

MONITORING

Prevention, testing and treatment services for migrant populations in relation to HIV, tuberculosis, viral hepatitis and sexually transmitted infections

Availability and access in the European Union/European Economic Area, 2025

Key findings

- Structural and social barriers continue to limit accessibility for migrants to health services. Legal restrictions, lack of health coverage, language obstacles, stigma, and discrimination all reduce opportunities for prevention, testing, and treatment. This contributes to continued transmission and widening health inequities.
- Migrant populations in the EU/EEA experience a disproportionately high burden of HIV, TB, and viral hepatitis. These infections – along with sexually transmitted infections (STIs) – can be prevented through the adoption of similar public health measures.
- ECDC monitoring indicates that availability and access to services for migrant populations can be strengthened across the EU/EEA. While progress has been made, gaps in the equitable provision of services persist.
- Most countries include migrants in HIV and TB strategies, but rarely STI and hepatitis policies, and undocumented migrants are less frequently included in national guidance, across all disease areas.
- Prevention gaps remain. These include limited mention of migrant populations in guidance on pre-exposure prophylaxis for HIV (PrEP), disproportionately low uptake of PrEP among migrant populations, limited implementation of systematic TB infection testing and provision of TB preventive treatment (TPT), and gaps in systematic testing of HBV and HBV vaccination for migrants.
- Opportunities for early diagnosis can be expanded. Migrant-friendly and user-friendly testing options such as community-based testing, self-sampling (home-testing), and self-testing for HIV and selected STIs, and mobile TB screening – remain unevenly available across countries.
- Treatment is generally provided for HIV and hepatitis B and C but is restricted in some countries for undocumented migrants. Although TB treatment is provided for all free of charge in nearly all countries, implementation gaps remain, including administrative barriers affecting continuity of care.
- To achieve SDG 3.3 targets, these gaps should be addressed to ensure equitable provision of prevention, testing, and treatment services for all migrants, across the EU/EEA.

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Abbreviations

ART	Antiretroviral Therapy
EACS	European AIDS Clinical Society
EASL	European Association for the Study of the Liver
ECDC	European Centre for Disease Prevention and Control
EEA	European Economic Area
EU	European Union
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
RDR/MDR-TB	Rifampicin-Resistant/Multidrug-Resistant Tuberculosis
NGO	Non-governmental organisation
PrEP	Pre-Exposure Prophylaxis
SDG	Sustainable Development Goal
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBI	Tuberculosis Infection
TPT	Tuberculosis Preventive Treatment
WHO	World Health Organization

Executive summary

Migrant populations continue to face a disproportionate burden of HIV, tuberculosis (TB), and viral hepatitis in the European Union and European Economic Area (EU/EEA). These infections, together with sexually transmitted infections (STIs), affect similar population groups and are preventable through similar evidence-based interventions for prevention and control.

Structural and social barriers continue to affect access to health services for migrants. Legal restrictions on eligibility, lack of health coverage, language obstacles, stigma, and discrimination reduce opportunities for prevention, testing, and effective treatment. This may affect the uptake of services, contribute to continued transmission within migrant communities and the broader population, widening health inequalities and undermining public health progress.

This report provides an assessment of reported availability and conditions affecting access for migrant populations to prevention, testing, and treatment services across 30 EU/EEA countries, drawing on ECDC monitoring data for HIV, TB, hepatitis, and STIs collected during 2024–2025. Further, it identifies gaps in policy frameworks and service provision.

Findings indicate variation in reported policies and service provision across diseases and countries. Most countries include migrants in HIV and TB strategies, while inclusion is less consistent for hepatitis and limited for sexually transmitted infections. Undocumented migrants are less frequently included in national guidance, across all disease areas.

Despite broad adoption of pre-exposure prophylaxis for HIV (PrEP) recommendations in the EU/EEA, only 16% of countries include migrants in their PrEP guidance, and migrants represented just 24% of PrEP users although almost half of new HIV diagnoses are among people born outside the reporting country. Many EU/EEA countries offer free tuberculosis infection (TBI) testing, TB preventive treatment (TPT), and hepatitis B (HBV) vaccination for all. However, systematic TBI screening and provision of TPT for migrants are implemented in only about one-third of countries. Few countries provide specific recommendations for HBV vaccination for migrants.

There are opportunities to strengthen early diagnosis for migrant populations. While most countries have national HIV testing policies and HIV testing services are generally reported as available for migrants, far fewer explicitly prioritise migrants in national guidance for HBV, HCV or STI testing. Migrant- and user-friendly testing options for HIV, viral hepatitis and STIs, such as community-based testing, self-sampling (home-testing), and self-testing remain unevenly available outside of HIV and select STI services. Few countries report performing systematic HBV testing. TB screening policies focus on migrant populations, but countries report challenges in reaching migrants. Mobile TB screening is also only provided in one-third of the EU/EEA countries.

Treatment is generally reported as widely available, but eligibility restrictions are reported for undocumented migrants, particularly for HIV and hepatitis. Although TB treatment is free of charge in nearly all countries, countries report practical barriers disrupting the continuity of TB care, particularly for asylum-seekers and migrants in irregular situations.

Overall, the findings indicate that while policy frameworks and services are in place in many countries, important gaps remain in their scope, consistency, and access. Strengthening monitoring, including the use of standardised indicators and improved data on migrant populations, may support comparability and inform efforts to enhance prevention, testing and treatment across EU/EEA settings.

Introduction

Within the framework of Sustainable Development Goal (SDG) 3.3, countries globally have committed to ending the epidemics of AIDS, tuberculosis (TB) and combating viral hepatitis and other communicable diseases by 2030. Recent data show that countries of the European Union and European Economic Area (EU/EEA) are off-track for several 2025 interim targets [1]. To accelerate progress, it is key to provide equitable access to prevention, testing, diagnosis, treatment and care for all populations at risk of acquiring these diseases [2].

Migration flows within the EU/EEA have remained broadly stable at around 2 million per year during the past 10 years. Migration from non-EU countries has fluctuated but increased overall during the same time period [3]. As of 2024, migrants accounted for around 10% of the EU/EEA population (about 43 million people), which represented a significant quantitative increase compared to roughly 34 million in 2010. Migration flows from outside the EU/EEA constitute the majority of immigration flows. Migrants from Ukraine remained among the highest numbers of newly registered migrants to EU/EEA countries overall, followed by migrants from India, Russia, Türkiye, and Belarus (latest available data, 2023–2024). In 2023 around 0.9 million migrants sought asylum, most commonly they were of Syrian, Afghan, and Turkish origin. The proportion of people born abroad vary across countries with Luxembourg (47%), Malta (28%), Cyprus (24%), Austria (19%), and Estonia (18%) having the highest proportions, while Slovakia, Poland

ⁱ, and Romania had migrant populations at around 1%. Migrants were generally younger than the overall EU population [4].

Migrant populations are diverse and heterogenous with various drivers for migration. Social conditions vary widely between individuals, groups and generations of migrants. These differences shape exposures to infectious disease risks. First generation migrants often experience risks linked to country-of-origin endemicity and structural barriers in host countries. Subsequent generations generally face lower but not eliminated risk. They have better healthcare access, improved vaccination coverage and greater integration. Yet, travel and mobility patterns continue to shape their exposure.

Migrants experience a higher burden of HIV, TB and hepatitis B virus (HBV) and hepatitis C virus (HCV) infection compared with the general population, and are therefore considered key populations for prevention and control efforts [5]. Some migrants also belong to additional key population groups, including gay, bisexual and other men who have sex with men (gbMSM); transgender people; sex workers; people who inject drugs (PWID); and people in prison.

Many migrants are vulnerable and face poorer health outcomes compared to non-migrants, especially when living and working conditions are sub-standard. Factors such as overcrowded housing, unstable employment, limited income, and poor working environments may heighten exposure risks and make it harder to seek timely care [6]. In addition, intersecting social and structural barriers exacerbate their vulnerability to diseases, including inadequate access to health-care services in transit or in host countries, irregular residence/legal status, language difficulties, stigma, discrimination, and lack of insurance coverage [7,8]. Such inequalities are well documented across European settings [8–10] and addressing them through inclusive prevention policies and services is central to disease elimination efforts in the EU/EEA. Evidence highlights that the social and structural barriers contribute to late diagnosis [11], reduced treatment uptake and adherence [12], and worse clinical outcomes for HIV and TB [13].

Migrants in the EU/EEA are a key population for the prevention of HIV, TB, HBV, HCV, and STIs. Regional frameworks, such as the Regional action plans for ending AIDS and the epidemics of viral hepatitis and STIs 2022–2030 and the Tuberculosis action plan for the WHO European Region, 2023–2030 emphasise that equitable access to prevention, testing, and care services is essential for achieving the Sustainable Development Goal (SDG) 3.3 targets on ending communicable epidemics in Europe [14–18].

The aim of this report is to assess the current situation regarding availability and access to prevention, testing, and treatment services for migrant populations in the EU/EEA regarding HIV, TB, hepatitis, and STI, based on disease monitoring data collected by ECDC in 2024–2025.

ⁱ Poland, Slovakia and Sweden did not include refugees from Ukraine who benefit from temporary protection in their population and migration statistics.

The burden of HIV, tuberculosis, viral hepatitis and STIs among migrant populations

Proportion of cases of HIV among migrants

In 2024, 29 EU/EEA countries provided data on the country of birth, nationality, or region of origin for 21 172 (87.6%) HIV diagnoses. Among these, 11 401 cases (47.2% of the total number of HIV diagnoses and 55.7% of those with known origin information) were reported among migrants. Country-specific proportions of HIV diagnoses among people born outside the reporting country varied widely across the EU/EEA, ranging from low levels (below 10%) in some countries to high levels (exceeding 80%) in others in 2023. In total, 3 670 (32.2%) were from Sub-Saharan Africa, 3 015 (26.4%) were from Central or Eastern Europe, 2 782 (24.4%) were from Latin America and the Caribbean, 598 (5.2%) were from Western Europe, 600 (5.3%) were from South and South-East Asia, and 736 (6.5%) were from other regions. From 2015 to 2024, the proportion of diagnoses among migrants increased by 45.4% [19]. Available data suggest that more than half of people with HIV get diagnosed at a late stage of infection, and that late diagnosis is more common among some migrant populations compared to non-migrants, resulting in poorer health outcomes and increased transmission [19].

Proportion of cases of tuberculosis among people born outside the reporting country

In 2024, of all 38 249 tuberculosis (TB) cases reported in 30 EU/EEA countries, 22 359 (58.5%) were born in, or citizens of the reporting country (referred to as 'native' cases), 14 400 (37.6%) were of foreign origin and 1 490 (3.9%) were of unknown origin. Country-specific proportions of foreign-origin TB cases ranged from below 2% in five countries (Bulgaria, Croatia, Latvia, Lithuania and Romania) to above 85% in five countries (Cyprus, Liechtenstein, Luxembourg, Malta and Norway). The overall proportion of TB cases in people born outside the reporting country increased from 36.0% in 2023 to 37.6% in 2024 [20].

Burden of viral hepatitis among migrants

Based on modelling data, in 2024, there were an estimated 1.73 million (uncertainty interval, UI: 1.04–2.66 million) migrants living with HBV and 1.03 million (UI: 757 000–1 559 000) living with HCV in the 27 countries of the EU, corresponding to migrant prevalences of 2.7% (UI: 1.6–4.2%) and 1.5% (UI: 1.2–2.5%) respectively. The contribution of migrants to the overall prevalence pool of viral hepatitis in the EU/EEA varies widely across countries, due to the diversity of the demographic composition and migration and population patterns [21].

The estimated hepatitis B prevalence among migrant populations in the EU/EEA is higher than among the general population and was estimated at 7% (0.2–37.3%), based on a modelling study (Trickey et al. 2023). The model incorporated data from 84 studies of migrant populations across the EU/EEA/UK, some of which included higher-risk groups such as refugees and migrants attending healthcare services, contributing to the wide range of observed prevalence estimates. At the country level, modelled HBsAg prevalence, a marker of active HBV infection, estimates were generally lower, with the highest estimate observed in Portugal (5.0%) and the lowest in Liechtenstein (~0.0%). The countries with the highest estimated prevalences of HBsAg among migrants were mostly in Southern Europe, although estimates were also high for some Scandinavian countries [22].

Burden of STIs among migrants

Migrants and refugees in general are not classified as key population for STIs, yet structural inequities contribute to elevated numbers of STI cases within this group. Displaced populations such as migrants and refugees may experience sub-optimal access to health and prevention services which affects transmission risks. [23] Bacterial STIs increased substantially in men who have sex with men over the past decade, including migrant MSM. While data on transgender and gender-diverse individuals remain limited, transgender women exhibit a high risk for STIs. Prevalence studies indicate higher prevalences among migrants [24].

Congenital syphilis (CS) has recently increased in the EU/EEA, with 140 confirmed CS cases reported in 2024. Among countries reporting consistently, rates of congenital syphilis increased by 79% since 2023 and by 300% in the last 10 years. In 2024, for 67 cases with available data on the mother's country of birth, 17 (25%) involved mothers born in a different country from the one reporting the case [25].

Methods

In 2023, ECDC initiated monitoring of STIs [26] and enhanced monitoring of TB [20], in addition to already existing monitoring systems for HIV (Dublin Declaration Monitoring) [27] and viral hepatitis [28] to oversee country responses to these infections in the EU/EEA. This report is predominantly based on data collected by ECDC through these online questionnaires disseminated to the 30 EU/EEA countries to monitor HIV, TB, viral hepatitis and STIs [29]. In addition, surveillance data for HIV, TB, viral hepatitis and STIs from 2024 were used to provide context and support the findings.

For HIV monitoring, data collection took place between February and April 2025, covering the status of the HIV response through the end of 2024. The questionnaire used was originally developed in 2009 to monitor implementation of the 2004 Dublin Declaration and has been regularly updated since. If countries did not report new data for 2024, the most recent available data were used, provided they were not older than five years. Data were available from all 30 EU/EEA countries.

Monitoring of hepatitis B and C in EU/EEA was introduced in 2017 to track responses to these epidemics. Data are collected biennially. The monitoring questionnaire has been revised over time based on feedback from an advisory group. The fourth round of data collection occurred between March and May 2025 and monitored status of country responses to these infections through the end of 2024. Twenty-nine countries responded; Bulgaria did not provide data.

Enhanced TB monitoring was implemented for the first time in May 2025, capturing the status of TB responses as of the end of 2024. Indicators were defined in 2024 by the TB monitoring advisory group based on the relevance and feasibility for EU/EEA. Twenty-nine countries responded; Luxembourg did not provide data. In addition to the monitoring data, the report also draws on findings from a survey conducted in 2024 by the ECDC working group on TB and migration. The survey collected detailed information on continuity of TB care for migrant populations [ref]. Twenty-two EU/EEA countries responded, as well as Bulgaria, Cyprus, Ireland, Italy, Liechtenstein, Lithuania, and Luxembourg; Slovenia did not participate in the survey.

For STIs, data collection was conducted between October and December 2024, primarily reflecting national responses to STI epidemics in EU/EEA countries up until the end of 2024 and coverage data as of the end of 2023. This was the first round of STI monitoring, and the questionnaire was newly developed in collaboration with an ECDC advisory group. Twenty-nine countries responded; Latvia did not provide data.

Data validation followed each round of data collection. Within the data validation exercise, consistency and completeness of responses were verified by designated ECDC contractors. In the case of inconsistencies, queries were sent to the respective countries and addressed.

All monitoring questionnaires included indicators related to the policy environment, such as national policies, strategies, and recommendations, as well as the status of provision of prevention, testing, and treatment services, with a particular focus on migrant populations.

The report provides a descriptive analysis of the response to monitoring questions for HIV, TB, viral hepatitis, and STIs in the context of migrant and foreign-born populations. Unless otherwise specified, the denominator for HIV is 30 countries, and for TB, viral hepatitis and STIs 29 countries.

For TB, where relevant, countries were grouped and cross-analysed according to the proportion of foreign-born individuals among TB notifications, based on the latest epidemiological data available to ECDC [30]. Countries with a high proportion of foreign-born among TB cases (more than 50%) included Austria, Belgium, Cyprus, Denmark, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, Malta, the Netherlands, Norway, Slovenia, and Sweden. Those with a medium proportion (25–49%) included Czechia, Finland, Portugal, and Spain, while those with low proportion (less than 25%) included Bulgaria, Croatia, Estonia, Hungary, Latvia, Liechtenstein, Lithuania, Poland, Romania, and Slovakia.

For this report, migrants are defined as 'people born abroad' (i.e. those born outside the reporting country). This categorisation encompasses a broad range of individuals. It includes those who have migrated from within the EU/EEA as well as those who have come from outside the region. The group is diverse in terms of socio-demographic and socio-economic characteristics including ethnicity, nationality, migration status, gender, income, and educational level.

The terms 'regular' and 'irregular' situations refer to specific terms derived from the IOM glossary [31]. Same applies for refugees and asylum-seekers. In addition, this report also uses the term 'undocumented migrant' which refers to a non-national who enters or stays in a country without the appropriate documentation.

Availability of services refers to the extent to which specific services are provided within relevant health settings or to specific groups. Access is defined as the opportunity to receive necessary services (such as prevention, testing, and treatment) in a timely and equitable manner [32]. Access conceptually also refers to how services are reachable or obtainable considering availability, affordability, accessibility, and absence of barriers. In this

report, the assessment of access refers to conditions for access. Conditions for access include reported inclusion of migrant populations in strategy and policy, provision of services and migrant eligibility, however, these conditions do not capture actual utilisation of services.

Availability and access to prevention services among migrant populations

Prevention policy context

At the end of 2024, almost all countries (29; 97%) had a national HIV prevention policy or strategy, with 26 (90%) explicitly prioritise migrants as a key population and 16 (55%) extending this focus to undocumented migrants (Annex 1).

The majority (23ⁱ countries, 79%) had a national strategy for viral hepatitis prevention and control as of the end of 2024. Information on whether these strategies prioritise migrants was not systematically collected and available through hepatitis monitoring.

In addition, at the end of 2024, 28ⁱⁱ countries reported prioritising certain risk groups for TB in guidance documents and of them: 17 (61%) prioritised migrants from high-prevalence settings, 12 (43%) people in refugee camps, two (7%) internally displaced persons, and five (18%) migrant workers (Annex 1). Interestingly, countries with medium or high proportion of foreign-born among TB notified cases did not exhibit higher rates of prioritisation of migrant groups (Annex 1).

A national strategy, plan, or policy for the prevention and control of STIs by mid-2024 was in place in 18 EU/EEA countries (62%). Eleven countries (61%) explicitly mentioned migrants as a key population in their strategy, plan, or policy, while only five (28%) extended this focus to undocumented migrants (Annex 1).

Availability and access to key prevention interventions

Both disease-specific and joint prevention tools are available and recommended by WHO and European clinical societies for the prevention of infectious diseases. Equitable inclusion of migrants in the prevention activities can avert new infections and break transmission chains [33].

Pre-exposure prophylaxis (PrEP) is a key intervention for HIV prevention, proven to substantially reduce new infections among people at higher risk of exposure [34,35]. The regional action plan set a target of 500 000 people on PrEP by 2025 for the WHO European region [18] which would correspond to approximately 300 000 people on PrEP in the EU/EEA [36]. No separate targets were set for key populations. Migrants, particularly those from high-prevalence regions or simultaneously belonging to other key populations for HIV (e.g. gay, bisexual and other men who have sex with men, people who inject drugs, sex workers, transgender people), can benefit significantly from PrEP as part of a comprehensive prevention package that includes testing, counselling, and linkage to care [37]. Offering PrEP in health settings free from stigma helps overcome barriers to care by giving people more control over their own protection, reducing new infections, and promoting trust in healthcare systems [18].

As of 2025, recommendations of the European AIDS Clinical Society on oral PrEP [38] have been widely adopted across EU/EEA countries (25ⁱⁱⁱ, 83%), showing broad policy alignment in HIV prevention and care. However, among countries with PrEP guidance, only four^{iv} (16%) recommend PrEP for migrants, and only 2^v (8%) extend this to undocumented migrants. Migrants represent only 24% of all PrEP users in nine countries reporting on the share of migrants among PrEP users in 2021–2024 (Figure 1) but represented 56% of new HIV diagnoses where information on migration was known. Countries reported on barriers for migrants to access PrEP. Twelve^{vi} EU/EEA countries (40%) reported difficulties reaching migrants, and 17^{vii} (57%) reported challenges with engaging undocumented migrants in services.

ⁱ All, except Belgium, Bulgaria, Croatia, Finland, Iceland, Poland, and Slovenia

ⁱⁱ All, except Iceland

ⁱⁱⁱ Bulgaria, Hungary, Latvia, Lithuania, and Slovenia did not report having PrEP guidelines

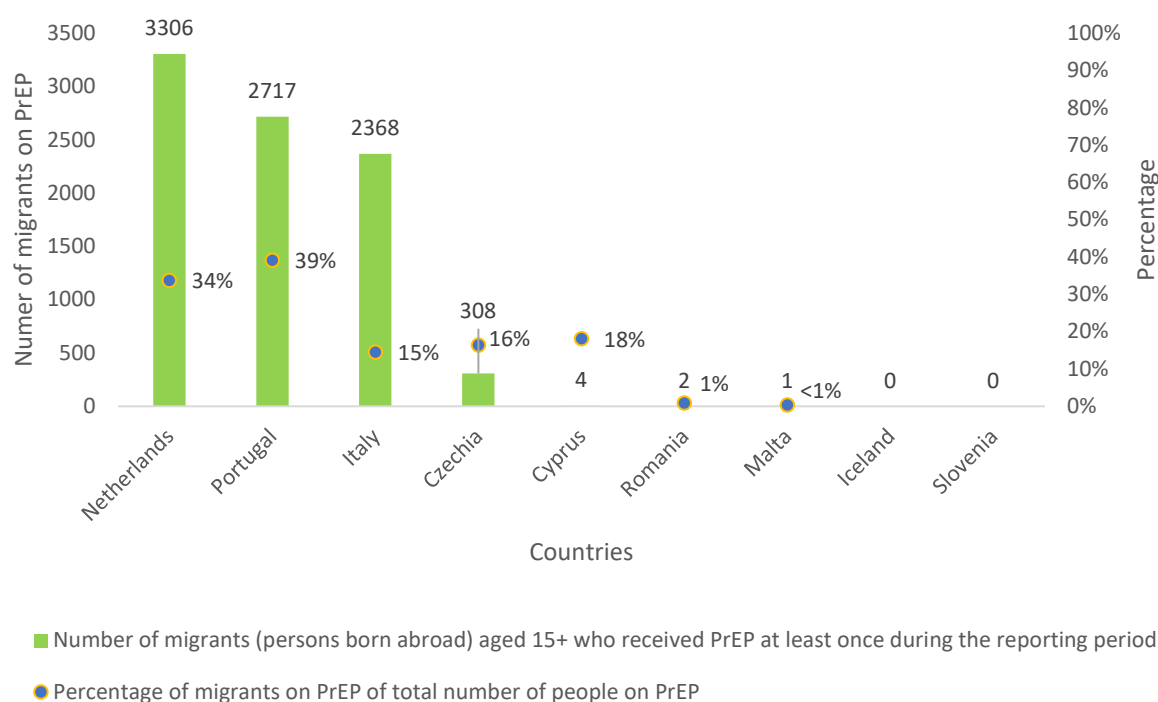
^{iv} France, Germany, Italy, and Portugal

^v France and Italy

^{vi} Belgium, Bulgaria, Croatia, Denmark, Finland, France, Germany, Luxembourg, Netherlands, Norway, Poland and Slovakia

^{vii} All, except Austria, Cyprus, Czechia, Estonia, Greece, Hungary, Ireland, Latvia, Liechtenstein, Lithuania, Romania, Slovenia and Sweden

Figure 1. Number of migrants on PrEP and proportion of migrants (aged 15+) among people who received PrEP at least once during the reporting period in EU/EEA, end of 2024* (n=9)



* Or most recent year with available data; Cyprus, Italy, Malta and Slovenia (2023 data); Iceland (2022 data); the Netherlands (2021 data).

TB infection (TBI) occurs when a person is infected with *Mycobacterium tuberculosis* but does not have active TB disease and has no symptoms of TB [39]. Tuberculosis preventive treatment (TPT) can effectively prevent TBI from development into TB disease and is essential for achieving TB elimination [39,40]. Effective TPT implementation depends on identification of TBI through screening and linkage of people identified with TBI to treatment services [41].

By the end of 2024, 22ⁱ (76%) countries offered free-of-charge TB infection testing, including for people without health insurance or a valid social security number. However, systematic free-of-charge TB infection testing among migrants was implemented in only 12ⁱⁱ countries (41%). When stratified by the proportion of migrants among TB notifications, systematic free-of-charge TB infection testing was offered in eightⁱⁱⁱ countries (53%) with a high proportion of migrant cases and in only one^{iv} country (25%) with a medium proportion. Despite migrants accounting for 38% of all new TB notifications in the EU/EEA in 2024[20], TBI testing efforts in most EU/EEA countries were not focussed on this group. By the end of 2024, TPT was systematically prescribed to migrants with a positive TBI test in only 10^v countries (34%). In addition, just two^{vi} countries (7%) offered TPT to migrants based on clinical assessment without prior testing of TB infection. At the sub-group level, only five^{vii} out of 15 countries (33%) with a high proportion of migrants in TB notification and one^{viii} out of four (25%) with a medium proportion were systematically prescribing TB to migrants with a positive TBI test.

Vaccination against HBV is among the most effective and cost-efficient public health interventions to prevent chronic liver disease and hepatocellular carcinoma. Migrant populations (in particular with origin from intermediate- or high-endemic countries) should be a priority group for HBV vaccination [42,43]. As of the end of 2024, only 10^{ix} (34%) EU/EEA countries recommended HBV vaccination for migrants [44].

ⁱ All except Croatia, Germany, Hungary, Lithuania, Liechtenstein Malta and Poland

ⁱⁱ Bulgaria, Cyprus, Denmark, Finland, France, Italy, Latvia, Malta, Norway, Slovakia, Slovenia and Sweden

ⁱⁱⁱ Cyprus, Denmark, France, Italy, Malta, Norway, Slovenia and Sweden

^{iv} Finland

^v Bulgaria, Cyprus, Hungary, Iceland, Italy, Liechtenstein, Netherlands, Portugal, Romania and Slovenia

^{vi} Italy and Liechtenstein

^{vii} Cyprus, Iceland, Italy, the Netherlands and Slovenia

^{viii} Portugal

^{ix} Austria, Finland, France, Ireland, Italy, Liechtenstein, Luxembourg, Netherlands, Norway and Sweden

Finally, as a multi-disease prevention measure, free provision of condoms and lubricants is a fundamental component of HIV, viral hepatitis, and STI prevention. It promotes safer sex practices, reduces transmission risk, and helps address inequalities faced by groups with limited financial means or restricted healthcare access [45] [35]. Across the EU/EEA, as of 2025, 14ⁱ countries (47%) provided condoms and lubricants free of charge to migrants, and 12ⁱⁱ (40%) countries extend this provision to undocumented migrants.

Availability and access to testing and diagnosis for migrants

Despite notable progress in recent years, significant gaps remain in diagnosing HIV, viral hepatitis and STIs across the EU/EEA. [1]. For migrant populations, promoting confidential, free of charge, integrated, and community-based testing models is essential to achieving earlier diagnosis to care for migrants [19] [1,19,46].

As of the end of 2024, 27 EU/EEA countries (90%) had a national HIV-testing policy, and 20 (74%) specifically identified migrants as a key population (Annex 2). According to reported data, HIV testing was considered generally available in EU/EEA to migrants, with only Finland and Germany (7%) out of all EU/EEA countries reporting restrictions for undocumented migrants.

During the same period, 17 countries (59%) reported having national testing guidance for HBV; of these, only two (12%) mentioned all migrants as a key population for testing, while 10 (59%) included migrants from high-endemic countries. Similarly, for HCV, 22 countries (76%) had guidance; of those, twoⁱⁱⁱ countries (9%) mentioned all migrants as a key population for testing and 14^{iv} (64%) included migrants from high-endemic settings (Annex 2).

Also, by the end of 2024, 23^v countries (79%) reported having a national policy or guidance on screening for TB disease. However, in practice more countries (27, 93%) conducted systematic screening for TB disease. Among these, 15 countries (56%) included migrants as a priority group in systematic screening efforts (Annex 2). Twenty-three^{vi} countries (85% of those conducting systematic screening) experienced constraints regarding screening for TB disease. Twenty^{vii} of these countries (87%) reported difficulties with reaching migrants.

By mid-2024, 18^{viii} EU/EEA countries (62%) had a national policy or strategy on testing for STI. Of those, seven^{ix} countries (39%) mentioned migrants in the context of testing within these policies. Six

^x countries (21%) reported following international guidelines and recommendations from WHO, the International Union against Sexually Transmitted Infections (IUSTI) Europe or the United States Centers for Disease Control and Prevention (US CDC).

To ensure that testing is accessible for migrants, it should be made available in migrant-friendly settings. Providing testing in migrant friendly settings helps to overcome legal, financial, and social barriers and encourages earlier diagnosis and rapid linkage to care [37,47]. Evidence from European and international studies [37,48] suggests that migrants define the following testing options or locations as preferable for one or several of the infections covered in this report:

- community and non-governmental organisation (NGO) centres (culturally sensitive, confidential);
- mobile clinics (bringing services to workplaces, community events, shelters);
- pharmacies (convenient, sometimes anonymous);
- home testing, also known as self-sampling (privacy, flexibility); and
- self-testing kits (confidential use but requires linkage to confirmatory services).

ⁱ Austria, Belgium, Bulgaria, Cyprus, Czechia, Estonia, Ireland, Italy, Latvia, Lithuania, Luxembourg, Norway, Portugal and Spain

ⁱⁱ Austria, Bulgaria, Cyprus, Czechia, Ireland, Italy, Latvia, Lithuania, Luxembourg, Norway, Portugal and Spain

ⁱⁱⁱ Belgium and Cyprus

^{iv} Belgium, Cyprus, Denmark, Finland, France, Germany, Ireland, Italy, Liechtenstein, Luxembourg, Netherlands, Norway, Slovakia and Spain

^v All except Austria, Finland, Hungary, Italy, Poland and Romania

^{vi} Estonia, Finland, Liechtenstein, Lithuania, and Slovakia reported no strains, Luxembourg and Sweden did not respond to the question.

^{vii} All, Except Croatia, Iceland and Malta

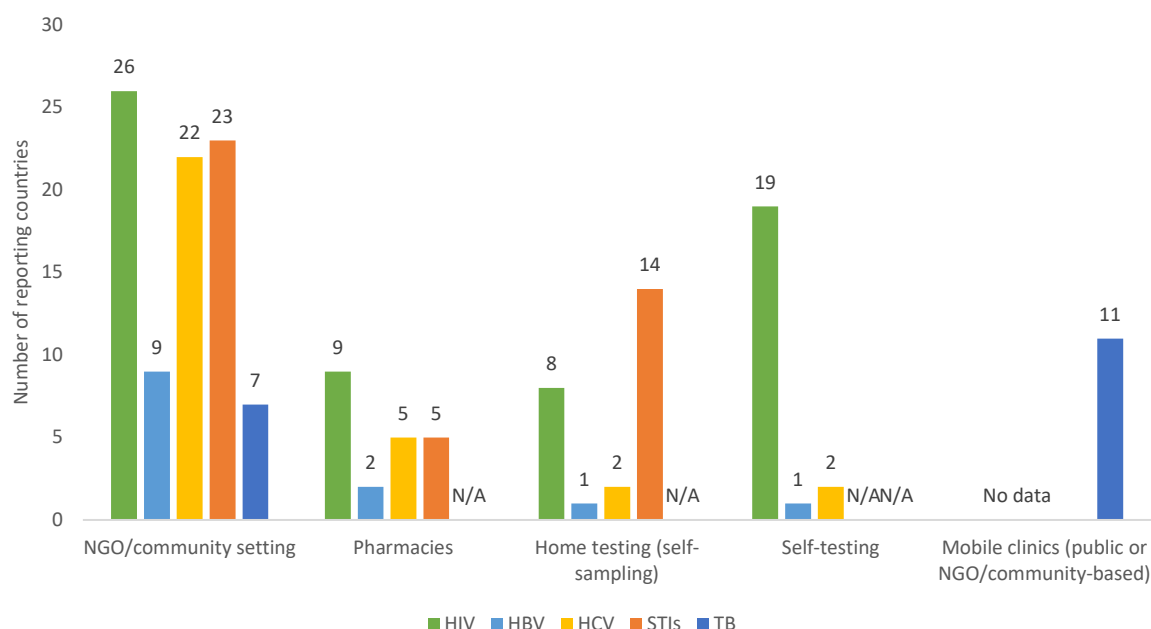
^{viii} Belgium, Bulgaria, Czechia, Denmark, Estonia, Finland, France, Hungary, Iceland, Ireland, Liechtenstein, Lithuania, the Netherlands, Norway, Portugal, Romania, Spain and Sweden

^{ix} Belgium, Denmark, France, Iceland, Netherlands, Norway and Spain

^x Austria, Germany, Italy, Malta, Slovakia, and Slovenia

Based on the diseases monitoring data, as of the end of 2024 testing offered by community and non-governmental organisations was widely implemented for HIV, STIs and HCV, with 25ⁱ (83%), 23ⁱⁱ (79%) and 22ⁱⁱⁱ (76%) countries implementing testing in these settings, respectively. However, only seven^{iv} countries (24%) used this setting to provide screening for TB, and nine^v (28%) to provide testing for HBV (Figure 2). Self-testing was more widely implemented for HIV (19^{vi}, 63% of countries), while only one^{vii} country (3%) had implemented it for HBV and two^{viii} (7%) for HCV.

Figure 2. Non-medical settings for provision of HIV, viral hepatitis, and STI^{ix} testing and TB screening in the EU/EEA, by the end of 2024 (n=30^x)



NGO: non-governmental organisation, HBV: hepatitis B, HCV: hepatitis C, TB: tuberculosis
N/A: not available

Pharmacy-based testing remains largely unavailable, with nine^{xi} countries (31%) offering HIV testing in pharmacies, five^{xii} (17%) offering testing for STIs, two^{xiii} for HBV (7%), and five^{xiv} (17%) for HCV.

Self-sampling (also referred to as home-testing) – a method in which individuals collect their own sample and send it to a laboratory for analysis – was more widely adopted for STIs (available in 14^{xv} or 48% of countries for chlamydia and gonorrhoea, and in nine^{xvi} or 28% of countries for syphilis, Figure 2) than for HIV (eight^{xvii} countries, 27%), HBV (one^{xviii} country, 3%), and HCV (two^{xix} countries, 7%). However, the extent of the availability of STI self-sampling was limited in most countries that had adopted this approach (Figure 3). Wider availability was mainly reported in Ireland, the Netherlands, Norway, and Sweden.

ⁱ All, except Liechtenstein, Lithuania, Luxembourg and Slovakia

ⁱⁱ All, except Bulgaria, Estonia, Hungary, Iceland, Liechtenstein and the Netherlands

ⁱⁱⁱ All, except Cyprus, Greece, Latvia, Liechtenstein, Malta, Romania and Sweden

^{iv} Denmark, Hungary, Ireland, Italy, Portugal, Slovenia and Spain

^v Austria, Belgium, Czechia, France, Germany, Italy, Lithuania, the Netherlands and Portugal

^{vi} All, except Bulgaria, Cyprus, Greece, Hungary, Iceland, Lithuania, Luxembourg, Norway, Poland, Romania and Slovakia

^{vii} Slovakia

^{viii} Estonia and the Netherlands

^{ix} Refers specifically to chlamydia, gonorrhoea and syphilis

^x N=30 for HIV, n=29 for TB, hepatitis and STIs

^{xi} Estonia, France, Ireland, Malta, Norway, Portugal, Romania, Slovenia and Spain

^{xii} Denmark, Germany, Luxembourg, the Netherlands and Sweden

^{xiii} Luxembourg and the Netherlands

^{xiv} Iceland, Ireland, Malta, Poland and Portugal

^{xv} Austria, Belgium, Bulgaria, Croatia, Denmark, Estonia, Finland, Germany, Ireland, the Netherlands, Norway, Poland, Romania and Sweden

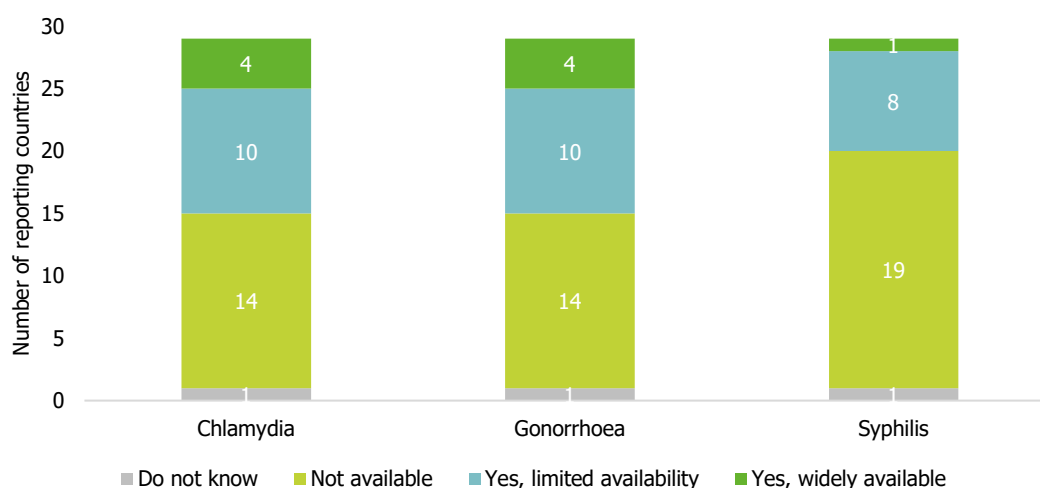
^{xvi} Austria, Belgium, Bulgaria, Germany, Ireland, the Netherlands, Norway, Poland and Romania

^{xvii} Austria, Belgium, Germany, Ireland, Malta, the Netherlands, Slovenia and Spain

^{xviii} Slovakia

^{xix} Ireland and the Netherlands

Figure 3. Extent of availability of self-sampling* for STIs at home, by infection, in the EU/EEA (n=29), 2024



* Self-sampling: When the individual collects any of the following samples from themselves using a suitable kit: urine, finger-prick blood, vaginal, throat or rectal swab, typically outside healthcare setting. The sample is then delivered to a designated laboratory for processing. Results are usually delivered by phone, text message or online, with referral mechanisms in place to ensure linkage to treatment and care as appropriate.

For TB, mobile clinics are considered one of the most effective outreach screening options, particularly for reaching underserved and high-risk populations, such as migrants and undocumented migrants. Mobile clinics can facilitate systematic screening using tools such as symptom checks, chest radiography, and rapid diagnostic tests, helping to identify cases that might otherwise be missed [49]. According to monitoring data, only 11ⁱ countries were implementing this screening approach. In the group of countries with a high proportion of foreign-born people among TB notifications only sixⁱⁱ out of 15 (40%) were implementing testing in this setting.

Access to treatment and care for migrants in EU/EEA

The UNAIDS 95-95-95 targets for HIV aim for 95% of people living with HIV to know their status, 95% of those diagnosed to be on ART, and 95% of those treated to achieve viral suppression by 2030 [50]. For TB, the WHO End TB Strategy sets a 90% treatment coverage and 90% treatment-success target by 2030 [51,52]. The Global Health Sector Strategies for viral hepatitis and STIs call for 90% of people with HBV and HCV diagnosed and 80% treated, and universal access to STI treatment and partner management by 2030 [16,53].

Access to timely and continuous treatment enables both individual recovery and community protection, which is particularly important for certain migrant groups residing in congregated settings. Many migrants (especially undocumented migrants) face barriers such as limited health-insurance coverage, administrative restrictions, stigma, and fear of deportation. These challenges can delay treatment initiation, interrupt continuity of care, and worsen treatment outcomes [54,55]. Removing barriers to treatment can help improve overall health outcomes in migrants and prevents onward transmission of communicable diseases and thereby strengthen health security in the EU/EEA.

According to the data, as of the end of 2024, almost all EU/EEA countries 29 (97%) provide ART for documented migrants with no restrictions. However, seven countries (23%) reported restrictions for undocumented migrants (Annex 3).

Similarly, as of the end of 2024, no EU/EEA country reported restrictions in access to HBV or HCV treatment for documented migrants. However, restrictions persisted for undocumented migrants in fiveⁱⁱⁱ countries (17%).

According to TB monitoring data, by the end of 2024, wide access to free-of-charge TB treatment was reported in almost all EU/EEA countries: 28 countries (97%) confirmed that, according to the existing health policies, people with TB who were not covered by health insurance could receive treatment for the full duration, and the same proportion applied to those without a valid social security number (Annex 3). Earlier in mid-2024, the ECDC working group on migrants and TB conducted a survey with 22 EU/EEA countries responding on continuity of TB care for arriving migrants with a known TB diagnosis and, according to the survey, 18^{iv} (82%) countries reported that TB

ⁱ Austria, Belgium, Denmark, France, Hungary, Ireland, Italy, Poland, Portugal, Romania and Spain

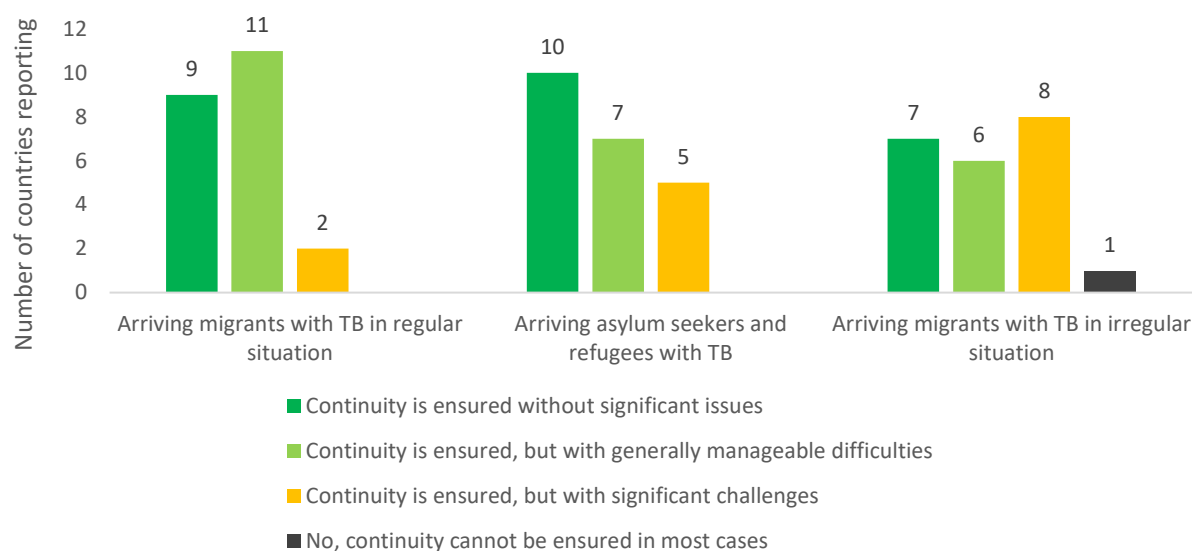
ⁱⁱ Austria, Belgium, Denmark, France, Ireland and Italy

ⁱⁱⁱ Belgium, Greece, Lithuania, Poland and Slovakia

^{iv} All except Austria, Germany, the Netherlands and Hungary

treatment and care were provided free of charge for all migrants, while fourⁱ countries (18%) applied conditions such as health-insurance requirements or partial co-payments. Overall, continuity of TB care for newly arriving migrants in regular situations was ensured in all countries with only twoⁱⁱ countries (9%) out of 22 reporting significant challenges. When it comes to asylum-seekers, fiveⁱⁱⁱ countries (23%) noted significant challenges. Finally, migrants in irregular situations face the highest vulnerability, with eight^{iv} countries (35%) reporting significant challenges, and one^v country (5%) reporting absence of continuity in most such cases (Figure 4).

Figure 4. Continuity of TB care for migrants arriving in EU/EEA, mid-2024 (n=22)



Providing targeted TB information to migrants, especially in their native language can increase linkage to care [33]. According to the survey by the ECDC working group on migrants and TB, targeted TB information for migrants was available in 14^{vi} of 22 (64%) countries, whereas 36%^{vii} still lacked adapted communication materials.

Providing the most effective and shortest WHO-recommended MDR/RR-TB treatment options is important. Doctors Without Borders (Médecins Sans Frontières, MSF) has reported numerous challenges with access to TB drugs in EU/EEA, including those required for the shorter six-month MDR-TB regimens [56]. According to ECDC data as of end of 2024, the vast majority (26^{viii}, 90%) of countries reported adopting at least one WHO-recommended 6-month treatment regimen. The remaining three countries were planning to introduce these regimens within the next two years. Countries also reported rapid progress in adopting the recently WHO-recommended 9-month modified treatment regimens, which are currently implemented in 22^{ix} countries (76%). Longer treatment regimens were still in use in nearly all EU/EEA countries, except for Malta and Norway, but they are no longer the only or the predominant option.

Among the 26 countries using 6-month treatment regimens for MDR-TB, 21^x (81%) reported sufficient coverage of all eligible patients with these shorter treatment options. Three^{xi} countries (12%) did not report data, and two^{xii} (8%) reported challenges in covering all eligible patients. In Hungary, the challenges were related to the procurement of Clofazimine and Pretomanid, as well as the high costs of Bedaquiline, Pretomanid, and Delamanid. In Lithuania, the difficulties stemmed from challenges in procuring Pretomanid and its high cost. According to surveillance data, in 2024 the uptake of these six-month treatment options was still slow, with 39% of eligible RR/MRD-TB patients in 18 reporting countries being placed on these regimens.

ⁱ Austria, Germany, The Netherlands and Hungary

ⁱⁱ Greece and Malta

ⁱⁱⁱ Croatia, Denmark, Greece, Malta and the Netherlands

^{iv} Croatia, Denmark, Finland, Greece, Germany, Iceland, the Netherlands and Norway

^v Hungary

^{vi} All, except Croatia, Sweden, Greece, Latvia, Czechia, Denmark, Iceland and Hungary

^{vii} Croatia, Sweden, Greece, Latvia, Czechia, Denmark, Iceland and Hungary

^{viii} All, except Cyprus, Iceland, and Malta

^{ix} Austria, Belgium, Croatia, Cyprus, Czechia, Estonia, France, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, and Sweden

^x All, except Denmark, France, Hungary, Italy, and Lithuania

^{xi} Denmark, France and Italy

^{xii} Hungary and Lithuania

Discussion

The reported provision and availability of prevention services such as PrEP for HIV prevention, TPT for the prevention of TB disease, vaccination for hepatitis B and condoms and lubricants to prevent sexual transmission of infectious disease remains uneven for migrants across the EU/EEA.

In addition, the reported availability of testing and screening across diseases remains uneven for migrants, including undocumented migrants, across disease. For HIV, migrants are widely included in testing policies. In contrast, although hepatitis testing guidance exists, migrants are less frequently specifically mentioned in these documents [57,58]. Similarly, for TB, around half of countries report including migrants in systematic screening. However, more than two thirds report challenges reaching migrant populations in practice. These findings suggest operational barriers affecting early diagnosis, especially for hepatitis and TB. Community-based approaches including outreach, free or low-cost self-testing options and clear linkage-to-care pathways can support improved access by overcoming barriers related to stigma, legal status and limited contact with health systems.

Treatment is generally reported to be available for migrants across the EU/EEA, although some restrictions persist for undocumented populations.

Overall, while essential care and effective treatment for these infections is available, availability of prevention, and testing is uneven and barriers related to legal status, cost and continuity of care persist for undocumented migrants.

Limitations

The monitoring data identify the existence of policies and provision of services as reported by countries. However, available data do not allow assessment of all aspects of access. The inclusion of migrant populations in policies and strategies guide the provision of services and dictate eligibility for access which is fundamental for uptake and use of services. Yet, there is an important difference between policy, provision of services and real-world accessibility for vulnerable groups

Monitoring questionnaires and variables differed between diseases, and certain topics were not universally covered across all disease questionnaires. This limited opportunities for harmonised data presentation in the report for all four disease areas.

Furthermore, as this is a cross-sectional survey, it reflects the situation during the data collection period. Policies and provision of services may have changed in some countries since the respective disease data collections took place.

Conclusions

Migrant populations in the EU/EEA experience a disproportionately high burden of HIV, TB, and viral hepatitis. In some contexts, migrants are also at higher risk for STIs. Yet availability and access to prevention, testing for migrant populations remain uneven and sometimes insufficient across the EU/EEA.

Most countries include migrants in HIV and tuberculosis strategies; inclusion is less frequent for hepatitis and rare for sexually transmitted infections, and undocumented migrants are rarely addressed across all disease areas.

There is limited mention of migrant populations in guidance on pre-exposure prophylaxis for HIV (PrEP) as well as disproportionately low use of PrEP among migrants, limited implementation of systematic TBI screening and TB preventive treatment (TPT), and gaps in HBV vaccination for migrants.

Testing policies for HIV and TB adequately prioritise migrants, while hepatitis and STI testing guidance seldom mention migrants. Opportunities for early diagnosis can be expanded for this group. Migrant-friendly and user-friendly testing options such as community-based testing, self-sampling (home-testing), and self-testing for HIV and selected STIs, systematic testing of HBV and mobile TB screening remain unevenly available across countries and can be scaled up to increase reach and coverage.

Treatment is generally provided to migrants but is often restricted for undocumented migrants, particularly for HIV and hepatitis. Although TB treatment is free of charge in nearly all countries, practical barriers still disrupt continuity of care, reinforcing the need for equitable, tailored and migrant-sensitive health systems and approaches to improve and sustain linkage to care and retention in treatment.

Monitoring data on provision of services for migrant populations can be further strengthened to capture quality and coverage, to further assess factors in relation to access and accessibility for migrant populations.

Priorities for action

To achieve SDG 3.3 targets, the gaps should be addressed by establishing operational mechanisms that enable equitable provision of and access to prevention, testing, treatment services for all migrants, across the EU/EEA.

Prevention

- Improve availability of prevention services for all migrants, including undocumented migrants.
- Expand PrEP eligibility criteria and efforts to increase demand and uptake among migrants
- Strengthen and expand and HBV vaccination programmes to more effectively reach and cover migrants
- Provide access to essential prevention tools, such as condoms and lubricants, for migrants
- Expand provision of TPT.

Testing

- Scale up systematic TB infection screening for migrants, especially in countries with medium and high proportion of migrants among people notified with TB
- Integrate migrant-specific guidance into hepatitis testing policies
- Expand availability of user-friendly testing options, including community approaches, self-sampling (home-testing) and self-testing for HIV, hepatitis B and C, STIs, and mobile clinics for TB screening.

Treatment

- Address legal and financial barriers for undocumented migrants to access HIV, TB, and hepatitis B and C treatment
- Strengthen continuity of TB care mechanisms for asylum-seekers and irregular migrants, including cross-border coordination efforts and systems to ensure uninterrupted TB treatment
- Provide culturally and linguistically tailored efforts to improve linkage and retention in care via, for example, cultural mediation and peer involvement.

General

- Address social barriers including stigma and discrimination in healthcare settings affecting migrants' access to services
- Strengthen monitoring and data systems to capture implementation quality and coverage for migrant populations.

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Other thematic reports in the series based on SDG 3.3-related ECDC monitoring can be found on ECDC's website at: <https://www.ecdc.europa.eu/en/sustainable-development-goals>

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Annex 1. Prioritisation of migrants in existing national strategic guidance on the prevention and control of HIV and STIs or guidance on risk groups in context of TB, 2024–2025

Country	HIV		STIs		TB			
	Migrants	Undocumented migrants	Migrants	Undocumented migrants	Immigrants from settings with a high prevalence of TB	People in refugee camps	Internally displaced persons	Migrant workers
Austria	No national strategy		No national strategy		Yes	Yes	Yes	No
Belgium	Yes	Yes	No national strategy		Yes	No	No	No
Bulgaria	Yes	Yes	Yes	No	No	Yes	No	Yes
Croatia	No	No	No	No	Yes	Yes	No	Yes
Cyprus	Yes	Yes	No national strategy		Yes	Yes	No	Yes
Czechia	Yes	No	No	No	Yes	No	No	No
Denmark	Yes	No	No	No	Yes	Yes	No	Yes
Estonia	No	No	No national strategy		Yes	No	No	No
Finland	Yes	Yes	No national strategy		No	No	No	No
France	Yes	No	Yes	Yes	No	No	No	No
Germany	Yes	No	Yes	No	No	No	No	No
Greece	Yes	Yes	No national strategy		Yes	Yes	No	No
Hungary	No	No	No	No	Yes	No	No	No
Iceland	Yes	No	No national strategy		Prioritisation not done			
Ireland	Yes	Yes	No	No	Yes	No	No	No
Italy	Yes	Yes	No	No	No	No	No	No
Latvia	Yes	No	No data		Yes	Yes	Yes	No
Liechtenstein	Yes	No	Yes	Yes	Yes	Yes	No	No
Lithuania	Yes	Yes	Yes	No	Yes	No	No	No
Luxembourg	Yes	Yes	Yes	Yes	No data			
Malta	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Netherlands	Yes	Yes	Yes	No	Yes	Yes	No	No
Norway	Yes	Yes	Yes	No	Yes	No	No	No
Poland	Yes	Yes	No national strategy		No	No	No	No
Portugal	Yes	Yes	No	No	No	No	No	No
Romania	Yes	No	No national strategy		Yes	Yes	No	No
Slovakia	Yes	No	No national strategy		No	Yes	No	No
Slovenia	Yes	No	No national strategy		No	No	No	No
Spain	Yes	Yes	Yes	Yes	No	No	No	No
Sweden	Yes	Yes	Yes	No	No	No	No	No

Annex 2. Focus on migrants in HIV, STIs and hepatitis B and C testing and TB systematic screening guidelines, 2024–2025

Country	HIV Migrants	HBV Migrants from high endemicity countries	HCV Migrants from high endemicity countries	STIs Migrants	TB Migrants
Austria	Yes	No	No	No national testing guidance	Yes
Belgium	Yes	Yes	Yes	Yes	Yes
Bulgaria	Yes	No data	No data	No	Yes
Croatia	Yes	No national testing guidance	No national testing guidance	No national testing guidance	No
Cyprus	Yes	Yes	Yes	No national testing guidance	Yes
Czechia	Yes	No	No	No	No
Denmark	Yes	No	Yes	Yes	No
Estonia	No	No national testing guidance	No	No	No
Finland	Yes	No national testing guidance	Yes	No	Yes
France	Yes	Yes	Yes	Yes	Yes
Germany	No national testing guidance	Yes	Yes	No national testing guidance	Yes
Greece	Yes	No national testing guidance	No data	No national testing guidance	No
Hungary	No national testing guidance	No national testing guidance	No national testing guidance	No	No
Iceland	Yes	No national testing guidance	No	Yes	Yes
Ireland	No national testing guidance	No national testing guidance	Yes	No	No
Italy	Yes	Yes	Yes	No national testing guidance	Yes
Latvia	No	No	No	No data	No
Liechtenstein	No	Yes	Yes	No	No
Lithuania	Yes	No	No	No	No
Luxembourg	No	Yes	Yes	No national testing guidance	No data
Malta	Yes	No national testing guidance	No national testing guidance	No national testing guidance	Yes
Netherlands	Yes	Yes	Yes	Yes	Yes
Norway	Yes	Yes	Yes	No national testing guidance	Yes
Poland	No	No national testing guidance	No national testing guidance	No national testing guidance	No
Portugal	Yes	No	No	No	No
Romania	Yes	No	No	No	No
Slovakia	No	Yes	Yes	No national testing guidance	Yes
Slovenia	No	No national testing guidance	No national testing guidance	No national testing guidance	Yes
Spain	Yes	No national testing guidance	Yes	Yes	No
Sweden	Yes	No national testing guidance	No national testing guidance	No	Yes

Annex 3. Restriction in access to HIV, TB and hepatitis B and C treatment for migrants in EU/EEA, 2024–2025

Country	HIV		TB		HBV		HCV	
	Documented migrants	Undocumented migrants	People not covered by health insurance	People without social security number	Documented migrants	Undocumented migrants	Documented migrants	Undocumented migrants
Austria	No	Yes	No	No	No	No	No	No
Belgium	No	No	No	No	No	Yes	No	Yes
Bulgaria	No	No	No	No	No data			
Croatia	No	No	Yes	Yes	No	No	No	No
Cyprus	No	No	No	No	No	No	No	No
Czechia	No	Yes	No	No	No	No	No	No
Denmark	No	No	No	No	No	No	No	No
Estonia	No	No	No	No	No	No	No	No
Finland	No	No	No	No	No	No	No	No
France	No	No	No	No	No	No	No	No
Germany	No	Yes	No	No	No	No	No	No
Greece	No	No	No	No	No	Yes	No	Yes
Hungary	No	No	No	No	No	No	No	No
Iceland	No	No	No	No	No	No	No	No
Ireland	No	No	No	No	No	No	No	No
Italy	No	No	No	No	No	No	No	No
Latvia	Yes	Yes	No	No	No	No	No	No
Liechtenstein	No	No	No	No	No	No	No	No
Lithuania	No	No	No	No	No	Yes	No	Yes
Luxembourg	No	Yes	No data		No	No	No	No
Malta	No	Yes	No	No	No	No	No	No
Netherlands	No	No	No	No	No	No	No	No
Norway	No	No	No	No	No	No	No	No
Poland	No	No	No	No	No	Yes	No	Yes
Portugal	No	No	No	No	No	No	No	No
Romania	No	No	No	No	No	No	No	No
Slovakia	No	No	No	No	No	Yes	No	Yes
Slovenia	No	Yes	No	No	No	No	No	No
Spain	No	No	No	No	No	No	No	No
Sweden	No	No	No	No	No	No	No	No