COMMISSION WORKING PAPER

COORDINATED AND INTEGRATED APPROACH TO COMBAT HIV/AIDS WITHIN THE EUROPEAN UNION AND IN ITS NEIGHBOURHOOD

1. OVERVIEW

The HIV/AIDS epidemic has been a key focus of concern and action for public health policy for the last twenty years. The European Union and its neighbouring countries now face the threat of a new epidemic. Parts of Europe have the fastest rate of new HIV/AIDS cases in the world. Figures released this year by UNAIDS have confirmed that the numbers of new infections are increasing throughout the 25 EU Member States, particularly in the 15-25 age group. In parts of the region, the transmission pattern is also changing and a rapid rise of new infections among intravenous (IV) drug users can be observed.

This new development presents a Europe-wide threat that requires a European response. The epidemic can only be countered through a co-ordinated approach with sustained political leadership and a re-focusing of attention by the European Union, its Member States, neighbouring countries, and partner organisations.

This response does not start from scratch. Cooperation among Member States at the European Union level has played an important part in containing earlier waves of the epidemic. The EU has funded projects and established networks to link public authorities, NGOs and stakeholders across the Member States to accelerate the dissemination of best practice and to address specific challenges faced by vulnerable groups (notably migrant populations, sex-workers, men who have sex with men, injecting drug users, prisoners, young people and the sexual partners of HIV positive individuals). The EU has also funded a range of longer term research projects.

In order to draw attention to the new threat posed by the rising HIV/AIDS epidemic in the European Union and its neighbouring countries, the Irish Presidency hosted the Dublin Ministerial Conference from 23-24 February 2004 entitled “Breaking the barriers – Partnership to fight HIV/AIDS in Europe and Central Asia”. The Conference declaration identified the need for a strong leadership, focus on prevention, combating stigma and discrimination of people living with HIV/AIDS, and building effective partnerships.

In June 2004 the European Council called for “… vigorous follow up by the Union and relevant regional bodies on the outcome of the Ministerial Conference on HIV/AIDS in Europe and Central Asia hosted by the Presidency in Dublin on 23/24 February”.

On the basis of an assessment of the renewed problem the enlarged EU and its neighbouring countries are facing, this paper aims to offer a synthesis of best practice in combating the latest wave of the epidemic, and suggests operational “Vilnius

action points", stretching to the end of 2005. Once a consensus is reached on these suggestions, this document should serve as the basis for priority setting and funding by concerned actors at all levels and will thus contribute to the forthcoming refocused EU approach to combat HIV/AIDS.

The underlying motivation behind this coordinated and integrated approach is the need for all public actors across the Member States of the European Union and its neighbouring countries to give a strong lead: there must be a self confident and positive common approach to address the challenge. Too often in the past, stigma and ignorance have fuelled the AIDS epidemic by driving the problem underground. This has been particularly devastating when political leaders have not acknowledged and confronted the HIV/AIDS threat in a timely manner.

At the same time, the European Union continues to act in developing countries and at global level. The EU and its 25 Member States together provide 55 percent of the funding for the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM). The Commission will shortly issue a progress report on the Programme for Action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction. The Commission will also issue a Communication which will set out a comprehensive EU/EC policy framework for confronting HIV/AIDS, tuberculosis and malaria globally.

2. THE NATURE OF THE PROBLEM IN THE EUROPEAN UNION AND IN ITS NEIGHBOURING COUNTRIES

The HIV/AIDS epidemic was first identified in the early 1980s in North America and Western Europe, spreading mainly among men having sex with men. At the global level, roughly 24 million people – including almost 5 million children – have already died since the beginning of the epidemic. Vigorous efforts to halt the epidemic were initiated by some governments and international organisations and through the involvement of people living with HIV/AIDS. These efforts focused primarily on the dissemination of information and the involvement of partners. This played an important role in preventing new infections, developing access to care, and raising awareness on HIV/AIDS.

European work on HIV/AIDS surveillance started in 1984, covering the reporting of AIDS cases in 17 countries. Now this network, called EuroHIV, financed by the European Community, covers 51 member countries of the World Health Organisation. Most European countries have also introduced notification requirements for HIV seropositivity.

Towards the end of the 1990s the HIV/AIDS epidemic in Western Europe stabilised and rates of new infections decreased. This was mainly due to the strong political commitment and awareness, which lead to the establishment of effective prevention programmes. The introduction of powerful antiretroviral drugs on a large scale in 1996 changed the picture of the disease in one aspect: the annual incidence of AIDS and the number of AIDS deaths decreased dramatically. By contrast, until 1994 only a small number of cases of HIV/AIDS had been reported from the Russian Federation and the CIS countries, most of them among men having sex with men. This started to change in 1995, with a large HIV outbreak among IV drug users in

Belarus, followed by the same type of outbreaks in Kaliningrad and other parts of the Russian Federation.

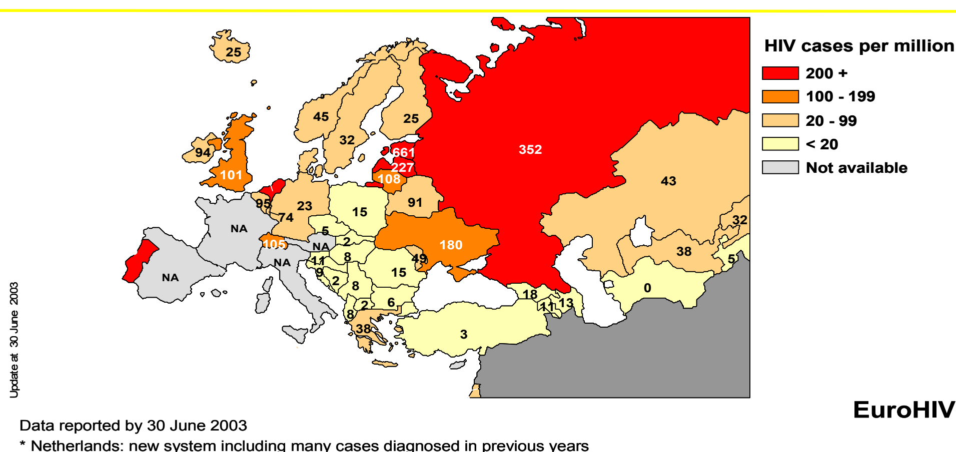

Figure Newly diagnosed HIV infections: cases reported in 2002 per million population in Europe.

The stabilisation in **Western Europe** proved to be only temporary. In spite of the availability of diagnostic tools and access to treatment and care, the number of newly reported HIV cases has doubled in Western Europe from 1995 to the present day. There are indications that prevention efforts are faltering in several countries. Although IV drug use is a prominent factor in the epidemics of several countries (France, Italy, Portugal and Spain), the dominant route for transmission remains sexual.

During recent years, some Western European countries have reported outbreaks of HIV/AIDS among IV drug users. At the same time, the cases of other sexually transmitted diseases, like chlamydial infections and gonorrhoea, have been increasing among young adults, showing a resurgence of unprotected sexual behaviour among young people. The picture is complex with regional disparities across all 25 Member States of the European Union. However, even in those countries and regions which to date have been largely spared from HIV/AIDS, high levels of drug-related and unprotected sexual behaviour are the forerunners of emerging epidemics.

The situation in the **new EU Member States** is more diverse. In the Baltic States the rates related to new cases of HIV infections have risen dramatically, with the HIV prevalence of 1.0 percent in Estonia and 0.4 percent in Latvia in 2001. This is particularly relevant for young people: up to 80 percent of people infected with HIV are under 25 years of age. Epidemiological trends in Central (Czech Republic, Hungary, Poland, Slovakia, and Slovenia) and South Eastern Europe (Turkey, Bulgaria , Romania, the former Yugoslav Republic) differ sharply from those in the Baltic States and in the CIS. Trends in newly reported HIV cases and AIDS deaths over the past decade have stabilised at low levels. According to the 2001 UNAIDS

data, none of these countries reported prevalence rates above 0.1 percent. By contrast, prevalence rates in Western Europe at the end of 2003 average 0.3 percent.

At the same time, the rate of new infections in the **Russian Federation, Ukraine, Belarus and other neighbouring countries** has been the highest in the world. Here the route of transmission is mostly sharing needles and other equipment when injecting drugs. In Russia and in Ukraine, one adult in every hundred is infected (a fifty fold increase in 10 years). At these levels of infection, the virus is spreading also in the general population and it is more difficult to follow and prevent.

In terms of response, within the European Union in general, the main challenge is to prevent the slackening of safer sex practices, to improve access to HIV testing and health care for all, and in particular for migrant and excluded populations, and to maintain prevention activities as a priority.

In the neighbouring countries and in some Member States where the growth of the epidemic is rapid and concentrated among IV drug users in unfavourable socio-economic conditions, the coverage of risk reduction programmes must be increased. Large-scale heterosexual transmission poses a real risk and interventions targeted at bridging populations, such as sexual partners of HIV positive individuals, are essential in halting the epidemic. At the same time, a significant AIDS epidemic which cannot be discounted given long asymptomatic periods (8-10 years on average) would stretch the resources of health care services. Together with the possible deterioration of the tuberculosis control programmes in these countries, this development calls for vigorous efforts to scale up accessible and affordable health care services.

3. THE RANGE OF ACTIONS

Previous experience in tackling the spread of HIV/AIDS has provided a wealth of information on the range of actions that are required to tackle the spread of infections. These actions fall into three main categories: prevention, treatment and care, and support and partnerships. This section of the paper seeks to outline the minimum key elements where action will be required at various levels if the new epidemic is to be tackled.

These actions can only be implemented through a co-ordinated approach – a partnership between the European, national and regional levels. The majority of these actions are not within the responsibility of the European Union or global level institutions, but for individual countries to take. The various elements are included to provide a "toolbox" for action where the Commission could offer to assist those who are primarily responsible.

3.1. Prevention of new HIV-infections

Prevention remains one of the cornerstones in the battle against the spread of the HIV/AIDS epidemic. However, developing and implementing effective prevention strategies is difficult because HIV is a moving target and difficult to contain in many vulnerable groups. Prevention programmes must be multifaceted, piloted in an epidemiologically sound, culturally relevant and evidence-based way, and ultimately

reach the whole population. Prevention programmes should also be combined with easy access to information, counselling, treatment, and social services.

3.1.1. Prevention of sexual transmission of HIV

The main elements to prevent the sexual transmission of HIV are awareness raising, solid and evidence-based information, and making available male/female condoms.

Information campaigns should be a prerequisite for more targeted interventions. Effective communication can inform and change attitudes and put people into a position to make properly informed choices. In many cases and in vulnerable and fragile populations in particular, information about sexual transmission is not sufficient without empowerment and negotiation skills. Hence, information campaigns should be accompanied by adequate skill building interventions wherever experience indicated the necessity and effectiveness of such."

HIV/AIDS is linked with stigma and discrimination, and is often met with suspicion and ignorance. Inadequate awareness and insufficient evidence-based information breed ineffective and politically harmful responses to HIV/AIDS.

Condoms are, to date, the most effective method of preventing HIV infection for both men and women. They also prevent sexually transmitted infections (STIs), reducing the risk of HIV linked to them. However, distribution is still patchy, supplies are erratic and prices vary.

Male and female condoms should be made easily accessible through small shops, bars, vending machines, workplace restrooms and more traditional outlets at affordable prices. Advocacy for the development of microbicides and other woman-controlled methods of contraception is also needed.

3.1.2. Prevention of transmission via IV drug use

Preventing HIV transmission via IV drug use should be part of a global strategy to counter drug dependence. The EU Drugs Strategy 2000-2004 includes a target to reduce substantially the incidence of drug-related health damage like HIV-infection. The Council Recommendation[1] on the prevention and reduction of health-related harm associated with drug dependence outlines best practices. These measures have demonstrated to be efficient in reducing drug-related death and serious health problems, notably HIV/AIDS and hepatitis B and C infections.

Information and counselling should be made accessible to drug users to promote risk reduction and to facilitate their access to appropriate services. Communities and families should be involved in this prevention work and a strong emphasis on outreach work is needed. Comprehensive substitution treatment, supported by psycho-social care should also be provided. Distribution of needles and syringes, including exchange programmes and exchange points should be established, and an appropriate integration between health and social primary care, and specialised approaches in risk reduction should be organised.

[1] Council Recommendation of 18 June 2003 on the prevention and reduction of health related harm associated with drug dependence OJ L 165, 03/07/2003, p. 31

3.1.3. *Mother to child transmission*

It is estimated that worldwide some 800 000 newborns contract HIV each year by vertical transmission. In the European Union, due to widely implemented programmes to reduce the risk of vertical transmission the number of HIV-infected newborn babies has decreased during the last decade. In neighbouring countries, where the prevalence of young HIV-infected women is increasing sharply, preventing mother-to-child transmission will be an important issue in the near future.

Programmes to reduce mother-to-child transmission rates can be very effective and inexpensive. Approaches that have proved to be successful focus on the prevention of HIV/AIDS among prospective parents, and on careful obstetric management and antiretroviral treatment of women living with HIV/AIDS. To achieve this requires women of child bearing age and their partners to have access to HIV prevention services, reproductive health services, and maternity clinics. Voluntary counselling and testing, birth control, and the availability of anti-retroviral (ARV) treatment and other preventive interventions are important.

ARV treatment is very effective in reducing the risk of mother-to-child transmission, with minimal side-effects, and at very low cost. However, preventing the infection of infants is only one element– treating their mothers is as crucial.

3.1.4. *Safety of blood transfusions, tissues, cells, and organ transplantations*

Ensuring blood safety is one of the most cost-effective and non-controversial HIV/AIDS prevention activities. Patients requiring blood transfusions or transplants of tissues, cells, or organs can be efficiently protected by following the standards set by EU legislation. The Treaty specifically requires the Community to ensure a high standard of quality and safety of organs and substances of human origin, including blood and blood derivatives.

The Community's legislative framework for blood[2] addresses the quality and safety requirements related to blood and plasma donations and puts in place requirements for the collection, testing, processing, storage, and distribution of human blood and blood components, quality and safety standards, as well as traceability procedures.

EC Directive 2004/23/EC sets out quality requirements related to the donation, procurement and testing of tissues and cells as well as standards for tissue establishments in order to ensure a comparable level of safety throughout the EU. Traceability standards are also introduced.

3.2. Reducing the negative impact of the epidemic

People living with HIV/AIDS often have complex health and social needs. HIV infection might be only one of their health problems and for some, their ability to maintain their health is adversely affected by social and economic factors, the lack of

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2 Directive 2002/98/EC of the European Parliament and of the Council of 27 January 2003 setting standards of quality and safety for the collection, testing, processing, storage and distribution of human blood and blood components and amending Directive 2001/83/EC. OJ L 033, 08/02/2003, p. 30-40

social support, and lack of employment. To improve life expectancy and the quality of life the health care system must provide accessible and comprehensive care.

3.2.1. *Treatment, care, and support*

Treatment, care, and support aim to improve the quality of life for HIV-infected people for as many years as possible. The availability of care and treatment also serves as a strong incentive for those at risk to be tested and know their serological status.

Sustainable health care systems

An affordable and accessible health care system is a prerequisite for HIV/AIDS prevention. This includes having trained personnel available for voluntary counselling and testing, monitoring treatment and side-effects, and adherence to treatment. Primary health care systems should serve as a basis for preventive activities (vaccinations, health promotion) or treatments required (infections related to AIDS, tuberculosis). People living with HIV/AIDS and their advocates should be meaningfully involved in planning and monitoring treatment and care services. The development of supporting social services is also of fundamental importance in order to secure sustainable good results.

Education of health professionals

Developing targeted education/training programmes for health professionals should be among the immediate priority actions. In many of countries, there is a lack of trained health care workers to deal with all aspects of the HIV/AIDS epidemic (general knowledge, prevention in different vulnerable groups, treatment etc.).

Access to affordable anti-retroviral (ARV) treatment

Antiretroviral treatment is widely available across Europe. There is concern, however, in some new EU Member States and neighbour countries about the impact of the cost of treatment on health care budgets, taking into account the increasing number of infections and the increasing prices of drugs within the EU.

In the EU neighbourhood the introduction of generic drugs has been the most important factor in reducing the price of ARV treatment. Another often-cited bottleneck is the regulatory process for the evaluation, authorisation and marketing of new anti-HIV medicines, including anti-retroviral treatment. The recent revision of the EU pharmaceutical legislation[3] lays out specific provisions to facilitate and speed-up this process in the case of life-threatening diseases, without compromising public health.

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[3] Regulation (EC) No 726/2004 of the European Parliament and of the Council of 31 March 2004 laying down Community procedures for the authorisation and supervision of medicinal products for human and veterinary use and establishing a European Medicines Agency. OJ L 136, 30/04/2004, p. 1-33 and Directive 2004/27/EC of the European Parliament and of the Council of 31 March 2004 amending Directive 2001/83/EC on the Community code relating to medicinal products for human use. OJ L 136, 30/04/2004, p. 34-57

In the CIS countries, only some 3000 out of the registered 250 000 HIV/AIDS patients are benefiting from ARV therapy, with 70 percent on monotherapeutic regimens administered in the Russian Federation due to home based manufacturing.

3.2.2. Employment strategies for people living with HIV/AIDS

In the world of work, discrimination against workers with known or suspected HIV/AIDS may originate from co-workers, customers, service suppliers or employers. Fear, ignorance, the prejudice surrounding the illness, and a lack of information about the prevention and the transmission of the virus are at the heart of discrimination at work based on HIV/AIDS status. Concerns about the costs that employing an HIV-positive worker may entail, in terms of both declines in productivity and increases in labour costs, also play an important role. Discrimination can take many forms, from the screening of any medical condition that could hamper the prospect of employment while leave to follow medication or treatment can also be restricted.

3.3. Mobilise resources and coordinate efforts

The HIV/AIDS challenge in the European Union and in its neighbouring countries is serious. Therefore, a clear understanding of the changing epidemiological situation together with strong political leadership are required to ensure the appropriate responses are taken.

3.3.1. Leadership and advocacy

The first prerequisite to respond effectively to the changing HIV/AIDS epidemic is to acknowledge its existence and to take specific commitments to combat it. By adopting the Millennium Declaration of 2000 and the Declaration of Commitment adopted at the 2001 UN General Assembly Special Session on AIDS, the foundations for appropriate responses at all levels of society were laid: "*Strong leadership at all levels of society is essential for an effective response to the epidemic. Leadership by governments in combating HIV/AIDS is essential and their efforts should be complemented by the full and active participation of civil society, the business community, and the private sector.*"[4]

3.3.2. Enhance the development of epidemiological surveillance of HIV/AIDS, including data on behaviour and social issues

Surveillance is vital in providing to public health decision makers reliable and timely information to anticipate the size and nature of the epidemic and trends over time. It should provide continuous and comparable data on risk behaviours, information on prevention, care, and treatment services and should also link data from various relevant sources to give a full picture of the epidemic. At the same time surveillance should conform to ethical standards and protect the rights of the individuals covered by it.

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[4] Declaration of Commitment; UN General Assembly Special Session on AIDS, 25-27 June 2001, New York

Good-quality surveillance systems are a pre-condition for an effective response to HIV/AIDS. Unfortunately, even within the European Union the surveillance systems are variable from one country to another and data are insufficient and incomplete.

3.3.3. *Research*

Research activities are critical to prevent and combat the HIV/AIDS pandemic. The development of new and effective drugs, microbicides, and vaccines will only be accomplished through a full commitment to research into HIV/AIDS. Increasing the financial assistance devoted to HIV/AIDS research, creating a real global partnership, and involving the private sector are paramount factors. The application of research results and the universal access to research outcomes will help to reduce the number of new HIV infections, as well as improving the quality of life for people living with HIV and AIDS.

In addition, investment in research activities aimed at increasing understanding of the social, economic, biomedical, clinical, health and public policy aspects of HIV/AIDS should be encouraged.

3.3.4. *Involvement of the Civil Society*

From the very beginning of the epidemic, community based organisations have been leaders in activism, advocacy, empowerment, and providing services. They play a key role in the collective response to HIV/AIDS. In those countries where combating HIV/AIDS has been a success, the role of non-governmental organisations and more generally civil society has been key. Many important cornerstones for effective responses have been developed and are implemented by community based organisations. They have been able to involve people living with HIV/AIDS in their activities, helping to break stigma and discrimination associated with HIV/AIDS. Nevertheless, in many countries there are still obstacles to a greater involvement of civil society in HIV/AIDS prevention programmes.

3.3.5. *Building partnerships*

Partnerships are essential in the fight against the HIV/AIDS epidemic because many of the root causes of HIV lie outside the direct influence of the health care system.

No country is struggling with the HIV/AIDS epidemic in a vacuum. Within the European Union and in neighbouring countries there is a ‘mixture of epidemics’ which in some countries is very recent and in some others is 20 years old. Therefore working together, pooling expertise and best practices is crucial for success. There is also a need to mobilise different actors, including the private sector and trade unions and work together with international organisations active in the field.

4. CO-OPERATION AMONG EU ACTORS

A clear signal was given by the Dublin declaration that leadership and more effective co-operation is required. The European Union and its 25 Member States must now take up this responsibility.

The fight against HIV/AIDS calls for policy actions in many areas, notably public health, pharmaceuticals, trade, social protection, development and external relations. The European Council has highlighted the need for a vigorous follow-up of the Dublin Ministerial Conference. In short, a comprehensive Community strategy is required on HIV/AIDS.

This will only work if all EU actors work together and in harmony with local and international organisations involved in the specific countries. The European Union and its Member States have clear lines of responsibility and competence. This is not in question. Within the EU, surveillance of HIV/AIDS is the responsibility of Member States. The Commission therefore has sought to co-ordinate these efforts and share lessons and best practice widely. For the Union, HIV/AIDS control has been, and continues to be, a key public health priority.

Today, the Community must enhance its efforts and improve co-operation and co-ordination at different levels.

EU actors must work effectively with international organisations involved in the region. Its work with UNAIDS, UNDP and the World Health Organisation is crucial to the success of its work. A wide range of initiatives have been taken on HIV/AIDS such as the Baltic Sea task force on Communicable Disease Control, the EU Northern Dimension Action Plan and the nomination of national HIV/AIDS Ambassadors. The key is to ensure that synergies rather than duplication of efforts are ensured.

The co-ordinated and integrated approach will not work if the respective Non Governmental Organisations (NGO's) are not involved from an early stage. They are the lifeblood of many of the concrete projects on the ground and effective support must be guaranteed. At the same time, the pharmaceutical industry can play a key role on accessible treatment if it has the confidence that reduced pricing will not be abused.

With a view to establishing a coordinated EU approach to meet the common challenge of combating HIV/AIDS, the Commission will seek to help build political leadership as well as assuming a coordination role within the European Union and in the Union's relations with neighbouring countries. The Commission is committed to identifying the problems and to promoting efforts to convince European citizens that these issues need to be addressed. The Commission will work in effective partnership with Member States and neighbouring countries to develop a comprehensive 'regional European HIV/AIDS policy' and to intensify efforts to persuade policy makers at all levels to take the necessary actions.

4.1. Funding

The challenge we face is not without costs. Adequate funding is an essential component of any effective response to the spread of HIV/AIDS. The European Community has programmed through the different instruments over 1.2 billion Euros for the period 2003-2006 in the fight against HIV/AIDS together with malaria and TB. A large number of HIV/AIDS related projects have been funded by the EU including those tackling stigma and discrimination and the challenges facing vulnerable groups. The European Union has also invested heavily in research into

HIV/AIDS and will continue to do so. Currently the EU has allocated 400 Euro million for the period 2003 to 2006. Half of these funds are allocated to the new European and developing Countries' Clinical Trials Partnership.

In neighbouring countries, particularly in the countries of the former Soviet Union (CIS), the Community has provided considerable financial support to the fight against HIV/AIDS through TACIS and other programmes. The Global Fund, which receives over 50 percent of its funding from the European Community and the Member States of the Union, has also been active in the CIS. The Commission has recently announced an additional allocation of 42 million Euro to the Global Fund.

The European Commission believes that access to affordable treatment is an essential component of AIDS control. However, the needs for prevention are as relevant and any strategy on treatment should integrate prevention. Additional spending on prevention is much less costly than dealing with treatment and care. Funding is the perfect example of where partnership across the respective international organisations requires a co-ordinated and integrated approach. However, the solution is not simply to provide additional funding as the only measure of action. While some countries clearly require additional resources, others are struggling to allocate and implement funding that has already provided.

4.2. Commitments

Building on the Dublin Declaration, the Commission commits itself to the following concrete steps over the next eighteen months. The measures outlined in this paper are short term and intended to provide an immediate response.

4.2.1. Prevention of new HIV-infections

Public information

- In December 2004, the Commission will host an open debate among all interested parties on the scope to develop an EU-wide umbrella information campaign, along the lines of recent similar exercises concerning tobacco.

- In 2005, the Commission will run a 'baseline' assessment of public awareness in the EU [25] using the "Eurobarometer" survey.

The Commission will work with interested parties to include an HIV/AIDS component in their youth campaigns for 2005-2006. Furthermore, the Commission will enhance the access of young people to information by drawing the attention of its youth networks to this issue and by establishing a link to related websites in its Youth Portal.

Tailor-made strategies for vulnerable groups

- The Commission will include a special focus on work with vulnerable groups among the priorities for the Public Health Programme in 2005.

- Concerning drug dependence the Commission will continue to work with Member States to ensure full implementation of the 2003 Council Recommendation[5].

- As young people are a vulnerable group the Commission will consider possibilities for enhanced cooperation with a view to taking youth more into account in health policies and risk prevention, further to its White Paper "A New Impetus for European Youth."

- Commission will convene by November 2004 an expert network to develop best practice recommendations on the prevention of mother-to-child transmission, with a view to proposing a Council Recommendation in the course of 2005. This work will be based on guidelines developed under Commission-funded research in recent years.

4.2.2. Reducing the negative impact of the epidemic

Sustainable health care systems

- The Commission has encouraged the newly founded group of Member States on Health Services and Medical Care to include HIV/AIDS needs in the scope of its work.

- The Commission will explore possibilities to support health care infrastructure development through the Structural Funds.

Education of health care personnel

- The Commission will include among the priorities for the Public Health Programme 2005 a focus on the development of tailor-made training curricula for health care personnel/other professionals working on the issue.

Access to affordable anti-retroviral treatment

- The Commission will convene in autumn 2004 a meeting of industry and government representatives to explore options available to support access to affordable anti-retroviral treatment.

- The Commission will implement specific legislative measures in the context of the recent revision of the EU pharmaceutical legislation, to facilitate and speed-up the regulatory process for the authorisation and marketing of innovative medicines against life-threatening diseases, such as new anti-retroviral treatments.

Social inclusion, employment, and health and safety at work

- The Commission will continue to work with Member States to ensure full implementation of the following sets of legislation;

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[5] Council Recommendation of 18 June 2003 on the prevention and reduction of health related harm associated with drug dependence OJ L 165, 03/07/2003, p. 31

- Measures to protect workers from the risks of biological agents, in particular in the medical sector (high risk sector for HIV transmission), where workers must receive an appropriate training on potential risks, precaution to be taken to prevent exposure, hygiene requirements, and use of protective equipment and clothing.

- Measures to improve occupational health for specific types of workers (pregnant women, young people).

- The Commission will continue to work with the Member States to ensure the full implementation of Directive prohibiting discrimination in employment on the grounds of religion and belief, disability, age and sexual orientation

- The Commission will continue to work with the Member States to ensure social and labour market integration, combat social exclusion and discrimination. EU and national financial instruments, including Structural Funds, could be used to support such measures, when appropriate.

- The Committee of the European Social Fund could have a meeting with national HIV/AIDS experts to examine if and how Social Fund within its legal framework could be used for actions to combat HIV/AIDS.

4.2.3. *Mobilise resources and coordinate efforts*

Enhance the development of epidemiological surveillance of HIV/AIDS

- The Commission will host in autumn 2004 a meeting among Member States, relevant surveillance networks, WHO, UNAIDS, and interested neighbouring countries in order to review the existing HIV/AIDS surveillance and a need to develop it towards more comprehensive surveillance, including data on behaviour and social issues.

- The Commission will work with the Member States to improve the protection of individuals regarding the confidentiality on processing of personal data and on the free movement of such data.

- Together with the work done under the 'health information' strand of the Public Health Action programme, and in the framework of the EURO-HIV network, the establishment of the European Centre for Disease Prevention and Control will further contribute to improving the epidemiological surveillance of HIV/AIDS.

Research

- The Commission will promote the participation of the new Member States and countries from EU neighbourhood in networking activities related to HIV/AIDS.

Involvement of Civil Society

- The Commission will include HIV/AIDS in the public health open forum conference 2005 to support the development of civil society's awareness and

capacity to address HIV/AIDS related issues throughout the European Union and in the neighbourhood.

Neighbouring countries

- Taking into account Action Plans agreed with neighbouring countries within the framework of the European Neighbourhood Policy, as well as the relevant Country Strategy Papers and Indicative Programmes, the Commission will, when pursuing project identification through the Annual Work Programmes for TACIS, encourage the inclusion of HIV/AIDS related activities as priorities in such programming documents. It should be noted that measures against HIV/AIDS are already part of the headline goals of ENP action plans.

- The Commission will make the best use of all existing instruments to better address the needs of the partner countries respecting the external aid procedures and mandate for action agreed in the relevant Country Strategy papers and Indicative programmes. This will allow operational services of the Commission to intervene as follows:

  - shifting from ad-hoc project approach towards interventions that are embedded within national strategy, programme of work and expenditure framework jointly agreed with national authorities and other involved partners;

  - where possible and partner country political commitment exists, join forces with other partners under such an approach to pave the way for what could be an example of good practices for neighbouring countries;

  - optimising through a stronger EC involvement on the spot the use of existing instruments co-funded by the EC such as the Global Fund to fight Aids, Tuberculosis and Malaria, where the Commission is strongly involved at various levels.

- On the basis of expressions of interest during the Vilnius Conference the Commission will host in Brussels in November 2004 informal discussions on HIV/AIDS cooperation among interested parties in neighbouring countries. The focus could include how to help these countries to benefit from the support of the Global Fund.

4.2.4. Conclusion

Taken together, the measures outlined in the preceding section aim to make a significant and sustainable contribution towards curbing the HIV/AIDS epidemic in the European Union and its neighbouring countries.

The Commission will ensure it fulfils its responsibilities. But action will only be effective if all actors work together to build an effective partnership to tackle the threat of the epidemic. The epidemic does not respect boundaries – and we must ensure in our response that we do not create our own artificial boundaries.

In order to assess the progress achieved in this field, the Commission will review the outcome of the measures outlined in this paper by the end of 2005.

Table of country-specific HIV/AIDS estimates and data, end 2003

Country	Estimated number of people living with HIVAIDS		AIDS deaths	
	Estimate	*[low estimate – high estimate]*	*Estimate*	*[low estimate – high estimate]*
Eastern Europe and Central Asia	**1,300.000**	**[860.000-1,900.000]**	**49.000**	**[32.000 – 71.000]**
Armenia	2.600	[1.200 – 4.300]	<200	[<400]
Azerbaijan	1.400	[500 – 2.800]	……………	………………
Belarus	……..	[12.000 – 42.000]	……………	[900 – 3.300]
Bosnia and Herzegovina	900	[300 – 1.800]	……………	………………
Bulgaria	<500	[<1.000]	……………	………………
Croatia	<200	[<400]	……………	………………
Czech Republic	2.500	[800 – 4.900]	……………	………………
Estonia	7.800	[2.600 – 15.000]	<200	[<400]
Georgia	3.000	[2.000 – 12.000]	<200	[<400]
Hungary	2.800	[900 – 5.500]	…………...	………………
Kazakhstan	16.500	[5.800 – 35.000]	<200	[<400]
Kyrgyzstan	3.900	[1.500 – 8.000]	<200	[<400]
Latvia	7.600	[3.700 – 12.000]	<500	[<1.000]
Lithuania	1.300	[400 – 2.600]	<200	[<400]
Poland	14.000	[6.900 – 23.000]	…………..	…………….
Republic of Moldova	5.500	[2.700 – 9.000]	…………..	…………….
Romania	6.500	[4.800 – 8.900]	…………..	…………….
Russian Federation	860.000	[420.000 – 1,400.000]	…………..	……………
Slovakia	<200	[<400]	…………..	……………
Tajikistan	<200	[<400]	…………..	…………….
Turkmenistan	<200	[<400]	…………..	…………….

Ukraine	360.000	[180.000 – 590.000]	20.000	[9.600 – 33.000]
Uzbekistan	11.000	[4.900 – 30.000]	<500	[<1.000]
Western Europe	**580.000**	**[460.000 – 730.000]**	**6.000**	**[<8.000]**
Albania	………	…………	………….	……………..
Austria	10.000	[5.000 – 16.000]	<100	[<200]
Belgium	10.000	[5.300 – 17.000]	<100	[<200]
Denmark	5.000	[2.500 – 8.200]	<100	[<200]
Finland	1.500	[500 – 3.000]	<100	[<200]
France	120.000	[60.000 – 200.000]	<1.000	[<2.000]
Germany	43.000	[21.000 – 71.000]	<1.000	[<2.000]
Greece	9.100	[4.500 – 15.000]	<100	[<200]
Iceland	<500	[<1.000]	<100	[<200]
Ireland	2.800	[1.100 – 5.300]	<100	[<200]
Italy	140.000	[67.000 – 220.000]	<1.000	[<2.000]
Luxembourg	<500	[<1.000]	<100	[<200]
Malta	<500	[<1.000]	<100	[<200]
Netherlands	19.000	[9.500 – 31.000]	<100	[<200]
Norway	2.100	[700 – 4.000]	<100	[<200]
Portugal	22.000	[11.000 – 36.000]	<1.000	[<2.000]

Source: UNAIDS, 2004 Report on the global AIDS epidemic