SOUTHEASTERN EUROPE CONFERENCE ON HIV/AIDS

IMPLEMENTING THE GLOBAL DECLARATION OF COMMITMENT ON HIV/AIDS

Bucharest, Romania
June 6–8, 2002
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This report highlights the proceedings, discussions, and recommendations of the Southeastern Europe Conference on HIV/AIDS, which was held in Bucharest, Romania, June 6 to 8, 2002. It reflects the consensus of meeting participants rather than the views of individuals.

The conference was sponsored and supported by the Department for International Development of the United Kingdom (DFID), the United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Children’s Fund (UNICEF), and the U.S. Agency for International Development (USAID).


The steering committee included Leo Kenny, UNICEF; Soknan Han Jung, UNDP; Bonnie Ohri, USAID; Allanna Armitage, UNFPA; Alison Forder, DFID; Bruce Harland, UNDP; and Sherry Greaves, Canadian International Development Agency.

The report contains an overview of HIV/AIDS in Southeastern Europe and responses to the epidemic, the proceedings and outcomes of the conference, and recommendations for future actions.

We are grateful to the presenters and experts, and representatives of United Nations, government, and international agencies who contributed to the content of this report.
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EXECUTIVE SUMMARY

The Southeastern Europe Conference on HIV/AIDS was convened in Bucharest, Romania, June 6–8, 2002. Its purpose was to review the regional strategic priorities and recommendations from those that were presented in November 1999 in Geneva and reinforced in Copenhagen a year later, and to adjust them to the current status of HIV and AIDS. The meeting was hosted by the government of Romania and was jointly supported by USAID, DFID, UNICEF, UNDP, and UNFPA. Dr. Daniela Bartos, Romania’s Minister of Health and Family, opened the conference and hosted the Ministerial Meeting on the second day.

The conference brought together a variety of government and nongovernment representatives from the sponsoring organizations, the UNAIDS Secretariat, the International Labor Organization, UNIFEM, the World Health Organization, the World Bank, International Office for Migration, Canadian International Development Agency, USAID, European Union, Swedish International Development Agency, Canadian Public Health Association, Project Hope, International Federation of the Red Cross, John Snow Incorporated, Population Services International, and Open Society Institute (Annex 4). The number of high-level representatives who participated in the conference reflected the growing political commitment in the region to treat HIV/AIDS as a national priority.

HIV/AIDS in Southeastern Europe

Southeastern Europe (SEE) has experienced political, social, and economic upheaval and transition, including major conflicts. Across the region, young people are trying to find their place in a rapidly changing and challenging environment. They behave in ways that make them much more vulnerable to contracting HIV and sexually transmitted infections (STIs) than other groups. Their high mobility, coupled with growing rates of unemployment and limited opportunities for the future, lead to greater risk-taking behaviors.

A significant consequence of the political situation in SEE has been the collapse of the health sector. This has resulted in weaker health information and services, and largely insufficient and inconsistent data collection, which means that reported HIV/AIDS cases probably do not reflect reality. However, from the limited data available one can assume that overall prevalence in SEE remains low, but this must not equate with low priority and low concern. Experiences in other countries have shown that an investment of modest resources to combat HIV/AIDS now will prevent high economic and human costs in the future.

Epidemiology

Although the region in general has a low HIV prevalence rate, the pattern of infection clearly shows wide variations. For example, Moldova reports 10 times as many cases per capita as the Former Yugoslav Republic (FYR) of Macedonia, and injecting drug use is the main mode of transmission in Moldova, whereas HIV is spread primarily through heterosexual contact in FYR Macedonia. At present, the pattern of the rapid spread of HIV in Moldova appears to share characteristics that are more similar to those of other Central European and Central Asian countries than it does with those in SEE. Further, Romania’s important pediatric epidemic is a peculiarity that is not shared by the other countries. However, the large cohort of children that have grown up HIV-positive due to blood transfusions or nosocomial infection are now entering adolescence and contributing to a growing rate of heterosexual transmission. On the other side of the spectrum are Bulgaria and Croatia, where the threat of HIV has been acknowledged and related activities have been initiated at an early stage.
The first cases of AIDS in SEE were reported around 1985–86, and the annual increase in reported cases has been slow. Examples include Bulgaria, where the annual incidence rose from 12 to 34 cases over a period of 8 years; and Croatia, with a comparable initial increase but an apparent stabilization over the last 2 years. Initial reports indicated that most infections were contracted abroad because the population was highly mobile, but now most new infections occur within the region. Two to three times more men as women are infected, and the ages at which most new HIV infections occur in people aged 20–25 and 30–35 (many new infections are diagnosed only after symptoms develop, which is usually several years after the initial infection occurred). The number of cases of mother-to-child transmission is still low.

The main mode of transmission is heterosexual contact, accounting for 80% of cases in Bulgaria and 39% in Croatia. Exceptions are Moldova and the Federal Republic of Yugoslavia (FRY), where transmission rates are 82% and 61%, respectively, primarily through injecting drug use. Transmission rates among men who have sex with men are assumed to be even more underreported than other modes because of the stigma attached to the practice.

With the notable exceptions of Moldova, Romania, and FRY, reported cases of STIs are dropping in SEE, but this probably does not reflect reality because private medical practices generally fail to register cases through the public reporting system and STI tracking systems are inconsistent or not well developed. In addition, reports indicate that commercial sex work is increasing and that condom use is low, especially among young people.

Higher rates of unprotected sex and STIs, intravenous drug use and needle sharing, and commercial sex work; the lack of understanding and stigma of HIV; the marginalization of vulnerable people; low condom use; and a young and highly mobile population are all factors that can fuel an HIV epidemic. However, with a strategic approach and sufficient albeit limited resources, it is possible to contain the spread of HIV in SEE.

**Country and Regional Responses**

The initial response to HIV/AIDS by countries in the region was generally monosectoral and led by ministries of health. The response was interrupted in the region when limited government resources were needed for acute and competing priorities resulting from conflict and economic and political transition. Now, the greater commitment to consider HIV/AIDS as a priority is accompanied by a better understanding of the need for a strategic, multisectoral response and for leadership in its development and implementation. There is greater awareness in some countries than in others. For example, national AIDS committees operate in, Croatia, the UN Administered Province of Kosovo, Bulgaria, Moldova, and Romania, and the latter three are implementing their national strategic plans. In Albania and Croatia, AIDS legislation has been passed that focuses on human rights and was designed to fight discrimination and stigmatization, thereby facilitating the development of interventions for highly vulnerable groups.

UNAIDS, its cosponsors, and bilateral agencies such as the Canadian International Development Agency and USAID are supporting SEE governments to establish national AIDS committees and coordinating their responses to the epidemic, including helping to develop and implement national strategic plans. In addition, all agencies provide technical and financial support within their mandates, most of which focuses on information, education, and communication efforts; condom promotion, and the integration of HIV/STI education efforts into reproductive health programs.
Currently, only a fraction of available resources target high-risk populations. Without exception these interventions remain limited to pilot projects, none of which are large enough to reduce the spread of HIV regardless of how promising they are. The rapid assessment and responses that were recently conducted in the region point to the need to focus on these groups. In addition, there is a still insufficient but growing acknowledgment of the important role for national and international nongovernmental organizations (NGOs), especially to perform outreach work.

**Discussion**

The conference participants agreed to the following regional priorities:
- Young people in general with a special focus on those who engage in high-risk behavior, notably injecting drug users and sex workers;
- Injecting drug use;
- STI prevention and treatment; and
- Victims of trafficking, primarily young women and children.

There was consensus that a strategic approach was a precondition for an effective response to the threat of HIV in order to ensure coordination, ownership, and sufficient available human and financial resources. In this context, support for the establishment and operation of national AIDS committees and the development and implementation of national strategic plans was iterated.

There was also consensus that appropriate information with gender disaggregated data is a precondition for the development and evaluation of strategic plans. A viable and sustainable second-generation sentinel surveillance was therefore considered to be a priority.

Whereas interventions for people who engage in high-risk behavior (i.e., injecting drug users, men who have sex with men, and commercial sex workers) are needed in each country, there was agreement that these could be successful only if contextual factors were appropriately addressed, especially those regarding stigma and marginalization. The main topics in this discussion were the need for special HIV/AIDS legislation and easily accessible and confidential voluntary counseling and testing, and the role of the media in education. The insufficient support for people living with HIV/AIDS and their treatment was discussed, and there was agreement on the urgent need to address this at different levels through capacity building among health professionals, legislation, and the health infrastructure. Further highlighted were the specific problems experienced by women and girls and their partners who engage in high-risk behavior, and also of homosexual young men.

Participants agreed that financial and human resources for interventions that target high-risk groups, especially injecting drug users, were far too limited. In order to mitigate the spread of HIV, these need to be vastly expanded.

**Recommendations**

On the final day of the conference participants passed the Southeastern Europe Declaration of Commitment, which calls for “urgent action to address this situation while a window of opportunity exists to prevent a wider-scale epidemic.” The declaration appears in Annex 6.

Key recommendations for immediate action were as follows:
- Establish national AIDS committees, make them operational, and develop national strategic plans;
• Establish second-generation sentinel surveillance as a basis for the development and evaluation of any strategic plan;
• Focus on prevention as the foundation of the response;
• Focus on the agreed priorities;
• Invest human and financial resources on interventions that focus on high-risk groups, especially injecting drug users;
• Take into account that stigma and marginalization need to be addressed simultaneously in order to effectively address the needs of high-risk populations;
• As appropriate, develop partnerships among central and local governments, civil society, the private sector, institutions, and foundations; and
• Enhance political advocacy for greater understanding and commitment.
CONFERENCE OVERVIEW

The Southeastern Europe (SEE) Conference on HIV/AIDS was convened in Bucharest, Romania, June 6–8, 2002. Its purpose was to review the regional strategic priorities and recommendations from those that were presented in November 1999 in Geneva in November 1999 during the Strategy Meeting to Better Coordinate Regional Support to National Responses to HIV/AIDS in Central and Eastern Europe and Central Asia, and were reinforced in Copenhagen one year later.

The meeting was hosted by the government of Romania with joint support provided by the U.S. Agency for International Development (USAID), the Department for International Development (DFID) of the United Kingdom, United Nations Children’s Fund (UNICEF), United Nations Development Programme (UNDP), and United Nations Population Fund (UNFPA). The United Nations General Assembly Special Session on HIV/AIDS provided the framework for the agenda and its political importance.

The following points were established as the meeting objectives:

- Mobilize political support and commitment for multisectoral strategies;
- Establish consensus for best practices among governments, nongovernmental organizations (NGOs), and other partners in order to respond to HIV/AIDS in SEE;
- Identify and address technical support needs and coordination by the region and individual countries;
- Identify and support opportunities for alliances between the nations in SEE;
- Mobilize financial resources for more and better country responses, and establish or strengthen regional support mechanisms; and
- Adopt an SEE Declaration of Commitment on HIV/AIDS based on the Global Declaration of Commitment to HIV/AIDS.

The conference brought together ministers and other government and nongovernment representatives from Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Federal Republic of Yugoslavia (FRY; Serbia and Montenegro), the UN Administered Province of Kosovo, the Former Yugoslav Republic (FYR) of Macedonia, Moldova, and Romania. The combined population of the region is approximately 58 million people.

Also in attendance were representatives from the sponsoring organizations: the UNAIDS Secretariat, the International Labor Organization, UNIFEM, the World Health Organization, the World Bank, International Office for Migration, Canadian International Development Agency, USAID, European Union, Swedish International Development Agency, Canadian Public Health Association, Project Hope, International Federation of the Red Cross, John Snow Incorporated, Population Services International, TtvT Associates/Synergy Project, and Open Society Institute (Annex 4 contains a list of participants).

Participation by high-level government and international officials reflected the growing political commitment in the region for developing an appropriate response to HIV/AIDS. Dr. Daniela Bartos, the Minister of Health and Family of Romania, opened the conference on behalf of the Romanian government. The minister also hosted the Ministerial Meeting on the second day of the conference.

This report highlights the proceedings, discussions, and recommendations from the conference. Its purpose is to reflect the consensus of the meeting rather than the views of individual participants.
HIV/AIDS IN SOUTHEASTERN EUROPE

Overview

In recent years, SEE has experienced political, social, and economic transitions and upheavals, including major conflicts. The nations in the region share many characteristics that have led to an alarming increase in HIV infections in Central and Eastern Europe (CEE) and the Commonwealth of Independent States (CIS). These include social and economic crises, unemployment and poverty, and a decrease in accessibility and quality of public services and educational opportunities. There has been an increase in postconflict social stresses such as substance abuse and sex work. These conditions have been aggravated by ineffective border controls, which have led to an increase in trafficking of drugs and human beings, particularly of women, for the purpose of sexual exploitation.

One of the results of the economic decline has been greater mobility across and within state borders. It has been well documented that mobile people have a greater vulnerability to contracting sexually transmitted infections (STIs), including HIV, through unsafe sexual behavior, sexual exploitation, lack of access to services, and substance abuse.

The effects of economic and political transition on young people are many and varied. Young people are eager to embrace new life styles and norms of behavior, but the negative sides of these may result in abuse of alcohol and drugs, unsafe sexual practices, and an underestimation of the risks these actions carry. Economic stresses may also lead one to accept work, often abroad, with vague promises of high remuneration. For women and children in particular, this often leads to susceptibility to sexual exploitation and other forms of abuse.

Although HIV has affected all strata of society, a greater number of people—particularly young people—are practicing behaviors that make them vulnerable to contracting HIV. A growing number of them reportedly engage in injecting drug use and commercial sex work. In addition, the number of men who have sex with men is believed to be increasing. Other affected groups are victims of trafficking, migrants, refugees, internally displaced people, young people without parental care (including street children and children in institutions), people living with HIV/AIDS, and ethnic minorities. All these groups are vulnerable and require interventions tailored to their specific needs.

Serious social problems in the region include stigma, discrimination, and the marginalizing of people at risk for HIV. There was general agreement that these issues warrant more attention, especially the promotion and protection of human rights, particularly for vulnerable people and those living with HIV/AIDS, and that these must be accomplished through a combination of social and political mobilization, legislation, and policy development.

Women are more vulnerable to HIV infection because of gender inequality and the power imbalance between men and women. This requires that social, cultural, and familial norms and expectations be addressed, including negotiations of sexual relationships, freedom from gender-based violence, and access to reproductive health information and services.

The quality of surveillance and data collection has been affected by economic transition and political conflict. There are strong indications that a relatively low prevalence of HIV/AIDS exists in the region, but actual reported cases of HIV/AIDS and other STIs may be inaccurate, and rates in almost all the countries are believed to be much higher. There was general agreement on the urgent need to establish effective and sustainable mechanisms for second-generation sentinel surveillance, for without these, it is not possible to develop, implement, or evaluate an effective strategic plan.
Experiences in other countries have taught us that only genuine national commitment and multisec-ctoral actions that are carefully developed, implemented, monitored, and evaluated can prevent HIV/AIDS from becoming a major problem in any country. Low prevalence must not be equated with low priority and low concern. An investment of modest resources now will prevent high eco-nomic and human costs in the future.

Epidemiology

Until 1995, it seemed as if the CEE/CIS region, including Southeastern Europe, would not be con-fronted with a major HIV threat. Based on mass screening programs in other countries, the total number of HIV-infected people in the entire CEE/CIS region was estimated to be less than 30,000. Meanwhile, in Western Europe, with a similar total population, this number was reported to be 474,000. In 1994, Ukraine, for example, reported 44 people living with HIV, however, in 1996 and 1997, respectively, 12,000 and 27,000 cases were reported. With an estimated number of 250,000 cases by the end of 2001, prevalence among people aged 15–49 years of age was estimated to be around 1%. Although Ukraine is not in SEE, it shares a number of potentially critical characteristics exhibited in the region and this example illustrates how dramatically the HIV/AIDS epidemic can explode if it remains unattended.

Since 1995, HIV has emerged among the rapidly growing population of injecting drug users. As a result, prevalence has increased exponentially, and by the end of 2001 the number of HIV infections in the entire region was estimated to be 1 million.

An accurate assessment of the HIV/AIDS situation in the region is hampered by a lack of consistent information (this is also the reason why figures in this document, all taken or calculated from official publications, may not tally with those from other official publications). For various reasons, registration systems for STIs and HIV/AIDS do not function well in the region, and most official fig-ures are at best an indication of trends.

Moldova and Romania have the highest rates of syphilis and gonorrhea in the region, and since 2000 there has been a sudden and rapid increase of syphilis in Serbia, otherwise, rates of syphilis and gonorrhea have not risen in the region. Croatia and FYR Macedonia have reported an increase in the number of cases of chlamydia and human papilloma virus. Unfortunately, these data are not reliable and do not allow us to draw general conclusions. Likewise, limited information exists on patterns of risk behaviors, and no comprehensive behavior monitoring systems have been developed.

Available data show that the first HIV infections in SEE became apparent around 1986. If the num-ber of annual reported cases is accurate in those countries with relatively reliable reporting systems, then it is clear that an increase in prevalence exists, albeit one that is slow. For example, in Bulgaria, the number of new infections per year grew from 12 to 38 over an eight-year period, and in Croatia, new infections grew from 20 to 34 per year over a seven-year period, with an apparent stabilization over the last two years.
The data in Table 1 probably do not reflect the actual number of cases of HIV. Nevertheless, despite their unreliability, prevalence rates are still relatively low, even in Moldova, which has by far the highest incidence. Therefore, with the exception of Moldova, the data indicate that SEE countries have not so far contributed to the enormous and continuing increase in HIV incidence in the larger CEE/CIS region.

The nature of HIV transmission varies considerably across SEE. Most countries report that heterosexual transmission is the main mode of infection. In Croatia, reported rates of homosexual and heterosexual transmission are 34% and 39%, respectively. HIV infection via injecting drug use varies widely, from 0.2% in Romania, to 6.7% in Albania, to 13.5% in FYR Macedonia, and to 82.2% in Moldova (in 2001). Injecting drug use may be practiced in a number of municipalities throughout Moldova, whereas in Serbia, injecting drug use, which accounts for 61% of HIV transmissions, is limited primarily to the capital. An ominous trend exists for HIV transmission through injecting drug use as exhibited in Serbia, where rates for this form of transmission grew from 48% to 61% in just one year, and in Moldova, where indications are that the number of injecting drug users under age 18 doubles every year. It is important to note that cultural and social norms of stigma against same-sex orientation and injecting drug use may influence reported rates of transmission.

Table 1: Cumulative Reported Cases of HIV/AIDS

<table>
<thead>
<tr>
<th>Country</th>
<th>Population (millions)</th>
<th>HIV/AIDS</th>
<th>AIDS</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albania (1994–2000)</td>
<td>3.1</td>
<td>78</td>
<td>93%</td>
<td>6.7%</td>
<td></td>
</tr>
<tr>
<td>Bosnia and Herzegovina (1996–2000)</td>
<td>3.9</td>
<td>50</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Bulgaria (1986–2000)</td>
<td>7.9</td>
<td>359</td>
<td>97</td>
<td>68%</td>
<td>32%</td>
</tr>
<tr>
<td>Croatia (1985–2001)</td>
<td>4.4</td>
<td>306</td>
<td>171</td>
<td>76.7%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Federal Republic of Yugoslavia</td>
<td>10.6</td>
<td>1234</td>
<td>961</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UN Administered Province of Kosovo (1986–2001)</td>
<td>2.1</td>
<td>41</td>
<td></td>
<td>67.6%</td>
<td>32.4%</td>
</tr>
<tr>
<td>FYR Macedonia</td>
<td>2.1</td>
<td>59</td>
<td>41</td>
<td>67.8%</td>
<td>32.2%</td>
</tr>
<tr>
<td>Moldova</td>
<td>4.4</td>
<td>1482</td>
<td></td>
<td>73.7%</td>
<td>27.3%</td>
</tr>
<tr>
<td>Romania (1985–2001)</td>
<td>22.4</td>
<td>2623*</td>
<td>1301*</td>
<td>5875†</td>
<td></td>
</tr>
</tbody>
</table>

*adults, †children

The data in Table 1 probably do not reflect the actual number of cases of HIV. Nevertheless, despite their unreliability, prevalence rates are still relatively low, even in Moldova, which has by far the highest incidence. Therefore, with the exception of Moldova, the data indicate that SEE countries have not so far contributed to the enormous and continuing increase in HIV incidence in the larger CEE/CIS region.

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Strong indications exist that most HIV infections were and still are brought in from outside the region. This is credible considering that many people in the region have spent time abroad often under difficult circumstances and without a social support system. In Croatia, reports indicate that infections among men who have sex with men are now mainly contracted in-country. One can assume that this trend is increasing, as are those for other modes of transmission in the other countries.

Injecting drug use is one of the major factors driving the HIV epidemic in CEE/CIE countries, and the SEE region shares many of the same characteristics that led to it. Most information on this subject is anecdotal, and it is likely that SEE has more users than official numbers suggest. For example, Moldova has 6,232 registered injecting drug users, but the real number is believed to be around 50,000. Injecting drug use has been documented in Croatia; Moldova; UN Administered Province of Kosovo; and in the cities of Belgrade, FRY; Skopje, FYR Macedonia; and Shkodër, Albania. A few small surveys have demonstrated HIV prevalence among this population—0% in Albania, 1.7% in Croatia, and 2% in Bulgaria—but the stigma around injecting drug use makes users a hidden group and one from which it is difficult to obtain accurate information.

Because registered cases of HIV infection are few in number, those of vertical transmission (i.e., mother-to-child transmission) are also low. Vertical transmission rates range from 0% in Bosnia and Herzegovina, to 1% in Bulgaria, and to 5.1% in FYR Macedonia, where the children of HIV-infected parents are routinely tested.
In most countries the ratio of infected men to women is between 2:1 and 3:1. In Albania, where 73% of infections are through heterosexual transmission and condom use is low, the reported ratio of 4:1 could well be another result of inconsistent reporting.

Most HIV infections in the SEE region are diagnosed in people between the ages of 20–25 and 35–40. Most people avoid testing as long as possible, probably because of the stigma attached to being diagnosed HIV-positive, and because of doubts surrounding the confidentiality of test results. In addition, most countries offer limited access to voluntary counseling and testing. In FYR Macedonia, 99% of HIV infections are diagnosed only at the onset of symptoms, long after the initial infection occurred, which makes it difficult to obtain a clear infection pattern. In Bulgaria, where stigma is a serious issue and where voluntary counseling and testing has been available since 1993 (106,000 voluntary tests were conducted in 2001), HIV infections are diagnosed at an earlier age (45.9% in people aged 20–30, and 7% in 15- to 19-year-olds). In Croatia, where confidential voluntary counseling and testing has been available since the late 1980s, a majority of HIV infections are diagnosed in people aged 30 to 40.

In conclusion, even with the relatively high number of HIV-infected injecting drug users in Belgrade FRY and Moldova, and with a great number of pediatric infections in Romania, the spread of HIV/AIDS in SEE is still in its initial stage. However, conference participants agreed there is no reason to assume that the number of HIV infections will not grow. The following factors have proven to be powerful influences in driving the HIV epidemic in other parts of the CEE/CIS region and need to be considered for SEE countries as well:

- The young population (UN Administered Province of Kosovo has one of Europe’s youngest populations, 50% are younger than age 22.5);
- Poverty and unemployment;
- Decline in quality and access to services;
- Trafficking of drugs and human beings, many of them young women;
- High population mobility;
- Stigma of HIV;
- Increase in sex work and injecting drug use, mainly by young people;
- A high number of international workers and peacekeepers; and
- The lingering effects of conflicts.

Responses to the Epidemic

**Government Responses**

By the 1980s a number of countries had already responded to the threat of HIV, and most had established an agency within their ministry of health that was responsible for developing the response. Most countries, often assisted by the World Health Organization, took steps to ensure blood safety, and several initiated HIV data collection. In some countries this took the form of compulsory, mass testing; these exercises absorbed a large part of the available funding and produced little useful information other than that prevalence was extremely low, and most results were neither representative nor reliable.

These activities were interrupted by political upheaval and conflicts that generated much more visible and acutely threatening priorities. Only with the relative political stabilization in the region has HIV returned to the stage. National AIDS commissions were revived or established through the late 1990s and beyond, and each government gave first priority to blood safety.
While many governments remained exclusively focused on HIV as a health issue, others began articulating the need for a multisectoral approach. Croatia established its first needle exchange program in 1996, and Bulgaria discontinued compulsory mass testing at a relatively early stage and made voluntary counseling and testing widely available.

In Albania, specific AIDS legislation was passed to establish, define, and structure a multisectoral national AIDS commission and to address confidentiality issues and equitable access to care and treatment for all. In Romania, the government and civil society at large focused most of their attention on the dramatic pediatric AIDS epidemic. In Moldova, most of its Global AIDS Fund monies will be absorbed by HIV prevention efforts among injecting drug users. These examples demonstrate that the regional perspective now goes far beyond HIV as a health issue.

The exploding HIV epidemic among injecting drug users in neighboring countries has played a role in the increasing interest in HIV transmission in SEE. There is now general awareness of the need for expanded and coordinated national strategic plans of action with multilateral support, bilateral support, or both. Bulgaria, Moldova, and Romania are already implementing their national strategic plans, whereas all other governments are now completing or embarking on a strategic planning exercise.

NGO Responses

Nongovernmental organizations are a new phenomenon in SEE, but the sector is developing rapidly, and NGOs have become indispensable partners in the response to HIV. Unfortunately, NGO activities are small-scale, especially those for hard-to-reach groups of people who engage in high-risk behaviors. In order to influence the spread of HIV, NGO activities need to be scaled up.

As elsewhere, NGOs aim to complement government actions and respond where the government does not intervene. For example, the FYR Macedonia government limits its contributions to the public health sector. NGOs are trying to fill the vacuum by focusing primarily on outreach work, particularly with hard-to-reach vulnerable groups. NGOs also complement government efforts in education, peer education, information, and communications.

The governments of Bulgaria, Croatia, and Romania, for example, fund NGO activities through a support program, and NGOs are relatively active in policy development and implementation. In most other countries in the region, however, neither governments nor donors are aware of potential NGO contributions and they should be encouraged to build and expand alliances to ensure a coordinated response to the epidemic.

International NGOs play important roles in capacity building and providing technical support to harm reduction, social marketing, research, and outreach projects. Among NGOs supporting the response to HIV/AIDS in SEE are the International Federation of the Red Cross, Médecins du Monde, Médecins Sans Frontières, Population Services International, Open Society Institute, TAMPEP, and LILA.

International Responses

The recent armed conflicts in several countries have brought many international workers and peacekeeping troops to the region. Their interest is primarily on security and economic recovery, but health and social improvements may come about as a result of this.
Cosponsors of UNAIDS, the International Organization for Migration, and the European Commission are the main international supporters of the response to HIV in the region. The participating bilateral development agencies include those of Canada (CIDA), Italy (Italian Cooperation in Development), Sweden (SIDA), Switzerland (Swiss Agency for Development and Cooperation), the United Kingdom (DFID), and the United States (USAID).

The United Nations established or revived UN Theme Groups on HIV/AIDS in all countries with a UN presence in an effort to address priorities and adapt responses to specific situations. Theme groups are primarily involved in advocating and supporting the establishment of national AIDS committees and in developing national strategic plans. In addition, theme groups are conducive to interagency coordination and cooperation.

Although it would be an exaggeration to say that the theme group mechanism has been optimally applied in all countries, there is general agreement that the groups play an important role throughout the region. Assistance from the regional advisor based in Sarajevo and support by the UNAIDS Secretariat and UNICEF were mentioned as having facilitated this process. National program assistants are being recruited, which demonstrates that the UN agencies acknowledge the need and potential for a coordinated approach to UN-sponsored support in national responses to HIV.

United Nations partners have made their HIV/AIDS activities stronger, each within their own mandate. Typical examples include training for health staff on treatment protocols, laboratory techniques, and universal precautions by the World Health Organization; integration of HIV/STIs in reproductive health activities by UNFPA; efforts to give young people knowledge and skills to protect themselves and others against HIV/STIs by UNICEF; and assistance in national strategic planning by UNDP. Cases also exist of close interagency coordination when mandates of different agencies overlap. For example, USAID and UNFPA will be implementing a regional SEE initiative to build NGO capacity and promote condom use. Another example is the Peer Education Initiative, which is being implemented in formal and informal settings throughout CEE/CIS, and is jointly supported by UNICEF, UNFPA, and WHO. This network will also be supported through a regional SEE initiative by USAID.

Targeted interventions have been limited for especially vulnerable groups (mostly young people), and the need for these is recognized. Of all HIV/AIDS-related external contributions, only 1.9% support prevention of transmission through injecting drug use, 3.3% support prevention among highly vulnerable groups, and 1.1% support activities to directly counteract stigma and marginalization (1.1% for advocacy, mass media, and information sharing; and 0% for legal, policy, and ethical issues). In order to prevent the spread of HIV among these people, their partners, and the general population, larger investments in advocacy and energy are needed. United Nations and bilateral agencies are aware of this and plan to increase their activities in these areas. The recent rapid assessment and response initiated by UNICEF and WHO, as well as the social marketing assessments initiated by USAID and supported by UNFPA and UNICEF, highlight the need to focus on especially vulnerable populations.

Bilateral agencies often provide technical support and capacity building to ministries of health. For example, in the UN Administered Province of Kosovo, USAID will support development of the national plan of action to prevent the spread of HIV/AIDS, and will include sentinel surveillance, voluntary counseling and testing, and targeted interventions to at-risk populations. Through CIDA, Canada has played an important role in supporting countries to develop and implement their strategic plans; Italy, through its Cooperation in Development agency, has assisted governments and
NGOs in developing HIV-related activities; and SIDA of Sweden has recently started activities in SEE on regional interventions, but it is also interested in working with national NGOs.

USAID work in Romania focuses on social marketing, behavior change, STI control, capacity building, child welfare, and surveillance. In early 2000, USAID began funding a social marketing campaign to promote safe sex and use of condoms to prevent HIV. In recent years, USAID/Romania has also funded innovative programs to teach prevention methods to persons at high risk for contracting HIV/AIDS, such as sex workers. Under the Romanian-American Sustainable Partnerships (RASP) program, USAID funds the Romanian-American Children’s Center in Constanta, which is designed to bring sustainable, state-of-the-art care and treatment to HIV-infected children.

USAID in Albania is supporting the design of HIV/AIDS sentinel surveillance and behavioral surveillance systems in order to target interventions for high-risk groups and to measure the effect of these efforts.

**Strategic Priorities**

The “First Strategy Meeting to Better Coordinate Regional Support to National Responses to HIV/AIDS in Central and Eastern Europe and Central Asia” was held in Geneva, December 4–5, 1999. It was held under the auspices of UNAIDS, and included UN agencies, multilateral and bilateral donors, and NGOs.

The meeting drew consensus that the priorities for the CEE/CIS region as a whole were as follows:
- Expand HIV prevention efforts among injecting drug users to a minimum level of 60%;
- Address the epidemic of sexually transmitted infections; and
- Develop comprehensive programs for the health, development, and protection of young people.

Commitments were made to contain the epidemic and reduce vulnerability through specific actions focused on these three strategic priorities. A year later, in December 2001 in Copenhagen, the following recommendations were added:
- Counteract the stigma of people living with HIV and AIDS through the development of comprehensive and integrated services including:
  - Care and support for drug users and people living with HIV/AIDS, and
  - Services for the prevention of mother-to-child transmission of HIV;
- Direct more attention to parenteral transmission of HIV among sex workers who inject drugs;
- Direct more attention to sexual transmission of HIV among injecting drug users; and
- Direct more attention to HIV prevention among prisoners, members of the armed forces, and ethnic minorities.

It is now recognized that mobile populations and trafficking of human beings, especially young women for the purpose of sexual exploitation, are also a priority in SEE.

A primary requirement for being able to respond to HIV and STIs is to understand the situation; that is, the level of prevalence and incidence of HIV and STIs in the target groups and the background to their risk behavior, including how they can be motivated to protect themselves and others, and assist in promoting this.
Injecting Drug Use

According to official data, in all countries in the SEE region, with the notable exception of Moldova and FRY Serbia, sexual contact is by far the most common path of HIV transmission. Injecting drug use plays a role in most countries in only 7%–8% of infections (these figures are considerably lower in Bulgaria and much higher in Moldova and FYR Serbia). This suggests that the contribution of injecting drug use to the spread of HIV in SEE cannot be compared with that of other CEE/CIS countries, where injecting drug use is by far the strongest factor driving the epidemic. This suggestion is reinforced by reports that prevalence of injecting drug use in the region is low. However, anecdotal data now emerging from reliable research indicate an increasing trend toward injecting drug use and other forms of substance abuse, especially among young people. These data point to the existence of a hidden population of illicit drug users whose culture and behavior are not well understood. Drug use is highly stigmatized throughout the region, and accessibility to drug treatment and harm reduction programs is limited.

Available information indicates that, with the exception of Moldova and possibly Serbia, it is unrealistic to state that SEE countries will definitely follow the trend of other countries, where injecting drug use is driving an exploding HIV epidemic. However, major lessons can be drawn from what has happened elsewhere. One of these is that it would be highly irresponsible to assume that the same cannot happen in SEE. The Working Group on Especially Vulnerable Populations reflected the view that “if there is going to be a rapid outbreak of HIV infection in this region, it will come from injecting drug use.” It is urgent that more information on the rate, causes, and patterns of drug use must be collected, and more support must be provided to develop and implement appropriate responses.

These issues were identified as the priorities for each SEE country:

- Develop and implement sentinel surveillance. Without knowledge of the scale of the problem, its causes, and ways to influence related behavior, it is not possible to develop an effective strategic plan.
- Support the expansion of HIV prevention programs among injecting drug users to a coverage level of a minimum of 60%, including support for drug treatment, and harm and demand reduction.

These were identified as regional priorities:
- Encourage greater involvement of the Open Society Institute and the Regional Task Force on Injecting Drug Use to facilitate the exchange of experiences and training in order to create an effective approach to the development and implementation of national activities.
- Establish a mechanism for centralized procurement of needles, syringes, and substitution drugs for the region in order to realize an economy of scale.

These priorities will be accomplished through political advocacy, rapid assessment and response mechanisms, other research, raising awareness to addresses stigma, and by adopting appropriate legislation.

Sexually Transmitted Infections

Heterosexual contact appears to be the main mode of STI transmission, although in some countries, reported numbers point to a considerable number of infections transmitted by men who have sex with men. This population is severely stigmatized, and this mode of transmission appears to be underreported. Although mandatory reporting of STIs (syphilis in particular) exists in most coun-
tries, it is not consistent and statistics are unreliable. However, the incidence and prevalence of STIs, including syphilis and gonorrhea, are showing alarming increases in Moldova and Romania. An increase in syphilis cases is also occurring in Serbia. Official reports from the remaining SEE countries do not show this trend, but their reliability is questionable. Croatia, for example, reports an increase in chlamydia and human papilloma virus infections, especially among young women, but this phenomenon might be the result of better diagnostic methods.

Condoms are readily available throughout the region, but at approximately 1 each they are expensive, especially for young people. Social marketing programs exist in Albania, UN Administered Province of Kosovo, and Romania, but research across the region reveals that condom use and understanding of their protective function is poor among young people. A recent USAID-funded condom social marketing assessment conducted in Bulgaria, Croatia, and Bosnia and Herzegovina indicated that attitudes were more powerful deterrents to condom use than pricing. There are plans to expand the social marketing approach to other countries in the region during 2002.

Little information exists on sexual networking patterns of high-risk groups, especially sex workers and injecting drug users, the groups identified as bridges of infection into the general population. Porous borders have resulted in a substantial increase in the trafficking of drugs and human beings, especially young women, with the countries of SEE being source, destination, and transit countries.

Trafficking for the purpose of sexual exploitation is directly connected to the insecurity of sustainable livelihoods, labor migration, and gender discrimination. The factors that increase the vulnerability of women and girls to being trafficked are the same factors that increase their vulnerability to STIs and HIV. While men, women, and children are all involved in the trafficking cycle, it is women and children who are most vulnerable due to their low social and economic status in society. Trafficking of women usually involves recruitment through coercion, deception, force, sexual exploitation, physical and psychological abuse, and debt bondage. This places a woman in a position in which she has no power to negotiate her rights to safe sex or protection from violence.

Trafficking of women and girls for the purpose of sexual exploitation is well documented and the associated risks of HIV infection and STIs are well understood. However, commercial sex work is heavily stigmatized in the region, and to address this topic a development and rights-based approach should be applied. This is not yet widely understood.

The following points were identified as priorities for action:

- Create and strengthen services to prevent STI transmission and provide care to those infected with an STI, with a special focus on the most vulnerable groups;
- Initiate education programs to raise awareness among the general population and more vulnerable groups; and
- Strengthen STI surveillance.

Young People

Young people in SEE—those aged 10 to 24 years—are facing notable risks. Education in the region is being compromised and undermined by political, social, cultural, and economic conditions.

Young people lack the ability to be part of a dialogue on smoking, alcohol, drug use, and STIs, including HIV/AIDS, or to engage in the processes that will enable them to develop skills to manage these challenges. Some very good and innovative peer education and life skills education programs
exist. To maximize their impact, however, they need to be scaled up and complemented with youth-friendly policies and services.

Research and surveys across the region consistently report that parents, teachers, and health professionals are not successful in providing effective information on these issues. Instead, the media, peers, and older siblings appear to be information sources. This is not sufficient, and those with a duty for providing care need better knowledge, awareness, and motivation.

The following points were identified as priorities for action:

- Young people (10 to 24 years old) should be at the center of prevention and intervention strategies because actual and potential risk behaviors are most prevalent among this group. This is also demonstrated through a high percentage of reported HIV and STI infections throughout the region among this age group.
- Working with young people and providing them with the information and skills to protect themselves from HIV should be at the core of all prevention efforts. Harnessing their positive and creative energy and ensuring their participation is essential for creating and implementing effective programs and strategies. The full participation of young people in all aspects of political, social, and cultural rights and their involvement in dialogue is critical to future strategies and interventions.
- Certain groups of young people in the region are more vulnerable than others and their behavior will be central to curtailing the spread of HIV. A combination of timely and appropriate actions and interventions focused on these groups and effective in-school and out-of-school education in life skills, including protection from HIV and STIs, is an effective way to contain the spread of HIV. A balance has to be found between efforts to reduce infection and stigmatization in especially vulnerable groups, and efforts to reduce the risk situations in which young people find themselves and to enhance their skills to manage them.
- Skill-based health and peer education programs must be developed and expanded both in and out of schools. Youth-friendly, confidential, and supportive services with particular attention to accessibility for especially vulnerable young people must be made available and accessible. The creation of appropriate meeting places where they can find information, support, and care needs consideration.

Mobile Populations

SEE has a highly mobile population of refugees, returnees, internally displaced persons, rural to urban migrants, labor migrants, sex workers, victims of trafficking, international peacekeepers, humanitarian workers, and in some countries, tourists. Mobile groups also include people whose work involves travel (e.g., construction workers, pilots, sailors, truck drivers, etc.). Many returnees and labor migrants are coming back from or moving between countries with a notable or high prevalence of HIV/AIDS. Sex workers, many of whom are young, are vulnerable and of particular concern. As mentioned earlier, an increase in the sex industry has been coupled with the trafficking of women from CEE/CIS countries for sexual exploitation.

The following points were identified as priorities for action:

- Include the needs of mobile populations and specifically address ways they can protect themselves from HIV in all national plans of action.
- Use evidence-based advocacy, including the development of necessary skills, to address the needs of these groups. Efforts must include the need to reduce the stigma against foreign workers.
International Workers

A large number of international workers are present in the region, particularly in the UN Administered Province of Kosovo (approximately 70,000) and in Bosnia and Herzegovina (approximately 40,000). Such a large presence of military and peacekeeping workers has been acknowledged in the spread of HIV/AIDS and STIs. The UN Security Council identified HIV/AIDS as a particular security concern for peacekeeping operations through the adoption of resolution 1308/2000. The resolution emphasizes the need for member states to develop long-term strategies for education, prevention, testing, counseling, and treatment of their personnel as a part of their preparation for peacekeeping missions.

The following points were identified as priorities for action:
- A recent UNAIDS mission to Bosnia and Herzegovina and the UN Administered Province of Kosovo recommends that all international peacekeepers should receive a culturally standardized induction training for HIV/AIDS;
- Training for all peacekeeping staff should be mandatory and include an understanding of the possible effect of their presence on sexual violence and assault, prostitution, child exploitation, and substance abuse; and
- Codes of conduct and standards of behavior for peacekeeping and other international staff often do not effectively address the needs of the local situation. There appears to be a need for more refined and appropriate versions.

Strategic Approaches

In October 2000, UNAIDS established the SEE Regional Initiative on HIV/AIDS. Its goal is to prevent the spread of HIV in the region and to support countries to implement accelerated, expanded, enhanced, and coordinated responses that can mitigate the effects of the epidemic. The core of the expanded response focuses on prevention strategies and targeted interventions among the most vulnerable groups.

A coordinated regional response should include the following principles:
- National strategic plans, including a well-articulated national program, should constitute the backbone of an effective response;
- Activities at the regional level must complement and support community and national responses rather than replace them; and
- Regional strategic priorities should be adjusted to the regional realities through a wide consultative process.

An intercountry or regional response will result in the following added values:
- Stronger national advocacy for HIV/AIDS programs;
- Better coordination and strategic and efficient use of resources at the regional level;
- Better networking between countries;
- More joint and targeted actions on common and cross-border issues and the development of mutually reinforcing programs; and
- Creation of a joint pool of local experts as well as capacity and resources for pooling and sharing information and experience.

The following strategies, documents, and mechanisms can play an important role in supporting countries to achieve a successful regional response:
Partnerships

Partnerships are an important step in establishing a national and regional approach to HIV prevention. In all countries over the past two years efforts have been made to mobilize a stronger, better coordinated, and more collaborative response. These include the establishment or strengthening of UN Theme Groups (UNTGs) on HIV/AIDS and national AIDS commissions. Through UNTGs, the eight cosponsors of UNAIDS will work with key partners to achieve this. UNTGs exist in every SEE country.

Stronger relationships between governments and NGOs need to be developed so that both parties are able to see the benefits of cooperation. In Croatia, the relationship between the government and NGOs is noteworthy because the government funds NGO activities through a special program. Given the early stage of civil society involvement throughout the region and the critically important role civil society has to play in mitigating the spread of HIV, international sponsorship for capacity building and institutional strengthening of governments and NGOs is indispensable. Opportunities for alliances must be identified and encouraged.

Political Advocacy

Political commitment, which is a fundamental requirement for an effective response to HIV, has been generally weak across the region. Governments need to be lobbied at all levels to support multisectoral prevention strategies. Governments need to be encouraged to invest relatively modest resources now to prevent HIV/AIDS from becoming a large social and economic burden in the future. To achieve this, UNTGs should develop and implement an advocacy strategy by focusing on the priorities of each country, taking into account the need for viable plans, including the collection of information.

Declaration of Commitment on HIV/AIDS

At the UN General Assembly Special Session on HIV/AIDS in June 2001, all SEE countries signed the UN Global Declaration of Commitment, which supports the development and implementation of national strategic plans.

Global Fund for AIDS, Tuberculosis, and Malaria

The Global Fund was established as a financial instrument to attract, manage, and disburse additional resources to combat HIV/AIDS, tuberculosis, and malaria. Its purpose is to develop a public-private partnership that will make a significant and sustainable contribution to the reduction of infection, illness, and death, thereby mitigating the effects of these diseases in countries in need, and contributing to poverty reduction.

The Global Fund bases its work on programs that reflect ownership for implementation and processes by individual countries. It therefore promotes partnerships among all relevant players within a country and across all sectors of society. It builds on existing coordination mechanisms and promotes new and innovative partnerships where none exist.

In short, the Global Fund presents an opportunity for establishing partnerships and developing and implementing country-owned medium-term and long-term plans that can have a significant impact on the epidemic.
Summary

The SEE region has a low prevalence of HIV despite considerable variations in statistics and modes of transmission. The lack of consistent and reliable data collection is characteristic of almost all countries in the region, and which is why estimates of prevalence, incidence, and modes of transmission do not reflect reality.

The major modes of transmission are injecting drug use in Moldova and Serbia and sexual transmission elsewhere. Risk behavior is on the increase, and is to a large extent driven by young people who are struggling to find their place in changing societies and who are experimenting with sex and drugs.

As in CEE/CIS countries, in SEE injecting drug use, STIs, and the needs of young people, particularly those who are vulnerable, need to be addressed in order to decrease the spread of HIV. Mobile populations and trafficking are also a priority.

Injecting drug use appears to be on the rise in SEE. There was consensus that the efficiency of HIV transmission through this behavior, particularly by those who share needles, warrants special attention. This consensus exists even among delegations from countries where HIV prevalence among injecting drug users is low.

Governments and donors acknowledge the need for a strategic approach to developing programs to contain the spread of HIV. Effective partnerships between governments, NGOs, and other partners are an important factor in developing and implementing such an approach. Participants agreed that a basic need in developing a strategic approach is knowledge and understanding of the situation; therefore, an urgent need exists to develop appropriate and sustainable systems for second-generation sentinel surveillance.

Participants agreed that a strategic response on several fronts should move forward simultaneously across the region. The response will focus on reducing sexual and injecting drug risk behaviors and on highly vulnerable groups of young people, as well as on young people in general.

To sustain these efforts, stigma and marginalization should be fought. Injecting drug users, sex workers and their clients, and people living with HIV and AIDS are not self-sustaining groups—they mix throughout society. Prevention efforts cannot succeed unless society as a whole takes on the issue of HIV/AIDS—in schools, press rooms, churches, and mosques.

Adoption of the Southeastern Europe Declaration of Commitment on HIV/AIDS

The Southeastern Europe Declaration of Commitment was proposed at the conference. A drafting committee had been established to work on the text at the start of the conference and attendance was open to any participant. Representatives from country delegations were also invited to offer their comments on the draft. After a brief discussion, all participants endorsed the declaration. The complete text of the declaration appears in Annex 6.
References

ANNEX 1

CONFERENCE PROCEEDINGS
Statement by Kathleen Cravero, Deputy Director of UNAIDS

Your Excellency, the Minister of Health and Family of Romania, other distinguished ministers, honored guests, colleagues. I speak to you on behalf of the Joint United Nations Programme on HIV/AIDS. UNAIDS brings together the strength and expertise of eight UN agencies—UNICEF, UNDP, UNFPA, UNDCP, WHO, International Labor Organization, UNESCO, the World Bank—many of whom are represented here.

We welcome the high-level attendance and the large number of participants who have gathered for this conference. It is a clear sign of growing awareness and commitment to address HIV/AIDS in Southeastern Europe. As HIV does not respect borders, this intercountry collaboration is essential to success.

My remarks will cover four areas: the significance of the Declaration of Commitment, the context within which our collective struggle against AIDS occurs (that is, the status of the epidemic), the special vulnerability of young people, and priority actions to reverse the epidemic in Southeastern Europe.

The United Nations General Assembly Special Session on HIV/AIDS and the adoption of its historic Declaration represented a turning point in political will and commitment to reverse the epidemic. For in endorsing the Declaration, the world’s leaders adopted a joint plan of action, including concrete goals and targets in ten key areas.

These areas are well covered in the draft SEE Declaration you will be considering over the next three days. The very theme of this conference—the follow up to the Declaration of Commitment—is a clear and hopeful sign that the declaration is more than just another empty international agreement.

In his opening remarks to the UN General Assembly Special Session on HIV/AIDS last year, the Secretary General called for extraordinary action. He said, “Up to now the world’s response has not measured up to the challenge. But at last the world has woken up. AIDS can no longer do its deadly work in the dark. Never, since the nightmare began, has there been such a moment of common purpose. Never have we felt such a need to combine leadership, partnership and solidarity.”

The scale of the global HIV/AIDS epidemic is unprecedented: 40 million people living with HIV/AIDS, 5 million infected during 2001, 3 million died during 2001, and more than half of new infections are among the young.

We face a gravely underestimated epidemic in Eastern Europe and Central Asia. Consider that, at the end of 2001, Eastern Europe and Central Asia had one million cumulative HIV cases and at least 250,000 new infections. In fact, the Commonwealth of Independent States and the Baltic States are experiencing the fastest growth ever in the history of the global AIDS epidemic, fueled by rising levels of sexually transmitted infections, injecting drug use, and unsafe sexual practices.

Southern–Eastern Europe is still characterized as a “low prevalence” region. With a few notable exceptions, the number of reported HIV cases remains limited.

How sustainable is low prevalence in this subregion? Is it the result of “inherent” protective factors in the social, cultural, or religious mores, or is it just a matter of time before the rate rises? In one
neighboring subregion, we see low and stable HIV rates, in another a rapidly spreading epidemic. Where will Southeastern Europe be five years from now?

There is no room for complacency. Danger signs include rising levels of STIs, rising levels of injecting drug use and drug trafficking, effects of socio-economic transitions (e.g., leading to dependence on sex work and rising levels of mobility), a large presence of military forces, and continuing potential for conflict.

Consider three other key facts about AIDS: if unchecked, it will wipe out the social and development gains of the last two decades; it strikes first and hardest the young—people in the prime of their lives (not the poor, the weak, the very young, or very old); and we are at the beginning of AIDS—the worst is yet to come.

This is why Kofi Annan describes the AIDS epidemic as “the biggest development challenge in the new century.” This is why HIV/AIDS appears on the agenda of every important global forum, including the General Assembly; the UN Security Council; the G-8 meetings in Japan, Italy, and next month, Canada; and the UN Millennium Assembly.

An important result of this increased attention is the identification of the resource gap (i.e., the need for a substantial increase in our collective investment against AIDS estimated some 7–10 billion dollars globally to scale up programs and reverse the tide of AIDS). There are five key channels for increasing available resources: national spending, international or bilateral assistance, multilateral assistance, Global Fund, and private sector.

The Global Fund to Fight AIDS, TB, and Malaria represents an important opportunity for resource mobilization and has leveraged an estimated 50% additional resources this year—but this is not the only source for funding. There is no magic bullet, no panacea, and no easy solution.

Led by the Secretary General’s strong determination and call for action, the UN—notably the UNAIDS cosponsors and Secretariat, but also a growing number of other UN agencies—are stepping up action on HIV/AIDS. There now exists a global leadership framework to guide this action and a UN System strategic plan for HIV/AIDS, in which 29 agencies have outlined their plans.

AIDS is decimating the next generation. Let’s look at the facts: 6,000 new infections among the young each day—one every 15 seconds. The confluence of high HIV prevalence and a disproportionately young population means the young are hit the hardest as infections rise. One-third of people living with HIV/AIDS are under 25, and a full 58% of annual new infections are among the young.

And among young people, girls are the most exposed. Overall, the infection rate among girls is 5–6 times higher than boys in hard-hit countries. Why? Because girls are biologically more vulnerable, because girls tend to have sex with older men, and because so many girls are pushed into sex early, by force or by circumstance.

Thus, let us recognize that AIDS is not “age neutral” or “gender neutral”—young people, especially young women, are at its core. Why? Young people don’t know about AIDS, don’t know how it is transmitted, and don’t know how to protect themselves.
In any society, young people tend to see themselves as low risk from disease and death. This is healthy—we call it the optimism of the young. It often results, however, in an unhealthy willingness to take risks.

When young people are struggling to find their place in rapidly changing societies, it accentuates this natural tendency to “experiment” with risky behaviors such as too much alcohol, use of drugs, and unsafe sex. In a world with AIDS, what might otherwise be a temporary lapse in judgment—one-off episodes of risky behavior—become death sentences for millions of youth across the world.

These young people are our children—or the children of our family and friends. It is both dangerous—and incorrect—to believe that AIDS in Southeastern Europe is a disease of drug addicts or some other marginalized, isolated group—much less one of desperate youth beyond hope or redemption.

It is therefore wholly inadequate to target interventions at those we prejudge to be most at risk (those who are “driving” the epidemic—sex workers, injecting drug users, and men who have sex with men).

Saving the young will require broad-based prevention programs in which information and services are available and affordable. It will demand the creation of environments in which questions can be asked without fear of ridicule or reprisal. It will happen only if stigma and discrimination are replaced by adequate care, understanding, and practical support.

What is more, the young need more than information. They need choices, options, and the possibility of an independent and dignified lifestyle. If not, they will simply take the best option open to them.

During the mid-1990s I had the privilege of serving as UNICEF Representative in Uganda. One of our main efforts was to convince young girls to stop having sexual relationships with older men. We produced brochures, we held group discussions, and we ran radio programs on the risks associated with this behavior. Two years later we found that the situation had not changed. We finally decided to survey the girls involved in this practice to find out why they were continuing along such a dangerous path. To our surprise, we found that the vast majority knew all about HIV—they could recite the modes of transmission and were acutely aware of the dangers they faced. But they saw their older partners as the only way out of grinding, hopeless poverty—and the only means to pay school fees. Their risk behavior was not borne out of ignorance but out of necessity. I will never forget what one 14-year-old girl wrote back on her questionnaire. “Please don’t give me any more advice,” she said. “Give me an education.”

What are our major challenges in follow-up to the Declaration of Commitment on HIV/AIDS in Southeastern Europe? Act early! No country can claim to be risk-free. The rapid spread of HIV among particular groups—injecting drug users for example—is only an advance warning of a much wider, more fundamental problem.

Prevention works. This is particularly true among young people. Given the right information and support, young people avoid risky behaviors, delay sexual activity, and increase condom use. We have concrete evidence of these trends in many countries.
Combine prevention with care. Prevention and care efforts reinforce each other. This is a universal principle. Where care is available, people will seek out testing; where prevention is well established, the “burden” of care will decrease.

Fight stigma and marginalization. Discrimination drives people at risk underground. It fundamentally undermines prevention efforts. Let me refer once again to the words of the Secretary General at the Special Session on AIDS. “We can not deal with AIDS by making moral judgments or refusing to face unpleasant facts—and still less by stigmatizing those who are infected, and making out that it is all their fault. We can only do it by speaking clearly and plainly, about the ways that people become infected, and about what they can do to avoid infection. Let no one imagine that we can protect ourselves by building barriers between us and them. For in the ruthless world of AIDS, there is no us and them.

Get countries in the driving seat. Sustainable and effective national responses require homegrown leadership. No amount of assistance can “bury”—or substitute for—this essential element of a national response.

Avoid the project trap. The thousands of small projects under way across this region—however effective or groundbreaking they might be—do not add up to the unprecedented, massive effort necessary to meet the challenge of AIDS. We need nationwide, scaled-up programs—and we need them now.

Empower civil society. In every country of the world, successful responses have involved—indeed depended on—vibrant civil society support, in particular networks of people living with HIV/AIDS. This requires partnership—based on respect, tolerance, and the recognition of common purpose. It requires reaching out to groups with whom we have never before worked—or even had contact.

Bridge the resource gap. A significant resource gap remains in the region, but as I indicated earlier, it exists alongside greatly increased opportunities for resource mobilization at global, regional, and country levels. We need to cost out our plans, fully develop the means to get resources to where they are needed most—and then go after the money.

Allow me to close with one more reference to the Special Session on AIDS. At the end of the session, Dr. Peter Piot, the Executive Director of UNAIDS, suggested that the world was at a crossroads in its response to AIDS. He described two paths. One, a path that leads to unimaginable loss and collective shame—to a place in which together, with all our wealth and resources, we fail to care for the sick, protect the orphaned, or stop the dying.

The other path is a path of commitment and hope—along which we never give up or allow the obstacles to defeat us.

Let this conference be the determining moment for Southeastern Europe. Let history record that in the first week of June 2002 the leaders of the region chose this second, noble path.

I thank you and wish you all the best in your deliberations, on which so many lives depend.
SUMMARY OF COUNTRY PRESENTATIONS

Representatives from each SEE nation presented information on the status of HIV/AIDS in their country. They were asked to provide an indication of government commitment, the degree of multi-sectoral involvement, the status of information collection and national strategic plans, prioritization, HIV-related legislation, support from UN Theme Groups and other partners, and a description of needs for external support.

Relevant observations and conclusions of all country presentations are summarized and discussed under the following headings:
1. Impact of transition and conflict;
2. Prevalence;
3. Modes of transmission;
4. Facilitating factors;
5. Government response;
6. International response;
7. Nongovernmental organization response;
8. Priorities; and
9. Next steps.

Impact of Transition and Conflict

Services: STIs, Care and Treatment, and Voluntary Counseling and Testing

With the exception of Bulgaria and Croatia, all countries expressed strong concerns about the state of affairs for these services. There was general agreement that qualitative and quantitative improvements are important for the treatment and preventive aspects of HIV.

Data Collection

With the exception of Bulgaria and Croatia where functioning data collection systems are in place (although they need improvement), all countries have established effective and sustainable mechanisms for collecting HIV epidemiological and behavioral data.

Young People

A growing number of young people are not successfully managing their risks. To a large extent this is due to a lack of information and an adult society that does not understand their predicament and does not facilitate responsible behavior. A considerable and growing number of young people appear to regularly engage in injecting drug use and sex work. Addressing their protection needs and those of their partners is urgent if HIV is to be prevented from developing into an epidemic among them and the wider population.

The need to scale up promising small-scale interventions that address the needs of these young people was brought up in several presentations.

Prevalence

Despite insufficient data collection systems, representatives were confident that prevalence is low in the general population and in high-risk groups in most countries. FYR Macedonia has the lowest
number of reported cases, but because of unreliable services and information collection, government officials do not see a trend. The number of HIV cases in Croatia is much larger, but the relative maturity of the response appears to have contributed to a stabilization of incidence. In Moldova, the spread of HIV among injecting drug users and the rapid increase of the practice among young people is alarming. In addition, the high prevalence of STIs facilitates further transmission. However, in all countries, the spread of HIV appears still to be in its initial stage.

**Modes of Transmission**

*Sexual*

In all countries transmission is mainly through heterosexual sex, although in Croatia, reported cases of homosexual transmission do not lag far behind those of heterosexual transmission. However, this could be a result of more accurate reporting than occurs in other parts of the region because the stigma of homosexuality in Croatia is not as great as it is elsewhere, and this group has better access to services.

*Injecting Drug Use*

With the exception of Moldova and Serbia, injecting drug users show a low prevalence of HIV. Representatives from all countries expressed grave concern that the real number of injecting drug users appears to be much higher than the reported number, and that needle sharing is common. Pilot interventions aimed at changing behavior among injecting drug users are being undertaken in all countries, but there was agreement that coverage is far too limited to slow the spread of HIV once it enters this population.

*Blood and Vertical Transmission*

All blood for transfusion is tested, and reported cases of vertical transmission are very low in all countries, with the exception of Romania. Antiretroviral therapy is included in the insurance packages in Croatia, Bulgaria, and Romania, although some HIV clinics in Romania have experienced temporary drug shortages.

**Facilitating Factors**

All presenters mentioned the following factors in facilitating the spread of HIV:

- Problems associated with transition and conflict, such as unemployment and poverty;
- Quantitatively and qualitatively insufficient availability of voluntary counseling and testing;
- The lack of interventions aimed at drug prevention, care, and behavior change;
- Risk behaviors are most widespread among young people, who constitute a high proportion of the population in many countries;
- Services to promote reproductive health and prevent and treat STIs are quantitatively and qualitatively insufficient in all countries;
- Trafficking of human beings and drugs plays a role throughout the region;
- Cross-border and internal mobile populations can facilitate the spread of HIV in all countries;
- Stigma and marginalization of high risk groups such as injecting drug users, men who have sex with men, sex workers, and people living with HIV/AIDS breaches human rights conventions and drives these groups underground, thereby impeding efforts to help them protect themselves and their partners; and
Open discussions of sex-related issues among children, their parents, their teachers, and social and medical service providers are hampered by social customs. This creates many misconceptions about sexual and reproductive health.

Government Response

Government responses vary widely among SEE countries. The response is fully multisectoral in Bulgaria, Croatia, Moldova, and Romania, whereas the health sector is far overrepresented on national AIDS commissions in other countries. In Bosnia and Herzegovina for example, the health ministry is the only one involved in the HIV response, although the Council of Ministers through the Ministry of Human Rights plays a leading role in HIV-related matters.

Thus far, Bosnia and Herzegovina does not have a national AIDS commission, whereas the commissions in Bulgaria, Moldova, and Romania are fully operational. In Croatia and UN Administered Province of Kosovo, commissions are actively involved in efforts to implement national plans of action. In all other countries, a multisectoral national AIDS commission has just been or is in the process of being established or revived.

Bulgaria, Moldova, and Romania are implementing national strategic plans. FYR Macedonia is developing one, while all other countries acknowledge the urgent need for one.

International Response

The United Nations is highly visible in all countries. Support from the UNAIDS Secretariat has helped HIV/AIDS Theme Groups become more operational than in the past. United Nations agencies are working to coordinate and establish national AIDS commissions, develop national strategic plans, and implement rapid assessments and responses. In the future, UN agencies will play a critical role in facilitating the process of preparing and submitting proposals to the Global Fund for AIDS, Tuberculosis, and Malaria.

Bilateral agencies and international NGOs are active in all countries. Much of their involvement is focused on making local NGOs stronger and supporting their activities. USAID was mentioned for its support in implementing the national action plan in UN Administered Province of Kosovo, and the Canadian International Development Agency was mentioned in connection with its support to the development of Romania’s national strategic plan. Another example is the Open Society Institute and its work with high-risk population efforts in many countries.

NGO Response

The importance of the role of NGOs was highlighted in the presentations by representatives from Croatia, Romania, FYR Macedonia, and Bulgaria, where NGOs represent 50% of one of the three bodies involved in policy making.

Priorities

Representatives from all countries came up with similar priorities, although they emphasized different aspects of them:
  * Young people should be at the center of every strategic response, but with an emphasis on “especially vulnerable young people”;
• Population groups and individuals who engage in high-risk behavior, many of whom will be young people;
• Mobile populations, particularly young women and children who are victims of trafficking;
• The lack of reliable information and, consequently, the need for establishing second-generation sentinel surveillance systems; and
• Easily accessible and confidential voluntary counseling and testing services.

A recurrent theme was the nonexistence of good information on sexual and reproductive health for young people. There is an urgent need for good, easily accessible information and media for in-school and out-of-school youth as well as for parents, medical providers, and social service providers.

Croatia’s representatives noted that the incidence of new HIV infections seems to have stabilized. This positive development was believed to be the result of sex education efforts in schools, the decriminalization of injecting drug use and homosexuality, the establishment of confidential voluntary counseling and testing programs, and relatively reliable information collecting systems that were all begun early in the epidemic.

These issues need to be supported by the international community:
• Presentations by representatives all countries, with the exception of Bulgaria, mentioned the need for surveillance. Representatives from Croatia noted that data collection methods were relatively efficient but they did not include behavioral data, and said that Croatia needs more technical support in this area.
• A regional initiative should include sharing of best practices.
• Health professionals urgently need training on all HIV issues, and this requires international support.
• Most countries need funding for HIV work.

Next Steps

The following topics need attention as national responses are developed:
• All countries need to establish a multisectoral national AIDS commission;
• National strategic plans need to be developed on the basis of reliable information;
• Priorities need to be established;
• Enabling legislation needs to be drafted and adopted;
• Confidential, voluntary counseling and testing needs to be expanded; and
• Treatment and care protocols need to be established.
Summary of Working Groups

Country reports and presentations led to a set of five regional priorities:
- Surveillance of HIV and STIs;
- Especially vulnerable youth;
- Prevention strategies and activities;
- Care support and treatment; and
- National strategic planning.

Participants separated into five working groups to discuss these topics. They shared country and personal experiences, opinions, and lessons they learned, and they discussed the country presentations that were made earlier in the conference. A summary of the notes from each group appears as a matrix in Annex 5. The following questions were provided to guide their discussions:
- What are the key needs?
- What is going on that should be scaled up?
- What are the gaps?
- What actions do you recommend at the country level?
- What actions do you recommend at the regional level?
- What actions do you recommend at the subregional level?

Their observations and recommendations are summarized below.

Surveillance of HIV/AIDS and STIs

There was agreement that while HIV/AIDS prevalence is generally low across Southeastern Europe, data collection is largely insufficient due to the relative decline of state health systems. In addition, politicians lack an understanding of the need for an urgent and effective response to HIV, and the importance of a viable and sustainable data collection system, which would promote the development and evaluation of a response to the epidemic. At the same time, good data that reflect the real situation would constitute an indispensable advocacy tool for generating political understanding and commitment.

The sentiment among participants was that HIV is still concentrated among groups whose behavior puts them at risk and who could become instrumental in spreading the virus within the general population. Possible links between all types of population groups were discussed and it was agreed that little was known about these mechanisms in the region.

HIV testing is taking place in many countries as part of national health surveillance systems, but it is being done in an uncoordinated and inconsistent manner, it is not considered as a priority, and it is underfunded.

Blood donors are a low-risk sentinel group and are consistently tested throughout SEE. HIV testing also takes place among other lower risk groups, such as military recruits and antenatal clinic attendees, but it is done infrequently, unsystematically, and inconsistently. Patients with tuberculosis have also been included in routine HIV testing protocols, but participants agreed that this is not appropriate in situations where low prevalence is suspected. In general, when these groups are tested for HIV, it is for objectives other than specific HIV surveillance and the data they produce can be considered "free" data.
The USAID proposed model for instituting sentinel surveillance in Albania was discussed extensively and considered to be realistic, feasible, and affordable. These so-called free data, together with other limited but focused data collection procedures, can detect HIV prevalence rates of 1%-2% in groups with the highest HIV risk behaviors.

Surveillance will target biological and behavioral specific HIV transmission modes among suspected high-risk groups (i.e., injecting drug users, sex workers, and men who have sex with men). This information is needed to develop a strategic response and to evaluate it. NGOs are generally better placed to work with these groups and need support and training to do so.

Rates of sexually transmitted infections, hepatitis B, and hepatitis C should be integrated into sentinel surveillance because the data will provide information on sexual and injecting risk behavior trends as well as those for sexually transmitted infections.

The group stressed the need for viable data as a precondition for conducting a situation-and-response analysis, on the basis of which a strategic plan can be developed, and to evaluate the effectiveness of its implementation.

The group concluded that second-generation (i.e., biological plus behavioral) HIV sentinel surveillance and its integration into the overall health surveillance system is urgently needed, and that good pilot initiatives should be scaled up in order to assess a country’s actual risk.

The group also agreed that testing policies need to be reviewed, particularly to protect confidentiality, and that the shortage of reference laboratories needs to be addressed.

Issues that need to be addressed at the regional level include the following:
- Exchanges of information, best practices, and lessons learned;
- Building technical capacity and training; and
- Resource mobilization.

Especially Vulnerable Youth

As a group, vulnerable young people may include injecting drug users, sex workers, men who have sex with men, ethnic minorities, prisoners, victims of trafficking, sexual partners of injecting drug users, and mobile populations. However, the working group decided to focus on injecting drug users because this population has the potential to play a primary role in the spread of HIV. The working group also chose to discuss what resources would be necessary to deliver harm reduction programs to at least 60% of injecting drug users, which was agreed to in the Declaration of Commitment.

One observer noted the obstacles faced by an NGO named HOPS in FYR Macedonia in its harm reduction programs: a lack of services for drug users, and a lack of education and information, which has resulted in little understanding of HIV, STIs, hepatitis, and other blood borne infections. Another obstacle is the lack of coordination and cooperation among experts in the health and social sectors and with and among NGOs. The same problems exist between local and national governments. Interventions have also been hampered by repression based on the stigma and marginalization of drug users.

The Initiative for Health Foundation in Bulgaria works conducts outreach work among sex workers and injecting drug users in the Roma community. The organization found that the Roma community was doubly disadvantaged. Noted one observer, “It is very difficult to buy syringes in a pharmacy in
Sofia if you are drug addict, and even more so if you are Roma.” This makes this already marginalized group even harder to reach, but the project has shown that if certain conditions are met, harm reduction efforts can be beneficial. Stigma against women and a high degree of unsafe sex practices and ignorance of the protecting functions of condoms were also cited as problems.

The UN Theme Group from Croatia articulated the idea of rethinking vulnerability in terms of attitudes as well as behavior. To reduce vulnerability is to recognize the right of other people to be different, and representatives of the group saw risk arising from stigmatization, discrimination, and marginalization. “The degree of vulnerability depends on the capacity of society to address these issues openly and promote safety.”

Key needs that were identified to effectively implement harm reduction activities included the following:

- Human and financial resources;
- Designing efficient programs based on harm reduction;
- Advocacy vis-à-vis legislators, law enforcement agencies, and health professionals in order to explain the benefits of harm reduction;
- Building community based approaches—with alliances between central and local governments, civil society, and law enforcement agencies; and
- Programs that articulate rights and ensure participation.

Other identified needs included the following:

- Legislation; advocacy; and information, education, and communication in order to counteract stigma and marginalization;
- The need for involvement of local governments;
- Ownership and involvement of target groups in the development of activities;
- The need to develop a needle exchange strategy;
- The need to analyze the nature of needle sharing (e.g., the implications of sharing in groups of 10 with a regular change of partners are very different from those of sharing between 2 steady partners); and
- The need for a careful impact evaluation before a program is expanded.

Needs at the regional level include the following:

- Making greater use of existing support from the Open Society Institute;
- More support from the United Nations;
- Long-term sustainable funding, including more national and local funding; and
- Partners of injecting drug users and the special needs of female injecting drug users need to be taken into consideration when activities are developed.

**Prevention Strategies and Activities**

The working group decided to focus on young people. Discussions covered how to achieve behavior change among young people through peer education and sexual and reproductive health and life skills training both in and out of school. These interventions should be targeted to young people in general, and focused on those whose behavior makes them especially vulnerable to HIV and STIs.

In Bosnia and Herzegovina, the Youth Against AIDS Action NGO started peer education activities in October 2000. The ultimate aim was to help young people protect themselves from contracting HIV or an STI. Different categories of young people have been targeted, and at present the initiative consists of two 6-month projects and two regional campaigns. The difficulties encountered included
cultural norms that resist open discussion of sexuality. Another was the strong doubts and lack of support from health and education professionals on the efficacy of the program.

The advantages of peer education were discussed, such as the enabling of better communication and knowledge transfer. The NGOs Youth Action Against AIDS and JAZAS offered successful examples such as participatory methods and local ownership of programs. Over time the organizations learned that different models had to be used to direct dependence disease programs and HIV/AIDS/STIs, and that approaches should be tailored to particular audiences such as those in primary schools, secondary schools, and universities. More than 400 people in 9 towns are now involved in JAZAS programs in the Federal Republic of Yugoslavia.

Among the key gaps identified were the difficulties in motivating young people to participate in prevention activities: identifying good candidates, motivating and recruiting them, and maintaining them as peer educators.

Young people need to be involved as partners and it is important to strengthen the capacity of civil society to contribute their talents, especially via the training of trainers. These efforts likely will promote sustainability. Another recommendation is that young people serve as members of national AIDS commissions.

Better cooperation between government and NGOs is needed in order ensure that projects sustainable. New and better curricula on sexual and reproductive health and life skills and training for teachers is an important government contribution. Donors could serve as catalysts and facilitators. Youth-friendly information must be tailored to the needs of various groups. This may include incorporating sex education into national school curricula.

The following needs were identified and should be addressed at the regional level:

- Facilitate the exchange of information, best practices, and lessons learned, with a view to replicating them and making more use of existing training materials. This could involve the connection of existing networks through websites and e-mail and the establishment of resource centers.
- Collect and share behavioral data. It may be possible to use an existing European mechanism for the collection and sharing of public health data.
- Develop youth policies and information tailored to their needs.
- Institute regional cooperation/coordination for the World AIDS Campaign.
- Improve access to services, treatment, and care.

**Care Support and Treatment**

The major issues raised in this group included the following:

- Quality of care for people living with HIV/AIDS;
- The need for adapting legislation;
- Budget considerations;
- Role of NGOs; and
- Opportunities for specific action.

Quality of care varies in the region but it is generally poor. A reason for this is the progressive deterioration of health services; another is the stigma attached to HIV/AIDS, often by health professionals.
The discussion covered the frequent lack of opportunities for patients to receive appropriate diagnosis and treatment, the urgent need for developing standards and training for health professionals to diagnose and treat HIV/AIDS and opportunistic infections, and the need for a change in attitudes among health professionals. The lack of psychosocial counseling is another obstacle, as was the scarcity of laboratory facilities. The role of pharmacies in ensuring sustained availability of drugs was also discussed.

The Romanian NGO ARAS made a presentation on its voluntary counseling and testing centers (in Bucharest, Iasi, and Constanta). Clients are being tested for HIV/AIDS/STIs and hepatitis B and hepatitis C, and they receive pretest and posttest counseling. They are referred to other medical services as appropriate, including information to prevent mother-to-child transmission of HIV. The procedure is free of charge and confidential. The centers are the only sites where these services are available. They work in collaboration with local public health authorities and they receive financial support from USAID, UNICEF, and the European Union. The centers have become a model for the rest of the country.

Legislation needs to be changed to protect confidentiality and ensure anonymous testing. This would protect the rights of persons living with HIV/AIDS and would facilitate the development of effective sentinel surveillance systems.

Changes in legislation should also help to facilitate the inclusion of certain HIV/AIDS drugs in countries’ essential drugs lists.

Participants said that medical associations could and should play a key role in improving quality of care and in developing legislation.

There was a consensus that budget issues could not be examined in isolation, but that HIV/AIDS should be considered in the context of the need for health sector reforms in general. In this regard, discussions centered on reasonable contributions that can be expected from governments and to what extent patients can be expected to contribute. Is equitable access for all affordable? In this regard, some countries in the region are more advanced than others.

The role of the NGO community has primary importance in advocacy and providing support to those affected. Support to the NGO community may facilitate the sharing of experiences and assist them to be sustainable.

NGOs need better capacity and this can be promoted through training, the sharing of experiences, and assistance to ensure program sustainability.

The capacity of medical professionals can be enhanced through:

- Practical training, continuing education, and sharing of experiences (an example is physicians in Moldova who are learning from those in Romania);
- Development of tools and guidelines, including WHO publications, and to ensure their easy accessibility;
- Development of minimum standards of care;
- Identification of a package for care/support/treatment, tailored to SEE; and
- Inclusion of gender considerations.

The following specific actions need to be taken regarding legislation:

- Ensure confidentiality and further ethically sound approaches;
National Strategic Planning

Discussions focused on the preconditions, mechanisms, and processes of developing a successful strategic plan.

A presenter explained that a national strategic plan is key to developing a clear understanding of the status of HIV/AIDS, and for establishing priorities. The epidemic has many dimensions and is driven by complex factors that require a multisectoral approach, one that requires the involvement of all ministries, but which is decentralized enough to help local authorities work on responses in their own area. The differences and inequities between men and women also have implications for management and planning.

Good strategic planning needs viable data and other documentation of HIV/AIDS from throughout a country that highlight HIV/AIDS from all aspects. These data could be used to foster high-level political support for a national, multisectoral strategic plan and for a mechanism to coordinate the strategic planning process. Sound information will lead to government commitments.

A national strategic plan should be made part of a broader social sector plan and it needs to have clear objectives, a time line, and a work plan. Gender issues need to be addressed as a key part of the process.

Several barriers stand in the way of developing national strategic plans:
- The reigning culture in SEE countries is not conducive to cooperation;
- A communications strategy does not exist;
- Technical expertise in strategic planning is unavailable;
- A lack of leadership. In order to ensure a multisectoral approach, ministries of health should not take the national lead, instead, a partnership in leadership is needed;
- A model for ensuring coordination does not exist; and
- There is too little money.

The following opportunities were identified:
- A growing awareness among decision-makers;
- Prevalence is low in all countries;
- Bulgaria, Moldova, and Romania have already developed national strategic plans, which means that experience in this process exists in the region;
- The political need for legislation to be adjusted to EU criteria;
- Donor interest; and
- The Global Fund for HIV/AIDS, Tuberculosis, and Malaria.

Plenary Discussion

In the plenary discussion following the working group presentations, the following observations were made:
- Voluntary counseling and testing needs to be seen as a critical part of an effective response to HIV.
- More attention needs to be paid to the needs of men who have sex with men.
• Gender issues need to be addressed, such as the needs of young men, and because most injecting drug users are men, their female partners.
• Several women’s NGOs are actively responding to HIV. Better use should be made of their potential.
• Key themes in the presentations included prioritization, leadership, partnership, ownership, data collection and dissemination, multisectorality, and sustainability (i.e., the need for long-term donor commitment and local resources).
• Remember: KISS ME (keep it straightforward, simple, manageable, effective).
Meeting of Ministerial Delegates

On the second day of the conference, ministers and delegates met from Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Federal Republic of Yugoslavia, the UN Administered Province of Kosovo, Former Yugoslav Republic of Macedonia, Moldova, and Romania.

The objectives of the meeting were to explore ways of developing regional cooperation on HIV/AIDS and to discuss mechanisms that would strengthen the visibility of the region in the eyes of the international community and donors. The meeting also served as a forum to discuss the proposed Southeastern Europe Conference Declaration and the commitments that it outlined.

The ministers agreed that regional cooperation needed to be stronger and vowed to better share information and technical assistance, and to address cross-border issues. Cooperation is to include bilateral and multilateral initiatives. The ministers agreed on the need to establish a mechanism to follow up on these proposals. They also discussed the Southeastern Europe Declaration of Commitment, and it was endorsed by all the ministers at the meeting.

Several specific actions were proposed; they included the establishment of a regional center for HIV/AIDS, a regional resource clearinghouse, a regional network of HIV surveillance systems, and the possibility of initiating an alliance for HIV/AIDS in Southeastern Europe. The prospect of working together to obtain funds from the Global Fund for HIV, Tuberculosis, and Malaria for the purpose of enhancing regional cooperation was discussed. Such an application would neither replace nor exclude individual country applications to the fund, but would complement individual applications.

It was proposed that these ideas should be analyzed at a later date by a group of people who would serve as focal points, and who would be nominated by each minister.

The Romanian Minister of Health and Family agreed to prepare a letter for the ministers of the countries that attended the conference; it would contain the details of the agreements that were reached. She also agreed to send another letter two weeks later to request the nomination of people to serve as focal points. These designated individuals were to start networking and establish a system of communication and to perhaps plan another meeting.

In the follow-up meeting, focal point individuals will have the mandate to define the terms of reference for regional coordination. Individuals in the focal point working group will also have the mandate to design a joint proposal for the Global Fund that will support regional cooperation. Technical assistance will be requested from UNAIDS to define a regional network and initiatives, and to develop proposals to submit to the Global Fund.

Global Fund for AIDS, Tuberculosis, and Malaria

A satellite meeting on the second day of the conference was held to discuss country perspectives on the Global Fund. The session was chaired by Kathleen Cravero, Deputy Director of UNAIDS, and Hakan Bjorkman of the UNDP Special Initiative on HIV/AIDS was present.

Representatives from Serbia and Moldova discussed their successful proposals to the Fund.

The Serbian proposal was developed with assistance from the University of Southern California. It proposed education for healthcare personnel, HIV/AIDS education in schools, social marketing and
distribution of condoms, control of mother-to-child transmission, and prevention programs for high-risk groups. Developers of the Serbian proposal were asked to provide additional details, including an explanation of why care activities were not included in the proposal. They were asked to revise the proposal and to provide a more realistic time chart for activities.

The two proposals shared several characteristics such as being multisectoral and based on a solid national plan that was technically sound; both had a recurrent theme of involving civil society organizations and people living with HIV/AIDS; and both were noted for having a balance between treatment, care, and prevention.

Representatives from the UN Theme Groups mentioned they were available to offer information, technical advice, and guidance on the fiduciary rules of the Fund.

Remarks from Donors

Conference participants thanked the organizers and the Romanian government for hosting the meetings, and reiterated their support for the SEE Declaration of Commitment. In general, participants and donors agreed to the following points:

- A high demand exists for HIV/AIDS prevention activities and donors would expand their work in this;
- A gender- and rights-based approach to HIV care and mitigation must be considered foremost;
- The rights of all individuals, and particularly those of people living with HIV/AIDS, must be absolutely respected;
- A regional approach is probably the best way to tackle the HIV/AIDS epidemic;
- A way must be found to purchase enough antiretroviral drugs, and to provide care and support to infected individuals;
- All governments must establish national AIDS commissions and maintain realistic national strategic plans; and
- The United Nations Theme Groups are in the best position to help coordinate activities and communications among donors in the region.

Representatives of donor organizations offered a variety of comments, which are listed below, by organization. Comments should not be construed as constituting official endorsements or commitments by the governments of the respective organizations.

Representatives from USAID offered the following comments:

- Donors should consider pooling their resources;
- The regional strategy needs more advocacy and political commitment;
- The region needs policies and interventions based on evidence; and
- USAID is committed to helping the region and is initiating a regional activity with UNFPA to make NGOs stronger and to promote condom use among young people. The agency has also initiated comprehensive STI and HIV prevention activities in Albania, Romania, and Kosovo Province.

Representatives from the Department for International Development of the United Kingdom offered these observations:

- A need exists for donors and governments to work on sustainable projects, and for better coordination of activities;
• National and international needs are competing for a limited pool of funds; nevertheless, the United Kingdom is committed to working in the region to combat HIV.

Representatives from the Italian Ministry of Foreign Affairs offered these observations:
• Italy is deeply committed to combating HIV in the region;
• Italy has thus far contributed 50 million to the Global Fund for HIV, Tuberculosis, and Malaria, and expects to contribute another 70 million.

Representatives from the Canadian International Development Agency offered the following observations:
• The conference organizers are to be commended for highlighting the critical issues associated with HIV in the region;
• The rapid assessments and response analyses conducted throughout the region are valuable;
• UNICEF is to be commended for its regional public health project; and
• Canada will reexamine its commitments to the region in the coming year.

Representatives from the Swedish International Development Agency offered these observations:
• SIDA has been offering international assistance since 1965, primarily to Africa, and its European programs are relatively new, although SIDA has conducted some work in FYR Macedonia since 1992;
• SIDA maintains small offices in Albania and FYR Macedonia, and it works primarily with NGOs on capacity building efforts; and
• Because SIDA has a limited administrative ability, it will seek larger, regional projects in which to combine its work.

Representatives from the World Bank offered these observations:
• The Bank’s primary role is to support local leadership and institutions, to evaluate best practices, and to improve the capacity to implement projects;
• The Bank’s work will aim to improve biological, behavioral, and epidemiological data collection and analysis, as it did in the Russian Federation; and
• The Bank will support policy dialogue; technical assistance; occasionally make grants; and will provide lending services, credits, and loans.

Remarks by Representatives of Nongovernmental Organizations

Igor Velkovic from HERA in FYR Macedonia, on behalf of NGOs, expressed his appreciation that all stakeholders had the opportunity to meet. He said that NGO representatives were pleased to have been invited to take part in the conference and given the opportunity to shape the HIV agenda for the region. He reiterated that NGOs were still the response leaders in the region, especially in providing care, support, and peer education. He added that NGO representatives believe a need exists for better cooperation and to establish regional approaches in responding to the HIV epidemic in the region.

Lack of communication and promotion of positive programs need to be addressed. However, Mr. Velkovic said that excellent networks existed among organizations in the region, especially in the fields of harm reduction and peer education.

Inclusion of NGOs in the country coordinating mechanisms is a major concern of several NGOs because the mechanisms were not as inclusive as NGO representatives wished they had been. He said, “The success of the Global Fund will depend on the quality and inclusiveness in the country
coordinating mechanisms,” and “the participation of civil society is the crucial feature of this fund, which differentiates it from other efforts.”

He said that NGOs had hoped the conference would result in the creation of a regional initiative, which is expected to be developed in the near future. NGOs endorsed the SEE Declaration of Commitment, and hoped it would lead to better cooperation across Southeastern Europe.
ANNEX 2

STATEMENT OF PURPOSE
Background

The dramatic shifts in societal and cultural norms across Southeastern Europe have resulted in an increase in the enabling factors for the spread of HIV/AIDS and sexually transmitted infections. The impact of conflict on some of the countries of the region has been significant. Political, economic, and social transition has led to decline and deterioration in many aspects of life. These include access to health and social services, education opportunities, access to livelihood, and employment. The result has been an increase in the incidence of stress and post trauma conditions and an increase in risk behaviors, such as substance abuse and unprotected sex, especially among young people (15 to 24 years).

Compared with the rest of the world, the overall prevalence of HIV/AIDS in the countries of SEE is still low. However, the experience in other countries in Central and Eastern Europe and Commonwealth Independent States (CEE/CIS) indicates that with the enabling presence of risk behaviors and higher vulnerability, this can change rapidly. It is generally accepted that the true extent of STI and HIV/AIDS prevalence is not known. However, existing data and anecdotal evidence indicate that there is an increase in risk behaviors, which make people more vulnerable to STI and HIV infections. Efforts to collect verifiable data to better understand the behavior of risk groups include the implementation of knowledge, attitudes, and practice surveys; epidemiological surveys; and rapid assessments and responses.

Young people remain the central focus for prevention and intervention strategies, as reported HIV and STI infections throughout the world are predominantly within this group. Working with and providing young people with the skills and information to protect themselves should be at the core of all efforts. Harnessing the positive and creative energy and ensuring the participation of young people is essential to create and shape effective programs and strategies.

Some young people in this region warrant special attention as part of groups already at risk, particularly injecting drug users, sex workers (including victims of trafficking), men who have sex with men, mobile populations, ethnic minority groups such as the Roma, young people in institutions, and people living with HIV/AIDS. A balance has to be found in our efforts to reduce infection and stigma in these more vulnerable groups and in reducing the risk situations in which young people find themselves.

Partnerships with nongovernmental organizations are fundamental to an effective response to HIV/AIDS. They are increasingly involved in HIV/AIDS prevention, service provision, advocacy, and care. Support to NGOs to build capacity to deliver sustainable programs and to be stronger advocates is essential for the establishment of effective alliances with governments and other actors.

Political commitment to date has varied from country to country. Governments must act now to implement multisectoral prevention strategies. Modest investment of resources now is necessary to prevent HIV/AIDS from becoming a high social and economic cost in the future. Opportunities for alliances must be identified and encouraged. Support to multisectoral national AIDS committees (NACs) needs to be established and strengthened.

The work in SEE aims to support and help coordinate country efforts and to develop and share regional expertise in response to HIV/AIDS. This covers nine countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Federal Republic of Yugoslavia (including the UN Administered Province of Kosovo), Former Yugoslav Republic of Macedonia, Moldova, Romania, and Slovenia.
Through the UN Theme Group mechanism, UN agencies, governments, and other actors in each country have already demonstrated that they are prepared to work together to coordinate and support the development and implementation of country responses.

The Global Declaration of Commitment on HIV/AIDS, signed in June 2001 by all member states, outlines a number of commitments to be fulfilled over the next 3 to 5 years. The present conference aims to strengthen support for governments to enable them to fulfill these commitments. If work is based on well-planned research and interventions with the participation of young people and people living with HIV/AIDS, there is a window of opportunity to have a significant impact on the epidemic.

The development and strengthening of partnerships is an important step in establishing country and regional approaches. Efforts to mobilize a stronger response have been taking place in all countries. These include the establishment or strengthening of national AIDS commissions; support to the strategic planning process in all countries; and support for surveys, assessments, interventions, and services. It is therefore a timely moment to mobilize technical and financial resources to help governments, local authorities, and NGOs to more rapidly develop and strengthen the coverage and effectiveness of country responses.

The goal of a coordinated and expanded response in Southeastern Europe is to prevent the spread of HIV/AIDS. The purpose of the conference is to support countries in the development and implementation of accelerated, expanded, enhanced, and coordinated responses that can have a real impact on the epidemic. The core of the expanded response will focus on prevention strategies and targeted interventions among the most vulnerable groups.

Participants

The Southeastern Europe Conference on HIV/AIDS will bring together government representatives; NGOs; UNAIDS and its cosponsors; other UN agencies; and bilateral, multilateral, and other donor organizations. Participation of people who are active in work on HIV/AIDS is essential for the development of relevant strategies and policy, including young people and people living with HIV/AIDS.

The objectives of the Southeastern Europe Conference on HIV/AIDS are these:

- To mobilize political support and commitment to develop and implement multisectoral strategies.
- To establish understanding and consensus among governments and NGOs and key partners to implement activities and best practices to respond to HIV/AIDS in SEE.
- To identify the needs for technical support and coordination at country and regional levels to address these priorities.
- To identify opportunities for alliances between the countries of SEE and support these.
- To mobilize the financial resources to support the further development and implementation of expanded country responses and the establishment or strengthening of regional support mechanisms.
- To adopt an SEE Declaration of Commitment on HIV/AIDS based on the Global Declaration of Commitment to HIV/AIDS.
ANNEX 3

CONFERENCE AGENDA
Southeastern Europe Conference on HIV/AIDS
Implementing the Global Declaration of Commitment on HIV/AIDS
Bucharest, Romania
June 6–8, 2002

Wednesday, June 5

16:00–18:00 Arrival and Registration

Thursday, June 6

08:00–09:00 Registration

09:00–10:15 Official Opening
   Chair: Soknan Han Jung, UNDP Resident Representative, UN Resident Coordinator, Romania
   • Welcome Speech. Dr. Daniela Bartos, Minister of Health and Family, Romania
   • Keynote Address. Presenter: Kathleen Cravero, Deputy Executive Director, UNAIDS, Geneva
   • Presentation: The Reality of Living with HIV/AIDS in SEE. Darko Cehic, HIV-AID (NGO), Federal Republic of Yugoslavia
   • Presentation: Building Bridges. Denny Robertson Director, USAID, Romania Mission
   • Objectives and Challenges. Karin Hulshof, Chair of UN Theme Group in Moldova and Romania and UNICEF Area Representative, Moldova and Romania
   • Presentation of the Draft Southeastern Europe Declaration of Commitment on HIV/AIDS Prevention

10:15–10:45 HIV/AIDS in South Eastern Europe: A Regional Overview
   • Q&A Discussion

10:45–11:30 Coffee Break (with press interviews)

11:30–13:00 PLENARY I: Country Presentations of Situation and Responses
   Co-Chairs: Head of delegation, or designate from UN Administered Province of Kosovo; and Cornelis Klein, UNDP Resident Representative, UN Resident Coordinator, and UNTG Chair, Croatia
   • Albania
   • Bosnia and Herzegovina
   • Bulgaria
   • Federal Republic of Yugoslavia
   • Q&A Discussion

13:00–14:30 Lunch
   Satellite Meeting: Presentation and discussion with representatives from Serbia and Moldova on their submissions to the Global Fund for HIV/AIDS, Tuberculosis, and Malaria

14:30–16:00 PLENARY I (continued)
   Co-Chairs: Head of delegation, or designate, from Albania and Christina Popivanova, UNDP Programme Officer and UNTG, Bulgaria
   • Croatia
• The UN Administered Province of Kosovo
• Former Yugoslav Republic of Macedonia
• Moldova
• Romania
• Q&A Discussion

16:00–16:15 Coffee Break

16:15–17:30 PLENARY II: Discussion of Country Presentations: Country and Subregional Priorities
Co-Chairs: Head of delegation or designate from Bulgaria; and Helena Eversole, UNICEF Assistant Representative and Chair of the Bosnia and Herzegovina UNTG
Discussant: Henning Mikkelsen, Senior Advisor Europe, UNAIDS, Geneva
• Presentation of summary of country and regional priorities. Dr. Hans de Knocke, Technical Consultant, USAID
• Reflections on country presentations. Henning Mikkelsen, UNAIDS Geneva
• Discussion with Panel of Country Situation Presenters

Friday, June 7

9:00–11:00 PLENARY III: Interventions and Activities in SEE
Co-Chairs: Head of delegation or designate, Croatia; and Jean-Michel Delmotte, UNICEF Assistant Representative and Chair of the Federal Republic of Yugoslavia UNTG

1. National Strategic Planning
• The Romania and Moldova Experience. Presenters: Dr. Stefan Gheorghita, Director, National AIDS Center Moldova; and Eduard Petrescu, UNAIDS Romania
• Surveillance in Albania. Presenter: Dr. Zhaneta Shatri, USAID, Albania
• Rapid Assessment and Response on Substance Abuse. Presenter: Dr. Xhevat Jakupi, AIDS Coordinator, UN Administered Province of Kosovo

2. Working on HIV Prevention
• Information and Communication Aimed at Reducing Risk Behavior. Presenters: Dimitra Dafalia, UNICEF Regional Coordinator of the Right to Know Project; and Atanas Kijrakovski, HERA NGO, FYR Macedonia
• Peer Education with Young People. Presenters: Predrag Stojicic, Youth of JAZAS, Federal Republic of Yugoslavia; and Elis Hrkalodvic, Youth Action Against AIDS, Bosnia and Herzegovina
• Condom Programming for HIV Prevention. Presenters: Kim Vazira, Population Services International; and Emir Nurkic, Forum for Solidarity, Bosnia and Herzegovina
• Youth Friendly Service—Strengthening Community Based Responses. Presenter: Vedran Mardesic, Drug Prevention Department, City Council, Split, Croatia

11:00–11:30 Coffee Break

11:30–13:00 PLENARY III (continued): Interventions and Activities in SEE
Chair: Head of delegation or designate, Federal Republic of Yugoslavia; and Debora Comini, UNICEF Assistant Representative and Chair of the FYR Macedonia UNTG
3. Working with Especially Vulnerable Young People

- Rapid Assessment and Response and Especially Vulnerable Young People in SEE. Presenters: Prof. Viktorija Cucic, Director, Institute of Social Medicine and Belgrade and Rapid Assessment and Response Coordinator, FRY; and Jadranka Mimica, UNTG and Rapid Assessment and Response Coordinator, Zagreb Croatia
- Injecting Drug Use and Harm Reduction. Presenter: Monica Ciupagea, Regional Program Officer, Open Society Institute; and Nora Stojanovik, HOPS, FYR Macedonia
- STI and HIV/AIDS Prevention Amongst Sex Workers in Bucharest and Roma Injecting Drug Users in Bulgaria. Presenter: Alina Mirela Bocai, UNDP, Romania; and Anna Pehlivanova, Initiative for Health Foundation, Bulgaria
- Care, Support, and Treatment
- Voluntary Counseling, and Testing. Presenter: Dr. Maria Georgescu, ARAS, Romania
- Treatment, Care and Support for People Living With HIV/AIDS. Presenter: Silvia Asandi, Director, Romanian Angel Appeal, Romania
- Q & A Discussion

13:00–14:00 Lunch

14:00–14:30 PLENARY IV: A Coordinated Subregional Response

Co-Chairs: Head of delegation or designate, Bosnia and Herzegovina; and Dr. Kathy J. Shroff, Head of UNFPA Office Albania
- Introduction to the Working Groups

14:30–16:45 Working Groups

1. Surveillance of HIV/AIDS and STIs
Facilitators: Dr. Srdan Matic, WHO; Dr. Arjan Harxhi, Albania
Rapporteur: Dr. Sanja Mandic, Bosnia and Herzegovina.

2. Interventions with Especially Vulnerable Groups
Facilitators: Dr. Anna Pehlivanova, Initiative for Health Foundation, Bulgaria; Dr. Jean Paul Grunde, UNAIDS, Vienna
Rapporteur: Jadranka Mimica, UNTG Croatia

3. Prevention Strategies and Activities
Facilitators: Leo Kenny UNICEF; Dr. Vesna Stefanovska, FYR Macedonia
Rapporteur: Dr. Maria Georgescu, ARAS, Romania

4. Access to Services (including Mother-to-Child Transmission)
Facilitators: Dr. Katy J. Shroff, UNFPA; Dr. Natasa Loncarevic YAAA, Bosnia and Herzegovina
Rapporteur: Osnat Lubrani, UNIFEM

5. Care, Support, and Treatment (Including Access to Drugs)
Facilitators: Dr. Andrew Ball, WHO Geneva; Dr. Josip Begovac, Croatia
Rapporteur: Jim Chauvin, Canadian Public Health Association
6. National Strategic Planning
Facilitators: Eduard Petrescu, UNAIDS, Romania; Dr. Ivana Misic, Federal Republic of Yugoslavia
Rapporteur: Dr. Ranko Petrovic, UNTG, Federal Republic of Yugoslavia

17:00–18:30 PLENARY V: Presentation and Feedback from Working Groups
Co-Chairs: Head of delegation or designate, FYR Macedonia; and Giovanna Barberis, Assistant Representative UNICEF and Chair of the Moldova UNTG
Discussants: Henning Mikkelsen, UNAIDS Geneva; and Jim Chauvin, Canadian Public Health Association, Ottawa

20:00 Evening Reception for Conference Participants, World Trade Center

Day 3, Saturday, June 8

09:00–11:00 PLENARY VI: Summary and Future Action
Co-Chairs: Dr. Stefan Gheorghita, Director, National AIDS Center, Moldova; and Karin Hulshof, Area Representative UNICEF, Romania and Moldova
• Summary of Feedback from Working Groups. Jim Chauvin, Canadian Public Health Association, Ottawa
• Statement from Ministers Meeting
• Feedback from NGOs
• Reflections from donors
• Wrap up and future action

11:00–11:30 Coffee Break

11:30–12:30 Discussion and Adoption of the SEE Declaration of Commitment on HIV/AIDS Prevention
Leo Kenny, Regional Adviser UNICEF, Geneva

12:30–13:00 CLOSING REMARKS
Soknan Han Jung, UNDP Resident Representative, UN Resident Coordinator, Romania
Henning Mikkelsen, UNAIDS Geneva
Prof. Radu Deac, Deputy Minister of Health and Family, Government of Romania
ANNEX 4

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ANNEX 5

WORKING GROUP MATRIX
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ANNEX 6

SOUTHEASTERN EUROPE DECLARATION
ON HIV/AIDS PREVENTION AND CARE
At the end of last year, an estimated 40 million people were living with HIV/AIDS worldwide. At a global level, political leadership and commitment to address this challenge has gained momentum. This was demonstrated by the UN General Assembly Special Session on HIV/AIDS, 25–27 June 2001, which produced the Declaration of Commitment on HIV/AIDS, to intensify and coordinate efforts to combat HIV/AIDS in a comprehensive manner.

In 2001, Eastern Europe witnessed the fastest global growth of the HIV epidemic, with some countries in the region reaching a prevalence rate of over 1%. This exceptionally rapid increase has been caused by a dramatic rise in risk behavior, predominantly injecting drug use (IDU), which is related to the social and economic shifts that many countries in the region are experiencing. While the prevalence of IDU and HIV/AIDS in Southeastern Europe is low compared with CIS countries, many of the conditions and rates of prevalence in Southeastern Europe today mirror the situation in Central and Eastern Europe seven years ago.

We the participants of this meeting call for urgent action to address this situation while a window of opportunity exists to prevent a wider-scale epidemic.

Although much more information is needed to understand the dynamics of the spread of HIV in order to be able to respond more effectively, young people are often clearly the most at risk, and they should be at the regional of our response to HIV. Risky and unsafe sexual behavior and injecting drug use are often the means by which HIV enters the wider population, therefore strategies, programs, and activities should address those factors that make individuals vulnerable. These should address the gender dimension, specify action taken to address vulnerability, and set targets for achievement.

At the “Southeastern Europe Conference on HIV/AIDS” held in Bucharest, Romania, 6–8 June 2002, representatives of the governments of Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Federal Republic of Yugoslavia, the UN Administered Province of Kosovo, Former Yugoslav Republic of Macedonia, Moldova, and Romania; as well as national and international NGO and bilateral partners and UNAIDS cosponsors, declared the following commitments to scale up national responses to HIV/AIDS:

We reaffirm our endorsement of the Declaration of Commitment on HIV/AIDS of the United Nations General Assembly Special Session on HIV/AIDS, and agree to implement the goals and time-bound targets that it expressed.

We accordingly declare our commitment to scale up national responses to HIV/AIDS to prevent a widespread HIV epidemic in Southeastern Europe; and to address the psychosocial and economic ramifications.

We agree to the following priorities for action:

**Leadership**

Strong leadership at all levels of society is essential for an effective response to the epidemic. Leadership by governments in combating HIV/AIDS is essential and their efforts will be comple-
mented by the full and active participation of civil society, including people living with HIV/AIDS, young people, and the private sector.

We recognize that effective leadership by governments, NGOs, civil society, and the private sector is needed to build a coherent response to the epidemic. We will strive for strong political and social commitment at all levels to address the priorities of action through the implementation of national strategic plans on HIV/AIDS. We will ensure the development, costing, and implementation of multisector national strategies and financing plans for combating HIV/AIDS.

We will take action to increase and prioritize national budgetary allocations for HIV/AIDS and to ensure that existing resources and structures contribute optimally, and that all ministries and other relevant stakeholders make appropriate allocations. We will take steps to integrate HIV/AIDS prevention, care, treatment, support, and impact mitigation priorities into the mainstream of development planning, including poverty eradication strategies, gender equality goals, national budget allocations, sector development plans, and legislative reviews.

We will ensure effective and operational coordination and collaboration mechanisms to enable the involvement of all sectors of society, both public and private. In this regard, we actively encourage and support the participation and collaboration between and among governments, nongovernmental organizations, young people, ethnic minorities, and other marginalized groups and people living with HIV/AIDS.

Prevention

Prevention will be the mainstay of our response

By 2003 we will establish national prevention targets as a part of the national planning process. We recognize the urgency to expand HIV prevention among young people and especially vulnerable groups including injecting drug users, sex workers, and men who have sex with men and other marginalized groups, in order to prevent the transmission of HIV. We will ensure effective prevention programs based on epidemiological and behavioral data, which reach a majority of these people, complemented by life skills and peer education programs for the wider youth population, to prevent the further spread of HIV/AIDS, STIs, and substance abuse. Such programs will address the specific needs of men and women and boys and girls and include expanded access to information, male and female condoms, life skills education, voluntary counseling and testing, drug treatment (particularly substitution therapy and withdrawal programs), access to clean needles, behavioral change interventions, and services based on youth-friendly approaches. They must also include services for pregnant women to prevent mother-to-child transmission.

We will actively support the expansion of such programs and, where appropriate, strengthen cross-border collaboration, exchange of best practices, and technical capacity in the region.

We recognize the urgent need to respond to the increase of STIs both as risk factors in relation to HIV, as well as major public health problems in their own right. Early diagnosis and treatment of STIs is cost-effective, and greatly reduces vulnerability to HIV infection. We will take action to strengthen primary prevention and effective case management, with special attention to young people and highly vulnerable groups such as injecting drug users, sex workers, men who have sex with men, and trafficked women.
Care, Support, and Treatment

Care, support and treatment are fundamental elements of an effective response

We support strategies to strengthen healthcare systems and address factors affecting the provision of HIV related drugs, particularly accelerating access to antiretrovirals. We support efforts to provide progressively and in a sustainable manner, the highest attainable standard of treatment for HIV/AIDS.

We will further support and develop a comprehensive care strategy to strengthen community and family based care, both by the informal sector and healthcare systems, to provide and monitor care, support, and treatment for people living with HIV/AIDS and families affected by HIV/AIDS.

We will ensure the availability and accessibility of comprehensive medical and psychosocial services based on the principles of strict confidentiality and equity.

HIV/AIDS and Human Rights

Realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS

Respect for the rights of people living with HIV/AIDS drives an effective response

All our HIV/AIDS efforts will be based on an approach that promotes and protects the fundamental rights and freedom of all individuals and groups. No individual or group should suffer discrimination or stigmatization in relation to HIV/AIDS. We will take action to enact, strengthen, and enforce legislation and measures to eliminate all forms of discrimination. We will promote and ensure respect for the rights and obligations of all individuals with extreme vigilance concerning injecting drug users, people living with HIV/AIDS, young people, sex workers, victims of trafficking, men who have sex with men, ethnic minorities, and members of other marginalized and vulnerable groups. We will address any existing legal barriers to effective HIV/AIDS prevention.

Reducing Vulnerability

The vulnerable will be given priority in the response

Empowering women and girls is essential for reducing vulnerability

We will support the development and expansion of health promotion and life skills-based programs, particularly focusing on the most vulnerable.

We will support the inclusion of health and life skills education, including HIV-related issues, in the national curricula for adolescents. We will support the training of service providers to ensure the provision of good quality, youth-friendly information and sexual education as well as counseling services, based on the principles of strict confidentiality. We further support efforts to expand and strengthen youth-friendly sexual and reproductive health programs for adolescent boys and girls. We support better access to peer education and outreach programs to promote healthy lifestyles, particularly for sexual health, gender relationships, and prevention of drug abuse.
Research and Development

*With no cure for HIV/AIDS yet found, further research and development are crucial*

We support increased research and data collection on epidemiology and behavior, because knowledge and comprehension of the actual HIV-related situation are preconditions for the development of effective strategic plans, with disaggregating where appropriate (e.g., for gender, ethnicity, and age). These data will help to shape more effective national and regional responses.

**HIV/AIDS in Conflict- and Disaster-Affected Areas**

*Conflicts and disasters contribute to the spread of HIV/AIDS*

Noting that violence and abuse of women and children has been a result of conflict in the region, we will support the incorporation of HIV/AIDS awareness and prevention, care, and treatment elements into programs among conflict-affected populations, including uniformed services, and call on partners to incorporate as a matter of urgency HIV/AIDS awareness, prevention, and gender training for their staff.

**National and Subregional Partnerships and Allegiances**

We support collaboration and networking among the Southeastern European countries, and we recognize that subregional activities can make a major contribution to halting the spread of HIV and AIDS. We recognize that each country has expertise and technical capacity in specific areas that can benefit others through exchange of information, lessons learned, and best practices.

We will therefore encourage collaboration between government and nongovernmental partners throughout the subregion, and support cross-border initiatives on areas that can best be addressed through joint efforts.

We support placing HIV/AIDS and health-related public concerns as appropriate on the agenda of regional meetings at all levels.

We urge international organizations and agencies to play an active role in supporting country efforts through increased international assistance and to participate in the implementation of the national strategic plans on HIV/AIDS and call for increased coordination of efforts between partners.

Bucharest, June 2002