

ECDC SPECIAL REPORT

The status of the HIV response in the European Union/European Economic Area, 2016

Dublin Declaration report

Key messages

HIV is still a significant public health problem in the EU/EEA.

In 2015, 29 747 new HIV infections were diagnosed in the EU/EEA, and the rate of new infections has not declined significantly over the last decade. An estimated 810 000 persons were living with HIV in the EU/EEA in 2015 (0.2% of the adult population), however the prevalence is much higher in some countries and among key populations. Men who have sex with men are the key population within which new infections continue to increase. Migrants also remain disproportionately affected and although some of them are infected prior to arriving in the country where they are diagnosed, there is growing evidence that sub-groups are at risk of acquiring HIV after arrival in the EU/EEA.

Coverage and uptake of prevention interventions is insufficient to reduce the number of new HIV infections.

Two out of three EU/EEA countries report that the funds available for prevention are insufficient to reduce the number of new HIV infections. Coverage of key prevention interventions, including condom promotion and distribution, behaviour change interventions, pre-exposure prophylaxis (PrEP) and harm reduction for people who inject drugs remains too low in many countries to make a real impact.

A significant proportion of people living with HIV infection in the EU/EEA have not been diagnosed and, among those diagnosed, nearly half are diagnosed late.

Based on data reported by 20 countries, 17% of people living with HIV are estimated to have not yet been diagnosed. When surveillance data reported from all 31 EU/EEA countries is modelled, this proportion was estimated at 15% in 2015. In 2015, 47% of all reported cases with information on their CD4 cell count at the time of diagnosis were diagnosed late (<350 cells/mm³), leading to higher healthcare costs and increasing the duration of possible HIV transmission. The high proportions of people with HIV who do not know their status or who are diagnosed late reflect insufficient testing, gaps in testing services or services not reaching those most at risk.

Treatment overall starts earlier and more people get treated. But one in six people in the EU/EEA diagnosed with HIV are still not on treatment.

The number of EU/EEA countries reporting that treatment is now initiated regardless of the CD4 cell count increased from four in 2014 to 24 in 2016. This policy has led to encouraging increases in the number of people on antiretroviral therapy (ART). However, based on data reported by 25 countries in 2016, 17% of people with HIV who have been diagnosed are still not receiving ART. Reasons for this include outdated treatment threshold policies, legal and policy barriers, health system resource challenges and social and cultural factors. Undocumented migrants face particular difficulties in accessing HIV treatment, with half of the EU/EEA countries not providing treatment for this population.

Almost 9 out of 10 people living with HIV who are on treatment are virally suppressed.

Based on data reported by 20 countries in 2016, 89% of people receiving treatment are virally suppressed, but this proportion varies among countries, ranging from 51–95%. The proportion of people living with HIV who are virally suppressed out of the total population of people living with HIV, is far lower (around 59%) but again, this varies considerably among countries.

Priorities for action.

To reduce the number of new HIV infections in Europe, prevention efforts need to be prioritised alongside an uptake of HIV testing and easier access to treatment.

Introduction

In 2004, European and Central Asian countries held a high-level conference 'Breaking the Barriers – Partnership to fight HIV/AIDS in Europe and Central Asia'. The conference resulted in the Dublin Declaration¹, which aimed to galvanise political action to tackle the epidemic in the region. The European Centre for Disease Prevention and Control (ECDC) monitors the implementation of the Dublin Declaration in Europe and Central Asia.

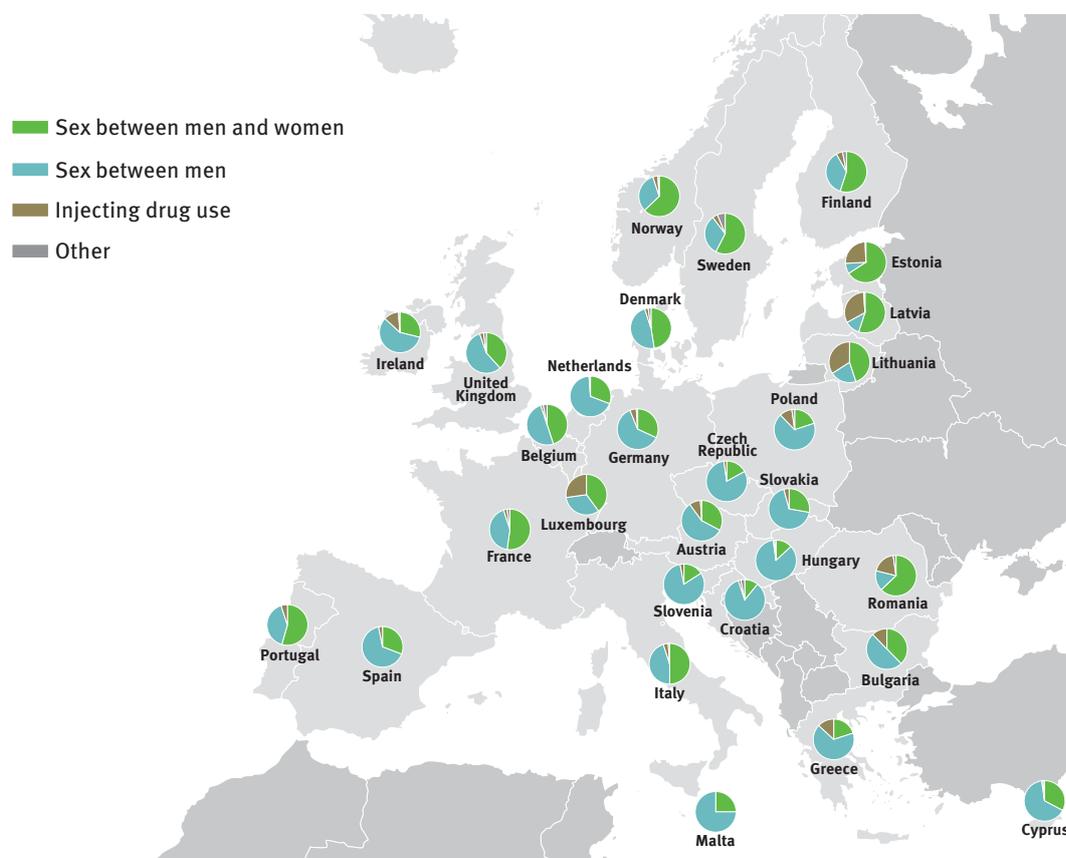
This report incorporates data from countries in the European Union/European Economic Area (EU/EEA) reported to ECDC for Dublin Declaration monitoring in 2014 and 2016, 2015 HIV surveillance data reported to ECDC and WHO's Regional Office for Europe, and country data reported in 2016 to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). In 2016, the focus of data collection for Dublin Declaration monitoring was prevention, testing and treatment for HIV, and this report is structured along the same lines. However, the report starts with a brief overview of the trends of HIV and AIDS diagnoses in the EU/EEA.

Trends in HIV and AIDS diagnoses in the European Union and European Economic Area²

HIV remains a significant public health problem in the EU/EEA. In 2015, 29 747 newly diagnosed HIV infections were reported in 31 EU/EEA countries. There has been only an insignificant decline in the rate of new diagnoses over the last decade, from 6.6 per 100 000 population in 2006 to 6.3 per 100 000 in 2015. In 2015, the rate of new diagnoses was higher among men (9.1 per 100 000) than among women (2.6 per 100 000). Sexual transmission is the main reason for most new infections in the EU/EEA.

HIV cases in men who have sex with men continue to rise. In 2015, 42% of all new cases reported in EU/EEA countries were in men who have sex with men (MSM). Sex between men accounted for more than half of new diagnoses in 15 EU/EEA countries in 2015 (Figure 1). MSM are the only key population in the EU/EEA that has not seen a decline in the number of new infections reported during the last decade. Reported cases have increased, both among men born in the reporting country and those born elsewhere.

Figure 1. Reported HIV modes of transmission in the EU/EEA, 2015



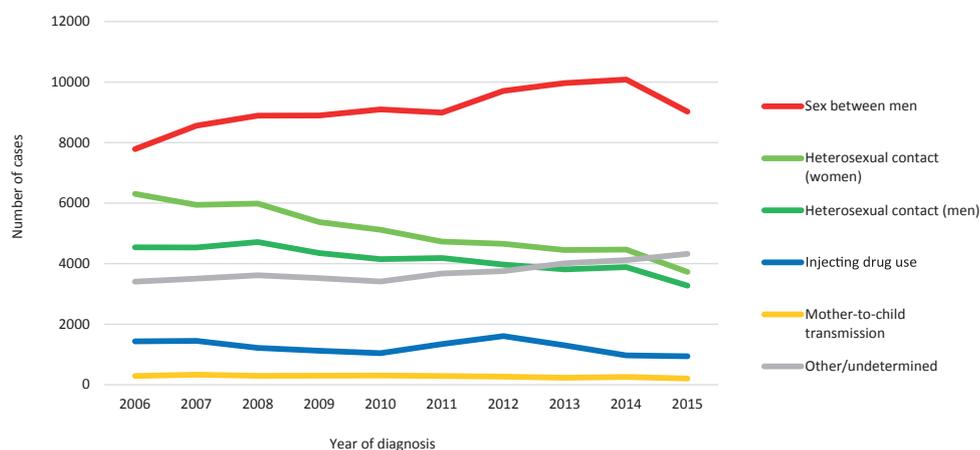
Source: European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2015. Stockholm: ECDC; 2016.

1 European Centre for Disease Prevention and Control (ECDC). Monitoring implementation of the Dublin Declaration. Stockholm: ECDC. [Accessed 4 Dec 2016]. Available from: <http://ecdc.europa.eu/en/healthtopics/aids/Pages/monitoring-dublin-declaration.aspx>

2 European Centre for Disease Prevention and Control, WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2015. Stockholm: ECDC; 2016.

There has been a decrease in heterosexually-acquired HIV cases, but this remains the main mode of transmission in one-third of EU/EEA countries. In 2015, 32% of new diagnoses were attributed to sex between men and women, with variations between the Member States. The number of reported cases acquired through heterosexual transmission in the EU/EEA declined among both women and men. Much of this decline is due to the decrease in cases reported in people originating from countries with generalised HIV epidemics.

Figure 2. Reported HIV modes of transmission in the EU/EEA, 2015



Source: European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2015. Stockholm: ECDC; 2016.

Migrants continue to be disproportionately affected by HIV. Overall, people born outside of the reporting country account for 37% of all newly diagnosed cases in the EU/EEA, varying from more than 70% in Luxembourg and Sweden to less than 5% in Croatia, Latvia, Lithuania, Poland and Romania. Although the overall number of HIV diagnoses in migrants from high HIV prevalence countries has decreased, this population still accounts for around 15% of all newly diagnosed cases and there is growing evidence that sub-groups of this population are at risk of acquiring HIV after arrival in the EU/EEA³. New HIV diagnoses among migrants from non-EU/EEA countries account for 22% of all new diagnoses and represent an increasing proportion of all new HIV diagnoses among migrants in the EU/EEA.

New infections among people who inject drugs have continued to decline in most EU/EEA countries. Between 2006 and 2015, the number of HIV cases in the EU/EEA acquired through injecting drug use decreased by 44% and in 2015, transmission due to injecting drug use accounted for only 4% of new reported HIV diagnoses. This reflects efforts by many countries in the region to implement harm reduction. In countries where a significant proportion of prisoners are people who inject or have injected drugs, HIV prevalence among prisoners has also declined. However, injecting drug use remains an important mode of transmission in some EU/EEA countries and risk factors for outbreaks in this population have been identified⁴. In 2015, a quarter or more of all newly diagnosed and reported HIV cases in four countries were attributed to injecting drug use.

New infections due to transmission from mother-to-child and transmission through blood transfusion have virtually been eliminated in the EU/EEA. Mother-to-child transmission and transmission through blood transfusion now account for less than 1% of new HIV cases diagnosed each year; the majority of these cases were born or thought to have been infected outside of the country in which the case was reported.

The annual number of AIDS cases and AIDS deaths continues to fall in the EU/EEA. In 2015, 3 754 people were diagnosed with AIDS compared with 8 465 in 2006. The number of AIDS deaths reported annually in countries has also decreased from 2 608 in 2006 to 885 in 2015 as a result of improvements in linkage to quality care, treatment and follow-up in the region.

³ European Centre for Disease Prevention and Control. Migrant health: Sexual transmission of HIV within migrant groups in the EU/EEA and implications for effective interventions. Stockholm: ECDC; 2013 [accessed 6 December 2016]. Available at: <http://ecdc.europa.eu/en/publications/publications/migrant-health-sexual-transmission.pdf>

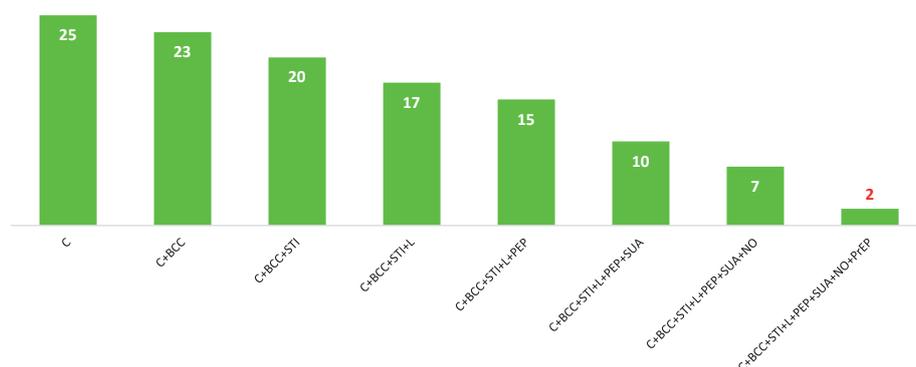
⁴ European Monitoring Centre for Drugs and Drug Addiction (2016). Drug-related infectious diseases in Europe. Update from the EMCDDA expert network. November 2016. Luxembourg: Publications Office of the European Union; 2016 [accessed 8 December 2016]. Available at: <http://www.emcdda.europa.eu/system/files/publications/3393/TD0416796ENN.pdf>

HIV prevention

Coverage and uptake of prevention interventions needs to improve to reduce the number of new infections. Primary prevention interventions, including condom promotion and distribution, health promotion and behaviour change interventions, PrEP, awareness raising and harm reduction, including needle and syringe programmes (NSP) and opioid substitution treatment (OST), are not reaching enough people.

Few countries are implementing comprehensive combination prevention programmes for key populations. Although many countries report that specific prevention interventions are in place, few are implementing a comprehensive package of prevention interventions needed for key populations. For example, Figure 3 shows that relatively few EU/EEA countries are implementing combined prevention interventions for MSM.

Figure 3. Number of EU/EEA countries implementing combination prevention interventions* for MSM (n=30)



* C (condoms), BCC (health promotion & behaviour change communication), STI (population-specific STI testing), L (lubricant), PEP (post-exposure prophylaxis), SUA (substance use/abuse programmes), NO (harm reduction for non-opioid drugs), PrEP (pre-exposure prophylaxis)

EU/EEA countries are starting to consider provision of pre-exposure prophylaxis (PrEP) for populations at highest risk of acquiring HIV infection. PrEP can reduce the risk of sexually-acquired HIV infection among those most at risk, and provision of PrEP as an additional prevention option for these populations has the potential to contribute to reducing HIV transmission. Use of the antiretroviral combined medication emtricitabine and tenofovir disoproxil fumarate (Truvada®)⁵ for PrEP has been approved in the EU/EEA, but currently only two countries, Norway and France, are providing PrEP for high-risk populations on a national basis, mainly to MSM at highest risk, through public health services. However, this situation may change as PrEP demonstration projects are being completed in one country, are ongoing in three countries and are being planned in a further 10 EU/EEA countries (Figure 4).

Cost of drugs and service delivery are among the main obstacles to PrEP implementation in the EU/EEA. Thirteen countries identified the cost of drugs as an important issue preventing or limiting PrEP implementation. In addition, 11 countries identified the cost of service delivery, nine reported concerns about the possible negative impact on condom use, nine had concerns about the possibility of increased transmission of other sexually transmitted infections and five identified overall feasibility as issues of high or medium importance.

Coverage of harm reduction programmes for people who inject drugs remains low in a few EU/EEA countries. Easily accessible opioid substitution therapy (OST) and needle and syringe programmes (NSP) are essential components of harm reduction programmes for people who inject drugs (PWID). The percentage of high-risk opioid users receiving OST can be estimated for 23 EU/EEA countries where recent estimates of the size of the target population are available⁶. Reported coverage ranges from 8–77%. Ten EU/EEA countries have high intervention coverage (>50% of the estimated target population) while in seven countries OST coverage is considered low (<30% of the estimated target population) (Figure 5). Data on the number of syringes distributed per person per year by NSP is available for 15 EU/EEA countries with recent population size estimates. Six of these countries had high intervention coverage (defined as >200 syringes/PWID/year) and seven have low intervention coverage (defined as <100 syringes/PWID/year) (Figure 5)⁷.

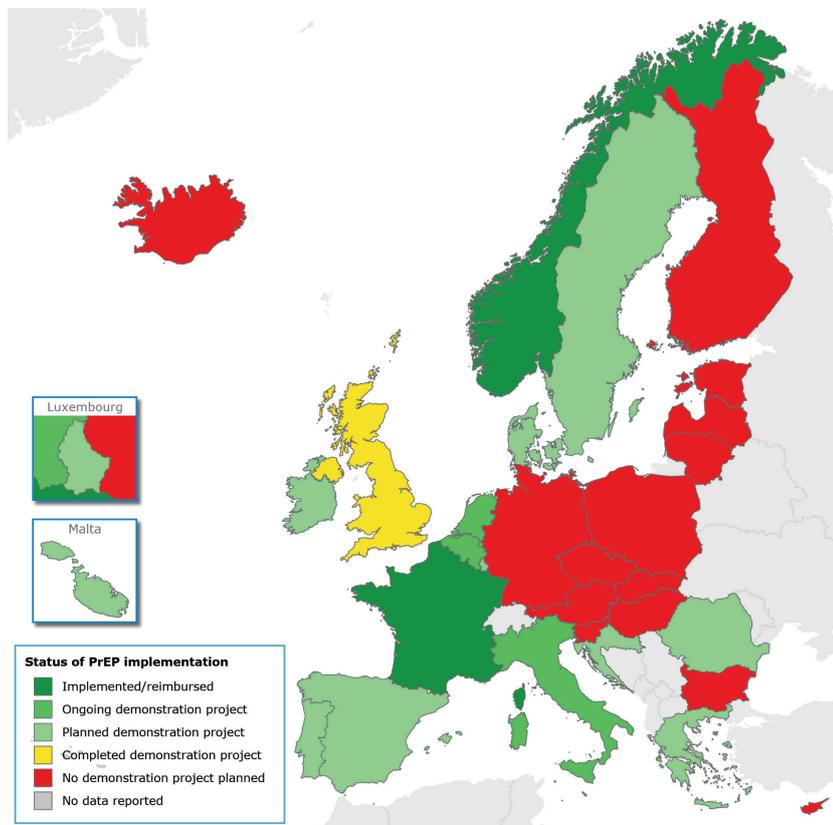
Harm reduction coverage is low in prison settings. In some countries, people who inject or have injected drugs account for a significant proportion of the prison population. OST is reported to be available in the prisons of 26 EU/EEA countries and still not available in four countries. A total of 15 countries report that OST is available in all prisons, four that it is available in most prisons and six that it is available in some prisons (one country could not provide information on coverage). However, NSP are far less available in prisons; only three countries report NSP availability in all prisons and two report availability in some prisons.

5 Any mention of commercial product or service within ECDC publications is for information only and does not suggest endorsement by ECDC. For more information see <http://ecdc.europa.eu/en/pages/legalnotice.aspx>

6 See footnote 4 above.

7 It is important to note that the number of syringes reported refers to those distributed through official needle and syringe programmes operating at drugs facilities and pharmacies. Syringes sold at pharmacies are not included.

Figure 4. Status of PrEP implementation in the EU/EEA (as of October 2016)



Source: European Centre for Disease Prevention and Control. Evidence brief: Pre-exposure prophylaxis for HIV prevention in Europe. Stockholm: ECDC; 2016.

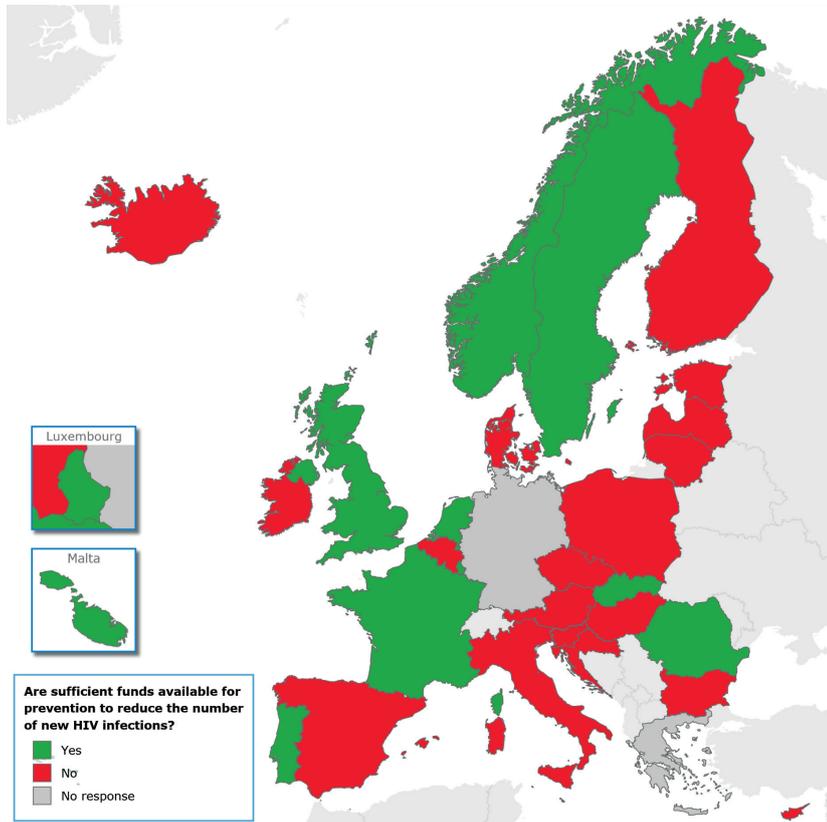
Figure 5. OST and NSP coverage in the EU/EEA, 2016



Source: European Monitoring Centre for Drugs and Drug Addiction (2016), Drug-related infectious diseases in Europe. Update from the EMCDDA expert network, November 2016. Publications Office of the European Union, Luxembourg.

Two out of three countries report that insufficient funds are available for HIV prevention. Of the 28 EU/EEA countries that responded, 18 reported that overall the funds available for prevention are insufficient to reduce the number of new HIV infections, while 10 reported that funding for prevention is sufficient (Figure 6). Moreover, two thirds of the national authorities responsible for HIV prevention report that not enough funds are available for prevention programmes implemented by civil society.

Figure 6. Countries reporting that funds available for prevention are sufficient to reduce the number of new HIV infections



Legal and policy barriers, as well as stigma and discrimination, contribute to limiting the provision and uptake of HIV prevention services for key populations. The main aspect of HIV prevention affected by legal and policy barriers in Europe is the provision of harm reduction interventions, in particular NSP, in prison settings. Almost 50% of EU/EEA countries report that they have laws or policies preventing or limiting this activity. More generally, 25% of EU/EEA countries have laws that criminalise HIV exposure and this is reported to also present a potential barrier to uptake of prevention services. Almost 75% of EU/EEA countries report that stigma and discrimination within the MSM community is a barrier to increasing the uptake of HIV prevention services and, surprisingly, 60% report that stigma and discrimination among healthcare professionals remains a barrier to the provision of adequate HIV prevention services for MSM and PWID.

HIV testing

Testing rates⁸ among populations most at risk of HIV remain too low. Although HIV testing rates vary considerably across the EU/EEA (Table 1), they are reported to be below 50% in a significant proportion of countries. In addition, relatively few countries have testing data for the key populations. Only 18 countries have data on testing among MSM, less than half of countries have data for other key populations, and only one country, Greece, reported data on testing among undocumented migrants.

Table 1. Summary of data on HIV testing rates in key populations reported by EU/EEA countries

Key population	Number of countries reporting data	Range of testing rates	Number of countries reporting testing rates of 50% or less
Men who have sex with men	18	19–87%	10
People who inject drugs	12	6–96%	4
Prisoners	6	2.5–59%	3
Sex workers	4	60–85%	0
Migrants from high prevalence countries	6	4–62%	5
Undocumented migrants	1	16.7%	1

Many people living with HIV in the EU/EEA have not yet been diagnosed. Based on reporting from 20 countries that have this data, around 83% of the estimated total number of people living with HIV (PLHIV) have been diagnosed. This means that 17% (range 9–43%) of PLHIV in these countries have not been tested and linked to care, highlighting the need to increase rates of testing among those who are most at risk of HIV. A modelled estimate of the undiagnosed proportion of people living with HIV was similar, estimating that 15% (95% CI: 14–17%) of PLHIV in the 31 countries of the EU/EEA, or 122 000, were not yet diagnosed⁹. Both of these estimates are very similar, which provides confidence in their robustness.

Among HIV cases that are diagnosed, nearly half are diagnosed late. Late diagnosis is associated with higher mortality, morbidity and healthcare costs and increases the duration of possible HIV transmission. Although the proportion of cases reported as late presenters in the EU/EEA has declined slightly in recent years, rates of late diagnosis are still unacceptably high. In 2015, among those reported cases where information on CD4 cell count at the time of diagnosis was available, 47% were reported as presenting late in the course of their infection (CD4 cell count <350/mm³) (Figure 7). The proportion of late presenters is highest among people who acquired HIV through injecting drug use (58%) and lowest among men who acquired HIV through sex with men (37%). Migrants from sub-Saharan Africa and south and south-east Asia are more likely to be diagnosed late than non-migrants.

Figure 7. Percentage of those with a CD4 count at time of diagnosis that are diagnosed late in the EU/EEA, 2015



Source: European Centre for Disease Prevention and Control/ WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2015. Stockholm: ECDC; 2016.

Gaps in HIV testing services contribute to low rates of testing and high rates of late diagnosis. Almost half of all EU/EEA countries report major gaps in testing services for undocumented migrants, and around one in four report major gaps in testing services for migrants from high-prevalence countries, MSM and sex workers (Table 2). Criminalisation, fear of knowing one's status, low risk perception, denial of risk behaviour, and stigma and discrimination within key populations and in healthcare settings also play a role in low uptake of testing and late diagnosis. A significant proportion of EU/EEA countries report that these factors contribute to late diagnosis among MSM and PWID in particular.

⁸ Defined by UNAIDS as number of people tested for HIV during the past 12 months who know their results. https://aidsreportingtool.unaids.org/static/docs/GARPR_Guidelines_2016_EN.pdf

⁹ Pharris A, Quinten C, Noori T, Amato-Gauci AJ, van Sighem A, the ECDC HIV/AIDS Surveillance and Dublin Declaration Monitoring Networks. Estimating HIV incidence and number of undiagnosed individuals living with HIV in the European Union/European Economic Area, 2015. Euro Surveill. 2016;21(48):pii=30417. DOI: <http://dx.doi.org/10.2807/1560-7917.ES.2016.21.48.30417>

Table 2. Countries reporting major gaps in HIV testing services for key populations (n=30)

Key population	Countries reporting gaps
Undocumented migrants	Austria, Belgium, Croatia, Finland, Germany, Greece, Ireland, Italy, Latvia, Netherlands, Norway, Portugal, Sweden
Migrants from high prevalence countries	Belgium, Croatia, Cyprus, Finland, Ireland, Italy, Latvia, Netherlands
Men who have sex with men	Croatia, Cyprus, Estonia, Finland, Ireland, Latvia, Lithuania
Sex workers	Croatia, Cyprus, Estonia, Finland, Ireland, Italy, Latvia, Netherlands
PWID	Croatia, Cyprus, Estonia, Ireland, Latvia
Prisoners	Croatia, Ireland, Latvia

Few countries authorise or implement alternative HIV testing approaches¹⁰ that could increase uptake and encourage earlier testing for those most at risk. Community-based services delivered by trained non-medical staff can increase the availability, accessibility and uptake of HIV testing for those who are most at risk and most likely to have undiagnosed infection; approaches such as home-sampling and self-testing also show promise. However, only 11 EU/EEA countries authorise community-based HIV testing delivered by trained non-medical staff, only five authorise home-sampling kits and only four authorise self-testing kits (Table 3). Moreover, a number of countries have laws or policies that prevent these approaches from being used.

Table 3. Countries reporting laws or policies that authorise or prevent approaches to HIV testing

	Authorise	Prevent	No applicable laws or policies
Community-based testing delivered by medical staff	24	0	5
Community-based testing delivered by non-medical staff	11	11	8
Home-sampling kits	5	5	19
Self-testing kits	4	7	19

¹⁰ Community testing outside of conventional health facilities can be delivered by trained medical or non-medical staff; home-sampling allows a person to collect their blood or saliva and send it to a laboratory for analysis; self-testing allows a person to collect a specimen, perform a test and see and interpret their results.

HIV treatment and care

Countries are starting treatment earlier. Many countries have stopped using CD4 cell count thresholds or have introduced higher thresholds for starting ART, in accordance with the European AIDS Clinical Society and WHO guidelines issued in 2015 recommending test and treat policies^{11,12}. The number of EU/EEA countries reporting that treatment is initiated irrespective of CD4 cell count has increased from four in 2014 to 24 in 2016 (Figure 8). As a result, together with efforts to increase access to treatment, the number of people on treatment in the EU/EEA has continued to rise.

Figure 8. Policy on ART initiation in the EU/EEA, 2014 and 2016 (as of November 2016)

	2014	2016
Initiation regardless of CD4 count	4 Austria, France, Italy, Romania	24 Austria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, United Kingdom
500 cells/mm³	11 Belgium, Czech Republic, Estonia, Finland, Iceland, Malta, Netherlands, Poland, Slovakia, Spain, Sweden	3 Belgium, Bulgaria, Luxembourg
350 cells/mm³	14 Bulgaria, Croatia, Cyprus, Denmark, Germany, Greece, Hungary, Ireland, Lithuania, Luxembourg, Norway, Portugal, Slovenia, United Kingdom	3 Ireland, Latvia, Lithuania
200 cells/mm³	1 Latvia	0

Despite progress, one in six people diagnosed with HIV are not receiving treatment. Based on reporting by 25 countries that have data¹³, it is estimated that 83% of people diagnosed with HIV are on treatment. This means that around 17% of people with HIV who have been diagnosed are not receiving or benefitting from highly effective treatment.

The proportion of all people estimated to be living with HIV in the EU/EEA and receiving treatment is low. Based on reporting by 19 countries that have data¹⁴, it is estimated that 69% of all people currently living with HIV are on treatment. This means that almost one in three people living with HIV are not receiving treatment. This proportion varies between countries, ranging from less than 25% to more than 85%.

Barriers to treatment include health system challenges and social and cultural factors. Health system challenges to increasing the proportions on treatment include weak referral mechanisms, concerns about confidentiality, limited availability of treatment programmes and poor integration with other health and support services. Stigma and discrimination within key populations and among health professionals, and in some cases language and culture, are further barriers to getting people diagnosed with HIV on to treatment in a number of countries.

Undocumented migrants face particular difficulties in accessing HIV treatment. Half of the countries in the EU/EEA do not provide HIV treatment for undocumented migrants. While 15 countries provide ART for undocumented migrants on the same basis or at the same cost as for others in the country, 15 countries do not (Figure 9).

Almost 9 out of 10 people living with HIV who are on treatment are virally suppressed. Based on reporting by 20 countries that have data¹⁵, it is estimated that 89% of PLHIV who are on treatment have achieved viral suppression. Although viral suppression rates are high in many countries, suggesting that the EU/EEA is close to reaching the UNAIDS target (90% of all people receiving ART achieving viral suppression by 2020) there are wide variations, ranging from 51–95%, with some countries a long way from achieving this target (Figure 10).

The proportion of all people living with HIV who are virally suppressed is low. Based on 2016 reporting by the 17 countries that have this data¹⁶, approximately 63% of those estimated to be living with HIV have achieved viral suppression. Again, there is considerable variation among countries, with the proportion ranging from 3–82%. Currently, three countries (Denmark, Sweden and the United Kingdom) report having achieved the UNAIDS target (73% of all PLHIV virally suppressed by 2020). However, a further five countries (Netherlands, France, Belgium, Germany and Spain) have viral suppression rates over 66% and are within reach of achieving the UNAIDS target by 2020.

11 European AIDS Clinical Society Guidelines. Version 8.0, October 2015 http://www.eacsociety.org/files/guidelines_8_0-english_web.pdf

12 Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach – Second edition. Geneva: World Health Organization; 2016 <http://www.who.int/hiv/pub/arv/arv-2016/en/>

13 No data available for both number diagnosed and number on treatment for Cyprus, Iceland, Liechtenstein, Norway and Slovakia.

14 Austria, Belgium, Bulgaria, Croatia, Denmark, Estonia, France, Germany, Greece, Hungary, Italy, Luxembourg, Netherlands, Poland, Portugal, Romania, Spain, Sweden, United Kingdom.

15 Austria, Belgium, Bulgaria, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Italy, Luxembourg, Netherlands, Portugal, Romania, Slovenia, Spain, Sweden, United Kingdom.

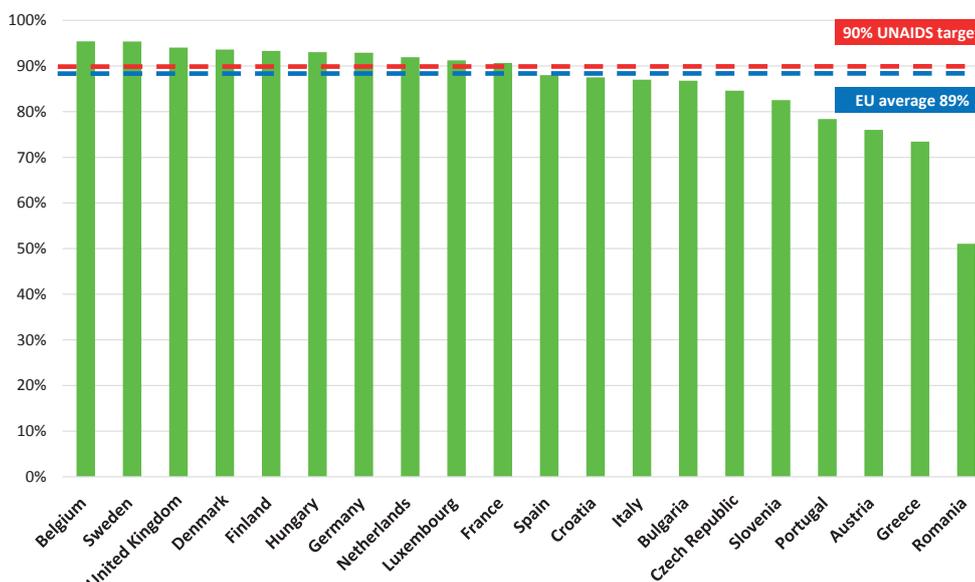
16 Austria, Belgium, Bulgaria, Croatia, Denmark, France, Germany, Greece, Hungary, Italy, Luxembourg, Netherlands, Portugal, Romania, Spain, Sweden, United Kingdom.

Overall treatment costs are increasing and sustainable financing will prove to be difficult for some countries. Rising costs, due to the growing numbers of people on treatment, the fact that people with HIV are now living longer and the higher cost of some of the new and second-line medicines are placing strain on countries' limited resources for HIV. In particular, EU countries that have depended on Global Fund grants will face substantial challenges in fully financing their national responses in future. Data reported by 18 countries in 2014 and 20 countries in 2016 also highlights the variation in the cost of antiretroviral drugs between countries. In 2014, this ranged from EUR 3 800 to EUR 17 500 and in 2016 from EUR 1 000 to more than EUR 20 000 per patient per year (Figure 12).

Figure 9. Access to ART for undocumented migrants in the EU/EEA, 2016



Figure 10. Proportion of people on treatment achieving viral suppression by country*



* Data reported from countries on the continuum of care and based on the latest available data, ranging from 2013 to 2016. For countries where estimates and data are from 2013, 2014 and 2015, progress since then will not be captured. It is important to note that there are methodological differences in how the number of PLHIV is estimated and the number of PLHIV on ART is determined, so data is not directly comparable across countries.

Figure 11. Proportion of all people estimated to be living with HIV having achieved viral suppression by country

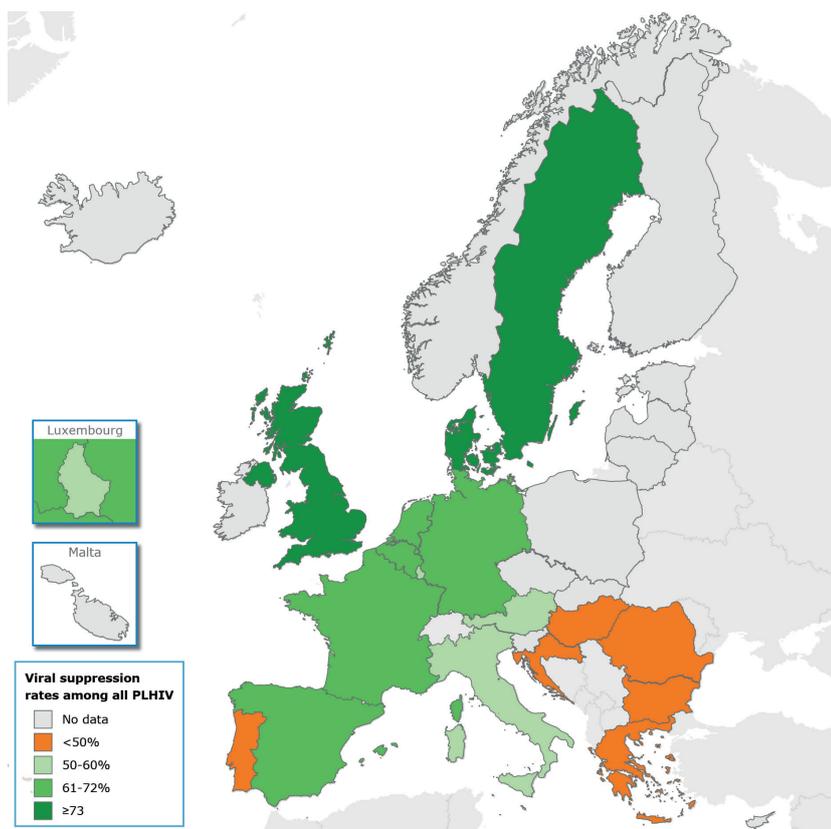
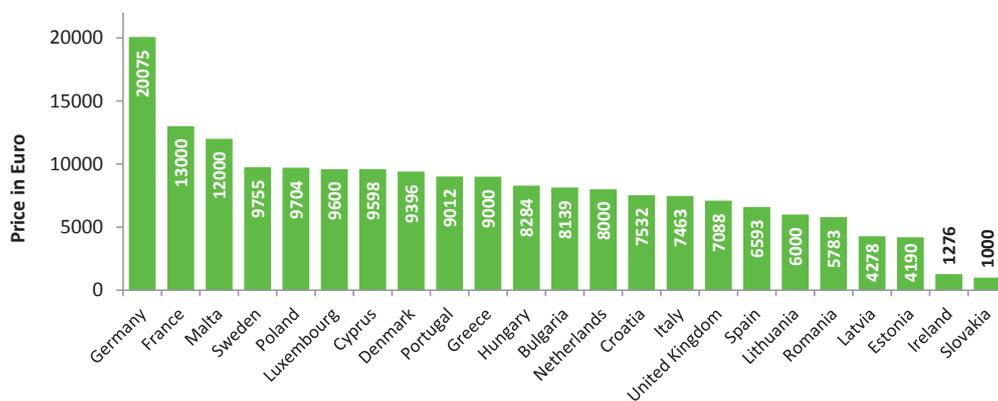


Figure 12. Reported mean cost of ART per patient per year by country, 2014 and 2016*



* Data on mean cost of ART per patient may be collected using slightly different definitions and therefore may not be directly comparable. Furthermore, data reported from Croatia, Ireland and Slovakia were reported to ECDC in 2014. Data provided in other currencies than Euro were converted into Euro using exchange rate for 31 March 2016.

Priorities for action

Prevention: strengthen HIV prevention to reduce the number of new HIV cases

Prevention must be given higher priority in the EU/EEA if it is to reduce the number of new cases of HIV and the resulting impact on individuals and health budgets. Two out of three countries report that funds available for prevention are insufficient to reduce the number of new HIV infections. More needs to be done to improve the delivery and uptake of evidence-based interventions and to ensure that prevention programmes implement a combination of interventions to maximise impact. Specific areas for action include:

- improving the targeting, scale and effectiveness of HIV combination prevention programmes for MSM, giving consideration to the provision of PrEP where this could have a significant impact on reducing new infections among MSM most at risk^{17,18};
- scaling up and sustaining HIV prevention programmes, including OST and NSP interventions, for people who inject drugs in EU/EEA countries where coverage is currently low and there is a risk of HIV outbreaks among this key population¹⁹;
- strengthening targeted HIV prevention programmes for migrants from high-HIV-prevalence countries and migrants from other regions who are at elevated risk of HIV, including migrant MSM and migrant sex workers.

Testing: address low rates of HIV testing and high rates of late HIV diagnosis among key populations

There is an urgent need to increase access to and uptake of HIV testing among key populations, especially those who are most at risk or harder to reach within these populations, in order to reduce the proportion of people living with HIV who do not know their status and who are diagnosed late in the EU/EEA. Specific areas for action include:

- ensuring national HIV testing policies incorporate innovative approaches to HIV testing - including community-based testing, self-testing and home sampling - and allocating adequate resources to support implementation and availability of these approaches;
- reducing missed opportunities for HIV diagnosis in health services, in particular in primary care and other clinical settings, including through routine or opt-out testing where appropriate, and implementing indicator condition guided testing;
- developing more focused and effective case detection approaches to reach the harder-to-reach undiagnosed individuals within key populations.

Treatment: improve access, uptake and sustainability of treatment programmes

Many people living with HIV in the EU are not receiving treatment. Treatment changes HIV from a life-threatening disease into a manageable chronic condition. Treatment also plays an important role in preventing transmission of HIV. Specific areas for action include:

- adopting the 'test and treat' policy in all EU/EEA countries, as per the European AIDS Clinical Society and WHO guidelines;
- reducing barriers to accessing treatment, including inadequate treatment programme coverage, weak referral mechanisms or links to other health and support services, and stigma and discrimination among key populations and health professionals;
- identifying opportunities to reduce the costs of antiretroviral treatment to ensure that all EU/EEA countries can continue to finance treatment for all people living with HIV in the medium and longer term.

17 Noori T, Pharris A. Meeting report: Pre-exposure Human Immunodeficiency Virus Prophylaxis in the EU/EEA: Challenges and Opportunities, Stockholm April 2016. Euro Surveill. 2016;21(25):pii=30263. DOI: <http://dx.doi.org/10.2807/1560-7917.ES.2016.21.25.30263>

18 European Centre for Disease Prevention and Control. HIV and STI prevention among men who have sex with men. Stockholm: ECDC; 2015.

19 European Centre for Disease Prevention and Control and European Monitoring Centre for Drugs and Drug Addiction. Prevention and control of infectious diseases among people who inject drugs. Stockholm: ECDC; 2011.

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