

UNGASS COUNTRY PROGRESS REPORT

The Netherlands and the Netherlands Antilles

Reporting period: January 2006–December 2007

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I. STATUS AT A GLANCE	2
Writing process	2
Summary of the epidemic	2
Response	2
1. <i>Primary prevention</i>	2
2. <i>Optimising tracing and treatment</i>	2
3. <i>Human rights and access to facilities in society</i>	3
<i>National coordination</i>	4
II. OVERVIEW OF THE HIV/AIDS EPIDEMIC	5
Diagnosed HIV cases in the Netherlands	5
Anonymous unlinked HIV surveys among high risk populations	7
III. NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC	8
Prevention:	8
Care/treatment and support:	8
Knowledge and behaviour change:	8
Impact alleviation	8
Youth	9
Men who have sex with men	9
Migrants	9
People with hiv	9
Prostitution:	10
Intravenous Drug Users:	10
Staff working in Dutch Embassies in HIV endemic area	10
IV. BEST PRACTICES	10
V. MAJOR CHALLENGES	10
VI. SUPPORT REQUIRED	11
VII. MONITORING AND EVALUATION	11
VIII. OVERVIEW SITUATION NETHERLANDS ANTILLES	13
ANNEXES	15

I. STATUS AT A GLANCE

Writing process

This report is based on earlier reports and compiled by the Centre of Infectious Disease Control, RIVM. The report was discussed with the Ministry of Foreign Affairs and has been subject of discussion during an STI/HIV Platform meeting, where all relevant NGOs and PHW are represented. STI/Aids Netherlands has been instrumental in coordinating specific response from NGOs, for instance for filling in Part B of the NCIP and collecting indicator-data related to prevention and behaviour.

Summary of the epidemic

In June 2007, a cumulative total of more than 13000 HIV cases, under medical care had been registered in the Netherlands. The adult HIV prevalence rate across the total population of age 15-49 is estimated at 0.23% [2005 estimate]. The total number of adults (15-49 years) living with HIV/AIDS in the Netherlands is estimated at 18500 [10000-28000] [estimate end of 2005]

Of all registered cases, 10130 (77%) were men and 2956 (23%) were women. In 2006, 871 newly diagnosed cases of HIV reported for treatment. In this group, MSM accounted for 59% of the new diagnoses, heterosexuals for 33% and IDU for 1%. The coming years, additional patients first diagnosed in 2006 may still report for treatment.

Response

The number and percentage positive of diagnosed HIV and other STI's have been on the rise in the period 2000-2005. Data from 2006 and (preliminary) from 2007 show that the trends have stabilised. The response in our country is based on 3 goals. For every principle we indicate the actions that were taken in 2003-2006.

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. For each risk group there is one coordinating organisation (ngo) for the prevention program aimed at that specific group. STI AIDS Netherlands is the expert organization and national ngo for the coordination of various prevention programs and the connection between them, Schorer specifically focuses on gay people, and Mainline on drug users. Major challenges in the promotion of safe sex exist among men who have sex with men and among ethnic minorities/migrant populations. For the first group, novel specifically tailored interventions need to be explored, for the latter there is still lack of knowledge and of effective interventions. The development of a mix of interventions that support safe sex among people with hiv is still in its early stages, which is in contrast to the high risk of this group. For the group of drug users prevention does not only focus on harm reduction by needle exchange programmes, as injecting drug use is on its decrease. Prevention is more and more focused on VTC and safe sex promotion, as druguse is still related to unsafe behaviour. Specific attention is paid to drug users on HIV treatment, to increase compliance.

2. *Optimising tracing and treatment*

In the Netherlands there are relatively many people that are not aware of their HIV status (estimates vary between 30-40%). 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 60% of the STI in the Netherlands are found by the GP's, the new protocol stimulates them to use contacts with patients to offer a HIV-test.
- the improvement of the organisation of the additional (non-GP) facilities for anonymous, voluntary and free of charge counseling and testing on HIV and other STI's. More testing facilities are in place since January 2006 and resources have increased from 6.4 to more than 17 million euros in 2007. The financing system is set up in a way that payment is related to the number of diagnosed STI, enhancing a risk-based approach.
- -mass media campaign and internet interventions that promote HIV-testing, particularly targeted at MSM . 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 often (from 54% in 2003 to 71% in 2004).

cART Treatment is available for all patients with an indication in the Netherlands (and has been since ART became available). Registration shows [2007] that 80% of the people with HIV who are in monitoring, are treated with cART. The other 20% are treated in another regimen and/ or not in need of cART yet, e.g. because of high CD4 counts. Initial treatment success is seen among 80% of those treated. Almost half of all treated patients were now using a regimen containing tenofovir instead of zidovudine, as zidovudine has a less favourable toxicity profile than tenofovir.

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, incidents of stigmatisation and discrimination of people with HIV remain a fact.

- Human rights and immigrants

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 other STI education and prevention. The situation is not so good for asylum seekers with HIV, whose request for asylum is rejected and who start a procedure for temporary stay on basis of their HIV status. 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.

For people who are infected with HIV and who are illegal in the Netherlands, the situation is even more difficult. They 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 a risk not only for the individual's health, but also for public health, as resistance is more likely to develop in these circumstances. Moreover, people struggling for a living may not always be able to prevent further spread.

- Prosecution of unsafe sex

Since 2001 the Public Prosecutor has prosecuted a number of people with HIV who had consensual sex but did not tell their partners of their own HIV-status. This development was in conflict with the policy of the Ministry of Health stating that everybody is responsible for each own's health. Based on a review made by an NGO committee, the Cabinet took the

position that people with HIV should not be prosecuted for unsafe sex unless force, disparity in terms of power or misleading are involved .

In 2007, this discussion set off again, based on several incidents where intentional infections were involved. Fortunately, the position of the Cabinet has not changed.

After it was suggested that some HIV positive men promoted unsafe sex by other HIV positive men, the HIV patient organisation clearly indicated that safe sex for HIV positive men should be stimulated.

- Hiv and insurances

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 the HIV patient organisation played an important role. 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) has also been instrumental.

On the basis of figures of the HIV Monitoring Foundation, the Insurers' Association is now 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 be higher but still affordable.

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.

National coordination

Since 2005 the Centre for Infectious Disease Control (which is related to the MoH) is responsible for the implementation of the national prevention policy. The CIB is responsible for funding NGOs and (through these NGOs) the municipal governments. Moreover, the Centre is coordinating VTC clinics and is the national unit for monitoring and evaluation. Finally, the Centre will coordinate activities related sexual and reproductive health, that will be incorporated in the VTC clinics next year.

II. OVERVIEW OF THE HIV/AIDS EPIDEMIC

Diagnosed HIV cases in the Netherlands

National HIV/Aids registry

By 1 June 2007, the total HIV-infected population registered in the database of the HIV Monitoring Foundation was 13,556 patients. Of these patients, 292 were being followed in Willemstad in Curaçao (HMF) ¹. Of these patients, 12,958 (97.7%) were infected with HIV-1, and 78 (0.6%) were infected with HIV-2. For 95 (0.7%) patients seroreactivity to both HIV-1 and HIV-2 were found, and for 133 (1.0%) patients serologic results were inconclusive or not (yet) known.

The majority of the 10,095 (76.1%) patients aged 13 years or older and in follow-up as of 1 June 2007 were men (77.9%) who originated from the Netherlands (58.5%) and were infected via homosexual contact (55.7%). In total, 1354 (13.4%) men and 1954 (19.5%) women were infected via heterosexual contact, whereas patients infected via injection drug use accounted for 3.5% of the population.

The prevalence of hepatitis B and C co-infection reportedly was approximately 10%. HBV was most frequently found in IDUs and MSM, whilst HCV was mostly found in IDUs..

The adult HIV prevalence rate across the total population of age 15-49 is estimated at 0.23% [2005 estimate]².

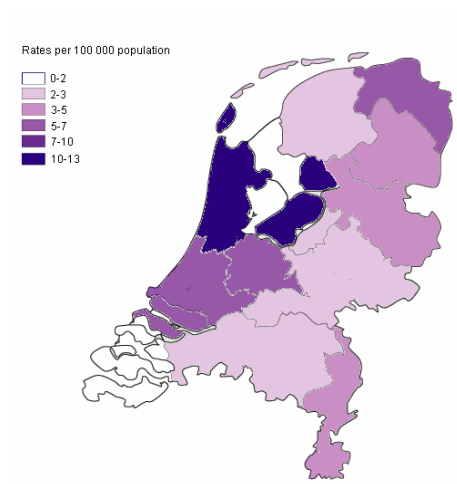


Figure 1: Number of HIV diagnoses in 2006 per 100000 inhabitants; calculations based on HIV infections recorded in the various HIV treatment centres in each province

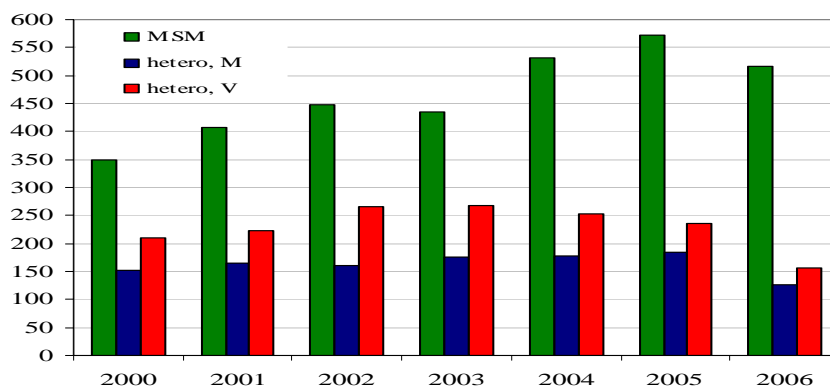
In 2006, 871 newly diagnosed cases of HIV were registered. In that year, MSM accounted for 59% of the new diagnoses, heterosexuals 33% and IDU 1%.

In 2004 and 2005, the number of newly diagnosed HIV cases in the HIV registry increased among MSM (up to 572). In 2006, 516 HIV infections among MSM registering for care were recorded, but this number may further increase due to reporting delay (Figure 6). The total number of HIV cases registered among heterosexual men remained relatively stable since 2000. The total number of registered cases among heterosexual women decreased slightly after 2002 (2006 still incomplete).

¹ www.hiv-monitoring.nl

² *Sexually transmitted infections in the Netherlands in 2005.*, IM de Boer, ELM Op de Coul, FDH Koedijk, MG. van Veen, AI van Sighem. MJIW van de Laar. RIVM report 441100024/2006, Bilthoven, the Netherlands

The number of HIV registrations recorded in IDUs is decreasing up to 1% in 2006.. Mother-to-child transmission and risk through blood (products) both accounted for less than 1% of the all registered infections in 2006. In 6% of the HIV cases the transmission risk group was unknown.



Footnote: only HIV patients with a known date of diagnosis are included (Source; HIV Monitoring Foundation)

Figure 2: Number of HIV cases, by year of HIV diagnosis and transmission risk group

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

	2005	2006
MSM	572 (52%)	516 (59%)
Heterosexual contact	421 (38%)	284 (33%)
IDU	14 (1%)	8 (0.9%)
Blood (products)	4 (0.4%)	3 (0.3%)
Mother to child	7 (0.6%)	2 (0.2%)
Needle stick injury	4 (0.4%)	4 (0.4%)
Other/NK	77 (7%)	56 (6%)
Total	1099	871

National registration STI centres

In 2006, 256 individuals were newly diagnosed with HIV (225 men and 31 women) at the STI centres³. Seventy-five percent (n=193) of all HIV infections were diagnosed among MSM. Among men, 53% were aged 25-39 years. Most diagnoses in women were made among women aged 20-29 years (45%).

Rates of positive HIV test results (the percentage of positive tests to the total number of HIV tests) were higher in MSM (3.1%) than in heterosexual men (0.2%) and women (0.1%). The highest rate was found in MSM aged 35-39 (6.7%). The positivity rate in MSM decreased for the first time after three years (2006: 3.1%, 2005: 5.0%). Despite this trend, the regular diagnosis of concurrent STI in this group indicates that unsafe sex practices are still common. In heterosexuals the positivity rate did not change significantly over the last four years (Figure 3).

³ Sexually transmitted infections in the Netherlands in 2006. MG. van Veen, FDH Koedijk, IVF van den Broek, ELM Op de Coul, IM de Boer. AI van Sighem. LAB. van der Sande. RIVM report 210261003/2007, Bilthoven, the Netherlands

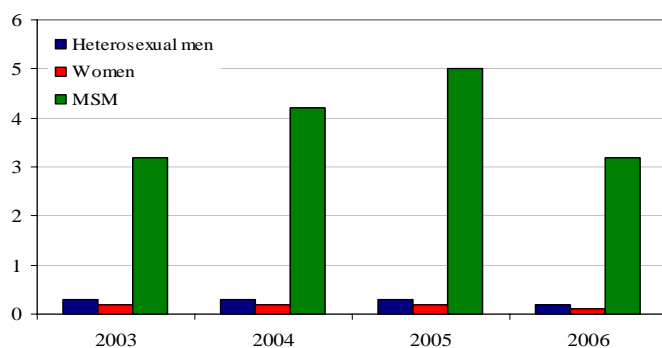


Figure 3. Rates of positive HIV test results by risk groups: heterosexual men, MSM, women, STI sentinel surveillance network, 2003-2006

Anonymous unlinked HIV surveys among high risk populations

Sub-Saharan Africans, Surinamese and Antilleans form relatively large migrant populations in the Netherlands. To obtain more insight in risk behaviour, 'intercultural mixing' (sexual contact between various ethnic groups), and the potential to further spread of HIV, anonymous unlinked surveys were conducted among these populations between 2002 and 2006. In 2006, a repeated survey was carried out in Rotterdam. In this survey the HIV prevalence among Antillean migrants increased compared to the first survey in 2002. Results are summarized in Table 2

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	0.0%	9%	43%	77%
	Amsterdam	2003/2004	0.7% [0.1-2.5%]	15%	53%	65%
	The Hague	2005	0.7% [0.2-2.0%]	12%	46%	73%
	Rotterdam	2006	0.8% [0.2-2.1%]	11%	54%	72%
Antilleans/ Arubans	Rotterdam	2002/2003	0.0%	9%	36%	26%
	Amsterdam	2003/2004	0.0%	9%	44%	67%
	The Hague	2005	0.6% [0.1-2.1%]	12%	53%	73%
	Rotterdam	2006	0.8-3.2%	4%	55%	68%
Cape Verdeans	Rotterdam	2002/2003	1.0% [0.1-3.8%]	12%	51%	81%
	Rotterdam	2006	0.7% [0.1-2.3%]	8%	59%	77%
Ghanaian	Amsterdam	2003/2004	0.6% [0-3.1%]	26%	57%	42%
	The Hague	2005	1.8% [0.6-4.3%]	12%	71%	75%

^v Condom use: last 6 months always used condoms

HIV screening in low risk populations

In the Netherlands, the only nationwide ongoing serosurveillance is that of blood donors and pregnant women. In 2006, 439131 blood donors were registered in the Netherlands. The overall prevalence and incidence of HIV antibodies have been low in that year: new donors: 3.1 per 10⁵ donors (prevalence), regular donors: 1.0 per 10⁵ donor years (incidence). Prevalence of HIV increased until 1994 and leveled off to a stable low prevalence thereafter.

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. Since 2006, the Centre for National Screening Programmes (CVB) is coordinating the screening program on infectious diseases in pregnant women. An evaluation of the programme is currently ongoing.

III. NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC

Changes in national commitment and programme implementation 2005-2007:
(see also I. Status at a glance)

Prevention:

In 2004 the policy was sharper focused on risk groups (including people with hiv), more emphasis was put on an active testing policy and access to 'low threshold' STI clinics was increased.

Prevention activities targeted at MSM were subject to an external evaluation in 2006. The evaluators concluded that activities were of high quality but could be strengthened.

In 2007 a new Centre for Healthy Living was established at the National Institute of Public Health (RIVM). Aim of this centre is to evaluate and assess public health interventions on behavioural change, and increase evidence. As HIV and STI prevention is also about 'making healthy choices', part of the prevention activities will be evaluated within the workplan of this new Centre. The centre will be partially 'virtual', staffed by people already working in prevention in related NGOs, and in the field of STIs will work closely with the Centre for Infectious Disease Control (CIb).

In 2008, a new policy on sexual and reproductive health will be further implemented. Coordination of local activities will be placed within the municipal health services, who are already responsible for HIV and STI prevention and control. Also at the National level, the steering of sexual and reproductive health will be linked to HIV and STI control (and vice versa). An additional research budget was made available for the development and adaptation of preventive interventions.

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 23 hiv-treatment centres spread out all over the Netherlands. Next to specialized clinicians, there are also specialized HIV/AIDS nurses active as case-managers. Mortality and morbidity related to HIV infections decreased dramatically over the last decade. Research shows that people with HIV are in general satisfied with the care they receive. Points of concern are the limited treatment success among ethnic minorities/migrants and the lacking interculturalisation of the care services. A continued challenge in the next period is the incorporating of support for the sexual health of people with HIV (including prevention of spread of HIV and other STIs) in the care context.

Knowledge and behaviour change:

A comprehensive systematic and national behavioural surveillance is not established, but current insights are based on a range of different studies. While these studies are not linked and thus nationwide comparable, they provide data from different perspectives. Results indicate a high level of HIV/AIDS knowledge among most high-risk groups (the exception being migrants and people with limited education), high intentions for safe sex among most of the high-risk groups, but a limited implementation of safe sex behaviour in reality for a minority within these high-risk groups. The major challenge therefore is to enhance skills needed to transform the intention for safe sex in actual behaviour and in creating a supportive environment for safe behaviour.

Impact alleviation

Policy is not indicated in the Netherlands

Youth

A national study into the sexual health of young people (12-25 year) in the Netherlands, carried out in 2005⁴, showed several interesting findings:

- At an age of 17 almost half of the young people had experience with sexual intercourse ; this is almost the same as in a study ten year ago (ref?). Only a small group (7%) had this experience at the age of 12/13 year.
- A substantial minority of the young people reported sexual intercourse and/or anal sex with four or more partners (37% of the boys and 28% of the girls). Casual sexual contacts were becoming less frequent with the growing age of the youngsters.
- The quality of their sexual contacts were perceived by the young as high: they experienced little feelings of shame or guilt and they were generally satisfied about the sexual contacts with their latest partner.
- Protective behaviour of the young people between 12 – 25 years was more frequently reported than 10 years ago. Some 75% used a condom at first intercourse; 63% of the boys and 56% of the girls also reported that oral contraceptives were used; 41% of the boys and 46% of the girls choose for 'Double Dutch' at first intercourse (pill and condom).

Men who have sex with men

In 2007 sexual behaviour among MSM was monitored in an online study⁵, as it was done in 2006. 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 remained about 30%. Unprotected (anal) sex was related to a positive HIV-status, having a steady partner, using drugs, visiting dark rooms or having casual partners through internet.

No changes were made in national commitment and programme implementation for the group MSM.

Migrants

Studies among three migrants groups in Rotterdam⁶ showed that condom use with steady partners was very low. Condom use with casual sex partners was low to moderate (table 2) Men from these groups had a higher sexual risk behaviour then women, they had more sexual partners, and had more sexual partners at the same time and they mixed more with sexual partners of other migrant groups. However, women reported condom use less often. Almost half of the studied migrant groups traveled to the land of origin. During their stay 19 – 32 % of them had sexual partners there. Condom use with sexual partners in the land of origin was relatively high (table 2).

People with hiv

In a recent online study among MSM⁵, 65% of the men with HIV reported having unprotected anal sex with their partner. In another (older) study⁷, 33% of HIV positive men who had casual sex partners reported having unprotected anal sex. 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.

⁴ 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

⁵ *Schorer Monitor 2007*, HJ Hospers, TT Dörfler, W Zuilhof

⁶ Van Veen MG et al. *Hiv surveys bij Surinamers, Antillianen en Kaapverdianen in Rotterdam 2006*. RIVM rapport 210261002/2007. Bilthoven: RIVM

⁷ 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)

In the earlier mentioned online study, 33% recorded having concurrent STIs. Data from the STI clinics³ showed that in 2006 46% of HIV positive MSM had concurrent STIs.

Prostitution:

See Country report Netherlands 2005². No new data available.

Intravenous Drug Users:

See Country report Netherlands 2005². No new data available.

Staff working in Dutch Embassies in HIV endemic area

Dutch Embassies that are placed in HIV endemic areas, are actively committed to the ILO code of conduct. HIV prevention and care is provided to all staff members.

IV. BEST PRACTICES

HIV and STI prevention and control in the Netherlands has its strengths and weaknesses. The establishment of a broad network of low threshold outpatient clinics for VTC, both for HIV as other STI's, can be considered as an important achievement. The fact that there is a basic insurance for everyone (although there are marginalised groups being uninsured), which is covering HIV treatment and care, only further increases the effectiveness of a VTC policy. But besides these 'measurable' practices, there is also a positive cultural environment for HIV and STI prevention. The government has a clear commitment towards prevention activities and it supports a wide range of NGOs that play a major role in carrying out these activities. Attention is paid to all vulnerable groups as this is considered to be more effective than a general approach. Discrimination or denial of any vulnerable group is not accepted.

Our country has been very successful in implementing harm reduction programs for IDU's which contribute to the fact that the prevalence of hiv/aids among this group is among the lowest in Europe.

Finally, we feel that the recent implemented strengthening for interaction between HIV, other STDs and sexual and reproductive health will provide a lot of synergy.

V. MAJOR CHALLENGES

The major challenges in the Netherlands remain more or less unchanged compared to 2005:

- Finding HIV-infections earlier; more people with high-risk behaviour should take tests: VTC clinics are established but there is continuous need to motivate risk groups and providers in other health care settings for screening.
- Strengthening the support for the sexual health of people living with HIV, including the prevention of spread of HIV and other STI's. The HIV patient foundation has already been strengthened. More interaction with HIV/Aids treatment centers and specialized nurses is needed to increase prevention within the curative sector.
- Strengthening tailored prevention, particularly targeted at MSM subgroups (based on evaluation).The major challenge remains to enhance skills needed to transform the intention for safe sex in actual behaviour and in creating a supportive environment for safe behaviour.
- Strengthening prevention targeted at ethnic minorities/migrant communities and stimulating behaviour change towards safe sex among these groups by developing community approach and developing effective interventions. A new national program started in 2006 but not all the planned activities are implemented yet.
- Strengthen national coordination, 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 in early stage with establishment coordination function at Centre for Infectious Disease Control)
- The primary prevention of hiv/aids needs to be more evidence based. Scientific research on the effectiveness of an intervention can be costly and time consuming and research resources are limited.
 - Incidents of stigmatization and discrimination of people with HIV remain a fact and thus a constant point of attention. We should continue to condemn incidents.
 - The unfavourable preconditions for therapy among illegal immigrants, remains a concern.
 - Finally, there is a continuous challenge in adjusting the needed investments for HIV/AIDS/STI control to the limited budget.

VI. SUPPORT REQUIRED

Not applicable for the Netherlands.

VII. MONITORING AND EVALUATION

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 evaluation of the Dutch strategy for preventing HIV and other STIs in MSM
- 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 Centre has also asked an external evaluation to provide guidance on how to perform its task, in order to have a more coordinated policy. The Centre for Infectious Disease Control also 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 are responsible for monitoring 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. 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.
The Centre is the competent body for the European Centre for Disease prevention and Control (ECDC) and therefore representing the field in the ECDC Advisory Forum.
- 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 reporting into specialized care. The HMF is one of the very few organisations in the world that systematically collects data on an observational clinical cohort that is truly nation wide, with 23 (24, including Curacao) 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 are or were followed up in one of the 23 national HIV Treatment centres.

- 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 towards relevant authorities.

Several NGOs also play an important role in monitoring an evaluation:

- 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 advises the government. They also represent Dutch NGOs in Aids Action Europe and in the Think Tank for the European commission.
- The HIV patient organisation monitors the response from a patient perspective.
- The Schorer foundation is periodically monitoring HIV/STDs in relation to behaviour among their target group, MSM.
- 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 a role in monitoring the response to the epidemic. It discussed recent developments and draws attention to weak spots in the system.
- Mainline monitors and evaluates infectious drug-related diseases such as hiv, hep B and c by contacts and communication with drugusers through outreach work.

In order to combine all expertise, a yearly 'surveillance expert meeting' is organized by the Centre of Infectious Disease control in which data on STI and HIV of the previous year are presented and discussed. All relevant parties (e.g. M&E, researchers, prevention and treatment workers, government officials, NGO's, PLWHA etc.) are invited. The main conclusions and new trends are discussed as well as suggestions for further activities (eg new or adjusted policy, surveillance, research).

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

VIII. OVERVIEW SITUATION NETHERLANDS ANTILLES ⁸

The data presented in this chapter are cumulative data of a laboratory based HIV-registration for the 5 islands of the Netherlands Antilles in the years 1985 thru 2006. Data are obtained from:

1. Analytic Diagnostic Center, Public Health Laboratory of the Netherlands Antilles
2. Red Cross Blood Bank, Curaçao
3. Central Bureau of Statistics for population data

The total cumulative known cases for 1985-2006 is 1729 persons. Of these there may well be some deceased but the data on mortality cannot be merged with the HIV-registration.

Of the 1729 known HIV-infected persons 988 (57.1%) are male and 741 (42.9%) are female. The majority (65.3%) of the registered HIV-infected were diagnosed in the age-group of 25-44 years of age and 3.7% are children diagnosed under 15 years of age. The mean age at diagnosis HIV+ for all 1729 registered persons was 37.2 years for males and 34.8 for females. The mean age at diagnosis HIV+ increased from approximately 31 years of age to approximately 40 years of age during the years 1985 through 2006.

Since 1990 there is a mean of approximately 85 new known HIV-infections per year for the 5 Islands of the Netherlands Antilles. The mean new known cases show an increase from approximately 84 a year between 1996 through 2000 compared to a mean of 100 new cases a year for the years 2001 through 2006.

HIV-infections are more prevalent on the islands Curaçao and Sint Maarten, respectively 1134 (65.6%) and 550 (31.8%) of all registered cases.

When the data are analyzed for St. Maarten and Curaçao separately, the increase in incidence seen for the Netherlands Antilles can almost entirely be explained due to the sharp increase in incidence in St. Maarten, especially among the male population. On the other hand, the trends indicate that Curaçao either was not able to ever make a dent in incidence rates over the past 20 years.

At the end of 2005, the HIV Monitoring Foundation¹ started registration and data collection for HIV-infected patients living in Curaçao. In 2007, 292 patients were included in the studypopulation. Of these patients, 97% was infected with HIV-1.

A comparative study found that the HIV-infected population in Curaçao showed similar demographics to two Caribbean migrant populations in the Netherlands. Patients in Curaçao were, however, older at diagnosis and reported a smaller proportion homosexual contacts as most likely route of infection. Although the short term therapy outcome in the Netherlands Antilles was comparable to the Netherlands, the long-term outcome was substantially worse, probably as a consequence of the limited number of therapy options in Curaçao. The absence in Curacao of most antiretroviral drugs presently available in the Netherlands for treatment of HIV-infected patients is a major concern. Despite the large proportion of treatment failures, transmission of resistant virus strains was not found.

In November 2003 a study was carried out on attitudes of healthcare providers to homosexuality and HIV in the Netherlands Antilles, using The Index of Attitudes towards Homosexuality (Hudson and Ricketts, 1980) as well as a question from the International Social Survey Program 1998/1999 relating to attitudes towards homosexuals⁹. In the general practitioner survey, 82% of physicians participated in the study. Analyses showed that homophobia was inversely associated with age. The highest level of homophobic attitudes was noted in Caribbean born practitioners, compared with practitioners of other nationalities. Data in this subgroup revealed tolerance

⁸ Reported by Drs. Norédiz Lourents & Izzy Gerstenbluth, MD

⁹ A. Radix, C. Buncamper, G van Osch, *Attitudes of Healthcare providers to homosexuality and HIV in the Netherlands Antilles. Abstract 'A Multicultural Caribbean against HIV/Aids' conference 2004.*

scores that were among the lowest internationally. Stigma against PLWHAs was low in Saba with 72.6% favorable responses. Further analysis of data suggested a lack of knowledge about HIV transmission among healthcare workers persisted. This result was confirmed in another study carried out among preclinical students¹⁰, where the majority overestimated transmission risks.

In a Carec report from 2002¹¹, it is concluded that the Netherlands Antilles are facing a growing HIV/AIDS epidemic affecting young people and specifically the productive age group of 25-44 irrespective of their sex. This is influenced by migration and possibly tourism. Because of the variations observed in the sex ratio, CAREC recommends that island-specific public health programmes should be put in place to:

- promote sexual health among MSM, young people and adult males and females.
- promote collaboration with neighbouring countries and islands to address jointly the threat posed by the epidemic.
- promote care and treatment programmes to improve the quality of reporting and of life of people living with HIV/AIDS.

Also, the HIV/AIDS/STI surveillance system should be strengthened to capture more useful information which can help decision makers to better understand the magnitude of the epidemic and to support the design of comprehensive public health prevention and control programmes to address it.

At this moment, there is no clear and integrated HIV-policy implemented in this area. Activities that do take place, are mainly the result of individuals or private organizations that are active in the region. Although there are multilateral organizations that active in HIV/Aids prevention (PanCab, CAREC), participation of the Netherlands Antilles in these organizations has been limited.

So far, public health policy has been the responsibility of the Netherlands Antilles and Aruba themselves, both having their own Minister of Health. Currently the governance of all former overseas territories is under major revision. As it stands today, Bonaire, St Eustace and Saba will become 'municipalities' of the Netherlands. This will lead to more direct interaction between the Dutch and 'BES' public health authorities.

The other islands (Aruba, Curacao and St Maarten) will be (more) independent from the Dutch government with their own responsibility for public health.

¹⁰ A. Radix, D. Bansal, J. le Sneur: *Prevention of occupational HIV transmission in the Caribbean: a survey of knowledge and attitudes concerning workplace exposure among pre-clinical medical students*, Abstract, XVI International Aids Conference Toronto, 2006.

¹¹ *Status and Trends Analysis of the Caribbean HIV/AIDS Epidemic 1982-2002, The Netherlands Antilles*

ANNEXES

- ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS

*Please email your complete UNGASS Country Progress Report **before January 31 2008** to UNAIDS Evaluation Department at: ungassindicators@unaids.org.*

If the Country Response Information System (CRIS) is not used for submission of indicator data, please submit reports by January 15 2008 to allow time for the manual entry of data into the Global Response Information Database in Geneva.

Printed copies may be posted to:

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