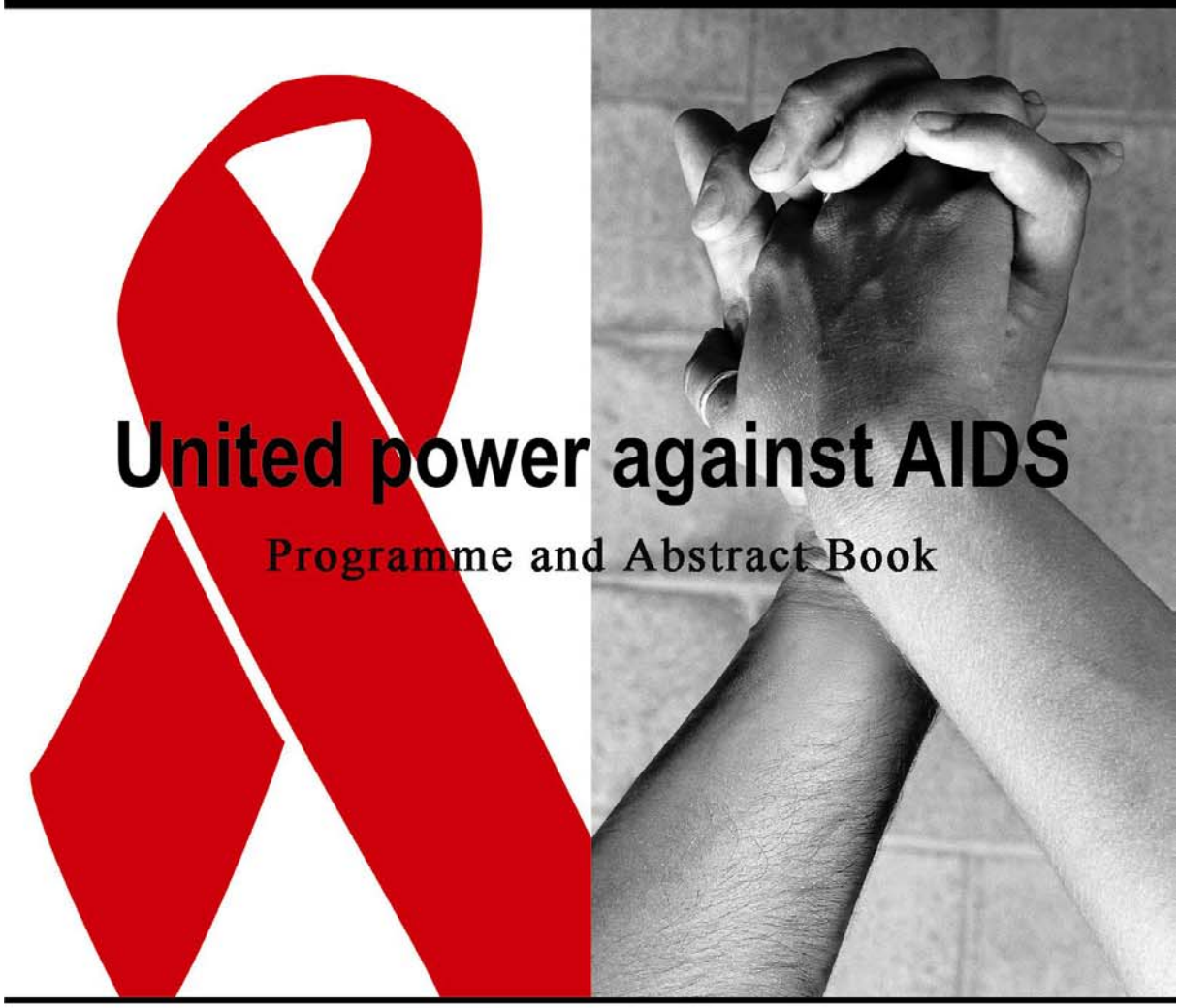
2nd Open Europe AIDS Conference

# "Europe and HIV/AIDS: new challenges, new opportunities"

September 16–18, 2004 Vilnius, Lithuania



# United power against AIDS

## Programme and Abstract Book

Organizers:

GOVERNMENT OF THE REPUBLIC OF LITHUANIA

MINISTRY OF HEALTH OF THE REPUBLIC OF LITHUANIA

AIDS 2nd Open Europe Conference 2004 VILNIUS new challenges, new opportunities

**ORGANISED BY**

European Commission
Government of the Republic of Lithuania
Ministry of Health of the Republic of Lithuania

**IN COLLABORATION WITH:**

UNDP
UNAIDS
WHO
ILO
UNESCO
WORLD BANK

***Under the patronage of H.E. Mr. Algirdas Mykolas Brazauskas, the Prime Minister of the Republic of Lithuania***

**EUROPEAN COMMISSION**
**GOVERNMENT OF THE REPUBLIC OF LITHUANIA**
**MINISTRY OF HEALTH OF THE REPUBLIC OF LITHUANIA**

# 2ND OPEN EUROPE AIDS CONFERENCE
# "EUROPE AND HIV/AIDS: NEW CHALLENGES, NEW OPPORTUNITIES"

September 16-18th, 2004, Vilnius, Lithuania

## Programme and Abstract Book

**VILNIUS**
**PUBLISHING HOUSE OF THE LITHUANIAN AIDS CENTRE**
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## *Dear Colleagues*

It is my great pleasure and honour to invite you to the 2nd Open Europe Conference **"Europe and HIV/AIDS: New Challenges, New Opportunities"** to be held in Vilnius, Lithuania on 16-18th September 2004.

You are welcome to Vilnius - the capital of Lithuania. It is the largest city in the country. The Old Town, historical centre of Vilnius, is one of the largest in Eastern Europe. The most valuable historic and cultural heritage is concentrated here. The buildings in the old town were built in a number of different centuries; therefore, it is a mixture of all European architectural styles. Because of its uniqueness, the Old Town of Vilnius was inscribed on the UNESCO World Heritage List. Vilnius is also the largest administrative centre in Lithuania with all major political, economic, social and cultural centres. Vilnius is easily accessible by all means of transport from all the capitals and main cities of Europe.

The Conference primary target is to strengthen networking and partnership on HIV/AIDS and related issues among the new EU members that have joined the EU on the 1st of May 2004 and the "old-timers", and further with countries outside EU, and to make effort in helping to adopt the EU policy and way of working in the newcomers. Many current challenges can only be solved by working in partnership with international organisations, ministries of health, and national HIV/AIDS programmes including a wide range of institutions and authorities, building new partnerships with civil society, private enterprises. Therefore the primary target audience for the Conference are policy-makers and other decision makers in the health sector as well as experts in the field of HIV/AIDS prevention and control. More time will be made available for participant discussion. There will be considerable opportunity to exchange information, problems and solutions.

The scientific programme will consist of traditional plenaries to give the opportunity to deliver present state-of-the-art lectures, while the symposia, consisting of mini-lectures on a specific topics, will leave place to debate and exchanges. Poster sessions will also take place during the Conference. The Conference will host a satellite training workshop and a pre-conference training.

We are looking forward to seeing you in Vilnius.

***Juozas Olekas***
***Minister of Health of the Republic of Lithuania***

**Organising Committee**

**Chairman** Vytautas Bakasenas, Director, State Public Health Care Service under the Ministry of Health

Saulius Caplinskas, Director, Lithuanian AIDS Centre

Lina Jakucioniene, Head, Public Relations Department at the Ministry of Health

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Assoc. prof. Saulius Caplinskas (Chair)

Prof. Luc Montagnier, President, World Foundation for AIDS Research and Prevention, France

Prof. Prakash Chandra, Frankfurt University Medical School, Germany

Dr. Martin Donoghoe, WHO

Prof. Christine Katlama, President, European AIDS Clinical Society (EACS), France

Dr. Andrzej Horban, Director, AIDS Diagnosis and Therapy Center, Poland

Prof. Ludmila Viksna, Latvian State Centre of Infectology, Latvia

Prof. Heiko Schneitler, Duesseldorf Health Service, Germany

2nd Open Europe AIDS Conference
**"Europe and HIV/AIDS: New Challenges, New Opportunities"**
Crowne Plaza Hotel, Vilnius, Lithuania
**September 16-18, 2004**

# Programme

**September 13-22, 2004**

**Exhibition of photograph installations** "Doors?!" (Life of a woman with HIV). Venue: Club Gallery "Intro", Maironio St. 3, Vilnius. Opening: 17.00, 13th September.

**September 14-15, 2004**

**Pre-conference training workshop** "Baltic McMaster Regional HIV Training" (conducted by Canadian McMaster University, Kaunas Medical University, Lithuanian AIDS Centre). Venue: "E-guesthouse" , T. Sevcenkos St. 16, Vilnius.

**September 16-19, 2004**

**Training** of the girl group leaders' participating in the project "*Girlpower in Lithuania"*. Facilitator: Mia Hanstrom, "Save the Children", Finland. Organisers: Missing People Families Support Centre, Lithuanian AIDs Centre. Venue: Drop-In Centre at the Lithuanian AIDS Centre, Pasaku St. 1B.

**September 16-18, 2004**

Visits to the organisations active in the AIDS and drug use prevention field in Vilnius (please ask for schedule at the Registration Desk).

**September 15, 2004**

18.00-21.00 Registration

19.00-21.30 **(Saphire) "Uniting our voices and strengths in the fight against HIV & AIDS".** Open meeting for NGOs and networks representing civil society. Organised by AIDS Action Europe, the Pan European NGO Partnership on HIV & AIDS. **Chair:** Ton Coenen, Director, Soa Aids Nederland (STI AIDS Netherlands), member of the AIDS Action Europe Steering Committee.

**September 16, 2004**

8.00-10.00 Registration
10.00 **(Saphire)** Opening. **Chair**: Saulius Caplinskas, Director, Lithuanian AIDS Centre.

- Juozas Olekas, Minister of Health of the Republic of Lithuania.
- Matti Rajala, SANCO, European Commission .
- Henning Mikkelsen, Europe Regional Coordinator, UNAIDS. *"After the Dublin Conference: How we can build a new partnership to fight HIV/AIDS in the European Union and it new neighbourhood?"*

10.30-11.30 **(Saphire)** Plenary "**EU health strategy and policy**".

- Marianne Takki, DG SANCO, EC. *Public Health Strategy.*
- Wilfried Kamphausen, DG SANCO, EC. *HIV/AIDS policy of the EU* .

11.30-12.00 Coffee break **(Lobby Bar, Horizon Bar).**
12.00-13.00 **(Saphire)** Plenary "**HIV/AIDS and related health policy aspects in Community programmes**" .

- Peter Ungar, DG REGIO, EC. *The European Regional Development Fund as partner in the provision of health infrastructures.*
- Manuel Romaris, DG RTD, EC. *6th Framework Programme – research opportunities for the region"*.
- AIDCO (to be confirmed).
- RELEX (to be confirmed).

13.00-14.00 Lunch **(Lobby Bar, Breakfast Hall, Restaurant Seasons)**
14.00-15.30 **(Saphire)** Plenary **"Existing EU programmes and other funded research and/or support networks: policy on integrating new members". Chairs:** Gille Brűcker, Director, Institut de Vaille Sanitaire, France; Christine Katlama, Service of the Tropical and Infectious Diseases, France.

- Gille Brűcker, France. *EuroHIV Project.*
- Christine Katlama*, France. EACS* .
- Georg Brőring, The Netherlands. *AIDS and Mobility project*
- Martine de Schutter, The Netherlands. *AIDS Action Europe*
- Licia Brussa, The Netherlands. *TAMPEP project*
- Grzegorz Stanczak, Poland. *SPREAD, CATCH, WATCH as an example of European collaboration study – principals and proposal for Central/Eastern Europe.*

15.30-16.00 Coffee break **(Lobby Bar, Horizon Bar).**
16.00-17.30 **(Saphire)** Session **"Building partnership and sharing knowledge within and outside EU to address HIV/AIDS"**. Moderator: Cihan Sultanoglu, UNDP Resident Representative in Lithuania.

- Denis Kalmaldinov, Russia. *Partnerships: using advocacy in development of regional policy.*
- Sergey Mysienko, Ukraine. *Cooperation between City Aids Center, Red cross and All Ukrainian Network of PLHWA* .
- Mr. Tomczynski, Poland. PLWA: cooperation with Government, international organisations.
- Andris Gailitis, Ilze Jekabsone, Latvia. *Development of outreach/counseling centers for IDU.*
- Mamasobir Burchanov, Kyrgystan. *IDUs and cooperation with other sectors*
- Raminta Stuikyte, Lithuania. *CEE – Harm reduction and analysis.*
- Galina Kolyada, Andrey Kovylyaev, Ukraine. *Public private partnerships – media/communisations in HIV/AIDS.*
- Farther Dutko, Russian Orthodox church, Russia. *How the church is looking for its place in teh national response.*
- Jacek Kitlinski, Aleksandra Duda, Poland. *EU/neighbouring countries cooperation: South Eastern Poland and Lviv Region, Ukraine.*

16.00-17.30 **(Coral)** Session "**Capacity building on HIV/AIDS interventions. The policy decision making process enforcement".** Laima Bulotaite, Department of General Psychology at Phylosophy Faculty under Vilnius University; Andrey Kozlov, Russia; Ludmila Viksna, Latvian Infectology Centre.

- Frank de Wolf, HIV Monitoring Foundation, the Netherlands. *Monitoring of HIV in the Netherlands.*
- Andrey Kozlov, Russia. *The uncertainty of complementary descriptions of biosocial systems and the theory of compromises.*
- Aleksey Mazus, Moscow AIDS Centre, Russia. *Realisation of strategical approaches in fighting HIV infection in Moscow.*
- Sofia Modigh, Sweden. *Prevention work in the Internet – experience of drug use prevention.*

- Dale Guenter, Canada. *Policy and practice in prenatal HIV testing: what has determinde success and failure in the Canadian experience?*
- Arletty Pinel, Global AIDS, Malaria and Tuberculosis Fund.

17.45-18.30 **(Coral)** Poster Session **"Best practices in Lithuania". Chairs:** Vytautas Vaiciuvenas, Kaunas Medical Univertisy, Lithuania; Robertas Petkevicius, WHO/EURO, Head of Country Office in Lithuania.

18.30 and 18.45 Bus transportation to the city centre. Free time.
20.30 and 20.45 Bus transportation back to the Hotel.

21.00 **Get-together party (Saphire).**

**September 17, 2004**

9.00-10.30 **(Saphire C)** Session "**Key elements in successful responses to HIV/AIDS**". **Chairs:** Mukesh Chawla, World Bank;

- Mary Joy Pigozzi, Division for the Promotion of Quality Education , UNESCO.
- Mukesh Chawla. Sr. Human Development Economist, World Bank. *Economics of HIV/AIDS.*
- Anthony Lisle,UNICEF. *Programming for young people's participation in respnding to HIV/AIDS.*
- Steve Bullock, European Neighbourhood Team, DFID, UK. *UK's HIV/AIDS strategy.*
- Michela Martini. HIV/AIDS and Mobility for the Mediterranean IOM Rome. *Mobility and vulnerability to HIV/AIDS.*

9.00-10.30 **(Saphire AB)** Session **"Comprehensive approach to IDU". Chairs:** Audrone Astrauskiene, Drug Control Department at the Government fo Lithuania, Lithuania;

- Mauro Guarinieri, Chair of the European AIDS Treatment Group, Member of the International Harm Reduction Development Program Advisory Group. *Toward comprehensive approach to IDU. An HIV/AIDS tretament activist agenda.*
- Konstantin Lezhentsev. *Access to HIV tretament and care for drug users.*
- Kerstin Kall, Tomas Hallberg. Sweden. *Harm reduction – is it a successful strategy of combating HIV among intravenous drug addicts?*
- Torkel Moestrud, Department of Infectious Diseases, Generral Hospital Malmö, Sweden. *Physician and a drug user.*
- Darius Dirzys, Baltic American Clinic, Lithuania. *Complex support to the drug users as a key component in the HIV prevention in Lithuania.*

9.00-10.30 **(Coral)** Session "**Clinical management and research of HIV in Europe". Chair:** Gudjon Magnusson, Director, Division of Technical Support, WHO Regional Office for Europe; Andrzej Horban, AIDS Diagnostics and Therapy Centre, Poland.

- Katlama Christine. Service of the Tropical and Infectious Diseases, France. *Current issues in HIV treatment/Management of HIV patients.*
- Lundgren Jens D. Director, Copenhagen HIV Programme, Coordinating Centre of EuroSIDA. *Eastern Europe as a player in clinical HIV research programmes.*
- Martin Donoghoe. Public Health Officer, STIs/HIV/AIDS, WHO Regional Office for Europe. *Access to anti-retroviral therapy in Europe: an overview.*
- Kees de Joncheere. Regional Adviser, Health Technology and Pharmaceuticals, WHO Regional Office for Europe. *Strategies for improving access and reducing prices of ARVs in Europe.*

10.30-11.00 Coffee Break **(Lobby Bar, Horizon Bar)**

10.30-11.00 **(Malachite A)** Coffee/Round table discussion with scientists interested in behavioural and social science research options through the National Institutes of Health

(USA). **Moderator**: Paul Gaist, Health Scientist Administrator, Office of AIDS Research, Office of Director, NIH, USA. **(Language: English, no simultaneous translation will be available)**

11.00-12.30 **(Saphire C)** Session **"Organising prevention and care for marginal population – MSMs, SW**". **Chairs:** Evita Leskovsek. Institute of Public Health, Slovenia.

- Marzena Kulis, Health Operations Officer, World Bank. *Presentation of report:* T*ruck drivers and casual sex. An inquiry into the potential spread of HIV/AIDS in the Baltic region.*
- Evita Leskovsek, Institue of Public Health of Slovenia. *Public health aspect of immigration and human trafficking in East Europe.*
- Oleg Yeriomin, NGO "Vstrecha". *6 years of successful work on preventive maintenance of HIV/AIDS and STI among MSMs in Belarus.*
- Jakob Haff, STOP AIDS Denmark, Denmark.

11.00-12.30 **(Saphire AB)** Session "**Organising prevention and care for marginal population - prisoners". Chairs:** R. Kugys, Prison Department, Lithuania; Ilona Burduja, Moldovan Ministry of Justice; Edoardo Spacca, Cranstoun Drug Services. UK.

- Ilona Burduja, Moldovan Ministry of Justice, NGO Health Reforms in Prisons. *System-wide syringe exchange programme in Moldovan prisons.*
- Edoardo Spacca, European Network of Drug Service in Prisons, Cranstoun Drug Services, UK. *Policies, strategies and interventions with drug users in European prisons.*
- Christer Karlsson, KRIS, Sweden.
- Julijana Rakickiene, Lithuania. *Problems of people with HIV in Lithuanian prisons and possible solutions.*
- Edita Gruodyte, Lithuanian Law University, Lithuania. *Drug using delinquents and HIV: new challenges, new opportunities.*

11.00-12.30 **(Coral)** Session **"Ongoing clinical research programmes in Eastern Europe – an update on EuroSIDA, ESPRIT and SMART**" **Chair**: Jens D. Lundgren, Director, Copenhagen HIV Programme, Coordinating Centre of EuroSIDA.

- Podlekareva Daria. Copenhagen HIV Programme, Hvidovre University Hospital, Copenhagen, Denmark.*HIV-patients across Europe: regional differences in patient characteristics.*
- Ole Kirk, Co-ordinating Centre for EuroSIDA. *Response to HAART in Eastern Europe.*
- Podlekareva Daria. Copenhagen HIV Programme, Hvidovre University Hospital, Copenhagen, Denmark. *Baseline characteristics of patients enrolled in the SMART study.*
- Jens D. Lundgren, Director of Copenhagen HIV Programme, Coordinating Centre of EuroSIDA, Hvidovre University Hospital, Copenhagen, Denmark.*Comparison of HIV-1 infected patients from Poland and other countries enrolled in the ESPRIT study.*

12.30-13.30 Lunch, poster presentations **(Lobby Bar, Breakfast Hall, Restaurant Seasons)**

13.30-15.30 **(Saphire AB)** Session **"HIV/AIDS in the world of work**" . **Chairs:** Sabine Beckmann, Senior Technical Specialist, ILO Programme on HIV/AIDS and the World of Work, Switzerland; Anna Marzec-Boguslawska, Director, National AIDS Centre, Poland.

- Franklyn Lisk, Director, ILO/AIDS, Swtizerland. *Introduction to the ILO/AIDS programme on HIV/AIDS in the workplace, the ILO Code of Practice; combating stigma and discrimination and provision of social benefits in the workplace .*
- Sabine Beckmann, Senior technical specialist, ILO/AIDS, Switzerland. *Comments and discussion.*
- Anna Marzec Boguslawska, Director, National AIDS Centre, Poland. *Challenges for HIV/AIDS, treatment and prevention in Poland.*

- Uwe Oppermann-Brandenburg, Volkswagen, Germany. *Development of Workplace programmes and policies in Eastern Europe: lessons learnt.*
- Aldona Baublyte, Trade Union of Health Workers, Lithuania. *HIV/AIDS and health sector workers- A trade union perspective.*
- Elisabeth Girrbach, GTZ, Germany. *GTZ and its Workplace policy on HIV/AIDS: Lessons learnt from introducing workplace policies in organisations.*
- Svetlana Misikhina, ILO/AIDS Moscow, Russia. *The Socio-economic model on HIV/AIDS in Russia.*
- Yuri Privalov, Ukraine. *HIV/AIDS and the workplace in the context of social-economical development.*

13.30-14.00 **(Malachite A)** Mia Hanström, Save the Children Sweden Kumlinge, Åland, Finland. **Project presentation** *"Girl group - a method to strengthen girls and an important piece in the prevention work, the project "Girlpower in Lithuania***" (language: English, no simultaneous translation will be available)**

14.00-15.30 **(Saphire C)** Joint Session "**Fighting stigma and discrimination as key approach in HIV/AIDS prevention and care/involvement and participation of people living with HIV/AIDS**"/ **"Media analysis and working with media". Chairs**: Georg Bröring, NIGZ/AIDS & Mobility Europe, The Netherlands; Monica Ciupagea, IHRD; Dainius Radzevicius, Chairman of the Lithuanian Journalist Association.

- Monica Ciupagea, IHRD. *Efforts to work with the media.*
- L. Meškauskaitė, Lithuania. *Privacy protection in mass media.*
- Fredrik Michelet, Accredited as Military Representative to OSMTH Delegation to UN Geneva, Norway. "Project of virtual international multidisciplinary academy".
- Susan Cole, UKC – The voice of people living with HIV and AIDS in UK.
- Andrew Harvey, UKC – The voice of people living with HIV and AIDS in UK.

13.30-14.30 **(Coral)** Session **"Methodological issues and practice in second generation HIV surveillance". Chairs:** Irena Klavs, Institute of Public Health of the Republic of Slovenia, Ljubljana, Slovenia; Prof. Tatiana Smolskaya, North-Westerm District AIDS Centre of Russian Ministry of Public Health.

- Irena Klavs. Institute of Public Health of the Republic of Slovenia, Ljubljana, Slovenia. *Second generation HIV surveillance in a low HIV epidemic country, Slovenia.*
- Laura Papantoniou, National AIDS Programme, Ministry of Health, Cyprus. *tudy of the knowledge, attitudes and behaviour regarding AIDS, sex and STD among the adult population of the Limassol towna dnRural areas, Cyprus 2000-2001.*
- Andrzej Horban, AIDS diagnosis and Therapy Center, Poland.*Genotyping in CEE as an example of cooperation between East and West European Countries.*
- Tatiana Smolskaya. North-Westerm District AIDS Centre of Russian Ministry of Public Health, Russia. *HIV/STI and behavioural survey among the street-based female sex-workers in Saint-Petersburg, RF, 2003.*

14.30-15.30 **(Coral)** Round table discussion Epidemiological s*urveillance of HIV/AIDS: experience and perspectives*. **Moderator**: Giedrius Likatavicius, Institut de Vaille Sanitaire, France; Irena Klavs, Institute of Public Health of the Republic of Slovenia, Ljubljana, Slovenia.

15.30-16.00 Coffee break **(Lobby Bar, Horizon Bar)**

16.00-17.00 **(Saphire AB)** Closing

- Gediminas Cerniauskas, Vice Minister of Health of Lithuania. *Short presentation of the adopted Declaration.*
- Rapporteurs. *Summary of work results by track.* *****

17.30-20.00 Chico, Peace Ambassador of UNESCO, and the Gipsy Kings **(Horizon Bar, 16th Floor)**

**September 18, 2004**

10.00-13.00 **(Saphire) Open meeting to discuss common issues to be addressed through the EU programmes for internal and cross-border co-operation.**

## *Conference Tracks

**Track 1:**

### Media, public opinion and policy

1. EU health strategy and policy.
2. Existing EU programmes and other funded research and/or support networks: policy on integrating new members.
3. Capacity building on HIV/AIDS interventions.
4. Fighting stigma and discrimination as key approach in HIV/AIDS prevention and care / the involvement and participation of people living with HIV/AIDS.
5. Media analysis and working with media

**Track 2:**

### Focus Prevention

1. HIV/AIDS and related health policy aspects in Community programmes.
2. Building partnership and sharing knowledge within and outside EU to address HIV/AIDS.
3. Key elements in successful responses to HIV/AIDS .
4. Organising prevention and care for marginal population – MSM, SW.
5. HIV/AIDS in the world of work.

**Track 3:**

### IDU

1. Comprehensive approach to IDU.
2. Organising prevention and care for marginal population – prisoners.

**Track 4:**

### Epidemiology and Clinical management

1. Clinical management and research of HIV in Europe.
2. Ongoing clinical research programmes in Eastern Europe – an update on EuroSIDA, ESPRIT and SMART.
3. Methodological issues and practice in second generation surveillance.

**II-oji atviros Europos AIDS konferencija**
**"Europa ir ŽIV infekcija bei AIDS: nauji iššūkiai, naujos galimybės"**
Viešbutis "Crowne Plaza", Vilnius

2004 m. rugsėjo 16-18 d.

# Programa

2004 m. rugsėjo 13-22 d.

**Instaliacinių nuotraukų paroda** "Durys?!" (ŽIV užsikrėtusios merginos gyvenimas) klube galerijoje "Intro", Maironio g. 3, Vilnius. Atidarymas rugsėjo 13 d. 17.00 val. (dalyvauja parodos herojė).

2004 m. rugsėjo 14-15 d.

**Mokomasis seminaras** "McMaster universiteto Baltijos regiono ŽIV mokymai" (vedėjai: Kanados McMaster universitetas, Kauno medicinos universitetas, Lietuvos AIDS centras). Viešbutis "E-guesthouse" , T.Ševčenkos g. 16, Vilnius.

2004 m. rugsėjo 16-19 d.

**Projekto "Merginų gebėjimų stiprinimas Lietuvoje" merginų grupių vadovių mokymai.** Vedėja: Mia Hanstrom, organizacija "Gelbėkite vaikus", Suomija. Organizatoriai: Dingusių žmonių šeimų paramos centras, Lietuvos AIDS centras. Mokymų vieta: Lietuvos AIDS centro Dienos centras, Pasakų g. 1B.

2004 m. rugsėjo 16-18 d.

Lankymasis Vilniaus organizacijose, dirgančiose AIDS ir narkomanijo prevencijos srityje (registruotis ir gauti tvarkaraštį galima prie registracijos stalo).

2004 m. rugsėjo 15 d.

18.00-21.00 Dalyvių registravimas.

19.00-20.30 **(salė "Saphire") "Vienykime savo jėgas ir balsus, kovodami su ŽIV ir AIDS".** Atviras nevyriausybinių organizacijų ir pilietinės visuomenės bendrijų atstovų pasitarimas. Organizatoriai: "Europos AIDS aktyvistų grupė" (AIDS Action Europe), Europos NVO "ŽIV/AIDS koalicija". Pirmininkauja: Tonas Coenenas, Soa AIDS Nederland (LPI, AIDS Olandija) direktorius, "Europos AIDS aktyvistų grupės" vykdomojo komiteto narys.

**2004 m. rugsėjo 16 d.**

8.00-10.00 Dalyvių registravimas

10.00-10.30 **("Saphire") Atidarymo ceremonija**. Pirmininkauja: S. Čaplinskas, Lietuvos AIDS centro direktorius.

- Juozas Olekas, Lietuvos sveikatos apsaugos ministras.

- Matti Rajala, Europos Komisija.
- Henningas Mikkelsenas, JT AIDS programos Europos regiono koordinatorius. “Po Dublino konferencijos: galimybės stiprinti Europos Sąjungos ir kaimyninių šalių bendradarbiavimą ŽIV ir AIDS prevencijos srityje”.

10.30-11.30 **(“Saphire”)** Plenarinis posėdis “**ES sveikatos apsaugos strategija ir politika**”.
- Marianne Takki, DG SANCO, Europos Komisija. “Visuomenės sveikatos strategija”.
- Wilfried Kamphausen, DG SANCO, Europos Komisija. “Europos Sąjungos ŽIV/AIDS politika”.

11.30-12.00 Kavos pertrauka **(vestibiulio baras, baras “Horizon”)**, stendinių pranešimų peržiūra.

12.00-13.00 **(“Saphire”)**Plenarinis posėdis “**ŽIV, AIDS ir jais susiję sveikatos politikos aspektai Bendrijos programose**”.
- Peter Ungar, DG REGIO, Europos Komisija. “Europos regioninis plėtros fondas - sveikatos infrastruktūros aprūpinimo partneris”.
- Manuel Romaris, DG RTD, Europos Komisija. “VI-ji struktūrinė programa – regiono mokslo tyrimų galimybės”.
- AIDCO (bus patvirtinta).
- RELEX (bus patvirtinta).

13.00-14.00 Pietūs **(vestibiulio baras, pusryčių salė, restoranas “Seasons”)**, stendinių pranešimų peržiūra.

14.00-15.30 **(“Saphire”)** Sekcija **“Šiuo metu vykdomos ES programos ir kiti ES finansuojami mokslo tyrimo bei paramos tinklai: naujų narių integravimo politika”. Pirmininkauja:** Gilleis Bruckeris, Higienos institutas, Prancūzija; Christine Katlama, Infekcinių ir tropinių ligų tarnyba, Prancūzija.
- Gilleis Bruckeris, Prancūzija. “Europos ŽIV projektas”
- Christine Katlama, Prancūzija. “Europos AIDS klinikinė bendrija”
- Georgas Broringas, Olandija. “Projektas “AIDS ir mobilumas”
- Martine de Schutter, Olandija. “Projektas “Europos AIDS aktyvistų grupė” (AIDS Action Europe)
- Licia Brussa, Olandija. “Tarptautinis AIDS ir LPI prevencijos tarp migruojančių prostitučių projektas” (TAMPEP).
- Grzegorzas Stanczakas, Lenkija. “Projektai SPREAD, CATCH, WATCH – bendrų Europos šalių tyrimų pavyzdys – principai ir pasiūlymai Rytų ir Centrinei Europai”.

15.30-16.00 Kavos pertrauka **(vestibiulio baras, baras “Horizon”)**, stendinių pranešimų peržiūra.

16.00-17.30 **(“Saphire”)** Sekcija **“Bendradarbiavimas ir patirties skleidimas ŽIV ir AIDS srityje Europos Sąjungoje ir už jos ribų ”.** Pirmininkauja: Cihan Sultanoglu, JT Vystymo programos atstovė Lietuvoje.
- Denis Kalmaldinovas, Rusija. “Partnerystė: politinio palaikymo būtinybė vystant regiono politiką”.
- Sergejus Mysienko, Ukraina. “Miesto AIDS centro, “Raudonojo kryžiaus” organizacijos ir Ukrainos ŽIV užsikrėtusiųjų ir sergančiųjų AIDS tinklo bendradarbiavimas”.

- Tomczynskis, Lenkija. “Žmonės, gyvenantys su ŽIV/AIDS: bendradarbiavimas su vyriausybe, tarptautinėmis organizacijomis”
- Andris Gailitis, Ilzė Jekabsonė, Latvija. “Mobiliųjų paslaugų ir konsultavimo centrų narkotikų vartotojams steigimas”.
- Mamasobiras Burchanovas, Kirgizstanas. “Narkotikų vartotojai ir daugiasektorinis bendradarbiavimas”.
- Galina Koliada, Andrejus Kovyliajevas, Ukraina. “Visuomenės ir privataus sektorių partnerystė”.
- Tėvas Dutko, Rusijos ortodoksų bažnyčios atstovas, Rusija. “Bažnyčios vieta nacionalinio atsako programoje”.
- Jacekas Kitlinskis, Aleksandra Duda, Lenkija. “Pasienio regionų bendradarbiavimas – Pietryčių Lenkija ir Lvovo sritis, Ukraina”.

16.00-17.30 **(“Coral”)** Sekcija **“ŽIV ir AIDS intervencijų kompetencijos didinimas. Politinių sprendimų proceso tobulinimas”.** Pirmininkauja: Liudmila Viksna, Latvijos infektologijos institutas, Latvija; Andrejus Kozlovas, Rusija; Laima Bulotaitė, VU Filosofijos fakulteto Bendrosios psichologijos katedros vedėja.

- Frankas de Wolfas, ŽIV kontrolės fondas, Olandija. “ŽIV kontrolė Olandijoje”.
- Andrejus Kozlovas, Rusija. “Kompleksinio biosocialinių sistemų aprašymo neapibrėžtumas ir kompromisų teorija”.
- Aleksejus Mazusas, Maskvos AIDS centras, Rusija. “ŽIV infekcijos prevencijos strateginių krypčių įgyvendinimas Maskvoje”.
- Sofia Modigh, Švedija. “Prevencinis darbas internete – narkotikų vartojimo prevencijos patirtis”.
- Dale Guenter, Kanada. “Prenatalinio ŽIV tyrimo politika ir praktika: kas lėmė Kanados laimėjimus ir klaidas?”
- Arletty Pinel, Pasaulio AIDS, maliarijos ir tuberkuliozės fondas.

17.45-18.30 **(“Coral”)**Stendinių pranešimų sekcija **“Geriausia Lietuvos patirtis”**. Pirmininkauja: Vytautas Vaičiuvėnas, Kauno medicinos universiteto profesorius, Lietuva; Robertas Petkevičius, PSO biuro Lietuvoje vadovas, Lietuva.

18.30 ir 18.45 Autobusai išvyksta iš viešbučio į miesto centrą. Laisvas laikas mieste.
20.30 ir 20.45 Iš miesto centro autobusai grįžta į viešbutį.

21.00 **Dalyvių vakaronė (“Saphire”).**

**2004 m. rugsėjo 17 d.**

9.00-10.30 **(“Saphire C)** Sekcija **“Svarbiausios sėkmingos ŽIV ir AIDS programos sudedamosios dalys”.** Pirmininkauja: Mukeshas Chawla, Pasaulio Bankas;

- Mary Joy Pigozzi, Kokybiško švietimo skatinimo skyrius, JT Švietimo, mokslo ir kultūros organizacija
- Mukeshas Chawla, Pasaulio Bankas. “ŽIV ir AIDS ekonomika”.
- Anthonys Lisleas, JT vaikų fondas. “Jaunimo dalyvavimo ŽIV ir AIDS programose planavimas.
- Stevas Bullockas, DFID “Europos kaimynystės” grupė, JK. “Jungtinės karalystės ŽIV ir AIDS strategija”.
- Michela Martini, Tarptautinės migracijos organizacijos Vidužemio jūros regiono padalinio ŽIV ir AIDS ir mobilumo skyrius, Italija. “Mobilumas ir pažeidžiamumas ŽIV ir AIDS”.

9.00-10.30 **("Saphire AB")** Sekcija **"Kompleksinis požiūris į narkomanijos problemą**". Pirmininkauja: Audronė Astrauskienė, Narkotikų kontrolės departamentas prie Lietuvos Respublikos Vyriausybės, Lietuva.

- Mauro Guarinieri, Europos AIDS gydymo grupė, Tarptautinės žalos mažinimo plėtros programos patariamoji grupė. "Kuriant visapusę pagalbos narkotikų vartotojams programą. ŽIV ir AIDS gydymo aktyvisto darbotvarkė".
- Konstantinas Ležencevas. "ŽIV gydymo ir sveikatos priežiūros prieinamumas narkotikų vartotojams".
- Kerstin Kall , Tomas Hallbergas, Europos miestai prieš narkotikus, Švedija. "Ar žalos mažinimas yra tinkamas ŽIV prevencijos tarp injekcinių narkotikų vartotojų metodas?".
- Torkelis Moestrudas, Malmo centrinės ligoninės Infekcinių ligų skyrius, Švedija. "Vidaus ligų gydytojas ir narkotikų vartotojas".
- Darius Diržys, Baltijos ir Amerikos klinika, Lietuva. "Kompleksinė pagalba narkotikų vartotojams kaip esminis ŽIV prevencijos komponentas Lietuvoje"

9.00-10.30 **("Coral")** Sekcija **"ŽIV gydymas ir gydymo tyrimai Europoje"**. Pirmininkauja: Gudjonas Magnussonas, PSO Europos regiono biuro Techninės pagalbos grupė; Andrzejus Horbanas, AIDS diagnozės ir gydymo centro direktorius, Lenkija .

- Christine Katlama, Infekcinių ir tropinių ligų tarnyba, Prancūzija. "Šiuolaikinio ŽIV gydymo aspektai".
- Jensas D. Lundgrenas, Kopenhagos ŽIV programa, "EuroSIDA" projekto koordinacinis centras. " Rytų Europa – ŽIV gydymo mokslo tyrimų programų dalyvė".
- Martinas Donoghoe, PSO Europos regiono biuro visuomenės sveikatos LPI, ŽIV, AIDS poskyrio darbuotojas. "Retrovirusinio gydymo prieinamumo Europoje įvertinimas".
- Keesas de Joncheere, PSO Europos regiono biuro patarėjas sveikatos technologijos ir vaistų klausimais. "Retrovirusinio gydymo prieinamumo ir kainų mažinimo strategija Europoje".

10.30-11.00 Kavos pertrauka **(vestibiulio baras, baras "Horizon")**, stendinių pranešimų peržiūra.

10.30-11.00 **("Malachite")** Apskrito stalo diskusija/kava su mokslininkais, besidominčiais elgesio ir socialinių mokslų tyrimų galimybėmis, padedant JAV Nacionaliniam sveikatos institutui. Vedėjas: Paulas Gaistas, JAV Nacionalinis sveikatos institutas. **(Diskusija vyks anglų kalba, sinchroninio vertimo nebus).**

11.00-12.30 **("Saphire"C)** Sekcija **"Socialinės atskirties grupių sveikatos priežiūros organizavimas – homoseksualai ir prostitutės" .** Pirmininkauja: Evita Leskovsek, Slovėnijos visuomenės sveikatos institutas.

- Marzena Kulis, Pasaulio Bankas. **"**Sunkvežimių vairuotojų atsitiktiniai lytiniai santykiai".
- Evita Leskovsek, Slovėnijos visuomenės sveikatos institutas. "Imigracija ir prekyba žmonėmis Rytų Europoje visuomenės sveikatos aspektu".
- Olegas Jeriominas, NVO "Vstreča", Baltarusija. NVO "Vstreča" – šešeri metai sėkmingo darbo ŽIV, AIDS, LPI prevencijos tarp homoseksualų srityje Baltarusijoje".
- Jacobas Haffas, STOP AIDS Denmark, Danija.

11.00-12.30 **("Saphire AB")** Sekcija **"Socialinės atskirties grupių sveikatos priežiūros organizavimas - kaliniai".** Pirmininkauja: R.Kugys, Kalėjimo departamento direktorius, Lietuva; Ilona Burduja, Moldavijos teisingumo ministerija; Edoardo Spacca, Europos paslaugų narkotikus vartojantiems kaliniams tinklas, JK.

- Ilona Burduja, Moldovos teisingumo ministerija, NVO "Sveikatos reforma kalėjimuose". "Švirkštų keitimo programa Moldovos kalėjimuose".
- Edoardo Spacca, Europos paslaugų narkotikus vartojantiems kaliniams tinklas, Krenstono narkotikų tarnyba, JK. "Narkotikų vartojimo politika, strategijos ir intervencijos Europos kalėjimuose".
- Christeris Karlssonas, KRIS, Švedija.
- Julijana Rakickienė, Įkalinimo įstaigų ligoninė, Lietuva. "ŽIV užsikrėtusių kalinių problemos Lietuvoje ir galimi sprendimai".
- Edita Gruodytė, Lietuvos teisės universitetas, Lietuva. "Narkotikus vartojantys pažeidėjai ir ŽIV: nauji išūkiai, naujos galimubės".

11.00-12.30 **("Coral")** Sekcija **"Rytų Europos klinikiniai mokslo tyrimai – EuroSIDA, ESPRIT ir SMART programų apžvalga**". Pirmininkauja: Jensas D. Lundgrenas, Kopenhagos ŽIV programos direktorius, "EuroSIDA" koordinacinis centras.

- Daria Podlekareva, Kopenhagos ŽIV programa, Hvidovrės universiteto ligoninė, Kopenhaga, Danija. "Europos ŽIV užsikrėtę pacientai: regioniniai pacientų duomenų skirtumai".
- Olė Kirkas, "EuroSIDA" projekto koordinacinis centras. "Didelio efektyvumo retrovirusinio gydymo rezultatai Rytų Europoje".
- Daria Podlekareva, Kopenhagos ŽIV programa, Hvidovrės universiteto ligoninė, Kopenhaga, Danija. "Pagrindiniai "SMART" tyrime dalyvaujančių pacientų duomenys".
- Jensas D. Lundgrenas, Hvidovrės universitetao ligoninė, Kopenhaga, Danija. "ŽIV užsikrėtusių pacientų Lenkijoje ir kitose ESPRIT tyrimuose dalyvaujančiose šalyse palyginimas".

12.30-13.30 Pietūs **(vestibiulio baras, pusryčių salė, restoranas "Seasons")**, stendinių pranešimų peržiūra.

13.30-15.30 **("Saphire AB")** Sekcija **"ŽIV ir AIDS darbo pasaulyje"** Pirmininkauja: Sabine Beckmann, Tarptautinės darbo organizacijos "ŽIV ir AIDS ir darbo pasaulio programa" vyresnioji techninė specialistė, Šveicarija; Anna Marzec-Boguslawska, Lenkijos AIDS centro direktorė.

- Franklynas Liskas, Tarptautinės darbo organizacijos AIDS programa, Šveicarija. "Tarptautinės darbo organizacijos AIDS programos pristatymas, Tarptautinės darbo organizacijos Praktikos kodeksas; kova su diskriminavimu darbo vietoje ir socialinių privilegijų darbo vietoje užtikrinimas".
- Sabine Beckmann, Tarptautinės darbo organizacijos AIDS programa, Šveicarija. Komentarai ir diskusija.
- Anna Marzec Boguslawska, Lenkijos AIDS centras, Lenkija. "Lenkijos ŽIV ir AIDS problemos, gydymas ir prevencija".
- Uwe Oppermannas-Brandenburgas, Volkswagen, Vokietija. "Darbo vietos programų ir politikos plėtra Rytų Europoje: teigiama ir neigiama patirtis".
- Aldona Baublytė, Sveikatos apsaugos darbuotojų profesinė sąjunga, Lietuva. "ŽIV ir AIDS ir sveikatos apsaugos darbuotojai profesinių sąjungų požiūriu".
- Elisabethė Girrbach, GTZ, Vokietija. "GTZ ir jos darbo vietos ŽIV ir AIDS politika: darbo vietos politikos įtraukimo į organizacijų veiklą patirtis".

- Svetlana Misichina, Tarptautinės darbo organizacijos AIDS programos Maskvos padalinys, Rusija. “Rusijos ŽIV ir AIDS socialinis ekonominis modelis”.
- Jurijus Privalovas, Ukraina. “ŽIV, AIDS ir darbovietė socialinės ekonominės plėtros kontekste”.

13.30-14.00 **(“Malachite”)** Mia Hanstrom, oranizacija “Gelbėkite vaikus”, Suomija. Lietuvos projekto **“Mergaičių grupė – mergaičių įgalinimo metodas ir svarbi prevencijos darbo dalis”** pristatymas. **(Diskusija vyks anglų kalba, sinchroninio vertimo nebus).**

14.00-15.30 **(“Saphire C”)**Jungtinė sekcija “**Kova su diskriminacijos apraiškomis - svarbiausia ŽIV ir AIDS prevencijos ir priežiūros prielaida, su ŽIV ir AIDS gyvenančių žmonių įtraukimas ir dalyvavimas”/ “Žiniasklaidos vaidmens analizė ir darbas su žiniasklaida”.**. Pirmininkauja: Georgas Broringas, NVO “AIDS ir mobilumas”, Olandija; Monica Ciupagea, Tarptautinė žalos mažinimo plėtros programa; Dainius Radzevicius, Lietuvos žurnalistų sajungos pirmininkas.

- Monica Ciupagea, Tarptautinė žalos mažinimo plėtros programa. “Darbo su žiniasklaida pastangos”.
- L. Meškauskaitė, advokatė, socialinių mokslų daktarė, Lietuva. "Duomenų apie asmens sveikatos būklę apsaugos problemos žiniasklaidoje".
- Fredrik S. Michelet, Norvegija.”Virtualios tarptautinės daugiadisciplinės akademijos projektas”
- Susana Cole, NVO “Su ŽIV/AIDS gyvenančių žmonių balsas”, JK.
- Andrew Harveys, NVO “Su ŽIV/AIDS gyvenančių žmonių balsas”, JK.

13.30-14.30 **(“Coral”)** Sekcija **“Antros kartos epidemiologinės stebėsenos metodologija ir praktika**”. Pirmininkauja: Irena Klavs, Slovėnijos visuomenės sveikatos institutas; Tatjana Smolskaja, Rusijos visuomenės sveikatos ministerijos Šiaurės Vakarų rajono AIDS centras.

- Irena Klavs, Slovėnijos visuomenės sveikatos institutas. “Antros kartos ŽIV stebėsena mažo ŽIV paplitimo šalyse – Slovėnijoje”.
- Laura Papantoniou, Kipro sveikatos apsaugos minsterijos AIDS programa. “Žinių, požiūrių ir elgesio AIDS, lytinių santykių ir LPI srityje tyrimas tarp Limasolio miesto ir kaimo regionų gyventojų, Kipras, 2000-2001”.
- Andrzejus Horbanas, AIDS diagnozės ir gydymo centras, Lenkija. “Genų tipų nustatymas Rytų ir Centrinės Europos šalyse - Rytų ir Vakarų Europos valstyių bendradarbiavimo pavyzdys”.
- Tatjana Smolskaja, Rusijos visuomenės sveikatos ministerijos Šiaurės Vakarų rajono AIDS centras. “Sankt Peterburgo gatvėse dirbančių prostitučių užsikrėtimo ŽIV, LPI ir elgesio tyrimai, Rusijos Federacija, 2003”.

14.30-15.30 **(“Coral”)** Apskrito stalo diskusija/kava **“ŽIV ir AIDS epidemiologinė priežiūra: patirtis ir perspektyvos”**. Moderatoriai: Irena Klavs, Slovėnijos visuomenės sveikatos Institutas; Giedrius Likatavičius, Higienos institutas, Prancūzija.

]15.30-16.00 Kavos pertrauka **(vestibiulio baras, baras “Horizon”)**, stendinių pranešimų peržiūra.

16.00-17.00 **(“Saphire AB”)Konferencijos uždarymas**. Pirmininkauja: Saulius Čaplinskas, UNAIDS atstovas

- Gediminas Černiauskas, sveikatos apsaugos ministro pavaduotojas. Ministrų priimtos deklaracijos pristatymas.
- Konferencijos rezultatų pagal sekcijų temines grupes* pristatymas.

18.00 – 20.00 **Chico ir Gipsy Kings (baras "Horizon", 16-as aukštas)**

2004 m. rugsėjo 18 d.

10.00-13.00 **("Saphire")** Atvira konferencijos dalyvių diskusija **"Bendradarbiavimo Europos Sąjungoje ir už jos ribų perspektyvos"**. Pirmininkauja:

***Konferencijos sekcijų teminės grupės:**

**1. Žiniasklaida, visuomenės nuomonė ir politika.**

Sekcijos:

**1. "ES sveikatos apsaugos strategija ir politika"**

**2. "Šiuo metu vykdomos ES programos ir kiti ES finansuojami mokslo tyrimo bei paramos tinklai: naujų narių integravimo politika".**

**3. "ŽIV ir AIDS intervencijų pajėgumo didinimas. Politinių sprendimų proceso tobulinimas".**

**4. "Kova su diskriminacijos apraiškomis - svarbiausia ŽIV ir AIDS prevencijos ir priežiūros prielaida, su ŽIV ir AIDS gyvenančių žmonių įtraukimas ir dalyvavimas".**

**5. "Žiniasklaidos vaidmens analizė ir darbas su žiniasklaida".**

**2. Tikslinė prevencija.**

Sekcijos:

**1. "ŽIV, AIDS ir susiję sveikatos politikos aspektai Bendrijos programose"**

**2. "Bendradarbiavimas ir patirties skleidimas ŽIV ir AIDS srityje Europos Sąjungoje ir už jos ribų ".**

**3. "Svarbiausios sėkmingos ŽIV ir AIDS programos sudedamosios dalys".**

**4. "Socialinės atskirties grupių sveikatos priežiūros organizavimas – homoseksualai ir prostitutės".**

**5. "ŽIV ir AIDS darbo pasaulyje"**

**3. Intraveninių narkotikų vartojimas.**

Sekcijos:

**1. "Visapusė pagalbos narkotikų vartotojams programa".**

**2. "Socialinės atskirties grupių sveikatos priežiūros organizavimas - kaliniai".**

**4. Epidemiologija ir gydymas.**

Sekcijos:

**1. "ŽIV gydymas ir gydymo tyrimai Europoje".**

**2. "Rytų Europos klinikiniai mokslo tyrimai – EuroSIDA, ESPRIT ir SMART programų apžvalga".**

**3. "Antros kartos epidemiologinės stebėsenos metodologija ir praktika".**

**MINISTERIAL CONFERENCE**
**"EUROPE AND HIV/AIDS: NEW CHALLENGES, NEW OPPORTUNITIES"**
**September 16-17, 2004**
**Vilnius, Lithuania**

**16 September, Thursday**

Arrival (meeting at the airport and pick up to the hotel)

**20:00-22:00** **Welcome reception** at Trakai castle, hosted by Juozas Olekas, Minister of Health of the Republic of Lithuania

**17 September, Friday**

**9:00-10:00** ***Opening Ceremony***
Chair: **Mr. Juozas Olekas,** Minister of Health of the Republic of Lithuania
**Mr. Algirdas Brazauskas**, Prime Minister of the Republic of Lithuania
**Mr. Pavel Telicka**, Member of the European Commission
**Mr. Lars O. Kallings**, Special Envoy of the UN Secretary-General for HIV/AIDS in Eastern Europe
**Mr. Jack Chow,** Assistant Director-General for HIV/AIDS, Tuberculosis and Malaria, WHO
**Ms. Purnima Mane**, Director of the Social Mobilization and Information Department, UNAIDS

**10:00-10:15** Photograph with H.E. Prime Minister
**10:15-10:45** Press conference
**10:15-11:00** Coffee break

**11:00-13:00** ***Messages from partners***
Chair: **Mr. Juozas Olekas**, Minister of Health of the Republic of Lithuania
The Expert Conference, **Professor Pauli Leinikki,** National Public Health Institute, Finland
Pharmaceutical Industry**, Mr. Brian Ager**, Director General of European Federation of Pharmaceutical Industries and Associations, EFPIA
NGOs (to be confirmed)

**Plenary Discussion of the Ministers**

**13:00-14:30** Lunch

**14:30-16:30** ***Role of the International Organizations***
Chair: **Mr. Pavel Telicka**, Member of the European Commission
HIV/AIDS in the WHO Europe, **Dr. Marc Danzon**, Regional Director, WHO/Europe
UNDP and HIV/AIDS, **Mr. Kalman Mizsei**, Regional Director, UNDP/Europe and CIS

**Plenary Discussion of the Ministers continues**

**16:30-17:00** Adoption of the declaration and closing of the conference,
**Mr. Juozas Olekas, Mr. Pavel Telicka**

Departure to the airport

**CONTENT**

## AIDS & MOBILITY EUROPE – A NETWORK ON MIGRATION AND HIV/AIDS

G. Bröring
NIGZ – AIDS & Mobility Europe, Woerden, The Netherlands

**Issues:** HIV prevention, treatment, care and support for migrants and ethnic minorities in Europe are an area of concern for health care providers and migrant populations alike. Young migrants and people from endemic areas have particular information and care needs. The enlargement of the European Union will have an impact on mobility patterns and the AIDS epidemic in Europe.

**Description:** The AIDS & Mobility Europe (A&M) is a networking organisation, committed to support non-governmental and governmental organisations to provide migrants and ethnic minorities with appropriate HIV/AIDS information and care, and to develop suitable policies. A&M strives to put the issue of migration and AIDS on the agenda of policy makers at the national and international level. A&M facilitates the exchange of knowledge, skills and expertise between different European countries and at various levels (governmental, non-governmental and community-based).

A&M fulfils its tasks in close collaboration with National Focal Points in the European Member States.

**Lessons learned:**

- Continuous efforts of HIV prevention and health promotion for migrants and ethnic minorities remain important, as new populations enter the scene and new health problems emerge.
- Specific sub-populations of migrants and ethnic minorities, like young people and people with problems to access information and care, such as asylum seekers and undocumented migrants, require attention.
- Availability, accessibility and affordability of prevention and treatment – both in Europe and in countries of origin – have an impact on the populations involved and on public health in general.
- The enlargement of the European Union will make the issue of mobility and migration in relation to HIV and STD's even more important.

**Recommendations:** Joint efforts – of both NGO's and GO's – are needed to improve access to information and treatment for migrants and ethnic minorities in Europe. Prevention and care efforts need to take changes in Europe – enlargement, new mobile populations, changing epidemic – into account.

Additional research and (pilot) interventions are needed aimed at migrants and ethnic minorities in the new European member states.

## EUROPEAN NETWORK FOR TRANSNATIONAL AIDS/STI PREVENTION AMONG MIGRANT PROSTITUTES: TAMPEP NETWORK

L. Brussa
TAMPEP, International Foundation

**Issues:** TAMPEP stands for Trans-national AIDS/STI Prevention among Migrant Prostitutes in Europe. It is an international network and intervention project operating in 25 countries in Europe, including 10 Central and Eastern European countries.

It is a model of intervention, reaching more than 40 different nationalities of female and transgender sex workers from Central and Eastern Europe, South East Asia, Africa and Latin America.

Aims of the TAMPEP network are: to advocate for the human and civil rights of migrant sex workers; to facilitate the sharing of knowledge, experience and good practice amongst the member countries; to develop and implement effective strategies of HIV and STI prevention amongst migrant sex workers across Europe.

Description: TAMPEP provides (migrant) sex workers with culturally appropriate HIV/STI education, resources and materials.- It has developed specific information and educational materials in 14 languages. -It seeks to increase empowerment and self-esteem among migrant sex workers.-It educates social and medical establishments to respond better to the needs of migrant sex workers' health and well-being. -It is a reference point for migrant sex workers as a network of community based organisations -It investigates the social, legal and working conditions of migrant sex workers through fieldwork in the different areas of prostitution, formulates policy advices and carries out lobbying and advocacy activities.

**Lessons learned:** AIDS/STI prevention must be included in a broader framework of general health promotion, and the development of such a framework should be recognized as a present priority.

A broad spectrum of community based initiatives, directed at empowerment of (migrant) sex workers, can have a major impact on primary prevention inasmuch as it allows sex workers more scope in their contractual position with clients, brothel owners, pimps and public authorities.

**Recommendation:** the internationalisation of prostitution and national and trans-national mobility of sex workers requires cooperation on a European level if the human and civil rights of sex workers and public health interest are to be protected.

# AIDS PREVENTION BY THE TRANSFER OF EXAMPLES OF SUCCESSFUL INTERVENTION IN THIS FIELD ON THE LEVEL OF NATIONAL NETWORK OF ORGANIZATIONS WORKING IN AIDS, STDS AND DRUG ABUSE PREVENTION

A. Fonari, O. Turcanu

The Network of Organizations working in the field of AIDS, STDs and Drug abuse prevention from Moldova, Young and Free: Training Resource Centre, Moldova

**Issue/Problem**: The premises of creation of the First Network of Organizations working in the field of AIDS, STDs and Drugs abuse prevention from Moldova (AIDS Network): - It ‘s not possible to obtain good results in AIDS prevention without integrate the primary prevention, the second and the third and establish an efficient mechanism of communication between the actors of these stages. - Phenomenon of doubling the funds and activities of AIDS prevention among the NGOs that work in this domain started two years ago. Or, it is more efficient to work in an unite team that accumulates different experiences and uses a single and bigger fund because it will permit the implementation of the activities of AIDS prevention and will have a larger impact.

**Description of Project**: - The AIDS Network from Moldova was created in 2001 and is made-up of 11 active organizations (who work in departments) and another 20 NGOs who profit from the activities of the Network. - The ideea to constitute a Network was submited by few organizations like: the Ministry of Health of Republic of Moldova, Departement for International Development from British Embassy in Chisinau and 8 NGOs working in this domain. The goal of the creation was to strengthen networking (NGO-NGO, NGO-state) and partnership on HIV/AIDS and related issues. - Objectives of AIDS Network: -facility of knowledge, communication and collaboration between organizations who are members of Network; -promotion of NGOs image working in this domain on the community and governmental level; -support the organizations members to establish / maintain the relation with the institutions working in this domain, on the national and international level; - promotion of the concept of lasting activities in the environment of organizations who are members of Network; -promotion of successful national and international examples in prevention of HIV/AIDS, STDs and Drugs abuse. - The National Strategy of AIDS epidemic prevention in Republic of Moldova: 2000-2005 – was elaborate in collaboration with the representatives of NGOs working in this domain.

**Results and Impact:** - The results of the National Strategy of the AIDS epidemic prevention in Republic of Moldova for 2000-2005: the number of persons infected in the result of intravenous doping has decreased from 83 % in 1996 to 52% in 2003, but by heterosexual way has increased from 17% in 1996 to 42% in 2003. - The program of Harm Reduction – the most important NGOs who implement these programs work in the AIDS Network of Moldova.] - The founders began to understand that the communication with NGOs will help to decide the main directions of the financement of the civil society; - Communication and establishment of common strategies between the donors and NGOs exclude the doubling of financement/activities and increase efficiency/durability of the activities, services and national programs/strategies. - The existence and the activity of this Network, even in absence of financement have demonstrated the utility of integration of primary, second and third prevention and the necessity of exchange of experience with neighbouring countries. It’s not just about the collaboration between NGOs, but between the Networks of NGOs from neighbouring countries. Such an example is the project « Transfer of experience in the field of AIDS, STDs and Drugs abuse prevention» which AIDS Network has been developing since 2003 in collaboration with NGOs Networks working in this domain from Belarus and Ukraine.

# MAIN STRATEGIES OF FIGHTING HIV EPIDEMIC IN MOSCOW

A. Mazus
Moscow Centre for HIV/AIDS Prevention and Treatment

At the present time there exist several viewpoints on the problem of HIV prevalence in Russia, expressed by national and foreign centres studying HIV/AIDS, as well as NGOs and independent experts. These viewpoints vary from extremely panicky to quite optimistic. And though many of them are often based on the same official statistics the conclusions made differ greatly at times. This does not only show how complicated the matter is but also reveals certain political, departmental and commercial implications in the way the situation is analyzed and estimated.

Among the countries affected by HIV/AIDS Russia occupies a peculiar place. In this country with its population of 145 million people, a vast territory, diversity of climatic conditions and geographical peculiarities, high rate of social and economic stratification, different modes of living, HIV epidemic is not homogenous within regions. The all-Russia strategic data on HIV prevalence only approximately reflect the real situation. As a matter of fact in each part of the Federation HIV epidemic is of peculiar character. Even the Federal regions of the Russian Federation differ in HIV prevalence from 46 per 100 000 persons in the Southern region to 430 per 100 000 persons in Ural. Thus the epidemiological situation differs considerably throughout the country.

In terms of typology Russian territories are classified according to HIV prevalence. At one pole there are regions with a relatively low level of susceptibility to HIV infection and thus a low HIV prevalence. At the other pole there are regions characterized by a high social susceptibility to HIV infection and a high HIV prevalence among the population.

It is known for certain that almost all the largest industrially and financially developed cities and regions together with the territories close to important transport junctions have a high level of social susceptibility to HIV infection. It is there that the consequences of uncontrolled spread of the epidemic can be most harmful for social and economic development of the regions.

It is hardly arguable that among the main factors influencing HIV prevalence is drug industry. At present Russia as many other countries is experiencing epidemic of drug and psychoactive substances addiction and the majority of drug users are 16 to 30 years old.

To this extent Moscow is among the most vulnerable Russian regions in terms of HIV prevalence. At the same time the capital of Russia has a considerable social-economic potential for fighting HIV infection. Our experience has shown that this potential can only be fulfilled if mobilizing programs are created and implemented.

By resolution of the Moscow government in 2001 there was adopted The Target Complex Program for Prevention from Spreading in Moscow the Disease Transmitted through Human Immunodeficiency Virus (HIV) “AntiHIV/AIDS”

Carrying out a complex of medical activities has allowed to prolong life of people suffering from AIDS. HIV/AIDS death rate has lowered and an overwhelming majority of patients getting antiretroviral treatment are actively working.

Today high activity antiretroviral therapy is provided for all HIV-infected patients in need of the specific treatment, who are registered in the Moscow AIDS Centre.

Since 2001 a large-scale campaign for educating people on the matters of HIV prevention has been carried out in Moscow.

There has been implemented a program for preventing mother-to-child transmission of HIV during pregnancy, labour and delivery. For the last 3 years the risk of perinatal HIV transmission has decreased from 35-40% to less than 3%. It is to be specially noted that Moscow is the only subject of the Russian Federation where an infrastructure has been

created that allows to provide antiretroviral prophylaxis to all HIV-infected pregnant women who have come to medical institutions of Moscow.

The most important result of the Target Complex Program is stabilizing the epidemiological situation in the city. The tempo of HIV-epidemic spread in Moscow is among the lowest in Russia.

For further control of HIV infection spread in the city there are intradepartmental activities carried out, which are specified in a new version of the City Target Program "AntiHIV/AIDS" for the years 2004-2006.

At the present time HIV infection in Russia on the whole develops as an uncontrolled epidemic in its initial stage. The majority of cases are registered among intravenous drug users. And the spread of drug addiction is favourable for further growth of HIV epidemic.

Without depreciating the real threat coming from the growth of HIV epidemic it is to state as contra-productive the "catastrophe" concept according to which Russia is supposedly to loose more than a half of its population and turn into a demographic desert by the year 2020. Such an appraisal makes useless any effort to restraint the growth of the epidemic and does not favour adequate reaction to the real danger.

It is to admit that long-term prognoses for social and economic consequences of HIV epidemic for the period of 14-20 years and further have a weak scientific ground and thus are not enough reliable. Such long-term conclusions aren't based on the necessary empiric information on Russia at the present time.

## AFTER THE DUBLIN CONFERENCE: HOW WE CAN BUILD A NEW PARTNERSHIP TO FIGHT HIV/AIDS IN THE EUROPEAN UNION AND ITS NEW NEIGHBOURHOOD?

H. Mikkelsen
Europe Regional Coordinator, UNAIDS

The rapidly expanding HIV epidemics in Eastern Europe and Central Asia, and the recurrence of increasing HIV infections in Western and Central Europe have reinvigorated the need for partnership and horizontal collaboration in response to AIDS among countries in the region. This presentation will explore the potential added value for such partnership and collaboration, based on an analysis of current trends in the epidemics and the response. Important areas for collaboration in terms of high level policy dialogue, technical collaboration, and networking and empowerment among people living with HIV/AIDS and civil society organizations will be defined. Reviewing the commitments made in the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia, possible models for partnership and horizontal collaboration will be described, and the possible roles of key stakeholders – governments, civil society, EU, the UN and other intergovernmental organizations – will be discussed.

# AIDS ACTION EUROPE: THE PAN EUROPEAN NGO PARTNERSHIP ON HIV AND AIDS

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AIDS Action Europe, Amsterdam, The Netherlands

Last March, AIDS Action Europe, the Pan European NGO Partnership on HIV and AIDS, was formally launched during the Open Forum on AIDS Action in Europe. AIDS Action Europe is a continuation and extension of the EuroCASO network and will serve as the European contact for the International Council of AIDS Service Organisations (ICASO). AIDS Action Europe wants to contribute to the global fight against HIV and AIDS through the strengthening of NGO exchange, interaction and joint action. AIDS Action Europe focuses on three areas: - HIV in Central and Eastern Europe - the role of NGOs, capacity building and the exchange of experience and information. - HIV in Western Europe - re-prioritising HIV on national and European agendas. - Resource mobilisation for the global epidemic. AIDS Action Europe is committed to include NGOs and community organisations from Central and Eastern Europe and Central Asia among its members and steering committee. Starting next year, the secretariat will include the ICASO Eastern European Partnership Office (EEPO), based in Lithuania. EEPO will focus specifically on supporting NGOs in the Russian Federation and Ukraine. The European Commission has recently granted the 'AIDS Action & Integration Projects 2005-2008', which is coordinated by AIDES and supported by AIDS Action Europe and other European networks. This project focuses on the 10 new member states and 3 accession countries. This project will make available the best Pan European practices on prevention and support, harm reduction and sexual health promotion.

## THE INTEGRATION PROJECTS: MAIN RESULTS.

A.W. Simon
AIDES, France

**Objective :** To integrate emergent NGOs from the new and future member states of the European Union into the European Mobilisation on HIV and AIDS.

**Method :** To the extent that they best represent the needs of the most vulnerable communities, including People living with HIV/AIDS, NGOs can play an central role in strengthening national responses to HIV/AIDS. With partial funding from the European Commission, the French NGO AIDES initiated in 2001 the Integration Projects (www.integration-projects.org) with AIDSi-Tugikeskus (Estonia) ARAS (Romania), BADZ Z NAMI (Poland), the AIDS Society (Czech Rep.), DIA+LOGS (Latvia), the AIDS Council (Finland), and PLUSS (Hungary). The project included (1) an analysis of the local needs and priorities on HIV/AIDS (2) sharing best practices on HIV/AIDS.

**Results :**

- Publication in 2004 of 7 country-reports.
- Internships and joint-seminars enabled 40 NGO representatives to build their capacities in the fields of (a) NGO management, (b) harm reduction, prevention, treatment, peer-support (c) the EU institutions.
- Participation in the launch of AIDS ACTION EUROPE, the pan-European NGO partnership on HIV and AIDS.

**Conclusion :** In new and future EU member countries, specific challenges for NGOs include 1/ getting acknowledged by local government as trusted partners 2/ implementing coherent projects with funding originating mostly from international donors who have their own priorities 3/ adapting to transition economies, including EU-related reforms.

Overall, entry in the EU does not in itself give access to significant new resources for NGOs yet many international funders are reducing their support for new EU member countries. With local shortcomings remaining in terms of access to prevention, harm reduction and optimal anti-HIV treatments, the EU needs to renew its targeted support for HIV/AIDS NGOs and encourage national governments to work with local civil society.

# SPREAD, CATCH AND WATCH AS THE EXAMPLES FOR EUROPEAN COLLABORATION STUDY – PRINCIPLES AND PROPOSAL FOR CENTRAL/EASTERN EUROPE

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SPREAD is an official European Commission supported programme (QLK2-CT-2001-01344). The SPREAD programme aims to develop a strategy to control spread of HIV drug resistance in Europe. Within SPREAD clinicians, virologists and epidemiologists from 29 European countries have implemented a structured and quality controlled European surveillance programme. SPREAD is coordinated by the Department of Virology of the University Medical Centre, Utrecht, the Netherlands. The project leader is prof. Charles Boucher, the daily coordinator is dr Annemarie Wensing and the project epidemiologist is dr David van de Vijver. The focus of SPREAD is to determine the transmission of drug resistant HIV and to identify risk factors for transmission of resistance. The final aims of the programme are: the development of a European strategy to control the further spread of drug resistant HIV, the establishment of European surveillance program, the installment of network of reference laboratories, the development of a European database of HIV-drug resistant strains and the generation of viral panels, representative for the resistant viruses circulating in Europe. More information about SPREAD can be found at www.spread-europe.org.

The SPREAD-NAS project (established in 2003) is an extension of the SPREAD programme to the newly associated states of the European Union, Bulgaria, Romania and the Ukraine.

CATCH (Combined Analysis of resistance Transmission over time of Chronically and acute infected HIV-patients in Europe) is a sub-study of SPREAD. The objective of this study is to determine the prevalence of genotypic drug resistance mutations among antiretroviral naïve patients in Europe from 1996 to 2002, which is the period before SPREAD started collecting data. It is a multi-center study including patients from 19 countries. CATCH focuses on acute or chronically infected HIV-1 positive patients not exposed to antiretroviral drugs at or before the time of performing the genotyping assay. Consecutive analyses indicate significant percentage of drug resistant HIV strains up to 10,5% and increasing prevalence of non-B subtypes. The results of CATCH study are cited by world wide media.

The establishment of presented programmes and the importance of obtained data are an excellent example of beneficial and enriching intraeuropean collaboration.

Based on the experience gained from the CATCH, a world-wide WATCH study has been recently initiated.

# MONITORING OF HIV IN THE NETHERLANDS: A CHANGING EPIDEMIC

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**Background:** A large proportion of HIV-infected individuals is clinically followed in one of the 22 HIV treatment centres throughout the Netherlands. Antiretroviral therapy is provided through these centres. The HIV Monitoring Foundation (HMF) is appointed to perform the monitoring of HIV in the Netherlands.

**Aim:** The aim of the HMF is to further knowledge and understanding of the epidemiology and course of the treated an untreated HIV infection.

**Methods:** The activities to achieve this are:

- To collect, maintain and analyse data obtained from HIV infected patients, irrespective their antiretroviral treatment, and report, amongst others, to the Dutch Government;
- To make data available for HIV-treating physicians, for scientific research and consensus policy, and other groups.

**Results:** The HMF maintains the so-called ATHENA observational cohort of presently >9000 HIV-infected patients. Inclusion started in 1996. Over time until 2004 the prevalence of HIV increased among homosexual men >30 yr. Heterosexual transmission was found in 27% of the study group. The contribution of women increased to >30% in 2002/03. Women were median 6 years younger than men. 40% of the study group and 68% of the women were of non-Dutch origin. CD4 cell counts at HIV diagnosis were lower in women than in men.
80% of the study population was treated with HAART, 2/3 without prior antiretroviral treatment. Resistance to anti-HIV drugs did occur in 4.8% of the newly diagnosed and in 6% of the newly infected population. 3.3% of the naïve and 13% of the experienced HAART-treated patients had resistant virus. CD4 cell counts and HIV-RNA load at baseline and after 24 weeks of HAART predicted outcome. In 68% of the naïve patients viral load declined to <500 copies/ml after 6 months and in 78-84% an increase of 100 CD4 cells was found after 12 months of HAART. There were no significant differences between the major HAART regimens used frequently in 2002/2003. The rate of therapy success was slower and rapid failure more frequent among patients of non-Dutch origin. 90% of the patients had their initial HAART regimen changed with women at higher risk than men.

The incidence of a first CDC-C event declined from 15.3 per 100 person-years in 1996 to 1.8 in 2002. HIV-related mortality declined from 3.4 in 1996 to 0.61 in 2003.

**Conclusions:** The HIV epidemic in The Netherlands is changing. Men having sex with men are still the largest risk group, however heterosexual transmission is becoming more important, with a rising number and proportion of relatively young HIV infected women from non-Dutch origins, who acquired HIV in the region of origin and are being diagnosed in a later stage of infection. Effect of HAART over a median period of 63.2 months is substantial, resulting in a still limited level of resistance.

# WORKPLACE PROGRAMMES AND POLICIES ON HIV/AIDS IN EASTERN EUROPE ADOPTED BY ILO CORPORATES WITH A FOCUS ON THE FOLLOWING COUNTRIES: RUSSIA, MOLDOVA, UKRAINE, POLAND AND LITHUANIA

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A.M.-Boguslawska, National AIDS Centre, Poland, E. Girrbach, GTZ, Germany,
A. Baublyte, Trade Union of Health Workers, Lithuania.
S. Mishkina, Russia, T. Konoplytska, Ukraine

**ILO/AIDS in Eastern Europe**

The purpose of the ILO's programme is to make the workplace a catalyst for efforts to prevent the spread of HIV and reduce the impact of the epidemic. It focuses on three main areas: research and policy analysis, technical cooperation, and information and communications. The ILO has produced a blueprint for workplace action in its *Code of Practice on HIV/AIDS and the world of work*. In the field of technical cooperation, the ILO is organizing a wide range of initiatives in all regions based on the Code of Practice to support the efforts of governments and their social partners to combat the epidemic at national, sector and workplace levels. They include the following:

- Advisory services for governments on labour legislation and policy issues, especially stigma and discrimination.
- Projects with the social partners – including guidance in the application of the Code of Practice and the initiation of workplace programmes on HIV/AIDS, encompassing prevention, care and measures to mitigate the impact of AIDS on workplace activity.
- Training programmes to strengthen the capacity of ILO's tripartite constituents in strategic planning and policy development at national and workplace levels.
- Promotion of access to care and support for infected workers and their families (WHO 3x5 initiative)
- Research and policy analysis on the impact of HIV/AIDS on the labour market, employment and social consequences

ILOAIDS in partnership with WHO, GTZ, USDOL, UNAIDS, UNDP, the Transatlantic Partnership against AIDS and others has been active and already is implementing together with ILO's partners a number of activities and projects in the CIS countries (Russia, Ukraine, Armenia etc.) and Central Asia.

ILO/AIDS and GTZ have formed a partnership to develop and carry out a joint project to strengthen the capacity of governments and social partners in the world of work (business and labour) to formulate and implement policies and activities to prevent the spread of HIV/AIDS. In the frame of the ILOAIDS-GTZ project 'Implementing HIV/AIDS workplace policies and programmes', interventions in Eastern Europe and the Baltics can be supported financially and technically in order to move the process of discussion and activities concerning HIV/AIDS and the world of work forward.

The latest global AIDS estimates by ILO and UNAIDS (2004) show the rapid increase of the epidemic in Eastern Europe and the Baltic states. As underlined during the last Governing Body meeting, ILO's constituents have identified the global fight against the HIV/AIDS in the world of work as a priority. ILO as a UNAIDS co-sponsor is therefore contributing in close collaboration with its constituents to the worldwide effort to control the epidemic.

The GTZ and ILO/AIDS have issued to joint publication on HIV/AIDS in the workplace and the mitigation of its impact on socio-economic development in Ukraine and Moldova. The objective of these papers is to discuss some of the essential issues that need to be taken into consideration while developing a strategy for support for these countries. The focus of the paper is on an area that has received very little attention in the literature on AIDS in Eastern Europe – the effects of AIDS on labour markets and its implications on sustained development. The GTZ and ILO/AIDS joint project's ultimate goal is to strengthen and support capacity building of government and social partners (i.e.

government, workers) and employers in the world of work in implementing policies to prevent the spread of HIV/AIDS.

**Moldova:** The epidemic is still being driven by intravenous drug use, but there are signs of beginning of HIV-infection spread across the entire population. The National response to HIV/AIDS has not been adequate due to socioeconomic turmoil, deteriorating health care system and collapse of social safety nets. The results of the report call for immediate action from the ILO and its constituents in the following areas:

- to government and social partners
- to provide, in the context of HIV/AIDS, prevention, care and support at the workplace ranging from protecting workers against stigma and discrimination to ensuring their access to available treatment and social security.
- to develop national policies on HIV/AIDS in the workplace based on ILO Code of practice , work with trade unions to ensure that workers living with HIV/AIDS do not face any discrimination from fellow workers.
- To improve occupational safety and health conditions of workers at risk of exposure to the virus through the development of appropriate labour market policies.
- Provide training and advisory services to integrate workplace policies into the national action.

**Ukraine**: The HIV/AIDS epidemic will further intensify the fall in demographic indicators by aggravating the reduction in life expectancy and increasing mortality rates in the country. Lack of health-care facilities, nursery provision and nutrition has led to a reduction in fertility and life expectancy. There are also certain behavioural and socio-economic factors that have played a role in the rapid spread of HIV infection, not only in Ukraine but also in neighbouring countries in Eastern Europe and Central Asia. Although initially concentrated among injecting drug users (IDUs) only, the infection has started to spread into the general population. The significant deterioration in socio-economic indicators confirms the need to address the problem of HIV/AIDS. Sectors such as mining, agriculture, the army and sex work have been badly hit by the epidemic. Evidence from firms suggest that businesses have become aware of the number of employees infected in Ukraine and are beginning to commit themselves to implementing workplace programmes on HIV prevention and care.

Based on the results, the ILO response to the epidemic, in cooperation with its tripartite partners, should be multi-pronged and should include implementation of an effective prevention programme at the national, *oblast*, city and township levels. It would also include employers'organizations and labour unions and assess their existing competence for active involvement in workplace programmes, training and other activities.

**GTZ and its Workplace policy on HIV/AIDS: Lessons learnt from introducing workplace policies in organisations" :** Increasingly, international cooperation organizations and private companies meet the enormous challenge AIDS poses to sustainable development and corporate social responsibility by initiating workplace policy and programmes their own organizations. This presentation will illustrate the experiences of GTZ, describing the process leading to the adoption of GTZ's corporate HIV/AIDS policy and workplace programme. Implementing workplace programmes is a complex process that depends on the involvement of all actors in a participatory manner, as well as on strong leadership and technical capacity within an organization. Creating a common understanding of the workplace programme and designating roles and responsibilities clearly is crucial.

**Poland:** Nearly 60% of all infections were due to IDU. A significant increase in the number of infections due to heterosexual behaviour in Poland is observed. Within the first years of the epidemic the **state's policy** was first of all aimed at educating and informing on HIV/AIDS. In order to prevent social damages connected with IDU, **the exchange of needles and syringes** has been practiced since 1991. PLWHA have an access to the specialized free of charge **treatment** since 1990. Presently more 2300 patients have been treated with anti-retroviral drugs. A **gradual development of stable state policy in management of HIV and AIDS** related issues is remarkable. It has been very dynamic for the last years and is shown among others by:

## *2. Focus Prevention*

- Establishing organizational and governmental structures to deal with HIV/AIDS issues: The National AIDS Centre; Office for Drug Addiction Prevention; and Office for Drug Addiction Crime Fighting set up by the Police Headquarters; 14 specialized, reference centres for HIV
- Raising funds for HIV/AIDS prevention and AIDS treatment.
- Supporting non-government organizations dealing with HIV/AIDS prevention.
- Appointing provincial coordinators to deal with execution of state's policy at the regional level.
- **Trainings or continuing education courses** are organised at the central and local level
- A strategic national document reiterating the country's multi-sectoral policy on HIV/AIDS "**The National Programme of Prevention of HIV Infections and Care Offered to the People Living with HIV and AIDS"**, (third edition) 2004 – 2006.

Addressing **HIV/AIDS prevention in the work place**, an inventory of the existing situation is being carried out in Poland in cooperation with UNDP in order to prepare guidelines concerning HIV/AIDS and human rights at work place, addressed to employees, employers and civic society institutions. The National AIDS Centre co-operates with the ILO and would like to implement into Polish "An ILO code of practice on HIV/AIDS and the world of work" as well as other initiatives.

**Russia:** This study was initiated and funded entirely by ILO/AIDS Geneva in cooperation with ILO Moscow. Social protection systems in the CIS states are very similar, therefore the model can be applied to other countries of the sub region with some adjustments. The model may undergo changes, after the pension reform which is underway in some countries, including Russia. It was developed to assess the social and economic consequences of the HIV epidemic in Russia. The model can be used to make projections on the following:

- The number of people infected with HIV/AIDS
- Expenditures on the health care sector for treatment of people infected by HIV/AIDS
- Calculation of cost increases to pay short-term disability benefits
- The impact on the pension fund financial stability

The model resulted in the following findings (until 2050):

- The expected level of resulting reduction of GDP falls within 2-5%
- The population numbers shrink approximately the same way
- The cost of health expenditure (0.5 % of GDP) can reach its peak in the years 2010-15, due to the transition of a large group of individuals infected in 2000-02 into the AIDS phase
- The additional cost of short-term disability benefits amounts to 5-7%
- The pension fund revenues can decrease by 2-6% and the affordable replacement rate can reach 2%

**Lithuania:** The World Health Organisation and UNAIDS identify Lithuania as a country with low HIV prevalence. However the epidemiological situation might be underestimated due to labour migration.
Stigma and discrimination of the infected population is increasing, especially in the case of medical workers, who are themselves considered being a vulnerable group for the infection with HIV/AIDS.
Trade unions, in line with the workers of the public service sector, also in other countries, strive for safer working conditions for the medical workers, including insurance and psychological training on how to cope with the HIV/AIDS epidemic.

**The multinational company Volkswagen** has an outstanding experience of their workplace policy and programme against HIV/AIDS to share, globally and in Eastern Europe

## HIV/AIDS IN THE WORLD OF WORK- A BASELINE STUDY

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International Labour Organisation, Geneva, Switzerland

**Issue :** The report was developed with the technical cooperation of ILO/AIDS and GTZ (Deutsche Gesellschaft für Technische Zusammenarbeit) as part of a series of studies examining the impact of HIV/AIDS at the country level. It examines the socio-economic and demographic impact of HIV/AIDS in Ukraine. It addresses the effect of HIV/AIDS on labour supply and demand in key skills and occupations, with a view to identifying current and potential shortages vital for human development and economic growth.

**Description:** The plan of the paper is as follows: Section A focuses on the recent economic and labour market situation, with analyses of the current epidemiological trends. The estimates of the epidemic and its impact on the demographic and labour market are also explored. Section B describes the macroeconomic and microeconomic impact of HIV/AIDS on the labour force in Ukraine, as well as the impact on economic variables and on human capital accumulation in various sectors. Section C identifies key areas of significance for ILO/AIDS in developing its programme of support for Ukraine.

**Results:** The study unfolded the following results: The HIV/AIDS epidemic will further intensify the fall in demographic indicators by aggravating the reduction in life expectancy and increasing mortality rates in the country. Lack of health-care facilities, nursery provision and nutrition has led to a reduction in fertility and life expectancy. There are also certain behavioural and socio-economic factors that have played a role in the rapid spread of HIV infection, not only in Ukraine but also in neighbouring countries in Eastern Europe and Central Asia. Although initially concentrated among injecting drug users (IDUs) only, the infection has started to spread into the general population. The opening up of society, the breakdown of political institutions and diminishing social cohesion have prompted a change in sexual behaviour. This significant deterioration in socio-economic indicators confirms the need to address the problem of HIV/AIDS. The fall in GDP had led to increased poverty and unemployment, sometimes driving young women into prostitution, and young men into drug and alcohol abuse. The opening up of borders has contributed to cross-border sex trade. Unemployment and increased poverty have led to the expansion of shadow economies, including those associated with crime, sex work, and trafficking, which also form the bedrock for the spread of HIV infection. Sectors such as mining, agriculture, the army and sex work have been badly hit by the epidemic. Evidence from firms suggest that businesses have become aware of the number of employees infected in Ukraine and are beginning to commit themselves to implementing workplace programmes on HIV prevention and care. At the household level, the extremely low levels of pension support force the working-age population to take care of their elderly parents, as well as look after their own children. And when young people die from AIDS, their parents are left without financial support and care in their old age, and their children become orphans with no one to take care of them.

**Lessons learned:** Based on the results obtained above, the paper develops policy implications and provides recommendations for a coherent intervention by the ILO, in cooperation with its tripartite partners. The response to the pandemic should be multi-pronged and should include implementation of an effective prevention programme at the national, *oblast*, city and township levels. It would also include employers'organizations and labour unions and assess their existing competence for active involvement in workplace programmes, training and other activities. The starting point would be an assessment of changes in the availability of key skills and occupations; review of training capacity relative to the needs of specific sectors; and proposals for system reform, so as to ensure that key labour potential is retained to meet national priorities (such as health, education etc). Moreover, any kind of programme intervention will also require involvement with the informal sector and medium-sized enterprises.

## HIV/AIDS, WORK AND DEVELOPMENT- THE CASE OF MOLDOVA

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International Labour Organization, Geneva, Switzerland

**Issue:** This paper is a joint publication by the GTZ and ILO/AIDS on HIV/AIDS in the workplace and the mitigation of its impact on socio-economic development. **The objective** of this paper is to discuss some of the essential issues that need to be taken into consideration while developing a strategy for support for Moldova, where HIV/AIDS is undermining any development progress achieved since its independence.

**The focus** of the paper is on an area that has received very little attention in the literature on AIDS in Eastern Europe– the effects of AIDS on labour markets and its implications on sustained development. The GTZ and ILO/AIDS joint project's ultimate goal is to support capacity building of government and social partners i.e. government, workers and employers in the world of work in implementing policies to prevent the spread of HIV/AIDS.

**Description:** In 2000, Moldova was ranked third among countries of CIS in HIV prevalence (24 per 100,000 populations). By the end of 2001, estimated 5,500 people live with HIV (UNAIDS/WHO estimates). The epidemic is still being driven by intravenous drug use, but there are signs of beginning of HIV-infection spread across the entire population. High and increasing prevalence of STI poses a threat of large scale sexually transmitted epidemic.

**Results:** The report reveals that the main determinants for the epidemic of HIV/AIDS include:

- Difficult social and economic situation in the country;
- Shrinking of the health care budget;
- The high rate and increasing trend of illicit drug use among teenagers and young people (especially injecting drugs);
- High STI incidence favouring the transmission of HIV/AIDS (along with a high prevalence of TB);
- Growing unemployment, deteriorating standards of living and moral values and very high levels of commercial sex;
- High migration of people of reproductive age in search of jobs and commercial sex into other countries, e.g. those with high prevalence of HIV/AIDS;

The National response to HIV/AIDS has not been adequate due to socioeconomic turmoil, deteriorating health care system and collapse of social safety nets. Although there have been various efforts to target vulnerable groups in Moldova these initiatives do not ensure a significant impact on the epidemic. The epidemic is still regarded as mainly a health issue and Inter-Departmental Committee on HIV/AIDS is chaired by Minister of Health

**Lessons learnt:** The results of the report call for immediate action from the ILO and its constituents in the following areas:

- to provide training and advisory services to government and social partners
- to provide, in the context of HIV/AIDS, care and support at the workplace ranging from protecting workers against stigma and discrimination to ensuring their access to available treatment and social security.
- to support prevention programmes at work place to reach large number of people and with high impact.
- to develop national policies on HIV/AIDS in the workplace based on ILO Code of practice , work with trade unions to ensure that workers living with HIV/AIDS do not face any discrimination from fellow workers.
- to work with employers set up optimal structures of care and support; network with available support structures if counselling and medical treatment are not available at workplace.
- To improve occupational safety and health conditions of workers at risk of exposure to the virus through the development of appropriate labour market policies.
- to integrate workplace policies into the national action plans and strategies
- to not limit the ILO response to targeted interventions for those perceived to be at risk – intravenous drug users, sex workers, etc but rather the world of work dimension should be integrated into prevention of HIV/AIDS locally.

## HIV/AIDS IN POLAND IN THE CONTEXT OF WORKPLACE

A.M. Boguslawska, K. Rozycka
The National AIDS Centre, Poland

Almost twenty years after appearing the first HIV/AIDS cases the epidemic still remains for us a challenge.

The HIV epidemics entered in to the Polish society in the early 1980s. In Poland the first HIV infection was detected in 1985 and the first case of AIDS was diagnosed in 1986. From the beginning of the epidemic to the end of July 2004 the cumulative number of people infected with HIV in Poland was 8896, although experts estimate the actual figure is between 20 and 30 000 cases, about 20% of which women. The 57,8% of all infections were due to IDU. 1453 AIDS cases were diagnosed in Poland and 705 patients died. The population of Poland is over 38 millions. A significant increase in the number of infections due to heterosexual behaviour in Poland is observed.

Within the first years of the epidemic the **state's policy** was first of all aimed at educating and informing on HIV/AIDS.

The first NGO for AIDS prevention was set up in 1989. People being an authority on medicine, humanism, law as well as social activists. Currently there are several NGO's working with the HIV issue. Government and NGOs have sought to raise awareness and concern, counteract stigmatization and perhaps most controversially „ democratize „ risk

In order to prevent social damages connected with IDU, **the exchange of needles and syringes** has been practiced since 1991.

People living with HIV/AIDS have an access to the specialized free of charge **treatment** since 1990. Presently more 2300 patients have been treated with anti-retroviral drugs.

The **methadone maintenance programmes** as a substitution therapy are available in few centres in Poland as the pilot studies. Supporting care by the health professional is essential to assist the patient in maintaining maximum quality of life and social values like equity, sense of self-esteem and self-efficacy.

Current preventive activities cover all groups of risky behaviour.

A **gradual development of stabile state's policy in management of HIV and AIDS** related issues is remarkable. It has been very dynamic for the last years and is shown among others by:

- Establishing organizational and governmental structures to deal with HIV/AIDS issues: *The National AIDS Centre; Office for Drug Addiction Prevention; and Office for Drug Addiction Crime Fighting set up by the Police Headquarters;* 14 specialized, reference centres for HIV and AIDS therapy.
- Raising funds for HIV/AIDS prevention and AIDS treatment.
- Supporting non-government organizations dealing with HIV/AIDS prevention.

Appointing provincial coordinators to deal with execution of state's policy at the regional level.

## NGO "VSTRECHA" (MEETING) - 6 YEARS OF SUCCESSFUL WORK ON PREVENTIVE MAINTENANCE HIV/AIDS and STI AMONG MEN HAVING SEX WITH MEN IN BELARUS

O.V. Eryomin
NGO “Vstrecha”, Minsk, Belarus

NGO "Vstrecha", the organization created in 1997 on the basis of the same named magazine, was engaged with preventive activity in sphere HIV/AIDS among MSM (men having sex with men) and MSB (men of sex - business).

In 1997 "Vstrecha" together with the adviser of the United Nations on a problem AIDS Henning Mikkelson and the adviser of the World organization of public health services Robert Oostfogelsom has been prepared the pilot project "Preventive work HIV/AIDS/STD among MSM, Minsk, Belarus ". From May, 1, till August, 1, 1999 at financial support of UNAIDS and WHO group "Vstrecha" the given project has been realized. Roughly with the project it is covered about 3000 representatives of target group.

From July, 29 till August, 9, 1999 two external experts and two workers of the project had been made an estimation of activity of the project. The increase at 10 % of regular use of condoms and as on 30 % from time to time, increase in a level of knowledge among target group about safe sexual behaviour, growth of comprehension of necessity cares about own health is marked.

The experts who were carrying out the review of the project, had been gave a positive estimation by results of the project, the deepening of the project was recommended, the idea of expansion of the project on some cities of Belarus has received as support.

Recommendations of experts of the review have underlain for a new 2 years projects which realization began since September, 2001

25 volunteers from Minsk and all regional cities of Belarus are prepared.

In each city “ hot” telephone lines are open. Free-of-charge anonymous inspection on a HIV and STD representatives of the given target group is organized. Information materials on HIV/AIDS/STD, to safe sexual behaviour are developed and are prepared to release.

The basic emphasis in activity of volunteers is done for work in "field" conditions, i.e. workers of the project go in places of meetings, circles of friends and carry out information-explanatory work, distribute condoms and lubrificants, coupons on free-of-charge anonymous inspection on STD.

At financial support IHRD and UNDP the project has been prolonged up to the end 2004.

# SUSTAINABLE NETWORKING OF LOW-THRESHOLD CENTRES AS A RESPONSE TO CONCENTRATED HIV EPIDEMIC AMONG IDUS IN LATVIA

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AIDS Prevention Centre, Riga, Latvia

**Issues:** Latvia experiences an ongoing outbreak of HIV-1 infections since the end of 1997, when heroin was widely introduced and IDUs population increased dramatically. A sharp increase peaked in 2001 and declined in 2002 and 2003. Implementation harm-reduction programs through a network of outreach counselling or low threshold centers (LTCs) countrywide was used to respond to concentrated HIV epidemic.

**Description:** The first needle exchange programme (NEP) was initiated by donor funding in Riga in 1997 as a response to rapidly growing epidemic among IDUs. During 1998 -1999 NEP was transformed into LTC – an easy access service for IDUs providing NEP, outreach, VCT, free condoms, disinfectants, information, psychological and social support, reference and entry to drug and HIV treatment programmes. UNDP and Baltic Sea Task Force on Communicable Disease Control Project *"Development of the Network of Outreach/Counseling Centers for Intravenous Drug Users"* was focused to expanded the network of LTCs to other municipalities and to increase role of the municipality in operation of LTC thus insuring sustainability and continuity of HIV/AIDS prevention services to high risk populations, mainly IDUs and their relatives. As of now, 12 municipalities have established and run LTCs under the supervision of AIDS Prevention center.

**Main factors of success:** The project evaluation indicates that profound preparatory work with assiduity to partnership arrangements and strong emphasis on local ownership; continuous support from key actors in the municipalities which was sustained through presence of municipal coordinators; flexible and targeted PR work and ability to find a balance in relationships with the police where the main factors which contributed to the success. Ongoing training and supervision of local staff have been of paramount importance to increase capacity of LTCs employees in area of HIV/AIDS prevention beyond the goals of harm-reduction programs.

**Main risks and challenges:** Challenges to establish LTCs have been related to finding a balance on the political level; developing the contractual framework of state-municipal cooperation; enhancing the role of social services in municipalities. In running the LTCs the main challenges included failure to choose a suitable location, retaining of outreach workers. The mistrust of the LTCs target audience into official services and conflicting mutual relationships have to be accounted for at the initial stage of operation. Boundaries of the roles of various agencies remain to be an issue: especially it concerns the police.

**Lessons learned:** The project facilitated development of new services on HIV/AIDS prevention for hard to reach populations at municipal level. Municipality administrated LTCs have been able to reach "less than half" to "most" previously hidden IDUs and are considered as focal points for provision of comprehensive social services to meet their and their family needs.

A unique countrywide system of uniform first-hand data gathering was introduced through LTCs, which forms the basis for national epidemiological HIV/AIDS monitoring as well as research.

## HIV/AIDS AT WORK PLACE

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Center of Social Expertise, Institute of Sociology,
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Upon the request of the ILO the experts of the Center of Social Expertise of the Institute of Sociology of the National Academy of Sciences of Ukraine have conducted the sociological study on "HIV\AIDS at work place" for the period of September 2003 through February 2004. The objective of this work is to study the issue of HIV/AIDS spread at work in Zakarpattya oblast' and develop a system of social indicators on the impact of HIV/AIDS at work for further monitoring. Tasks: - Assessment of the socio-economic situation in Zakarpattya oblast'; - Assessment of the impact of labour migration on the risk of HIV-infection at work; - Gender equality and HIV/AIDS at work; -Informal economy and HIV/AIDS at work: evaluation of the influence; - Factors stipulating for HIV-infection risk at workplace; - Level of awareness, attitude of the target groups towards HIV/AIDS, spread of risky behavior models in Zakarpattya oblast'; - Legal aspect of HIV/AIDS at work place; - Implementation of HIV/AIDS workplace prevention programmes at the national and enterprise level. In the course of the study: - Statistical data at the national and oblast' level on socio-economic situation in Zakarpattya oblast' have been analyzed; - 4 focus group interviews in the target groups have been conducted (truck drivers, tourism workers, railway transport workers and industry workers); - 100 experts representing health, tourism, transport and other industrial sectors, law-enforcement bodies, boundary service and oblast' administration have been interviewed; - proposals on fighting HIV/AIDS at work based on the study results have been developed; - proposals on the development of the data base and the monitoring system have been developed

## POLICY AND PRACTICE IN PRENATAL HIV TESTING: SUCCESS AND FAILUER IN THE CANADIAN EXPERIENCE

D. Guenter
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It is considered a standard of practice in Canada to offer all pregnant women HIV testing. There are 10 Canadian provinces and territories, and each one has developed its own policies on the informed consent process for prenatal HIV testing. The "opt in" policy (in which all women are offered testing and must agree before the test is done) has been adopted by some provinces. The "opt out" policy (in which all women are told they will be tested unless they sign to say they decline testing) has been adopted by others.

The actual rate of testing among pregnant women varies between provinces, with some having rates near 100%, and others approximately 50%. The type of policy in the province is not the only determinant of testing rates, but rather, the degree to which physicians have been willing to offer testing and the way that they discuss testing with women has been more important. In this presentation, I will discuss the process of developing prenatal testing policy in one Canadian province, the impact of policy on practitioners, the impact of policy on patients, and the effectiveness of policy in achieving public health goals. I will also outline the ethical debate that is taking place in Canada about prenatal HIV testing.

## GIRLGROUP A METHOD TO STRENGTHEN GIRLS AND AN IMPORTANT PIECE IN THE PREVENTION WORK, THE PROJECT GIRLPOWER IN LITHUANIA

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Save the Children Sweden Kumlinge, Åland, Finland

The Girlgroup method has proven to be useful for a number of reasons. It enforces each girl's strength. It empowers girls to have a more positive outlook on life and think as creative people, not victims. It is a method, which is developed in Sweden and Åland Island. I will stress that the focus on girls not is the same as that we say that girls and women is the problem, fact is that inequality is the problem both in a democratic sight and as a health sight. Overgoals for the project:

To promote the readiness of socially marginalized young girls and women to take part in the society in a secure and equal way.
To make socially marginalized young girls capable to take control over their own lives and to improve their self- confidence, and thus develop a means for taking part in forming the future of their lives.

To prevent young girls and women from being victims of trafficking and to empower victims of trafficking.

To increase gender equality as a part of the bigger democratisation process.
What is a Girlgroup?

It is not a school or an education even though girls and leaders learn a lot, both about society and about theme selves. It is a method, which the girls freely choose to enjoy, and it shall be fun and interesting to be in the group. Within the group the girls are given the possibility to talk about things that interests them, what they find important and things they wonder about. The girls also get the opportunity to try different activities. The main activity is discussions, and the base is "values clarification" It means providing people with skills necessary to analyse their own attitudes and actions.

Today the project has educated 36 leaders all of them from different organisation and different places in Lithuania. Now we develop new and old working methods for different subjects as the girls will discuss and handle. The leaders get mentoring and next year we start building up an education structure if finance will be found.

## SCALING UP THE RESPONSE TO HIV IN ESTONIA

M. Harro
National Institute for Health Development, Tallinn, Estonia

The prevention of HIV has been actively taken place in Estonia for more than 15 years. In the end of 80-ies HIV testing was introduced and first anonymous cabinets opened. The first national program to prevent AIDS was launched in 1992 and was based on the strategy worked out by the Association Anti-AIDS. The second national program to prevent HIV/AIDS and other sexually transmitted diseases was carried out in 1997 to 2001. The third national programme started in 2002.

***2. Focus Prevention***

Although the preventive work started in the beginning of 90-ies, and the warning signs about possible epidemic were obvious, Estonia was not able to avoid rapid transmission of HIV among injecting drug users (IDU). Two years after introduction of cheap heroin into Estonian "black market", the number of HIV-infected persons started to increase very quickly in North-East of Estonia, a county called Ida-Virumaa. In 2001 the concentrated epidemic among IDU was announced. Most of the IDU are Russian-speaking, large proportion of them does not have Estonian citizenship, medical insurance, access to medical and social services.

The highest number of infected persons (1474) was registered in 2001. It was followed by 899 persons in 2002 and 840 in 2003. The epidemic spread quickly to Tallinn, the capital of Estonia; from 7.1% of all registered infected persons in 2000 to 39.6% in 2001 and 43.1% in 2003.

The proportion of IDU-s among infected persons has started to decrease and the percentage of HIV-infection transmitted via sexual contact to increase. In 2004 the proportion of sexually infected persons is 50% in Ida-Viru and 30% in Tallinn area.

In 2002 WHO expert commission evaluated HIV prevention program in Estonia. The conclusion was that Estonia has to increase dramatically the coverage and funding and strengthen all HIV preventive services, especially harm reduction activities among IDU-s, Russian speaking and non-insured persons. Reorganisation of the coordination of HIV prevention and introduction of effective monitoring and evaluation system was strongly recommended.
The coordination of HIV prevention in Estonia was reorganised in 2003 when the National Institute for Health Development (NIHD) was founded. New opportunities to scale up the response to HIV in Estonia opened from October 2003 with the funding received from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF). NIHD has been chosen to be the primary recipient of 3.9 million US dollars for 2003-2005.

GF program has 6 main directions: young people, IDU-s, commercial sex workers, men who have sex with men, prisoners and HIV-infected persons. NIHD has more than 30 contracts with NGO-s and hospitals, that offer different preventive, testing and treatment services. Every direction has special indicators and objectives for each quarter of the program. A monitoring and evaluation (M&E) system to assess the coverage of risk groups with services and the effectiveness of preventive activities has been functioning actively since 2004. Thanks to M&E system the effectiveness of the program activities is constantly monitored and the weaknesses and implementing problems can be detected quickly.

## HIV/AIDS PREVENTION AND PEER-TO-PEER EDUCATION IN ESTONIA: THE SOUL CARE FOUNDATION EXPERIENCE

T. Kauba
Anti-Liew & Soul Care Foundation, Tallinn, ESTONIA

Issue/Problem. Estonia became a leader in EU with very high rate of new HIV infection-cases, especially among the young people. The reasons are mainly the high number of unemployment near the "heroin gate" and the extreme Estonian liberalism as a popular trend of the public opinion (*"no rules!"*). Role of mass media in the formation of this opinion has not yet studied.

The team of Soul Care Foundation (SCF) as ngo has experiences of teaching and training of family members of drug users and alcoholics more than 10 years, also the schooling of

sexual health for the school-children. The main area of SCF is mental health care, especially the secondary and tertiary prevention of illness.

Description of the Project. The peer-to-peer education is a valuable young people tool for increasing the knowledge and adequacy in communication with risk group for preventing HIV-infection and for psychological support for people with HIV.

Using special training with high-educated psychologists, medical doctors and social workers the SCF create a network of person in the age from 14 to 24 year. Groups of young peers in Tallinn and in North-East part of Estonia – approximately 170 persons - took part in special training 4 times 6 hours and will be supervised during a year. The main topic of training is sexual health education, the condom handling, all this based on the knowledge of HIV/AIDS infection. The training includes as well the first step of consultation skills (get involved in peer counseling). The preliminary basis of knowledge of peer's were tested, the results showed several misunderstanding and myths about HIV/AIDS infection.

Using for communication the direct communication and the Internet-lists (www.hot.ee/peereducation) all the participators (peers) should have more possibilities to use their activity for preventing HIV/AIDS. This peer-to-peer network is able to give valuable advice and knowledge to prevent the high-risk contacts.

## PUBLIC HEALTH ASPECT OF IMIGRATION AND HUMAN TRAFFICKING IN EAST EUROPE

E. Leskovsek
Institute of Public Health of the Republic of Slovenia

**Issue:** One out of 35 persons worldwide is an international migrant, in 2002 there were 175 million according to the IOM report that is 2.9% of the world population. 48% of them are women and more than 2 million women/children are estimated to be trafficked each year worldwide. According to the UN office for Drug Control and Crime Prevention (UN ODCCP), trafficking in human beings is now the fastest-growing business of organized crime. It is estimated that 175 000 people are trafficked from Central and Eastern Europe and the CIS each year and this number is on the rise. Russian, Ukrainians, Yugoslav, Turks and Albanian control most of the prostitution in Europe.

**Objectives:** Victims of trafficking are often subjected to extreme physical and mental abuse, torture, starvation, imprisonment, death threats and often forced drug consumption. Alarmingly, the age of women engaged in sexual exploitation is getting lower every year.

According to the RAR study in Albania on trafficked women, 74% of them have a STD, 38% during the last year. Only 5% of them were tested for hepatitis B and Hepatitis C, more than one third of the commercial sex workers who participated in the study (36%) have used drugs.
Recent data from Ukraine, registered that out of 500 00 women trafficked, 15% of them are HIV positive.

As reported in Slovenia, the new social conditions in the states of the former Eastern bloc and Yugoslavia, changing living conditions and illegal prostitution are some of the factors behind a higher incidence of early syphilis.

**Conclusion:** The response to the trafficking of human beings should point to the need of a wider approach, including public health approach and complexity of the ethical and the human rights issues.

***2. Focus Prevention***

Target interventions to modify the high-risk behavior patterns are crucial and have to be a public health priority. There is a need of an coordinative mechanism among the most relevant actors in the field in order to prevent and to reduce the vulnerability to drug abuse, to HIV&AIDS and other STDs among trafficked human beings.

## HV/AIDS AND VULNERABILITY TO HIV/AIDS

Michela Martini
IOM, Rome, Italy

Mobility and vulnerability to HIV/AIDS: the scientific evidence.
The presentation highlights the three major strategic approaches that have characterized the research on the issues of Mobility and HIV/AIDS, (leading us to the science-based evidence of the link between mobility and HIV/AIDS). The first approach tackles the epidemic spread in relation to the migration pattern. The second, compares HIV prevalence among mobile groups vs. people who do not move. A third pattern of research focuses on at risk groups on the move.

In order to explore the issue of mobility and vulnerability to HIV/AIDS several determinants have to be taken into consideration: Poverty, marginalization; Lack of legal protection; Separation from socio-cultural norms that regulate behaviour in stable communities; Work in isolated environments with limited recreation and easy access to CSWs, drugs and alcohol; Limited access to health facilities, including treatment for sexually transmitted infections (STIs) and HIV/AIDS prevention and care programmes; Types of accommodation such as single-sex, overcrowded living quarters or having to sleep in trucks;Difficult and dangerous working conditions, with high risk of physical injury; Workplaces dominated by men;Vulnerability to transactional sex, sexual abuse and sexual violence;A sense of anonymity which allows for more sexual freedom. In short the social disruption, which characterizes certain types of migration determines vulnerability to HIV/AIDS.

The international migration world-wide Over the last 35 years, the number of international migrants has more than doubled. At the start of the 21$^{st}$ century, one out of every 35 persons world-wide is an international migrant. The total number of international migrants is estimated at some 175 million persons (2.9% of the world population). Some 48% of all international migrants are women. 700.000 to 2 million women/children are estimated to be trafficked each year. People may move from one place to another - temporarily, seasonally or permanently - for a host of reasons: in search of professional or economic opportunity, to join family members, pushed by war, human rights abuses, ethnic tensions, violence, famine, persecution. As a result of conflict and of social instability South East Europe (SEE) has been heavily affected by population mobility. The number of asylum seekers is increasing rapidly changing the migration pattern in the area. *Given that there is a link between mobility and vulnerability to HIV/AIDS and that mobility is increasing world-wide, it becomes more and more important to prevent a further spread of HIV/AIDS among mobile population and support these already with HIV.*

Major concerns and recommendations. To reduce HIV vulnerability of mobile population in the long term, the socio-economic and political factors that drive mobility should be addressed. Programmes aiming to train peer educators in the workplace and to distribute prevention material and condoms are extremely important. Yet, they do not address the root causes of vulnerability. Programmes have to reinforce/protect basic human rights and improve governmental policies related to the living condition and well being of mobile population. Addressing these factors means bringing together key actors from source, transit,

and destination countries. It requires going beyond national approaches to develop regional and cross-regional approaches. According to IOM the big challenge is targeting mobile groups yet avoiding further discrimination, basing programmes on a universal right to know rather than pointing to risk groups.
In conclusion: develop a solid policy framework in each country; conduct more research looking at the mobility system; promote cross-country programme; implement interventions to reduce vulnerability and increase support; integrate actions at all stage of migration: Source/Transit/Destination/Return; promote advocacy activities aimed at integrating the policy and research. Population mobility is likely to continue to be important in SEE: it is thus critical to address migration issues when addressing HIV/AIDS in the region.

## SOCIO-ECONOMIC CONSEQUENCES OF HIV/AIDS IN RUSSIA: ILO MODEL

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The absolute number of persons living with HIV/AIDS (PLWHA) in the Russian Federation is relatively low according to official data. By January 1, 2003, there were 229049 officially registered cases in the Russian Federation, or 158 per 100,000. However, untill recently the rate of growth of newly diagnosed cases of HIV was among the highest in the world. By January 1, 2000, compared to 1996, the morbidity rate grew more than 30 times.

To assess consequences of HIV/AIDS epidemic for Russia the ILO Subregional office for Eastern Europe and Central Asia and the ILO Programme on HIV/AIDS and the World of Work has implemented a project "Modelling Socio-Economic Consequences of HIV/AIDS Spread in the Russian Federation".

The project has developed a computer model which allows the number of PLWHA to be forecasted and to assess an impact of HIV/AIDS on:

- Population,
- Labour market,
- Health care,
- Pension system,
- Short-term disability benefits.
- GDP.

The model permits the development of different scenarios of HIV/AIDS epidemic depending on assumptions on the number of PLWHA, probability to be infected by HIV etc.

The number of HIV cases would peak at 0.6 – 1.2 million in 2006 – 2008 depending on scenarios, number of AIDS cases would rise to 255,000 – 385,000 in 2010-2012.

The additional health care costs would be equal 0.25 – 0.43% of GDP in 2010-1012 (total expenditures of federal budget for health care in 2004 are expected to be equal 0.25 - 0.26% of GDP).

A projection to 2050 in comparison with scenario that ignored HIV/AIDS shows:

- GDP would fall by 1-5% with similar decrease of population,
- Incomes of the Pension Fund will fall by 2-6%,
- Expenditures on short-term disability benefits would rise by 5-7%.

Social protection systems in the Commonwealth of Independent States are similar; therefore the model can be applied to other CIS countries with some adjustments.

# GLOBAL HIV PREVENTION USING A PRIMARY HEALTH CARE MODEL: EXAMPLES FROM A WHO COLLABORATING CENTRE AT THE UNIVERSITY OF ILLINOIS AT CHICAGO

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**ISSUE:** The WHO Collaborating Centre for International Nursing Development in Primary Health Care at the College of Nursing, University of Illinois at Chicago (www.uic.edu/nursing/globalhealth), is dedicated to advancing global health through primary health care The HIV/AIDS pandemic is a global health crisis, and the need for HIV prevention is especially great in developing countries where the epidemic is widespread and resources are limited. Primary health care provides an effective, low technology, affordable approach for preventing HIV transmission. Researchers at the Centre have focused on key aspects of HIV prevention such as preparing health workers to be HIV prevention leaders and partnership with communities for grass-roots HIV prevention. This presentation will briefly discuss selected programs, includingwork in Lithuania, and then discuss lessons learned.

**Programs and results:** Health professionals foster HIV prevention by practicing universal precautions consistently in their work and personal lives and by being role models to the community. One example of this approach is the Lithuanian Health Professions Training Project. In 1997-1999, Dr. Norr and UIC colleagues as well as Mrs. Slutas of Lithuanian Mercy Lift trained over 300 Lithuanian health professionals to be informal community peer leaders in AIDS prevention and developed a training manual for Lithuania (Norr et al, 2000). The trained peer leaders now volunteer their time in AIDS prevention at work, at home and at community meeting places. The program is sustained by the national continuing education program for nurses. Other examples include the Health Motivators Project in Swaziland by Carol Christiansen, Beverly McElmurry, and colleagues from the Ministry of Health that trained community health workers (n=3200) and their nurse-supervisors (n=600) as well as local chiefs (n=300) to bring HIV prevention and home care messages to rural households. Building on the Swaziland model, they are now training Chinese nurses from 15 provinces and 4 universities for HIV/AIDS risk reduction and end of life care in China.

Using a primary health care model of nurse-community collaboration, UIC researchers have also developed programs to help communities prevent the spread of HIV. The programs integrate three essential concepts: gender inequality as a major barrier to behavioral change, the social learning and diffusion of innovations models as effective strategies for behavioral change, and the primary health care model for community-based, sustainable dissemination. One such intervention consists of six peer group sessions led by community members that has been effective in reducing risky behaviors for over 300 women in Botswana (Norr, Tlou and McElmurry) and for over 300 school teachers in Malawi (Norr, Kaponda et. al). The Malawi Project is now working with district health workers to bring the program to rural adults and young people. Dr. Dancy and colleagues have been effective in helping African-American women in Chicago reduce their HIV risk and they are now testing a program where community mothers teach their young daughters about HIV prevention.

**Lessons learned:** These primary health care models of HIV prevention emphasize availability, acceptability, affordability and partnership with the community. This approach offers several key strategic advantages:

- Programs build on the existing health care system, taking advantage of the health infrastructure to allow rapid dissemination and reduce costs.
- Partnerships between health professionals and community members take advantage of health professionals' health promotion expertise and community residents' local knowledge.

Involving participants empowers them to continue the program after initial funding and fosters hopefulness about overcoming the AIDS epidemic.

## HIV PREVENTION PROJECT AMONG VOCATIONAL SCHOOL STUDENTS AND ARMY RECRUITS IN ESTONIA

L. Priimägi
Estonian Association Anti-AIDS, Tallinn, Estonia

**Issue.** The Global Fund finances a project of HIV Prevention among vocational school students and army recruits in Estonia. The work is in most part carried out by the Estonian Association Anti-AIDS.

**Description of the Project.** During the project (from January, 2004 until September, 2005) there are planned to perform 150 4-hours trainings for total 2250 young people, about 15 participants in every group. All participants are provided with condoms and informative materials about HIV/AIDS/STDs and getting help.

The trainings are done with methods of active learning, worked out or adapted by our Association, based on publications of WHO, UNESCO and other international organizations. Topics of the trainings:

- development of social skills to understand social pressure, development of values and group norms
- development of communication, negotiation and refusing skills
- information about risks of drug use and unprotected sex
- safer sex to prevent transmission of HIV/AIDS, other STDs and unwanted pregnancy
- harm reduction when using illicit drugs
- development of participants` attitudes against unsafe sexual behavior and drug use on the level of an individual and a group.

Facilitators analyzed every training, using feedback questionnaires, filled in by participants. Young people were asked to evaluate the training on the scale 1 to 5 concerning being interesting and informative. Evaluations are processed by computer after every training.

**Results.** During 1st half of 2004, there were carried out 74 trainings (instead of planned 44) with 1338 participants (instead of planned 667). From 73% to 100% of participants have evaluated the trainings as interesting and informative.
National Institute for Health Development will do evaluation of the project. For that purpose, we ask all participants to fill in pre-training questionnaires. The Institute will ask some participants to fill in the same questionnaires 2 - 3 months later to get to know the long-term effect of the training.

## HIV PREVENTION BY TALLINN MUNICIPALITY

A.Raudsepp, E.Tomberg
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**Issue/Problem**. Tallinn, the capital of Estonia, has a population of about 400,000. Rapid spread of HIV started in 2000, mostly among drug users. In 2001–2003, 1228 people were tested HIV+ in the city, 69% aged between 15 and 24. Description of the Project The Social Welfare and Health Care Board of Tallinn City Government have been involved in HIV and drug prevention since 2002. According to the Action Plan for the Prevention of Spread of Drugs and HIV/AIDS in Tallinn for 2003 – 2007 (adopted in 2003), the city finances HIV and drug prevention projects, which are run mostly by NGOs. The most important activities to prevent HIV are: running a free of charge drug and HIV/AIDS hotline; providing interactive HIV/AIDS and drugs training programmes to young people (special programmes for at-risk

youth) in schools and summer camps; supporting youth events and media broadcasts which promote healthy lifestyle. The city also finances drug abuse treatment, incl. methadone treatment and Buprenorphine treatment of minors and young people and supports different institutions and rehabilitation groups for drug users. Projects are supervised to ensure the efficient use of finances. The Global Fund started extensive support for HIV prevention and drug users` rehabilitation in Estonia at the beginning of 2004. The Global Fund, the Tallinn City, the National Institute for Health Development and some other sponsors have started to co-ordinate their activities.

**Results**. HIV prevention activities have become more systematic compared to earlier years; most important areas are covered; double financing is less likely.

**Persisting problems**. Some important activities might discontinue owing to cash flow problems (which often occur at the beginning of a year) or if sponsors run out of money. Continuous (not project-based) financial support for the most important projects has not been achieved.

## MORE PRONOUNCED IMPACT OF SYPHILIS ON NUMBER OF NEWLY DIAGNOSED HIV INFECTIONS AMONG MSM IN REGIONS WITH LOW COMPARED TO HIGH HIV PREVALENCE IN GERMANY

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**Background:** Germany has experienced a considerable increase in syphilis incidence among men having sex with men (MSM) during the last 4 years. During the same period the number of newly diagnosed HIV infections among MSM increased only moderately.

**Methods:** We compared the development of newly diagnosed HIV infections and their correlation with syphilis incidence among MSM between HIV high prevalence metropolitan areas in western Germany including the western part of Berlin and eastern Germany including the eastern part of Berlin (former German Democratic Republic), a region with a comparatively low HIV prevalence.

**Results:** Although in Western Germany a high proportion of syphilis patients is co-infected with HIV (approx. 40-50% according to sentinel surveillance data), there is little impact of changes in syphilis incidence on the number of newly diagnosed HIV-infections. Compared to Western Germany we find a stronger impact of syphilis incidence on incidence of newly diagnosed HIV infections among MSM in the HIV low prevalence region Eastern Germany.

**Conclusions:** In Western German metropolitan areas a greater proportion of sexual risk contacts may occur between HIV sero-concordant partners, i.e. more MSM with sexual risk behaviour, that would place them at risk for syphilis and HIV, are already infected with HIV. This is probably different in the HIV low prevalence region Eastern Germany, where a greater proportion of MSM with sexual risk behaviour is still susceptible for HIV. MSM friendly facilities for diagnosis and treatment of sexually transmitted infections (STIs) may play an important role in reducing the cofactor role of STIs and thus may help to prevent a rapid increase of HIV incidence among MSM in HIV low prevalence regions (for MSM) like Central and Eastern European countries.

# SOME LESSONS LEARNT FROM IMPLEMENTATION OF PROJECTS ON HIV/AIDS ISSUES IN THE COMMONWEALTH OF INDEPENDENT STATES (CIS) COUNTRIES

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The challenge of HIV/AIDS poses a new tasks not only for state healthcare and social systems of affected countries in Eastern Europe but for Western charity organizations that have been working there for years. Thus, German organization "Diakonisches Werk der EKD" have been working in Russia and in other CIS countries for 15 years and among the projects it supports there are the projects on HIV/AIDS issues as well. Among them there is a very successful project "Educational Network on HIV/AIDS for Healthcare Professionals from State medical Institutions and NGOs from Russia. Ukraine and Belarus" that was implemented in St. Petersburg by NGO "Vozvrastcheniye" in 1999-2003. In the framework of this project more than 200 infectiologists, narcologists, toxicologists, as well as social workers, psychologists and clergymen from 16 cities of Russia, Ukraine and Belarus were trained on HIV/AIDS and drug abuse issues. A system or multidisciplinary approach and different forms of training including 10 day workshops, traineeships in different cities-participants of the projects and field visits of current projects run by NGOs have been used for reaching of the project goal. This project has shown the possibility and importance of cooperation between government and non-government structures to fight against dual epidemic – epidemic of drug addition and HIV/AIDS epidemic and great effectiveness of a system approach for education on these issues. As one of the results of this project the network of healthcare professionals and people from NGOs was created. At the moment the project on creation of network and networking of state healthcare institutions and non-governmental organizations for aid for HIV infected and AIDS affected people in Ekaterinburg in the Ural region of Russia is in active preparation. The lessons learnt show a necessity of right selection of NGO-partners in Eastern Europe as well as existence of a commitment of state and city authorities for cooperation with NGOs to establish a common infrastructure for aid for people living with HIV/AIDS (PLWHA).

## RESEARCH OF ASPECTS OF A SEXUAL LIFE OF THE PERSONS USING INJECTION DRUGS

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Sociological research has been carried out to the period from October till December, 2002 NGO "Vstrecha" on a theme « Research of aspects of a sexual life of the persons using injection drugs (IDU)». As object of research acted the consumers of drugs living in Svetlogorsk and Minsk . The basic ***purposes*** of research were:

1. Revealing the experience of the use of drugs.
2. Revealing kinds of drugs used most frequently.
3. Revealing a degree of influence of narcotic substances on a degree of sexual activity of drug users.
4. Definition of frequency of sexual contacts of IDU.
5. Revealing use of a condom among d in sexual practicies.

During preparation for the research have been put forward the following ***hypotheses*** :

1. IDU have sexual contacts mainly at short experience of consumption of drugs.
2. IDU combine some kinds of drugs
3. For IDU are characteristic bisexual relations .
4. In sexual practicies addicts do not use condoms.
5. The experience of the use of drugs influences sexual activity of IDU.
6. For IDU are not characteristic constant sexual relations .
7. The kind of a used drug determines character of sexual relations.

Gathering of the information was carried out ***by a method*** *of sociological questionnaire* and ***a method*** *formalized* (standardized, included, open) supervision.

Thus, CONCLUSIONS OF the RESEARCH.

- The experience of the use of drugs reduces sexual activity.
- At the initial stage injection drugs, it is especial perventin (“screw”), raise sexual activity.
- In drug-users’ environment homosexual relations are not welcomed, but for the sake of reception of a drug many are ready for homosexual contact.
- Risky sexual behavior is typical for drug-users.

## TOWARD A COMPREHENSIVE APPROACH TO IDU. AN HIV/AIDS TREATMENT ACTIVIST AGENDA

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UNAIDS estimates that injecting drug use accounts for ten percent of annual HIV infections worldwide, as many as one of three new HIV infections outside Africa, and the driving force behind the world's fastest growing epidemics. All of the countries of Eastern Europe, Central Asia, and many in Southeast Asia and the Southern Cone of Latin America report that IDUs account for a majority of HIV infections or a rapidly growing share of total cases. In Russia, as many as one million people have been infected with HIV in less than ten years, with over 80% of infections being among injecting drug users (IDUs), and the EU itself now contains countries where infection rates and prevalence among injecting drug users are on par with what is happening further eastward.

Although this should be a matter of urgency, HIV continues to spread among and from IDUs much more rapidly than the adoption and expansion of effective harm reduction interventions. Drug users are often stigmatised, treated badly by various institutions (along a continuum that has insults at one end and violent death at the other), explicitly excluded from treatment program or simply denied access to effective treatment and health care, based on the well establish belief that they are socially useless and intrinsically unable to adhere to treatment.

AIDS activists denounced many times that drug users still represent a minority of those receiving ARV, and called on the international community to ensure the inclusion of injecting drug users in the scale-up of antiretroviral therapy. They committed to establishing better and stronger linkages with drug users and harm reduction networks, noting that in many countries drug users have set up their own organizations that work to reduce the spread of infectious diseases, to decrease discrimination against drug users in society, and to improve medical treatment of all sorts for drug users.

AIDS activists acknowledged that in the context of antiretroviral treatment methadone or buprenorphine substitution therapy provides additional entry points for scaling up treatment for HIV, improves adherence and access to care to those who are often marginalized and discriminated against in accessing the health care system, and it has to be considered an essential component of HIV treatment. They also acknowledged that repressive national drug policies are among the main obstacles for ensuring adequate access to treatment and prevention programs for IDUs.

Harm reduction and HIV treatment activists have been building their capacity for the last years, by calling for a worldwide revolt of public opinion on injecting drugs use, denouncing that inadequate political attention and leadership contribute to the spread of HIV infection as the virus itself, acknowledging that eliminating repressive drug laws and stop widespread propaganda that blames injecting drug users for evils of all descriptions can only support the functioning of IDU in society, that good public health policy mandates that drug users can and should have access to ARV and to any other treatments they need, that drug users should not be discriminated against, and that respect for human rights and human dignity are paramount in responding to the epidemic.

The only measure of both our success or our failure will be the number of lives that are saved, the adoption and implementation of evidence based policies to ensure a comprehensive approach to injecting drug use, the elimination of criminalization, stigmatization and marginalization of drug users, and a substantial reduction in the number of drug users sent to prisons.

# ACCESS TO TREATMENT AND CARE FOR DRUG USERS

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The era of HAART (Highly Active Antiretroviral Therapy) has improved significantly the duration and quality of life of people living with HIV/AIDS in the world. However, the access to life-saving therapy is limited to a great extend to those who are leaving in the developing countries or counties with transitional economy. There is a gap between the developed world where HIV is now officially described as a chronic infectious disease and the rest of the world where HIV remains to be a death sentence for 90% of people living with HIV/AIDS.

However, there is a special category of patients whose access to treatment was not limited only by the economic barriers. But to bigger extend by unwillingness of the medical infrastructure to meet the demands of these patients, as well as moralistic and stigmatizing approach determined more by law enforcement rather than healthcare principles.

The recent studies in the western countries has shown that even with the wide availability of ARVs only 40% of ID-users are receiving HAART (Strathdee et al, 1998). More recent study from Vancouver demonstrated an increase in uptake of ART by IDUs but with still 30% of treatment eligible IDUs are not receiving therapy.

There are number of obstacles that prevent equal access to treatment for injecting drug-users in the countries of Central and Eastern Europe, including new EU countries. First of all it is stigma and discrimination in medical institutions, absence of the adequate national standards on ARV treatment, vertical and centralized AIDS-service infrastructure, limited access to substitution therapy (buprenorphine and methadone), absence of fixed dose combination, lack of political commitment to scale up harm reduction programs in countries.
Equal access to HIV treatment and care especially for those from marginalized groups is a cornerstone of any effective response to HIV epidemic that is why it is needed to prioritize public health and human rights principles over the law enforcement programs combating drug use. There are following obstacles that we need to tackle on both national and international level for moving forward effective prevention and treatment programs for ID-users in the region:

- In order to make methadone therapy available in every country methadone should become an integrated part of HIV care kit and has to be included in WHO Essential Drugs List.
- AIDS-service infrastructure should be decentralized and integrated into general healthcare system, the reference with drug treatment and TB services are critically important.
- The expertise of Harm reduction organizations should be used to a bigger extend to provide effective outreach to the target group both in terms of VCT and access to treatment, implementing peer principle for monitoring and follow up of the clients on ARV.
- Representatives of IDU community have to be involved on all levels of decision making regarding strategy towards HIV epidemic and drug policy. Feedback from the clients should be a priority factor for reforming healthcare infrastructure and changing approaches for prevention and care among marginalized groups.

## A DELPHI STUDY of SYRINGE EXCHANGE PROGRAMMES (SEPs) FROM SOUTHERN EUROPEAN COUNTRIES

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**Introduction:** PESESUD was an EC-funded project carried out between 1996 and 2000 which aimed to monitor the implementation of SEPs in France, Italy, Spain and Portugal. Two censuses of the operating SEPs were carried out and their structural, operational and activity characteristics described and compared. In addition, controversial issues regarding their operational rules were identified and a consensus process started through a DELPHI study.

**Methods:** Areas with the highest discrepancy opened to consensus development were: presence of "secondary exchangers" and provision of public health services by SEPs. Results: A first mail-questionnaire was sent to 155 individuals, and 109 responses obtained. Following analysis of the returned questionnaires, a second was designed and sent to 116 individuals (response rate of 82%). A consensus was reached in all countries, except Portugal, on the desirability of "secondary exchangers", especially in those SEPs that know or suspect low. However it was agreed that acceptance of "secondary exchangers' requires training provision as well as follow up mechanisms. . No consensus regarding payment for this activity was reached. All participant countries considered hepatitis B vaccine availability and the distribution of *Naloxone* from SEPs to be additional public health interventions that should be provided by these programmes. Several difficulties in introducing programmes were identified and a consensus that SEPs should use and take advantage of the established health care resources in the area before setting up parallel services. Conclusion: New public health programmes require attention to effectiveness of implementation measures as much as to outcome evaluation.

## POLICIES & INTERVENTIONS WITH DRUG USERS IN EUROPEAN PRISONS

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Cranstoun Drug Services – ENDIPP

The presentation will revolve around the work of the European Network for Drugs and Infections Prevention in Prison, the new name for 3 European Networks who have been on the field of prison drug policies since 1995 thanks to the continous support from the European Commission. Policies and interventions for drug users in prisons in Europe will be briefly discussed, and rational for action in this field analyzed.

## HIV PREVENTION AMONG IDUS IN PENAL CONDITIONS

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More than half of the HIV infected in Serbia is among IDUs.The studu of IDUs conducted in Belgrade showed that the prevalence of HIV infection in that population is about 10 percent,and the prevalence of Hepatitis C about 60 percent.Most of IDUs in Serbia are living in Belgrade,or about 80%.Many experts perceive the urgent need for HIV prevention throught long term interventions.The recent studies show that about the 43% of IDUs stated that they used old syringes,and in the one study 57% of interviewed IDUs said that they shared needles and syringes.One study showed that almost half of them never use condoms.

Our subjects in the project are addicts wo are on the treatment in the Department for treatment of drug addiction,there is now more than 120 patients.All of them often use old needles,share syringes,needles for tatooing;they are sexually active group,often promiscuous,sometimes they have homosexual or bisexual tendencies.They often develop "induced homosexuality" becouse they are in sexually homogenous groups.They are also prone to self mutilitation with sharp objects,and auto destructive behaviour in general.Becides this common problems, we shall pay attention to the group of female patients,becouse of overlapping of intravenous drug use and prostitution.The group on semi-opened treatment will also be treated becouse they are permitted to go out during weekends, and they are even more exposed to risk behaviour.We shall try to educate them to realize global and local importance of HIV/AIDS,by pointing to health and social consequences of this infection,particulary higlighting the ways of transmission of HIV virus.We shall try to give them advice how to protect themselves,distrubute material for education and protection.We shall work on conrol of factors that cause risk behaviour.

Our patients ae intelligent and urban population and thay want tolearn new things.We have mentioned alredy that our patients mainly have personality disorder, a complex and resistant psychopathological dimension,where every change in desirable direction and precious for them, and their environment.

## RESPONSE TO HAART IN EASTERN EUROPE

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B. Ledergerber, S. Chaplinskas, J. Gatell, J. Lundgren, O. Kirk, A. Phillips

**Purpose of study.** To compare virologic/immunologic response to HAART in regions of Europe, following inclusion of East European countries into EuroSIDA.

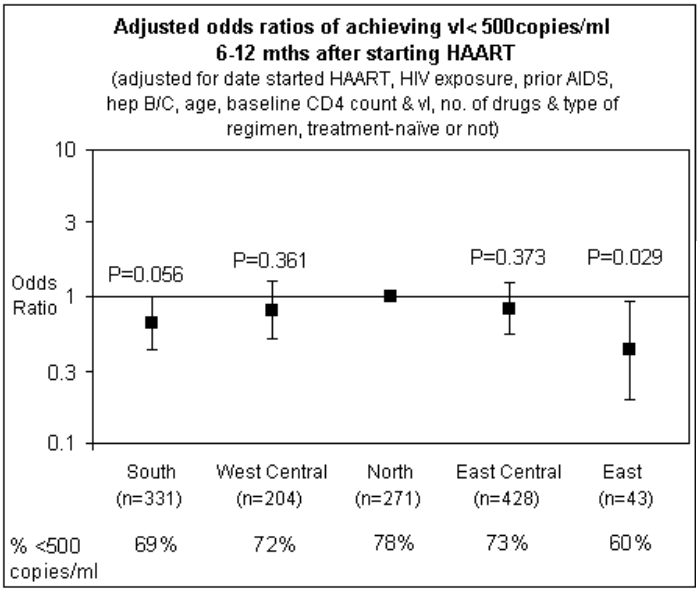
**Methods.** Virologic (viral load<500 copies/ml) & immunologic response (50% CD4 cell increase) to HAART were analysed via logistic regression on first measurements 6-12 mths after starting HAART, excluding missing values. Regions were: South (SE), West Central (WC), North (NE), East Central (EC), East (EE).

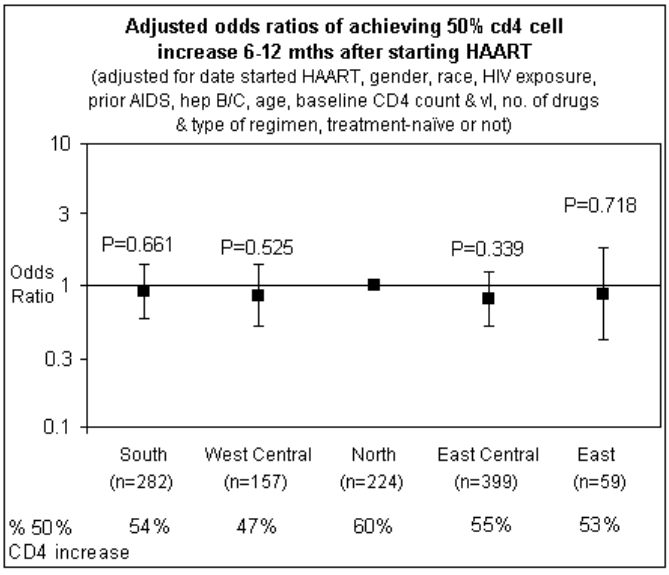
**Results.** 2582 patients who were enrolled into EuroSIDA post-1997 started HAART; 23% SE, 26% WC, 19% NE, 27% EC & 5% EE. Over half in all regions were treatment-naive at starting HAART, except for N with 42%, P<0.001**.**

After adjustment, there were no significant differences in immunologic response to HAART. There was some indication that EE had poorer virologic response but numbers of patients included are small.

**Conclusions**

Response to HAART appears to be similar across regions including EC. As numbers of patients studied in EE increase, it will be possible to make more robust comparisons between EE & other regions.



# BASELINE CHARACTERISTICS OF PATIENTS ENROLLED IN THE SMART STUDY

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**Background:** SMART is an international, randomized (1:1) trial to compare two antiretroviral therapy (ART) strategies in terms of the risk of AIDS or death among patients (pts) with baseline CD4 ≥350 cells/mm3: **A)** Viral suppression through continuous ART compared to **B)** Drug conservation through episodic ART based on CD4 count. The trial will randomize and follow 6000 pts for 6 years. We examined baseline characteristics of pts enrolled to date.

**Methods:** Trial inclusion criteria are broad; exclusions are limited to pregnant at baseline. At baseline, history of ART use, opportunistic diseases (OD), hepatitis B & C co-infection status, CD4 counts (baseline, during the past year and nadir) and HIV RNA (baseline, during past year and peak) were recorded.

**Results:** In total, 157 sites globally are registered for enrolment and new sites are currently being established including in Estonia, Lithuania, Poland, Romania, and Russia. Through June 2004, baseline data was available for 1993 pts enrolled by sites in the United States, South America, Australia and Europe. At entry mean age was 46 yrs, 25% are women, and 44% white. Median CD4 count was 582 cells/mm3 (IQR: 459-790) and median nadir CD4+ count 263 cells/mm3 (IQR: 154-380); 10% had a nadir CD4 count <50 cells/mm3. Viral load at entry was <400 copies/mL for 59% of pts, 401-10,000 for 23%, and 10,000+ for 18%. OD(s) prior to entry was seen in 25%; 3% were co-infected with hepatitis B and 20% with hepatitis C. Median time since first prescribed ART was 6 yrs (IQR: 4-8). Forty one percent of pts have taken at least one drug from all three classes of drugs, and 5% of pts are ART naïve. Median time since known to be HIV positive is 8 yrs (IQR: 5-12). Likely mode of HIV infection: 54% sexual contact with the person of the same sex, 15% prior injection drug use.

**Conclusion:** The SMART study has enrolled a diverse HIV-1 infected population on a global scale. This will enhance the generalizability of the findings of the trial. Sites from Eastern Europe will make an important contribution to the global effort to answer the key SMART research question.

# ACCESS TO ANTI-RETROVIRAL THERAPY IN EUROPE: AN OVERVIEW

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**A comprehensive response: prevention and treatment**

A comprehensive response to HIV/AIDS must provide effective prevention, treatment and care to all people living with HIV/AIDS (PLWHA). Access to antiretroviral treatment (ART) is essential, but a comprehensive response must also include a wide range of treatment, care and support options including: accessible HIV testing and counselling; prevention and treatment of opportunistic and concurrent infections (such as tuberculosis and sexually transmitted infections) and providing a continuum of care. Furthermore, a comprehensive response must integrate prevention and treatment. Evidence indicates that introducing treatment in affected communities can reduce fear, stigma and discrimination, increase demand for uptake of HIV testing and counselling and reinforce prevention efforts. ART also reduces the level of HIV in the body to undetectable levels in many patients. While the virus is never eliminated (and no one is cured), the risk of a person on effective treatment transmitting HIV is also GREATLY REDUCED. Coupled with strategies to emphasise safer behaviours of those in treatment, there will be a considerable impact and acceleration of HIV prevention.

**Access to anti-retroviral therapy (ART) in Europe**

In Europe differences in the course of, and responses to, the HIV/AIDS epidemic, result in inequities in provision of treatment and care. In **Western Europe** ART is available to all, or most, of those who need it. However, recent increases in HIV and AIDS in some western European countries raises concerns about increased risk behaviours, treatment complacency, waning Government commitment and slipping prevention efforts. In **Central Europe**, where in recent years rates of HIV and AIDS remain relatively stable and low, ART coverage is comparable with that in Western Europe. However, high levels of HIV risk behaviour, low levels of knowledge and poorly developed prevention and treatment services create conditions for potentially devastating epidemics. In **Eastern Europe,** where HIV rates increased dramatically between 1995 and 2002, mainly among injection drug users, access to ART is severely limited or unavailable. Thus in those European countries that are experiencing the most serious escalation of the epidemic ART coverage is lowest.

**Increasing access to ART**

A global '3 by 5'initiative has been launched to take extraordinary measures to dramatically increase access to ART. A global target was set to provide ART to at least three million eligible people in developing and transitional countries by the 2005. In Europe there is an urgent need to scale up access to ART, especially in countries of Eastern Europe where the gaps between treatment access and treatment need are immense. A target has been set by the WHO Regional Office for Europe of providing ART to 100,000 PLWHA, in the twenty-two countries in Europe where access to such treatment is currently less than universal. '3 by 5' will help ensure sustainability and expansion of treatment beyond the immediate '3 by 5' target by working to strengthen health systems and improving health infrastructures.

In 2003 an estimated 80,000 people in Europe met the WHO criteria for needing ART, but only an estimated 6,500 were receiving treatment with a recommended combination of at least three antiretroviral drugs (highly active ART or HAART). Recent data collected by the WHO Regional Office for Europe suggest that while overall ART coverage remains low, many countries have increased access since 2003. Many obstacles to increasing access to ART remain, not least the continued reluctance to address the particular treatment NEEDS OF INJECTION drug users, including the provision of substitution maintenance therapy.

## COMPARISON OF HIV-1 INFECTED PATIENTS FROM POLAND AND OTHER COUNTRIES ENROLLED IN THE ESPRIT STUDY

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**Background:** ESPRIT is an international, randomised (1:1), open-label trial comparing the effect of subcutaneous recombinant interleukin–2 (rIL-2) on disease progression and death among HIV-1 infected patients (pts) with baseline CD4 ≥300 cells/mm$^3$ who are on combination antiretroviral therapy.

**Methods:** We compared baseline characteristics and CD4 response to IL-2 at 8 months for Polish pts and those enrolled elsewhere (OTHER).

**Results:** ESPRIT randomised 4150 pts from 273 sites, of which 2090 were assigned rIL-2. In Poland 100 pts were enrolled, (rIL-2: 46). At entry (OTHER [Poland]) mean age was 41.3 [35.4] yrs p<0.0001, 18.5% [19.6%] women (p=0.86) and 74.6%[100%] white (p<0.0001). Median CD4 count was 466 (IQR: 374-594); [511 (406-633)] cells/mm$^3$ p=0.05, and median nadir CD4 count 200 (IQR:96-311) [165 (83-285)] cells/mm$^3$ p=0.18. Sixty-one percent [50%] were CDC cat. A, 15.2% [23.9%] CDC B and 23.8% [26.1%] had experienced disease progression according to ESPRIT definition (CDC C + additional diagnoses) (p=0.72). HBV and HCV co-infection was seen in 54% [74%](p=0.01) and 70% [100%] HCV, p<0.0001, respectively. Median time since first prescribed ART was 4 (2-6) [3 (2-5)] yrs, p=0.01. Likely mode of infection: 47% [28%] sexual contact with the person of the same sex, 29% [9%] sexual contact with opposite sex, 6% [54%] IDU p<0.0001.

After 8 months of IL-2 treatment median CD4 count was 700 (524-950) [886 (682-1167)] cells/mm$^3$, p=0.0008, with a median change of 221 (71-402) [370 (176-591)] cells/mm$^3$, p=0.002. Fifty-five percent [75%] of subjects achieved a CD4 count rise ≥ 200/mm$^3$, p=0.008.

**Conclusion:** ESPRIT is the largest international study to evaluate treatment benefits of IL-2 in HIV-1 infected pts. A diverse patient population has been enrolled. Polish pts are primarily young IDUs co-infected with HCV. Polish pts had a better IL-2 treatment response after 8 months of treatment, but assessment of clinical benefit requires several more years of follow-up.

## REGIONAL ADVISER HEALTH TECHNOLOGY AND PHARMACEUTICALS WHO REGIONAL OFFICE FOR EUROPE

K. de Joncheere
Regional Adviser, Health Technology and Pharmaceuticals,
WHO Regional Office for Europe

Access to anti-retroviral medicines has become a major concern worldwide over the last few years. As the AIDS epidemic continues to spread, the pressure on health care systems to finance the medicines and on pharmaceutical companies to drop the prices, has rapidly

increased, not only in Africa, but also now in many of the middle income countries. Whereas for the very poor countries, major price reductions have been achieved, through direct negotiations, and also making use of the public health safeguards contemplated in the WTO/TRIPS agreement, the situation in the middle income countries in Central Europe is becoming increasingly complex. While the numbers of patients under treatment are growing, prices of ARV`s are largely similar to those in western European countries. The situation is further complicated due to the patent situation and EU single market principles, that influence the possibilities for price reductions.

This session will present an overview of pricing issues on ARVs in Central Europe, it will present a price comparison, and it will discuss the various strategies that could be employed to bring prices down, including generic competition and patent issues, pooled procurement, direct price negotiations, and decreasing taxes and duties.

Possible options for further progress in this area will be presented ".

## SOCIAL AND CULTURAL PROBLEMS OF HIV PREVENTION IN EMIGRANTS FROM THE FORMER USSR TO GERMANY

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Since 2002 an epidemic outbreak of HIV infection has been recognized in countries of the former USSR. More than two million people from those countries – mostly late German emigrants and Jews – have emigrated to Germany since 1950. The number of emigrants has decreased over the last years but remained at a relatively high level with a peak of 71.000 new refugees in 2003. The German Ministry of Health encourages now primary preventive measures against HIV infection. The adequate adoption of HIV prevention is the most important aspect in this campaign.

The HIV prevention campaign for emigrants from the former USSR has to face some serious problems. Emigrants are confronted with a complicated integration process and with social isolation. One important aspect is the lack of adequate language skills. Most of the late German emigrants have worse German skills than early refugees have. Unfortunately, the duration of a German language course has been reduced from 12 to 6 months because of a shortage in governmental financing. Inadequate language skills cause difficulties for medical and social organizations to propagate disease and HIV prevention measures. Especially in intimate situations for which HIV prevention measures the presence a third person or translator is not always possible.

Another aspect is the cultural shock regarding life style, culture norms and social values of the western European society. Emigrants often come from various social, cultural, educational backgrounds. The grew up in a socialistic-communistic system with corresponding ideals and norms often coming from small villages of East European or Asian republics with traditional and conservative values. Those values seem to be inappropriate and wrong in the new society. This affects their social life in respect of sexuality, homosexuality and alcohol consumption. They have never learned to manage HIV prevention with a partner or in the family at a western European standard.

Adequate HIV prevention in the population of emigrants from the former USSR has also become difficult because of little information about the situation and the absence of social and cultural investigations. How is the prevalence of HIV infections, the mechanism of transmission, sexual behavior, individual knowledge about infection and prevention,

acceptance of using adequate preventive measures? The following investigations try to elucidate these questions and develop new strategies of HIV prevention for emigrants from the former USSR to Germany.

## SECOND GENERATION HIV SURVEILLANCE IN A LOW HIV EPIDEMIC COUNTRY, SLOVENIA

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**Introduction:**
HIV surveillance is essential for the development of evidence based prevention and control strategies, targeting interventions and monitoring their impact.

**Methods:** Second generation HIV surveillance is based on (1) universal cases reporting (HIV/AIDS cases, AIDS deaths); (2) monitoring changes in HIV infection prevalence (among men who have sex with men (MSM), injecting drug users (IDU), patients of clinics for sexually transmitted infections (STI), clients of national HIV testing site, pregnant women, and blood donors); (3) behavioural surveillance among MSM and IDU; and (4) interpreting STI surveillance data. In addition, other relevant high-risk behaviour information is collated.

**Results:** Until 2003, the annual reported incidence rates of HIV infection ranged from the lowest 1.5 per million population to the highest 10.5 per million population. Annual reported incidence rates of AIDS ranged from the lowest 0.5 per million population to the highest 8.0 per million population and AIDS deaths from the lowest 0 per million population to the highest 6.0 per million population. The national annual HIV prevalence estimates for IDU varied from 0% to 0.7%, for MSM from 0% to 3.4%, for STD patients from 0% to 0.5%, for pregnant women from 0% to 0.01%, and for blood donations from 0% to 0.003%. The proportion of IDU reporting sharing needles and syringes at first treatment demand has decreased from 42% in 2000 to 27% in 2003. It is of concern, that the proportion of MSM who reported to have never used a condom at anal sex during the preceding year doubled in 2002 and 2003 in comparison to 2000.

**Conclusions:** Slovenia remains a country with a low level HIV epidemic. The most affected group are men who have sex with men. Fortunately, rapid spread of HIV among IDU and their sexual partners has not begun yet. Second generation HIV surveillance should be developed further. Monitoring selected high-risk behaviour indicators in groups at higher behavioural risk for HIV should be strengthened with targeted behavioural surveillance surveys with integrated biological indicators in these groups.

# STUDY ON THE KNOWLEDGE, ATTITUDES AND BEHAVIOUR REGARDING AIDS SEX AND SEXUALLY TRANSMITTED DISEASES AMONG THE ADULT POPULATION OF THE LIMASSOL TOWN AND RURAL AREAS, CYPRUS 2000-2001

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**Issue/problem**

Cyprus is a low prevalence country for HIV/AIDS, where the main mode of transmission is sexual intercourse. Behavioural surveillance, in addition to biomedical surveillance, is essential for early warning and improved response to the epidemic. The general population was targeted for behavioural surveillance related to HIV/AIDS.

**Description of project**

A cluster survey was carried out in 2000/2001 among permanent residents of Limassol town and district, which have the highest rates of HIV infection. The participants, 243 and 262 women aged 18 to 50, self-completed anonymously a questionnaire, after being instructed by trained interviewers.

**Results**

Participation rate was 84%.
Mean age at first sex is 17 years for a man, 20 years for a woman. Sex with a person of the same gender is reported by 6,3% of men and 3,8% of women. Having been forced to have sex is reported by 5,7% of men and 7,0% of women. Among those who ever had casual sex in their lifetime, 63% reported condom use and 37% non-use during the last casual intercourse. Intravenous drug use is reported by 1,7% and having had sex with someone who used drugs by 2,4%.

Main modes of HIV infection are acknowledged by 80%-98% of participants and main modes of protecting oneself by over 93%.
Guarding virginity until marriage was essential regarding women for 35% of participants and regarding men for 14%

Sixty eight percent could be friends with an HIV-infected person and 84% disagree that they should be isolated.

**Lessons learned**

Despite adequate knowledge and late onset of sexual activity compared with other European countries, risk factors (inadequate condom use with casual partners, sex between men, intravenous drug use) and traditional gender prototypes are documented, guiding prevention and future planning of services and interventions.
This pilot study will guide future research, providing insight into key areas for further investigation and improvement of the questionnaire content and structure.

# HIV-PATIENTS ACROSS EUROPE: REGIONAL DIFFERENCES IN PATIENT CHARACTERISTICS.

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**Purpose of the Study:** To compare characteristics of HIV-patients (pts) in regions of Europe with special focus on Eastern Europe.

**Methods:** Analysis of 7104 HIV-pts under active follow-up in September 2003 within the EuroSIDA study. Regions were: South (SE), West Central (WC), North (NE), East Central (EC) and East (EE).

**Summary of Results:** 7104 pts were included (Table 1). Pts in EE were younger and primarily IVDU. 33% of these pts were co-infected with HCV. A shorter duration of known HIV-infection, a higher nadir CD4 count and a lower percentage with an AIDS diagnosis in CE and EE reflect a more recent epidemic in these regions. There were several regional differences in the pattern of AIDS events. Of special interest, the percentage of pts with pulmonary tuberculosis (TB) among all pts with an AIDS diagnosis was higher in EE, CE and SE. Fewer pts in EE received HAART. This was also true after adjustment for other regional differences. Odds ratio of beeing on HAART for EE versus NE was 0,27 (CI 0,2-0,36).

**Conclusions:** These results reflect substantial regional differences in demographic and clinical characteristics of HIV-pts across Europe and demonstrate the more recent epidemic in CE and EE. The implications of the limited usage of HAART in EE require continuous follow-up. The high percentage of AIDS pts in CE and EE who have TB is a special concern, as high prevalence of multi-resistent mycobacteria have been reported in these regions.

**Table 1**

Characteristics of patients followed in September 2003 in the EuroSIDA study

| | SE (n=1888) | WC (n=1911) | NE (n=1974) | EC (n=890) | EE (n=441) | p-value |
|---|---|---|---|---|---|---|
| Age, yrs; median (IQR) | 41 (37-47) | 43 (39-51) | 44 (39-52) | 36 (31-44) | 30 (24-39) | <0,001 |
| Female, % | 28 | 23 | 18 | 30 | 31 | <0,001 |
| IVDU, % | 29 | 14 | 11 | 30 | 51 | <0,001 |
| AIDS diagnosis, n (%) | 509 (27) | 588 (31) | 684 (35) | 214 (24) | 117 (26,5) | <0,001 |
| Pts with pulmonary tuberculosis, n (%) | 74 (16) | 66 (11) | 63 (9) | 42 (20) | 20 (17) | <0,001 |
| HCV, % | 30 | 17,5 | 13 | 34 | 33 | <0,001 |
| CD4 count cells/mm3; median (IQR) | 459 (291-679) | 429 (281-601) | 449 (300-620) | 484 (297-659) | 337 (185-593) | <0,001 |
| Nadir CD4 count cells/mm3; median (IQR) | 150 (57-263) | 131 (49-229) | 113 (42-200) | 144 (65-270) | 270 (131-476) | <0,001 |
| Time from HIV diagnosis, mths; median (IQR) | 122 (78-164) | 134 (96-177) | 136 (96-186) | 75 (39-119) | 32 (18-53) | <0,001 |
| on HAART, % | 77 | 80 | 84 | 78 | 30 | <0,001 |

SE: Spain, Portugal, Italy, Greece, Serbia and Montenegro, Israel, Argentina
WC: France, Belgium, south Germany, Luxembourg, Switzerland, Austria
NE: United Kingdom, Ireland, Netherlands, north Germany, Denmark, Sweden, Norway
EC: Poland, Czech Republic, Slovakia, Hungary, Romania
EE: Estonia, Latvia, Lithuania, Belarus, Ukraine, Russia

## WOMEN AND HIV/AIDS IN ESTONIA

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HIV (human immunodeficiency virus) infection started to increase from 2000 in Estonia. By the end 2003, 3699 people were tested HIV-positive in Estonia since 1988 when registration of HIV-positive cases began. Of the new HIV infections in 2000 to 2003 most cases have been attributed to injecting drug use. But the number of new infections via heterosexual contact is rising steadily.

The number of women with HIV infection has also been increasing steadily in Estonia. By the end of July 2004, according to the Health Protection Inspectorate a total of 959 women aged 15–49 had been registered as HIV-positive in Estonia since 1988, accounting for approximately 25% percent of adults registered. The most vulnerable group among women is the 15-19 and 20-24 aged. In previous years there were more new HIV-cases among men in every age group. In 2004 for the very first time there were more new HIV-cases among 15–19 year old young women than among men in the same age group.

The estimated number of injecting drug users (IDU) in the whole country is 12 000 – 15 000. Approximately 25% of IDUs are young women, some of them have already contracted HIV and they may give birth to children who are also HIV-positive.

Another group of women who are at especially great risk of contracting HIV and other sexually transmitted diseases is commercial sex workers (CSW). According to the experts the number of CSW in Estonia is approximately 3 000–5 000 (UNAIDS 2002). Many of CSW are also drug users.

In Estonia every pregnant woman attending antenatal clinic is suggested to take a HIV test and most women agree to do so. The number of pregnant women tested positive has also increased in recent years being 35 in 2001, 55 in 2002, and 64 in 2003. The first case of HIV in pregnant woman was registered in 1993 and the first birth from HIV-positive mother in 1999. By the end of 2003 in total 63 HIV-positive women had given birth and 5 children were known to have acquired HIV from their mother.

By the end of 2003 43 people were diagnosed as having AIDS in Estonia since 1992. Only 3 of them have been women aged 15–29.

It is also well known that HIV leads to rapid increase in TB incidence. In general after the regained independence in Estonia the incidence of new cases of tuberculosis, mortality and multidrug resistant tuberculosis have continuously increased since 1993. There have been 42 cases of dual infection with tuberculosis and HIV by the end of 2003. Most of them were people aged 20 to 44. 23% of them were women and 77% were men.

# RISK BEHAVIOR OF ESTONIAN YOUNG PEOPLE IN THEIR SEXUAL RELATIONSHIPS – RESULTS OF A YOUTH SURVEY IN 2003

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**Objectives:** The research *Knowledge, Attitudes and Behavior related to HIV/AIDS Among Estonian Youth* was carried out among young people aged 10-29 for getting a better overview of youth's: level of knowledge; scope of risk behavior; attitudes and stigma, and sources for getting information in relation to HIV/AIDS. The present abstract gives an overview of the study results on 14-29 year old young people's risk behavior in connection with their sexual relationships.

**Methods:**

- Sampling: 2 separate samples: 10-18 years old young people - uniform sequence selection; 19-29 years old - stratified random sample.
- Questioning: 10-18-years old - during the visits of the school lessons, 19-29 years - by mail. Questioning was carried out from February to May 2003.
- The data of 6.499 young people was used for analyses.

**Results:**

- Amount of young people who have experienced sexual intercourse: 14-15 – 20%, 16-18 – 47%, 19-24 – 89%, 25-29 – 97%.
- Amount of young people who have had two or more partners during last 12 months: 14-18 – 38%, 19-29 – 30%.
- Amount of young people using condoms: 51% of those aged 14-18 used always condoms in the case of non-regular partners during the last 12 months. In the case of 19-29-years old young people the figure was 36%.
- The main reasons for not using the condom: steady partner and mutual trust, do not believe that the partner has STD or HIV, condoms are not always at hand.

**Conclusions:**

- The group aged 19-29 includes most young people with the highest risk level in sexual relationships.
- The risk liable sexual behavior is more common among the young men; especially among grown-up men.
- The young persons aged 19-29 with lover education level risk more in their sexual relationships.
- The ones who are more aware of the matters related to HIV transmission are also more aware of the prevention method of STDs. The relationship between knowledge and risk behavior is controversial in different age groups.

## DEVELOPMENT OF THE HIV/AIDS EPIDEMIC IN UKRAINE

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The first HIV-positive cases in Ukraine were recorded in 1987 when population screening for the HIV antibodies was started. Until 1994 (inclusive) HIV spreading was sporadic and slow. It was primarily sexually transmitted, with prevalence of the heterosexual transmission. The ratio between HIV-positive males and females was virtually equal. The overall number of HIV-positive residents of Ukraine recorded over that period was 183 cases.

Late in 1994, the first two cases of the HIV infection were identified among injecting drug users (IDUs) residing in Nikolaev.

In the early 1995, the cases of HIV-infected IDUs were recorded in Odessa. Later on, the number of recorded HIV-positive IDUs started to grow in geometrical progression.

Representatives of this risk group in other regions have quickly got involved into the epidemic process, and, in 1997, there was no region left in Ukraine where HIV-positive would not be recorded.

In Ukraine, during the period of 1987-2004, the dynamical change of the HIV transmission ways has been observed:1987-1994 – the sexual way prevails;1995-1998 – the parental way dominates; 1998-2004 – the part of sexual way of transmission grows, which entails the growing part of HIV-infected cases among newborn children.

Thus, there are three developing waves of the epidemic in the country: first one is most aggressive – among IDUs; second one is slow, but it exceeds the bounds of certain groups and covers general population, and third one is consequence of two above-mentioned ways, which is observed among newborn children. Epidemiological surveillance shows that in case of no ARV prophylactic is undertaken - 25-30% of children, who was born from HIV-positive mothers, will be infected with HIV.

If the first two waves require big efforts to stabilize the situation, the prevention of HIV-infection among children born from HIV-positive mothers, can be realized already today. With the support and participation of the international organizations, such as UNICEF and “Medicine san frontier”, the preventive activities, started in Ukraine, led already to the positive results, demonstrated in Odessa, where percentage of HIV-infected children, born from HIV-positive mothers decreased by 3 times.

The results of the HIV sentinel surveillance which, with the UNAIDS support, was in the first time conducted in Ukraine, has shown the high level of HIV prevalence among IDUs in six large cities – within the limits of 17-64%. In the same cities the routine surveillance has revealed that only 10% IDUs are HIV infected.

According to statistical data, the greatest number of HIV positive was officially recorded in 1997 - 8,934 cases. In the beginning of 1998, the number of cases decreased: 1998 – 8,590 cases, 1999 – 5,830 cases. Starting from 2000 there was increase of cases - 6,216 cases, 2001 – 7,009, 2002 – 8,761, 2003 – 10,013 cases.

According to the data from the Ukrainian AIDS Center, as of 01.01.04, 62,672 of HIV infected people have been registered in the country, including 40,366 IDUs and 6,185 children, born from HIV- positive mothers; 6,175 AIDS cases are diagnosed, about 3,592 patients have died from this disease. The average level of the HIV prevalence in the country is 98,08 on 100 thousand population. The HIV transmission through the parenteral way among IDUs is still dominating. Last time the increase of heterosexual transmission of HIV took place and the percentage rate of the transmission came to 38% of all cases. Heterosexual transmission occurs mainly through sexual partners of IDUs.

# HIV INFECTION IN SR – OVERVIEW OF SURVEILLANCE STUDIES /1996-2003/

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The first HIV-positive case was found in the former Czechoslovakia in 1985. In 1986 mandatory testing of blood donors was established in western Slovak Republic and in 1987 it was established all over SR. Now mandatory testing is required for blood, sperm, tissue, organ and milk donors. From 1986 to June 30, 2004 there have been 200 HIV-positive cases registered in SR, of which 73 were foreigners. 79 of 127 infected Slovak citizens were infected by unprotected homo/bisexual contacts. Only 2 persons were infected via injecting drugs. Six newborns were born to HIV-infected pregnant women, 5 were confirmed HIV-negative and one left SR with his mother after delivery. Recently 1-2 newly diagnosed HIV-positive cases have been found in SR per month.

Overview of HIV surveillance studies in SR /1996-2002/
/provided in NRC HIV/AIDS, Slovak Medical University, Bratislava/

| year | tested group | cooperating organization | HIV+ cases (%) | No. of tested persons |
|---|---|---|---|---|
| 1996 | MSM | NGO Slovak AIDS Help (Bratislava) | 5.4<br>1.6 | 170<br>124 |
| 1997/8 | IVDUS | GO Inst. for Treatment of Drug Dependencies (Bratislava) | 0 | 276 |
| 1997 | Youth | Secondary schools(Bratislava) | 0 | 952 |
| 1998 | Prisoners | GO Corps of Prison & Court Guard (Bratislava, Nitra, Martin) | 0 | 32 |
| 1999 | IVDUs/CSWs | NGO Odyseus (Bratislava) | 0 | 75 |
| 2001 | Roma | Roma NGOs | 0 | 116 |
| 2001 | IVDUs/CSWs | NGOs Odyseus(Bratislava), Prima(Bratislava), Heureka(Banska Bystrica) | 0.82 | 121 |
| 2002 | Pregnant women | Dept. Inf. Dis.of Derer´s Hospital (Bratislava) | 0 | 96 |

# THE IMPORTANCE OF PARTNERSHIP ON HIV/AIDS PREVENTION AND CONTROL IN MUNICIPALITIES OF LITHUANIA

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**Issue/problem:** In Lithuania, about 80 percent among HIV positive people are injecting drug users (www.aids.lt). It is very important to coordinate and concentrate efforts of state institutions and municipalities and non-governmental organizations (NGOs) on this issue. Coalition "I can live" (Coalition) unites 13 NGOs, 3 state and municipal institutions which are seeking to influence decision making processes concerning vulnerable groups (people with HIV/AIDS, drug users, sex workers, etc.). Municipalities in Lithuania have obligations to support health care of their population, prepare and implement health programs, carry out primary health care and public health services, provide social services, and organize education for children, youth and adults and the protection of children and youth rights. These issues have close connection with HIV/AIDS prevention and control.

**Description of the project:** Coalition carries out the project and organizes round-table discussions and surveys for politicians and state servants in municipalities, leaders of health care and public health, social and educational institutions, and NGOs.

**Results and lessons learned:** in 2004, four round-table discussions were organized and surveys carried out in municipalities the Vilnius, Kaunas, Klaipėda, and Alytus cities. The main problems were identified:

- financing of municipal health programs for HIV/AIDS prevention and control had interruptions;
- municipalities have few possibilities to financially support people at risk who are not covered by the state health insurance system;
- there is a lack of inter-sectoral team work and transferability of vulnerable groups between institutions;
- development of low-threshold programmes for drug users for prevention of HIV/AIDS and other infections on community level is slow;
- there is a lack of standards of the syringe and needle exchange services;
- there is a lack of training material and courses for municipal politicians, decision makers and specialists in the field of HIV/AIDS and related issues;
- there is a lack of the partnership activities for vulnerable groups and their relatives;
- tolerance level among specialists and leaders of municipal authorities towards socially excluded persons (people with HIV/AIDS, drug users, sex workers etc.) is low.

# COORDINATION MECHANISM IN THE FIELD OF DRUGS BEST PRACTICES: LITHUANIAN EXAMPLE

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The drug phenomenon is undoubtedly one of the most complex problems of our time. It involves a wide variety of issues and disciplines such as ethics, culture, health, sociology, criminology and etc. Single actions in specific spheres can be useful but the overall effectiveness is conditioned to the linkage of single activities in a "multidisciplinary approach". This is underlined in the several treaties and documents providing the basis for international drug control: UN drugs conventions, the Political declaration of the United nations General Assembly Special session and in the EU Strategy and Action plan on Drugs. A main thread traced in all these texts, is the need, for each country to find mechanisms and systems that could assure implementation of measures in the field of drug prevention and drug control. Coordination mechanisms are therefore identified with the concept of *"effective systems against drug abuse and illicit trafficking"*.

Coordination in the field of drugs is not a novelty in the European Union, however it is a new thing for Lithuania and all other countries, which joined the European Community on the 1st of May 2004. Coordination as a whole is an essential compliment to manage the different sides within public administration. Interdepartmental coordination of drug control and drug prevention in the country is not only the object of the United Nations conventions' but also one of the main strategic tasks of the European Union Drug Strategy against drugs for the year 2000-2004.

The meaning of coordination can be rather different according to the country concerned. In Member states coordination of drug policy is usually located at the highest hierarchical level in government. Furthermore, if we look at the "coordination instruments" in the European Union and Norway, the main charactersing elements are type of drug coordination, location of the drug coordination and scope of the drug coordination.

Drug problem became especially relevant in the past few years. According to the Drug Control Department data 69031 addicts were registered in the year 2003 and 4698 out of the total number are drug addicts. 18,4 percent out of the total number are women, 81,6 percent are men. During the last year 48 deaths were related to drug use.

In order to settle the problems related to an implementation of the drugs prevention and drug control policy the Drug Control Department under the Government of the Republic of Lithuania was established on the 1st of February 2004. The department is a coordinating institution on the national level. The main tasks of the Department are to implement drug prevention and drug control policy, to organize an implementation of the measures of drug prevention and drug control as well as to coordinate activities of state and municipal institutions and organizations in the sphere of drug prevention and drug control. In order to find the most suitable and relevant variant of coordination mechanism for Lithuania, methods of drug control policy in the European Union and Norway were analyzed. The issue of coordination mechanisms is of vital importance and thus a lot of attention is given to it both on the national and international levels. The department cooperates closely both with national and international institutions, non-governmental organizations, media and other interest groups. On the international level, the department works with European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). To this end, the Focal point was established in Lithuania, which ensures collection, analyses as well as dissemination of data and information on drug issues. It also cooperates with EU institutions, international partners and with non-European countries.

Establishment of such department in Lithuania shows that necessary steps to solve problems in the field of drugs are being taken. Activities of the department were also highly praised in the Annual Report of European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

## PUBLIC ENTERPRISE BUSINESS COALITION AGAINST AIDS

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HIV/AIDS is a problem that affects everyone all around the world; therefore everyone should be involved in trying to prevent it. Public Enterprise Business Coalition Against AIDS started its activities in 2001 when initiative businesswoman Loreta Bosiene united partial businessmen and businesswomen in Klaipeda city. Business Coalition Against AIDS initiate, encourage and financially support various activities, international conferences with neighborhood countries, seminars with the Baltic countries and prevention projects in the field of HIV/AIDS and substance abuse. Business Coalition Against AIDS works in partnership with active NGOs:

- (NGO) Youth Health Center "Peers" (Bendraamžiai");
- (Public enterprise) "Seashore Health House" ("Pamario sveikatingumo namai");
- (NGO) "AIDS prevention education center" ("AIDS profilaktikos ir žinių propagavimo centras").

In 2001 Business Coalition Against AIDS and Youth Health Center "Peers" established the first anonymous consultation cabinet for adolescents that started to provide youth friendly services in Lithuania. At this moment doctor gynecologist voluntary and free of charge consult and provide medical examination for young girls.

As it was mentioned above Business Coalition Against AIDS organizes various activities. The latest and the biggest activities organized with the partner organizations were:

- Civil initiative "Klaipėda citizens - lets protect children from drugs";
- Action "We are for the class without drugs".

## THE EPIDEMIOLOGY OF HIV IN LITHUANIA

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**Background.** HIV/AIDS epidemics trends are similar in the Eastern Europe and Baltic countries including Lithuania. However the epidemic situation is much better in Lithuania. Present research has an objective to analyse HIV transmission trends in Lithuania.

**Methods.** Research performed retrospectively Research type – descriptive epidemiological investigation. Research group included 906 HIV positive people (reported data: from 1988 to 30.06.2004). Mathematic statistical data analysis was performed by application of statistical SPSS 7.0 package. Indicator distribution was counted in absolute numbers and in percent, statistical reliability indicator "p" also analysed.

**Results.** 906 HIV positive people were reported in Lithuania (24,4 cases for 100,000 population). Up to 1997 the sexual HIV transmission mode prevailed in Lithuania. First HIV cases were reported in homosexual community. In 1997 HIV entered intravenous drug user (IDUs) community and up to 30.06.2004 HIV was still predominantly transmitted parenterally, e.g. through contaminated needles while injecting drugs intravenously. 80% of new annual HIV cases have been IDUs. However since 2003 number of heterosexual HIV transmission cases has been on increase. 78 people acquired HIV heterosexually ( in 2003 – 13, in 2004 - 8 people acquired HIV heterosexually). Retrospective analysis proves reliable twofold increase of people infected through heterosexual intercourse as compared with 2002

($p<0.05$). 2 cases of homosexual HIV infection were identified in 2004, which is reliably less than in 1999 and 2000 ($P<0.05$).

**Conclusions.** The main HIV transmission mode in Lithuania still remains intravenous drug injection. However the critical point was reached for virus spreading through heterosexual intercourse. Number of new HIV cases in homosexual community is not high but latent since HIV infection is diagnosed in this group on the latest stages of infection. However Lithuania is still a country with low HIV prevalence.

## DRUG USERS' SOCIAL AND PSYCHOLOGICAL REHABILITATION: ANALYSIS OF RESULTS OF LITHUANIAN AIDS CENTRE

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**Objective:** Evaluation of results of Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts in 1993-2003.

**Methods:** Questionnaire for drug users, who were accepted to community in 1993-2003. Also questionnaire was designed for directors of drug users rehabilitation communities to evaluate impact of LAC rehabilitation community on their work.

**Results:** Lithuanian AIDS centre's psychological-social rehabilitation community for drug users can accept 13 patients. They are treated by DAYTOP (Drug Addict Youth Treatment on Probation) programme. In 1993 – 2003 116 drug users were accepted in rehabilitation community. 64 (55%) of them succesfully graduate full course of treatment. 12 patients (10%) also stopped to use drugs, though they do not finish full course of treatment. 13 patients are still in rehabilitation community and participate in program at present moment. So from all 116 patients, who get help in rehabilitation community, at present moment do not use drugs 89 patients (77%). Most of them after graduation of treatment course get job (90%). 6 of them work in Lithuanian AIDS center. At all there were treated 77 men and 30 women in rehabilitation community. The mean of their age is 26 year.

Twelve directors of drug users rehabilitation institutions were questioned. All rehabilitation communities completely or partially base their activities on Lithuanian AIDS Center's publication "Methodical recommendations for drug users psychological-social rehabilitation". Nine directors of rehabilitation said that specialists of drug users psychological rehabilitation community of LAC consulted and trained them. The participants think that this help was very useful in practice. Once a week the LAC welcomes and consults the representatives of other organizations. Four of twelve rehabilitation organizers completed drug users psychological-social rehabilitation of LAC and do not use drugs. Three institutions also noted that ex-drug users work and share their experience with staff and help drug users. Six out of twelve rehabilitation institutions state that they invite periodically LAC specialists to their institutions to deliver lectures for patients and staff on HIV/AIDS prevention.

**Conclusions:** After evaluation of results of Lithuanian AIDS centre's psychological-social rehabilitation community for drug users in 1993-2003 it is possible to say that treatment program applied by rehabilitation centre is effective. Also activity of LAC rehabilitation community had significant impact on other rehabilitation communities for drug users in Lithuania by providing professional counselling and methodological help.

# COST-EFFECTIVENESS OF LITHUANIAN AIDS CENTRE'S PSYCHOLOGICAL-SOCIAL REHABILITATION COMMUNITY FOR DRUG ADDICTS

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**Background:** Evaluation of cost-effectiveness of Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts.

**Methods:** The financial analysis of activity of Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts was made. The harm which untreated addicts cause for society was evaluated. Also cost-effectiveness and resources of Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts was evaluated.

**Results:** The rehabilitation community cost for governmental budget is 176 000 Lt (44 000 $) per year. The course of one addict treatment cost 14 000 Lt (3500 $). This is small cost because:

1) Untreated drug addict spend about 47 750 Lt (11937,5 $) for drugs per year. The average daily dose of drugs for one addict cost 130 Lt (32,5$). The money for drugs usually are get by various crime.

2) Untreated drug addicts cost for governmental budget even more. Such are intensive therapy in hospitals (HIV/AIDS, hepatitis, sepsis, and other illnesses), the disturbance of relatives of addicts and the impact on their working abilities, the cost of investigation of crimes made by addicts, imprisoning, introducing of other persons into drug use and etc. This cost can be hardly estimated exactly.

3) Most of rehabilitation community's patients get jobs successfully and return the money spent on their treatment by taxes. The person with average salary pays about 300 Lt (75 $) of taxes for governmental budget per month. So the successful course can be paid to governmental budget through 4 years.

4) Present rehabilitation of drug addicts can be even more cost-effective, if rehabilitation community could use its resources more effective. The staff of rehabilitation community has enough experience and can work with more patients, without need to enhance the number of staff. So enhancement of rehabilitation community needs only direct finance for patients (food and other expenses). This can reduce the cost of rehabilitation even more with minimal investment.

**Conclusions:** Financial analysis of activity of Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts revealed that long-term rehabilitation of drug addicts are cost-effective. The treated addict can pay by taxes to governmental budget for his/her treatment through 4 years. The untreated addict cost much more than addict in rehabilitation community.

# DROP OUT RATES AND REASONS IN LITHUANIAN AIDS CENTRE'S PSYCHOLOGICAL-SOCIAL REHABILITATION COMMUNITY FOR DRUG ADDICTS

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**Objective:** Retention and drop out rates is important problem in treatment of drug addicts. The purpose of this research is to find reasons why drug addicts drop out from Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts.

**Methods:** Interview with for addicts who prematurely left therapeutic community about reasons of their leaving, also estimations of these reasons by therapeutic community staff.

**Results:** In Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts 100 drug addicts were treated. 43 of them left prematurely. In most cases drop outs are determined by many complex reasons (e.g., conflicts, rule violation etc.), but for the sake of research one main reason for each patient was defined. So the main categories for the most cases were extracted. 15 addicts (34,9% of all drop outs) were excluded from treatment for the violation of rules. Most of them were excluded for the drug use (7 addicts, 16,3%) and for the alcohol use (6 addicts, 14,0%). 2 addicts were expelled for other violations (as regular violations of rules). 28 addicts (65,1% of all drop outs) decided to leave treatment themselves. 11 of them (25,6%) left for the interpersonal conflicts in therapeutic community. 7 (16,3%) addicts left therapeutic community because of intimate and sexual relationships, which are prohibited in community. 5 addicts (11,6%) left community because they thought that they spend enough time for their treatment in their community. 5 addicts (11,6%) left community without explanations and without obviously seen reason of their drop out.

**Conclusions:** The research stated the main reasons, why for the part of patient in Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts do not succeed successfully graduate the full rehabilitation course. The main reasons are violations of rehabilitation community rules (when drug and alcohol is used) and the problems in interpersonal relationships. This results is useful for the staff of therapeutic community for designing successful treatment.

## LONG TERM TREATMENT OF HIV INFECTED DRUG ADDICTS

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**Background:** Evaluation of treatment peculiarities of HIV infected drug addicts in Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts and efficacy of long term treatment of HIV infected drug addicts.

**Methods:** HIV infected drug addicts, who were treated in Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts in 1993 – 2003, was evaluated.

**Results:** There were treated 6 HIV infected drug addicts in Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts in 1993-2003. 4 of them successfully graduate full treatment course. 2 did not finish full treatment course. Though efficacy of HIV infected drug addicts is similar to HIV not infected drug addicts, but their rehabilitation is more complex process. It is illustrated by fact that one of three successfully graduated patients was not so successful in his first time in rehabilitation community and he returned for treatment second time. The rehabilitation of HIV infected drug addicts has more peculiarities and particular dynamic because of their characteristics, which required more intensive crisis intervention and prevention, enhancement of motivation for rehabilitation and education in rehabilitation community.

**Conclusions:** It is essential for HIV infected drug addicts treatment effective long-term rehabilitation. Also there is need to tune rehabilitation program for HIV infected drug addicts characteristics and peculiarities. Also all indications and contraindications for long-term rehabilitation must be keep in mind.

## ACTIVITY IN DRUG ABUSE PREVENTION OF LITHUANIAN AIDS CENTRE'S PSYCHOLOGICAL-SOCIAL REHABILITATION COMMUNITY FOR DRUG ADDICTS

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**Background:** Evaluation of Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts activities in prevention of drug abuse.

**Methods:** The work in prevention of drug abuse of Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts in 1993-2003 was reviewed and evaluated.

**Results:** Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts actively participate in prevention of drug abuse. For this purpose ex-addicts, who finished rehabilitation are educated. 14 of them work in prevention and treatment of drug abuse area. Also staff and members of rehabilitation community gives lectures and seminars for children, their parents, teachers, social workers, medical staff and others. The rehabilitation community also participate in various actions for high risk groups (e.g. prisoners). The purpose of such actions is early diagnose of HIV/AIDS, hepatitis, and other STD, also epidemiological survey, medical and social help. Also staff of rehabilitation

community participate in various conferences, like European 3 regional conference about drug precursors, 12 world wide AIDS conference in Geneva and others.

Specialists of rehabilitation community also actively participate in creating various educational material for drug prevention, like film "Drug prevention and possibilities of harm reduction" and "Methodical recommendations for residential psychological-social rehabilitation of drug addicts".

**Conclusions:** The specialists of Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts actively shared by their experience about drug addiction and its treatment with various groups of society. In such way rehabilitation community do impact on the Lithuanian health policy about drug addiction and its prevention.

## DAY CENTER FOR DRUG ABUSING YOUTH OF LITHUANIAN AIDS CENTRE'S PSYCHOLOGICAL-SOCIAL REHABILITATION COMMUNITY FOR DRUG ADDICTS

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**Background:** Evaluation of results of day centre for drug abusing youth of Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts in 2000-2003.

**Methods:** Questionnaire for addicts, who participated in day centre program for drug abusing youth in 2000-2003. Efficacy was measured for addict 3 months after he/her graduate programme.

**Results:** Day centre for drug abusing youth of Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts was opened 18 of September 2000. The day centre's purpose is to help for drug abusing persons of 16-25 years age. From 18 of September 2000 until 31 of December 2003 the 62 persons participated in programme. 19 of them were women and 43 men.

The analysis of questionnaire's results showed:

20 persons finished the rehabilitation course at day centre and were motivated to continue treatment in the long-term rehabilitation programme. They continue their treatment in Lithuanian long-term residential communities.

20 persons who participated in day centre's programme improved their well-being and at present moment participate in Narcotics Anonymous and Alcoholic Anonymous groups.

9 persons was excluded from treatment because of using drugs.

9 persons finished the programme but relapsed into drug use.

2 person participate in day centre programme as volunteer and help for other participants to adapt to programme.

2 persons continue treatment in the programme at present moment.

For persons who left programme the outpatient counselling and help are provided.

**Conclusions:** After evaluation of results of day centre of Lithuanian AIDS centre's psychological-social rehabilitation community for drug addicts in 2000-2003 it was stated that programme is effective to motivate drug addicts to stop use drugs and to motivate them for treatment continuation.

## COOPERATION BETWEEN THE EUROPEAN CITIES AGAINST DRUGS (ECAD) AND LITHUANIAN AIDS CENTRE (LAC)

S. Caplinskas
Lithuanian AIDS Centre, Vilnius, Lithuania

**Objectives.** LAC, while targeting the HIV/AIDS and related issues, is constantly looking for foreign partners that are experienced in the field and have achieved positive results. Since 1999 LAC has been involved into the project "Vilnius Against Drugs" initiated by the international organisation ECAD and aimed at reduction of drug demand and supply in Vilnius, and, consequently, at stopping the HIV/AIDS spread as drug use and HIV epidemics are tightly related.

**Methods**. Cooperation has been started with meetings with and seminars for city Mayors, Municipality and public health experts, police, schoolchildren and teachers, and, gradually, developed into multi-sectorial projects not only in the capital but also all over the country. A team including psychologists, medical workers, former IDUs have visited more than 50 schools. Every year the summer camps for former IDUs from Sweden and Lithuania have been organised following an aim to exchange ideas, experiences. Camp attendants used to visit penal establishments to communicate with inmates, most of whom are active drug users. Parallelly, camps for schoolchildren from two schools have been also organised to train them on primary drug use prevention. The ECAD has financed trips to Sweden for the winners of annual competition "Schoolchildren Against AIDS". Groups of schoolchildren and teachers from 4 schools have already visited Sweden. Drug dependent people received treatment in Swedish rehabilitation communities. Charity aid including computers, office equipment, second-hand clothing was distributed among NGOs, prisons and gypsy children.

**Results**. So far, 5 cities and towns in Lithuania became ECAD members: Vilnius, Klaipeda, Mazeikiai, Trakai and Kretinga. Further 2 (Kaunas and Alytus) to join the ECAD in the nearest future.

**Conclusions**. The project gained wide response not only from general population but also mass media, which has been always present during the events. Methodical assistance through providing information and developing programmes has reached the county level.

## THE EVALUATION OF HIV/AIDS AND DRUG USE SITUATIONAL ANALYSIS IN MUNICIPALITIES

S. Caplinskas
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**Objective:** Lithuanian AIDS Center (LAC) cooperates with different organizations which work in the sector of HIV/AIDS/STI and drug abuse prevention. LAC seeking to evaluate the situation and HIV/AIDS/STI programs, also the opinion and experience of specialists performed a pilot research in selected municipalities. The research is based on HIV/AIDS/STI spread and drug abuse prevention in separate regions of Lithuania and the relevance of activities.

**Methods:** In 2003 five municipalities (Druskininkai, Marijampole, Visaginas, Alytus, Vilnius old city board) participated in this research. The sociological survey was made. Nine questions were presented in the questionnaire for evaluating the point of view of administration of municipalities, community, youth, medical staff, teachers and local media to

the relevance of HIV/AIDS and drug abuse problems. Also the problems of politicians and specialists in the sector of HIV/AIDS and drug abuse prevention were mentioned.

**Results:** The specialists in the municipalities were divided into 6 groups: representatives from mass-media (4), policemen (11), medics (9), teachers (15), psychologists (5) and others (12). Usually to the question about the point of view of municipalities to HIV/AIDS/STI and drug abuse, the respondents stated that these sectors were underlying (42.9 %), fewer respondents said, that municipalities were less interested in those problems (41.1 %). More than a half of the respondents (53.6 %) said that community treated HIV/AIDS/STI and drug abuse problems as medium priority. The third of respondents pointed out that community treated HIV/AIDS/STI and drug abuse problems as underlying. The majority of the respondents (48.2%) evaluated the point of view of young people to HIV/AIDS/STI and drug abuse problems while answering the question as medium priority, more than the third of the respondents pointed out as sufficient (35.7%), 14.3 % thought that young people expressed little interest in HIV/AIDS/STI and drug abuse problems. Medics were presented as HIV/AIDS/STI and drug abuse minded. 69.6 % of the respondents noted that medic's referred to HIV/AIDS/STI and drug abuse problems as underlying. Teachers were also mentioned as HIV/AIDS/STI and drug abuse minded (60.7 %).

The third (33.9 %) said that medics treated HIV/AIDS/STI and drug abuse problems as medium priority. To the question about mass-media priority to HIV/AIDS/STI and drug abuse problems, half of the respondents stated that mass media paid average attention to HIV/AIDS/STI and drug abuse problems (55.4%), and the third (28.6%) said that local media referred to HIV/AIDS/STI and drug abuse problems as underlying.

The main problem in municipalities for politicians and other specialists was the lack of money or incorrect distribution of them. The majority of respondents felt the absence of intensive cooperation with the representatives from local media. The elections, concrete work liabilities, legal control and other measures were indicated as methods which should make politicians and other specialists to underline the problems of municipalities.

**Conclusion:** HIV/AIDS and drug abuse problem is still the problem of medics. The lack of other specialists and social sectors is felt in this sphere. Furthermore, teachers also try to solve the problems of present situation and enact prevention. The activity of exact sector gets an addresser quicker and brings advantages. The continuation of such research is necessary while evaluating the present situation not only in separate regions but in the whole Lithuania as well.

## ATTITUDES OF LITHUANIAN POPULATION TOWARDS HIV/AIDS

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**Objective.** To estimate the attitudes of Lithuanian population towards HIV/AIDS.

**Methodology**. As per order of the Lithuanian AIDS Centre, the Lithuanian-Great Britain market and public opinion investigation company has performed representative survey of the Lithuanian residents aged 15-74.

**Results.** 71% of urban and 60% of rural population would conceal HIV infection of a family member. 21% of questioned people would not do this. By age group – the most of young people (aged 15-29) – 70%, 66% of senior and 59% of retired respondents would try to conceal the HIV infection of their close people. Women more than men are apt to keep a secret about HIV infection in their family - 66.1%. 20.4% said they would not hide this, and 13.4% did not know or did not answer. Distribution of men's opinion was respectively 62.8%,

17.5% and 19.8%. Respondents with university education were the most predisposed to keep a silence about HIV diagnosis of their closest people, and those with unfinished secondary education – the least.

By social status – the retired people and workers were those who would the least likely conceal HIV diagnosis of their family members – 23.6% and 20.6% respectively. Farmers, fishermen and housewives the most likely would not talk about this. By household incomes – respondents with the lowest incomes (up to 500 Litas) were those who were the least apt to keep a secret about HIV infection in their family. The higher incomes, the more people would like to conceal the presence of HIV positive family member. Tenth of questioned people would take care of HIV infected person, 27% would probably take care, 17% would not do this for sure, and 22% probably would not, remaining 24% did not know or did not answered. HIV positive people were rated as one of the most undesirable neighbours ranking below drug users, alcohol dependants and previously convicted people, i.e. on the fourth place in a list.

**Conclusion.** Most of Lithuanian population would like to conceal information about HIV infection of one of their family members. The reason is that HIV infection results from certain behaviour (sex, drug use), which is not an acceptable subject to public discussion. Attitudes of Lithuanian population prove high stigmatisation of people living with HIV/AIDS. Only a tenth of respondents would without any doubts take care of HIV infected person. Population is not sufficiently tolerant towards people living with HIV/AIDS and is apt to keep a longer social distance from those people.

## KNOWLEDGE OF INTRAVENOUS DRUG USERS ON HIV/AIDS AND HEPATITIS

I. Caplinskiene
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**Objectives**: to assess the knowledge on HIV/AIDS and virus Hepatitis B/C in IDUs attending the syringes exchange programme at the Lithuanian AIDS Centre.

**Methods.** Anonymous questionnaire was used including questions on HIV and HCV/HBV transmission modes, protection means, testing. Blood specimen was tested to detect antibodies to HIV, HBV, HCV, syphilis and other infection markers. Totally 103 IDU were questioned and tested.

**Results.** The respondents included 80 (77.7%) men and 23 (22.3%) women. Mean age=25.3. Social characteristics: 84.5% had secondary education, 7.8% - lower school education, none - university education; 83.5% were jobless and did not attended a school. 77.7% lived with their family or relatives; intravenous drug were used at average for 6.4 years. All the respondents were aware about risk of HIV and HBV/HCV infection through contaminated needles. 64.1% knew that a condom may protect from infection with HIV, and 59.2% - from HBV/HCV; 30.1% think that there are no means to protect from HIV, and 38.8% - from HBV/HCV. 81.6% knew that one constant HIV-free partner might guarantee protection from infection with HIV, and 78.6% - from infection with HBV/HCV. 89.3% and 65% respectively ticked "One will not acquire HIV or HBV/HCV while eating with an infected person", and "one will contract the HIV or HBV/HCV" – 2.9% and 19.4% respectively. "You cannot infect with HIV and HBV/HCV through an insect bite", stated 84.5% and 82.5%, you can – 4.9% and 10.7% respectively. 35% were aware that a woman with HIV might infect her newborn, 7.8% stated that it is impossible, and 57.3% had no idea. 52.4% think that you cannot judge about HIV infection from person's appearance, 39.8% - that there are signs of HIV infection in people's appearance, and 7.8% did not know. 98.1% had undergone a HIV test, and 96% - a HBV/HCV test. 94.1% knew results of their HIV test, and 98.1% - of their HBV/HCV test. 92.2% knew people with HIV or those died of AIDS, and all the respondents knew someone with HBV or HCV. Testing: HIV was identified in two cases, 44 had had HBV, and 9 had acute HBV, 5 had had syphilis episode, 97 were infected with HCV. 97% knew the condom outlets. The Lithuanian AIDS Centre was the main source of information on HIV, STI and other blood-borne diseases.

**Conclusions.** IDU were well informed and were aware of main HIV transmission modes or protection means, except of mother-to-child transmission. This knowledge was sufficiently deep as the majority were aware that HIV does not spread through an insect bite. Knowledge on HCV/HBV transmission modes was a little worse. Majority underwent the HIV and Hepatitis tests, though not all knew results of their testing. HCV is highly prevalent among the respondents, which proved their risky behaviour, i.e., sharing of injection equipment. STI might be transmitted from IDU to general population through unprotected sex. HIV preventative programmes to be enlarged in the contingents at risk, and risk of HIV transmission from IDU to general population reduced in this way.

# RESEARCH OF DRUG USE AND BIOLOGICAL MARKERS IN THE CLIENTS OF THE HARM REDUCTION SITE AT THE LITHUANIAN AIDS CENTRE

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**Objectives:** to establish drug use characteristics and biological markers in IDUs attending the syringes exchange programme in the Lithuanian AIDS Centre (LAC).

**Methods:** Anonymous questionnaires were used for collection of data on specific characteristics of drug use and on participation in the methadone programme. Blood specimen was tested to detect antibodies to HIV, HBV, HCV, syphilis and other infection markers. Totally 103 IDU were questioned and tested.

**Results.** The respondents included 80 (77.7%) men and 23 (22.3%) women. Mean age=25.3. *Social characteristics*: 84.5% had secondary education, 7.8% - lower school education, none - university education; 83.5% were jobless and did not attend a school. 77.7% lived with their family or relatives. 96.1% admitted that their parents or relatives are aware about their drug use. They have learnt about this in average after 10.5 months. Drug use: drug use debut happened in average at 16.8 years of age. The first consumed narcotic substance: 46.6% volatile substances, 20.3% - cannabis, 12.6% opiates, 5.8% amphetamine and heroin the each, 4.8% sedatives, 3.8% - other substances. Majority have tried intravenous drugs for the first time at 19±0,9 years of age. Intravenous drug were used at average for 6.4 years. The vast share injected narcotics because of curiosity (35%), under peer pressure – 27%, others indicated different reasons. 77.7% always used a new syringe/needle, 13.4% - always reused syringe/needle, 8.7% - sometimes used new, sometimes reused syringe/needle. Their own syringes shared 73.7% of respondents. 46.8% never underwent the treatment of dependence, 23.3% participated or are participating in the methadone programme, majority (69.5%) attended the short-time methadone programme, and 95.6% have used other narcotics while in the methadone programme. All the respondents were aware about risk of HIV and HBV/HCV infection through contaminated needles. 98.1% had undergone a HIV test, and 96% - a HBV/HCV test. 94.1% knew results of their HIV test, and 98.1% - of their HBV/HCV test. 92.2% knew people with HIV or those died of AIDS, and all the respondents knew someone with HBV or HCV. *Testing*: Two were tested HIV positive, 44 had had HBV episodes, 9 had acute HBV, and 5 had cured syphilis, 97 were infected with HCV. 97% were aware about the condom outlets. Respondents have usually got information on HIV, STI and other blood borne diseases from Lithuanian AIDS Centre.

**Conclusions:** This study shows: majority of respondents have involved into drug use in their adolescent. Almost all the families are aware on their drug use. Most of them underwent the HIV and Hepatitis tests and know the results of the testing. HCV is highly prevalent among the respondents, which proved their risky behaviour, i.e., sharing of injection equipment. HIV prevalence is not high however behavioural and biological indicators (HCV, HBV, syphilis) indicate possible HIV spread in the IDU community. Existing syringes exchange and methadone programmes alone are not sufficient to motivate for behavioural changes. Therefore there is a need for expansion of HIV prevention programmes targeting the risk groups and for improvement of their efficiency. STI might be transmitted from IDU to general population through unprotected sex. HIV preventative programmes to be enlarged in the contingents at risk, and risk of HIV transmission from IDU to general population reduced in this way.

# INTERNET INQUIRIES AS REFLECTION OF HIV/AIDS INFORMATION CAMPAIGNS

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**Background**: Lithuanian AIDS Centre website www.aids.lt includes information about HIV/AIDS and related issues in Lithuanian, English and Russian languages. About 130 visitors visit it daily. In 2003 the rubric "Questions and Answers" appeared. Since 2004 a person asking a question is requested to indicate his/her age and gender. The rubric is convenient and anonymous way to get professional answer and consultation to all the interested people.

**Methods**: 129 rubric inquiries using social analysis method were analysed according to topics.

**Results:** 69.06% questions were asked by women, of them 62.5% were aged 20-29. Share of male questions – 30.94%, majority (44.18%) were 15-19 years old. 43.16% questions were related to HIV/AIDS, 18.7% – to STI, 8.6% to drug abuse, the rest – to prevention, etc.

Most respondents were interested in HIV/AIDS. Namely, risk sexual behaviour consequences, HIV infection risk while having unprotected sex or kissing (31.66%). Almost the same number of respondents was interested in primary HIV symptoms, chances for cure, AIDS symptoms and in reliability of HIV test (25.0% the each). Even 18.33% were interested in HIV test cost and test availability.

Men were mainly interested in HIV transmission modes. They were worried about symptoms similar to those of HIV (temperature, rash, swollen lymphatic nodes, etc.) after risky contacts and about possibility to be infected with HIV. Several questions regarded amenability for HIV spread; many respondents confessed being worried to wait for the end of "window" period and for HIV test result afterwards.

**Conclusions:** The results of the survey showed that in 2004, as well as in 2003, respondents were mainly interested in details of HIV sexual transmission, confidentiality, anonymity and reliability of HIV test. This proves sufficiency of basic information in general population.

None of the questions was related to HIV/AIDS epidemiological situation in the country and the world (in 2003 such the questions made 13.59%), which shows sufficiency of this information. These questions are more important to younger men. Inquiries related to availability of HIV test prove public interest in their HIV status.

## ARTICLE TITLES REFLECT ATTITUDES TOWARD HIV/AIDS

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**Background**: Data of sociological surveys in Lithuania show that youth and general population get the vast share of information on HIV/AIDS from mass media. TV remains on the first place (18.5%); press on the second (17.5%). Rapid assessment of knowledge on HIV/AIDS performed by the Lithuanian AIDS Centre with support from UNICEF showed that the daily "Lietuvos rytas" was the most popular among youth.

**Method:** article titles including words HIV and AIDS in period of 1998-2003 were analysed using the database of the daily "Lietuvos rytas" (http://search.lrytas.lt/).

**Results**: during six years 1303 articles including HIV and AIDS were published, of them 108 had HIV and AIDS in the title. Analysis of the latter shows that majority of such articles were published in 2002 – the year of HIV outbreak in one of Lithuanian penitentiaries. The most often HIV and AIDS were used in the titles of articles published under the heading "Topicality" (46.29%), some less under "Local news" or "The world" (15.74% and 14.81% respectively). Starting from 2002 noticeably more article titles appeared under the heading "Fifth page" intended to crime.

By topic majority of articles (36.11%) with HIV and AIDS in their titles described epidemiological situation and its evaluation ("List of those HIV infected prolonged", "Five more HIV cases identified", "Number of HIV cases in Lithuania increases annually", "Tempo of HIV spread diminished"). 22.2% of article titles included HIV problem in penitentiaries. HIV and AIDS were accompanied by such words as danger, panic, fear, concern, victim, ghost, and alive HIV bombs. 16.66% of titles informed about preventative actions ("Participants of the anti-AIDS action united by musicians' hymn", "For Utena residents – a day of good news about AIDS", "Alive chain against AIDS", etc.).

**Conclusions.** Though HIV and AIDS would meet the mass media seek for sensational news, only a slight part of articles include HIV and AIDS in their titles (8.28%). Titles of the articles describing HIV situation in penitentiaries had lots of threatening words, which increased public fear of HIV/AIDS and, respectively, stigmatisation. More optimistic titles were used while reporting on preventative actions or informing about HIV/AIDS epidemiological situation.

## IMPORTANCE OF COOPERATION BETWEEN POLICE OFFICERS AND HEALTH CARE SPECIALISTS TO DRUG AND HIV/AIDS PREVENTION

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**Objectives:** HIV/AIDS and drug abuse is a multiple phenomenon. Drug abuse prevention is efficient when work is performed into three directions: reduction of supply, demand and harm. Work methods and perception of responsible organizations often differ. LAC- seeking to unite efforts -signed Cooperation Agreement with Police Department under Ministry of Interior Affairs in 2000. The Agreement sets forth plan to stabilize the spread of HIV/AIDS and drug.

***5. Best practices in Lithuania***

**Methods**: LAC cooperates with the police into several directions: information exchange, training and joint campaigns. Social surveys show that police lack knowledge, how to recognize and communicate with drug users (DU's), decide which prevention is most effective and protect oneself from viral infections at work. Officers were trained nationally. The guide to police Drug Abuse and its Prevention was published.

Various campaigns were organized. During the first one, LAC- free of charge -tested individuals - delivered by the police - suspected for drug abuse. 68% of suspicions were proved correct. Mostly (79%) it were opiates, 18% - benzodiazepin, 3% - marihuana. Another campaign was organized with Police Commissariat of Vilnius region: the police and ex-DU's visited discos. This campaign aimed to teach police officers to recognize DU's. LAC with police officers visited schools, discussed with schoolchildren about drug abuse, drug trafficking etc.

**Results**: Cooperation helped to understand the problems faced by the police. The aims of LAC and police differ: LAC promotes public health, the police identifies violation and punishes. To involve the police into prevention, LAC organizes seminars and discussions with medics, ex-DU and their parents. This work increases work quality of medics and policepeople.

**Conclusions**: Joined prevention brings better results. The surveys showed that the knowledge of police bettered but also the attitude towards DU's and PLWA changed. Police officers understood that punishment is not the way out. They discuss how to expand the activities, develop legal basis and find alternative punishments. LAC seeks to further expand cooperation, share experience in HIV/AIDS prevention and globalize work.

## EFFICIENCY OF HIV AG/AB COMBO TESTS IN SELECTIVE TESTING DURING THE LOCAL OUTBREAK

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**Issues**. HIV Ag/Ak tests reduce the "window" period as compared to HIV Ab tests. However such reduction is relatively slight with common HIV infection natural development, while expenses for this testing are higher. Research objective was to assess the real diagnostic applicability of these tests during an HIV outbreak.

**Description**. In 2002 HIV internal outbreak occurred in one of penal establishments in Lithuania. In 7 months 299 new HIV infection cases were reported. Volunteer inmates with risky behaviour were only tested by antibody systems. Additional aid helped to retrospectively test sera sampled during the outbreak (450 negative and 211 positive) by application of HIV Ag/Ab combo test kits produced by two companies.

**Lessons learned**. Testing of 416 negative sera resulted in 7 positive reactions; in 1 case HIV infection was confirmed by seroconversion. Comparison of HIV Ag/Ab combo tests with traditional HIV Ab test of 3$^{rd}$ generation proves higher applicability of the latter ones. Practical usefulness of HIV Ag/Ab is more theoretical.

**Recommendations**. Testing results show non-efficiency of exchange HIV Ab tests of 3$^{rd}$ generation with HIV Ag/Ab combined test in local HIV outbreak. They might be used as supplemental tests grey zone HIV Ab results sera retesting.

# ANALYSIS OF HIV ANTIBODY TESTS CARRIED OUT IN KLAIPEDA HOSPITAL 1999-2003

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**Introduction.** AIDS centre in the Klaipeda hospital was opened in the 1996 April. The main works directions are preventive, diagnostic works and medical help for persons with HIV.

HIV antibody tests are doing by ELISA method. The main purpose is not only definite new HIV/AIDS cases, but estimate HIV/AIDS epidemiology in the Klaipeda county, and important thing- the contact with person for reaching behavior and decrease risk for HIV transmission.

**Work purpose -** estimate HIV infection epidemiology among drug users (I group) and among persons with sexual transmission infections or who had not safe sex (II group).

**Methods.** Analysis of scientific literature and practical work of Klaipeda hospital AIDS centre.

**Results.**

HIV antibody tests for I group persons carried out in the Klaipeda hospital 1999-2003:

1999-317 men ( it was 77 % of all carried out HIV antibody tests for drug users men in the Klaipeda county and 17 % of HIV antibody tests in the Klaipeda hospital), 79 women (it was 77 % of all carried out HIV antibody tests for drug users women in the Klaipeda county and 4 % of HIV antibody tests in the Klaipeda hospital);

2000- 415 men (accordingly- 99,8 % and 29 %), 100 women (accordingly- 100 % and 7 %);

2001- 444 men (accordingly- 99,8 % and 44 %), 96 women (accordingly- 100 % and 10 %);

2002-2002- 277 men (accordingly- 100 % and 27,8 %), 162 women (accordingly- 100 % and 6,2 %); 2003- 237 men (accordingly- 100 % and 27 %), 72 women (accordingly- 100 % and 8,2 %).

HIV antibody tests for II group persons carried out in the Klaipeda hospital 1999-2003:

1999- 63 men (it was 27 % of all carried out HIV antibody tests for men with sexual transmission infections or who had not safe sex and 3 % of HIV antibody tests in the Klaipeda hospital), 54 women ( it was 77 % of all carried out HIV antibody tests for women with sexual transmission infections or who had not safe sex and 3 % of HIV antibody tests in the Klaipeda hospital);

2000- 10 men (accordingly- 20 % and 0,7 %), 66 women (accordingly- 84 % and 4,7 %);

2001- 2 men (accordingly- 99,8 % and 0,2 %), 8 women (accordingly- 100 % and 0,8 %);

2002- 17 men (accordingly- 23 % and 2 %), 25 women (accordingly- 45 % and 3 %);

2003- 1 man (accordingly- 2 % and 0,1 %), 1 woman (accordingly- 5 % and 0,1 %). HIV was diagnosed only for I group persons:

1999- 4 men (it was 80 % of all new HIV diagnosis in the Klaipeda hospital this year);

2000- 4 men (accordingly 100 %);

2001- 3 men and 1 women (accordingly 100 %);

2002-2 men (accordingly 80 %);

2003-2003- 10 men (accordingly 66 %);

**Conclusions.**

1. 1999- 2003 were carried out the most HIV antibody tests for Klaipeda county drug users in the Klaipeda hospital.
2. Must be more expedient prevention among drug users.
3. It is necessary to increase HIV antibody tests among persons with sexual transmission infections or who had not safe sex.

# POPULARITY OF PREVENTATIVE HIV/AIDS POSTCARD AMONG STUDENTS

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**Objective**: to improve the knowledge of general population and especially of youth on the HIV/AIDS transmission modes through attractive and innovative HIV/AIDS preventative work forms.

**Method.** In cooperation with the advertising agency *Advista* belonging to the Media Cards System free information postcards "You could not wash everything" have been distributed in the public places of youth accumulation in Vilnius and Klaipeda (universities (13), cinemas (3), bars and cafes (19), fitness clubs (9).
Demand for postcards during the first action month was analysed to assess the need of present action.

**Results.** During the first month 12,700 postcards were distributed in 44 public institutions. Majority of postcards (42.91%) was distributed in the universities, 31.49% - in cafes, the remaining – in fitness clubs and cinemas.
By University profile the main interest for the postcards showed future seafarers and social workers in Klaipeda, designers, economists, teachers and military officers – in Vilnius.
The postcards were also published in the website http://www.atvirukas.lt enabling to e-mail them to the friends.

During the first action month 169 postcards were resent. More often the postcards assigned to girls as compared to those assigned to boys (32.54%) used to be sent.

**Conclusions.** Such a special attention of certain students in the postcards might be explained in a way that for future social workers and teachers they were an example of social marketing, which would be useful in their working field or as an impact mean stimulating the youth to think on risky behaviour and its consequences. Seafarers and officers are very interested because of specific study environment, gender, and leisure habits. The boys apt to risky behaviour mainly choose these specialities. High demand for postcards in this groups shows that they often think about consequences of their risky behaviours. Relation to art might explain an interest of the design students, as the postcards are one of the art form. High demand for the postcards proved necessity of this innovative public information form in Lithuania. Interest of the students in this information proves attraction and necessity of information presented in this form.

## LITHUANIAN JUVENILE GIRLS' ATTITUDE TOWARDS PROSTITUTION

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**Situational analysis**: The results of social study have shown that every eighth/tenth young person in the Baltics had a direct encounter with trafficking in women and exploiting them for prostitution. Prostitution is a criminal act and teenage girls' involvement in it is often achieved by means of force or seduction. Prostitution has an extremely negative impact on the quality of teenage lives.

**Objective**: to ascertain juvenile girls' attitude towards prostitution.

**Methods**: The method of individual standardized interview was employed in the study. 924 females of 16.4±0.04 years on the average participated in it. The distribution of females according to nationality, level of education, living place and family make-up, very closely corresponded to their distribution in Lithuanian society.

**Results**: The study has shown that the majority of juvenile girls possess a positive attitude towards prostitution. The majority of girls interviewed believed that a prostitute might secure her own well-being. 25% of participants believed that a prostitute might be respected; she might have intimate and loving relationships within the family and happy children. Only few respondents considered that involvement with prostitution might have a harmful impact on a woman's health depriving her of a possibility to bear a healthy child. According to most girls, involvement with prostitution would not leave any impact on her future life, would not prevent her from getting a loving husband and gaining society's respect. Such attitudes only confirm prostitution propaganda being rather successful and warn us of high risks of juvenile girls' involvement with prostitution thus showing the need of taking further steps in prevention work.

## MEDIA: PROMOTING HIV/AIDS PREVENTION AMONG YOUTH. A joint project of Lithuanian and Moscow AIDS Centre – presenting the magazine *Teritoriya Zdravogo Smysla* and creating websites for *AIDS* servicing organizations in Russian

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**Objective.** Promoting HIV/AIDS prevention in young audiences mass media.

**General description.** The Lithuanian AIDS Centre has years of experience in publishing all kinds of literature on AIDS from special publications to wide spectrum international youth magazine.

By the end of 2003 the magazine *Mezdu Nami* published by the Lithuanian AIDS Centre developed into youth magazine in Russian *Teritoriya Zdravogo Smysla* (Common Sense Zone). The first edition of the magazine appeared in print on Rememberance Day that year. In this publication not only HIV/AIDS and drug abuse but also other various subjects of interest for younger generation are covered. Materials published in the magazine cultivate the principle of *involvement* by discussing music, movies, so called interesting character or a role model *Ntechnology* etc. It cultivates healthy principles and positive outlook and at the same time reducing HIV/AIDS incidence among youth.

An assay on *Russian WebPages of AIDS servicing institutions* conducted by Lithuanian AIDS Centre this year (published in *Russian magazine on HIV/AIDS and related issues*) showed a low promotion effectiveness of current websites and WebPages targeted at young

audiences in terms of HIV/AIDS prevention. Evaluation criteria: low attendance by targeted population, lack of appeal in presentation and obvious shortage of WebPages for the young.

**Conclusions.** In order to influence young people not only the media but also traditional (paper publications) as well as modern ways of informing people like WebPages on the Internet have to be employed. WebPages need to be adapted and should meet the demands of younger generation. HIV/AIDS subject matter has to be presented attractively as it is being done in publication issued in cooperation by Lithuanian and Moscow AIDS Centre *Teritoriya Zdravogo Smysla* (Common Sense Zone) and in this way more effective utilization of the e-media for prevention and reducing HIV/AIDS epidemic could be achieved.

## PROBLEMS OF PEOPLE LIVING WITH HIV IN LITHUANIA PRISONS AND POSSIBLE SOLUTIONS

J. Rakickienė, R. Gagys
Prison Hospital, Vilnius, Lithuania

Here are presented the health problems of people living with HIV in prisons.
The first HIV positive person in Lithuanian prison appeared in 1992. Now in Lithuanian prisons about 2,5 % of all prisoners are HIV positive. Their healthcare is one part of National AIDS Prophylaxis programme. This programme is comprised of three levels:

- First level – primary healthcare in prison,
- Second level – prisons hospital and its specialists,
- Third level – academic clinics.

The problem should be solved is patients psychical health and capability to solve the communication with each other problems, with family members and to adapt in freedom.
Next problem- it is concomitant diseases: the curing of viral hepatitis C, B and tuberculosis.
Easily accessible medical and consultation help is necessary;
To use the time spent in prison for health rehabilitation and for changing of the way of living.

## SITUATION OF HIV/AIDS IN PRISONS OF LITHUANIA

B. Semenaite
Medical Division of the Prison Department at the Ministry of Justice of Lithuania

In most countries (including Lithuania) the rates of infectious diseases is a great deal higher among prisoners than among the population outside prison. This situation is often exacerbated by high rates of viral hepatitis, HIV/AIDS and tuberculosis (TB). Prisoners living with HIV/AIDS face the increased risk of the co-infection with hepatitis or TB.

Lithuania is not among the countries of high spreading of HIV infection. According to the data of AIDS centre of Lithuania HIV infection in Lithuania started to spread in 1983-1984. In 1987 in Lithuania began to carry out the laboratory analyses of HIV. This year we started to make the serological analysis of HIV in the penitentiary system too. The analyses are carried for everyone, during the admission to the prisons.

We can state, that HIV infection in Lithuania increases and number of persons with HIV entering the prison, increase too. The majority of people with HIV entering the prison, are already registered at the AIDS centre (known cases). But we have also cases then HIV is diagnosed while in prison (new cases).

In 1992 the first case of the HIV infection in prison was registered. It was a case known to the AIDS center and the infection was transmitted during the sexual intercourse. The

second case of HIV caught in prison was registered in 1996. The HIV virus was spreading fast among the intravenous drug users within the community so more people with HIV were admitted to prison. By January 1, 2002 the total number of persons with HIV (both known and new cases) in prison was 118. The majority of the HIV infected people (cases registered in the year of 2000 and 2001) were circulating inside and outside prison. About 70-80 % of the infected with HIV came to prison no later than in 6 months after having caught HIV. At that time we started being suspicious of the situation – the data seemed not to correspond to the reality. According to the data accumulated by January 1, 2002 the total number of 1301 of drug users were registered among prison population which made 11,25 % of all prisoners. At the same period, by January 1 last year it was 8,8% of all prisoners. According to the same data form 86,6 % of all drug users took intravenous drugs. The epidemic situation of HIV infection in the neighboring countries gives a good reason for the analysis too. According to this situation we arranged the anonymous questionnaire in prisons. Therefore in May, 2002 we together with AIDS center of Lithuania started making prophylactic laboratory analyses of HIV among prison population. Lithuanian people were shocked mostly by the fact that the new cases had been diagnosed in an isolated area, in Alytus, in one of the Correction Houses. Since 1988 in Lithuania all persons who are punished by imprisonment are tested for HIV, therefore such HIV outbreak was unexpected for the specialists. The first HIV positive case from Alytus Correction House was diagnosed on May 3, 2002. After that voluntary HIV testing was proposed to all prisoners. The total number of new HIV positive cases detected in Alytus Correction House was 299. After the epidemic situation in Alytus Correction House testing was carried out in all penitentiary institutions of Lithuania. None of the other places revealed HIV positive cases.

Up to 1st January 2003 283 persons with HIV (both known and new cases) stayed in the prisons of Lithuania and up to 1st January 2004 – 233. Compared to the general public, the number of HIV cases per 1000 persons is higher in prison.

It is of vital importance to have good programs of HIV/AIDS prevention in prisons. People in prison have the same right to health service provision as the people outside, and the life and health problems of the prison population are closely connected to those of the people outside prison. Protecting the health of prisoners we also protect the health of all the members of the community. Protecting prisoners also means protecting prison staff, who also have the right to be protected against HIV/AIDS, hepatitis and TB.

## HARM REDUCTION PROGRAMES IN KLAIPEDA - SHARING EXPERIENCE ON NATIONAL AND INTERNATIONAL LEVELS

A. Slatvickis
Center for Addictive Disorder, Klaipeda, Lithuania

At the end of nineties spreading of HIV infection among mostly vulnerable group in country – intravenous drug users (IDUs) became the one of biggest challenges for community health care both on national and local levels. As response to problem on local level in Klaipeda community during 1995-1997 were started few harm reduction programs addressed to IDUs. First program was methadone maintenance treatment (MMT) for opiates users and was started at the end of 1995. Second program was stationary needle exchange (NEP) for hidden population of IDUs and was started in 1997 with strong support of Klaipeda Municipality. As continuation of stationary NEP outreach NEP program was started in 1998 and was funded from Open Society Fund-Lithuania. All programs successfully run till recent days. During more than 8 years 230 opiates users were treated in MMT, about 20 of them quitted to use drugs. More than 1800 previously unknown IDUs were involved in NEP during 7 years. Permanent contacts with NEP facilities keep more than 450 IDUs. Efforts of HR programs stabilized spreading of HIV on local level. HR program in Klaipeda was included into the UNAIDS/UNDCP best practice collection in 2001. Starting from 1999-2000 HR activist actively participated in sharing of experience in the countries of Central and Eastern Europe, former Soviet Union and Central Asia. In collaboration with International Harm Reduction program were conducted HR workshops in Belarus, Azerbaijan, Kazakhstan and others countries. In 2002 the project "Harm reduction conferences in Lithuanian municipalities – experience sharing and advocacy" was carried out. As a result of educational and advocacy activities establishing of new HR programs or improving of existed HR programs was observed through the regions.

## EVALUATION OF THE PROJECT "SCHOOL CHILDREN AGAINST AIDS

L. Stoniene, S. Caplinskas
Lithuanian AIDS Centre, Vilnius, Lithuania

**Issues**: One of the most effective forms of prevention are peer education programmes. Project "School children against AIDS" dedicated to WAD is based on this method and cooperation with the governmental organizations and NGO, private sector and media.

**Description**: The project lasts for 5 years. It is competition of teams of 5 gymnasium students (15-18 y.). Evaluation of the teams was based on 4 tasks: presentation of a team, clothing with anti-AIDS promotion, knowledge test and social advertisement video-clip. The project takes about 3 months each year and is executed in 4 rounds: 1st– in schools, 2nd – districts, 3rd – zones (every is represented by 9-11 teams) and final (Republic). The project attracts 6000-10 000 participants, because teams prepare fans' that support them. The winner team is granted a one-week trip to Sweden (established by the ECAD and UNDP).

**Lessons learned**: The use of competition is a useful tool to convey HIV/AIDS messages to peers and it involves many people. Multi-sector cooperation has proved success when it involves various specialists and everyone is in disposal of the work that s/he is an expert in. The participation of the Ministry of Education and Science ensures information spread and including project into education strategies. Youth through active participation make it

especially interesting; attract society and media attention to HIV/AIDS. This advocacy brings new donors from private sector.

**Recommendations**: The form and tasks of the competition must be changed after 4-5 y. in order to avoid lack of ideas. The tasks must be well understood and standardize because otherwise the way is given to mistrust and activeness is suppressed. The evaluation commission must consist of specialist from different fields and tasks must be evaluated publicly with based arguments. Tasks are evaluated with different amount of points. Web page for the project is good way for information dissemination; it also became chart room and continues communication.

## INPUT OF METHODOLOGICAL PROGRAMMES IN FORMATION OF ATTITUDE TO HIV/AIDS

L.Stoniene, S. Caplinskas
Lithuanian AIDS Centre, Vilnius, Lithuania

**Background**: The level of involvement of teachers in HIV/AIDS prevention depends on comprehensive, easy applicable and effective education programmes. Methodological material "How to Protect Dream School from Drugs" allows to involve the youth into solutions of HIV/AIDS and drug problems. This programme is translated, added with HIV/AIDS and adopted to Lithuanian school needs by Lithuanian AIDS Centre specialists with permission from Centre for Civic Education material "Drugs in the Schools".

**Methods**: Teachers from 27 schools in Vilnius were questioned, who took part in the pilot project for three months aimed at evaluation of practical applicability and efficiency of methodical material. Data of sociological survey were processed by application of SPSS programme.

**Results**. Majority of teachers rated the methodical publication "good" (63%) and "very good" (29.6%). Indicated merits of the programme: understandable, clear and easily applicable information; interesting, actual and easy to remember situation and tasks; attractive design. Programme idea (to become experts able to analyse situation and prevention forms, to advise on how HIV/AIDS and drug use related problems in the Dream school to be solved) was attractive to the schoolchildren (33.3% took up at once, 55.6% - gradually). Discussions among the schoolchildren have constantly arisen, mainly on the topics of attitudes towards HIV/AIDS, drug use. The most argument took place because of "light" drugs, effective prevention methods. The most interest awoke evaluation of situation in the Dream school and information accumulation from various sources, especially mass media. The least interesting appeared assessment of attitudes towards drugs, the most difficult – design of prevention programme.

**Conclusion**. Vast majority of respondents (81.5%) stressed necessity of such programmes. Teachers accentuated usefulness of information, applicability to stimulate thinking and decision taking, to form attitudes and responsibility, to improve skills for group work, to develop and express own opinion and to respect the one of others. One third of respondents mentioned that the programme provoked an interest in these problems in own school and in designing local prevention programme. Part of schools has already initiated this activity: they perform sociological surveys and intend to engage the parents.

## HIV STIGMA AND ATTITUDES TOWARD PLWA

L. Stoniene
Lithuanian AIDS Centre, Vilnius Pedagogical University, Lithuania

**Objectives**: Pervasive stigma has surrounded HIV/AIDS since the beginning of the epidemic. The purpose of this study was to examine the HIV related stigma between HIV infected prisoners after HIV outbreak.

**Methods**: 105 HIV infected young adults (22-34 yrs) prisoners (mean age=28,3) were interviewed using the HIV stigma scale (personalized stigma, disclosure concerns, negative self-image, and concern with public attitudes toward PLWA). A third acquired HIV 2 years ago, 62.9% in prison, 54.3% using intravenous drugs (23.8% don't know, 16.2% don't answer). The data of the survey was processed with the help of the specialized sociological programme SPSS.

**Results**: Research show that respondents feel personalized stigma: 38,1% respondents have been hurt by people's reaction to news, that they have HIV; 40.9 % feel isolated from the rest of the world; 51.4 % have stopped socializing with some people because of their reactions; and 57.2% felt that some people have grown more distant. However only 44.7 % think, that people close to them are afraid, others will reject them if it becomes known that they have HIV.

While analysing disclosure concerns, become clear that 55.2% agree or strongly agree that telling someone about HIV status is risky, but 54.3% don't keep HIV status in secret, 60.9% respondents never felt the need to hide the HIV status.

Assessment of negative self-image evidence showed that only 35.2% agree or strongly agree that having HIV makes feel that he is a bad person; 43.8% affirm that people's attitudes towards HIV make feel worse about themselves, and only 46.6% feel guilty because they have HIV. However 53.4% agree or strongly agree that having HIV is disgusting to them, and 45.8% feel ashamed of having HIV.
Consideration of public attitudes towards PLWA, proved, that 62.9% agreed that some people act as though it's their fault to have HIV, 59.0% agreed that people look for flaws in your character, even 63.8% agreed that most people believe that a person with HIV is dirty, 50.5% think that people with HIV are treated like outcasts.

**Conclusion**: Even all people living with HIV feel stigmatisation, the research show, that there are some differences between those infected in prison and those acquiring HIV outside prison. The latter experience more negative public attitudes towards them as PLWAs: 76.5% agree that most people believe that a person with HIV is dirty, 70.6% - that people look for flaws in your character, 58.8% have stopped socializing with some people because of their reactions to them. People acquiring HIV outside prison feel less guilt because of their infection (35.3%) as those infected in penitentiaries (54.7%).

# SPECIFIC ANTIRETROVIRAL THERAPY OF HIV INFECTION IN LITHUANIA

V.Uzdaviniene, S. Caplinskas, A. Treciokas
Lithuanian AIDS Centre, Vilnius, Lithuania

**Issue/Problem**. By 1 August, 2004 there were 916 HIV infected individuals in Lithuania identified. AIDS was diagnosed to 76 individuals. Specific treatment of HIV infection using antiretroviral therapy (ART) causes viral load suppression, restoration and preservation of immune function, improvement of the quality of HIV infected patients' life and reduction of HIV-related morbidity and mortality. Our aim is to evaluate the accessibility of specific treatment in Lithuania.

**Description of the problem and results**

HIV treatment with specific antiretroviral drugs was introduced in Lithuania in 1992, when the first medication for HIV (Zidovudine) was registered. Primarily monotherapy was applied. Later the combination of two antiretroviral drugs was introduced and 1-10 patients were treated every year. Since 1998 a highly active antiretroviral therapy (HAART) has been applied as a standard (three and more drugs). Till now we have 15 approved antiretroviral drugs.

Since 2002 specific antiretroviral drugs have been compensated from Compulsory Health insurance fund and have become accessible to all suffering from AIDS. In 2004 the decree of compensatory HIV diagnosis and treatment methodology from Compulsory Health insurance fund was endorsed by Lithuanian Ministry of Health not only for individuals suffering from AIDS but also for those with high risks of disease progression. Clinical, immunological and virological criteria are decisive in taking the decision to start ART. ART is offered regardless of the social group individual belongs to. The crucial thing in prescribing antiretroviral therapy is individual's readiness and desire to take up ART treatment, because poor adherence may lead to development resistance to HIV that would limit further treatment possibilities and facilitate the spread of such a resistant virus. In 2004 the HAART has been administered to 40 HIV positive persons.

On 24 of May, 2003 the Lithuanian Ministry of Health minister's order *Regarding dangerous infectious diseases from which people are insured by the Compulsory health insurance fund* came into effect. In accordance to it insurance of the all persons infected with human immunodeficiency virus (HIV) is budgeted from the Compulsory Health insurance fund.

Free of charge treatment is provided to HIV positive women during pregnancy and delivery: six HIV positive pregnant women have been under care; all of whom underwent antiretroviral therapy during their pregnancy and delivery and preventive treatment to neonates was used. All of them have already delivered, preliminary results show that their neonates are not infected.

**Conclusion**

1. Insurance of the all persons infected with human immunodeficiency virus (HIV) is budgeted from the Compulsory Health insurance fund.
2. HAART (highly active antiretroviral therapy) has been applied for treatment of HIV infection in Lithuania.
3. State-funded treatment is offered on the basis of Lithuanian Ministry of health order not only to those suffering from AIDS but also to individuals with high risk of disease progression.
4. ART is prescribed to all HIV positive women during their pregnancy and delivery and prophylaxis to their neonates.

# HIV/AIDS POLICY OF LITHUANIA

**Saulius Caplinskas,**
*Lithuanian AIDS centre, Vilnius, Lithuania*

HIV/AIDS policy is reflected in the National AIDS Prevention Programme. The first National AIDS prevention programme was launched in 1990. Every other year the Programme has been reviewed taking into account epidemiological situation and international recommendations.

In 2003 the Government has approved the National HIV/AIDS Prevention and Control Programme 2003-2008.

LIETUVOS RESPUBLIKOS VYRIAUSYBĖ

NUTARIMAS
DĖL VALSTYBINĖS ŽIV/AIDS PROFILAKTIKOS IR KONTROLĖS
2003-2008 METŲ PROGRAMOS PATVIRTINIMO

2003 m. spalio 14 d. Nr. 1273
Vilnius

Įgyvendindama Lietuvos Respublikos Vyriausybės 2001-2004 metų programos įgyvendinimo priemonių, patvirtintų Lietuvos Respublikos Vyriausybės 2001 m. spalio 4 d. nutarimu Nr. 1196 (Žin., 2001, Nr. 86-3015; 2003, Nr. 73-3398), 123 punktą, Lietuvos Respublikos Vyriausybė nutaria:

1. Patvirtinti Valstybinę ŽIV/AIDS profilaktikos ir kontrolės 2003-2008 metų programą (pridedama).

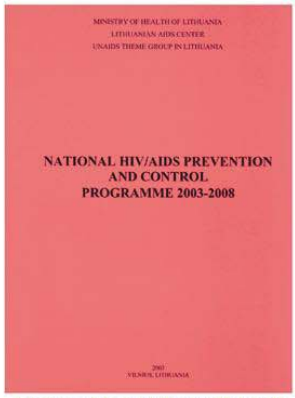
2. Nustatyti, kad:

2.1. Nurodyta 1 punkte programa finansuojama iš Lietuvos Respublikos valstybės biudžete atitinkamoms ministerijoms ir kitoms institucijoms, atsakingoms už programos vykdymą, patvirtintų bendrųjų asignavimų, valstybės investicijų programų lėšų, Privalomojo sveikatos draudimo fondo biudžeto ir kitų šaltinių.

2.2. Nurodytajai programai įgyvendinti reikiamos lėšos tikslinamos rengiant kiekvienų metų Lietuvos Respublikos valstybės biudžeto ir savivaldybių biudžetų finansinių rodiklių patvirtinimo įstatymo projektą, Valstybės investicijų programą ir Privalomojo sveikatos draudimo fondo biudžeto projektą.

Ministras Pirmininkas Algirdas Brazauskas

Sveikatos apsaugos ministras Juozas Olekas




**PROGRAMME IS AVAILABLE AT THE WEBSITE:**
**http://www.aids.lt/download.php**

Key **objectives** of the programme are:
to reduce transmission of HIV/AIDS and related infections in Lithuania;
to mitigate negative consequences of HIV and related infections to an individual and society;
to provide appropriate health care services to people with HIV and AIDS;
to improve HIV/AIDS surveillance system.

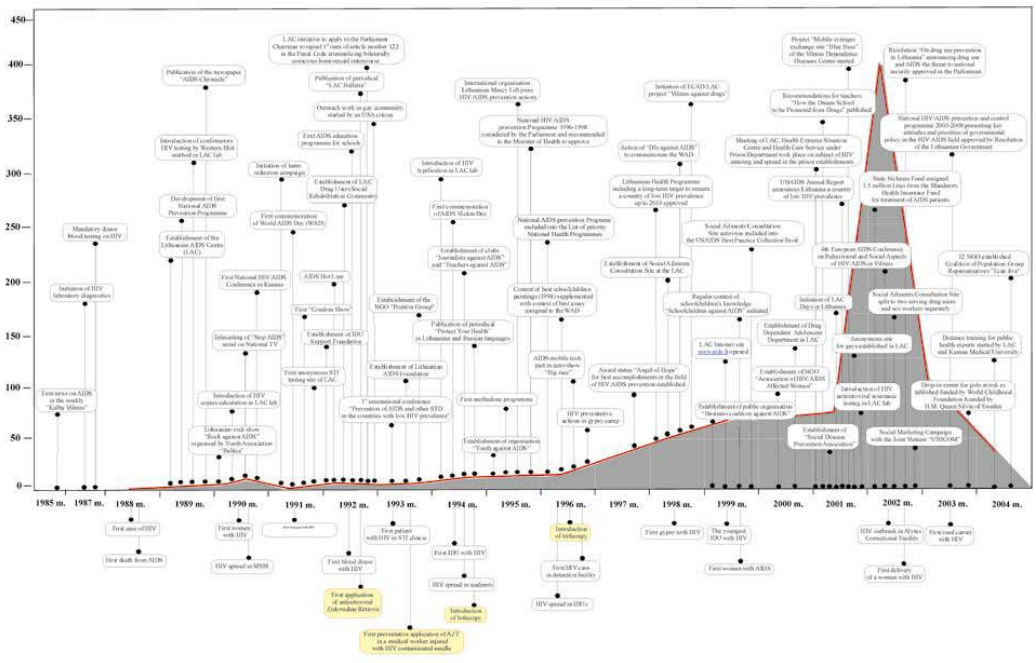
**Priorities**:
primary HIV prevention, collaboration with other institutions and non-governmental organizations and communities;
continual education on HIV and promotion of healthy living style;
behavioural changes; voluntary testing on HIV and related infections, and counselling;
provision of good-quality health care to people living with HIV/AIDS, availability of good-quality care and assistance services, and reducing discrimination of people with HIV/AIDS.
**Priority of preventive activity** people falling within high-risk groups.

**Tasks and directions**:
prevention of parenteral HIV transmission, HIV mother-to-child transmission, HIV transmission through sexual intercourse;
HIV/AIDS epidemiological surveillance;
improved care and social services for people living with HIV/AIDS;
inclusion of HIV/AIDS prevention and control issues into school curricula and post-diploma improvement programmes.

**Programme executors**: the Ministry of Health is the supervisor and main executor the Lithuanian AIDS Centre.

MINISTRY OF HEALTH OF THE REPUBLIC OF LITHUANIA

**Major achievements in the field of HIV/AIDS prevention in Lithuania**



# HIV/AIDS PREVENTION IN LITHUANIAN MUNICIPALITIES

**Saulius Caplinskas,**
*Lithuanian AIDS centre, Vilnius, Lithuania*

**Objectives:** to assess HIV/AIDS preventative activities on municipal level.

**Methods:** analysis of data of regional public health centres and municipalities.

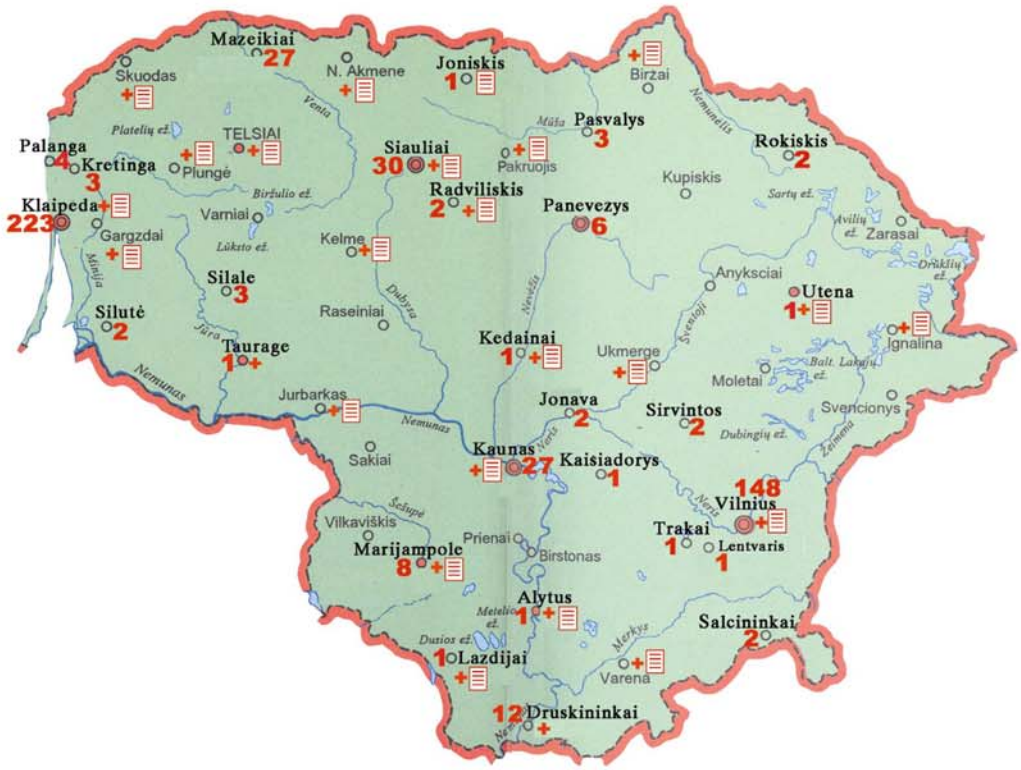
**Results:** During the early epidemics the law HIV incidence in Lithuania predetermined slight attention towards HIV problem in the counties. Along with increase of the number HIV cases, attention of municipalities to HIV/AIDS also increased. Up to 1998 totally 10 municipalities (out of 60) have implemented AIDS prevention programmes. The Lithuanian AIDS Centre (LAC) has designed a sample action plan for municipalities/counties on AIDS/STI/drug use prevention, work with target groups, mass media, and proposed this to the mayors. LAC has organised meetings with city mayors, specialists in education, health care, police officers, and representatives of child rights protection service, mass media. Seminars for pedagogues and schoolchildren took place. In 2003 inter-sectorial councils on HIV/AIDS, drug use and related problems were active in 24 municipalities. HIV/AIDS prevention programmes were designed and have been implemented in 22 municipalities.

In 2003 year the project "Capacity Building in Strengthening the Multi-Sectorial Response to the HIV/AIDS Epidemic at Sub-National Level in Lithuania" was implemented in collaboration with the Canadian Embassy. As project result a number of new projects were proposed at the municipal level. From 13 proposed projects 5 were selected for funding from the Canadian Embassy:

1. "Community against AIDS" Panevezys Public health centre, Birzai branch office;
2. "HIV/AIDS/STI and drug use prevention programme in Marijampole district for 2004-2005 year" Marijampole Public health centre;
3. "HIV/AIDS and drug use prevention and control in risk groups in Utena district" Utena Public health centre;
4. HIV/AIDS and drug use prevention measures implementation program in Kedainiai district for 2004-2006 year" - Kaunas Public health centre, Kedainiai branch office;
5. "Drug use prevention groups formation of the valuable skills" Pravieniskes 1st penitentiary.

Public health centres and branches have paid much attention to HIV/AIDS and related problems: on occasion of World AIDS Day 2003 they organised 234 various events.

**Municipality response to HIV/AIDS (February 14th, 2003)**




\+ - Intersectorial board on HIV/AIDS, drug use and related problems established

▤ - Action plan on prevention of HIV/AIDS, drug use and related problems developed

**Figures** - Reported HIV cases in the municipality (May 1 st, 2004)
Total number of HIV cases reported up to may 1 st, 2004: **515**

**Conclusions:** network established to solve HIV/AIDS and related problems proves not only the active cooperation between LAC and districts, but also the active response of municipal politicians and experts; the network to be further expanded on a basis of best practices.

# COMPARISON OF HIV TESTING RESULTS IN TARGET GROUPS IN THREE BALTIC COUNTRIES (ESTONIA, LATVIA, LITHUANIA)

**Saulius Caplinskas,**
*Lithuanian AIDS centre, Vilnius, Lithuania*

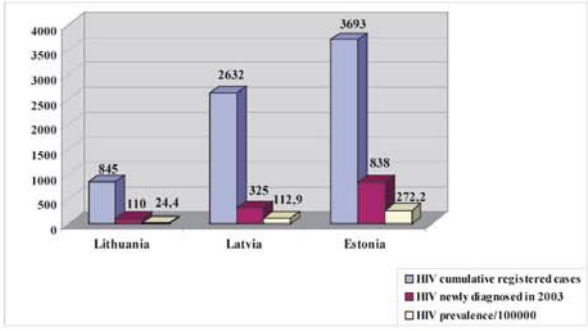
**Objective**. To find out if officially reported HIV prevalence in three Baltic countries does meet the real epidemiological situation.

**Methods.** Number of people from various target groups including prisoners, IDUs (not imprisoned), pregnant females, persons with clinical indications, STI patients, and donors tested for HIV and identified HIV cases in Estonia, Latvia and Lithuania up to 2003 was compared. HIV positive cases for 100 000 applied tests and data reliability indicator "p" were calculated.

**Results.** Up to January 2004 there were 845 officially reported HIV cases in Lithuania, in Latvia - 2632, in Estonia 3693. HIV prevalence in 100,000 population respectively: 24.4, 112.9, 272.2, i.e. it is 11 times higher in Estonia and 4.6 times higher in Latvia as compared to Lithuania.

Total number of performed HIV tests in Lithuania was 160,120, in Latvia 161,849, and in Estonia 99,211 in 2002. In all the target groups tested in 2002 HIV prevalence in Lithuania is loweras compared to Estonia and Latvia: in prisoners p<0.001; in IDUs p<0.001; in persons with clinical indications to perform a HIV test p<0.001; in STI patients p<0.05; in others p<0.001; in donors p<0.001.

**HIV cumulative numbers in Baltic countries, for Jan 2004**




**Comparison of HIV testing in Lithuania and Latvia**
**Data for the year 2002**

| | Lithuania | | | Latvia | | | |
|---|---|---|---|---|---|---|---|
| Groups tested | Tests | HIV+ | * | Tests | HIV+ | * | |
| Prisoners | 24 138 | 350 | 1 449,9 | 6 684 | 295 | 4 413,5 | p<0,001 |
| IDU (not imprisoned) | 2 831 | 28 | 989,0 | 2 980 | 71 | 2 382,5 | p<0,001 |
| Pregnant females | 2 398 | 0 | 0 | 22 692 | 23 | 101,3 | p<0,001 |
| Clinical indications | 5 780 | 5 | 86,5 | 4 208 | 20 | 475,2 | p<0,001 |
| STI patients | 1 328 | 2 | 150,6 | 10 101 | 46 | 455,4 | p<0,05 |
| Others | 40 769 | 12 | 29,4 | 26 406 | 156 | 590,7 | p<0,001 |
| Subtotal: | 77 244 | 397 | 513,9 | 81 940 | 611 | 745,6 | p<0,001 |
| Donor testing | 82 876 | 0 | 0 | 79 909 | 9 | 11,2 | p<0,001 |
| Total: | 160 120 | 397 | 257,9 | 161 849 | 620 | 383,0 | p<0,001 |
| | * HIV + for 100 000 tests | | | | | | |

*Source: Lithuanian an Latvian AIDS Centers 2003*

**Comparison of HIV testing in Lithuania and Estonia**
**Data for the year 2002**

| | Lithuania | | | Estonia | | | |
|---|---|---|---|---|---|---|---|
| Groups tested | Tests | HIV+ | * | Tests | HIV+ | * | |
| Prisoners | 24 138 | 350 | 1 449,9 | 1 923 | 243 | 12 636,5 | p<0,001 |
| IDU (not imprisoned) | 2 831 | 28 | 989,0 | 1 186 | 73 | 6 155,1 | p<0,001 |
| Pregnant females | 2 398 | 0 | 0 | 19 374 | 44 | 227,1 | p<0,001 |
| Clinical indications | 5 780 | 5 | 86,5 | 3 203 | 119 | 3 715,2 | p<0,001 |
| STI patients | 1 328 | 2 | 150,6 | 2 898 | 17 | 586,6 | p<0,05 |
| Others | 40 769 | 12 | 29,4 | 22 511 | 378 | 1 679,1 | p<0,001 |
| Subtotal: | 77 244 | 397 | 513,9 | 51 095 | 874 | 1 710,5 | p<0,001 |
| Donor testing | 82 876 | 0 | 0 | 48 116 | 25 | 51,9 | p<0,001 |
| Total: | 160 120 | 397 | 257,9 | 99 211 | 899 | 906,1 | p<0,001 |
| | * HIV + for 100 000 tests | | | | | | |

*Source: Lithuanian an Estonian AIDS Centers 2003*

**Estimated size of core population groups at high risk of HIV by country**

| Country | IDU (Prevalence in %) | MSM | Sex workers (F and M) | Prisoners (rate per 1000,000) |
|---|---|---|---|---|
| **Estonia** | 10,000-15,000 (0.72-1.1) | 5,000-12,000 | 3,000-5,000 | 5,000 (361) |
| **Latvia** | 9,000-12,000 (0.4-0.5) | 6,000-19,000 | 4,000-15,000 | 8,100 (352) |
| **Lithuania** | 7,000-11,000 (0,2-0,3) | 17,000-44,000 | 5,000-8,000 | 11,400 (327) |
| **Russian Rederation** | 1,500,000-3,500,000 (1.01-2.4) | 400,000-2,000,000 | 150,000-300,000 | 875,000 (611) |
| **Ukraine** | 400,000-600,000 (0.78-1.17) | 200,00 | 45,000-55,000 | 200,000 (413) |

*Source: WHO EURO data collection (2003)*

**Conclusions.** Data analysis has proved insufficiency of HIV testing in inmates in Estonia (only 1,923 HIV tests as compared to 24,138 in Lithuania and 6,684 in Latvia). A need to continue comparative research of number of applied serosystems is obvious. Such comparative research might be of help to fight HIV. Factual HIV prevalence in Lithuania is reliably lower as in other two Baltic countries.

# RISK FACTORS OF HIV SPREAD IN LITHUANIAN MEN HAVING SEX WITH MEN (MSM) COMMUNITY

**S. Caplinskas**
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**Background.** 7% of HIV cases and 64% of AIDS cases in Lithuania are reported in MSM. About a half of people died of AIDS acquired HIV through homosexual intercourse.

**Methods.** Internet survey of MSM organised by the Lithuanian AIDS Centre in 2003 aiming to find out features of MSM sexual behaviour and risk factors predetermining the HIV spread. Anonymous questionnaire was designed basing on the one of the Family Health International. Statistical analysis performed by SPSS 10,0 for Windows programme package.

Survey participants men having sex with men were found: Through NGO 1; Through contact persons 4; Through other MSMs 50; Through counsellors 3; Other 24; Not indicated 8; Total - 90.

**Results**. 90 MSMs from 7 cities were questioned.

**Chart 1. HIV infection cases in MSM in Lithuania**

**Chart 2. HIV cases and transmission mode in Lithuania (01.06.2004)**

**Demographic data:** one third of the men have university education, 30% - unfinished university, others lower (secondary, vocational) education.

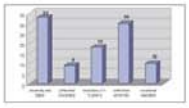
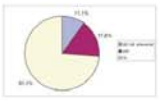


**Chart 3. Distribution of the respondents by education**

17.8% indicated being married presently or before, 81.1% - single and 11.1% did not answered to the question.



**Chat 4. Marriage**

**Sexual behaviour:** 90% of the respondents indicated voluntary sex debut with a man, 4.4% - violent sex debut, 1.2% did not remember, and 4.4% - did not answered.

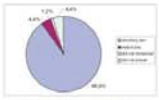


**Chart 5. Sexual debut**

Majority had their sex debut at 16 years of age with a man, at 17 years with a woman. Partner was in average 5 years older in majority of cases.

In the last 6 months 57.8% had one constant partner; 24.9% - 2; 31% - 3, 4.7% had more than 10 partners.

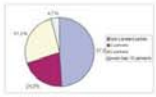


**Chart 6. Sexual partners**

94.5% practice oral, and 69.3% anal sex with a regular partner.

**Chart 7. Sexual practices**

Only 20% did not have accidental sexual partners in the last 6 months, 80% - had.

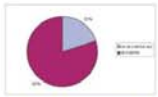


**Chart 8. Accidental sex**

68.6% used a condom during accidental sex, and 31.4% did not.

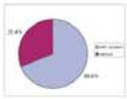


**Chart 9. Condom use during accidental sex**

52.3% of respondents had commercial sex partners in the same period. 75% practiced anal sex, and 71.4% used a condom.

| Had commercial sex partners % | practiced anal sex % | used a condom % |
|---|---|---|
| 52.3 | 71.4 | 75 |

*Note*: Reason of unprotected sex with commercial partner dislike.

**Table 1. Commercial sex**

58.9 % of respondents indicated often trips to other cities.

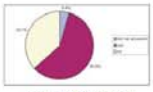


**Chart 10. Migration**

- In the last 30 days a third part of the respondents had sex with a woman. Only 20% used a condom while having sex with a woman.
- Tenth part of questioned MSM had STI.
- 22.2% knew people with HIV or those died of AIDS.

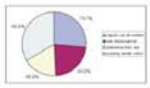


**Chart 11. Knowledge on HIV protection means**

**Knowledge on HIV protection means:** 1) proper use of a condom during every intercourse (76.7%); 2) sex with only one stable partner (64%), 3) abstention from sex (48.9%); 4) avoiding needle share (96.6%).

- 84.3% knew addresses of anonymous HIV testing sites.
- 90.3% voluntarily underwent a HIV test but only 67.6% knew the testing results.

**Conclusions.** The surveyed MSM community behaves risky while having sex: multiple partners, insufficient use of condoms, commercial sex partners, and migration. Despite the relatively good knowledge on HIV transmission modes, MSM do not respectively modify their behaviour, which proves a need for continuation of educational actions in this group. Because of sex with women, HIV might spread to heterosexual part of population. Condom promotion in general population must be strengthened to reduce a risk of HIV transmission.

# LITHUANIAN POPULATION'S TOLERANCE TOWARDS VULNERABLE GROUPS

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**Background.** By an order of the Lithuanian AIDS Centre, representative population survey (n=1009) was performed in 2003 to find out the degree of population tolerance towards various social groups drug users, people living with HIV/AIDS, ex-prisoners, MSMs, alcohol-dependents, etc.

**Methods:** The standard scale of social groups was applied in the survey, and respondents were asked to answer, which people they would not like to have in neighbourhood. Indirect tolerance indicator was measured. Results compared with analogical surveys in 1990 (n=1000), 1997 (n=1011), 1999 (n=1017).

**Results:** In 2003 the major part of respondents would not like to live in neighbourhood of drug users 81%, 62% - of alcohol-dependents, 57% - of former prisoners, 49% - of people with HIV/AIDS, 37% each of emotionally instable people and MSM. Results of the survey in 1990 (n=1000): 88.9% would not like to live in neighbourhood of drug users, 91.6% - of alcohol dependents, 87.4% - of homosexuals, 77.6% - of people with HIV/AIDS, 68.5% - of ex-prisoners, 48.3% - of emotionally instable people. This proves increased tolerance of population towards the most vulnerable groups. In 13 years number of people not wishing to have those with HIV/AIDS as neighbours has decreased 1.5 times; number of homophobes - 2.3, and number of those avoiding ex-convicts - 1.2 times. In majority of cases young people (15-29 years) are more tolerantly predisposed towards people with HIV than those aged 50-74 as well as people with university education and higher income.

**Conclusions:** Tolerance of Lithuanian population towards people with HIV/AIDS, ex-convicts and MSM has increased proving expedient design and implementation of educational actions and information on HIV/AIDS and related problems. A slight change in tolerance attitudes towards drug users indicates the still high stigmatisation requiring correction of public information and education methods.

Tolerance in regard of various social groups is being measured by a standard scale. Indirect tolerance indicator is achieved by finding out with whom the people would not like to live in the neighbourhood.

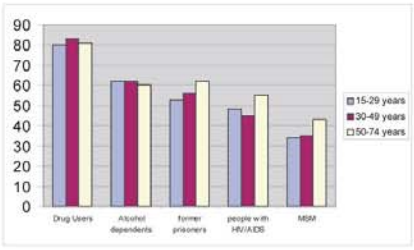


**Chart 1. Social distance (Tolerance) by age in % (2003)**

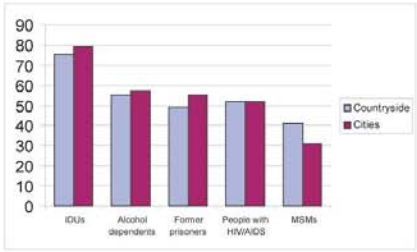


**Chart 2. Social distance (Tolerance) by residence place in % (2003)**

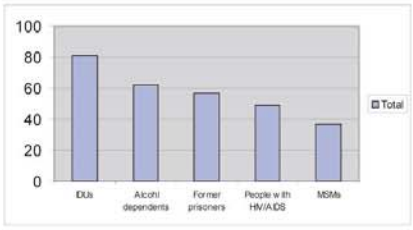


**Chart 3. Social distance (Tolerance) total in % (2003)**

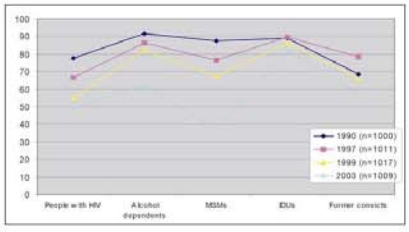


**Chart 4. Trends of the tolerance in regard of vulnerable groups in Lithuania in % (1990-2003)**

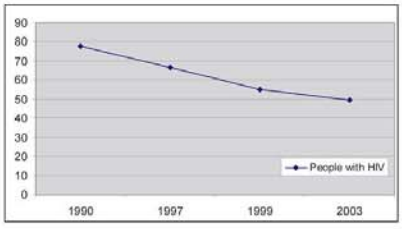


**Chart 5. Trends of the tolerance towards people with HIV/AIDS in Lithuania in % (1990-2003)**

Survey performed by the joint Great Britain and Lithuanian company of public opinion and market investigation "Baltic Survey"

# NATIONAL SURVEY ON KNOWLEDGE, ATTITUDES AND INFORMATION SOURCES REGARDING HIV/AIDS

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**Background:** This study was designed to establish population knowledge on and attitudes towards HIV/AIDS by place of residence, age, gender, education and to determine future message for AIDS public campaigns.

**Methods.** By an order of the Lithuanian AIDS Centre, representative population survey was performed in 2003. 1009 individuals, aged 15-74, were interviewed by independent Lithuanian and Great Britain Public Opinion and Market Investigation Company "Baltic Surveys".

**Results:** Lithuanians have especially good knowledge on HIV transmission through contaminated syringes - 95% including 98.5% of young people aged 15-29 and 89.6% of those aged 50-74. 86% of respondents knew vertical transmission mode. 75% were aware that a condom could prevent HIV infection, and 74% - that sexual abstinence helped avoiding HIV infection. 86% agreed that healthy appearance did not guarantee a negative HIV status. Incorrect notions included transmission via insect bites - 38%. Youth proved having better knowledge in all the fields. There were no differences in answers of rural and urban population. Women appeared to be slightly better informed than men. Direct relation was found between education and HIV knowledge: the higher education, the better knowledge on HIV. The major HIV information source is mass media. People aged 15-29 received most knowledge from mass media, however, this groups also got enough information from teachers (29.9%), friends (27.7%) and Internet (13.9%). 64% of population would conceal HIV infection of a family member. Women more than men are apt to keep a secret about HIV infection in their family (66.1%) as well as people with university education.

**Conclusions:** Lithuanian population is quite well informed on HIV/AIDS transmission modes and protection means. Information dissemination methods are rightly chosen to reach the youth and both rural and urban population. Attitudes of population prove high stigmatisation of people with HIV/AIDS.

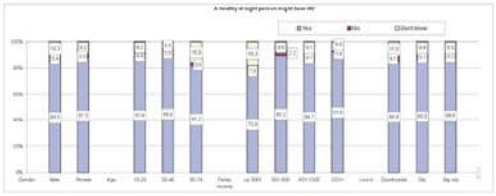

Chart 1. A healthy at sight person might have HIV

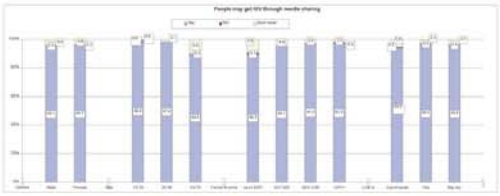

Chart 2. People may get HIV through needle sharing

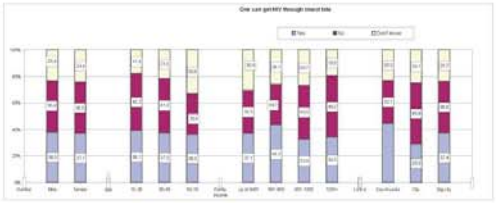

Chart 3. One can get HIV through insect bite

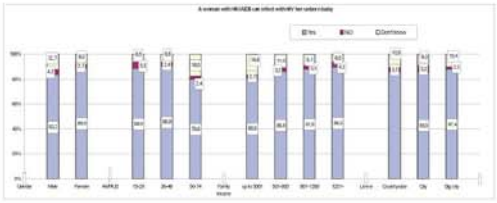

Chart 4. A woman with HIV/AIDS can infect with HIV her unborn baby

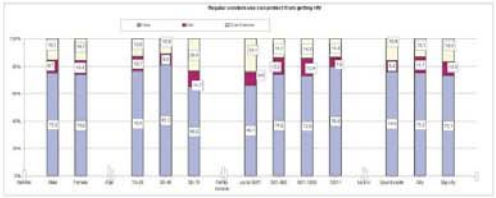

Chart 5. Regular condom use can protect from getting HIV

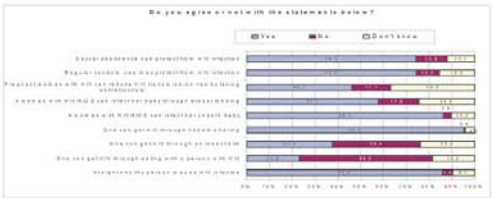

Chart 6. Do you agree or not with the statements below?

| | Age | | | Residence place | | | Total |
|---|---|---|---|---|---|---|---|
| | 15-29 | 30-49 | 50-74 | Country-side | City | Big city | |
| TV | 83 | 87 | 85 | 82 | 84 | 87 | 85 |
| Press | 62 | 70 | 53 | 54 | 64 | 66 | 62 |
| Radio | 35 | 40 | 47 | 42 | 45 | 37 | 41 |
| Friends | 19 | 15 | 28 | 14 | 16 | 19 | 17 |
| Teachers | 10 | 12 | 30 | 9 | 9 | 16 | 11 |
| Medical workers | 10 | 9 | 14 | 5 | 9 | 13 | 10 |
| Books | 8 | 9 | 14 | 5 | 10 | 12 | 9 |
| Internet | 15 | 6 | 14 | 5 | 14 | 8 | 8 |
| Family | 6 | 6 | 10 | 6 | 7 | 6 | 6 |
| Other | 1 | 1 | 1 | 0,2 | 0 | 1 | 1 |
| Lack of knowledge | 2 | 2 | 0 | 2 | 2 | 2 | 2 |
| Didn't know, didn't answer | 4 | 2 | 2 | 6 | 1 | 2 | 3 |

Table 1. What are the main sources of your knowledge on HIV/AIDS? (%), 2003

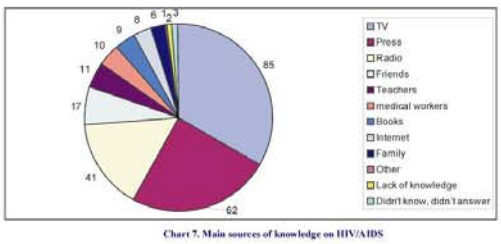


Chart 7. Main sources of knowledge on HIV/AIDS

# HIV TRANSMISSION TRENDS IN LITHUANIA

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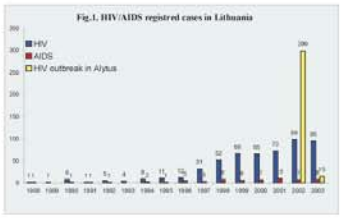
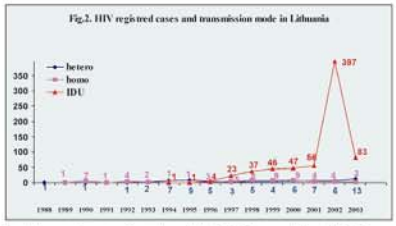
**Objective:** to evaluate HIV transmission trends in Lithuania.

**Methods:** retrospective analysis of national data on HIV.

**Results:** The systematic surveillance of HIV infection in Lithuania was introduced in 1987. The first HIV positive person was reported in 1988 (Fig.1.).




Up to 1997 the sexual HIV transmission mode prevailed. In 1997-2003 HIV was predominantly transmitted through contaminated needles in IDU population (Fig.2.).

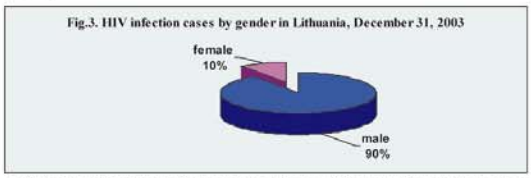
80% of new annual HIV cases have been IDUs ( Table 1.).

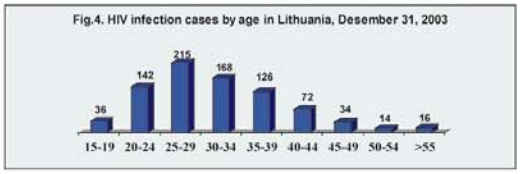
**Table 1. HIV transmission mode in Lithuania, December 31, 2003**

| Probable route of infection | Males | Females | Total (%) |
|---|---|---|---|
| Intravenous drug use | 613 | 65 | 678(80.8%) |
| Homosexual | 63 | 0 | 63 (8.0%) |
| Heterosexual | 55 | 15 | 70 (7.8%) |
| Blood products | 0 | 0 | 0 (0 %) |
| Mother-to-child | 0 | 0 | 0 (0 %) |
| Unknown | 31 | 3 | 34( 3.4%) |
| Total | 762 | 83 | 845 |

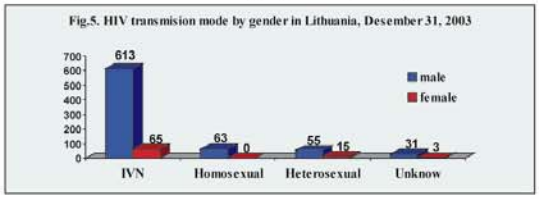
Up to December 31, 2003 a total of 845 HIV cases were reported: 762 male, 83 female (Fig.3.).

HIV has been mostly reported in the age groups of 25-29 and 30-34 years, while 76 percent of total cases were identified in the age group of 20-39 years (Fig.4.).




65% of all HIV-infected individuals have episodes of incarceration. Number of female cases is on increase. Ratio of HIV infected male/female cases made 7:1 in 2003 (Fig.5.). Majority of reported females are at their reproductive age, at average 29 years and 78%-IDU. The number of female HIV cases presumably includes 18 former or active sex workers. Neither cases of HIV mother-to-child transmission, nor HIV infection in children younger than 15, nor occupational HIV cases were reported .




HIV prevalence in year 1996 was 1.45 for 100,000 of population,19.6 in 2002, and estimated 24,4 in 2003. In 1996 HIV incidence for 100 000 population was 0.33, and in 2002 10.9 (table 2).

**Table 2. Incidence and prevalence of HIV/AIDS per 100 000 population in Lithuania (1996-2002)**

| | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 |
|---|---|---|---|---|---|---|---|
| **AIDS** | | | | | | | |
| Incidence | 0.14 | 0.08 | 0.23 | 0.17 | 0.2 | 0.26 | 0.26 |
| Prevalence | 0.33 | 0.42 | 0.65 | 0.83 | 1.03 | 1.29 | 1.59 |
| **HIV infection** | | | | | | | |
| Incidence | 0.33 | 0.87 | 1.47 | 1.87 | 1.86 | 2.07 | 10,9 |
| Prevalence | 1.45 | 2.33 | 3.82 | 5.72 | 7.63 | 9.72 | 19.6 |

High increase of HIV incidence in 2002 is attributable to HIV outbreak in Alytus prison (299 new HIV cases). Prevalence of AIDS cases for 100,000 population has gradually increased from 0.33 cases in 1996 up to 1.59 in 2002 (table 2). From introduction of the HIV registry, AIDS was diagnosed in 64 persons. There were 60 death of HIV infected persons reported, of them 28 because of AIDS (table.3).

**Table 3. AIDS cases in Lithuania, December 31, 2003**

| AIDS cases | Males | Females | IDU | Total |
|---|---|---|---|---|
| Number of AIDS diagnosed | 59 | 5 | 5 | 64 |
| Number of deaths: | 53 | 7 | 11 | 60 |
| AIDS | 28 | | | 28 |
| Others reasons | 25 | 7 | 23 | 32 |

The mean time from AIDS diagnosis to death was 12 months.

**Conclusion:** A relatively slow virus spread in drug users to be attributed to an active preventive work of LAC and other institutions targeted at the high risk behaviour groups.

# INTRAVENOUS DRUG USER' CHARACTERISTICS AND RISK BEHAVIOUR

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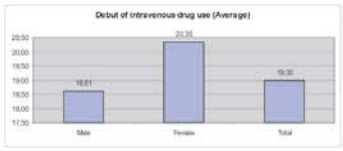
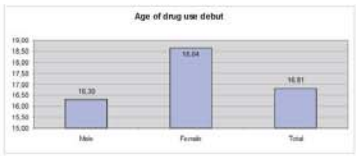
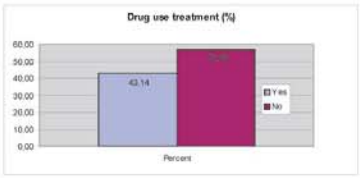
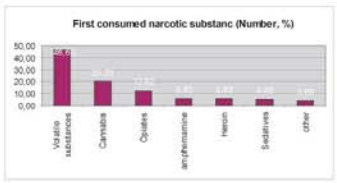
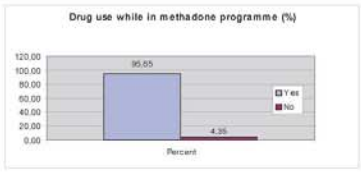
**Objective:** To identify possible important behaviour factors and social characteristics in IDUs attending the Lithuanian AIDS Centre's syringe exchange programme.
**Methods:** Anonymous questionnaires were used for collection of data on speeific characteristics of drug use and sexual behaviour. Blood specimen was tested to detect antibodies to HIV, HBV, syphilis and other infection.
**Results:** 80 (77,7%) males and 23 (22.3%) females were questioned. Mean age: 25.3 years. Social characteristics: 84.5% with secondary, 7.8% with initial education, 83.5% unemployed or did not study.
77.7% lived with their family or relatives.
96.1% insisted that their parents or relatives were aware about their drug use. The parents got learned about it in average after 10.5 months.
Drug use: debut of drug consummation happened in average at 16.8 years of age. Experience of drug use made in average 6.4 years. Debut of intravenous drug injection happened at 19+0.9 years of age in majority of cases. First consumed narcotic substance: 46.6% - toxic substances, 20.3% - marihuana, 12.6% - opiates, each 5.8% - amphetamine and heroin, 4.8% - sedatives, 3.8% - other substances.
Majority of respondents have first infected intravenous drugs because of curiosity (35%), because of peer pressure 27%, others have indicated different reasons.
Only 77.7% always use a new syringe/needle, 13.4% reused, 8.7% sometimes used a new needle/syringe, sometimes reused. 73.7% of respondent shared the own syringe with others.
56.8% of respondents have never undergone a treatment from drug use, 22.3% - participated or have participated in methadone programme. Majority (69.5%) took part in short-term methadone programme. 95.6% of methadone programme attendees have used other narcotics while in the programme.
All (100%) were aware that unsafe drug injection may result into HIV infection, all underwent a HIV test, 96% were tested on HCV and HBV. 94.1% of respondents knew their HIV test result, and 98.1% - their HCV and HBV test result.
92.2% of respondents knew people with HIV/AIDS or those deceased with AIDS, and 100% of questioned drug users knew people with HCV and HBV.
Two were tested HIV positive, 44 had had HBV episodes, 9 had acute HBV, and 5 had cured syphilis. Majority were aware about safer sex, 97% - about the condom outlets. Respondents have usually got information on HIV, STI and other blood borne diseases from Lithuanian AIDS Centre.
64.7% have had a stable sex partner during a year, 33.3% had different partners. 62.7% did not use condoms. 17.4% females and 7.5% males had commercial sex partner in 12 last months. 70% did not use condom while having sex with sex worker.

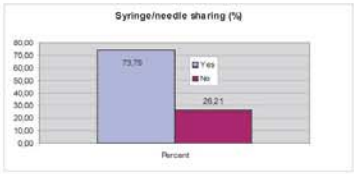


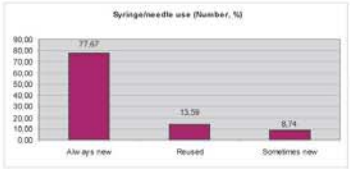



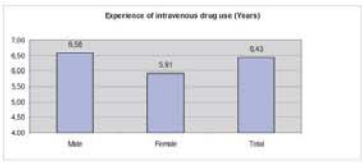



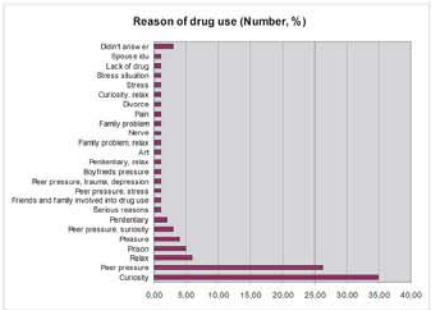




**Conclusions:** Majority of the respondents had their drug use debut in adolescence. Almost all the relatives were aware about their drug dependence.
Risky behaviour in regard of drug use and sex was typical to the questioned group. Despite a good knowledge on HIV transmission modes and protection means STI prevalence was high.
Majority of questioned people had undergone test on HIV and hepatitis, and majority of them knew the test result.
Hepatitis C was highly prevalent due to the sharing of syringes/needles. Prevalence of HIV in the questioned group was not high at the time being, however their behaviour and biological indicators (hepatitis B/C, syphilis) prove reliability of HIV spread.
STI/HIV may enter general population from IDUs because of unsafe sex habits. Methadone programmes and syringes exchange is not enough to change their behaviour. Therefore there is a need for expansion of HIV prevention programmes targeting the risk groups. The window of opportunity is shot, and additional preventive actions are urgently required.

# VIRAL LOUD TESTING IN PATIENTS WITH AIDS ON HAART THERAPY

**Griskevicius A., Lipnickiene V., Lazickiene A., Caplinskas S.**
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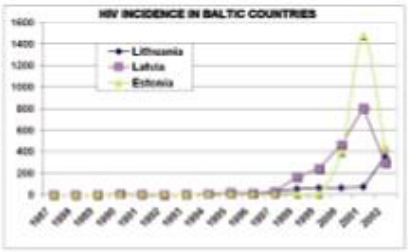
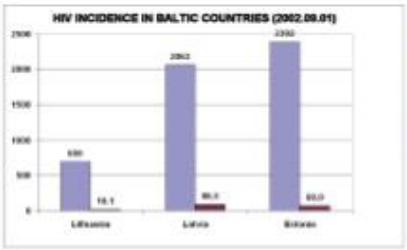
## Background

HIV prevalence in Lithuania is one of the lowest in the Europe. Despite insufficient budget assigned for the treatment of HIV infected people, in most of cases HAART is applied. In accordance with current legislation, this therapy is initiated on the AIDS stage.



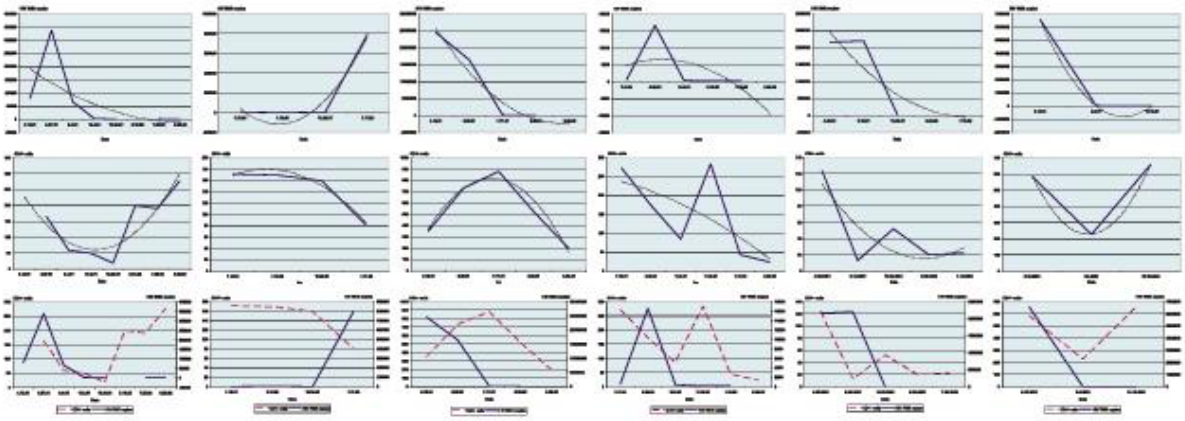




## Objective

To assess treatment adequacy in the people with AIDS.

## Methods

Patients on the HAART used to be tested to find out the count of CD4 T-lymphocytes by flow cytometric method ( FACSCalibur, Becton Dickinson) and count of HIV RNA copies (Amplicor HIV-1 Monitor Test, version 1.5, Roche, and LCx HIV RNA quantitative assay, ABBOTT laboratories). In this study we involved patients tested three and more times in 2001 -2002.



## Results

Of 11 treated patients 6 persons were tested three and more times. Only in two cases the count of HIV RNR copies was found to be below detectable limit of the test. However in four other cases, the count has decreased during the treatment. In 3 cases count of CD4 T- lymphocytes has increased, in two cases was stable, and in one case has decreased.

## Conclusions

1. Follow-up of the people with AIDS receiving antiretroviral treatment has to be legally better regulated.
2. Though the laboratory testing showed that the applied therapy was not adequate, we were not able to modify the treatment regimen because of insufficient budget.

# STI AND HIV PREVALENCE IN VILNIUS SEX WORKERS

**Jarasuniene R., Caplinskas S.**
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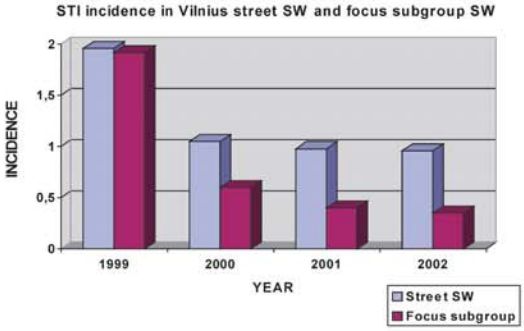
**Objective.** To assess sexual health of commercial sex workers (SW) applying for services to the Lithuanian AIDS Centre's (LAC) Women/s Health Site, and look after possible changes in the group behaviour resulting from targeted actions of LAC.

**Methods.** In 1999 a focus group including 56 female SW soliciting on the streets was formed to regularly investigate their STI/HIV prevalence rate. In 2002 the group decreased up to 49 women: 1 died with drug overdose, 2 did not paid any visit more, 4 were incarcerated. SW have been annually (1999, 2000, 2002) examined by gynaecologist and tested for syphilis, gonorrhoea, chlamydeous infection, bacterial vaginosis, HCV/HBV, endocervicitis, urethritis, and HIV. Other part of research included comparison of HIV/STI infection rate in free groups: "street" SW (n=105), those working with a pimp ("call girls") (n=57), and without pimp (bar, massage parlour SW) (n=21).

**Results.** STI incidence in the focus subgroup has decreased from 86.2% up to 6.1%, while in the general population of sex workers the incidence was still quite high: 68.9%.




Prevalence of syphilis and gonorrhoea has been on decrease. In 1999 only 2 of 56 SW had no STI, in 2000- 14, and in 2002 of 49 SW 16 were healthy. No cases of HIV were found.

**STI in the focus subgroup of Vilnius sex workers**

| STI | Initial testing (n=56) | Second testing (n=56) | Third testing (n=49) |
|---|---|---|---|
| HIV | 0 | 0 | 0 |
| Syphilis | 19 | 1 | 0 |
| Gonorrhoea | 9 | 4 | 1 |
| Chlamydeous infection | 10 | 3 | 2 |
| Bacterial vaginosis | 35 | 16 | 17 |
| Trichomonosis | 9 | 8 | 0 |
| HCV | 23 | 25 | 21 |
| HBV | 3 | 0 | 0 |

The comparison of STI/HIV prevalence in three different SW groups showed that SW working on their own acquire less STI. STI sickness rate was the highest in SW working with pimp, presumably, because a pimp is an obstacle in taking care of their health. Street SW are more apt to use drugs. SW working with pimps are younger (mean age 22.7 years). Older SW usually have no pimp (mean age 27 years) or solicit on the streets (mean age 25.5 years).

**STI incidence in Vilnius sex workers**

| Subgroup | Street SW (n=105) | With a pimp (n=54) | Without a pimp (n=21) |
|---|---|---|---|
| With STI | 76 | 52 | 7 |
| Healthy | 29 | 2 | 14 |

Comparative data on STI incidence in "street" SW and SW working with a pimp are statistically reliable ($p<0.05$), and risk to acquire any STI is alike in the both subgroups. Comparative data on STI incidence in street SW and those working without a pimp are also statistically reliable ($p<0.05$), and risk to get infected with STI is 4.14 time the risk of the latter subgroup. Because of a low number of the surveyed people, comparative data on STI incidence in SW working with or without a pimp are not statistically reliable, and the STI risk is 1.14.

**STI cases in Vilnius sex workers**

| STI | Street SW (n=105) | SW working with a pimp (n=57) | SW without a pimp (n=21) |
|---|---|---|---|
| HIV | 0 | 0 | 0 |
| Syphilis | 1 | 1 | 0 |
| Gonorrhoea | 2 | 2 | 0 |
| Chlamydeous infection | 3 | 2 | 0 |
| Bacterial vaginosis | 72 | 51 | 14 |
| Trichomonosis | 1 | 1 | 0 |

The most prevalent in all the groups is bacterial vaginosis.

**Conclusions.** Accessible medical services, effective treatment, education on safer sex, condom availability are determinants for decrease of STI incidence.

# EFFICIENCY IMPROVEMENT OF HPV SELECTIVE TESTING IN PREVENTION OF CERVIX CANCER

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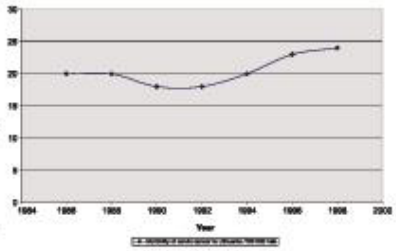
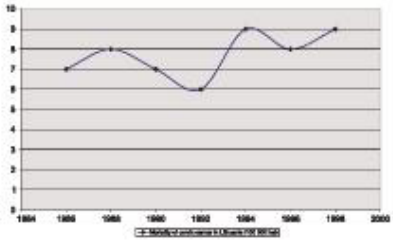
* Lithuanian AIDS Center, Vilnius, Lithuania
** Lithuanian Oncology Center, Vilnius, Lithuania

## Objective

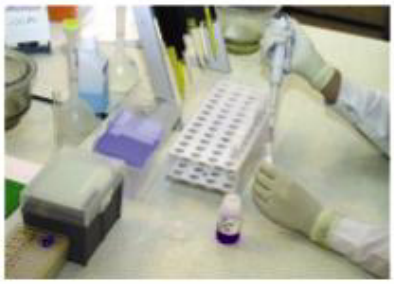
Despite achievements of the infectious diseases molecular diagnostics, the high price of the testing prevents from applying these methods for screening purposes, especially in the new independent countries of 20th century. This problem turns out to be even more serious while reforming the health care system and passing from passive disease prevention to the active one. As in 2000 even 30 percent of women's death cases caused by cancer in Lithuania were due to cervix cancer, selective testing proves its importance even if resources are rather scarce. Objective of our research was to clear up a question if women with cervix pathology would be willing to participate in selective testing on human papilloma virus. In this way the screening price would be reduced and its efficiency improved.





## Methods

A mass media campaign was initiated to widely inform about the screening testing on HPV and ailments induced by this virus. The action continued through 15 days. Women taking care of their health were invited to apply for a test. Sampling was performed with special samplers (Digene Cervical sampler). The samples were stored and prepared following instructions of Digene HPV Test. After hibridization reaction, results were evaluated while using the DML2000 luminometer, again, in accordance with producer's instruction.

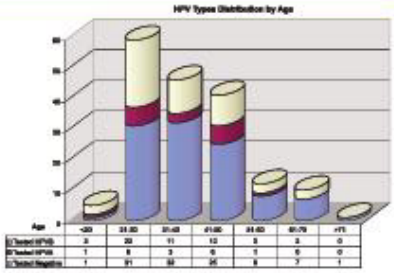



Daugiau ŽIV nešiotojų Vilniuje rasti nepavyko

## Results

Totally 306 women underwent the test. Of them 105 (34,3%) were tested positive.

| Positive | Positive results | % |
|---|---|---|
| High risk group (16/18/31/33/35/39/45/51/52/56/58/59/68) | 73 | 69.5 |
| Low risk group (6/11/42/43/44) | 12 | 11.4 |
| Both high and low risk groups | 20 | 19.1 |




In three cases of positive result with high HPV risk group, the cervix cancer was consequently diagnosed in the Women's clinic of Medical faculty of Vilnius University.

## Conclusions

1. Voluntary selective testing on HPV prove to be effective and reduce expenditures of such the testing.
2. To save resources, the selective HPV high risk group testing is applicable.
3. For referrals to an oncologist, it is important to combine molecular and cytological testing methods.

# RISK OF STI SPREAD THROUGH ACCIDENTAL AND COMMERCIAL SEX

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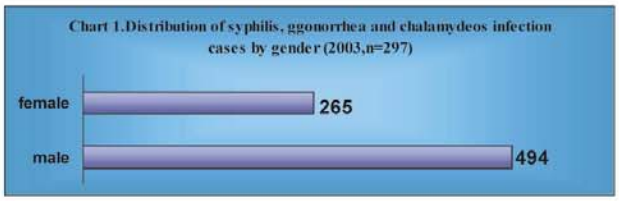
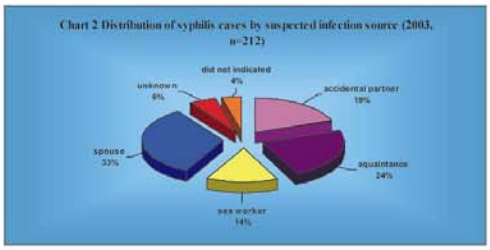
**Objective.** Sexually transmitted infections often result into serious sequels in a patient and are one of predisposing factors of HIV spread. About 3% of HIV cases in Lithuania had any STI episode before HIV infection. Objective was to analyse the STI transmission trends.

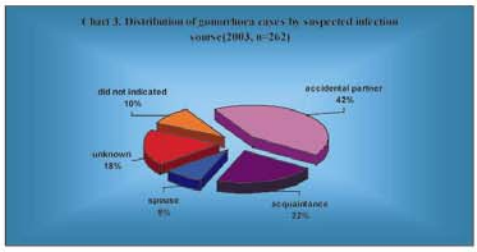
**Methods:** retrospective data analysis, descriptive epidemiological research. Distribution of indicators in absolute numbers and distribution in percent was calculated.

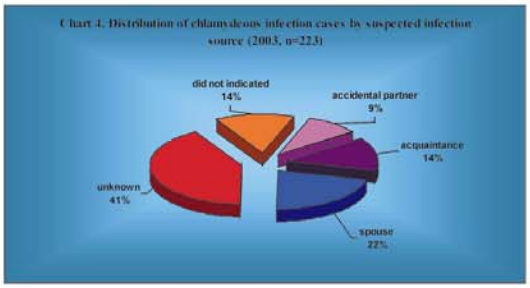
**Results.** Totally 697 Protocols on STI, HIV Carrier and HIV Disease Research (212 syphilis, 262 gonorrhoea, 223 chlamydeous infection cases), Form No. 151-9/a were analysed. Percent of men (65 %) with sexually transmitted disease diagnosis was higher ($p<0.05$) as that of women (35 %)(Chart 1). 87 (50%) of respondents that indicated accidental sex as possible infection mode were youth (up to 25 years): syphilis and gonorrhoea has been mostly registered in the age group of 20-24 years, chlamydeous infection in the group of age 25-29 years. The youngest infected person was 17.




174 (25%) of respondents indicated accidental partner as possible infection source. Even 24% of infected people have no idea about the infection source. In opinion of 19% of the respondents they have acquired infection from an acquaintance, 18% - from spouse, 4.3% - from sex worker. 19% of people with syphilis judge that they have got infected by accidental partner, 14% - by sex worker (chart 2). 112 (43%) people with gonorrhoea and 21 (10%) with chlamydeous infection acknowledged only accidental sex (Charts 3-4).



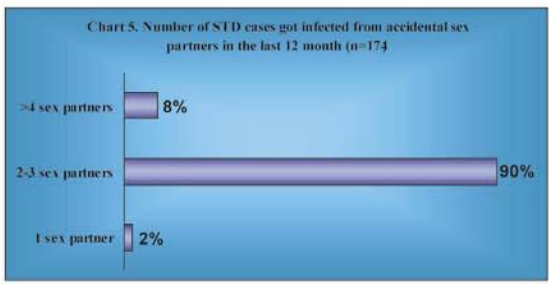



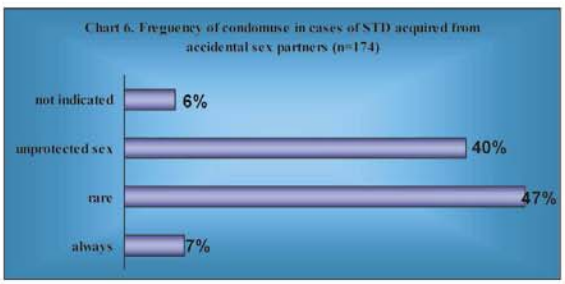




36% of people with STD insisted to have one partner in the last 12 months, 48% - two and more partners. More men as women admitted having two and more partners (60% and 24% accordingly).

Cases of unprotected sex were more common in men as compared to women (52% and 39% respectively). 60.4% of syphilis cases (55% male 66.3% female), 26% of gonorrhoea cases (20.5% male, 55.8% female), and 27.1% of chlamydeous infection cases (18.5% male, 35.3% female) did not use a condom while having sex.

Even 156 (90%) people infected by accidental sex partner noted having 2-3 and more sex partners during the last 12 months, and only 12 (7%) always used a condom.




**Conclusions.** STI is highly prevalent in people with risky behaviour. HIV infection could be early diagnosed; education to motivate behavioural changes and to follow safer sex rules to be assured in STI clinics.

# EPIDEMIOLOGICAL RESEARCH OF SYPHILIS OUTBREAK IN SILUTE DISTRICT

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[2]*Public Institution Silute Hospital, Silute, Lithuania,*

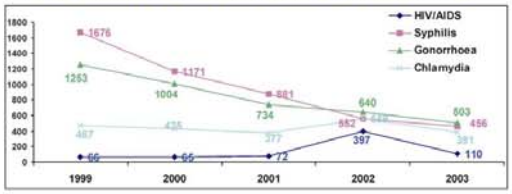
[3]*Lithuanian AIDS Centre, Vilnius, Lithuania*

**Objective.** To analyse causes of syphilis outbreak in Silute district in Lithuania, as syphilis incidence is the most reliable indicator of STI incidence.

**Methods.** Retrospective consideration. Research type descriptive epidemiological research. Distribution of indicators in absolute numbers and in percent was calculated.

**Results.** Incidence of syphilis and gonorrhoea has gradually decreased in five years. Number of Chlamydeous infection cases is different every year, and, supposedly, depends more on registration precision. Number of HIV cases has increased on annual basis (Chart 1).

**Chart 1. Incidence of STI, HIV disease and AIDS in Lithuania in 1999-2003.**



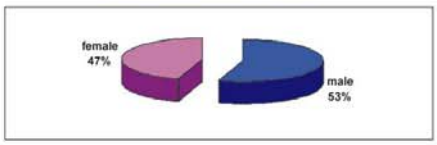

The highest incidence of syphilis (Chart 2) was reported in Silutes county, totalling to 9.6 cases in 10 000 population, in Visaginas town 5.9, and in Klaipeda county 3.9. In the biggest five cities this indicator did not exceed two in 10 000 population (in Siauliai 1.9, Klaipeda 1.4, Vilnius 1.2, Kaunas 0.8, Panevezys 0.6).

**Chart 2. Syphilis incidence in Lithuania in 2003 (absolute numbers).**


**Chart 3. Syphilis incidence in Lithuania in 2003 for 10 000 population.**


In 2002-2003 10.5% of all syphilis cases in Lithuania were reported in Silute district (106 cases of 1008). In two first months of 2004 13 new cases were reported in this district. 49 cases in 2003 and 13 in 2004 were analysed. 34 cases (53%) were male, 28 (47%) female (Chart 3), even 35 (56.5%) cases were countryside residents.

**Chart 4. Cases distribution by gender.**




About 50% of syphilis cases were reported in people up to 30 years (10 people with identified syphilis in Silute district are younger than 20). 35 primary or secondary and 27 latent syphilis cases were reported. 10% were married. 10 patients (16%) applied personally, 12 (20%) were identified in women clinics, 2 (3.2%) by general practitioner, 28 (45%) - as contact persons (Chart 4).

**Chart 4. Case diagnosing.**

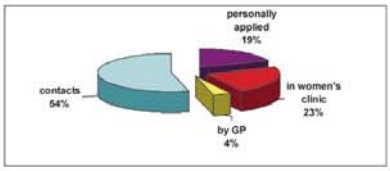
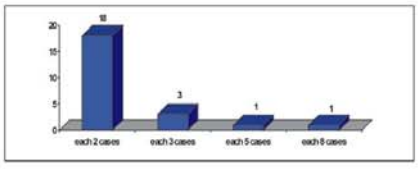



**Chart 5. Number of syphilis clusters.**




34 syphilis sources were registered, and 101 contact persons tested. 30 schoolchildren were preventively tested due to 5 cases with mental disorder. 18 clusters with 2 cases in each, 3 clusters with 3 cases, one cluster with 5 and 8 cases were identified (Chart 5).

**Conclusions.** Syphilis transmission rate is the highest in Silute district in Lithuania. Urgent specific interventions need to be taken to stop the spread of syphilis in this district.

# PECULIARITIES OF HIV DIAGNOSIS ON THE LATE DISEASE STAGE

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*Lithuanian AIDS center, Vilnius, Lithuania*

**Objectives.** To identify frequency and peculiarities of HIV diagnosis on the late disease stage (AIDS) in Lithuania.

**Methods.** Retrospective analysis of clinical condition and epidemiological data of 845 HIV positive patients at the moment of HIV diagnosis (diagram1). Period from first visit to a general practitioner up to final diagnosis was taken into account.

**Diagram 1**

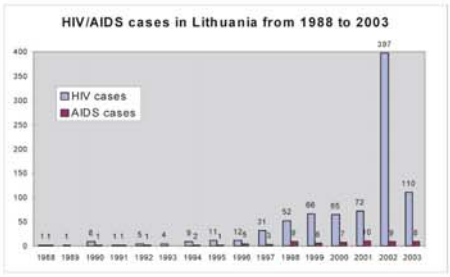
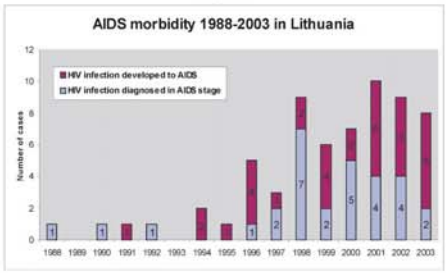



**Diagram 2**




**Results.** From 1988 up to 1st January 2004 totally 845 HIV cases were reported in Lithuania including 64 cases of AIDS. Several HIV cases have been annually identified on the late disease stage: in 30 cases HIV was diagnosed on the developed AIDS stage along with diagnosis of any AIDS indicator diseases (diagram 2). This makes 3.5 percent of all reported HIV cases or 46 percent of all AIDS cases. Consequently, those people acquired HIV 8-10 years ago.

Almost all the patients (n= 30) were males (96%). Majority of them (21 cases 70%) were infected homosexually, 6 heterosexually, virus transmission mode was unknown in 3 cases. Mean age 48 years (ranging from 27 to 68 years). Typical characteristic of a patient: male at his middle age, mostly having sex with men, with complaints of respiratory tract disorders. Average period from the first visit to a family doctor up to final diagnosis was 15 months (the longest one took 48 months). Such patients used to be frequently treated for a long time on outpatient basis by family doctor because of respiratory tract pathology (diagram 3). In 90 percent of cases final diagnosis was made in health care institutions of second/third level (out-patient and in-patient departments (diagram 4). Majority of patients were in poor clinical condition; 2 and more AIDS indicator diseases were diagnosed (diagram 5).

**Diagram 3**

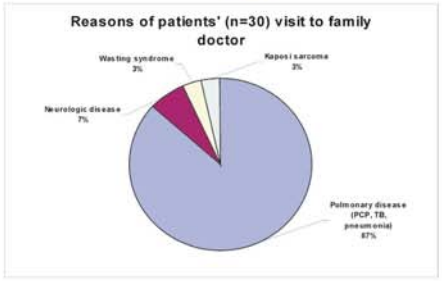



**Diagram 4**

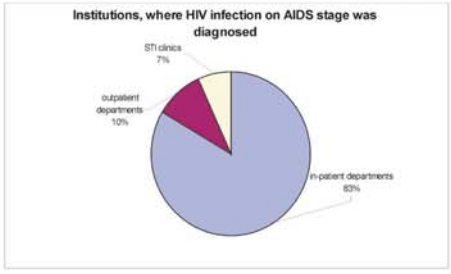
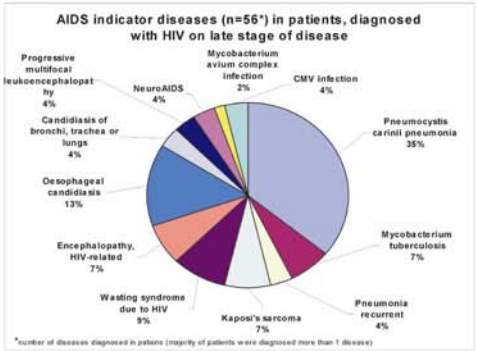



**Diagram 5**




**Conclusions.**

1. 3.5% of all HIV cases were identified on the AIDS stage.
2. Average period from first visit to a family doctor up to final diagnosis was 15 months.
3. This proves a lack of clinical alertness and, sometimes, insufficient knowledge of HIV/AIDS symptoms and differential diagnostics among primary level physicians or among doctors of other specialities. More attention should be paid to HIV/AIDS problem in curricula of medical universities and in qualification improvement programmes of health care professionals.
4. The Lithuanian AIDS Centre has initiated design of HIV/AIDS distance training course for general practitioners.

# AIDS INDICATIVE DISEASES AMONG HIV POSITIVES IN LITHUANIA

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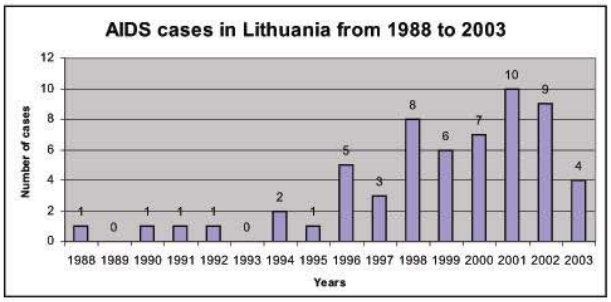
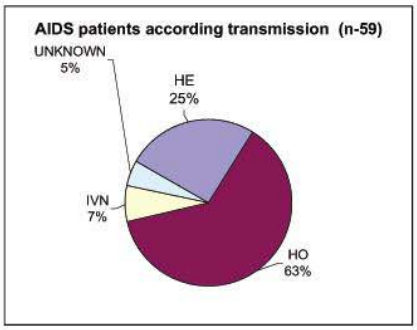
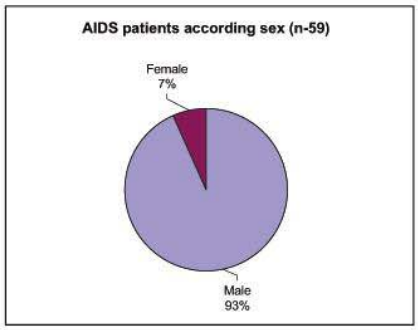
**Background:** First AIDS case was diagnosed in 1988 in Lithuania. Until the mid of 2003, there were 798 HIV positive persons, 59 of them were diagnosed with AIDS.




**Objective:** Analysis of the data from HIV/AIDS national registry, focusing on AIDS indicative diseases.

**Methods:** Among 59 patients with AIDS diagnose, 55 were male, 4 female. 37 AIDS patients were thought to be infected through homosexual contact, 15 - through heterosexual contact, 4 - intravenous drug users, 3 – HIV transmission route unknown. The target group was divided into two subgroups: first subgroup – people tested as HIV positive in the late stage of AIDS (n=28), second subgroup – people with HIV progression into AIDS (n=31). AIDS indicator diseases were diagnosed according 1993 European AIDS surveillance case definition. More than one AIDS indicator diseases were diagnosed for some of them. Incidence rate of various AIDS indicator diseases in AIDS patients in Lithuania was analysed and compared.




**Results:** Most frequent AIDS indicative disease was pneumocystis carinii pneumonia (PCP) – 34 (57.6 %). Among others: oesophageal candidiasis – 20 (33,8 %), wasting syndrome due to AIDS – 10 (16,9 %), pulmonary tuberculosis – 8 (13,5 %), HIV-related encephalopathy – 8 (13,5 %), Kaposi's sarcoma – 4 (6,7 %), candidiasis of bronchi, trachea – 3 (5 %), recurrent bacterial pneumonia – 2 (3,3 %), primary lymphoma of brain – 2 (3,3 %), immunoblastic lymphoma – 2 (3,3 %), progressive multifocal leukoencephalopathy – 1 (1,6 %), cytomegalovirus retinitis – 2 (3,3 %), cytomegalovirus desease – 1 (1,6 %), herpes simplex infection – 1 (1,6 %), extrapulmonary tuberculiosis – 1 (1,6 %), MAC infection – 1 (1,6 %).
From 28 patients, who were diagnosed as HIV positive in advanced stage (AIDS), 19 of them were diagnosed with PCP (68%), while only 15 (48 %) of 31 patients from the second subgroup had PCP. 2 AIDS indicative diseases at average were diagnosed in one patient with AIDS.

## AIDS indicative diseases in AIDS patients and different subgroups in Lithuania

| AIDS indicative diseases | Total AIDS patient number N=59 | HIV diagnosed in AIDS stage N=28 | HIV progressed to AIDS N=31 | Homosexual HIV transmission group N=37 | Heterosexual HIV transmission group N=15 |
|---|---|---|---|---|---|
| | Abs. N ( ) | Abs. N ( ) | Abs. N ( ) | Abs. N ( ) | Abs. N ( ) |
| P. carinii pneumonia | 34 (57.6 ) | 19 (67.8 ) | 15 (48.4 ) | 25 (67,5 ) | 8 (53,3 ) |
| Oesophageal candidiasis | 20 (33.8 ) | 7 (25 ) | 13 (41.9 ) | 15 (40,5 ) | 3 (20 ) |
| Pulmonary tuberculosis | 8 (13.5 ) | 3 (10.7 ) | 5 (16.1 ) | 4 (10,8 ) | 3 (20 ) |
| Extrapulmonary tuberculosis | 1 (1.6 ) | 1 (3.5 ) | - | 1 (2,7 ) | - |
| HIV wasting syndrome | 10 (16.9 ) | 5 (17.9 ) | 5 (15.1 ) | 7 (18,9 ) | 3 (20 ) |
| HIV encephalopathy | 8 (13.5 ) | 4 (14.3 ) | 4 (12.9 ) | 6 (16,2 ) | - |
| Kaposi's sarcoma | 4 (6.7 ) | 3 (10.7 ) | 1 (3.2 ) | 3 (8,1 ) | 1 (6,6 ) |
| CMV disease | 1 (1.6 ) | 1 (3.5 ) | - | 1 (2,7 ) | - |
| CMV retinitis | 2 (3.3 ) | 1 (3.5 ) | 1 (3.2 ) | 2 (5,4 ) | - |
| Recurrent bacterial pneumonia | 2 (3.3 ) | 1 (3.5 ) | 1 (3.2 ) | - | 1 (6,6 ) |
| Lymphoma, not specified | 2 (3.3 ) | 1 (3.5 ) | 1 (3.2 ) | 1 (2,7 ) | 1 (6,6 ) |
| Primary lymphoma of brain | 2 (3.3 ) | 1 (3.5 ) | 1 (3.2 ) | 1 (2,7 ) | - |
| Candidiasis of bronchi, trachea or lungs | 3 (5 ) | 1 (3.5 ) | 2 (6.4 ) | 2 (5,4 ) | 1 (6,6 ) |
| Herpes simplex virus infection | 1 (1.6 ) | - | 1 (3.2 ) | 1 (2,7 ) | - |
| Mycobacterium avium complex infection | 1 (1.6 ) | 1 (3.5 ) | - | 1 (2,7 ) | - |
| Progressive multifocal leukoencephalopathy | 1 (1.6 ) | - | 1 (3.2 ) | 1 (2,7 ) | - |

Data are a number of disease, some patients were diagnosed 2 and more disease; added percentages exceed 100 because some persons were diagnosed more than 1 AIDS indicative disease

**Conclusion:** Most frequent AIDS indicative disease among the patients were PCP and oesophageal candidiasis. A half of AIDS patients diagnosed as HIV positive in the late stage of AIDS. Therefore the primary health care specialists should improve their differential diagnostic skills and should more often propose to their patients to undergo a voluntary HIV test, while assuring the pre- and post-counselling.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Leadership**

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

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

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

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

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

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

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

**Prevention**

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

[1] Declaration of Commitment of the UN General Assembly Special Session on HIV/AIDS, paragraphs 65-67
[2] Declaration of Commitment of the UN General Assembly Special Session on HIV/AIDS, target 53, page 21.

9. By 2010, ensure through the scaling up of programmes that 80% of the persons at the highest risk of and most vulnerable to HIV/AIDS are covered by a wide range of prevention programmes providing access to information, services and prevention commodities and identifying and addressing factors that make these groups and communities particularly vulnerable to HIV infection and promote and protect their health, and intensify cross border, sub-regional and regional technical collaboration and sharing of best practices through the EU and regional organisations in the prevention of HIV transmission among vulnerable groups;

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

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

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

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

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

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

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

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

[3] The WHO recommends that at least 60% of injecting drug users have access to drug dependence treatment and harm reduction programmes in order to have an impact on the epidemic among this group.
[4] Elimination is defined as less than 2% of all new infections are acquired by an infant from his or her infected mother

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

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

**Living with HIV/AIDS**

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

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

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

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

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

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

**Partnership**

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

27. Involve civil society and faith-based organizations, as well as people living with HIV/AIDS and persons at the highest risk of and most vulnerable to HIV/AIDS infection in

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

the development and implementation of national HIV/AIDS prevention and care strategies and financing plans, including through participation in national partnership forums;

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

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

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

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

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

**Follow-up**

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

**24 February 2004**

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

# Dublino partnerystės kovojant su ŽIV infekcija ir AIDS Europoje ir Centrinėje Azijoje

# DEKLARACIJA

Atsižvelgdami į pasauliui gresiantį ŽIV/AIDS epidemijos pavojų, kai 40 milijonų žmonių pasaulyje gyvena su ŽIV/AIDS, 90 proc. - besivystančiose šalyse ir 75 proc. į pietus nuo Sacharos dykumos esančiose Afrikos šalyse, Europos ir Centrinės Azijos valstybių ir vyriausybių atstovai, dalyvaujant kviestiniams stebėtojams, 2004 m. vasario 23-24 d. susitiko Dubline, Airijoje, konferencijoje "Įveikiant kliūtis – partnerystė kovojant su ŽIV/AIDS Europoje ir Centrinėje Azijoje" bei parengė šią deklaraciją:

Pripažindami, kad skurdas, menkas išsivystymas ir neraštingumas – vieni svarbiausių ŽIV/AIDS plitimo veiksnių, ir su dideliu nerimu pažymėdami, kad ŽIV/AIDS didina skurdą bei daugelyje šalių šiuo metu stabdo ir trukdo vystymuisi;

Pabrėždami nuolatinio ekonomikos augimo, įgyvendinant skurdo mažinimo politiką, programas bei strategiją, svarbą siekiant sėkmingai kovoti su ŽIV/AIDS;

Pripažindami, kad moterų ir vyrų, mergaičių ir berniukų lygybės skatinimas ir reprodukcinės bei lytinės sveikatos teisių bei teisės į lytinį švietimą, informaciją ir sveikatos paslaugas bei atvirumą kalbant lytiniais klausimais gerbimas yra esminiai kovos su pandemija veiksniai;

Dar kartą pritardami ŽIV/AIDS Įsipareigojimo deklaracijai, priimtai JT Generalinės asamblėjos specialioje ŽIV/AIDS sesijoje, vykusioje 2001 m. birželio 27 d.;

Dar kartą pritardami vystymosi tikslams, numatytiems Tūkstantmečio deklaracijoje, 2000 m. rugsėjį priimtoje Jungtinių Tautų Generalinės asamblėjos 55 sesijoje, bei Jungtinių Tautų Tūkstantmečio deklaracijos įgyvendinimo nuorodose, ir kitiems tarptautinio vystymosi tikslams ir uždaviniams;

Dar kartą patvirtindami Tarptautinės visuomenės ir plėtros konferencijos (Kairas, 1994) programą bei svarbiausias Tarptautinės visuomenės ir plėtros konferencijos veiklos programos priemones, 1999 m. liepą numatytas JT Generalinės asamblėjos XXIV specialioje sesijoje;

Dar kartą patvirtindami Beižino veiklos platformą bei Beižino deklaracijos ir veiklos platformos įgyvendinimo tolesnes priemones, 2000 m. birželį numatytas JT Generalinės asamblėjos XXIII specialioje sesijoje;

Reikšdami gilų susirūpinimą, kad Europos ir Centrinės Azijos regione mažiausiai 2,1 milijono žmonių gyvena su ŽIV/AIDS;

Su giliu susirūpinimu stebėdami ypač greitą epidemijos plitimą tarp jaunimo Rytų Europoje, kur ŽIV paplitimas tarp suaugusiųjų kai kuriose šalyse siekia kritinę ribą, ir pripažindami didelę galimybę ŽIV paplisti Pietryčių Europoje bei Centrinėje Azijoje;

Taip pat su giliu susirūpinimu stebėdami vėl pradėjusį didėti ŽIV/AIDS atvejų skaičių bei antiretrovirusiniams vaistams atsparaus ŽIV viruso plitimą Vakarų Europoje, kur grėsmė užsikrėsti jauniems žmonėms tebėra didelė;

Pabrėždami, kad labiausiai paveiktose šalyse, ypač pietų Afrikoje, žlunga vienas ar daugiau visuomenės sektorių, bei sutikdami, kad ŽIV/AIDS epidemija gali tapti neturinčia precedento krize mūsų regione, kenkiančia daugumos mūsų šalių visuomenės sveikatai, plėtrai, socialiniam susitelkimui, nacionaliniam saugumui ir politiniam stabilumui;

Sutikdami, kad privalome stengtis kartu įveikti krizę, gerindami koordinaciją, bendradarbiavimą ir partnerystę mūsų šalyse bei tarp mūsų šalių, ir paskatinti konferencijoje

pateiktų pasiūlymų stiprinti Europos Sąjungos pajėgumus veiksmingai kovojant su ŽIV/AIDS epidemija;

Patvirtindami, kad žmogaus teisių gerbimas, sauga ir skatinimas būtini ŽIV plitimo prevencijai užtikrinti, pažeidžiamumui mažinti ir ŽIV/AIDS padariniams įveikti;

Pripažindami, kad ŽIV infekcijos prevencija, skatinant saugesnį ir atsakingą lytinį elgesį bei veiksmus, tarp jų ir prezervatyvų naudojimą, privalo būti laikoma svarbiausia vietos, nacionalinio, regioninio ir tarptautinio atsako į epidemiją dalimi, ir kad prevencija, užsikrėtusiųjų ir paveiktųjų priežiūra, parama bei gydymas yra veiksmingo atsako viena kitą įtakojančios sudėtinės dalys, kurias privalu integruoti į visapusę kovos su epidemija programą;

Pripažindami, kad mūsų regione užsikrėsti labiausiai rizikuoja bei yra labiausiai ŽIV/AIDS pažeidžiami injekcinių narkotikų vartotojai ir jų lytiniai partneriai, homoseksualai, sekso darbuotojai, prekybos žmonėmis aukos, kaliniai, tautinės mažumos bei migrantai, artimai susiję su didelio paplitimo šalimis;

Pabrėždami, kad nesiėmus skubių veiksmų, ŽIV/AIDS toliau skverbsis į bendrąją visuomenę;

Pripažindami, kad moterys ir mergaitės yra ypač pažeidžiamos ŽIV;

Pripažindami, kad kiekvienam ir visai visuomenei bus naudinga, jei daugiau dėmesio bus skiriama vyrų ir berniukų vaidmeniui stabdant ŽIV/AIDS plitimą ir skatinant lyčių lygybę, ir kad vyrų bei berniukų dalyvavimas paskatins juos imtis atsakomybės už savo lytinį elgesį ir gerbti moterų bei mergaičių teises;

Pripažindami, kad, siekiant įveikti ŽIV/AIDS krizę, mums reikia stiprios sveikatos priežiūros sistemos ir paslaugų, kurios užtikrintų visiems prieinamą ŽIV/AIDS prevenciją, gydymą ir priežiūrą;

Pripažindami, kad kovos su ŽIV/AIDS sėkmė susijusi su kova su kitomis lytiškai plintančiomis infekcijomis bei kova su tuberkulioze;

Pabrėždami, kad būdami pažeidžiami jauni žmonės yra svarbiausi kovos su ŽIV/AIDS veikėjai ir pokyčių garantai, vaidinantys svarbiausią vaidmenį nacionalinio ir regioninio lygių programose;

Pripažindami, kad žmonių, gyvenančių su ŽIV/AIDS, dalyvavimas labai svarbus užtikrinant etinį ir veiksmingą nacionalinį atsaką į epidemiją;

Suprasdami, kad investicijos į mokslą ir veiksmingesnių terapinių bei prevencinių priemonių kūrimą, pvz., mikrobicidų ir vakcinų kūrimą, bus būtinos siekiant užtikrinti ilgalaikę ŽIV ir AIDS atsako sėkmę;

Sutarėme dėl šių veiksmų ŽIV/AIDS Įsipareigojimo deklaracijos įgyvendinimui paspartinti:

**Vadovavimas**

1. Skatinti griežtą ir atsakingą mūsų valstybių ir vyriausybių vadovų vadovavimą siekiant apsaugoti žmones nuo šios grėsmės, užtikrinant žmogaus teises, stengiantis įveikti stigmą ir užtikrinant prieinamą švietimą, informaciją bei paslaugas visiems, kuriems to reikia;
2. Visuomenei ir privačiam sektoriui mūsų šalyse remti ir palengvinti griežtą vadovavimą siekiant įgyvendinti Įsipareigojimo deklaracijos tikslus ir uždavinius;
3. Spartinti Įsipareigojimo deklaracijos nuostatų, susijusių su našlaičiais bei ŽIV/AIDS užsikrėtusiomis bei paveiktomis mergaitėmis ir berniukais, įgyvendinimą[7];

[7] JT Generalinės asamblėjos specialiosios ŽIV/AIDS sesijos deklaracija, 65-67 skirsnis

4. Įsteigti ir stiprinti nacionalinės ŽIV/AIDS partnerystės forumus, dalyvaujant visuomenei ir ypač su ŽIV/AIDS gyvenantiems žmonėms bei jų šalininkams, rengti, peržiūrėti, kontroliuoti ir teikti ataskaitas apie kovos su liga sėkmę, laiku imtis ryžtingų veiksmų, nustatant ir įveikiant įgyvendinimo kliūtis;
5. 2004-2005 m. skatinti aktyvų Europos Sąjungos institucijų bei kitų atitinkamų institucijų ir organizacijų, pvz., Nepriklausomų valstybių Sąjungos, Europos Tarybos, Europos saugumo ir bendradarbiavimo organizacijos bei Pasaulinės Sveikatos Organizacijos regioninio komiteto dalyvavimą, bendradarbiaujant su Jungtinių Tautų AIDS Programa per jos agentūras rėmėjas ir jos sekretoriatą, mums visiems stengiantis stiprinti koordinaciją ir bendradarbiavimą;
6. Kovą su ŽIV/AIDS Europoje ir Centrinėje Azijoje įtraukti į mūsų regiono institucijų ir organizacijų darbotvarkę;
7. Užtikrinti didesnius ir rezultatus atitinkančius finansinius bei techninius išteklius, siekiant pagerinti prevencijos, priežiūros ir nepertraukiamo gydymo bei veiksmingo nebrangaus gydymo generiniais vaistais prieinamumą labiausiai paveiktose šalyse, kurioms labiausiai reikia nacionalinių ar regioninių bei Pasaulinio kovos su AIDS, TBC ir maliarija fondo, Europos Sąjungos, naujų visuomenės ir privačių bendrijų, daugiašalio ir dvišalio finansinių mechanizmų asignavimų;

**Prevencija**

8. Pagyvinti mūsų pastangas siekiant Įsipareigojimų deklaracijos[8] tikslų, kad iki 2005 m. mažiausiai 90 proc. 15-24 metų amžiaus vyrų ir moterų būtų prieinama informacija, švietimas, švietimas pagal principą bendraamžiai-bendraamžiams ir specialus jaunimo švietimas apie ŽIV, bei paslaugos gyvenimo įgūdžiams, būtiniems mažinti jų pažeidžiamumą ŽIV, vystyti, bendradarbiaujant su jaunimu, tėvais, šeimomis, švietėjais ir sveikatos priežiūros specialistais;
9. Iki 2010 m., plečiant programas užtikrinti, kad 80 proc. labiausiai rizikuojančių bei labiausiai ŽIV/AIDS pažeidžiamų žmonių dalyvautų įvairiose prevencinėse programose, užtikrinant prieinamą informaciją, paslaugas bei prevencijos reikmenis ir nustatant bei įveikiant šias grupes bei bendruomenes ŽIV infekcijai ypač pažeidžiamomis darančius veiksnius, skatinti sveikatinimą ir sveikatos apsaugą, stiprinti tarptautinį, nacionalinį ir regioninį techninį bendradarbiavimą bei per ES bei regionines organizacijas skleisti geriausią patirtį ŽIV plitimo pažeidžiamose grupėse prevencijos srityje;
10. Gerinti prevencijos, narkotikų priklausomybės bei žalos mažinimo paslaugų prieinamumą injekcinių narkotikų vartotojams[9] (pvz., adatų ir švirkštų keitimo programos, chlorkalkių ir prezervatyvų platinimas, savanoriškas ŽIV konsultavimas ir tyrimai, pakaitinė narkotikų terapija, LPI diagnozavimas ir gydymas) pagal nacionalinę politiką;
11. Užtikrinti, kad ŽIV užsikrėtusios moterims ir būsimoms motinoms būtų prieinamos aukštos kokybės motinos ir reprodukcinės sveikatos priežiūros paslaugos siekiant užtikrinti motinos-vaikui ŽIV perdavimo prevenciją;
12. Iki 2010 m. išnaikinti[10] ŽIV infekciją tarp kūdikių Europoje ir Centrinėje Azijoje;
13. Užtikrinti, kad visiems vyrams, moterims ir paaugliams būtų prieinamos visapusės, aukštos kokybės, saugios, įperkamos reprodukcinės bei lytinės sveikatos priežiūros paslaugos ir informacija, prevencijos priemonės – vyriški ir moteriški prezervatyvai, savanoriški tyrimai, konsultavimas ir paskesnės priemonės, skatinti visapusių aukštos

[8] JT Generalinės asamblėjos specialiosios ŽIV/AIDS sesijos deklaracija, 53 tikslas, p. 21
[9] PSO rekomenduoja, kad mažiausiai 60 proc. injekcinių narkotikų vartotojų būtų prieinamas priklausomybės gydymas ir žalos pažinimo programos siekiant įtakoti epidemiją šioje grupėje.
[10] Išnaikinimo apibrėžimas: mažiau nei 2 proc. naujų užsikrėtimo atvejų sudaro motinos-vaiko infekcija.

kokybės, saugių prieinamų, pasiekiamų ir patikimų reprodukcinės ir lytinė sveikatos priežiūros paslaugų naudojimą;

14. Iki 2005 m. parengti nacionalines ir regionines strategijas bei programas moterų ir paauglių kompetencijai, saugantis nuo ŽIV infekcijos, didinti bei jų pažeidžiamumui Ž/V/AIDS mažinti;
15. Iki 2005 m. parengti nacionalines ir regionines strategijas, užtikrinančias, kad visiems uniformuotiems vyrams ir moterims kariuomenėje bei civilinės gynybos pajėgose būtų prieinama informacija, paslaugos ir prevencinės priemonės rizikingo elgesio atvejams mažinti ir saugiam elgesiui skatinti, raginti Europos Sąjungą, NATO ir kitas regionines bei tarptautines saugumo institucijas kartu su Jungtinių Tautų AIDS programa vadovauti šioms pastangoms;
16. Kontroliuoti lytiškai plintančių ligų sergamumą ir paplitimą, ypač tarp labiausiai rizikuojančių ir labiausiai pažeidžiamų ŽIV/AIDS žmonių, didinant visuomenės supratimą apie jos vaidmenį plintant ŽIV, gerinant greitos diagnozės ir efektyvaus gydymo paslaugų prieinamumą;
17. Finansuoti, tobulinti ir harmonizuoti stebėsenos sistemas pagal tarptautinius standartus, sekti ir kontroliuoti epidemiją, rizikingą elgesį ir pažeidžiamumą ŽIV/AIDS;
18. Prašyti Pasaulinės tarptautinės migracijos komisijos savo darbe atsižvelgti į galimybę užsikrėsti ŽIV/AIDS – ypač keliaujančioms moterims bei vaikams be palydovo ir našlaičiams;
19. Didinti įsipareigojimą atlikti mokslo tyrimus ir vystyti naujas technologijas siekiant geriau tenkinti su ŽIV gyvenančių ar labiausiai pažeidžiamų žmonių poreikius, didinant visuomenės sektoriaus investicijas vakcinoms bei mikrobicidams kurti ŽIV prevencijos srityje;

**Gyvenimas su ŽIV/AIDS**

20. Kovoti su stigma ir diskriminacija žmonių, gyvenančių Europoje ir Centrinėje Azijoje, kritiškai peržiūrint ir kontroliuojant galiojančius įstatymus, politiką ir veiksmus, užtikrinant visas žmogaus teises žmonėms, gyvenantiems su ŽIV/AIDS, ir paveiktų bendruomenių nariams;
21. Iki 2005 m. užtikrinti visuotinį veiksmingos, įperkamos ir teisingos prevencijos, gydymo ir priežiūros prieinamumą, saugų žmonių gyvenančių su ŽIV/AIDS gydymą antiretrovirusiniais vaistais[11] mūsų regiono šalyse, kuriose šiuo metu gydymas nėra visiems prieinamas, naudojantis technine JT parama per pasaulinę Pasaulinės sveikatos organizacijos ir JT AIDS programos iniciatyvą, siekiant užtikrinti, kad 3 milijonai žmonių pasaulyje iki 2005 m. gautų antiretrovirusinius vaistus (“3 iš 5”). Efektyvaus antiretrovirusinio gydymo tikslų turi būti siekiama atsižvelgiant į skurdo lygį, gydymas turi būti teisingas ir skiriamas labiausiai rizikuojantiems ir labiausiai pažeidžiamiems ŽIV/AIDS žmonėms;
22. Užtikrinti greitą PPO 2003 m. rugpjūčio 30 d. nutarimo dėl Doha TRIPS sutarties ir visuomenės sveikatos deklaracijos 6 skirsnio įgyvendinimą;
23. Gerinti nediskriminacinės paliatyvinės priežiūros, konsultavimo, psichosocialinės paramos, pagalbos aprūpinant būstu ir kitų socialinių paslaugų prieinamumą su ŽIV/AIDS gyvenantiems žmonėms;
24. Investuoti į visuomenės tyrimus ir raidą, siekiant parengti įperkamą ir paprastą gydymą bei diagnozavimą geresniam gydymo prieinamumui užtikrinti ir žmonių gyvenančių su ŽIV gyvenimo kokybei pagerinti;

[11] PSO vertinimu 2003 m. regione mažiausiai 100 000 žmonių negauna reikiamo gydymo.

25. Ieškoti geriausios patirties pavyzdžių ir imtis konkrečių veiksmų keitimuisi informacija apie prevencijos, gydymo ir priežiūros paslaugas, ypač labiausiai rizikuojantiems ar labiausiai ŽIV/AIDS pažeidžiamiems žmonėms, užtikrint;

**Partnerystė**

26. Stiprinti Europos ir Centrinės Azijos šalių bei jų partnerių Amerikoje ir kitur veiklos koordinavimą, bendradarbiavimą ir partnerystę, didinti vietos pajėgumus kovojant su epidemija ir mažinant jos pasekmes daugumoje paveiktų šalių, kurių poreikiai didžiausi, bei šalyse, kuriose gresia didelė epidemija;
27. Įtraukti visuomenę ir religines organizacijas bei su ŽIV/AIDS gyvenančius žmones ir labiausiai rizikuojančius bei pažeidžiamiausius ŽIV/AIDS infekcijai žmones į nacionalinės ŽIV/AIDS prevencijos ir priežiūros strategijos bei finansinių planų kūrimą, užtikrinant jų dalyvavimą nacionaliniuose partnerystės forumuose;
28. Dirbti su privataus sektoriaus vadovais kovojant su ŽIV/AIDS, įgyvendinant švietimo darbo vietose programas, darbuotojų nediskriminavimo politiką, užtikrinant gydymą, konsultavimą, priežiūrą ir paramą bei įtraukiant vietos, nacionalinio ir regioninio lygio politikus;
29. Įtraukti nacionalinę ir tarptautinę farmacijos pramonę į visuomenės ir privataus sektoriaus bendradarbiavimą, įtraukiant atitinkamas tarptautines organizacijas, pvz., Pasaulinę sveikatos organizaciją, padėti kovoje su epidemija visose vaistų tiekimo grandinės taškuose – pradedant nuo gamybos ir baigiant kainos nustatymu ir platinimu;
30. Užtikrinti efektyvų visų rėmėjų, daugiašalių organizacijų, visuomenės ir vyriausybių veiksmų koordinavimą, siekiant užtikrinti efektyvią pagalbą šalims, kurioms jos labiausiai reikia, įgyvendinant jų nacionalinę ŽIV/AIDS strategiją, pagrįstą esamais supaprastinimo ir harmonizavimo procesais, ypač JT AIDS programos pagrindiniais principais;[12]
31. Užtikrinti ilgalaikį bendradarbiavimą su žiniasklaida, pripažįstant jos svarbų vaidmenį įtakojant pažiūras ir elgesį bei teikiant su ŽIV/AIDS susijusią informaciją;
32. Remti griežtesnį regioninį bendradarbiavimą ir žmonių, gyvenančių su ŽIV/AIDS, bei visuomenės organizacijų Europoje ir Centrinėje Azijoje bendravimą; kreiptis pagalbos į JT AIDS programą bei Europos Sąjungą, esamus visuomenės organizacijų tinklus ir kitas regiono partnerių institucijas gerinant ir koordinuojant tokį bendradarbiavimą;

**Paskesnės priemonės**

33. Įsipareigojame artimai kontroliuoti ir vertinti šioje deklaracijoje bei Jungtinių Tautų Generalinės asamblėjos ŽIV/AIDS sesijos Įsipareigojimo deklaracijoje numatytų priemonių įgyvendinimą, kreiptis į Europos Sąjungą ir kitas atitinkamas regionines institucijas ir organizacijas, bendradarbiaujant su Jungtinių Tautų AIDS programa, kad būtų sukurti atitinkami forumai ir mechanizmai, įtraukta visuomenė ir su ŽIV/AIDS gyvenantys žmonės progresui regiono lygyje vertinti kas antri metai, pradedant nuo 2006.

**2004 m. vasario 24 d.**

[12] Šie principai: turi būti suderintas nacionalinis ŽIV/AIDS veiksmų planas, derinantis visų partnerių veiksmus, nacionalinė AIDS valdžios įstaiga su plačiais daugiasektoriniais įgaliojimais ir suderinta šalies kontrolės ir vertinimo sistema.