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HIV/AIDS in Europe

Report
Social, Health and Family Affairs Committee
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Summary

HIV/AIDS has become a global disease, with the number of people living with HIV/AIDS continuously increasing. In 2005 the global total reached 40.3m, up from 37.5m in 2003. In 2005 4.9m new infections were registered, including 700,000 children. And 3.1m people, of whom 570,000 were children, died of AIDS-related illnesses.

Sub-Saharan African continues to be the worst-affected area, accounting for two-thirds of all people living with HIV. But the number infected is also increasing sharply elsewhere, especially Eastern Europe and Central Asia, where it jumped from 1.2m in 2003 to 1.6m in 2005. Russia, Ukraine and Estonia have an estimated HIV prevalence rate of over 1% of the population

These facts and figures show that prevention campaigns and the development of antiretroviral therapy (ART) have not had the effects they should have had. "AIDS fatigue" is a major obstacle to listening to these facts. The younger generations put little meaning to prevention campaigns when they explore their own sexuality. There is still the belief that HIV is an epidemic of 'others' and 'foreigners' and that when acquired**,** it can easily be managed through antiretroviral therapy.

From the beginning, HIV/AIDS has indeed been a 'politically charged' disease. It has pitted rich against poor, and puritans against realists. In most of the world, HIV/AIDS originally affected fairly marginalised groups, usually sex workers, men who have sex with men and intravenous drug users. In most societies these people are very vulnerable. Democracies like them no more than autocracies. When it comes to receiving help from taxpayers, these vulnerable groups are generally not at the top of the agenda, especially in countries so poor that basic health care is not available to most citizens.

The rapporteur believes that countries should address the structural determinants that underpin the HIV epidemic. HIV/AIDS is not only a health concern but also a human rights concern. HIV/AIDS strategies are closely linked to strengthening the general European values on human security and the protection of human rights, including sexual and reproductive rights, the rights of minorities and the fundamental rights of migrants, refugees and displaced persons. These rights are in many countries still violated when it concerns HIV+ people. This results in stigma and discrimination, lack of access to treatment and subsequently a risk of increased transmission.

On a global and national level, efforts to prevent the escalation of the HIV epidemic must be intensified. Overturning the HIV/AIDS pandemic requires having the courage to do what is known to be effective. HIV prevention requires that governments and communities have the courage to confront difficult issues in an open and informed way. (Even if the rapporteur understands that in many settings there is a cultural resistance to openly discussing sex, sexuality and drug use**.**)

A. Draft resolution

1. The Parliamentary Assembly recalls its Resoution 812 (1983) on the acquired immune deficiency syndrome (AIDS), Recommendation 1080 (1988) on a co-ordinated European health policy to prevent the spread of AIDS in prisons, Recommendation 1116 (1989) on AIDS and human rights as well as its Resolution 1399 (2004) and Recommendation 1675 (2004) on a European Strategy for the promotion of sexual and reproductive health and rights in view of the devastating impact HIV/AIDS has on human, social and economic development.

2. It also recalls the International Guidelines on HIV/AIDS and Human Rights, issued by the Joint United Nations programme on HIV/AIDS (UNAIDS) and the United Nations High Commissioner for Human Rights (UHCHR) in 1998, and the Declaration of Commitment on HIV/AIDS adopted by the United Nations General Assembly Special Session on HIV/AIDS in 2001 and the draft political declaration adopted by the United General Assembly Special Session on HIV/AIDS in 2006 as well as the European Union statement on HIV Prevention for an AIDS Free Generation of December 2005.

3. While reaffirming the Millennium Development Goals (MDGs) contained in the United Nations Millennium Declaration, the Assembly is aware that the achievement of the MDGs, will not be possible unless progress is made in addressing the challenge of sexually transmitted infections including HIV/AIDS and Sexual and Reproductive Health and Rights.

4. The Assembly is concerned that :

4.1. each year the number of people infected with HIV continues to rise; including the number of children who are being orphaned by HIV/AIDS,

4.2. physiologically and due to discrimination women are particularly vulnerable to HIV/AIDS;

4.3. ignorance and intolerance are still a reason for the marginalisation of persons affected or presumed to be affected by HIV/AIDS, which causes discriminatory acts in the fields of medical assistance, job opportunities, education, housing and, in general, in every aspect related to their social well-being,

4.4. some Governments are still reluctant to acknowledge the existence and gravity of the HIV/AIDS pandemic, and to recognise that stigma and discrimination faced by people living with HIV/AIDS, particularly women, hampers the effectiveness of responses to this pandemic.

5. The Assembly recognises that the global HIV/AIDS pandemic constitutes a formidable challenge to human life and dignity and to the full enjoyment of human rights, and that the full realisation of human rights and fundamental freedoms for the people affected is an essential element in the global response to the pandemic.

6. It also affirms that respect for, and the protection and fulfilment of, the human rights of women and girls are necessary and fundamental components of the approach to addressing HIV/AIDS. Moreover, the struggle against HIV/AIDS can not be separated from the struggle against poverty, which affects primarily women and children, thus undermining the workforce and hindering economic and social development,

7. The Assembly considers that although the use of antiretroviral medication combined with proper therapies can delay the advance of HIV/AIDS, millions of infected people cannot afford these treatments. In that context, it stresses that under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) of the World Trade Organization (WTO), WTO members may allow the production of patented medicines in the event of health emergencies, and it encourages World Health Organisation (WHO) member States to utilise fully the flexibilities in the TRIPS Agreement to promote access to antiretrovirals and other essential pharmaceutical products,

8. Aware that the realisation of the rights of people living with HIV/AIDS requires non-discriminatory access for them to services, including health care, treatment and social and legal services, within a supportive social environment, the Assembly is convinced that

8.1. recognising the degree of the infection levels of the HIV/AIDS pandemic within each country will help the respective governments tailor their prevention, treatment, care and support programmes to meet their particular needs;

8.2. capacity-building in the field of public health is critical to the effective prevention and treatment of HIV/AIDS;

8.3. any response to the epidemic will be effective only if it addresses the causes of its spread, including human trafficking, in particular trafficking in women and girls, drug abuse and illicit drug trafficking and gender-based violence, and in this context the pivotal roles of the family, religion and long-established fundamental ethical principles and values need to be underlined.

9. While emphasising that the HIV/AIDS pandemic is at the same time a medical, social and economic emergency, the Parliamentary Assembly calls upon parliaments and governments of the Council of Europe to:

9.1. ensure that their laws, policies and practices respect human rights in the context of HIV/AIDS, in particular the rights to education, work, privacy, protection and access to prevention, treatment, care and support;

9.2. protect people living with HIV/AIDS from all forms of discrimination in both the public and the private sectors, promote gender equality, ensure privacy and confidentiality in research involving human subjects, and provide for speedy and effective judicial, administrative and civil remedies in the event that the rights of people living with HIV/AIDS are violated;

9.3. ensure the development and accelerated implementation of national strategies for women's empowerment, inter alia by ensuring they have access to property rights, by promoting and protecting women's full enjoyment of all human rights and by reducing their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence; and protect the rights of women living with HIV/AIDS to make free decisions about their sexuality and reproductive health in particular by ensuring access to services that prevent mother to child transmission of HIV and provide pregnant women with access to long term ARV treatment;

9.4. adopt and finance the measures necessary to ensure, on a sustained basis and for all affected persons (irrespective of social status, legal situation, gender, age or sexual orientation), the availability and accessibility of good quality services and information for HIV/AIDS prevention, management, treatment, care and support, including the provision of HIV/AIDS prevention supplies such as male and female condoms, safe injection needles, and basic preventive care materials, as well as affordable antiretroviral drugs and other safe and effective medicines, psychological support, diagnostics and related technologies, for all persons, with particular attention to vulnerable individuals and populations such as women and children;

9.5. implement measures to increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through education, including peer education, and access to the provision of health care services, including those related to sexual and reproductive health;

9.6. adopt the measures necessary to continue, intensify, combine, make mutually beneficial and harmonise national and multinational research and development efforts aimed at developing new treatments for the fight against HIV/AIDS, including paediatric HIV/AIDS drugs prepared specifically for us in children living with HIV/AIDS, new means of prevention and new diagnostic tools and tests, including vaccines and female-controlled prevention methods such as microbicides;

9.7. recognise the health, socio-economic and other effects of HIV/AIDS on individuals, families, societies and nations, and to take the appropriate legislative and executive social measures to halt its spread;

9.8. adopt and implement policies that respect the human rights of persons living with HIV/AIDS, and through all available media, to advocate for and raise awareness of their rights;

9.9. develop and implement national legislation and policies that address the needs and human rights of the growing number of children orphaned and made vulnerable by the HIV/AIDS pandemic;

9.10. ban compulsory HIV/AIDS screening for people applying for travel visas, university enrolment, jobs, or asylum, in favour of voluntary testing;

9.11. establish coordinated, participatory, transparent and accountable national policies and programmes for HIV/AIDS response, and to translate these national policies into action at the district and local levels, wherever possible involving, in development and implementation, non-governmental and community-based

organisations, religious organisations, the private sector, and more importantly, people living with HIV/AIDS, and particularly the most vulnerable among them, including women and children.

10. The Parliamentary Assembly further invites member states of the Council of Europe to:

10.1. prepare national strategies with targets to stopping by 2015 the spread of HIV/AIDS and of beginning to reverse the development of this pandemic;

10.2. sponsor the official launch of national HIV/AIDS Strategies and the periodic establishment of national and regional reports taking stock of the degree of achievement of the fight against HIV/AIDS and the achievement of the MDGs, in particular in the field of the fight against HIV/AIDS;

10.3. in conformity with United Nations Security Council resolution 1325 (2000) on women, peace and security, to ensure adequate HIV/AIDS awareness training for members of the military and the police, and for peacekeeping personnel;

10.4. coordinate efforts with and support the work of the United Nations, non-governmental organisations and other bodies or institutions involved in HIV/AIDS prevention in order to ensure that the human rights of individuals living with HIV/AIDS are upheld and protected;

10.5. address poverty issues, intrinsically linked with HIV/AIDS and implement multisectoral approaches, to combat the negative effect on economic and social development;

10.6. allocate sufficient resources to their health systems, including resources for manpower and HIV/AIDS prevention, treatment, care and support; taking into consideration the UNAIDS "Three Ones" guiding principles for national authorities and their partners;

10.7. implement the measures recommended in the UNAIDS/WHO document Guidance on ethics and equitable access to HIV treatment and care to promote equity in the distribution of HIV care in resource-limited settings.

11. The Parliamentary Assembly calls upon parliaments to:

11.1. draw up laws or amend existing legislation to define national standards of protection for those suffering from HIV/AIDS, and especially for people in vulnerable groups, such as women and children, with particular attention paid to the situation of anyone suffering from the loss of close family members as a result of HIV/AIDS;

11.2. review and adjust legislation to ensure that it conforms to the International Guidelines on HIV/AIDS and Human Rights;

11.3. enact legislation to punish those who wilfully transmit HIV/AIDS.

12. In order to attain these goals, the Assembly calls upon parliamentarians to:

12.1. be informed about HIV/AIDS and act as advocates for people living with HIV/AIDS and demonstrate an ‘openness of approach’ in dealing with HIV;

12.2. speak out to reduce stigmatisation, social taboos and discrimination, and address myths;

12.3. visibly demonstrate the political will and commitment to combating HIV/AIDS, participate in national HIV bodies and support to NGOs including faith-based NGOs and community organisations addressing sexual and reproductive health and rights, sexually transmitted infections, HIV/AIDS and drug related issues, as well as private enterprises working in the area of HIV/AIDS;

12.4. create parliamentary committees and/or other structures formally linked to parliaments with the specific task of tackling the issue of halting and reversing the spread of HIV/AIDS, to share experiences, information and best practices and to involve all sectors of society through partnership programmes in high-level decision-making processes;

12.5. effectively utilise the parliamentary processes to provide for increased accountability and strengthen national mechanisms such as commissions, tribunals, legislation and coordinated strategies to protect, enforce and monitor, in their respective countries, the human rights of individuals infected with and affected

by HIV/AIDS, and to eliminate all forms of stigma and discrimination, especially in respect of vulnerable groups.

13. Finally the Parliamentary Assembly calls for special attention to be given to preventing HIV/AIDS by disseminating adequate and target group-oriented information, using all available media and multipliers, raising awareness and educating both men and women, with particular attention paid to adolescent boys and girls; and requests the inclusion of sex education in school curricula, for both boys and girls, as a means of prevention; it urges the national and local agencies concerned to give high priority to assisting pregnant and breastfeeding women suffering from HIV/AIDS in order to protect their babies from infection and provide mothers with ARV treatment to slow the progress of the HIV infection and thereby ensure they live longer and healthier lives.

B. Draft recommendation

1. The Parliamentary Assembly of the Council of Europe refers to its resolution … on European Strategy on HIV/AIDS in Europe and recommends that the Committee of Ministers:

1.1. forward this Resolution to the Governments of members states and request them to take it into account when formulating legislation and developing national HIV/AIDS Strategies;

1.2. instruct the appropriate committee, namely the European Health Committee in cooperation with relevant European partners to:

1.2.1.promote an exchange of experiences between members states on successful national HIV/AIDS strategies and approaches;

1.2.2. promote dialogue on HIV/AIDS and sexual and reproductive health in public health policy and protect the rights from a European Human Rights perspective and address the development and testing of medicines specifically for use in children living with HIV, and new technologies such as microbicides and HIV/AIDS vaccines;

1.2.3. support the development of HIV/AIDS indicators for comparable data;

1.2.4. develop guidelines to assist member states in drafting national HIV/AIDS strategies;

1.2.5. elicit responses from governments of members states on their progress in combating HIV/AIDS.

C. Explanatory memorandum by Mrs McCafferty, Rapporteur

I. INTRODUCTION

1. HIV/AIDS has become a global disease, with the number of people living with HIV/AIDS continuously increasing. In 2005 the global total reached 40.3m, up from 37.5m in 2003. In 2005 4.9m new infections were registered, including 700,000 children. And 3.1m people, of whom 570,000 were children, died of AIDS-related illnesses.

2. Sub-Saharan African continues to be the worst-affected area, accounting for two-thirds of all people living with HIV. But the number infected is also increasing sharply elsewhere, especially Eastern Europe and Central Asia, where it jumped from 1.2m in 2003 to 1.6m in 2005. Russia, Ukraine and Estonia have an estimated HIV prevalence rate of over 1% of the population.

3. It is estimated that in Eastern Europe and Central Asia around 62,000 people died of AIDS and some 270,000 were newly infected with HIV in 2005. The majority of people living with HIV in this region are young; 75% of the reported infections between 2000 and 2004 were people younger than 30 years of age while in Western Europe the corresponding figure was 33%.

4. Where in the past the majority of infections in Eastern Europe and Central Asia were due to injecting drug use, sexual transmission has now a growing share of the new infections. In Kazakhstan and Ukraine around 30% and in Belarus and the Republic of Moldova 45% of the newly reported HIV infections were due to unprotected sex. An increasing number of women are being affected, many of them acquiring HIV from male partners who became infected when injecting drugs. Injecting drug users who are also sex workers have a combined risk for transmission.

5. Since the transition of countries in Eastern Europe and Central Asia to market economies and, in varying degrees, democratic governments, HIV/AIDS very quickly became a major threat to health, economic stability and human development. The dramatic social and political change led to increased intravenous drug use, economic decline and failing healthcare systems and services.

6. Governments have been slow to recognize and respond to the epidemic and the health systems do not allow for appropriate registration. There is also a strong professional opposition to evidence-based medicine. All of these elements form important obstacles to the development of health-promoting public policies.

7. In Western Europe where infection rates had been declining or had stabilised, new HIV infections are increasing again, in some countries. These increases are partly due to heterosexual contact in people originating mainly from countries in sub-Saharan Africa, an increase is also seen with men who have sex with men in some countries.

8. These facts and figures show that prevention campaigns and the development of antiretroviral therapy (ART) have not had the effects they should have had. “AIDS fatigue” is a major obstacle to listening to these facts. The younger generations put little meaning to prevention campaigns when they explore their own sexuality. There is still the belief that HIV is an epidemic of ‘others’ and ‘foreigners’ and that when acquired, it can easily be managed through antiretroviral therapy.

9. HIV/AIDS is not only a health concern but also a human rights concern. HIV/AIDS strategies are closely linked to strengthening the general European values on human security and the protection of human rights, including sexual and reproductive rights, the rights of minorities and the fundamental rights of migrants, refugees and displaced persons. These rights are in many countries still violated when it concerns HIV+ people. This results in stigma and discrimination, lack of access to treatment and subsequently a risk of increased transmission.

10. There is no room for complacency. Over two decades into the epidemic, less than one person in five has access to basic HIV prevention services. The advent of effective and affordable treatment is welcomed but without a massive scaling-up of HIV prevention the trend in increasing numbers of people being infected each year will continue. This poses a major threat to countries’ ability to sustain progress towards treatment for all in need. Against this background, it is timely for the member States of the Council of Europe to review their commitments to Sexually Transmitted Infections (STIs) and HIV prevention as well as unplanned pregnancies as an integral component of a comprehensive HIV/AIDS response.

11. In fact, this year is an unusual and highly symbolic year in the fight against HIV/AIDS, since it is the 25th anniversary of when, in June 1981, the story of five gay men in Los Angeles with a mysterious pneumonia was published, since which time 65 million people have become infected and 25 million died of AIDS.

12. In addition, it is also the 10th anniversary of the discovery that antiretroviral treatment (ART) can stop the development of the disease and return people to their normal lives, which revolutionized the disease, at least in rich countries. It is only recently that this remarkable technological development is also becoming available in poorer countries, and it still remains a dream for many millions of people who need it today especially for women and children.

13. 2006 also marks the fifth anniversary of the special session of the UN General Assembly devoted to HIV/AIDS – the first time that the UN, at the highest political level, with 35 heads of state present, discussed a health issue and transformed HIV/AIDS from a public health problem, which of course it still is, into an issue that is discussed at the highest political level.

14. In the framework of the preparation of this report – based on reference No. 3005 (8 October 2004) – the Social Affairs Committee held a hearing with UNAIDS experts, Tanzanian Parliamentarians AIDS Coalition and NGOs from Sweden and Russia (17 December 2004), see Appendix I. On 23 September 2005 in Moscow, the Sub-Committee held a hearing on the situation in Russia. The rapporteur also visited AIDS Infoshare, a Russian NGO working in the field of HIV/AIDS. It particularly focuses on HIV prevention work, the protection of health, the defence of human rights, and does HIV/AIDS surveillance work in the Russian Federation, see Appendix II. The report draws on the conclusions of these consultations.

i. Regional characteristics: Western and Central Europe

15. More than half a million people are living with HIV in Western Europe, and that number continues to grow with signs in several countries of a resurgence of risky sexual behaviour. The biggest change in Western Europe has been the emergence of heterosexual contact as a major cause of new HIV infections in several countries. A substantial proportion of new diagnoses are in people originating from countries with serious epidemics, principally countries in sub-Saharan Africa.Risky sexual behaviour among men who have sex with men is also leading to an increasing number of new infections.

16. Of the more than 20,000 newly diagnosed HIV infections in 2004 (excluding Italy, Norway and Spain, where data was not available), more than one third were in women.

17. Although injecting drug use accounts for a diminishing share of newly diagnosed HIV infections in most Western European countries, it remains an important factor in several countries' epidemics, among them Italy, Portugal and Spain. In Portugal (where the rates of new HIV diagnoses are higher than elsewhere in Europe), injecting drug use still accounted for almost 50% of HIV diagnoses in 2002. HIV prevalence of 20% and higher is still being found among injecting drug users in parts of other countries (including France, Italy and the Netherlands). Some newly diagnosed HIV infections are acquired through sex workers and some through Mother to Child Transmission of HIV (MTCT). Some countries have succeeded in reducing HIV prevalence among sex workers, primarily due to policies supporting condom use with clients and to initiatives directly involving sex workers in condom promotion. Many countries have also been successful in decreasing MTCT through Voluntary Counselling and Testing (VCT), elective caesarean sections, ART and alternatives to breast milk.

18. In the countries of central Europe (including the Czech Republic and Hungary), numbers of new HIV infections have stayed stable since the late 1990s, with most of the new infections being recorded in Poland. In the Czech Republic, Hungary, Slovenia, and the Slovak Republic, sex between men is known to be the predominant mode of HIV transmission.

19. Unlike elsewhere in the world, a large majority of people in most countries in this region who need antiretroviral treatment do have access to it. As a result, the numbers of people developing AIDS and dying from AIDS have remained low since the introduction of ART in the mid-to-late 1990s.

20. In Western Europe, that trend has persisted, with deaths among people living with AIDS decreasing steeply from 3,905 in 2000 to 2,252 in 2004 - a 42% drop. In contrast, in Eastern Europe, where antiretroviral treatment coverage is limited, the number of people dying from AIDS has tripled since 2000.

21. Moreover, in some countries, a large share of HIV infections remains undiagnosed. In the United Kingdom, for example, an estimated one third of people with HIV do not know their serostatus and are likely

to discover it only once afflicted by HIV/AIDS related illnesses. There is also worrying evidence of antiretroviral drug resistance among some newly HIV-infected individuals in Western Europe.

ii. Regional characteristics: Eastern Europe and Central Asia

22. HIV has consolidated its presence in every part of the former Soviet Union, with the exception of Turkmenistan (where little information is available on the HIV epidemic). Several Central Asian and Caucasian republics are experiencing the early stages of epidemics, while quite high levels of risky behaviour in south-eastern Europe suggests that HIV could strengthen its presence there unless prevention efforts are stepped up.

23. The bulk of people living with HIV in this region are in two countries: the Russian Federation and Ukraine. Ukraine's epidemic continues to grow, with more new HIV diagnoses occurring each year, while the Russian Federation has the biggest HIV/AIDS epidemic in Europe. Both epidemics have matured to the point where they constitute massive prevention, treatment and care challenges.

24. At the heart of the countries' epidemic are the extraordinarily large numbers of young people who inject drugs. There were more than 340,000 registered injecting drug users in the Russian Federation at the end of 2004, though the actual number could be four to ten times as high. Unsafe drug injecting practices still account for most HIV transmission, with an estimated 30-40% of injecting drug users using non-sterile needles or syringes, which greatly increases the odds of HIV transmission.

25. The epidemic, meanwhile, is maturing. Most drug injectors are sexually active and, if HIV-infected, they can transmit the virus sexually to their casual or regular partners (since many of them do not engage in protected sex). Consequently, a significant rise in sexual transmission has been observed. About 6% of registered infections were related to sexual transmission in 2001; by 2004, that proportion had grown to 25% (Federal Service of the Russian Federation in Consumer Rights Protection and Human Welfare, 2005).

26. More women are acquiring HIV. Whilst the majority of people living with HIV in the Russian Federation are men, about 38% of total registered HIV cases are in women—a bigger share than ever before.

27. Meanwhile, more children are being born to HIV-positive mothers, making prevention of mother-to-child transmission a priority with specific attention to preventing primary HIV infection in women, preventing unwanted pregnancies in women living with HIV/AIDS, providing access to safe Caesarian Sections and safe alternative to breastfeeding and provide ARV treatment both to the mother and the child. Reported cases of pregnant women with HIV have increased greatly in the past six years, and the total number of children born to HIV-positive mothers in the Russian Federation now exceeds 13,000 (Russian Federal AIDS Centre, 2005). According to one recent survey, HIV-positive women and children, face widespread discrimination, including from health care professionals, (Human Rights Watch, 2005).

28. It is significant that by mid 2005 fewer than 10 % (a mere 4,000-6,500 people) of those in need of antiretroviral therapy in Russia were receiving it.

II. AREAS FOR CONCERN

i. Human Rights

29. Comprehensive HIV prevention depends on good governance and a supportive legal environment nationally and internationally. The HIV/AIDS pandemic continues to be fuelled by human rights abuses, such as the denial of the right to education about safer sex, violence against sexual minorities and other marginalized groups such as women and children, and mandatory HIV testing. Human rights violations add to the stigmatization of people at highest risk of infection and thus marginalize and drive underground those who need information, preventive services and treatment most desperately. Human rights abuses also follow infection and make it more difficult for people living with HIV and AIDS to prevent further ill health and to protect against onward transmission. National governments **must adopt laws and policies that protect and enforce the human rights** of their citizens as they relate to HIV/AIDS, sexual and reproductive health and rights, gender and international law.

ii. Prevention

30. Prevention remains the cornerstone for all other activities within the comprehensive approach to tackle HIV/AIDS. **Investment in education and information is needed**. HIV/AIDS is linked with stigma and

discrimination, and is often met with suspicion and ignorance. Awareness and evidence-based information are prerequisites for effective and successful responses to HIV/AIDS.

31. Evidence-based results of current prevention programmes tell us that they do not protect everyone. The ABC approach (Abstain; Be faithful, Use a condom) has been the approach towards prevention adopted by many major agencies. However, evidence from Africa and Asia shows that marriage is not a protective factor. In some areas married women are more likely to become infected with HIV than their unmarried counterparts. In marriage abstinence is not an option and women are unable to ensure their partner's faithfulness or condom use. The ABC approach is further eroded by the US administration's promotion of abstinence only programming. Many NGOs are receiving substantial funding for HIV prevention but with restrictions on comprehensive programming, particularly condom use. ABC fails to recognise the complex realities of comprehensive prevention; therefore prevention needs to be re-invented in order to place greater emphasis on how each new HIV infection takes place within its own socio-economic and political dimension.

32. Traditional prevention efforts have largely targeted those who are HIV negative. This is crucial, yet ignores the needs and important role of those who are HIV positive. Greater programmatic efforts need to be placed on addressing the sexual and reproductive needs of HIV positive people. Prevention for HIV positive people is an essential ingredient of linking prevention and care, and involves ensuring people living with HIV/AIDS (PLWHA) protect their sexual health, avoid other sexually transmitted infections, delay HIV disease progression and avoid passing HIV infection to others.

33. Linked to the importance of addressing the prevention needs of the HIV positive community is the role of people living with HIV/AIDS in policy and programme development. While the GIPA (Greater Involvement of People living with AIDS) principle has been endorsed and supported, it is abundantly clear that its implementation is failing. PLWHA networks need to be supported and political leadership is needed to ensure that GIPA moves from rhetoric to action.

34. Given the high transmission of HIV infection among injecting drug users, targeted prevention activities, including harm reduction programmes and needle exchange, need to be stepped up. The possession of clean needles by injecting drug users (IDUs) need to be decriminalized, as their vulnerability to HIV is greatly intensified in prison and therefore undermines any prevention programmes.

35. The rapidly increasing number of HIV positive children is driven by a failure to prevent mother to child transmission (MTCT). Globally, 90% of all HIV positive children are infected through MTCT. Providing a mother with a full range of preventative MTCT services, including elective caesareans, ARV treatment and alternatives to breast milk, can reduce the transmission to less than 2%. It is vital to scale-up programmes to prevent MTCT by providing the resources, technical assistance and new medicines to all women and children who need them.

iii. Surveillance

36. Decisions on public health have to be based on evidence. Therefore surveillance is vital to provide reliable and timely information so that the size and nature of the epidemic and trends over time can be estimated. Unfortunately, even within Europe the surveillance systems vary from country to country and resources to ensure a consistent collection are limited. HIV/AIDS case reporting has evolved into the key instrument for monitoring the epidemic in Europe. It is therefore crucial to have data from all European countries. Better strategies and more targeted measures need better information on the behavioural risk factors, like condom use or exchanges of needles and syringes.

37. In countries with low HIV prevalence, surveillance should also be organised in a way to detect early signs of the entry of HIV into the population groups more exposed to risk of infection. To help plan future treatment and service needs, the true number of new HIV infections per year [HIV incidence] should also be known. At the moment the majority of the newly reported cases are in fact infections contracted many years earlier.

iv. Voluntary counselling and testing, treatment, care and support

38. Affordable and accessible services and good treatment results can help reducing stigma and social exclusion and promote responsible sexual behaviour which, in turn, contributes to preventing the spread of HIV. There is a need for a comprehensive set of health services and systems to provide good quality treatment and care. VCT is vital for all services as it allows early diagnosis of HIV infection and ensures timely access to appropriate intervention for the infected. These services should also cover people living with HIV/AIDS with hepatitis B, hepatitis C or tuberculosis co-infection.

39. Drug substitution therapy for IDUs is an important component of services contributing to effective treatment and care. People living with HIV/AIDS should play an active role in managing their condition (treatment preparedness). The services provided should be supportive, inclusive and empowering, giving people more control over their lives. Social services should be integrated with health services where possible and should be specifically sensitive to vulnerable groups.

40. ART makes a significant impact on the quality of life of people living with HIV/AIDS. Successful use of ART implies considerable efforts to maintain adherence to lifelong treatment, plus resources to monitor response, drug toxicities and interactions. In several countries the lack of experienced service providers to reach certain vulnerable groups, such as injecting drug users and migrant populations, can further complicate the management of treatment. Training of service providers in quality of care and the respect of human rights needs to be emphasized.

41. Increased global pressure to act on the linkages between HIV/AIDS and sexual and reproductive health has ensured that there are greater synergies and better linkages between the services to tackle the epidemic. The recent UK APPG on PD&RH Parliamentary Hearing Report "The Missing Link" on Linking Sexual and Reproductive Health and HIV/AIDS and the UNAIDS/WHO/UNFPA/IPPF document *Framework for Priority Linkages,* both build on the *New York Call to Commitment* and the *Glion Call to Action*. However, translating these calls into action requires, for example, that global resources are directed into supporting these linkages and parliamentarians must get involved with civil society and show crucial leadership. The GFATM (Global Fund for AIDS, Tuberculosis and Malaria) serves as a good example of an unexplored avenue for ensuring that at a country level these linkages are acted upon.

v. Involving civil society

42. The importance of creating partnerships and of advocacy cannot be overemphasised. From the very beginning of the epidemic, community based organisations have been leaders in activism, advocacy, empowerment, and providing services. In countries where combating HIV/AIDS has been a success, the role of non-governmental organisations and more generally civil society has been crucial. We have to ensure that the voice of organisations representing HIV/AIDS patients are not just heard but involved in policy development. Therefore, the civil society, district and municipal levels of local government, as well as the private sector, need to be involved and enjoy governmental support to prevent further spread of HIV and to improve the quality of life of people living with HIV/AIDS.

III. RECOMMENDATIONS

43. The rapporteur suggests that the following are critical components of a comprehensive and evidence based response and urges Governments of the Council of Europe Member States to:

- develop and implement sound national multisectoral HIV/AIDS strategies, integrate their HIV/AIDS response into the mainstream of development planning and ensure the full and active participation of civil society, the business community and the private sector;

- ensure that the impact of poor SRHR Health and HIV/AIDS is included in the core indicators for measuring progress in implementing national strategies;

- protect and promote human rights of people living with HIV/AIDS, women and children, and people in vulnerable groups, and ensure that they are centrally involved in all aspects of the response;

- take action to confront and address gender based violence and to provide protection and support to victims of violence, including actions to prevent sexual violence at any time and specifically, as an act of war, through the education and training of armed forces;

- establish and enforce legislation and policies to eliminate HIV/AIDS-associated stigma and discrimination against people living with HIV, injecting drug users, sex workers, men who have sex with man and other vulnerable populations and encourage efforts to support community mobilisation and, at all levels, actions that challenge and combat HIV related stigma and discrimination;

- remove legal, regulatory or other barriers that block access to effective, evidence based HIV-prevention interventions and high quality commodities such as male and female condoms and harm reduction, including substitution therapy and clean injection equipment;

- guarantee access to comprehensive sexual and reproductive health information and services for women, men and young people, including people living with HIV/AIDS, to ensure that they have access to a full range of sexual and reproductive choices in accordance with the Cairo/ICPD Programme of Action;

- ensure equal access to services including HIV/AIDS treatment, along with recognition and support for home-based caregivers of people living with HIV/AIDS and orphans;

- provide accessible and integrated health promotion and harm reduction services for drug users;

- guarantee access to education, the provision of life-skills and sexuality education to increase protection against abuse, rape, unintended pregnancy and sexually transmitted infection including HIV;

- stimulate the integration of HIV prevention interventions, including voluntary counselling and testing for HIV, into other health services, including sexual and reproductive health, family planning, maternity and tuberculosis services including provision of maternal to child transmission services for HIV infected pregnant women, and strengthen existing health care and social systems.

- promote the adoption of good workplace practice in all places of employment; this should include universal infection control and blood safety to prevent onward transmission for patients, health workers, emergency staff and other front line workers;

- take measures where needed, to retain and motivate health workers, educators and community workers, including people living with HIV/AIDS and youth workers;

- adapt measures to strengthen human resources to provide HIV prevention, care and treatment to enable health, education and social systems to mount an effective HIV/AIDS response.

- support investment in the development of new biomedical prevention technologies including microbicides and vaccines and, recognising that these will not be available in the immediate future, place renewed emphasis on operational research on sexual health and behaviour to inform the design, delivery and use of existing HIV and AIDS prevention information, services and supplies;

- commit to an increase in the national budget to HIV/AIDS and SRHR services, including commodities, and increase the long-term funding of non governmental organisations' working in the area of HIV/AIDS prevention, care and treatment and those working on sexual and reproductive health and rights and assist civil society organisations in Eastern Europe through increased targeted support.

IV. CONCLUDING REMARKS

44. From the beginning, HIV/AIDS has been a politically charged disease. It has pitted rich against poor, and puritans against realists. In most of the world, HIV/AIDS originally affected fairly marginalised groups, usually sex workers, men who have sex with men and intravenous drug users. In most societies these people are very vulnerable. Democracies like them no more than autocracies. When it comes to receiving help from taxpayers, these vulnerable groups are generally not at the top of the agenda, especially in countries so poor that basic health care is not available to most citizens.

45. If HIV/AIDS is not prevented or contained, it soon affects all populations, as it has in Africa. There, it affects every section of the population—slum-dweller and sophisticate, peasant and professional. Everyone who engages in that near universal activity, sex, is at risk. As it is, HIV/AIDS is no respecter of morals: it affects babies as they are born, children as they are orphaned, and nurses as they are accidentally pricked by a dirty needle, patients of any kind as they receive a transfusion of contaminated blood.

46. Indeed, it affects the entire society in which its victims live and die. The lesson for rich and poor alike is that to contain HIV/AIDS, morality must take a back seat. Politicians may find it easier to yield to sanctimonious lobbyists than to explain why refraining from judging other people makes more sense. But that does not excuse them. Too many lives are at stake.

47. The rapporteur believes that countries should address the structural determinants that underpin the HIV epidemic; this demands action to reduce poverty and placing the protection, promotion and respect of human rights including gender equality, the elimination of gender based violence, stigma and discrimination at the foundation of all HIV/AIDS policy and programme planning and implementation.

48. The rapporteur also believes that these interventions must be designed to reach all vulnerable people including women, children and young people, drug users and their sexual partners, men who have sex with men, bi-sexual men, sex workers, trafficked women, prisoners, migrant and refugee populations and people living with HIV and AIDS.

49. On a global and national level, efforts to prevent the escalation of the HIV epidemic must be intensified. Overturning the HIV/AIDS pandemic requires having the courage to do what is known to be effective. HIV prevention requires that governments and communities have the courage to confront difficult issues in an open and informed way. (Even if the rapporteur understands that in many settings there is a cultural resistance to openly discussing sex, sexuality and drug use.)

50. HIV prevention needs to be put on an equal footing with HIV treatment. The goal should be to have an HIV-free generation: priority should be given to keeping infants and young people free from HIV, which is maybe even more challenging than access to treatment, but we simply have to do it. In the long run, it will mean changing norms and values in society. Finally, we must work urgently and immediately to strengthen existing delivery systems, which often are the 'Achilles heel' of many programmes.

* * *

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11. Minutes from Moscow Hearings (AS/Soc/Health (2005) PV 1)

Appendix I

Hearing of the
Parliamentary Assembly, Social, Health and Family Affairs Committee
Paris, 17 December 2004

During the hearing, the Committee heard evidence from and held an exchange of views with the following persons:

Mrs Irina Savtchenko, technical adviser at UNAIDS

Mrs Lediana Mafuru Mng'ong'o Tanzania Parliamentarians AIDS Coalition

Mrs Anastasia Kamlyk, representative of the "positive movement" NGOs

Mr Jan-Olof Morfeldt, Executive Director, Noaks Ark-Red Cross Foundation

Appendix II
Parliamentary Assembly, Social, Health and Family Affairs Committee

Programme of the visit of the Rapporteur to Russia 22-23 September 2005

Rapporteur:
Mrs Christine McCAFFERTY (MP, United Kingdom, SOC)

Secretariat:
Dana KARANJAC – Former Co-Secretary to the Committee
Agnes NOLLINGER – Secretary to the Committee
Judy BUTLER – Assistant to the Committee
Accompanying person :Kari MAWHOOD (United Kingdom)

Wednesday 21st September 2005

Arrival of Mrs McCAFFERTY in Moscow

Thursday 22nd September 2005

Meeting with AIDS Infoshare NGO at 1st Dorozhniy Proezd 9/10, office 350, Moscow
In attendance were Vlad MOGUILNY, Programme Director and Marina NIKITINA, Project Co-ordinator, GLOBUS as well as a large number of AIDS Infoshare staff who work on a number of their projects.

The organisation works with people with HIV, including target groups like commercial sex workers in Moscow and the Moscow region where they run several outreach programmes. They were set up as an NGO 12 years ago and originally focussed on data collection for HIV/AIDS at what was the beginning of the epidemic in Russia. There was a great need at that time for such an organisation. The NGO now has 29 workers that work in partnership with 10 Russian regions and also have close links to groups in St Petersburg. AIDS Infoshare used to deal mainly with prevention, this has moved towards a more supportive role for people with HIV/AIDS.

The charity works with GLOBUS and seeks to gain as much response as possible from regional groups. They undertake comprehensive research work and are members of the Coordination Council on AIDS for the Russian Federation. There will be a regional conference on HIV/AIDS in Eastern Europe and Central Asia in May 2006 – the first of its kind – and it will be held in Moscow. This will bring together the relevant politicians and experts in this field for updates and strategies on HIV/AIDS.

The two main areas that the NGO felt that the rapporteur should concentrate on were:

- prevention and treatment, which are inextricably connected
- access to treatment, which is vital

Friday 23rd September 2005

09.30 All day hearings held at the State Duma, Moscow.
Evidence was received from:

Vera OSKINA, Member of the State Duma Committee on Labour and Social Policy, Member of the PACE Sub-Committee on Health (Russia)

Vadim POKROVSKY, Head of the Russian Federal AIDS Center

Valery ZUBOV, Member of the State Duma Committee on Credit Organisations and Financial Markets, Member of the Interfactional Deputies' Working Group on Prevention and Fight Against AIDS

Christine McCAFFERTY, Rapporteur, Chair of UK All-Party Parliamentary Group on Population, Development and Reproductive Health

John TEDSTROM, President of Transatlantic Partners Against AIDS

Bertil LINDBLAD, Country Coordinator of Joint United Programme on HIV/AIDS (UNAIDS) in the Russian Federation

Elena DMITRIEVA, IPPF European Network President and Director of Health Russia Foundation

Mikhail GRISHANKOV, First Deputy Chair of State Duma Committee on Security, Member of the Interfactional Deputies' Working Group on Prevention and Fight Against AIDS

Gadzhimet SAFARALIYEV, First Deputy Chair of State Duma Committee on Local Governance, Member of the Interfactional Deputies' Working Group on Prevention and Fight Against AIDS

Aleksander GOLIUSOV, Head of the HIV Prevention Department of Federal Service on Monitoring of Customers' Rights and Human Wellbeing, Russian Ministry of Health Care and Social Development

Neil GERRARD, Chair of UK All-Party Parliamentary Group on AIDS

Akram ELTOM, World Health Organisation, 3x5 Country Officer

Flavio MIRELLA, UNODC Representative in the Russian Federation

Egor KORCHAGIN, Head of Healthcare Department of Krasnoyarsk Kray Administration

Marina ZHURAVLEVA, PhD Professor, I.Sechenov Moscow Medical Academy (on behalf of the Federal Service on Monitoring in Healthcare and Social Development, Russian Ministry of Healthcare and Social Development)

Aleksey BOBRIK, Deputy Director, Open Health Institute Foundation

Svetlana POLUBINSKAYA, Senior Researcher, Institute of State and Law, Russian Academy of Sciences

Saturday 24th September 2005

Departure of Mrs McCAFFERTY from Moscow

Appendix III

Account of the Rapporteur's fact-finding visit to Southern Spain
(22-25 July 2006)

In Europe there are different policies regarding HIV prevention, and voluntary testing and counselling, including the health care of HIV-infected people with a precarious residence status (asylum seekers and mobile populations). Also, national laws and local regulations might impose barriers, to the unlimited access, to the HIV-related services available to the local population.

In most European countries, HIV positive people, with a precarious residency status, are threatened with expulsion, to countries where treatment is not accessible. This policy can seriously limit the fundamental rights of people to health care, and can be seen as a violation of article 3 of the European Convention on Human Rights.

Epidemiological information about HIV infection in Spain, is based upon the National Registration of AIDS, which is a case notification system. This data has been used to inform various studies about HIV, in different groups and in particular, the immigrant population.

Although immigration in Spain is a relatively recent phenomenon, in recent years the immigrant population has grown so dramatically in size, that it has reached up to 6.24% of the total Spanish population.

The economic, cultural and social characteristics of the immigrant population, plays a very important role in determining health factors. In this context, prevention of HIV infection, in these communities, could pose a major problem.

Since the beginning of the epidemic, there have been 2,009 migrant cases of HIV in Spain, which constitutes 2.9% of presented cases. The most frequent origin of these was Latin America (27%), followed by sub-Saharan Africa (22%) and Western Europe (21%).

The epidemic of AIDS in Spain has fundamentally affected the indigenous population, although the proportion of diagnosed people, from other countries of origin, has increased in recent years.

Amongst the people who were voluntarily tested for HIV in 2000-2002, a third came from outside Spain, predominantly from Latin America. Amongst the newly diagnosed with HIV infection, from voluntary analysis in 2003, homosexual relations were the most common cause of infection. Source : Spanish Ministry of Health / October 2004.

Spain is an entry gate to Europe and a country where the tendency to migrate has changed dramatically, in the last fifteen years; it used to be a country "exporting" its work force, but now it has turned into a "receiving" country for migrants.

Spain is also an entry point for migrants, who want to travel to other countries in Europe. However, a large percentage of these transitory migrants, end up settling in Spain, due to the migration process presenting a much higher risk, for them being deported, due to the obstacles posed by the police.

The most vulnerable group of the migrant population, are those who have remained in the Spanish enclaves, like the towns of Ceuta and Melilla, on the North African coast. In the last few years, there has been an increase in migrants settling in such places.

This situation is a result of the difficulties of getting a visa, to enter Europe. For example, to enter Spain legally by boat, from Morocco, costs between 20 and 30 Euros, and entering by illegal means (with all the associated risks) costs around 1,500 Euros.

Since 2000, Spanish authorities have created centres of temporary stay, for migrants Inevitably, these centres were immediately overcrowded, because there were too many migrants, in the same situation.

Those migrants lucky enough to be accepted into such a centre, are well looked after by concerned and caring professionals. However, the limited numbers of places available, in these temporary detention centres, must have direct humanitarian and health consequences, for the migrant population.

Every migrant must go through a comprehensive health check, including an HIV test. For those diagnosed sero-positive, treatments are not started, if there is no guarantee of further treatment. Within this context, the actions of NGOs can be hampered, by the authorities, who sometimes make it more complicated, or even impossible, for them to do their job.

However, Spain does appear to treat HIV positive economic migrants and asylum seekers, with more sympathy, than many other Council of Europe member states.

Few national plans on AIDS, consider the mobility of the population, as an important factor to the epidemic. A favourable context should be created to give the right information and services to migrants with HIV/AIDS.

Spain does have a national plan concerning HIV/AIDS. Currently within this plan, there is gradual progression towards tackling HIV/AIDS amongst migrants, with a department dedicated to migrants and ethnic minorities, working in collaboration with the various NGOs, in the field.

However, there should be particular focus on the demographic movements and their link with HIV/AIDS, as well as adapted community resources (with enough resources) to help migrants in their daily life and their challenges.

Migrant communities are often segregated and marginalised. Their reintegration when they return to their home country is sometimes difficult too, as their families and communities evolve during their absence.

Some creative trans-border prevention, information, treatment and care actions allow migrants to be informed before their migration process, during migration and in their new country of residence. These actions involve the networking of NGOs, governments and the creation of auto-support associations within the communities.

Mobility is not by itself, a risk factor, to contract HIV/AIDS; the situations and the potential behaviour patterns adopted, during the migration process, are the factors, that increase vulnerability and the risk of getting infected by HIV.

Migrants can be marginalised from society during their transit, in their destination country, or in returning to their homeland. They can be victims of discrimination, xenophobia, exploitation, and accusation. They also have very little or no judicial, social and health protection. This increases their vulnerability to the HIV infection and also the difficulties of living with HIV/AIDS.

Migrants often have scarce or non-existent information on HIV; neither do they have acceptable access to the health system and to methods of HIV prevention.

Poverty and lack of income, may force migrants to increase their risk in contracting HIV, they may need to negotiate or sell sexual intercourse, possibly unprotected, to keep on living, or go on with their migratory process.

There is still much to do, to improve the situation of migrants living with HIV/AIDS,. They should have better access to the legal and health system, and receiving countries should be more aware, of the migrants' social and cultural backgrounds, in order to improve standards of care. There should be more efforts made towards counselling and voluntary testing, as well as, protection against the stigma and discrimination for people living with HIV.

Migrants living with HIV/AIDS often return to their own country, without knowing that they are infected. People who know their serological status are in a better position, to seek help and support, as well as to protect themselves and their partners.

We must remember that in developed and developing countries, the AIDS epidemic is a public health issue, however, in the developing world; it is now also an economic problem.

Throughout history, the migration process has been a way, that people have tried to improve their economic, social and health conditions.

Taking migrants into account, is a necessity for the world fight against HIV/AIDS, as they are potential agents of information and change, concerning HIV/AIDS, between countries of origin and transitory and residence regions

Reporting committee: Social, Health and Family Affairs Committee

Reference to Committee: Doc. 10307, Reference N° 3005 of 08.10.2004

Draft resolution and recommendation unanimously adopted by the Committee on 14 September 2006

Members of the Committee: Mrs Christine **McCafferty** (Chair), Mrs Patrizia Paoletti Tangheroni (2nd Vice Chair), Mrs Helena Bargholtz (3nd Vice Chair), MM. Vicenç Alay Ferrer, Giuseppe Arzilli, Jorodd **Asphjell**, Miguel Barcelo Perez, Miroslav Benes, Andris Berzins, Jaime Blanco, Mr Jean-Marie **Bockel,** Mrs Marida Bolognesi, Mrs Monika Bruning, Mr. Saulius Bucevicius, Ms Sanja Cekovic, MM. Igor Chernyshenko, Dessislav **Chukolov**, Mr John **Dupraz**, Mme Minodora Cliveti, M. Imre Czinege, Mrs Helen D'Amato, MM. Dirk Dees, Stepan Demirchayan, Karl Donabauer, Ioannis Dragassakis, Sören Espersen, Nigel **Evans**, Claude **Evin**, Mr Paul **Flynn**, Mrs Margrét **Frimannsdottir**, Mrs Doris Frommelt, MM. Jean-Marie Geveaux, Mr Stepan **Glävan**, Mr Marcel Glesener (alternate: Mr Jean **Huss**), MM. Igor Glukhovskiy, Mrs Claude Greff , MM. Ali Riza **Gülçiçek**, Michael **Hancock**, Mykhailo Hladiy, Mrs Sinikka **Hurskainen**, MM. Rafael Huseynov, MM. Fazail Ibrahimli, Mustafa **Ilicali**, Mrs Gratiela Denisa **Iordache**, Mrs Halide Incekara, Mr Denis Jacquat, Mrs Krinio Kanellopoulou, Mr Andras Kelemen, Mrs Katerina Konečná, M. Bohdan Kostynuk, Mrs Marie-José Laloy, MM. Slaven Letica, Jan Filip Libicki, Gadzhy Makhachev, Bernard **Marquet,** Paddy McHugh, Mrs Ljiljana Milićević, Philippe Monfils, Mrs Nino Nakashidzé, Mr Conny **Öhman,** Mrs Vera Oskina, Mrs Lajla Pernaska, MM. Cezar Florin **Preda**, Fiorello Provera, Anatoliy Pysarenko, Mrs Adoración Quesada (alternate: Mme Blanca **Fernandez-Capel**, MM. Andrea **Rigoni**, Walter **Riester,** Ricardo Rodrigues, Mrs Marlene Rupprecht, Mrs Maria de Belém Roseira, MM. Fidian Sarikas, Walter **Schmied**, Mrs Anna Sobecka, Mrs Darinka **Stantcheva**, Mrs Ewa **Tomaszewka,** MM. Oleg Tulea, Alexander Ulrich, Milan Urbani, Bart van **Winsen**, Mrs Ruth-Gaby Vermot-Mangold, Mr Aleksandar Vucic, Angela Watkinson, Mrs Gisela Wurm, Mr Andrej Zernovsksi, Mrs Barbara Žgajner-Tavs, N. …, N. …

N.B. The names of those members present at the meeting are printed in bold

Head of Secretariat: Mr Geza Mezei
Secretaries: Ms Agnès Nollinger, Ms Christine Meunier