

# Country Progress Report

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## I. Status at a Glance

### a. The inclusiveness of the stakeholders in the report writing process

The Guidelines of the UNAIDS report were presented at a stakeholder meeting in November 2011. The workload of collecting the data and coordinating it was distributed between the Ministry of Health, the Aids Hilfe Wien and the Austrian Aktionsbündnis gegen HIV/Aids.

For gathering the information HIV experts, PLHIV, organizations representing the target groups as well experts in human rights will be interviewed.

### b. The status of the epidemic

In the past years the number of new HIV infections that are published by the Department of Virology (Medical University of Vienna) is relative stable:

Year	Number of new Diagnoses
2006	435
2007	515
2008	505
2009	507
2010	487
2011	525

The number of HIV infected people living in Austria is estimated 9.000 by the Ministry of Health about two third men and one third women. According to the Department of Virology (Medical University of Vienna 70% of the new infections are diagnosed in Austrian citizens and 30% in migrants from other regions.. More than half of the new infections are diagnosed in Vienna the capital of Austria. In spite of a high per capita testing rate according to the AHIVCOS 17.1% of all patients had an “early” diagnosis, 50.2% a “late” diagnosis and 30.0% had an “advanced” diagnosis.

Further data on PLHIV is available from the patients participating in the Austrian Cohort Study AHIVCOS<sup>1</sup>. The cohort was initiated in 2001 and in the last reports, dating from 1.1.2011; there were 3.508 currently in care in the main seven HIV centers. The new infections in the AHIVCOS in the past years are also stable.

Year	Number of new Diagnoses in the AHIVCOS
2006	323
2007	329
2008	348
2009	291
2010	293

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<sup>1</sup> 19th report of the AHIVCOS

2011	
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The mode of transmission in the AHIVCOS in 2010 and cumulative (2001 -2010) was:

Mode of transmission	Number 2010 <sup>2</sup>	cumulative
MSM	49,1%	33,7 %
Hetero	32,1)	42, 8%
IDU	8,9%	15,8 %
others	9,9%	7,7 %

In the current cohort<sup>3</sup> 28, 3% of the participants were female. In the subgroup of the heterosexually infected the rate of women is 50, 9%.

17.1% of the examined patients in the AHIVCOS had an “early“ diagnosis, 50.2% a “late“ diagnosis and 30.0% had an “advanced“ diagnosis.

Since 1982 there have been 3.767 reported Aids cases in 2011 there were 64 new cases according to the Ministry of Health. Till End of 2011 there were 1.977 HIV-related deaths since the beginning of the epidemic. In 2011 there were 32 HIV related deaths reported.

In January 2010 HIV test as part of the mother-child booklet (Mutter-Kind Pass) was introduced in Austria and therefore almost every pregnant woman in Austria gets tested. In order to be eligible for childcare allowance (Kinderbetreuungsgeld) you must have the first ten examinations stipulated in the mother-child booklet done correctly and obtain proof of it. IN 2010 and in 2011 there were no mother to child transmissions. Since 200 zero to two cases are reported per year.

According to the AHIVCOS<sup>4</sup> there are 23 children under 18 and 19 over 18 living in Austria who have been infected vertically. Seven have died and altogether there were 49 infections.

### c. The policy and programmatic response:

The four pillars of Austria’s policy and programmatic response are prevention, social measures, public safety and health-related treatment measures:

- Ensure blood and product safety
- Eliminating mother to child transmission
- Fighting discrimination and stigmatization
- Assuring PEP (Post exposure Prophylaxis)
- Setting basic conditions for epidemiology and the AHIVCOS (Austrian HIV Cohort Study)
- Involving civil Society and PLHIV (People living with HIV)
- Prevention especially for MARP (Most at risk populations)
- Setting standards for quality in testing and handover of results
- VCT (Voluntary Counseling and Testing) before and after the test
- Treatment and social care for PLHIV

<sup>2</sup> 20th report of the AHIVCOS

<sup>3</sup> 19th report of the AHIVCOS

<sup>4</sup> 19th report of the AHIVCOS

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- Stakeholder meeting twice a year to guarantee information exchange

#### d. Indicator data in an overview table

Target	Indicator	Data
<b>Target 1: Reduce Sexual transmission of HIV by 50% by 2015:</b>	1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	557 Interviews with adolescent between 10 and 19 years by GFK(research institute) Austria in 2007. In the relevant age group (15-16) 30% were very well informed, 35% well and 32% adequate. In the age group from 17-18 48% are very well informed, 37% are well and 13% adequate.
	1.2 Percentage of young women and men aged 15-24 who have had sexual Intercourse before the age of 15	According to a survey conducted by ÖISP (Austrian Institute for sexual education) in 2001 of 1037 teenagers within the relevant age group (14-18 years) 40% of the interviewee had sexual intercourse before the age of 15.
	1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	No data in Austria available. German data or European data applicable.
	1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	According to a study by GFK in 2010 where 1000 adults (older than 15) were asked how they protect themselves against STIs 50% reported to use condoms.
	1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	826.256 persons without demographic determiner
	1.6 Percentage of young people aged 15-24 who are living with HIV*	According to AHIVCOS 690 young people aged 15 to 24
Sexworkers:	1.7 Percentage of sex workers reached with HIV prevention programs	
	1.8 Percentage of sex workers reporting the use of a condom	

	with their most recent client	
	1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	
	1.10 Percentage of sex workers who are living with HIV	
MSM:	1.11 Percentage of men who have sex with men reached with HIV prevention programs	82,3% MSM had good knowledge about HIV testing 69,4% MSM reported to have had a condom when needed (EMIS)
	1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	63% MSM reported have used a condom if they had anal sex within the last 12 months (EMIS)
	1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	75,2% MSM have been tested for HIV. 66,9 % HIV neg. MSM reported to have been tested within the last 12 months and knew the result (EMIS)
	1.14 Percentage of men who have sex with men who are living with HIV	5,4% MSM participating in EMIS had a positive test result
Migrants	Percentage of migrants from high prevalence countries who are living with HIV	
<b>Target 2: Reduce transmission of HIV among people who inject drugs by 50%</b>	2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	267 per person
	2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	
	2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	
	2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	100%
	2.5 Percentage of people who inject drugs who are living with HIV	1,16% of people who inject drugs are positive (1,34% males; 0,65% females)

<b>Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal death</b>	3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	
	3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	
	3.3 Mother-to-child transmission of HIV (modelled)	
<b>Target 4: Have 15 people living with HIV on antiretroviral treatment by 2015</b>	4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy*	100 % according to AHIVCOS
	4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	
<b>Target 5: Reduce Tuberculosis deaths in people living with HIV by 50% by 2015</b>	5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	0,00368 % of HIV-positive incident TB Cases that received treatment for both TB and HIV
<b>Target 6: Reach a significant level of annual global expenditure (US\$ in low and middle income countries)</b>	6.1 Domestic and international AIDS spending by categories and financing sources	
<b>Target 7: Critical enablers and synergies with development sector</b>	7.1 National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and Evaluation)	
	7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	
	7.3 Current school attendance among orphans and non-orphans aged 10–14*	
	7.4 Proportion of the poorest households who received external economic support in the last 3 months	

## II. Overview of the Aids epidemic<sup>5</sup>

### Who and how many are infected with HIV in Austria?

The median age at the diagnosis lies between 30 and 36 years since 1990. 28.3% of the current cohort participants are female. The rate is highest in Vorarlberg and Upper Austria (both 36.6%). In the subgroup of the heterosexually infected, the rate of women is 50.9%. It is highest in Upper Austria (56.2%), Vorarlberg (53.3%) and Vienna (51.7%). Among patients newly diagnosed in 2010, 32.0% have been infected through heterosexual contacts. Since 2000, 42.8% of newly diagnosed HIV infections were transmitted through heterosexual contacts.

Most of the cohort participants are Austrian nationals (78.4%). 10.4% come from high prevalence countries and 10.7% from low prevalence countries. Information on the nationality of the remaining patients is missing.

### Is the HIV test used efficiently? – Early and Late presenters

Austria has one of the highest rates of HIV tests per capita in Europe. Nevertheless, a substantial number of patients (20.8%) is already immune deficient (CD4 cell count <200/ $\mu$ l) at the time of the first contact with an HIV centre.

Therefore, risk factors for an early and a late diagnosis have been evaluated. Patients who have been diagnosed with HIV between 2001 and 2010 were analyzed. During this period, 3061 HIV infections were diagnosed (74.5% male, 25.5% female). The infections occurred in 42.8% through heterosexual transmission, in 33.7% through MSM and in 15.8% through IDU.

An early diagnosis is defined by: a seroconversion illness HIV infection (westernblot pattern or antigen/HIV RNA with corresponding clinical symptoms) or documented seroconversion with negative test not more than 3 years before the first positive HIV test.

A late diagnosis is defined by: CD4<350 at time of HIV diagnosis and/or AIDS within 3 months of HIV diagnosis.

An advanced diagnosis is defined by: CD4<200 at time of HIV diagnosis and/or AIDS within 3 months of HIV diagnosis

17.1% of the examined patients had an early diagnosis, 50.2% a late diagnosis and 30.0% had an advanced diagnosis.

A higher risk to be diagnosed late was found in older patients, in those who have been infected heterosexually, and in persons originating from high prevalence countries. The results were much the same for an advanced diagnosis.

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<sup>5</sup> 19th report of the AHIVCOS

An early diagnosis was found more frequently in younger patients, MSM and IDU and in patients originating from Austria or other low prevalence countries. Moreover, the smaller the population size of the area of residence, the more frequent were early diagnoses.

Thus, about half of the patients are diagnosed late and nearly a third of patients are diagnosed advanced, and this has not changed in the last years.

#### **Transmission of drug resistant HIV (.resistance before therapy)**

In all HIV-centers in Austria 127 (7.5%) of 1689 patients (in the CASCADE centers: 85 of 942 patients; 9.0%) were identified who had at least one resistance mutation before their first antiretroviral therapy. One patient had a 3-class resistance to NRTI, NNRTI and PI before starting ART. Three patients had a resistance to NRTI and PI, one patient had a resistance to NRTI and NNRTI. The transmission of drug resistant HI viruses has decreased in the last years. However, not all centers did resistance tests before ART initiation or at diagnosis, but most have implemented the routine testing in 2003.

#### **Stage of HIV disease**

The cohort participants represent all stages of HIV infection. Half of the patients have a CD4 nadir <200/ $\mu\text{l}$ . The median of the CD4 nadir in the current cohort is 198/ $\mu\text{l}$ . The current CD4 cell count is 522/ $\mu\text{l}$  (median at the last measurement). As of 31 December 2010, 319 (8.7%) of the participants in the current cohort had a CD4 cell count below 200/ $\mu\text{l}$  and only 51 (1.4%) had a CD4 cell count <50/ $\mu\text{l}$ . The mean CD4 cell count is currently 554/ $\mu\text{l}$ . Therefore the number of patients with an opportunistic infection will remain low in the following years.

#### **Mortality**

The reduction of mortality after the implementation of antiretroviral combination therapies is impressive. In 1992, the death rate of patients with AIDS was 41.1 per 100 person-years for men and 37.2 for women. Over the last years the rate decreased to below 5 for men and women. Between 1997 and 2008 (except for the year 2006), injecting drug users had a higher death rate than homosexual men. Only in 2006 the death rate of homosexual men was higher than for IDU.

Factors associated with increased mortality after the diagnosis AIDS include age below 43 years as well as transmission through MSM or IDU, a CD4 nadir below 200 cells/ $\mu\text{l}$  and residence in a metropolitan area with more than 1 million inhabitants. Moreover, mortality was higher when AIDS was diagnosed in the earlier years of the epidemic (especially before 1995).

#### **Viral suppression under antiretroviral therapy**

The rate of viral suppression under antiretroviral therapy in Austria is similar to figures from other countries. However, it has to be considered that the rate of viral suppression has been measured with the current cohort and that patients with loss of follow-up are not included.

#### **Increase of CD4 cell counts during antiretroviral therapy**

The CD4 cells during antiretroviral therapy have continuously increased, and the increase continues after 5 and 7.5 years of ART initiation. The increase is faster in patients on continuous ART compared to patients with treatment interruptions.

## **Access to antiretroviral therapy**

In general the Austrian HIV Cohort Study cannot evaluate if the access to the HIV centers differs by gender, mode of transmission, nationality or other factors and whether these influence the access to antiretroviral therapy. The HIV Cohort Study data show the following picture:

A minority of the study participants does not originate from Austria. About 32% of the heterosexually infected persons are non-Austrian nationals. The access to antiretroviral therapy for persons originating from high prevalence countries appears more difficult than for Austrians. Patients from high prevalence countries and injecting drug users are less likely to be on ART. The smaller the population size of the area of residence was, the likelier the patients were on ART. Patients living in a city or village with less than 1 million inhabitants are more likely to be on ART.

The seven HIV centers have to care for an increasing number of patients on antiretroviral treatment.

## **Development of resistances during antiretroviral therapy**

The probability of developing resistance to antiretroviral drugs seems to be decreasing. So, the risk of any resistance after more than 10 years of ART is about 48%, for NRTI-associated resistance 20% and for 3-class resistance 10%. The probability of NNRTI-associated resistance after more than 10 years is 20% in patients who started ART with NNRTIs. The probability of PI-associated resistance after 10 years is 45% in patients who had a PI-based antiretroviral combination therapy as their initial therapy. The results are about the same if transmitted resistances are excluded.

The strongest risk factor for the development of 3-class-resistance during antiretroviral therapy is initiation of ART before 1997, followed by low CD4 nadir and HIV RNA . 10000 copies/ml.

In the cohort, 35 patients of 4541 (0.8%) have a mutation of the codon 65 of the RT (K65R). The occurrence of the mutation K65R was more frequent in regimens including Tenofovir compared with Abacavir and could be found more often in patients with advanced immune deficiency

## **Coinfections**

Coinfections with syphilis, hepatitis B and hepatitis C are common. Like in other European countries, an enormous increase of new syphilis infections, especially among homosexual men, is apparent. This indicates a lack of prevention and "Safer Sex" practices. However, it is necessary to note that increased "serosorting" behaviour (sexual contacts with partners with the same HIV status) could have contributed essentially to this increase.

In Austria, infection with hepatitis C is uncommon in homosexual men. This supports the assumption that the transmission of hepatitis C only happens in special circumstances, e.g. parenteral drugs, trauma.

Not all patients are offered vaccination against hepatitis B, although it is recommended for all HIV infected persons.

## **Comorbidity**

A relatively high number of patients under treatment is suffering from other chronic diseases, such as psychiatric disorders (especially depression), osteoporosis, and diabetes. Of special concern are

cardiovascular diseases and the risk of myocardial infarctions. Unfortunately, data entry regarding comorbidities is still incomplete in some centers.

### **III. National response to the Aids epidemic**

#### **IAC 2010 :**

The international Aids conference 2010 was held in Vienna with 19.300 participants. By the close of AIDS 2010, over 12,725 scientists and other supporters had signed the Vienna Declaration and support continues to grow, with over 17,000 signatures collected as of 1 October 2010.

#### **Human Rights March:**

One of the highlights of the conference was the Human Rights March where about 9.000 activists joined a peaceful demonstration through the streets of Vienna. The March ended with a public rally at Heldenplatz, outside the Hofburg Imperial Palace. Several speakers, representing the diversity of the crowd, spoke and called for the safeguarding of human rights and for solidarity and support from everyone, including national and international politicians.

#### **Life Ball:**

The life Ball is organized by "Aids life" and is the biggest charity event in Europe. 2012 the 20<sup>th</sup> life ball will take place. In 2010 the event was even expanded from the city hall to the theatre located opposite. Till today 17 million dollars were generated and spent on national and international projects.

#### **Campaigns:**

In the past two years several campaigns were launched:

- national and regional youth campaigns
- Regional campaigns for MSM
- National workplace campaign for solidarity with PLHIV
- Regional campaign for migrants

#### **Prevention:**

A major input to prevention is guaranteed by the seven regional Aidshilfen especially in reaching out for the MARP.

##### *Youth:*

HIV Prevention for youth is linked with SRHR (Sexual Reproductive Health and Rights), it is part of the school curriculum, in addition workshops on HIV/AIDS and SRHR are offered for schools and out-of-school institutions, connected to the IAC 2010 a participatory national youth campaign focusing on solidarity and anti discrimination was conducted, there are peer-education trainings for youth who afterwards act as multiplier, also special youth film days were organized

##### *MSM:*

Information and condom distribution in the gay scene, at events and in cruising areas, health support at a MSM international internetplatform, presence at CSD (Christopher Street Day), yearly MSM campaign focusing 2011 on the promotion of counseling and testing focusing on MSM subgroups who are most at risk, working with peers. The support of condom dispensers and a project focused on male sex worker are further offers.

*Migrants:*

Prevention is focusing on migrants from high prevalence countries, participatory approaches, information material in different languages, legal support for HIV infected asylum seekers. Workshops for migrants on the topic of HIV.

*Professional groups:*

Prevention is focused on people who work or might work with people living with HIV. Lectures are held, coaching and Workshops are conducted for healthcare professionals and employers in social institution but as well as for companies in the private sector and the union.

NGOs responsible for IDU are also in charge for harm reduction programs and prevention. Sexworkers are informed by the STI ambulance where they have their obligatory, weekly examination as well as by other NGOs focusing on this target group.

**Testing:**

In Austria the per capita testing rate is very high. Cost free and anonymous VCT (Voluntary Counseling and Testing) is offered by the Aids Hilfen to everybody and other NGOs focusing on. Doctors, laboratories, STI ambulances and hospitals also provide testing. Since 2010 HIV testing is offered to all pregnant women in Austria as a part of the Austrian mother child care program. In the past two years the testing promotion was included in prevention messages and outreach testing programs to reach MARP (Most at risk populations), were conducted. Further efforts will be planned to lower the late presenter rate.

**Treatment, care and support:**

In Austria nearly the total population is insured and access to treatment and care is therefore guaranteed. This general insurance also covers HIV related testing and diagnostics, treatment and care as well as medical rehabilitation.

Almost all HIV positive patients are treated in one of the seven treatment centers or by a resident doctor according to the Austrian-German treatment guidelines. The well being of the patients is also considered as a priority and many are constantly monitored in and outside the in-patient treatment and care program. Improving adherence, quality of life and fighting stigma and discrimination enables patients to accept their diagnosis and move forward with positive attitudes. A special focus is also on HIV positive pregnant women or PLHIV who want to have children. The access to therapy for people without insurance or unsecure legal status remains challenging however in almost all known cases due to individual support and good collaboration between doctors, pharmacies, NGO and industry treatment was ensured. In addition to the national insurance care and psycho-social support for PLHIV are offered by the treatment centers, Aids Hilfen and patient support groups as well as by

other NGOs, like a mobile nurse team and buddies (volunteers who assist PLHIV). There are also support centers for IDU and substitution programs. There has been a joint effort of all stakeholders to fight discrimination and stigmatization.

#### **Coordination and cooperation:**

In Austria there have been major efforts to include civil society organizations and to enforce the collaboration between different stakeholders. The Austria Aids society ensures national and international medical information exchange and distribution, the Austrian society of doctors in private praxis (ÖGNÄ- Österreichische Gesellschaft Niedergelassener Ärzte zur Betreuung HIV Infizierter) treating PLHIV offers further information and exchange possibilities. The AHIVCOS supports epidemiological exchange between all HIV centers as well as with other stakeholders and is also an instrument for quality control to provide optimal patient care. The regional Aids Hilfen share a common umbrella group named "Die Aids Hilfen Österreichs" that supports collaboration and common strategies as well as exchange of experience.

Thanks to international projects and studies a close collaboration with international partners exists as well.

#### **Knowledge and behavior change:**

Especially in 2010 when the conference AIDS 2010 was held in Vienna there was a lot of press coverage to that topic. Also every year on World Aids Day, December 1<sup>st</sup> there is big media response. Different national and regional Websites inform about transmission and risks as well as services available. The Aids Hilfen distribute brochures for the general population, for youth and the different MARP, for migrants in different languages. In 2010 a survey was conducted by GFK focusing on the knowledge, awareness and risk protection of the general population showing that knowledge depends on age and on level of education: the younger and more educated people are the better they are informed. According to EMIS 2010 MSM have a very high knowledge but also in Austria, like in most other European countries, the number of new infections in this group remains stable or slightly increases. Another survey in 2011 focused on the quality of life of PLHIV including their safer sex behavior. 56,9% of all men asked reported to have always safer sex and 64,6% women.

#### **Blood and product safety<sup>6</sup>:**

Implementation of mechanisms to stop transmission by blood transfusions and blood products:

- education of specialized personal in interviewing potential donors
- blood patient management
- self-exclusion systems for people at risk implementation of mechanisms to stop nosocomial infections
- education of health professionals
- education of patients

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<sup>6</sup> <http://blog.aids2010.org/post/2010/07/13/Prevention-and-Treatment-Programmes-in-Austria-Lessons-Learned.aspx>

### **Vertical Transmission<sup>7</sup>:**

Austria's Mother-to-child-Prevention Program (PMTCT) has been strong since around 1997.

- HIV testing offered on a voluntary basis to all pregnant women
- counseling and training for both negative and positive women
- sustainable provision of antiretrovirals for mother and child, including free access to specialized delivery sites
- for young adolescents, especially girls and young women, implementation of special measures.

PEP (Post exposure prophylaxis):

- Inform MARP (Most at risk populations) about PEP
- Assurance of availability of PEP in HIV centers
- Usage of PEP according to German-Austrian treatment guidelines

## **IV. Best Practice**

Due to the participation in different EU programs and in the core group IQhiv (Improvement of quality in HIV prevention) best practice in prevention programs is applicable. Projects were conducted using different tools for quality assurance. The participation in national and international conferences as well as national and international collaborations guarantees best practice in prevention, treatment care and support.

Examples for best practice:

- Austrian-German treatment guidelines
- HIV Test as part of the pregnancy diagnostic
- Quality assurance included in prevention projects
- Biannual stakeholder meeting
- Participation in EU project Bordernetwork
- Participation in CSF (Civil Society Forum) and Think Tank
- AHIVCOS (Austrian HIV Cohort Study)
- Outreach Testing programs

## **V. Major challenges and remedial actions**

Major achievements in the past two years were hosting the IAC 2010, Improving AHIVCOS (Austrian HIV Cohort Study) and existing epidemiological data, receiving behavioral data from surveillance studies, participation in EU projects and in different European panels like the CSF and the Think Tank

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<sup>7</sup> <http://blog.aids2010.org/post/2010/07/13/Prevention-and-Treatment-Programmes-in-Austria-Lessons-Learned.aspx>

,enforcing existing networks by the biannual stakeholder meeting. Supporting PLHIV and reducing stigma and discrimination. Major challenges remain in finding the best testing strategies for MARP, assuring the retention of the budget for HIV/AIDS in the current economical situation and the increasing number of PLHIV. Launching effective prevention programs for MARP that cause behavior change.

## **VI Support for other countries<sup>8</sup>**

The Austrian Development Cooperation Program includes HIV/AIDS in an array of strategies and programs, in particular in our priority region sub-Saharan Africa. As part of this effort, Austrian Development Cooperation continuously supports the activities of UNAIDS by yearly funding the core-budget of the joint program. In addition, Austria has a long tradition of supporting UNDP's Thematic Trust Fund on HIV/AIDS, and co-financed a UNICEF HIV/AIDS-related project for women and children in the Ukraine. Austria will continue to support the work of the relevant organizations and programs of the United Nations family, in particular the work of UNAIDS in sub-Saharan Africa.

## **VII. Monitoring and evaluation environment**

Aids is a notifiable disease in Austria. HIV new infections are reported from the Institute of Virology to the Ministry of Health. In addition the AHIVCOS summarizes a lot of data of PLHIV in Austria. 2010 Austria participated in EMIS (European MSM Internet Survey) and the gained data was analyzed and published in 2011, there was another survey on the quality of life of PLHIV published by the Austrian Society of Resident Doctors. Another Sentinel Study is currently part of the EU project Bordernetwerk.

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<sup>8</sup> <http://www.un.org/en/ga/aidsmeeting2011/pdf/austria.pdf>