

HIV prevention in Europe

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.



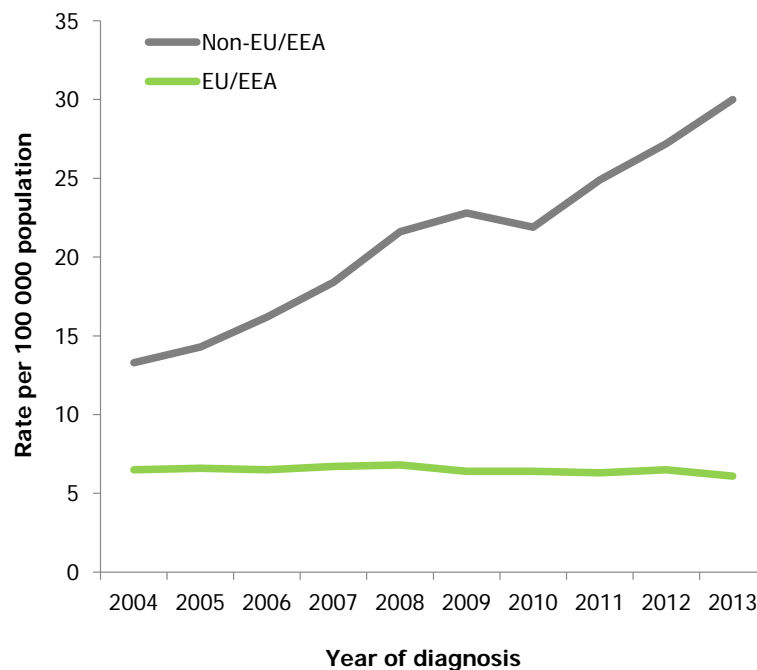
Following ECDC's 2010 and 2012 progress reports, a new series of thematic reports and evidence briefs present the main findings, discuss key issues, and assess the progress made since 2012 in Europe's response to HIV.

Why is HIV prevention important in Europe?

The number of people who are newly infected with HIV each year continues to be unacceptably high. Despite the existence of proven prevention interventions, more than 136 000 people were newly infected with HIV in Europe in 2013¹.

Rates of new infection show no signs of declining. During the last decade the rate of new infections has remained unchanged in the EU/EEA and has increased by 126% in non-EU/EEA countries.

Figure 1. Rate of newly reported HIV cases in EU/EEA and non-EU/EEA countries, 2004–2013¹



¹ European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2013. Stockholm: ECDC; 2014

New HIV cases in men who have sex with men continue to rise. In the EU/EEA, new cases of HIV in men who have sex with men (MSM) increased by 33% in the last decade; new cases nearly doubled in the MSM age group 20–24 years and increased by 83% in the 15–19 year age group. In non-EU/EEA countries, the number of new cases increased threefold during the same period. Although reported condom use is relatively high, a significant proportion of men who have sex with men are exposed to HIV infection through unprotected sex.

HIV transmission among people who inject drugs remains high in non-EU/EEA countries; HIV outbreaks have occurred in the EU/EEA.

In 2013, HIV infection due to injecting drug use accounted for 31% of all new cases in non-EU/EEA countries, but for only 5% of new cases in the EU/EEA. However, HIV outbreaks resulting in a significant number of new cases in people who inject drugs have been reported in some EU/EEA countries¹.

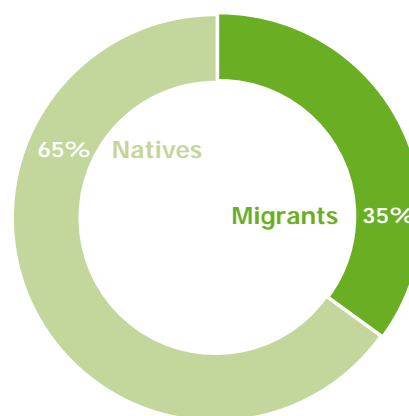
136 000
Number of people newly infected with HIV in the WHO European Region in 2013

107 000
Number of people newly infected with HIV in non-EU/EEA countries in 2013

29 000
Number of people newly infected with HIV in the EU/EEA in 2013

Migrants are disproportionately affected by HIV in the EU/EEA. In 2013, 35% of all new HIV diagnoses in the EU/EEA were in people who were born outside the country in which the case was reported¹. There is increasing evidence that migrants from countries with generalised epidemics, migrant men who have sex with men, and migrants who inject drugs are at risk of acquiring HIV after arrival in the EU/EEA.

Figure 2: Proportion of new HIV diagnoses among migrants and non-migrants, EU/EEA, 2013



Source: ECDC/WHO¹

What are the main challenges?

Countries across the region report major gaps in prevention programmes for populations most at risk of HIV. A significant proportion of countries report that they have gaps in programmes for MSM, prisoners, people who inject drugs, and migrants. Frequently cited gaps include a lack of targeted programmes for those who are most at risk, low coverage of proven interventions, poor uptake of interventions, insufficient funding, and poor availability of commodities such as condoms, needles and syringes. There is a lack of data about who is most at risk and about the effectiveness of prevention programmes.

Table 1. Governments reporting major gaps in prevention programmes for populations most at risk of HIV

	EU/EEA countries
Men who have sex with men	20/30
Prisoners	20/28
People who inject drugs	13/23
Migrants in general	9/25
Undocumented migrants	11/22

Prevention programmes are not targeting the people who are most at risk. Few countries have HIV prevention programmes that target subgroups of key populations who are at increased risk. This includes MSM who engage in high-risk sexual or drug-related behaviour; migrant MSM; younger MSM; sex workers who inject drugs; HIV-positive women who do not seek healthcare during pregnancy; and migrants at risk of post-arrival acquisition of HIV.

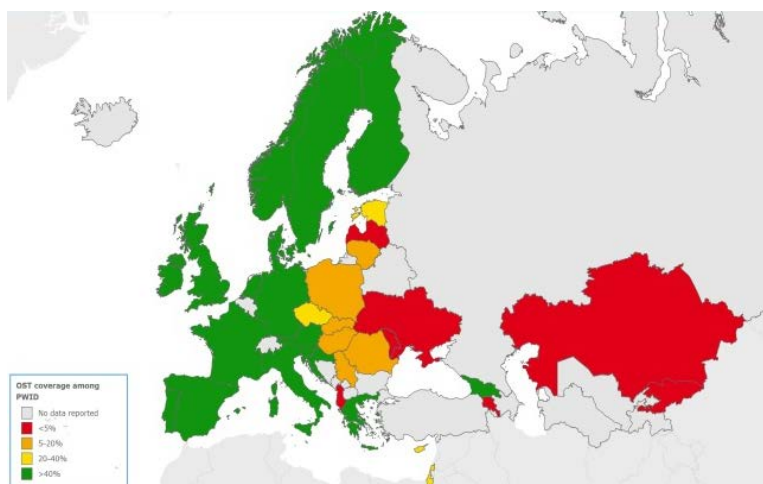
Coverage of HIV prevention programmes for key populations is inadequate. Almost one in four EU/EEA countries reports that prevention for men who have sex with men is not delivered at scale, and one in three state that prevention for sex workers is not delivered at scale. Prevention programmes for undocumented migrants are inadequate in more than half of countries in the region.

Table 2. Governments reporting whether prevention is delivered at the scale required to meet the needs of the majority of key populations in their programmes

	EU/EEA countries		Non-EU/EEA countries	
	Yes	No	Yes	No
People who inject drugs	27	3	17	1
Men who have sex with men	23	7	16	2
Prisoners	21	9	18	0
Sex workers	20	10	15	2
Migrants in general	16	12	10	6
Undocumented migrants	9	19	4	10

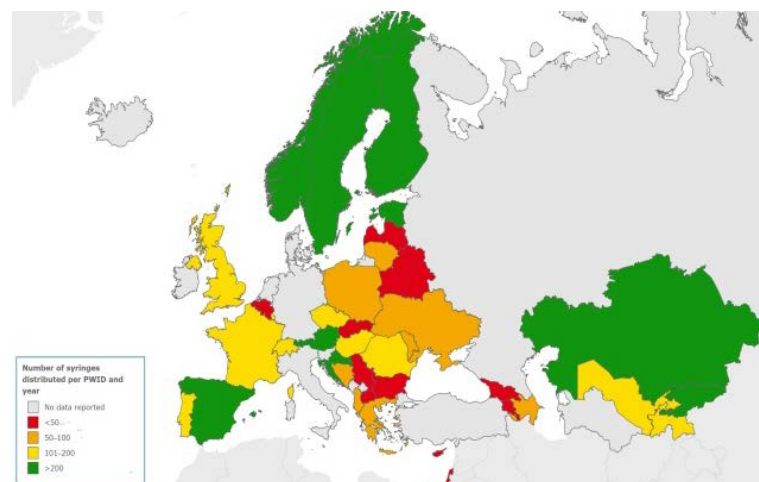
Availability of prevention interventions for people who inject drugs is low. Although most countries report that prevention programmes for people who inject drugs are delivered at scale, opioid substitution therapy coverage is reported to be low (<20%) in 6 of the 27 EU/EEA countries that reported data and in 7 of the 9 non-EU/EEA countries that reported data. While 18 of 27 EU/EEA countries report high coverage (>40%), only one non-EU/EEA country reported coverage above 40%. The number of syringes distributed is below acceptable standards¹ in one third of EU/EEA and most non-EU/EEA countries. Ongoing transmission of HIV among people who use drugs in many non-EU/EEA countries and recent HIV outbreaks in Greece and Romania highlight the need to maintain or scale up these interventions in all countries where this population may be at risk of infection.

Figure 3. Opioid substitution therapy (OST) programmes: coverage among people who inject drugs, 2014



¹ EMCCDA defines this as >200/person who injects drugs (PWID)/year although this will vary depending on the frequency of injecting; 100/PWID/per year is defined as the minimum standard.

Figure 4. Needle and syringe programmes: coverage among people who inject drugs (PWID), 2014



Availability of prevention interventions in prisons is also low. People who are or were involved in injecting drugs account for a high proportion of prisoners in many countries. Opioid substitution therapy is available to some extent in prisons in 50% of non-EU/EEA countries and more than 80% of EU/EEA countries, but only 18 EU/EEA countries and 4 non-EU/EEA countries provide it in all prisons. Far fewer countries provide sterile injecting equipment in prisons. Only 26% of EU/EEA and 39% of non-EU/EEA countries provide needles and syringes to some extent in prisons, and only three countries, all of them in the EU/EEA, provide injecting equipment in all prisons. Very few countries provide free condoms at sufficient scale in prisons.

Laws and policies can hinder the effectiveness of HIV prevention. Laws that criminalise drug use make it difficult to reach people who inject drugs with prevention interventions; they also discourage uptake of services. In many countries, laws and policies limit the implementation of harm reduction programmes in community settings and in prisons. Criminalisation of sex work is a barrier for HIV prevention programmes across the region, but there are particular concerns about the trend towards greater criminalisation of sex work and sex workers' clients in the EU/EEA because this may drive sex work underground and deter sex workers from accessing prevention and care services. Countries across the region also identified laws and policies that prevent people without health insurance, in particular undocumented migrants, from accessing HIV prevention services. In some non-EU/EEA countries, laws that criminalise homosexuality hinder HIV prevention for men who have sex with men.

Countries have insufficient data on who is most at risk; there is also a shortage of data on risk behaviours and risk-reduction behaviours among key populations. Limited data make it difficult to plan and implement effective prevention programmes. The lack of data about which subgroups of key populations are at greatest risk of HIV is particularly problematic. For example, only 10 EU/EEA and 5 non-EU/EEA countries report that they have data on risk behaviours among men who have sex with men; and only 7 EU/EEA and 2 non-EU/EEA countries have data on risk-reduction behaviours for the same population.

Few countries are using treatment as a preventive strategy. Effective ART for people living with HIV reduces their viral load and infectiousness, which helps to prevent onward transmission of HIV. However, the success of treatment as a preventive strategy depends on achieving higher HIV testing rates among key populations and retaining newly diagnosed people in care. To date, only a few countries, mostly in the EU/EEA, employ a test-and-treat strategy (regardless of CD4 count), and experience and evidence in this area is limited.

What needs to be done?

Effective HIV prevention is critical to reduce the impact of the epidemic in the region. Prevention also makes sound economic sense, given the costs of lifelong treatment for HIV. However, prevention programmes continue to be inadequate, coverage is too low, and impact is limited, despite the fact that many countries report that funding for prevention prioritises key populations and that prevention programmes are delivered at scale for these populations. The continuing increase in HIV infections among men who have sex with men and in other key populations highlights the need for urgent action to improve the reach and effectiveness of prevention programmes.

Key options for action

Implement **targeted, evidence-based HIV prevention programmes for key populations** who are most at risk but who are not being reached by (or are not responding to) current interventions, in particular men who have sex with men and migrants from countries with generalised epidemics.

Expand the availability of **key prevention interventions for people who inject drugs**, specifically injecting equipment and opioid substitution therapy, in countries where community and prison coverage is low.

Consider **reviewing repressive laws and policies** that limit provision and uptake of HIV prevention services among some key populations.

Collect better **data on subgroups** of key populations at increased HIV risk.

Improve and share **evidence about innovative approaches to HIV prevention**, including the feasibility, cost and effectiveness of treatment as prevention.

Explore options for supporting **sustainable financing of prevention programmes** in non-EU/EEA countries.

Stockholm, September 2015

ISBN 978-92-9193-666-3

doi 10.2900/719476

Catalogue number TQ-01-15-582-EN-N

© European Centre for Disease Prevention and Control, 2015

Reproduction is authorised, provided the source is acknowledged