

UNGASS COUNTRY PROGRESS REPORT

The Netherlands

and

Parts of the Dutch Kingdom in the Caribbean

Reporting period: December 2012–December 2015

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1. Status at a glance

1.1 Writing process

This Country Progress Report for the Global AIDS Response Progress Reporting 2016 is based on previous reports in connection with the WHO 'Global Health Sector Strategy on HIV' as well as the 2004 'Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia'.

The report is compiled by the Centre for Infectious Disease Control (CIb) of the National Institute for Public Health and the Environment (RIVM) with contributions of the Ministry of Health Welfare and Sport and from other ministries and stakeholders.

Parts of the report have been subject of discussion during meetings of the Dutch 'STI and sexual health platform' where civil society stakeholders are represented. STI AIDS Netherlands, a non-governmental organisation (NGO) and an expertise STI centre for HIV and other STI, commented on a final draft version of this Country Progress Report.

1.2 Status of the epidemic

The Netherlands has a concentrated HIV epidemic, i.e. a low prevalence of HIV infection in the general population but a higher prevalence in specific sub-populations. Primary high-risk sub-populations are men who have sex with men (MSM) and migrants from high-prevalence countries. The epidemic in the Netherlands is primarily fuelled by transmission among MSM. Since 2011 there has been a decreasing trend in the annual number of new HIV diagnoses to approximately 900-1,000 new diagnoses in recent years.

As of December 2014, 17,905 persons living with HIV in the Netherlands were known to be retained in care. Of these 94% had started combination antiretroviral therapy (cART), and of these 92% had suppressed viraemia to below the level of quantification at the time of their last available HIV-RNA measurement.

HIV testing rates appear to be increasing in certain settings. Moreover, the proportion of patients who are identified and start cART earlier in their infection (including during primary HIV infection) continues to increase, particularly amongst MSM.

The status of the epidemic is detailed under the prescribed headings of section '3. Overview of the AIDS epidemic'.

1.3 Policy and programmatic response

During the reporting period 2012-2015, the overall HIV/AIDS-related policy and programmatic frameworks in the Netherlands have remained largely unaltered, notwithstanding a number of important developments. Most important, in December 2011 we have published our first national policy plan STI/HIV 2012-2016 "To renew and reinforce" in which the Dutch HIV/STI policy for the coming years is described. The plan is developed by the Centre for Infectious Disease Control in close collaboration with the Ministry Health Welfare and Sport, and all other stakeholders involved in HIV and STI control ((sub-)national (non-)governmental stakeholders). An update of the policy plan is planned in the period 2016/2017.

HIV/AIDS policy is primarily a responsibility of the Ministry of Health. It should be recognised, however, that policy development in the realms of HIV/AIDS depends on the collaboration of a range

of (sub-) national (non-)governmental stakeholders. Similarly, the implementation of HIV/AIDS policy-related activities relies on collaboration among a multitude of stakeholders.

The Dutch government seeks to place HIV/AIDS policy in a larger framework of sexual health. The national STI/HIV plan builds upon previous policy reports, such as the sexual health policy document of 2009. Of further influence is the national note on health policy (Landelijke nota gezondheidsbeleid, 2011), which forms the basis for the current lifestyle policy, addressing multiple health issues, including sexual health. This national STI/HIV plan outlines central principles of Dutch HIV/AIDS policy, such as the importance of prevention, the importance of linkage between prevention and care as well as efforts to ensure low-threshold access to testing and treatment. The national plan further underlines the crucial contributions of different (non-)governmental stakeholders in the area of STI/HIV. The responsibilities and relations of these organisations are described in order to reduce overlap and gaps. The division of responsibilities are mainly organized by risk groups and serves to promote tailor-made approaches based on appropriate expertise.

Based on STI/HIV epidemiology in its behavioural context, the following risk populations are identified in the national STI/HIV plan:

- Young people
- Men who have sex with men (MSM)
- Migrants (primarily those from HIV-endemic countries)
- HIV-infected persons

Next to these key populations attention needs to be focussed on difficult to reach groups like sexworkers, IDU's and people who are part of more than one key population (e.g. MSM/ migrant)

Furthermore, the following points of special interest for STI/HIV control and policy are acknowledged:

- Lifestyle policy (referring to the national note)
- Antibiotic resistance to gonorrhoea
- Linkage between additional health care and regular health care settings
- Linkage between prevention and care
- Quality assurance
- Collaboration and control

The policy and programmatic responses are detailed under the prescribed headings of section 'IV. National response to the AIDS epidemic'.

1.4 GARPR/UNGASS indicator data

For historical reasons and considering local contexts, such as existing set-up of surveillance and monitoring activities, data and/or information are not consistently available to allow for a complete representation of GARPR/UNGASS indicators as per specific formats of the UNGASS reporting guidelines. However, relevant data and/or information in this regard are presented in this report.

2. Overview of the HIV epidemic

The Netherlands has a concentrated HIV epidemic, i.e. a low prevalence of HIV infection in the general population but a higher prevalence in specific sub-populations. Primary high-risk sub-populations are MSM and migrants from high-prevalence countries. The epidemic in the Netherlands is primarily fuelled by transmission among MSM. IDU are not considered a major risk group.

2.1 Population in care

Estimations of the HIV prevalence by risk group in the Netherlands are from 2012 and yielded the following results: MSM 8.3% (6.1-11.3), migrants from sub Saharan Africa 2.3% (1.9-2.9), and migrants from the Caribbean 0.3% (0.2-0.4). The estimated HIV infection prevalence for the total population is 0.2%. HIV infections are highly concentrated in the large cities (e.g. Amsterdam, Rotterdam) (Figure 1).

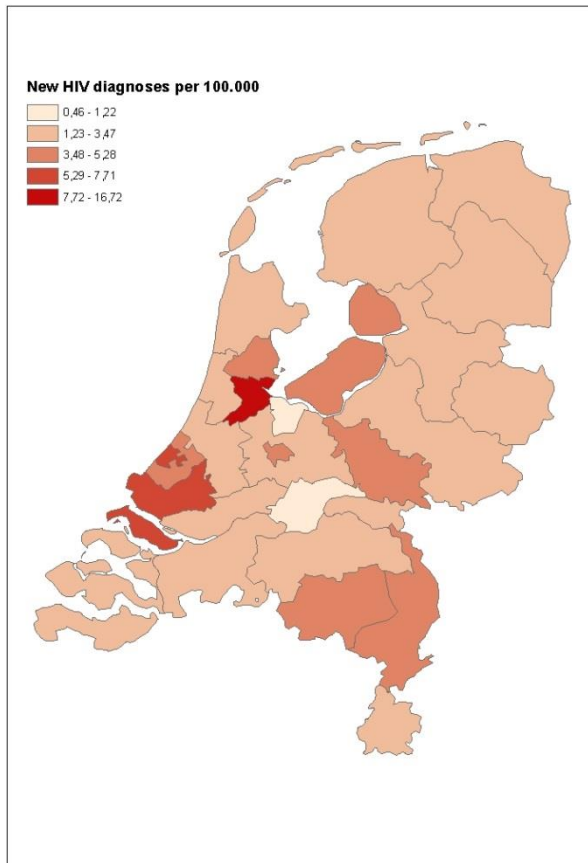


Figure 1. Number of new HIV diagnoses per 100,000 inhabitants per region, the Netherlands, 2014

HIV infection is not notifiable by law in the Netherlands. However, data about HIV infected individuals are collected by SHM as part of routine health care for HIV patients. Treatment data for all HIV patients receiving care at 27 HIV treatment centres are collected.

The number of HIV-infected individuals living in the Netherlands on 31December14 has been estimated to be 22,100 (Figure 2). About 88% of people infected with HIV was estimated to have been diagnosed and linked to care (n=19,382). 17,905 patients were known to be retained in care. Of these, 94% had started combination antiretroviral therapy (cART), and of these 92% had suppressed viraemia to below the level of quantification at the time of their last available HIV-RNA measurement.

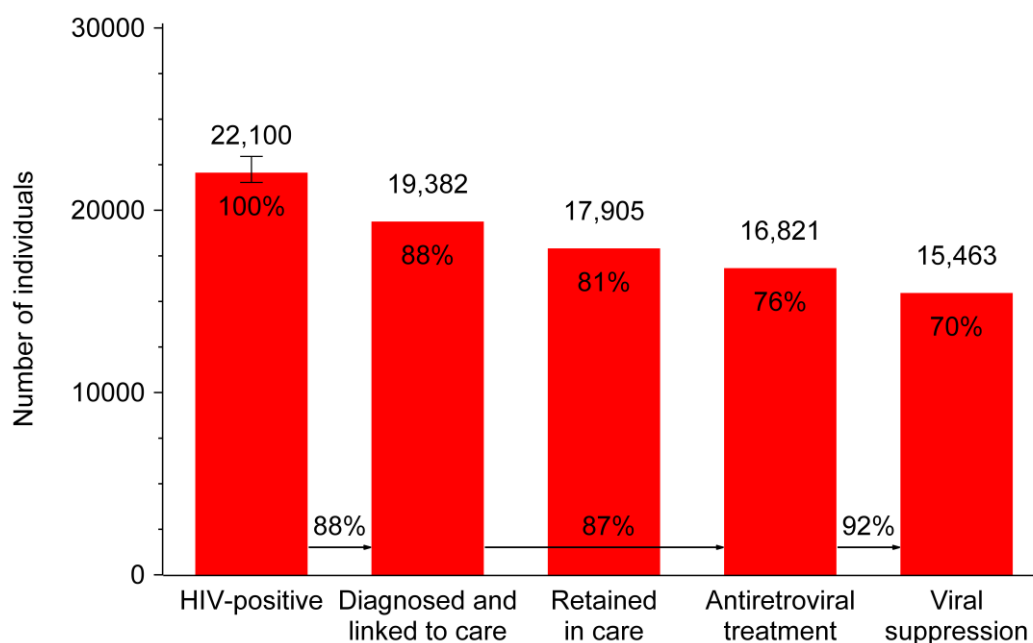


Figure 2. Continuum of care for the total estimated HIV-infected population in the Netherlands as of December 2014 (Source: SHM)

2.2 Registration of Stichting HIV Monitoring (SHM)

Since 2011 there has been a decreasing trend in the annual number of new HIV diagnoses to approximately 900-1,000 new diagnoses in recent years. Although this decreasing trend continued in 2015, the projected number of diagnoses may have been underestimated, as registration of HIV diagnoses for this year has not yet been finalised. Nonetheless, this decreasing trend appears to be reflected in the MSM population aged 25-44 years, but remains less marked in MSM both 25 years and younger and 45 years and older, as well as in heterosexuals 45 years and older. Finally, overall, over 90 percent of persons newly diagnosed with HIV entered into specialised care within 6 weeks after diagnosis. There is little variation in these figures, regardless of where individuals were diagnosed.

In 2015, the majority (65%) of newly diagnosed infections in adults were in men who have sex with men (MSM), 29% were acquired through heterosexual contact, 0% in IDU, and around 6% through other or unknown modes of transmission (Figure 3). Of note, almost one quarter of all newly diagnosed patients in 2015 were 50 years or older.

Heterosexuals included a considerable proportion of individuals originating from other countries than the Netherlands. The most common areas of origin were sub Saharan Africa, Western Europe and Latin America.

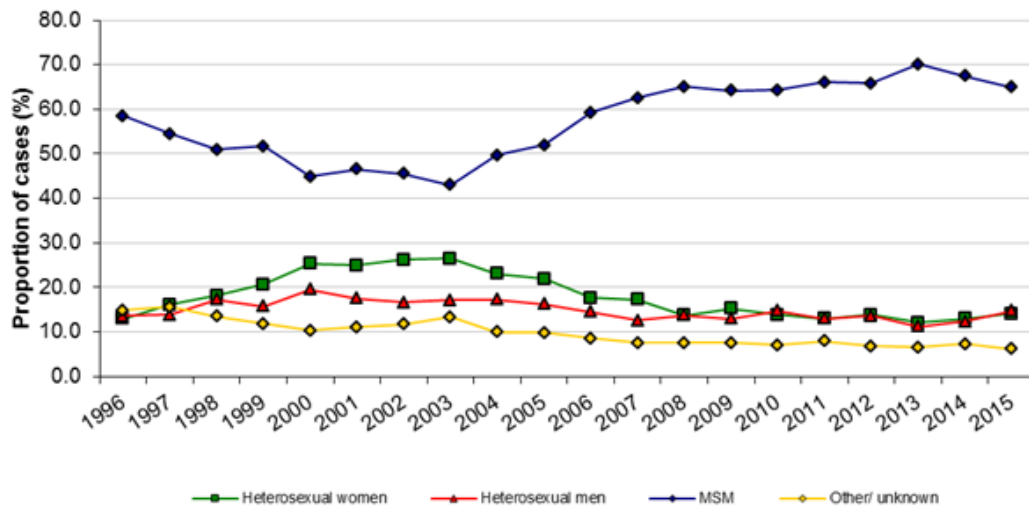


Figure 3. Proportion of annual HIV cases in care by transmission risk group and year of diagnosis, the Netherlands, 1996-2015 (Source: SHM)

Of patients diagnosed in 2015, 44% presented late (CD4 < 350/mm³, or AIDS-defining event regardless of CD4 count). This proportion was lower for MSM (3%) than for women (4%) and heterosexual men (68%). (Figure 4)

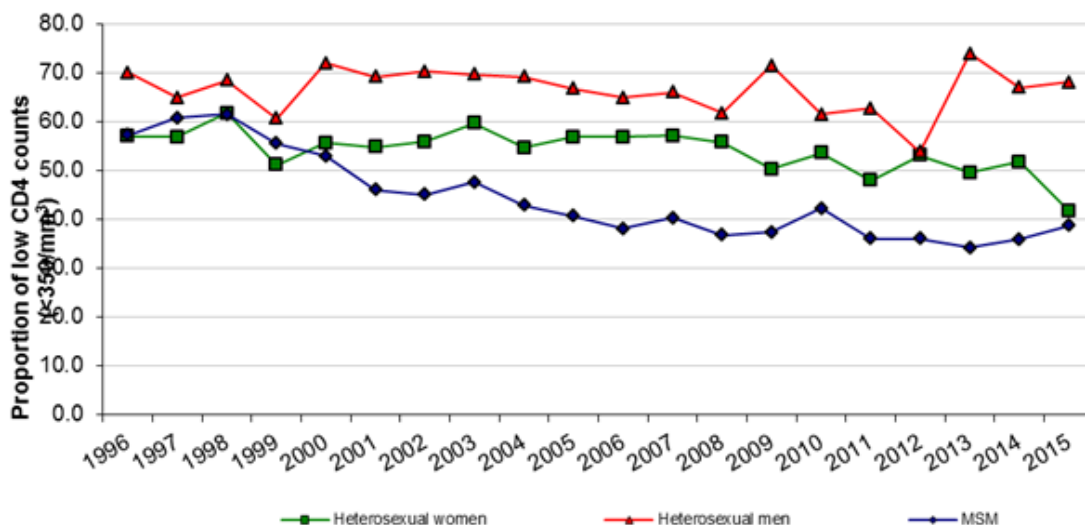


Figure 4. Proportion of late presentation (CD4 count < 350/mm³ or AIDS at diagnosis) by transmission risk group, 1996-2015

The rates of testing for HIV appear to be increasing in certain settings. Interestingly, the proportion of patients with a previously negative HIV test has also increased (73% MSM and 40% heterosexuals had a known previous negative test in 2014). Moreover, fortunately, the proportion of patients who are identified and start cART earlier in their infection (including during primary HIV infection) continues to increase, particularly amongst MSM. This is reflected in the CD4 count, both at diagnosis and at start of cART, gradually having risen over time to a median of 385 and 410 cells/mm³, respectively, in 2014. The likelihood of patients starting cART at higher CD4 counts has also clearly increased. While in 2013, 49% of patients with a CD4 count of 500 cells/mm³ had begun cART within

6 months of diagnosis, this proportion rose to 68% in 2014. Nonetheless, far too many patients continue to present late for care. In 2015, 44% of newly diagnosed patients presented late for care, i.e., with AIDS or a CD4 count less than 350 cells/mm³, and 29% presented with advanced HIV disease, i.e., with a CD4 count less than 200 cells/mm³ or AIDS. Generally, the likelihood of presenting late for care or with advanced HIV disease was greater for men with heterosexually acquired infection, individuals originating from South and South-East Asia and Sub-Saharan Africa, and individuals aged 45 years or older.

Additional information is available in the reports of SHM that are published in English on an annual basis <http://www.hiv-monitoring.nl/index.php/nederlands/>.

2.3 Surveillance based on data from Centres for Sexual Health

An STI/HIV surveillance system is in place where eight coordinating municipal health services (GGD) report STI/HIV-related data and information to the RIVM/Cib. The system is based on a network of centres for sexual health with nationwide coverage. The STI centres provide low-threshold and free of charge STI/HIV testing and care primarily for high risk groups and young people (see also section '4. National response to the AIDS epidemic').

In 2015, 288 individuals were newly diagnosed with HIV at the STI clinics of the Centres of Sexual Health in the Netherlands. Of these infections, (90%) occurred in MSM, 4% in heterosexual men and 6% among women. The positivity rate among MSM decreased further to 0.9% (in 2009 2.4%, in 2008 3.0%), among heterosexual men and women it remained <0.1%. (Figure 5) Among heterosexual STI clinic attendees the HIV positivity rate was highest among those from sub-Saharan African origin (heterosexual men 0.2%, women 0.4%, MSM 2.0%). Among MSM, HIV positivity rate was highest among MSM aged 35-39 years (1.2%). Among newly diagnosed HIV-positive MSM, 6.5% was concurrently diagnosed with syphilis, 20% with gonorrhoea and 28% with chlamydia. These findings suggest the presence of considerable sexual risk behaviours in certain sub-populations of HIV-infected individuals.

Additional information is available STI/HIV publications of RIVM/Cib, including comprehensive reports published in English on an annual basis.

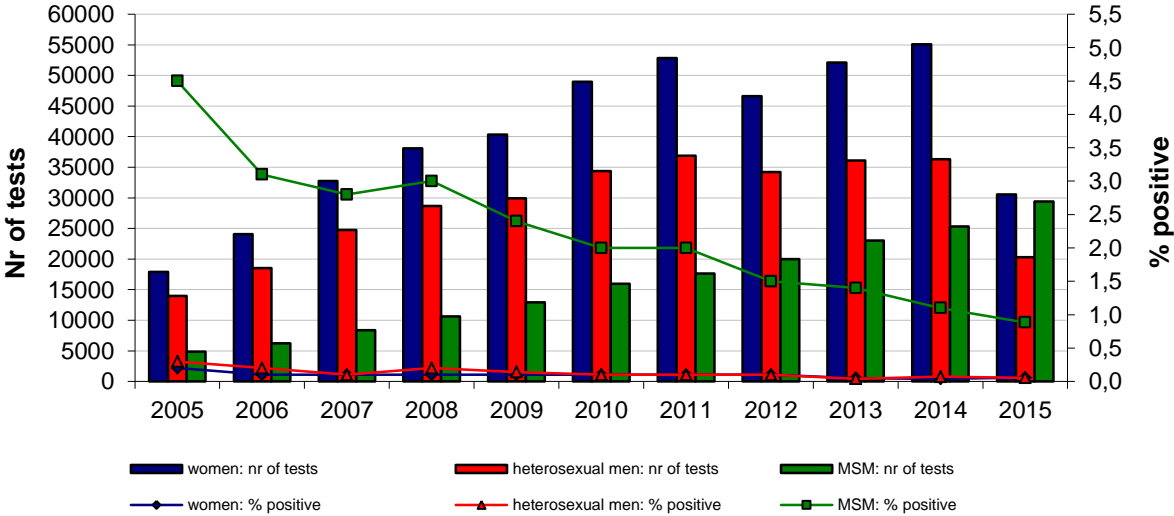


Figure 5. Total number of HIV tests and positivity rate of new HIV diagnoses by gender and sexual preference, centres for sexual health, the Netherlands, 2005-2015 (Source: RIVM/Cib)

2.4 Screening programmes

Antenatal screening

Routine screening for HIV infection is offered to all pregnant women since January 2004. About 175,000 women are tested annually and the participation rate remains constant at 99.8%. The HIV testing is conducted according to the 'opting out' approach and is combined with other antenatal screening activities. HIV prevalence among pregnant women is low: 0.06% in 2013/2014. In that same period 2 children were born with HIV.

Blood screening

Sanquin Blood Supply Foundation screens blood donated by new and existing donors for HIV (and Hepatitis B and C, and syphilis). People with certain riskbehaviour are excluded from blood donation. In 2015, 1 new donor was found to be HIV infected (3,5 per 100.000) and none of the repeated donors showed HIV seroconversion.

Specific studies in high-risk populations

The Amsterdam cohort studies monitor HIV incidence in self-selected populations of MSM and drug users in Amsterdam. The latter group has been excluded starting 2015, following to the observation that from 2006 onwards no HIV occurred among this group within the cohort. The HIV incidence in the MSM cohort has further decreases compared to earlier years (2015: 0.4/100 pY). These cohorts are useful to monitor trends in these groups but generalization may not be possible.

In 2011, the RIVM started, in collaboration with both regular health care and STI clinics at Centres of Sexual Health, a study to assess the cost effectiveness of routine screening for Chlamydia and gonorrhoea in HIV infected MSM who are in specialised HIV care.

3. National response to the HIV epidemic

Human rights aspects such as universal access to comprehensive prevention programmes, treatment, care and support constitute a fundamental principle in the Netherlands. During the reporting period 2012-2015, we have published our first national policy plan STI/HIV 2012-2016 "To renew and reinforce" in which the overall HIV/AIDS policy and programmatic frameworks are explained. Continuous commitment, monitoring and development are needed to ensure adequate policy and programmatic frameworks.

3.1 Stakeholders of the national response

The Ministry of Health is primarily responsible for the development and implementation of HIV/AIDS policy and programmatic frameworks. However, related activities depend on the collaboration of a range of (sub-)national (non-)governmental stakeholders.

The National Institute of Health and the Environment (RIVM) and its Centres for Infectious Diseases Control (CIb) is affiliated with the Ministry of Health and advises, where indicated in consultation with relevant stakeholders, civil society organisations and professionals, the Ministry about STI/HIV policy. RIVM/CIb conducts STI/HIV surveillance, control and research and has a coordinating role among stakeholders. Further to the above, RIVM/CIb assesses work plans of other organisations in the area of STI/HIV prevention and grants subsidies within the framework of national policy.

NGOs that receive governmental subsidies for HIV/AIDS-related programmes include: STI AIDS Netherlands (SAN) (having programmes focusing on policy, professionals, general public, MSM, youth, as well as sex workers and their clients), Mainline (focusing on drug users) and Rutgers (focusing on intervention development and monitoring of sexual health). The government subsidises two organisations that concentrate on people living with HIV/AIDS (PLWHA): the HIV Vereniging Nederland (HVN)(focusing on information and support) and Stichting Hiv Monitoring (SHM) (focusing on surveillance and research based on HIV patients in medical care). The governmental subsidies to these NGOs amount to about €10 million per year. The national 'STI and sexual health platform' meets four times per year and provides, among others, a platform for information exchange, dialogue, policy advice among experts and governmental stakeholders.

Municipal authorities are legally co-responsible for STI/HIV-related prevention and care. These municipal tasks are typically conducted by the municipal health services (GGD). Apart from their legal duties, GGD's receive subsidy (€33 million per year) in order install and exploit the Centres for Sexual health mentioned earlier(chapter 3).

3.2 Prevention

Primary prevention

The frameworks for STI/HIV prevention activities in the Netherlands are described in the national STI/HIV policy plan 2012-2016 and in the sexual health policy document from 2009. The country policy plan is currently under revision.

The promotion of safe (sexual) practices by provision of information is an important component of primary HIV/AIDS prevention. In this regard schools play an important role in informing youth and comprehensive sexuality education will be obligatory from 2012 onwards.

Information about safe sex and prevention of STI/HIV is mainly communicated by means of targeted communication activities for specific groups such as MSM, migrants , sex workers , IDU , youth and other vulnerable groups. NGOs play key roles in development of interventions targeted at these key populations. The GGD and youth health care services are important intermediates in disseminating interventions and information about safe practices.

Momentarily, a demonstration project on PrEP is conducted by the municipal health service in Amsterdam together with many partners (AMPrEP). Outcomes of the project can facilitate the decision of policymakers regarding the introduction of PrEP in the Netherlands. NGO's stated the need for a broader access to PrEP in the Netherlands¹.The demonstration project is part of a bigger multidisciplinary and integrative approach aimed at elimination of HIV transmission in Amsterdam(HIV Transmission Elimination AMsterdam project, H-TEAM). This project involves and is designed by a consortium of relevant stakeholders from public health, civil society, key affected communities, general practitioners and HIV-treating physicians in Amsterdam. Amsterdam has signed the Fast-Fracking Cities Initiative.

Among drug users, harm reduction has proven to be a successful and cost-effective approach to HIV/AIDS prevention. Harm reduction is one component of a larger context which also includes prevention and treatment of the drug use per se. Methadone treatment programmes are available for opiate addicts and the majority of them participate in such programmes. The percentage of injecting drug use is relatively low (about 9% of heroin users). There are no national data on the number of needles and syringes distributed to IDU although some information is available at subnational levels.

¹ <https://www.soa aids.nl/nl/maak-prep-toegankelijk-nederland>

The RIVM Centre for Healthy Living has established an online database of different life-style interventions, including descriptions of evidence regarding effectiveness, in order to increase access of the interventions for stakeholders.

Low-threshold access to information, testing and care

Promotion of HIV testing is conceived of as a crucial aspect of HIV prevention in the Netherlands. Persons who know they are HIV-infected can receive care and support, which can prevent further transmission of the infection.

As mentioned above, a large proportion (about 40%) of HIV-infected individuals is estimated to be unaware of their infection. To date we apply an 'active testing policy', including antenatal screening (introduced 2004) and integration of the active testing policy in the STI/HIV-protocol for GPs .

Moreover, since 2006 and in addition to the regular system for health care delivery and health promotion, there is a specific regulation ('Aanvullende Seksuele gezondheidszorg' (ASG)) to provide low-threshold and free of charge STI/HIV testing and care for high-risk groups at Centres of Sexual Health. In these settings general safe sex counselling as well as other sexuality issues (especially for young people) can be addressed, free of charge. These services are intended to complement, not replace, the regular health care services. In this setting HIV testing is performed on 'opt out' basis. Quality documents support the delivery of high quality services. The RIVM/Cib coordinates the implementation of the regulation. The costs for the regulation amount to about €33 million per year.

In order to generate and facilitate low threshold care and information a stepped care approach is being developed, involving e-health approaches like informative websites and online care facilities focussing on proper and timely reference to face to face care, if needed. Also, ways are being explored to offer to the public trustworthy selftesting and homebased testing services, although at the moment legal restrictions are still in place.

Linkage between prevention and care

The national STI/HIV policy plan underlines the value of linking STI/HIV prevention and care. The setting of STI/HIV care presents an opportunity to reach people in high risk groups and to modify (risk) behaviours. By means of partner notification, additional persons at risk for transmission are given the opportunity to access testing and care.

Care, treatment and support

In The Netherlands the general principle is that everyone in need should receive appropriate health care, HIV/AIDS included. The Netherlands Health Care Inspectorate (IGZ) supervises the access to and quality of care in the Netherlands.

HIV treatment is available for all patients. To date, 27 HIV treatment centres throughout the Netherlands provide high quality care including 2 centres specialized in paediatric treatment. In addition to specialized clinicians, there are also specialised HIV/AIDS nurses who serve as case-managers.

Everyone receiving health care is charged by the health care provider, regardless of one's nationality or legal status. However, the costs can be covered under a health insurance, an international social security regulation (like Regulation (EC) no. 1408/71) or a bilateral social security convention. In these latter cases the (E)111-procedure will apply. Under the Health Insurance Act, all residents of the Netherlands are obliged to have a health insurance. The legislation prohibits insurance companies to decline health insurance for persons (including HIV-infected individuals) who are legally entitled/obliged to be insured. The Netherlands has a system where health insurers are compensated

for predictable health care cost of their insured portfolio. Therefore, health insurers have no benefit in refusing people with an existing condition.

Asylum seekers and individuals without legal basis for residence

There are arrangements to provide HIV/AIDS prevention and care for (failed) asylum seekers in the Netherlands. The Dutch Government compensates the healthcare providers for the costs associated with healthcare for individuals with an ongoing request for asylum. The principle is that health care provided corresponds to standard care in the Netherlands. Asylum seekers accommodated in asylum centres receive, in collaboration with the GGD, information about infectious disease prevention including HIV/AIDS and are screened for tuberculosis. Asylum seekers with an assigned asylum status must arrange their own insurance coverage.

The Netherlands does not regard HIV/AIDS per se as a reason for granting asylum, unless under exceptional circumstances pursuant to the European 'Convention for the Protection of Human Rights and Fundamental Freedoms'. Should a person in need of treatment have to leave the country Dutch authorities will, if necessary, establish contact with counterparts in the country of destination in order to facilitate continuation of treatment. Under certain circumstances, failed asylum seekers are granted to stay in the Netherlands based on medical grounds, including HIV/AIDS. Signalling of medical problems at an early stage in the asylum process can help to avoid a gap between a failed asylum request and a decision regarding a request based on medical grounds. Furthermore, since January 2010 rejected asylum seekers with an ongoing request based on medical grounds are under certain circumstances entitled to accommodation and reimbursements for costs associated with health insurance.

Persons who are illegally present in the Netherlands have to pay their own health care expenses. They are not covered by the Health Insurance Act, nor can they apply for social assistance. Should these undocumented persons fail to pay for the cost of medical care, the health care provider can claim part of his costs from a national health insurance board.

Notwithstanding the above-mentioned arrangements, unfamiliarity with the Dutch health care system may be a possible obstacle for asylum seekers and individuals without legal basis for residence. In asylum centres this is therefore given due consideration by provision of information, both routinely and in response to specific needs.

Stigmatisation and discrimination

Stigmatisation and incidents of discrimination due to HIV infection are still a problem in Dutch society. The current policy continues to increase knowledge about STI/HIV. Furthermore, by normalising test and treatment of HIV/AIDS an effort is made to reduce stigmatisation and discrimination. Also, general social acceptance of risk groups, such as MSM, can contribute to the success of initiatives throughout the full spectrum of the HIV/AIDS prevention and response efforts.

The Ministry of Health maintains the position that HIV-infected individuals should not be prosecuted for unsafe sex unless coercion, deception or disparity in terms of power are involved. This is consistent with the notion that everyone carries a responsibility for his or hers own health.

Since August 2009, legislation against discrimination on the work place has been strengthened. Employers are obliged to have developed a policy based on risk assessment and evaluation to prevent and handle incidents of discrimination. Discrimination based on medical conditions or handicap (thus including HIV/AIDS) is prohibited. The Labour Inspectorate supervises the implementation of this legislation.

Knowledge and behaviour change

A comprehensive national behavioural surveillance system is not yet established; however more effort is directed towards increasing our knowledge in this field. To date knowledge about behaviour in relation to HIV/AIDS is based on a range of different studies and surveys. Although the results of the different initiatives are usually difficult to compare due to methodological differences existing findings illustrate that knowledge and intention to practice safe sex are frequently inadequately translated into actual safe sex. Thus, a major challenge is to foster a supportive environment for safe behaviour and build skills needed to translate intention into actual behaviour.

In 2013 Rutgers performed the first behavioural survey among lesbians, MSM, bisexuals and transgenders (LHBT)². This survey addressed several themes including sexual risk behavior, risk for STI/HIV, and sexual health issues. Previously, survey were performed annually among high risk MSM (until 2011) that concentrated on sexual risk behaviour like condom use, determinants of safe sex (drug use, disclosure of HIV infection) and knowledge of post-exposure prophylaxis. Also motivation and behaviour regarding (HIV) testing and treatment was explored.

General population

From 2015 onwards annual monitors regarding life-style (including sexual health) behaviour is conducted in a sample of the Dutch population. In 2016 Rutgers will perform an in-depth monitor among the general population regarding sexual and reproductive health. Earlier studies, performed within a panel of about 6,000 individuals in the age groups 15-70 years, corroborate the notion that knowledge about STI/HIV among the Dutch population is relatively high. A lower level of knowledge was noted among young people (especially boys 15-18 years), less educated people and among ethnic minorities.

Condom use during the past six months was relatively low (20%) among people with a steady partner, or during anal sex with a steady partner (15%). During sexual contacts with temporary partners in the past six months, about 50% of men and women always used a condom, while about 25% used a condom sometimes or never, respectively. Condom use appeared to be lower among older age groups and among lower educated individuals.

The report of Rutgers further indicated that about one-third of men, and a somewhat larger proportion of women, had ever been tested for an STI/HIV infection. Women had primarily been tested by the GP (61%) while men were more likely to have undergone the test at the GGD/STI clinic at the Centres of Sexual Health (49%).

Staff working in Dutch embassies in HIV-endemic areas

Dutch Embassies in HIV-endemic areas are actively committed to the code of conduct of the International labour Organisation (ILO). All staff members have access to HIV/AIDS prevention and care.

Impact alleviation

Not applicable.

4. Best practices

- Surveillance data indicate that testing is becoming more widespread. This may be interpreted as an achievement attributable to the range of efforts that seek to stimulate HIV testing.

² <http://shop.rutgers.nl/webwinkel/zoekenwat-maakt-het-verschil-onderzoeksrapport/48161&page=>

These efforts include communication about the value of testing and maintenance of low-threshold access to HIV testing, in particular for high risk groups (ASG regulation). But also communicating about the (missing) quality of self testing options.

- An enabling environment is fostered by the commitment and contributions of a range of (sub)national (non)governmental stakeholders that engage in constructive dialogue on a regular basis.
- Monitoring and evaluation are recognised as essential and are applied to inform development and implementation of the HIV/AIDS policy and programmatic frameworks. Possibilities are explored to use existing data and so called big data for a more tailored approach on hot spots.
- The first national policy plan STI/HIV 2012-2016 “To renew and reinforce” was published and will be updated by 2017.
- Big city approach to eliminate HIV within the H-team project (HIV Transmission Elimination AMsterdam). Including a demonstration project on PrEP.
- Harm reduction has been, and continuous to be, a successful component of HIV/AIDS prevention and control among IDU.
- The revision of a national website for young people with information on sexual health (Sense.info) has led to a substantial increase in its users
- A new strategic framework for the control of HIV and STI among MSM guides practice with priorities on: more and easier testing, earlier treatment and ‘stay safe’.
- More and more target groups are reached and informed through online activities. This includes getting target groups to visit websites that support their sexual health (Young People, MSM), informing target groups on HIV and other STI’s inside existing online communities (Antillean and Moroccan youth), finding and informing members of target groups through online outreach work (sexworkers).

5. Major challenges and remedial actions

Maintenance and further development of HIV/AIDS policy and programmatic frameworks pose a number of challenges that call for sustained commitment:

- Recognising that stigmatisation and discrimination of PLWHA is still a problem in Dutch society, this is acknowledged in the national STI/HIV policy plan as an important challenge.
- An estimated 12% of HIV infected individuals are not diagnosed. This emphasizes the necessity of maintaining activities among risk groups and professionals and aiming to stimulate HIV testing.
- Notwithstanding significant communication efforts, sexual risk behaviour remains at high levels in certain groups, such as MSM and ethnic minorities. The high rates of HIV/STI co-infections in HIV infected MSM underline the need for sustained control measures targeting this group. Stimulating behaviour change in high risk groups remains a significant challenge;

especially in an era in which risk reduction strategies in practice are diversifying (e.g. serosorting) and more PLWHIV are undetectable and not able to transmit HIV.

- STI/HIV testing, and therefore opportunities for prevention, typically occurs in the GP setting. The interaction between public health professionals and GPs in the benefit of STI/HIV control remains challenging. In general, partner notification deserves recognition to stimulate exploitation of the full potential of its application by different health professionals.
- Financial and human resources are finite and pose limitations to the implementation of programmes. For example, the costs associated with providing low-threshold access to STI/HIV testing and treatment (ASG regulation) for high risk groups have increased in recent years leading to maximisation of funds allocated to these services. The consequences of this policy need to be addressed in the near future. Discussion has been initiated regarding how to maximize health benefits of these services while keeping the related finances sound.

6. Support from the country's development partners

Not applicable.

7. Monitoring and evaluation environment

As mentioned above, monitoring and evaluation are recognised as fundamentals to inform development and implementation of the HIV/AIDS policy and programmatic frameworks. The Ministry of Health is responsible for overall monitoring and evaluation regarding the HIV/AIDS policy and programmatic frameworks. In practice, key responsibilities in this regard have been delegated to the RIVM/Cib that publishes an annual comprehensive surveillance report as well as a brief annual policy letter. The former accommodates data and information from different STI/HIV surveillance activities and brings these together for a joint interpretation to inform national STI/HIV policy. Data and information sources include the registration of HIV patients at HIV treatment centres, managed by SHM, STI/HIV surveillance at Centres of Sexual Health and in GP networks, and screening of pregnant women and blood donors.

NGOs contribute to the overall monitoring and evaluation system through research, surveillance and evaluations in their areas of expertise. For example, as illustrated above, Rutgers has produced behavioural research/surveillance that is considered in the present report. NGOs serve an important function to identify weaknesses of the HIV/AIDS policy and programmatic frameworks and suggest possible solutions.

In addition to regular routine interactions, the RIVM/Cib organises national expert meetings on an annual basis. The expert meetings offers an opportunity for (sub)national (non)governmental stakeholders to discuss recent surveillance data, research and other developments (e.g. new approaches to reach certain key populations) and exchange ideas, thereby informing future policy and activities in the area of STI/HIV. Furthermore, STI AIDS Netherlands organises the previously mentioned 'STI and sexual health platform' meetings on four occasions per year. Participants principally take part in these meetings in their capacity as experts, but they are also employed by Rutgers, HIV Vereniging Nederland, Mainline, Centres of Sexual Health, RIVM/Cib and the Ministry of

Health. These meetings provide a platform for dialogue and thereby help to address the challenge of maintaining an overview of undertakings by various stakeholders.

Specific evaluations of organisations/stakeholders are conducted on a regular basis to assess the suitability of individual programmes/activities. For example, in the current reporting period an evaluation was performed to assess the functioning of the SHM. As mentioned above, the health inspectorate (IGZ) supervises the access to and quality of care in the Netherlands.

The government seeks to engage in international activities in the area of HIV/AIDS. This includes participation in fora of and cooperation with for example the European Centre for Disease Prevention and Control (ECDC), European Commission, World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS). These activities and related exchange of experiences can inspire and facilitate policy and programmatic development.

The Netherlands participates in the European Joint Action on Improving HIV Prevention. Dutch expertise on health promotion is used to develop a new quality assessment tool for HIV prevention project aimed at IDU's, which will be widely used in Europe. European expertise on quality assessment is applied on Dutch HIV prevention projects.

8. Parts of the Dutch Kingdom in the Caribbean

The transition process for new administrative relations within the Kingdom of the Netherlands is completed. This resulted in closer ties between the Netherlands and three islands of the Netherlands Antilles (Bonaire, St. Eustatius and Saba) which have now the status of a Dutch municipality, whereas the islands of Curaçao and St. Maarten have a more independent status within the Kingdom of the Netherlands. This situation has consequences for the HIV/AIDS policy and programmatic frameworks in the Dutch part of the Caribbean as the municipality governments are directly responsible for the HIV/AIDS policy on these islands. They can make use of the expertise of a local health authority of the mainland and of the RIVM.

Since 2005 the Stichting HIV Monitoring follows HIV patients at the treatment centre on Curaçao. Of the total of 960 HIV-infected patients registered in Curaçao as of May 2015, 171 (18%) have died since the initial registration and 12 (1%) have moved abroad and 547 (69%) were retained in clinical care. Reported data show that approximately two thirds were infected via heterosexual contact. In total, 483 (74%) patients had started cART. Between 2001 and May 2015, 650 additional patients were diagnosed and entered care. Declining numbers of late presenters indicate that patients are diagnosed at an earlier stage of their infection. Quality of monitoring and treatment of HIV-patients has improved considerably. Continuity of care as well as patient compliance to therapy remains suboptimal. Also, STI/HIV-related knowledge and skills among the public and professionals should be strengthened. Intensified surveillance and research are needed to shed further light on the characteristics of the epidemic, especially on risk groups and risk behaviours. The resulting information would be valuable to inform the development of policy and programmatic frameworks.

9. Contributions to international HIV/AIDS response

The Dutch government focuses on four priorities, among which Sexual and Reproductive Health and Rights, including HIV/Aids. With regard to HIV/AIDS and SRHR development assistance, the

Netherlands is among the largest contributors per capita, with an annual disbursement for SRHR and HIV/AIDS amounting to € 428 million in 2010 and € 370 million in 2011. The Dutch contribution is channelled through UNAIDS, United Nations Population Fund (UNFPA), the Global Fund to Fight AIDS, Tuberculosis and Malaria, government-to-government, public private and product development partnerships as well as through international and Dutch NGOs.

The Netherlands has an integrated policy with regard to HIV/AIDS and sexual and reproductive health which is informed by two distinct perspectives: human rights and prevention, which are seen as inextricably linked. Within these perspectives the focus is on young people and on marginalized groups. The rights-based approach directs attention to the inequality of access to prevention, treatment and care services and on the discriminatory practices that rob people of the opportunity to assert their right to health. In addition to young people, the Dutch policy is particularly concerned with populations who are at increased risk of HIV and other infectious diseases such as men who have sex with men (MSM), sex workers (SW), sexual minorities and mobile populations and, to a lesser extent, prison inmates and intravenous drug users (IDU).

The Dutch approach is characterized by pragmatism and informed by scientific research. The success of this policy is reflected in the Netherlands' low rates of teenage pregnancies, abortions and HIV, the latter especially among injecting drug users. These results add credibility to Dutch SRHR policy on the international arena. The objective of universal access to prevention, treatment and care, both with respect to SRHR and HIV/AIDS, is advocated across the entire spectrum of foreign policy by Dutch officials including the Ambassador for Sexual Health and Aids.