SPECIAL REPORT

HIV and migrants

Monitoring the implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2022 progress report

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This report of the European Centre for Disease Prevention and Control (ECDC) was coordinated by Teymur Noori with support from Juliana Reyes and Charlotte Deogan.

This report is one in a series of thematic reports based on information submitted by reporting countries in 2022 on monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS.

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

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Abbreviations

ART	Antiretroviral treatment
EEA	European Economic Area
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
GAM	Global AIDS Monitoring
PLHIV	People living with HIV
PrEP	Pro-exposure prophylaxis
PWID	People who inject drugs
STI	Sexually transmitted infection
WHO	World Health Organization
UNAIDS	The Joint United Nations Programme on HIV/AIDS

Executive summary

Background

In recent years, migrants have accounted for more than 40% of new HIV diagnoses in the EU/EEA. Migrants living with HIV can face numerous intersecting stigmas related to their HIV and migration status, as well as broader racial and cultural discrimination. For the purposes of this report, migrants are defined as 'people born abroad' (i.e. those born outside the reporting country, regardless of place of HIV acquisition or diagnosis). 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, and socio-economic status.

Methods

Between February and March 2022, a European Centre for Disease Prevention and Control (ECDC) survey was used to collect data to monitor the implementation of the 2004 Dublin Declaration. The survey contained specific questions in relation to the HIV epidemic among migrants, in addition to questions relating to the current national prevention interventions, policies and barriers to the public health response. This report presents the results of the survey.

Continuum of HIV care

The continuum of HIV care is a conceptual framework that provides a snapshot of the critical stages in achieving viral suppression among people living with HIV. Data availability along the continuum of HIV care for migrants has slightly declined since 2020. Only six countries provided data, five EU countries and the United Kingdom (UK). Key findings include:

- There is progress along the continuum of HIV care across Europe and Central Asia, but available data suggest that the region is currently not meeting all of the Joint United Nations Programme on HIV/AIDS (UNAIDS) 95-95-95 targets, which are meant to be achieved by 2030:
  - Approximately 91% of migrants living with HIV in the region know their HIV status (86% in the EU countries providing data).
  - Of migrants diagnosed with HIV, 96% have initiated antiretroviral treatment (90% in the EU countries providing data).
  - Of the migrants on treatment, 95% are virally suppressed (90% in the EU countries providing data).
- Currently, only one country, the UK, is meeting the 2030 target of 86% viral suppression among all migrants estimated to be living with HIV.

It is important to note that these figures are based on limited data, and therefore may not be representative of the regional progress towards the 2030 targets.

Combination prevention

Combination prevention is an approach that brings together biomedical, behavioural, and structural interventions and strategies for HIV prevention and works on different levels, including individual, community, and societal/national level into one comprehensive programme. Key findings include:

- Thirty countries (out of 45 responding to this question) reported that they had a national HIV prevention strategy which specifically mentions migrants as a key population to whom actions and services are targeted. Only 19 countries had national HIV prevention strategies which included undocumented migrants.
- Condoms continue to be an important element of HIV prevention, however, only 10 countries reported medium-to-high coverage of condom and lubricant provision programmes targeting migrants.
- Pro-exposure prophylaxis (PrEP) availability in the World Health Organization (WHO) European Region has improved significantly since 2016. While data on the number of migrants accessing PrEP are limited, the available data suggest that PrEP may be inaccessible to many migrants in Europe and Central Asia.
- Fourteen countries reported that there was limited or no access to PrEP for undocumented migrants.
- There are a range of testing interventions which are implemented in the WHO European Region, including community-based testing by a medical professional, provider-initiated HIV testing and routine HIV indicator condition testing. Home testing, lay provider testing and self-testing remain among the least frequently reported testing interventions. However, there are limited data available on the number of migrants accessing HIV testing services.
- Most countries in Europe and Central Asia reported that treatment is initiated regardless of CD4 count, in line with recommendations from the WHO and the European AIDS Clinical Society. However, Bulgaria and Uzbekistan reported treatment initiation criteria.
- In the WHO European Region, 20% of reporting countries indicated that national treatment policies exclude undocumented migrants from accessing ART.

1 Introduction

Migrants are a key population affected by HIV across Europe and Central Asia, accounting for 42% of new HIV diagnoses in the EU/EEA in 2021 and 48% of those diagnosed in 2022 [1]. Migrants, in particular undocumented migrants, who are living with HIV can experience intersecting stigmas related to their HIV and migration status, as well as racial and broader cultural discrimination [2]. 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 'people 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 socio-demographic and socio-economic characteristics including ethnicity, nationality, migration status, gender, income, and educational level.

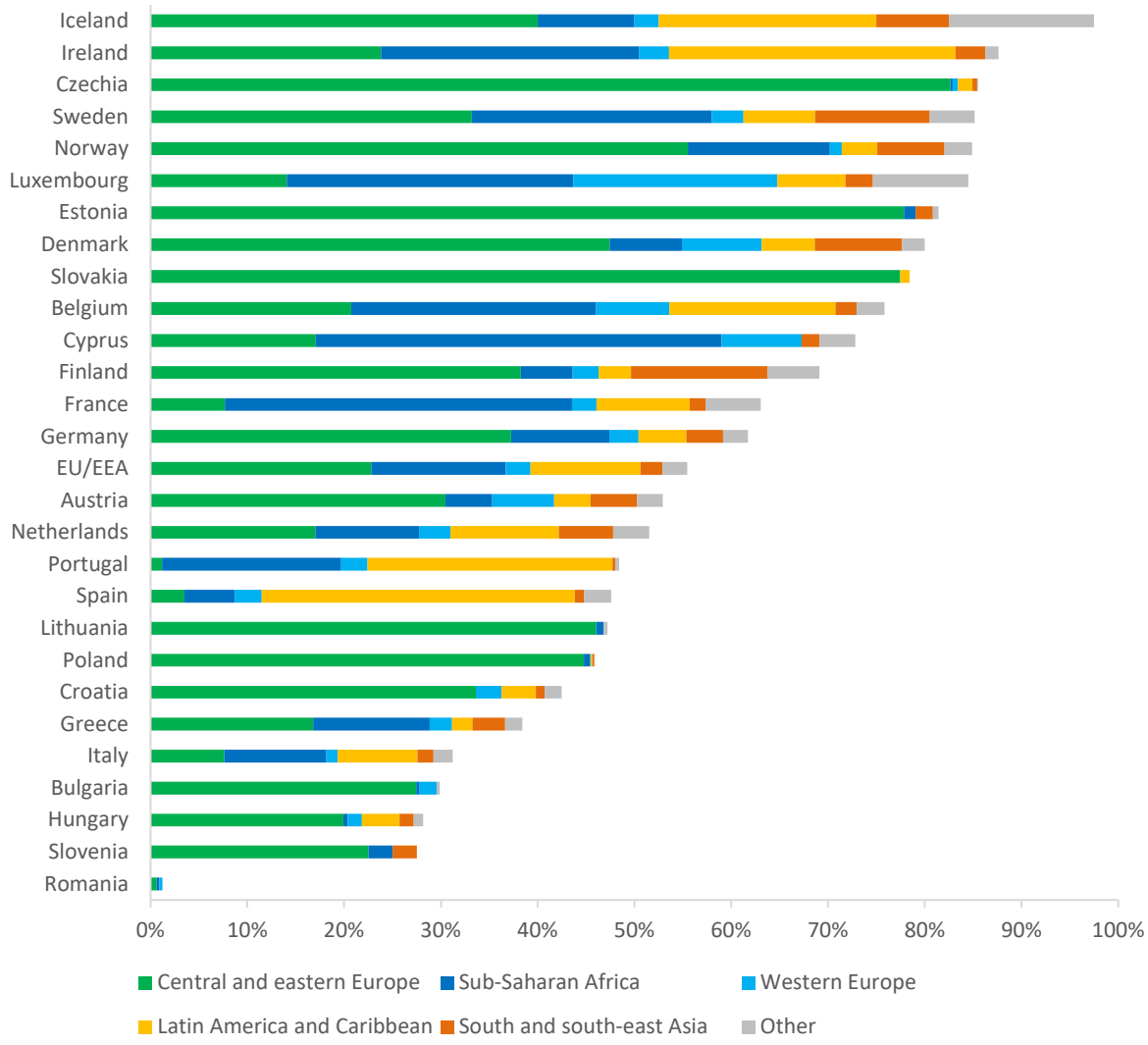
The aim of this report is to assess the situation for migrants at risk of or living with HIV, and to identify the efforts that are being made across the region regarding HIV prevention among migrants.

Epidemiological context

HIV diagnoses among migrants in the EU/EEA

In recent years, over 50% of all people diagnosed with HIV in the EU/EEA have been migrants, defined as originating from outside of the country in which they were diagnosed [1]. In 2022, from those with known information on region of origin, 23% of those diagnosed with HIV originated from other countries in central and eastern Europe, 14% from countries in sub-Saharan Africa, 11% from countries in Latin America and the Caribbean, and 3% from other countries in western Europe. The distribution of newly diagnosed cases among migrants and the regions from which migrants originate vary greatly across EU/EEA countries (Figure 1). As a consequence of population displacement due to the war in Ukraine since February 2022, many countries have increased numbers of HIV diagnoses among migrants reported in 2022, including from central and eastern Europe. These migration patterns suggest a need for targeted and culturally sensitive HIV testing and prevention programmes in addition to broader HIV elimination efforts.

Figure 1. Percentage of HIV diagnoses among migrants out of all reported cases with known information on region of origin, by country of report, EU/EEA, 2022 (n = 20 016)



Source: WHO Regional Office for Europe, European Centre for Disease Prevention and Control. HIV/AIDS surveillance in Europe 2023 – 2022 data.
Liechtenstein reported one case for 2022 and is excluded from the figure. Malta and Latvia are not included in the figure as they have more that 50% of the cases with unknow region of origin. Unknown route of transmission is excluded from the proportions presented here.

Box 1. Migrants and late diagnosis in EU/EEA

Late diagnosis is associated with an increased likelihood of mortality and morbidity. In the EU/EEA, most new AIDS diagnoses can be attributed to late HIV diagnosis [1]. Late diagnosis also increases the risk of onwards HIV transmission. Reducing late diagnosis is an important intervention for improving health outcomes for people living with HIV and preventing onward transmission.

In the EU/EEA, 55.5% of new HIV diagnoses were classed as a late diagnosis, however, these proportions were higher among certain migrant populations. Approximately two-thirds of migrants from South and South-East Asia diagnosed with HIV and 60% of migrants from sub-Saharan Africa diagnosed with HIV were diagnosed late [1].

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 country generally acquired HIV before or after migration. Stigmatising narratives about migrants and 'health tourism' rest on assumptions that migrants bring HIV, and an associated public health burden, to their receiving countries. However, growing evidence suggests that migrants continue to be at an increased risk of acquiring HIV post-migration [3,4].

Box 2. Post-migration HIV acquisition among migrants in four countries in the WHO European Region

A 2021 study found that migrants continue to be at an increased risk of HIV acquisition post-migration, especially MSM migrants. This highlights the importance of targeted, culturally appropriate, and accessible HIV prevention and care services.

Italy

Among 1 470 migrants an estimated 34% of migrants acquired HIV post-migration between 2007 and 2016. In MSM migrants, the proportion of HIV-positive migrants who acquired HIV post-migration rose to 56%.

Sweden

Of 1 634 migrants 409 (25%) acquired HIV post-migration.

Belgium

It is estimated that 29% of migrants acquired HIV post-migration.

United Kingdom

Between 2007 and 2016, 44% of migrants diagnosed with HIV in the UK acquired HIV post-migration.

Source: Yin et al., 2021

2 Methods

Between February and March 2022, an ECDC survey was used to collect data to monitor the implementation of the 2004 Dublin Declaration. The WHO European Region includes 53 countries in Europe and Central Asia that are further divided into three subregions (West, Centre, East). For the purposes of Dublin Declaration monitoring, Kosovo[2] and Liechtenstein have also been included and assigned to the Centre and West subregions, respectively, and the 55 countries are referred to herein as Europe and Central Asia. The monitoring questionnaire was disseminated to these 55 countries via an online survey.

National health authorities were asked to complete the Dublin Declaration survey[3] between February and the end of March. In July and August 2022, a validation exercise was performed by each country and corrections were made where necessary.

The survey contained specific questions in relation to the HIV epidemic among migrants, in addition to questions relating to current national prevention interventions, policies and barriers to the public health response to the epidemic.

This report presents the current situation among migrants, a key population affected by HIV in the WHO European Region. As well as considering the picture for the whole of the Europe and Central Asia region, findings are presented by the WHO subregions West, Centre, and East, which broadly group areas of Europe and Central Asia by geography and epidemic type, as depicted in Figure 2, and for the EU/EEA.

Data for this report have also been supplemented with data from The European Surveillance System for the WHO European Region.

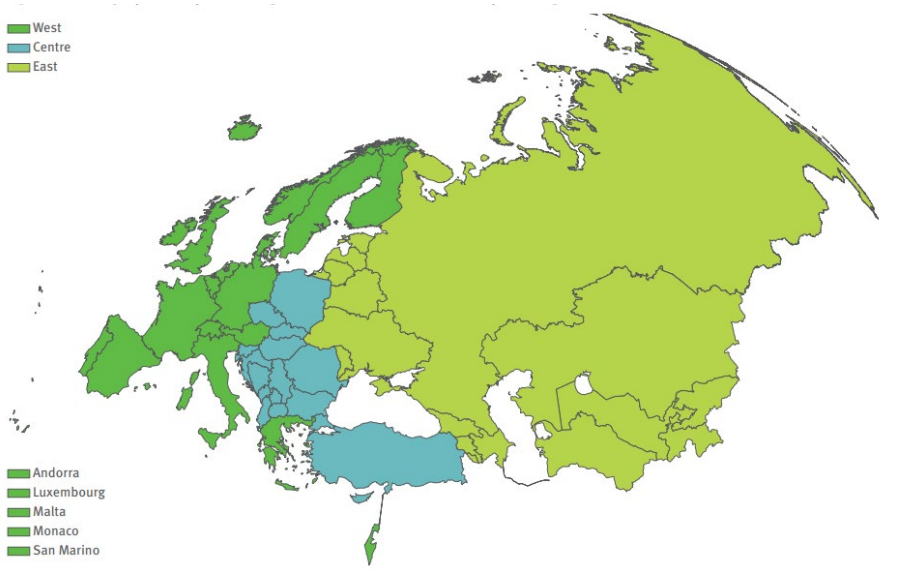
The countries covered by the report are grouped as follows:

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, and the UK.

Centre, 16 countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czechia, Hungary, Kosovo, North Macedonia, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia, and Türkiye.

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

Figure 2. Geographical and epidemiological divisions of the WHO European Region into subregions



Source: WHO Regional Office for Europe (WHO/Europe), European Centre for Disease Prevention and Control (ECDC). HIV/AIDS surveillance in Europe 2022–2021 data. Copenhagen, Stockholm: WHO/Europe, ECDC; 2023. Available at: http://www.ecdc.europa.eu/en/publications-data/hiv-aids-joint-report-surveillance-2021-data

[2] This designation is without prejudice to positions on status and is in line with UNSCR 1244 and the ICJ Opinion on the Kosovo Declaration of Independence.

[3] https://www.ecdc.europa.eu/en/infectious-disease-topics/z-disease-list/hiv-infection-and-aids/prevention-and-control/monitoring-0

Continuum of HIV care for migrants

The continuum of HIV care is a conceptual framework that provides a snapshot of the critical stages in achieving viral suppression among people living with HIV. 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.

Presenting the continuum by key population allows countries to measure outcomes for groups that are disproportionately affected by HIV. It also means that disparities between key populations that are hidden at the aggregate level can be revealed.

Box 3. Consensus definitions for monitoring the continuum of HIV care

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, UNAIDS Spectrum model 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.

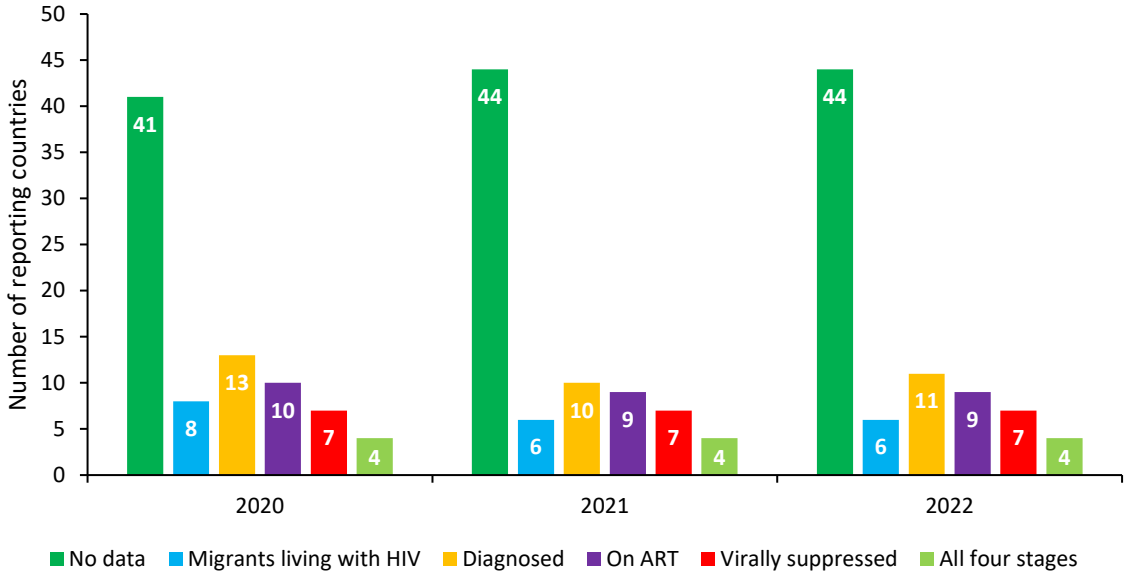
Stage 3: Number/percentage of above (estimated number of people living with HIV in the country, ever having been diagnosed) who are currently on antiretroviral treatment
The number should include all people currently on ART, regardless of treatment regimen or treatment interruptions/discontinuation.

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/ml at last visit (virally suppressed)
The number should include all those who have ever initiated ART, regardless of regimen or treatment interruptions/discontinuation.

Data availability

By 2022, all four stages of the continuum of HIV care for migrants were reported by four countries (Figure 3) [5]. At least two stages were reported by nine countries. There has been no major improvement in reporting on the continuum of HIV care for migrants, with some stages even seeing a decline in number of reporting countries since the 2020 reporting round.

Figure 3. Number of countries reporting data for different stages of the continuum of HIV care for migrants, Europe and Central Asia, reported by 2020, 2021, and 2022



95-95-95 targets and overall viral suppression among migrants living with HIV

In the six countries able to report data within Europe and Central Asia for stages 1 and 2, an estimated 91% (43 836 migrants; range: 65–94%) of the 47 945 migrants living with HIV have been diagnosed with HIV. The equivalent percentage for the five EU countries is 86% (Figure 4). Only one country, the UK, is currently meeting the 95% target. An additional three countries are within 10% of the target, and two countries are more than 10% off the target.

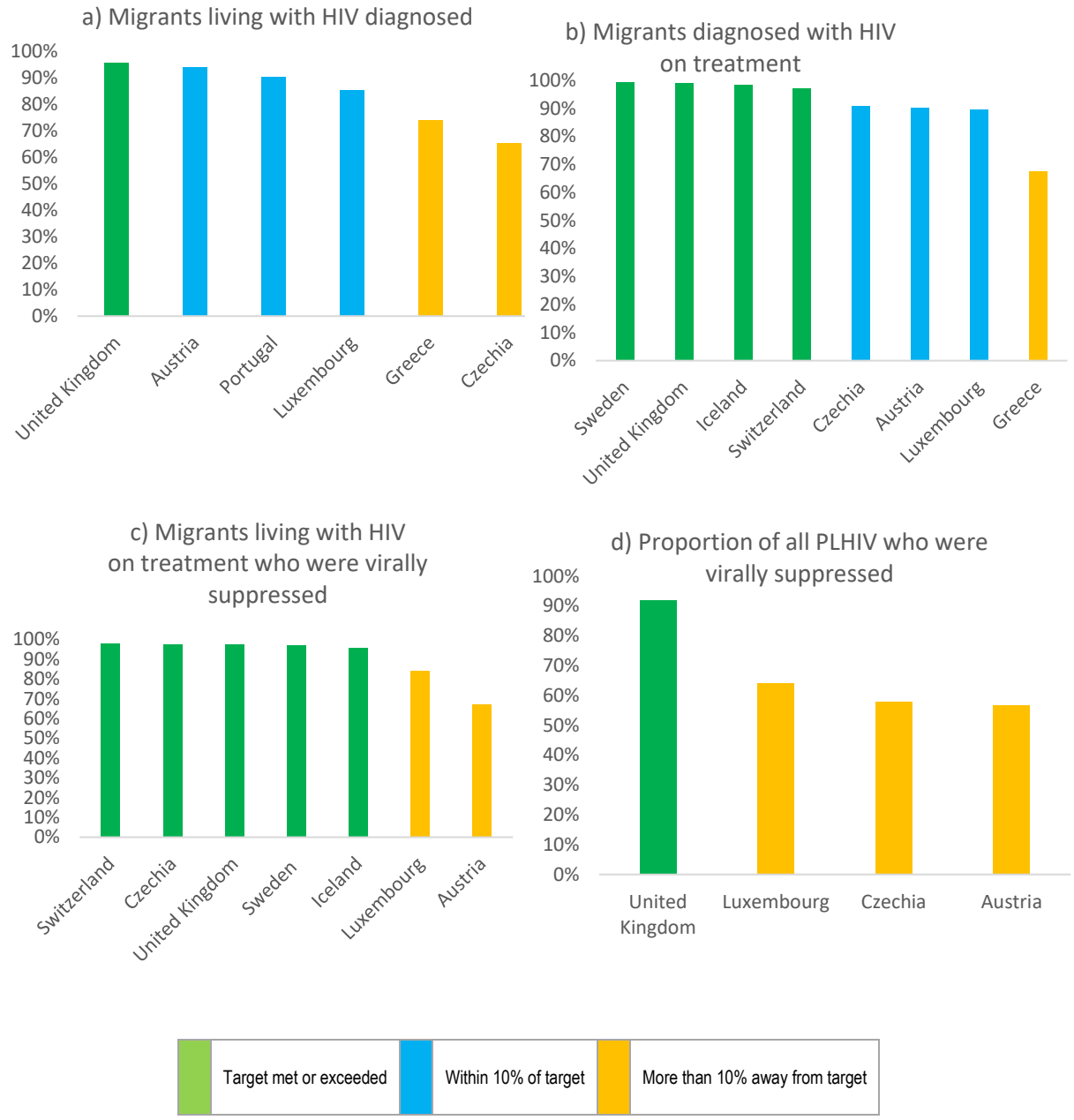
In the eight countries able to report data for stages 2 and 3, 96% (39 740 migrants; range: 68–99%) of the 41 604 migrants diagnosed with HIV are on ART. Four countries are currently meeting or exceeding the global target of 95% of all migrants diagnosed with HIV accessing ART. Of the remaining countries, three are within 10% of the target and one is more than 10% away from the target.

In the seven countries reporting data for stages 3 and 4, 95% (35 710 migrants; range: 67–98%) of the 37 631 migrants on ART are virally suppressed. Four countries are currently meeting or exceeding the 95% global target. The remaining three countries are more than 10% from the target.

Finally, in the four countries reporting data for stages 1 and 4, 87% (28 227 migrants; range: 57-92%) of 32 589 migrants living with HIV are virally suppressed. One country, the UK, is meeting the substantive target of 86% of all migrants living with HIV achieving viral suppression. The other three countries are not currently meeting the target.

A summary of the continuum of HIV care for countries reporting migrant data is provided in Annex 1.

Figure 4. Progress towards the global 95-95-95 targets and the 86% substantive target for viral suppression among migrants living with HIV in Europe and Central Asia, reported in 2022



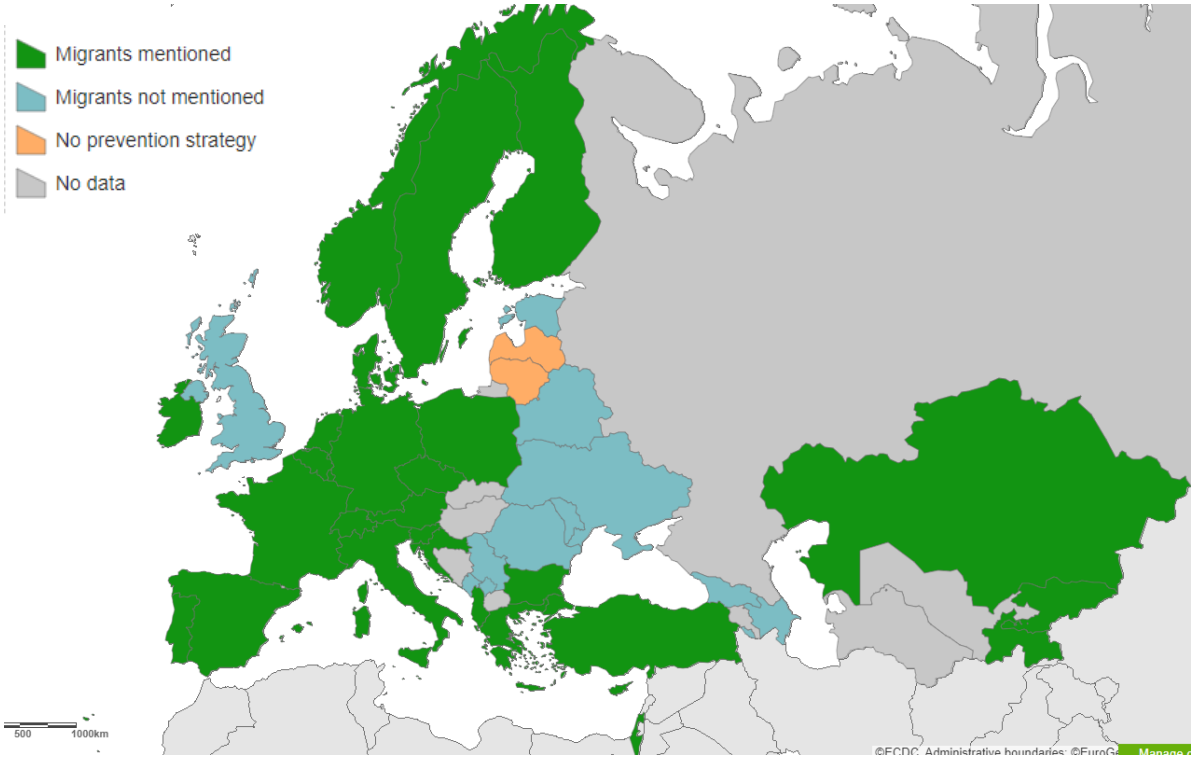
PLHIV: people living with HIV.
The information in this figure reflects the latest available data reported by countries in 2022. See Annex 2 for information on which years the reported data relate to.

It is important to note that the countries that were able to monitor the continuum of HIV care in key populations (including migrants) were also likely to report better HIV outcomes overall [5]. There are 44 countries unable to provide any continuum of HIV care data specific to migrants. In these countries, there may be significant inequalities in outcomes for this key population, beyond those described here.

Prevention services for migrants

Forty-five countries reported that they had a national HIV prevention strategy to reduce the number of new HIV infections, with 30 countries (67%) reporting their strategies specifically mention migrants as a key population to whom actions and services are targeted (Figure 5). Only 19 countries (42%) reported that their national prevention strategies mentioned undocumented migrants.

Figure 5. Countries with national HIV prevention strategies which include migrants, 2022



Combination prevention

HIV combination prevention brings together single prevention initiatives into a comprehensive prevention programme and works on individual, community, and national levels. Importantly, the specific elements take effect across the life course of HIV infection and encompass primary prevention, secondary prevention, and tertiary prevention interventions. Primary prevention programmes aim to prevent people from acquiring HIV and can include services such as condom provision and PrEP. Secondary prevention programmes are aimed towards preventing the onward transmission of HIV, including treatment as prevention (TasP), and tertiary prevention interventions help improve the health-related quality of life of those living with HIV.

The interventions implemented will vary depending on the needs of the target 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.

Primary prevention

Condom provision and use

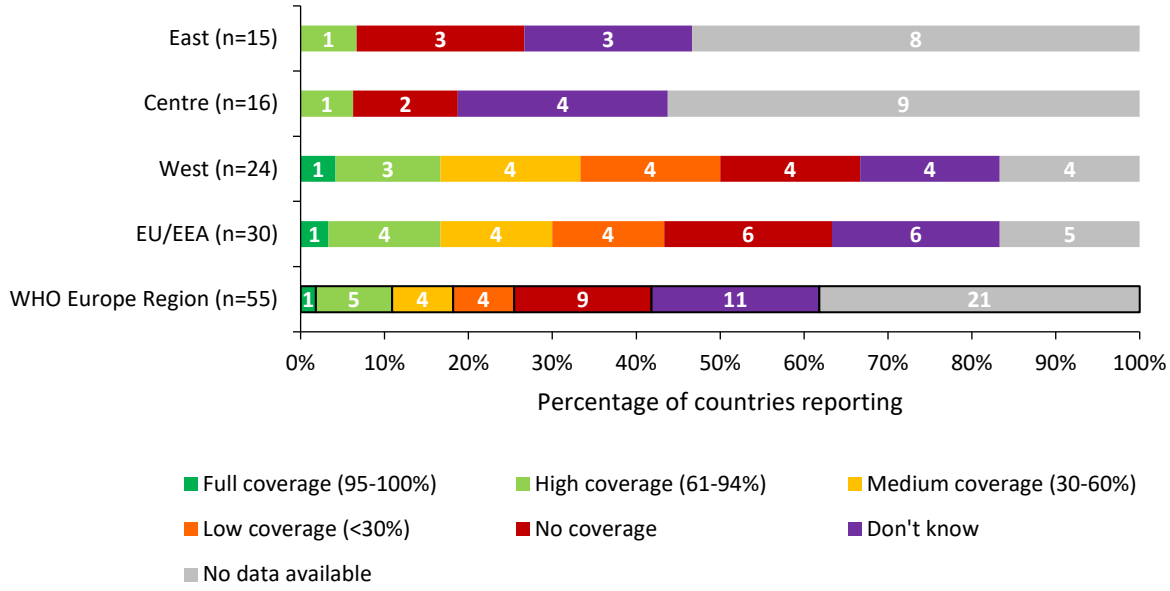
Condoms have long formed an important component of primary HIV prevention. Condom promotion and distribution programmes aim to ensure that people have access to condoms when needed. Twenty countries[4] in Europe and Central Asia (13 in the EU/EEA) reported that condoms and lubricant are available for free for migrants.

Countries also reported on the coverage[5] of condom and lubricant provision programmes (Figure 6). Of the 34 reporting countries, 10 reported medium coverage (30–60%) or greater. France was the only country that reported their condom and lubricant distribution programme had full coverage (95–100%). Approximately one-third of reporting countries did not know the coverage of such programmes, and an additional 21 countries did not report data, highlighting a gap in surveillance data.

[4] Albania, Austria, Belarus, Croatia, Cyprus, Czechia, Finland, France, Iceland, Italy, Kazakhstan, Latvia, Luxembourg, North Macedonia, Norway, Portugal, Spain, Tajikistan, Ukraine, and the UK.

[5] 'Coverage' is defined as having been given condoms and lubricants (for example, through an outreach service, drop-in centre or sexual health clinic).

Figure 6. Coverage of condom provision programmes for migrants in Europe and Central Asia by subregion, 2022



Box 4. Condom use among migrants in three EU countries: Cyprus, Portugal, and Poland

Cyprus
According to data collected at community voluntary counselling and testing centres in Cyprus between 1 January 2021 and 31 December 2021, 65% of migrants in Cyprus reported using a condom when they last had sex.

Portugal
Data from a 2021 behavioural surveillance survey in Portugal found that 15% of migrants used a condom when they last had sex.

Poland
Based on data collected from VCT centres in Poland between 1 January 2021 and 31 December 2021, approximately 15% of male migrants over 25 years old reported that they always used a condom during sex in the past year, and 34% reported using a condom sometimes when they had sex over the last year. Twenty-six percent of female migrants over 25 years old reported always using a condom during sex over the last year, and 41% reported sometimes using a condom during sex over the last year.

Pre-exposure prophylaxis

Pre-exposure prophylaxis (PrEP) is extremely effective at preventing the 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, and consent. WHO recommends that individuals with a 3% or greater risk of HIV acquisition use PrEP.

The situation regarding PrEP implementation and availability in Europe and Central Asia is fast-moving and evolving with advances in medical sciences. PrEP implementation in Europe and Central Asia has improved substantially since 2016, and, in 2022, 22 countries reported that PrEP was available and reimbursed through their healthcare system (14 in the EU/EEA), either through insurance or paid by the public sector[6]. In addition, 16 countries (10 in the EU/EEA) reported that generic PrEP was available in healthcare settings, although not fully reimbursed[7].

However, data availability on migrant access to PrEP is limited, and where available suggests that migrants are not accessing PrEP services to a high extent (Figure 7). Only eight countries were able to provide data on the

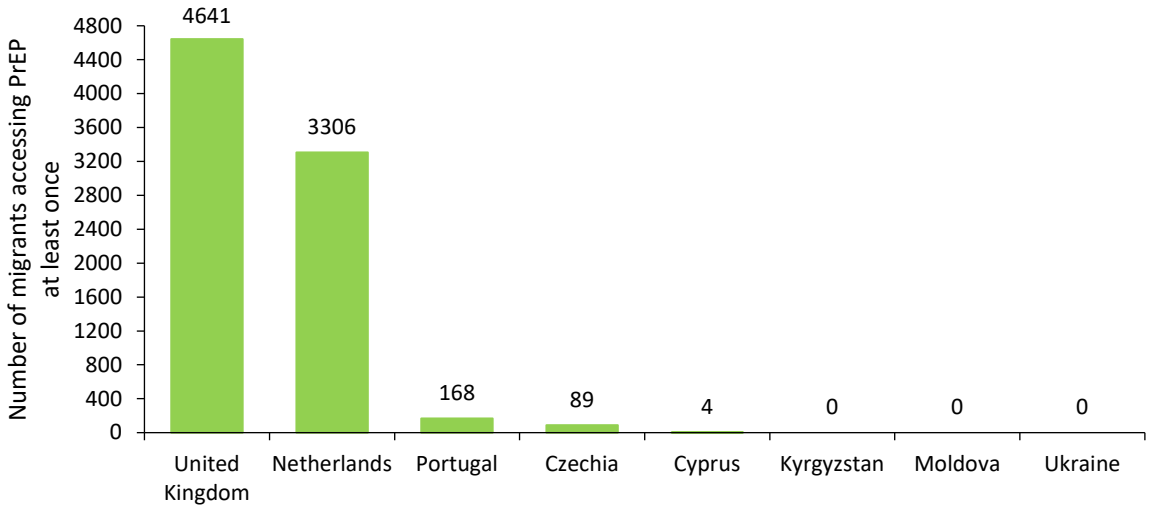
[6] Bosnia and Herzegovina, Croatia, Denmark, Finland, France, Georgia, Germany, Iceland, Ireland, Kazakhstan, Kyrgyzstan, Liechtenstein, Luxembourg, Monaco, North Macedonia, Norway, Portugal, Slovenia, Spain, Sweden, Ukraine, and the UK.

[7] Armenia, Austria, Belgium, Czechia, Estonia, Hungary, Israel, Italy, Lithuania, North Macedonia, Malta, Montenegro, Poland, Slovakia, Switzerland, and Türkiye.

number of migrants who accessed PrEP at least once in a 12-month period, ranging from 4 641 in the UK to zero in Kyrgyzstan, Moldova, and Ukraine. Three of the eight countries (37.5%) reported that no migrants accessed PrEP, and one country, Cyprus, reported that fewer than five migrants accessed PrEP at least once during a 12-month period.

These data indicate that PrEP may be inaccessible to many migrants in Europe and Central Asia. The main barriers most likely include an inability to identify high-risk subgroups of migrants and the lack of migrant-specific services to provide PrEP.

Figure 7. Number of migrants accessing PrEP at least once in a 12-month period in Europe and Central Asia, 2022



Secondary prevention

Testing

High levels of testing, combined with prompt linkage to care and treatment provision, is crucial for reducing overall HIV incidence. ECDC recommends offering all migrants from high prevalence counties an HIV test with clear referral pathways into prevention, treatment, and care services, and WHO recommends community-based testing in addition to provider-based testing. Both ECDC and WHO strongly advise against mandatory HIV testing for migrants, emphasising that all HIV testing should be voluntary and confidential, with informed consent [6,7,8].

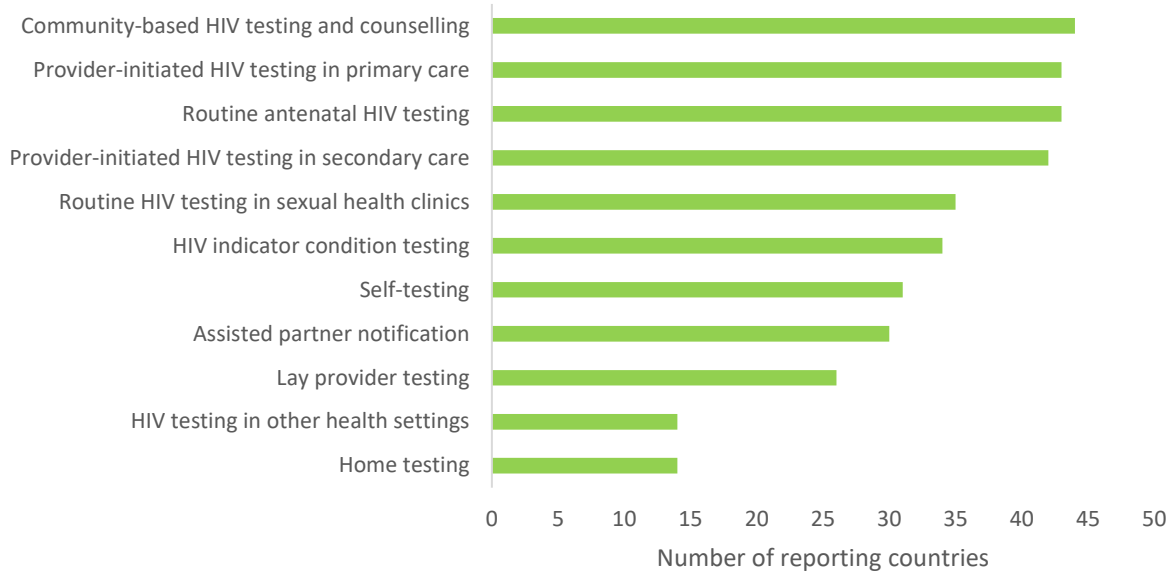
Data availability on the number of migrants who have been tested for HIV and know their HIV status is limited, with only five countries able to report data. The numbers of migrants tested ranged from 54 (Cyprus) to 30 143 (Kazakhstan), with the percentage of migrants who know their status ranging from 16% (Portugal) to 100% (Poland).

Implementation of different testing services

There are a range of traditional and non-traditional HIV testing interventions currently employed in the WHO European Region. In 2022, community-based testing by a medical professional was the most implemented testing intervention in the region (Figure 8). 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. Therefore, the high level of community-based testing may help migrants access HIV testing.

However, many non-traditional testing interventions, such as home testing, HIV testing in other health settings, lay provider testing, and self-testing are the least implemented of all the testing interventions. Migrants, especially undocumented migrants, tend to avoid formal health services for fear of intersecting stigmas and disclosure of their migration status. It is therefore reasonable to assume that a range of non-traditional 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. While the number of countries implementing these non-traditional testing interventions has increased, further exploration is required to understand the factors limiting the implementation of these interventions across Europe and Central Asia.

Figure 8. Implementation of different HIV testing interventions in Europe and Central Asia, 2022



Treatment as prevention

Ensuring prompt access to HIV treatment usually results in a normal life span and reduces the risk of HIV transmission. In 2022, 35 countries (25 in the EU/EEA) reported that they had a national treatment policy. In accordance with WHO and European AIDS Clinical Society clinical guidelines, 33 of the 35 countries (24 of 25 EU/EEA countries) reported that treatment is initiated regardless of CD4 count [9,10]. Bulgaria reported that treatment was initiated at ≤500 cells/mm^3 and Uzbekistan reported other treatment initiation criteria but did not specify.

While the adoption of test and treat policies indicates progress from 2014, when only four countries reported that treatment was initiated regardless of CD4 count, the implementation levels of these policies are less clear [11]. As Figure 4 in the continuum of HIV care section of this report shows, disaggregated data on treatment coverage among migrants remain limited. Where data have been provided, there is a variation in coverage, and only four countries (Iceland, Sweden, Switzerland, and the UK) out of the eight that provided relevant data are currently meeting the 2025 target of 95% of diagnosed migrants living with HIV receiving treatment. It is crucial that these policies are fully implemented and treatment coverage data are available for all key populations, including migrants.

Box 5. Treatment adherence and mental health among migrants living with HIV

People living with HIV have an increased incidence of poor mental health. A 2014 study suggests that the prevalence of depressive symptoms among PLHIV ranges from between 12.8–78% [12]. Additionally, studies suggest that migrants are more likely to experience poor mental health [13,14]. A 2019 study found that migrants living with HIV with poorer mental health were less likely to have good treatment adherence than those with better mental health [15,16]. Therefore, it is important to ensure that migrants living with HIV have access to appropriate and culturally sensitive mental health resources.

However, across the WHO European Region, data on mental health services available to people living with HIV are limited. Eight of 10 countries[8] reported that regular mental health screenings are not integrated with HIV care across the entire country. Countries should consider implementing regular mental health screening for people accessing HIV services, and integrate mental health services into HIV services.

Tertiary prevention

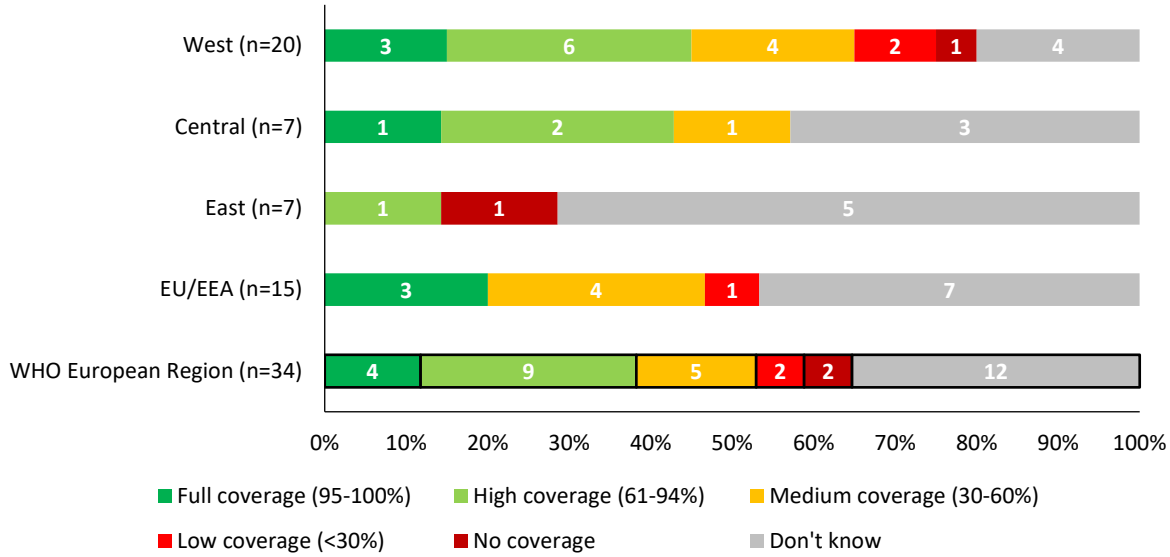
STI testing and treatment services

Access to STI testing and treatment is important because it comprises an element of comprehensive healthcare for people living with HIV, but also because STIs increase risk of HIV acquisition. Based on expert opinion, only

[8] Two countries reported that some regions have implemented regular mental health screening in HIV services; however, it varies between individual services.

13 countries[9,10] (38%) in the WHO European Region reported that they had high or full coverage of STI testing for migrants (Figure 9). Five countries[11] reported medium coverage of STI testing, and four countries[12,13] reported low or no coverage of STI testing for migrants. Only three of the 15 reporting countries in the EU/EEA reported that they had high or full coverage of STI testing for migrants, four reported medium coverage and one low coverage (Figure 9).

Figure 9. Coverage of STI testing programmes for migrants, in Europe and Central Asia by subregion, 2022



Box 6. Websites and Accessible Information – A Case Study from Czechia

The internet is a powerful tool to help disseminate information on HIV and STIs. In Czechia, a website (www.tadyted.com) has been established to help provide migrants with general information on STIs and HIV. Additionally, it has information on testing and treatment services across the country, as well as links to support services such as the National AIDS Hotline. The website is available in eight languages, including English, Russian and Ukrainian. Ensuring that non-stigmatising information on HIV and STIs is accessible to migrants is a vital part of preventing new HIV cases among migrants, and the internet can play an important role in this.

Linkage to support services

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.

Migrants living with HIV could need access to the full range of support services listed in Figure 10. Some of these services are more likely to be in demand among migrants, such as immigration support. However, immigration support services for people living with HIV are the least likely to be fully in place out of the services listed in countries across Europe and Central Asia: Only six of 44 countries (14%) reported that they had fully in place immigration services. Twenty-one countries (48%) reported that immigration services were partially in place and eight countries[14] (18%) reported that no services were in places. An additional nine countries reported that the status of immigration support service implementation was unknown.

[9] Countries reporting full (≥95%) coverage: Denmark, Israel, Slovakia, and Spain.

[10] Countries reporting high (61–94%) coverage: Cyprus, Czechia, Finland, France, Italy, Lithuania, Malta, Norway, and the UK.

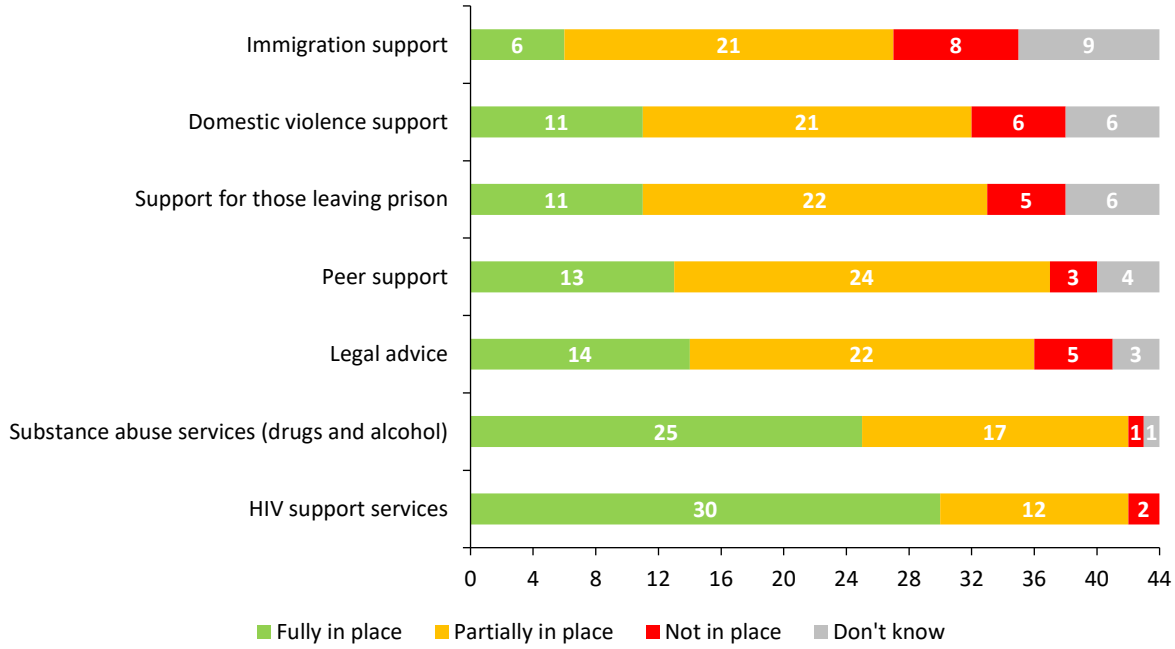
[11] Countries reporting medium (30–60%) coverage: Belgium, Bulgaria, Germany, Greece, and the Netherlands.

[12] Countries reporting low (<30%) coverage: Austria and Ireland.

[13] Countries reporting no coverage: Andorra and Belarus.

[14] Countries reporting no immigration support services: Bulgaria, Cyprus, Estonia, Georgia, Latvia, Montenegro, North Macedonia, and Romania.

Figure 10. Support services for people living with HIV in 44 countries in Europe and Central Asia, 2022



Undocumented migrants and HIV care

Undocumented migrants can face additional barriers when attempting to access healthcare services, including HIV care. Many services may be unavailable to undocumented migrants, such as PrEP and HIV testing. Data availability for this population is limited, so it is difficult to reach comprehensive conclusions on the HIV epidemic and response for undocumented migrants.

Of the 43 countries with national HIV prevention strategies, only 19 (44%) specifically mention undocumented migrants as a key population. Inclusion in national strategies is important to ensure the specific needs of key populations are considered and that the implementation of targeted prevention services are available and accessible throughout the country.

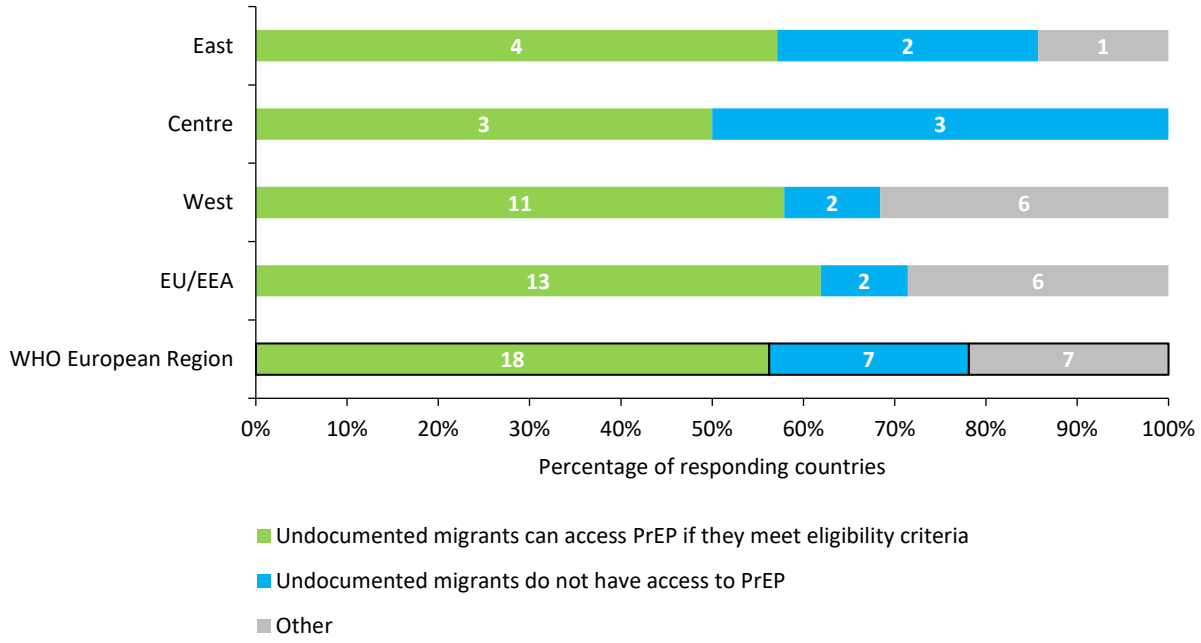
Access to PrEP for undocumented migrants

In the WHO European Region, 18 countries[15] (13 in the EU/EEA) reported that undocumented migrants could access PrEP if they met eligibility criteria, while seven countries[16] reported it was not available for undocumented migrants (Figure 11). Belgium reported that PrEP may be available for undocumented migrants through non-governmental and community-based organisations, but was not available through the health system. Finland, Germany, and Sweden reported that PrEP is available at cost for undocumented migrants which creates barriers to accessibility. The Netherlands, Spain, and Ukraine reported that PrEP accessibility for undocumented migrants is limited.

[15] Countries reporting that PrEP is available for undocumented migrants: Austria, Czechia, Estonia, France, Georgia, Iceland, Ireland, Italy, Kyrgyzstan, Liechtenstein, Luxembourg, Norway, Moldova, Poland, Portugal, Slovenia, Switzerland, and the UK.

[16] Countries reporting that PrEP is not available for undocumented migrants: Albania, Belarus, Croatia, Denmark, Israel, Kazakhstan, and North Macedonia.

Figure 11. Accessibility of PrEP for undocumented migrants in Europe and Central Asia, by subregion, 2022



Testing and treatment services for undocumented migrants

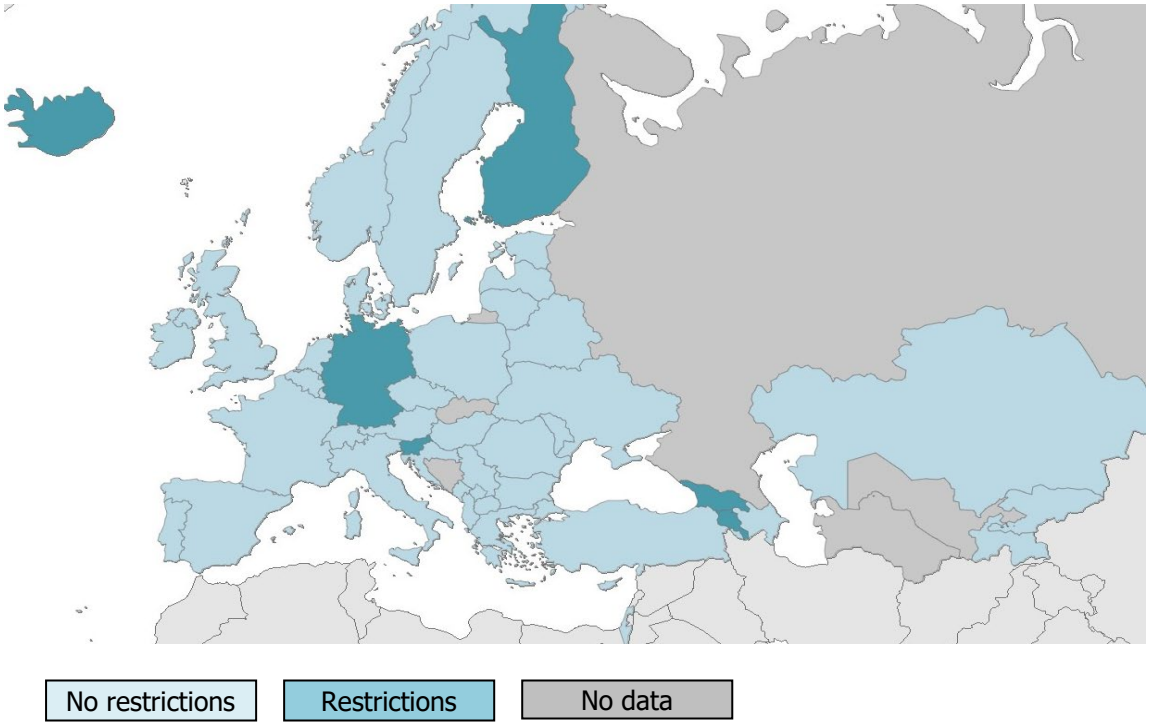
Access to testing and treatment is important to reduce the number of new HIV transmissions and improve the quality of life of those living with HIV. However, across Europe and Central Asia, undocumented migrants face barriers to accessing these essential HIV services (Figure 12). Universal access to HIV testing is an essential element in the response to HIV, however, across Europe and Central Asia six countries reported that access to HIV testing was restricted for undocumented migrants.

HIV treatment improves the health, lifespan, and quality of life of people living with HIV, and it reduces the risk of onward transmission. However, nine of 44 countries (20%) reported national policies which exclude undocumented migrants from receiving antiretroviral treatment (ART). Of the countries reporting restrictions on ART access for undocumented migrants, one country, Austria, reported that civil society organisations may provide access to ART for undocumented migrants and two countries, Finland and Greece, reported that ART was available to undocumented migrants living with HIV if they are pregnant.

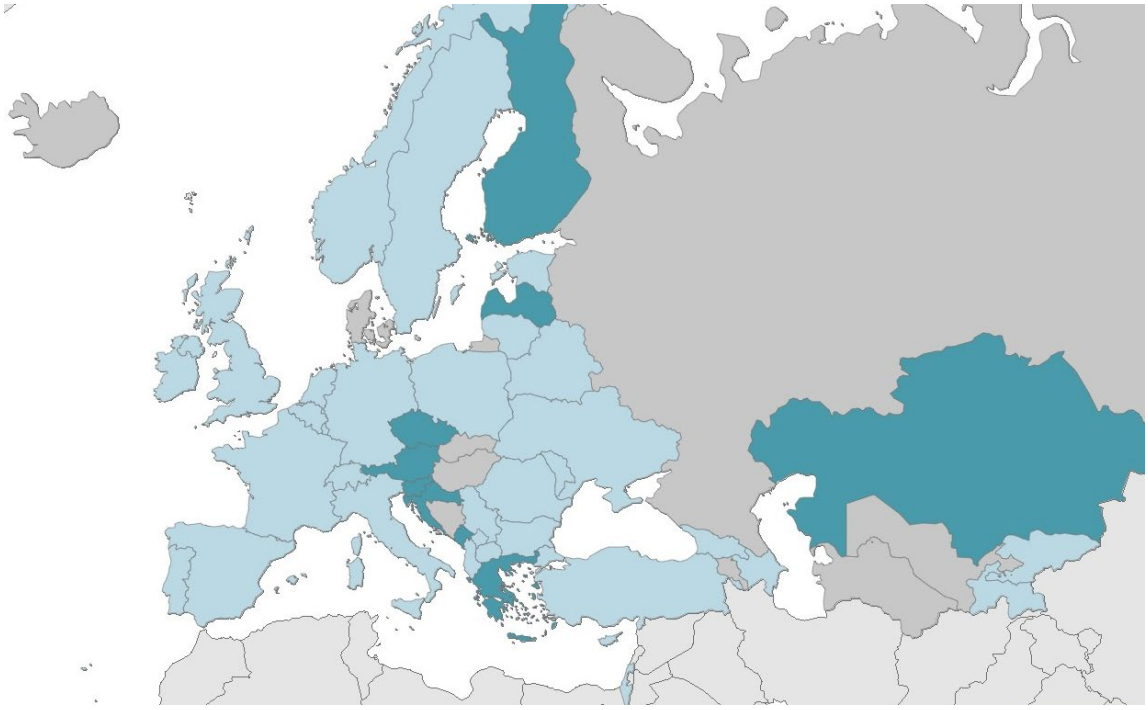
Even in countries with national policies that do not specifically exclude undocumented migrants, undocumented migrants may face barriers to accessing ART. For example, Germany reported that undocumented migrants have no de facto access to treatment except through special programmes in Berlin and Hamburg, while Belgium reported that administrative barriers may interfere with access.

Figure 12. Countries in Europe and Central Asia reporting restrictions on testing (A) and treatment (B) for undocumented migrants, 2022

A. Restriction on testing



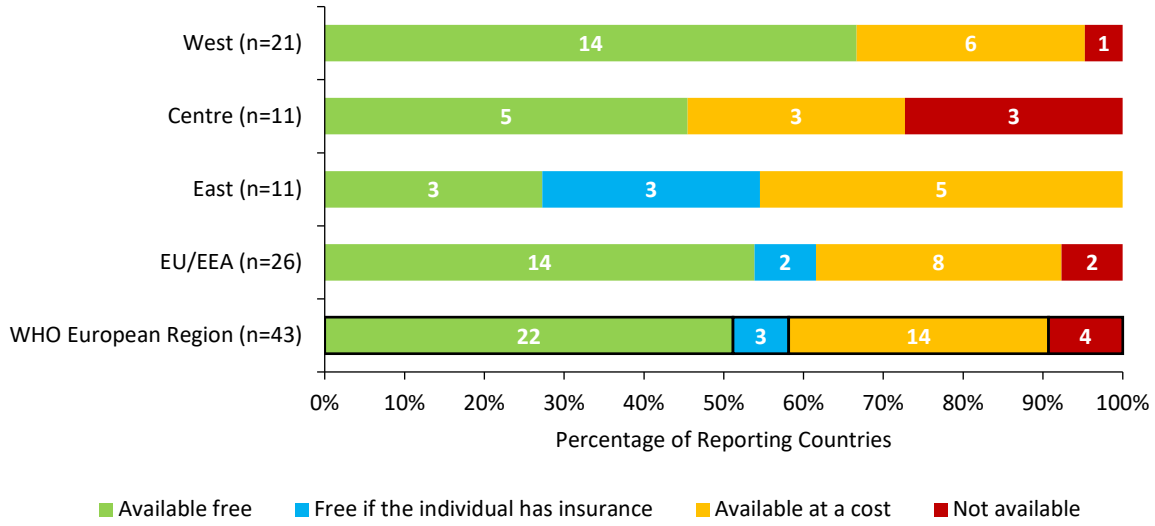
B. Restriction on treatment



Access to STI testing for undocumented migrants

In Europe and Central Asia, STI testing is available to undocumented migrants for free in 22 of 43 reporting countries (14 of 26 in the EU/EEA) (Figure 13). Three countries reported testing for STIs was free for undocumented migrants if the individual has insurance and 14 countries reported that STI testing was only available at cost for undocumented migrants. Insurance and payment requirements are a barrier to access for undocumented migrants, therefore, levels of STI testing among undocumented migrants in these countries may be limited. Four countries (Denmark, North Macedonia, Montenegro, and Slovenia) reported that STI testing was not available for undocumented migrants.

Figure 13. Availability of STI testing for undocumented migrants in 43 countries in Europe and Central Asia, by WHO subregion, 2022



3 Conclusions

Overall progress

In the WHO European Region, migrants are a key population affected by HIV. Migrants, especially undocumented migrants, can face numerous barriers when accessing HIV prevention, testing, and care services due to discriminatory legislation and intersecting stigmas.

Data along the continuum of HIV care for migrants remain very limited, with only four of 55 countries (53 WHO European Region countries plus Kosovo and Liechtenstein) able to provide data for the entire continuum. Due to the limited data available, it is not possible to assess the regional progress towards the 2030 elimination targets within this key population. Of the four countries able to provide data for all four stages, only one, the UK, is currently meeting the 2030 substantive target of 86% of all migrants living with HIV achieving viral suppression.

Primary prevention programmes aim to prevent people from acquiring HIV and include condom provision and PrEP. While condom distribution programmes aimed towards migrants exist across Europe, just under a third of countries reported that their condom distribution programmes for migrants achieved medium coverage or greater. Although the number of countries implementing PrEP has steadily increased, the available data suggest that most migrants are not accessing PrEP services. Ensuring access to primary prevention services is vital to reduce the number of new HIV infections among migrants, and countries are encouraged to explore the needs of their migrant community to create tailored prevention programmes.

Secondary prevention programmes are aimed towards preventing onward transmission of HIV, and include testing. Due to the limited data available, it is difficult to assess the extent to which migrants are accessing HIV testing services. There are a range of HIV testing modalities implemented in Europe and Central Asia, however, non-traditional interventions, such as home- and self-testing remain among the least reported interventions. Migrants, especially undocumented migrants, tend to avoid formal health services for fear of intersecting stigmas and disclosure of their migration status, therefore, 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.

Undocumented migrants can face additional barriers when accessing HIV services, including legal restrictions to access. Indeed, many countries reported restrictions or barriers to accessing prevention, testing and treatment services for undocumented migrants. Universal access to HIV prevention, testing and treatment services is important to end new transmissions by 2030. Countries with restrictions on access to these services are encouraged to remove these restrictions and countries reporting barriers should explore opportunities to create healthcare that is accessible for all migrants, including undocumented migrants.

Limitations

Throughout this report, migrants are defined as people born abroad, which means that nationals born abroad are included in the data count. In practice, nationals born abroad are less likely to experience stigma attached to the 'migrant' status and are 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, sex workers, and transgender people. 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 also considerable levels of missing data which makes it difficult to generalise findings for the entire Europe and Central Asia region.

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

Priorities for action

- Countries should consider improving 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 HIV care is important and countries may request ECDC technical support in this area if needed.
- Countries are encouraged to reflect on how to best engage with and provide information to migrants on HIV testing and treatment as early as possible upon arrival.
- 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.
- Countries can consider tailored migrant targeted campaigns that address wider barriers to HIV care and general information surrounding access to the healthcare systems.
- Countries should explore the feasibility of expanding primary prevention services, including condom provision programmes and PrEP implementation, to ensure that they are accessible for migrants.
- Holistic approaches to testing and treating HIV that integrate links between HIV support services and other services (i.e. housing, mental health, financial, legal) are necessary to address psychosocial factors such as poverty and homelessness.
- 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 are encouraged to reflect on how general attitudes and legislation around migrants, especially undocumented migrants, may impact their willingness to seek out medical support and what needs to be done on local and national levels to help create more accessible medical services for all migrants.

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Annex 1. Continuum of care for migrants living with HIV in the countries of Europe and Central Asia: number of people and targets reported by 2022

						95-95-95 Targets			95-90-86 Targets		
Subregion	Country	Number of MLHIV	Number of MLHIV who are diagnosed	Number of MLHIV who are receiving ART	Number of MLHIV who are virally suppressed	% of MLHIV who are diagnosed	% of diagnosed MLHIV who are on ART	% on ART who are virally suppressed	% of MLHIV who are diagnosed	% of MLHIV who are on ART	% of MLHIV who are virally suppressed
West	Andorra										
	Austria	3 088	2 897	2 613	1 749	94%	90%	67%	94%	85%	57%
	Belgium										
	Denmark										
	Finland										
	France										
	Germany		13 000								
	Greece	4 237	3 124	2 109		74%	68%		74%	50%	
	Iceland		117	115	110		98%	96%			
	Ireland										
	Israel		6 398								
	Italy										
	Liechtenstein										
	Luxembourg	1 011	860	769	647	85%	89%	84%	85%	76%	64%
	Malta			256							
	Monaco										
	The Netherlands										
	Norway										
	Portugal	11 119	10 043			90%			90%		
	San Marino										
	Spain										
	Sweden		5 475	5 434	5 267		99%	97%			
	Switzerland		2 219	2 154	2 106		97%	98%			
	The United Kingdom	27 400	26 200	25 900	25 200	96%	99%	97%	96%	95%	92%
	Subregion total	**31 499**	**29 957**	**29 282**	**27 596**	**95%**	**98%**	**94%**	**95%**	**93%**	**88%**
Centre	Albania										
	Bosnia and Herzegovina										
	Bulgaria										

	Croatia										
	Cyprus										
	Czechia	1 090	712	646	631	65%	91%	98%	65%	59%	58%
	Hungary										
	Kosovo										
	Montenegro										
	North Macedonia										
	Poland										
	Romania										
	Serbia										
	Slovakia										
	Slovenia										
	Türkiye										
	Subregion total	**1 090**	**712**	**646**	**631**	**65%**	**91%**	**98%**	**65%**	**59%**	**58%**
East	Armenia										
	Azerbaijan										
	Belarus										
	Estonia										
	Georgia										
	Kazakhstan										
	Kyrgyzstan										
	Latvia										
	Lithuania										
	Moldova										
	Russia										
	Tajikistan										
	Turkmenistan										
	Ukraine										
	Uzbekistan										
	Subregion total										
Total		**32 589**	**30 669**	**29 928**	**28 227**	**94%**	**98%**	**94%**	**94%**	**92%**	**87%**

	Target met or exceeded		Within 10% of target		More than 10% away from target

ART: antiretroviral treatment; MLHIV: migrants living with HIV.
** Sub-totals and totals for numbers 95-95-95 and 95-90-86 only include countries where all four stages of the continuum of care were reported. Sub-totals and totals for 95-95-95 targets include countries where the relevant two consecutive stages of the continuum of care were reported.*

European Centre for Disease Prevention and Control (ECDC)

Gustav III:s Boulevard 40
16973 Solna, Sweden

Tel. +46 858601000
ECDC.info@ecdc.europa.eu

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