ECDC EVIDENCE BRIEF

September 2015

HIV and leadership

Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia – 2014 progress report

Dublin Declaration

This ECDC evidence brief summarises key issues and priorities for action in Europe. It draws on country data reported to ECDC for Dublin Declaration monitoring and UNAIDS global reporting in 2012 and 2014 and surveillance data reported by countries to ECDC and WHO Europe since 2004.

Following ECDC's 2010 and 2012 progress reports, a new series of thematic reports and evidence briefs present the main findings, discuss key issues, and assess the progress made since 2012 in Europe's response to HIV.

What are the main leadership issues in Europe?

Strong leadership is vital when dealing with any public health crisis, including the HIV epidemic in Europe. The issues that public health leaders choose to prioritise, the actions they take to support those priorities and the allocation of resources to critical interventions provide valuable insights into a country's commitment to HIV response. Strong leadership should ensure that:

- adequate and sustainable financing is available for effective HIV programmes, including support for national programmes and the global response;
- funding is allocated in line with the dynamics of the epidemic, including sufficient funding for programmes focused on those populations most affected by HIV; examples include prevention programmes to reduce the number of new infections, testing programmes to address low rates of HIV testing and high rates of late diagnosis, and treatment programmes to expand coverage and effectiveness;
- gaps in service delivery are identified and addressed, particularly services for key populations who lack widespread social and political support;
- laws and policies are not barriers to the delivery of vital HIV services; and
- HIV-related stigma and discrimination do not hinder the uptake of services or have an adverse effect on the quality of life for people living with HIV.

Resources

Few countries can produce specific data on the amount of HIV prevention funding and how it is allocated. Despite the fact that governments in more than 80% of EU/EEA countries and more than 90% of non-EU/EEA countries report that their prevention funding is prioritised for key populations, only eight EU/EEA countries and 11 non-EU/EEA countries could produce information on the exact amount of funding and how it is allocated. If countries do not track their prevention funds, there is a significant risk these funds will not be spent where they would have the biggest impact. A commitment to prioritised funding is only meaningful if allocations are tracked and effectiveness is assessed.

Suggested citation: European Centre for Disease Prevention and Control. Evidence brief: HIV and leadership. Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia – 2014 progress report. Stockholm: ECDC; 2015.

Limited funds are allocated for HIV prevention, particularly in EU/EEA countries. Approximately 2% of overall HIV spending is reported to be allocated for prevention in the eight EU/EEA countries that provided data in 2014[1]. This percentage rises to 23% in the 11 non-EU/EEA countries providing data[2]. The high percentage of EU/EEA countries which reported prevention programmes are being delivered at scale for key populations does not seem to be supported by the limited funds allocated for this purpose. However, in countries where prevention funding is precisely targeted, it may be possible to achieve the desired outcomes with limited resources.

Resources allocated for treatment have increased between 2011 and 2013 in most countries in the region, but not everyone needing treatment is receiving it. Reasons for higher spending include an increase in the number of new diagnoses, which in some cases reflects improved case ascertainment, resulting in an increase in the number of people on treatment; a reduction in death rates among those on treatment, resulting in people with HIV on treatment living longer; and, to a lesser extent, higher costs of new drugs and second-line treatment. While a willingness to increase spending on treatment is one indication of positive political leadership, it does not mean that all people in need of treatment are receiving it. Despite these increases in spending, national governments in many countries still report that treatment is not delivered at scale to the various key populations.

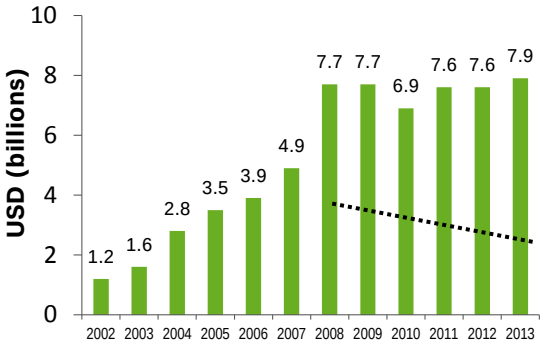
Table 1. HIV treatment delivered at scale: government respondents

Target group for HIV treatment	Treatment delivered at scale: number of positive replies/total number of respondents	
	EU/EEA countries	Non-EU/EEA countries
People who inject drugs	29/30	16/18
Men who have sex with men	29/30	18/18
Prisoners	29/30	17/18
Sex workers	26/30	18/18
Migrants in general	25/28	13/16
Undocumented migrants	15/27	5/16

HIV-related projects and programmes run by civil society are still underfunded. Across the region, 53% of governments and 82% of civil society respondents report funding gaps. Many HIV-related projects and programmes run by civil society are essential components of national responses, and funding shortages jeopardise their viability.

European funding for the global HIV response has declined. Overall, international funds for HIV programmes have essentially been static since 2008. However, the proportion of the total funding provided by European countries has declined from 40% in 2008 to 28% in 2013 (see Figure 1). Similarly, European contributions to the *Global Fund to Fight AIDS, Tuberculosis and Malaria* for its HIV programmes have declined from a peak of more than one billion USD in 2008 to USD 873 million in 2013. In 2006 and 2007, 60% of all country contributions to the Global Fund were from Europe; by 2013, only 43% were contributed by Europe.

Figure 1. International AIDS assistance from donor governments: 2002–2013



Dotted line indicates the proportion of EU contributions from 2008 (40%) to 2013 (28%)

Gaps in service delivery

Table 2. HIV services delivered at scale: government responders

Target group for HIV treatment	HIV services delivered at scale: number of positive replies/total number of respondents	
	EU/EEA countries	Non-EU/EEA countries
People who inject drugs	24/31	14/18
Men who have sex with men	21/30	14/18
Prisoners	20/30	15/18
Sex workers	15/30	13/18
Migrants in general	13/29	9/16
Undocumented migrants	5/28	3/16

Services for migrants are not available at scale in the majority of countries. Although many governments report that the full range of HIV services (i.e. prevention, testing, treatment, care and support) are available at scale for most key populations, there is a notable gap in the services that are available to migrants. The gap is particularly pronounced for undocumented migrants, with only five EU/EEA and three non-EU/EEA countries reporting that these services are delivered at scale. In addition, a significant number of countries are not delivering services at scale for other key populations. Many countries also report significant gaps in service delivery, particularly prevention services (see Table 2.)

A high percentage of countries report gaps in HIV prevention services for different key populations. Gaps in prevention services for key populations appear to be a widespread problem in countries across the region. If these gaps are not filled, prevention programmes will struggle to reduce the number of new HIV infections.

Table 3. Key populations and percentage of countries reporting gaps in HIV prevention services

Key population	Percentage of countries reporting gaps in HIV prevention services	
	EU/EEA countries	Non-EU/EEA countries
Men who have sex with men	67%	72%
Prisoners	67%	55%
Undocumented migrants	50%	62%
People who inject drugs	46%	65%
Migrants in general	36%	47%

[1] Bulgaria, Croatia, the Czech Republic, Estonia, Latvia, Poland, Portugal, Spain

[2] Armenia, Azerbaijan, Belarus, Bosnia, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Serbia, Tajikistan, Uzbekistan

Data triangulation raises questions about the reported delivery of HIV services at scale. Government-reported data raise questions about whether HIV services are actually being delivered at scale. For example, 21 EU/EEA countries report that HIV prevention is delivered at scale for prisoners but only two countries report needle and syringe programmes in all prisons. Twenty-three EU/EEA countries report that HIV prevention is delivered at scale for men who have sex with men, but many of these countries are also seeing an increasing number of HIV cases among this population. Given the importance of high rates of coverage for HIV interventions, 'at scale' is a term that needs to be carefully defined and consistently applied by countries. Efforts must be made to provide services at the scale required to impact the course of the epidemic.

Laws and policies

Two-thirds of countries in the region highlighted HIV-related legal or policy issues that need to be addressed. These issues, which have an adverse impact on the availability and effectiveness of prevention, testing and treatment services, include criminalisation of HIV transmission, criminalisation of sex workers or their clients, regulations restricting the availability of needle exchange and opioid substitution therapy in prisons, and limiting access to HIV-related services by undocumented migrants.

The HIV-related legal and policy environment for undocumented migrants is challenging in many countries. Nine EU/EEA countries specifically report having laws and/or policies that negatively affect access by undocumented migrants to HIV prevention, treatment and care services. Only 14 EU/EEA countries report a supportive legal and policy environment for free and anonymous HIV testing and the availability of, and access to, HIV treatment and care for undocumented migrants. When combined with data for undocumented migrants on HIV testing at scale (only 14 EU/EEA countries provided such data) and treatment at scale (only 15 EU/EEA countries provided data) – the breadth and depth of the challenges facing this population is clear.

Stigma and discrimination

Governments in 40% of EU/EEA and 50% of non-EU/EEA countries cannot report whether stigma and discrimination have increased, decreased or stayed the same over the past two years. In addition, civil society in 32% of EU/EEA and 25% of non-EU/EEA countries report not having this information either. Among governments that do have some knowledge of the situation, stigma and discrimination are decreasing or staying the same; no government reports that stigma has increased. However, the high percentage of countries that do not have data on stigma and discrimination represents a serious and significant gap in the understanding of the national HIV situation.

A significant proportion of countries report that stigma and discrimination are a barrier to HIV testing. Thirty-nine per cent of EU/EEA and 70% of non-EU/EEA governments report that stigma and discrimination have a moderate to significant effect on the uptake of HIV testing. Civil society is more likely to view stigma and discrimination as a barrier, with 73% and 83% of the EU/EEA and non-EU/EEA respondents respectively reporting moderate to significant effects. Given the low rates of HIV testing and the high rates of late diagnosis in the region, the fact that stigma and discrimination remain a barrier to testing is a serious concern.

For people who are HIV-positive, stigma and discrimination remain a major barrier to getting a job or accessing other health services in many countries, particularly in non-EU/EEA countries. Fifty-six per cent of non-EU/EEA governments and 83% of civil society respondents in non-EU/EEA countries report that stigma and discrimination moderately to significantly limit the ability of people who are HIV-positive to get a job; 56% of non-EU/EEA governments and 92% of civil society report that stigma and discrimination limit access to other health services. In EU/EEA countries, the impact of stigma and discrimination is less significant, but it remains a problem in many countries: 29% of governments and 59% of civil society respondents report that it has a moderate to significant effect on getting a job; 18% of governments and 68% of civil society respondents report the same effect on accessing other health services.

Only half of countries in the region have laws or policies prohibiting HIV screening for general employment purposes. Fifty-three percent of EU/EEA and 47% of non-EU/EEA governments report having laws and policies prohibiting HIV screening for general employment purposes. These laws and policies are a fundamental protection of human rights and should be standard practice in all countries.

What needs to be done?

Strong leadership is crucial to the success of the HIV response at national, regional and global levels. Leadership can help mobilise prioritised prevention funds for those populations at the greatest risk of infection. It is critical to improve the uptake of HIV testing and early initiation of treatment, treatment adherence and the quality of life of people who are living with HIV. Most importantly, strong leadership is essential to securing adequate and sustained financing for an effective HIV response.

Key options for action

Ensure that the necessary political commitment and resources are in place to provide HIV services at the scale required to have an impact on the epidemic, particularly services for those populations most affected by HIV. This same combination of prioritisation, commitment and resources is required to reduce the number of new infections, improve rates of HIV testing, decrease the number of late HIV diagnoses and expand access to, and the effectiveness of, treatment services among these same populations. In many countries, this will require a two-pronged approach: 1) a strong commitment to the delivery of services to key populations, even in the face of prejudice and political opposition, and 2) better targeting and/or an increase in funds for essential HIV services.

Consider addressing legal and policy issues that limit or are directly damaging the scope and effectiveness of the HIV response, for example the ban on providing treatment for undocumented migrants, the criminalisation of sex work, and the restrictions on harm reduction services for people who inject drugs. Opportunities should be explored for countries to share their successful approaches to ensure that laws and policies are not barriers to the uptake, delivery and/or sustainability of HIV services.

Identify practical strategies for reducing HIV-related stigma and discrimination, particularly where it has an adverse impact on the uptake of essential HIV services, including prevention, testing and treatment. Strategies should be developed to ensure that HIV-related stigma and discrimination do not affect the ability to seek employment and access healthcare.

Consider securing the funding required to sustain an effective HIV response, including sufficient resources for prevention, testing and treatment services to be delivered at scale to all affected populations by government and civil society stakeholders.

Stockholm, September 2015

ISBN 978-92-9193-667-0

doi 10.2900/159419

Catalogue number TQ-01-15-583-EN-N