UNGASS COUNTRY PROGRESS REPORT

The Netherlands
and the Netherlands Antilles

Reporting period: January 2008–December 2009

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Abbreviations

(Ministry of) VWS .... (Ministry of) Health, Welfare and Sport
ACS ....‘Aanvullende Curatieve Soa-bestrijding’
AIDS ....Acquired immunodeficiency syndrome
ASH ....‘Aanvullende Seksualiteitshulpverlening’
cART .... Combination antiretroviral treatment
CIb .... Centre for Infectious Disease Control
CVZ ....‘College voor Zorgverzekeringen’
ECDC ....European Centre for Disease Prevention and Control
GDP ....Gross domestic product
GGD... Municipal health service
GP ....General practitioner
HIV ....Human immunodeficiency virus
IDU ....Intravenous drug use
IGZ ....The Netherlands Health Care Inspectorate
MSM .... Men who have sex with men
NCPI ....National Composite Policy Index
NGO..Non-governmental organisation
PLWHA .... People living with HIV/AIDS
RIVM... National Institute for Public Health and the Environment
SHM ....‘Stichting HIV Monitoring’
SRHR .... Sexual and reproductive health and rights
STI .... Sexually transmitted infection
UNAIDS ....The Joint United Nations Programme on HIV/AIDS
UNFPA..United Nations Population Fund
WBMV ....‘Wet op Bijzondere Medische Verrichtingen’
WHO .... World Health Organization

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II. Status at a glance

Writing process

This Country Progress Report is based on previous reports in connection with the 2001 'Declaration of Commitment on HIV/AIDS' as well as the 2004 'Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia'. The report is compiled by the Ministry of Health Welfare and Sport (VWS) and the Centre for Infectious Disease Control (CIb) of the National Institute for Public Health and the Environment (RIVM) with contributions from other ministries and stakeholders. The preparation of the report has been subject of discussion during a meeting of the Dutch 'STI and sexual health platform' where civil society stakeholders are represented. STI AIDS Netherlands, a non-governmental organisation (NGO) and an expertise STI centre for HIV and other STI, has consolidated the input from other NGOs. In particular, this involved completing part B of the National Composite Policy Index (NCPI) questionnaire and commenting on a final draft version of this Country Progress Report.

Status of the epidemic

The HIV epidemic in The Netherlands is evolving slowly and its characteristics have not changed substantially during the reporting period 2008-2009.

The Netherlands has a concentrated HIV epidemic, i.e. a low prevalence of HIV infection in the general population but a higher prevalence in specific sub-populations[1]. Primary high-risk sub-populations are men who have sex with men (MSM) and migrants from high-prevalence countries. The epidemic in the Netherlands is primarily fuelled by transmission among MSM.

The number of HIV-infected individuals (15-70 years) living in the Netherlands on 1 January 2008 has been estimated to be 21,500 (19,000-24,000)[2]. This represents an increase of about 10% in comparison with the previous estimate in 15-49-year-olds from 2005. The estimated HIV infection prevalence remained at 0.2% in the adult population. Of the HIV infections in January 2008, 55% were estimated to be attributed to MSM transmission, 40% to heterosexual contacts and 4% to intravenous drug use (IDU).

In June 2009, 16,129 patients at HIV treatment centres in the Netherlands were registered by the Stichting HIV Monitoring (SHM)[3]. The total number includes 1,169 (8%) new patients in the Netherlands during the previous year. Of 12,405 (79%) patients in follow-up in the Netherlands as of June 2009, 12,258 (99%) were adults (≥18 years) and 147 (1%) were children and adolescents. Of the 12,258 adult patients, 79% were male and 21% were female. The median age was 44 years (interquartile range 38-51 years). The HIV patient population is ageing and currently 3,469 (28%) of the patients are 50 years or older.

Of adult patients in follow-up in the Netherlands as of June 2009, the largest group was MSM (57%). Heterosexuals accounted for 32% of patients (17% of men and 89% of women). Heterosexuals included a considerable proportion of individuals originating from other countries than the Netherlands (61% of heterosexual men and 76% of heterosexual women). The most common areas of origin were sub Saharan Africa (34% of heterosexual

[1] UNAIDS and WHO. 2000. Guidelines for second generation HIV surveillance. Available from: http://www.who.int/hiv/pub/surveillance/en/cds_edc_2000_5.pdf
[2] RIVM/CIb. 2009. National estimate of HIV prevalence in the Netherlands: comparison and applicability of different estimation tools
[3] SHM. 2009. Monitoring of Human Immunodeficiency Virus (HIV) infection in the Netherlands. Available from: http://www.hiv-monitoring.nl/_site1134/images/091250-HIVM-2009-KL.pdf

men and 49% of heterosexual women), Latin America (10% of heterosexual men and 9% of heterosexual women). IDU constituted 3% of patients (3% of men and 4% of women).

Until 2008, 7,777 AIDS cases and 4,794 deaths among HIV patients have been registered in the Netherlands. The AIDS incidence and mortality among HIV-infected individuals appear to exhibit a slight decline in recent years[4, 5].

The status of the epidemic is detailed under the prescribed headings of section 'III. Overview of the AIDS epidemic'.

Policy and programmatic response

During the reporting period 2008-2009, the overall HIV/AIDS-related policy and programmatic frameworks in the Netherlands have remained largely unaltered, notwithstanding a number of important developments.

HIV/AIDS policy is primarily a responsibility of the Ministry of VWS. It should be recognised, however, that policy development in the realms of HIV/AIDS depends on the collaboration of a range of (sub-)national (non-)governmental stakeholders. Similarly, the implementation of HIV/AIDS policy-related activities relies on collaboration among a multitude of stakeholders.

The Dutch government seeks to place HIV/AIDS policy in a larger framework of sexual health. In 2009 a sexual health policy document was developed in consultation with several stakeholders[6]. The policy document briefly outlines national STI/HIV policy and refers to a consultation process during 2010 to inform the development of a national STI/HIV plan.

At present, part of the current STI/HIV policy is described in the STI/HIV prevention plan from 2004[7]. This document outlines central principles of Dutch HIV/AIDS policy, such as the importance of prevention, the importance of linkage between prevention and care as well as efforts to ensure low-threshold access to testing and treatment.

The STI/HIV prevention plan further underlines the crucial contributions of different (non-)governmental stakeholders in the area of STI/HIV. The responsibilities and relations of these organisations are described in order to reduce overlap and gaps. The division of responsibilities are mainly organized by risk groups and serves to promote tailor-made approaches based on appropriate expertise. The groups identified in the STI/HIV prevention plan are:

- MSM
- Migrants (primarily those from HIV-endemic countries)
- Young people
- Sex workers and their clients
- Drug users
- HIV-infected persons

The policy and programmatic responses are detailed under the prescribed headings of section 'IV. National response to the AIDS epidemic'.

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[4] RIVM/CIb. 2009. Sexually transmitted infections, including HIV, in the Netherlands in 2008. Available from: http://www.rivm.nl/cib/binaries/090292_SOAHIVjaarrapport_2009_tcm92-60978.pdf
[5] SHM. 2009. Monitoring of Human Immunodeficiency Virus (HIV) infection in the Netherlands. Available from: http://www.hiv-monitoring.nl/_site1134/images/091250-HIVM-2009-KL.pdf
[6] VWS. 2009. Seksuele gezondheid. Available from: http://www.minvws.nl/includes/dl/openbestand.asp?File=/images/seksuele-gezondheid-_tcm19-190298.pdf
[7] VWS. 2004. Preventieplan soa en hiv in Nederland. Available from: http://www.minvws.nl/images/PG-2537024_tcm19-98419.pdf

UNGASS indicator data

For historical reasons and considering local contexts, such as existing set-up of surveillance and monitoring activities, data and/or information are not consistently available to allow for a complete representation of UNGASS indicators as per specific formats of the UNGASS reporting guidelines. However, relevant data and/or information in this regard are presented in this report.

III. Overview of the AIDS epidemic

The Netherlands has a concentrated HIV epidemic, i.e. a low prevalence of HIV infection in the general population but a higher prevalence in specific sub-populations[8]. Primary high-risk sub-populations are MSM and migrants from high-prevalence countries. The epidemic in the Netherlands is primarily fuelled by transmission among MSM.

Estimation of the HIV epidemic[9]

The number of HIV-infected individuals (15-70 years) living in the Netherlands on 1 January 2008 has been estimated to be 21,500 (19,000-24,000) (Figure 1). This represents an increase of about 10% in comparison with the previous estimate in 15-49-year-olds from 2005. The estimated HIV infection prevalence remained at 0.2% in the adult population.

Of the HIV infections in January 2008, 55% were estimated to be attributed to MSM transmission, 40% to heterosexual contacts and 4% to IDU. Estimation of the HIV prevalence in risk groups in the Netherlands in 2008 yielded the following preliminary results: MSM 5.1%, IDU 7.1%, migrants from sub Saharan Africa 3.1%, migrants from the Caribbean 0.4%, female sex workers 1.8%, and for the remaining population 0.02%.

About 60% (53-67%) of people infected with HIV was estimated to have been diagnosed. The estimated proportion of diagnosed infections exhibited geographical variations, 85% in Amsterdam, 54% in Rotterdam and 53% in the rest of the country. The estimated proportion of diagnosed infections also differed by risk group. Of HIV-infected MSM, 65% were estimated to have been diagnosed. Of infected sex workers, 34% were estimated to have been diagnosed. In the IDU population, the estimated proportion of diagnosed individuals varied between 57% in Rotterdam to 91% in Amsterdam. With regard to migrant populations, 50% of infected migrants from sub-Saharan Africa and 55% of infected migrants from the Caribbean were estimated to have been diagnosed. In general, women were more likely to have been diagnosed than men, probably due to antenatal screening and differences in health care seeking behaviour.

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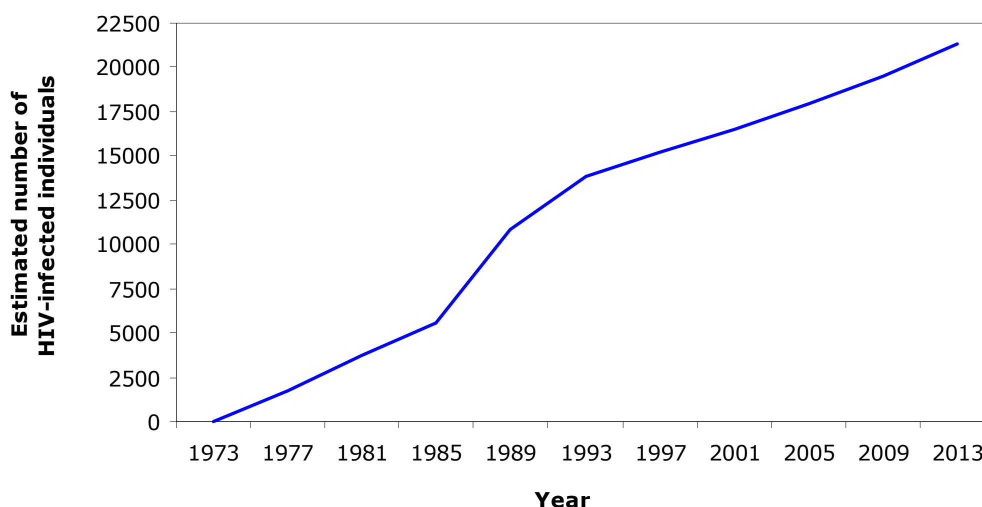
[8] UNAIDS and WHO. 2000. Guidelines for second generation HIV surveillance. Available from: http://www.who.int/hiv/pub/surveillance/en/cds_edc_2000_5.pdf
[9] RIVM/CIb. 2009. National estimate of HIV prevalence in the Netherlands: comparison and applicability of different estimation tools.

Figure 1. Estimated number of people living with HIV-infection, The Netherlands, 1973-2013 (Source: RIVM/CIb)



Registration of Stichting HIV Monitoring (SHM)[10]

HIV infection is not notifiable by law in the Netherlands. However, data about HIV infected individuals are collected by SHM as part of routine health care for HIV patients. Treatment data for all HIV patients receiving care at 25 HIV treatment centres are collected.

In June 2009, 16,129 patients at HIV treatment centres in the Netherlands were registered by SHM. The total number includes 1,169 (8%) new patients in the Netherlands during the previous year. Of 12,405 (79%) patients in follow-up in the Netherlands as of June 2009, 12,258 (99%) were adults (≥18 years) and 147 (1%) were children and adolescents. Of the 12,258 adult patients, 79% were male and 21% were female. The median age was 44 years (interquartile range 38-51 years). The HIV patient population is ageing and currently 3,469 (28%) of the patients are 50 years or older.

Table 1 describes basic characteristics of adult HIV-infected patients in follow-up in the Netherlands as of June 2009. The largest group was MSM (57%). Heterosexuals accounted for 32% of patients (17% of men and 89% of women). Heterosexuals included a considerable proportion of individuals originating from other countries than the Netherlands (61% of heterosexual men and 76% of heterosexual women). The most common areas of origin were sub Saharan Africa (34% of heterosexual men and 49% of heterosexual women), Latin America (10% of heterosexual men and 9% of heterosexual women). IDU constituted 3% of patients (3% of men and 4% of women).

In 2008, 68% (710 of 1041) of diagnosed cases were MSM. Of all registered HIV-infected MSM, 73% (6,235 of 8,553) were of Dutch origin. Since 1996 there has been increase in the proportion of MSM with a recent infection (8% in 1996 and 35% in 2008). Recent infection is defined as having had a negative HIV test in the 18 months preceding diagnosis.

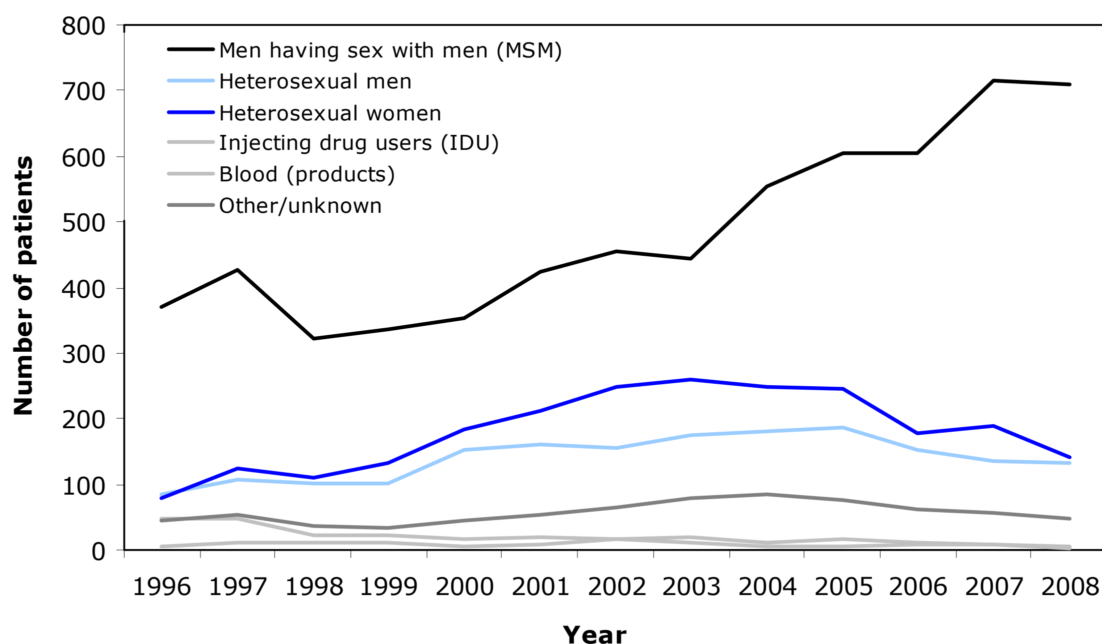
[10] SHM. 2009. Monitoring of Human Immunodeficiency Virus (HIV) infection in the Netherlands. Available from: http://www.hiv-monitoring.nl/_site1134/images/091250-HIVM-2009-KL.pdf

Table 1. Characteristics of the adult HIV-infected patients in follow-up, the Netherlands, June 2009 (Source: SHM)

Category	Men		Women		Total	
	n	%	n	%	n	%
All	9,709	79	2,549	21	12,258	100
Transmission						
MSM*	6,953	72			6,953	57
Heterosexual	1,610	17	2,262	89	3,872	32
IDU*	242	3	93	4	335	3
Blood (products)	102	1	67	3	169	1
Vertical	9	0.1	8	0.3	17	0.1
Other / unknown	793	8	119	5	912	7
Age category (years)						
18-24	167	2	131	5	298	2
25-34	1,242	13	669	26	1,911	16
35-44	3,288	34	1,005	39	4,293	35
45-54	3,224	33	534	21	3,758	31
55-64	1,408	15	152	6	1,560	13
65-	380	4	58	2	438	4
Region of origin						
The Netherlands	6,482	67	709	28	7,191	59
Sub-Saharan Africa	784	8	1,123	44	1,907	16
Western Europe	636	7	114	5	750	6
Latin America	675	7	224	9	899	7
Caribbean	324	3	137	5	461	4

* MSM, men who have sex with men; IDU, intravenous drug use

Figure 2. Number of HIV-1 diagnoses among adults by transmission risk group and year of diagnosis, the Netherlands, 1996-2008 (data for year 2009 are incomplete and not shown) (Source: SHM)



Until 2008, 7,777 AIDS cases and 4,794 deaths among HIV patients have been registered in the Netherlands. The AIDS incidence and mortality among HIV-infected individuals appear to exhibit a slight decline in recent years[11, 12].

Of the 12,258 adult patients in follow-up in June 2009, combination antiretroviral treatment (cART) was administered to 9,757 (80%) patients. Non-cART treatment was given to 24 (0.3%) patients and 2,459 (20%) patients were not (yet) treated. The four most frequently used regimens accounted for 43% of all regimens as compared to 36% in 2008: i) tenofovir, emtricitabine, efavirenz, ii) tenofovir, emtricitabine, nevirapine, iii) zidovudine, lamivudine, nevirapine, and iv) tenofovir, emtricitabine, ritonavir-boosted atazanavir. In the future the increasing age of the HIV patient population in the Netherlands is expected to result in more complicated and costly treatment due to co-morbidities associated with older age. The costs for antiretrovirals amount to about €103 million per year[13].

Of the 16,129 patients registered in a treatment centre in the Netherlands, 97% was infected with HIV-1. Furthermore, 0.5% was infected with HIV-2, 0.3% had seroreactivity to both HIV-1 and HIV-2 and corresponding data were not available for 2.2%. The proportion of HIV patients tested for co-infection with Hepatitis B (HBsAg/DNA) and Hepatitis C (serology/RNA) increased from 64% in 2006 to 95% in 2009. The prevalence of co-infection among HIV patients was 8% for Hepatitis B (primarily MSM and heterosexuals), 12% for Hepatitis C (primarily IDU) and 1% for Hepatitis B and C (primarily MSM and IDU).

Additional information is available in the reports of SHM that are published in English on an annual basis[14].

Surveillance based on data from STI centres[15]

An STI/HIV surveillance system is in place where eight coordinating municipal health services (GGD) report STI/HIV-related data and information to the RIVM/CIb. The system is based on 29 STI centres with nationwide coverage. The STI centres cater for high-risk groups and people who wish to remain anonymous. They provide low-threshold and free of charge STI/HIV testing and care (see section 'IV. National response to the AIDS epidemic').

In 2008, 393 individuals were newly diagnosed with HIV at the STI clinics in the Netherlands. Of these infections, 320 (81%) occurred in MSM, 43 (11%) in heterosexual men and 30 (8%) among women. The positivity rate among MSM was 3.0% (in 2007 2.8%), among heterosexual men 0.2% (in 2007 0.1%) and among women 0.1% (in 2007 0.1%). Among heterosexual STI clinic attendees the HIV positivity rate was highest among those from sub-Saharan African origin (men 2.0%, women 2.3%). Among MSM, HIV positivity rate was highest among MSM aged 35-39 years (4.8%).

Among newly diagnosed HIV-positive MSM, 24% was concurrently diagnosed with chlamydia and 19% with gonorrhoea. Of in total 2,194 STI clinic attendees (97% MSM), who were known to be HIV infected at entry in the clinic, 20% were diagnosed with chlamydia and 13% with gonorrhoea. These findings suggest the presence of considerable sexual risk behaviours in certain sub-populations of HIV-infected individuals.

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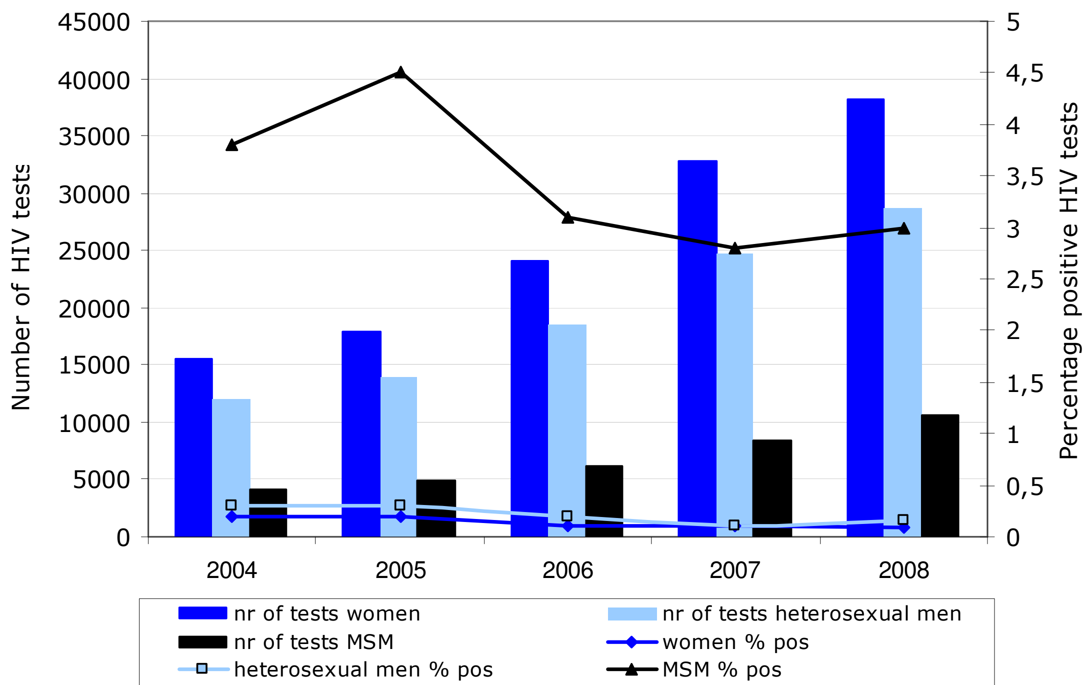
[11] RIVM/CIb. 2009. Sexually transmitted infections, including HIV, in the Netherlands in 2008. Available from: http://www.rivm.nl/cib/binaries/090292_SOAHIVjaarrapport_2009_tcm92-60978.pdf
[12] SHM. 2009. Monitoring of Human Immunodeficiency Virus (HIV) infection in the Netherlands. Available from: http://www.hiv-monitoring.nl/_site1134/images/091250-HIVM-2009-KL.pdf
[13] Source: Stichting Farmaceutische Kengetallen (SFK)
[14] SHM: http://www.hiv-monitoring.nl/
[15] RIVM/CIb. 2009. Sexually transmitted infections, including HIV, in the Netherlands in 2008. Available from: http://www.rivm.nl/cib/binaries/090292_SOAHIVjaarrapport_2009_tcm92-60978.pdf

The STI centre surveillance showed that the HIV test uptake had increased from 56% in 2004 to 90% in 2008 in STI clinic attendees who were not previously diagnosed with HIV. In 2009, the RIVM/CIb in collaboration with SHM and several STI centres initiated a study to document delay between primary diagnosis at an STI centre and reporting in care. The results are expected to provide more insight into HIV transmission dynamics and indicate potential interventions to reduce such delays.

Additional information is available STI/HIV publications of RIVM/CIb, including comprehensive reports published in English on an annual basis[16].

Figure 3. Total number and positivity rate of new HIV diagnoses by gender and sexual preference, STI centres, the Netherlands, 2004-2008 (Source: RIVM/CIb)



Screening programmes

Antenatal screening[17]

Routine screening for HIV infection is offered to all pregnant women since January 2004. About 185,000 women are tested annually and in 2006-2008 the participation rate was 99.8%. The HIV testing is conducted according to the 'opting out' approach and is combined with other antenatal screening activities. There have been no reports of children born with HIV in the Netherlands in 2006-2008.

[16] RIVM/CIb STI/HIV: http://www.rivm.nl/cib/themas/soa/
[17] RIVM/CIb. 2009. Effectiveness of antenatal screening for HIV, hepatitis B and syphilis in the Netherlands, 2006-2008.

In 2009 a study of the effectiveness of antenatal screening for HIV was conducted. This study estimated that 0.05% (0.04-0.07%) of pregnant women in the Netherlands are infected with HIV. Forty percent of the HIV infections among pregnant women in 2006-2008 were newly diagnosed. The prenatal screening is estimated to prevent 5-10 HIV infections per year among newborns.

Blood screening[18]

Sanquin Blood Supply Foundation screens blood donated by new and existing donors for HIV (and Hepatitis B and C, and syphilis). In 2008 three new donors (11 per 100,000) were found to be HIV infected. No HIV infections were detected among existing donors. These results may be biased by the exclusion of individuals with a higher risk for infection from the donor population. The costs associated with the HIV testing of blood products is about €6.8 per year[19].

Specific studies in high-risk populations

The Amsterdam cohort studies monitor HIV incidence in self-selected populations of MSM and drug users in Amsterdam[20]. In this sample of MSM the HIV incidence was to 2.1 per 100 person-years in 2008, compared to 2.6 and 1.7 in 2006 and 2007, respectively. In contrast, the HIV incidence among drug users in this sample has declined to zero in recent years. These cohorts are useful to monitor trends in these groups but generalization may not be possible.

In 2002-2006 surveys were conducted in population groups at high risk for HIV infection, i.e. different ethnic minorities, sex workers, clients of sex workers and IDU[21]. Similar systematic surveillance efforts have not been conducted during the present reporting period. Following an evaluation of the surveys in 2007[22], it was concluded that it would be more valuable and efficient to monitor trend in these high risk groups through routinely collected data from STI clinics, general practitioners (GP), methadone posts, etc.

In 2007/2008, in view of the high STI occurrence among HIV infected clients at STI centres, an STI prevalence study among HIV infected MSM was conducted. This revealed high occurrence of chlamydia or gonorrhoea (10.5%), syphilis (4.9%), infectious Hepatitis B (0.2%) and new Hepatitis C infections (0.5%). These results indicate frequent presence of risk behaviours and co-infections that could facilitate transmission of HIV. The results prompted the modification of guidelines to extend testing for syphilis and Hepatitis B and C in regular care. Discussion is ongoing regarding how to address the high chlamydia or gonorrhoea prevalence in this group of people.

[18] Sanquin. 2009. De gezichten van 2008: jaarverslag 2009. Available from: http://www.jaarverslagsanquin.nl/sanquin_jaarverslag_2008.pdf#page=19
[19] Source: Sanquin Blood Supply Foundation
[20] The Amsterdam Cohort Studies. 2009. The Amsterdam Cohort Studies on HIV infection and AIDS: a summary of the results 2001-2009. Available from: http://www.amsterdamcohortstudies.org/menu/reports/ACSSummary20012009.pdf
[21] UNGASS Country Progress Report, the Netherlands, 2008
[22] RIVM/CIb. 2009. Evaluatie RIVM hiv-surveys hoogrisicogroepen. Available from: http://www.rivm.nl/bibliotheek/rapporten/210261001.pdf

IV. National response to the AIDS epidemic

Human rights aspects such as universal access to comprehensive prevention programmes, treatment, care and support constitute a fundamental principle in the Netherlands. During the reporting period 2008-2009, the overall HIV/AIDS policy and programmatic frameworks have remained largely unaltered, notwithstanding a number of important developments. This reflects the notion that appropriate services are usually deemed to be in place. Nonetheless, continuous commitment, monitoring and development are needed to ensure adequate policy and programmatic frameworks.

Stakeholders of the national response

The Ministry of VWS[23] is primarily responsible for the development and implementation of HIV/AIDS policy and programmatic frameworks. However, related activities depend on the collaboration of a range of (sub-)national (non-)governmental stakeholders.

RIVM/CIb[24] is affiliated with the Ministry of VWS and advises, where indicated in consultation with relevant stakeholders, civil society organisations and professionals, the Ministry about STI/HIV policy. RIVM/CIb conducts STI/HIV surveillance, control and research and has a coordinating role among stakeholders. Further to the above, RIVM/CIb assesses work plans of other organisations in the area of STI/HIV prevention and grants subsidies within the framework of national policy.

NGOs that receive governmental subsidies for HIV/AIDS-related programmes include: STI AIDS Netherlands[25] (having programmes focusing on policy, professionals, general public, ethnic minorities, youth, as well as sex workers and their clients), Schorer[26] (focusing on lesbians, gay men, bisexuals and transgenders), Mainline[27] (focusing on drug users) and Rutgers Nisso Group[28] (focusing on sexual health). The government subsidises two organisations that concentrate on people living with HIV/AIDS (PLWHA): the HIV Vereniging Nederland[29] (focusing on information and support) and SHM[30] (focusing on surveillance and research based on HIV patients in medical care). The governmental subsidies to these NGOs amount to about €10 million per year. The national 'STI and sexual health platform' meetings four times per year provide, among other fora, a platform for information exchange and coordination among NGO and governmental stakeholders.

Municipal authorities are legally co-responsible for STI/HIV-related prevention and care. These municipal tasks are typically conducted by the GGD. In 2009, part I of a handbook was completed to support health professionals at (sub-)national level in STI/HIV prevention and care[31]. Part II of the handbook is concerned with sexuality and reproduction.

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[23] Ministry of VWS: http://www.minvws.nl/
[24] RIVM/CIb: http://www.rivm.nl/cib/
[25] STI AIDS Netherlands: http://www.soaaids.nl/
[26] Schorer: http://www.schorer.nl/
[27] Mainline: http://www.mainline.nl/
[28] Rutgers Nisso Groep: http://www.rng.nl/
[29] HIV Vereniging Nederland: http://www.hivnet.org/
[30] SHM: http://www.hiv-monitoring.nl/
[31] RIVM/CIb. 2009. Seksuele Gezondheidszorg: deel 1 handboek soa. Available from: http://www.rivm.nl/cib/binaries/Handboek%20Soa%20webversie_tcm92-65408.pdf

Prevention

Primary prevention

The frameworks for STI/HIV prevention activities in the Netherlands are described in the national STI/HIV prevention plan from 2004[32], as well as in the sexual health policy document from 2009[33]. The promotion of safe (sexual) practices by provision of information is an important component of primary HIV/AIDS prevention. In this regard schools play an important role in informing youth although comprehensive sexuality education is not obligatory. The GGD and youth health care services are other settings where information about safe practices is disseminated.

Information about safe sex and prevention of STI/HIV is also communicated by means of national information campaigns[34]. A main initiative is the national 'vrij veilig' campaign by STI AIDS Netherlands (€850,000 per year). Other communication activities target specific groups such as MSM[35], migrants[36], sex workers[37], IDU[38], and youth[39]. In general, NGOs play key roles in primary prevention of HIV by provision of information, especially among high risk groups. Information activities utilize internet, printed materials, peer-to-peer education, outreach activities, etc. In 2009, the Ministry of VWS will make additional investment of €1 million to strengthen sexual health among ethnic minorities in collaboration with NGOs and GGDs.

Among drug users, harm reduction has proven to be a successful and cost-effective approach to HIV/AIDS prevention. Harm reduction is one component of a larger context which also includes prevention and treatment of the drug use per se. Methadone treatment programmes are available for opiate addicts and the majority of them participate in such programmes. The percentage of injecting drug use is relatively low (about 9% of heroine users). In 2009, there were about 115 needle exchange programmes throughout the Netherlands. There are no national data on the number of needles and syringes distributed to IDU although some information is available at subnational levels. The Ministry of VWS also contributes, e.g. financially, to international harm reduction projects.

Low-threshold access to information, testing and care

Promotion of HIV testing is conceived of as a crucial aspect of HIV prevention in the Netherlands. Persons who know they are HIV-infected can receive care and support, which can prevent further transmission of the infection.

As mentioned above, a large proportion (about 40%) of HIV-infected individuals is estimated to be unaware of their infection. In 2002, an 'active testing policy' was put in place, including antenatal screening (introduced 2004) and integration of the active testing policy in the STI/HIV-protocol for GPs[40].

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[32] VWS. 2004. Preventieplan soa en hiv in Nederland. Available from: http://www.minvws.nl/images/PG-2537024_tcm19-98419.pdf
[33] VWS. 2009. Seksuele gezondheid. Available from: http://www.minvws.nl/includes/dl/openbestand.asp?File=/images/seksuele-gezondheid-_tcm19-190298.pdf
[34] http://www.soaaids-professionals.nl/soaaids_nl/publieksvoorlichting
[35] http://www.schorer.nl/
[36] http://www.soaaids-professionals.nl/soaaids_nl/etnisch
[37] http://www.soaaids-professionals.nl/soaaids_nl/prostitutie
[38] http://www.mainline.nl/
[39] http://www.soaaids-professionals.nl/soaaids_nl/jongeren
[40] UNGASS Country Progress Report, the Netherlands, 2008

Moreover, since 2006 and in addition to the regular system for health care delivery and health promotion, there is a specific regulation ('Aanvullende Curatieve Soa-bestrijding' (ACS)) to provide low-threshold and free of charge STI/HIV testing and care. These services target high-risk groups and people who wish to remain anonymous. The services are provided at 29 STI centres spread over the country. Eight GGDs have a coordinating responsibility in their regions. The RIVM/CIb coordinates the implementation of the regulation. Quality documents support the delivery of high quality services. The associated costs are reimbursed in proportion to the number of identified STIs, which should stimulate a focus on high-risk groups. The costs for the regulation amount to about €20 million per year.

In 2009, to further stimulate HIV testing, it was decided that HIV testing according to the 'opting out' approach would be included in the above-mentioned ACS regulation. This means that a HIV test is performed as a standard. The patients is informed about the practice and may choose not to undergo the HIV test. The intensified HIV testing policy applies as of January 2010 and €300,000 per year has been reserved for this purpose.

In 2008, the above-mentioned ACS regulation was supplemented with an additional regulation that caters for young people under the age of 25 years ('Aanvullende Seksualiteitshulpverlening' (ASH)). The ASH regulation offers low-threshold services that can support youth with questions and problems regarding sexuality. Consultation services are offered with the support of governmental funds of about €3.5 million per year. In addition, a related website[41] and a toolkit sexual health[42] have been developed.

Linkage between prevention and care

The prevention plan underlines the value of linking STI/HIV prevention and care. The setting of STI/HIV care presents an opportunity to reach people in high risk groups and to modify (risk) behaviours. By means of partner notification additional persons at risk for transmission may be given the opportunity to access testing and care. In the spirit of this notion, the 2009 policy document on sexual health underlines the need for further integration of the ACS and ASH regulations.

Care, treatment and support

The general principle in the Netherlands is that everyone in need should receive appropriate health care. HIV/AIDS is not an exception in this context. The Netherlands Health Care Inspectorate (IGZ) supervises the access to and quality of care in the Netherlands.

HIV treatment is available for all patients with an indication (and has been since ART became available). The provision of treatment is legally regulated to ensure its high quality ('Wet op Bijzondere Medische Verrichtingen' (WBMV)). This legislation gives responsibility for the actual care to specialists situated in 25 HIV treatment centres throughout the Netherlands. Two treatment centres are specialized in paediatric treatment. In addition to specialized clinicians there are also specialised HIV/AIDS nurses who serve as case-managers.

In principle everyone who receives health care is charged by the health care provider for the care received, regardless of one's nationality or legal status. However, the costs can be covered under a health insurance, an international social security regulation (like Regulation (EC) no. 1408/71) or a bilateral social security convention. In these latter cases the (E)111-procedure will apply. Under the Health Insurance Act ('Zorgverzekeringswet'), all residents of

[41] Sense website: http://www.sense.info/
[42] RIVM/CIb. Toolkit seksuele gezondheid: http://preventieziektezorg.rivmvoorlichtingscentrum.nl/toolkitseksuelegezondheid/

the Netherlands are obliged to have a health insurance. Further to the above, the legislation prohibits insurance companies to decline health insurance for persons (including HIV-infected individuals) who are legally entitled/obliged to be insured. There is a system for governmental financial support to insurance companies to compensate for costs associated with patients requiring costly care.

Asylum seekers and individuals without legal basis for residence

There are arrangements to provide HIV/AIDS prevention and care for (failed) asylum seekers in the Netherlands. The Dutch Government reimburses individuals with an ongoing request for asylum for costs associated with health insurance (currently €3,313 per asylum seeker per year) ('Regeling Verstrekkingen Asielzoekers' and Regeling Ziektekosten Asielzoekers'). The principle is that health care provided corresponds to standard care in the Netherlands. Asylum seekers accommodated in asylum centres receive, in collaboration with the GGD, information about STI/HIV prevention. In this regard a yearly plan is developed by the asylum centre and the GGD. Asylum seekers with an assigned asylum status must (as Dutch nationals) arrange their own insurance coverage.

The Netherlands does not regard HIV/AIDS alone as a reason for granting asylum, unless under exceptional circumstances pursuant to the European 'Convention for the Protection of Human Rights and Fundamental Freedoms'. Should a person in need of treatment have to leave the country, Dutch authorities will if necessary establish contact with counterparts in the country of destination in order to facilitate continuation of treatment. Under certain circumstances, failed asylum seekers may be granted to stay in the Netherlands based on medical grounds, including HIV/AIDS. Signalling of medical problems at an early stage in the asylum process can help to avoid a gap between a failed asylum request and a decision regarding a request based on medical grounds. A current review of asylum procedures is looking into this issue. Furthermore, since January 2010 asylum seekers with an ongoing request based on medical grounds are under certain circumstances entitled to accommodation and reimbursements for costs associated with health insurance. Should the request to stay in the Netherlands based on medical grounds be granted the asylum seeker must (as Dutch nationals) arrange their own health insurance.

Persons who are illegally present in the Netherlands have to pay their own health care expenses. They are not covered by the Health Insurance Act, nor can they apply for social assistance. Should these undocumented persons fail to pay for the cost of medical care, the health care provider can claim part of his costs from a national health insurance board ('College voor Zorgverzekeringen' (CVZ)). For this purpose the CVZ receives approximately €45 million per year out of the budget of the Ministry of VWS.

Notwithstanding the above-mentioned arrangements, unfamiliarity with the Dutch health care system may be a possible obstacle for asylum seekers and individuals without legal basis for residence. In asylum centres this is therefore given due consideration by provision of information, both routinely and in response to specific needs.

Supplementary services

As mentioned above, there are additional services that aim to provide low-threshold and free of charge access to STI/HIV testing and treatment for high-risk groups. These services are intended to complement, not replace, the regular health care services. The regulations for the additional STI/HIV health care services do not differentiate between individuals based on nationality or legal status. As mentioned above, promoting testing is considered important

for prevention purposes. Additionally, facilitating testing can lead to earlier HIV diagnoses and earlier treatment, thus benefitting the health of the infected individual as well.

Stigmatisation and discrimination

Stigmatisation and incidents of discrimination due to HIV infection is still a problem in Dutch society. This notion is supported by research from 2009 that suggests the presence of relatively widespread negative attitudes towards PLWHA and misconceptions about transmission of HIV[43].

The government has sustained its policy to increase knowledge about STI/HIV and thereby, among other things, seeks to reduce stigmatisation and discrimination due to HIV/AIDS. The sexual health policy document from 2009 underlines the contributions in this regard of several NGOs that operate with governmental subsidies.

Also, the Ministry of VWS maintains the position that HIV-infected individuals should not be prosecuted for unsafe sex unless coercion, deception or disparity in terms of power are involved. This is consistent with the notion that everyone carries a responsibility for his or hers own health.

Since August 2009, legislation ('Arbeidsomstandighedenwet') against discrimination on the work place has been strengthened. Employers are obliged to have developed a policy based on risk assessment and evaluation to prevent and handle incidents of discrimination. Discrimination based on medical conditions or handicap (thus including HIV/AIDS) is prohibited. This applies to discrimination between employees and employers as well as among employees. The Labour Inspectorate ('Arbeidsinspectie') supervises the implementation of this legislation.

General social acceptance of risk groups, such as MSM, can contribute to the success of initiatives throughout the full spectrum of the HIV/AIDS prevention and response efforts. A policy document, compiled by a coordinating ministry and with the contributions of several stakeholders, outlines the policy to enhance social acceptance of MSM[44].

Knowledge and behaviour change

A comprehensive national behavioural surveillance system is not established. Current insights about knowledge and behaviour in relation to HIV/AIDS are based on a range of different studies and surveillance activities. The results of different initiatives are usually not comparable due to methodological differences.

Nevertheless, existing findings illustrate that knowledge and intention to practice safe sex are frequently inadequately translated into actual safe sex. Thus, a major challenge is to foster a supportive environment for safe behaviour and build skills needed to translate intention into actual behaviour. The Centre for Healthy Living, part of the RIVM and established in 2007, has taken a step in this direction by establishing an inventory of different life-style interventions including descriptions of evidence regarding effectiveness[45].

[43] TNS NIPO. 2009. Hiv en stigmatisering in Nederland: cognities, houding en gedragsintenties omtrent hiv en aids. Available from: http://www.soaaids-professionals.nl/documenten/Rapportage-hiv-en-stigma.pdf
[44] Ministry of OCW. 2007. Gewoon homo zijn: lesbisch- en homo-emancipatiebeleid 2008-2011. Available from: http://www.minocw.nl/documenten/Homo_emancipatie.pdf
[45] RIVM/CGL website 'Loket gezond leven': http://www.loketgezondleven.nl/kwaliteit-van-interventies/beoordeelde-interventies/

High risk groups

Schorer performs an annual online survey, the Schorer Monitor, among MSM[46]. The 2009 survey is based on 4,635 respondents primarily recruited through internet. The results in 2009 are not directly comparable to results in previous years due to differences of the study populations.

The Schorer monitor asked MSM to rate their knowledge about STI/HIV/AIDS using a five-tiered scale (from 1=very little to 5=very much). The mean score was highest for 'risk of unprotected anal sex' (4.4), 'regular STI test' (3.9) and 'risks associated with ejaculation during oral sex' (3.9). The mean score was lowest for 'living with HIV/AIDS' (2.8), 'ART treatment of HIV' (2.9) and 'advice regarding unprotected anal sex with a steady partner' (3.5).

The prospect of using a condom during anal intercourse with temporary partners was usually reported as 'definitely' (72%) and 'very likely' (12%). Unprotected anal intercourse with a temporary partner was reported by 33% of respondents who had had sexual contact with temporary partners during the previous six months. Determinants of unprotected anal intercourse with temporary partners were the absence of a steady partner, lower education level, younger age (<26 years), drug use, as well as finding partners through internet, cruising areas and darkrooms. Post-exposure prophylaxis was familiar to 43% of respondents and 25% had vaguely heard about it.

Of MSM respondents with sexual experience, 73% had ever been tested for HIV infection, of which 44% during the past year. Fifteen percent of those ever tested were HIV positive, of which 98% went to controls at a HIV treatment centre, and 70% received ART. Of the HIV-negative men, the last HIV test had typically been performed at the GGD (37%), GP (34%) or an STI clinic (17%). The Schorer Monitors in 2006, 2007 and 2008 suggest an increase in the proportion of MSM ever tested for HIV (60%, 63% and 66%, respectively), as well as in the proportion of MSM tested in the previous six months (30%, 32% and 39%, respectively).

Also see 'Specific studies in high risk populations' under section III 'Overview of the AIDS epidemic'.

General population

In 2009 the Rutgers Nisso Group published a study about sexual and reproductive health. The study is based on a sample of 6,428 individuals in the age groups 15-70 years in the Netherlands[47]. This publication is a first follow-up of an initial study in 2006. The changes as compared to the study in 2006 are small, as anticipated in the light of the rather short time elapsed since 2006.

The results corroborate the notion that knowledge about STI/HIV among the Dutch population is relatively high. Of respondents below 50 years of age, 70-92% gives correct answers to statements about STI/HIV (e.g. refuting that washing after sex and using birth control reduce the risk for STI/HIV infection). A lower level of knowledge was noted among boys 15-18 years of age, less educated men and women and men among ethnic minorities.

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[46] Schorer. 2009. Schorer Monitor 2009. Available from: http://www.schorer.nl/58/schorer-monitor/schorer-monitor-2009/

[47] Rutgers Nisso Groep. 2009. Seksuele gezondheid in Nederland 2009. Available from: http://www.rng.nl/productenendiensten/onderzoekspublicaties/onderzoekspublicaties-1/downloadbare-publicaties-in-pdf/rapport-seksuele-gezondheid-in-nederland-2009

A majority did not use a condom during the past six months during sexual intercourse with a steady partner (men 78%, women 80%), or during anal sex with a steady partner (men 85%, women 88%). During sexual contacts with temporary partners in the past six months, about 50% of men and women always used a condom, while about 25% used a condom sometimes or never, respectively. Condom use appeared to be lower among older age groups and among lower educated individuals.

The report of the Rutgers Nisso Group further indicated that about one-third of men, and a somewhat larger proportion of women, had ever been tested for an STI/HIV infection. About 10% had been tested during the past year. Women had primarily been tested by the GP (61%) while men were more likely to have undergone the test at the GGD/STI clinic (49%) as compared to at the GP (44%).

Staff working in Dutch embassies in HIV-endemic areas

Dutch Embassies in HIV-endemic areas are actively committed to the code of conduct of the International labour Organisation (ILO). All staff members have access to HIV/AIDS prevention and care.

Impact alleviation

Not applicable.

V. Best practices

- Surveillance data indicate that testing is becoming more widespread. This may be interpreted as an achievement attributable to the range of efforts that seek to stimulate HIV testing. These efforts include communication about the value of testing and maintenance of low-threshold access to HIV testing, in particular for high risk groups (ACS regulation).

- An enabling environment is fostered by the commitment and contributions of a range of (sub)national (non)governmental stakeholders that engage in constructive dialogue on a regular basis.

- Monitoring and evaluation are recognised as essential and are applied to inform development and implementation of the HIV/AIDS policy and programmatic frameworks.

- The integration of HIV/AIDS policy in a broader framework of sexual health is considered to offer potential for synergistic effects and the effective use of resources.

- Harm reduction has been, and continuous to be, a successful component of HIV/AIDS prevention and control among IDU.

VI. Major challenges and remedial actions

Maintenance and further development of HIV/AIDS policy and programmatic frameworks pose a number of challenges that call for sustained commitment:

- Recognising that stigmatisation and discrimination of PLWHA is still a problem in Dutch society, the sexual health policy document announced a consultation process as a first step to address this issue.

- A large proportion (estimated about 40%) of HIV infected individuals are not diagnosed. This emphasizes the necessity of maintaining activities among risk groups and professionals and aiming to stimulate HIV testing. The incorporation of HIV testing as per the 'opting out' approach in STI centres (ACS regulation) as of January 2010 is one step in this direction.

- Notwithstanding significant communication efforts, sexual risk behaviours remain at high levels in certain groups, such as MSM and ethnic minorities. The high rates of HIV/STI co-infections in HIV infected MSM underline the need for sustained control measures targeting this group. Stimulating behaviour change in high risk groups remains a significant challenge. In the context of primary prevention, the principle of evidence-based practice could occasionally be further strengthened. The Centre for Healthy Living at the RIVM is anticipated to continue stimulating the use of evidence-based interventions in the area of HIV/AIDS prevention. Moreover, additional resources were released in 2009 in order to promote the sexual health among ethnic minorities.

- STI/HIV testing, and hence also opportunities for prevention, typically occurs in the GP setting. The interaction between public health professionals and GPs in the benefit of STI/HIV control remains challenging. In general, partner notification deserves recognition to stimulate exploitation of the full potential of its application by different health professionals.

- Financial and human resources are finite and pose limitations to the implementation of programmes. For example, the costs associated with providing low-threshold access to STI/HIV testing and treatment (ACS regulation) for high risk groups have increased in recent years. Discussion has been initiated regarding how to maximize health benefits of these services while keeping the related finances sound.

VII. Support from the country's development partners

Not applicable.

VIII. Monitoring and evaluation environment

As mentioned above, monitoring and evaluation are recognised as fundamentals to inform development and implementation of the HIV/AIDS policy and programmatic frameworks. The Ministry of VWS is responsible for overall monitoring and evaluation regarding the HIV/AIDS policy and programmatic frameworks. In practice, key responsibilities in this regard have been delegated to the RIVM/CIb that publishes an annual comprehensive surveillance report

as well as briefer bi-annual interim reports. The former accommodates data and information from different STI/HIV surveillance activities and brings these together for a joint interpretation to inform national STI/HIV policy. Data and information sources include the registration of HIV patients at HIV treatment centres, managed by SHM, STI/HIV surveillance at STI centres and in GP networks, and screening of pregnant women and blood donors.

In addition, specific evaluations are conducted on a regular basis to assess the suitability of individual programmes/activities. For example, in the current reporting period evaluations have addressed the ACS and ASH regulations, respectively, that provide low-threshold access to information, testing and treatment for STI/HIV. Also, two initiatives have addressed the organisation[48] and effectiveness of the antenatal screening[49], respectively. The RIVM/CIb as a whole has also been evaluated and the outcome is currently under consideration by RIVM/CIb and the Ministry of VWS. As mentioned above, the IGZ supervises the access to and quality of care in the Netherlands.

NGOs contribute to the overall monitoring and evaluation system through research, surveillance and evaluations in their areas of expertise. For example, as illustrated above, the Rutgers Nisso Group and Schorer have produced behavioural research/surveillance that is considered in the present report. NGOs serve an important function to identify weaknesses of the HIV/AIDS policy and programmatic frameworks and suggest possible solutions.

In addition to regular routine interactions, the RIVM/CIb organises a national expert meeting each year. The expert meeting offers an opportunity for (sub)national (non)governmental stakeholders to discuss recent surveillance data, research and other developments and exchange ideas, thereby informing future policy and activities in the area of STI/HIV. Furthermore, STI AIDS Netherlands organises the above-mentioned 'STI and sexual health platform' meetings on four occasions per year. Participants principally take part in these meetings in their capacity as experts, but they are also employed by Schorer, Rutgers Nisso Groep, HIV Vereninging Nederland, Mainline, GGD/STI clinics, RIVM/CIb and the Ministry of VWS. These meetings provide a platform for dialogue and thereby help address the challenge of maintaining an overview of undertakings by various stakeholders.

The government seeks to engage in international activities in the area of HIV/AIDS. This includes participation in fora of and cooperation with for example the European Centre for Disease Prevention and Control (ECDC), European Commission, World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS). These activities and related exchange of experiences can inspire and facilitate policy and programmatic development.

IX. Netherlands Antilles

The authorities of the Netherlands Antilles are currently responsible for public health, including HIV/AIDS. During the current reporting period, general political/administrative activities have prepared for a political transition process that by the end of 2010 will result in closer ties between the Netherlands and three islands of the Netherlands Antilles (Bonaire,

[48] TNO and RIVM/CIb. 2008. Procesmonitoring prenatale screening infectieziekten en erytrocytenimmunisatie 2005-2007. Available from: http://www.rivm.nl/pns/Images/2008.036%20TNO%20rapport%20Procesmonitoring%20PSIE%202005-2007_tcm95-60636.pdf
[49] RIVM/CIb. 2009. Effectiveness of antenatal screening for HIV, hepatitis B and syphilis in the Netherlands, 2006-2008.

St. Eustatius and Saba - BES), whereas the islands of Curaçao and St. Maarten will gain a more independent status within the Kingdom of the Netherlands. This process is anticipated to have consequences for the HIV/AIDS policy and programmatic frameworks in the future, as the Netherlands will be more directly responsible for HIV/AIDS policy on the aforementioned three BES islands.

Combined data indicate that the cumulative total of HIV-infected individuals on the Netherlands Antilles amounts to 1,926 individuals (including preliminary data for 2008). Data sources include the Analytical Diagnostic Centre, Red Cross Blood Bank Foundation and the Central Bureau of Statistic of the Netherlands Antilles. These data translate into an increase of 197 (11%) HIV cases as compared to the cumulative total of 1,729 individuals in 2006[50]. The total number of HIV infected individuals appears to exhibit a relatively stable increase of about 100 persons per year. The total proportions of males and females are 57% and 43%, respectively. Sixty-four percent of the cumulative total of HIV infected individuals are attributed to the age groups of 25-44 years.

Since 2005 the Stichting HIV Monitoring follows HIV patients at the treatment centre on Curaçao. As of June 2009, 586 HIV patients were reported from this treatment centre, of which 139 (31%) during the previous year, and 482 who were still alive. Reported data show that majority of the patients were male (63%), were infected via heterosexual contact (67%), and originated from the Antilles (77%). The median age at diagnosis 38 years (interquartile range 31-47 years). In total, 381 (65%) patients had started cART.

The development of policy and programmatic frameworks for STI/HIV surveillance, prevention and care in the Netherlands Antilles pose challenges to concerned stakeholders. STI/HIV-related knowledge and skills among the public and professionals should be strengthened. Intensified surveillance and research are needed to shed further light on the characteristics of the epidemic, especially on risk groups and risk behaviours. The resulting information would be valuable to inform the development of policy and programmatic frameworks.

X. Contributions to international HIV/AIDS response

The Netherlands allocates 0.8% of its gross domestic product (GDP) to development assistance. The commitment to sexual and reproductive health and rights (SRHR) and to universal access to HIV/AIDS prevention, treatment and care are priorities in Dutch foreign policy. With regard to HIV/AIDS and SRHR development assistance, the Netherlands is the largest contributor per capita, with an annual disbursement for SRHR and HIV/AIDS amounting to €475 million in 2008 and €487 million in 2009. As a result of the decrease in the GDP, the figures for 2010 and beyond will turn out lower. The Dutch contribution is channelled through UNAIDS, United Nations Population Fund (UNFPA), the Global Fund to Fight AIDS, Tuberculosis and Malaria, government-to-government as well as through international and Dutch NGOs.

The Dutch policy with regard to HIV/AIDS and sexual and reproductive health is informed by two distinct perspectives: human rights and prevention, which are seen as inextricably linked. Within these perspectives the focus is on young people and on marginalised groups. The rights-based approach directs attention to the inequality of access to prevention, treatment and care services and on the discriminatory practices that rob people of the opportunity to assert their right to health. In addition to young people, the Dutch policy is

[50] UNGASS Country Progress Report, the Netherlands, 2008

particularly concerned with populations who are at increased risk of HIV and other infectious diseases such as people who use drugs, sex workers, men who have sex with men, sexual minorities, prison inmates and mobile populations.

The Dutch approach is characterised by pragmatism and informed by scientific research. The success of this policy is reflected in the Netherlands' low rates of teenage pregnancies, abortions and HIV. These results add credibility to Dutch SRHR policy on the international arena. The objective of universal access to prevention, treatment and care, both with respect to SRHR and HIV/AIDS, is advocated across the entire spectrum of foreign policy by Dutch officials including the AIDS Ambassador.

ANNEXES

ANNEX I: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS

ANNEX II: National Composite Policy Index questionnaire

Please submit your complete UNGASS Country Progress Report ***before 31 March 2010*** *using the UNGASS reporting website (www.unaids.org/UNGASS2010).*

*Please direct all enquiries related to UNGASS reporting to UNAIDS Monitoring and Evaluation Division at:****ungassindicators@unaids.org.***

If the Country Response Information System version 3 (CRIS3) or the UNGASS reporting website (www.unaids.org/UNGASS2010) is not used for submission of indicator data, please submit reports by 15 March 2010 to allow time for the manual entry of data into the Global Response Database in Geneva.