MONITORING

HIV and migrants in the EU/EEA

Monitoring the implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2024 progress report (2023 data)

ECDC MONITORING

HIV and migrants in the EU/EEA

Monitoring the implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2024 progress report (2023 data)

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

This report is one in a series of thematic reports based on information submitted by reporting countries in 2024 on monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS. Other reports in the series can be found on ECDC's website at: https://www.ecdc.europa.eu/en/infectious-disease-topics/hiv-infection-and-aids/surveillance-and-updates-hiv-and-aids#monitoring-implementation-of-the-dublin-declaration.

The draft version of the report was produced by Centre of Excellence for Health, Immunity and Infections (CHIP), Copenhagen, Denmark, under Specific contract No 4 ECD.16131 by Oleksandr Korotych with input from Cæcilie Bom Kahama, Marie-Louise Jakobsen, Sarah North, Dorthe Raben and Annemarie Stengaard.

Acknowledgements
ECDC would like to acknowledge the support and guidance provided by members of the Dublin Declaration advisory group. Members of the advisory group include: Irene Kászoni-Rückerl (Austria), Jessika Deblonde (Belgium), Anna Kubatova (Czechia), Rachael Metrustry (Ireland), Arild Johan Myrberg (Norway), Vítor Cabral Veríssimo (Portugal), Thomas Seyler (EUDA), Filippo Pericoli (EUDA), Sini Pasanen (HivFinland), Magdalena Ankiersztejn-Bartczak (Foundation for Social Education), Adam Shanley (MPOWER), Giorgi Kuchukhidze (WHO Regional Office for Europe), Victoria Bendaud (UNAIDS), Ali Feizzadeh (UNAIDS), Eline Korenromp (UNAIDS).

ECDC would also like to thank the following people for providing data through the Dublin Declaration questionnaire: Lena König, Andrea Brunner, Gisela Leierer, Irene Kászoni-Rückerl, Robert Zangerle, David Chromy, Irene Schmutterer, Martin Busch (Austria), Jessika Deblonde, Ben Serrien, Dominique Van Beckhoven (Belgium), Kristiyan Hristov, Angelina Yaneva (Bulgaria), Tatjana Nemeth Blažić, Josip Begovac, Mirjana Lana Kosanović Ličina, Šime Zekan (Croatia), Fani Theophanous, Christos Krasidis, Christiana Stavraki, Evi Kyprianou, Georgios Siakallis, Ioanna Yiasemi (Cyprus), Anna Kubatova, Ivo Procházka, Marek Malý (Czechia), Maria Wessman (Denmark), Iveta Tomera (Estonia), Henrikki Brummer-Korvenkontio, Sini Pasanen, Kirsi Liitsola (Finland), Soraya Belgherbi, Florence Lot (France), Ulrich Marcus, Silke Klumb, Binod Mahanty (Germany), Chryssa Tsiara, Stergios Matis, Anastasios Fotiou, Eleftheria Kanavou (Greece), Anna Margrét Guðmundsdóttir, Einar Thor Jonsson, Maríanna Þórðardóttir, Hildigunnur Anna Hall (Iceland), Rachael Metrustry, Kate O'Donnell, Derval Igoe (Ireland), Anna Caraglia, Maria Luisa Cosmaro (Italy), Sarlote Konova, Kristine Ozolina (Latvia), Esther Walser-Domjan (Liechtenstein), Oksana Juciene, Laura Bliujienė, Kęstutis Rudaitis (Lithuania), Pierre Braquet, Yolanda Pires, Valerie Etienne (Luxembourg), Jackie Maistre Melillo, Norman Galea, Aaron Schembri (Malta), Silke David, Eline Op de Coul (Netherlands), Arild Johan Myrberg (Norway), Marta Niedźwiedzka-Stadnik (Poland), Joana Bettencourt, Amilcar Soares, Helena Cortes Martins, Alexandre Gomes, Rogério Ruas, Cristina Mora, Pedro Morais (Portugal), Mariana Mardarescu, Monica Dan, Iulian Petre, Odette Popovici, Alexandra Popescu, Valentina Stefan (Romania), Alexandra Brazinova (Slovakia), Irena Klavs, Janja Krizman-Miklavcic, Janez Tomažič, Tomaž Vovko, Tanja Kustec (Slovenia), Julia del Amo Valero, Reyes Velayos, Asuncion Diaz, Javier Gómez Castellá, Juan Hoyos Miller, Néstor Nuño Martínez (Spain), Lilian Van Leest, Jonas Jonsson, Klara Abrahamsson (Sweden).

ECDC would like to thank the operational contact points for HIV surveillance from EU/EEA Member States for making available HIV/AIDS surveillance data.

ECDC would like to thank the European Union Drugs Agency and UNAIDS for harmonising their monitoring systems with ECDC and making available country-reported data for the purposes of monitoring the Dublin Declaration. ECDC would also like to thank the WHO Regional Office for Europe for jointly coordinating HIV surveillance in the WHO European Region.

Suggested citation: European Centre for Disease Prevention and Control. HIV and migrants in the EU/EEA. Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2024 progress report. Stockholm: ECDC; 2024.

Stockholm, November 2024

ISBN: 978-92-9498-762-4
doi: 10.2900/2587251
Catalogue number: TQ-01-24-018-EN-N

Contents

Figures

Tables

Abbreviations

ART	Antiretroviral treatment
EEA	European Economic Area
EU	European Union
PrEP	Pre-exposure prophylaxis
STI	Sexually transmitted infection
WHO	World Health Organization
UNAIDS	The Joint United Nations Programme on HIV/AIDS

Executive summary

Background

In 2023, migrants accounted for almost half of new HIV diagnoses in the European Union and European Economic Area (EU/EEA) remaining a key population affected by HIV across the European region. Migrants living with HIV face numerous intersecting stigmas related to their HIV and migration status, as well as broader racial and cultural discrimination. Moreover, access to health services for undocumented migrants is not universally guaranteed in the EU/EEA, which hinders HIV prevention, testing and treatment services for this group and could contribute to HIV transmission in these communities, including post-migration acquirement of HIV.

For 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, people who inject drugs, or sex workers. It includes those who have migrated from within the EU/EEA 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.

Methods

ECDC monitors the implementation of the 2004 Dublin Declaration [1,2]. Between February and May 2024, ECDC implemented an online survey among EU/EEA Member States to collect the most recent data from 2023. 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.

Status of implementation of combination prevention

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

- Twenty-seven countries of the EU/EEA reported having a national HIV prevention strategy to reduce the number of new HIV infections. Of those, 89% (24 countries) reported that their strategy specifically mentioned migrants as a key population to whom actions and services are targeted.
- Only seven countries reported medium-to-high coverage of condom and lubricant provision programmes targeting migrants.
- Pre-exposure prophylaxis (PrEP) availability in the EU/EEA has improved significantly since 2016. While data on the number of migrants accessing PrEP was generally limited, other findings suggest that PrEP may be inaccessible to many migrants: 13 countries reported difficulties in reaching both documented and undocumented migrants with PrEP, and three more countries reported difficulties in reaching only undocumented migrants. Seven countries reported that PrEP was not accessible for undocumented migrants, and in at least five more countries, it was accessible only at cost or through private providers.
- The vast majority of countries reported no restrictions on access to testing for undocumented migrants. They also reported the availability of different testing interventions which might facilitate access to testing for undocumented migrants. However, no data to support this assumption were available. It should also be noted that self-testing and community-based testing were not universally provided across EU/EEA countries and these need to be scaled up to reach key migrant populations.

Progress in reaching the continuum of HIV care targets

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. Only five out of 30 countries provided full data to monitor all stages of the continuum of care for migrants. Key findings include:

- There is progress for migrants along the continuum of HIV care across the EU/EEA, but limited available data suggest that only some countries were meeting one or more of the Joint United Nations Programme on HIV/AIDS (UNAIDS) 95-95-95 targets to be achieved by 2025:
  - Approximately 93% of migrants living with HIV in the EU/EEA knew their HIV status (based on reporting from six countries).
  - Of migrants diagnosed with HIV, 84% had initiated antiretroviral treatment (ART), (based on reporting from nine countries).
  - Of the migrants on treatment, 95% were virally suppressed (based on reporting from nine countries).
- As of 2023, only Luxembourg was meeting the 2025 substantive target of 86% viral suppression among all migrants estimated to be living with HIV, followed by Belgium, which was within 5% of the target.

Conclusions and recommendations

Progress has been made in the implementation of combination prevention and in reaching the continuum of HIV care targets for migrant populations in the EU/EEA. Recommendations include implementing migrant-tailored, non-stigmatising, linguistically and culturally appropriate HIV prevention programmes for all migrant populations, scaling up testing services, in particular community-based efforts including self- and home testing, and strengthening links between HIV support services and other services such as social services to meet patient needs.

Only five countries within the EU/EEA reported data for all stages of the continuum of care. Countries should continue to improve monitoring and surveillance data for HIV in migrant populations, to inform decision-making on the provision and targeting of prevention, testing and care services.

1. Introduction

Migrants are a key population affected by HIV across the EU/EEA, accounting for 48% of those diagnosed both in 2022 and 2023 [3,4]. Migration can place people in situations of increased vulnerability to HIV, influenced by social, economic and healthcare factors in both the country of origin and host countries. 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 [5]. Access to health services for undocumented migrants is not universally guaranteed in the EU/EEA [6], which hinders HIV prevention, testing and treatment services for this group and could contribute to HIV transmission in these communities, including post-migration acquirement of HIV. While these prejudices and challenges may not be consistent across the EU/EEA, they set the context for decisions about the availability of and access to HIV treatment and prevention services for migrants.

This report aims to assess the situation for migrants at risk of or living with HIV, and to identify the efforts being made across the region regarding HIV prevention among this group. This report provides a snapshot of the situation regarding care for migrants living with HIV in the EU/EEA and offers an overview of the accessibility of HIV combination prevention for migrant populations.

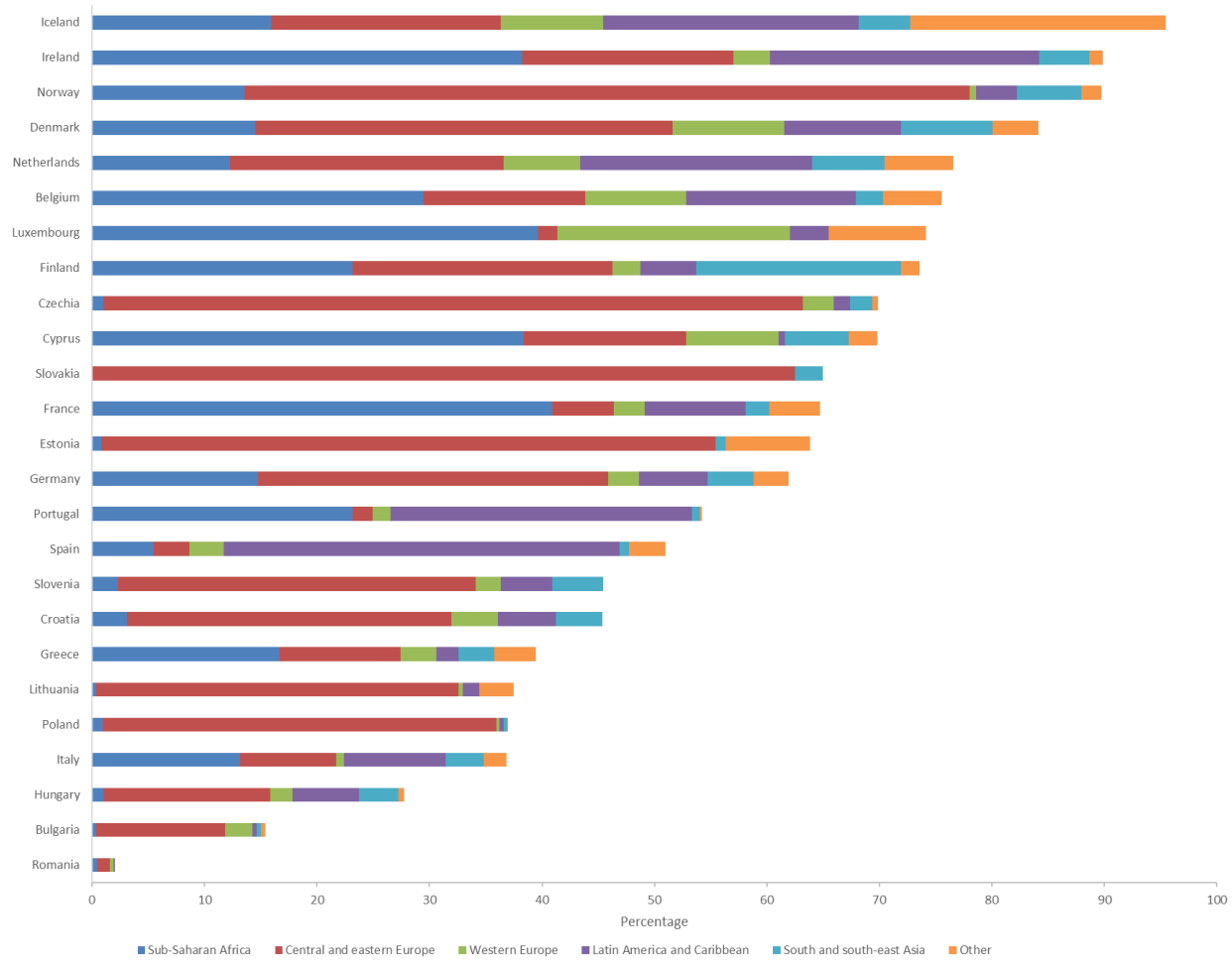
Epidemiological context

HIV diagnoses among migrants in the EU/EEA

In 2023, a total of 24 731 HIV diagnoses were reported across 30 EU/EEA countries, resulting in a rate of 5.3 per 100 000 population. Since 2014, this rate has decreased by 15.9%, down from 6.3 per 100 000. Twenty-eight EU/EEA countries provided data to the European Surveillance System (TESSy) on the country of birth, nationality, or region of origin for 21 230, which was 85.8% of all HIV diagnoses notified in 2023 [4]. Among these, 11 837 cases (47.9% of total HIV diagnoses and 55.8% of those with known origin information) were reported among migrants (Figure 1). Of these, 3 770 (31.8%) were from sub-Saharan Africa, 3 548 (30.0%) from Central and Eastern Europe, and 2 703 (22.8%) from Latin America and the Caribbean. In addition, 605 (5.1%) originated from another Western European country, 587 (5.0%) from South and South-East Asia, and 624 (5.3%) from other regions. The countries with more than half of their HIV diagnoses among people originating from outside of the reporting country were Austria, Belgium, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Ireland, Luxembourg, the Netherlands, Norway, Portugal, Slovakia, Spain and Sweden.

For HIV diagnoses reported among transgender people in 2023, 86.4% (178) originated from a country outside of the reporting country, 12.1% (25) were born in the reporting country, and in 1.5% (three) of cases, the region of origin was unknown. Among those with known regions of origin and born abroad, 74.7% (133) came from Latin America and the Caribbean, 11.8% (21) from sub-Saharan Africa, 7.9% (14) from Central and Eastern Europe, 2.8% (five) from South and South-East Asia, 1.7% (three) from other regions, and 1.1% (two) from other Western European countries [4].

Figure 1. Percentage of HIV diagnoses among migrants out of all reported cases with known information on the region of origin, by reporting country, EU/EEA, 2023 (n = 21 230)



Source: WHO Regional Office for Europe, European Centre for Disease Prevention and Control. HIV/AIDS surveillance in Europe 2024–2023 data.

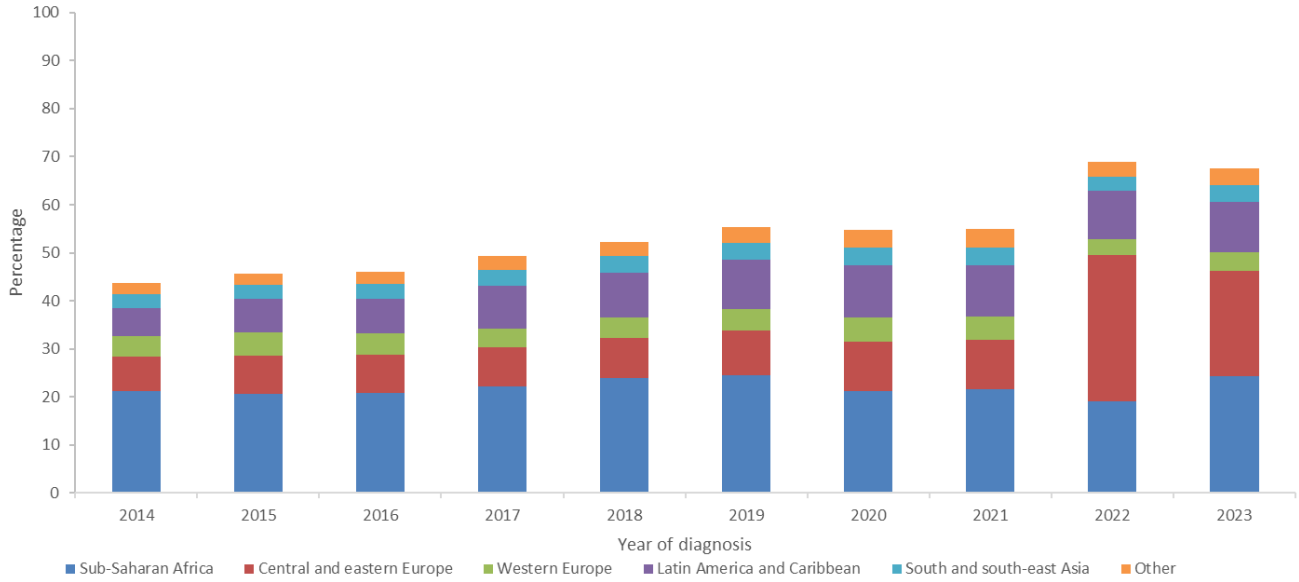
Note: Liechtenstein, which reported only one case for 2023, is excluded from the figure. Estonia, Latvia, and Poland were excluded from the figure as more than 50% of their reported cases did not include information on the mode of transmission. A total of 6 824 people with an unknown mode of transmission have been excluded from the proportions presented for the countries included in the figure. This figure is organised by the proportion of diagnoses resulting from sex between men in descending order.

In the trend analysis from 2014 to 2023, HIV diagnoses among individuals born outside the reporting country – excluding Finland, Latvia, Malta, and Slovakia (where over 50% of reported cases lack information on the region of origin) – accounted for 44.6% of all diagnoses in 2014. This proportion increased steadily to 50.1% in 2020, slightly declined to 46.3% in 2021, rose again to 53.6% in 2022, and then decreased to 47.9% in 2023.

When excluding cases with an unknown region of origin, the proportion of migrants among HIV diagnoses increased from 47.3% in 2014 to 55.8% in 2023, marking a 17.9% rise over the period.

In 2023, compared to 2022, there was a significant 20.4% increase in diagnoses among individuals from sub-Saharan Africa, rising from 2 566 reported cases in 2022 to 3 090 in 2023. Conversely, diagnoses among individuals from Central and Eastern Europe saw a 32.5% decrease, with cases dropping from 4 131 in 2022 to 2 789 in 2023. (Figure 2).

Figure 2. Percentage of diagnoses among people born outside of the reporting country by year of diagnosis and region of origin, EU/EEA, 2014–2023



Note: HIV reported diagnoses from Finland, Latvia, Malta, and Slovakia have been excluded from this figure as more than 50% of reported cases in these countries have an unknown region of origin. From 2014 to 2023, a total of 122 293 reported HIV diagnoses were excluded from the countries included in the figure due to an unknown region of origin. The proportions are calculated based on the total number of cases reported with a known region of origin for the entire period (n = 118 786).

When focusing on mode of transmission data from those countries[1] that have consistently reported over the past decade (2014–2023) and analysing data with known modes of transmission, the following trends become evident:

- The proportion of HIV diagnoses with a known mode of transmission attributed to sex between men decreased from 52.1% in 2014 to 46.9% in 2023. Among men who have sex with men who were migrants, there was a 37.7% increase in HIV diagnoses, rising from 2 659 in 2014 to 3 661 in 2023.
- The proportion of HIV diagnoses with a known mode of transmission attributed to heterosexual transmission in both women and men increased from 41.4% in 2014 to 46.2% in 2023. A smaller increase was also observed among heterosexual migrants, with diagnoses rising from 4 889 in 2014 to 4 990 in 2023, representing a 2.1% increase.

The proportion of HIV diagnoses reported to be due to mother-to-child transmission (MTCT) of HIV has increased from 0.8% to 1.1% between 2014 and 2023, although the number declined from 274 in 2022 to 196 in 2023. In 2023, 78.8% of HIV diagnoses where the mode of transmission was through MTCT were reported among migrants.

Hence, surveillance data suggests that migrant populations (including heterosexual individuals, men who have sex with men, and transgender individuals) should continue to be a focus in HIV prevention and control programmes across the EU/EEA, as they represent a major share of new HIV diagnoses in recent years.

Probable country of infection

To ensure effective targeting of public health interventions, it is important to know whether the migrant population within any country generally acquired HIV before migration or post-arrival. A recent meta-analysis based on 15 eligible publications (primarily on the EU/EEA, but also including Switzerland and the United Kingdom) reported a pooled average proportion of post-migration HIV acquisition in Europe of 30%, varying from 21% in Sweden to 54% in the Netherlands [7]. The findings also varied significantly depending on the host country, region of origin, sex, sexuality, and methods of classifying post-migration HIV acquisition.

[1] Estonia, Latvia, and Poland were excluded from the figure as more than 50% of their reported cases did not include information on the mode of transmission.

2. Methods

Between February and April 2024, ECDC conducted an online survey [2] among EU/EEA Member States to collect the most recent data as of 2023 to monitor the implementation of the 2004 Dublin Declaration. The survey was followed by data validation from May to August 2024, during which each country performed a validation exercise and made corrections where necessary.

The survey contained specific questions related to the HIV epidemic among migrants, in addition to questions about current national prevention interventions, policies, and barriers to the public health response. This report presents the current situation among migrants, a key population affected by HIV in the EU/EEA, based on the most recent data reported by each country (between 2019–2023). Data for this report have also been supplemented with information from TESSy for the World Health Organization (WHO) European Region, and Eurostat.

The concept of 'Combination HIV prevention'

HIV combination prevention brings together single prevention initiatives into a comprehensive prevention programme addressing both individual, community and national levels [8]. Importantly, the specific elements take effect across the life course of HIV infection and encompass primary, secondary, and tertiary prevention interventions.

Box 1. Provision of HIV combination prevention for migrant populations

Definition: Combination HIV prevention is defined by UNAIDS as "rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural, and structural interventions, prioritized to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections" [9].

Primary prevention focuses on preventing the initial occurrence of HIV infection through strategies such as education, condom distribution, and pre-exposure prophylaxis (PrEP).

Secondary prevention aims to reduce the impact of HIV once it has occurred, which includes early detection, prompt treatment, and measures to prevent the spread of the virus to others [10].

Tertiary prevention aims to improve the health-related quality of life for those living with HIV and includes STI testing and treatment, needle and syringe exchange programs and opioid substitution therapy.

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 of attending healthcare facilities on a person's immigration status have been removed. In this report, we focus on the following aspects of combination prevention that are relevant to migrants: condom provision and use, safe sex counselling, PrEP, HIV testing and treatment, and access to sexually transmitted infection testing and treatment.

The framework of '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. 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 these populations that are hidden at the aggregate level can be revealed.

Box 2. 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 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 estimated number of people living with HIV in the country, ever having been diagnosed who are currently on ART
The number should include all people currently on ART, regardless of treatment regimen or treatment interruptions/discontinuation.

Stage 4: Number/percentage of estimated number of people living with HIV in the country, ever having been diagnosed or having initiated antiretroviral treatment who had a viral load (VL) of ≤200 copies/ml at last visit (i.e. virally suppressed)
The number should include all those who have ever initiated ART, regardless of regimen or treatment interruptions/discontinuation.

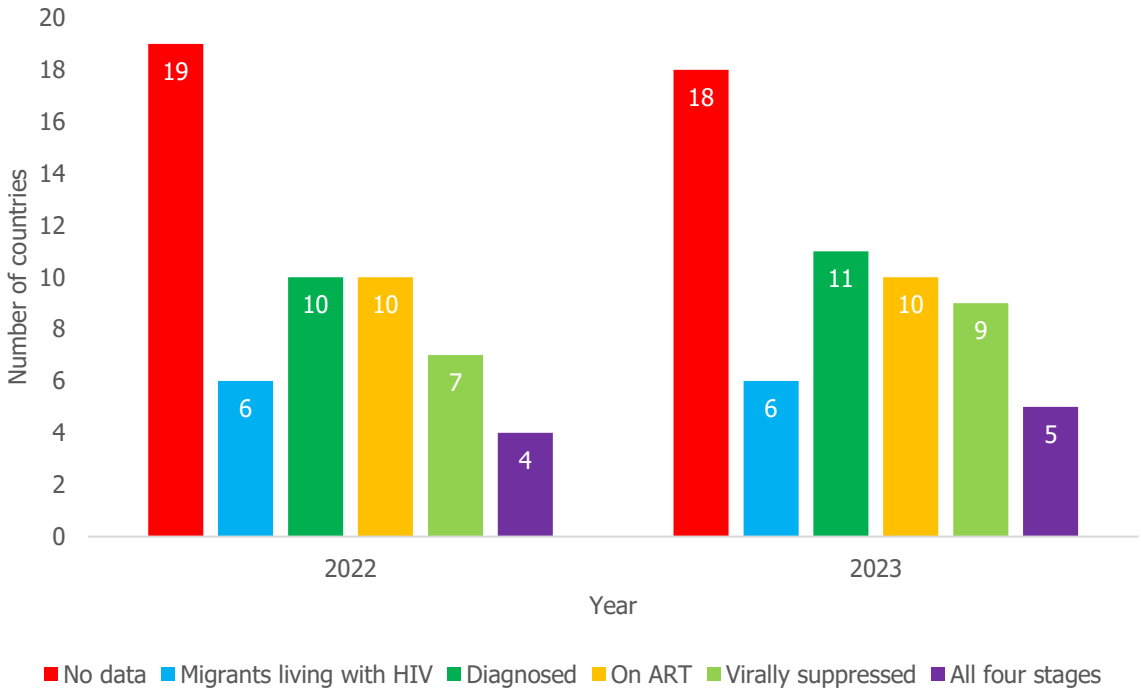
Data availability

The monitoring questionnaire gathered data on combination prevention from both policy and coverage dimensions. While policy data was mostly complete, with response rates ranging from 87% to 97% (26 to 29 EU/EEA countries out of 30) per question, data availability on coverage of combination prevention services was much lower. Seventeen countries[1] (57%) reported data on condom provision coverage, three countries[2] (10%) reported data on condom use by migrants, four countries[3] (13%) reported data on the number of migrants accessing PrEP, and 15 countries[4] (50%) provided data on migrants' access to STI testing.

By 2023, all four stages of the continuum of HIV care for migrants living with HIV were reported by five[5] out of 30 EU/EEA Member States (17%), as shown in Figure 3. At least two stages were reported by 10[6] out of 30 countries (33%). There have been only minor improvements in reporting on the continuum of HIV care for migrants compared with the 2022 Dublin Declaration HIV Monitoring cycle.

[1] Austria, Belgium, Bulgaria, Czechia, Estonia, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Malta, Netherlands, Norway, Slovakia, and Sweden.
[2] Cyprus, Greece, and Portugal.
[3] Cyprus, Czechia, Malta, and Portugal.
[4] Belgium, Bulgaria, Czechia, Finland, France, Germany, Greece, Ireland, Italy, Malta, Netherlands, Norway, Luxembourg, Slovakia, and Sweden.
[5] Austria, Belgium, Czechia, Greece, and Luxembourg.
[6] Austria, Belgium, Czechia, Greece, Iceland, Luxembourg, Netherlands, Portugal, Romania, and Sweden.

Figure 3. Number of countries reporting data for different stages of the continuum of HIV care for migrants, EU/EEA, 2024 (n=12[1])



ART: antiretroviral therapy.

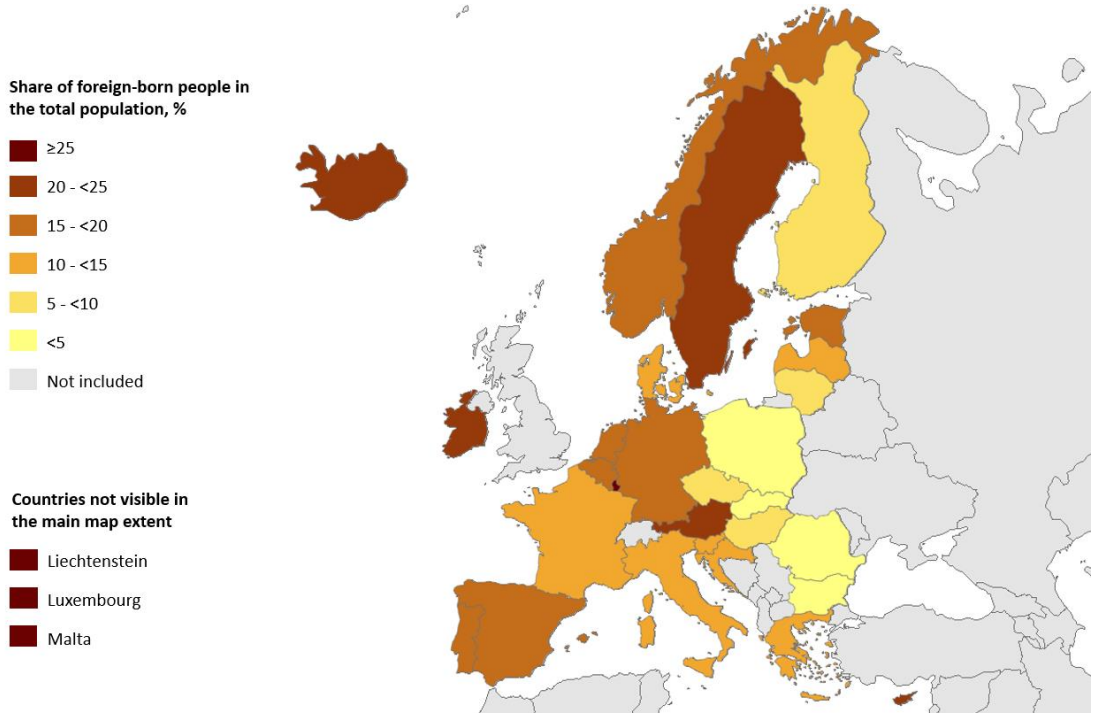
[1] Austria, Belgium, Czechia, Greece, Iceland, Luxembourg, Netherlands, Portugal, Romania, and Sweden, Germany and Malta.

3. Population size

A starting point in designing and targeting HIV prevention interventions is to estimate key population size. In order to indicate the sizes of the two migrant populations which vary across EU/EEA countries, we retrieved the most recent data reported by countries to Eurostat on the share of foreign-born people in the total population as well as the share of third-country nationals in the total population for each EU/EEA country [11,12].. Foreign-born are all people not born in the reporting country while third-country nationals are migrants in the reporting country who are not citizens of the European Union and who do not enjoy the right to free movement [13]

Overall, as of 1 January 2023, more than 61 million people in the EU/EEA resided outside their country of birth (either within the EU/EEA or from outside), constituting 13% of the EU/EEA population. This percentage ranged from as low as under 3% for Bulgaria, Poland, and Romania, to as high as 28% for Malta, 50% for Luxembourg, and 69% for Liechtenstein (Annex 1, Figure 4). The numbers include a broad range of migrants, from those who arrived recently to those who have been in their current country of residence for many years.

Figure 4. Share of foreign-born people in the total population of EU/EEA countries, data as of 1 January 2023

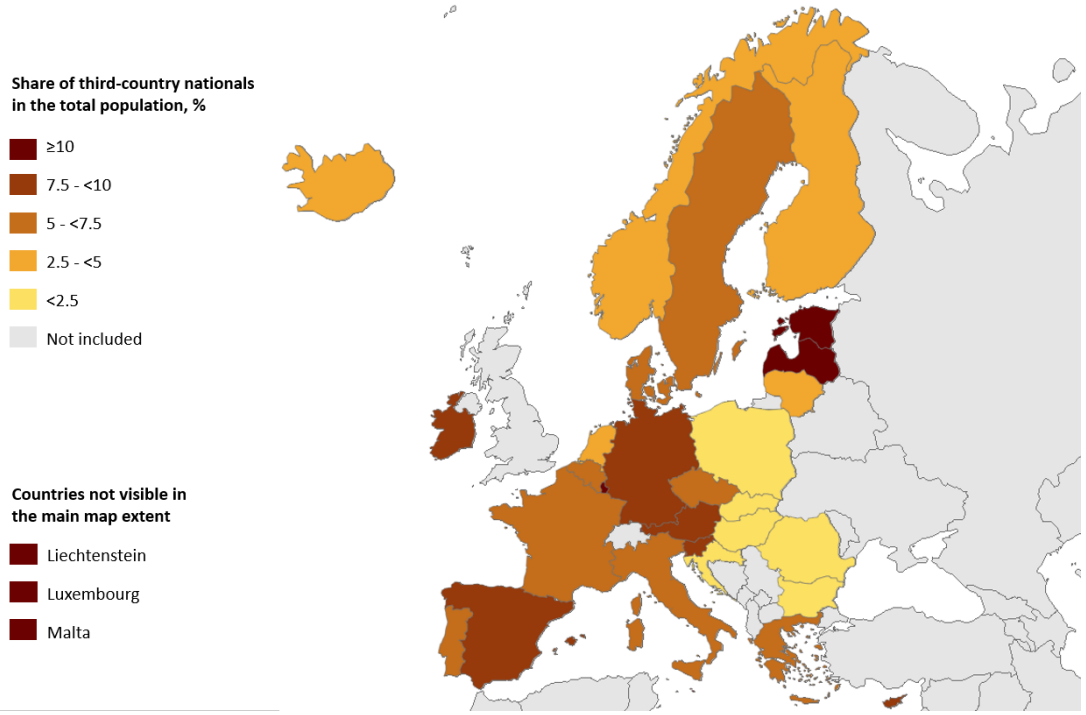


Source: Eurostat 2024

As HIV surveillance data suggest that a large proportion of newly-diagnosed migrants living with HIV in 2023 came from regions outside of the EU/EEA, it is also worth noting that as of 1 January 2023, EU/EEA countries also had almost 28 million nationals of third countries, constituting 6% of the overall EU/EEA population (Annex 1, Figure 5). The share ranged from less than 2% of the population for Bulgaria, Croatia, Hungary, Poland, Romania, and Slovakia to over 15% for Estonia, Liechtenstein, and Luxembourg.

While both numbers must be considered for planning HIV interventions for migrants, neither constitutes a proxy for migrant populations at high risk of HIV transmission. Data on the prevalence of HIV among migrant populations were only provided by three countries during the 2024 Dublin Declaration monitoring data collection round (see Box 2).

Figure 5. Share of third-country nationals in the total population of EU/EEA countries, data as of 1 January 2023



Source: Eurostat 2024

Box 3. Available data on HIV prevalence among migrants: Cyprus, Lithuania, and Portugal

Cyprus
According to data collected at community voluntary counselling and testing centres in Cyprus between 1 January 2023 and 31 December 2023, 2% of migrants tested (305 people) received an HIV-positive test result.

Lithuania
Data from a State Border Guard Service at the Ministry of the Interior of the Republic of Lithuania collected between 1 January 2019 and 31 December 2019 indicated an HIV prevalence of 0.4% among 239 people tested.

Portugal
Based on data from a Portuguese Community Screening Network and Lisbon Cohort of men who have sex with men collected in Portugal between 1 January 2023 and 31 December 2023, 5.2% of migrants tested (7 473 people) had positive HIV test results.

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

Adopted by United Nations Member States in 2021, the 95-95-95 targets envision 95% of all people living with HIV should be diagnosed (HIV testing), 95% of PLWH should be on treatment (treatment), and 95% of people on treatment should be virally suppressed (viral suppression). Combining these, consequently, 86% of all people living with HIV should be virally suppressed (overall viral suppression). In six EU/EEA countries reporting data for the numerator and the denominator of the first global 95 target, an estimated 93% (19 122, range: 78%–100%) of the 20 668 migrants living with HIV have been diagnosed with HIV. Two countries (Belgium and Luxembourg) met the 95% target, two countries (Austria and Portugal) were within 5% of achieving the target, and an additional two countries (Czechia and Greece) were more than 5% off the target (Figure 6).

In nine EU/EEA countries reporting data for the second global 95 target, an estimated 88% (31 552, range: 46%–99%) of the 35 668 migrants diagnosed with HIV were on ART. Four countries (Iceland, Luxembourg, Romania, and Sweden) were meeting the 95% target, four countries (Austria, Belgium, Czechia, and the Netherlands) were within 5% of achieving the target, and only Greece was more than 5% off the target.

In nine EU/EEA countries reporting data for the third global 95 target, an estimated 95% (29 983, range: 65%–98%) of the 31 552 migrants on ART were virally suppressed. Five countries (Belgium, Czechia, Iceland, the Netherlands, and Sweden) were meeting the 95% target, two countries (Greece and Luxembourg) were within 5% of achieving the target, and two other countries (Austria and Romania) were more than 5% off the target.

Finally, in five EU/EEA countries reporting data for all stages of the continuum of care for migrants living with HIV, 73% (15 116, range: 37%–91%) of 20 668 migrants living with HIV were virally suppressed. One country (Luxembourg) was meeting the global substantive 86% target, one country (Belgium) was within 5% of meeting the target, and three countries (Austria, Czechia, and Greece) were more than 5% away from the target. In comparison, an overall 78% of the total population of all people living with HIV in the same five countries had achieved viral suppression.

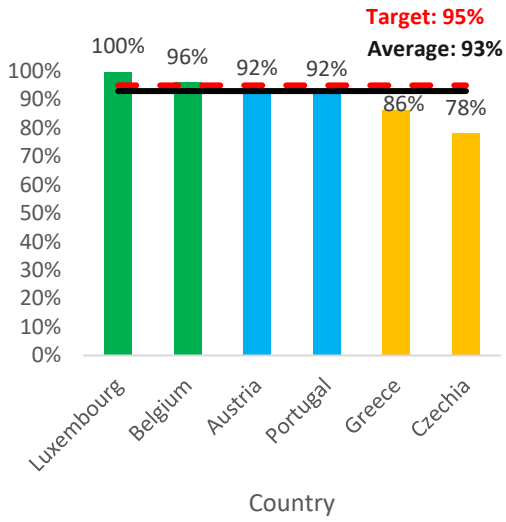
A summary of the continuum of HIV care for countries reporting migrant data is provided in Annex 2.

It is important to note that the countries able to monitor the continuum of HIV care in key populations (including migrants) were also likely to report better HIV outcomes overall [14]. There were 18 countries[1] 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.

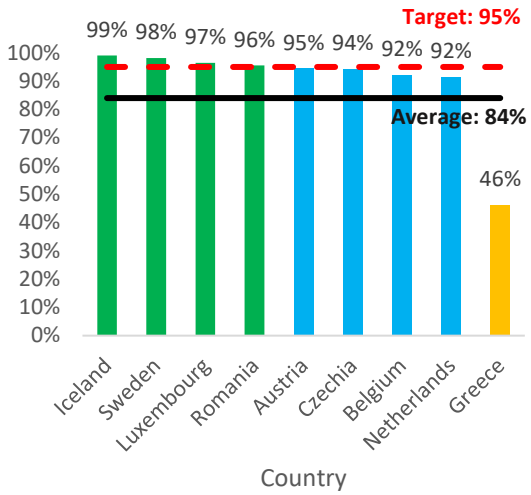
[1] Bulgaria, Croatia, Cyprus, Denmark, Estonia, Finland, France, Hungary, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Norway, Poland, Slovakia, Slovenia and Spain.

Figure 6. Progress towards the global 95-95-95 targets and the 86% substantive target for viral suppression among migrants living with HIV in EU/EEA, end of 2023*

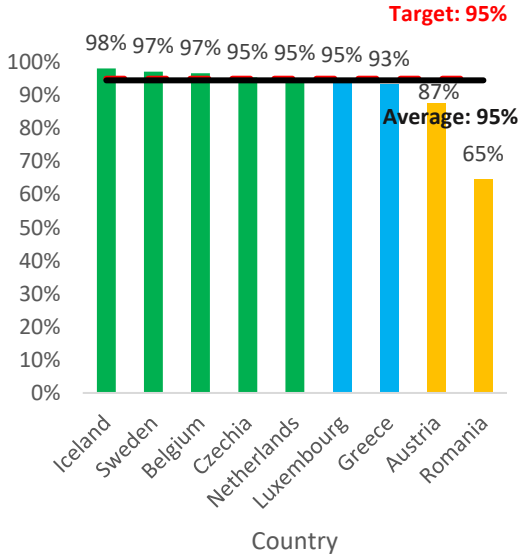
a) Migrants living with HIV diagnosed (n=6)



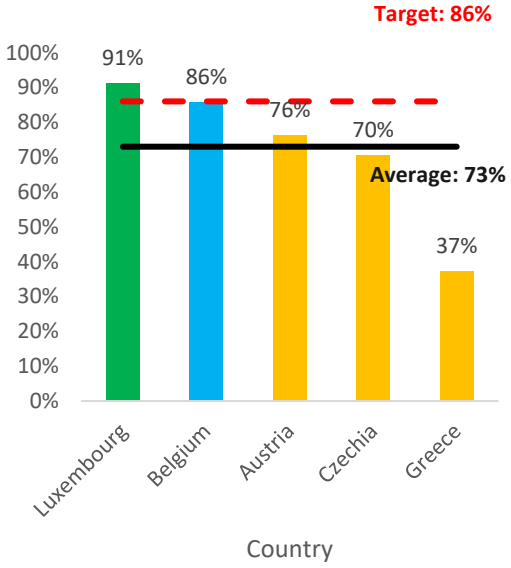
b) Migrants living with HIV diagnosed on treatment (n=9)

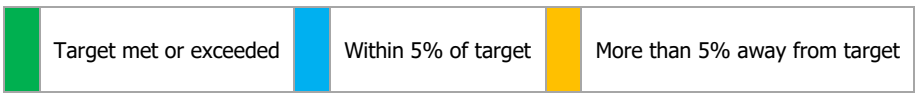


c) Migrants living with HIV on treatment who were virally suppressed (n=9)



d) Proportion of all people living with HIV who were virally suppressed (n=5)



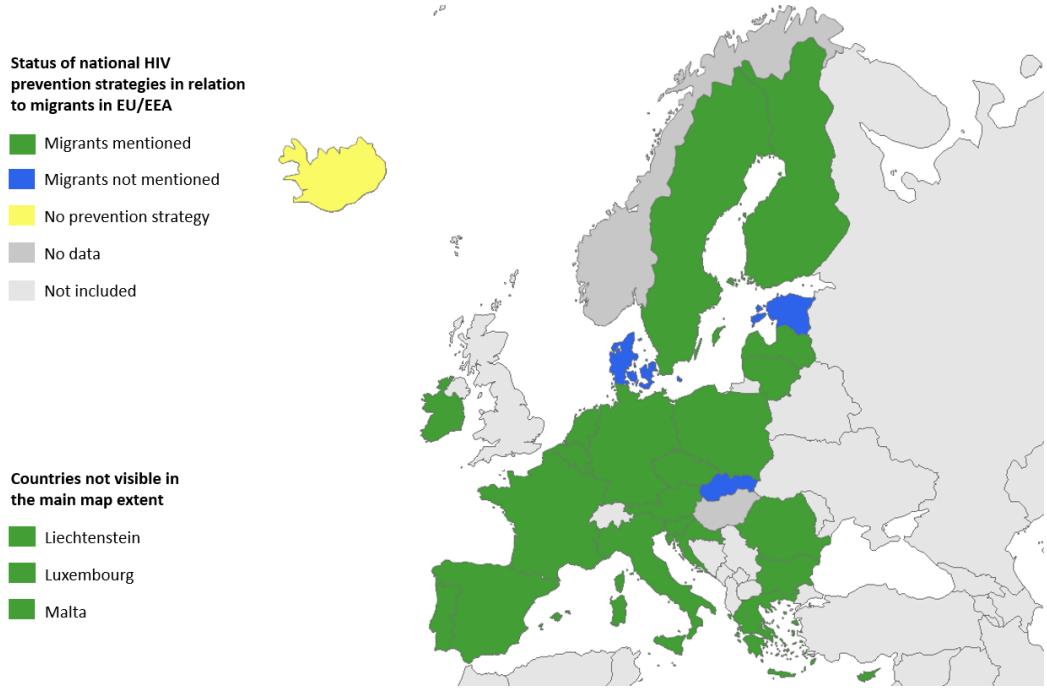


** Data as of 2023 or most recent year with available data (2019 or later). For Luxembourg this is for the end of 2021; for Austria, Belgium, the Netherlands, Portugal and Romania it is for the end of 2022 .*

5. Prevention policies and migrants

Twenty-seven EU/EEA countries (out of 28 that responded to the question) reported having a national HIV prevention strategy for reducing the number of new HIV infections. Of those, 89% (24 countries) reported that their strategy specifically mention migrants as a key population to whom actions and services are targeted (Figure 7). Only 14 countries (58% of those mentioning migrants) reported that condoms and lubricants were available free of charge for migrants. Eleven countries[1], or 41% of those with a national HIV prevention strategy, reported that migrants participate in developing national policies, guidelines, and strategies relating to their health.

Figure 7. Status of national HIV prevention strategies which include migrants in the EU/EEA, 2024* (n=28)



** 2024 or most recent year with available data (2019 or later).*

[1] Belgium, Bulgaria, Finland, France, Germany, Greece, Ireland, Italy, Portugal, Spain, and Sweden.

6. Combination prevention

Primary prevention

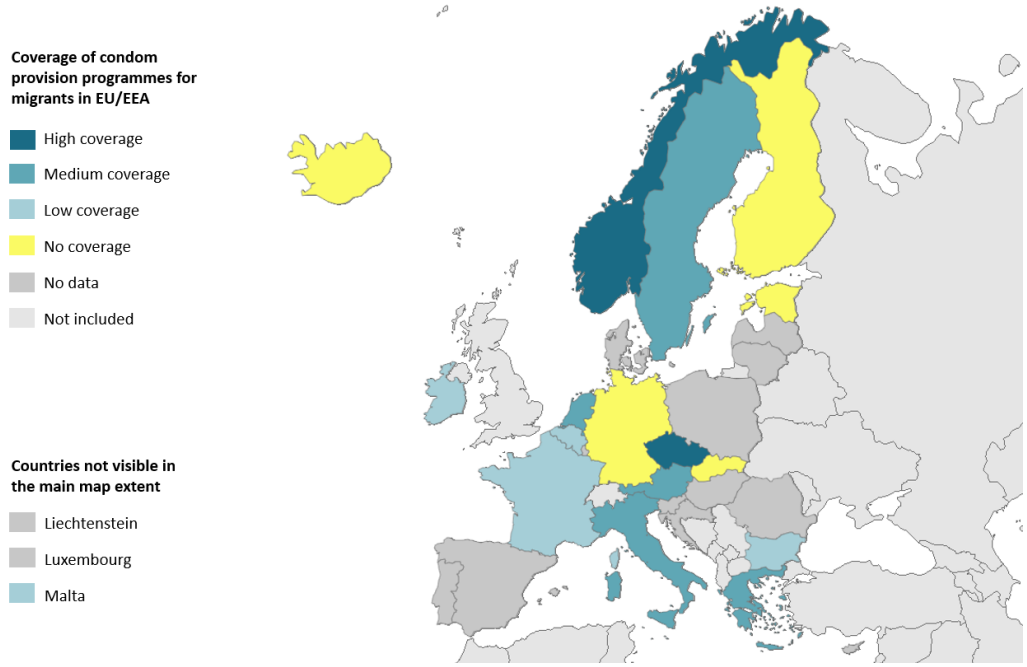
Condom provision, condom use and safe sex counselling

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.

Seventeen countries reported on the coverage[1] of condom and lubricant provision programmes (Figure 8). Of the 17, two reported high coverage (61–95%), five reported medium coverage (30–60%), five reported low coverage (below 30%), and another five countries reported no coverage. Compared to other key populations, the coverage of reported condom and lubrication provision to migrants is poor. Among reporting countries, a high level of condom and lubrication provision coverage was more frequently reported for men who have sex with men (four of 12 countries), sex workers (six of 17 countries) and people who inject drugs (four of 13 countries). Moreover, fewer reporting countries noted no coverage of condom and lubrication provision to men who have sex with men (one of 12 countries), sex workers (one of 17 countries) and people who inject drugs (one of 13 countries).

Fourteen countries[2] in the EU/EEA reported that they have a policy of providing condoms and lubricants for free to migrants. Among these, seven countries (Croatia, Cyprus, Latvia, Lithuania, Luxembourg, Portugal, and Spain) did not report any condom provision coverage data. Additionally, four countries (Sweden, Norway, Greece, and the Netherlands) did not report the availability of a policy for the provision of condoms and lubricants for free for migrants, but reported coverage data. This indicates that condoms are still provided, despite the absence of a national policy.

Figure 8. Coverage of condom provision programmes for migrants in EU/EEA, end of 2023* (n=17)



** Data as of 2023 or most recent year with available data (2019 or later).*

Effective counselling on condom use and safe sex provides individuals with accurate information on HIV transmission, encourages safer sexual practices, develops skills in using prevention effectively, reduces stigma and provides emotional support and connection of individuals to additional resources, such as testing services.

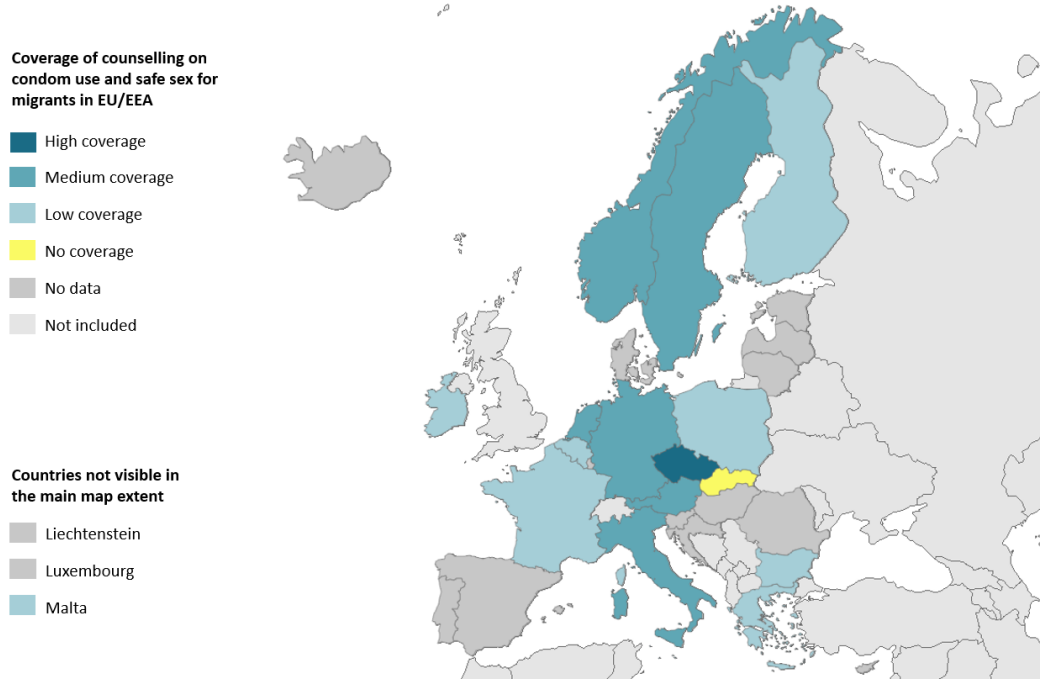
[1] Expert opinion. Based on the WHO definition of universal health coverage, full coverage was defined as 'all who need the service can use it, that the service is of sufficient quality to be effective, and that use of the service will not expose the user to financial hardship'. Countries were able to choose from a scale, based on the percentage of the population that can use the effective, affordable service, as follows: No coverage: service is not provided; Low coverage: <30% of the population can use the effective affordable service; Medium coverage: 30–60%; High coverage: 61–94%; Full coverage: 95–100%.

[2] Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, France, Ireland, Italy, Latvia, Lithuania, Luxembourg, Portugal, and Spain.

Consequently, condom provision programmes for migrants should also ensure provision of counselling of condom use and safe sex.

Sixteen EU/EEA countries reported coverage data of counselling on condom use and safe sex for migrants (Figure 9). Of them, one country reported high coverage (61–95%), six reported medium coverage (30–60%), and eight reported low coverage (below 30%) and another one reported no coverage.

Figure 9. Coverage of counselling on condom use and safe sex for migrants in EU/EEA, end of 2023* (n=16)



** Data as of 2023 or most recent year with available data (2019 or later).*

Data on the use of condoms among migrants are extremely limited. In 2023, only three countries (Cyprus, Greece, and Portugal) reported data (Box 3). Of these, two countries (Cyprus and Portugal) had also reported these data in previous years.

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

Cyprus

According to data collected at community voluntary counselling and testing centres in Cyprus between 1 January and 31 December 2023, 53% of migrants (among 305 respondents) reported using a condom when they last had sex, which is lower than in 2022 (65%).

Greece

Dara from Greece collected between 1 January and 31 December 2023 by non-governmental organisations suggests that in Greece, 38% of migrants (among 1 985 respondents) reported using a condom when they last had sex. This constitutes 58% of those migrants that reported having sex in the past six months.

Portugal

Based on data from the Portuguese Community Screening Network and the Lisbon Cohort of men who have sex with men collected in Portugal between 1 January 2023 and 31 December 2023, 11% of migrants (among 29 365 respondents) reported using a condom the last time they had sex. This constitutes 14% of those migrants who reported having sex in the past 12 months (23 551). Among people who reported having sex in the past 12 months, condom use during the last time of having sex was higher among male migrants compared to female migrants (17% versus 11%). The proportion was even higher for transgender migrants who reported having sex in the past 12 months: 30% reported using a condom during the last time they had sex. Finally, 28% of undocumented migrants who reported having sex in the past 12 months also reported using a condom the last time they had sex.

Pre-exposure prophylaxis

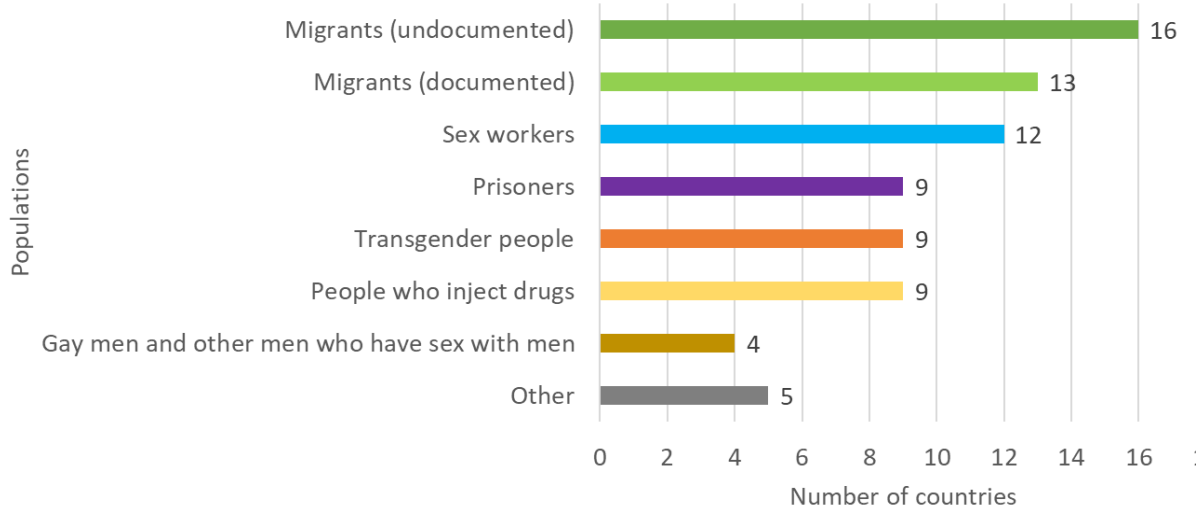
An additional important component of primary prevention is PrEP. WHO recommends the use of PrEP for populations at substantial risk of HIV acquisition, defined as an HIV incidence greater than three per 100 person-years. This primarily includes men who have sex with men, transgender women, and heterosexual men and women who have sexual partners with undiagnosed or untreated HIV infection [15]. Such a level of HIV incidence is considered cost-effective or cost-saving for using PrEP, although PrEP may still be cost-effective at lower HIV incidence levels. Individual risk varies considerably within populations depending on individual behaviour and the behaviour of sexual partners. Hence, the WHO notes that in settings with a low overall incidence of HIV infection, there might be other individuals at substantial risk who should be offered PrEP services [15].

In the EU/EEA context, where migrants account for almost half of new HIV diagnoses, prioritising PrEP uptake for migrant populations at a high risk of HIV transmission high-risk should be considered. This is also supported by the WHO's global action plan on promoting the health of refugees and migrants, which highlights the need for comprehensive sexual and reproductive health services. Ensuring access to these services helps mitigate the risk of HIV transmission and supports the overall wellbeing of migrant communities [16].

The uptake of PrEP in the EU/EEA progressed in 2023, with 23 out of 30 EU/EEA countries[1] reporting the availability and implementation of PrEP guidelines, which is two more compared to data reported from 2022. However, four out of these 23 countries[2] noted that no national government funding was available for the programme's implementation, while for the rest, the cost of PrEP for end users was either fully or partially reimbursed for all high-risk individuals.

Data on migrants' access to PrEP is limited, and the eligibility of migrants for PrEP was not monitored during this data collection round. This question will be included in the next iterations of the questionnaire. However, in 2024, 13 countries reported difficulties in reaching both documented and undocumented migrants with PrEP, and three more countries[3] reported difficulties in reaching only undocumented migrants (Figure 10).

Figure 10. Number of countries experiencing difficulties in reaching certain key population groups with pre-exposure prophylaxis for HIV, 2024* (n=30)



** 2024 or most recent year with available data (2019 or later).*

Only four countries were able to report data on the number of migrants accessing PrEP in 2023. The highest number (984 people) was reported by Portugal, which constitutes 22% of all 4 499 people receiving PrEP in Portugal. In other countries, the proportion of migrants receiving PrEP among all recipients was: 24% for Cyprus (four out of a total of 17 people), 13% for Czechia (166 out of 1 317), and less than 1% for Malta (one out of 267).

Observed tendencies indicate that PrEP may be inaccessible to many migrants in the EU/EEA.

[1] Austria, Belgium, Croatia, Czechia, Denmark, Estonia, Finland, France, Germany, Iceland, Ireland, Liechtenstein, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, and Sweden
[2] Czechia, Malta, Poland, and Sweden
[3] Cyprus, Estonia, and Slovenia.

Secondary prevention

Testing

Elaborate scaled-up 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. 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 [17-19].

Data availability on the number of migrants who have been tested for HIV and the proportion of HIV infected who know their HIV status is limited, with only six[1] and three countries[2] able to report data, respectively. The number of migrants tested ranged from 305 (Cyprus) to 7 471 (Portugal). In the three countries able to report data on migrants who know their HIV status, the proportions were: 16% in Poland, 56% in Portugal, and 100% in Cyprus.

Implementation of different testing services

In July 2024, WHO released consolidated guidelines on differentiated HIV testing services, advising countries to offer a range of testing approaches to reach as many people with HIV who do not know their status as possible. Facility-based testing, community-based testing, network-based testing, and self-testing services are all recommended and should be prioritised and adapted for implementation according to the local context [20].

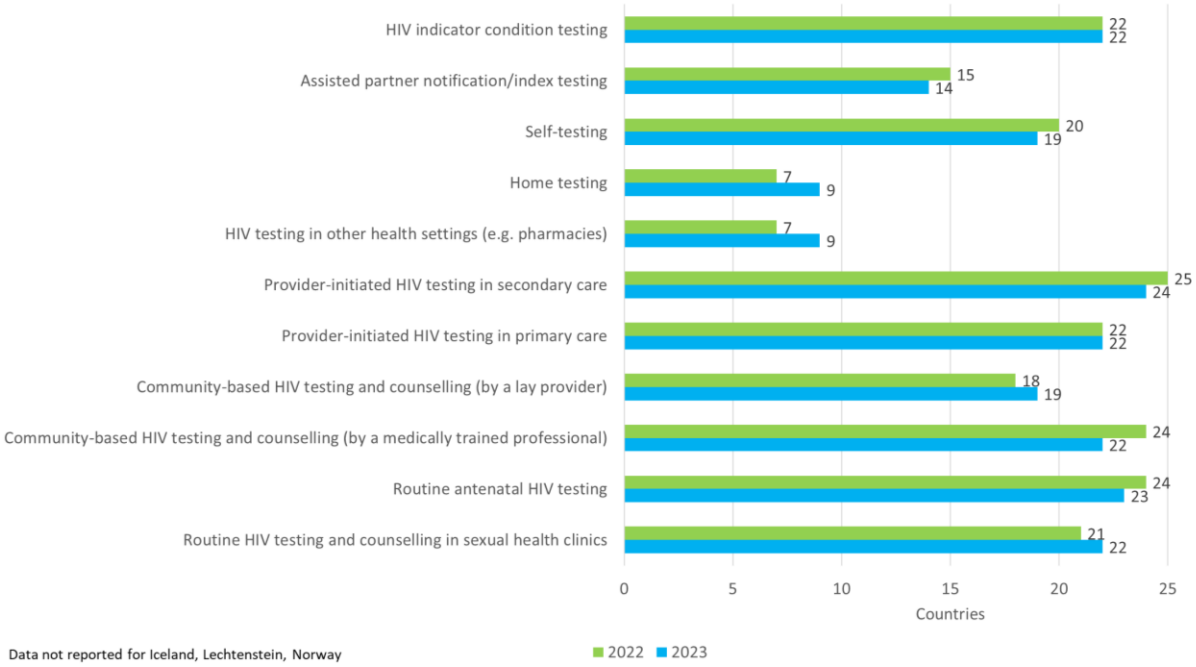
Among EU/EEA countries in 2024, provider-initiated testing in secondary care was the most implemented testing intervention, followed by routine antenatal HIV testing and thirdly community-based HIV testing, routine HIV testing and counselling at sexual health clinics and HIV indicator testing (Figure 11).

The new WHO guidelines also highlight the expanding role of self-testing, which can now also be used for initiating PrEP [20]. In 2024, 19 EU/EEA countries reported the availability of self-testing. The availability of community-based testing by lay providers was the same as self-testing. Other non-traditional testing interventions, such as home testing and HIV testing in other health settings, were the least implemented of all the testing interventions.

Migrants, especially undocumented migrants, tend to avoid formal health services for fear of discrimination and disclosure of their migration status.[21] It is therefore reasonable to assume that the availability of a range of testing interventions outside of traditional healthcare facilities can address 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 non-traditional testing interventions has increased, there are still opportunities to widen the variety of testing choices.

[1] Cyprus, Greece, Ireland, Lithuania, Poland, Portugal.
[2] Cyprus, Poland and Portugal.

Figure 11. Implementation of different HIV testing interventions in EU/EEA, 2024* (n=27)



** 2024 or most recent year with available data (2019 or later).*

Treatment as prevention

Ensuring prompt access to HIV treatment usually enables a normal lifespan, improves health outcomes for people living with HIV, and reduces the risk of further HIV transmission. Data on access to treatment was not collected in the current monitoring round.

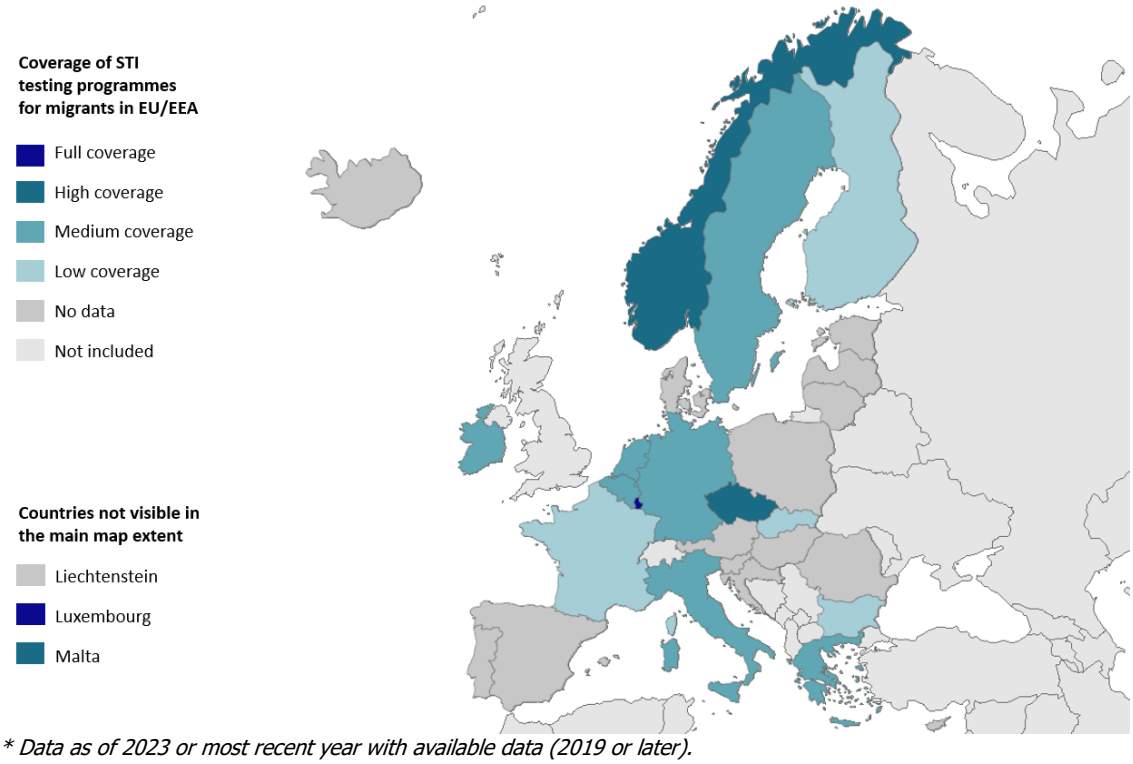
As Figure 6 in the continuum of HIV care section of this report shows, data on treatment coverage among migrants remain limited. Where data have been provided, there is a variation in coverage, and only four countries (Iceland, Luxembourg, Romania, Sweden) out of the nine that provided relevant data are currently meeting the 2025 target of 95% of diagnosed migrants living with HIV receiving treatment.

Tertiary prevention

STI testing and treatment services

HIV and STI co-infection is common. Access to STI testing and treatment is important because it not only comprises an element of comprehensive healthcare for people living with HIV, but also because STIs increase the risk of HIV acquisition. Based on reported expert opinion, only one country (Luxembourg) reported full coverage of STI testing programmes for migrants (Figure 12). Three countries (Czechia, Malta, and Norway) reported high coverage, seven countries (Belgium, Germany, Greece, Ireland, Italy, the Netherlands, and Sweden) reported medium coverage, and four countries (Bulgaria, Finland, France, and Slovakia) reported low coverage. Fifteen other EU/EEA countries did not report data. These data show gaps in access to STI testing for migrants.

Figure 12. Coverage[1] of STI testing programmes for migrants in EU/EEA, end of 2023* (n=15)



** Data as of 2023 or most recent year with available data (2019 or later).*

1 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 were able to choose from a scale, based on the percentage of the population that can use the effective, affordable service, as follows: No coverage: service is not provided; Low coverage: <30% of the population can use the effective affordable service; Medium coverage: 30–60%; High coverage: 61–94%; Full coverage: 95–100%.

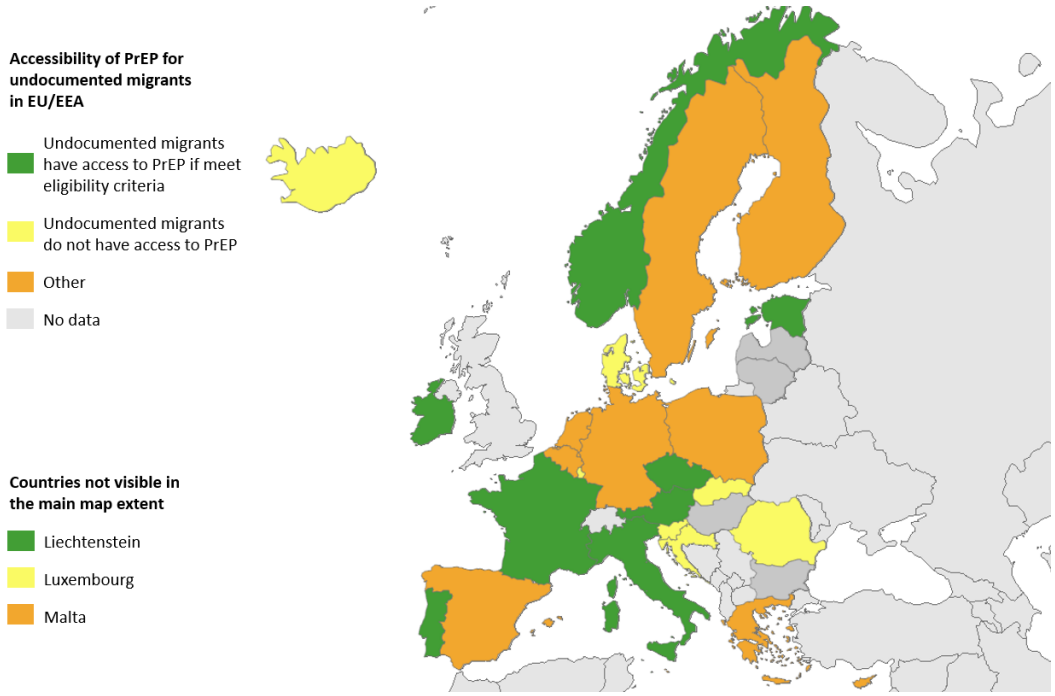
7. Undocumented migrants and HIV care

Undocumented migrants can face barriers when attempting to access healthcare services, including HIV care. Undocumented migrants do not have the same entitlements to health insurance schemes that make healthcare affordable as citizens [22]. Many services may be unavailable to undocumented migrants, such as PrEP and HIV testing. Hence, specific attention is given in this report to monitor the availability of HIV services for undocumented migrants.

Access to PrEP for undocumented migrants

In nine EU/EEA countries (Austria, Czechia, Estonia, France, Ireland, Italy, Liechtenstein, Norway, and Portugal), undocumented migrants could access PrEP if they met eligibility criteria. However, seven countries (Croatia, Denmark, Iceland, Luxembourg, Romania, Slovakia, and Slovenia) reported that PrEP was unavailable for undocumented migrants (Figure 13). Among the ten countries[1] that answered Other," five (Finland, Germany, Malta, the Netherlands, and Sweden) specified that PrEP is available for undocumented migrants at a cost or through private providers.

Figure 13. Accessibility of PrEP for undocumented migrants in EU/EEA, 2024* (n=26)



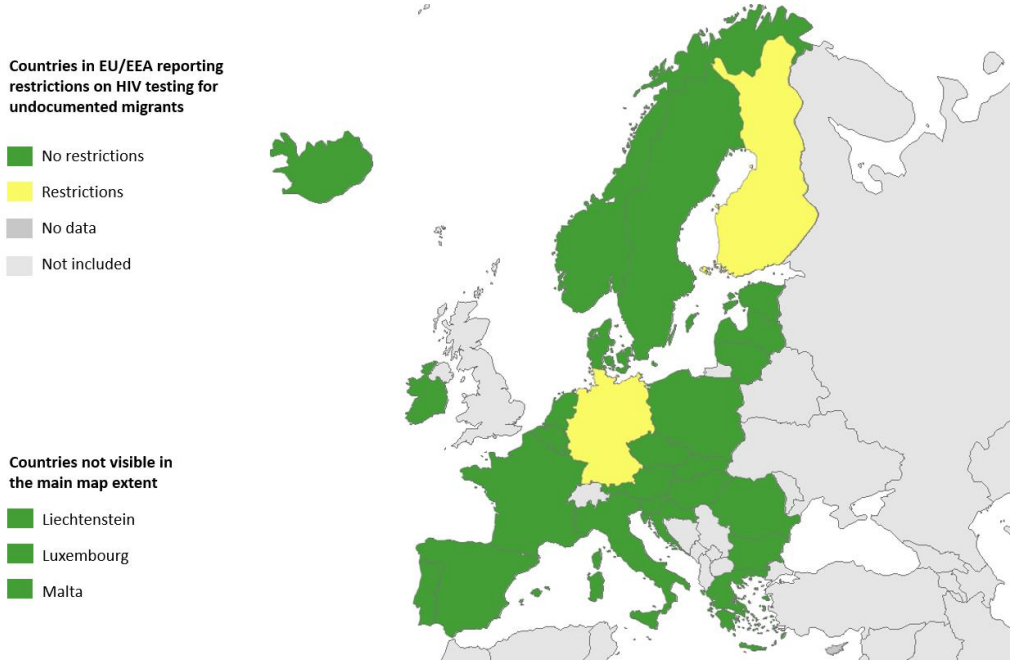
** 2024 or most recent year with available data (2019 or later).*

Testing 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 for those living with HIV. Among 30 EU/EEA countries, 90% (27 countries) reported no restrictions on access to HIV testing for undocumented migrants (Figure 14). Restrictions were in place in only two countries: Germany and Finland.

[1] Belgium, Cyprus, Finland, Germany, Greece, Malta, the Netherlands, Poland, Spain, and Sweden.

Figure 14. Countries in EU/EEA reporting restrictions on HIV testing for undocumented migrants, 2024* (n=29)

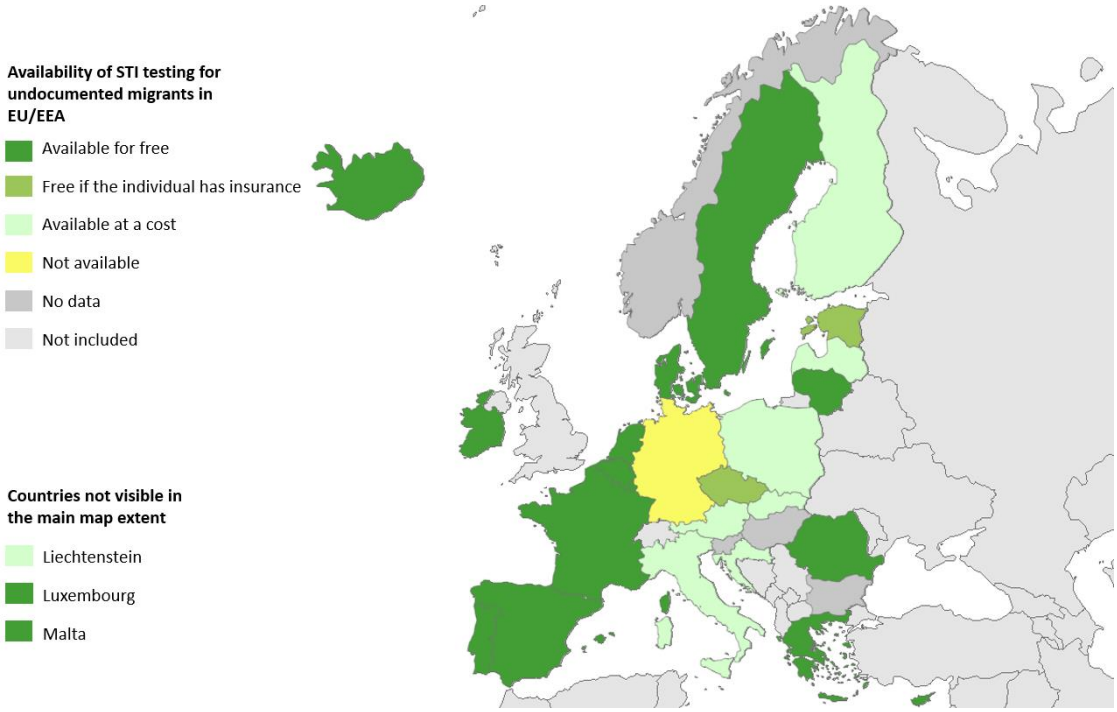


** 2024 or most recent year with available data (2019 or later).*

Access to STI testing for undocumented migrants

In 2024, only half[1] of EU/EEA countries reported providing free-of-charge STI testing to migrants (Figure 15). Two countries (Czechia and Estonia) provided STI testing if the individual had insurance. In eight countries, STI testing for undocumented migrants was available at a cost, while in Germany it was not available at all.

Figure 15. Availability of STI testing for undocumented migrants in EU/EEA, 2024* (n=26)



** 2024 or most recent year with available data (2019 or later).*

[1] Belgium, Cyprus, Denmark, France, Greece, Iceland, Ireland, Lithuania, Luxembourg, Malta, Netherlands, Portugal, Romania, Spain and Sweden

8. Conclusions

Overall progress

In the EU/EEA, where almost half of new HIV diagnoses are attributed to people born abroad, specific attention should be given to ensuring equitable access to HIV prevention, testing, and care services to migrants. Stigma, discrimination, and institutional barriers can greatly hinder such access for migrant populations, especially for undocumented migrants. Yet, data on HIV and migrants remain limited, and therefore it is challenging to draw conclusions on the progress of interventions.

Only five countries within the EU/EEA were able to report data for all stages of the continuum of care for migrants living with HIV. As of the end of 2023, only 73% (15 116, range: 37% - 91%) of 20 668 migrants living with HIV were virally suppressed, which is far below the global substantive target of 86% by 2025. This compares to 78% of the total population of all people living with HIV being virally suppressed in the same five countries. Only one country (Luxembourg) was meeting the global 86% target; one country (Belgium) was within 5% of meeting the target, and three countries (Austria, Czechia, and Greece) were more than 5% away from the target.

Primary prevention programmes aim to prevent people from acquiring HIV and include the provision of condoms and PrEP. While condom distribution programmes aimed at migrants exist in around half of EU/EEA countries, only seven 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 suggests that most migrants in need of PrEP, particularly those who are undocumented, do not have access to 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 communities to create tailored prevention programmes.

Secondary prevention programmes are aimed at preventing the onward transmission of HIV and include testing. Due to the limited data available, it is difficult to assess the extent to which migrants are tested for HIV in the EU/EEA. However, as of 2023 many countries (22) offer community-based testing, which might be more culturally appropriate and targeted to reach migrant populations, although a slight decrease in the availability of this intervention has been recorded over the years. Self-testing, which plays an important role in recent WHO guidelines, was available in 20 out of 27 EU/EEA countries reporting data and still needs to be scaled up. Home testing and testing in other health settings remain the least implemented 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 offering a wide range of testing interventions can overcome barriers to accessing testing and better target those who are most at risk.

When it comes to undocumented migrants, most EU/EEA countries report no restrictions on HIV testing. However, there are significant limitations in access to PrEP and STI testing. It appears that HIV prevention services struggle to reach the most vulnerable migrants. The percentage of undocumented migrants linked to treatment remains unknown. However, continuum of care data highlight the need to scale up access to treatment, as only four out of nine countries that reported data on the number of migrants living with HIV who know their status and are on ART were meeting the second 95 target.

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 their '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 men who have sex with men, people who inject drugs, sex workers, and transgender people. Differences among migrants, perhaps most obviously in terms of their relative poverty or wealth, mean that access to services and the capacity to pay for services that are not free will vary. This is partly dealt with in this survey by specific questions on undocumented migrants, who are the most marginalised and vulnerable among this key population. Another limitation is data comparability. 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. Variations in data sources, sample sizes, timeframes, analysis and quality limit the scope for directly comparing data between countries. In addition, considerable missing data make it difficult to generalise findings for the entire EU/EEA.

Finally, one difficulty in analysing progress concerning new diagnoses, the continuum of HIV care, or the efficacy of interventions is that progress may reflect changes in migration patterns and not only changes in response to the epidemic.

Recommendations

- Countries are advised to scale up the implementation of various testing services, particularly community-based testing and self-testing, which are believed to improve migrants' access to testing.
- Countries should explore the feasibility of expanding primary prevention services, including condom provision programmes and PrEP implementation, to ensure they are accessible to migrants, including undocumented migrants.
- Comprehensive approaches to testing and treating HIV that integrate links between HIV support services and other services such as housing, mental health, financial, and legal, which are often necessary to address patients' needs can reduce issues of stigma as well There is evidence that HIV among the migrant population is often acquired after arrival, and only providing testing or screening for newly-arrived migrants may not be enough to tackle the epidemic among this key population. This underscores the need for targeted, non-stigmatising, culturally and linguistically sensitive HIV prevention programs for all migrants, including those who have been in the country for some time and those who are undocumented.
- Countries are encouraged to reflect on how general attitudes and legislation around migrants, especially undocumented migrants, may impact their willingness to seek medical support. Countries should consider what needs to be done at local and national levels to help create more accessible medical services for all migrants.
- Countries are encouraged to provide information on how migrants can access HIV services, including HIV prevention, testing, and treatment as early as possible upon arrival.
- Countries should consider improving HIV monitoring and surveillance in the context of migrant populations, as good quality data strengthens the evidence base for effective, targeted interventions. Reporting data on the continuum of HIV care for migrant populations is particularly important, as this group constitutes a major proportion of the estimated incidence of HIV in the EU/EEA.
- While the population share of foreign-born and third-country nationals must be considered for planning HIV interventions for migrants, neither is a proxy for migrant populations at high risk of HIV transmission. Given the scarcity of data on the prevalence of HIV among migrant populations, other methods should be explored. Targeted special surveys with robust sample size designed to prioritise groups in need of targeted combination HIV prevention should be considered, especially in countries where foreign-born individuals constitute a significant proportion of the population.

References

1. Aids Action Europe. Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia. Dublin. 2004. Available at: https://www.aidsactioneurope.org/en/publication/dublin-declaration-partnership-fight-hivaids-europe-and-central-asia
2. European Centre for Disease Prevention and Control. (ECDC). Monitoring implementation of the Dublin Declaration. Stockholm; ECDC; 2024. Available at: https://www.ecdc.europa.eu/en/infectious-disease-topics/hiv-infection-and-aids/surveillance-and-updates-hiv-and-aids
3. European Centre for Disease Prevention and Control (ECDC) and World Health Organization (WHO). HIV/AIDS surveillance in Europe 2023 – 2022 data. Stockholm; ECDC; 2023. Available at: https://www.ecdc.europa.eu/en/publications-data/hivaids-surveillance-europe-2023-2022-data
4. European Centre for Disease Prevention and Control (ECDC) and World Health Organization (WHO). HIV/AIDS Surveillance in Europe 2024 – 2023 data. Stockholm; ECDC; 2024. Available at: HIV/AIDS Surveillance in Europe 2024 – 2023 data
5. UNAIDS. Global Partnership for Action to Eliminate All Forms of HIV-Related Stigma and Discrimination2023. Available at: https://www.unaids.org/en/resources/documents/2023/global-partnership-hiv-stigma-discrimination
6. HUMA network. Access to health care for undocumented migrants and asyum seekers in 10 EU countries: law and practice. 2009. Available at: https://www.episouth.org/doc/r_documents/Rapport_huma-network.pdf
7. Mann S, Mougammadou Z, Wohlfahrt J, Elmahdi R. Post-migration HIV acquisition: A systematic review and meta-analysis. Epidemiol Infect. 2024 Mar 1;152:e49. Available at: doi: 10.1017/S0950268824000372
8. European Centre for Disease Prevention and Control. (ECDC). HIV Combination prevention. Stockholm; ECDC; 2020. Available at: https://www.ecdc.europa.eu/sites/default/files/documents/HIV-combination-prevention-dublin-declaration.docx.pdf
9. The Joint United Nations Programme on HIV/AIDS (UNAIDS). Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioural and Structural Strategies to Reduce New HIV Infections: A UNAIDS Discussion Paper. Geneva; UNAIDS; 2010. Available at: https://www.unaids.org/en/resources/documents/2010/20101006_JC2007_Combination_Prevention_paper
10. The Joint United Nations Programme on HIV/AIDS (UNAIDS). Seizing the moment: tackling entrenched inequalities to end epidemics. Geneva; UNIADS; 2020. Available at: https://www.unaids.org/en/resources/documents/2020/global-aids-report
11. Eurostat. Population on 1 January by age group, sex and citizenship. 2024. Available at: https://ec.europa.eu/eurostat/databrowser/view/migr_pop1ctz__custom_11963196/bookmark/table?lang=en&bookmarkId=53ffe470-ae99-46f5-8b19-6c228f4f0265
12. Eurostat. Foreign-born population. 2024. Available at: https://ec.europa.eu/eurostat/databrowser/view/tps00178/default/table
13. European Commission. Migration and Home Affairs. 2024. Available at: https://home-affairs.ec.europa.eu/networks/european-migration-network-emn/emn-asylum-and-migration-glossary/glossary/third-country-national_en#:~:text=Definition(s),movement%20%2C%20as%20defined%20in%20Art.
14. European Centre for Disease Prevention and Control. (ECDC). Continuum of HIV care. Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2024 progress report. Stockholm; ECDC;2024. Available at: Continuum of HIV care - Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2024 progress report
15. World Health Organization (WHO). Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach, 2021 update. Geneva; WHO; 2021. Available at: https://iris.who.int/handle/10665/342899
16. World Health Organization (WHO). Global action plan on promoting the health of refugees and migrants, 2019–2030. Geneva; WHO; 2024. Available at: https://www.who.int/publications/i/item/9789240093928
17. World Health Organization (WHO). Consolidated guidelines on HIV testing services: 5Cs: consent, confidentiality, counselling, correct results and connection 2015. Geneva; WHO; 2015. Available at: https://iris.who.int/handle/10665/179870
18. United Nations High Commissioner for Refugees (UNHCR). Policy Statement on HIV Testing and Counselling for Refugees and other persons of concern to UNHCR. Geneva; UNHCR; 2014. Available at: https://cdn.who.int/media/docs/default-source/documents/publications/policy-statement-on-hiv-testing-and-counselling-for-refugees-and-other-persons-of-concern-to-unhcr401760a9-37b0-4f46-9dbf-5d5f1ad8f9f3.pdf?sfvrsn=41209c85_1&download=true
19. European Centre for Disease Prevention and Control (ECDC). Public health guidance on HIV, hepatitis B and C testing in the EU/EEA – An integrated approach. Stockholm; ECDC; 2018. Available at: https://www.ecdc.europa.eu/en/publications-data/public-health-guidance-hiv-hepatitis-b-and-c-testing-eueea
20. World Health Organization (WHO). Consolidated guidelines on differentiated HIV testing services. Geneva; WHO; 2024. Available at: https://www.who.int/publications/i/item/9789240096394
21. Stevenson K, Antia K, Burns R, Mosca D, Gencianos G, Rechel B, et al. Universal health coverage for undocumented migrants in the WHO European region: a long way to go. The Lancet Regional Health – Europe. 2024;41 Available at: https://doi.org/10.1016/j.lanepe.2023.100803
22. The Joint United Nations Programme on HIV/AIDS (UNAIDS). The gap report 2014. Geneva; UNAIDS; 2014. Available at: https://www.unaids.org/en/resources/documents/2014/20140716_UNAIDS_gap_report

Annex 1.

Table A1. Migrant population size estimates, 2023 data

Country	Number of foreign-born people in reporting country	Share of foreign-born people in the total population, %	Number of third-country nationals in reporting country[1]	Share of third country nationals in the total population, %	Total population per country
Austria	1 963 312	21.6%	847 309	9.3%	9 104 772
Belgium	2 246 910	19.1%	607 330	5.2%	11 742 796
Bulgaria	168 595	2.6%	65 117	1.0%	6 447 710
Croatia	490 555	12.7%	55 272	1.4%	3 850 894
Cyprus	208 843	22.7%	90 455	9.8%	920 701
Czechia	764 171	7.1%	675 288	6.2%	10 827 529
Denmark	804 061	13.6%	365 304	6.2%	5 932 654
Estonia	234 743	17.2%	213 742	15.6%	1 365 884
Finland	461 205	8.3%	216 026	3.9%	5 563 970
France	8 942 059	13.1%	4 074 573	6.0%	68 172 977
Germany	16 476 370	19.5%	7 725 593	9.2%	84 358 845
Greece	1 173 236	11.3%	649 874	6.2%	10 413 982
Hungary	644 496	6.7%	142 421	1.5%	9 599 744
Iceland	82 227	21.2%	15 519	4.0%	387 758
Ireland	1 150 590	21.8%	411 544	7.8%	5271395
Italy	6 417 206	10.9%	3 747 559	6.4%	58 997 201
Latvia	241 096	12.8%	255 311	13.6%	1 883 008
Liechtenstein	27 435	69.1%	6 473	16.3%	39 677
Lithuania	231 822	8.1%	96 422	3.4%	2 857 279
Luxembourg	333 085	50.4%	67 489	10.2%	660 809
Malta	153 361	28.3%	94 766	17.5%	542 051
Netherlands	2 776 950	15.6%	718 660	4.0%	17 811 291
Norway	965 546	17.6%	252 286	4.6%	5 488 984
Poland	933 118	2.5%	403 413	1.1%	36 753 736
Portugal	1 733 067	16.5%	614 528	5.8%	10 516 621
Romania	529 974	2.8%	158 800	0.8%	19 054 548
Slovakia	213 178	3.9%	22 560	0.4%	5 428 792
Slovenia	309 289	14.6%	168 971	8.0%	2 116 972
Spain	8 204 206	17.1%	4 398 888	9.1%	48 085 361
Sweden	2 144 268	20.4%	545 232	5.2%	10 521 556
EU/EEA	**61 024 974**	**13.4%**	**27 706 725**	**6.1%**	**454 719 497**

Source: Eurostat [11,12].

[1] Third country national is any person who is not a citizen of the European Union and who is not a person enjoying the European Union right to free movement, as defined in Art. 2(5) of the Regulation (EU) 2016/399 (Schengen Borders Code).

Annex 2.

Table A2. Continuum of care for migrants living with HIV in the EU/EEA - number of people and targets, end of 2023 (n=12)

					95-95-95 targets			95-91-86		
Country	Number of migrants living with HIV	Number of migrants living with HIV who are diagnosed	Number of migrants living with HIV who are receiving ART	Number of migrants living with HIV who are virally suppressed	% of migrants living with HIV who are diagnosed	% of migrants living with HIV who are on ART	% of migrants living with HIV who are virally suppressed	% of migrants living with HIV who are diagnosed	% of migrants living with HIV who are on ART	% of migrants living with HIV who are virally suppressed
Austria	3 117	2 870	2 715	2 373	92%	95%	87%	92%	87%	76%
Belgium	10 889	10 469	9 650	9 327*	96%	92%	97%	96%	89%	86%
Bulgaria										
Croatia										
Cyprus										
Czechia	1 198	937	884	843	78%	94%	95%	78%	74%	70%
Denmark										
Estonia										
Finland										
France										
Germany		18 000								
Greece	4 453	3 837	1 772	1 652	86%	46%	93%	86%	40%	37%
Hungary										
Iceland		216	214	210		99%	98%			
Ireland										
Italy										
Latvia										
Liechtenstein										
Lithuania										
Luxembourg	1 011	1 009	974	921	100%	97%	95%	100%	96%	91%
Malta			345							
Netherlands		10 595	9 695	9 216		92%	95%			
Norway										
Poland										
Portugal	14 502	13 318			92%			92%		
Romania		136	130	84		96%	65%			
Slovakia										
Slovenia										
Spain										
Sweden		5 619	5 518	5 357		98%	97%			
EU/EEA	20 668	19 122	15 995	15 116	93%	84%	95%	93%	77%	73%

ART: antiretroviral therapy.
**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.*
**Number reported for those routinely tested for viral load, which might not include the whole population of people living with HIV on ART.*
The information in this figure reflects the latest available data reported by countries in 2024. For Austria, Belgium, Malta, Netherlands, Portugal, and Romania presented data is as of 31.12.2022; for Czechia, Germany, Greece, Iceland, Luxembourg, and Sweden presented data is as of 31.12.2023.

European Centre for Disease Prevention and Control (ECDC)

Gustav III:s Boulevard 40
16973 Solna, Sweden

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

www.ecdc.europa.eu

Follow ECDC on social media
Twitter: @ECDC_EU
Facebook: www.facebook.com/ECDC.EU
Linkedin: www.linkedin.com/company/ecdc/

Publications Office
of the European Union