Responding to the Epidemic

Key findings of the Dublin Declaration monitoring report

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ECDC
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Outline of presentation

1. Background
2. Selected findings & chapter conclusions
3. Cross-cutting conclusions

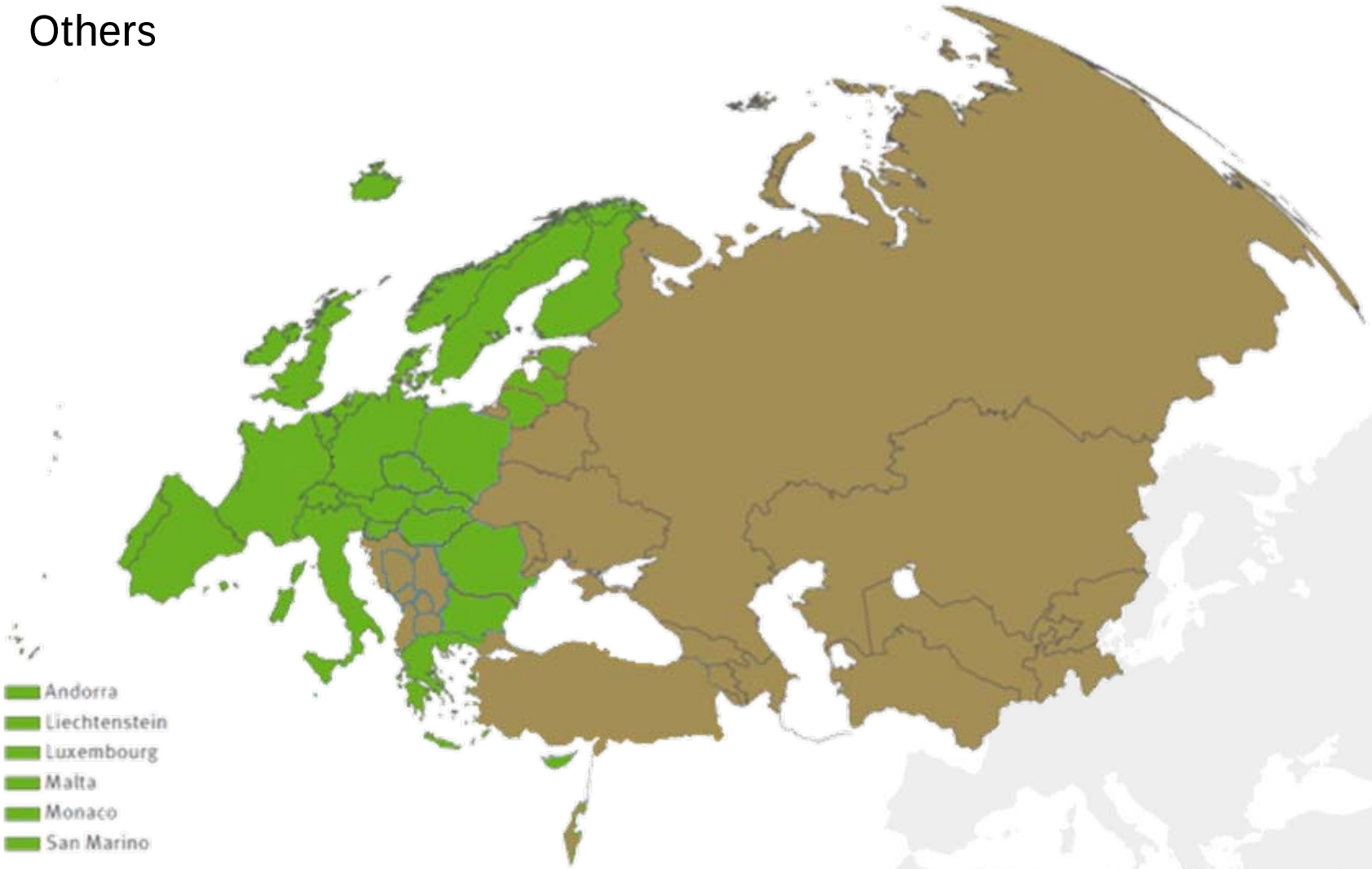
BACKGROUND

Background

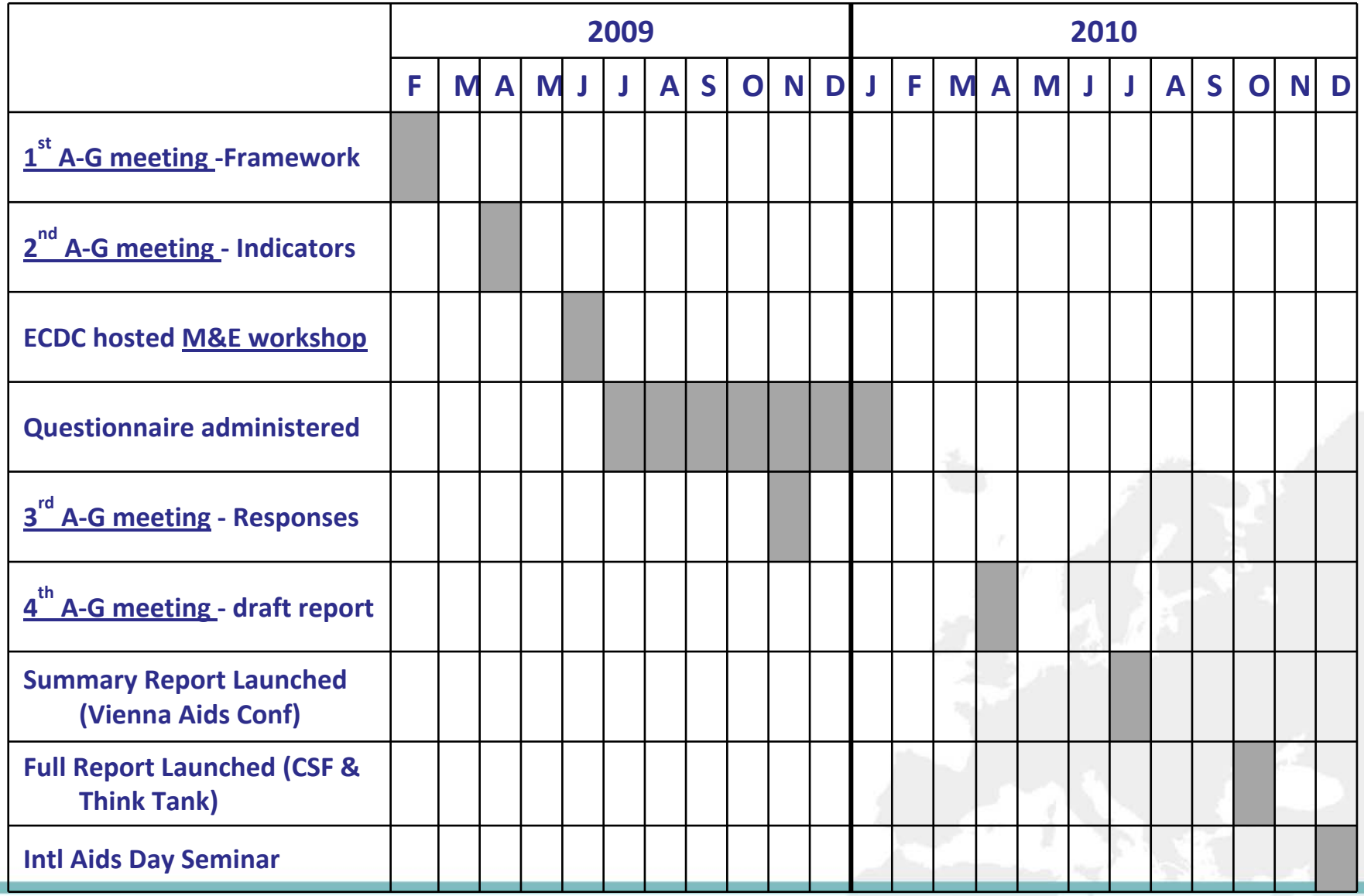
- UNGASS HIV - Declaration of Commitment 2001
- Irish Presidency to the EU Council 2004 - signed the Dublin Declaration
- WHO/UNAIDS pilot monitoring released in 2008 – sample of a few countries
- EU COM mandated ECDC to perform systematic monitoring in close cooperation with countries
- Tailored questionnaire harmonised with UNGASS and EMCDDA data (38 indicators)
- Summary Report at presented in Vienna 2010, Full Report published in September 2010
- Available on website www.ecdc.europa.eu

Region covered by the Dublin Declaration

- EU/EEA
- Others



Timeline


2009
2010
F M A M J J A S O N D J F M A M J J A S O N D
1st A-G meeting -Framework
2nd A-G meeting - Indicators
ECDC hosted M&E workshop
Questionnaire administered
3rd A-G meeting - Responses
4th A-G meeting - draft report
Summary Report Launched (Vienna Aids Conf)
Full Report Launched (CSF & Think Tank)
Intl Aids Day Seminar

Submission rates of the 55 countries

Albania	Finland	**Liechtenstein**	Serbia
Andorra	France	Lithuania	**Slovakia**
Armenia	Georgia	**Luxembourg**	Slovenia
Austria	Germany	**Malta**	Spain
Azerbaijan	Greece	Moldova	Sweden
Belarus	Hungary	**Monaco**	Switzerland
Belgium	**Iceland**	Montenegro	Tajikistan
Bosnia & Herzeg.	Ireland	Netherlands	TFYROM
Bulgaria	Israel	**Norway**	Turkey
Croatia	**Italy**	Poland	**Turkmenistan**
Cyprus	Kazakhstan	**Portugal**	Ukraine
Czech Republic	Kosovo (UNSCR 1244)	Romania	United Kingdom
Denmark	Kyrgyzstan	Russian Federation	Uzbekistan
Estonia	Latvia	**San Marino**	

Overall submission rate: 49/55 = 89%

SELECTED FINDINGS & CONCLUSIONS

Issues addressed in the Report

Leadership and Partnership

1. Political leadership: planning and coordination
2. Civil Society
3. Financial resources

Prevention

1. HIV prevention: an overview
2. Injecting drug users
3. Men who have sex with men
4. Sex workers
5. Migrants
6. Prisoners
7. Promotion of sexual health among *young people*

Living with HIV

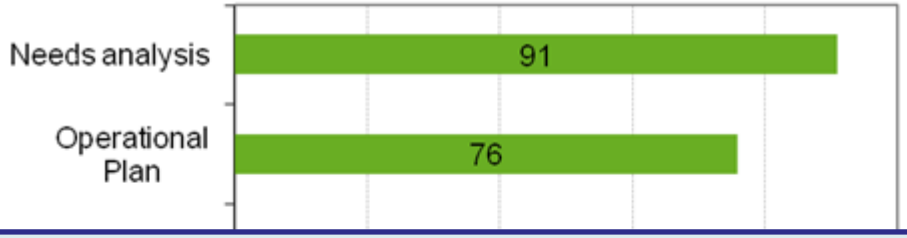
1. Treatment and care
2. Stigma and discrimination

Monitoring and evaluation

1. Political leadership: monitoring and evaluation
1. UNGASS reporting in Europe and central Asia

Political Leadership

Percentage of countries reporting particular features in their strategic framework or their national response to HIV



What is political leadership?

One national strategic framework

Prioritising prevention funding for those **groups most affected** by the epidemic

Conclusions

- Need to ensure that plans and structures translate into practical action
- Need to demonstrate political leadership by focusing the response on populations most affected by HIV
- Need to replace current indicators of political leadership with (e.g.):
  - Degree to which financial resources are allocated to prevention among key populations
  - Extent to which countries have implemented harm reduction programmes for IDUs
  - Extent to which countries are providing ART coverage for key populations, particularly IDU, migrants and prisoners

Civil Society

Percentage of positive responses by government showing support from AIDS management/coordination bodies for civil society organisations

Conclusions

- Need to promote partnership between government and civil society
- Need for all countries to involve key populations in all aspects of programmes that affect them
- Need to evaluate civil society's contributions and ability to contribute to the national response, e.g. by delivering essential HIV services to MARPS
- Need for adequate & sustainable financial support to the work of civil society

Prevention

Percentage of countries reporting that particular prevention services are available to the majority of those in need: Government and civil society responses

Conclusions

- Although prevention services are excellent in many subject areas, coverage is surprisingly low & clearly at sufficient level for some key populations
- There is a need for countries to ensure that spending is targeted in line with the epidemiology of the epidemic
- Need to ensure that policies and strategies are translated into decisive action through the implementation of prevention programmes, particularly those focused on IDUs, MSM, migrants & prisoners
- It is essential that key services are delivered at sufficient scale to make a difference

Injecting Drug Use

Reported HIV prevalence among IDU in Europe and central Asia

Conclusions

- IDUs particularly affected by HIV, especially in eastern and south-western parts
- High coverage of OST and needle provision in some EU/EFTA countries
- Low rates of condom use
- Need for most countries to scale up the provision of HIV programmes for IDU to levels recommended by WHO, e.g. 200 needle/syringes per IDU/year and ensuring that 30-40% of opioid-using IDU are on OST
- Access to ART coverage and HIV testing & counselling needs to be improved, both in community settings and attached to addiction and other health services
- Need to ensure adequate focus on preventing sexual transmission among IDUs

MSM

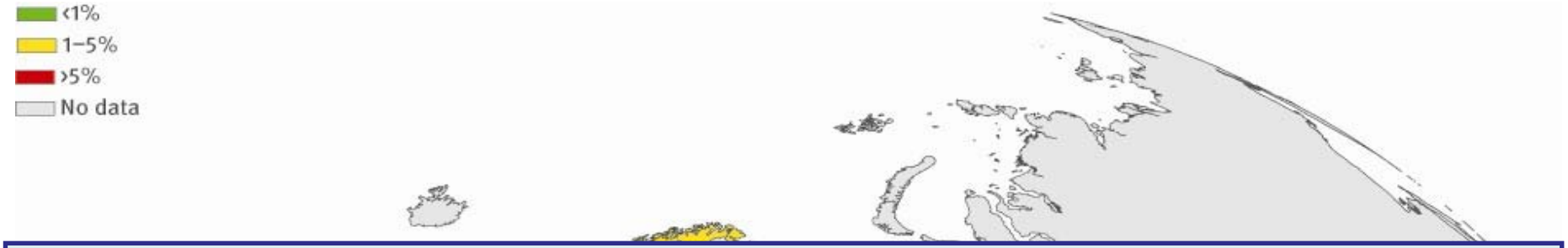
Reported HIV prevalence among MSM in Europe and central Asia

Conclusions

- Rising rates of HIV infection among MSM in many countries is cause for concern
- Concerns over high rates of unprotected anal sex
- Need for all countries of the region to recognize the continued risk of HIV transmission among MSM and to demonstrate the political leadership to respond
- Need to improve region-wide data collection and analysis of trends on specific risks and risk perception in MSM communities through development of behavioural surveillance programmes
- Need for programme responses to recognize that MSM are a heterogeneous group and that some MSM are more vulnerable to HIV infection and less likely to be reached by HIV prevention programmes than others

Sex workers

Reported HIV prevalence among sex workers in Europe and central Asia

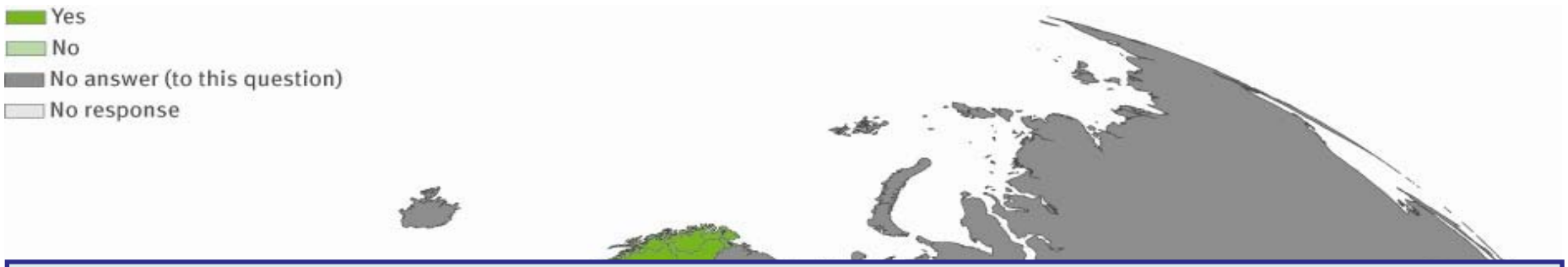


Conclusions

- Sex work (SW) does not seem to be a driver of HIV in Europe and central Asia
- However, the fact that HIV prevalence in SW exceeds 1% in 14 countries is of concern
- Reported data suggests that HIV prevalence is much higher among specific subgroups of SW, incl. SW who inject drugs, male & transgender SW, street SW & SW from countries with generalised epidemics
- Data on sex workers in the region needs to improve
- Need to identify and work for improved prevention with those subgroups of SW who may be at elevated risk of HIV

Migrants

Identified as an important subpopulation in the national response to HIV (60%)

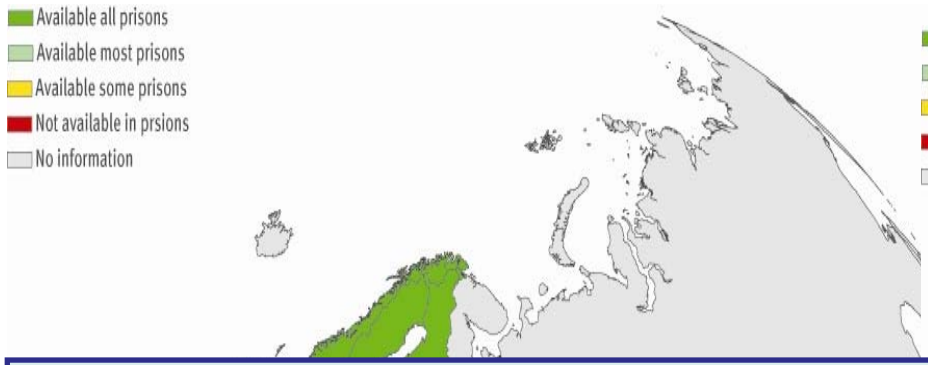


Conclusions

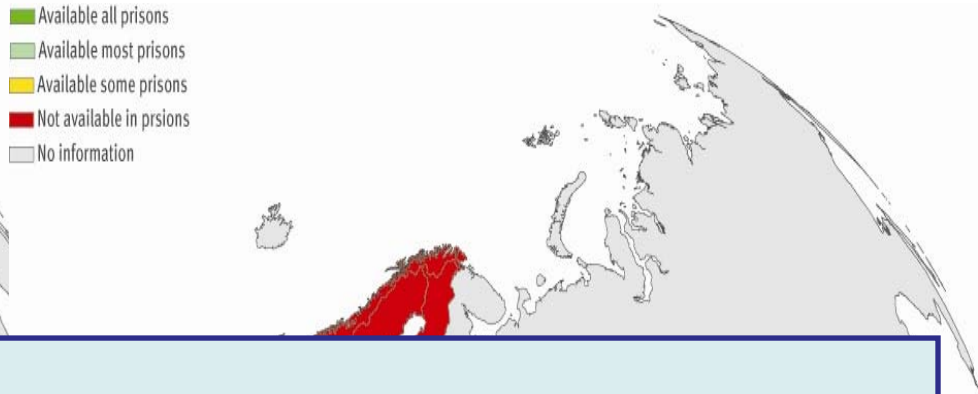
- Seen as an important subgroup regionally, but overlooked internationally
- Strong evidence that migrants from countries with generalised epidemics are disproportionally affected by HIV in EU/EFTA countries
- Need to agree on a standard definitions of categories of migrants in relation to HIV, strong argument for one of these categories to be someone born in a country with a generalised epidemic
- Need to ensure equitable access to services regardless of legal status
- Scaling up specific services targeted toward migrants within other key populations, e.g. IDU, MSM, sex workers

Prisoners

Extent to which opioid substitution therapy is reported to be available in prisons in Europe and central Asia



Extent to which needle and syringe programmes are reported to be available in prisons in Europe and central Asia



Conclusions

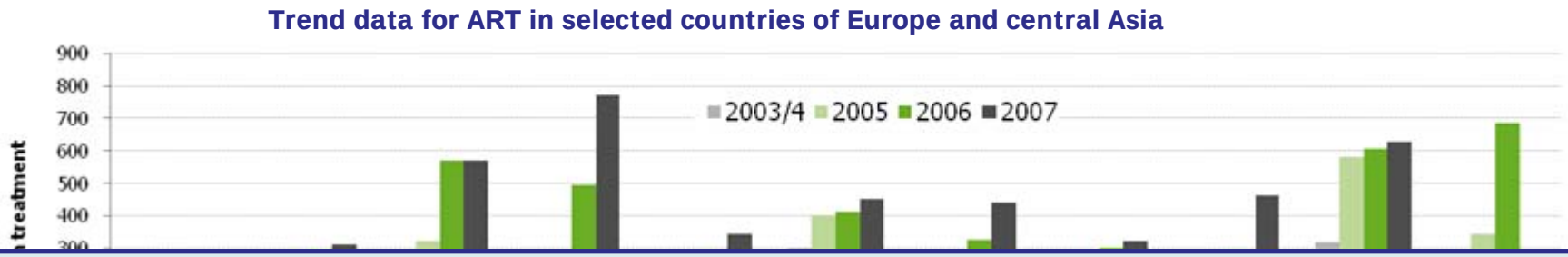
- Serious gaps in coverage of key services, in particular opioid substitution therapy and needle and syringe programmes, in prisons in many countries of the region
- In principle, the same services should be available to prisoners as to other citizens but the evidence shows that prisoners do not have equal access to services
- Need for all countries in Europe and central Asia to recognise that mandatory HIV testing in prison settings violates ethical principles and cannot be justified from a public health perspective

Promotion of sexual health among young people

Conclusions

- Data submitted to the ECDC shows that 13% of newly diagnosed cases in EU/EFTA countries in 2008 were in those aged 15-24
- However, available data suggests that HIV infection in young people in the region is associated with the predominant modes of transmission rather than age per se
- Most countries have a policy/strategy to promote HIV-related reproductive and sexual health education for young people (82%) and include HIV education in the secondary school curriculum (76%)
- Service provision needs to be focused on those young people particularly at risk of HIV infection, such as young IDU, young sexual partners of IDU, young sex workers, young MSM, young migrants form high prevalence regions and young people in correctional and prison settings

Treatment and Care



Conclusions

- There has been an increase in the overall number of PLHIV receiving ART in the region since 2004 and coverage is good in most, but not all countries of the region
- There is a need for countries of Europe and central Asia to focus on addressing the critical issue of late diagnosis of HIV infection as this is resulting in delays in starting ART for a significant number of PLHIV
- There is a need for countries of Europe and central Asia to address the obstacles faced by some populations in accessing ART. These include, in particular, IDU, prisoners and migrants
- The fact that some countries still experience easily-preventable mother-to-child transmission, albeit limited, cannot be considered acceptable in the region

Cross-cutting conclusions

1. There is evidence of strong political commitment in some countries, characterized by highly-focused action rather than presence of prescribed structures.

2. The environment for civil society organizations is improving but they still face problems securing funding.

3. There is a need for all European countries to reach and maintain the level of funding to the international response to HIV achieved by a few EU/EFTA countries.

4. Some countries have appropriately-focused their response to HIV on the most-affected key populations while others have not yet done so.

5. Migrants from countries with generalized HIV epidemics bear a high burden of HIV in the region.

Cross-cutting conclusions

6. Essential HIV services are lacking in many prisons. EU/EFTA countries have shown leadership on providing opioid substitution in prisons. Less progress has been made with needle exchange services.

7. There are rising numbers of people on ART but some populations still face obstacles in accessing treatment.

8. Rates of late diagnosis are unacceptably high across the region meaning people are receiving treatment later than medically-indicated.

9. Countries have large quantities of data available but responses are not always based on analysis of the available data.

10. Steps need to be taken to make international HIV reporting more relevant and less burdensome to countries of the region.

Special thanks to advisory group members

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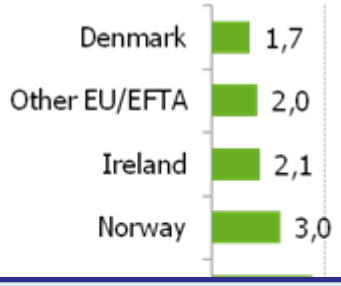
Niklas Karlsson - **Sweden**	Matthew Warner-Smith - **UNAIDS**
Brian Rice - **United Kingdom**	
Olga Varetska - **Ukraine**	

THANK YOU

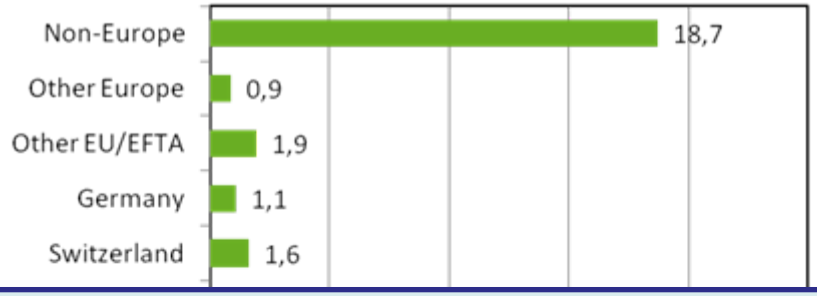
Additional reserve slides

Financial Resources

Percentage of European HIV-related contributions to the Global Fund by origin, 2008 (61% of total)



Percentage of total country contributions to UNAIDS by origin, 2008



Conclusions

- The European region shows strong commitment to international HIV/AIDS action as shown country contributions to the Global Fund and UNAIDS
- There is a need for countries of Europe and central Asia to agree a common approach for monitoring HIV-related expenditure
- There is a need for countries to focus HIV prevention spending on those key populations most affected by HIV. This would result in a more effective HIV response and efficient savings, i.e. services being delivered at a lower overall cost

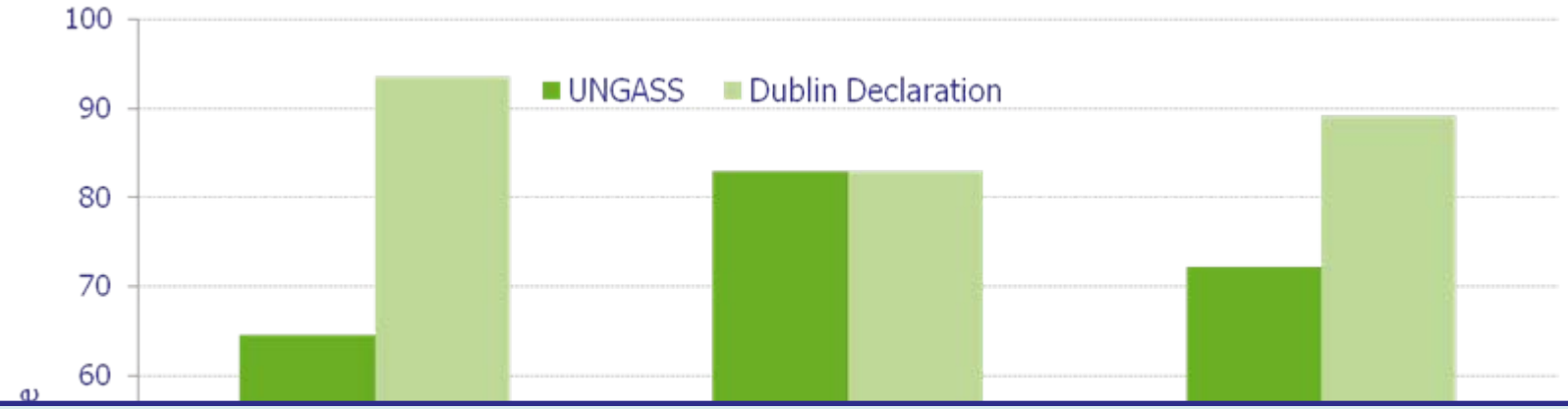
Stigma and discrimination

Percentage of government and civil society respondents reporting the existence of non-discrimination laws and regulations covering specific populations

Conclusions

- Almost all countries (84%) reported that stigma and discrimination is addressed in their national strategies. However, this is not consistently reflected in policies and programmes
- Less than half of countries have a policy prohibiting screening for general employment purposes and only just over just over half have programmes in place to reduce HIV-related stigma and discrimination
- Around half of countries report general non-discrimination laws that guarantee the rights of all citizens or non-discrimination laws or regulations that specify protections for most-at-risk or other vulnerable subpopulations
- Fewer countries report mechanisms to ensure laws are implemented or to address cases of discrimination or human rights violations
- Identified gap between protection of human rights on paper and actual practice.

Monitoring and evaluation



Conclusions

- Reporting rates in the region improved compared to 2008 UNGASS reporting, especially among EU/EFTA countries
- Regional relevance of UNGASS questionable, need for a regional approach
- Need to reduce country burden by combining multiple reporting mechanisms into one process (UNGASS, WHO Universal Access, Dublin)
- ECDC, WHO & UNAIDS currently working to achieve this