

APPENDIX 5:

COUNTRY REPORTING FORMAT

Reporting period: January 2003 - December 2005

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I. STATUS AT A GLANCE

Summary of the epidemic:

In June 2005, a cumulative total of more than 10600 HIV cases had been registered in the Netherlands. The adult HIV prevalence rate across the total population of age 15-49 is estimated at 0.2% [2003 estimate]. The total number of people infected with HIV is estimated at 16 000 to 23 000 [estimate end of 2003]

Of all registered cases, 8215 (77%) were men and 2404 (23%) were women. In 2004, HIV diagnoses only increased among MSM. In that year, MSM accounted for 49% of the new diagnoses; heterosexuals 40% and IDUs 1%.

Respons:

The number of HIV and other STI's have been on the rise since 2000. The respons in our country is based on 3 goals. For every principle we indicate the actions that were taken in 2003-2005.

1. primary prevention

In the Netherlands primary prevention of hiv/aids consists mainly of the promotion of safe sex. Municipal governments are co-responsible for this behaviour oriented prevention. The national government, the Ministry of Health, is responsible for the national prevention policy.

Based on an evaluation of the hiv (and STI) prevention in the Netherlands, the Minister of Health took the following measures in 2004 to enhance results:

- sharper focus on risk groups (men who have sex with men, young people, ethnic minorities/migrants, commercial sex workers, drug users) and adding people with hiv as risk group for the further spread of hiv
- for each risk group there is one responsible organization (ngo) for the prevention program aimed at that specific group.
- more funding for the national prevention program aimed at ethnic minorities/migrants
- stronger coordination of the national support through the prevention programs and a better match with the support needs of the municipalities
- better linking of the promotion of safe sex with the promotion of knowing whether you are infected with hiv
- better linking of the promotion of safe sex with the promotion of sexual and reproductive health

Since 2005 the Centre for Infectious Disease Control (which is related to the MoH) is responsible for the implementation of the national prevention policy and for funding programs that support the municipal governments. STI AIDS Netherlands is the expert organization and national ngo for the coordination of the various programs and the connection between them.

Major challenges in the promotion of safe sex are among men who have sex with men and among ethnic minorities/migrant populations. For the first new more tailored interventions might be an answer, for the latter there is a lack of knowledge and of effective interventions. The development of a mix of interventions that support safe sex among people with hiv is in its early stages, this in contrast to the priority of this risk group. For the group of drug users it is important that prevention doesn't only focus on needle sharing as a transmission route for HIV. Prevention targeted at (intravenous) drug users should acknowledge that safe sex promotion is important too. Especially for people who use cocaine, which seems to be related to unsafe behaviour.

The primary prevention of hiv/aids needs to be evidence based. Scientific research on the effectiveness of an intervention is valuable but also costly and time consuming. It can take

several years and hundreds of thousands of euros to develop an evidence based intervention. The resources for that development are by no means always available, not even for the main risk groups.

Apart from promotion of safe sex, other methods of primary HIV prevention in the Netherlands are for example screening of pregnant women on HIV (prevention of infection of the child), screening of blood donors and harm reduction methods such as syringe exchange programs for intravenous drug users.

2. optimising tracing and treatment

In the Netherlands there are relatively many people that are not aware of their HIV status. We have therefore put in place an 'active testing policy' in 2002. Most important part of the measures have been:

-national program for screening pregnant women for hiv. Since January 2004, standard screening is offered to all pregnant women in the Netherlands (opting out method). The hiv-test is offered as part of the prenatal screening programme.

-the integration of the active testing policy in the STI/HIV-protocol for General Practitioners (GP's) in 2005. It is estimated that 80% of the STI in the Netherlands are found by the GP's, the new protocol stimulates them to use contacts with patients to find out whether a hiv-test is relevant.

- the improvement of the organisation of the additional (to GP) facilities for anonymous, voluntary and free of charge counselling and testing on HIV and other STI's. More testing facilities are in place starting January 2006 and resources have increased from 6.4 to more than 12 million euros in 2006. The financing system is set up in a way that if STI numbers rise the resources for VTC do so equally.

-mass media campaign and internet interventions that promote hiv-testing among men who have sex with men. Social norms about testing and knowing your hiv-status are influenced by campaign slogans like "It is better to know". To stimulate gay men with an intention for an hiv-test to actually take action on this intention proved possible through an internet intervention (www.soatest.nl). Research showed in 2004 that gay men in Amsterdam are getting tested for hiv more (from 54% in 2003 to 71% in 2004).

ART Treatment is available for all patients in need in the Netherlands (and has been since ART became available). Registration showed in 2004 that 80% of the people with hiv who are in monitoring, are treated with ART. The other 20% are not in need of ART yet, e.g. because of high CD4 counts. Initial treatment success is seen among 80% of those treated.

3. human rights and access to facilities in society.

Human rights and access to facilities in society for people living with hiv/aids in the Netherlands are in general well regulated. Nonetheless in the Dutch society incidents of stigmatisation and discrimination of people with hiv are a fact. Examples: panic at a kindergarten when one of the children happens to have hiv, a press conference of a football team warning their adversaries that one of their players has hiv, a hairdresser with hiv is fired because his employer thinks he is risk for the clients, a mayor warns his constituency for a civilian with hiv who had sex at a gay cruising area and a medical examiner that diagnoses a men with hiv as healthy but advises not to let him work with people. Patterns in these incidents are: being uninformed, overreacting and fear. Issues that have to be addressed in the coming period.

Next to that there are several issues on this item:

- Prosecution of unsafe sex by people with hiv: Since 2001 the Public Prosecutor has prosecuted a number of people with hiv. Before having unsafe sex these hiv-positive

persons had not told their partners of their own hiv-status. In most cases no hiv-infection took place and the unsafe sex was consensual. This new development was in conflict with the policy of the Ministry of Health stating that everybody is responsible for each own's health. It also conflicted with the Infectious Diseases Act of 1999 which does not state hiv, because it is an infection against people which can easily protect themselves. At the initiative of an NGO a committee reviewed the situation and came to the conclusion that prosecution of people with hiv for unsafe sex is fundamentally wrong, unless force, disparity in terms of power or misleading were involved (Aids Fonds/STI AIDS Netherlands: Penitence of Prevention? On the consequences of the application of criminal law for public health and the position of people with hiv. Amsterdam, 2004). In response to this the cabinet took the position that prosecution of people with hiv for unsafe sex has more disadvantages than advantages and therefore did not come up with new legislation. At the moment the prosecution of people with hiv for unsafe sex has slowed down because the supreme court has verdeted that the risk of transmission is that small that prosecution is not recommended. It is recognised that the prevention of unsafe sex among people with hiv can best be reached by promoting and supporting behaviour change.

- For asylum seekers with hiv, access to VCT, information and medical care is regulated. They receive shelter, insurance and a modest income from the Central Relief Asylum seekers. Personnel are trained in hiv and STI education and prevention. The situation is not so good for asylum seekers with hiv, who's request for asylum is rejected and who start a procedure for temporary stay on basis of the fact that they have hiv. Access to medical care is regulated (although in reality not always easy obtainable), they are allowed to stay in the Netherlands but access to housing, insurance and income is blocked. Their procedure can take a long time. Even worse is the situation for people who are infected with hiv and who are illegal in the Netherlands. Because of their illegal status they don't have the rights that other people in the Netherlands have. They too do have access to medical care, but they are not allowed to stay in the Netherlands and therefore receive no housing, insurance and income. Afraid for official institutes they often come in care too late. This means that if the last two groups need to start with treatment (ART) they get the medication but not the preconditions for therapy success; a stable living condition. This is dangerous not only for the individual health, but also for the public health. Resistant hiv-virus can develop in these circumstances among people who are desperate to survive and not always able to prevent the further spread of hiv.
- Insurance: A major recent achievement is the access to life insurances for people with hiv (needed for a mortgage). In 2004 the Dutch Union of Insurances Companies reviewed the data on the prognoses of people with hiv on ART and came to the conclusion that there are no longer reasons to block life insurances for people with hiv as a principle. This was the result of a long process in which a number of parties worked closely together. The HIV patient organisation played an important role, the Ministry of Health was also involved later in the process and used the UNGASS declaration 2001, article 58 of the chapter on human rights, as one of the arguments to offer life insurances (next to Public Health arguments). At the moment several Dutch insurance companies are preparing an offer for life insurances for a specific group of people with hiv. The Dutch Union of Insurances Companies and the HIV patient organisation are very willing to share their experience on this matter with other countries. Some European countries already expressed their interest.

Further information on insurance:

March 2005: The first step towards the insurability of PLHIV has been taken.

Some PLHIV can be accepted for life insurance, which is often important for financing their mortgage. Recent figures show that the life expectancy of PLHIV has increased in leaps and

bounds in recent years due to the HAART programme. This only relates to some PLHIV, however, namely those who have successfully undergone medical treatment, experience no further medical complications and have not used intravenous drugs.

These conclusions can be drawn from a study into the insurability of HIV based on the most recent figures provided by the HIV Monitoring Foundation. In close consultation with the Dutch HIV Association, the Dutch Association of Insurers has advised its members to include these findings in their life-insurance acceptance policies. Every insurer is free to determine its own acceptance policy. Each company will therefore have to take a decision on this.

The insurers are willing to cover a risk comparable to people with diabetes or a serious heart condition. Given the level of this risk, this means a shorter insurance term and possibly a higher premium for the insurance.

Who will be insurable?

The HIV Monitoring Foundation shows that the life expectancy of people with aids has increased thanks to treatment with antiretroviral therapy. The foundation conducted research on 3,500 HIV patients who have been receiving treatment for years. On the basis of these figures, the Insurers' Association is advising insurance only for those PLHIV who respond successfully to the treatment after 24 weeks. But because the chances of dying within this group are still higher, the premium will indeed also be higher but still affordable.

The Dutch HIV Associations comments on the advice:

PLHIV, who, on their doctor's advice, do not need to start treatment yet because their immune system is functioning properly, have a relatively favourable prognosis. The Dutch Association of Insurers therefore states in its report that the medical advisor will be able to give a favourable acceptance recommendation for this group *probably* without objection. The Dutch HIV Association thinks that insurers should go a step further and argues that medical advisors should always give a favourable acceptance recommendation for life insurance for this group of PLHIV. In order to further strengthen the social position of PLHIV, the Dutch Association of Insurers will have to adapt the acceptance policy for PLHIV every year according to the most recent medical insights and on the basis of the latest statistics. Expectations are that the life expectancy of PLHIV will increasingly normalize, which means that the higher premiums can go down.

II. OVERVIEW OF THE HIV/AIDS EPIDEMIC

Diagnosed HIV cases in the Netherlands

In June 2005, a cumulative total of more than 10600 HIV cases had been registered by the HIV Monitoring Foundation (HMF)¹ [www.hiv-monitoring.nl]. {RIVM report 2005}

The adult HIV prevalence rate across the total population of age 15-49 is estimated at 0.2% [2003 estimate]. {RIVM report 2004}

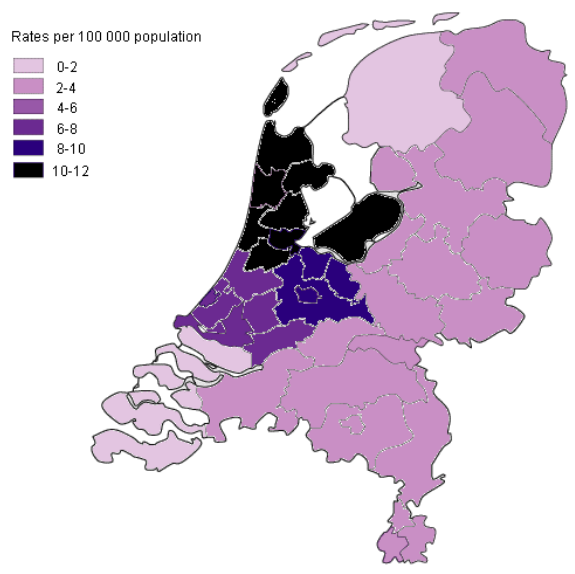


Figure 1. Number of HIV diagnoses in 2004 per 100000 inhabitants; calculations based on HIV infections diagnosed in the various HIV treatment centres in each province

In 2004, 938 new cases of HIV were diagnosed (Table 1). Of all registered cases, 8215 (77%) were men and 2404 (23%) were women. In 2004, HIV diagnoses only increased among MSM. In that year, MSM accounted for 49% of the new diagnoses; heterosexuals 40% and IDUs 1%.

Table 1: Number of HIV cases, by year of diagnosis and transmission risk group

	2003	2004
MSM	419 (44%)	459 (49%)
Heterosexual contact	417 (43%)	373 (40%)
IDU	20 (2%)	9 (1%)
Blood (products)	6 (0.6%)	4 (0.4%)
Mother to child	14 (1%)	6 (0.6%)
Needle stick injury	2 (0.2%)	3 (0.3%)
Other/NK	82 (9%)	84 (9%)
Total	960	938

NK: not known

Anonymous unlinked HIV surveys among high risk populations

In the Netherlands, anonymous HIV surveys are conducted among high risk populations (IDUs, migrant populations, CSWs, STI clinic attendees) to obtain more insight in HIV prevalence, risk behaviour, and the potential to further spread of HIV. Between 200-400 participants were recruited per subgroup. Between 2002 and 2004, two HIV surveys were conducted in Rotterdam and Amsterdam, in collaboration with the local public health services. The results of these surveys are summarized below.

Table 2: HIV prevalence and risk behaviour amongst migrants

	Region	Year of survey	HIV prevalence	Condom use ^v steady partner	Condom use ^v casual partner	Condom use ^v casual partner in country of origin
Surinamese	Rotterdam	2002/2003	0.5% [0-1.5%]	9%	43%	77%
Surinamese	Amsterdam	2003/2004	0.6% [0-1.8%]	15%	53%	65%
Antilleans/ Arubans	Rotterdam	2002/2003	0.5% [0-1.7%]	9%	36%	26%
Antilleans/ Arubans	Amsterdam	2003/2004	0.6% [0-1.6%]	9%	44%	67%
Cape Verdians	Rotterdam	2002/2004	1.0% [0-2.7%]	12%	51%	81%
Ghanese	Amsterdam	2003/2004	0.6% [0-1.7%]	26%	57%	42%

^v Condom use: last 6 months always used condoms

The main purpose of the survey among commercial sex workers (CSW) was to investigate HIV prevalence, sexual risk behaviour with clients and non-commercial partners, and the mobility of CSW. The first CSW surveys were conducted in Rotterdam (2002) and Amsterdam (2003/2004).

Table 3: HIV prevalence and risk behaviour amongst CSW in Rotterdam and Amsterdam

Region	HIV prevalence *	Condom use ^v clients	Condom use ^v steady partner	Condom use ^v casual partner
Rotterdam (2002/2003)				
Total population CSW	7.2% [2.8-12.0%]	88%	15%	25%
Street-based CSW	12.3% [5.2-21.0%]	84%	15%	33%
Establishment-based CSW	1.9% [0.0-5.9%]	92%	15%	17%
Amsterdam (2003/2004)				
Total population CSW	6.5% [3.7-9.9%]	79%	10%	40%
Female CSW	3.1% [0.6-6.3%]	94%	10%	36%
Drug using CSW	11.3% [3.8-20.8%]	40%	0%	25%
Transgender CSW	17.1% [3.4-31.0%]	70%	17%	64%

^v Condom use: last 6 months always used condoms

Table 4 provides an overview of trends in HIV positive test results obtained from surveys at STI clinics in Amsterdam and Rotterdam, and the STI sentinel surveillance network (from 2003). Among MSM, HIV prevalence rates varied between 0 and 32%. HIV prevalence in the anonymous surveys is higher than that in regular HIV tests by name. At 'Checkpoint', a one-hour HIV testing facility in Amsterdam that started in June 2002, the HIV prevalence among MSM was 4.6% in 2004, which is similar to the prevalence at the regular screening at the STI clinic (4.2%). HIV prevalence among heterosexual visitors of STI clinics was low (0-1.4%) and stable over time.

Table 4: HIV prevalence among STI clinic attendees and other test sites

Region and source	2003	2004
<i>MSM</i>		
STI clinic Amsterdam		
- Regular	4.2%	5.7%**
- Anonymous*	20.1%	18.8%#
Alternative test site Amsterdam	3.5%	1.8%
STI clinic Rotterdam		
- Regular	1.7%	4.5%
- Anonymous*	22.4%	32.1%
STI sentinel surveillance network	3.3%	4.2%**
Checkpoint	4.8%	4.6%
<i>Heterosexual risk groups</i>		
STI clinic Amsterdam	0.3%	0.3%**
- Regular, male	1.0%	0.5%#
- Anonymous, male	0.3%	0.3%**
- Regular, female	0.5%	0.2%#
- Anonymous, female		
Alternative test site Amsterdam		
- Male	0%	1.8%
- Female	0%	0%
STI clinic Rotterdam		
- Regular, male	0.5%	1.0%
- Anonymous, male	1.0%	0.9%
- Regular, female	0.3%	0.3%
- Anonymous, female	1.0%	0.7%
STI sentinel surveillance network		
- Male	0.3%	0.3%**
- Female	0.3%	0.2%**
Checkpoint		
- Male	0.3%	0.4%
- Female	1.0%	0.5%

* Known HIV infected included, ** preliminary data, # based on 1 research period (previous year: 2 research periods)

The last HIV survey among IDUs was conducted in 2002/2003 in Rotterdam (Table 5).

Table 5: HIV prevalence and risk behaviour amongst IDUs

Region	Year of survey	HIV prevalence	Borrowing ^I	Condom use ^V steady partner	Condom use ^V casual partner	Condom use ^V clients
Rotterdam	2002/2003	10%	8%	15%	57%	68%

Footnote: IDU: ever injected drugs and using hard drugs at least once a week (i.e. heroine, cocaine products, amphetamine or methadone) in the six months prior to recruitment I. Percentage of IDUs that borrowed used syringes or needles in the last six months. V. Condom use: last 6 months always used condoms. NA= not available

HIV screening in low risk populations

In the Netherlands, the only nationwide ongoing serosurveillance is that of blood donors and pregnant women.

In 2004, 503008 blood donors were registered in the Netherlands. The overall prevalence and incidence of HIV antibodies have been low in that year: new donors: 0.0 per 10⁵ donors (prevalence), regular donors: 0.9 per 10⁵ donor years (incidence). No marked trend over time was observed.

Since January 2004, standard screening for HIV is offered to all pregnant women in the Netherlands (opting out method). The HIV test is offered as part of the prenatal screening.

In the first six months of 2004, approximately 95000 women were tested for HIV. Of those women, 60 were HIV positive (HIV prevalence: 0.06%). The highest prevalence was observed in Amsterdam: 0.17% (9/5385). The results of the second half of 2004 are not available yet.

Data source: HIV and sexually transmitted infections in the Netherlands in 2004. An update: nov 2005. MJW van de Laar, IM de Boer, FDH Koedijk, ELM Op de Coul. RIVM report 441100022/2005, Bilthoven, the Netherlands

III. National response to the HIV/AIDS epidemic

Changes in national commitment and programme implementation 2003-2005:
(see also I. Status at a glance)

Prevention:

In the prevention policy recent changes are: sharper focus on risk groups (including people with hiv), better linking of hiv-prevention with the active testing policy, with STI control and with sexual and reproductive health promotion, stronger national support for hiv-prevention aimed at migrants. There is no clear picture of the local and regional implementation of hiv-prevention because this responsibility was decentralised. As results of hiv-prevention there are in general relatively high levels of protective behaviour, but there are major challenges among subgroups (people with hiv, MSM, migrants, some youth) and in maintaining obtained level of safe sex.

Care/treatment and support:

The care and treatment policy for hiv has not changed because the chosen set up is satisfying . A high quality of hiv-treatment is legally (WBMV) regulated by concentrating hiv-treatment in the hands of specialists. Implementation takes place in 24 hiv-treatment centres in the Netherlands. Next to specialised clinicians, there are also specialised hiv/aids nurses active as case-managers. Results are that 80% of the people with hiv who are in monitoring is in treatment. Mortality and morbidity has reduced strongly. Research shows that people with hiv are satisfied with the care they receive. Points of concern are the lacking treatment success among ethnic minorities/migrants and the lacking interculturalisation of the care services. A major challenge in the next period is the incorporating of support for the sexual health of people with hiv (including prevention of further spread of hiv) in the care context.

Knowledge and behaviour change:

Regarding policy it is realised that a systematic and national behaviour surveillance is lacking therefore a national behavioural monitor is in development. Given this situation the

implementation of behavioural surveillance is split up in different studies and therefore of limited comparability. Results indicate in general a high level of hiv/aids knowledge among all risk groups (with exceptions among migrants en the lower educated), high intentions for safe sex among most of the risk groups, but a lacking of safe sex behaviour in practice for a minority within risk groups. The major challenge therefore is in supporting the skills needed to transform the intention for safe sex in actual behaviour and in creating environmental changes that support safe behaviour.

Impact alleviation policy is not needed in the Netherlands

Youth

A recent national study into the sexual health of young people (12-25 year) in the Netherlands showed several interesting findings:

-At an age of 17 almost half of the young people have experience with sexual intercourse ; this is almost the same as in a study ten year ago. Only a small group (7%) has this experience at the age of 12/13 year.

-Almost all the young people have experienced falling in love and courting, but Turkish and Moroccan youth have relatively less experience with these.

-A substantial minority of the young people rapport sexual intercourse and/or anal sex with four or more partners (37% of the boys and 28% of the girls). Casual sexual contacts are becoming less frequent with the growing age of the youngsters. For most of the young people their latest sexpartner is in the context of a steady/love relationship

The quality of their sexual contacts are perceived by the young as high: they experience little feelings of shame or guilt and they are generally satisfied about the sexual contacts with their latest partner.

-Protective behaviour of the young people between 12 – 25 years has increased in the last 10 years. Some 75% use a condom at first intercourse; with 63% of the boys and 56% of the girls the pill was (also) used; and 41% of the boys and 46% of the girls choose for 'Double Dutch' at first intercourse (pill and condom). This last strategy has increased since 10 years ago.

(De Graaf e.a. Seks onder je 25^{ste}. Seksuele gezondheid van jongeren in Nederland anno 2005; Rutgers Nisso Groep/Soa Aids Nederland; Eburon, Delft, 2005)

Men who have sex with men

The percentage of men with casual sex partners who sometimes or always had unprotected sex in the previous six months with one or more partners, rose from 21% in 2000 to 28% in 2003. It is not known how often both partners had the same HIV-status. The increase is the result of a rise in ejaculation in the partner's mouth and a rise in anal sex.

Percentage of men with a steady sex partner who sometimes or always had unprotected sex in the previous six months with that partner, rose from 59% in 2000 to 63% in 2003.

(Hospers e.a. Monitor onderzoek 2003. Amsterdam, Schorerstichting. 2003

Changes made in national commitment and programme implementation for the group MSM are: more focus on HIV and STI testing for MSM, prevention and support of sexual health for HIV-positive MSM, better evidenced based prevention and data-collection on MSM, targeted interventions through the use of internet and better integration of prevention and cure.

Most points also apply for the other risk groups.

Migrants:

In a recent study among three migrants groups in Rotterdam it was found that condom use with steady partners was very low (8,6% among Antilleans, 9% among Surinamese and 12% among Cape Verdeans). Condom use with casual sex partners was low to moderate (35,9% among Antilleans, 49,9% among Surinamese and 51,3 among Cape Verdeans). Men from these groups

have a higher sexual risk behaviour than women, they have more sexual partners, and have more sexual partners at the same time and they mix more with sexual partners of other migrant groups.

Almost half of the studied migrant groups travel to the land of origin. During their stay 19 – 32 % of them have sexual partners there. Condom use with sexual partners in the land of origin is part low part high (26,7% among Antilleans, 76,9% among the Surinamese and 81,3% among the Cape Verdeans).

(Van Veen MG et al. Hiv surveys bij hoog-risicogroepen in Rotterdam 2002-2003. RIVM rapport 441100019. Bilthoven: RIVM, 2005)

People with hiv

In a study among hiv-positive gay men 23% of the men with a steady sex partner reported having unprotected anal sex with their steady partner. Of the men who had casual sex partners 33% reported having unprotected anal sex with one or more casual partners. In the study was not asked for sero-(dis)cordancy so it is not known how often both of the partners had the same HIV status.

(Van Kesteren e.a. Planmatige ontwikkeling van een hiv-preventieve interventie voor HIV-geïnfecteerde mannen die seks hebben met mannen. Presentatie ZonMw implementatie meeting, oktober 2003)

Prostitution:

Recent hiv-survey among prostitutes in Rotterdam showed:

-condom use with clients: 88%

-experience with condom breakage: 49%

(Van Veen et al. Hiv surveys bij hoog-risicogroepen in Rotterdam 2002-2003, RIVM/GGD Rotterdam, 2005)

Intravenous Drug Users:

The percentage of IDU's in Rotterdam who have recently used another person's needle had decreased in Rotterdam from 18% in 1994 to 8% in 2002. The risky sexual behaviour however has remained just as high: inconsistent condom use among 85% with the steady partners, among 43% with casual partners and among 32% with customers. IDU's who know that they are HIV positive generally report consistent condom use more often, but 58% of the IDU's in Rotterdam who have hiv are unaware of their serostatus.

(Boer e.a.. Trends in HIV prevalentie en risicogedrag onder injecterende druggebruikers in Rotterdam 1994-2002. Ned Tijdschr Geneesk 2004, 20 november; 148 (47))

IV. Major challenges faced and actions needed to achieve the goals/targets

The major challenges in the Netherlands are:

-finding hiv-infections more and earlier; more people in risk should take tests (action has been taken)

-strengthening the support for the sexual health of people living with hiv, including the prevention of further spread of hiv (action is in early stage)

-stopping and reverting negative behaviour changes among men who have sex with men, resulting in unprotected sex and a rise of STI/HIV (evaluation of strategy is planned)

-breaking the taboo surrounding hiv/aids among ethnic minorities/migrant communities and stimulating behaviour change towards safe sex among these groups by developing community approach and developing effective interventions (new national program starts 2006)

-preparing the Dutch society for an growing number of people living with hiv and participating in all elements of society; preventing incidents in stigmatisation and discrimination (action needed)

-strengthen the local and regional implementation of the hiv/aids control; strengthen regional coordination, strengthen match between national en local/regional priorities, improve insight in local/regional results of implementation, improve integration of prevention into STI and hiv care, testing and treatment (action taken for VTC facilities, otherwise action needed)

-investments in hiv/aids control: more funding is available for active testing but not for prevention aimed at MSM and people with hiv, lacking funds for prevention research, growing number of people with hiv with growing complexity in needs for cure, care and support without growing budgets for this (action needed)

V. Support required from country's development partners

Not applicable for the Netherlands.

VI. Monitoring and evaluation environment

The questions on monitoring and evaluation of the national composite policy index are answered in the questionnaire.

Different actors play a role in the monitoring and evaluation environment:

- The Ministry of Health is responsible for 'the system' for monitoring and evaluation of HIV and other STI's and gives specific assignments such as the report 'A delicate balance, The state of affairs of HIV and other STIs in the Netherlands' (included in the package we send you) and the evaluation of the Dutch strategy for preventing HIV and other STIs in the risk group men who have sex with men.
- The State Inspectorate of Health, which is an autonomous part of the Ministry of Health, is responsible for the supervision and monitoring of the health care and the health status of the Dutch population. If necessary the State Inspectorate of Health takes active measures.
- In the 'platform on STI's, HIV and sexual health', which meets four times a year, all relevant parties (government, NGO's, PLWHA, medical personal, prevention workers etc.) are represented. This platform plays an important role in monitoring the response to the epidemic. It for example produces action plans in which it analyses the state of the STI and HIV epidemic, draws conclusions and prioritises necessary actions.
- The Ministry of Health has delegated (coordinating and monitoring) tasks to the Centre for Infectious Disease Control (part of the National Institute for Public Health and the environment). The Centre for Infectious Disease Control for instance funds NGO's who execute different tasks for different risk groups.
- The NGO STI AIDS Netherlands coordinates the STI/HIV prevention programmes targeted at different risk groups and monitors the status of the epidemic and the national response and advices the government.
- The Ministry of Health funds the HIV patient organisation for advocacy. The HIV patient organisation monitors the response from a patient perspective.

Our surveillance system (monitoring and evaluation):

- The Ministry of Health is responsible and has delegated the HIV and STI surveillance tasks to the Centre for Infectious Disease Control, based at the National Institute for Public Health and the environment.

- The Centre for Infectious disease control serves as the 'national STI and HIV surveillance Unit'.
- They carry out monitoring and surveillance projects themselves, for instance anonymous HIV surveys conducted among high risk populations and monitoring of the STI and HIV prevalence in the anonymous STI clinics where VTC takes place.
- They also gather all available information from other sources, for instance serosurveillance of blood donors and pregnant women and the HIV cases registered by the HIV Monitoring Foundation.
- The Dutch Minister of Health appointed the HIV Monitoring Foundation (HMF) in 2001 as the executive body for the registration and monitoring of HIV infected patients. The HMF is one of the very few organisations in the world that represents an observational clinical cohort that is truly nation wide, with 23 participating hospitals that specialise in HIV treatment. It furthers the knowledge of the HIV epidemic in The Netherlands by studying the development of the HIV epidemic and making its results available for scientific research, information and public policy making. The cohort includes all HIV infected individuals in The Netherlands who were followed up in one of the 23 national HIV Treatment centres.
- All STI and HIV data are reported to the Minister of Health and through professional media to relevant parties at an early preliminary stage (to avoid delays in actions if necessary).
- Definite data are presented in a yearly report.
- Also a yearly 'expert meeting' is organised. All data on STI and HIV of the previous year are presented. All relevant parties (e.g. M&E, researchers, prevention and treatment workers, government officials, NGO's, PLWHA etc.) are present. The main conclusions and new trends are discussed and advice on new actions (new policy and new surveillance/research needs) is given.

The Netherlands do not need technical assistance regarding M&E and capacity building.

APPENDIX 2

Consultation/preparation process for the National Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

1) Which institutions/entities were responsible for filling out the indicator forms?

- | | |
|----------------------|-----|
| a) NAC or equivalent | No |
| b) NAP | No |
| c) Others | Yes |

(please specify) We don't have one national HIV/AIDS body. The Ministry of Health was responsible for the national report. Other organisations contributed: The NGO's STI AIDS Netherlands and Schorer Foundation, the HIV patient organisation, the HIV Monitoring Foundation, the Centre for Infectious Disease Control and the Ministry of Foreign Affairs.

2) With inputs from

Ministries:

- | | |
|------------------|-----|
| Education | No |
| Health | Yes |
| Labour | No |
| Foreign Affairs | Yes |
| Others | No |
| (please specify) | |

3) Was the report discussed in a large forum? Yes (the content was discussed in a forum with STI AIDS Netherlands, HIV Patient organisation, the Ministry of Health and the Centre for Infectious Disease Control) The final report will be discussed in a larger forum with all relevant parties.

4) Are the survey results stored centrally? Yes

5) Are data available for public consultation? Yes

Name / title: Mrs. Barbara Blommerde, M.D. senior policy officer

Date: _____

Signature: _____

APPENDIX 3

NATIONAL COMPOSITE POLICY INDEX - 2006

Country: The Netherlands

Name of the National AIDS Council officer in charge: Mrs. L Kootstra (director of the Public Health Department of the Ministry of Health, Welfare and Sports

Signed by: Mrs. L. Kootstra

Address:

contact person: Barbara Blommerde
Ministry of Health, Welfare and Sport
Public Health Department
P.O. Box 20350
2500 EJ The Hague
The Netherlands

TEL: 00 31 70 340 7764

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E-MAIL: b.blommerde@minvws.nl

DATE:

Once the questionnaire is completed, please return it by e-mail, mail or fax to:

Evaluation Unit
UNAIDS Geneva

Tel:

Fax:

E-mail:

INSTRUCTIONS

BACKGROUND

The following instrument measures the second UNGASS *national commitment and action* indicator, a composite policy index designed to assess progress in the development and implementation of national level HIV/AIDS policies and strategies. It is an integral part of the list of core indicators, to be completed as part of UNGASS country reports 2006. The instrument supplements the previous one used in 2003, which serves as the baseline for comparable questions (see National Composite Policy Index in *Guidelines on construction of core indicators*, UNAIDS, Geneva, 2002).

This revised National Composite Policy Index is more detailed than the previous one and puts more emphasis on progress made in policy implementation. It also aims to estimate the amount of effort put into national HIV/AIDS programmes by national level government, non-governmental organizations and by international organizations. It intends to measure the strength of effort for programme inputs and outputs, to complement data on programme outcomes, such as behaviour change or decline in HIV prevalence that are reported on under “National behaviour and impact indicators”. To the extent possible, this instrument has integrated many items of another survey, the “AIDS Programme Index effort” conducted in many countries by UNAIDS, USAID and the Policy project. It is hoped that this streamlined process of collecting data will help countries identify gaps as well as prioritize programme activities.

STRUCTURE OF THE QUESTIONNAIRE

The National Composite Policy Index (NCPI) is divided into two parts.

Part A to be administered to governments’ officials (National AIDS Councils or equivalent).

This part covers five broad areas:

1. Strategic plan
2. Political support (*new section*)
3. Prevention
4. Care and support
5. Monitoring and evaluation (*new section*)

In sections 1, 3 and 4, there are similar questions on policy development to those found in the 2003 NCPI. However, more detailed items related to the *content* of policies and programmes have been added for 2006 reporting. Most sections also contain summary questions that ask for opinions about the overall level of effort in that area both in 2003 and 2005 to assess changes over time.

Part B administered to representatives from the governments' primary partners including non-governmental organizations, bilateral agencies, and UN system organizations. This part covers three broad areas with a particular focus on policy *implementation* for the last topic:

1. Human rights
2. Civil society involvement (*new section*)
3. Prevention
4. Care and support

The section on civil society participation has been developed based on lessons learnt from 2003 reporting. It was felt that the full involvement and participation of the civil society in the design, planning, implementation and evaluation of HIV/AIDS programmes was not sufficiently assessed in the previous reporting.

The overall responsibility for collecting information related to the National Composite Policy Index lies with National governments, through their National AIDS Councils (NAC) or equivalent, with support from UNAIDS and partners.

Responses to most questionnaires' categories often require more explanation than just a *yes* or *no*. There is a space in the questionnaire, under "*comment?*", that should be selectively used to shortly explain why, for example, a particular policy has not been implemented, or if it has been implemented what difficulties there have been in particular areas. For example, if sex work HIV prevention education is given in re-education camps, it will be important information to be mentioned. Qualitative analysis of the comments will be performed. If a section or question is *not relevant* for a specific country, the response "non applicable" should be used and explanation provided (when appropriate).

The 2006 NCPI asks respondents to provide both a score for *2003* and *2005* to be able to measure change over time. Such comparison is required for the specific questions on implementation and for the overall rating.

PROPOSED STEPS FOR DATA GATHERING

1. Designation of two technical coordinators for the study (one for each part)

Technical coordinators (preferably from the NAC (or equivalent) for Part A and a person outside the government for Part B) should be given responsibility to undertake the desk review and carry out specific interviews for this indicator. This person should ideally have a monitoring and evaluation background and may request the assistance of a national consultant with a similar background. It is strongly recommended that civil society representatives be part of the survey team for Part B.

2. Designation of a technical working group led by the NAC or equivalent (4 to 6 members)

Composition: representatives from the government (key line ministries and officials at sub-national level), NGOs, UN and bilateral agencies.

Role: Agree on (1) the process and timeline; (2) the selection of best respondents for each section; (3) the final results from both parts.

3. Selection of key informants for each section

- *Strategic Plan and Political Support*: the Director or Deputy Director of the National AIDS Programme or National AIDS Council;
- *Monitoring and Evaluation*: officers of the National AIDS Council or equivalent, Ministry of Health and HIV focal points of other ministries
- *Human rights*: Experts such as the Ministry of Justice officials, human rights commissioners, and representatives of human rights NGOs or legal aid centres/institutions.
- *Civil society participation*: representative sample of major civil society organizations working in the area of HIV/AIDS
- *Prevention and care and support sections*: major implementing agencies in those areas.

4. Data gathering

Each section should be completed by desk review and by interviewing the two or three people most knowledgeable about that topic.

5. Data entry, analysis and interpretation

Once both sections are filled out, the technical coordinators need to carefully review similar questions and check whether there are any discrepancies between the government and other counterparts' responses. If such is the case, a meeting with members of the working group should be organized to discuss and address those issues before the final consensus meeting on the UNGASS national report. This stage may require additional selected consultations and more documents to review. Validated data are entered into the CRIS, and analysis and interpretation done by both coordinators.

6. Consensus workshop organized by the NAC (or equivalent)

UNAIDS secretariat strongly recommends that NAC or equivalent organize a one-day broad consultation forum to discuss and endorse the major findings of the UNGASS national report, including this section on policy development and implementation.

NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE PART A

I. Strategic plan

1. **Has your country developed a national multi-sectoral strategy/action framework to combat HIV/AIDS?^{1*}**

(Multi-sectoral strategies should include, but not be limited to, those developed by Ministries such as the ones mentioned below)

No *Period covered:*

- 1.1 *IF YES*, which sectors are included?

Sectors included	Strategy/Action framework		Focal point/Responsible	
	Yes	No	Yes	No
Health	Yes	No	Yes	No
Education	Yes	No	Yes	No
Labour	Yes	No	Yes	No
Transportation	Yes	No	Yes	No
Military	Yes	No	Yes	No
Women	Yes	No	Yes	No
Youth	Yes	No	Yes	No
Others to specify*	Yes	No	Yes	No

* Any of the following: Agriculture, Finance, Human Resources, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

Comments: We don't have a national action framework (HIV/ Aids epidemic is relatively limited in the Netherlands) but we do have a multisectoral approach and a recent paper on the status of the epidemic, the response, what is going well and what not etc. In 1.2 I address the issues the Ministry of Health is involved in.

- 1.2 *IF YES*, does the national strategy/action framework address the following me areas, target populations and cross-cutting issues? (Yes/ No)

Programme	
a. Voluntary counselling and testing?	a yes ___
b. Condom promotion and distribution?	b no ___
c. STI prevention and treatment?	c yes ___
d. Blood safety?	d yes ___
e. Prevention of mother-to-child transmission?	e yes ___
f. Breastfeeding?	f yes ___
g. Care and treatment?	g yes ___
h. Migration?	h yes ___
Target populations	
i. Women and girls?	i yes ___
j. Youth?	j yes ___
k. Most-at-risk populations ² ?	k yes ___
l. Orphans and other vulnerable children?	l N/A_
Cross-cutting issues	
m. HIV/AIDS and poverty?	m N/A

¹ All questions bolded and with an asterisk are also relevant for the "Three Ones" monitoring at country level

n. Human rights?	n yes _____
o. PLHA involvement?	o yes _____

1.3 *IF YES*, does it include an operational plan? N/A

1.4 *IF YES*, does the strategy/operational plan include: N/A

- | | | |
|--------------------------------------|-----|----|
| a. formal programme goals? | Yes | No |
| b. detailed budget of costs? | Yes | No |
| c. indications of funding sources? | Yes | No |
| d. a monitoring and evaluation plan? | Yes | No |

1.5 Has your country ensured “full involvement and participation” of civil society in the planning phase?

Yes

1.6 Has the national strategy/action framework been endorsed by key stakeholders?

N/A

Comments: we don't have a national action framework so it has not been endorsed (1.6). For our new policy decisions and actions we always ensure involvement of civil society (NGO's and/or PLWHA) (1.5)

2. Has your country integrated HIV/AIDS into its general development plans (such as: a) National Development Plans, b) United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, and d) Common Country Assessments)?

N/A (HIV/AIDS is however integrated in our foreign policies, especially development cooperation)

2.1 *IF YES*, in which development plan? a)_____b)_____c) other

Covering which of the following aspects? (Yes/ No)

	a)	b)	c)
HIV Prevention			
Care and support			
HIV/AIDS Impact alleviation			
Reduction of gender inequalities as relates to HIV/AIDS prevention/care			
Reduction of income inequalities as relates to HIV prevention/care			
Others:			

² Most-at-risk populations are groups that have been *locally* identified as being at higher risk of HIV transmission (injecting drug users, men having sex with men, commercial sex workers, moto-taxi drivers etc)

3. Has your country evaluated the impact of HIV/AIDS on its economic development for planning purposes?

N/A

IF YES, how much has it informed resource allocation decisions? (Low to High)

Low High
0 1 2 3 4 5 6 7 8 9 10

Comments: The Netherlands is not a developing country. In the Netherlands we have 10.000 people who are known to be infected with HIV (population over 16 million). The economic impact is very limited therefore, also because all people in need receive treatment and can often continue working.

4. Does your country have a strategy/action framework for addressing HIV/AIDS issues among its national uniformed services, military, peacekeepers and police?

Yes

4.1 IF YES, which of the following have been implemented?

HIV Prevention	Yes
Care and support	Yes
Voluntary HIV testing and counselling	Yes
Mandatory HIV testing and counselling	No
Others to specify:	

Comments: The Dutch HIV patient association provides information to all HIV-infected persons regarding HIV and work. Military personnel that are dispatched are educated on (among others) sexual behaviour and STD/HIV-prevention. At 19 Royal Netherlands Embassies (RNEs) in Africa prevention, care and treatment programmes are being implemented. At these embassies all staff including local staff of RNEs and local employed domestic staff of Dutch diplomats have access to prevention, care and ARV-treatment.

Overall, how would you rate strategy planning efforts in the HIV/AIDS programmes?										
2005	Poor									Good
	0	1	2	3	4	5	6	7	8	9 10
2003	Poor									Good
	0	1	2	3	4	5	6	7	8	9 10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: The last two years we have put a lot of effort in improving the prevention of STI's including HIV and in expanding access to anonymous VTC for STI's including HIV.</i>										

II. POLITICAL SUPPORT

Strong political support includes government and political leaders who speak out often about AIDS and regularly chair important meetings, allocation of national budgets to support the AIDS programmes and effective use of government and civil society organizations and processes to support effective AIDS programmes.

1. Does the head of the government and/or other high officials speak publicly and favourably about AIDS efforts at least twice a year?

Head of government
Other high officials

No (not at least twice every year)
Yes

2. Does your country have a national multi-sectoral HIV/AIDS management/coordination body recognized in law? (National AIDS Council or Commission)*

No

2.1 IF YES, when was it created? Year:

2.2 Does it include?

Terms of reference	<i>Yes</i>	<i>No</i>
Defined membership	<i>Yes</i>	<i>No</i>
Including civil society	<i>Yes</i>	<i>No</i>
PLHIV	<i>Yes</i>	<i>No</i>
Private sector	<i>Yes</i>	<i>No</i>
Action plan	<i>Yes</i>	<i>No</i>
Functional Secretariat	<i>Yes</i>	<i>No</i>
Date of last meeting of the Secretariat	Date:	

Comments: We don't have one national body. The Ministry of Health is responsible for HIV/AIDS policy and has delegated tasks (e.g. coordinating tasks) to the Centre for Infectious Disease Control (part of the National Institute for Public Health and the environment). The Ministry of Health has also delegated tasks and funds NGO's to coordinate HIV/AIDS and STI control and to execute tasks. We have a 'platform on STI's, HIV and sexual Health' which meets four times a year and in which all relevant parties (government, NGO's, PLWHA, medical personal, prevention workers etc.) are represented. We do have a multi-sectoral approach.

3. Does your country have a national HIV/AIDS body that promotes interaction between government, PLHIV, the private sector and civil society for implementing HIV/AIDS strategies/programmes?

No

3.1 IF YES, does it include?

Terms of reference	<i>Yes</i>	<i>No</i>
--------------------	------------	-----------

Defined membership	Yes No
Action plan	Yes No
Functional Secretariat	Yes No
Date of last meeting	Date:

Comments: The government works very closely together with civil society and funds and delegates task to NGO's and the HIV patient association (such as prevention programmes, policy advice).

4. Does your country have a national HIV/AIDS body that is supporting coordination of HIV-related service delivery by civil society organizations?

Yes

4.1 IF YES, does it include?

Terms of reference	Yes No
Defined membership	Yes No
Action plan	Yes No
Functional Secretariat	Yes No
Date of last meeting	Date:

Comments: The Centre for Infectious disease control (National Institute for Public Health and the environment) coordinates HIV-related services by civil society.

Overall, how would you rate the political support for the HIV/AIDS programme?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	<u>8</u>	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	<u>7</u>	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: In 2005 the government decided to improve prevention programmes on a national level and to improve local VTC services and invest extra money in VTC.</i>											

III. Prevention³

1. Does your country have a policy or strategy that promotes information, education and communication (IEC) on HIV/AIDS to the general population?

³ Strategies/policies discussed under *Prevention* may be included in the national strategy/action framework discussed in I.1 or separate

Yes

1.1 In the last year, did you implement an active programme to promote accurate HIV/AIDS reporting by the media?

Yes

Comments: We actively work on getting relevant and sound information to the media, e.g. by press conferences and press releases. STI AIDS Netherlands informs and educates the public on HIV/AIDS and other STI's (through government funding).

2. Does your country have a policy or strategy promoting HIV/AIDS related reproductive and sexual health education for young people?

Yes

2.1 Is HIV education part of the curriculum in

primary schools No secondary schools No

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes

Comments: Both young men and woman are educated and informed. Where necessary it is tailored to the sex. Schools are not obliged to education on HIV/ Aids however programmes and trainings are offered and used. There are also other means of education for young people (mass media campaigns, internet, outreach activities etc.)

3. Does your country have a policy or strategy to promote IEC and other preventive health interventions for most-at-risk populations?

Yes

3.1 Does your country have a policy or strategy for these most-at-risk populations?

Injecting drug users, including: - Risk reduction information, education and counselling? - Needle and syringe programmes? - Treatment services? - If yes, drug substitution treatment?	Yes Yes Yes Yes
Men who have sex with men?	Yes
Sex workers?	Yes
Prison inmates?	Yes
Cross-border migrants, mobile populations	Yes
Refugees and/or displaced populations?	Yes
Other most-at-risk populations? <i>Please specify</i>	Yes

Comments: Other groups: migrants from endemic countries, young people and PLWHA

4. Does your country have a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities? (These commodities include, but are not limited to, access to VCT, condoms, sterile needles and STD drugs)

Yes

Do you have programmes in support of the policy or strategy?

A social marketing programme for condoms?	No
A blood safety programme?	Yes
A programme to ensure safe injections in health care settings?	Yes
A programme on ante-natal syphilis screening	Yes
Other programmes? <i>Please specify</i>	Yes

Comments: ante-natal screening on HIV and Hepatitis B, harm reduction programmes

Overall, how would you rate policy efforts in support of prevention?											
2005	Poor										Good
	0	1	2	3	4	5	6	7	<u>8</u>	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	7	<u>8</u>	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>											

5. Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV prevention policy/strategy?

(Check all programmes that are implemented beyond the pilot stage to a significant portion in both the urban and rural populations).

	2003	2005
a. A programme to promote accurate HIV/AIDS reporting by the media.	a. <u> x </u>	a. <u> x </u>
b. A social marketing programme for condoms	b. <u> </u>	b. <u> </u>
c. School-based AIDS education for youth	c. <u> x </u>	c. <u> x </u>
d. Behaviour change communications	d. <u> x </u>	d. <u> x </u>
e. Voluntary counselling and testing	e. <u> x </u>	e. <u> x </u>
f. Programmes for sex workers	f. <u> x </u>	f. <u> x </u>

g. Programmes for men who have sex with men	g. <input checked="" type="checkbox"/>	g. <input checked="" type="checkbox"/>
h. Programmes for injecting drug users, if applicable	h. <input checked="" type="checkbox"/>	h. <input checked="" type="checkbox"/>
i. Programmes for other most-at-risk populations	i. <input checked="" type="checkbox"/>	i. <input checked="" type="checkbox"/>
j. Blood safety	j. <input checked="" type="checkbox"/>	j. <input checked="" type="checkbox"/>
k. Programmes to prevent mother-to-child transmission of HIV	k. <input checked="" type="checkbox"/>	k. <input checked="" type="checkbox"/>
l. Programmes to ensure universal precautions in health care settings	l. <input checked="" type="checkbox"/>	l. <input checked="" type="checkbox"/>

Overall, how would you rate the efforts in the implementation of HIV prevention programmes?											
2005	Poor										Good
	0	1	2	3	4	5	6	<u>7</u>	8	9	10
2003	Poor										Good
	0	1	2	3	4	5	6	<u>7</u>	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>											
<i>On a national level there was put more effort into prevention programmes but on a local level the effort differs and did not improve on the whole..</i>											

IV. Care and support⁴

1. Does your country have a policy or strategy to promote comprehensive HIV/AIDS care and support, with sufficient attention to barriers for women, children and most-at-risk populations? (Comprehensive care includes, but is not limited to, VCT, psychosocial care, access to medicines, and home and community-based care.)

Yes

2. Which of the following activities have been implemented under the care and treatment of HIV/AIDS programmes?

	2003	2005
HIV screening of blood transfusion	x	x
Universal precautions	x	x
Treatment of opportunistic infections (OI)	x	x
Antiretroviral therapy (ART)	x	x
Nutritional care	x	x
STI care	x	x
Family planning services	x	x
Psychosocial support for PLHIV and their families	x	x
Home-based care	x	x
Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)	x	x
Cotrimoxazole prophylaxis among HIV-infected people	x	x

⁴ Strategies/policies discussed under *Care and Support* may be included in the national strategy/action framework discussed in I.1 or separate

Post exposure prophylaxis (e.g. occupational exposures to HIV, rape) Other: <i>(please specify)</i>	x	x
--	---	---

Comments:

Overall, how would you rate the efforts in care and treatment of the HIV/AIDS programme?										
2005	Poor								Good	
	0	1	2	3	4	5	6	7	8	<u>9</u> 10
2003	Poor								Good	
	0	1	2	3	4	5	6	7	8	<u>9</u> 10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>										

3. Does your country have a policy or strategy to address the additional HIV/AIDS related needs of orphans and other vulnerable children (OVC)?

No

- 3.1 *IF YES*, Is there an operational definition for OVC in the country? Yes, No

IF YES, please provide definition: _____

- 3.2 Which of the following activities have been implemented under OVC programmes?

	2003	2005
School fees for OVC		
Community programmes		
Other: <i>(please specify)</i>		

Comments: As the number of HIV infected children is limited, we do not encounter specific problems with these children. In the Netherlands, there are specific schools for seriously ill children. However, due to effective treatment, most of the children can go to a normal school. We have specialised doctors and treatment centres for children living with HIV/Aids. There are hardly any AIDS-related orphans (non official number: two orphans).

Overall, how would you rate the efforts to meet the needs of OVC?		
2005	Poor	Good

	0	1	2	3	4	5	6	7	8	9	10
2003	Poor					Good					
	0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i> NA											

V. Monitoring and Evaluation^{5*}

1. Does your country have one national Monitoring and Evaluation (M&E) plan?

Yes

Years covered:

1.1. *IF YES*, was it endorsed by key partners in evaluation?

Yes

Comments:

1.2. Was the M&E plan developed in consultation with civil society, PLHIV?

Yes

2. Does the M&E plan include?

- data collection, analysis, reporting and information feed back

Yes

- well defined standardized set of indicators

Yes

- guidelines on tools for data collection

Yes

- a data management plan

Yes

3. Is there a budget for the M&E plan?

Yes

Years covered:

3.1 If yes, has funding been secured?

Yes

4. Is there a Monitoring and Evaluation functional Unit or Department?

Yes

⁵ The whole M&E section is relevant for the “Third One”

9. Is there a functional* Health Information System?

National level	Yes
Sub-national*	Yes

(*reporting regularly data from health facilities aggregated at district level and sent to national level, analyzed, and used at different levels)

10. Is there a functional Education Information System?

National level	No
Sub-national*	No

* If yes, please specify the level, i.e., district

11. Does your country publish at least once a year an evaluation report on HIV/AIDS, including HIV surveillance reports?

Yes

12. To what extent strategic information is used in planning and implementation?

Low High
 0 1 2 3 4 5 6 7 8 9 10

Comments: We have a system of reporting. All data are gathered, reported at preliminary stages and definite data are presented at a yearly meeting. All relevant parties (e.g. M&E, prevention/treatment workers, government officials, NGO's, PLWHA etc.) are present. The main conclusions, trends etc are discussed and advise on new actions is given.

Policy analyses is done by and advice (both pro-active and on request) is given by the 'platform on STI's, HIV and sexual Health'

13. In the last year, was training in M&E conducted

- At national level? Yes
- At sub-national level? Yes
- Including civil society? Yes

Overall, how would you rate the monitoring and evaluation efforts of the HIV/AIDS programme?										
2005	Poor									Good
	0	1	2	3	4	5	6	7	<u>8</u>	9 10
2003	Poor									Good
	0	1	2	3	4	5	6	<u>7</u>	8	9 10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>										
The new system (one national unit and yearly system of reporting) was										

implemented the last few years.

PART B

I. Human rights

1. Does your country have laws and regulations that protect people living with HIV/AIDS against discrimination (such as general non-discrimination provisions or those that specifically mention HIV, that focus on schooling, housing, employment, etc.)?

Yes

No

N/A

Comments:

We have general laws against discrimination

2. Does your country have non-discrimination laws or regulations which specify protections for certain **groups** of people identified as being especially vulnerable to HIV/AIDS discrimination (i.e., groups such as IDUs, MSM, sex workers, youth, mobile populations, and prison inmates)?

Yes

No

N/A

IF YES, please list groups:

3. Does your country have laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations?

Yes

No

N/A

IF YES, please list:

For people who are illegal in the country it is difficult to have good access to prevention and care. It is not impossible, but the legal demands make it difficult.

The last few years several people living with HIV have been prosecuted after having unsafe sex. Some people see this as a threat to being open about their HIV-status or do not seek for testing facilities because of this.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV/AIDS policy/strategy?

Yes

No

N/A

Comments:

5. Has the Government, through political and financial support, involved vulnerable populations in governmental HIV policy design and programme implementation?

Yes

No

N/A

IF YES, give examples:

In the development of the prevention program all groups, including PLWHA are included. The Association for PLWHA are financed to contribute to prevention activities and also receive funding for the patient information on all aspects of living with hiv/ aids.

6. Does your country have a policy to ensure equal access, between men and women, to prevention and care?

Yes No N/A

Comments:

7. Does your country have a policy to ensure equal access to prevention and care for most-at-risk populations?

Yes No N/A

Comments:

The only exception are people who are illegal in the Netherlands. Since quite a group of them come from countries with high-prevalence of HIV they belong to the most-at-risk groups. Illegal persons don't have equal access. They only have access to medical care that is necessary. In practice this means that some get quite some good care, but it is dependent on how the health professionals define 'necessary care'.

8. Does your country have a policy prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits)?

Yes No N/A

9. Does your country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes No N/A

- 9.1 *IF YES*, does the ethical review committee include civil society and PLHIV?

Yes No N/A

Comments: The ethical committees are not specific for HIV/ Aids

10. Does your country have the following monitoring and enforcement mechanisms?

- Collection of information on human rights and HIV/AIDS issues and use of this information in policy and programme development reform

Yes No X

- Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions and ombudspersons which consider HIV/AIDS related issues within their work

Yes X No

- Establishment of focal points within governmental health and other departments to monitor HIV-related human rights abuses

Yes No X

- Development of performance indicators or benchmarks for compliance with human rights standards in the context of HIV/AIDS efforts

Yes No X

11. Have members of the judiciary been trained/sensitized to HIV/AIDS and human rights issues that may come up in the context of their work?

Yes No X

12. Are the following legal support services available in your country?

- Legal aid systems for HIV/AIDS casework

Yes X No

- State support to private sector laws firms or university based centers to provide free pro bono legal services to people living with HIV/AIDS in areas such as discrimination

Yes X No

- Programmes to educate, raise awareness among people living with HIV/AIDS concerning their rights

Yes X No

13. Are there programmes designed to change **societal attitudes** of discrimination and stigmatization associated with HIV/AIDS to understanding and acceptance?

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV/AIDS?											
2005	Poor							X			Good
		0	1	2	3	4	5	6	7	8	9 10
2003	Poor									X	Good
		0	1	2	3	4	5	6	7	8	9 10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: Especially on the prosecution of PLWHA the ministry of Health has taken a much clearer position which it also promotes amongst the other ministries. Next to that there has been new policy on</i>											

Overall, how would you rate the efforts to increase civil society participation?												
2005	Poor								X			Good
		0	1	2	3	4	5	6	7	8	9	10
2003	Poor								X			Good
		0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>												

III. Prevention

- Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV prevention policy/strategy?

(Check all programmes that are implemented beyond the pilot stage to a significant portion of both the urban and rural populations).

	2003	2005
A programme to promote accurate HIV/AIDS reporting by the media.	a. _____	a. ____
A social marketing programme for condoms	b. _____	b. ____
School-based AIDS education for youth	c. <u>X</u>	c. <u>X</u>
Behaviour change communications	d. <u>X</u>	d. <u>X</u>
Voluntary counselling and testing	e. <u>X</u>	e. <u>X</u>
Programmes for sex workers	f. <u>X</u>	f. <u>X</u>
Programmes for men who have sex with men	g. <u>X</u>	g. <u>X</u>
Programmes for injecting drug users, if applicable	h. <u>X</u>	h. <u>X</u>
Programmes for other most-at-risk populations*: migrants	i. <u>X</u>	i. <u>X</u>
Blood safety	j. <u>X</u>	j. <u>X</u>
Programmes to prevent mother-to-child transmission of HIV	k. <u>X</u>	k. <u>X</u>
Programmes to ensure safe injections in health care settings	l. <u>X</u>	l. <u>X</u>

* Please define

Overall, how would you rate the efforts in the implementation of HIV prevention programmes?												
2005	Poor								X			Good
		0	1	2	3	4	5	6	7	8	9	10
2003	Poor								X			Good
		0	1	2	3	4	5	6	7	8	9	10

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:

More effort and policy is directed at implementation of prevention programs on a national level. On a local level there is a lack of policy to implement

IV. Care and support

1. Which of the following activities have been implemented under the care and treatment of HIV/AIDS programmes?

	2003	2005
HIV screening of blood transfusion	X	X
Universal precautions	X	X
Treatment of opportunistic infections (OI)	X	X
Antiretroviral therapy (ART)	X	X
Nutritional care	X	X
STI care	X	X
Family planning services		
Psychosocial support for PLHA and their families	X	X
Home-based care	X	X
Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)	X	X
Cotrimoxazole prophylaxis among HIV-infected people	X	X
Post exposure prophylaxis (e.g. occupational exposures to HIV, rape)	X	X
Other: (please specify)		

Overall, how would you rate the care and treatment efforts of the HIV/AIDS programme?												
2005	Poor										Good	
	0	1	2	3	4	5	6	7	8	X	9	10
2003	Poor										Good	
	0	1	2	3	4	5	6	7	8	X	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>												

2. Does your country have a policy or strategy to address the additional HIV/AIDS related needs of orphans and other vulnerable children (OVC)?

Yes No X N/A

- 2.1 Which of the following activities have been implemented under the OVC programmes?

	2003	2005
School fees for OVC		
Community programmes		
Other: (please specify)		

Comments: Since there are hardly any OVC because of HIV/AIDS this is not a field of specific policy.

Overall, how would you rate the efforts to meet the needs of OVC?												
2005	Poor											Good
		0	1	2	3	4	5	6	7	8	9	10
2003	Poor											Good
		0	1	2	3	4	5	6	7	8	9	10
<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>												