



*HIV and other STIs among MSM in the
European Region
– Report on a consultation*

Bled, 26–27 May 2008

ABSTRACT

The WHO European Region technical consultation on HIV and other STIs among MSM was held under the auspices of the Slovenia European Union presidency, in partnership with the Slovenian Institute of Public Health of the Republic of Slovenia and in collaboration with the European Centre for Disease Prevention and Control (ECDC) in Bled, Slovenia, 26–27 May 2008, to foster dialogue among nongovernmental organizations (NGOs) and international agencies working with HIV and men who have sex with men (MSM) in the WHO European Region. Thirty-five participants, including nongovernmental organization (NGO) and United Nations agency representatives from 25 countries, attended this two-day consultation. The discussions included United Nations, governmental and nongovernmental activities and perspectives and epidemiological, human rights and programme issues.

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KEY FINDINGS AND OUTCOMES

- Although only limited data from biological and behavioural surveys or surveillance on HIV and other STIs among men who have sex with men (MSM) are recorded in the Region, the consensus was that there has been a resurgence of HIV and other STIs among MSM living in Europe since the introduction of combination antiretroviral therapy in 1996. Greater, more sustained and better targeted government and community efforts are necessary to reverse this trend.
- Poor surveillance of HIV and other STIs, a lack of harmonized definitions of behavioural indicators, stigmatization, discrimination and a lack of political will conceal the extent of the MSM HIV epidemic and make targeted prevention very difficult. Governments and international bodies should commit resources to carry out effective surveillance. Surveillance also needs to be standardized, cover relevant behaviours and prevention efforts, and incorporate training of the health providers who collect the raw data.
- The European Centre for Disease Prevention and Control (ECDC) is developing indicators for HIV and STI behavioural surveillance to facilitate standardized surveillance, with MSM as one of eight target groups. Such surveillance should be implemented for the entire European Region (in partnership with WHO/Europe, for example) and involve NGOs as well as governments. The project includes a survey on behavioural surveillance in the European Union targeting different risk groups.
- A WHO commissioned review of MSM and HIV literature for countries in central and eastern Europe, documenting the patchy nature of scientific studies while uncovering some largely unknown investigations, was presented. Consultation participants were urged to contribute additional literature and data to the review before it is finalized. The review findings could be submitted as an article in a peer-reviewed journal.
- Stigmatization of and discrimination against MSM remain at unacceptable levels, particularly in central and eastern Europe, though there has been some progress. More legal remedies, sexuality education, public awareness campaigns, community mobilization and implementation of international commitments such as the Dublin Declaration are needed.
- The development of a strategy consolidating HIV efforts targeting MSM by United Nations Development Programme (UNDP) as the United Nations' lead co-sponsor is most welcome.
- A pan-European network of MSM to address HIV (and perhaps major co-epidemics) was suggested. Facilities, administrative help and a large financial contribution were offered by representatives of attending NGOs.
- A prevention and information campaign aimed at travelling MSM was proposed to cover a major unaddressed regional need. It was suggested that the EU fund this and a regional NGO develop and implement it in cooperation with local community groups.
- A follow-up consultation was suggested for the French presidency of the EU during the second half of 2008. It could be on 21 November in Paris, and funding is available, but there was no agreement on a topical focus, and it remains unclear whether the follow-up would take place then or during the Czech presidency in the first half of 2009.
- WHO headquarters will continue to address MSM HIV issues, particularly the role of the health sector in addressing prevention and treatment of HIV and other STIs, through a global consultation in September 2008 in Geneva. By reviewing what is known about HIV

epidemiology, risks and transmission among MSM, the consultation will identify priorities for surveillance, research and interventions.

- WHO/Europe will continue to support global, Regional and national initiatives with respective partners. It will continue to monitor the development of the epidemic among MSM with its partners, including MSM access to health care services for treatment of HIV and coinfections such as hepatitis.

INTRODUCTION

The meeting was intended to foster dialogue among nongovernmental organizations (NGOs) and international agencies working with HIV and men who have sex with men (MSM) in the WHO European Region. Thirty-five participants, including NGO and United Nations agency representatives from 25 countries, attended the two-day consultation. The chief objectives were to:

- identify current areas of HIV efforts targeting MSM in central and eastern Europe, including the five central Asian republics;
- identify gaps in the HIV MSM response in the WHO European Region, particularly in central and eastern Europe, in the areas of:
 - ◊ epidemiological/surveillance issues
 - ◊ stigma and discrimination issues
 - ◊ programmatic issues
- develop a framework of key areas of work and objectives related to MSM and HIV;
- identify the next steps for addressing HIV among MSM in the Region.

Jeffrey V. Lazarus, of the WHO Regional Office for Europe (WHO/Europe) opened the consultation by urging frankness and stressing the importance of further research.

Mojca Gruntar Činč (Deputy Director, Public Health Directorate, Ministry of Health of the Republic of Slovenia) welcomed participants to Bled and noted that HIV is one of the priorities for the Slovenian presidency of the European Union. In Slovenia, the epidemic is concentrated among MSM, with prevalence stabilized at less than 5%, and public health efforts focus on prevention. The government ensures universal access to HIV testing, treatment and care, but the effort to combat HIV must be sustained to be effective, with the full realization of human rights at its centre.

REPORT ON THE DISCUSSIONS

The HIV situation of MSM in Europe

MSM community groups have led the response to HIV from the start, yet incidence rates are again rising among MSM in large, affluent cities. The advent of combination therapy in 1996 brought increased complacency among MSM, and their incidence rates for HIV, hepatitis C and other STIs have risen. In high-income countries, MSM remain the group at highest risk for HIV.

Transgendered people who have sex with men have some of the highest infection rates and do not necessarily identify themselves as MSM. UNAIDS and WHO have stressed the centrality of consistent condom use in preventing HIV and other STIs as part of public health programmes. In low- and middle-income countries, such as those of eastern and central Europe, data on MSM and HIV are sparse and of poor quality; among MSM, preventive behaviour is minimal, knowledge is poor and HIV prevalence is high and rising. Key problems are human rights violations, lack of implemented national policies, inadequate funding, dismal access to prevention services for MSM (just 1 in 20), a lack of project continuity and sustainability, and a dearth of research. Countries there vastly underreport HIV infections among MSM (e.g. the eight reporting countries of eastern Europe registered only 67 new cases in 2000–2003), and most of them do not address MSM and HIV explicitly. State support is minimal at best. Donor countries have hitherto had little to show for their prevention efforts among MSM.

According to the UNGASS reports, more countries had prevention programmes targeting high-risk groups in 2007 than in 2005. More MSM also had access to condoms and HIV tests, averaging 40% in 2007 in the 28 countries responding, yet this figure remains far below the 80% that defines universal access among risk populations. In eastern and central Europe, MSM involvement in developing national HIV plans remains sporadic, yet most countries there now include MSM in their national frameworks and have established universal access targets for MSM. To succeed in getting MSM and other risk groups mentioned explicitly in UNGASS documents, such as the Declaration of Commitment follow-up reports, it would be more effective to lobby national delegations than the United Nations.

A WHO/Europe literature review of both published and unpublished studies in the area of MSM and HIV incidence, risk behaviours and programming in 27 countries in central and eastern Europe and central Asia found that homosexual transmission was responsible for more than 40% of reported HIV cases in Croatia, Cyprus, Hungary, Serbia, Slovakia and Slovenia, while significant under-reporting masked the true situation in the former USSR. More than half the countries included in the review had no reliable estimates of HIV prevalence among MSM, while STI data for MSM were nearly nonexistent. While outreach and voluntary counselling and testing (VCT) programmes have been established in almost every country in the area, few services specifically target MSM.

The review further found that information on prevention effectiveness includes only one randomized controlled trial (RCT); most MSM prevention efforts in the area are carried out by gay NGOs with inadequate resources, and coverage tends to be best in countries receiving grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM, which is phasing out support in eastern and central Europe). There is however, an absence of monitoring and evaluation of HIV prevention programmes among MSM where they do occur. Similarly, sporadic research efforts indicate that stigmatization and discrimination directed at MSM are widespread throughout the area, with the noteworthy exception of the Czech Republic.

It was recommended that the review, while still underway, be submitted as a late-breaker abstract to the International AIDS Conference in Mexico City, and also be written as article for a peer reviewed journal.

UN, governmental and nongovernmental activities

The best partners for MSM organizations working with HIV are rarely United Nations agencies. Nonetheless, United Nations agencies have established useful frameworks such as the UNGASS Declaration of Commitment and the Millennium Development Goals. The United Nations HIV response for MSM is being consolidated under the United Nations Development Programme (UNDP).

Key WHO activities addressing HIV and other STIs among MSM, including national HIV programme reviews, the upcoming global consultation on surveillance and interventions (September 2008), a rapid assessment and response tool, a new behavioural interventions guide and plans to improve MSM surveillance.

After its founding in 1996, UNAIDS concentrated on increasing the involvement of its cosponsors and Member States in combating HIV. In addition, to ensure coordination and help consolidate others' efforts, a "division of labour" based on the comparative advantages of each cosponsor

guides the technical support offered to countries. For each area of work, a lead organization and main partners are identified.

As the only agency represented at the meeting that really addresses HIV in western Europe, WHO must therefore stand as the main facilitator of East–West dialogue on HIV in the Region. UNDP country offices should be mobilized, and developing a UNDP strategy on MSM and HIV will be a priority.

On 1 January 2008, ECDC and the WHO Regional Office for Europe took over the activities of the European Centre for the Epidemiological Monitoring of AIDS (EuroHIV). Besides monitoring and evaluation, ECDC also performs epidemiology, surveillance and risk assessment. ECDC has made behavioural surveillance related to HIV and other STIs a priority in order to better target prevention efforts and the evaluations over time and among countries. It is developing a behavioural surveillance approach for eight target populations, including MSM, with the goal of promoting implementation of second-generation surveillance and national behavioural survey programmes in the EU. Toward this end, it conducted a major literature review of the behavioural indicators used in published studies, finding only 13 qualifying MSM studies in 9 EU countries. The ECDC has retained the University Institute of Social and Preventive Medicine (IUMSP) in Lausanne to develop a behavioural surveillance protocol for HIV and other STIs by 2009. Depending on available resources, development of user-friendly toolkits and pilot surveys is planned for 2009/2010. The toolkits will be available online, though training through ECDC and behavioural surveillance would be available to EU Member States, not NGOs or community organizations. There is a need for methodological guidance for eastern European countries and NGOs for using such toolkits.

Governments around the world are demonstrating more interest in MSM and HIV, targeting interventions better and more widely acknowledging the gravity of stigma and discrimination. In contrast to the current regional approach, agencies could, for example, adopt a three-part approach based on how countries treat people living with HIV (PLHIV), that is, whether they engage them, ignore them or actively persecute them.

Among NGO efforts, The Global Forum on MSM & HIV seeks to become the focal point for human rights and MSM living with HIV. The Foundation for AIDS Research (amfAR) MSM Initiative has not yet extended funding to eastern Europe, but offers a good model to emulate, and there may be European funding to extend this initiative to central and eastern Europe, if amfAR can provide guidance.

Working group reports

Epidemiology and surveillance

The epidemiology and surveillance group began by identifying key obstacles to obtaining reliable biological and behavioural data for HIV and other STIs. Foremost was a lack of resources to enable continuous surveillance, largely due to a lack of political understanding of how sustained surveillance is a precondition for effective, targeted prevention. Within the EU, Member States are in fact obliged to report routine epidemiological surveillance data to the ECDC according to EU standards. Regional coordination is improving but still inadequate, particularly for behavioural surveillance. Confidentiality needs to be assured to help allay stigma and discrimination concerns and improve data quality. Major data gaps and shortcomings include:

- a lack of information on modes of transmission;
- less-than-national coverage of HIV surveillance data in several countries;
- variations that prevent comparisons among countries and over time;
- substandard sampling methods, including limited use and promotion of probabilistic methods;
- a reluctance among MSM to identify themselves during sampling;
- variations in the definition of MSM; and
- a lack of STI data in HIV prevalence studies.

Confidentiality issues are still a key problem in HIV and STI surveillance; for example, the United States Centers for Disease Control and Prevention (US CDC) has just shifted to a name-based reporting system for HIV because it provided more reliable data. Though rapid tests can be quick and anonymous, EU standards for prevalence testing require confirmation by a western blot. Developed nations seem to have a double standard, requiring developing countries to report data before disbursing aid but not reporting data themselves. Eastern Europe is better represented in global HIV data sets than western Europe. There appears to be a lot of data variation in Europe, one reason why the EU established the ECDC. Most countries rely solely on sentinel surveillance, as recommended by UNAIDS, but many European countries insist on case reporting, as it is well established in the Region and has proved useful. A contributing problem is that UNGASS and other global report templates are designed for developing and high-prevalence countries, and many of the individual questions can strike respondents for developed low-prevalence nations as irrelevant. This is one of the reasons that it is important to monitor Dublin Declaration adherence.

Human rights and stigmatization

The MSM who face the greatest challenges are those who must confront multiple stigmas, for instance by also being PLHIV, injecting drug users (IDUs), migrants, sex workers and/or prisoners. Suggested strategies to address these various stigmas include awareness training of health providers, media campaigns and church initiatives. MSM and PLHIV antidiscrimination statutes do not exist or are not enforced in many countries. Helpful measure might include a broader EU antidiscrimination directive, since the current one refers only to disability; better sustained monitoring and evaluation of antidiscrimination policies and laws and their enforcement; and greater utilization of international instruments and institutions, notably the Council of Europe and the Organization for Security and Co-operation in Europe (OSCE).

Essential strategies for combating discrimination include gay-friendly services, MSM community-building, promoting the rights of patients and people living with disabilities and enforcement of laws guaranteeing freedom of association and assembly. PLHIV and members of major risk groups – which include MSM in many countries – need to be meaningfully involved in HIV policy- and decision-making. This would require both formalizing their involvement and supporting it financially, since most community-based organizations cannot afford to underwrite member participation. Informal involvement and advocacy by community members also need to be supported through funding and training civil society groups and networking. Balanced sexuality education should be made a part of national curricula, including teaching of tolerance and openness towards homosexual and bisexual behaviour.

The Greater Involvement of People Living with HIV/AIDS (GIPA) principle should be extended to uninfected members of major risk groups and vulnerable populations. The Dublin and Vilnius Declarations call for commitment to involving PLHIV and risk group members in meaningful HIV policy development and implementation and should be used to hold governments accountable.

Programme issues

HIV and STI programmes for MSM should be of sufficient scope, gay-friendly and evidence-based. More behavioural evidence is necessary from the European Region; meanwhile, there is a need to act in the absence of evidence. A platform for sharing practices and approaches would be useful. Some of the greatest problems in European HIV programming for MSM are: weak civil societies in former Soviet republics; counterproductive struggles between potential partners, such as Lesbian, Gay, Bisexual and Transgender (LGBT) community groups and HIV service organizations; religion-supported homophobia; and absent or under-utilized essential services. One possibility would be a transnational campaign using the high mobility of MSM as a means for promoting prevention and treatment services. The campaign would provide condoms, lubricants and information to MSM travelling to “gay hubs” such as Vienna, Barcelona and Kiev, letting them know where to find gay-friendly testing and treatment facilities for HIV and STIs, local MSM NGO contacts, etc. It would rely on smart, attractive branding and a few key European languages, and it would utilize the private sector with central involvement of local community organizations. Ideally, an international NGO would coordinate the project and the EU would provide funding. It is also important that programmes address STI coepidemics, since HIV-positive MSM have 20–30% annual incidence rates for some STIs, in which serosorting is a major contributing factor. Hepatitis C and TB coinfections should be included in the priority list.

There is a need to build community in a wider sense, since many MSM do not consider themselves to be members of the “gay community”. A network comparable to the successful European networks of migrants and commercial sex workers could be started. AAE has discussed sharing facilities with the headquarters of such a network, and the Dutch NGO AIDS Fonds has funds to set it up. The network could also include STIs, hepatitis and TB.

RECOMMENDATIONS

- use HIV prevalence studies with representative methods, adequate sample sizes and clinical settings in developing effective prevention strategies;
- increase prevention funding and promote VCT;
- use rapid assessment technology to describe MSM populations more precisely;
- institute common methodology for conducting prevalence and behavioural studies for HIV and other STIs;
- develop a self-assessment tool for evaluating national surveillance systems;
- publicize gaps in data of countries who fail to collect key data to pressure them to comply;
- promote the guideline that HIV prevention funding devoted to MSM be roughly proportionate to the percentage of HIV infections attributable to homosexual transmission.
- establish a European gold standard for prevention interventions;
- foster collaboration between research institutions and NGOs on field studies;
- undertake behavioural and intervention studies among MSM;
- expand internet outreach and explore its use in surveillance;
- develop new strategies to increase hepatitis A and B vaccination among MSM;
- increase provision of condoms and water-based lubricants;
- make sexual health and HIV services more MSM-friendly;
- ensure that MSM interventions are a key part of national HIV response.
- train health care providers;
- provide services targeting female partners of MSM;

- establish a Regional network of MSM living with HIV;
- provide broad access to post-exposure prophylaxis (PEP);
- develop new prevention tools (vaccines and anal microbicides) and better behavioural and social research;
- encourage institutional tackling of LGBT stigmatization and discrimination, with the example of the [LaSky](#) project in the Russian Federation, which has forged partnerships with AIDS centres and STI centres to combat discrimination by medical professionals;
- ensure human rights protections and non-threatening sources of targeted information and referrals;
- renew prevention campaigns for each new generation of MSM;
- decriminalize homosexual behaviours and HIV transmission
- enforce antidiscrimination statutes
- provide MSM with legal aid
- sensitize the media on MSM issues
- initiate public campaigns to combat homophobia;
- confront the opportunistic use of homophobia by politicians;
- address policy and enforcement issues for MSM who are in the military, in prison or are members of another risk group;
- address the implications of low socioeconomic status in MSM access to services;
- combat travel restrictions on PLHIV and MSM;
- engage religious organizations in changing public attitudes.

ANNEX 1. PROGRAMME

Monday, 26 May 2008

- 12.45–13.15 Registration
- 13.15–13.30 Welcoming remarks, Mojca Gruntar Činč (Directorate of Public Health, Ministry of Health of the Republic of Slovenia)
- 13.30–14.00 Introduction to the meeting, objectives, and participants, Jeffrey V. Lazarus (WHO/Europe)
- 14.00–15.00 Introduction to the UN's work on MSM and an overview of UNAIDS/WHO activities/initiatives, Jeff O'Malley (UNDP), Ying-Ru Lo (WHO headquarters) and Michael Bartos (UNAIDS)
- 15.00–15.30 NGO perspective: developments at the global and regional levels, Ton Coenen (AIDS Action Europe) and Michal Minalto (Polish Social AIDS Comm)
- 15.30–16.00 Tea/coffee break
- 16.00–17.00 Overview of the results of behavioural surveys in western Europe and recommendations regarding European indicators for sexual behaviour, Marita van de Laar (ECDC)
- 20.00 Restaurant Panorama in Grand Hotel Toplice (Bled), hosted by the Ministry of Health

Tuesday, 27 May 2008

- 09.00–10.00 Presentation of the literature review on MSM and HIV in eastern and central Europe, Ivana Bozicevic (Andrija Stampar School of Public Health, WHO Collaborating Centre for Capacity Building in HIV/AIDS Surveillance)
- 10.00–10.15 Explanation of group discussions, Monique Munz (WHO/Europe)
- 10.15–11.45 Group discussions (three working groups: epidemiological/ surveillance issues, human rights issues (policy, legislation & advocacy), programmatic issues;), facilitators Marita van de Laar (ECDC), Jeff O'Malley (UNDP) and Michael Bartos (UNAIDS)
- 10.45 –11.15 Tea/coffee break (during group work)
- 11.45–12.45 Presentation of group work and discussion; presenters: Annemarie Rinder Stengaard (WHO/Europe), Ninoslav Mladenovic (Ludwig Boltzmann Institute of Human Rights and EATG) Arnaud Simon (AIDES)
- 12.45–13.45 Lunch
- 13.45–15.00 Presentation of group work and discussion (cont'd)
- 15.00–15.45 Conclusion and next steps, Ying-Ru Lo (WHO headquarters), Michael Bartos (UNAIDS) and Jeff O'Malley (UNDP)
- 15.45-16.00 Closing, Jeffrey V. Lazarus (WHO/Europe)

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