



SPECIAL REPORT

Thematic report: Men who have sex with men

Monitoring implementation of the Dublin Declaration on
Partnership to Fight HIV/AIDS in Europe and Central Asia:
2014 progress report

ECDC SPECIAL REPORT

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Monitoring implementation of the Dublin Declaration on Partnership to
Fight HIV/AIDS in Europe and Central Asia: 2014 progress report



This report of the European Centre for Disease Prevention and Control (ECDC) was managed by Teymur Noori, with technical support provided by Andrew J. Amato-Gauci, Anastasia Pharris, César Velasco Muñoz, Lara Tivoschi, Otilia Mårdh, Gianfranco Spiteri, Caroline Daamen, Pierluigi Lopalco, Denis Coulombier and Piotr Kramarz.

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* This designation is without prejudice to positions on status, and is in line with UNSC 1244 and the ICJ Opinion on the Kosovo Declaration of Independence.

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Abbreviations

ART	Antiretroviral therapy
ECDC	European Centre for Disease Prevention and Control
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EMIS	The European MSM Internet Survey
EU/EEA	European Union/European Economic Area
GARPR	Global AIDS Response Progress Reporting
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
MSM	Men who have sex with men
NGO	Non-governmental organisation
NSP	Needle and syringe programmes
OST	Opioid substitution therapy
PMTCT	Prevention of mother-to-child transmission
PWID	People who inject drugs
STI	Sexually transmitted infection
WHO	World Health Organization

Men who have sex with men

This report, which is based on data provided by countries for reporting on the Dublin Declaration¹, summarises key issues related to HIV and men who have sex with men (MSM) in Europe and Central Asia. It identifies priority options for action to improve the HIV response for this key population.

Note on data sources

This report uses the latest data reported by countries, in 2012 or 2014, for three Global AIDS Response Progress Reporting (GARPR) indicators: HIV prevalence, HIV testing and condom use; additional data were collected by means of a Dublin Declaration questionnaire. The report also draws on surveillance data reported to ECDC for 2004–2013 and data collected through the SIALON study (see Box 1 below). The 2014 Dublin questionnaire included a specific section on MSM with questions about risk factors and risk behaviours, programmes to promote HIV testing, testing uptake, and the effectiveness of prevention programmes. It also included questions about the scale at which interventions are delivered for MSM, the extent of stigma and discrimination MSM experience, and MSM involvement in policy and implementation. It is important to note that some of these questions were open to interpretation by respondents. The questionnaire and data tables are available on the ECDC website².

Men who have sex with men: the situation

Significant gaps in HIV and MSM data

Information on HIV and MSM has improved, but still varies widely across the region. Most reported data are from surveys that are based on small sample sizes and use different methods. This means there are limited nationally representative data on HIV prevalence, HIV testing or condom use among MSM. In addition, data quality is too low to produce meaningful comparisons over time and across countries. Other gaps include data on MSM subgroups who may be at higher risk of HIV infection and on risk behaviours and risk reduction strategies.

HIV prevalence among MSM is 5% or higher in more than half of the EU/EEA countries

Recent data³ on HIV prevalence rates among MSM are available from 38 countries in the region – 21 EU/EEA countries and 17 non-EU/EEA countries (Figure 1). In the included EU/EEA countries⁴, reported prevalence ranged from < 1% in Bulgaria to 17.7% in France. Prevalence was 5% or above in 12 countries (Belgium, France, Germany, Greece, Ireland, Italy, Latvia, the Netherlands, Portugal, Romania, Slovenia and Spain). In the 17 non-EU/EEA countries⁵, reported prevalence ranged from < 1% in Andorra and the former Yugoslav Republic of Macedonia to 11.2% in Switzerland. Prevalence was 5% or above in seven of these 17 countries (Belarus, Georgia, Kyrgyzstan, Moldova, Serbia, Switzerland and Ukraine).

In 2014, 19 countries reported prevalence data disaggregated by age. Overall, reported prevalence is lower for MSM 25 years of age or younger (2.9%) than for MSM over 25 years of age (7.7%). This difference is similar for EU/EEA and non-EU/EEA countries. It was expected that prevalence would be lower among younger men, but reported prevalence rates do not yet reflect the increase in new diagnoses observed in younger MSM.

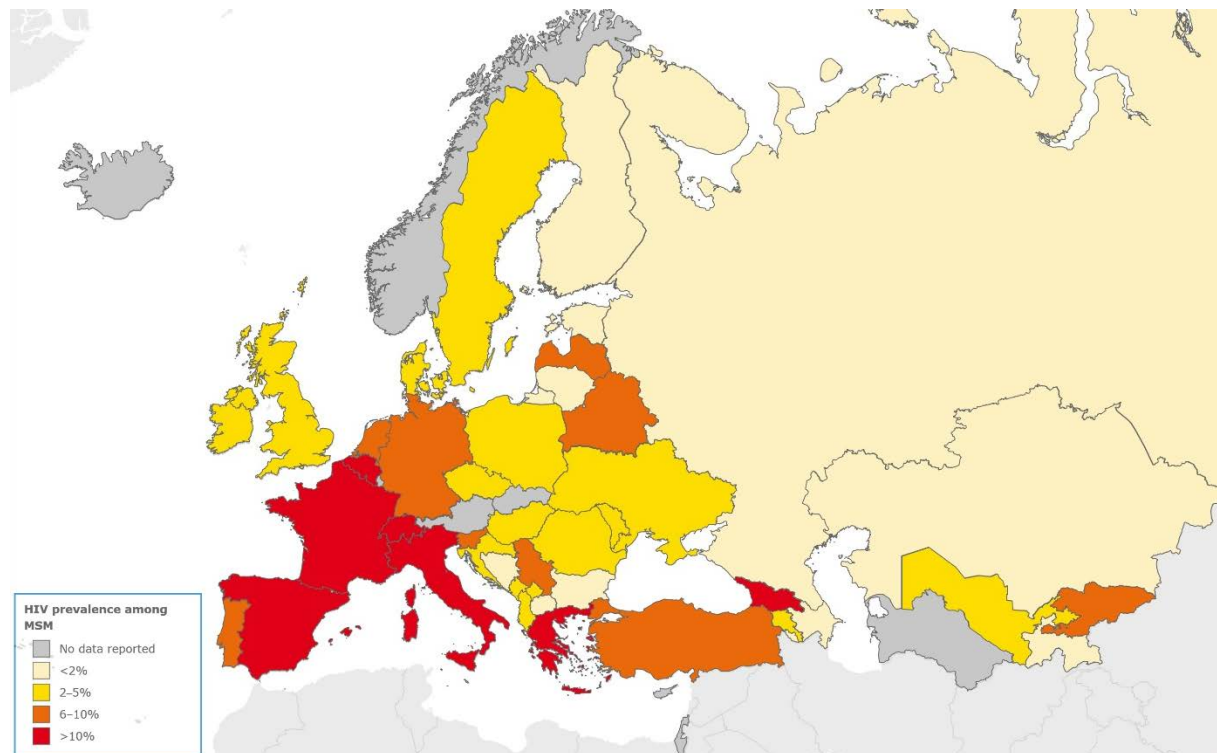
¹ WHO Regional Office for Europe. Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia. [Internet]. 2004 [cited 2015 Jun 1]. Available from: <http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/policy/guiding-policy-documents-and-frameworks-for-whoeuropes-work-on-hiv/dublin-declaration-on-partnership-to-fighthivaids-in-europe-and-central-asia>

² European Centre for Disease Prevention and Control. Monitoring of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia – Questionnaire. Stockholm: ECDC; 2009. Available from: http://ecdc.europa.eu/en/healthtopics/documents/1009_questionnaire_to_monitor_dublin_declaration.pdf

³ Data reported in 2014 or 2012.

⁴ No data were reported by Austria, Cyprus, Iceland, Luxembourg, Malta, Norway and Slovakia.

⁵ No data were reported by Andorra, Israel, Kosovo, Monaco, Russia, San Marino, Turkey and Turkmenistan.

Figure 1. Reported HIV prevalence among MSM, 2011–2013

Box 1. Other data on HIV prevalence

The EU-funded SIALON II* project collected data on HIV prevalence in 11 European cities among a total of 4 966 MSM in 2013 and 2014. Findings showed that HIV prevalence in MSM was < 5% in five cities (Bratislava, Ljubljana, Sofia, Stockholm and Vilnius), between 5 and 10% in three (Hamburg, Verona and Warsaw), and between 10 and 20% in five (Barcelona, Brighton, Brussels, Bucharest and Lisbon).

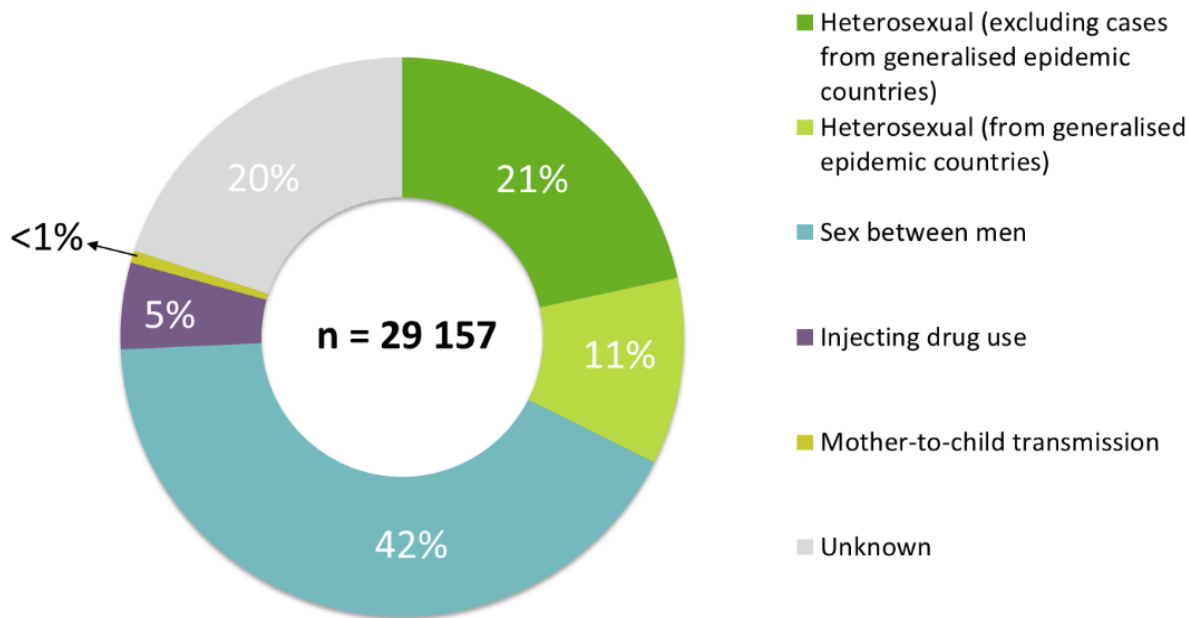
Source: SIALON II Project: GARPR indicators in Barcelona, Bratislava, Brighton, Brussels, Bucharest, Hamburg, Lisbon, Ljubljana, Sofia, Stockholm, Verona, Vilnius and Warsaw among MSM. [Unpublished draft report] Berlin; 2015. To be made available at: www.sialon.eu

* SIALON II. Projects: overview. [Internet]. (c) 2008–13 [cited 2015 Jun 2]. Available from: <http://www.sialon.eu/en/what-is-sialon-projects/>

Sex between men is the predominant mode of transmission in the EU/EEA; in 2013 more than 40% of all new cases reported were in MSM

In 2013, 42% of all newly diagnosed HIV cases reported in the EU/EEA were in MSM (Figure 2); in the region as a whole, the proportion of new cases attributed to sex between men was 24%.

Figure 2. Mode of transmission of newly diagnosed HIV cases reported in the EU/EEA, 2013

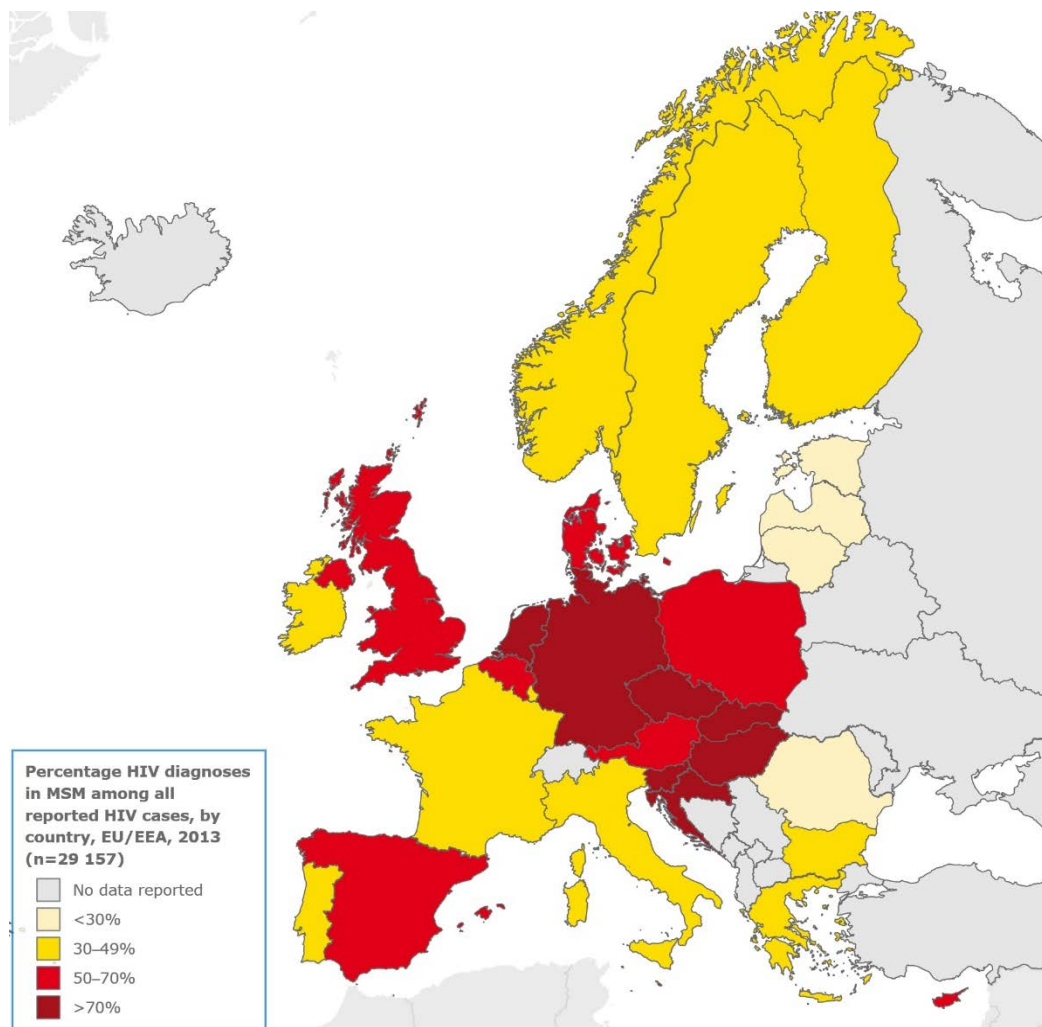


Source: ECDC/WHO⁶

However, the proportion is higher in some EU/EEA countries. More than 50% of all new diagnoses in 2013 in Austria, Belgium, Croatia, Cyprus, the Czech Republic, Denmark, Germany, Hungary, Malta, the Netherlands, Poland, Slovakia, Slovenia, Spain and the UK were in MSM (Figure 3).

⁶ European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2013. Stockholm: ECDC; 2014

Figure 3. Percentage of new HIV diagnoses acquired through sex between men out of all reported HIV diagnoses with known mode of HIV transmission, by country, EU/EEA, 2013 (n=23 416)¹



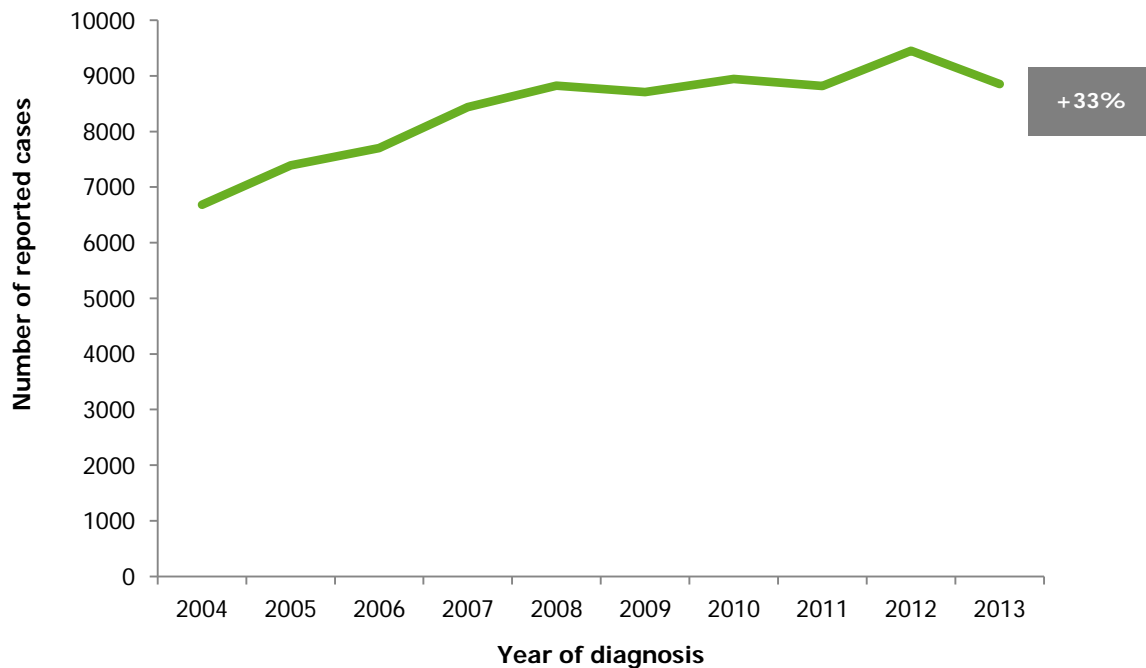
Source: ECDC/WHO⁶

Between 2004 and 2013, the number of new HIV cases in MSM in the EU/EEA increased by 33%

MSM are the only key population in the EU/EEA that has not seen a decline in new infections during the past decade. Surveillance data for 2004–2013 from 26 EU/EEA countries that consistently reported on mode of transmission during this period⁷, show an overall increase in the number of newly diagnosed HIV cases reported in MSM, from 6 682 cases in 2004 to 8 864 in 2013 (Figure 4). There were increases in all but four countries; in some countries, the increase was substantial. In Bulgaria, Croatia, Cyprus, the Czech Republic, Hungary, Ireland, Latvia, Lithuania, Malta, Romania and Slovakia, the number of new cases in MSM increased by more than 100% between 2004 and 2013. EU/EEA countries reporting the highest number of cases in 2013 were: the United Kingdom (2 943); Germany (1 735); Spain (1 678); Italy (1 420); and France (1 068). While these countries account for 62% of the EU/EEA population, they accounted for 72% of newly diagnosed HIV cases in MSM reported in 2013.

⁷ Excludes Estonia, Italy, Poland and Spain. Data for Estonia and Poland are incomplete; Italy and Spain expanded surveillance system coverage during this period.

Figure 4. Number of new HIV diagnoses among MSM by year of diagnosis, EU/EEA, 2004–2013^{8;9}

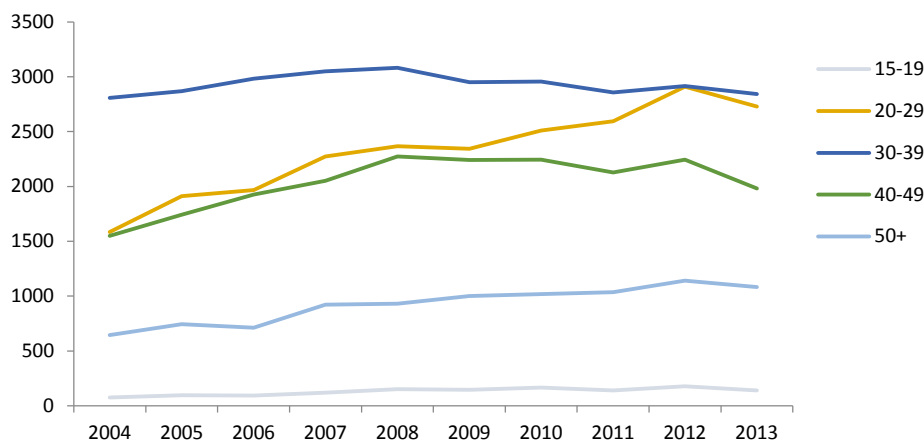


Source: ECDC/WHO⁸

New diagnoses in younger MSM in the EU/EEA have increased substantially

Between 2004 and 2013, new HIV cases reported among MSM aged 20–29 years almost doubled. In those aged 15–19 years, new cases increased by 83%. In MSM aged 30–39 years, the number of new diagnoses has been relatively stable while in men over 40 years of age the number of new diagnoses increased over the same time period (Figure 5).

Figure 5. Number of new HIV diagnoses among MSM by year and age group, EU/EEA, 2004–2013^{10;11}



⁸ European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2013. Stockholm: ECDC; 2014.

⁹ Doses not include Estonia, Italy, Poland and Spain.

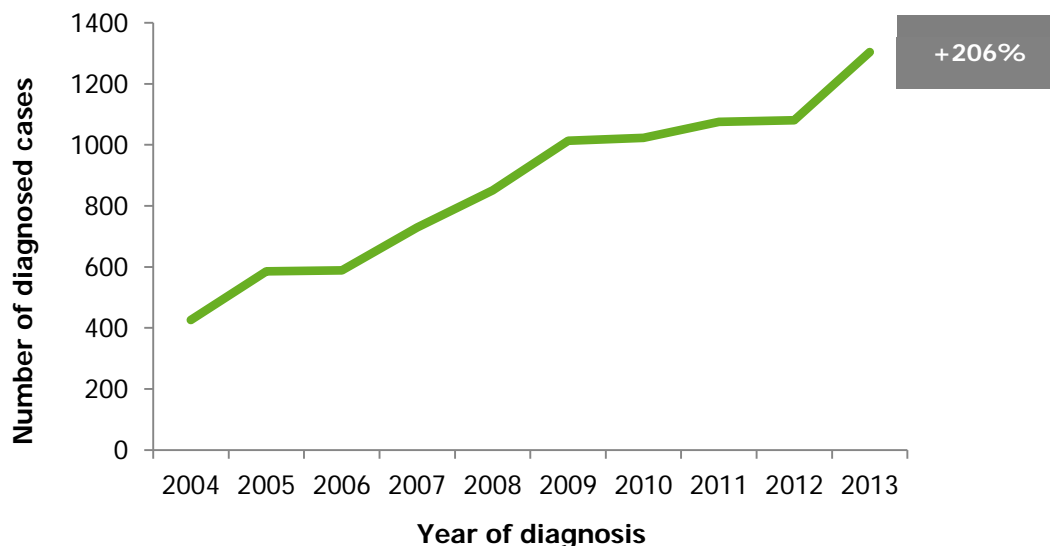
¹⁰ Pharris A, Spiteri G, Noori T, Amato-Gauci AJ. Ten years after Dublin: principal trends in HIV surveillance in the EU/EEA, 2004 to 2013. Euro Surveill. 2014 Nov 27;19(47):20968.

¹¹ Excludes data from countries with changed coverage over the period (Italy, Spain) and incomplete data on transmission mode (Estonia, Poland).

Although MSM only account for a low proportion of HIV cases in non-EU/EEA countries, the number of new cases reported in MSM increased threefold between 2004 and 2013

In non-EU/EEA countries, surveillance data for the period 2004–2013 show an overall upward trend in the annual number of newly diagnosed HIV cases (Figure 6).

Figure 6. Number of new HIV diagnoses among MSM, non-EU/EEA countries, 2004–2013¹²



Source: ECDC/WHO¹³

More than one third of HIV cases in MSM are being diagnosed late

Although the rate of late diagnosis among MSM is lower than in some of the other HIV risk populations – e.g. heterosexuals from countries with generalised HIV epidemics or people who inject drugs (PWID) – the number of MSM diagnosed with HIV infection remains very high. In some countries, for example Finland, Latvia, Italy, Portugal and Slovenia, the proportion of late diagnoses among MSM is higher than in others. In addition, sex between men as the mode of transmission is likely to be underreported in a number of countries where many MSM do not disclose their sexuality to health professionals.

There is evidence of overlapping risk between MSM and other key populations

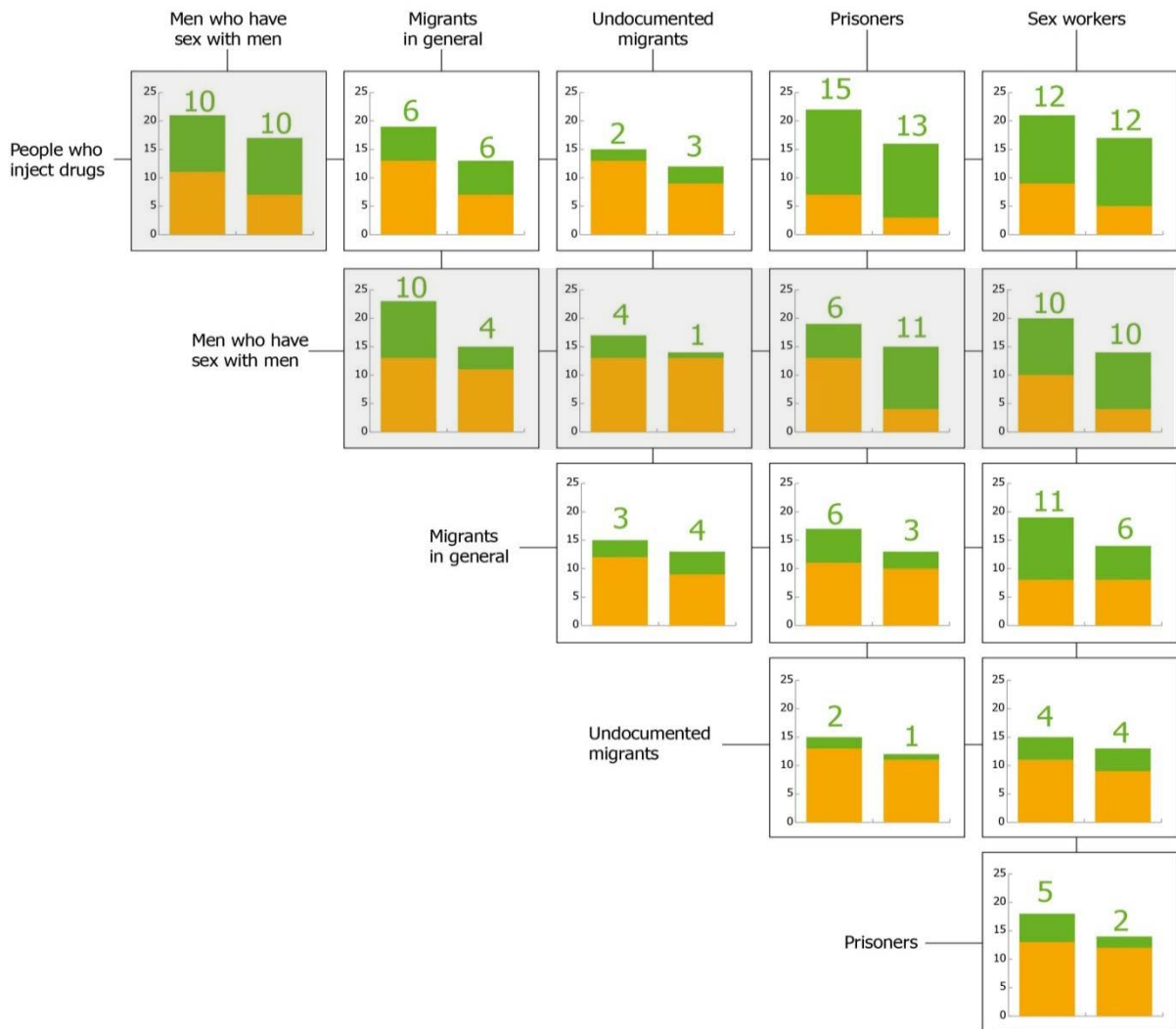
Governments in more than half of the countries in the region stated that there was evidence of overlapping risk between MSM and injecting drug users, sex workers, migrants or prisoners. Overall, responses were consistent with the epidemiological data. EU/EEA countries were more likely to report that there was overlap between MSM and PWID¹⁴, sex workers and migrants in general. Non-EU/EEA countries were more likely to report that there was overlap with PWID, prisoners and sex workers.

¹² Does not include Russia, Turkmenistan and Uzbekistan.

¹³ European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2013. Stockholm: ECDC; 2014.

¹⁴ Some caution is required in interpreting responses concerning drug use; a number of countries pointed out overlap with drug use but referred to recreational drug use, which does not always involve injection.

Figure 7. Number of countries reporting evidence of overlapping risk between MSM and other key populations

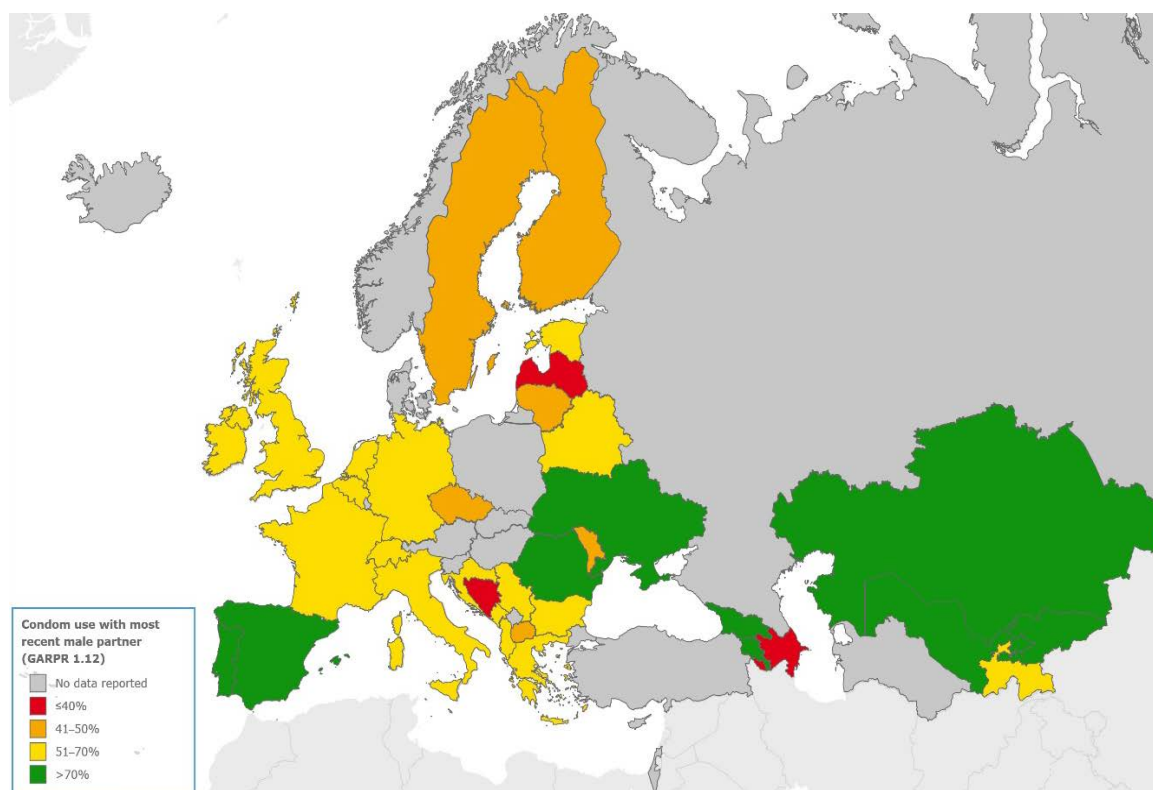


Legend:
 Y axis: Number of reporting countries
 Left bar: EU countries
 Right bar: Non-EU countries
 Green: Number of countries reporting evidence of overlapping risk
 Orange: Number of countries reporting no evidence of overlapping risk
 Note: Data on MSM shown with grey overlay

In most countries, more than half of MSM report using condoms with their last male partner, but a sizeable minority still engage in unprotected anal sex

Data on the percentage of MSM reporting the use of a condom during most recent anal intercourse with a male partner is available from 20 EU/EEA countries and 16 non-EU/EEA countries (Figure 8)¹⁵. In the 20 EU/EEA countries that shared data¹⁶, the reported percentage of condom use ranged from 40% in Latvia to 78% in Romania. In the remaining 18 countries, reported condom use was above 70% in two countries (Portugal and Spain), between 50% and 75% in 11 countries (Belgium, Bulgaria, Croatia, Estonia, France, Germany, Ireland, Italy, Luxembourg, Netherlands and the UK), and below 50% in four countries (the Czech Republic, Finland, Lithuania and Sweden). Condom use in the sixteen non-EU/EEA countries¹⁷ ranged from 20% in Bosnia and Herzegovina to 88.4% in Kazakhstan. All but three countries (Azerbaijan, the former Yugoslav Republic of Macedonia and Moldova) reported condom use of between 50% and 80%. Overall, there are no significant differences in reported percentages of condom use between MSM 25 years and younger and MSM over 25 years of age. However, significant age-based differences can be found at the country level.

Figure 8. Reported percentage of condom use among MSM, 2011–2013



Information from behavioural research provided by several countries also shows that most MSM, most of the time, use condoms with partners of unknown or different HIV status. However, a proportion of them have unprotected anal intercourse with partners of unknown or different HIV status. Some countries report lower levels of risk awareness and condom use as well as gaps in prevention knowledge and skills. Examples include MSM with low knowledge of HIV transmission in Hungary and Montenegro, or MSM who used condoms incorrectly in Latvia.

¹⁵ The GARPR indicator (1.12) has several limitations. GARPR asks about condom use for anal intercourse with the most recent male partner but does not provide data about consistent condom use, or condom use with different types of partners; also, HIV status is not taken into account.

¹⁶ No data were reported by Austria, Cyprus, Denmark, Hungary, Iceland, Malta, Norway, Poland, Slovenia and Slovakia.

¹⁷ No data were reported by Andorra, Israel, Kosovo, Monaco, Russia, San Marino, Turkey and Turkmenistan.

Box 2. Other data on condom use

The EU-funded SIALON II project collected data on condom use among a total of 4 966 MSM in 2013 and 2014 in 11 European cities. Findings showed that rates of condom use ranged from 45.2% in Bratislava to 69.1% in Lisbon. Reported rates of condom use were below 50% in only one other city (Ljubljana) and were between 50% and 69% in the other ten cities (Barcelona, Brighton, Brussels, Bucharest, Hamburg, Sofia, Stockholm, Verona, Vilnius and Warsaw). The study also found that reported condom use with steady partners was much lower than with non-steady partners; in general, rates of condom use with non-steady partners were high.

Source: SIALON II Project: GARPR indicators in Barcelona, Bratislava, Brighton, Brussels, Bucharest, Hamburg, Lisbon, Ljubljana, Sofia, Stockholm, Verona, Vilnius and Warsaw among MSM. Draft report: www.sialon.eu

Most countries have some data on risk factors, risk behaviour and risk reduction for MSM in general, but few have these data for MSM subgroups who are most at risk

Two thirds of countries collected data on risk factors for HIV transmission among MSM. Data provided suggest that risk factors include higher number of sexual partners, use of alcohol and recreational drugs, low socio-economic or educational status, poor mental health, previous or concurrent sexually transmitted infection (STI), self-stigma and early sexual debut. Many of these factors may reflect wider societal stigma and discrimination towards MSM.

Box 3. Evidence about risk factors

According to the 2009 Prevagay survey, HIV prevalence in France was higher among MSM who were older and had no university degree. Prevalence was also higher in MSM who had had more than ten sexual partners, at least one occasion of unprotected anal intercourse with a casual partner, or at least one STI during the last 12 months.

The 2010 European MSM Internet Survey (EMIS) indicated that socio-economic factors play an important role in Sweden. In Sweden, "MSM who have unprotected anal sex are to a higher extent without employment, have more often than others used drugs or alcohol in connection with sex, have had an earlier sexual debut, have had an STI, have had more sexual partners, or have been paid for sex".

Source: Smittskyddsinstitutet. EMIS 2010 Sverige. Svenska resultat från den europeiska internetundersökningen EMIS 2010 – en studie om män som har sex med män. Solna: SMI; 2013, p. 16. Available from: <https://www.folkhalsomyndigheten.se/pagefiles/12854/emis%E2%80%9393the-european-msm-internet-survey-2010.pdf>

A quarter of Scottish gay men who are newly diagnosed with HIV or a rectal STI report two or more vulnerabilities such as problematic alcohol use, low self-esteem, mental health problems, social deprivation, or experience of violence and childhood sexual abuse.

The United Kingdom highlights multiple health inequalities experienced by MSM including greater use of alcohol, drugs and tobacco; higher rates of depression, anxiety and suicidal thoughts; and poorer sexual health than the general population. These are shaped by the wider socio-economic and cultural context in which MSM live and include experience or fear of stigma and discrimination in all areas of life.

Source: Public Health England. Promoting the health and wellbeing of gay, bisexual and other men who have sex with men. [Internet]. [cited 2 Jun 2015] PHE: London; 2014. Available from: <https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-gay-bisexual-and-other-men-who-have-sex-with-men>

While most countries have available data on risk behaviour among MSM, less than one third of government and civil society respondents in both EU/EEA and non-EU/EEA countries state that data are available on risk behaviour for subgroups of MSM. Similarly, respondents report data availability on risk reduction behaviour for MSM in general, but not for subgroups of MSM. Most countries only collect data on condom use. Few investigate other risk reduction strategies such as serological or viral load sorting. Where data are available, for example in Germany, rates of these risk reduction behaviours are reported to be high.

MSM face moderate or significant stigma and discrimination in more than half of the countries in Europe

According to responses from government respondents, MSM experience moderate or significant general stigma and discrimination in 26 of 43 reporting countries; in 23 of 43 countries, MSM experience moderate or significant HIV-related stigma and discrimination. Non-EU/EEA countries and civil society respondents were more likely than EU/EEA countries and government respondents to report significant levels of stigma and discrimination.

Government respondents reported significant general stigma and discrimination in one EU/EEA country (Latvia) and seven non-EU/EEA countries (Albania, Bosnia and Herzegovina, Kyrgyzstan, Moldova, Montenegro, Serbia, and Tajikistan). Civil society respondents reported significant general stigma and discrimination in almost one third of countries that reported (10 of 34). No EU/EEA government reported significant HIV-related stigma and discrimination, but six non-EU/EEA countries reported that HIV-related stigma and discrimination was significant (Albania, Bosnia and Herzegovina, Kosovo, Kyrgyzstan, Moldova, and Montenegro). Civil society respondents in nearly two thirds of countries (20 of 34) reported significant HIV-related stigma and discrimination towards MSM. Stigma and discrimination were cited as factors that increase HIV risk, limit provision and uptake of HIV services, and have a negative impact on the quality of services for MSM. Stigma and discrimination were cited as factors that increase HIV risk, limit provision and uptake of HIV services, and have a negative impact on the quality of services for MSM.

EU/EEA countries are more likely than non-EU/EEA countries to report having a supportive environment for non-discrimination linked to sexual identity

Twenty-five EU/EEA and 10 non-EU/EEA countries report there is a favourable environment for non-discrimination with regard to sexual identity. Only one EU/EEA country said that laws and policies do not exist in this area; five non-EU/EEA countries reported the same.

MSM: the response

Most governments report that HIV testing is delivered at scale¹⁸ for MSM, although civil society reports a less positive view

Government respondents almost universally reported the existence and implementation of effective HIV testing policies for MSM. Government and civil society responses diverge as to the extent to which HIV testing is delivered at scale. As Table 1 shows, government respondents in the majority of countries were more likely to report that HIV testing programmes for MSM are delivered at scale, but fewer civil society respondents agree, particularly in the EU/EEA.

Table. Positive responses to ‘Are HIV testing programmes delivered at scale?’, EU/EEA and non-EU/EEA countries, 2014

Countries	Government	Civil society
EU/EEA	27/30	12/22
Non-EU/EEA	17/18	8/12
Total	44/48	20/34

Legend: positive answers/total number of reporting countries

Although most countries report that data on uptake of HIV testing among MSM in general are available, few have data on uptake for MSM subgroups. Consequently, it is difficult to know if testing programmes are reaching those MSM who may be at higher risk of HIV.

Box 4. Other data on HIV testing

The EU-funded SIALON II project collected data on HIV testing in 11 European cities among a total of 4 966 MSM in 2013 and 2014. Findings were broadly consistent with country GARPR reporting. Data showed that HIV testing rates ranged from 37% in Bratislava to 74% in Sofia. Testing rates were below 50% in six cities (Bratislava, Brighton, Bucharest, Ljubljana, Verona and Vilnius), and above 50% in seven cities (Barcelona, Brussels, Hamburg, Lisbon, Sofia, Stockholm and Warsaw).

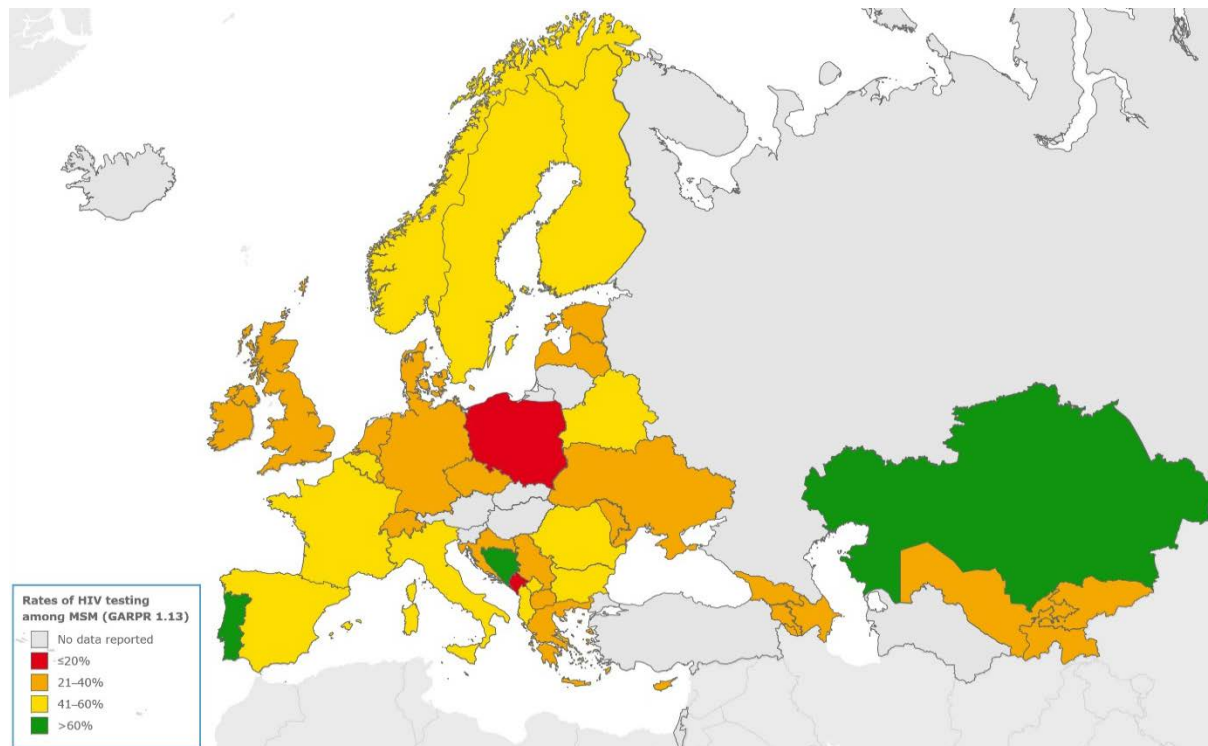
Source: SIALON II Project: GARPR indicators in Barcelona, Bratislava, Brighton, Brussels, Bucharest, Hamburg, Lisbon, Ljubljana, Sofia, Stockholm, Verona, Vilnius and Warsaw among MSM. [Unpublished draft report] Berlin; 2015. To be made available at: www.sialon.eu

¹⁸ 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’.

Although countries report that HIV testing programmes are delivered at scale, HIV testing rates among MSM remain low

Reported data¹⁹ on HIV testing among MSM are available from 22 EU/EEA²⁰ and 17 non-EU/EEA²¹ countries (Figure 9).²² In the EU/EEA, testing rates range from 15.4% in Malta to 72.8% in Portugal. Of the other 20 countries, only five reported HIV testing rates above 50% (Norway, Romania, France, Bulgaria and Italy); testing rates in the other 15 countries were below 50%. In the 17 non-EU/EEA countries, reported testing rates range from 15.5% in Montenegro to 96.5% in Bosnia and Herzegovina. Of the other 15 countries, only one reported an HIV testing rate above 50% (Kazakhstan 74.5%); testing rates in the remaining 14 countries were below 50%. In non-EU/EEA countries, reported testing rates for MSM under the age of 25 are slightly lower overall than for MSM over the age of 25.

Figure 9. Reported HIV testing levels among MSM in EU/EEA and non-EU/EEA countries, 2011–2013²³



Uptake of HIV testing is influenced by multiple factors including accessibility, cost, and confidentiality

Most countries reported high levels of knowledge among MSM about where to obtain an HIV test. This suggests that other factors negatively influence the uptake of HIV testing. Respondents noted that the characteristics of services, for example location, opening hours, relationship with staff, and type of test offered, have a significant effect on uptake. Many respondents mentioned free, anonymous testing at NGO-run facilities or community-based and outreach interventions that offer rapid testing as the most accessible options for MSM. However, few countries provided data on how specific services influence testing uptake. Ireland reported that there was evidence of increased uptake of community-based testing, particularly by younger MSM and MSM from outside Dublin. In Georgia, increased testing uptake among MSM was attributed to the introduction of rapid testing to an outreach programme.

¹⁹ Data reported through the Dublin Declaration and Global AIDS Response Progress Reporting in 2014 or 2012.

²⁰ No data reported by Austria, Cyprus, Denmark, Hungary, Iceland, Poland, Slovakia and Slovenia

²¹ No data reported by Andorra, Israel, Monaco, Russia, San Marino, Turkey and Turkmenistan

²² It is important to note that the GARPR indicator has several limitations: it asks about testing within the last 12 months rather than whether MSM have ever been tested; as some MSM already know that they are HIV positive, it is highly unlikely that will get tested again.

²³ Percentage of MSM who received an HIV test in the past 12 months and know their results

Respondents also highlighted the need to address barriers such as cost and lack of confidentiality. In Lithuania, 17% of surveyed MSM said they could afford to pay for an HIV test, 25% could not afford it, and 58% did not know if they could. In Italy and Portugal, 8% and 3% of surveyed MSM, respectively, had concerns about confidentiality.

Most governments report that HIV prevention programmes are delivered at scale for MSM; civil society view differs

Twenty-three of 30 government respondents from EU/EEA countries stated that HIV prevention programmes are delivered at scale for MSM; only nine of 27 of civil society respondents agreed. In non-EU/EEA countries, 16 of 18 government respondents reported that HIV prevention programmes for MSM are delivered at scale; 7 of 12 of civil society respondents agreed. However, very few countries have coverage data. Exceptions include Serbia, where 51% of sampled MSM were reported to have been reached by preventive services in 2013, and Belarus, where more than 90% of MSM reported having good access to HIV information, testing and counselling, and STI services. More than 75% of the surveyed MSM reported that they could also obtain free condoms and lubricants.

Few countries have data on the effectiveness of their prevention programmes

Most countries do not measure the impact of their prevention programmes on HIV infection rates among MSM directly, but instead measure variables such as knowledge, campaign recognition, campaign acceptability, and uptake of community-based testing. Serbia, for example, reported that surveys show that MSM reached by prevention programmes have a higher comprehensive knowledge of HIV and are more likely to go for HIV counselling and testing than those who were not reached. Germany reported that provisional data indicate that HIV prevention campaigns are well known and highly accepted and have stabilised risk behaviour.

There are major gaps in HIV testing coverage, prevention programmes, and targeted interventions for most-at-risk MSM

Three quarters of the surveyed countries report that they have programmes to increase HIV testing among MSM, but only 30% of EU/EEA and 15% of non-EU/EEA countries have programmes targeting MSM subgroups, for example those who may be at a higher risk of HIV infection. Respondents from all countries state that the failure to reach MSM subgroups is perceived as a gap in prevention programmes. Countries across the region also reported gaps in programme coverage. Examples included lack of counselling of HIV-negative MSM and of programmes to encourage testing, lack of community-based testing coverage and of test kits. Some countries reported that there are no prevention programmes for MSM, that programme coverage is low or that programmes are not comprehensive. For example, in Georgia, lubricant use is low, as they are not distributed by prevention programmes, and MSM do not buy them at pharmacies to avoid disclosing their sexual orientation. Respondents in four countries pointed out limitations in the availability of free condoms.

Programme gaps reflect funding, capacity, political, and legal issues

Countries across the region reported limited or decreasing funding at the national or local level; some highlighted the lack of long-term funding for programmes that target MSM subgroups. Programme coverage and quality is also reported to be affected by a lack of capacity of healthcare providers and NGOs. Quality issues include long waiting times, delays in receiving test results, ineffective links to care, and inadequate implementation of existing guidelines. Other factors include lack of political will, lack of support from the health system, gaps in health insurance coverage for testing, poor stakeholder coordination, and legal barriers, for example bureaucratic obstacles to registering NGOs which focus on MSM or complications in receiving funds from donors.

In general, HIV treatment is widely available for MSM, but in some countries MSM experience difficulties in accessing treatment

In the EU/EEA, 29 of 30 government respondents reported that HIV treatment programmes are delivered at scale for MSM. Twenty-one of 22 civil society respondents agreed. All 18 non-EU/EEA countries that reported stated that treatment programmes for MSM are delivered at scale. Eleven of 12 civil society respondents agreed. However, a fifth of civil society respondents reported that MSM have difficulty in accessing treatment. Two civil society respondents cited stigma as a barrier, with one reporting that MSM seek treatment abroad for this reason. Another barrier is centralised systems for HIV care, whereby all HIV patients must travel to the capital city to access treatment.

Conclusions

Sex between men is the predominant mode of HIV transmission in the EU/EEA, accounting for more than 40% of newly diagnosed cases reported in 2013. In EU/EEA countries, the number of new cases in MSM increased by 33% between 2004 and 2013, and MSM are the only key population in the EU/EEA where cases of HIV continue to rise steadily. The increase in the number of new cases among younger MSM is of particular concern, as these MSM are likely to have been infected more recently, suggesting that current prevention efforts are not reaching them or have only limited impact, because younger men are not a target group for many prevention interventions.

There is evidence to suggest that specific MSM subgroups may be at greater risk of HIV infection, including those who engage in high-risk sexual behaviours. At-risk subgroups also include MSM who are migrants, drug users or those who sell sex. However, there is a need for more and better data on MSM subgroups that are most at risk.

Rates of HIV testing among MSM remain low. This contributes to high rates of late diagnosis and undiagnosed HIV infection among MSM. There is evidence that a significant proportion of HIV infections in MSM are diagnosed late. Late diagnosis is associated with higher rates of complications and illness and also increases the duration of possible ongoing HIV transmission. Many countries highlighted the need to reach those MSM living with HIV who have not been tested and are therefore unaware that they are HIV positive. In the UK, for example, the incidence of HIV among MSM is still high, even though a high proportion of MSM achieve viral suppression through treatment and care; this suggests that transmission is largely occurring among undiagnosed MSM. In addition, while most countries report that they have data on testing availability and accessibility for MSM in general, most do not have data for MSM subgroups. Overall testing rates, even if based on large samples and consistent methodology, are of limited use if subgroups most at risk of having undetected HIV infection are not among those who get tested regularly.

More efforts are needed to increase the frequency of testing among those MSM who may be at increased risk of HIV as well as to promote earlier testing and to reach the undiagnosed fraction. Reported data suggest that it is essential to tackle stigma and discrimination and improve the availability and accessibility of testing, particularly through community-based approaches.

Reported data also highlight the need to improve the coverage and impact of HIV prevention programmes for MSM. In particular, there is a need for more targeted and effective prevention interventions for MSM subgroups who are most at risk but who are not being reached by, or are not responding to, current interventions. While reported condom use is relatively high, a significant proportion of MSM remains at high risk of HIV infection through unprotected anal intercourse. Better data about risk and risk-reduction behaviours and the factors that influence them are required to inform prevention programmes.

Priority options for action

Address low rates of HIV testing, late diagnosis and the undiagnosed fraction among MSM.

- Expand proven approaches that increase uptake and frequency of testing and promote earlier testing, e.g. through community-based testing services.
- Target MSM who are most at risk and most likely to have undiagnosed infection.
- Develop and implement country-specific testing guidelines for MSM.
- Address barriers to testing, for example stigma and discrimination in healthcare settings.

Strengthen and expand prevention programmes for MSM.

- Develop and implement targeted prevention interventions for MSM subgroups at increased risk of HIV, for example younger MSM.
- Scale up programmes to address gaps in coverage and ensure that MSM have access to comprehensive services (condoms, lubricants, diagnosis and treatment of other STIs).
- Improve and share evidence about innovative and effective approaches to HIV prevention among MSM.
- Ensure there is sustainable funding and capacity to deliver prevention programmes for MSM.

Improve data availability and data quality with regard to HIV and MSM.

- Collect country-specific data on MSM subgroups that are at increased risk of HIV infection.
- Improve data availability/data quality on risk behaviours, risk-reduction strategies and factors that limit uptake of services and preventive measures.
- Improve the availability and quality of epidemiological and behavioural data, for example through joint funding, capacity building, and harmonised data collection tools.

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