SPECIAL REPORT

Thematic report: Migrants

Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2014 progress report

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Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2014 progress report

This report of the European Centre for Disease Prevention and Control (ECDC) was coordinated by Teymur Noori with technical support provided by Andrew J. Amato-Gauci, Anastasia Pharris, César Velasco Muñoz, Lara Tavoschi, Otilia Mårdh, Gianfranco Spiteri, Caroline Daamen, Pierluigi Lopalco, Denis Coulombier and Piotr Kramarz.

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* This designation is without prejudice to positions on status, and is in line with UNSC 1244 and the ICJ Opinion on the Kosovo Declaration of Independence.

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Abbreviations

ART	Antiretroviral therapy
ECDC	European Centre for Disease Prevention and Control
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EMIS	The European MSM Internet Survey
EU/EEA	European Union/European Economic Area
GARPR	Global AIDS Response Progress Reporting
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
MSM	Men who have sex with men
NGO	Non-governmental organisation
NSP	Needle and syringe programmes
OST	Opioid substitution therapy
PMTCT	Prevention of mother-to-child transmission
PWID	People who inject drugs
STI	Sexually transmitted infection
WHO	World Health Organization

HIV and migrants

This report is based on data provided by countries for reporting on the Dublin Declaration[1] and summarises key issues related to HIV and migrants in Europe and Central Asia. It also identifies priority options for action to improve the HIV response for this population.

Note on data sources

This report uses data provided by countries in 2014 through a Dublin Declaration questionnaire[2], data submitted for Dublin Declaration reporting in 2012 and, where appropriate, data from other sources, including surveillance data reported by countries to ECDC. The 2014 Dublin Declaration questionnaire included questions about migrants in general and undocumented migrants specifically, as well as questions about the scale at which interventions are delivered for migrants, gaps in prevention programmes, and the extent of their involvement in policy and implementation. These questions are open to interpretation by respondents. The questionnaire is available on the ECDC website.

Introduction

There is no commonly agreed definition of what constitutes a migrant

Dublin Declaration reporting does not attempt to define migrants, as countries use the term migrants in different ways. In the context of HIV, countries refer to three main groups: migrants from countries with generalised HIV epidemics; migrants who are part of particular sub-populations at increased risk of HIV infection, such as men who have sex with men (MSM), sex workers and people who inject drugs (PWID); and labour migrants.

There is limited data on HIV and migrants

Few countries have reliable estimates of migrant population size and most reported data are from surveys that are based on variable sample sizes and use different methods. This means that nationally representative data on HIV prevalence, HIV testing, condom use or treatment coverage among migrants are scarce and that data cannot be compared over time or across countries. Few countries have specific data on undocumented migrants.

HIV and migrants: the situation

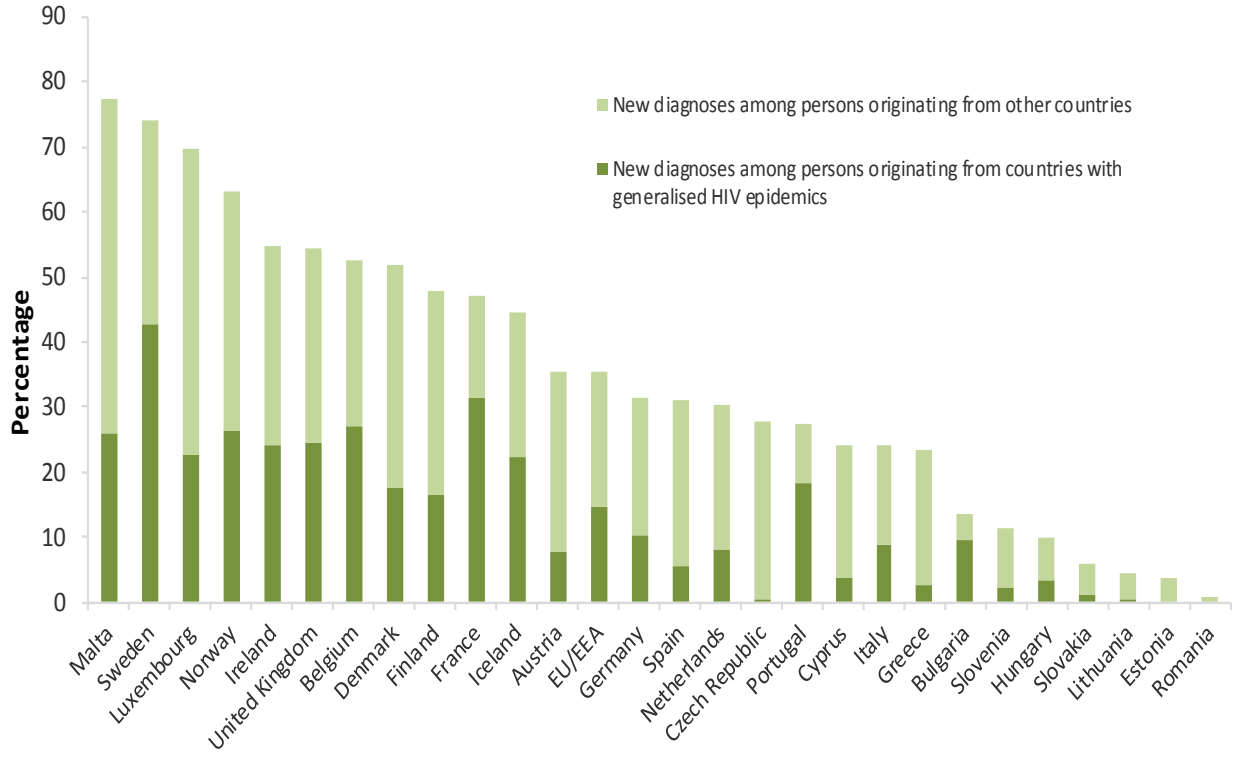
Cases of HIV among migrants are decreasing, but migrants still account for a substantial proportion of all newly-diagnosed cases in the EU/EEA

Surveillance data for the EU/EEA in 2013 show that foreign-born persons represented 35% of all newly-diagnosed cases of HIV where information was known on region or country of birth. However, data reported for 2013 also show the extent to which the proportion of migrants among new HIV cases varies between EU/EEA countries, from less than 5% in Romania to more than 75% in Malta (see Figure 1).

[1] WHO Regional Office for Europe. Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia. [Internet]. 2004 [cited 1 June 2015]. Available from: http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/policy/guiding-policy-documents-and-frameworks-for-whoeuropes-work-on-hiv/dublin-declaration-on-partnership-to-fighthivaids-in-europe-and-central-asia

[2] European Centre for Disease Prevention and Control. Monitoring of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia – Questionnaire. Stockholm: ECDC; 2009. Available from: http://ecdc.europa.eu/en/healthtopics/documents/1009_questionnaire_to_monitor_dublin_declaration.pdf

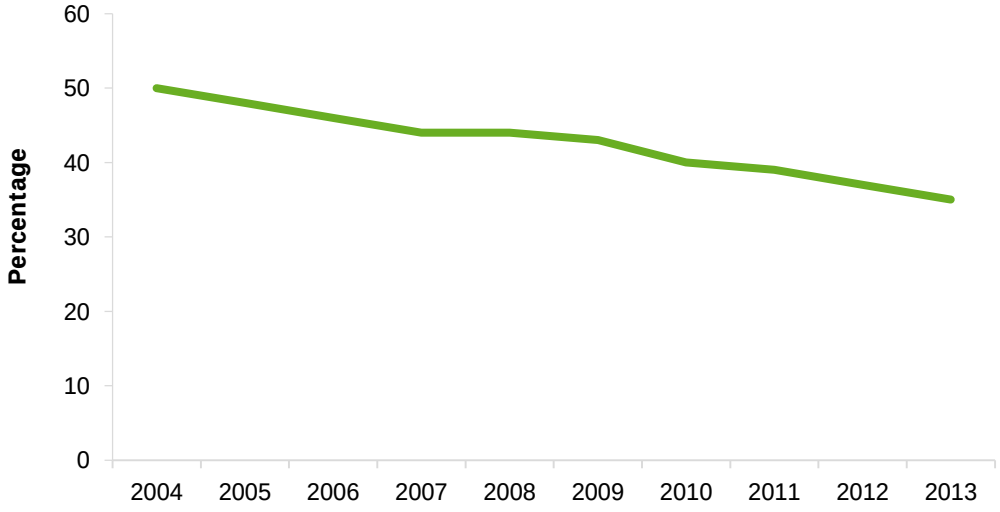
Figure 1. Proportion of migrants among all new HIV diagnoses reported by countries with known country of origin, EU/EEA, 2013



Source: ECDC/WHO

However, the proportion of all reported cases represented by migrants declined between 2004 and 2013, with migrants accounting for 50% of HIV cases reported in the EU/EEA in 2004 and 35% in 2013 (see Figure 2).

Figure 2. Proportion of migrants among all new HIV diagnoses reported in EU/EEA countries with known country of origin, 2004–2013



Source: ECDC/WHO

Few countries have HIV prevalence data for migrants

In 2012, five EU/EEA countries could provide prevalence data:

- Czech Republic – in a 2011 survey, 14 of 7 081 migrants tested were HIV positive – i.e. a prevalence of 0.2%.
- Lithuania – national HIV surveillance data from 2011 showed one in 25 migrants tested was HIV positive – i.e. a prevalence of 4%.
- Netherlands – data from mathematical modelling projects conducted in 2007 and 2008 showed HIV prevalence among migrants of 3.1% overall, 3.4% in men and 2.8% in women.
- Spain – behavioural surveillance conducted in 2010 revealed that 187 of 4 641 migrants tested were HIV positive – i.e. a prevalence of 4% (prevalence was 7.9% in men and 0.95% in women).
- UK – a survey of Africans living in England conducted in 2008–2009 found that 12.1% had tested HIV positive at some time prior to the survey. The Health Protection Agency estimated that in 2010 HIV prevalence among black African men and women in England and Wales was 47/1 000; among men, it was 31/1 000 population and among women it was 64/1 000; among African-born pregnant women in London it was 21/1 000.

In 2014, only three EU/EEA countries provided data:[3]

- Italy – reported prevalence of 16.8% among migrants in general (2005) and 0.97% in undocumented migrants (2009).
- Luxembourg – reported prevalence of 0.52% in asylum seekers (2012–2013).
- Netherlands – reported prevalence of 0.5% (1996–2000) and 1% (2004–2009) among migrants in general.

Three non-EU/EEA countries provided prevalence data in 2014: Tajikistan reported prevalence of 0.4%; Uzbekistan 0.1%; and Israel estimated that 1 805 in every 100 000 of their migrants are living with HIV.

Half of EU/EEA countries report that some sub-groups of migrants are at increased risk of HIV

In 2014 Dublin Declaration reporting, governments in 14 of 28 EU/EEA countries reported that there is evidence that some migrants re disproportionately affected by HIV[4]. Evidence provided (see Box 1) suggests that those most affected are migrants from countries with generalised epidemics and migrants with overlapping risk factors. Only four EU/EEA countries reported that there was evidence on the extent to which HIV affects undocumented migrants.

Box 1. Evidence on HIV among migrants

In Belgium, a significant proportion of people diagnosed with HIV are from countries with generalised epidemics. Among those diagnosed with HIV from the beginning of the epidemic to 31 December 2012 with known nationality, 59.1% were of non-Belgian nationality. Of 1 539 people of non-Belgian nationality diagnosed with HIV from 2010 to 2012, 62% were from sub-Saharan Africa.

In Denmark, migrants comprise 40% of registered HIV-positives but less than 10% of the total Danish population.

In Finland, HIV/AIDS data in the national infections disease register show that the proportion of foreign citizens among new HIV diagnoses was 48.4 % in 2012 and 52.3 % in 2013.

In Germany, migrants with overlapping risk factors such as drug use and sex work are disproportionately affected. A small proportion of migrants – around 2% – are from sub-Saharan Africa, and this sub-group of migrants is disproportionately affected by HIV.

In Greece, 17% of cases reported since the beginning of the epidemic have been in those who are foreign-born.

In Ireland, a high proportion of new diagnoses are in migrants.

In Italy, the incidence of new HIV infections among migrants, both documented and undocumented, is 4.5 times higher than that observed among Italians.

In Spain, 2010 EPI-HIV data show that overall HIV prevalence is higher among migrants than among Spaniards (4% vs. 3%), higher in certain groups of migrants – e.g. those from Latin America (4.9%) and Sub-Saharan Africa (3.9%) – and lower in migrants from central/eastern Europe (2.3%) and North Africa (1.5%).

In Sweden, around 75% of all new HIV cases in 2013 were in foreign-born individuals.

[3] Spain reported prevalence of 4%, based on 2010 surveillance, the same figure as reported in 2012. Civil society in Portugal reported that HIV prevalence is higher in migrants from sub-Saharan Africa and Latin America than in the general population. Bulgaria, Croatia and France reported that data are available. Greece reported that studies are being conducted to assess HIV prevalence in the general population and in migrants.

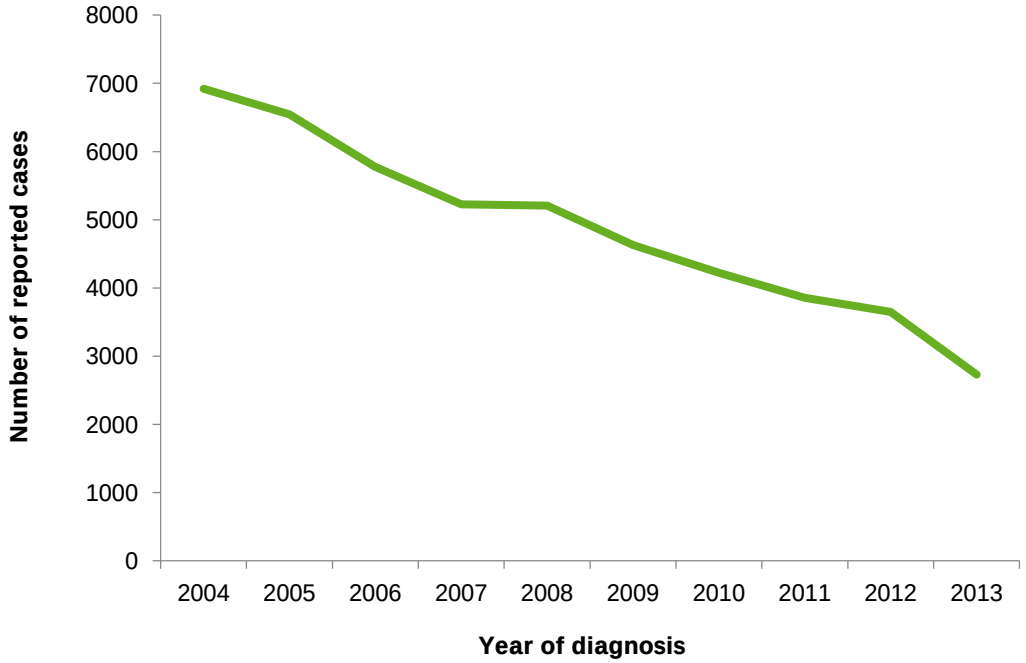
[4] In some EU/EEA countries, for example Croatia, evidence relates to native-born migrant workers. The UK does not collect data on migration status. Black African and some other black and ethnic minority groups are disproportionately affected; some but not all will be migrants. It is important to note that many countries do not have migrant population size estimates (i.e. a denominator) and it is therefore difficult to determine the extent to which migrants are more affected. Non-EU/EEA countries were less likely to report that HIV disproportionately affects migrants; in countries that did, those affected are mainly labour migrants.

Cases among migrants due to heterosexual transmission have decreased in the EU/EEA, but migrants still account for one third of the new heterosexually-acquired infections reported

Between 2004 and 2013, newly-diagnosed cases due to heterosexual transmission among migrants from countries with generalised epidemics declined by 61%, from 6 922 cases to 2 732 cases. It is unclear whether this decline reflects a lower incidence of HIV in the country of origin, reduced migration from these countries or a lower uptake of testing among migrants.

However, migrants from countries with generalised epidemics still accounted for 33% of all newly-diagnosed cases among heterosexuals in the EU/EEA in 2013. The proportion varies between countries. For example, in 2013, Belgium, France, Ireland, Luxembourg and Sweden reported more than 50% of heterosexually transmitted cases in people originating from sub-Saharan Africa, whereas the Czech Republic and Slovakia reported less than 10% of heterosexually transmitted cases in people from sub-Saharan Africa.

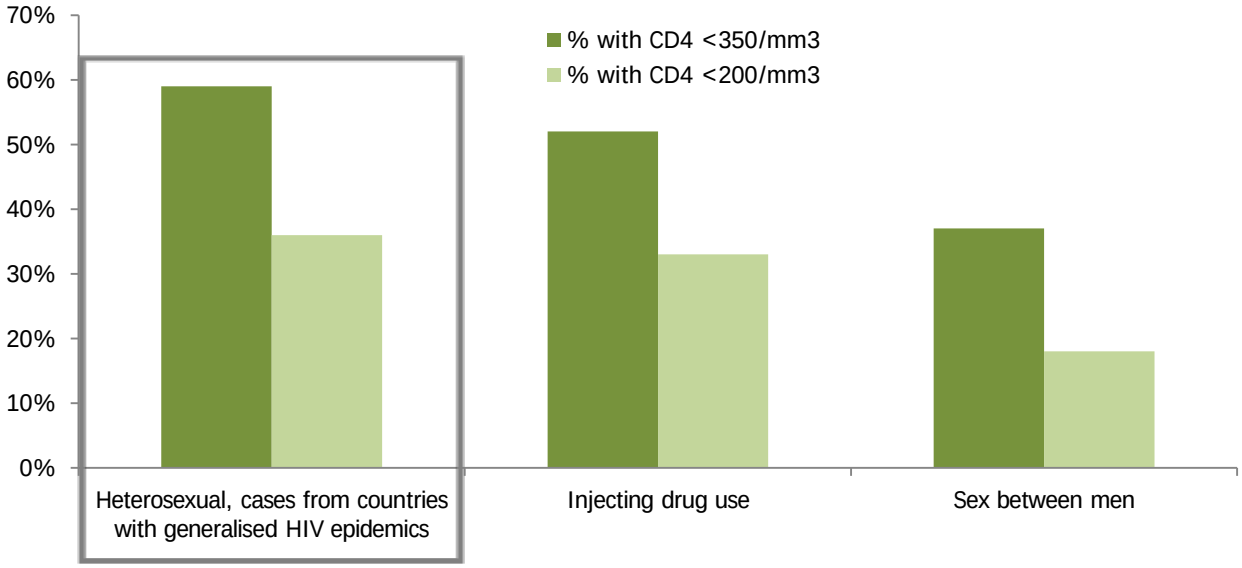
Figure 3. New HIV cases due to heterosexual transmission in migrants from countries with generalised epidemics reported by EU/EEA countries, 2004–2013



Migrants are more likely to be diagnosed late than other populations

In 2013, 21 EU/EEA countries provided information on CD4 cell count at the time of HIV diagnosis. Information was available for 61% of the newly-diagnosed cases reported. Nearly half (47%) of these were late presenters –i.e. with a CD4 cell count of <350/mm^3. However, the proportion of late presenters was highest (59%) in those with heterosexually-acquired infection who were from countries with generalised HIV epidemics (see Figure 4). Regardless of mode of transmission, migrants from some regions are more likely to be diagnosed late than native-born cases.

Figure 4. Late diagnosis by transmission mode reported by EU/EEA countries, 2013[5]



Dublin Declaration reporting also highlights the issue of late diagnosis among migrants. In 2012, rates of late diagnosis were reported to be higher in migrants from countries with high HIV prevalence than in non-migrants by four of the six countries that provided data (Belgium, Finland, Germany and Spain). Austria, Germany, Italy, the Netherlands and the UK also identified late diagnosis as an issue among migrants from high prevalence countries. In 2014, Sweden noted that migrants were predominant among late presenters. UK data from 2012 showed that 66% of Black African men and 61% of Black Caribbean women were diagnosed late, compared with 47% of newly diagnosed people overall.

Other data presented at an ECDC expert meeting on migrant health in October 2013 suggests migrants are more likely to be diagnosed late. In Belgium, in 2011, 51% of migrants from sub-Saharan Africa were diagnosed late compared with 42% of cases overall. France and Spain reported higher rates of late diagnosis among migrants from sub-Saharan Africa. In Greece, rates of late diagnosis were 72% among those of African origin, compared with 51% in those of Greek origin. In the Netherlands, rates of late diagnosis ranged from 60–80% in non-Dutch heterosexuals and from 40-60% in Dutch heterosexuals.

Migrants are also at risk of HIV acquisition after their arrival in the EU/EEA

In 2014, government respondents in 10 EU/EEA countries reported evidence of ongoing transmission in migrants in general[6]; four reported that there is evidence of this in undocumented migrants[7]. Data included:

- Belgium – Probable country of infection was reported by 67.2% of non-Belgians diagnosed with HIV in 2012; 61% of those from sub-Saharan Africa and 25.7% of those of other European nationalities reported that they had acquired HIV in Belgium.
- Germany – Government estimates that up to 30% of migrants with HIV have acquired infection while living in Germany.
- Norway – Available data show an increasing number of new HIV infections in migrants after arrival.
- Sweden – Those who are foreign born are over-represented in newly diagnosed HIV cases among MSM and heterosexuals contracting HIV in Sweden.

Governments in five non-EU/EEA countries[8] reported that there is evidence of ongoing transmission among migrants in general and one country[9] had evidence of this in undocumented migrants.

[5] European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2013. Stockholm: ECDC; 2014.

[6] Belgium, France, Germany, Italy, Malta, Netherlands, Norway, Poland, Spain and Sweden

[7] Belgium, France, Italy and Poland

[8] Armenia, Azerbaijan, Bosnia and Herzegovina, Israel and Uzbekistan

[9] Israel

Box 2. Other data on acquisition of HIV after arrival in the EU/EEA

A recent ECDC report presented the results of a survey asking countries if they had estimates of the extent to which HIV acquisition occurs after arrival in the EU/EEA. Reliable estimates were only available from two countries. Norway estimated that 14% of migrants diagnosed with HIV in 2011 were likely to have acquired HIV infection post-arrival. UK 2010 data indicated that 46% of heterosexually-acquired infections reported among people born abroad were likely to have been acquired in the UK, an increase from 24% in 2004.

Data were also presented at an ECDC expert meeting in Madrid in October 2013 on migrant health. Belgium reported that, in 2011, the probable country of infection was Belgium in some HIV cases among migrants from all regions of the world. Italy and Spain also presented data showing that there was evidence of HIV acquisition in the host country. France reported data suggesting that, in 2011, at least 25% of new HIV infections diagnosed among people born in sub-Saharan Africa were likely to have been acquired in France.

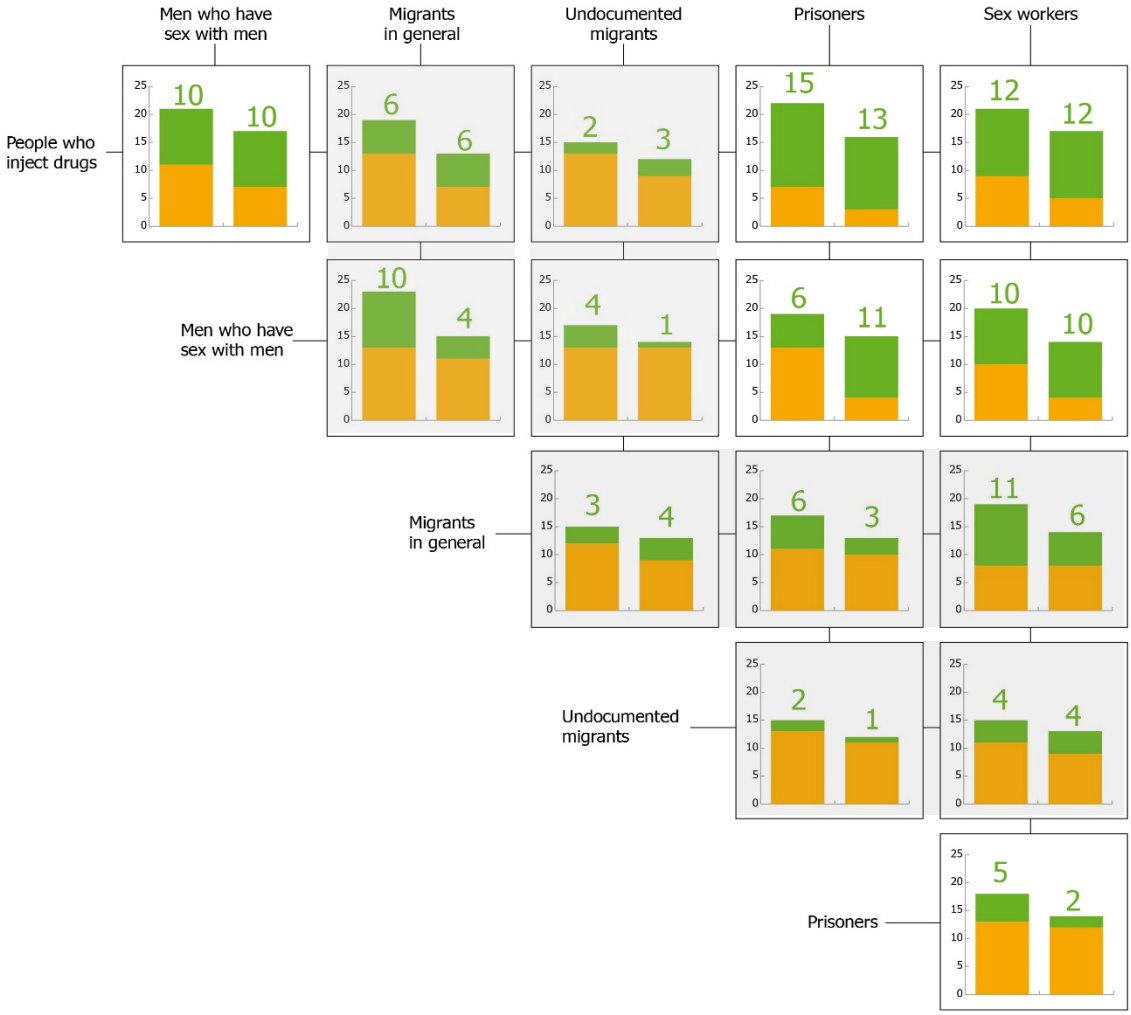
Assigning probable country of infection

Given concerns about the accuracy of clinic-based methods (sexual history) for assigning probable country of infection among people with HIV born abroad, an ECDC project is piloting an objective method, based on modelling rates of CD4 cell count decline, in Belgium, Italy, Sweden and the UK. Initial findings suggest that a significant proportion of people born abroad acquired HIV infection in these countries, highlighting the need to monitor in-country acquisition and organise targeted interventions to reduce late diagnosis and onward transmission.

Migrants are represented in all risk populations; in the EU/EEA there is more evidence of overlap with sex workers and MSM

In 2014, countries were asked about evidence of multiple or overlapping risk. Based on government responses, Figure 5 shows the number of countries that reported overlapping risk between migrants and other key populations. In Norway, national surveillance indicates that a high proportion of PWID who are newly infected with HIV are migrants. In Sweden, 2013 surveillance data show that 12 out of 14 new HIV cases reported among PWID and 94 of 148 new cases reported among MSM were foreign-born. In Luxembourg, programme data show that many people detained in prison are migrants, some of whom are also PWID. In Italy, undocumented migrants are represented among sex workers and prisoners. Sub-groups of migrants identified by EU/EEA countries as being at increased risk of HIV included migrant sex workers (Belgium, Germany, Spain, Switzerland), migrants who inject drugs (Czech Republic, Germany, Netherlands, Norway, Spain), migrant MSM from North and sub-Saharan Africa (France) and Latin America (Spain), and migrant prisoners from sub-Saharan Africa (France).

Figure 5. Number of countries reporting evidence of overlapping risk between migrants, including undocumented migrants, and other key populations



Legend:

Y axis: Number of reporting countries
Left bar: EU countries
Right bar: Non-EU countries
Green: Number of countries reporting evidence of overlapping risk
Orange: Number of countries reporting no evidence of overlapping risk

** Note: Data on migrants in general and undocumented migrants highlighted with grey overlay*

HIV and migrants: the response

In 2014, two thirds of EU/EEA (20 out of 30 countries) and half of non-EU/EEA governments (eight out of 16) reported that migrants were a priority population in their national response. The extent to which countries prioritise migrants is generally consistent with their epidemic profile. Fewer countries monitor the HIV response in migrants. In the EU/EEA, 12 countries monitor the response for migrants in general and four monitor the response for undocumented migrants.

HIV prevention programmes for migrants in the EU/EEA are inadequate

A significant proportion of EU/EEA government (12 out of 28 countries) and civil society (15 out of 20) respondents reported that HIV prevention programmes for migrants in general are not delivered at the scale required. The situation is worse for undocumented migrants: government respondents in 19 out of 28 countries and civil society respondents in 19 out of 21 countries reported that HIV prevention programmes are not delivered at scale for this population. Fewer EU/EEA countries report that prevention programmes are delivered at scale for migrants than for other key populations (see Table 1).

Table. Prevention delivered at scale[10] for most at-risk populations in the EU/EEA, 2014

	EU/EEA countries		Non-EU/EEA countries	
Key population	**Yes**	**No**	**Yes**	**No**
People who inject drugs	27 (90%)	3 (10%)	17 (94%)	1 (6%)
Men who have sex with men	23 (77%)	7 (23%)	16 (89%)	2 (11%)
Prisoners	21 (70%)	9 (30%)	18 (100%)	0 (0%)
Sex workers	20 (67%)	10 (33%)	15 (88%)	2 (12%)
Migrants in general	16 (57%)	12 (43%)	10 (63%)	6 (38%)
Undocumented migrants	9 (32%)	19 (68%)	4 (29%)	10 (71%)

Responses concerning targeted HIV prevention programmes for migrants were similar. Governments in 17 out of 27 EU/EEA countries reported having targeted prevention programmes for migrants in general and seven out of 23 EU/EEA countries had targeted programmes for undocumented migrants.

Gaps in prevention services are more significant for undocumented migrants. Nine out of 25 EU/EEA countries reported gaps in prevention services for migrants in general and 11 out of 22 reported gaps in prevention services for undocumented migrants. Gaps include:

- Lack of a clear policy or strategy (e.g. Greece, Ireland)
- Low availability or coverage of services (e.g. Finland, Greece, Malta, Portugal)
- Low uptake of services (e.g. Denmark, Greece, UK)
- Difficulty in reaching migrants, particularly undocumented migrants (e.g. Belgium, Finland, Lithuania)
- Lack of awareness or understanding of health services among migrants (e.g. Denmark)
- Lack of interpreters and peer educators (e.g. France), lack of culturally and linguistically adapted programmes (e.g. Greece, Portugal, UK)
- Lack of data on undocumented migrants (e.g. Germany)
- Lack of funding (e.g. Greece, Portugal)
- Lack of HIV competence in health services for migrants (e.g. Italy)

[10] In the ECDC questionnaire to monitor the implementation of the Dublin Declaration, 'at scale' was defined as 'at the scale required to meet the needs of the majority of the key population'

Box 3. Examples of targeted prevention programmes for migrants

In Belgium, the HIV-SAM Project supports HIV prevention and sexual health promotion for sub-Saharan African migrants. Tailored prevention, including promotion of HIV testing and culturally-sensitive counselling for people living with HIV, are developed and implemented in collaboration with community leaders.

In Bulgaria, the national HIV/STI programme includes a package of HIV prevention interventions targeting migrants. This includes provision of information; prevention; care and support through outreach in cooperation with NGOs and migrant communities; condom distribution and voluntary HIV counselling and testing through fixed and mobile services. NGO outreach activities include targeting migrant sex workers, PWID and MSM.

In Germany, migrants are a target group within general prevention campaigns. In addition, NGOs target and involve migrants, and some public health services have established specific services for migrants. Information is available in different languages and for sub-groups of migrants – e.g. prisoners, PWID and male and female sex workers.

In Greece, the NGO Praksis implements targeted prevention programmes for migrant. Other NGOs provide mobile testing services in collaboration with migrant communities. Mobile units funded by the European Refugee Fund target undocumented migrants, providing information and free, anonymous testing.

In Italy, HIV counselling and legal advice is offered to migrants through the AIDS and STI Helpline of the Istituto Superiore di Sanità.

In Luxembourg, free and voluntary testing is provided for asylum seekers.

In Spain, NGO HIV prevention programmes for migrants are funded at the national, regional and local level.

In Sweden, county councils have a duty to offer a health examination to newly-arrived individuals; however, only about 50% of asylum seekers are examined.

In the UK, the national prevention programme, funded by the Department of Health and implemented by the voluntary, public and private sectors, aims to increase testing to reduce undiagnosed and late-diagnosed HIV in African communities.

Most EU/EEA governments report that HIV testing is available for migrants, but civil society views differ; undocumented migrants are less well served

In the EU/EEA, government respondents in 21 of 29 countries, but civil society respondents in only nine of 21 countries, reported that HIV testing programmes are delivered at scale for migrants. The situation is worse for undocumented migrants. Only half (14 out of 28) of government and a quarter (six out of 22) of civil society respondents reported that HIV testing is delivered at scale for undocumented migrants.

Few EU/EEA countries have data on HIV testing among migrants

The reasons offered for the lack of testing data include: data are not collected; data on the number of tests performed nationally are not available; data are not disaggregated by nationality or migrant status; and data are from a range of sources or are incomplete. In 2012 Dublin Declaration reporting, seven countries[11] provided quantitative data but, with the exception of Portugal, this was either based on small samples or related to labour migrants. Portugal reported the findings of a survey of 1 513 migrants, 51% of whom reported having been tested for HIV at some time.

In 2014, government respondents in eight EU/EEA countries reported that data were available on the uptake of testing for migrants in general, and in five out of 26, data were also available for undocumented migrants. Reported data included:

- Germany – The 2012 public awareness of HIV/AIDS survey found that 34% of the general population had been tested for HIV, compared with 32% of migrants; 11% of the general population had had a test in the past 12 months compared with 7% of migrants. A study in Hamburg of 612 migrants from sub-Saharan Africa revealed that 67% had been tested: 71% of those who had health insurance had been tested compared with 56% of those without insurance.
- Greece – In a study exploring migrants' knowledge and attitudes about HIV transmission, 24.5% of 147 migrants questioned reported having had an HIV test[12].
- Spain – The 2010 EMIS report showed that 83% of MSM from Latin America had at some time been tested for HIV, compared with 71% of Spanish MSM.

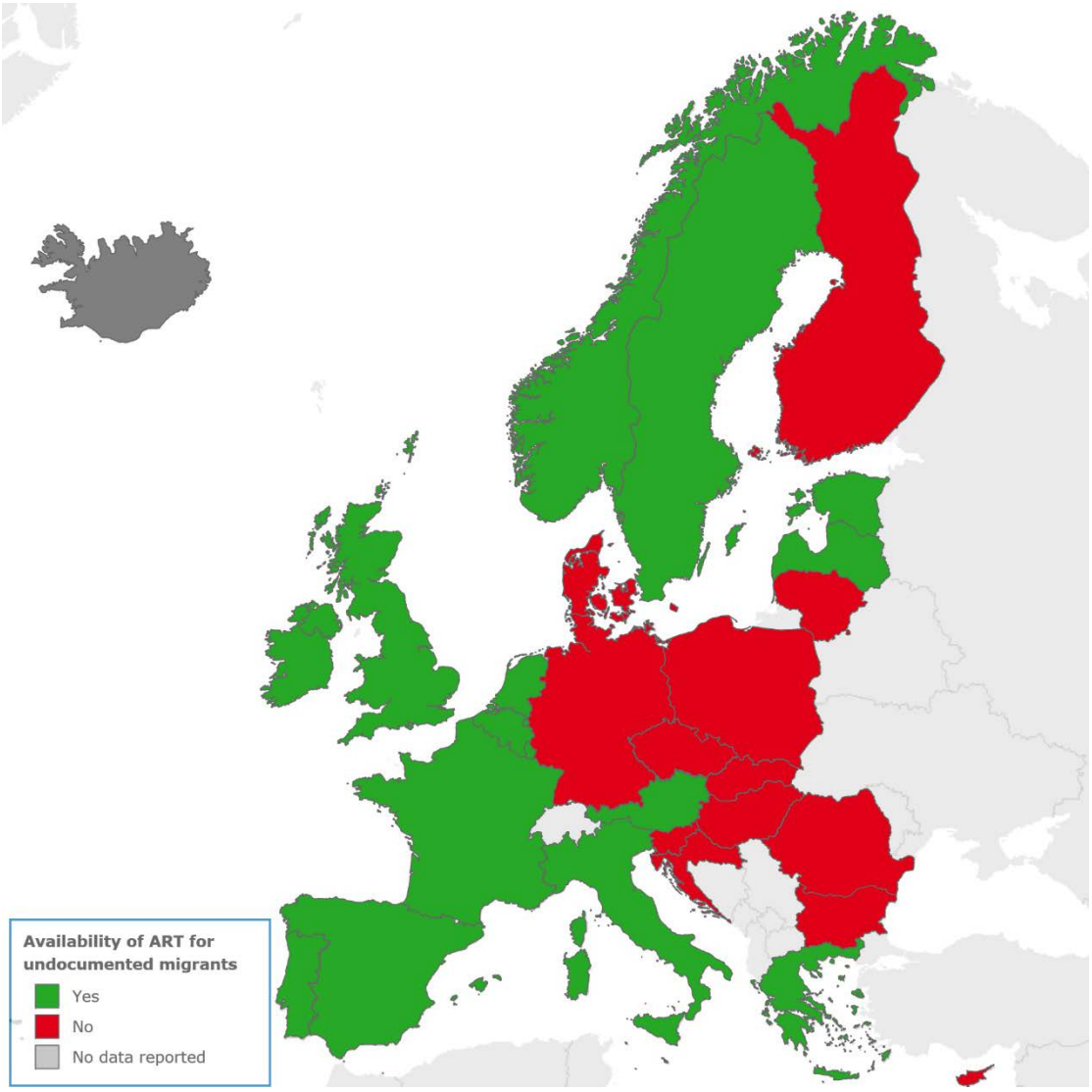
[11] Azerbaijan, Germany, Greece, Lithuania, Portugal, Tajikistan, Uzbekistan

[12] Act Up MDM study

Only half of EU/EEA countries provide HIV treatment for undocumented migrants

In EU/EEA countries, most governments (25 out of 28) reported that HIV treatment programmes are delivered at scale for migrants in general. Only Finland, Latvia and Italy reported that treatment is not delivered at scale. Civil society was less likely (15 out of 21) to report that HIV treatment is delivered at scale. However, far fewer countries deliver HIV treatment at scale for undocumented migrants: only 15 out of 27 government and six out of 22 civil society respondents reported that treatment is delivered at scale for this population. These responses are consistent with data about provision of ART for undocumented migrants: 15 EU/EEA countries reported that antiretroviral therapy (ART) is provided for undocumented migrants and 14 that it is not (see Figure 6). Lack of legal residence status and health insurance are the main barriers. In many countries, undocumented migrants are only entitled to emergency healthcare and therefore do not have access to HIV treatment (see Box 4).

Figure 6. Provision of ART for undocumented migrants, EU/EEA countries, 2014



Box 4. Evidence of barriers that prevent undocumented migrants from accessing HIV treatment

In Belgium, in principle, undocumented migrants have access to healthcare through the Urgent Medical Assistance system, subject to certain conditions. Medical regularisation can be granted if a person is seriously ill and if the treatment needed is not available in their home country. Rejected asylum seekers who are HIV-positive are often granted regularisation, but more recently, such applications have been declined.

In Bulgaria, refugees and asylum seekers have equal rights to healthcare, but for undocumented migrants who do not have identification documents, access is very limited.

In the Czech Republic, treatment of all HIV-positive persons is obligatory by law and the Ministry of the Interior is obliged to cover costs for those without health insurance, but in practice undocumented migrants may experience problems accessing treatment.

In Denmark, undocumented migrants do not have access to social security or treatment.

In Finland, refugees and asylum seekers are entitled to health services free of charge. Migrants without permanent residence have access only if they are in need of urgent medical attention. Civil society reports that undocumented migrants are not entitled to receive HIV treatment.

In France there have been difficulties in applying the law which allows residence permits for undocumented migrants who are ill following a change in immigration regulations in June 2011.

In Germany, undocumented migrants are entitled to emergency healthcare, but provision of long-term ART under this regulation is very difficult. People without health insurance, including migrants from other EU Member States and undocumented migrants, have difficulties in accessing long-term care, including free HIV treatment.

In Greece, undocumented migrants are offered emergency care, including treatment for HIV and other infectious diseases, but the treatment is only provided until their health has stabilised. Budget constraints have made it more difficult for health facilities to treat people who have no health insurance.

In Hungary, people without compulsory state health insurance, including undocumented migrants, are not entitled to free HIV treatment and care services.

In Luxembourg, people without social security experience delays in receiving treatment.

In the Netherlands, undocumented migrants cannot obtain insurance and have to pay for healthcare; they are eligible for treatment through a special fund but not all health professionals are aware of or implement this regulation.

In Slovakia, HIV treatment is conditional on having health insurance; this is a barrier for undocumented migrants.

In the UK, civil society highlighted concerns about the Immigration Bill which will introduce barriers to migrants accessing healthcare, including charges for emergency care and some primary care services, which may undermine the uptake of HIV testing and effective HIV care.

Other barriers prevent migrants from accessing HIV services

These include lack of information concerning HIV, health services and rights; culture, language and religion; denial of risk, self-stigma and fear of the consequences of a positive HIV test result including deportation, stigma and discrimination; bureaucratic procedures; and health worker attitudes towards migrants. Migrants also have limited involvement in the planning and implementation of HIV programmes. In the EU/EEA, government respondents in 12 countries reported that there was no involvement of migrants in planning and 12 noted that there was no involvement in implementation. Civil society reported lower levels of involvement than governments.

Conclusions

Lack of data on HIV and migrants in the region, in particular data on undocumented migrants, makes it more difficult to understand the situation or to assess trends and the effectiveness of the response to HIV in migrants. However, surveillance data and Dublin Declaration monitoring data confirm that in some EU/EEA countries migrants from countries with generalised HIV epidemics and migrants represented in key populations are an important risk group for HIV.

Although the number of cases reported among migrants declined between 2004 and 2013, migrants continue to represent a significant proportion of all HIV cases reported by EU/EEA countries. Migrants represented 35% of all newly-diagnosed HIV cases reported in 2013, and 33% of cases due to heterosexual transmission reported in the same year. There is increasing evidence that migrant MSM are particularly vulnerable to HIV and in some countries there have been increases in HIV diagnoses among foreign-born PWID. A better understanding of migrant sub-groups among high-risk populations would help to inform targeted prevention programmes.

Dublin Declaration reporting suggests that the HIV prevention response for migrants is inadequate. In many EU/EEA countries the scale of prevention programmes is not commensurate with need, programmes are not targeted and there are critical gaps in prevention services for migrants. There is clear evidence that migrants, particularly migrants from countries with generalised HIV epidemics, are more likely to be diagnosed later than other populations and specific measures are needed to increase early uptake of testing and reduce late diagnosis in this group of migrants. There is also growing evidence that some migrants, in particular migrants from countries with generalised epidemics and migrant MSM, are at risk of HIV acquisition after arrival in the EU/EEA. Improved monitoring, better understanding of risk factors and targeted prevention programmes are needed to address this.

Almost all countries in the region provide ART for documented migrants, but only half of EU/EEA countries provide free treatment for undocumented migrants. Undocumented migrants also face a range of barriers that make it difficult for them to access HIV prevention and testing services.

Priority options for action

Strengthen prevention programmes for migrants

- Promote increased uptake of HIV testing among migrants who are most at risk, in particular migrants from countries with generalised epidemics and migrant MSM, to reach the undiagnosed and reduce late diagnosis, including through community-based approaches.
- Develop more effective prevention interventions targeted at migrants most affected by HIV, including migrants from countries with generalised HIV epidemics, migrant MSM and migrants who inject drugs, and targeted prevention programmes for migrants at risk of acquiring HIV after arrival.

Address barriers to provision of services for undocumented migrants

- Consider reviewing or revising laws and policies that prevent migrants, in particular undocumented migrants, from accessing essential HIV prevention and testing services.
- Take steps to ensure that ART is made available to undocumented migrants.
- Support coordinated action to address barriers to provision and uptake of services.

Strengthen the evidence base on HIV and migrants

- Improve monitoring of HIV prevalence, incidence and post-arrival acquisition among migrants.
- Collect country-specific data to identify sub-groups of migrants who are most at risk.
- Improve availability and quality of data on HIV testing and late diagnosis among migrants and sub-groups of migrants who may be at increased risk of HIV.
- Collect data on risk behaviour and risk reduction, including condom use, among sub-groups of migrants most at risk of HIV infection.
- Improve the availability and quality of epidemiological and behavioural data, including through joint funding and harmonised data collection tools.

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