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TECHNICAL REPORT

HIV and migrants

Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2018 progress report

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This report of the European Centre for Disease Prevention and Control (ECDC) was coordinated by Teymur Noori and Anastasia Pharris.

This report is one in a series of key population reports based on information submitted by reporting countries in 2018 on monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS. Other reports in the series can be found on the ECDC website at: https://ecdc.europa.eu/en/infectious-diseases-public-health/hiv-infection-and-aids/prevention-and-control/monitoring-0.

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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

EU/EEA	European Union/European Economic Area
GAM	Global AIDS monitoring
MSM	Men who have sex with men
NGO	Non-governmental organisation
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS

Introduction

Migrants are a key population affected by HIV across Europe. While most migrants are HIV negative [1], a minority of migrant communities may be more vulnerable to HIV [2] due to a higher prevalence in their countries of origin and to sexual mixing within communities of higher prevalence following migration. Migrants, and especially undocumented migrants who are living with HIV, experience stigmas related to their HIV and migration status, as well as racial and broader cultural discrimination. While these prejudices may not be consistent across Europe and Central Asia, in general they set the context for decisions about availability of and access to treatment and prevention services for migrants.

For the purposes of this report, migrants are defined as 'persons born abroad' (i.e. those born outside the reporting country, regardless of place of HIV acquisition or diagnosis). This categorisation encompasses a broad range of individuals, some of whom may also be included in other key populations such as men who have sex with men (MSM), people who inject drugs (PWID), or sex workers. It includes those who have migrated from within Europe as well as those who have come from outside the region, and will be diverse in terms of race, nationality, gender, socio-economic status and so forth.

The aim of this report is to assess the situation for migrants at risk of or living with HIV, and to identify the efforts that are being made across the Region regarding HIV prevention among migrants.

Methodology

Between January and March 2018, a European Centre for Disease Prevention and Control (ECDC) survey was used to collect data to monitor implementation of the 2004 Dublin Declaration.[1] The monitoring questionnaire was disseminated to the 53 countries that are part of the WHO European Region, plus Kosovo (UNSC 1244)[2] and Liechtenstein via an online survey. Bosnia and Herzegovina, San Marino and Turkmenistan did not provide a response to the survey.

In the 2018 reporting year, ECDC further harmonised data collection with UNAIDS to ensure compatibility and reduce the reporting burden on national health authorities. ECDC was responsible for collecting a core set of Global AIDS Monitoring (GAM) indicators through Dublin Declaration monitoring for European Union/European Economic Area (EU/EEA) Member States, meaning there was no separate GAM reporting for EU/EEA Member States. Non-EU/EEA Member States continued to complete GAM through UNAIDS and were asked to complete a shortened ECDC Dublin Declaration questionnaire, with any GAM questions removed. The data collected through these processes were then combined and included in the analysis for this report.

National health authorities were requested to complete the Dublin Declaration survey between mid-February and the end of March 2018. In May 2018, the information reported by each country was returned for validation. Subsequent notifications of corrections were used to update the information reported. Validation of data collected through the GAM process was conducted by UNAIDS.

In addition to general questions relating to current prevention interventions, policies and barriers to the public health response, countries were asked specific questions relating to the epidemic among their migrant population including questions about service provision for undocumented migrants.

Data for this report have been supplemented with data from the European Surveillance System (TESSy) for the WHO European region.

This report summarises recent data on HIV among migrants in the WHO European region, including the extent to which countries in the region are moving towards viral suppression among their migrant populations. It also examines a range of prevention interventions, particularly regarding the extent to which prevention programmes are targeted at migrants and, specifically, undocumented migrants. Case studies provided by health authorities in their survey responses that highlight developments in public health policy and programme implementation relevant to migrants are also cited.

As well as considering the picture for the overall European and Central Asian region, findings are presented by WHO sub-regions (West, Centre, and East) which broadly group areas of Europe and Central Asia by geography and epidemic type, as depicted in Figure 1.

1 Both the EU and non-EU versions (including Russian translation) can be accessed on ECDC's website at https://ecdc.europa.eu/en/infectious-diseases-public-health/hiv-infection-and-aids/prevention-and-control/monitoring-0

[2] 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.

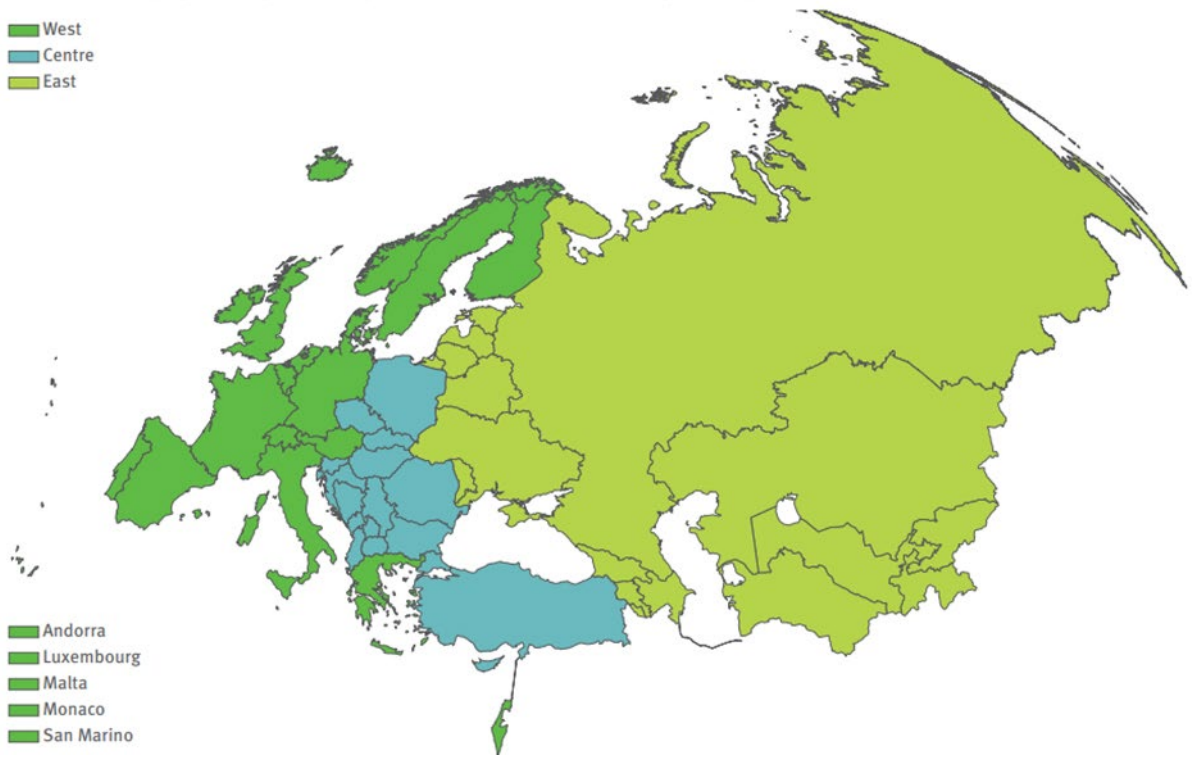
The countries covered by the report are grouped as follows:

West, 24 countries: Andorra, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Liechtenstein, Malta, Monaco, the Netherlands, Norway, Portugal, San Marino, Spain, Sweden, Switzerland, the United Kingdom.

Centre, 16 countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic, Hungary, Kosovo, North Macedonia, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia, Turkey.

East, 15 countries: Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan.

Figure 1. Geographical/epidemiological division of the WHO European Region



Why focus on migrants?

New HIV diagnoses

Across the Europe and Central Asia Region, migrant populations have particular HIV-related needs. Of the 52 countries that provided the data discussed in this report, 20 consider migrants to be a key population with 13 (25% of reporting countries) rating migrants as their second priority. After men who have sex with men (MSM) and people who inject drugs (PWID), migrants are the clear third priority key population for the Region as a whole.

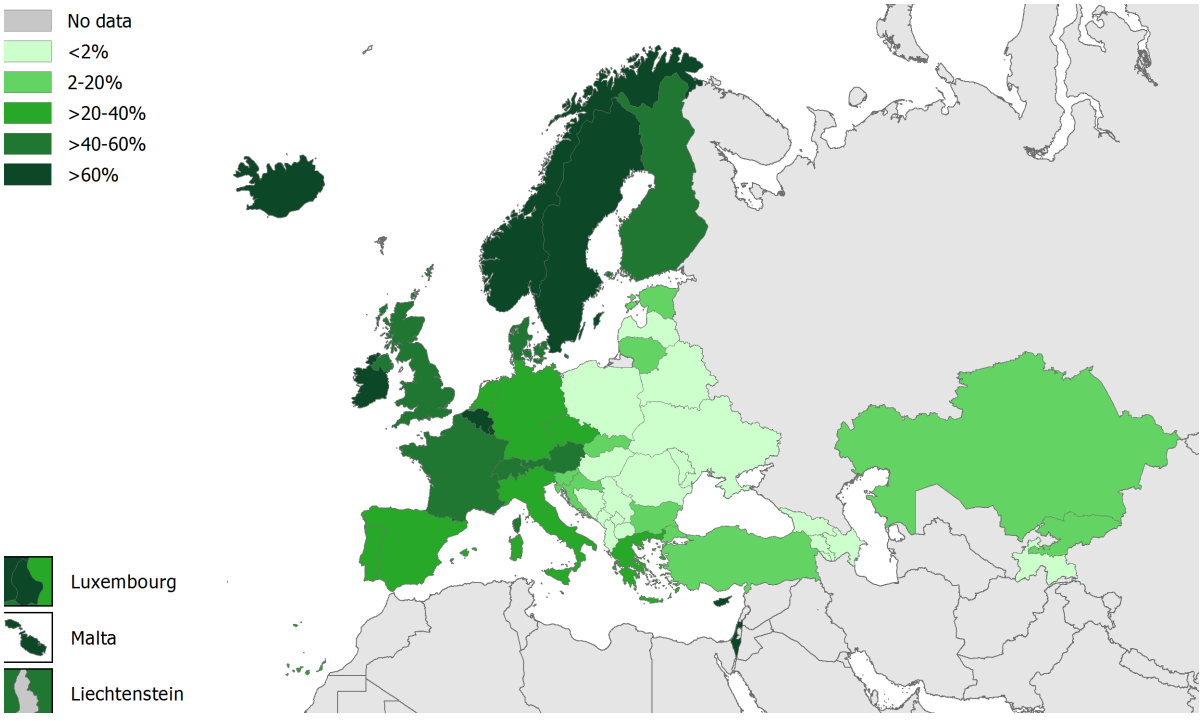
HIV disproportionately affects migrants. Across Europe and Central Asia, 19.2% of new diagnoses in 2017 where country of birth was known were among the migrant population [6], which is considerably higher than the percentage of the general population who are migrants. For example, 10.5% of the population of Europe were foreign born in 2017. [3]

The proportion of new diagnoses among migrants varies across the Region. The reported data show in the East sub-region migrants account for less than 1% of new diagnoses in 2017 where country of birth was known, 10% in the Centre, but over 47% in the West. [6] However, these figures are reliant on accurate country of birth reporting for those who are newly diagnosed, and this is known to be inconsistent across Europe and Central Asia and especially poor in the East sub-region[1]. Undoubtedly, this could mean that HIV diagnoses in migrants are underreported in some parts of Europe.

Eight of the 12 countries in the East sub-region that provided data reported that less than 2% of their new diagnoses in 2017 were among migrants, and three of those countries reported zero new diagnoses among migrants. [6]

In contrast, 15 of the 16 countries in which diagnoses of migrants accounted for over 40% of all known new diagnoses in 2017 are in the West sub-region (Figure 2). Apart from Monaco, all countries in the West sub-region that were able to provide data reported that at least three in ten of their new diagnoses in 2017 were among migrants.

Figure 2. Percentage of all new HIV diagnoses in migrants in Europe and Central Asia, 2017 [6]



In some countries, particularly among those in the West sub-region, the high proportion of new diagnoses among migrants result in high absolute numbers of newly-diagnosed migrants. For example, in the United Kingdom 56.8% of new diagnoses were among migrants, which amounts to 2 184 migrants receiving an HIV diagnosis in 2017 (Table 1). France, Spain, and Italy all report more than 1 000 new diagnoses among migrants in 2017, although in

[1] European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2019 – 2018 data. Stockholm: ECDC; 2019.

France, as in England, this represents about one-half of all new diagnoses, whereas in Spain and Italy the number of new diagnoses among migrants comprises about one-third of all new diagnoses in 2017.

However, in some countries where a high proportion of the new diagnoses in 2017 are among migrants, the absolute numbers remain quite low. The most obvious examples are Luxembourg, Malta, and Iceland where, in each case, over 60% of new diagnoses in 2017 were among migrants, but this translates to fewer than 50 migrants receiving an HIV diagnosis (Table 1).

Table 1. Number and proportion of all new HIV diagnoses reported in migrants, Europe and Central Asia, 2017[1] [6]

Country	Proportion of new diagnoses, with known region of origin, who are migrants	Total number of new diagnoses	New diagnoses with known region of origin	Number of newly diagnosed known to be migrants
Sweden	77.1%	434	423	326
Luxembourg	74.6%	59	59	44
Ireland	70.2%	483	393	276
Israel	67.2%	405	405	272
Malta	64.4%	45	45	29
Norway	62.8%	213	199	125
Iceland	62.5%	24	24	15
Cyprus	62.4%	85	85	53
Belgium	61.2%	890	685	419
United Kingdom	56.8%	4 363	3 847	2 184
France	55.1%	5 211	2 952	1628
Denmark	53.7%	242	242	130
Finland	50.4%	158	141	71
Austria	47.6%	270	269	128
Switzerland	46.8%	443	359	168
Germany[2]	39.0%	3 144	2 855	1 127
Netherlands	38.8%	716	685	266
Spain	37.0%	3 249	3 134	1 160
Italy	34.4%	3 443	3 428	1 179
Portugal	33.1%	1 068	1 034	342
Czech Republic	30.7%	254	254	78
Greece	30.0%	628	614	184
Croatia	17.9%	106	106	19
Turkey	13.6%	2 844	2 760	376
Estonia	10.0%	219	110	11
Slovakia	8.6%	70	70	6
Slovenia	8.3%	39	36	3
Kyrgyzstan	5.2%	840	840	44
Kazakhstan	5.1%	3 019	3 019	155
Lithuania	3.8%	263	263	10
Bulgaria	2.9%	241	241	7
Azerbaijan	1.9%	570	570	11
Poland	1.3%	1 325	820	11
Serbia	1.1%	356	356	4
Latvia	1.1%	371	369	4
WHO European Region	**19.2%**	**55 198**	**50 858**	**9 755**

Data are only included for those countries where the reported number of newly diagnosed exceeds 10 or the proportion of the newly diagnosed who are known to be migrants exceeds 1%.

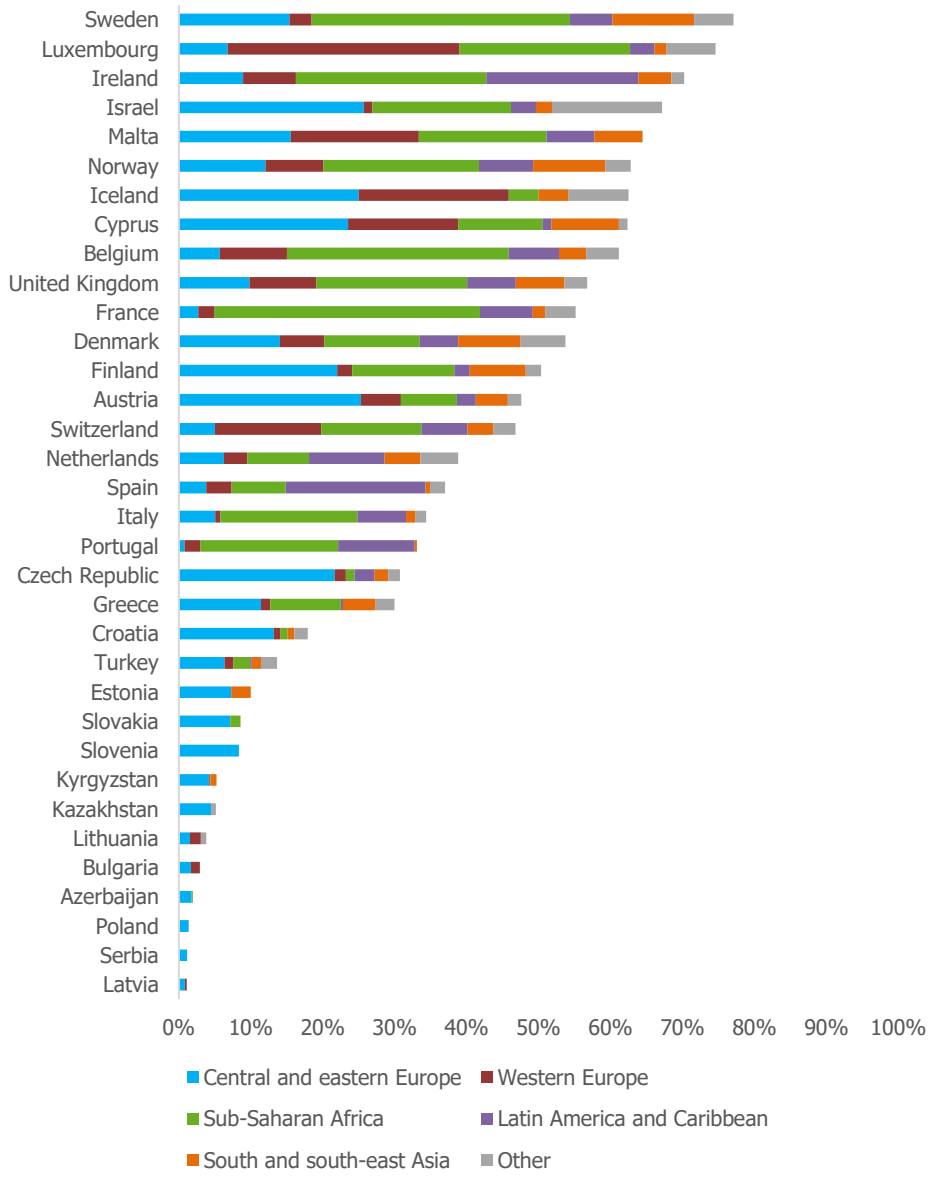
.

Germany is not included in the totals due to a data transfer issue, but German data have subsequently become available so are included in this table and in Figure 2

Political and socio-economic changes affect the volume, direction and origin of migration, so migration patterns can be quickly disrupted. However, the snapshot of new diagnoses in 2017 by region of origin (Figure 3) shows that migrants with new diagnoses in the countries of the Centre and East sub-regions predominantly come from other countries within Central and Eastern Europe. By contrast, within the West sub-region there are far higher proportions of new diagnoses among migrants from outside Western Europe, with a notable proportion of these are from sub-Saharan Africa (in Sweden, Belgium, UK, France, Italy and Portugal) and from central and eastern Europe (in Sweden, Israel, Denmark, Ireland and Austria).

Primarily this reflects long-standing migration patterns based on geographical proximity or historical and political ties. However, some newer trends (e.g. a higher proportion of new diagnoses among the Latin American and Caribbean population in Ireland) indicate new migration patterns and the need for new, targeted responses.

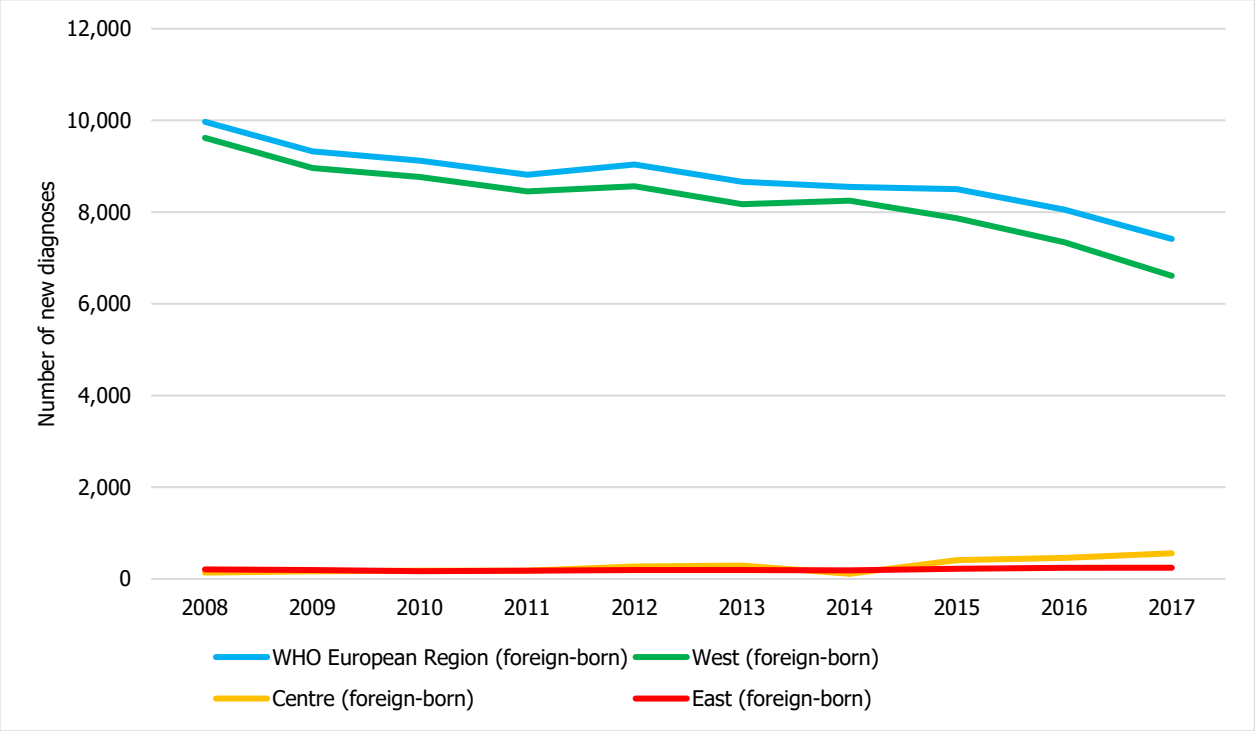
Figure 3. Proportion of diagnoses in migrants by region of origin, 20171 [6]



Data are only included for those countries where the reported proportion of the newly diagnosed who are known to be migrants exceeds 1%.

New diagnoses among migrants have fallen from 9 970 to 7 416 over the decade in countries reporting consistently in the Region – a decline of 26% (Figure 4). The vast majority of new diagnoses among migrants are in the West sub-region, and therefore trends there overwhelmingly shape trends in the Region as a whole. These data have to be qualified by the quality of country of birth reporting. The West sub-region has a slightly higher proportion of new diagnoses where country of birth is 'unknown', but it is difficult to ascertain the accuracy of country of birth reporting across the Region as a whole.

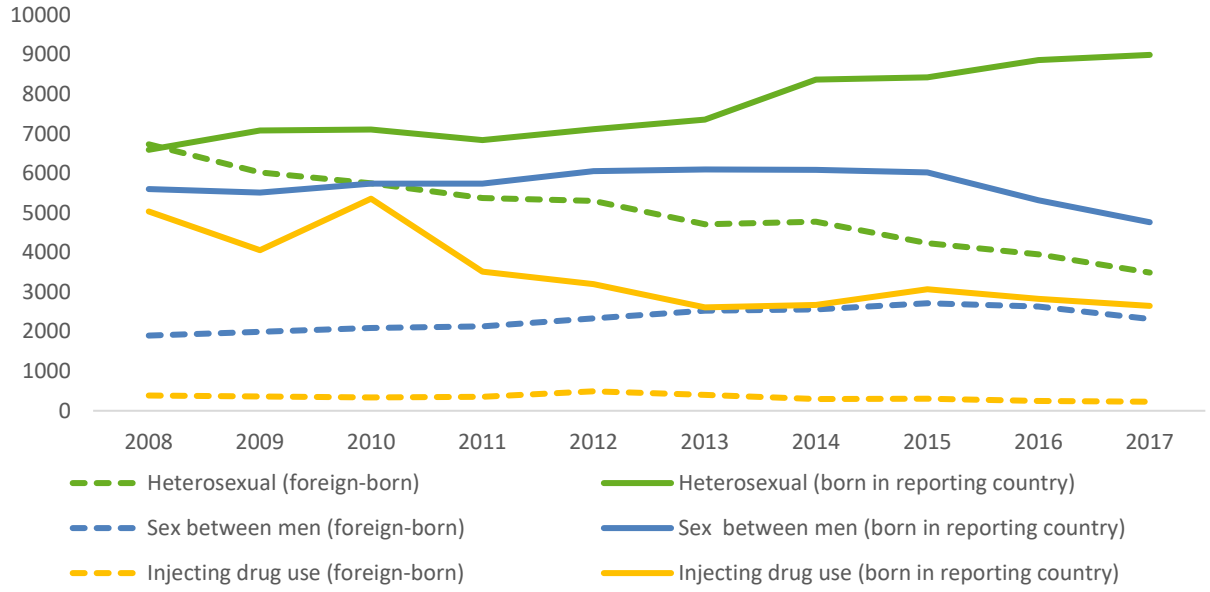
Figure 4. New HIV diagnoses in migrants in Europe and Central Asia overall and by sub-region, 2008–2017[1] [6]



This graph excludes countries which did not report national data during part of the period and those where transmission and/or the region of birth variable completeness was low. Therefore, Spain, Italy, Ukraine, Germany, and Russia are not included in this analysis.

There is considerable variation in the trends in new diagnoses between groups categorised by transmission route (Figure 5). New diagnoses among heterosexual migrants have almost halved over the last decade, whereas diagnoses among migrant MSM have increased, although that trend has started to reverse in the last two years. Transmission via injecting drug use remains comparatively low among migrants. Trends in new diagnoses by transmission routes among domestic MSM and PWID populations are broadly echoed in the migrant community. However, from an almost identical starting point in 2008, the trend in new diagnoses of heterosexual transmissions among migrants have radically diverged from trends in the domestic population. These trends may be a consequence of shifting migration patterns.

Figure 5. New HIV diagnoses in migrants in Europe and Central Asia by transmission route, 2008–2017[1] [6]



This graph excludes countries which did not report national data during part of the period and those where transmission and/or the region of birth variable completeness was low. Therefore, Spain, Italy, Ukraine, Estonia, Poland, Turkey, Germany, and Russia are not included in this analysis.

Probable country of infection

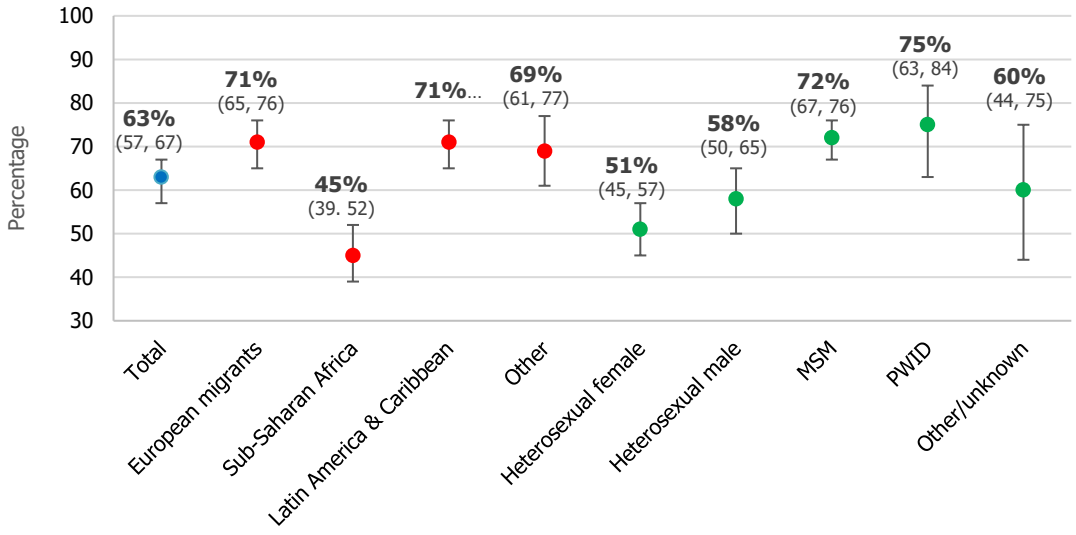
In order to ensure effective targeting of public health interventions it is important to know whether the migrant population within any given country generally acquired HIV before or after migration. Stigmatising narratives about migrants and about 'health tourism' rest on assumptions that migrants bring HIV, and an associated public health burden, to their receiving countries, but the data show that this is not the case.

A 2012 study showed that clinician reporting in the UK significantly underestimated post-migration HIV acquisition among black African adults born abroad when compared with estimations derived from CD4 counts. [4] More recently, investigating migrants diagnosed in 57 clinics across nine countries in Western Europe established that 63% of the sample population acquired HIV after migration (Figure 6).

These data indicate that there is an ongoing risk of acquiring HIV post-migration. Therefore, options for public health response to HIV prevalence among migrants entail more than offering HIV testing to new arrivals, and should be tailored to the needs within established migrant communities.

An ongoing elevated risk of HIV acquisition post-migration may be attributable to sexual mixing among those with a shared cultural background or, especially for MSM, where people have migrated to countries where it is easier for them to be open about their sexuality. In the Western European study [5] (Figure 6), post-migration acquisition rates were highest among migrants who were also MSM or PWID, indicating that it is especially vital to ensure that prevention measures among these cohorts reach migrants.

Figure 6. Estimated post-migration HIV acquisition probability by mode of transmission and geographical origin and destination country [5]



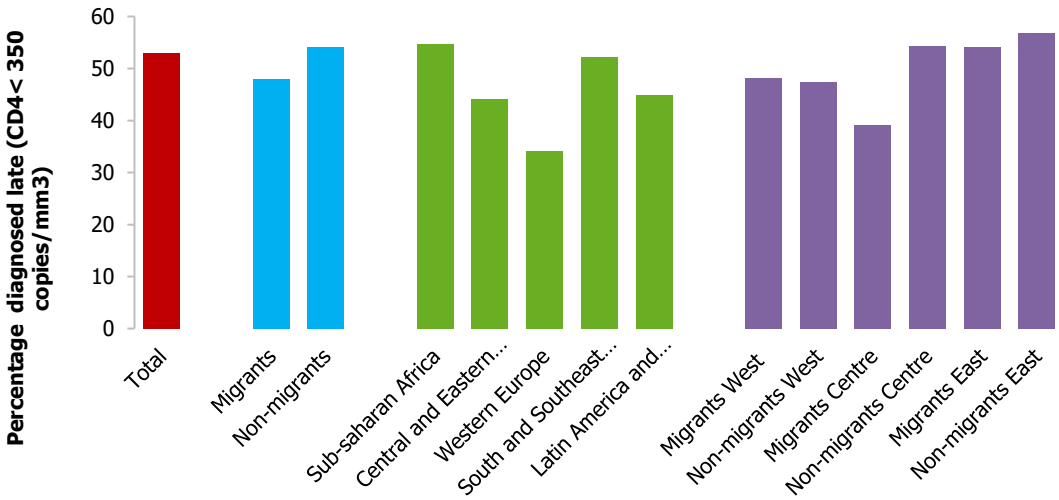
Late HIV diagnoses

Late diagnosis is associated with increased likelihood of mortality and morbidity, with most reported AIDS cases in the EU/EEA attributed to late diagnosis of HIV infection. [6] Late diagnosis also increases the risk of onward transmission of HIV. On average, people diagnosed late (with a CD4 <350 copies/mm^3) have been living with undiagnosed HIV infection for around three to four years [7]. Reducing late diagnosis is a key intervention for improving health outcomes for people living with HIV and in preventing onward transmission.

In 2017, 48% of migrants were diagnosed late in Europe and Central Asia, which is six percentage points lower than among non-migrants (Figure 7). [6] When disaggregated by sub-region, late diagnosis rates are highest in the East region and lowest in the Centre. Comparing migrant and non-migrant populations in each of the regions, the rates of late diagnosis are roughly comparable in the West sub-region, slightly lower for non-migrants in the East, and significantly lower in the Centre.

While it is notable that late diagnosis rates are higher among non-migrants, rates amongst migrants are still far too high and undoubtedly contribute to the ongoing risk of HIV incidence and poorer health outcomes among this group. When disaggregated by area of origin, late diagnosis rates are highest among people from sub-Saharan Africa and South and South-east Asia. Therefore targeting testing towards these groups may improve the long-term impact on late diagnoses among migrants in the Region as a whole.

Figure 7. Late HIV diagnosis among migrants in Europe and Central Asia, 2017 [6]



Progress and remaining challenges

Continuum of HIV care

The continuum of HIV care is a conceptual framework that provides a snapshot of critical stages in achieving viral suppression among people living with HIV (PLHIV) [8]. It has become one of the central metrics through which the public health response to HIV is evaluated at the local, national and international level [9]. In 2014, the Joint United Nations Programme on HIV/AIDS (UNAIDS) established the 90-90-90 targets. These targets aim that by 2020; 90% of all people living with HIV are diagnosed, 90% of those diagnosed receive treatment and 90% of those receiving treatment achieve viral suppression. This translates to a target of 73% viral suppression among all PLHIV. To be able to report on each of the three '90' targets it is necessary to have data for the two relevant consecutive stages of the continuum of care. The definitions for each of the four stages of the continuum of care are provided in Table 2.

Table 2. Consensus definitions for monitoring the continuum of HIV care during Dublin Declaration monitoring 2018 [1]

Stage 1: Total estimated number of people living with HIV in the country The total estimated number should be based on an empirical modelling approach, using the ECDC HIV Modelling Tool [10], Spectrum or any other empirical estimate. The estimate should include diagnosed and undiagnosed people.
Stage 2: Number/percentage of above (estimated number of people living with HIV in the country) ever having been diagnosed The number should include all new HIV or AIDS diagnoses. It should also include those people who are in care and those who have not been linked to care.
Stage 3: Number/percentage of above (estimated number of people living with HIV in the country, ever having been diagnosed) who are currently on antiretroviral treatment (ART). The number should include all people currently on ART, regardless of treatment regimen or treatment interruptions/discontinuation.
Stage 4: Number/percentage of above (estimated number of people living with HIV in the country, ever having been diagnosed or having initiated antiretroviral treatment) who had viral load (VL) ≤200 copies/mm^3 at last visit (virally suppressed)[2] The number should include all those who have ever initiated ART, regardless of regimen or treatment interruptions/discontinuation.

Presenting the continuum of care by key population allows countries to measure outcomes for groups who are disproportionately affected by HIV. It also reveals disparities between key populations that would otherwise remain hidden at the aggregate level..

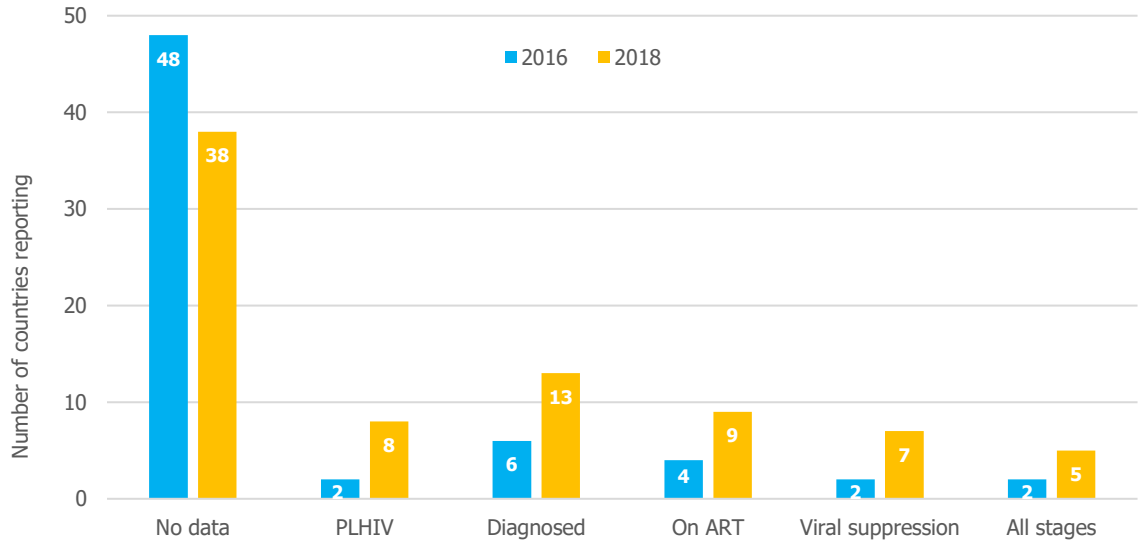
Although few countries in Europe and Central Asia were able to submit data for migrants for all four stages of the continuum in 2018, there was an improvement from the amount of data provided in 2016, particularly for stages three and four. In 2018, all four data stages for migrants were reported by five countries (Austria, the Czech Republic, France, Luxembourg, and the United Kingdom) compared with two countries in 2016 (Figure 8). At least two consecutive stages were reported by ten countries. There has also been a reduction in the number of countries unable to report data for migrants at any stage of the continuum of care.

However, it is notable that apart from the Czech Republic, which reported for all four stages, and Slovakia which reported the percentage of migrants on treatment, all the countries able to report continuum of care data for this population are from the West sub-region.

[1] Gourlay et al 2017, https://oce.ovid.com/article/00002030-201709240-00002/HTML

[2] A viral load threshold for viral suppression of <200 copies/mm3 was used to allow for changes over time in the lower detection limits of viral load assays. A threshold of 200 copies/mL for population-level monitoring is consistent with recommendations in a recent systematic review of guidelines produced by IAPAC - www.iapac.org/uploads/JIAPAC-IAPAC-Guidelines-for-Optimizing-the-HIV-Care-Continuum-Supplement-Nov-Dec-2015.pdf and the US Centers for Disease Control and Prevention - www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf

Figure 8. Number of countries reporting data for different stages of the HIV continuum of care for migrants, Europe and Central Asia, reported in 2016 and 2018



Overall, in 2018, the proportion of migrants living with HIV (diagnosed and undiagnosed) who are virally suppressed could only be estimated for five countries. Estimates ranged from 34–84% (Figure 9), with only the UK surpassing the target of 73% of all migrants living with HIV being virally suppressed, although Luxembourg (68%), France (67%) and Austria (65%) all made good progress towards meeting the target.

Nearly all of the countries that were able to report the percentage of migrants on treatment who had reached viral suppression achieved the 90% target for that stage. Moreover, in all of these countries, the discrepancy between the percentage of migrants on treatment achieving viral suppression and the equivalent figure for all PLHIV was at most 2%. This indicates that in the countries that were able to report that migrants have access to treatment, there are generally no barriers to them achieving viral suppression because of their migrant status.

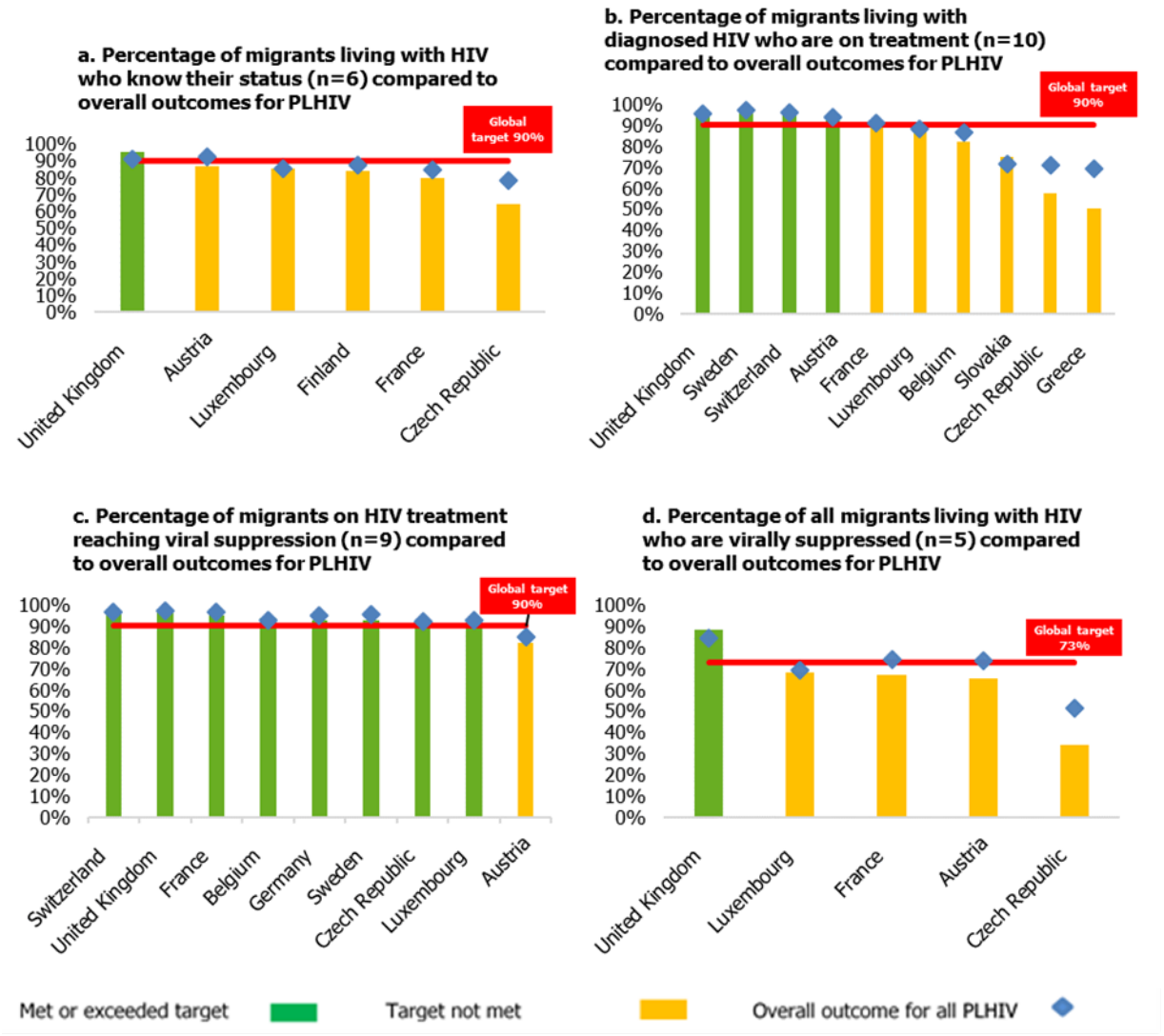
The only country that did not achieve the 90% target for migrants on treatment-achieving viral suppression is Austria, where the figure is 82%. Interestingly, the equivalent figure among all PLHIV in Austria is only 3% higher at 85%, which indicates that although in Austria there may be some general challenges to achieving viral suppression for people on treatment, this is not especially a consequence of migrant status.

Slovakia and Greece were able to report the percentage of diagnosed migrants who are on treatment but were unable to report the percentage of those who had achieved viral suppression.. While this raises issues concerning the monitoring of people on treatment, these countries were also unable to report viral suppression for MSM or PWID on treatment, indicating that this is not a problem exclusively attached to migrant status.

The most significant areas of concern in the reported continuum of care data for migrants relates to the percentage who are diagnosed and the percentage of those who are on treatment. The UK is the only country that reached the target of 90% diagnosed, although when compared against overall outcomes for all PLHIV, it is encouraging that in most reporting countries migrants are achieving outcomes that are not too far removed from the general population. The exception to this is the Czech Republic, where 64% of migrants know their status compared with 78% in the general population. Also, only six countries were able to report how many of their migrant population living with HIV had been diagnosed, which suggests the likelihood of a significant testing and/or monitoring of testing gap across the region as a whole.

The second area for concern is the number of countries that are not reaching the 90% target for the percentage of diagnosed migrants on treatment. Only four of the ten countries who were able to report the percentage of migrants on treatment had reached the target (UK, Sweden, Switzerland and Austria), although France and Luxembourg were both close. The Czech Republic and Greece both reported low percentages of their diagnosed migrant population being on treatment.

Figure 9. Estimates provided for each stage of the continuum of care for migrants living with HIV in Europe and Central Asia, reported in 2018



It is important to note that the countries that were able to monitor the continuum of care in key populations were also likely to be the countries with better HIV outcomes overall. There are 38 countries unable to provide any continuum of care data specific to migrants, meaning there are likely to be significant inequalities in outcomes for this key population across Europe and Central Asia, beyond those described here.

Combination prevention

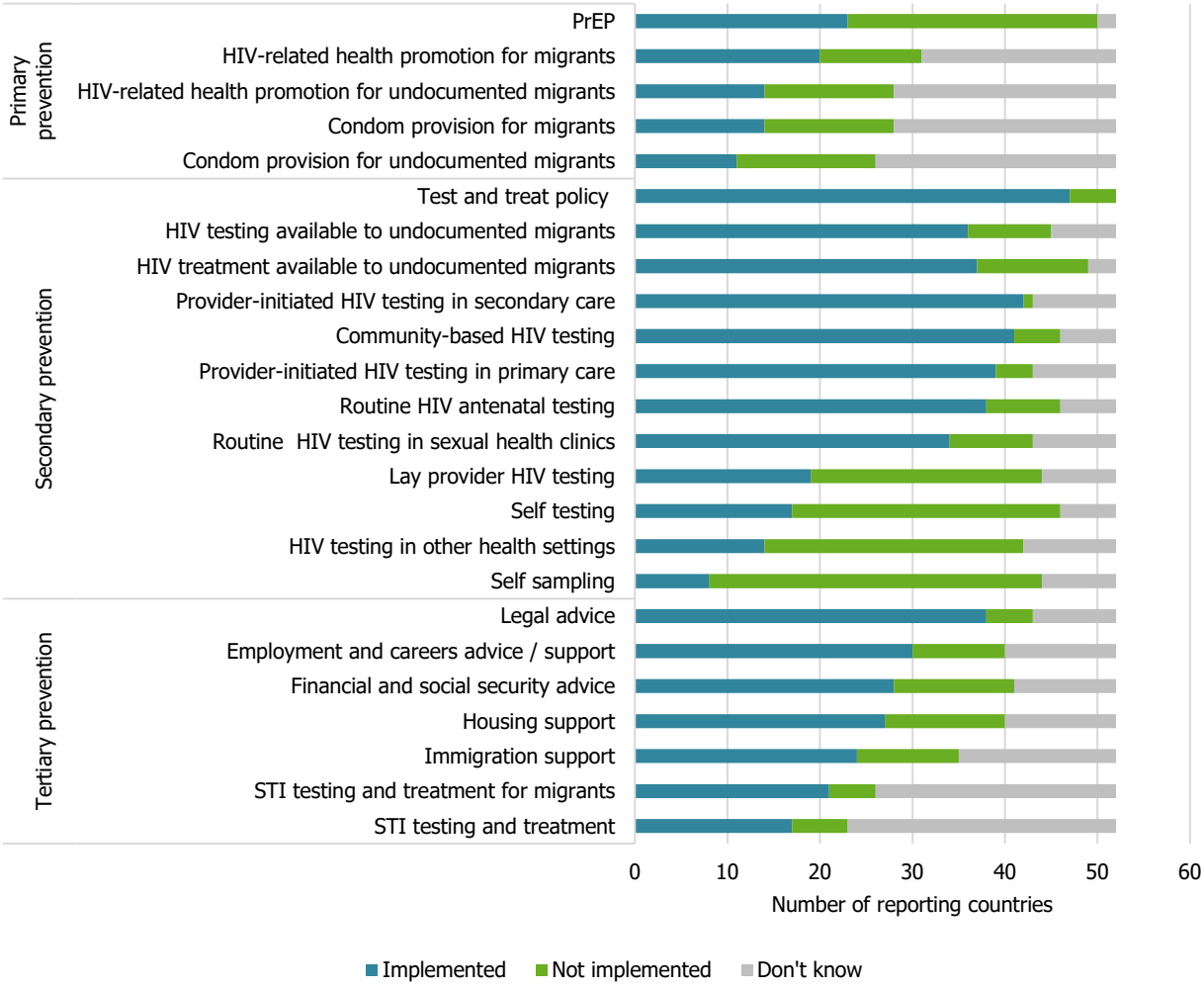
HIV combination prevention brings together single prevention initiatives into a comprehensive programme. Importantly, the specific elements take effect across the life course of HIV infection and encompass primary prevention (preventing people without the virus from acquiring HIV), secondary prevention (preventing onward transmission from those living with HIV) and tertiary interventions (which improve the health-related quality of life of those living with HIV). The interventions implemented will vary depending on the needs of the key population, but it is important that they are implemented at scale and in combination to maximise their benefits. The effectiveness of these interventions significantly increases when delivered in a non-discriminatory environment, where structural barriers such as concerns about the consequences for immigration status of attending healthcare facilities have been removed.

Unlike for other key populations (MSM and PWID), there is no clear guidance on the key components of combination prevention that should be available for migrants. ECDC recommend testing migrants from high prevalence counties with clear referral pathways into prevention, treatment and care services, and WHO recommend community-based testing in addition to provider-based testing. [11, 12]

More research is needed on the efficacy, ethical requirements and cost effectiveness of migrant-specific screening, and on the factors causing vulnerability to acquisition, especially in the context of increased awareness of high levels of post-migration acquisition[11].

Figure 10 outlines the level of reported combination prevention measures implemented across Europe and Central Asia, some of which reflect general availability while others are particularly targeted at specific sub-populations of migrants or undocumented migrants. The remainder of this section describes the extent of implementation of the different strands of combination prevention.

Figure 10. Implementation of HIV prevention interventions that affect migrants and undocumented migrants across Europe and Central Asia, 2018



Overcoming the language barrier

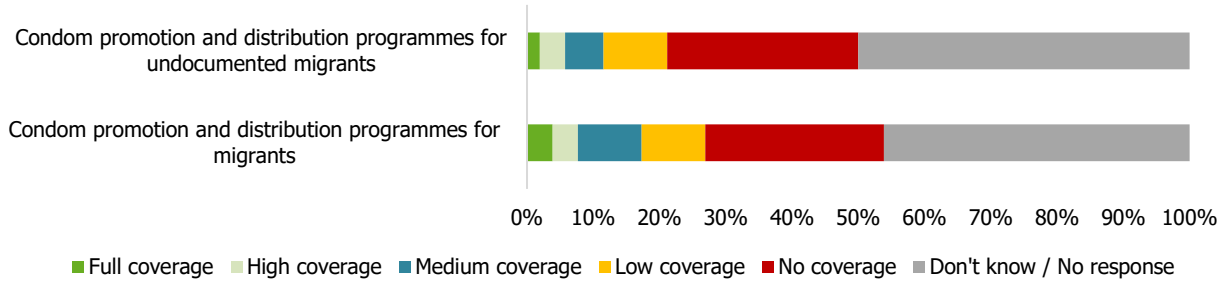
In Greece, Positive Voice (the association for people living with HIV) and Checkpoint (HIV prevention and testing services) target migrants and the refugee population by translating information on STIs, prevention and testing into 12 different languages spoken by these key populations.

Primary HIV prevention

Condom provision

Condoms have long formed a core component of HIV primary prevention. Condom promotion and distribution programmes aim to ensure that people have access to condoms when needed. However, there is very low coverage of condom promotion and distribution programmes for migrants, especially undocumented migrants, across Europe and Central Asia (Figure 11). Only 18% (9) of reporting countries have at least medium coverage for migrants, while this drops to only 12% (6) for undocumented migrants. Approximately three-quarters of countries either do not have or cannot say if they have provision of condom programmes for migrants and undocumented migrants.

Figure 11. Estimated coverage of condom promotion and distribution programmes for migrants and undocumented migrants across Europe and Central Asia (n=52)

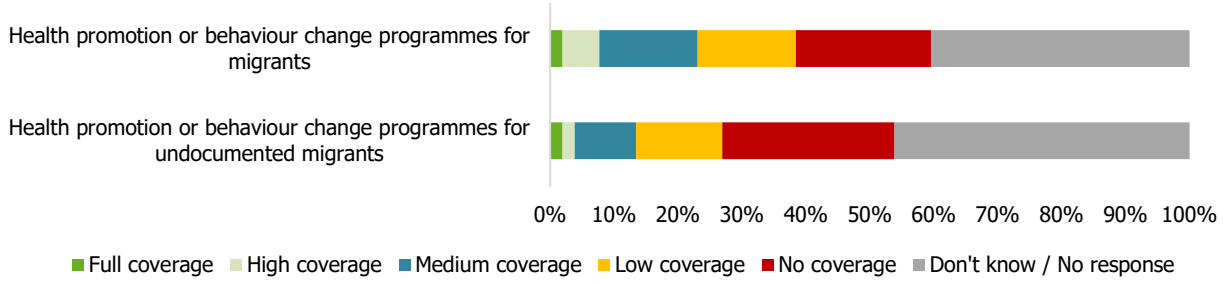


Health promotion programmes

Health promotion programmes seek to reduce HIV acquisition by addressing inadequate knowledge of transmission risk and high-risk behaviour. Effective interventions can be information-based or behavioural, such as supporting adherence or increasing the use of condoms or clean needles among migrants who are also PWID. These may be particularly relevant for migrant populations where there can be low levels of HIV-related knowledge [11] as well as uncertainty concerning how and where to access services.

The extent of coverage of health promotion programmes for migrants echoes the poor coverage of condom provision, with only 23% (12) countries reporting the availability of health promotion programmes for migrants and 13% (7) reporting provision for undocumented migrants (Figure 12). Again, the overwhelming majority of countries either didn't provide or didn't know if they provided health promotion programmes for this key population.

Figure 12. Estimated coverage of health promotion or behaviour change programmes for migrants and undocumented migrants across Europe and Central Asia (n=52)



Pre-exposure prophylaxis

Pre-exposure prophylaxis (PrEP) has been hailed as a game-changer in HIV prevention; there is clear evidence that it is extremely effective at preventing acquisition of HIV. It is a particularly crucial prevention strategy for those at risk who struggle to use condoms consistently for a range of reasons, including issues related to power dynamics, stigma, negotiation, communication, consent and sexual pleasure.

Data collected via Dublin Declaration monitoring provide a snapshot of a rapidly changing situation on the state of PrEP provision with substantial diversity across the Region (Figure 13). By 2019, 16 out of 53 reporting countries reported reimbursed PrEP within their national health service, either through insurance or from the public sector (Belgium, Bosnia and Herzegovina, Croatia, Denmark, France, Germany, Iceland, Ireland, Luxembourg, Moldova, the Netherlands, Norway, Portugal, Spain, Sweden, and Scotland within the United Kingdom). The results show that progress has been made since 2016, when only France reported that PrEP was nationally available and reimbursed. [13]

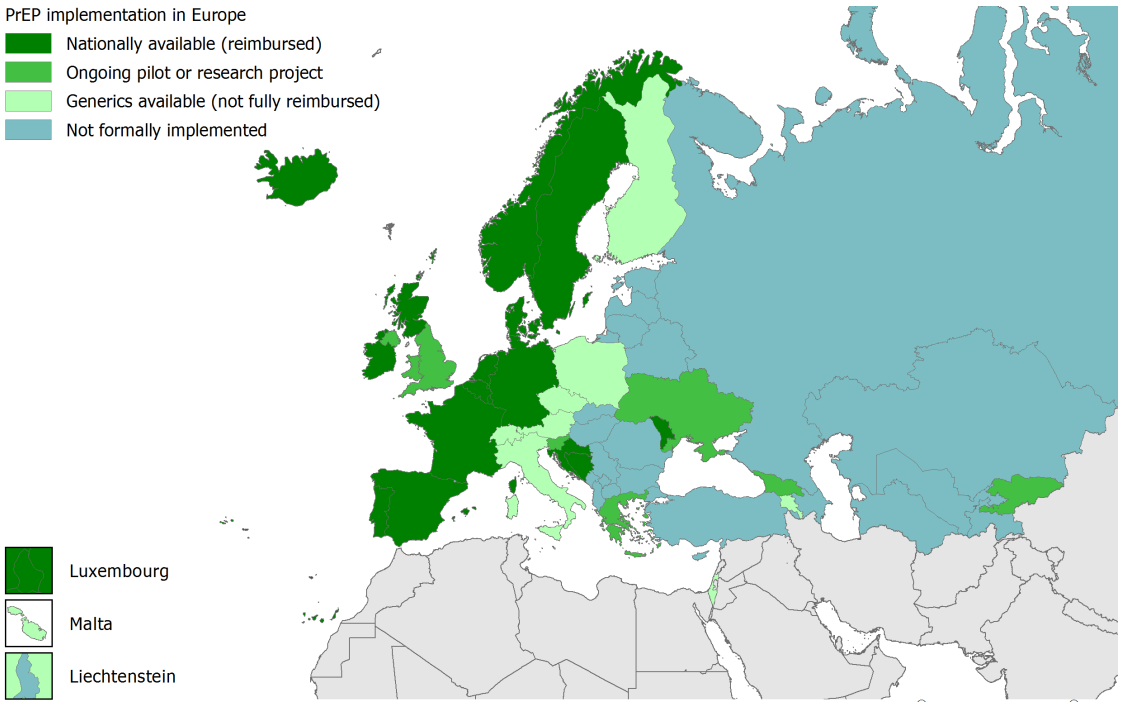
Nine countries report that generic PrEP is available in healthcare settings, but it is not fully reimbursed (Armenia, Austria, the Czech Republic, Finland, Israel, Italy, Malta, Poland and Switzerland).

Five countries report PrEP availability only through pilot, research or demonstration projects at national or sub-national level (Georgia, Greece, Slovenia, Ukraine, and England, Northern Ireland and Wales within the United Kingdom).

The monitoring survey did not include a question on whether there are any eligibility restrictions for migrants aiming to access PrEP. However, PrEP may be a particularly important prevention method for certain sub-groups of migrants, such as MSM. [14]

While many people at risk who are living in countries with poor availability of PrEP will purchase the drug online, this option is less available to migrants as a group, given their disproportionate levels of poverty. [15][1] This may be especially profound among undocumented migrants, who generally experience limited access to welfare provisions and formal labour markets. Inclusion of migrants in interventions, including PrEP, would contribute to the better prevention of HIV infection in this population.

Figure 13. Status of PrEP implementation in Europe and Central Asia, November 2019



Secondary HIV prevention

HIV testing

High levels of testing, combined with the provision of prompt treatment, is crucial for reducing overall HIV incidence. Uptake of screening programmes is high among migrant groups, [11] indicating that where measures are taken to improve testing for this key population they are likely to be successful.

Out of 40 countries with testing guidelines, 11 mentioned migrants either as a key population or by a more specific reference to people originating from countries with high prevalence. In addition, Malta is currently drafting guidelines that will include migrants as a key population.

Data on HIV testing rates among migrants are very limited. Seven countries were able to provide data on the percentage of migrants tested in a 12 month period and only Greece was able to report data (from 2014) for undocumented migrants. Apart from Hungary, all the countries that were able to report testing rates among their migrant populations are in the West sub-region. None of the reporting countries were able to provide data for 2017, indicating that, even where data are collected, monitoring is insufficiently frequent.

The migrant testing rates were generally poor, ranging from 3% in Hungary to 62% in Greece, which is the only country to report a rate over 50%. The testing rate for undocumented migrants in Greece was 16.3%.

Countries were asked under what conditions testing is available to their undocumented migrant populations[2]. Twenty-two countries reported that access to testing is free of charge for undocumented migrants (Figure 14). This

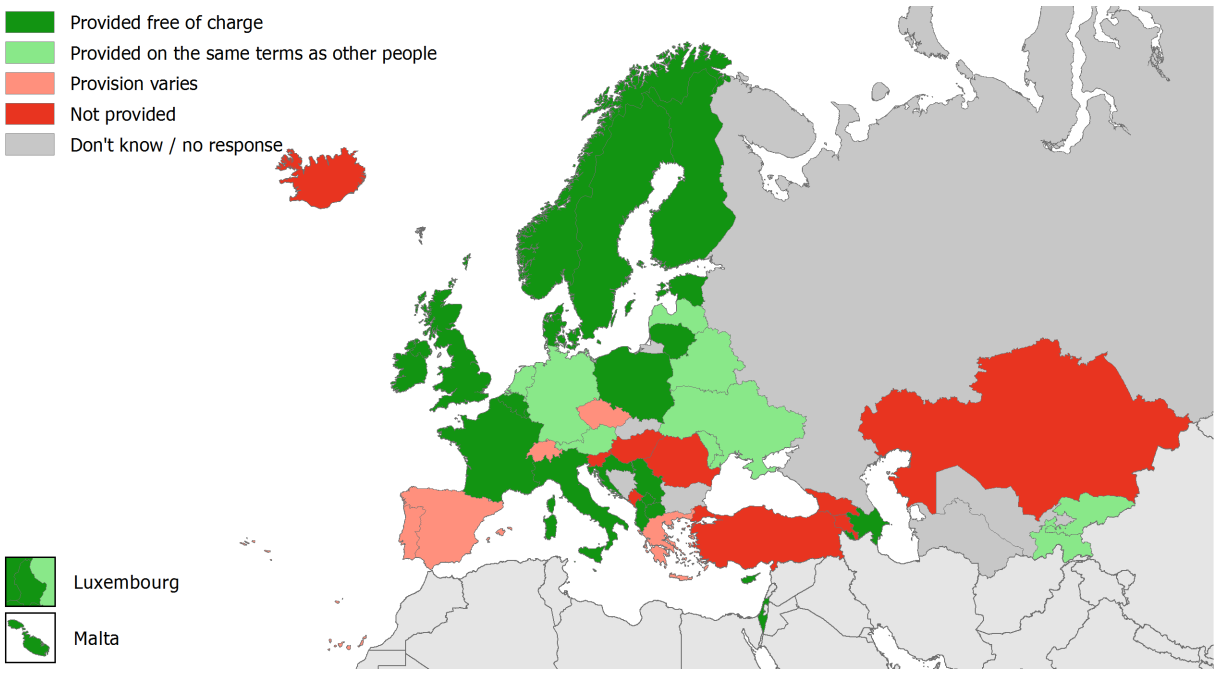
[1] Eurostat data indicate that the risk of poverty across the European Union is over twice as high among those whose citizenship is not from the country where they are resident.

[2] Responding countries could check as many responses as are relevant and, for example, some indicated that testing for undocumented migrants is provided for free, which is on the same terms as other people, but also that provision varies. Where a country replied that provision varies, that is taken as the key indicator because it means that testing is not universally available to

was true for roughly half the countries in both the West and Centre sub-regions, but only three countries in the East sub-region (Azerbaijan, Estonia and Lithuania). The nine countries that reported that they do not provide testing for undocumented migrants were all in the Centre or East sub-region, except Iceland that reported it does not have any undocumented migrants.

The 16 countries where provision varies or where provision is on the same terms as other people (but not also free of charge) are spread across the three sub-regions. Provision on the same terms as other people may indicate that the availability of testing for undocumented migrants is variable because it usually relies on them being able to pay for it.

Figure 14. Access to testing for undocumented migrants across Europe and Central Asia, 2018



Dispelling fears about the impact of an HIV test on legal status

In Ireland, the voluntary organisation HIV Ireland conducts an outreach service to migrants and works together with community migrant services to improve awareness and lower the barriers to HIV testing. In conjunction with members of the migrant community, they have produced a guide to the HIV Ireland testing service that makes it clear that HIV testing will not affect a person's legal status or asylum application.

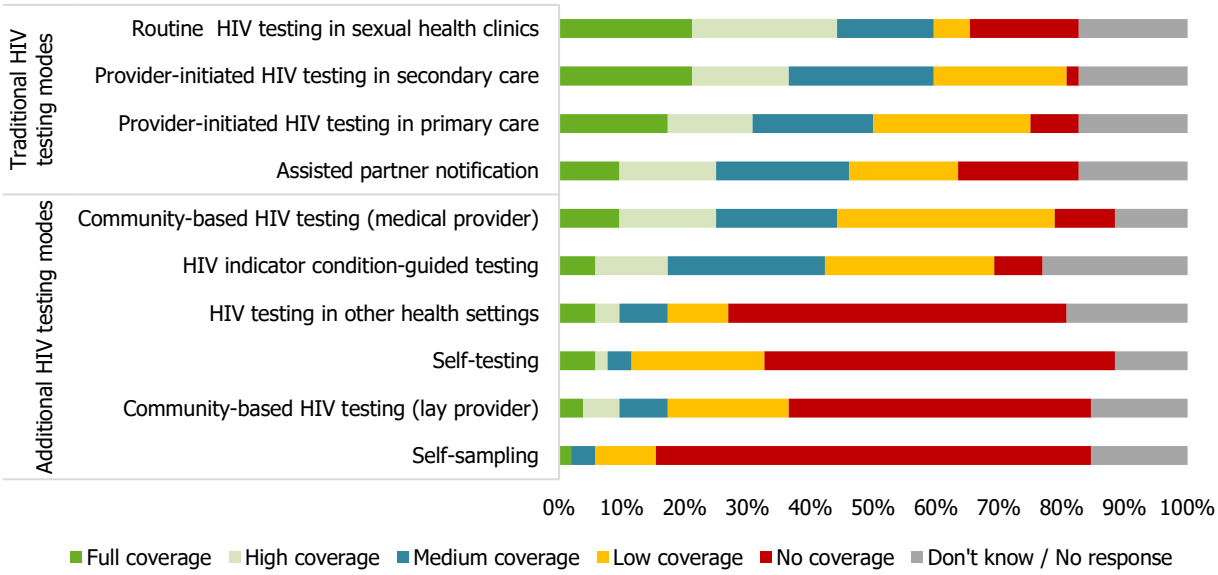
Implementation of different HIV testing modes

The availability of data on migrant uptake of testing is so poor that it is difficult to quantify exactly how important alternative modes of testing might be for reducing the numbers of undiagnosed migrants in the region as a whole. However, given that migrants, especially undocumented migrants, tend to avoid formal health services for fear of intersecting stigmas and disclosure of their migration status, it is reasonable to assume that a range of testing interventions can overcome barriers to accessing testing and better target those who are at most risk. In particular, self-testing overcomes concerns around stigma and community-based testing is more likely to be conducted in a culturally-appropriate environment, which is recognised as an important element of effective screening in migrant populations. [11]

Testing strategies such as HIV testing in other health settings, community-based testing by a lay provider, self-testing and self-sampling are the least implemented of all the testing interventions (Figure 15). With only eight countries (16%) implementing self-sampling and 16 (33%) implementing self-testing, further exploration is required to understand what is limiting implementation of these interventions. While only 19 countries (37%) implement lay-provider HIV testing, a larger proportion of countries (79%) do implement some level of community-based testing administered by a trained medical professional, indicating that legal restrictions on who can administer HIV tests may be preventing wider implementation of lay-provider testing.

undocumented migrants. Where a response indicated that provision is available free of charge and provided on the same terms as for other people, the fact that free universal care is available was assumed to be the most significant feature of provision.

Figure 15. Level of implementation of different testing modes in Europe and Central Asia, reported in 2018



Countries were asked which testing modes were implemented and what level of coverage was implemented. Based on the WHO definition of universal health coverage, full coverage was defined as 'all who need the service can use it, that the service is of sufficient quality to be effective, and that use of the service will not expose the user to financial hardship'. Countries could choose from a scale of coverage, as follows: No coverage: The service is not provided; Low coverage: <30% of the population can use the effective, affordable service; Medium coverage: 30-60% of the population can use the effective, affordable service; High coverage: 61-95% of the population can use the effective, affordable service; Full coverage: 95-100% of the population can use the effective, affordable service.
Although Bosnia & Herzegovina did not officially submit data to the 2018 Dublin Declaration monitoring round, current treatment policy was confirmed via email by country focal point.

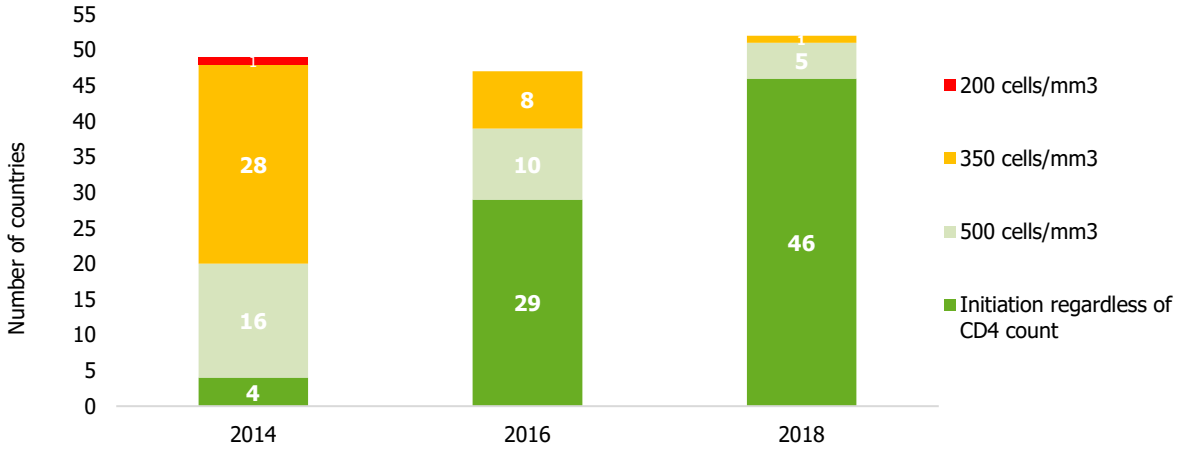
Expanding access to testing via non-traditional settings

Ukraine has drafted new protocols to implement WHO recommendations for HIV testing services, including expansion of testing by non-medical workers and in community settings. Migrants are considered to be a significant beneficiary of this strategy.

Treatment guidelines

Ensuring prompt access to treatment after diagnosis usually results in a normal life span and reduces the risk of HIV transmission. Since 2014, there has been a significant increase in the number of countries in Europe and Central Asia advising the initiation of prompt treatment following diagnosis, regardless of CD4 count (so called test and treat strategy) (Figure 16). In 2018, 46 countries had adopted this advice, in accordance with WHO [16] and EACS [17] clinical guidelines. Six countries, however, continue to maintain a CD4 threshold for initiating HIV treatment – Azerbaijan, Bosnia & Herzegovina, Latvia, Moldova, Tajikistan and Uzbekistan.

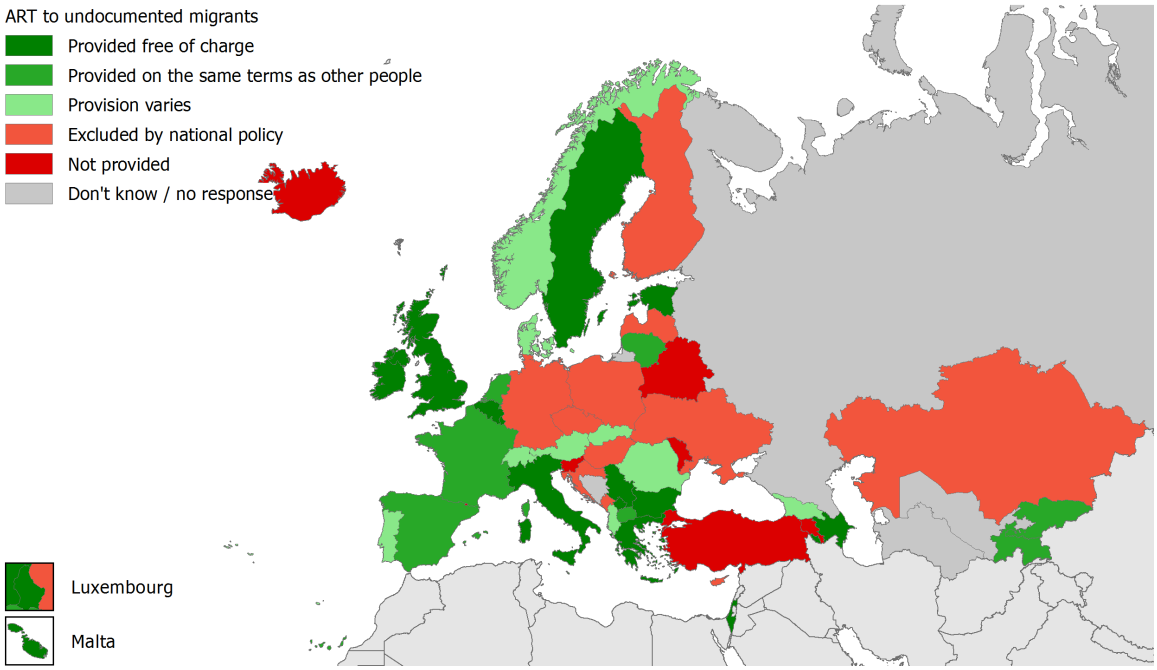
Figure 16. Changing policy on initiation of ART by CD4 count



Whilst the greater adoption of test and treat strategies indicate positive progress, it is less clear how this is being implemented in practice. As the continuum of care data in this report (Figure 9b) show, the availability of data for treatment coverage among diagnosed migrants is poor, and almost non-existent outside the West sub-region. The data reported indicate significant variation in treatment coverage, with only four out of the ten countries that submitted data indicating that the target of 90% diagnosed migrants receiving treatment had been reached.

Of even more concern are the data on access to treatment for undocumented migrants (Figure 17) [1]. Seven countries do not provide treatment for undocumented migrants, while a further 11 countries report that undocumented migrants are actively excluded from accessing treatment by national policies. These 18 countries span the whole region of Europe and Central Asia, although countries in the Centre sub-region appear to be slightly more prominent. Of the remaining countries, there are nine that reported that the provision varies. Not all of these nine gave further explanation of this variation but, of those that did, most indicate that treatment may be available for undocumented migrants from healthcare providers or NGOs, on a case by case basis. Seven countries report that ART is available to undocumented migrants on the same terms as it is available to other people in the country, which will often mean that there is a charge for treatment. Only 15 of the 52 reporting countries provide treatment free of charge to undocumented migrants; ten of these are in the West sub-region, three in the Centre and two in the East.

Figure 17. Access to treatment for undocumented migrants across Europe and Central Asia, 2018



[1] As with the access to testing map for undocumented migrants, the 'key' indicator that best describes the experience of access to treatment for undocumented migrants has been recorded for each country.

As well as affecting opportunities to achieve viral suppression, the lack of availability of treatment for undocumented migrants, whether through formal policy or practice, also affects the numbers of people coming forward for testing. It is important that test and treat policies are fully implemented and treatment coverage data are available for all key populations, including undocumented migrants.

Access to treatment for undocumented migrants.

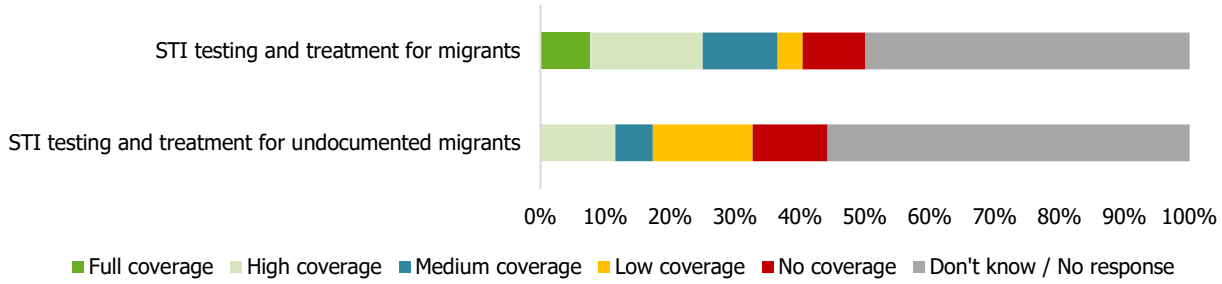
In Israel, the Ministry of Health has taken over full responsibility for ensuring delivery of prevention, testing, and treatment services, free of charge, to undocumented migrants. The eligibility criteria for its undocumented migrants' treatment programme were broadened to include all people living with HIV regardless of CD4 count. Virtually all undocumented migrants who seek treatment now receive it because the amount of ART available has increased and all pharmacies affiliated with HIV centres now give free ART to undocumented migrants.

Tertiary HIV prevention

STI testing and treatment service for migrants

Access to STI testing and treatment is important because it comprises an element of holistic healthcare for people living with HIV, but also because STIs increase risk of HIV acquisition. As identified in Figure 17, 37% (19) of reporting countries provide at least medium coverage of STI testing and treatment for migrants, although this falls to 18% (9) for undocumented migrants.

Figure 18. Estimated coverage of STI testing and treatment services for migrants and undocumented migrants across Europe and Central Asia (n=52)



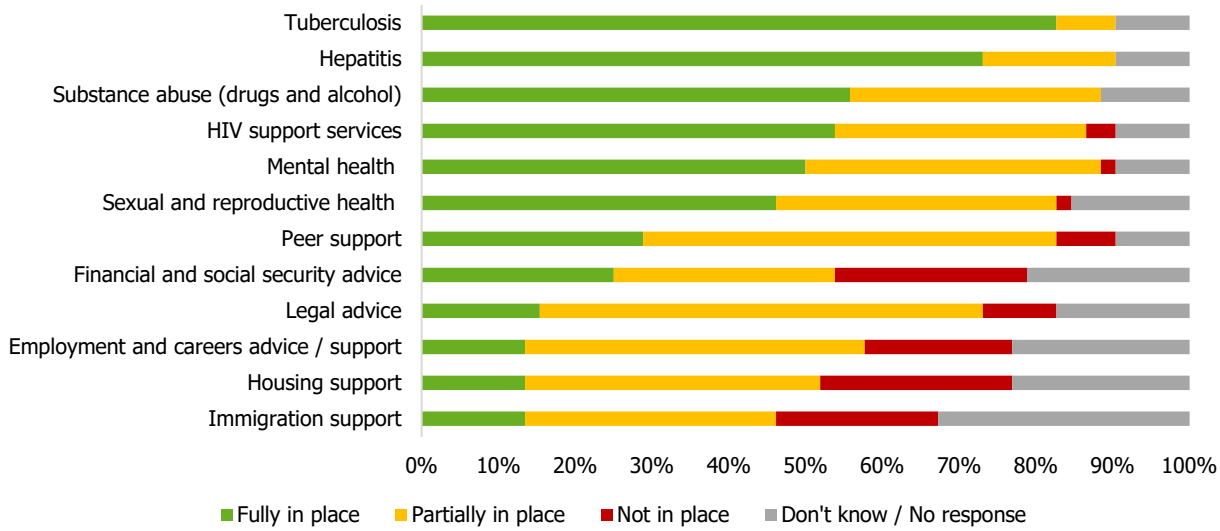
Linkage to support services for migrants

Access to a range of services to respond to co-infection and provide psychosocial and practical support delivers a holistic response to health and wellbeing needs. Beyond the direct response to need that these services provide, the resulting benefits in terms of general health and wellbeing outcomes also link to better adherence rates and improved HIV-related outcomes.

Some of these services are more likely to be in demand among migrants. Immigration support is a key provision which can affect the wellbeing of migrants but, of all the services that the survey asked for data on, immigration support was the service that was least likely to be provided (Figure 19). It is fully in place in 13% (7) of countries in the region, and partially in place in a further 33% (17).

Migrants could need access to the full range of services listed in Figure 18 but, given the tendency for a higher incidence of poverty in migrant communities, [15] they may be more likely than the general population to have demand for practical services like financial and employment advice and housing support. As indicated in Figure 18, these are the services that are provided in the fewest number of countries. There is evidence that poverty and other social stresses adversely affect treatment retention and adherence, so these data are concerning for public health as well as the individual health of migrants.

Figure 19. Estimated implementation of systems to ensure linkage to other services from HIV care across Europe and Central Asia, 2018



Addressing barriers to services

Persistent barriers to prevention and testing services remain for migrants. In 2016, countries reported that barriers to uptake of prevention services included stigma and discrimination within migrant populations and among healthcare services. [18] The main barriers to provision of testing services for migrants and undocumented migrants alike, were described as funding for testing services, availability of community-based services, and knowledge and attitudes among health professionals. The main barriers to uptake of HIV testing were reported as stigma among migrant populations and healthcare professionals, and limited availability of testing services, especially in community settings. [18]

In 2018, 16 countries reported that they had taken action to address barriers to HIV prevention, testing and treatment services with a direct impact on migrants. Of these, 13 countries have taken action to remove barriers to prevention services, 11 countries have taken action on barriers to testing, and eight countries have taken action on barriers to treatment.

Fear of stigma around migration status and concerns about identification are additional concerns that migrants have to face when accessing prevention, treatment and care. It is promising to see multiple examples of prevention, testing and treatment interventions designed to reduce the barriers presented by differences in language and culture (in 12 countries), and to see changes to laws and policies around access to treatment in some countries (four countries).

Embedding cultural shifts with policy changes.

In **Germany**, information on testing services and HIV treatment is being provided for migrants from sub-Saharan Africa in cooperation with priests in African churches in several cities. Training is being provided for peer educators who promote HIV testing and treatment in migrant communities, and on intercultural communication and diversity for HIV/STI prevention staff and health workers.

Pilot projects on anonymous healthcare vouchers have been undertaken in two federal states. These vouchers enable anonymous healthcare for undocumented migrants. A distributing office/clearing house for anonymous healthcare vouchers has been established in the federal state of Berlin.

In addition, other actions taken included increases in funding (two countries); improvements to service delivery (six countries); improvements in surveillance and monitoring (two countries); interventions to improve education and awareness amongst health professionals (three countries) and migrants (two countries). Some of these actions have been included as case studies throughout this report.

Despite advances in some countries around enabling the preservation of anonymity in the 2018 reporting round, new barriers concerning identification and anonymity were reported by four countries (Greece, Romania, Switzerland and the UK).

Conclusions and priorities for action

Overall progress

The lack of data on migrants is a significant problem across the Region. Despite concerns about the impact of intersecting stigmas on access to HIV prevention and treatment, the UK – where, according to the survey respondent, 18% of migrants avoid health services due to fear of stigma and discrimination – is the only country with data on the impact of stigma on migrants health. In general, there is an absence of data for migrants, and especially for undocumented migrants. For example, continuum of care data, while not good across any key population, are particularly low for migrants. About half the reporting countries were unable to provide data for condom provision and health promotion programmes. Only seven countries could report testing rates among migrants and this fell to one country when the population in question was undocumented migrants. All of these data were at least one year out of date and in many cases up to four years old.

Nearly all of the countries that were able to report the percentage of migrants on treatment who had reached viral suppression achieved the 90% target for that stage. Moreover, in all of these countries the discrepancy between the percentage of migrants on treatment achieving viral suppression and the equivalent figure for all people living with HIV was at most 2%. This indicates that in the countries that were able to report that migrants have access to treatment there are generally no barriers to them achieving viral suppression because of their migrant status. This indicates that data collection is itself an element in an effective non-discriminatory health response for migrants.

Data provision is especially poor among undocumented migrants, who are the most vulnerable in terms of rights and capacity to respond, and therefore the population that is most in need of proactive policies to act in their interests. There is scope in all countries across Europe and Central Asia for improving their data collection.

Given the volume of new diagnoses among migrants in the West (Figure 4), there is a clear need for countries in that sub-region to take stock of their response to acquisition of HIV among their migrant populations. However, there are promising indications in some countries in the West sub-region around the number of diagnosed migrants who are on treatment, and the numbers of these who are virally-suppressed. Data quality is generally poorer for the number of migrants in the sub-region who know their status, suggesting that there is much to do regarding surveillance of migrant testing practices and, potentially, to reduce the numbers of undiagnosed migrants in the West.

Only one country in the Centre could disaggregate continuum of HIV care data by migrant status, and no country in the East could provide disaggregated data. Therefore, while the numbers of new diagnoses among migrants in both these regions are vastly lower than in the West, there is still work to do to improve monitoring across the region as a whole.

Aggregate data can mask inequalities experienced by key populations at risk of HIV, and identifying these disparities is a first crucial step to knowing how best to address them. Therefore, although new diagnoses among migrants have remained fairly constant for Europe and Central Asia as a whole, there cannot be complacency around ways to combat new diagnoses in the migrant population across the entire Region. Moreover, while levels of late diagnoses across the region are slightly better for migrants than for non-migrants, the rates remain high, and migrants should be considered as a key population in relation to efforts to target late diagnoses.

Data on the probable country of infection give a good indication that HIV acquisition among migrant populations happens post-migration and needs to be recognised more as a national public health problem in the receiving countries. However, the number of countries with primary prevention measures such as condom distribution and health promotion targeted at migrants remain low, and provision specifically for undocumented migrants is always poorer. Twenty-seven countries now have some form of formal implementation of PrEP, of which 12 have a national policy to provide PrEP free at the point of delivery. However, a significant number of countries are not providing PrEP at scale to meet the demand of those at risk for acquiring HIV. The availability of and access to PrEP for all those who need it can contribute to further improving prevention of HIV infection. Those countries that still do not provide PrEP should explore options for overcoming barriers to implementation, especially since the cost of the drugs have reduced significantly.

Data on HIV testing for migrants are poor across the region, and conditions under which undocumented migrants can access testing for migrants are highly variable. Monitoring testing behaviour and increasing testing frequency among migrants needs to be considered by all countries in Europe and Central Asia, as a key tool to reducing the proportion of migrants living with undiagnosed HIV and reducing late diagnosis. Broadening access to testing by increasing the use of less traditional testing modes will be essential to addressing this problem.

It is encouraging that most countries across Europe and Central Asia have adopted a strategy of prompt treatment regardless of CD4 count, with 88% of reporting countries having done so. It is important though that practice reflects policy, and it will only be possible to ascertain this through the collection of data indicating how many

migrants who have received an HIV diagnosis are accessing treatment. Moreover, policy and practice around access to treatment for undocumented migrants is highly variable across the region, and 18 of the 52 countries either don't provide, or have a national policy that specifically excludes treatment for undocumented migrants. The lack of treatment availability affects progress towards viral suppression for the population, but also deters people from testing. Full implementation of test and treat policies is extremely important, if efforts to tackle the epidemic across the region are to be effective.

In addition to prompt treatment, it is also important that services that support the broader wellbeing of migrants are implemented to reduce the risk of HIV transmission and improve the health outcomes of those living with HIV. This should include testing and treatment for STIs and targeted services such as immigration support. The availability of these tertiary services is highly variable across the region.

Limitations

Throughout this report, migrants are defined as persons born abroad, which means that nationals born abroad are included in the data count. In practice, nationals born abroad are less likely to endure stigma attached to migrant status and far more likely to have the same access to services as the domestic population.

In addition, being born abroad does not inherently link to HIV-risk factors in the same way that it does for other key populations such as MSM, PWID and sex workers. Differences among migrants, perhaps most obviously in terms of their relative poverty or wealth, mean that the experience of access to services and the capacity to pay for services that are not free at the point of use will vary. This is partly dealt with in this survey by specific questions on undocumented migrants, who are the most marginalised among this key population.

Data comparability has other limitations. Although accompanying definitions were provided alongside questions as much as possible, in practice, some countries use slightly different definitions, so caution is required when making comparisons. There are also variations in data sources, sample sizes, timeframes, analysis and quality, which limit the scope for directly comparing data between countries.

There are still considerable levels of missing data which makes it difficult to generalise findings for the entire European and Central Asian region. Moreover, it is likely that countries with comparatively better surveillance and monitoring systems (and, therefore, better data) usually provide better services, meaning that the data presented here are likely to present an overly-optimistic version of the experience of migrants in the Region.

Furthermore, data submitted to the Dublin Declaration monitoring process are self-reported by national health authorities, which may compromise accuracy where measures are more subjective (for example, coverage questions which ask the respondent to answer 'high, medium or low').

Finally, one difficulty in analysing progress in relation to new diagnoses, the continuum of care, or the efficacy of interventions is that trends may reflect changes in migration patterns as much as changes in response to the epidemic.

Priority options for action

- Countries with no indication of a decline in new HIV diagnoses among migrants should consider implementing a targeted combination prevention approach, with effective monitoring in place to determine impact and identify any barriers to effectiveness.
- Countries should improve monitoring and surveillance of their migrant populations as good quality data strengthen the evidence base for effective, targeted interventions. Particularly, disaggregation of data for the continuum of care is important and countries may request ECDC technical support in this area if needed.
- There is evidence that HIV among the migrant population is often acquired after arrival and only screening newly arrived migrants at point of entry may not be enough to tackle the epidemic among this key population. Ongoing public health programmes that are targeted at all migrants, including those who have been in the country for some time and those who are undocumented should be considered.
- Availability of and access to testing and treatment, regardless of residential and migrant status, can contribute to further improving prevention and treatment of HIV infection.
- Countries should consider developing and delivering targeted primary HIV prevention programmes to migrant populations at risk but, in so doing, the diversity among migrant groups needs to be considered. There may be advantages of ensuring that prevention targeted at other key populations (MSM, PWID, sex workers) is inclusive of migrants within those groups. A wider range of testing interventions could be implemented to improve uptake and frequency of testing among migrants with effective monitoring of these interventions put in place to measure their impact.
- Countries should consider ensuring the removal of barriers preventing undocumented migrants from having access to testing and treatment.

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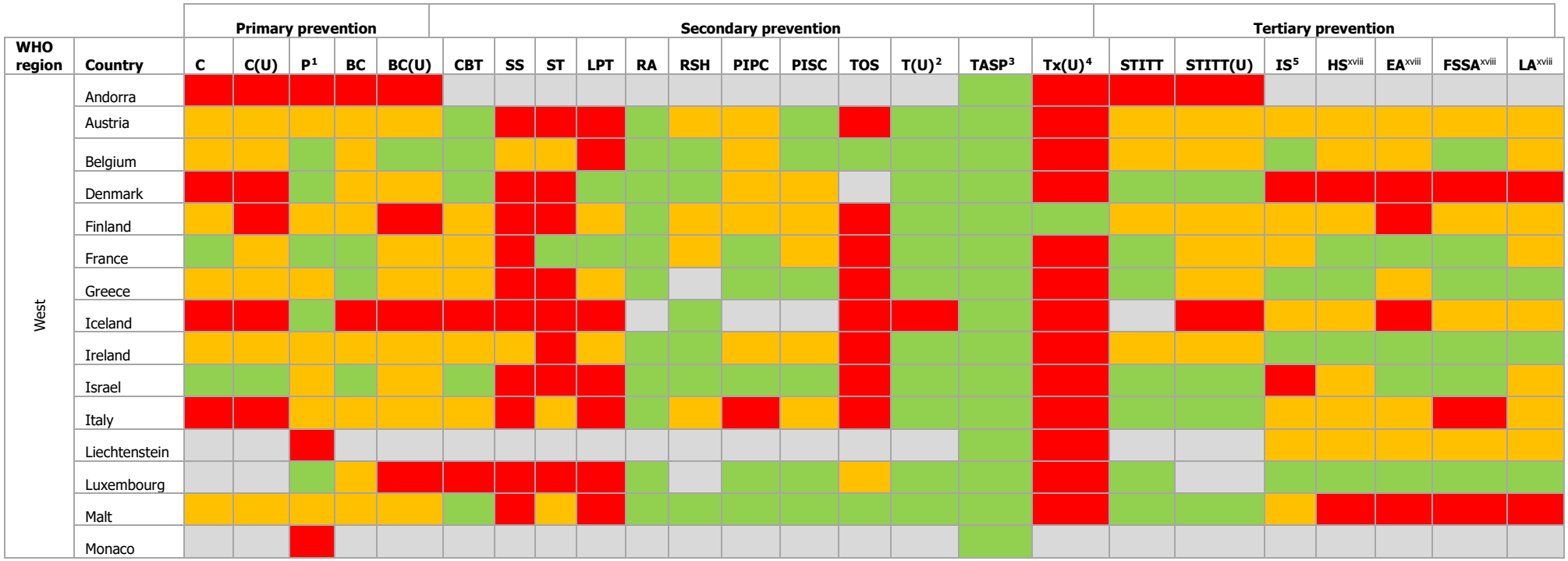
Annex 1. Combination prevention for migrants by country

- C – Condom programmes for migrants
- C(U) – Condoms programmes for undocumented migrants
- P – PrEP
- BC – HIV-related health promotion or behaviour change programmes for migrants
- BC(U) – HIV-related health promotion or behaviour change programmes for undocumented migrants
- CBT – Community-based HIV testing
- SS – Self sampling
- ST – Self testing
- LPT – Lay provider testing
- RA – Routine HIV antenatal testing
- RSH – Routine HIV testing in sexual health clinics
- PIPC – Provider-initiated HIV testing in primary care
- PISC - Provider-initiated HIV testing in secondary care
- TOS – HIV testing in other settings
- T(U) - HIV testing available to undocumented migrants
- TASP – Treatment as Prevention
- Tx(U) – National HIV treatment policies exclude undocumented migrants
- STITT – STI testing and treatment for migrants
- STITT(U) – STI testing and treatment for undocumented migrants
- IS – Immigration Support
- HS – Housing Support
- EA – Employment advice
- FSSA – Financial and social security advice
- LA – Legal advice

Reported as high to full coverage | Reported as low to medium coverage | Reported as not implemented | Don't know / no response



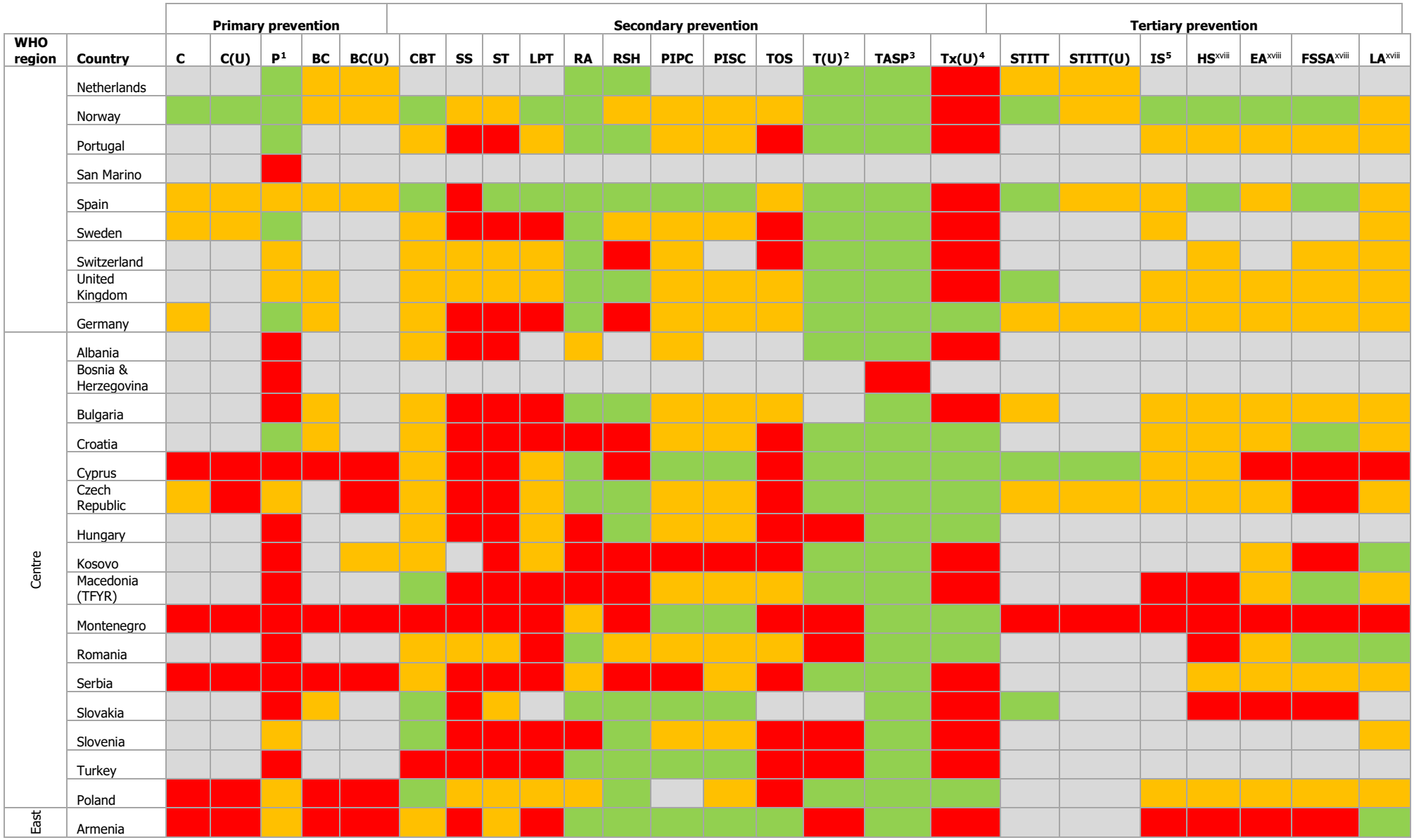
[1] In the case of PrEP, countries were given the options of responding 'Nationally available (reimbursed)' (categorised as green), 'Generics available in healthcare settings (not reimbursed)', 'Ongoing research or pilot projects' (both categorised as orange), or 'Not formally implemented' (categorised as red).

[2] When asked whether HIV testing is provided to undocumented migrants, countries were only given the option of yes (categorised as green), no (categorised as red) or don't know (categorised as grey).

[3] When asked whether they implemented a policy of treatment as prevention, countries were only given the option of yes (categorised as green), no (categorised as red) or don't know (categorised as grey).

[4] When asked whether national HIV treatment policies exclude undocumented migrants, countries were only given the option of yes (categorised as green) or no (categorised as red). No response is categorised as grey.

[5] When asked about systems for linkage to immigration support, housing support, employment advice, financial and social security advice and legal advice, countries were given the options of responding 'Fully in place' (categorised as green), 'Partially in place' (categorised as orange), 'Not in place' (categorised as red) or 'Don't know' (categorised as grey)


Primary prevention
Secondary prevention
Tertiary prevention
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LPT
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RSH
PIPC
PISC
TOS
T(U)[2]
TASP[3]
Tx(U)[4]
STITT
STITT(U)
IS[5]
HS[xviii]
EA[xviii]
FSSA[xviii]
LA[xviii]
Netherlands
Norway
Portugal
San Marino
Spain
Sweden
Switzerland
United Kingdom
Germany
Albania
Bosnia & Herzegovina
Bulgaria
Croatia
Cyprus
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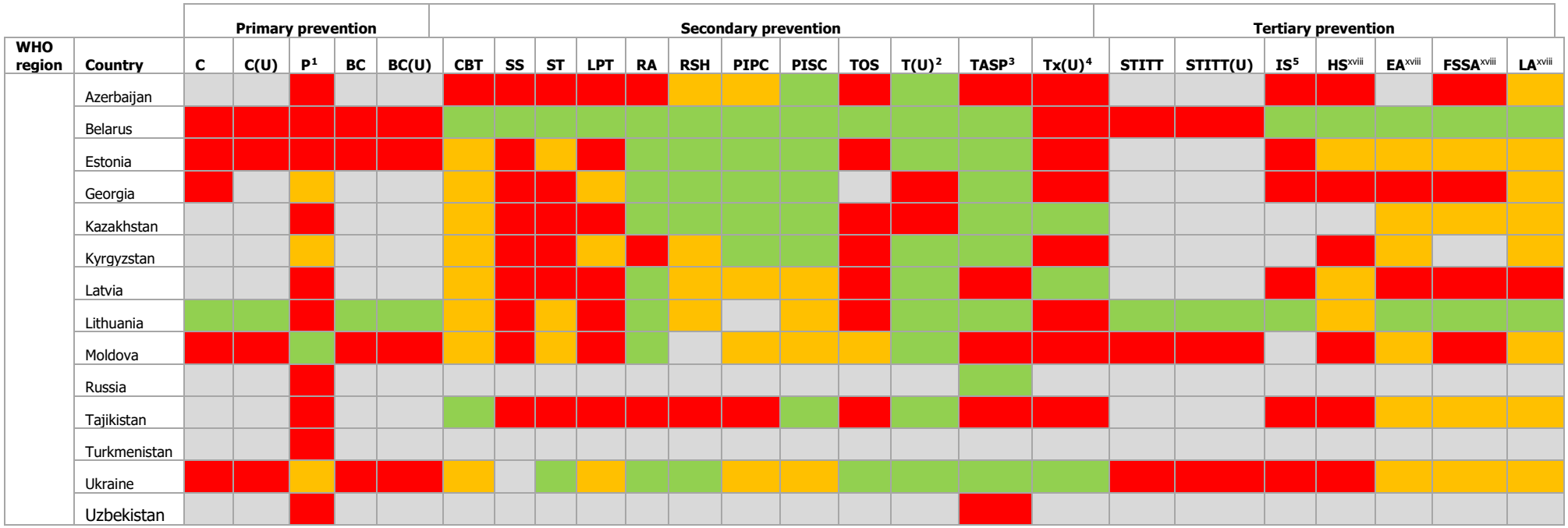
Primary prevention
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