ECDC SPECIAL REPORT

From Dublin to Rome: ten years of responding to HIV in Europe and Central Asia

Summary report

Background

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 Declaration, which aimed to galvanise political action to tackle the epidemic in the region. This brief summarises what has been achieved since 2004, areas where there has been less progress, and priorities for future action. It draws on data reported by countries as part of their monitoring activities for the Dublin Declaration and for UNAIDS global reporting in 2010, 2012 and 2014, and on surveillance data reported by countries to ECDC and WHO's Regional Office for Europe since 2004. In November 2014, the Italian Presidency to the EU Council will host a ministerial conference in Rome to reflect on achievements since the adoption of the Dublin Declaration in 2004 and to propose a new political declaration, focusing on aspects of the response that need attention.

Main achievements

Overall, there has been strong political leadership on HIV in the EU/EEA. Many countries have taken the political decisions required to respond to the epidemic. They have focused resources on the populations most at risk of HIV, provided prevention and testing services and ensured that people with HIV have access to life-saving treatment. In 2014, 80% of EU/EEA countries reported that their prevention funding targets the populations most affected by HIV. Countries have taken steps to create a supportive environment for delivery of services. Governments have worked in partnership with civil society organisations to strengthen and expand the HIV response and civil society organisations have played an important role in providing HIV services across the region and are recognised as an essential partner in almost all EU/EEA countries.

Many EU/EEA countries have expanded prevention programmes for populations most at risk of HIV infection. Country decisions to prioritise funding for those most at risk of HIV infection have resulted in improvements in the coverage and reach of prevention programmes for these populations. In 2014, 90% of EU/EEA countries reported that HIV prevention is delivered at scale[1] for people who inject drugs; 77% reported the same for men who have sex with men; and 67% for sex workers. Although coverage varies largely within and between countries, 93% of EU/EEA countries report that effective policies and laws exist regarding the provision of needle and syringe programmes for people who inject drugs and that these laws are implemented.

[1] In the ECDC questionnaire to monitor the implementation of the Dublin Declaration, 'at scale' was defined as 'at the scale required to meet the needs of the majority of the key population'.

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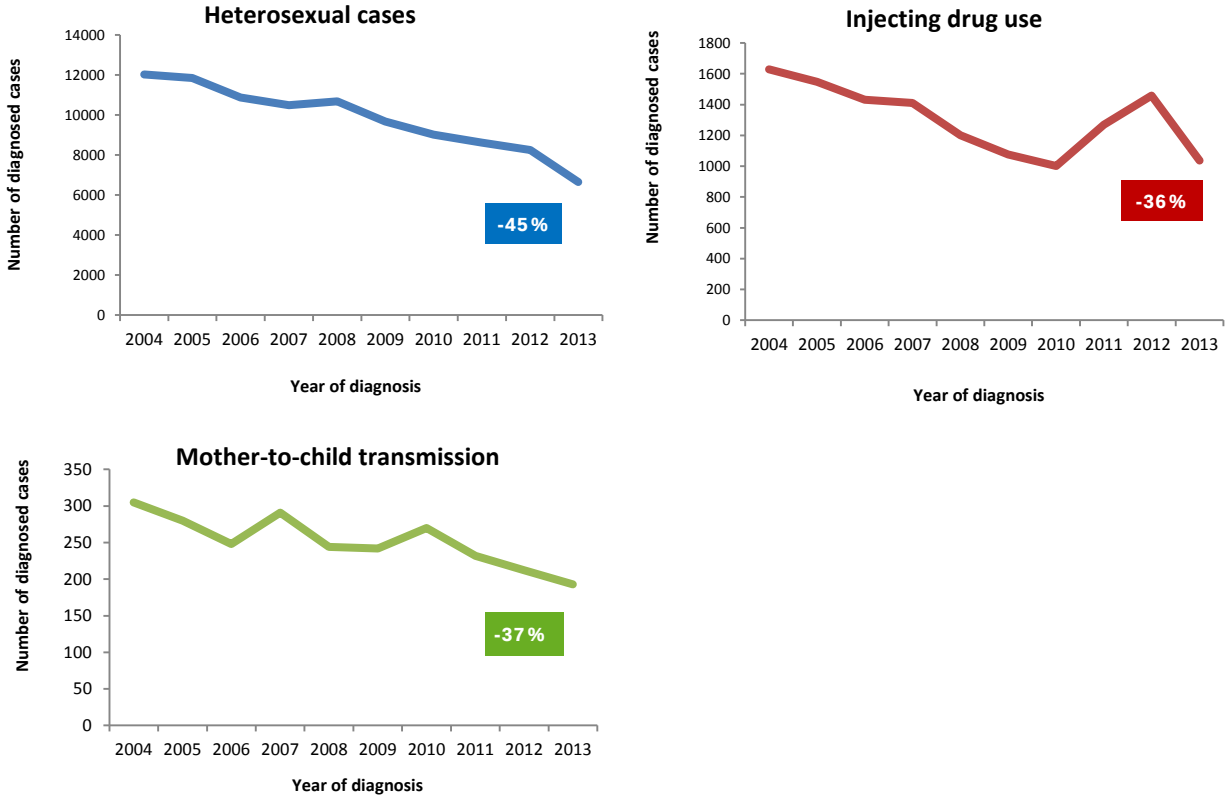
There has been a significant decrease in the number of heterosexually-acquired HIV infections in most countries in the EU/EEA over the past decade. A considerable part of this decrease is due to the decline in the number of heterosexually-acquired cases in people originating from countries with generalised HIV epidemics. Among heterosexual men and women from these countries, the number of new cases declined by 60% and 61%, respectively. While further investigation is required to understand the reasons for the decrease in heterosexually-acquired cases of HIV, the overall trend is a positive one.

New infections among people who inject drugs have declined in most EU/EEA and some non-EU/EEA countries. During the last ten years, there has been a 36% decrease in newly reported cases of HIV among people who inject drugs in the EU/EEA (although there was a slight increase in 2011 and 2012 due to localised outbreaks in Greece and Romania). In 2013, transmission due to injecting drug use in the EU/EEA accounted for only 5% of new reported HIV diagnoses. This reflects the significant efforts made by many countries to implement effective harm reduction programmes at scale. In countries where people who inject drugs account for a significant proportion of prisoners, HIV prevalence among prisoners has also declined.

New infections due to transmission from mother-to-child and transmission and through blood transfusion have decreased dramatically in the EU/EEA. Between 2004 and 2013, mother-to-child transmission and transmission through blood transfusion declined and now account for less than 1% of HIV cases diagnosed. The number of cases of HIV transmitted from mother-to-child declined from 359 in 2004 to 218 in 2013. The number of cases due to transfusion of blood and its products declined from 89 in 2004 to 40 in 2013.

Figure 1. Decreasing trends of HIV diagnosis in the EU/EEA, 2004–2013 (heterosexual cases, injecting drug use, mother-to-child transmission)



Source: ECDC/WHO 2014

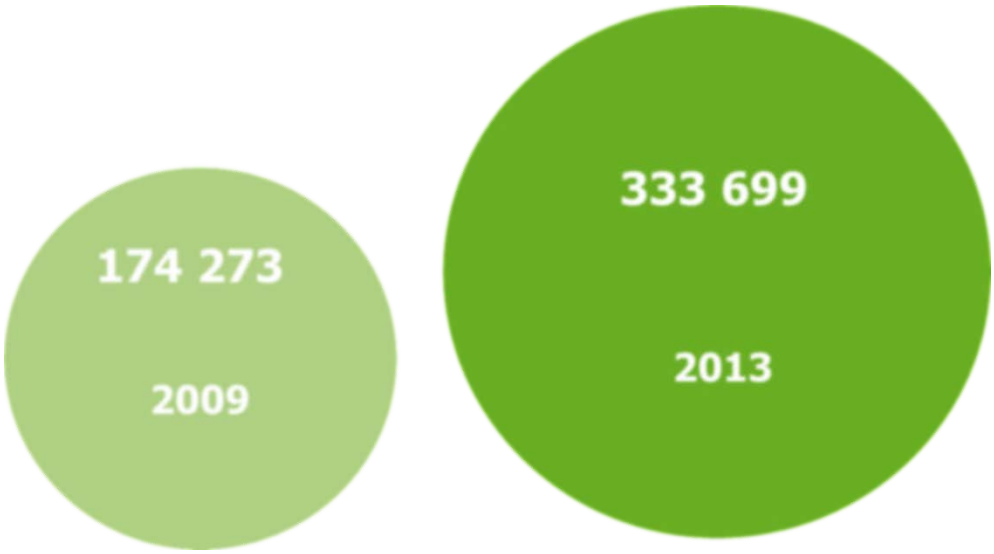
Countries are moving towards a higher CD4 count as a threshold for starting treatment. In most countries, the threshold for starting ART is at CD4 count of ≤350 cells/mm^3. Only Latvia reported currently using a CD4 count of ≤200 cells/mm^3 as the threshold for starting ART. Eighteen countries reported using a CD4 count of 500 cells/mm^3 as the threshold for starting treatment. Several countries, including Austria, France and Greece report that they no longer operate CD4 count-based thresholds for treatment. Twenty countries reported that they are planning to change their treatment guidelines.

Figure 2. CD4 threshold for initiating ART

500 cells/mm³	18 Austria, Belgium, Bosnia and Herzegovina, Czech Republic, Estonia, Finland, France, Georgia, Iceland, Israel, Malta, Netherlands, Poland, Romania, Slovakia, Spain, Sweden, Turkey
350 cells/mm³	29 Albania, Armenia, Azerbaijan, Belarus, Bulgaria, Croatia, Cyprus, Denmark, Germany, Greece, Hungary, Ireland, Italy, Kazakhstan, Kosovo, Kyrgyzstan, Lithuania, Luxembourg, Moldova, Montenegro, Norway, Portugal, Serbia, Slovenia, Switzerland, Tajikistan, Ukraine, United Kingdom, Uzbekistan
200 cells/mm³	1 Latvia
No data reported	7 Andorra, The former Yugoslav Republic of Macedonia, Liechtenstein, Monaco, Russia, San Marino, Turkmenistan

Access to treatment has increased across the region. Data from the 29 countries in the region that reported consistently for the three Dublin monitoring rounds show that the number of people on antiretroviral therapy (ART) in these countries has almost doubled from 174 273 to 333 699.[2] Few countries report that key populations experience difficulties in accessing treatment. In 2014, less than 10% of government respondents reported that sex workers, people who inject drugs, men who have sex with men or prisoners experienced problems accessing ART.

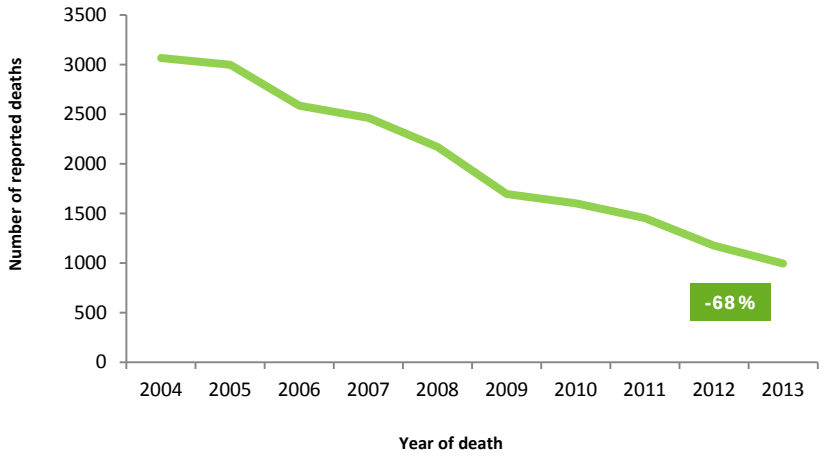
Figure 3. Number of people on antiretroviral therapy in 29 countries with consistent reporting, 2009–2013



The annual number of reported AIDS cases and AIDS deaths has decreased significantly in the EU/EEA during the past decade. In 2013, 4 369 AIDS cases were diagnosed and reported by 29 EU/EEA countries, compared with 9 389 in 2004. Between 2004 and 2013, the number of AIDS deaths each year in the EU/EEA declined significantly, from 3 067 deaths in 2004, to 997 deaths in 2013.

[2] Incomplete data. Figures for countries with large numbers of people on treatment, including France, Netherlands, Portugal, Russia and Switzerland are not included.

Figure 4. Number of AIDS-related deaths reported in EU/EEA countries, 2004–2013

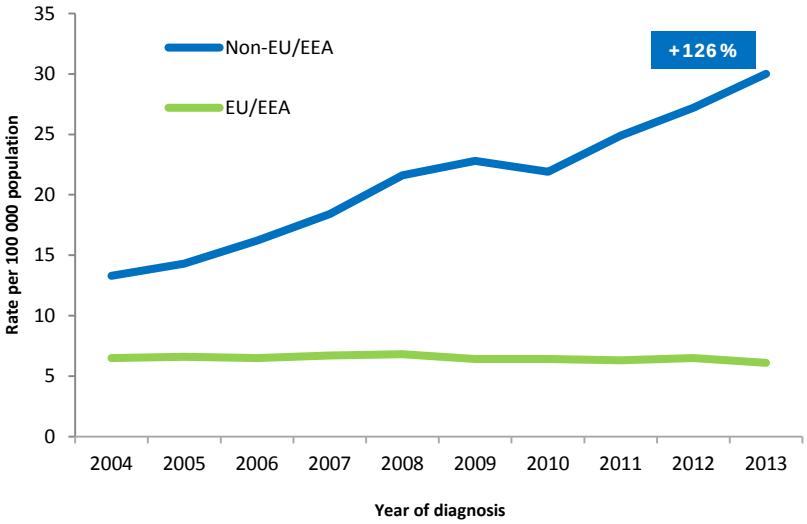


Source: ECDC/WHO 2014

Remaining challenges

HIV remains a significant public health problem in the region. In 2013, 136 235 new HIV infections were diagnosed in 51 of the 53 countries in the region.[3] Of these, 29 157 were diagnosed in 30 EU/EEA countries, where the rate of HIV per 100 000 population has not declined. In non-EU/EEA countries the rate per 100 000 population has more than doubled in the past decade. This highlights the growing divergence in the epidemic across the region, between EU/EEA and non-EU/EEA countries.

Figure 5. Rate of newly reported HIV diagnoses EU/EEA vs. non-EU/EEA countries, 2004–2013

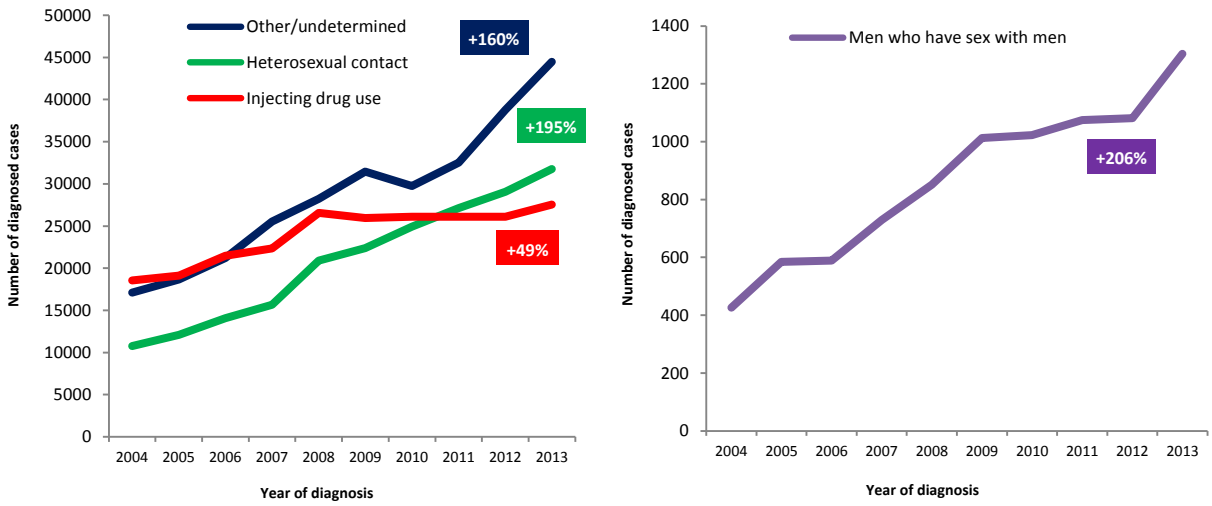


Source: ECDC/WHO 2014

In non-EU/EEA countries most new HIV diagnoses with known transmission mode are reported as heterosexual transmission and injecting drug use. In 2013, the transmission mode was not known for 42% of all cases diagnosed. Among cases where transmission mode was known, 52% of new cases reported were attributed to heterosexual transmission and 45% of new cases were attributed to injecting drug use. Although men who have sex with men account for a much lower proportion of diagnosed cases in non-EU/EEA countries (2% in 2013), a threefold increase is observed for the period 2004–2013.

[3] ECDC/WHO 2014. No data available from Uzbekistan or Turkmenistan. Of the 136 235 infections, 56 507 were officially reported by 50 countries including 29 157 infections from the EU/EEA, while information about 79 728 infections was published by the Russian Federal Scientific and Methodological Center for Prevention and Control of AIDS (HIV-infection Bulletin number 39. Moscow: The Federal Service for Surveillance of Consumer Rights Protection and human well-being; 2014).

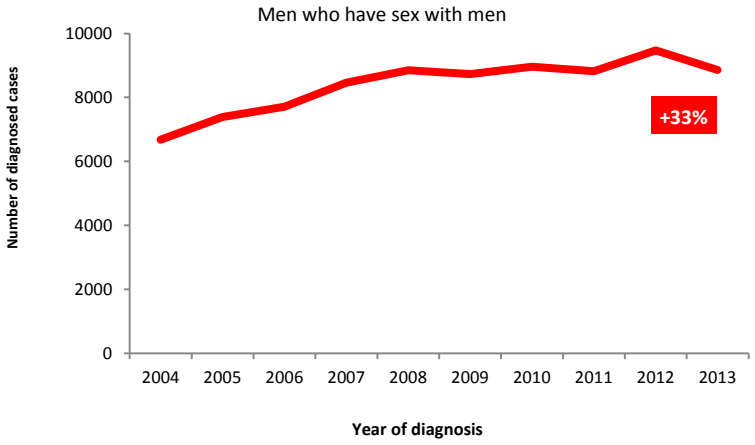
Figure 6. Increasing trends of HIV diagnosis in the non-EU/EEA countries, 2004–2013



Source: ECDC/WHO 2014

HIV infections in men who have sex with men continue to rise in EU/EEA countries. Reported cases among men who have sex with men have increased by 33% since 2004. In 2013, 42% of new cases reported in EU/EEA countries were in men who have sex with men. Moreover, men who have sex with men are the only key population in EU/EEA countries that has not seen a decline in new infections, despite efforts by countries to deliver prevention services at scale to this population. HIV prevalence among men who have sex with men is 5% or higher in 16 EU/EEA countries. Between 2004 and 2013, new cases among men who have sex with men aged 20–24 nearly doubled and increased by 83% among 15–19 year olds. The rising number of cases among younger men who have sex with men is of particular concern, as these are likely to have been infected more recently, suggesting that current prevention efforts may not be having the necessary impact to reduce transmission.

Figure 7. Trends in reported HIV diagnoses among men who have sex with men, EU/EEA, 2004–2013



Source: ECDC/WHO 2014

Migrants are disproportionately affected by HIV in the EU/EEA. Overall, people born outside of the country where they are diagnosed with HIV account for 35% of new cases in the region. Although the number of HIV diagnoses among people coming from countries with generalised epidemics has decreased significantly over the past decade, this relatively small population group still accounts for 15% of all new diagnoses in the EU/EEA. There is also increasing evidence that certain sub-groups of this population are at risk of acquiring HIV after arrival in the EU/EEA.

Prevention programmes for populations at highest risk of HIV infection need to be improved. The continuing increase in HIV infections among men who have sex with men and the continuing occurrence of new infections among other key populations highlight the need to improve the coverage and effectiveness of prevention programmes.

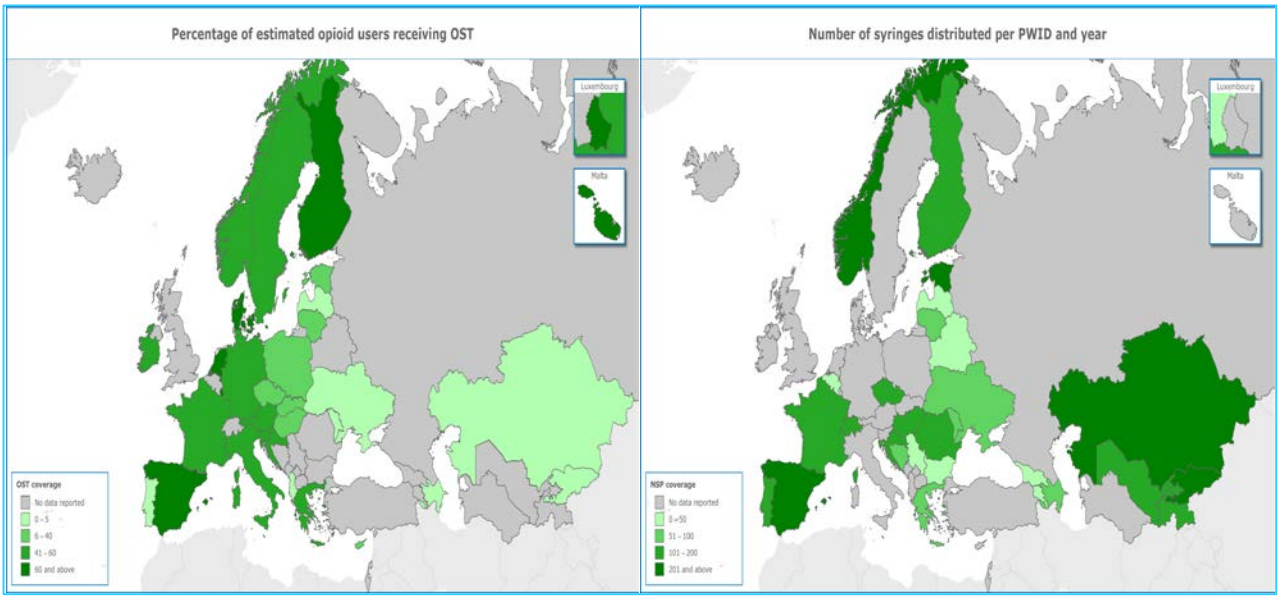
The present coverage and uptake of HIV prevention is insufficient to reduce the number of new infections among all key populations. Despite many countries reporting that prevention is delivered at scale for key populations, primary prevention programmes, including condom promotion and distribution, behavioural interventions, needle and syringe and opioid substitution treatment programmes are not reaching enough people. As shown in Table 1 below, prevention is not delivered at scale for key populations in a number of countries. Coverage and uptake remain too low, particularly among some sub-groups of key populations. Legal and policy barriers, as well as stigma and discrimination, still limit outreach and uptake of services in a number of countries.

Table 1. Prevention delivered at the scale required to meet the needs of the majority population, 2014

	EU/EEA countries		Non-EU/EEA countries	
Key population	**Yes**	**No**	**Yes**	**No**
People who inject drugs	27 (90%)	3 (10%)	17 (94%)	1 (6%)
Men who have sex with men	23 (77%)	7 (23%)	16 (89%)	2 (11%)
Prisoners	21 (70%)	9 (30%)	18 (100%)	0 (0%)
Sex workers	20 (67%)	10 (33%)	15 (88%)	2 (12%)
Migrants in general	16 (57%)	12 (43%)	10 (63%)	6 (38%)
Undocumented migrants	9 (32%)	19 (68%)	4 (29%)	10 (71%)

Coverage of harm reduction programmes is low in most non-EU/EEA countries and some EU/EEA countries. Opioid substitution treatment (OST) and needle and syringe programmes (NSP) are proven, essential, and effective components of harm reduction programmes for people who inject drugs. In 2014, 25 EU/EEA countries reported data on OST coverage, ranging from <1% to >80%. Only 10 EU/EEA countries report coverage above 50%; in six countries, OST coverage is below 20%. OST and NSP coverage is especially low in many non-EU/EEA countries.

Figure 8. OST and NSP coverage among people who inject drugs in Europe and Central Asia, 2014



Coverage of harm reduction programmes is too low in prison settings. In many countries, people who inject drugs account for a significant proportion of prisoners. OST is reported to be available to some extent in prisons in 83% of EU/EEA countries and in 55% of non-EU/EEA countries. However, NSP are far less available in prisons in the region: only 26% of EU/EEA countries and 39% of non-EU/EEA countries report that needles and syringes are available in prison settings.

Limited financial data is available on prevention programmes. In 2014, only 30% of EU/EEA and 50% of non-EU/EEA countries reported having essential data on what proportion of their HIV budget is spent on prevention programmes. Among the countries that do have this data, only seven EU/EEA and nine non-EU/EEA countries report having more detailed information on prevention spending for key populations. Among EU/EEA countries reporting data in 2014, the average percentage of HIV funds spent on prevention was 2% and among the non-EU/EEA countries reporting, the average was 23%.

Low rates of testing and high rates of late diagnosis undermine the effectiveness of the HIV response in the region. Improving uptake of testing and encouraging earlier testing is vital for reducing the proportion of people with HIV who are diagnosed late. Late diagnosis is associated with nearly ten-fold higher mortality in the year following diagnosis, higher morbidity and healthcare costs, and increased duration of possible HIV transmission prior to being diagnosed and treated.

A significant proportion of people who are most at risk of infection have never been tested for HIV. Although rates of HIV testing[4] vary considerably between countries, available data suggests that testing rates are consistently low among key populations including men who sex with men, people who inject drugs and migrants. In 2014, countries reported testing rates of 20–50% among men who have sex with men and 30–60% among people who inject drugs. These low rates of testing mean that many people who need ART are not receiving it because they have not been diagnosed.

Almost half of the reported HIV cases are diagnosed late and are in need of treatment when they are diagnosed. In 2013, 49% of newly reported cases in the WHO European Region were late presenters (CD4 cell count <350/mm3) and 28% had evidence of advanced HIV infection (CD4 cell count <200/mm3). The proportion of late presenters is highest among heterosexual people coming from countries with generalised HIV epidemics (59%) and then among people who inject drugs (56%). More than one third of men who have sex with men are also diagnosed late.

Figure 9. Percentage of those with a CD4 count at time of diagnosis that are diagnosed late, WHO European Region, 2013

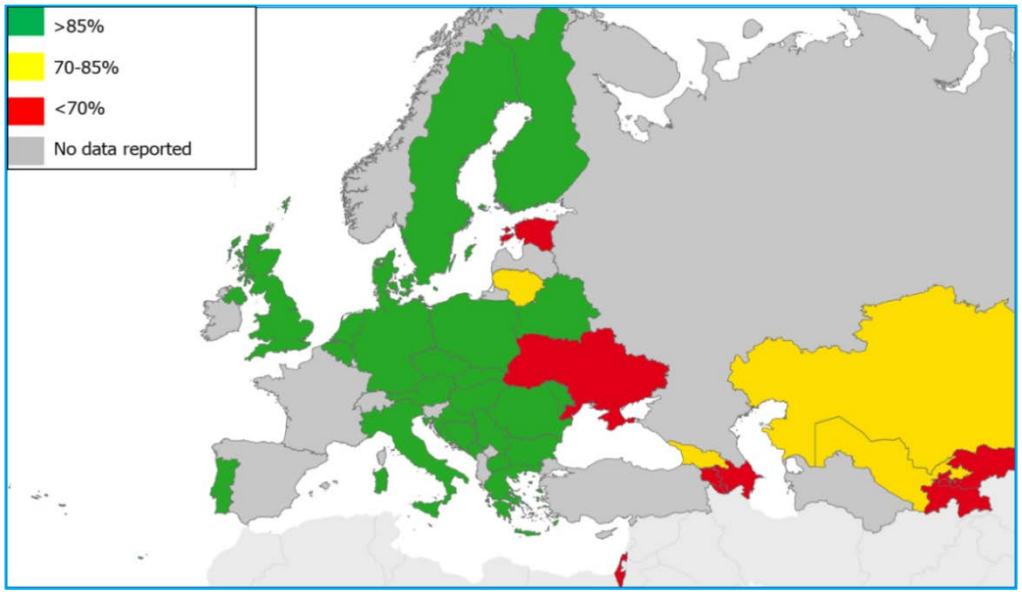
Source: ECDC/WHO 2014

Treatment is still a major challenge in some EU/EEA and many non-EU/EEA countries. Despite progress, a significant percentage of people still do not have access to treatment, particularly in non-EU/EEA countries, and sustaining financing for treatment is a concern for several of these countries.

Some people diagnosed with HIV and eligible to start ART do not receive it. This is the exception in some EU/EEA countries but is the norm in many non-EU/EEA countries. Of 36 countries with available data, more than 85% of people known to have HIV and considered to need ART received it in most of them. However, 11 countries reported figures below this level, with reported rates as low as 18%. Most of these countries are outside the EU/EEA. A total of 19 countries were unable to provide relevant data during this period

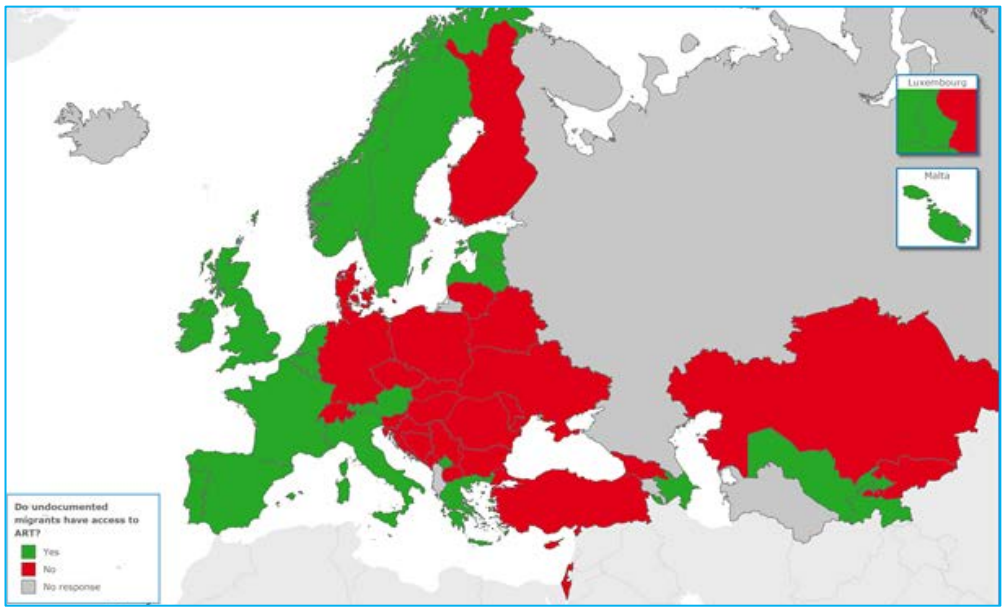
[4] Percentage of people who have received an HIV test in the past 12 months and know their results.

Figure 10. Proportion of PLHIV[5] eligible for treatment and receiving it[6] (2010–2013)



Undocumented migrants face particular difficulties in accessing HIV-related services. Undocumented migrants are more likely to face barriers to prevention, testing, treatment and care, due to lack of legal residence status and health insurance. In many countries, undocumented migrants are only entitled to emergency healthcare and therefore do not have access to long-term HIV treatment. In 2014, 26 out of 46 (57%) countries reported that undocumented migrants have difficulty accessing HIV treatment, care and support.

Figure 11. Availability of ART to undocumented migrants in Europe and Central Asia, 2014

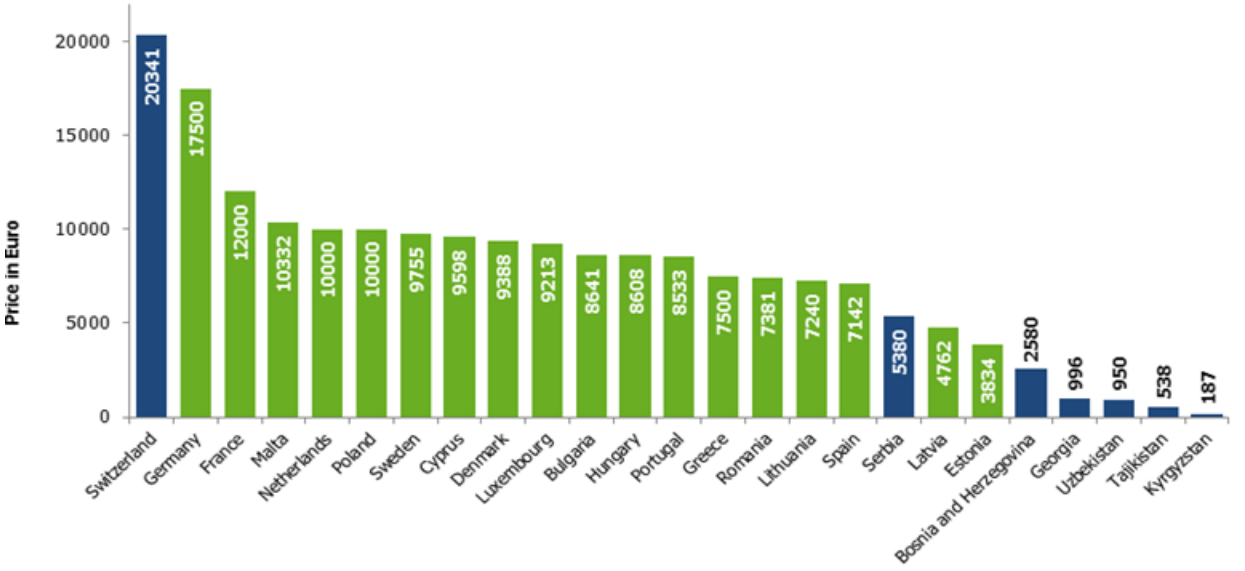


Treatment costs are increasing and financing an adequate HIV response will be challenging for some countries. In 2014, 37 governments reported an increase in national spending on treatment over the last two years. Rising costs are due to the increasing numbers of people who are on treatment as well as the high cost of new and second-line medicines. Data reported by countries also highlights the variation in costs of antiretroviral drugs between countries (see Figure 12). In addition, low and middle-income non-EU/EEA countries that are highly dependent on international funding, such as Global Fund grants, will face substantial challenges financing their national responses if this support is reduced or terminated.

[5] PLHIV – people living with HIV and AIDS

[6] Country reported estimates; some countries could not provide estimates and many provided the proportion of diagnosed people living with HIV/AIDS on treatment.

Figure 12. Reported average cost of ART per patient and year (2013)



Too many people in the region, particularly in non-EU/EEA countries, are still developing AIDS-related illnesses or dying from AIDS. This is because they are either not getting tested, are tested too late, or are not getting treatment or start treatment too late. In 2013, a total of 15 789 AIDS cases were diagnosed in 49 countries of the WHO European Region. The number of AIDS cases reported by non-EU/EEA countries increased from 3 585 in 2004 to 11 420 in 2013. The number of reported AIDS deaths increased in non-EU/EEA countries, from 2 224 in 2004 to 4 040 in 2013.[7]

There is still inadequate or missing data on many critical aspects of the HIV situation and response. There are significant gaps in knowledge of: the state of the epidemic (e.g. incidence, prevalence and co-infections); key populations (e.g. demographics, risk behaviour, factors that influence risk and uptake of services, sub-populations at increased risk and overlapping risk behaviour, especially among prisoners and sex workers); and the state of the response (e.g. testing uptake, late diagnosis, treatment access, adequacy of funding and effective prevention interventions for hard-to-reach populations). In addition, many countries lack information on the continuum of HIV care, which tracks critical data ranging from the estimated number of people who are infected with HIV to the number of people on treatment who are virally suppressed.

Essential priorities for action

PREVENTION: improve coverage, uptake and targeting of evidence-based prevention programmes across the region. For men who have sex with men there is an urgent need for countries to improve the coverage, scale and effectiveness of targeted HIV prevention programmes. In addition to sexual behaviour messages that use appropriate language and promote condom use, early testing and treatment, consideration should be given to the role of biomedical interventions, such as pre-exposure prophylaxis and post-exposure prophylaxis where appropriate. For people who inject drugs effective harm reduction and HIV prevention programmes need to be scaled up[8] significantly, especially OST and NSP in non-EU/EEA countries and in EU/EEA countries where coverage is currently low. For migrants, given that they account for 35% of all new infections reported in the EU/EEA and that about one-third of the heterosexually-acquired HIV cases are among migrants originating from countries with generalised epidemics, prevention interventions targeting these populations need to be developed and implemented at scale. For prisoners, there is a need to ensure that essential evidence-based HIV prevention interventions, including OST, NSP and condoms, are made available in all prisons.

TESTING: address low rates of HIV testing and high rates of late HIV diagnosis among key populations. There is a pressing need to increase uptake of HIV testing among key populations and promote earlier diagnosis. This may require innovative and community-based approaches to ensure that HIV testing services are targeted at, accessible to and used by those people who are most at risk of infection.

TREATMENT: expand access to treatment and improve the effectiveness of treatment services. There is a need to scale up the provision of ART, especially in non-EU/EEA countries in the region, as well as to address the factors that prevent key populations from accessing treatment. Increasing the proportion of people with an undetectable viral load is critical to reducing the long-term impact of the HIV epidemic in Europe.

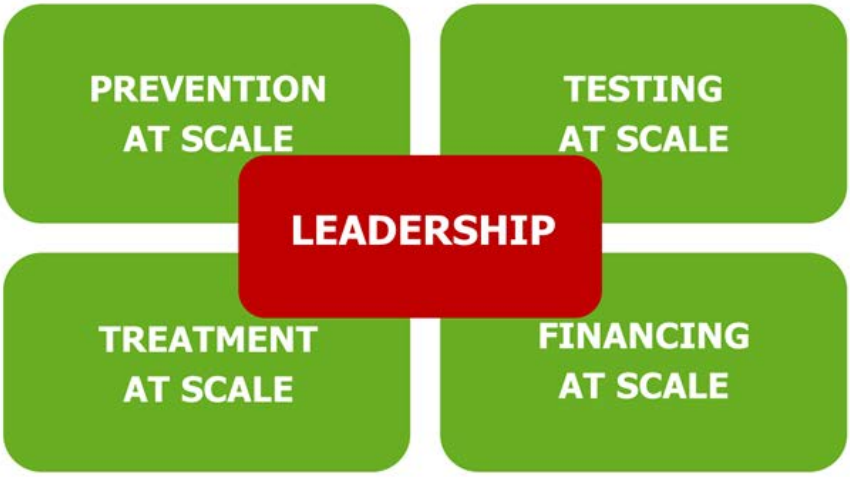
[7] Does not include data from Russia.

[8] 'At scale' is here defined as 'meeting the needs of the majority of the target population to have a desired impact on reducing new infections.'

FINANCING: ensure adequate and sustainable financing for national HIV responses. There are five critical issues: sustaining adequate funding for politically sensitive interventions such as harm reduction and funding for targeted prevention for men who have sex with men in Central and Eastern Europe; managing the costs of antiretroviral drugs; ensuring enough resources are allocated for core prevention activities to be delivered at scale; ensuring that those countries heavily dependent on external funding can take on the financing of future HIV programmes; and sustain funding for civil society organisations to deliver key services essential for effective national responses.

LEADERSHIP: provide strong political leadership to ensure effective national responses to HIV. Strong political leadership at national and regional level will be central to ensuring the actions identified above are given precedence over competing priorities and to ensure that funding is sustained and allocated to programmes targeting the populations who are most affected by HIV.

Figure 13. Essential priorities for action based on data provided to ECDC through the framework of monitoring the Dublin Declaration



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