
A focused response to HIV in Europe



Policy Recommendations

European AIDS Treatment Group

**Correlation - Network on Social Inclusion and
Health**

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Executive summary

Correlation - Network on Social Inclusion and Health, a project funded by the European Commission, aims to tackle health inequalities in Europe and to improve prevention, care and treatment services, targeting blood-borne infectious diseases (BBID), in particular Hepatitis C and HIV/AIDS among vulnerable and high risk populations (e.g. drug users and young people at risk). Its aim was to contribute to the European Health Programme by collecting, developing and disseminating information regarding BBID, including by convening a European-wide network of experts.

The prevalence of HIV/AIDS and other blood-borne infectious diseases is known to be high in vulnerable populations. It is believed that this reflects a health situation in Europe which remains characterized by considerable health inequalities. Concerned about a resurgent HIV epidemic concentrated among key populations in the European Union (EU) and European Free Trade Area countries (EFTA), service providers and community leaders from across Europe decided to develop policy recommendations to inform policy making in Europe, both at national level and at EU level, with a view to reducing existing HIV/AIDS-related health inequalities. The European Aids Treatment Group (EATG) led the activities of the Work Package on HIV/AIDS Policy Recommendations. The aim of the package was to analyse the vulnerability of four groups to HIV transmission (IDUs, migrants, sex workers and MSM); analyse existing policy interventions; and make recommendations for each group. A researcher/writer was commissioned to conduct a literature review, analyse data, and produce policy recommendations.

The below policy recommendations focus on the HIV epidemiology affecting the four risk groups, the adequacy of current policies and programmes, and the implications and recommendations for policy makers at the national and EU levels.

Practitioners call on EU/EFTA States and their governments to take the following steps:

1. Restate their commitments on a biannual basis to a core set of basic principles, international conventions, and practical norms to guide their national response to HIV/AIDS. States that have not ratified these should do so without delay.
2. Safeguard the human rights of populations most affected by HIV/AIDS. Governments should restate key commitments (conventions, norms) on human rights for these groups. Governments should repeal laws that serve to criminalize key groups, and act to reduce discrimination. Governments should recognize the unintended HIV risks/public health consequences of national policies and practices that serve to criminalize and discriminate against MSM, IDU, migrants and sex workers).
3. Ensure civic participation in all aspects of the national response. Governments should involve civil society stakeholders in designing, implementing and evaluating the response, and in particular, they should involve most affected populations, subpopulations and their representatives as primary stakeholders in the response.
4. Provide greater accountability for national HIV policies. Governments should define national HIV policy priorities explicitly in relation to core HIV commitments, human rights, epidemiological data and analysis, and evidence of effectiveness. Governments should urgently ensure coherence between HIV policy and other policy areas, most notably law enforcement policies.
5. Ensure universal access to HIV services. Governments should scale up efforts to reach key populations, and ensure equitable access to services by removing barriers faced by migrants, sex workers and prisoners. Governments should ensure timely diagnosis, full ART coverage, and TB services to all PLHIV.
6. Focus the national HIV response on populations most affected by the epidemic. Governments should collect and analyse epidemiological data systematically, and develop prevention programmes according to the epidemiology. Governments should focus response on key populations (MSM, IDU, migrants, sex workers, prisoners), and on vulnerable sub-populations (IDU in prison, migrants from countries with generalized HIV epidemics, migrant sex workers, young IDU, bisexual men).
7. Ensure that national HIV programmes are effective. Governments should invest in programmes that based on solid evidence of effectiveness where that is available and on reasonable probability of effectiveness where solid evidence is not available. Governments should be informed by learning about effectiveness in HIV services, including services aimed at key populations. Governments should develop a culture of evaluation to inform policies.
8. Ensure adequate funding to implement the national response and effective spending of limited resources. Governments should provide additional funding from domestic sources, including from the redeployment of resources from programmes that serve to criminalize, and thus increase the vulnerability of, populations most affected. Governments should concentrate existing resources on addressing the epidemic among populations most affected, and prioritize effective prevention interventions.
9. Delegate political leadership to implement the national response. Governments should appoint a strong political and public authority to implement these recommendations, and to address specific national HIV policy challenges.
10. Participate in the regional response to HIV/AIDS. Governments should address these common challenges at regional level.

I. Introduction

Community representatives together with health care providers across Europe are concerned that a resurgent HIV epidemic is concentrated among key populations. The following recommendations are offered to the Governments of EU/EFTA States with a view to refining their response to a more concentrated HIV/AIDS epidemic in the region. They include fundamental principles (1, 2), policy priorities (3, 4, 5, 6), and practical advice (7, 8, 9, 10).

Scope

These recommendations have been developed by people representing the voices of the HIV community and practitioners and community leaders from across the EU/EFTA countries, working together through the Correlation project. They are aimed at government policymakers and intended to support their efforts to improve HIV/AIDS services for vulnerable and high risk populations. The European AIDS Treatment Group (EATG) is responsible for coordinating the development of these recommendations, and received significant input from collaborating partners.

The overall recommendations are developed largely from a review of the ECDC (2010) report on progress in implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia.¹ In 2004, high-level representatives of European and central Asian countries issued the Dublin Declaration, which called on the European Union and other relevant regional institutions and organisations, in partnership with the Joint UN Programme on HIV and AIDS (UNAIDS), to establish forums and mechanisms to closely monitor and evaluate the implementation of the Declaration.²

Process

- First, experts, representing the HIV community developed a detailed working plan, including a division of tasks and responsibilities. A systematic literature review and analysis was carried out on HIV/AIDS and the various prevention, care and treatment programmes in Europe. Four working groups were created to focus on relevant populations: injecting drug users (IDU); men who have sex with men (MSM); migrants; and sex workers. Each group recommended key documents for review.
- Second, experts met to consider the review results and begin drafting policy recommendations. As numerous sets of evidence-based policy recommendations had already been made at the European level, participants decided to focus efforts on representing these recommendations in a single document. A survey was carried out among best practitioners across Europe in order to collect further evidence and opinions, with a view to prioritizing the existing recommendations from their perspective.
- Third, these policy recommendations were to be presented to a seminar 29-30 June 2011, in Brussels, attended by European HIV and AIDS (community) representatives and policy makers.

II. Process Report

(Andrew Lawday, UK)

Participants

The **Correlation Network** is a European network on social inclusion and health. The overall aim of Correlation is to tackle health inequalities, and to improve prevention, care and treatment services, targeting blood borne infection diseases (BBID's), in particular HIV/AIDS and viral hepatitis (HBV/HCV) among vulnerable and high risk populations (e.g. drug users, young people at risk, sex workers). Its aim is to contribute to the European Health Programme by collecting, developing and disseminating information regarding BBID, including by convening a European-wide network of experts. The project works with an extensive network of grass root organisations, service providers, researchers and activists throughout Eastern and Western Europe.

Target groups are service providers, including peer educators, notably those working in drug services, harm reduction facilities or health services for young people at risk; policy makers, notably those involved in policy development on drugs and BBID. The project approaches the issue from different angles and with interventions, which have been identified as effective, such as outreach/early intervention, e-health and peer support.

Main activities are to

- Review models of good practice
 - Implement field testing's
 - Develop guidance documents
 - Develop and implement training modules
 - Support and strengthen capacities of health service providers
 - Influence policy agendas by formulating evidence based policy recommendations
- An essential method of Correlation is the multi-disciplinary approach, which combines and bridges the gap between research, practice and policy. Correlation unites health experts from various professional and geographic backgrounds, including peer educators, and combines different approaches to improve health promotion.

For more information about Correlation, please check: <http://correlation-net.org/>

The **European Aids Treatment Group** (EATG) led the activities of the Work Package on HIV/AIDS Policy Recommendations. The aim of the package was to analyse the vulnerability of four groups to HIV transmission (IDUs, migrants, sex workers and MSM); analyse existing policy interventions; and make recommendations for each group. The coordination happened in close collaboration between the Policy Adviser within EATG (Nicole Heine) and the Policy Working Group co-chairs Peter Wiessner and Raminta Stuiyte (with support of the Board of Directors, other members and staff). A researcher/writer was commissioned to conduct a literature review, analyse data, and produce policy recommendations.

For more information about EATG, please check: <http://www.eatg.org>

Partners: Some 20-30 partner organizations took part in the process. They were divided into four subgroups: IDUs, migrants, MSM and sex workers. Each subgroup was led by a coordinator who will work very closely with the writer (channelling information and feedback received from the different organisations). The coordinators collaborated closely with the EATG policy adviser and the writer/researcher.

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Purpose

Background: The prevalence of HIV/AIDS and other blood-borne infectious diseases is known to be high in vulnerable populations. It is believed that this reflects a health situation in Europe which remains characterized by considerable health inequalities.

Scope: The policy recommendations were developed to inform policy making in Europe, both at national level and at EU level, with a view to reducing existing HIV/AIDS-related health inequalities. Drawing on community-level experience, the policy recommendations would focus on the HIV epidemiology affecting the four risk groups, the adequacy of current policies and programmes, and the implications and recommendations for policy makers at the national and EU levels.

Objectives: To produce evidence-based policy recommendations, for the Work Package 8 HIV/AIDS Policy Recommendations of the EU-funded Correlation Network project, based on the preparation of a literature review, data analysis, and policy recommendations.

Approach/Methodology

Assumptions: The starting point was that HIV/AIDS vulnerabilities and epidemiological trends should be analyzed according to the specific groups, and that the analysis required a focus on the patient, lessons from community responses, and evidence available.

- ✓ Milestone 1: First Experts Meeting was held (Amsterdam, 18-19. June 2009). At this meeting, participants developed a working plan, specifying the division of tasks and responsibilities.

Literature Review

Document selection: It was decided in February 2010 that 3-4 key documents for each group would be selected for analysis. EATG provided criteria for document selection, emphasizing relevance and credibility/quality. The coordinators, in consultation with the partners involved, identified the documents and provided them to the writer/researcher for review.

Initial review: An initial review was conducted between 26 February and 4 March 2010, yielding preliminary findings in response to questions. Feedback was collected from each coordinator and the policy adviser, and overall headings and conclusions were outlined with the policy adviser and coordinators.

- ✓ Output 1: Initial findings from the literature review were drafted by 1 March 2010, and presented at the Porto conference on 5 March 2010. ([PPT presentation available](#))
- ✓ Milestone 2: Second Experts Meeting held in Porto 4-6 March 2010. At this meeting, initial review results and draft policy recommendations were presented. It was decided that the document review should focus on analyzing existing sets of recommendations, rather than formulating entirely new ones. Participants also discussed the survey to be conducted. ([EATG Report available](#))

Detailed review: A detailed review was conducted of recommendations for each of the four groups during June 2010, as well as a review of additional documentation during August 2010. Feedback was collected from coordinators.

- ✓ Outputs 2, 3, 4, 5: The final review findings were delivered in November 2010 in the form of four sets of recommendations relating to each of the risk groups: MSM, IDU, Migrants, and Sex Workers, synthesizing existing recommendations relating to each of the groups. A common framework was developed, offering coherence across the different sets of recommendation. (See addendum 1)

Survey/Data Analysis

The aim of the survey was to inform, prioritise and lend support to the draft policy recommendations on HIV/AIDS on four vulnerable groups with bottom-up information from a community best practitioners' perspective, identifying the drawbacks of existing policies and programmes, and capturing best practices.

The data were collected through an online survey, open to invited “good practitioners” only as identified by peers, the country *focal points* provided by the European networks related to HIV/AIDS, of which the Correlation Network. A draft questionnaire was prepared by the researcher.

The results are presented in addendum 2. Part of the results are also integrated in the Policy Recommendations report.

Policy Recommendations

Recommendations framework: A framework was developed in the form of an Excel spreadsheet to organize all the existing recommendations from mid-2010 until mid-2011. The framework enabled the organization, alignment and integration of all recommendations into an overall framework, including recommendations overall, recommendations for each group, and recommendations targeted at different levels, each along with supporting information and named sources. This approach also enabled the development of an overarching narrative theme. (Recommendations framework available)

First draft: The first draft was developed during April 2011. It sought to articulate the main sets of recommendations from the recommendations framework, taking into account additional comments provided by coordinators on the submitted literature reviews. The first draft focused on developing an overall a structure for presenting the recommendations, proposing eight overarching recommendations and several headline recommendations below them. These were followed by the numerous specific recommendations from the document reviews. The overall approach was agreed with coordinators, the policy adviser and the Policy Working Group co-chairs.

- ✓ Output 6: Preliminary ‘draft policy recommendations’ by mid-September 2010.

Second draft: The second draft was developed by mid-May 2011. It sought to shape the second layer of ‘headline’ recommendations, slightly amending the overall structure in response to comments. It included a more developed introduction section, and an annotated bibliography of sources presented in an annex.

Third draft: The third draft was developed by end May 2011. It sought to refine, integrate, and align all the existing recommendations collected from the review under the overarching and headline

recommendations. This involved much attention to language, fusion of detailed recommendations, and reduction of repetition. It also required the integration of selected verbatim quotes from the survey.

- ✓ Output 7: Draft of policy recommendations by 1 November 2010 (120pp with annexes).

Finalization: The recommendations were finalized during June 2011, along with the production of a four-page policy summary for participants at the meeting in Brussels. In response to a suggestion from coordinators, the recommendations were also produced in a 'report card' format, by which stakeholders could advocate to their governments for an improved HIV response.

- ✓ Output 8: Finalized policy recommendations by 1 February 2011 (summative document ~25pp max). The document will be produced as a 'Policy Brief' for wide distribution.
- ✓ Milestone 3: European HIV/AIDS Seminar: At this seminar, draft policy recommendations were presented to service providers and policy makers.

The Correlation Policy Dialogue Meeting "Breaking the barriers, bridging the gaps: Health inequalities, the HIV/AIDS response and political leadership in the European Union" organised by the EATG on 29-30 June in Brussels provided the opportunity to present and discuss the Correlation draft policy recommendations on HIV/AIDS – and to engage policy makers to address priority issues identified and to engage representative of the HIV and harm reduction communities from across Europe in joint advocacy activities.

Speakers included representatives from the European Commission (DG Sanco and DG Justice), the European Centre for Disease Prevention and Control (ECDC), the EU HIV/AIDS Civil Society Forum (CSF), National HIV/AIDS coordinators (Poland, Portugal, and Denmark), Correlation partners as well as HIV, members of affected groups as well as harm reduction and public health community representatives.

The first part of the seminar aimed at setting the stage giving an introduction to EU policy making and public health and HIV related processes at EU level, and participants identified upcoming advocacy opportunities – as for example linking the national level and EU policy level by engaging respective Members of the European Parliament from participants countries to work on a resolution on HIV/AIDS, providing input to the upcoming EU drug strategy from a public health perspective and more generally speaking together with other partners seeking to ensure public health is sufficiently funded in the next EU budget. Furthermore, participants strategized on how to best raise their concerns during the second part of the seminar in the European Parliament.

The recommendations were presented during part of the second part seminar taking place in the European Parliament in Brussels - hosted by Members of the European Parliament Marisa Matias (GUE/NGL, PT) and Elisa Ferreira (S&D, PT), and opened by Michael Cashman (S&D, UK) and Antonia Parvanova (ALDE, BG) giving introductory statements on the importance of scaling up political leadership in the HIV/AIDS response in the EU and neighbouring countries now. The recommendations presented call on governments to ratify and live up to the existing conventions and norms embedded therein, and to focus on safeguarding the human rights of populations most affected by HIV (MSM, IDU, migrants, sex workers and including sub-populations such as prisoners). Furthermore, states should ensure participation of civil society participation and affected

communities in all aspects of the national response and provide greater accountability for their national HIV policies. Universal access to HIV services access should be ensured by scaling up efforts to reach out to most affected populations, removing specific barriers to access, and ensuring timely diagnosis as well as subsequent referral to comprehensive services. Governments should align

Glossary of key terms

MSM: Men who have sex with men -- including gay, bisexual and transgender people

IDU: Injecting Drug Users or People who inject drugs. While we prefer the term 'people who inject drugs' to 'injecting drug users,' we use the acronym IDU because it is widely known

Migrants: While there is no single definition across the EU/EFTA for 'migrants', the term is used in its broadest sense to include immigrants, refugees and asylum seekers and mobile populations in all their diversity.¹ Mobile populations are typically difficult to reach with service provision.

Sex workers: This term is used broadly to refer to female sex workers, as well as male, and transgender sex workers. The term sex work may be used to cover a broad range of transactions and sex workers are not a homogenous group.¹

Prisoners: This refers broadly to convicted prisoners, as well as people held in detention – including immigration detention

PLHIV: People living with HIV

resources with burden of disease, and ensure that programmes are adequately funded, redeploying resources from programmes that serve to criminalize and increase the vulnerability of populations most affected. States should exert political leadership by ensuring that plans and structures translate into effective actions.

The seminar concluded with a discussion on how to turn the recommendations into action, focusing on injecting drug users, men having sex with men, migrants and sex workers. In The Correlation discussion on HIV policy priorities and political leadership took place at an opportunity point in time in terms of HIV advocacy in Europe – right after the UN High Level Meeting in New York, and with a discussion in the European Parliament ensuing as to the EU communication on HIV/AIDS and its implementation as it is now coming into its mid-term. In the run up to World AIDS Day 2011 and the final Correlation seminar participants will use this opportunity and join forces in advocacy work on the Correlation recommendations at national and EU level.

- ✓ Milestone 4: Final Conference: At this conference, the outcomes and results of the Work Package were presented, along with the final policy recommendations.

III. Background

The survey

The **aim** of the survey was to inform, prioritise and lend support to the draft policy recommendations on HIV/AIDS on four vulnerable groups with bottom-up information from a community best practitioners' perspective, identifying the drawbacks of existing policies and programmes, and capturing best practices. The main **objectives** were to collect quantitative and qualitative information from a sample of identified "good practitioners" from within the EU Member States working with at least one of the vulnerable groups (MSM, IDU, sex workers, migrants), and provide the project leader and the writer of the recommendations with:

- descriptive statistics at the EU, Member State and regional levels, globally and for each vulnerable group
- an exploration of the possible effect of underlying cross-cutting factors, such as the practitioners themselves

- a typology of the practitioners' opinions on the policies and programmes
- some examples of remarks and best practices to illustrate the final report and support advocacy

Methodology

Data were collected through an online survey, open to the invited “good practitioners” only. For each country, “good practitioners” were identified by the country *focal points* provided by the European networks related to HIV/AIDS, of which the Correlation Network. The sampling aimed at assuring a balanced representation of the different Member States and groups, and a sample size large enough for ensuring statistical significance. The result of the recruitment was a group of potential surveyees, the *practitioner pool*, from which the researcher builds an *invitation sample* of *practitioners* by a stratified random sampling.

The survey stayed open for 13 days, including two full weekends. A total of three email reminders were sent. Raw data were extracted from the online database as a tabulated file to be imported into statistical software for analysis, and a grapher for graph drawing. After data quality control, the researcher provided the writer with the results and rough graphs to illustrate them. The qualitative data were sent as a file to the writer and project coordinator.

Recruitment

The recruitment for the sample was done in two steps, and aimed at getting a minimum of 6 final *respondents* per EU country (except for the smaller ones), for statistical reasons:

- Step 1 – building the list of *focal points*
- Step 2 – building the list of *local practitioners* and the *practitioner pool*

This list of *local practitioners* is merged with the list of *focal points*, to constitute the *practitioner pool*.

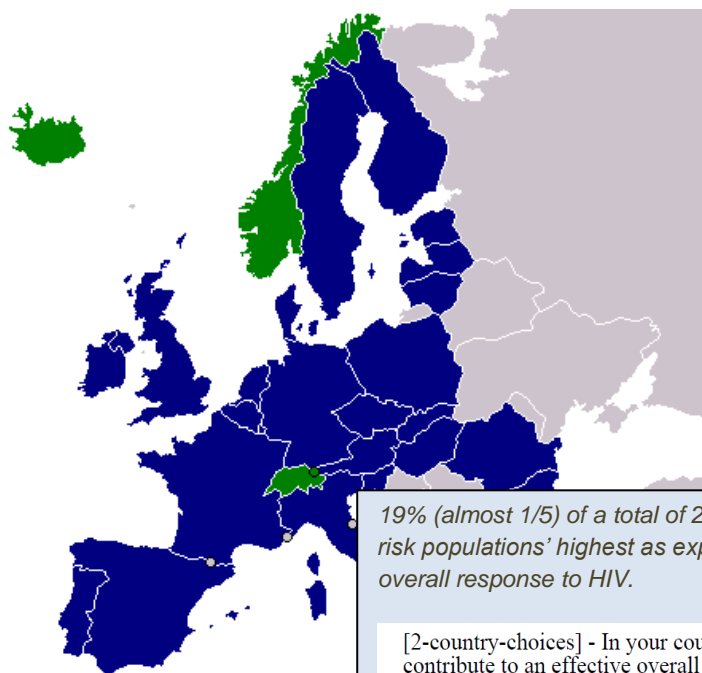
Sampling

The *practitioner pool* was used as the source for the stratified sampling to provide the list of the *practitioners* who were invited to answer the questionnaire. Each country was allocated a maximum number of *practitioners*, to try to represent their weight in term of population and political impact at the EU level. The *survey sample* was submitted to descriptive statistics to be added in the materials and methods.

The recommendations

The [HIV/AIDS] situation in Europe is characterized by considerable inequalities, with a high prevalence of HIV in vulnerable populations, unequal access to HIV services, and lack of services tailored for specific groups. These recommendations are aimed at addressing the HIV epidemic across the countries that make up the European Union (EU)³ and the European Free Trade Association (EFTA).⁴ Needless to say, we recognize that the HIV epidemic in Europe cannot be adequately understood solely within the political and economic constructs of the EU and EFTA.⁵

Map: EU and EFTA countries



Source:

<http://en.wikipedia.org/wiki/File:EU-EFTA.PNG>

The HIV epidemic is on the rise again across the EU/EFTA countries,

particularly among the most vulnerable populations. Some 30,000 people were newly infected with HIV in Western and Central Europe during 2008,⁶ and the rate of newly reported cases nearly

19% (almost 1/5) of a total of 206 respondents ranked 'focusing efforts on most-at-risk populations' highest as expected effectiveness to best contribute to an effective overall response to HIV.

[2-country-choices] - In your country, which strategic choices do you think would best contribute to an effective overall response to HIV? Please rank them by their expected effectiveness, 1 being the lowest and 9 the highest.

	1	2	3	4	5	6	7	8	9	Tot al	M ea n	Va ria n ce
Focusing efforts on most-at-risk populations	11 (5%)	19 (9%)	15 (7%)	19 (9%)	26 (13%)	23 (11%)	18 (9%)	35 (17%)	40 (19%)	206	5.8	6.5

[1-organisation-groups] - This survey focuses on four most-at-risk groups. If your field organisation works with/for any of these groups, please indicate which one(s).

Response	Chart	Percentage	Count
Injecting drug users		54%	115
Men who have sex with men		67%	143
Migrants		56%	120
Sex workers		56%	120
None of the above		7%	14
Total Responses			213

doubled between 2000 and 2007.⁷ There is evidence of increasing sexual (both heterosexual and homosexual) transmission in many countries.⁸ Heterosexual transmission accounts for 29% new cases in Western Europe, and a majority (53%) of new cases in Central Europe.⁹

This resurgence risks offsetting progress to date. Overall, some 850,000 people live with HIV in Western/Central Europe, representing about 0.03% of the region's population. Still, this is a relatively small fraction of the world's 33.4 million PLWH, and a low rate compared to worst affected regions.¹⁰ Mother-to-child HIV transmission has been virtually eliminated in the region due to the availability of HIV prevention services for pregnant women.¹¹ The number of AIDS-related deaths has dropped considerably due to widespread access to antiretroviral therapy in high-income countries, with some 13 000 people dying of AIDS-related causes in Western and Central Europe in 2008.¹²

Evidence also shows that HIV/AIDS is now concentrated among certain populations, who are most affected by the epidemic. The national HIV epidemics in Western and Central Europe are concentrated among key populations at higher risk, especially men who have sex with men (MSM),

injecting drug users (IDU) and migrants.¹³ Moreover, certain sub-populations that ‘intersect’ two or more of these key populations are considered at even higher risk of HIV. Moreover, certain sub-populations that ‘intersect’ two or more of these key populations are considered at even higher risk of HIV.

Men who have sex with men (MSM)

MSM are the group most disproportionately affected by the HIV epidemic in Europe. Despite the relatively low absolute number of cases among this group, MSM continue to be the population most affected by HIV in Europe, and the group at highest risk for HIV.¹⁴

The number of new HIV infections among MSM has increased over the past decade in high-income countries,¹⁵ and rates of infection increased faster among MSM than any other risk group.¹⁶ Notwithstanding differences across Europe, sex between men represents the dominant mode of transmission in the European Union.¹⁷ Further, there has been an increase in the rate of MSM who report unprotected anal intercourse,¹⁸ and recent outbreaks of syphilis and gonorrhoea in several major European cities also suggest a trend toward increased sexual risk taking among MSM.¹⁹ Social discrimination, including homophobia and related stigma, is understood to be an important risk factor for HIV infection among MSM.²⁰

People who inject drugs (IDU)

44% of respondents considered ‘ensuring early screening and treatment of other sexually transmitted diseases’ by ranking it 8 (24%) and 9 (20%).

[4-MSM-treatment]											Total	Mean	Variance
1	2	3	4	5	6	7	8	9					
Ensuring early screening and treatment of other sexually transmitted diseases	5 (4%)	7 (6%)	5 (4%)	11 (9%)	7 (6%)	15 (12%)	19 (15%)	30 (24%)	24 (20%)	123	6.4	5.4	

IDUs are another group disproportionately affected by the HIV epidemic in Europe. Although the IDU population in the EU/EFTA region remains disproportionately affected by HIV,²¹ HIV incidence and prevalence has declined in the past decade, owing substantially to the effectiveness of harm reduction programs targeting IDU. In Western and Central Europe, IDU represented 8% and 13%, respectively, of new HIV diagnoses by 2009.²² The EU Council Recommendation of 2003 (EC 2003) urged EU Member States to set as a public health objective the prevention of drug dependence and the reduction of related risks (i.e. “harm reduction”).

By 2006, researchers found that all EU Member States had policies in place that made the prevention of drug-related harm a public health objective and a component of the national drug strategy, though gaps in implementation were identified particularly in prison settings.²³ Recently,

there has been a backlash as to the political support and provision of harm reduction services.

Migrants

Some migrants are at higher risk of HIV in Europe, and almost three-quarters of responding EU/EFTA countries regard migrants as an important sub-population in their national response to HIV.²⁴ Around 40% of cases of heterosexual transmission in Europe were diagnosed in individuals originating from countries with generalised epidemics who may have been infected outside of Europe.²⁵ There is

strong evidence that migrants from countries with generalised HIV epidemics are disproportionately affected by HIV in many EU/EFTA countries.²⁶

Within the context of harm reduction other factors should also be considered. Access to antiretroviral remains an important obstacle as also shown by 40% of respondents to our survey. Scores of 8 (16%) and 9 (24%) were given to highlight the need of putting more focus ‘improving access to antiretroviral therapy and counselling’ within HIV/AIDS treatment and care programmes in the next 5 years.

[4-IDU-treatment] - For this group, what should be the focus of HIV/AIDS treatment and care programmes in the next 5 years in your country? Please rank them, 1 being the lowest priority and 9 the highest. Please note that no item can be given the same rank as another.

	1	2	3	4	5	6	7	8	9	T ot al	M ea n	Va ria n c e
Improving access to antiretroviral therapy (ART) and counselling	11 (12%)	4 (4%)	8 (9%)	10 (11%)	7 (8%)	7 (8%)	9 (10%)	15 (16%)	22 (24%)	93	5.8	7.8

1 out of 4 service providers mention the ‘provision of opioid substitution therapy’ as highest priority of HIV/AIDS prevention programmes in the next 5 years by ranking it 8 (20%) and 9 (5%). Respectively 17% and 16% gave ranking 8 and 9 to ‘focusing on injecting drug users in situation of increased risk (sex workers, undocumented migrants, prisoners ...) as highest priority for HIV/AIDS prevention programmes in the next 5 years. 28% of respondents equally mention ‘decriminalising and de-penalising drug use’ as highest priority by ranking it 8 (11%) and 9 (17%).

[4-IDU-prevention] - For this group, what should be the focus of HIV/AIDS prevention programmes in the next 5 years in your country? Please rank these objectives according to their priority, 1 being the lowest and 9 the highest. Please note that no item can be given the same rank as another.

	1	2	3	4	5	6	7	8	9	T ot al	M ea n	Va ria n c e
Providing opioid substitution therapy	8 (8%)	11 (12%)	10 (11)	11 (12%)	9 (9%)	10 (11)	12 (13%)	19 (20%)	5 (5%)	95	5.2	6.2
Focusing on injecting drug users in situation of increased risk (sex workers, undocumented migrants, prisoners...)	8 (8%)	3 (3%)	9 (9%)	13 (14%)	5 (5%)	16 (17)	10 (11%)	16 (17%)	15 (16%)	95	5.8	6.3
Decriminalising or depenalising drug use	19 (20%)	10 (11%)	6 (6%)	11 (12%)	6 (6%)	8 (8%)	9 (9%)	10 (11%)	16 (17%)	95	4.9	8.7

Although some countries are concerned about other groups of migrants, such as those from other European countries, there is little evidence that these groups are disproportionately affected by HIV, independent of other risk behaviours such as injecting drug use.²⁷ More broadly, migrants may bear a heightened risk of HIV infection resulting from the conditions and structures of migration processes.²⁸ European countries have adopted policy and legal instruments intended to ensure that migrants have access to healthcare, including HIV prevention, treatment, and care and support services.²⁹

Putting more attention to specific sub-groups of sex workers was also strongly supported by the respondents of our survey. A total of 41% gave ranking 8 (22%) and 9 (19%) to have 'improving prevention among most vulnerable sub-groups of sex workers' as one of the highest priorities for HIV/AIDS prevention programmes in the next 5 years.

One out of 4 respondents feels that 'considering sex workers a key target population for HIV initiatives' should equally be among the high priorities of prevention efforts in the following 5 years.

[4-sexworkers-prevention] - For this group, what should be the focus of HIV/AIDS prevention programmes in the next 5 years in your country? Please rank these objectives according to their priority, 1 being the lowest and 9 the highest. Please note that no item can be given the same rank as another.

	1	2	3	4	5	6	7	8	9	T ot al	M ea n	Va ria nc e
Considering sex workers a key target population for HIV initiatives	3 (3%)	6 (7%)	11 (12)	15 (17)	9 (10%)	10 (11%)	12 (14%)	12 (14%)	10 (11%)	88	5.5	5.4
Improving prevention among most vulnerable sub-groups of sex workers	2 (2%)	1 (1%)	5 (6%)	5 (6%)	16 (18%)	12 (14%)	11 (12%)	19 (22%)	17 (19%)	88	6.5	4.2

Sex workers

In our survey 'providing free and voluntary HIV testing and counselling services to all migrants, regardless of their legal status' was supported by 46% of respondents as highest priority for HIV/AIDS prevention programmes in the next 5 years by ranking it 8 (18%) and 9 (28%).

[4-migrants-prevention] - For this group, what should be the focus of HIV/AIDS prevention programmes in the next 5 years in your country? Please rank these objectives according to their priority, 1 being the lowest and 9 the highest. Please note that no item can be given the same rank as another.

	1	2	3	4	5	6	7	8	9	T ot al	M ea n	Va ria nc e
Providing free and voluntary HIV testing and counselling services to all migrants, regardless of their legal status	5 (5%)	6 (7%)	8 (9%)	3 (3%)	4 (4%)	10 (11)	13 (14)	17 (18)	26 (28)	92	6.5	6.6

workers was as high as 20% in some locales, compared with 3% or less among female sex workers who did not inject drugs.

The United Kingdom reported data showing higher HIV prevalence among male sex workers than among female sex workers, and Norway has attributed a recent increase in HIV prevalence to an influx of sex workers from countries with generalised epidemics.³¹ Overall, however, sex work does not seem to be a key driver of the HIV epidemic in Europe, in contrast to some parts of the world.³² In almost all EU countries, HIV prevalence rates among sex workers are less than 5%, and some countries have formally decided that sex workers are no longer a priority in their national response to HIV.

Still, it is widely recognized that sex workers face shame and blame, which enhance their vulnerability to HIV infection, create barriers to the realization of their human rights, and more broadly impede attempts to contain the HIV/AIDS epidemic.³³

Some sex workers are at higher risk of HIV infection in Europe. HIV prevalence among sex workers exceeds 1% in 14 countries,³⁰ and reported data suggest that HIV prevalence is higher among specific sub-groups of sex workers, including sex workers who inject drugs, male and transgender sex workers, street-based sex workers and sex workers from countries with generalised HIV epidemics. For example, the Netherlands reported data showing that prevalence among sex workers who inject drugs and transgender sex

As our survey also suggests certain policies, laws/legal precedents, regulations or cultural contexts undermine an effective response to HIV. Legal or de facto discrimination on the basis of sexual orientation and gender are identified as highly undermining factors for an effective response to HIV by 29% of our respondents. Criminalisation of HIV transmission or criminalisation / penalisation of illicit drug use or possession are considered highly undermining an effective response to HIV by respectively 20% and 30% of respondents, thus showing the high importance of addressing legal barriers. Some other highly undermining factors were equally identified. 36% of respondents did score the influence of religious beliefs or institutions on policy design as highly undermining an effective response to HIV. 46% of respondents provide the same high score for prison regulations on sexual activities and/or drug use.

[2-country-policies] - Do you think that in your country some policies, laws / legal precedents, regulations or cultural contexts undermine an effective response to HIV? If an item is not applicable to the situation in your country, please choose "not applicable".

	Not at all undermining	Slightly undermining	Moderately undermining	Highly undermining	Not applicable	Total	Mean	Variance
Legal or de facto discrimination on the basis of sexual orientation and gender identity	14 (7%)	51 (25%)	55 (27%)	58 (29%)	24 (12%)	202	1.0	3.8
Criminalisation of HIV transmission	42 (21%)	38 (19%)	41 (20%)	41 (20%)	40 (20%)	202	1.0	6.0
Criminalisation or penalisation of illicit drug use or possession	27 (13%)	44 (22%)	62 (31%)	61 (30%)	8 (4%)	202	0.6	2.9
Restrictions on universal access to healthcare	23 (11%)	44 (22%)	48 (24%)	42 (21%)	45 (22%)	202	1.3	5.6
Immigration restriction law enforcement	23 (11%)	41 (20%)	55 (27%)	55 (27%)	28 (14%)	202	1.1	4.3
Criminalisation or penalisation of sex work	20 (10%)	34 (17%)	49 (24%)	56 (28%)	43 (21%)	202	1.5	5.0
Restriction on the free circulation of people within the European Union based on HIV status	56 (28%)	25 (12%)	26 (13%)	21 (10%)	74 (37%)	202	1.5	8.8
Influence of religious beliefs or institutions on policy design	31 (15%)	36 (18%)	41 (20%)	73 (36%)	21 (10%)	202	1.0	4.1
Regulations on compulsory education programmes on sexual health	44 (22%)	31 (15%)	35 (17%)	46 (23%)	46 (23%)	202	1.2	6.4
Prison regulations on sexual activities and/or drug use	18 (9%)	30 (15%)	45 (22%)	92 (46%)	17 (8%)	202	1.2	3.2
Recognition of sex work as a legitimate occupation	45 (22%)	20 (10%)	36 (18%)	31 (15%)	70 (35%)	202	1.7	7.7

IV. The Policy Recommendations

1. Basic principles

EU/EFTA States should restate their commitments, on a biannual basis, to a core set of basic principles, international conventions, and practical norms to guide their national response to HIV/AIDS. States that have not ratified these should do so without delay.

HIV response

- The Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia (2004), the Vilnius Declaration on Measures to Strengthen Responses to HIV/AIDS in the European Union and in Neighbouring Countries (2004), and the Bremen Declaration on Responsibility and Partnership (2007)
- The EU Communication on HIV/AIDS (2009-2013)³⁴
- International Guidelines on HIV/AIDS and Human Rights³⁵
- European Parliament resolution of 8 July 2010 on a rights-based approach to the EU's response to HIV/AIDS 2010³⁶

Public health

- The 'right to health' as a fundamental human right
- A human rights-based approach to public health
- Public health services on the principles of universal accessibility
- Efficient and effective service delivery
- Evidence-based policy development

Universal access

- Ensure immediate and comprehensive STI, HIV and AIDS prevention, treatment, care and support – independent of legal, insurance and/or occupational status.³⁷
- Ensure access to health services by vulnerable and marginalized groups, such as members of ethnic minorities, undocumented migrants, migrant sex workers, incarcerated migrants, migrant people living with HIV and migrant injecting drug users
- Adopt approaches that are sensitive to culture, religion and language
- Ensure timely HIV diagnosis and referral to services, and reduce barriers to timely diagnosis and testing³⁸

Self-determination

- Ensure that the use of all services is voluntary and confidential
- Ensure that all HIV testing, including testing in prisons and detention centres, is voluntary and accompanied by appropriate pre- and post- test counselling. Test results must be kept confidential.
- Mandatory HIV testing in prison settings violates the widely accepted principle of self-determination in the area of health, and cannot be justified from a public health perspective.

2. Upholding rights

EU/EFTA States should safeguard the human rights of populations most affected by HIV/AIDS.

They should

- **ratify or restate key commitments (conventions, norms) on human rights for these groups.**
- **repeal laws that criminalize key groups and increase vulnerability to HIV**
- **seek to eliminate discriminatory practices, national policies, and stigma that increase vulnerability to HIV, especially among MSM, IDU, migrants, and sex workers**

As shown by the results of our survey human rights and universal access to healthcare are considered crucial overarching fundamental principles to guide national policy response to HIV in different countries.

[2-country-principles-human] - What overarching fundamental principles should guide national policy response to HIV in your country? Please rank them in order of importance, 1 being the lowest and 3 the highest. Please note that no item can be given the same rank as another.

	1	2	3	Total	Mean	Variance
Public health (at the whole population level)	80 (40%)	68 (34%)	54 (27%)	202	1.9	0.7
Human rights (including the right to physical integrity)	72 (36%)	55 (27%)	75 (37%)	202	2.0	0.7
Universal access to healthcare (at the individual level)	50 (25%)	79 (39%)	73 (36%)	202	2.1	0.6

MSM

- Fully implement the Charter of Fundamental Rights of the European Union³⁹
- Fully implement the Yogyakarta Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity⁴⁰
- Fully implement the UN Statement on Sexual Orientation and Gender Identity
- Enact policy changes that are designed to protect the rights gay men and MSM and facilitate uptake of social and health services, including through anti-discrimination laws related to HIV status, sexual orientation and gender identity within all social structures.⁴¹
- Repeal all laws that may be used to discriminate against MSM and other sexual minorities

In our survey specific attention to 'advocating for a full societal acceptance of sexual and gender variants' or 'tackling discrimination among healthcare practitioners' was only considered a high priority for prevention programmes in the next 5 years by respectively 18% and 10% of respondents (ranking them at 8 and 9).

[4-MSM-prevention] - For this group, what should be the focus of HIV/AIDS prevention programmes in the next 5 years in your country? Please rank these objectives according to their priority, 1 being the lowest and 9 the highest. Please note that no item can be given the same rank as another.

	1	2	3	4	5	6	7	8	9	Total	Mean	Variance
Advocating for a full societal acceptance of sexual and gender variants	12 (10%)	13 (11)	15 (12)	20 (16)	12 (10)	14 (11%)	14 (11%)	14 (11%)	9 (7%)	123	4.9	6.0
Tackling discrimination among healthcare practitioners	14 (11%)	24 (20)	16 (13)	14 (11)	17 (14)	16 (13%)	10 (8%)	11 (9%)	1 (1%)	123	4.2	5.0

IDU

- Fully implement the EU Council Recommendation of 2003 (EC 2003)⁴²
- Scale up evidence-based drug dependence treatment programs
- Implement the comprehensive package of HIV interventions spelled out in the WHO, UNODC and UNAIDS Target Setting Guide⁴³
- Undertake a transparent review of the effectiveness of current drug policies, including unintended consequences with regard to HIV among IDU⁴⁴

- Decriminalise people who use drugs by removing criminal sanctions for behaviours associated with drug use and dependency and prioritizing public health- and rights-based approaches to illegal drugs.⁴⁵

Migrants

- Fully implement the right to HIV/AIDS prevention, treatment, care and support for migrants and ethnic minorities in Europe⁴⁶
- Fully implement the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families⁴⁷
- Implement recommendations from Migration Health: Better Health for All in Europe⁴⁸
- Establish policies on access to HIV treatment and related healthcare for undocumented and uninsured migrants⁴⁹
- Ensure that policies subjecting individuals to deportation are always coupled with protection of that individual's right to challenge his or her deportation through due process of law;
- Reconsider deportation policies for people living with HIV/AIDS, implementing recommendations on deportation of HIV-positive migrants⁵⁰
- Re-examine deportation of HIV-positive individuals to countries where treatment and social support structures are inadequate, in accordance with international

'Tackling discrimination' was considered one of the highest priorities for HIV/AIDS treatment and care programmes in the next 5 years by 17% of respondents by ranking it 8 (11%) and 9 (6%).

[4-IDU-treatment] - For this group, what should be the focus of HIV/AIDS treatment and care programmes in the next 5 years in your country? Please rank them, 1 being the lowest priority and 9 the highest. Please note that no item can be given the same rank as another.

	1	2	3	4	5	6	7	8	9	T	M	Va
										ot	ea	ria
										al	n	nc
												e
Tackling discrimination	10 (11%)	8 (9%)	7 (8%)	10 (11%)	19 (20%)	7 (8%)	16 (17%)	10 (11%)	6 (6%)	93	5.1	5.7

'Decriminalising or depenalising drug use' was defined as highest priority for HIV/AIDS prevention programmes in the next 5 years by 28% of respondents by ranking it 8(11%) and 9 (17%).

[4-IDU-prevention] - For this group, what should be the focus of HIV/AIDS prevention programmes in the next 5 years in your country? Please rank these objectives according to their priority, 1 being the lowest and 9 the highest. Please note that no item can be given the same rank as another.

	1	2	3	4	5	6	7	8	9	T	M	Va
										ot	ea	ria
										al	n	nc
												e
Decriminalising or depenalising drug use	19 (20%)	10 (11%)	6 (6%)	11 (12%)	6 (6%)	8 (8%)	9 (9%)	10 (11%)	16 (17%)	95	4.9	8.7

Deportation problems are also mentioned within our survey. For migrants the focus of HIV/AIDS treatment and care programmes should be on 'ensuring continuity of treatment when deportation does take place' as stated by 22% of respondents ranking it 8 (11%) and 9 (11%). 1 out of 4 respondents also suggests making 'appealing deportation to countries where the migrant's life is at stake because treatment cannot be ensured' one of the highest priorities for this group in the next 5 years by ranking it 8 (13%) and 9 (12%).

[4-migrants-treatment] - For this group, what should be the focus of HIV/AIDS treatment and care programmes in the next 5 years in your country? Please rank them, 1 being the lowest priority and 9 the highest. Please note that no item can be given the same rank as another.

	1	2	3	4	5	6	7	8	9	T	M	Va
										ot	ea	ria
										al	n	nc
												e
Ensuring continuity of treatment when deportation does take place	6 (6%)	9 (10%)	5 (5%)	16 (17%)	9 (10%)	12 (13%)	16 (17%)	10 (11%)	10 (11%)	93	5.4	5.7
Appealing deportation to countries where the migrant's life is at stake because treatment	17 (18%)	6 (6%)	10 (11%)	8 (9%)	7 (8%)	10 (11%)	12 (13%)	12 (13%)	11 (12%)	93	5.0	7.8

and regional non-refoulement prohibitions on deportation and additional complementary bases of protection; i.e. to avoid deportation to 'extraordinary hardship [...] amounting to a death sentence' as a matter of good practice, states—in cooperation with international agencies and donors—should attempt to make provision for continuity of treatment when deportation does take place⁵¹

- End all discriminatory practices, such as deportation connected with HIV status;⁵²
- Repeal all HIV-related entry and residence restrictions⁵³
- Recognize that discrimination against migrants cannot be part of a rational public health strategy toward HIV/AIDS prevention, treatment and care

Sex workers

- Implement the 'sex worker frame', which recognizes sex work as an occupational activity and ensures that it is endowed with labour and social rights⁵⁴
- Implement the recommendations on the inter-sectionality of sex work, migration and health policies⁵⁵
- Protect the human rights of sex workers, including migrant and mobile sex workers.
- Promote universal access for sex workers to HIV prevention, treatment, care and support services
- Implement and guarantee a holistic approach to health as a human right for sex workers, including for migrant and mobile sex workers⁵⁶
- Minimize discrimination and stigma experienced by sex workers, recognizing that these are an important factor in their vulnerability to HIV, and support sex workers to formulate positive strategies and tactics that avoid the pitfalls of felt stigma and deviance.⁵⁷
- Ensure that policies protect the dignity and self-determination of sex workers,⁵⁸ and promote the personal empowerment of sex workers as the best means to reduce shame and blame, which is an important factor of vulnerability to HIV among sex workers. Sex worker empowerment is the best way to address the complex interplay between sex work, shame and blame, and HIV infection.⁵⁹

27% of respondents felt that 'decriminalising / depenalising sex work' should be the focus of HIV/AIDS prevention programmes in the next 5 years, ranking it 8 (10%) and 9 (17%).

29% also feel that 'fighting the trafficking of human beings' should be part of the focus of HIV/AIDS prevention programmes in the next 5 years, ranking it 8 (12%) and 9 (17%).

[4-sexworkers-prevention] - For this group, what should be the focus of HIV/AIDS prevention programmes in the next 5 years in your country? Please rank these objectives according to their priority, 1 being the lowest and 9 the highest. Please note that no item can be given the same rank as another.

	1	2	3	4	5	6	7	8	9	T	M	Va
										ot	ea	ria
										al	n	nc
												e
Decriminalising / depenalising sex work	6 (7%)	11 (12%)	12 (14)	15 (17)	4 (5%)	8 (9%)	8 (9%)	9 (10%)	15 (17%)	88	5.2	7.1
Fighting the trafficking of human beings	3 (3%)	12 (14%)	7 (8%)	2 (2%)	10 (11%)	14 (16%)	14 (16%)	11 (12%)	15 (17%)	88	5.8	6.2

Following the results of our survey 32% of respondents strongly feel that the focus for sex workers of HIV/AIDS treatment and care programmes in the next 5 years should be on 'overcoming policy barriers such as criminalisation that prevent access to health services, ranking it 8 (14%) and 9 (18%).

[4-sexworkers-treatment] - For this group, what should be the focus of HIV/AIDS treatment and care programmes in the next 5 years in your country? Please rank them, 1 being the lowest priority and 9 the highest. Please note that no item can be given the same rank as another.

	1	2	3	4	5	6	7	8	9	T	M	Va
										ot	ea	ria
										al	n	nc
												e
Overcoming policy barriers, such as criminalisation, that prevent access to health services	7 (8%)	12 (14%)	8 (9%)	8 (9%)	12 (14%)	8 (9%)	5 (6%)	12 (14%)	16 (18)	88	5.3	7.4

- Abolish policies that criminalise sex workers, in particular all punitive measures that violate sex workers' human rights.⁶⁰

PLHIV

- Expand efforts to address HIV-related stigma and discrimination. In particular, there is a need to ensure that mechanisms exist to remedy stigma and discrimination when they occur and that these mechanisms are accessible and result in appropriate, timely action.
- Track the existence of both accepting and discriminatory attitudes among the population through periodic surveys. It is essential that survey questions are relevant to the countries of the region and examine stigma and discrimination experienced by marginalised populations who are particularly affected by HIV, in addition to stigma and discrimination experienced by PLHIV generally.⁶¹
- Implement UNAIDS recommendations on the criminalization of HIV transmission⁶²

Prisoners

- Guarantee that prison-based HIV prevention, care and treatment services – as well as general health care – are equivalent to such services available in the community, including services specifically benefitting MSM and IDU.
- As HIV testing should always be voluntary, mandatory testing of prisoners violates the widely accepted principle of self-determination in the area of health. Appropriate policies should offer free routine HIV testing in prison settings with appropriate pre- and post-test counselling and promote follow-on linkages to the health system.⁶³
- Ensure that policies protect the confidentiality of prisoners' HIV status.
- As the vast majority of prisoners are eventually released, continuity of HIV prevention, care and treatment services for prisoners upon release into the community should be ensured.

Following 14% of respondents the focus of HIV/AIDS programmes in the next 5 years should be on 'ensuring that people in prison or detention centres have access to the same prevention measures as key populations outside prisons' rating it 9 (9%) and 10 (5%).

[3-programmes-prevention] - PREVENTION: in your country, what should be the focus of HIV/AIDS programmes in the next 5 years? Please rank them, 1 being the lowest priority and 10 the highest.

	1	2	3	4	5	6	7	8	9	10	Total	Mean	Variance
Ensuring that people in prison or detention centres have access to the same prevention measures as key populations outside prisons	16 (9%)	19 (10%)	25 (14%)	27 (15%)	15 (8%)	18 (10%)	14 (8%)	22 (12%)	16 (9%)	9 (5%)	181	5.1	7.2

3. Civil society participation

EU/EFTA States must ensure civic participation in all aspects of the national response. They should involve civil society stakeholders in designing, implementing and evaluating the response, and in particular, they should involve most affected populations, subpopulations and their representatives as primary stakeholders in the response.

Civil society stakeholders, including community people living with or at risk of HIV infection, should be involved meaningfully at all levels in the design, implementation and evaluation of national HIV programs

- Civil society stakeholders have a demonstrated record of improving the scale and quality of the response to HIV in many countries in the EU/EFTA region, and deserve leadership roles in the formulation of national HIV policies
- Partnerships between government and civil society should be promoted based on mutual accountability measures, including through the evaluation of essential HIV services for most-at-risk populations.
- Affected populations and their representatives participate as the primary stakeholders in the development, implementation and assessment of the national response
- Governments and private agencies should invest in supporting community organizing and

The percentage of new infections is higher especially in the last two years. The public sector is insufficient in its informative and educational role. Stigma and discrimination against PLHIV is still the same. (Greece)

The response today is better than 5 years ago because of the full involvement of NGOs. This is something that the government has already admitted. (Greece)

A lot of work has been done and is still done thanks to the commitment of the NGOs. The government authorities however still have problems promoting the condom as an effective mean of protection, granting access to testing, targeting specific populations etc. (Italy)

Civil society participation - the 'greater involvement of People living with HIV/AIDS' - was also identified as one of two most important fundamental action principles to guide the national policy response to HIV together with an 'evidence based approach'.

[2-country-principles-action] - What action principles should guide national policy response to HIV in your country? Please rank them in order of importance, 1 being the lowest and 3 the highest. Please note that no item can be given the same rank as another.

	1	2	3	Total	Mean	Variance
Evidence-base	35 (17%)	82 (41%)	85 (42%)	202	2.2	0.5
Cost-effectiveness	128 (63%)	44 (22%)	30 (15%)	202	1.5	0.5
Greater Involvement of People living with HIV/AIDS	39 (19%)	76 (38%)	87 (43%)	202	2.2	0.6

Greater involvement of people living with HIV already happens as 59% of respondents mention that their organisation has participated in shaping the national policy plan.

[3-policy-national-plan-input-organisation] - Did your organisation participate in shaping it?

Response	Chart	Percentage	Count
YES		59%	92
NO		36%	57
I don't know		5%	8
Total Responses			157

67% of respondents also mention that most-at-risk groups and/or civil society representatives did participate in shaping the national policy plan.

[3-policy-national-plan-input-others] - Did people from most-at-risk groups and/or civil society representatives participate in shaping it?

Response	Chart	Percentage	Count
YES		67%	105
NO		13%	21
I don't know		20%	31
Total Responses			157

consultation among key populations

- Constituency-based representatives of most affected populations should be involved in all aspects of programmes that affect them, including in substantive leadership roles. This should include, though not be limited to, involvement of representatives of most affected groups and sub-groups in National AIDS committees as community delegates.

4. Policy accountability

EU/EFTA States should provide greater accountability for national HIV policies. They should define national HIV policy priorities explicitly in relation to core HIV commitments, human rights, epidemiology, and evidence of effectiveness. They should urgently ensure coherence between HIV policy and other areas, most notably criminal justice policy.

Monitoring and evaluation⁶⁴

An effective HIV policy requires a monitoring and evaluation system

- Data and analysis should guide national responses and resource allocation in a manner appropriate to the nature of the HIV epidemic in any particular country.
- Adequate human and financial resources, including efforts to improve technical capacity where needed, should be made available to monitor and evaluate the national HIV response.
- As much as possible data collection should be simplified to reduce the burden of reporting
- National monitoring and evaluation systems should ensure that marginalized and most-at-risk populations are captured in data collection efforts.

'Legal or de facto discrimination on the basis of sexual orientation and gender identity' was considered as highly undermining an effective response to HIV by 29% of respondents to our survey. Another 27% said it was moderately undermining an effective response. 20% of respondents also indicated that 'criminalisation of HIV transmission' was a highly undermining factor to an effective HIV response. Another 20% thought it was moderately undermining such a response.

[2-country-policies] - Do you think that in your country some policies, laws / legal precedents, regulations or cultural contexts undermine an effective response to HIV? If an item is not applicable to the situation in your country, please choose "not applicable".

	Not at all undermining	Slightly undermining	Moderately undermining	Highly undermining	Not applicable	Total	Mean	Variance
Legal or de facto discrimination on the basis of sexual orientation and gender identity	14 (7%)	51 (25%)	55 (27%)	58 (29%)	24 (12%)	202	1.0	3.8
Criminalisation of HIV transmission	42 (21%)	38 (19%)	41 (20%)	41 (20%)	40 (20%)	202	1.0	6.0

'Providing adequate legal framework' was identified as a highly important priority by 37% of respondents. 65% stated that 'combating stigma and discrimination' is a high priority.

[3-policy-objectives] - Priority level (importance)

	1	2	3	4	5	Total	Mean	Variance
Providing adequate legal framework	7 (4%)	16 (9%)	36 (19%)	60 (32%)	69 (37%)	188	1.3	1.2
Combating stigma and discrimination	8 (4%)	1 (1%)	17 (9%)	41 (22%)	122 (65%)	189	1.6	0.8

Integrated services

HIV services aimed at key populations should be integrated into public health and social welfare strategies.

- National responses should promote a comprehensive and integrated aimed at risk reduction for **IDUs** as an integral part of overall drug demand and harm reduction policies.
- Strategies to address the health needs of marginalised **migrant** groups should be integrated into public health strategies and action plans at local, national and international levels.
- The healthcare sector should be enabled to guarantee continuous access to HIV, prevention, care and treatment for **migrants**, ensuring that access is monitored and evaluated and with the involvement of HIV community groups in both countries of destination and countries of origin.
- Policies promoting the full protection of **sex workers'** human rights, including their access to public health and social care services, should be established and continually monitored.

Consistent policies⁶⁵

Law enforcement policies should be harmonized with health, human rights, and HIV policies

- A transparent review should be undertaken to examine the effectiveness of current drug policies, including their impact on **IDUs**. Evidence-based strategies should be enacted that reduce the harms associated with drug use and drug policy, and which prioritize public health and human rights protections.
- The reduction of **prisoner** populations should be recognized as an essential part of a comprehensive strategy to prevent HIV transmission among incarcerated migrants and IDU. Overcrowding in prisons is understood to be detrimental to health and promotes the spread of HIV infection, TB, and other negative health outcomes. Alternatives to incarceration should be adopted and prioritized. Immigration-related detention should be used only as a last resort, while sex work and simple drug use should not result in incarceration. Responsibility for organizing health services in prisons and places of detention should be with Ministries of Health,

80% of respondents to our survey mention that there is a national policy on HIV/AIDS in their country.

[3-policy-national-plan] - The national policy on HIV/AIDS in your country

Response	Chart	Percentage	Count
YES		80%	155
NO		15%	28
I don't know		5%	10
Total Responses			193

67% of respondents acknowledge that people from most-at-risk groups and/or civil society representatives helped shaping it.

[3-policy-national-plan-input-others] - Did people from most-at-risk groups and/or civil society representatives participate in shaping it?

Response	Chart	Percentage	Count
YES		67%	105
NO		13%	21
I don't know		20%	31
Total Responses			157

47,4% of respondents are moderately satisfied with the overall response to HIV in their country. 21,8% however are dissatisfied and 5,2% are very dissatisfied about the overall response.

[2-country-overall-response-rate] - Rate the overall response to HIV in your country, from 1 (very dissatisfying) to 5 (very satisfying)

Response	Chart	Percentage	Count
1		5.2%	11
2		21.8%	46
3		47.4%	100
4		22.3%	47
5		3.3%	7
Total Responses			211

27% of respondents to our survey suggested that public health principles are highly important to guide the national policy response to HIV. 37% consider that human rights (including the right to physical integrity) are equally important. For 36% of the respondents 'universal access to healthcare (at the individual level)' should be an overarching fundamental principle to guide a national policy response to HIV in their country.

[2-country-principles-human] - What overarching fundamental principles should guide national policy response to HIV in your country? Please rank them in order of importance, 1 being the lowest and 3 the highest. Please note that no item can be given the same rank as another.

	1	2	3	Total	Mean	Variance
Public health (at the whole population level)	80 (40%)	68 (34%)	54 (27%)	202	1.9	0.7
Human rights (including the right to physical integrity)	72 (36%)	55 (27%)	75 (37%)	202	2.0	0.7
Universal access to healthcare (at the individual level)	50 (25%)	79 (39%)	73 (36%)	202	2.1	0.6

- The rights of **migrants** should be clarified and made consistent with respect to health, social and related issues. Inconsistencies between HIV-related public health policies and immigration control policies should be addressed, including through policy coordination by state agencies dealing with public health and immigration.

- The criminalization of **sex workers** through legislation and policies should be reviewed, along with the increasingly repressive policies and practices that appear to be the dominant approach to sex workers across the region. A national approach to sex workers should be based on recognition, decriminalization, and unrestricted legal protection for the human rights of sex workers, including migrant sex workers. The distinction between sex work and human trafficking should be clarified in policy and practice. Anti-trafficking policies should not be used as instruments to target sex workers, in particular migrant and mobile sex workers.

There is no HIV/AIDS strategy in the country. (Hungary)

National coordination is lacking. There is no concrete national HIV strategy. (Finland)

A government agenda and will for serious intervention are lacking. (Slovenia)

In my country HIV, homosexual intercourse and sex in general are still public taboo. No strategies are conceived for prevention and health promotion among MSM. (Italy)

5. Ensuring access

EU/EFTA States should ensure universal access to HIV services. They should scale up efforts to reach key populations, and ensure equitable access to services by removing barriers faced by MSM, people who inject drugs, migrants, sex workers and prisoners. They should ensure timely diagnosis, full ART coverage, and TB and hepatitis services to all PLHIV.

Scaling up services⁶⁶

HIV services should be scaled up to reach key populations

- Interventions to reach key populations with effective HIV prevention, treatment, care and support services should be available on an adequate scale to meet the MDG commitment of universal access to HIV services

- The provision of HIV programmes for **IDU** should be scaled up to levels currently recommended by WHO, UNAIDS and UNODC, including scaling up harm reduction interventions, and aspiring to the high

levels of programme coverage achieved by some countries. Needle and syringe exchange and safer injection education, along with complimentary HIV testing and counselling and outreach services, should be available to all injecting drug users, including those in prisons

- HIV prevention, care and treatment services should be scaled up to provide universal access for **MSM**. Discrimination against MSM should be addressed through both public health and human rights perspectives. Homophobia makes MSM difficult to reach, and negative and judgemental attitudes by healthcare personal undermine supportive policies, services and health for MSM.
- Universal access to HIV services should be ensured for **sex workers**, with particular attention to those who are most vulnerable to HIV infection, including sex workers who inject drugs
- Access to prevention of **mother-to-child transmission**, including for migrant and drug using women, should be ensured. National policies and programs should strive to reduce the number of cases of mother-to-child transmission to as close to zero as possible.

Access for migrants⁶⁷

Access to HIV services should be ensured for migrants

- The problem of inadequate access to health services by migrant populations should be recognized and addressed at the highest political levels
- Denying migrants access to HIV/AIDS prevention, treatment and care should be recognized as counterproductive in the response to the HIV epidemic, as it perpetuates HIV transmission and frustrate efforts toward controlling the HIV/AIDS epidemic
- Adequate HIV prevention, treatment, and care services should be provided for migrants and citizens alike, regardless of national policies on HIV-related entry and residence restrictions

Testing remains one of the major needs as to the outcomes of our survey and is considered as one of the major priorities to be included in HIV/AIDS programmes in the next 5 years. 46% rank 'implementing testing policies to ensure timely diagnosis and treatment of HIV infection' 8 (13%), 9 (15%) and 10 (18%) thus making it one of the highest priority for the next 5 years.

[3-programmes-treatment] - TREATMENT and CARE: in your country, what should be the focus of HIV/AIDS programmes in the next 5 years? Please rank them, 1 being the lowest priority and 10 the highest. Please note that no item can be given the same rank as another.

	1	2	3	4	5	6	7	8	9	10	Tot al	M ea n	Va ri a n c e
Implementing testing policies to ensure timely diagnosis and treatment of HIV infection	8 (4%)	15 (8%)	9 (5%)	9 (5%)	19 (11%)	16 (9%)	21 (12%)	24 (13%)	27 (15%)	32 (18%)	180	6.6	7.7

- Health systems should be adapted to better meet the needs of migrants living with or at risk of HIV (e.g. through structural changes, bilingual or multilingual staff and culturally sensitized personnel)
- Programmes focused on key populations should provide equitable access to services, including to those born in other countries or having a particular nationality or ethnicity, regardless of legal status






Access for sex workers⁶⁸

Access to HIV services should be ensured for sex workers

- The serious negative consequences of barriers to access health services for sex workers should be recognized
- Sex workers should have equal access to HIV prevention, information, counselling, testing, diagnostic, and treatment services that are provided anonymously and free of charge by both public health care institutions and NGOs
- All migrant sex workers (including undocumented, uninsured, mobile and migrant sex workers) should have full access to public health systems. Policies that create barriers to national health services and steer migrant sex workers primarily to NGO providers should be reformed
- Policies should be developed to overcome barriers preventing sex workers' access to public health services, including unrecognized or unregulated labour status, non-EU citizenship, fees based on insurance status, 'the trafficking equation', criminalization and discrimination

49,8% of respondents don't see much change in today's response compared to 5 years ago. 23,7% see things getting better and 3,3% see real improvement. A total of 23,2% however see a worse response now than 5 years ago.

[2-country-overall-response-change] - Compare today response to what it was 5 years ago, from 1 (much worse) to 5 (much better)

Response	Chart	Percentage	Count
1		2.8%	6
2		20.4%	43
3		49.8%	105
4		23.7%	50
5		3.3%	7
Total Responses			211

Because of the expense of treatment, sometimes HIV testing is not encouraged within certain populations at risk. Though, of course, whoever wishes to test for HIV has the freedom and possibility to do so. (Malta)

Migrants accounted for significant rise (40% of new infections between 2003 – 2009). This is now declining, but HIV services have found it very difficult to engage with and support this group. (Ireland)

In most (European) countries there is no clear law or provision for positive migrant women (without a status, in prisons or in centres) to access medication or services so they live under the radar and end up falling very ill and ending up in hospitals. (UK)

Among Sex workers we have a large rate of migrants, especially women from new EU-countries, without health insurance. Migrant sex workers are double stigmatized. (Germany)

Access for prisoners⁶⁹

Access to HIV services should be ensured for prisoners

- Prisoners should have access to HIV treatment and care services 'equivalent'⁷⁰ to those available in community settings, including access to TB and hepatitis A and B vaccination⁷¹, diagnosis and treatment
- Essential HIV prevention programmes should be available in all prisons, including syringe exchange and opioid substitution therapy services for IDU and condom distribution and sexual health services for MSM and others at risk of sexual transmission. It also includes substitution treatment to IDUs in prison, both in adequate dosages and during their entire imprisonment. Sterile injecting equipment is freely provided to prisoners in need.

There is a lack of ensured continuity to treatment in prison settings, (Italy)

Timely diagnosis⁷²

Access to early diagnosis should be strengthened for all PLHIV

- The critical issue of late diagnosis of HIV infection should be addressed and the proportion of PLHIV who are delayed in starting ART because of late diagnosis should be reduced. This should include rigorously tracking the proportion of PLHIV with late diagnosis (i.e. a CD4 count < 350 at the time of diagnosis).

- Rapid tests and proper counselling should be integrated in low-threshold community programs for key populations (MSM, IDU, sex workers and migrants), and equivalent programs should be made available in prison settings.
- Efforts to provide accessible HIV testing services for **migrants** should be increased, e.g. through community organisations and outreach. HIV counselling and testing services should be made available so that they are free of charge, voluntary and anonymous, regardless of one's legal or insurance status
- Access to HIV voluntary counselling and testing among **IDU** should be improved, both in community settings generally and through linkages with drug treatment, harm reduction, and other health services.

ART coverage⁷³

ART should be ensured for all PLHIV

- Antiretroviral therapy (ART), as well as tuberculosis and hepatitis B and C prevention, diagnostic and treatment services, should be universally available for key populations, particularly for underserved IDU, migrant and prisoner populations

Ensuring universal access to antiretroviral therapy has been ranked even higher as priority topic of HIV/AIDS programmes in the next 5 years by our respondents. Scores of 8, 9 and 10 were given by respectively 9%, 11% and 30% (!) of respondents, thus defining access to treatment as highest priority.

[3-programmes-treatment] - TREATMENT and CARE: in your country, what should be the focus of HIV/AIDS programmes in the next 5 years? Please rank them, 1 being the lowest priority and 10 the highest. Please note that no item can be given the same rank as another.

	1	2	3	4	5	6	7	8	9	10	Tot al	M ea n	Va ri a n c e
Ensuring universal access to antiretroviral therapy (ART)	21 (12)	10 (6%)	9 (5%)	12 (7%)	12 (7%)	9 (5%)	17 (9%)	16 (9%)	20 (11%)	54 (30)	180	6.7	10.5

27% of respondents rank 'providing free and voluntary access to HIV testing and counselling services' as highest priority with scores of 9 (13%) and 10 (14%) for HIV/AIDS programmes in the next 5 years.

[3-programmes-prevention] - PREVENTION: in your country, what should be the focus of HIV/AIDS programmes in the next 5 years? Please rank them, 1 being the lowest priority and 10 the highest.

	1	2	3	4	5	6	7	8	9	10	Tot al	M ea n	Va ri a n c e
Providing free and voluntary access to HIV testing and counselling services	9 (5%)	11 (6%)	19 (10%)	10 (6%)	12 (7%)	18 (10%)	27 (15%)	25 (14%)	24 (13%)	26 (14)	181	6.4	7.5

- Access to ART among **IDU** should be improved and better linked to drug dependency, harm reduction, and primary health care services. Evidence-based drug treatment options, including opioid substitution therapy, should be provided in accordance with the individual needs of IDU.
- Comprehensive treatment and care services should take into account the social circumstances and needs of **migrants**. ART should be provided to migrants on the same terms as to citizens, including for migrants in detention awaiting deportation . Cross-border treatment mechanisms should be established in order to improve continuity of care, recognizing the links between HIV treatment interruption, illness, development of drug resistance, and death.. Barriers to migrants' access to ART should be eliminated, including through health provider education on patients' rights.

The funding is so limited that the scope and reach of prevention and support activities are very low. The involvement of the government in prevention for vulnerable populations (in a low prevalence concentrated epidemic setting) has been zero. More recently, the government has been failing to fulfil its commitment for free ARV for all who need it. (Romania)

Information, Education and Communication⁷⁴

Appropriate Information, Education and Communication (IEC) should be provided

- Information about existing services, including how they are structured and how to access them, should be accessible and culturally appropriate,
- Campaigns should be implemented to promote HIV testing and counselling for asylum seekers and undocumented **migrants**. Negative public attitudes towards migrants exacerbate their marginalisation and exclusion

'Providing information about HIV/AIDS and HIV prevention services to the general public' was ranked at 9 (10%) and 10 (10%) thus being supported by 20% as needed focus of HIV/AIDS programmes in the next 5 years.

[3-programmes-prevention] - PREVENTION: in your country, what should be the focus of HIV/AIDS programmes in the next 5 years? Please rank them, 1 being the lowest priority and 10 the highest.

	1	2	3	4	5	6	7	8	9	10	Tot al	M ea n	Va ri a n c e
Providing information about HIV/AIDS and HIV prevention services to the general public	20 (11)	20 (11%)	14 (8%)	14 (8%)	23 (13)	24 (13%)	15 (8%)	15 (8%)	18 (10%)	18 (10)	181	5.4	8.3

- High quality sexual and reproductive health education should be provided to **young people** in all countries' schools and included in curricula used to train teachers.
- Public awareness about HIV should be raised in order to combat the stigma and discrimination that drive the HIV epidemic
- Peer education should be supported and integrated within services for key populations and young people.

Whilst there has been significant improvement in treatment and care services, there has been very little public awareness campaigning. Young people under 30 years of age know very little about transmission routes. Surveys have shown that a lot of misinformation and myths still abound. (UK)

Very little importance is given to sex education at all levels. Health Promotion services are underfunded although they do attempt to be inclusive of LGBT persons in their campaigns. There is a Genito-Urinary Clinic which has a relatively good reputation among the LGBT community however there is very little outreach done (Malta)

There is a strategy of terror, which makes people not think about the risks at all. (Poland)

6. Aligning resources and burden of disease

EU/EFTA States should focus their national HIV responses on populations most affected by the epidemic. They should collect and analyse epidemiological data systematically, and base their HIV programmes based on epidemiological findings. Overall existing data suggest that they should focus responses on key populations (MSM, IDU, migrants, sex workers, prisoners), and on vulnerable sub-populations (IDU in prison, migrants from countries with generalized HIV epidemics, migrant sex workers, young IDU, bisexual men).

Data collection and analysis⁷⁵

Epidemiological data should be systematically collected and analyzed

- Available data should be used to focus national responses on populations most affected by HIV. Monitoring and evaluation data should be analysed and used to ensure that national responses to HIV are appropriate to the nature of the national HIV epidemic
- Data concerning **migrants** should be included in epidemiological monitoring. Collection and analysis of epidemiological information regarding sub-populations of migrants should be improved. Studies should be conducted into risk behaviours of migrants and specific subpopulations, their beliefs and attitudes, the quality of life, coping strategies and support needs. Qualitative studies should be utilized to provide greater insights into migrant health and the impact of legal regulations for non-EU migrants.
- Further research should be conducted on the needs of **MSM** in general, and specific subgroups of MSM in particular, to provide a basis for adapting interventions and developing new ones. The critical and multifaceted roles played by social discrimination and stigma in the spread of HIV/AIDS among MSM should be investigated and addressed.
- The accuracy of HIV prevalence estimation studies should be improved with regard to **IDUs**. National agencies should adopt the methodology recommended by the EMCDDA to estimate the size of IDU populations. More accurate IDU population estimates should serve as the basis for ensuring that WHO/Europe coverage targets for IDU services are met. OST should be provided to a high proportion (at least 40%) of opioid-using IDU and covering at least 60% of problematic drug users with prevention and other support.⁷⁶

*We still live with the prejudice that HIV only exists among drug abusers and men that have sex with men. At the moment, heterosexuals have the biggest rate of HIV infection, especially among young and older people.
(Portugal)*

Prevention programmes

Prevention programmes should be supported in line with epidemiological research findings

- Policies and strategies are translated into decisive action through the implementation of prevention programmes, and particularly those focused on key populations.
- Political pressure is resisted to divert limited prevention resources to spending on activities for populations at significantly lower risk of HIV infection, and to ensure that spending is targeted in line with the epidemiology of the epidemic.

Focus on key populations⁷⁷

The response should be focused on identified key populations.

- The focus on key populations affected by HIV should be maintained and based on up-to-date epidemiological research.

It is much better with the prevention activities, esp. among drug users, MSM, prisoners and prison staff. (Belgium)

Urgent action is essential in the migrant population, because this population is significant in our country and because the vast majority are outside the health system. (Portugal)

Because services for migrants are lagging behind, I have given them a higher priority than sex workers, who also deserve continuing support to maintain safe sex. (Germany)

These populations may include IDU, MSM, sex workers, migrants from countries with generalised epidemics, and prisoners.

Focus on sub-populations⁷⁸

More specifically, the response should be focused on vulnerable sub-populations.

- Overlapping vulnerabilities should be identified and recognized for sub-populations who may be particularly vulnerable to HIV infection and less likely to access HIV services. These may include IDU in prisons, migrant sex workers, bisexual men, and young IDU.
- Data collection and programme responses should recognise 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.
- Improved prevention is developed for sub-groups of sex workers who may be at elevated risk of HIV, recognizing that sex work per se is not a major driver of HIV transmission in most countries of the region. Vulnerable sub-populations may include sex workers who also inject drugs, male and transgender sex workers, street sex workers, young sex workers and sex workers from countries with generalised HIV epidemics.
- More data is collected on young people and the heterogeneity of HIV risk. Service provision is focused on young people particularly at risk of HIV infection, such as young IDU, young sexual partners of IDU, young sex workers, young MSM, young migrants from high prevalence regions and young people in correctional and prison settings.

One of the major changes in the past 5 years is the influx of irregular migrants from African countries where the rate of infection is generally high. There is no screening programme in place for such persons since detection would lead to the necessity of providing treatment. This is considered to be expensive by the government. (Malta) More and more we hear that sex workers are asked to work without condoms by the clients. The group with the more risk is men sex men (Belgium)

7. Effective programmes

EU/EFTA States should ensure that national HIV programmes are effective. They should invest in programmes that are based on solid evidence of effectiveness where that is available, and on reasonable expectation of effectiveness where solid evidence is not available. Governments should be informed by public health research on the effectiveness of HIV services, including services aimed at key populations. Governments should develop a culture of evaluation to inform policies. .

Evidence of effectiveness⁷⁹

Investments should be made in programmes based on solid evidence of effectiveness, wherever available.

- Policy prioritization decisions are made based on solid evidence of effectiveness where that is available
- Pragmatic policy choices are made, where that is necessary, based on evidence that interventions produce no harm, and offer some benefit

Probable effectiveness⁸⁰

Investments should be made based on reasonable probability expectation of effectiveness when an unambiguous evidence base is not available.

- When conclusive evidence is lacking, policies should be based on a careful estimation that interventions are more likely to reduce harm than increase harm
- The absence of conclusive evidence should not be used in and of itself to justify inaction
- Investment into finding innovative ways to address HIV should be in place at national and the EU/EFTA levels.

More than 40% of respondents rank 'providing free and voluntary access to HIV testing and counselling' between 8-10 on a scale of highest priorities for HIV/AIDS programmes in the next 5 years. 43% of respondents also provide scores between 8 and 10 of HIV/AIDS programme priorities for the next 5 years to 'providing targeted and evidence-based prevention services to key populations. So even if 'testing should not be assumed to be effective as prevention intervention as such', it should be considered an important aspect of HIV/AIDS programmes.

[3-programmes-prevention] - PREVENTION: in your country, what should be the focus of HIV/AIDS programmes in the next 5 years? Please rank them, 1 being the lowest priority and 10 the highest.

	1	2	3	4	5	6	7	8	9	10	Total	Mean	Variance
Finding more effective ways to help people change their risky behaviour	6 (3%)	11 (6%)	13 (7%)	10 (6%)	23 (13)	17 (9%)	14 (8%)	30 (17%)	29 (16%)	28 (15)	181	6.6	7.1
Providing free harm reduction supplies (syringes and needles, condoms, lubes,...)	7 (4%)	14 (8%)	20 (11%)	22 (12%)	17 (9%)	22 (12%)	19 (10%)	33 (18%)	18 (10%)	9 (5%)	181	5.8	6.3

Effective prevention⁸¹

Efforts should be made to identify effective prevention interventions

- Prevention interventions that lead to behaviour change and thus reduce sexual risk-taking should be identified, as well as the attributes of interventions that have the greatest impact on reducing sexual risk taking
- Research on new HIV prevention interventions should be monitored closely, and appropriate innovations and adaptations made
- HIV counselling and testing should not be assumed to be effective as prevention interventions as such

Factors promoting effective HIV programmes

Factors supporting effective interventions may include participation, appropriateness, and holistic integrated service

- Participation: this means that key populations and their representatives are meaningfully involved in the planning, delivery and evaluation of HIV services.
- Appropriateness: this means that the particular vulnerabilities, needs, opinions and situation of key populations are taken into account in all aspects of programme planning, delivery and evaluation.
- Holistic/integrated service: this means that a holistic range of integrated services is provided, and top-down, 'siloed' services are avoided. Thus, HIV is addressed in relation to sexual and reproductive health in general. Integrated services may involve, for example, collaboration between physicians, social workers, psychologists and community workers in order to provide comprehensive HIV services, and services that address wider issues, e.g. broader health, gender, sexual violence, trafficking and social exclusion.

Services for MSM⁸²

The following assumptions should be made when seeking to develop effective services for MSM

- Limiting sexual risk behaviours is central to the efforts to decrease sexually transmitted infections, including HIV, among MSM
- Data collection and programme responses should recognise 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
- Assessment of stigma reduction interventions should be conducted periodically and cumulative 'good practices' disseminated
- The collection of stigma-related data should be supported, with specific attention to how it relates to MSM, and such information should be used to advocate for necessary shifts in policy and funding that more effectively target the response to the epidemic
- The following prevention interventions may be more effective with MSM: group-level interventions (compared to individual-level interventions), multi-component interventions including individual-level interventions, multi-session or extended interventions with help from peer educators and popular opinion leaders, and interventions that include a cognitive element, skills training, and /or a theoretical framework.

The HIV epidemic in Paris is mostly centred in the homosexual population. This population is well-informed and yet continues to be infected in relatively high numbers (France)

[...] more important however are national campaigns that make everybody aware of the risk of unprotected sex and that HIV and other sexual transferable infections exist! (Sweden)

The clients we see most frequently, such as IDU/ mental health or migrants, have multiple needs. The system does not facilitate the level of psychosocial support required in order to break the cycle for meaningful long-term change to occur. ... Multi-disciplinary cooperation seems lacking and needs to occur for case management to be successful. (Ireland)

Services for IDU⁸³

The following assumptions should be made when seeking to develop effective services for IDU

- Focusing on IDUs requires investing in harm reduction interventions aimed at prevention through vulnerability reduction, risk reduction, and preventing transmission. Harm reduction interventions may also be aimed at supporting access and adherence to treatment and care, and mitigating HIV's impact.

- Condoms and sexual health counselling and education should be provided and their use promoted among IDU and their sexual partners,
- Sterile needles and syringes, along with other safe injecting equipment, should be distributed to IDUs without undue restrictions that limit the likelihood that a new, sterile syringe is available for every injection.
- Access to HIV testing and counselling programmes for IDU should be ensured
- IDU-focused HIV services are greatly enhanced by a broader array of harm reduction services, including programs addressing mental health, hepatitis, overdose, and drug dependency treatment. A comprehensive approach to drug use, with HIV as one crucially important component, should be the basis of all harm reduction programs.
- Additional Information, Education and Communication (IEC) should be provided for specific groups of IDU, their sexual partners, families and their communities.

Needle exchange ... has continued to keep new infection in this group relatively low. (UK)

Most of injecting drug users have changed their behaviours after harm reduction programs (Italy)

Generally, holistic, integrated approach to harm reduction services ... does not exist. This does not allow for proper outreach to people who use drugs (Poland)

With ranking of 9 (10%) and 10 (7%) almost 1 on 5 respondents considered making 'providing free and integrated harm reduction services' the focus of HIV/AIDS programmes in the next 5 years.

[3-programmes-treatment] - TREATMENT and CARE: in your country, what should be the focus of HIV/AIDS programmes in the next 5 years? Please rank them, 1 being the lowest priority and 10 the highest. Please note that no item can be given the same rank as another.

	1	2	3	4	5	6	7	8	9	10	Total	Mean	Variance
Providing free and integrated harm reduction services	17 (9%)	16 (9%)	23 (13%)	17 (9%)	21 (12%)	16 (9%)	17 (9%)	23 (13%)	18 (10%)	12 (7%)	180	5.4	7.7

Services for migrants

The following assumptions should be made when seeking to develop effective services for migrants

- Targeted outreach work should be conducted to respond to the needs of migrants and ethnic minorities, such as peer education and cultural mediation
- Training, education and efforts to sensitize health workers should be provided to meet the specific needs of vulnerable groups and ensure non-discriminatory approaches
- Multilingual and culturally sensitive materials should be developed, in particular prevention information for new arrivals and for specific migrant sub-populations, e.g. young people, women, MSM, sex workers, drug users.
- Cultural mediators and translators should be introduced in service provision.
- Monitoring should be conducted to determine whether these programmes are delivered on a sufficient scale
- The effectiveness and impact of services and interventions aimed at migrants should be regularly assessed, as should the effectiveness of health screening of asylum seekers.

Evaluation culture⁸⁴

A culture of evaluation should be developed in order to inform policies

- An 'evaluation culture' should be promoted, including by staff training and stakeholder participation
- Funding criteria should utilize program indicators or deliverables in order to promote quality assurance for HIV services through regular evaluation

- All HIV/AIDS policy stakeholders should collaborate in the collection and subsequent sharing of knowledge. These may include community actors, civil society, social researchers, donors, and rights advocates
- Studies should be conducted into the effectiveness of prevention interventions in reducing HIV incidence among MSM who engage in unprotected anal intercourse (done systematically, focusing specifically on MSM, and using clear inclusion criteria). Rigorous evaluation of HIV risk reduction activities aimed at MSM should be promoted and used to inform policies and practices. Additional resources should be made available to address the deficit in evaluation of sexual behaviour interventions among MSM.

18% of respondents see 'ensuring access to treatment and care to undocumented migrants' as focus of HIV/AIDS programmes in the next 5 years by ranking it 9 (9%) and 10 (9%).

[3-programmes-treatment] - TREATMENT and CARE: in your country, what should be the focus of HIV/AIDS programmes in the next 5 years? Please rank them, 1 being the lowest priority and 10 the highest. Please note that no item can be given the same rank as another.

	1	2	3	4	5	6	7	8	9	10	Tot al	M ea n	Va ria nc e
Ensuring access to treatment and care to undocumented migrants	27 (15)	22 (12)	15 (8%)	15 (8%)	17 (9%)	19 (11%)	13 (7%)	20 (11%)	16 (9%)	16 (9%)	180	5.2	9.0

18% of respondents are convinced that 'overcoming language, educational and/or cultural barriers in relation to sexual health education and HIV prevention should become the focus of HIV/AIDS programmes in the next 5 years ranking it 9 (10%) and 10 (8%).

[3-programmes-prevention] - PREVENTION: in your country, what should be the focus of HIV/AIDS programmes in the next 5 years? Please rank them, 1 being the lowest priority and 10 the highest.

	1	2	3	4	5	6	7	8	9	10	Tot al	M ea n	Va ria nc e
Overcoming language, educational and/or cultural barriers in relation to sexual health education and HIV prevention	15 (8%)	20 (11%)	20 (11%)	16 (9%)	21 (12)	19 (10%)	21 (12%)	15 (8%)	19 (10%)	15 (8%)	181	5.4	7.8

8. Adequate funding

EU/EFTA States should ensure adequate funding to implement the national response. They should provide additional funding from domestic sources, including from the redeployment of resources from programmes that serve to criminalize, and thus increase the vulnerability of, populations most affected. They should concentrate existing resources on addressing the epidemic among populations most affected, and prioritize effective prevention, treatment and care interventions.

Adequate resources⁸⁵

Adequate funding, including additional funding from domestic sources, should be provided for the national response

- Appropriate systems and adequate human and financial resources should be provided to plan, implement, and evaluate the national HIV response.
- Adequate public funding should be provided to civil society groups involved in the response
- Continuity and predictability of funding should be ensured in order to avoid gaps in services, especially for NGOs that receive contracts or grants to provide services
- Increased funding for national responses to HIV should be made available from domestic resources
- Legislative priority and government resources should be redirected from maintaining costly and discriminatory law enforcement policies, and refocus on providing prevention, care, and treatment programs that target and serve non-citizens and citizens

In Slovakia we do not have [the] budget for the National AIDS Programme (Slovakia)

Actually HIV is not a priority in the Italian health care system, so in these worldwide times of crises, this means cutting funds for our services (Italy)

All services for MSM which started during the Global Fund program were stopped and don't exist anymore, because the government refuses to finance them. We still do not have even one single MSM specific project with possibility for HIV/STI testing. Our organization provides it only for male sex workers. (Estonia)

As the only HIV/AIDS social respite organization currently active in the UK, we receive no statutory funding. Social services, who are effectively our client, have cut funding for respite increasingly over the years to the point that we have now reduced our respite fees in order to make our services more accessible to service-users seeking funding for respite.(UK)

Focus⁸⁶

Existing resources should be concentrated on addressing the epidemic among most affected populations

- Funding should be focused on key populations to ensure better value for money, and result in a more effective response overall.
- Investment should be made to address the epidemic in proportion to the disease burden among **MSM**, and additional resources for specific services targeting **migrants** within these key populations.

15% consider 'providing adequate scale, coverage and funding' a high priority for the implementation of HIV and 7% consider it the highest priority.

[3-policy-objectives] - Implementation in your country

	N/A	1	2	3	4	5	Total	Mean	Variance
Providing adequate scale, coverage and funding of HIV services	6 (3%)	35 (19%)	58 (31%)	48 (25%)	28 (15%)	14 (7%)	189	0.4	3.7

- Resources should be invested into culturally sensitive prevention programmes, with priority given to prevention interventions with the strongest evidence of cost effectiveness.

Effectiveness

Resources should be used to prioritize scaling up effective interventions.

- Resources should be aimed at scaling up those interventions proven effective on the ground through rigorous evaluation

...in the last 10 years the focus on prevention and social support has decreased as well as the funding of these activities while pharmacological treatments have been improved (Italy).

Because of the Global Fund in Bulgaria there is, for now, sustainability; but I'm not sure what will happen when the Global Fund program [...] finishes. (Bulgaria) Sexual Health is more important than 5 years ago; however, with spending cuts looming I'm unsure whether this will continue (UK)

The government is trying to reduce the available funds for HIV infection prevention and limit access to free ARV treatment. (Poland)

Support⁸⁷

External financial support should be provided for HIV responses in low-middle income countries

- External financial support should be provided for HIV responses in the low- and middle income countries of the region for the foreseeable future through mechanisms established by the EU or other bodies.

... the NGO programs covering prevention for specific vulnerable groups (MSM, IDU, sex workers) are underfinanced. Instead of investing in keeping the prevalence low, we are (almost) sleeping on the certainty that nothing can happen (Slovenia)

Over the last few years, prevention and awareness campaigns have been reduced due to the restricted financial and media attention (Italy)

9. Political leadership

EU/EFTA States should designate and empower political leadership to implement the national response. They should appoint a strong political and public authority to implement these recommendations, and to address specific national HIV policy challenges.

National challenges

Political leadership should address national challenges HIV policy challenges by ensuring that:

- Plans and structures are translated into practical actions
- The response is focused on populations most affected by HIV
- Financial resources for HIV prevention are appropriately targeted on key populations and the level of resources allocated to prevention among these populations
- Programmes implemented for IDU, MSM, sex workers and migrants are of a sufficient scale to provide them with access to treatment, care and support as well as to effective prevention services
- Difficult but essential policy issues are addressed, such as the provision of harm reduction programmes for IDU in prison settings
- ART coverage is provided for key populations, particularly IDU, migrants and prisoners
- Appropriate response exists to the continued risk of HIV transmission among **MSM**

Although the HIV epidemic among the largest groups, MSM, is growing at a similar or even higher rate as compared to the epidemic growth in the beginning of the eighties, the sense of urgency among government, politicians and policy makers has disappeared. The general feeling is that AIDS and HIV have been solved. (Netherlands).

The overall issue of HIV and AIDS is not a priority at policy level, the national co-ordinating committee has not been meeting and there is no national sexual health strategy in place. There is little recognition at policy or political level of the need to keep the issue of HIV and AIDS on the policy agenda. (Ireland)

There is not much investment in prevention on the government's part. This is not exactly a top priority among MPs. (Portugal)

'Reporting on international obligations or commitments' scores good to weak by our respondents with respectively 34% and 33% of answers. 9% even thinks it is very weak or absent. 37% feel that 'availability of data for evidence-based HIV policy and programmes' is weak. The 'use of data for policy and/or programme development or improvement' is scored good by 32% of respondents and 8% scores it very good. 'Monitoring of programmes' is scored good (36%) to weak (40%). 'Evaluation of programmes' also scores good (36%) to weak (38%). Most respondents also rank 'research into policy challenges' good (17%) to weak (51%).

[3-evaluation-type] - How would you rate these different aspects of the analysis of HIV programmes and services, in your country?

	Very weak or absent	Weak	Good	Very good	I don't know	Total	Mean	Variance
Reporting on international obligations or commitments	16 (9%)	60 (33%)	62 (34%)	14 (8%)	30 (16%)	182	0.8	4.8
Availability of data for evidence-based HIV policy and programmes	9 (5%)	68 (37%)	71 (39%)	25 (14%)	9 (5%)	182	0.4	2.6
Use of data for policy and/or programme development or improvement	8 (4%)	90 (49%)	58 (32%)	14 (8%)	12 (7%)	182	0.2	2.9
Monitoring of programmes (how they are conducted)	10 (5%)	73 (40%)	66 (36%)	14 (8%)	19 (10%)	182	0.5	3.6
Evaluation of programmes (the results they produce)	17 (9%)	70 (38%)	66 (36%)	10 (5%)	19 (10%)	182	0.4	3.8
Research into policy challenges	29 (16%)	92 (51%)	31 (17%)	2 (1%)	28 (15%)	182	0.1	5.2

10. Regional facilitation and collaboration

National governments should seek to collaborate towards a joint response to HIV/AIDS where appropriate and where of added value. In particular the following common challenges should be addressed at regional and European level:

Policy

- Urgently adopt a regional approach to UNGASS and Dublin reporting.⁸⁸ Combine the multiple reporting mechanisms currently being used by international organisations, including UNGASS, into one exercise. The various international stakeholders could then extract the data from the consolidated process to use in their different reports. Conducting a single exercise would make it a more routine activity for countries, which is likely to make it easier to manage internally and easier to support externally, e.g. through ECDC. Clarity is needed on what data need to be reported and how often.

‘Needs assessment’

- Lack of **standardisation**: The main methodological challenge for all studies attempting to compare the situation of migrants within the EU is that the **term ‘migrant’** is used in different ways in different European countries.
- A systematic **review of HIV/STI prevention interventions targeted at MSM in Europe** is needed in order to guide funding and research, and to update the current knowledge base about HIV/STI prevention efforts targeted at MSM in Europe⁸⁹
- Improving region-wide data collection and analysis of trends on specific risks and risk perception in MSM communities** through development of behavioural surveillance programmes.
- Reviewing the relevance of current indicators. For example, if knowledge indicators are to be used, they need to be more specific for MSM.

Greater clarity is needed on how to measure coverage of HIV prevention programmes for MSM. Indicators of HIV testing and counselling may need to be tailored to specific policy environments. For example, it makes sense to enquire about testing in the last year if the aim is to test each MSM once per year. A focus on measuring reported

Rates of evaluation and reporting on HIV/AIDS programmes are mainly rated good to weak for all most-at-risk groups. For injecting drug users the ranking is good (39%) to poor (34%). The same ranking goes for MSM with ranking by 34% for good and 33% for weak evaluation and reporting. Evaluation and reporting on HIV/AIDS programmes for sex workers is ranked good by 24% and weak by 45%. Migrants are ranked the lowest on evaluation and reporting on their HIV/AIDS programmes with 45% saying it is weak and 25% saying it is very weak.

[3-evaluation-groups] - How would you overall rate the evaluation and reporting on HIV/AIDS programmes and services for these four most-at-risk groups, in your country?

	Very weak or absent	Weak	Good	Very good	I don't know	Total	Mean	Variance
Injecting drug users	9 (5%)	61 (34%)	71 (39%)	22 (12%)	19 (10%)	182	0.7	3.5
Men who have sex with men	15 (8%)	60 (33%)	61 (34%)	33 (18%)	13 (7%)	182	0.6	3.2
Migrants	46 (25%)	78 (43%)	31 (17%)	3 (2%)	24 (13%)	182	-0.1	5.0
Sex workers	28 (15%)	82 (45%)	44 (24%)	6 (3%)	22 (12%)	182	0.2	4.5

condom use is highly appropriate given concerns that unprotected anal sex is still one of the major determinants of HIV transmission among MSM in the region. Disaggregated data about condom use with different types of partner and with regards to HIV status may be of particular value.⁹⁰

- Replace the current composite UNGASS indicator for measuring HIV programme coverage among IDU with more relevant indicators such as the number of needles/syringes distributed

per IDU; the frequency with which IDU do not have access to sterile needles/syringes; the proportion of IDU receiving OST; and the proportion of HIV-positive IDU receiving ART.⁹¹

- Review the relevance of current indicators to measure HIV-related knowledge among sex workers and to identify indicators to measure programme coverage that are appropriate to the regional context, including indicators that are flexible enough to take account of the diverse nature of sex work and sex workers. It may be worth focusing efforts on those indicators which countries appear to consider most relevant, such as the rate of reported condom use.

Funding

- Continue providing financial support for HIV responses in the low- and middle income countries of the region, which is likely to be needed for the foreseeable future.⁹²

63% of respondents declare they have dedicated funding programmes for intravenous drug users in their country. For 26% of respondents no such programmes were available.

[4-IDU-funding] - In your country, are there dedicated funding programmes for HIV/AIDS projects targeting this group?

Response	Chart	Percentage	Count
Yes		63%	60
No		26%	25
I don't know		11%	10
Total Responses			95

48% of respondents felt that dedicated funding programmes were available to target sexworkers whereas 39% said they had no such programmes

[4-sexworkers-funding] - In your country, are there dedicated funding programmes for HIV/AIDS projects targeting this group?

Response	Chart	Percentage	Count
Yes		48%	42
No		39%	34
I don't know		14%	12
Total Responses			88

Dedicated funding programmes are available in their country to target migrant populations as stated by 54% of respondents. 33% did not have any programme.

[4-migrants-funding] - In your country, are there dedicated funding programmes for HIV/AIDS projects targeting this group?

Response	Chart	Percentage	Count
Yes		54%	50
No		33%	31
I don't know		13%	12
Total Responses			93

To target MSM groups 66% of respondents say that dedicated funding programmes are available. 31% indicate that such programmes do not exist in their country.

[4-MSM-funding] - In your country, are there dedicated funding programmes for HIV/AIDS projects targeting this group?

Response	Chart	Percentage	Count
Yes		66%	82
No		31%	38
I don't know		3%	4
Total Responses			124

Conclusion

The policy recommendations within this document have been developed starting from the adequacy of current policies and programmes, the implications and recommendations for policy makers at the national and EU level and other factors affecting men who have sex with men, migrants, sex workers and intravenous drug users.

We hope that these recommendations will become a tool to be used by community representatives at local, national and international level. The recommendations should support civil society, their advocates, policy makers and other actors to review and improve their policies.

The final outcome of these evidence-based recommendations should be a reduction of existing HIV/AIDS-related health inequalities.

We thank the coordinators of the Correlation Network project for the opportunity to support the development of these Policy Recommendations and for all who contributed to it. We encourage everyone to make it part of their future advocacy work and to use it as widely as possible.

References

¹ ECDC (2010), Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2010 progress report: summary. (Stockholm: European Centre for Disease Prevention and Control; 2010)

² The report is based on data from 49 countries and reflects the contributions of a wide range of individuals and organisations.

³ Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, United Kingdom

⁴ Iceland, Liechtenstein, Norway, and Switzerland

⁵ For example, UNAIDS data is presented according to three 'European' regions: Western Europe, Central Europe, and Eastern Europe. These recommendations are broadly aimed Western and Central European countries, although they may apply to some Eastern European countries.

⁶ UNAIDS, Global Facts and Figures (2009),
http://data.unaids.org/pub/FactSheet/2009/20091124_FS_global_en.pdf

⁷ UNAIDS/WHO Fact Sheet 2009: North America and Western and Central Europe

⁸ ECDC (2010)

⁹ UNAIDS/WHO Fact Sheet 2009: North America and Western and Central Europe

¹⁰ UNAIDS, Global Facts and Figures (2009),
http://data.unaids.org/pub/FactSheet/2009/20091124_FS_global_en.pdf

¹¹ UNAIDS/WHO Fact Sheet 2009: North America and Western and Central Europe

¹² UNAIDS, Global Facts and Figures (2009),
http://data.unaids.org/pub/FactSheet/2009/20091124_FS_global_en.pdf

¹³ UNAIDS/WHO Fact Sheet 2009: North America and Western and Central Europe

¹⁴ ECDC (2009), citing ECDC/WHO Regional Office for Europe, HIV/AIDS surveillance in Europe 2007, (Stockholm: ECDC; 2008)

¹⁵ UNAIDS/WHO *ibid*

¹⁶ van de Laar (2009)

¹⁷ UNAIDS/WHO *ibid*

¹⁸ ECDC (2009), citing Elford J, Bolding G, Sherr L; Highrisk sexual behaviour increases among London gay men between 1998–2001: What is the role of HIV optimism? *AIDS* 2002;16:15371544

¹⁹ ECDC (2009), citing multiple sources

²⁰ Ayala, G., Beck, J., Lauer, K., Reynolds, R., and Sundararaj, M. (2010) *Social Discrimination Against Men Who Have Sex With Men (MSM): Implications for HIV Policy and Programs*, May 2010, The Global Forum on MSM and HIV (MSMGF), Oakland, CA, United States

²¹ European Centre for Disease Prevention and Control (ECDC); Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2010 progress report: summary. Stockholm: ECDC; 2010

²² UNAIDS/WHO Fact Sheet 2009: *ibid*

²³ van der Gouwe, D., Gallà, M., van Gageldonk, A., Croes, E., Engelhardt, J., van Laar, M., and Buster, M. (2006), *Prevention and reduction of health-related harm associated with drug dependence: An inventory of policies, evidence and practices in the EU relevant to the implementation of the Council Recommendation of 18 June 2003, Synthesis report*, Trimboos Institute Netherlands Institute of Mental Health & Addiction Unit International Affairs, Utrecht The Netherlands

²⁴ ECDC 2010, notes that countries have rich and varied data relating to migrants and HIV, however much of it is qualitative in nature. Relatively few countries have robust, quantitative data available, apart from figures derived from HIV and AIDS case reporting.

²⁵ ECDC (2010)

²⁶ However, ECDC 2010 adds that definitions of the term ‘migrants’ vary considerably across the region

²⁷ ECDC 2010 adds that But there is no compelling evidence that other migrant groups, independent of risk factors such as injecting drug use, are particularly affected by HIV in the region. A number of countries, such as the Czech Republic, Estonia and the United Kingdom reported that a particular ethnic group and/or group of migrants were disproportionately affected by HIV, but this is more likely to reflect injecting drug use (see Section 2.2) than ethnicity or migration per se.

²⁸ See EATG (2007)

²⁹ ECDC (2009) reaches this conclusion, offering an extensive list of EU commitments and actions

³⁰ ECDC (2010)

³¹ ECDC (2010)

³² Scambler and Paoli (2008), citing WHO (2006) estimates that there are probably ‘tens of millions’ of sex workers worldwide, with clients ‘in the hundreds of millions’

³³ Scambler and Paoli (2008)

³⁴ Commission of the European Communities (2009); *Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions: Combating HIV/AIDS in the European Union and neighbouring countries, 2009 -2013* (Brussels, 26.10.2009,

COM(2009)569 final)

³⁵ Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006 Consolidated Version, http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf)

³⁶ European Parliament resolution of 8 July 2010 on a rights-based approach to the EU's response to HIV/AIDS, AIDS/HIV in view of the XVIII International AIDS Conference (Vienna July 18-23, 2010; (<http://www.europarl.europa.eu/sides/getDoc.do?type=TA&reference=P7-TA-2010-0284&language=EN&ring=B7-2010-0412>)

³⁷ These recommendations are made, for example, by TAMPEP (2009)

³⁸ See the European Parliament resolution on HIV/AIDS: early diagnosis and early care 2008, (<http://www.europarl.europa.eu/sides/getDoc.do?type=TA&reference=P6-TA-2008-0566&language=EN>)

³⁹ Charter of Fundamental Rights of the European Union (2000/C 364/01), http://www.europarl.europa.eu/charter/pdf/text_en.pdf, see in particular Article 12, part 1:

Any discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited.

⁴⁰ The Yogyakarta Principles on the Application of international human rights law in relation to sexual orientation, (March 2007; http://www.yogyakartaprinciples.org/principles_en.pdf)

⁴¹ This global recommendation is made by Ayala et al (2010), who say a collaborative effort led by communities in partnership with global health and development bodies, human rights and legal institutions, and other stakeholders is necessary to identify and repeal existing and emerging criminal laws and other policies targeting lesbian, gay, bisexual and transgender (LGBT) communities.

⁴² This recommendation is evolved from the finding by Davoli (2010), that the Council Recommendation has set a 'benchmark for existing policies' and thus successfully guided and supported policy development in [EU] member states. However, he notes it is still early to assess the real impact of the Council Recommendation on the Member States policies, services and facilities.

⁴³ WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, (WHO, UNODC, UNAIDS 2009; http://www.unodc.org/documents/hiv-aids/idu_target_setting_guide.pdf)

⁴⁴ This is a main element of the Vienna Declaration, the official declaration of the XVIII International AIDS Conference (AIDS 2010) held in Vienna, Austria from 18-23 July 2010; <http://www.viennadeclaration.com/wordpress/wp-content/uploads/2011/04/Vienna-Declaration-Download.pdf>)

⁴⁵ The Global Commission on Drugs (2011), in its report, *War on Drugs: Report of the Global Commission on Drugs Policy*, concludes that “the global war on drugs has failed, with devastating consequences for individuals and societies around the world. (...) Vast expenditures on criminalization and repressive measures directed at producers, traffickers and consumers of illegal drugs have clearly failed to effectively curtail supply or consumption.” Calling for end the criminalization, marginalization and stigmatization of people who use drugs but who do no harm to others, it refers to unintended negative consequences of the war on drugs. Concerning HIV/AIDS, it cites evidence from UNAIDS and other sources suggesting that “countries that implemented harm reduction and public health strategies early have experienced consistently low rates of HIV transmission among people who inject drugs. (...) On the other hand, many countries that have relied on repression and deterrence as a response to increasing rates of drug-related HIV transmission are experiencing the highest rates of HIV among drug using populations.”

⁴⁶ The right to HIV/AIDS prevention, treatment, care and support for migrants and ethnic minorities in Europe: The community perspective; The Lisbon conference Health and migration in the EU (2007)

⁴⁷ International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, Adopted by General Assembly resolution 45/158 of 18 December 1990 (<http://www2.ohchr.org/english/law/cmw.htm>)

⁴⁸ Recommendations listed in the document, International Organization for Migration, *Migration Health: Better Health for All in Europe*, (IOM 2009, <http://www.migrant-health-europe.org/files/AMAC%20Public%20Report.pdf>)

⁴⁹ These recommendations are made by ECDC (2009). They emphasize the principle that undocumented migrants should be covered by public health policies.

⁵⁰ Human Rights Watch, Deutsche AIDS-Hilfe, the European AIDS Treatment Group, and the African HIV Policy Network, *Returned to Risk: Deportation of HIV-Positive Migrants*; (2009 Human Rights Watch; <http://www.hrw.org/en/node/85610>)

⁵¹ See HRW (2009)

⁵² These recommendations come from general recommendations made by European AIDS Treatment Group (2007?). They emphasize the primary importance of human rights principles in responding to HIV/AIDS in Europe.

⁵³ These restrictions are monitored and held on a global database: www.hivrestrictions.org

⁵⁴ These recommendations are derived from TAMPEP (2009), which finds from the evaluation of the national legislations and policies throughout Europe regarding sex work, an alarming extent of criminalisation and exclusion of sex workers. The 'sex work frame', an approach that recognizes sex work as an occupational activity and ensures that it is also endowed with labour and social rights, is only rarely visible and – where implemented – only takes EU citizens into consideration. Migrant sex workers are forced into the dominant discourse on trafficking that spans all of Europe and uses the rhetoric of alleged victim protection to implement restrictive regulations on migration and prostitution. Within this context, migrant sex workers are not perceived as having any agency and their rights as migrants and as workers are constantly being violated by the restrictive policies and practices. This includes the widespread measures that in effect prohibit street prostitution, collective forms of work and support client criminalisation. Separating the discourse around trafficking from the discourse on sex work is a necessary step in order to create an approach centred on the protection of sex workers' rights. This approach must recognise the current transnational reality of sex work and must include sex workers as experts with equal rights in conceptualising and implementing legislation and policies.

⁵⁵ See Tampep (2009)

⁵⁶ These recommendations are made by, and very slightly adapted from, TAMPEP (2009). The study finds sex workers in Europe face practical barriers to public health services, including those referred to above. Between the contradictory contexts of legal status, insurance status and employment status, sex workers are faced with a series of barriers, which make it extremely difficult to access public health services.

⁵⁷ The first recommendation is made by TAMPEP (2009) as a general recommendation. The second recommendation is derived from the finding by Scambler and Paoli (2008), citing the WHO, that the attributions of shame and blame ubiquitously applied with FSW enhance their vulnerability, impair their human rights, and impede attempts by third parties from national governments to NGOs to local health initiatives, to contain the HIV/AIDS epidemic. They also recognize the risk of 'felt stigma,' and find that all studies of chronic and disabling illness, again including those of HIV/AIDS, reveal people who formulate positive strategies and tactics that acknowledge the risks of enacted stigma and deviance whilst trying to avoid the pitfalls of felt stigma and deviance: these strategies and tactics, in our terminology, constitute their 'projects'.

⁵⁸ These recommendations are derived from TAMPEP (2009), which finds that the dominant frames that represent state approaches towards sex work result in a set of laws that centre around the exclusion of sex workers and often make legal prostitution virtually impossible. These regulations that focus on 'prohibition', 'prevention' (of disease, organised crime, abuse, public nuisance) and 'protection' (of the public, the family, of morals and of minors) do not consider the prevention of human rights violations against sex workers and the protection of sex workers. These regulations have a seriously harmful impact on sex workers, their working and living conditions as well as their health and well-being.

⁵⁹ These recommendations are derived from the five [somewhat abstract] ‘orienting themes’ that Scambler and Paoli (2008) say “promise both a comparative understanding of the charges of shame and blame ubiquitously laid at the feet of FSW in the era of HIV/ AIDS, and a social pathway to the accomplishment of the very personal matter of FSW empowerment.”

⁶⁰ These recommendations are made by TAMPEP (2009).

⁶¹ These are based on conclusions by ECDC (2010). They also follow ECDC (2010) findings that almost all countries (84%) report that stigma and discrimination is addressed in national strategies or action frameworks for HIV and AIDS, but this is not consistently reflected in policies and programmes (see Figure 30). There is also strong evidence of residual stigmatisation and discriminatory attitudes in countries of the region and the extent to which available mechanisms, such as relevant laws and policies, are used to combat stigma and discrimination is unclear.

⁶² UNAIDS Policy Brief: Criminalization of HIV Transmission
(http://data.unaids.org/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf)

⁶³ These recommendations flow from the ECDC (2010)’s suggestion that these issues need further action. They are also based on its findings: (i) Prisoners, especially those that inject drugs, are also highly vulnerable to HIV infection in the region. (ii) Although the same HIV services should be available in prisons as in the community, this is not the case in many countries of the region. (iii) EU/EFTA countries have demonstrated a strong lead in providing opioid substitution therapy in prisons (see Figure 23), (iv) but this approach has not been taken up in many other countries of the region and has not been reflected in the provision of sterile injecting equipment in prison settings (see Figure 23).

⁶⁴ ECDC (2010) finds that almost all countries of Europe and central Asia report having structures and systems in place for monitoring their national responses to HIV; however, far fewer have a strategy for assessing the quality and accuracy of data or a budget for the M&E plan. ECDC (2010) also finds the value of international reporting on HIV responses is recognised in the countries of Europe and central Asia; high response rates are possible when countries are approached with relevant indicators by a trusted regional organisation and in a way that takes account of previously submitted data; and lessons can be learned for UNGASS reporting and other international reporting processes.

⁶⁵ This recommendation is derived from a widespread concern about coherence between policies toward populations most affected by the HIV epidemic and other policies. ECDC (2009) call for upholding and clarifying the health rights of migrants in the context of immigration control policies. TAMPEP (2009) stress that anti-trafficking policies should not be used as instruments to target sex workers, while Scambler and Paoli (2008) reject the presumption that all migrant sex workers are trafficked. Further, there is a need to make harm reduction policies more coherent with broader health and social services. Davoli et al (2010) says that harm reduction programmes on the ground need to move beyond single interventions delivered in isolation, to a comprehensive set of interventions linked in with broader health and social services. van der Gouwe et al. (2006) suggest that States should consider placing greater emphasis on the further integration of harm reduction in a broader public (mental) health and social care and welfare policy,

⁶⁶ Concerning the need to scale up services, Ayala et al (2010), for example, note “striking evidence that gay men and other MSM have been left behind” in relation to Universal Access to HIV prevention, treatment, care and support, a significant component of the Millennium Development Goals. ECDC (2010) also points to evidence in many countries that HIV transmission among IDU can be controlled if effective services are provided “on a sufficient scale to make a difference”.

⁶⁷ TAMPEP (2009) finds “great shortcomings in the accessibility of public health care systems” in the 25 European countries included in their study, none of which show any integrative approaches to protecting the rights of sex workers. Undocumented and/or uninsured sex workers are explicitly excluded from most of the systems. Most of the public health systems rely on a person’s citizenship, legal status, residence status and/or insurance status.

⁶⁸ TAMPEP (2009) finds combined factors that create a specific type of vulnerability that endangers the life, health and well-being of migrant sex workers. First, in most of the 25 European countries in their study, sex work is not legally recognised or regulated as a form of labour for nationals or migrant sex workers. Therefore, there are hardly any regulations that refer to migrant sex workers in any of the national legislations. At the same time, migrant sex workers are also affected by restrictive immigration legislations throughout EU countries. This lack of legal protection for sex workers and the explicit exclusion of migrants contribute to the vulnerability of migrant sex workers. Second, in countries with legal regulations on sex work, migrant sex workers from EU countries and those from non-EU countries are treated differently. Non-EU citizens are largely excluded from the possibilities for establishing residence and finding legal employment within the EU. Third, the dominant framing of migrant sex workers as victims of trafficking and the frequent equation of migration for sex work and trafficking further increases the vulnerability of migrant sex workers. Fourth, migrant sex workers – regardless of their legal status – frequently experience criminalisation and often racist discrimination. Further, access to HIV/AIDS testing and treatment for sex workers is implemented in different manners in the 25 European countries, including major barriers to accessing public treatment services whose fees are based on the person’s insurance status.

⁶⁹ The Council Recommendation (EC 2003) urges EU States to consider making available to people who use drugs in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison. van der Gouwe et al. (2006) also find that maintenance or substitution treatment may be a feasible treatment option in prisons, provided that adequate dosages are distributed during the entire imprisonment period. Both methadone and buprenorphine are effective in reducing injecting drug use, needles sharing, and transmission of infectious diseases. These maintenance treatments probably also improve the health situation of drug using prisoners.

⁷⁰ This refers to the principle of equivalence

⁷¹ Vaccination is not available for Hepatitis C

⁷² UNAIDS (2009) reports that early HIV diagnosis remains a challenge in high-income countries; for Europe as a whole, between 15% and 38% of HIV-positive people are diagnosed late. In France and the UK, people with heterosexually acquired HIV are most likely to be diagnosed late. Yet TAMPEP

(2009) finds that in most of 25 European countries, HIV testing and counselling are available free of charge, voluntary and anonymous, regardless of one's legal or insurance status.

⁷³ ECDC (2010) finds that obstacles to treatment still exist for key populations in many countries of the region, particularly for IDU, migrants and prisoners. Since 2004, there has been an increase in the number of PLHIV receiving ART in some countries of the region, but these increases took place from a very low base in those countries. Ball (2010) also notes increasing evidence that people living with HIV who use drugs can achieve good outcomes with antiretroviral therapy; that harm reduction programmes should benefit from new developments in HIV/AIDS treatment, care and support; and there is a need to develop effective approaches to HCV infection which is found virtually universally at high prevalence among drug injectors across Europe. van der Gouwe et al. (2006) note that maintenance or substitution treatments with methadone or buprenorphine are effective in reducing opiate use and related risk behaviours, and in keeping opiate users in treatment. Davoli et al. (2010) note that current treatments for HIV/ AIDS, hepatitis B and C and tuberculosis (...) are all effective in reducing drug-related infectious diseases.

⁷⁴ Concerning stigma and discrimination, Ayala et al (2010) say that scaling up HIV services and information to a level of universal access for gay men and other MSM – and for all communities, for that matter – requires that each one of us not only understand the role of stigma and discrimination in driving the epidemic, but also that we re-position this issue as an essential pillar of the HIV response. Concerning young people, ECDC (2010)'s suggests that these issues need further action, since it remains contentious how much young people in general are vulnerable to HIV infection in countries of the region. It is clear that young people cannot be considered a homogeneous group in terms of HIV risk. Some are at significant risk, e.g. young IDU and young MSM and there is some evidence that programmatic responses are less able to reach these groups than older age groups. Although more than three quarters of countries reported that HIV education is part of the curriculum in secondary schools, comprehensive sexual health education is not available for all young people in the region, particularly for the youngest, e.g. in primary schools.

⁷⁵ ECDC (2010) finds that almost all countries of Europe and central Asia report have structures and systems in place for monitoring their national responses to HIV. For example, 85% of countries report that they have or are developing a national monitoring and evaluation plan. However, some elements of these plans are better developed than others. While almost all countries have systems for HIV and behavioural surveillance, far fewer have a strategy for assessing the quality and accuracy of data or a budget for the M&E plan. ECDC (2010) finds that although sex workers are seen as being particularly at risk of HIV infection globally, there is less evidence that this is the case in the region. For example, HIV prevalence rates among sex workers are relatively low in many countries. However, this is not true of all sex workers. Some categories of sex workers have higher rates of HIV infection, including those who also inject drugs, male and transgender sex workers, those from countries with generalised epidemics and those who work on the street. Among sex workers as a whole, reported rates of condom use during commercial sex are relatively high and probably more relevant than generic measures of knowledge and programme coverage. Tikkanen (2007) finds that research on the needs of MSM is very important and can form the basis of effective HIV prevention interventions adapted to specific subgroups of MSM. The six international research reviews all stress

the importance of adapting HIV prevention interventions to the particular needs of various MSM subgroups.

⁷⁶ WHO, UNODC, UNAIDS Technical Guide (2009) for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users.

⁷⁷ While ECDC (2010) concludes that these issues need further action, UNAIDS data indicate that fewer than 40% of young people have basic information about HIV and less than 40% of people living with HIV know their status; and that the number of new HIV infections continues to outstrip the numbers on treatment—for every two people starting treatment, a further five become infected with the virus. In addition, the effectiveness of prioritized prevention activities is underscored by lessons that in Europe, mother-to-child HIV transmission has been virtually eliminated, and that high coverage of services to prevent mother-to-child HIV transmission has now been achieved in Eastern Europe and Central Asia. One of the biggest achievements in the AIDS response in the region has been the high coverage of services to prevent mother-to-child HIV transmission. In December 2008, the coverage of services to prevent mother-to-child transmission exceeded 90% in Eastern Europe and Central Asia.

⁷⁸ ECDC (2010) finds that financing for national HIV responses in the region is coming increasingly from domestic sources. Given the global financial crisis, the increased focus on the poorest countries with the largest burden of HIV infection and the increasing focus on strengthening health systems, low- and middle-income countries in the region are concerned about the likelihood of current funding streams (such as those from the Global Fund) to these countries being sustained. There is also evidence that many countries in Europe and central Asia have appropriately focused their HIV responses on key populations affected by the epidemic. However, this focus is not seen clearly in all countries. Injecting drug users remain vulnerable to HIV infection across the region. There is evidence of rising rates of HIV infection among MSM in many countries, not only in the western part of the region. Ayala et al (2010) find that multiple stigmas/layers of social discrimination complicate MSM access to services; besides sexual orientation, MSM may be stigmatized on account of additional identities as migrants, sex workers, drug users, or people living with HIV. In many cases, stigma and discrimination pervade the very systems that deliver HIV treatment, care and support services. Discrimination against MSM living with HIV may reduce their (crucial) involvement in prevention efforts

⁷⁹ Concerning harm reduction, Davoli et al. (2010) indicate that where a lack of robust evidence exists to make confident judgements, policy-makers will be forced to make pragmatic choices. They may do so on the basis of evidence that interventions are (a) not producing harm to those that receive them or to the wider community, and (b) are reaching their intended recipients, who are appearing to benefit from well-constructed measures. .

⁸⁰ Concerning harm reduction, Davoli et al. (2010) emphasize that the absence of evidence does not necessarily justify the absence of action. ‘Values’ have to be taken into account. The challenge for the research community is to provide policymakers with a higher degree of certainty that the policies and actions they pursue are more likely to reduce rather than augment harm. RCT is ‘gold standard’ for evaluation of effectiveness, but it is not easy to use for harm reduction interventions,

which take place in real world settings where other interventions may also be taking place, confounding variables are difficult to control for, and outcomes may be complex to interpret and difficult to measure. It is also hard to apply to social policy, where practical, methodological and ethical challenges exist to developing convincing RCT study designs.

⁸¹ ECDC (2010) observes that countries of Europe have large quantities of data available concerning their responses to HIV, and analyses of these data provide a rich picture of the nature and diversity of responses to HIV in the region. However, the degree to which this is used to focus national responses on populations most affected by HIV varies markedly across Europe and central Asia. Ball (2010) notes that new developments in biomedical technologies have implications for how harm reduction programmes might be structured in the future. Concerning HIV counselling and testing, Tikkanen (2007) finds that its effectiveness in prevention is unclear. The results are contradictory. Additional research and methodological development are needed.

⁸² Concerning the effectiveness of services for MSM, Tikkanen (2007) finds that group-level interventions are particularly effective; multi-component interventions are more effective than single-component interventions; multi-session interventions, or single-session interventions that last for at least four hours (such as a half-day workshop), are most effective; the inclusion of peer educators and popular opinion leaders is a successful component of HIV prevention intervention; and interventions containing a cognitive element generate favourable results.

⁸³ Concerning IDU, Ball (2010) outlines a set of priority harm reduction interventions that reflect the nine priority interventions in the broader package defined by the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The global economic downturn, competing public health and development priorities, and calls for prioritisation of investments and definition of essential packages of interventions may be an opportunity to bring greater focus to harm reduction work; however, such prioritization must not compromise public health goals of universal access, health equity and social health protection. Davoli et al. (2010) find that IEC may enhance effectiveness of other interventions, although it is uncertain whether merely the delivery of relevant information, education and communication (IEC) is effective to prevent drug-related infectious diseases among injecting drug users.

⁸⁴ Concerning MSM, ECDC (2009) find that rigorous outcome evaluations of any form of behavioural HIV/STI intervention for MSM in Europe are far and few between. Concerning IDU, van der Gouwe et al. (2006) find that across EU, few States use funding criteria as an instrument to promote quality and evaluation; require needs assessments, and collect information about good practice. Only a limited number of States report examples of evaluation schemes that are designed to inform policy. It seems that the evaluation culture is well developed in countries in North-Western Europe, i.e. in Member States such as the United Kingdom, the Netherlands, Luxembourg and Germany. The strengthening of an evaluation culture by providing training to staff and by involving stakeholders in evaluation processes is still a point of attention for Member States.

⁸⁵ ECDC (2010) finds there has been an almost fivefold increase in funds available for the global response to HIV since the Dublin Declaration. In 2008, 40% of all disbursements for international

AIDS assistance from donor countries came from European Union Member States, European Free Trade Association (EFTA) countries and the European Commission. Given the current global financial crisis and competing priorities for funding, it could be challenging for European countries and institutions to maintain and further increase these levels of funding; however, this funding support needs to be sustained and there is a need for all countries to show the same level of commitment to this as has, to date, been shown by a rather small number of EU and EFTA countries. Indeed, UNAIDS suggests that the global funding of HIV services may not be meeting requirements. In 2008, US\$ 15.6 billion was estimated to be available from all sources for HIV. For 2010, UNAIDS estimates that US\$ 25 billion will be needed for HIV services.

⁸⁶ Concerning MSM, for example, Ayala et al (2010) state that anti-stigma initiatives are critical to improving access to HIV-related services for MSM. Given recently available data showing increased trends of HIV prevalence among MSM worldwide, there is significant need for investments in programs and initiatives to mitigate the impact of the epidemic in this population.

⁸⁷ ECDC (2010) observes that financing for national HIV responses in the region is coming increasingly from domestic sources. Given the global financial crisis, the increased focus on the poorest countries with the largest burden of HIV infection and the increasing focus on strengthening health systems, low- and middle-income countries in the region are concerned about the likelihood of current funding streams (such as those from the Global Fund) to these countries being sustained. There is evidence that many countries in Europe and central Asia have appropriately focused their HIV responses on key populations affected by the epidemic. However, this focus is not seen clearly in all countries. Injecting drug users remain vulnerable to HIV infection across the region. There is evidence of rising rates of HIV infection among MSM in many countries, not only in the western part of the region. Finally, these recommendations seem to correlate with the epidemiological data provided by UNAIDS (see introduction above).

⁸⁸ This recommendation is based on a conclusion by ECDC (2010). It notes a number of compelling reasons to make this shift:

- Harmonised indicators that are more epidemic- and region-specific. Harmonising indicators should also mean there are fewer of them which would reduce the reporting burden for countries.
- The ability to identify and provide countries with clearly defined benefits of reporting, e.g. shared learning, inter-country benchmarking and regional analysis of issues that affect multiple countries.
- The ability of international bodies such as ECDC and WHO Regional Office for Europe to provide enhanced support for the reporting process.
- Higher response rates from countries in the region.

⁸⁹ This recommendation is derived from the finding by ECDC (2009) that programme planners and policymakers need descriptions of specific interventions and quantitative estimates of intervention effects to make informed decisions concerning prevention funding and research. There is a need for

a systematic review that updates the current knowledge base about HIV/STI preventive interventions targeted at MSM in Europe.

⁹⁰ These recommendations are made by ECDC (2010), who state:

(i) It is well known that MSM have been particularly affected by HIV in certain countries and regions, including parts of Europe.

(ii) MSM are particularly affected by HIV not only in the western part of the region, but there is also evidence that they are more affected than previously recognised in other parts of the region and that, in some countries, infection rates among MSM are continuing to rise.

(iii) Coverage remains low in many countries and rates of unprotected anal sex remain unacceptably high among some MSM.

(iv) There is also evidence from some countries that particular groups of MSM – the young, those outside capital cities, those who are less well educated and those who identify themselves as bisexual – are less likely to be reached by HIV programmes.

⁹¹ These recommendations are made by ECDC (2010). The focusing of public health on HIV prevention appears to stem from the recognition that HIV is among infectious diseases associated with problem drug use, that HIV infection is life-threatening, and that HIV generates social costs, if untreated. The recommendations are also related to the finding that there are multiple intervention points where HIV risk and harm can be reduced; however most harm reduction programmes still focus on a limited number of interventions, particularly those that target specific HIV risk behaviours (ECDC 2010). They are also linked to the finding that needle and syringe exchange (with testing/counselling, and outreach) are probably effective in reducing the transmission of HIV.

⁹² These are based on explicit suggestions made by ECDC (2010) and reflect several related findings: First, financing for national HIV responses in the region is coming increasingly from domestic sources. Second, given the global financial crisis, the increased focus on the poorest countries with the largest burden of HIV infection and the increasing focus on strengthening health systems, low- and middle-income countries in the region are concerned about the likelihood of current funding streams (such as those from the Global Fund) to these countries being sustained. Third, there is evidence that many countries in Europe and central Asia have appropriately focused their HIV responses on key populations affected by the epidemic. However, this focus is not seen clearly in all countries. Injecting drug users (Section 2.2) remain vulnerable to HIV infection across the region. There is evidence of rising rates of HIV infection among MSM (Section 2.3) in many countries, not only in the western part of the region. Finally, these recommendations seem to correlate with the epidemiological data provided by UNAIDS (see introduction above).