidence of new HIV cases has been relatively low. A peak in 1999, when 1281 new cases were reported, is partly attributed to retrospective reporting of past infections. However, HIV cases distributed by year of diagnosis (rather than year of report) reveal an upward trend that peaked in 1998. Thereafter, the annual incidence of new cases has been declining. Due to the advent of ARV, the number of AIDS cases also declined markedly after 1997 and remains low. There were 3050 people on ARV as of 1 November 2005.

Hungary (pop. 10 129 551) - By the end of 2004, there had been 1175 HIV cases reported in Hungary, in which 471 people were reported to have developed AIDS, including 266 who died. In the year 2004 itself, there were reported 71 new HIV cases, 22 new AIDS cases and 9 AIDS deaths. The incidence of AIDS cases is relatively low and stable. Recent reductions in AIDS death are due to the introduction of ARV in the country. Eighty-one per cent of the AIDS cases registered through the end of 2003 were among MSM and 0.5% in IDUs. Similarly, most reported HIV infections in Hungary have been among MSM and heterosexual women, with relatively fewer cases amongst IDUs (approximately 2%). A closer analysis of heterosexual cases reveals that in 2002–2003, 32% were imported from countries with generalized HIV epidemics. HIV testing is mandatory for blood donors. A national HIV reporting system has existed since 1985. A total of 568 HIV/AIDS patients were treated for their condition in 2004. By the end of that year, there were 347 people were on ARV, and as of 25 May 2005, 371.

Ireland (pop. 3 978 862) - By the end of 2004, Ireland had reported a cumulative total of 3764 HIV cases; these reports included 813 people who had developed AIDS, of whom 378 had died. Among all the HIV cases reported with a known mode of transmission, approximately 37% had been infected through heterosexual contact, 33% injecting drug use and 23% among men who have sex with men. For the single year 2004, the country reported 356 new HIV infections, 38 new AIDS cases and 4 AIDS deaths. Since 1998, the epidemiology of HIV in Ireland has changed considerably, with significant increases in the numbers of infections acquired heterosexually. Of the 178 cases acquired through heterosexual contact for which data is available, the majority were born in sub-Saharan Africa (85 female and 37 male), with another large cohort born in Ireland (20 female and 15 male). The number of new diagnoses among IDUs increased from 49 in 2003 to 71 in 2004, highlighting the need for maintaining harm-reduction measures. In addition, 62 newly diagnosed cases were reported among MSM in 2004. This figure is of concern in the context of the continuing endemicity of syphilis in Ireland following the syphilis outbreak among MSM that began in Dublin in 2000.

It is important to note that data were incomplete with respect to 49 (13.7%) of the 356 newly diagnosed HIV infections reported in 2004, making data analysis and trend interpretation difficult. Ireland has an estimated 1600 people on ARV.

Italy (pop. 57 604 656) - By the end of 2004, Italy had reported a cumulative total of 54 497 AIDS cases, including 34 358 people who had died. For the year 2004 itself, it estimated approximately 3500 new HIV cases and reported 1673 new AIDS cases and 439 AIDS deaths. It should be noted that HIV reporting exists in only 7 of the country's 20 regions – Bolzano, Friuli Venezia-Giulia, Lazio, Modena, Piemonte, Trento and Veneto – which makes analysis of the national epidemic difficult. The most recent estimate for the cumulative number of people living with HIV/AIDS in Italy is 110 000 to 130 000, at the end of 2003. The actual HIV incidence for 2003 was estimated to be between 3500 and 4000 new infections, with 65% males and 20% foreigners. The annual incidence of AIDS cases peaked in 1995, when more than 5500 cases were registered. The ensuing decline in new AIDS cases and AIDS deaths was primarily due to increasing use of ARV. In recent years, the incidence of reported AIDS cases has stabilized at around 1800 per year. Early on in the epidemic, the main route of transmission was through injecting drug use. However, new infections in recent years have been predominantly due to sexual transmission. Around 40% of new HIV infections are attributed to heterosexual sex, 35% to injecting drug use and 20% to men having sex with men. In 1994, just under 2% of AIDS cases were found in foreigners, whereas in 2003 about 20% were among non-Italians. AIDS incidence in Italy varies greatly by region. The cities of Rome and Milan have the highest annual AIDS incidence rates (4.9 and 4.8 AIDS cases per 100 000, respectively), followed by Genoa (4.1/100 000) and Bologna (3.7/100 000).

Latvia (pop. 2 325 342) - By the end of 2004, Latvia had reported a cumulative total of 3033 HIV cases; it had also reported that 322 of the infected individuals had developed AIDS, including 38 who had died. In the year 2004 alone, the republic reported 323 new HIV cases, 71 new AIDS cases and 7 AIDS deaths. The first case of HIV in Latvia was registered in 1987 and the first case of AIDS was detected in 1990. During the period from 1987 until the end of 1997, HIV incidence in Latvia remained low and all transmission was reported to be sexual, mostly among MSM. By the end of this period, there were 88 Latvians known to be living with HIV.

In November and December 1997, the first five HIV-infected IDUs were registered, and since 1998, the main mode of HIV transmission has been through injecting drug use. The estimated number of people living with HIV/AIDS in Latvia is 6000. As of the end of 2004, Latvia had reported that 70% of HIV infections had been among IDUs and 4% among MSM, while 67.0% of AIDS cases were among IDUs, 15.5% among MSM and 1.2% among children and the newborn. Many IDUs are imprisoned. All prisoners in Latvia are tested for HIV upon entering prison, and in 2000 and 2001, 30% of the new HIV infections registered were diagnosed in this way. Women are counselled to undergo HIV testing during pregnancy, and the HIV rate in 2001 among pregnant women was 1.13 per 1000 tested. HIV testing and counselling is available through all doctors in the country and is free. The syphilis incidence rate has decreased from a 1996 peak of 126 per 100 000 population to 25/100 000 in 2004.

Lithuania (pop. 3 454 205) - By the end of 2004, Lithuania had reported a cumulative total of 980 HIV cases; it had also reported that 86 of those infected had developed AIDS, including 41 who had died. Eighty nine per cent of the registered HIV cases have been male. In the HIV cases with a known mode of transmission, 80% were infected through injecting drug use, 10% through heterosexual contact and 7% through men having sex with men. For the year 2004, the authorities reported 135 new HIV cases (78% IDUs), 22 new AIDS cases and 10 AIDS deaths. That same year, the estimated number of people living with HIV/ AIDS in Lithuania was 1300 (range: 400–2600). Most PLWHA are adults younger than 30. Klaipeda is the Lithuanian city with the greatest number of PLWHA. The number of HIV cases has been steadily increasing since the first HIV case was reported in 1989. Up to 1997, HIV in Lithuania was reported as being transmitted through sexual contacts, mostly among MSM and among seamen who contracted the virus heterosexually in countries with generalized epidemics. Since 1997, there has been a rapid spread of HIV infections among IDUs, especially in prisons. In 2002, for example, 263 prisoners at the Alytus prison tested positive for HIV, though tests at Lithuania's other 14 prisons found only 18 cases. Before the tests at the Alytus prison, Lithuania had reported just 300 cases of HIV in the whole country. All HIV diagnoses are incorporated in a single national database. The reported HIV prevalence in 2004 was 26.1 per 100 000 population (19.9/100 000 in 2002 and 22.8/100 000 in 2003), which is the lowest in the Baltic Sea region.

The incidence of syphilis cases increased dramatically from fewer than 10 cases per 100 000 in 1983–1991 to 101.4/100 000 in 1996, before dropping back to 9.8/100 000 in 2004. In 2004, approximately 365 Lithuanian HIV/AIDS patients received medical treatment for their condition. They include the 47 people who were on ARV at the end of 2004 (40 of them male, 5 of them IDUs). Three months later, there were 51 people on ARV.

Luxembourg (pop. 449 951) - By the end of 2004, Luxembourg authorities had reported a cumulative total of 652 HIV cases; they also reported that 177 of the infected residents had developed AIDS, including 105 who had died. Among those HIV cases for which a transmission mode was known, approximately 16% had been infected through injecting drug use. Among the reported AIDS cases, 57% are attributed to men having sex with men, 22% to heterosexual sex and 20% to injecting drug use. The incidence of AIDS cases remains relatively low and stable. In the year 2004, the authorities reported 60 new HIV cases, 12 new AIDS cases and 6 AIDS deaths. Of the HIV infections newly diagnosed in persons infected heterosexually, approximately one third are cases originating in countries with generalized HIV epidemics. In 2004, 279 HIV/AIDS patients received medical care for their condition, including the 217 people who were on ARV at the end of the year.

Malta (pop. 398 582) - By the end of 2004, Maltese authorities had reported a cumulative total of 103 HIV cases; they had also reported that 58 of the infected individuals had developed AIDS, including 50 who had died. Reporting of AIDS cases includes only Maltese residents. Reliable data on HIV cases only started being collected in January 2004. In the year 2004, Malta reported 15 new HIV cases (including 5 foreigners who left the island soon after diagnosis), 2 AIDS cases and 1 AIDS death. Of the 103 HIV cases reported to date, an estimated 15 were infected through injecting drug use. Of the 58 AIDS cases, 31 are attributed to sex between men, 9 to heterosexual sex, 13 to infected blood and blood products and 1 to mother-to-child transmission, while 4 have been due to unknown causes. HIV testing is mandatory for Maltese blood donors, STI patients and IDUs at treatment centres. Prevalence data comes mostly from these testing programmes. Data on diagnosed HIV cases are reported to a national database. In 2004, 64 HIV/AIDS patients received medical treatment for their condition, including 47 people who were on ARV at the end of the year.

Netherlands (pop. 16 225 296) - From 1983 through 2004, Dutch authorities registered 6563 AIDS cases and 4150 AIDS deaths. From 2002 through 2004, they also registered 10 371 HIV cases, including many that had been diagnosed in previous years. Of the HIV cases with a known transmission source, approximately 6% were infected through injecting drug use. For the year 2004, authorities reported 766 new HIV cases, 196 new AIDS cases and 38 AIDS deaths. HIV prevalence in the Netherlands is highest among MSM and IDUs. People living with HIV also account for a significant proportion of the prevalence of other STIs: for instance, 20% of the diagnoses of gonorrhoea, chlamydia and syphilis among MSM were seen in MSM who were known to be HIV-positive. Data from all of the country's new HIV diagnoses have been collected only since January 2002. The registration is coordinated by the HIV Monitoring Foundation in Amsterdam and is based on reports from the 22 HIV/AIDS treatment centres in the country. HIV testing is systematic for blood donors and for certain insurance applicants. In 2004, universal screening of pregnant women in the Netherlands started. Since 1991, unlinked anonymous surveys have been conducted among STI clinic attendees and IDUs. HIV surveillance of two other risk groups began in 2003: migrant populations from high-endemicity areas and CSWs and their clients. HIV prevalence among IDUs has been shown to be very high in the capital, Amsterdam, (26%) and one city in the south (Heerlen, 22%), but it is also considered high in other cities (10% in Rotterdam and 5% in Utrecht). In 2004, there were 9137 Dutch PLWHA who received medical treatment for their condition, including 7342 people who were on ARV at the end of the year.

Poland (pop. 38 195 176) - By the end of 2004, Polish authorities had reported a cumulative total of 9151 HIV cases; they also reported that 1537 of the infected individuals had developed AIDS, including 724 who had died. Among the HIV cases with a known route of transmission, approximately 82% were infected through injecting drug use. In 2004, the authorities reported 656 new HIV cases, 172 new AIDS cases and 57 AIDS deaths. Twenty-eight per cent of the new HIV cases were among IDUs, while the transmission route of 62% was unknown. Poland has a more severe epidemic than most of central Europe, and it is driven by injecting drug use, which started in the mid-1980s.

The number of new HIV cases peaked in 1990 with 809 registered cases, declined to 384 cases in 1993, and has increased slowly since. Currently, the most affected regions are Dolnoslaskie in the south-west (bordering the Czech Republic and Germany), with an average annual incidence in 1999–2004 of 35 new HIV infections per million population, and Warminsko–Mazurskie in the north-east (bordering the Kaliningrad district of the Russian Federation), with an annual rate of 22 per million. HIV testing is mandatory for Polish blood donors, and all other groups are tested on a voluntary basis. The laboratories confirming an HIV diagnosis report all cases to the national HIV database using personal identifiers. According to surveillance data, approximately 4–10 new HIV infections are detected for every 100 tests administered to IDUs. Harm-reduction programmes in Poland have been operating since 1986 and are subsidized by the state. However, opioid substitution programmes are high-threshold programmes, and eligibility criteria thus keep many drug users from being able to access the services. Despite the state-guaranteed universal availability of ARV, AIDS incidence continues to rise due to a rapidly increasing number of late-presenting cases. Reported AIDS mortality tended to decrease after 1996, when ARV was introduced, but a comparison with official death statistics indicates much underreporting of AIDS-related deaths. There were 2247 Poles on ARV at the end of 2004, including 90 in prison.

Portugal (pop. 10 441 075) - By the end of 2004, Portuguese authorities had reported a cumulative total of 25 968 HIV cases; they had also reported that 11 755 of the infected individuals had developed AIDS, including 6046 who had died. Prior to 2000, Portugal did not report HIV (asymptomatic) cases, which makes analysis of the epidemic difficult. However, since 2000, the country has been reporting HIV cases, and available data indicates that it has the highest HIV incidence rate in western Europe (280.5 new diagnoses per million population in 2004). Of the HIV cases with a known source of transmission, approximately 50% were infected through injecting drug use, 33% through heterosexual contact and 12% through men having sex with men. In 2004, authorities reported 2825 new HIV cases, 802 new AIDS cases and 285 AIDS deaths. AIDS incidence appears to have peaked in 2000 with 1124 new cases; however another 1069 cases were reported in 2002. Reporting delays, often more than four years, between diagnosis and notification suggest a slightly earlier peak (in 1999) and may be the reason for the decline in annually reported AIDS cases thereafter. Among the cumulative AIDS cases reported to the end of 2003, most were male (83%), and most were aged 25–39. Almost half the reported cases (49%) were among IDUs. A further 30% were heterosexually transmitted, and 14% were among MSM. The fewer cases in 2003 (both diagnosed and notified) suggests a levelling off and decline in annual AIDS incidence due to ARV, but the trend has not yet been confirmed.

The number of new AIDS cases reported among IDUs also appears to have been declining in recent years, from 598 cases in 1998 to 212 in 2003, while the number of heterosexual transmission cases has risen. The number of AIDS deaths peaked in 1996 with 561 cases. Thereafter the death rate declined, reflecting the impact of ARV. Most of the country's AIDS deaths are from tuberculosis (41%).

Romania (pop. 21 733 556) - By the end of 2004, Romanian authorities had reported a cumulative total of 15 471 HIV cases; they had also reported that 9258 of the infected individuals had developed AIDS, including 4231 who had died. Among the cumulative HIV cases with a known route of transmission, approximately 0.1% were infected through injecting drug use. In the year 2004 itself, officials reported 293 new HIV cases, 238 AIDS cases and 179 AIDS deaths. Despite two extensive reviews of the country's case-reporting, irregularities in past case-reporting prevent accurate assessments of the number of Romanians living with AIDS. In 1989, Romania experienced a unique major nosocomial HIV epidemic in which more than 10 000 institutionalized children contracted HIV through blood transfusions and infected needles. As a result, Romania probably has the highest number of HIV infections in central Europe. Many of the new cases of HIV/AIDS infections continue to be patients born between 1987 and 1989 who were infected through unsterilized blood and blood products and the repeated use of contaminated needles.

These patients present with illnesses associated with severe immune suppression; in 2002, over a third of new HIV diagnoses reported (122 of 335) were of nosocomial infections in children and adolescents that were probably acquired around 1990. Since 1994–1995, there has been a steady increase in the HIV/AIDS incidence rate among adults, mainly related to transmission of the virus via sexual contact and injecting drug use. The increase in sexual transmission is correlated with a growing incidence in other STIs, particularly syphilis. In 2004, 7854 Romanian HIV/AIDS patients received medical treatment for their condition, including 5922 people who were on ARV at the end of the year.

Slovakia (pop. 5 402 000) - By the end of 2004, Slovak authorities had reported a cumulative total of 216 HIV cases; they had also reported that 39 of the infected individuals had developed AIDS, including 26 who had died. For the year 2004 itself, they reported 15 new HIV cases, 2 new AIDS cases and 3 AIDS deaths. Slovakia has been reporting the number of new HIV and AIDS cases since 1985 and has a relatively low prevalence and a stable epidemic. HIV in Slovakia is predominantly transmitted by men who have sex with men. Well-designed national HIV/AIDS programmes are thought to have contributed to the low prevalence of the disease among IDUs and the low incidence in non-injecting populations. A needle and syringe exchange programme has been operating in Bratislava since 1994. There were 36 people on ARV in Slovakia at the end of 2004, and 39 in June 2005.

Slovenia (pop. 1 996 773) - Slovenia has a low-level HIV epidemic, and the first HIV infections were reported in 1986. By the end of 2004, Slovene authorities had reported a cumulative total of 245 HIV cases; they had also reported that 112 of the infected individuals had developed AIDS, including 75 who had died. Among the HIV cases with a known mode of transmission, approximately 7% were infected through injecting drug use. In the year 2004, authorities reported 25 new HIV cases, 7 new AIDS cases and 2 AIDS deaths. Forty-five per cent of all HIV infections have been reported in the capital, Ljubljana, while 84% of all cases are men, and two thirds were infected through male-to-male sex. Sentinel surveillance of HIV prevalence among IDUs shows rates of less than 1% over many years. Access to both harm-reduction services and methadone substitution therapy is very good in Slovenia, and there is universal access to antiretroviral treatment. The epidemiological situation in Slovenia has been stable for a number of years, and the risk of explosive growth is considered to be low. During 2004, 137 HIV/AIDS patients received medical treatment for their condition, including 105 who were on ARV at the end of the year.

Spain (pop. 41 061 000) - By the end of 2004, Spanish authorities had reported a cumulative total of 71 039 cases of AIDS, and the deaths of more than 45 000 PLWHA. For the year 2004 itself, they reported 1712 new AIDS cases. Spain does not report national HIV data, though HIV case-reporting does exist in some regions. It is estimated that between 115 000 and 155 000 Spaniards are living with HIV/AIDS, and that about 75% of them are aware of their serostatus. Data from the regions that do report HIV cases show that during the 1980s, HIV spread widely among IDUs and, to a much lesser extent, MSM. The large number of sexually active young adults among HIV-positive IDUs led to the infection of non-injecting sexual partners and, through vertical transmission, children. By the start of the 1990s, more than 100 000 people had already been infected with HIV, and HIV-related mortality ranked first in 1994 among the major causes of adult death and potential years of life lost. In the 1990s, intensified targeted interventions led to marked reductions in the incidence of new infections among IDUs, MSM and female CSWs. As of June 2005, most of Spain's reported AIDS cases (46%) were IDUs.

A further 29% had been infected heterosexually, and 16% were MSM. Spain has the largest cumulative total of AIDS cases, and of IDUs with AIDS, of any European country. The Spanish AIDS epidemic appears to have peaked in 1994, followed thereafter by a rapid decline in the number of annually reported cases: from 7428 new cases in 1994 to 1712 in 2004. The number of AIDS deaths peaked in the mid-1990s with more than 5000 deaths annually. Since then, there has been a rapid decline in the number of deaths, reflecting the impact of ARV since its introduction in 1996. At the end of 2004, up to 75 000 Spaniards were on antiretroviral therapy, including 70 000 on ARV.

Sweden (pop. 8 958 000) - By the end of 2004, Swedish authorities had reported a cumulative total of 6704 HIV cases; they had also reported that 1981 of the infected individuals had developed AIDS, including 1283 who had died. Seventy-two per cent of all HIV cases have been among men. In the year 2004, the country reported 426 new HIV cases, 67 new AIDS cases and 21 AIDS deaths.

Of the new HIV cases, 59% were transmitted heterosexually, 18% by men having sex with men, 6% by injecting drug use, 3% vertically (mother-to-child), 1% by blood and blood products and 12% by other or unknown causes. Most cases of heterosexual transmission are found among non-Swedish migrants, mainly those who come from sub-Saharan Africa. People who have been infected outside Sweden constitute two thirds of the reported cases in recent years. Most of this cohort acquired HIV prior to their immigration to Sweden. The year 2003 saw a continued increase in registered STI cases: 596 new cases of gonorrhoea (the highest incidence in 10 years), 26 802 new cases of chlamydia and 179 new cases of syphilis (the highest incidence in 20 years.) HIV testing is mandatory for blood donors and systematic but voluntary for pregnant women, women having abortions, IDUs, STI patients, immigrants, refugees and autopsies. All diagnosed HIV infections are registered with an identifying code in the national HIV case-reporting system. The Communicable Disease Act sets out guidelines for Swedes living with HIV/AIDS, including: a ban on donating blood and organs; the obligation to inform care providers as well as personnel who make non-medical interventions about one's HIV status; the obligation to inform sexual partners about one's HIV status. In addition, a county administrative court can issue a compulsory isolation order if there is well-founded reason to believe that an HIV-positive individual is not following the above behavioural guidelines, and that the lack of compliance entails a clear risk for the spread of infection. There is no maximum time limit to how long such isolation may continue. AIDS mortality has been relatively low in recent years due to the widespread introduction of ARV.

United Kingdom (pop. 59 553 760) - By the end of 2004, British authorities had reported a cumulative total of 68 556 HIV cases in the United Kingdom; they also reported that 21 010 of the infected individuals had developed AIDS, including 13 082 who had died. Among all the HIV cases that had been reported by the end of March 2005, approximately 6–7% of the infections with known transmission modes were transmitted through injecting drug use. For the year 2004, the authorities reported 7258 new HIV cases, 810 new AIDS cases and 183 AIDS deaths. Early in the epidemic, the government coordinated a multisectoral response that included broad-based awareness-raising programmes aimed at the general population and prevention programmes aggressively targeting IDUs, MSM and CSWs, thereby containing potentially serious HIV epidemics to low levels in the late 1980s. Since then, the country's reported incidence of new HIV infections has been on the rise. The more recent increases are particularly noteworthy; for instance, 7258 new cases of HIV were reported in 2004, a dramatic increase from the 2967 cases reported in 1998. The key factors driving these increases are thought to be an increase in transmission among MSM and the continued migration of HIV-infected heterosexual men and women from sub-Saharan Africa. The 4086 new heterosexual HIV infections in 2004 represent a more than twofold increase in the number diagnosed in 2000. Three quarters of heterosexually acquired HIV infections diagnosed in the country in 2003 were probably acquired in Africa. At the same time, HIV prevalence among IDUs has remained low – below 1% – since the late 1980s. AIDS diagnoses and deaths declined after the introduction of ARV in 1996, and in recent years they have remained at low and relatively stable levels. In 2004, a total of 44 706 HIV/AIDS patients were seen for medical treatment of their condition in the United Kingdom. They include 29 174 who received antiretroviral therapy, including 27 775 on ARV at the end of the year.

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