ECDC EVIDENCE BRIEF

May 2017

Impact of stigma and discrimination on access to HIV services in Europe

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

Dublin Declaration

This ECDC evidence brief summarises key issues related to the impact of stigma and discrimination on access to HIV services in Europe, focusing on the EU/EEA and identifying priority actions for improvement. It draws on 2016 Dublin Declaration monitoring data reported to ECDC by 48 countries.

In 2004, under the leadership of the Irish Presidency of the EU Council, countries came together and adopted the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia. Since 2009, ECDC has been responsible for monitoring its implementation.

Key messages

- Two out of three countries in Europe and Central Asia acknowledge that stigma and discrimination within key affected populations is a barrier to the uptake of HIV prevention and testing services.
- Stigma and discrimination among health professionals, particularly with respect to sex workers, men who have sex with men and people who inject drugs, reportedly persists across the region and plays a role in preventing these key populations from accessing HIV prevention, testing and treatment.
- Many countries report that stigma and discrimination is a factor that contributes to late diagnosis of HIV.
- More needs to be done to reduce stigma and discrimination, both within affected communities and in healthcare settings.

This evidence brief summarises information, reported to ECDC by government representatives in 48 countries for Dublin Declaration monitoring in 2016. It reviews the extent to which stigma and discrimination are perceived to affect access to and uptake of HIV prevention, testing and treatment services for key populations in the region and highlights priority options for action.

It is important to note that there may be some differences in the way respondents have defined stigma and discrimination and that the Dublin Declaration monitoring did not ask respondents to provide detailed information, examples or evidence to support their responses. This brief therefore provides a broad overview of the situation rather than a systematic cross-country comparison or assessment of stigma and discrimination and their impact on HIV service delivery and uptake.

It is also important to note that stigma and discrimination may also reflect and be reinforced by the legal and policy environment. The extent to which laws and policies affect access to and uptake of HIV services, based on Dublin Declaration monitoring, is discussed in a separate brief.

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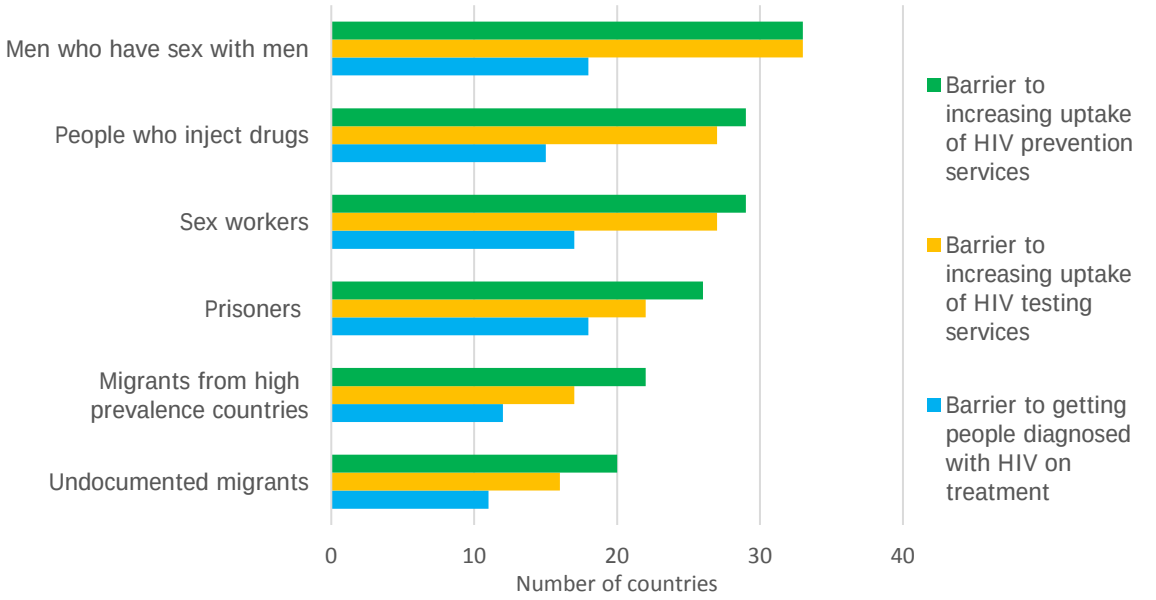
What are the main challenges?

Stigma and discrimination within key populations limit uptake of HIV services. Many countries in the region report that stigma and discrimination within key populations represent a barrier to increasing the uptake of HIV services (Figure 1). Stigma and discrimination within key populations are more frequently reported as a barrier to increasing the uptake of prevention and testing services rather than a barrier to getting people diagnosed with HIV onto treatment.

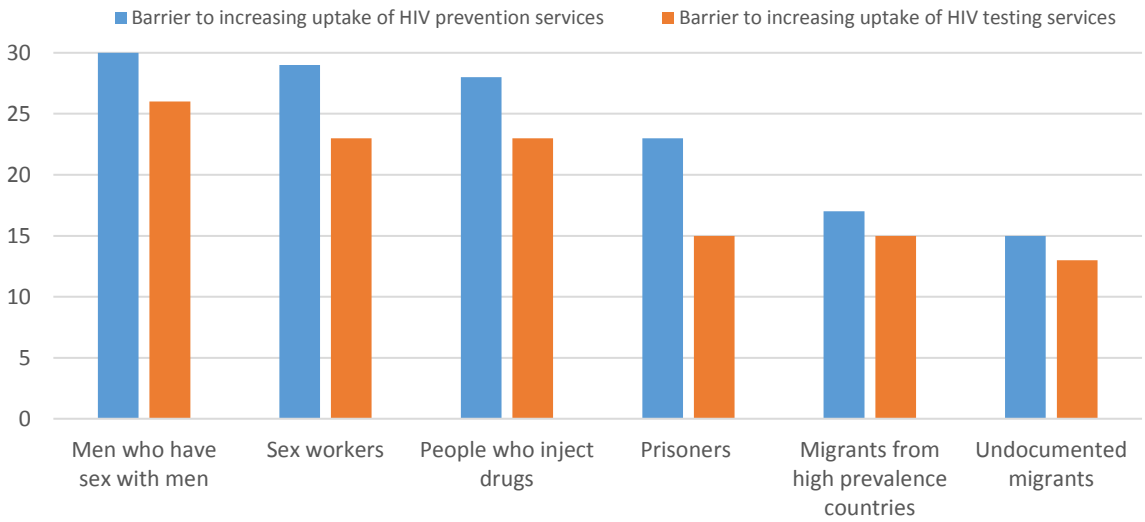
Over half of the reporting countries state that stigma and discrimination within the key population are a barrier to the uptake of prevention services for men who have sex with men (34/48 countries; 23 EU/EEA and 11 non-EU/EEA), people who inject drugs (29/48; 18 EU/EEA and 11 non-EU/EEA), sex workers (29/48; 18 EU/EEA and 11 non-EU/EEA) and prisoners (26/48; 17 EU/EEA and nine non-EU/EEA). A similar proportion of countries report that stigma and discrimination within the affected population represent a barrier to the uptake of testing services for the same key populations (Figure 1).

Figure 1. Number of countries reporting stigma and discrimination within key populations is a barrier to uptake of HIV services, 2016



Stigma and discrimination among health professionals also limits uptake of HIV prevention and testing services. Over half of the reporting countries state that stigma and discrimination among health professionals represent a barrier to the uptake of HIV prevention services by men who have sex with men (31 of 48 countries; 18 EU/EEA and 13 non-EU/EEA), sex workers (29/48; 15 EU/EEA and 14 non-EU/EEA) and people who inject drugs (28/48; 16 EU/EEA and 12 non-EU/EEA) (Figure 2). A lower, but still significant number of countries reports that stigma and discrimination among health professionals represent a barrier to the uptake of HIV testing services for the same key populations (Figure 2).

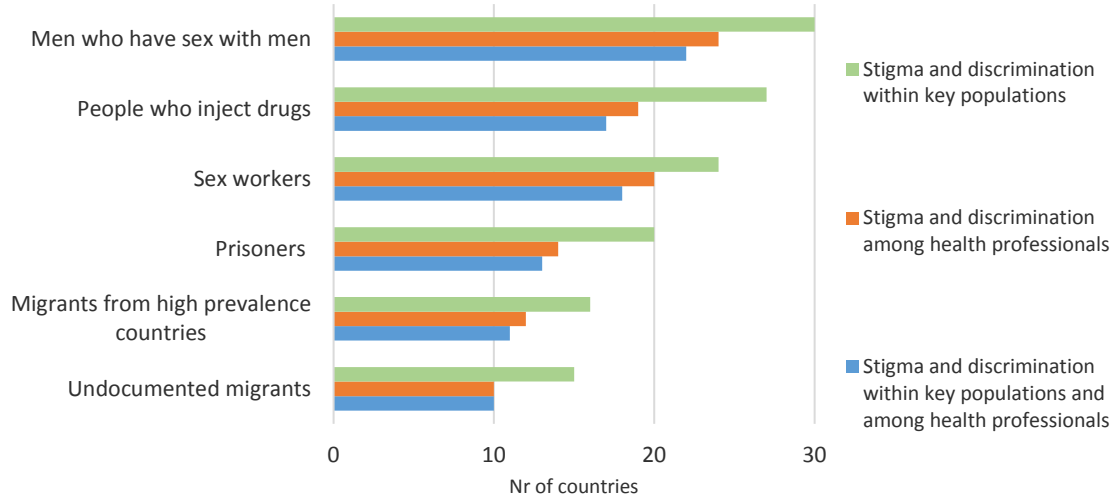
Figure 2. Number of countries reporting that stigma and discrimination among health workers represent a barrier to the uptake of HIV prevention and testing services



Stigma and discrimination are also reported to contribute to late diagnosis of HIV. Stigma and discrimination within key populations are more frequently reported as a factor in late diagnosis than stigma and discrimination among health professionals, although the number of countries reporting the latter is also high (Figure 3).

Half of the countries in the region report that stigma and discrimination within key populations contribute to late diagnosis among men who have sex with men (31/48; 19 EU/EEA and 12 non-EU/EEA), people who inject drugs (25/48; 14 EU/EEA and 11 non-EU/EEA) and sex workers (24/48; 13 EU/EEA and 11 non-EU/EEA) (Figure 3).

Figure 3. Number of countries reporting that stigma and discrimination contribute to late diagnosis of HIV, 2016



Stigma and discrimination among health professionals may also limit provision of HIV services, in particular HIV prevention services, for key populations. A considerable proportion of countries in the region report that stigma and discrimination among health professionals represent a barrier to the provision of HIV prevention services for key populations – 65% of countries report this for men who have sex with men, 62% for people who inject drugs, 56% for sex workers and 48% for prisoners. A lower, but still significant, proportion of countries reports that stigma and discrimination among health professionals represent a barrier to the provision of HIV testing services for key populations – 50% of countries report this for men who have sex with men, 46% for sex workers, 42% for people who inject drugs and 31% for prisoners. A higher number of EU/EEA than non-EU/EEA countries reported that stigma and discrimination among health professionals represent a barrier to the provision of HIV prevention and testing services across all key populations.

Stigma and discrimination among health professionals also represents a barrier to getting people diagnosed with HIV onto treatment. Again, this affects certain key populations more than others, with countries most likely to report that stigma and discrimination among health professionals represent a barrier to getting people who inject drugs, men who have sex with men and sex workers onto treatment. Around one in four countries report this as a barrier for their key populations (Table 1).

Table 1. Countries reporting that stigma and discrimination among health workers represent a barrier to getting people diagnosed with HIV onto treatment, 2016

	Percentage of countries	Number of countries
People who inject drugs	33%	16
Men who have sex with men	27%	13
Sex workers	27%	13
Prisoners	25%	12
Undocumented migrants	15%	7
Migrants	13%	6

What needs to be done?

The response from European and Central Asian countries indicates that stigma and discrimination within key populations and among health professionals are factors that limit efforts to increase the provision and uptake of HIV prevention and testing services in the region and to reduce late diagnosis of HIV. The impact is greatest for men who have sex with men, sex workers and people who inject drugs. These responses highlight the need for greater efforts to tackle stigma and discrimination, both within affected communities and in healthcare settings.

Some countries did not respond to Dublin Declaration monitoring questions about stigma and discrimination; this may be because available data suggest that it is not a problem or because there are no data. In countries where the latter is the case it may be important to improve monitoring of the prevalence of stigma and discrimination within key populations and healthcare settings and monitoring of the impact of stigma and discrimination on the provision and uptake of HIV services for key populations.

Priority options for action

- Improve evidence showing the extent and nature of stigma and discrimination among key populations and health professionals and the way in which this affects the provision and uptake of HIV prevention and testing services.
- Develop and implement more effective approaches to eliminate stigma and discrimination towards key populations, particularly within healthcare settings.
- Collaborate with and support community organisations to develop and implement more effective approaches to reducing stigma and discrimination within key populations, including self-stigma, and to support individuals in challenging stigma and discrimination.

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